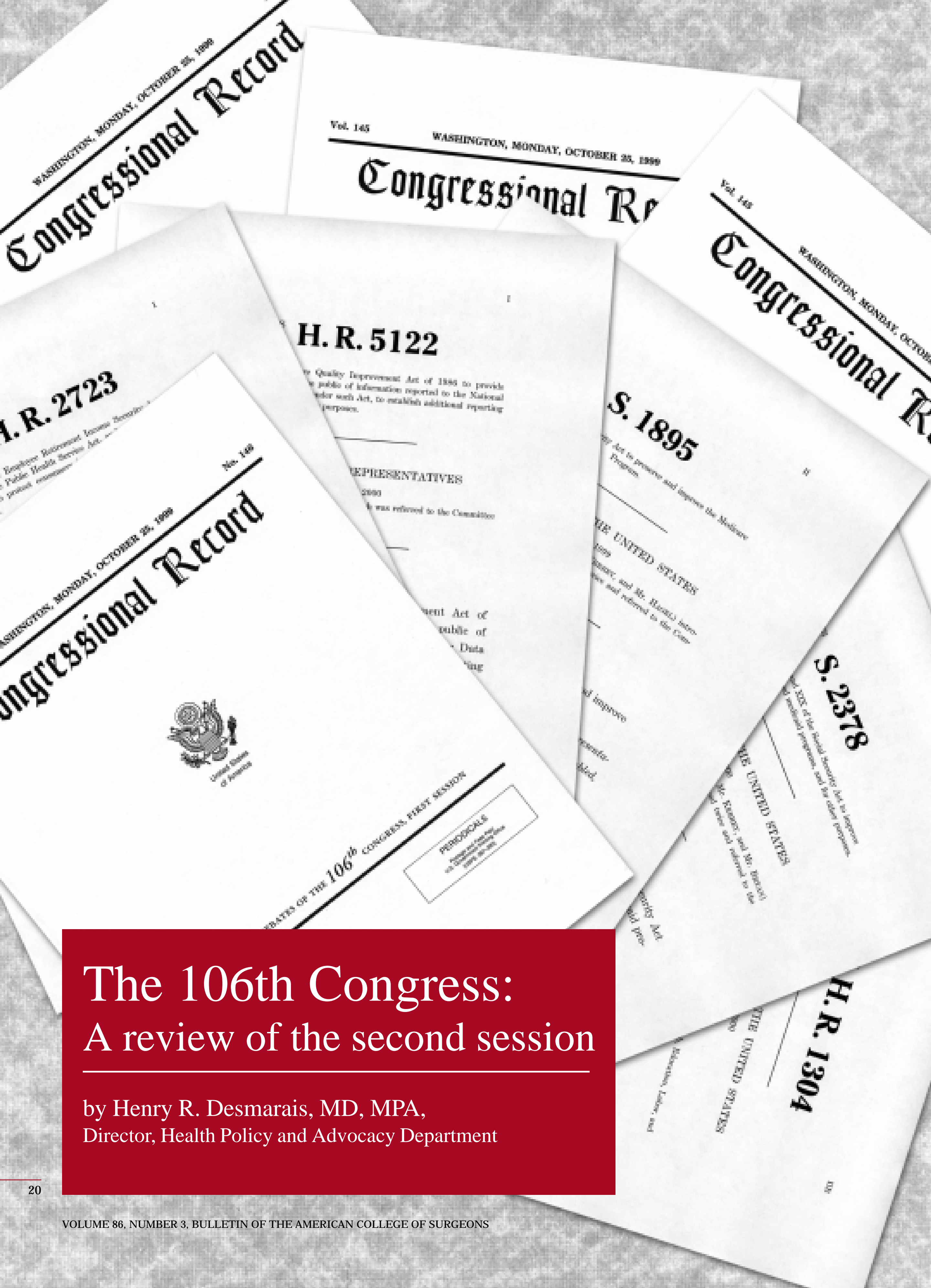

The 106th Congress:
A review of the second session

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The 106th Congress finally came to an end on December 15, 2000. The Senate adjourned at 8:03 pm, and the House followed suit at 8:41 pm. It was not necessarily a model Congress. While it did produce legislation of significance for surgeons and their patients, unfortunately it also failed to approve or even consider several other important matters.

Early last year, I provided a report about the first session of the 106th Congress.[1] A little later, I reviewed the key issues confronting the Congress during its second session, focusing especially on patient safety, patient protection, patient confidentiality, Medicare reform, and collective bargaining by physicians.[2] This article completes the story by providing a report about the outcome of this second session of the 106th Congress.

Patient safety

As the year began, there was some trepidation that concerns about medical errors, prompted by the considerable publicity accorded a major report by the Institute of Medicine, would prompt Congress to "do something," whether it made sense or not. In particular, it certainly seemed possible that Congress would create a nationwide mandatory reporting system for the collection of standardized information about adverse events that result in death or serious harm to patients, as recommended by the Institute of Medicine report.[3] In fact, a bill introduced by Senators Charles Grassley (R-IA) and Joseph Lieberman (D-CT), S. 2378, the Stop All Frequent Errors in Medicare and Medicaid Act of 2000, essentially called for just such a mandatory system.

In the end, however, Congress approved only modest steps, providing an additional $50 million to the Agency for Healthcare Research and Quality (AHRQ) for patient safety research and related activities. It deferred action on other more difficult issues. This outcome is probably not all bad. The College was among the first organizations to caution against precipitate action. On February 22, 2000, Thomas R. Russell, MD, FACS, the College's Executive Director, appeared before a joint session of the Senate Health, Education, Labor and Pensions (HELP) Committee and the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies. In his testimony, Dr. Russell asserted that the Congress should not create a mandatory reporting system. Instead, he urged the Congress to adopt legislation that would extend peer review protections (that is, confidentiality protection and protection from discovery) to all data and work products related to patient safety and quality improvements. Dr. Russell noted that, in the College's view, this was the step that would be likely to bear immediate dividends with respect to patient safety, as it would, among other things, encourage the development and successful operation of voluntary reporting systems.

Later in the year, key members of the HELP Committee introduced two separate bills addressing patient safety concerns. Senators Jim Jeffords (R-VT) and Bill Frist, MD, FACS (R-TN), sponsored the Patient Safety and Errors Reduction Act, S. 2378, while Senators Edward Kennedy (D-MA) and Christopher Dodd (D-CT) authored the Error Reduction and Improvement in Patient Safety Act, S. 2743. While the two bills differed in important ways, it was rather significant that both called for voluntary, rather than mandatory, medical error reporting systems. Both bills also would have established a Center for Patient Safety within AHRQ and provided strong federal peer review protections for medical error-related information. These protections closely mirrored a set of general principles developed during the spring and summer by a broad-based coalition of health care organizations, including the College. Additionally, the Kennedy-Dodd legislation would also have required the new Center for Patient Safety to establish "best practices" based on information gathered through the reporting system, and authorized the Secretary of Health and Human Services (HHS) to determine which of them to apply to federal health care programs, such as Medicare.

Although the 106th Congress did not adopt a comprehensive program to address patient safety, it seems likely that the issue will be back on the agenda in 2001. During a September 18, 2000, meeting with the College's Patient Safety and Professional Liability Committee, congressional staff representing both Senators Jeffords and Kennedy made clear they were already beginning to plan for this possibility.

Patient bill of rights

Throughout the year 2000, the College continued to push for enactment of strong patient protection legislation (that is, managed care reform

or patient bill of rights legislation). We did this through the many ACS Chapters that sent representatives to Washington as part of the Capitol Hill Visit Program (19 of them in 2000 alone), and through the members of the College's Congressional Action Program, a growing cadre of Fellows committed to serving as the College's grassroots army.

Our preferred approach for providing patient protections was a House-passed bill, the Bipartisan Consensus Managed Care Improvement Act, H.R. 2723, authored by Representatives Charlie Norwood (R-GA), John Dingell (D-MI), and Greg Ganske, MD, FACS (R-IA). Our support for this bill surprised some Fellows, largely because the proposal was supported by far more Democrats than Republicans. However, this bill was much stronger than the bill passed by the Senate in 1999, and its protections would have applied to many more patients.

Among other provisions, H.R. 2723 would have prohibited so-called gag rules and required health plans to use a "prudent layperson" standard when determining coverage for emergency care services. It also would have mandated that health plans ensure access to needed specialty care and permit independent external review of coverage and treatment decisions. Its most controversial provision would have held health plans liable for their medical decisions, rather than allowing them to be shielded by the current broad interpretation of the Employee Retirement Income Security Act (ERISA). Of course, those supporting this provision were not doing so out of a love affair with malpractice suits. Instead, proponents believed that the litigation option would cause most health plans to "clean up their act" in order to avoid litigation. At the same time, health plans and physicians would find themselves on a more level playing field with respect to liability. In fact, earlier in 2000, at a key point during congressional deliberations, the College felt compelled to send a letter urging Congress not to enact a managed care reform bill that would provide for different levels of liability for health plans and physicians (for example, by limiting noneconomic damages for health plans to some maximum dollar amount, without doing the same for physicians).

In any case, what the Congress needed to do during its second session, at least in theory, was to reconcile differences between the two bills passed by the House and Senate in 1999. The legislative wheels grind slowly, however, and the outcome was uncertain until very late in the session. The usual House-Senate conference process for resolving differences failed, probably because there was insufficient interest in making it work. In fact, at many points during the year, pontificators and pundits of varying political stripes would argue that few in Congress really wanted a resolution. Some said that the Democratic Party just wanted a campaign issue. Others alleged that many Republicans were primarily interested in protecting the interests of their campaign contributors (that is, the insurance companies, giant managed care organizations, and big business). In the midst of all of these pronouncements, it was difficult to determine the truth. Certainly, much time, effort and money was spent by both proponents and opponents of patient protection/bill of rights legislation. And, at a critical point in the debate, the President announced that he would simply promulgate regulations providing some of the patient protections being discussed—and that he would do so before the November elections! It was an obvious political slap at a gridlocked Congress.

Given all of this pressure, the Congress made one more valiant effort. A wide variety of deals were negotiated and renegotiated. However, in the end, negotiators were unable—or perhaps simply unwilling—to reach a compromise. This issue will almost certainly be taken up by the 107th Congress, perhaps even before this article is published in the *Bulletin*.

Medicare payment policies

Congress failed to act on another matter of importance to surgeons and their patients—providing relief on Medicare practice expense relative value units (RVUs). New, lower practice expense RVUs are being phased in for many surgical services by Medicare and other third-party payors. While Congress had directed the Health Care Financing Administration (HCFA) to refine these new values prior to their full implementation, the agency has made relatively little progress in this effort.

The College joined a coalition of about 30 medical and surgical specialty societies to promote a legislative remedy for this problem. This proposal

would have halted the transition to new practice expense RVUs at the midway point—a 50/50 blend of "old" and "new" practice expense RVUs for most services. Exempted from this would have been 19 office-based evaluation and management services, including new and established office visits, office consultations, and eye visit services, whose practice expense values would have been allowed to rise. The resulting net increase in Medicare payments would have been covered from the budget surplus, rather than through another redistribution of Medicare payments from other services.

There was some hope that this proposal would be acceptable because it did not harm the primary care physicians (in fact, many would have benefitted from the 50/50 blend of "old" and "new" values for services other than the 19 exempted, while still receiving anticipated RVU increases for evaluation and management services) and because Congress was already contemplating using the federal budget surplus to restore previous Medicare cuts. Hopes soared further when the College and its coalition partners successfully convinced the American Medical Association's (AMA's) House of Delegates to approve a resolution placing the AMA squarely in support of the proposal rather than remaining a neutral bystander.

As time passed, however, it became clear that this effort would be much more difficult. Several primary care specialties opposed the proposal. Moreover, policymakers eventually decided to devote a large proportion of the budget surplus to paying down the national debt, leaving far less to spend on other things. The College and its coalition partners responded by developing a less costly, alternative proposal, one that would provide for a three-year halt in the practice expense RVU transition, rather than a permanent one, with the assumption being that this would give HCFA more time to make necessary refinements in the new practice expense RVUs. It would also, of course, give interested parties more time to lobby policymakers for more permanent relief of one kind or another. Even this more modest proposal found no congressional takers.

Instead, Congress passed legislation requiring yet another study of Medicare's RVU methodology. The College and its specialty society allies attempted to convince Congress that this study would only make sense if it were accompanied by at least a temporary freeze on current practice expense RVUs. However, in the end, Congress would have none of this. Thus, the new practice expense RVUs continue to be phased in, which means that Medicare is using a 25/75 blend of the "old" and "new" values for 2001.

Fortunately, another College initiative did have a positive impact on most surgical specialties. This involved the refinement of practice expense RVUs for several evaluation and management services, including office visits. These RVU refinements (that is, reductions) had the effect of freeing up RVUs for allocation to other services, including surgical procedures. Another College initiative aimed at improving work RVUs for many surgical services is ongoing and appears promising. Any new values would be implemented beginning January 1, 2002.

Although Congress did not provide relief on Medicare practice expense RVUs, it did approve Medicare payment provisions benefitting hospitals (including teaching facilities), nursing homes, home health agencies, and Medicare+ Choice plans. For example, teaching hospitals will benefit from provisions that will: maintain the indirect medical education adjustment factor at the current 6.5 percent for two more years, increase the proportion of hospital bad debt that can be reimbursed by Medicare from 55 to 70 percent, and provide the full market basket increase for 2001 hospital inpatient services.

Trauma-related issues

The College persuaded Congress to earmark $3 million in fiscal year 2001 to fund the Trauma Care Systems Planning and Development Act. This program authorizes the Secretary of Health and Human Services to award grants to states to assist them in planning, implementing, and developing comprehensive trauma care systems, taking into account the College's guidelines for optimal care of injured patients. Our success was not easy, especially given all the competition for federal funds, and the fact that the relevant appropriations bill had plenty of unrelated political problems. College staff, most especially Christopher Gallagher, the Senior Government Affairs Associate in the Washington Office, worked relentlessly to coordinate the efforts of other interested groups, enlist the help of the College's Committee on

Trauma, and educate innumerable congressional staff members. Eventually, the College was able to garner public support for this initiative from more than 100 members of Congress and over half of all U.S. senators.

In a related area, the College also lent its support to another successful legislative effort: adoption of a federal definition of drunken driving based on a blood alcohol level of 0.08 percent, with states given time to come into compliance (before facing the loss of federal highway funding if they do not). In this fight, traffic safety groups faced very powerful opponents, including alcohol and restaurant lobbyists and even the National Governors' Association.

Finally, the College supported the efforts of the American College of Emergency Physicians in securing a government study of the problems facing many physicians due to their expanding obligations under the Emergency Medical Treatment and Labor Act (EMTALA). As a result, Congress mandated that its investigative arm, the General Accounting Office (GAO), study the effect of EMTALA on hospitals, emergency physicians, and physicians covering emergency department call throughout the U.S. Among other issues, GAO will be expected to look at the level of uncompensated care costs that are being borne by hospitals and physicians as a result of the EMTALA statute and implementing regulations.

"Cats and dogs"

In congressional parlance, the term "cats and dogs" refers to those miscellaneous provisions in a larger bill that cover a wide range of matters. While the term is sometimes viewed as implying that the provisions in question are relatively unimportant, this often is not the case, at least from the perspective of those demanding congressional action on some issue. For purposes of this summary of the second session of the 106th Congress, I thought the term "cats and dogs" would serve as a catchy way to introduce a discussion of a wide variety of congressional actions, not to mention congressional inaction on other matters.

In the good news department was congressional inaction on a proposal to allow public access to the National Practitioner Data Bank (NPDB), the federal repository of malpractice data and information about disciplinary actions taken by hospitals and others against physicians and other health care practitioners. Retiring Rep. Tom Bliley (R-VA) authored the bill in question, H.R. 5122, the Patient Protection Act of 2000. Some saw Representative Bliley's proposal as a vengeful response to the physician community's—especially the AMA's—support for a comprehensive Patient Bill of Rights. On September 20, 2000, Representative Bliley, the outgoing chair of the House Commerce Committee, convened a public hearing to consider his bill. However, he found little enthusiasm for the proposal, even among his own Commerce Committee colleagues, with Rep. Greg Ganske, MD, FACS (R-IA), being especially vocal in his opposition. Among other things, opponents questioned the quality and value of the data that would be shared with the public. In the end, Congress failed to act on the Bliley bill, leaving access to the NPDB as it was—limited to health plans, hospitals, and a few other selected entities.

The second session of the 106th Congress also saw President Clinton sign the Breast Cancer Research Stamp Reauthorization Act, authored by Sen. Dianne Feinstein (D-CA) and Rep. Charlie Bass (R-NH). The College strongly supported the legislation, which continues the practice of allowing a surcharge of up to 25 percent above the value of a first-class stamp, with the surplus revenues going to breast cancer research. The original idea of selling a stamp to raise money for breast cancer research was conceived by Ernie Bodai, MD, FACS, a general surgeon currently practicing in Sacramento, CA. First passed into law by Congress in August 1997, the program has raised more than $15 million for breast cancer research, and its 40-cent stamp (first issued in 1998) has become the second highest selling stamp in postal service history. The new legislation provides a two-year extension of the breast cancer research semipostal and also includes a provision preventing the money raised from the sale of the stamps from being deducted from other federal funds that a research institute receives.

On June 30, 2000, the House of Representatives approved a bill that would have permitted independent physicians to negotiate collectively with their health plans. The vote was 276 to 136. The House-passed bill was an amended version of H.R. 1304, the Quality Health Care Coalition Act authored by Representatives Tom Campbell (R-

CA) and John Conyers, Jr. (D-MI). Unfortunately, this was the end of the road for the measure. Strong opposition from Senate Republican leaders and end-of-the-session gridlock prevented further action. Now that Representative Campbell has been defeated in his bid to unseat Sen. Dianne Feinstein, it remains to be seen whether the issue of collective negotiating by self-employed physicians will find another congressional champion. The College was among the physician organizations that supported H.R. 1304 throughout the 106th Congress.

My March 2000 article in the *Bulletin* discussed at some length the contents of a comprehensive Medicare reform proposal, S. 1895, authored by Senators John Breaux (D-LA) and Bill Frist, MD, FACS (R-TN). Among other things, the bill called for a competitive Medicare premium system, involving both private and government-sponsored health plans, modeled after the Federal Employees Health Benefits Program, and appointment of a seven-member Medicare Board to administer the competitive system. I noted then that the Breaux-Frist bill would likely be followed by others, and that the most likely outcome would be deferral of major Medicare reforms until after the November 2000 elections. In fact, the 106th Congress not only deferred action on comprehensive Medicare reforms, it even failed to agree on legislation improving Medicare coverage for prescription drugs, despite strong public support. The Medicare reform issue will be back. The challenge for policymakers will be finding a way to assure the continued solvency of the Medicare program without compromising patient access to high-quality care. Given continued turmoil in the managed care component of the Medicare program, Medicare+Choice, this would seem to be a very tall order but one in which the surgical community will need to take an interest.

Finally, another matter not addressed by the Congress in 2000 was patient medical record confidentiality. Instead, the Congress appeared to prefer to await the release of final regulations on the subject, recognizing that these rules would have a delayed effective date that would give Congress plenty of time to intervene. These final rules and accompanying preamble, together exceeding 365 pages of fine print, were issued on December 21, 2000. The College was among the organizations that submitted detailed comments about the proposed patient confidentiality regulations published on November 3, 1999. At this writing, College staff and consultants are reviewing the new regulations, which give most covered entities a full two years to come into compliance. Given the far-reaching nature of the new regulations, the new Congress could very well intervene in some fashion to require revisions or further delay, or even suspend, their enforcement. A future *Bulletin* article will provide more information about the new national standards to protect patients' personal medical records.

Concluding note

One Congress ends and another soon begins, and the same issues have a way of coming back. This year, the College plans to redouble its efforts to recruit Fellows for our Congressional Action Program. And, changes in the College's Web site will, we hope, facilitate surgeon involvement in matters that are before the Congress. While the College's leadership and staff make every effort to represent the Fellowship, we know full well that our work has little chance of bearing fruit unless members of Congress believe that the people "back home" really care. That's where individual surgeons and their patients play a crucial role.

On behalf of Dr. Russell and the rest of the College's leadership, I'd like to thank all of those who contributed to the College's advocacy efforts during 2000. This includes the College's chapters, College committees, the members of our Congressional Action Program, and countless other Fellows of the College. I'd also like to acknowledge the hard work of the College's Washington staff, especially Cindy Brown, Associate Director of the Health Policy and Advocacy Department, and the critically important support of our many colleagues in the College's Chicago headquarters. Ω

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