Election results and health issues

In general, the Presidential and Congressional election results bode no good, but no evil. Most Congressional leaders in health care were reelected, save one serious loss, and the Presidential election was unlikely to change health care much anyway. In Congress, Senator Lowell Weicker (R-Ct.), a staunch advocate of expanded spending for health care, lost to Democratic Attorney General Lieberman. Otherwise, all Congressional leaders in health care were reelected, generally by substantial margins; e.g., Bentsen in Texas, Mitchell in Maine, Durenburger in Minnesota, Waxman and Stark in California, Madigan in Illinois, Dingell in Michigan, Kennedy and Conte in Massachusetts and Natcher in Kentucky. In addition, as expected, the House and Senate will remain overwhelmingly Democratic, since few members retired, and almost all incumbent members were reelected.

Members of the House and Senate who have been active supporters of CRNAs and our interests all were reelected except Senator Weicker. His loss will be felt seriously in matters related to education and training of nurses and nursing research. He also was actively supportive of CRNAs on a number of controversial issues involving the Department of Health and Human Services. With respect to the Medicare program and the CRNA direct reimbursement program, the leaders who have helped us most in the past are all back and in their same committee positions: Senator Matsunaga, Congressman Madigan, Congressman Waxman, Senator Packwood, Senator Durenburger, Congressman Stark, Senator Daschle, Senator Reigle, Congressman Dingell, Congressman Tauke, Congressman Synar, Senator Mitchell, Senator Bentsen, Senator Dole, Senator Inouye, Congressman Frank, Congressman Vander Jagt, Congressman Pursell and many others.

One major leadership post in Congress is being contested at this writing, that of the Senate majority leader. Senator Robert Byrd (D-WV) has resigned from his majority leader position, and an election among Senate Democrats will take place to replace him. There are three major contenders for the position: Senators Johnston of Louisiana, Mitchell of Maine and Inouye of Hawaii. The latter two have been very involved in nursing and CRNA issues.

In the executive branch, there will be some major changes, since Otis Bowen, MD, secretary of HHS, is likely to leave his position and so is Bill Roper, MD, administrator of HCFA. Roper has been mentioned as a successor to Secretary Bowen, as has Carolyn Davis, former HCFA Administrator and a nurse and educator. Also mentioned as possible Bowen replacements are Congressman Gadison (R) of Cincinnati and Senator Weicker. It is generally believed that Weicker is too liberal for appointment to this position. Sheila Burke, who is also a nurse and Senator Dole's chief of staff, has been mentioned as HCFA Administrator. These and other appointments probably will be made in December and January.

1989 issues: Medicare and the deficit

By all accounts of economists and experts knowledgeable in fiscal affairs, the budget deficit for the next fiscal year will be higher than estimated earlier this year. In order to comply with the requirements of the Gramm-Rudman-Hollings' law for fiscal 1990, which sets deficit reduction targets,
perhaps as much as $30 to $50 billion in cuts below 1990 spending levels may be required. Cuts seem necessary because the deficit targets of Gramm-Rudman-Hollings must be met and taxes will not be raised, since President-elect Bush is opposed inalterably to tax increases. Only about half of the necessary cuts are likely to be taken from defense spending, so half will have to come from domestic spending. The major programs involving domestic spending are Social Security and Medicare, which total about $300 billion, but Social Security cuts have not been made for the past five years and are very unlikely to be made during the next year. Once again, this leaves Medicare as the principal target for domestic spending cuts, with Medicaid next. Educational spending is far smaller than Medicare and is an area to which President-elect Bush will add some expenditures. Most other domestic programs already are reduced quite substantially.

In Medicare, hospital payments have taken substantial cuts every year for the past five or so years. In no year have DRG payment rates been at the level required by the original DRG law. Evidence also is accumulating that hospital revenues are way down for most hospitals. As a result, the main target for Medicare cuts in fiscal years 1990 and 1991 is likely to be physicians' payments. This focus on spending reductions comes at a time when a major study has just been released which recommends a total restructuring of the Medicare physician payment system. That study is the HCFA-financed Harvard Resource Based Relative Value Scales (RBRVS). The AMA served as a contractor to Harvard on this study, which was reported on September 28. On November 2, a hearing was held on the study by the Physician Payment Review Commission, an agency created by Congress to review and report to Congress and the President on physician payment issues.

RBRVS and its implications for CRNAs

The RBRVS is a proposal for a common method of valuing all physician services. It is a program by which Medicare would be able to establish a national fee schedule for physician services. The intention of the proposal is not to generate cuts in physician payments, but to revalue them based upon an assessment of the work involved in a service, the practice costs related to the specialty involved and an estimated value of the time spent in training for that specialty. Work or effort in delivering a service is defined in terms of time spent, mental effort, judgment, physical skill and stress related to the responsibility for the case. In all, 16 specialties were studied utilizing panels of experts from each, and a major survey of physicians was used as well. Panels of physicians were used to establish cross-specialty relationships. The 16 specialties studied included those with the highest volumes of Medicare claims, among them anesthesia, radiology, pathology, general surgery, ophthalmology, orthopedic surgery, thoracic and cardiovascular surgery, dermatology, urology, internal medicine and family medicine.

After assessing the relative value of the services reviewed, the values were compared to current Medicare charges. Some services were found to be overpriced and others underpriced relative to current charges. Anesthesia was not assessed finally, and additional research was found to be necessary, mainly because it was difficult to relate the anesthesia findings to current charges, since the anesthesia payment system uses a reactive value system rather than a simple charge system like other services to which it was being compared. On one estimate of general impact, however, anesthesia is shown as being overpriced, but not by an enormous margin. Thoracic and cardiovascular surgery, ophthalmology, radiology and pathology were found to be the most overpriced services, and internal medicine and family medicine were found to be the most underpriced.

For these relative value scales to be put into effect as a Medicare fee schedule, Congress will have to pass legislation requiring that the RBRVS replace the current customary and prevailing charge system. It is likely that the system will not be effective until 1991, even if enacted. Congress required that the study be done and in general is viewed as liking the RBRVS concept. However, the critical concerns for Congress this next year and in 1990 will be deficit reduction and probably spending cuts. If it passes an RBRVS fee schedule, Congress will do so only as part of a package of changes requiring that total physician payments be cut.

In looking at areas of physician payments to be cut, anesthesia is likely to be a primary target, based on actions by Congress in 1987. While the RBRVS study may not call for major anesthesiology cuts, the recent research reported by Cromwell and Rosenbach in the fall volume of Health Affairs looks at the high incomes and fees generated from the medical direction of multiple procedures by anesthesiologists serving Medicare patients. Cuts in physician anesthesia payments after January 1, 1989, will have less direct impact on CRNAs than those same cuts would have had in prior years, because after January 1, 1989, payment for CRNA services will be independent of physician payments and will be made according to the new CRNA fee schedule.