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

DR. ADAM STRIKER (HOST):

Welcome back to Central Line. I'm your podcast host and editor, Dr. Adam Striker. Today, Manny Bonilla, ASA's Chief Advocacy Officer, is joining the show to talk about what's happened since the No Surprises Act passed. Spoiler alert: it hasn't gone quite as well as we had hoped. Manny, welcome back.

MANNY BONILLA:

Thank you, Dr. Striker. It's great to be with you today.

DR. STRIKER:

Well, I'm sure our listeners know all about surprise billing, but for anyone new to the topic that happens to be listening, do you mind reminding us what it is and why it's a problem?

MR. BONILLA:

Certainly. This is an issue that we've been working on for a number of years and going back to around 2015, 2016, we saw a growing interest at the federal level in trying to address surprise medical bills. A number of states had been dealing with surprise medical bill legislation at the state level, but there was an interest at the federal level in trying to address, number one, those states that don't have their own surprise medical bill law. And then also to address surprise medical bills that were happening in ERISA plan. So ERISA plans are federally regulated and states cannot regulate them. So there was a need for for federal action.
And what we saw was while an anesthesiology, we know that the vast, vast majority of claims are in-network, over 90 percent according to the data that we've seen, we saw that the federal government and Congress in particular started to take a look at anesthesiology, radiology, emergency medicine, pathology assistance and surgery. And they identified and really targeted our specialties because of surprise medical bills or basically balance billing, when insurers underpaid for the services of these particular physicians.

So we spent about four to five years working on this issue in Congress. Many of the podcast listeners were partners with us, doing their grassroots and key contact efforts, trying to ensure that we ended up with the best legislation possible.

And ultimately, in December of 2020, they passed the No Surprises Act, which basically bans balance billing in many scenarios that anesthesiologists are involved in, and also created an Independent Dispute Resolution process that physicians could use to resolve their payment disputes with with insurers. Let me just say this is certainly not the way that ASA would have solved this problem, but it’s ultimately where the consensus developed. We fought. We had some wins, we had some losses. And so we’re at the point now of the implementation, which began January 1, 2022.

DR. STRIKER:

Well, let's delve into a little bit more on the No Surprises Act. Originally, I think you touched on the overall arching goal, but specifically, what was it intended to accomplish? And then also, let's talk about what we need to know as anesthesiologists about this bill.

MR. BONILLA:

Right. The purpose of the law from the perspective of policymakers was to protect patients from balance billing and specifically to take them out of the middle of the payment disputes between physicians and insurers.

The law specifically bans balance billing for emergency services by out-of-network physicians and other providers, including hospitals standalone emergency facilities. It also bans balance billing for non-emergency services provided by an out-of-network physician and other health care providers in in-network hospitals, hospital outpatient departments and ambulatory surgical centers.
So as I mentioned, with this prohibition on balance billing there needed to be some type of mechanism to resolve the ultimately the payment disputes between insurers and physicians. So there's the creation of this Independence Dispute Resolution process.

DR. STRIKER:

Ok, well, then let's talk about what ASA members should know specifically.

MR. BONILLA:

There's no doubt among any of us who have worked on this issue, it's going to be a bumpy ride for the first quarter of this year. The federal government has set a very aggressive timeline for the implementation of this law. And I think the responsible federal agencies are really challenged in implementing such a complex law and extremely complex regulations. So I think it's important to understand for our listeners that implementation is going to be tough and patience is going to be required.

DR. STRIKER:

Well, Manny, if you had to pick three things that NASA members should know about this act, what would they be?

MR. BONILLA:

The first thing I think that our physicians need to understand is how this federal law interacts with their state law. As I mentioned, some states have their own surprise medical bill law. This federal law does not supersede the state law, and it merely adds an option if the state does not have its own state surprise medical bill law. They're going to need to understand how this federal law interacts with the state law, mostly around the Independent Dispute Resolution process. And if they're not certain standards met by the state law, then this federal law will apply. You also will have this federal law applying to your ERISA plan so your large insurers or your large employer plans and your union plans would likely be your local ERISA plans.

The second thing that our members need to understand is that one of the requirements that's in the law is that health care professionals need to provide uninsured or self-pay patients a good faith estimate of the cost of the service they're considering. And if that's if the patient requests such an estimate. this part of the law is currently in effect. So it is worth visiting our website to look at the government's official guidance on how to do this and to make sure that our members do it the right way.
And then the third thing that I think our members need to understand is start to study the Independent Dispute Resolution process. This is where many of our anesthesiologists are going to end up having to use this IDR process in order to respond to what we anticipate will be unfairly low payments from insurers. Of course, these insurers are enjoying record profits, but we still think they're going to try to put forth unreasonably low payments for the services of anesthesiologists and other physicians.

DR. STRIKER:

Well, let's just stay on that specific topic, because I know this probably is a source of either confusion or generates indifference in certain practitioners who may feel that it doesn't affect them, but the process itself, take us through exactly how that will work, if someone is either in-network or out-of-network just for people that may not understand.

MR. BONILLA:

Right. So this is only going to apply to out-of-network physicians providing, let's say, non-emergency services. So you're in an in-network hospital. Your practice, you are not in-network with the insurer. The patient receives a service from you. And what's going to happen is you will submit a claim to the insurer for the service you provided. The insurer by law has to respond within 30 days by either paying the charges that you've submitted, denying the claim, or paying what's called an initial or interim payment. If the insurer sends you this initial or interim payment and as a physician, you're not satisfied with that, you believe that is unfairly low payment, then the physician has 30 days to decide the next steps. They can accept that payment, or they can choose to engage in a 30-day negotiation period. So, for example, you receive a low payment for a service, and in that 30-day period you decide to negotiate, you would respond to that insurer saying, I believe that the payment is inappropriate and this is what the payment should be. The law lays out certain requirements that the insurer has to provide the information that the insurer has to provide to you. But the physician has those 30 days to begin what's called an open negotiation period with the insurer. Ideally, the physician will receive a reasonable payment as part of that negotiation process. If that doesn't happen, then on the 31st day that physician can choose to participate in this Independent Dispute Resolution process, which is going to be an online mechanism. There will be an online portal and insurers and physicians will submit their offers and information supporting their position to an independent arbiter.

Now what makes this very frustrating for all of us is that the portal does not exist right now, so this very important mechanism for resolving these payment disputes does not exist online where it's going to be. So our physicians do not have the chance to look at it in advance of participating in the process. They haven't had the chance to beta test it to
see how it works, what type of information they're going to need to successfully participate. So it's very frustrating. Government has assured us it's coming, but we have raised concerns with the government about the need to get that portal online as soon as possible.

So each of the parties, the insurer and the physician will submit information and that the types of information that can be submitted or laid out in the regulation and then ultimately the arbiter makes a decision. The loser pays and there's also a fee, the loser also pays a fee for participating in that process. One of the things that we worked very hard on is to make sure that physicians could bundle claims together so they may collect similar claims for the same insurer for a 30 day period. So instead of taking one claim for anesthesia, for a particular procedure to the IDR process, they can bundle 10, 20, 30, however, many claims they have that are similar and submit those to the IDR process and have it resolved in a single decision by the arbiter.

DR. STRIKER:

Well, it's a great explanation and hopefully helps clear up some of the confusion as to what exactly this process does. But I know that there is going to be an effect on physicians that just bill in-network eventually, or there's going to be an indirect effect. Can you tell us how that would manifest or why physicians that may not have to deal with this right off the bat will eventually be affected by this process?

MR. BONILLA:

We're continuing to carefully monitor the situation, but what we expect to happen is insurers will try to drive down those in-network rates as well and/or push physicians out of network. This is all supposition right now, but based upon insurers behavior, we do think that's very likely to happen. I think as you know, the ASA has sent a request to the Department of Justice to have them investigate what we believe are aggressive tactics by insurers and ask the Department of Justice to look at that behavior. But in the interim, we are watching closely to see how insurers respond and the specific impact on in-network payment rates.

DR. STRIKER:

Okay. Now based on all of this, the ASA has filed a lawsuit due to these concerns. Manny, do you mind, you've obviously explained the process, a lot of the details and the concerns. But do you mind taking us through this lawsuit and why did the ASA do it? What did they do exactly?
Right, so going back to the description that I gave about the Independent Dispute Resolution process, there are certain requirements that are spelled out in the law and certainly one of the things that ASA and all of our partners in medicine worked on as part of the congressional process was to make sure that this Independent Dispute Resolution process was as fair as possible. We wanted to ensure that our anesthesiologist would have a more than reasonable chance to receive a fair payment from insurers if they had to go through this IDR process to resolve a payment dispute. So the law specifically provides, as I mentioned, for an independent arbiter to select a reasonable payment based upon offers that are submitted by the physician and the offer that's submitted by the insurer. Both parties are permitted to provide information to the arbiter, just as I mentioned. And in fact, the law specifically spells out what type of information physicians can submit to the arbiter to support their case for a fair payment, then can submit information about their previously contracted rates, so if they had a rate with that same insurer three years ago, they can introduce that. They can talk about their training, their individual training that their board certified. They can talk about any quality information that they may have. Their practice may be, have data that indicates they're the top quality anesthesia practice in the state. They can also bring the patient acuity into the discussion. So there's a whole list of specific items that are permitted that the anesthesiologist may submit to the arbiter for the arbiter's consideration. And what the law said was the arbiter must consider all these pieces of information.

However, when the federal agencies wrote the regulations implementing the law, they took a completely separate and, frankly, in our opinion, the wrong direction. The implementing regulations say that the arbiter can consider the number of factors and making a decision. So all that information that I just mentioned in making a decision about the appropriate payment. But the agency said that the arbiter should presume--and the language that they use is there's a presumption that the insurers median in-network rate, also known as the qualifying payment amount or QPA is the appropriate payment. So the QPA is the insurers meeting a network amount for that particular service in that particular geographic area. It is calculated by the insurer and it is one of the items that the arbiter may take into consideration. However, the law does not say anything about it being, the arbiter making a presumption that that is the appropriate payment rate. And that's wrong. The law intended for the arbiter to consider all those factors equally so the acuity of the patient, the physician's training, previously contracted rates, all that should be taken into consideration equally, as well as the insurers median in-network rate. So in our opinion, the regulators botched that rule. The regulation, implementing the law and what that left us with is unfair and in our view, threatens our members practices and ultimately patient access to our member services. And so that's why we filed the lawsuit in Chicago.
DR. STRIKER:

Just a reminder, the lawsuit is not just the ASA we've joined with other organizations as well. Correct?

MR. BONILLA:

That's correct. ASA filed the lawsuit with the American College of Emergency Physicians and the American College of Radiology. There is also a similar lawsuit pending in Tyler, Texas, that was filed by the Texas Medical Association. And there is a third suit that was filed by the AMA, American Medical Association, jointly with the American Hospital Association that is similar to ours as well. So there are basically three lawsuits, all of which make this largely the same arguments regarding the failure of the regulators to accurately interpret what the law said and put that into the implementing regulations.

DR. STRIKER:

With the multitude of lawsuits. Do you think there's a good chance that this piece will get resolved?

MR. BONILLA:

We believe the law is very clear. And we worked very specifically for that language in that provision of the law that requires the arbiter to equally consider all these different factors. So I would say we're cautiously optimistic.

DR. STRIKER:

And then overall, with the surprise medical billing issue, how do you think the future is going to ultimately unfold?

MR. BONILLA:

As I mentioned, I do think we're in for a rocky road, especially for this first quarter of 2022 and perhaps for the entire year. I don't want to mislead anyone that I don't think this is going to be a particularly smooth implementation of a very complex law, but we’re working on it. We're continuing to create resources to help our members, and we are continuing to work with the regulators and with Congress to make changes to the law, if
necessary, to make sure that our anesthesiologists are able to secure a fair payment for the services that they provide.

DR. STRIKER:

Well, let's talk about how the ASA is helping their members navigate all of this. What resources are available or where can listeners go to get the information they need or seek out some avenues to help?

MR. BONILLA:

We have a fairly comprehensive set of no surprises act resources available on our website. It's under our surprise billing resources page, that's in the members only section of the ASA website. It includes some of the material developed by ASA during the legislative and regulatory process. You can see the comments that we formally submitted to the agencies regarding the implementing regulations and some of the changes that we wanted to see made and that we're continuing to work for. There's also official government guidance, including FAQs from the regulating federal department, so some of that information can be very helpful in understanding how the government sees this. We also have available an anesthesiologist specific FAQ. This is in response to questions that we've received from frontline anesthesiologist and business managers who had specific, very specific questions about the application of the law and the regulations on anesthesiology practices. So those FAQs are a living document. The more questions we receive, the more questions we add to those facts. Over the long term, our ultimate deliverable is going to be a toolkit. Ideally, we want to be able to guide physicians as they navigate the IDR process. We want to try to identify information that they can submit as part of that IDR process that will be most favorable to them. And then we also want to identify best practices so as our members start to go through the IDR process. What are the things that they did that assured them a favorable outcome? What are some of the things that they did that perhaps were not ideal and resulted in a less than favorable ruling from the arbiter? So ultimately, we want to provide as much information as possible so people are comfortable and feel well-informed and going through that independent dispute resolution process.

DR. STRIKER:

Well, it's certainly a lot of information, and just to remind everyone that's on the ASA website, ASAHQ.org. And it's in the members section.

Well, Manny, we obviously had you on to discuss surprise medical billing and in the current status of that issue. But you were our second guest on the Central Line podcast
back when we started in 2019, and a lot has changed in the political landscape, in the advocacy landscape. I really wanted to at least get your take on other issues that are currently on the docket of things we should be concerned with or be abreast of in your in your opinion. So if you don't mind just kind of giving us a brief overview of issues that are going on right now that that we should kind of be cognizant of.

MR. BONILLA:

The implementation of the No Surprises Act and the surprise medical bill issue is is a priority for ASA right now. But we also have some other issues that are very, very important to the ASA and to our members.

We are currently again engaged with the U.S. Department of Veterans Affairs on their efforts to dismantle team-based anesthesia. As many of our listeners may remember, from 2013 to 2016, the VA undertook a very similar effort in trying to dismantle team-based anesthesia and granting certain advanced practice registered nurses the opportunity to work in the nurse only model without any type of physician oversight and outside the team. With the help of so many of our ASA members, we were able to secure a big win for veterans and we preserve the team-based model in the VA. Subsequently, there was a directive issued in 2019 that formalized the team-based model of anesthesia in the VA. So we thought that we had put that issue to rest. Subsequently in April 2020, Richard Stone, the executive in charge of the VA and the spouse of a CRNA, reintroduced this issue with the memo that we refer to as a Stone Memo that strongly encouraged VA facilities to change their bylaws to permit independent practice by CRNAs. That touched off this current battle where we're working against the VA and the bureaucrats in the VA who we think are moving in a direction of anesthesia care based on a CRNA-only model. So we will be reaching out to our members again, seeking their assistance, both in engaging Congress and also in engaging the VA.

We continue to have many issues at the state level. Our state team, state affairs team is very active, working on scope of practice issues. We also have medical title misappropriation challenges. There are a number of CRNAs who have started to adopt this term nurse anesthesiologist. In some states that is already illegal, that is inappropriate. But we want to try to standardize across states that that is inappropriate and represents medical title misappropriation. So we're working with a number of states on proactive legislation to protect that title.

We are also working with the Certified Anesthesiologist Assistance to expand their ability to practice in partnership with anesthesiologists. Last year, we just had our 18th
state that authorized practice of CAAs, and we hope to have more states moving forward on that.

I would take this opportunity to say with so much work at the state level that if your state component contacts you, if you receive an email from the leadership of your state component or their lobbyists and they ask you to take action, please help out the folks who are on the front lines of the states in working to protect our specialty and do what they ask you to do, whether it's contact a lawmaker via email or make a phone call or visit the State House. It's critically important that all of our members be engaged and help carry the message of our specialty.

DR. STRIKER:

Well, it certainly, certainly seems like there's never a shortage of issues to tackle for anesthesiologists. Yeah, I'd like to echo that, the point about the state component society involvement just being involved at the state level because I feel like oftentimes the, the state issues may be even more prescient depending on where you practice, but oftentimes take a backseat in terms of publicity to the larger national issues. And so, so I think it's a it's a good thing to reemphasize.

Well, Manny, thanks for coming back to the show. Thanks for giving us an update on the surprise medical billing issue, but also about the other advocacy issues that are important to the ASA and also for how the ASA is actively tackling these and what resources are available to members. Look forward to having you back on the on the show again soon for some more updates.

MR. BONILLA:

Thank you for the opportunity to be with you.

DR. STRIKER:

Well, thanks everyone. Hope you enjoy the show! If you did, please leave a review and subscribe wherever you get your podcasts. That would be great. We'd appreciate it. And tune in again next time. Thanks. Take care.

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