ASA Legislative Conference 2023
Overview by Dr. Eric Reilly, 2023 RCGC President

What is it?

The delegations for each State (Anesthesia State Component Society leadership) as well as other ASA members attend a 3-day conference in Washington D.C. The conference has three main goals:

1. Educate ASA members about current issues facing anesthesiologists
2. Provide organized insight into how we can ask Congress to fix these issues
3. Send ASA members off to Capitol Hill to meet directly with their respective members of Congress to ask for their support on our issues

Each State sent multiple attending anesthesiologists, resident anesthesiologists, and even some CAAs so advocate on behalf of their patients.

Why Go?

The ASA has a legislative team in D.C. who does this every day. The ASA similarly has a State affairs team who does this every day in each individual State. Those teams review new legislation, rally for support for certain legislation, rally against other legislation, meet with members of Congress, secure letters to help support our needs, inspire phone calls, lobby for our causes, etc. Those efforts by the ASA are extremely important, but showing your face and telling your stories as a physician truly moves lawmakers in a way where they are inclined to help their constituents. Our anesthesiologists attended hundreds of Congressional meetings during the conference and those delegations helped inspire members of Congress to author bills, co-sponsor bills, make phone calls, send letters, etc. to help support our goals for our practices and our patients. Many Senators and Representatives were ‘shocked’ by their constituent anesthesiologists’ stories – and some even offered to take immediate action with letters and bill co-sponsorships. Such pledges are possible because our ASA members showed up and made their voices heard.

On the flipside, there are others who will show up if you don’t. The Congressional logbooks showed the names of groups who visited the offices just a few weeks prior – groups with a primary goal of removing physicians from patient care. If you don’t speak up, somebody else will. Your voice matters.
What Was Discussed With Lawmakers?

1. Preserving Safe Care for Veterans
   a. What is it?
      i. The Department of Veterans Affairs (VA) is proposing a National Standards of Practice which would allow CRNA’s to work independently in the VA. This movement appears to be largely influenced and promoted by nursing groups both within and outside of the VA.
   b. Why is it important?
      i. If this passes, the VA standards could supersede State law and allow independent CRNA practice in every single State. It’s a clever way for anti-physician groups to establish federal precedent in their pursuit of non-physician independent practice in every State. Not only would VA patients be at risk, but all patients could be. Such a move could also remove resident training from VA hospitals, as residents can only train alongside physicians.
   c. What did we accomplish?
      i. Multiple members of Congress plan to send letters and make phone calls to the VA in our support
      ii. Rallied support and co-sponsors for House Bill HR 3347 which would keep anesthesiologists in the VA
      iii. Inspired support and are hopeful a similar Bill may be introduced in the Senate
      iv. Spoke with the VA officials directly to voice our concerns

2. No Surprises Act (NSA)
   a. What is it?
      i. The NSA was passed in 2020 in an attempt to protect patients from out-of-network ‘surprise’ medical bills. The bill outlines an inefficient independent dispute resolution (IDR) process which insurance companies are supposed to honor to fairly compensate physicians. Insurance companies are not honoring the IDR process and it is leaving physicians unpaid. The IDR process is poorly enforced, prohibitively expensive, and does not allow batching of claims. – all which creates a system where physicians are not paid for their work.
   b. Why is it important?
      i. The NSA is being hijacked by insurance companies to pay physicians extremely low rates, if anything, for their services. If physicians and groups are not properly compensated, then they cannot remain in practice. This act alone has caused numerous private practices to sell to hospitals or private equity groups. Such sells may foreshadow widespread staff reductions and cuts of service – at the expense of a community’s patients and their physicians
   c. What did we accomplish?
      i. Numerous Congress members from the committee who originally passed the NSA were in attendance at our conference and recognize the bill is not being implemented as intended. They plan to start an extensive oversight process to fix the NSA
      ii. Our asks for batching, IDR fee limits, insurance accountability, etc. were all well-received by the Congress members who will be leading oversight efforts
3. Medicare Payment Reform
   a. What is it?
      i. Currently Medicare pays roughly 30% of commercial rates for anesthesia services. In other words, if a private insurance pays you $500 for providing anesthesia for a CABG, then Medicare would pay you about $150. These rates have not been adjusted for inflation, and are grossly outdated with current expenses of healthcare.
   b. Why is this important?
      i. Low payment rates lead to physician refusal to accept Medicare, as the expense of caring for those patients can sometimes eclipse the expected payment. When private practices refuse Medicare, then patients rely on hospitals for their healthcare, and then the hospital takes a hit and struggles to pay its physicians, which leads to the hospital decreasing its staff and services, which worsens working conditions and access to care. Low Medicare payment rates also make it difficult for private practice groups to survive – especially if those groups serve a large proportion of Medicare patients – which could force them to sell to hospitals or private equity.
   c. What did we accomplish?
      i. We rallied support for the House Bill HR 2474 which would add an annual Medicare inflation update
      ii. We spoke with Congress about how low Medicare rates create access issues for patients in both well-served and underserved areas, and our messages were well-received

4. A Robust Anesthesiology Workforce
   a. What is it?
      i. Our workspace is changing as more surgeries are moved from hospitals to surgery centers. Workforce needs are exacerbated by the national nursing shortages, a lack of new residency spots, and the financial burdens of medical education
   b. Why is this important?
      i. Some misguided groups use ‘workforce shortages’ and ‘access’ as their number one talking point to try and achieve independent practice for non-physicians. We have data to show that opt-outs and independent practice laws DO NOT increase healthcare access in rural or under-served areas. We have data that shows non-physician independent practice WORSENS OUTCOMES, increases costs, increases readmission rates, etc. We have a strong anesthesiologist workforce, however there is often a lack of incentive for anesthesiologists to practice in underserved areas. Our goal is to expand the anesthesiologist workforce in a way which preserves equity with access.
   c. What did we accomplish?
      i. Gathered support for HR 2389 and S 1302, two bills which would provide funding for 14,000 additional residency spots
      ii. Gathered support for HR 1202 and S 704, two bills which represent the REDI Act. This act would allow borrowers to qualify for interest free deferment on their student loans while in residency. This act IS NOT blatant loan forgiveness, but rather cuts the accrual of loan interest while in residency – thus is it well supported on both sides of the aisle
iii. Gathered support for the SPARC Act (HR 2761 and S 705), which would authorize loan repayment programs to encourage specialty medicine physicians to serve in underserved and rural communities.

5. Expanded Access to Naloxone
   a. What is it?
      i. Deaths from illicit opioids have grown rapidly in the past decade, and one of the best defenses is affordable access to naloxone. The ASA has long supported efforts to expand naloxone access, and even pioneered REVIVEme—a program designed to educate the public about how to recognize and treat an opioid overdose. We applaud recent decision for the FDA to approve OTC naloxone.
   b. Why is it important?
      i. Anesthesiologists are key players in battling the opioid epidemic. Our ability to treat patients safely while also addressing the opioid epidemic as anesthesiologists is an invaluable skill. At risk patients deserve the attention of a physician, and—in the name of equity—such care should not be independently provided by non-physicians.
   c. What did we accomplish?
      i. We heralded the work done by the ASA, the FDA, and anesthesiologists every day to help expand access to naloxone in the fight against illicit fentanyl and the opioid epidemic.
      ii. We made sure congress was aware of our past efforts and that they recognized the invaluable role of the ASA and anesthesiologists in this battle.