



American Society of
Anesthesiologists™

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VOICEOVER:

Welcome to ASA's Central Line, the official podcast of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

MANUEL BONILLA (HOST):

Hello and welcome to this special episode of Central Line. I'm your guest host, Manny Bonilla. I'm ASA's Chief Advocacy and Practice Officer. Today, I'm highlighting a new ASA initiative, Payment Progress. This initiative is all about the many ways ASA is working to help anesthesiologists secure their economic futures. To better understand some of the economic challenges the specialty faces, and what ASA is doing to address them, I spoke with Dr. Beverly Philip, ASA's President, about the society's efforts. And to dig deeper into a few key topics, I also spoke with Dr. Mary Dale Peterson about surprise billing, Dr. Jonathan Pregler about the 33% problem, and Dr. Neal Cohen about the Public Option. Here's what they had to say.

First, Dr. Philip joined me to explain what the Payment Progress initiative is and why we should care. Welcome to the show, Dr. Philip.

DR. BEVERLY PHILIP:

Well, thank you for having me.

MANUEL BONILLA:

Let's start with the big picture. What is the Payment Progress Initiative?

DR. PHILIP:

The Payment Progress Initiative is a society-wide effort to promote the economic sustainability of our practices and our specialty to ensure appropriate payment levels for anesthesia services and to right historical wrongs in government payment models. ASA wants to help members understand a number of specific payment issues and how these

issues impact anesthesiologists, practices, hospitals and patients. And for that, we've created a resource center that is packed with informative content to help educate your members on key economic issues that impact you. We also want to share information about what the Society is doing to address various economic issues and to let members know what they can do to support the specialty.

MANUEL BONILLA:

Thank you, Dr. Philip. Can you tell our listeners why this is so important? Why does it matter if they understand the mechanisms around payment?

DR. PHILIP:

Well, the current health care environment is certainly complex, and the changes that are coming in payment models and shift to value-based payment models will make it more complex and more confusing than ever. Market conditions are as uncertain as they've ever been. So in order to enhance the value of anesthesia practices and secure adequate payment for the specialty, we all have to understand how we're paid, what influences payment and what can be done to ensure fair payment going forward.

MANUEL BONILLA:

It's important to let our members know what Society is doing about a range of economic issues. Can you tell our listeners how widespread this effort is within the Society?

DR. PHILIP:

We are making the economic, health and viability of your practices a priority across ASA. The Society's efforts include multiple ongoing work streams, a variety of committees, and as a governance bodies are tackling all these issues. And specifically, we're addressing the three key initiatives that you're going to touch on in this podcast, the 33% Problem, Surprise Medical Billing and the Public Option. Beyond that, there are five other economic initiatives that we're also working on. And just to name a few of them, we're also working on enhancing AQI NACOR to support value-based payment models and working to ensure CMS doesn't exclude anesthesiology away from alternative payment models or MIPS value pathways in practice.

Now, in general the work aims to advocate for the specialty and demonstrate anesthesia's value to colleagues, the public and lawmakers. And given the integral role anesthesiology plays in medicine, it's crucial that anesthesiologists are valued appropriately and that we receive fair payment for our services.

MANUEL BONILLA:

Thank you. Finally, what do you want listeners to do? Can you share a few action steps people can take now to support the Society's efforts?

DR. PHILIP:

ASA really needs everybody's help. What you can do is participate in ASA's Annual Conversion Factor survey. You can communicate the value of anesthesia with colleagues and with the public. You can engage with lawmakers at the local, state and federal level urging them to prevent significant Medicare physician payment cuts. You can connect with ASA on issues that concern you and always visit asahq.org/payment often to learn more about economic issues and see the latest action items that we want members to act on.

MANUEL BONILLA:

Thank you for joining us today, Dr. Philip.

DR. PHILIP:

Thank you. It's been a pleasure.

MANUEL BONILLA:

Now, let's dig into the topic of surprise medical bills and what the society is doing to address this problem. Dr. Mary Dale Peterson, ASA's immediate past President. Welcome to the show, Dr. Peterson.

DR. MARY DALE PETERSON:

Thank you.

MANUEL BONILLA:

As you know, Dr. Peterson as a physician in Texas, you have been on the front lines of the Surprise Medical Bill issue there. And you know that surprise medical bills occur when a patient receives a bill for the difference between the out of network provider's payment and the amount covered by health insurance after your co-pays and

deductibles. Are these bills simply a matter of aggressive insurance practices? Can you shed light on what's really driving the problem?

DR. PETERSON:

Yes, I can, and I believe it's really caused by greed from insurance companies. You know, I recently received a report that UnitedHealth's profits in the first quarter of this year, is 4.9 billion dollars. That's with a B. And last year, the same quarter, and that was right in the middle of the pandemic, it was 3.4 billion dollars with a B. And so, you know, I, I got many calls from members in my year as president when the pandemic first hit and they were just in shock that they were, their insurance contracts were being canceled in the middle of the pandemic when really insurance companies were making a lot of profits because of the decreased utilization overall in services. And of course, this was at the time that anesthesiologists were working on the front lines and were being redeployed to our intensive care units. And yet they were being dropped from insurance companies and then told to come back to the table. They would have to accept a 30 to 60 percent cut.

So I, I would call this really egregious behavior, you know, trying to take advantage of the providers on the front lines in an emergency situation. And really, the problem is inadequate networks and these so-called narrow networks where insurance companies are profiting from that.

MANUEL BONILLA:

Let's build on that remark. You talked about narrow networks, what can you share how these surprise bills negatively affect patients, as well as providers, as well as anesthesiologists?

DR. PETERSON:

Well, I think the harm to patients is pretty clear. So you need to have, let's say, an elective surgical procedure, your hospital submits a request for authorization from the insurance company and they give you an authorization. But they don't tell you that they've kicked out the anesthesia group in that hospital. And so you get what's called a Surprise Medical Bill. In other words, you're out of network for that physician group. And it's really no fault necessarily of the anesthesiologist but the insurance company that isn't really being transparent about what's covered and what isn't covered. And by making these networks narrow, where hospital based physicians are kicked out but allow the surgery to happen anyway, knowing the patients are going to get a surprise bill.

As an example, we had an insurance company in Texas that was fined seven hundred and fifty thousand dollars because they had such a narrow network that there were no anesthesiologists in a major metropolitan area network. As far as the providers go, I don't think any of us really want to deal with having to bill patients directly. It's, it's slow. You know, we really want patients to be in network and we want to be in network. It makes payment a lot faster. It helps your cash flow and you know what your contracted rates are. And so I, I think, you know, we strive to be a network where we can, but obviously it's a negotiation between the physician group and the health insurers. And in some of the markets, the health insurers have a monopsony. And so it's very difficult to negotiate reasonable rates.

MANUEL BONILLA:

Thank you for those insights. As I mentioned in my introduction, as a physician in Texas, you've been on the front lines of dealing with state laws, dealing with surprise medical bills. Different states have dealt with this issue to varying degrees. And, of course, most recently here at the federal level, we've had the No Surprises Act, which was signed into law in January of 2021. ASA successfully lobbied for a number of key provisions, including ensuring that there was a dispute resolution process. I, I think that our efforts here in Washington, we were trying to mirror the successful models that Texas and New York have in place for their dispute resolution processes. Can you tell us, based on your experience and what you've observed, why the dispute resolution process is so important for anesthesiologists?

DR. PETERSON:

Well, we, we need a fair process so that, you know, we have a mechanism to respond to unfair payments from health insurance companies and I believe the independent dispute resolution process can accomplish that, assuming that some details are taken care of in the rulemaking.

We have had, I think, a successful process in Texas, and I know New York is experienced the same thing, where you get the patients out of the middle and, you know, it's a negotiation, you know, hopefully even before you get to the independent dispute resolution or IDR process so that you can get a timely resolution of, of their payments. But if you're not able to accomplish that, then you can have an arbiter or mediator help with that. And of course, the devil in the details there is making sure that the mediator or arbitrator has the appropriate information that's allowed and available to help decide what is a fair payment.

MANUEL BONILLA:

During the congressional debate about the Surprise Medical Bill issue, there was a lot of media attention on the issue, news reports, you'd read about it in the newspapers and magazines, online. Not so much now. So what's happening with the law? Is there still work that needs to be done? And if so, what's ASA doing about it?

DR. PETERSON:

Well, there is work to be done. We're fortunate, I think, that we got at least the framework legislated with all the help of our members who wrote in and called to our Congress. But we are now working on the, with the administration to implement the proper rules. So that would be with US Department of Health and Human Services. And we just want to make sure that the rules are implemented in a way that we believe was legislatively intended. So things like making sure there is an appropriate independent dispute resolution process that's accessible for our members, that is timely. You know insurance companies got deep pockets and a lot of our members are in small and medium groups where cash flow is critical. And so we, we can't drag this out forever to get the dispute taken care of. So we also want to make sure that the rules of engagement are fair and that it's cost efficient. We want to make sure that if there is a particular insurance company that's not paying fairly on similar bills, that all of those can be bundled together. And that, you know, cost of paying for that mediator or arbitrator is a one time shot instead of, you know, iterated multiple times.

MANUEL BONILLA:

Sounds like there's still a lot of work to be done on this issue, and, and our focus is going to need to be on this rulemaking process that you described. One last question before we let you go. What is it that you want our members to know about ASA's work on this issue?

DR. PETERSON:

Well, first of all, I, I want to thank our members. Without your persistence and letters, this legislation that I think is fair would not have happened and that would have been very problematic for our profession.

I also need to thank you and the advocacy team, as well as all of our key contacts and grassroots to really push this over the finish line. When we first started this process, this summer two years ago, it, it was a train rolling down the tracks and the insurance companies thought they had it in the bag. And if it wasn't for the huge outcry and

persistence that this was a grossly unfair piece of legislation that was initially promulgated, you know, we wouldn't have gotten there.

We do need to keep involved and keep you involved with the rulemaking process so that we can put pressure on the administration if those rules aren't going as well as we would like. So we, we do need to stay engaged on this issue, and we know there's more battles to fight. And we need to have your continued participation in making sure that we can continue to win these battles.

MANUEL BONILLA:

Thank you, Dr. Peterson.

DR. PETERSON:

Thank you. Always a pleasure.

MANUEL BONILLA:

Now to share some thoughts about the 33% Problem, we're fortunate to have with us Dr. Jonathan Pregler. He's the Chair of the ASA's Committee on Economics, 33% Work Group. Welcome, Dr. Pregler.

DR. JONATHAN PREGLER:

Hey, thanks, Manny. It's great to join you and to everyone who's listening in today.

MANUEL BONILLA:

Dr. Pegler, for nearly three decades, Medicare payment rates for anesthesia services have been far lower than the rates for other specialties. As we all know, anesthesiologists are paid about 33% of commercial rates, thus the 33% Problem designation. Other specialties are paid approximately 80% to commercial rates. Can you share with us what you know about the history of this issue and how did we get here?

DR. PREGLER:

Yes, certainly, I mean, prior to 1992, you know, Medicare paid for professional services based on three principles: customary, prevailing and reasonable. And to put that into simple terms, payments were based on a calculated rate that was roughly 90% of the

median charges for a service in a geographic region. And Medicare paid either the lowest of either the calculated rate or the actual charges that were billed to Medicare.

At that time, Medicare was really seeking more predictability to payments and the resource based relative value scale was developed by Hsiao and Co. as a new payment system at that time. And this was the birth of our RBRVS. So in 1992, with the official conversion to RBRVS, it resulted in a 29% decrease in anesthesia payments by Medicare.

Hsiao had published a series of papers that documented the development of our RBRVS and some of the key facts that led to this lower valuation for the anesthesia conversion factor were, were one and assumption that anesthesia was over valued by 41% at that time, two, that anesthesia was different from the rest of medicine for a variety of reasons, one of which was our use of time in calculating payments. And three, that they, they based their calculations on a very few anesthesia codes, specifically three codes, and then expanded them to extrapolate them out to the rest of our code set. And this resulted in, in the valuation that occurred at the time, which resulted in the reduction.

So when our RBRVS was first enacted, there was a plan to correct the payment disparities in the system, since it was a new and, and untested methodology for payment, that created a five year review process. The ASA participated in each of these reviews and in 1995 there was the Abt Study, which expanded the number of procedures that were used to compare anesthesia to other specialties. The result of that request for review resulted in a 16% increase in the anesthesia conversion factor.

Then in 2000, the ASA came back with what's called the Building Block Analysis, which broke down the components of anesthesia services into different units of work, which could be compared across the specialties. And this effort yielded a one, only a 1.6% increase. It turned out that the committee which reviewed the request had trouble with the, valuing the post induction work. That became a sticking point.

Then in 2005, the Regression Model was submitted, which demonstrated the value of post induction work that we provide during anesthesia. And that was the most successful of all the reviews, resulting in a 23% increase, which was approved and went into effect in 2008. So that really ended the three five year reviews and the formal process to get Medicare rates modified.

MANUEL BONILLA:

In 2005, the (sic) approved ASA's proposed 23% increase for anesthesia payment rates as part of their five-year review process. And yet we still have that problem. Why is that?

DR. PREGLER:

Well, first of all, of the increases were applied to a very low starting conversion factor that was created with where RBRVS, started in 1992, and that made it very difficult to catch up to changing anesthesia payments.

When the increases went into effect, commercial rates had advanced to the point where a 23% increase, was, was insufficient. To illustrate this point, if, if you look at the data on table five in the Monitor article, the change in commercial rates from 2005 to 2009 was increasing at a rate of 22% over those four years alone. The 23% increase that we received in 2008 barely kept us at the same Medicare payment percentages we had at the time that the 2005 review was submitted.

It is also worth looking at inflation over this time. To keep parity just with inflation, Medicare payments in 2008 needed to be \$30.46 to maintain the purchasing power back to 1991. And instead the conversion factor was only \$19.97 cents after the increase.

So moving to the current day, the disparity has continued to widen. Market forces have increased the average negotiated commercial conversion factor, as reported in the ASA's Commercial Conversion Factor Survey. Inflation has continued over the life of our RBRVS, and although inflation has been low in recent years, that effect, compounded over decades, is still significant.

Most importantly, during this time, the Medicare conversion factor has languished. In 2021, Medicare was paying 27% of our latest commercial survey mean value for conversion factor, which is of course, our best estimate of commercial payment rates. Future payment cuts would obviously add to the shortfall should they be implemented in 2022 and could be up to 10%. If these payment cuts go into effect, the Medicare payments could be under \$20 per unit, which would be back to 2008 levels in the RBRVS era and close to where we were in 1991.

MANUEL BONILLA:

Dr. Pregler, can you tell us why this matters? Obviously, anesthesiologists do incredible lifesaving work and deserve fair payment, but this has repercussions beyond the pocketbook, right?

DR. PREGLER:

Yes, and in fact, the significance of the Medicare payment rates goes beyond just Medicare. As the number of patients being covered by Medicare is increasing, so will the effect on the specialty. The aging of the population is one factor, of course, increasing the number of Medicare beneficiaries in everyone's practice. And more patients are being covered by government payment programs outside of the normal aging process.

So in the future, the risk of either a Public Option allowing younger individuals to buy into Medicare or a new Medicare for All program could result in a huge expansion of the percent of Medicare covered payments for the specialty. If Medicare becomes the dominant payer than the proliferation of these rates could be disastrous.

We are also at risk that Medicare fees are becoming a benchmark rate for other negotiations. Negotiations with private payers and even internal negotiations in integrated health care systems and settings are frequently being based on some percent of Medicare. Out of network payment legislation that is based on Medicare rates is also of concern. The out of network legislation also has the side effect of potentially setting a benchmark for contracting, since poorly crafted legislation can lead to unanticipated effects on contract negotiations.

We also have to consider other practice changes that Medicare has failed to consider. Anesthesia as a practice has changed significantly over the last three decades. We handle patients with more medical complexity and advanced monitoring than has existed in the past. As such, our work intensity and stresses have changed. Payment rates for professional services should reflect those changes and have not kept up with Medicare rates.

There should be recognition of what anesthesiologists do besides, beyond providing care in the OR. Our work in the perioperative preparation and care for patients provide significant value beyond the time spent in the OR and also our constant availability in labor and delivery and the acute care settings and trauma centers has value that is not recognized in Medicare payment for anesthesia services. I'm afraid that if Medicare rates don't get corrected to keep up with the changes in our practice and to maintain an appropriate level for professional payment, it will become more difficult to recruit the best and brightest of our graduating medical students to our specialty.

MANUEL BONILLA:

Let's look forward, what's ASA doing to address the 33% Problem?

DR. PREGLER:

The first task of the 33% Work Group was to learn from the past. The Monitor article did that by taking a comprehensive look at the issue, including the history of the problem. In this publication it is important to provide everyone the same basic background about how we got to this place with Medicare payments. That review is also fundamental to planning what strategies might work in the future to get a change in valuation. We have to learn from the past arguments that were made to correct poor Medicare payments, and we need to be careful not to repeat unsuccessful efforts from the past.

Table six in the article laid out several options for how to continue this effort. The ASA is pursuing further analysis of all of the options in that table. Several approaches that have been identified include looking at other governmental programs that pay for anesthesia services at what is close to market rates to demonstrate that Medicare is out of step with the other branches of the federal government. Consider how to revalue the anesthesia conversion factor with a focus on the current work and intensity that has changed over the past three decades. Finally, evaluate the fundamentals of how payments for anesthesia services are structured to see if there is an opportunity to increase the values assigned to our clinical work. Anything we do needs a defined pathway for a successful outcome, and the ASA will be pursuing decision-making support to ensure that happens.

The next task for the 33% Work Group are to prepare documents to help our members in contract negotiations and other settings to demonstrate that Medicare is not an appropriate benchmark for anesthesia payments. ASA will also support members in understanding how to participate in alternative payment models.

MANUEL BONILLA:

Thanks so much for joining us, Dr. Pegler, that has been very helpful information.

DR. PREGLER:

Thank you so much, Manny. It's been great to participate in this process.

MANUEL BONILLA:

Now we turn to Dr. Neal Cohen, the Chair of ASA's Section on Professional Practice, to dig into what a Public Option would mean for our specialty. Welcome to the show, Dr. Cohen.

DR. NEAL COHEN:

Thanks, Manny.

MANUEL BONILLA:

The Public Option is a proposed government run health care plan that would compete with private plans. We also know there are discussions about expanding Medicare to individuals age 60 or even 55. We've been talking about the 33% Problem earlier in the program. So let's tie all these strands together. Can you tell our listeners why the 33% Problem matters as legislators consider these Medicare related options?

DR. COHEN:

When we talk about Public Options, we're really talking about a variety of different approaches to both providing access to health care and a publicly managed health care option for them. And so it varies from Medicare for All, expanding the ACA to individual Public Options that may address individual patient populations, including reducing Medicare eligibility to a lower age.

Any of the Public Options, no matter which one we're discussing, that are based on Medicare payment, perpetuate the 33% Problem. So if we rely on Medicare as the primary payer for anesthesia services, it will be devastating to the specialty. In addition, it will be devastating to hospitals and health systems. So it has major implications for our specialty.

MANUEL BONILLA:

Well, that's a great opening point with regard to what's at stake for our specialty. Can you talk a little bit more about how you think the Public Option would impact the practices of anesthesiologists?

DR. COHEN:

Obviously, a, a Public Option that increases access for patients that didn't previously have any health care would be positive in terms of the number of patients. But if our payment is based on Medicare rates overall, our practices could be devastated.

In addition to the impact on the individual practices, many of these patients may have pre-existing conditions or additional health care problems needing higher levels of care. Again, if payment is based on a 33% of commercial rates, we will be disadvantaged while also caring for people that may have significant medical problems and be more complex to care for.

The implications for the hospitals are similar. The hospital's bottom line will be affected significantly if their payer mix is transitioned to a larger percentage of Medicare or Medicaid payments and any support that anesthesia services are receiving for call coverage, medical direction and other services from health systems may also be impacted by a larger percentage of patients covered under various Public Option models.

The implications for training programs may similarly be, probably misunderstood, but could be significant depending on the level of GME support from the federal government, as well as the implications for the patient population and complexity of patients that may impact how residents are, are trained and the clinical exposure they have.

It's important to note that many anesthesiologists provide services that are reimbursed under RBRVS, including pain medicine, sleep medicine, critical care medicine, palliative care and some other services. These would be impacted differently by any Public Option in that the payment would be similar to what it is for other physician services. The balance of payment for RBRVS or these other services and anesthesia services within an individual practice could have significant impact on the bottom line of the practice, particularly if the majority of the services are provided in the operating room or for peri-procedural services.

MANUEL BONILLA:

So, Dr. Cohen, what about patients? How might a Public Option impact anesthesia care for patients?

DR. COHEN:

Well, in the broadest sense, the Public Option should increase access to health care, but the implications of the various Public Options could have negative consequences. For example, Medicare for All system or any system that has a larger percentage of payment based on Medicare rates for anesthesiology services could impact availability of anesthesia services, both because of the hospital's willingness to provide care to the

patients as well as the anesthesia practices. And many of these patients, as I mentioned before, could have coexisting conditions or previous health care conditions that have not been addressed so could be significantly sicker and require greater resources, which would have major impact for both anesthesia practices and the hospitals.

Probably most important, while the goal of this might be to improve access to small hospitals and rural facilities, these facilities may not be supported on a largely Public Option or Medicare for All payment methodology. So in fact, some of these hospitals and facilities could close, making access actually worse rather than better for many of the patients needing it most.

MANUEL BONILLA:

Well, Dr. Cohen, you've laid out the challenges very clearly, I guess the question that our listeners have is, what is ASA doing about this? Can you talk about the steps that our Society is taking to ensure fair payments and that we're ready for some of these changes that may be on the horizon?

DR. COHEN:

Yes, the ASA has been actively addressing these issues from a number of perspectives. Obviously, we continue to monitor the discussions on Capitol Hill and with the administration and are obviously looking at the reality of Public Options and those that might be passed by a very dysfunctional Congress. Clearly, change in Medicare age or other selected Public Options may be on the plate of Congress. It's unlikely that we would end up with a Medicare for All system in this current Congress.

At the same time as we're discussing the reality of what happened, happen in the administration, we're also trying to understand the implications of the various Public Options models, including Medicare for All on anesthesia services, based on what we understand about current payment for anesthesia services, as well as proposed payment methodologies under these various models.

The ASA has solicited input from outside consultants who have been working with us to define the scope of the changes that would occur with respect to payment and ways in which we might be able to strategize to address the significant limitations. And we are discussing with and, and considering the implications of these payment models on hospitals and how anesthesiologists and their relationship to health systems will be impacted by that.

We've talked about some of the impacts so far in, in this discussion, but we're going to continue to have ongoing dialogue both within the ASA and within the house of medicine, as well as with legislatures and the administration to describe the positive and negative aspects of Public Options with respect to quality of care, access to care, and one of the other issues that's most concerning to all of us as anesthesiologists and to society as a whole is equity of access to health care that might be adversely impacted by some of these Public Options.

MANUEL BONILLA:

Dr. Cohen, thank you so much for your insights into this issue. This is a very important issue for the ASA and we appreciate your sharing your expertise with us.

DR. COHEN:

Thank you, Manny.

MANUEL BONILLA:

Thanks for listening to this special episode of Central Line. We hope it's been informative and we hope you'll help us advance fair solutions and advocate for our specialty. Individual anesthesiologists have a vital role to play, so get to know your legislators and engage with them to keep them informed. Understand the range of economic issues and proposals and where the Society stands on them. Speak up so colleagues and the public understand the value of anesthesiologists. And visit asahq.org/payment to learn more about these three topics and the many other ways that ASA is fighting to ensure your financial future,

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VOICEOVER:

Your economic future, that's the bottom line of ASA's Payment Progress Initiative. Learn more about the Society's strategies to ensure fair payment for anesthesiologists. Visit asahq.org/payment.

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