American Society of Anesthesiologists™

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July 30, 2021

The Honorable Frank Pallone, Jr.
Chairman, House Committee on Energy and Commerce
2107 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Patty Murray
Chair, Senate Committee on Health, Education, Labor & Pensions
154 Russell Senate Office Building
Washington, D.C. 20510

Re: Request for information on design considerations for a public health insurance option

Dear Chairman Pallone and Chair Murray:

As President of the American Society of Anesthesiologists® (ASA), and on behalf of our more than 53,000 members who practice anesthesiology, pain, and critical care medicine, I write to express our priorities and concerns as House and Senate leaders consider the design of a potential public health insurance option. We commend your commitment to ensuring that everyone across America has access to affordable health insurance and high-quality medical care. However, we strongly oppose a public health insurance option based upon Medicare payment rates.

Medicare has historically undervalued anesthesiology services, and any expansion of the current Medicare reimbursement methodology into a public option plan would be financially catastrophic for our members and adversely impact the patients they serve. In a 2007 report, the Government Accountability Office (GAO) concluded that Medicare pays anesthesiologists 33 percent of what commercial insurers pay.[1] In contrast, Medicare pays other medical specialties 85 percent of what commercial insurers pay.[2] A more recent GAO report suggests that this anesthesiology underpayment, relative to other medical specialties, has only continued to worsen over time.[3]

Our research into this payment disparity paints an even bleaker picture. Every summer, we conduct a survey of anesthesiology practices across the country to assess payment rates and other

[1] GAO-07-463 (July 2007), available at https://www.gao.gov/assets/gao-07-463.pdf.
[2] Medicare Payment Advisory Commission, *Medicare Payment Policy: Report to the Congress* (March 2009), available at http://www.medpac.gov/docs/default-source/reports/march-2009-report-to-congress-medicare-payment-policy.pdf.
[3] GAO-21-41 (October 2020), available at https://www.gao.gov/assets/gao-21-41.pdf.

information from the practices' five largest commercial managed care contracts. In our 2019 survey, Medicare payments were 28.9 percent of what commercial insurers paid for anesthesiology services. In the 2020 survey, Medicare fell to just 27.03 percent of commercial payments.[4]

The payment disparity between anesthesiology and other medical specialties traces back to the original establishment of the Medicare Physician Fee Schedule. Despite efforts to rebalance the decades-old disparity, budget neutrality mandates have prevented any meaningful corrections. Further, recently announced Medicare payment enhancements for evaluation and management services will likely continue to worsen the disparity for anesthesia services.[5]

Unlike other medical specialties, anesthesia practices have limited latitude to offset revenue reductions. Anesthesiology practices do not directly solicit patients, nor do they control patient volume. Instead, anesthesiology services permit another physician's direct care of patients. Also, standard contracting practices with hospitals require anesthesiologists to accept all patients, regardless of insurance type. While some hospitals subsidize anesthesiology groups to support a full complement of services around the clock, this is neither universal in application and nor does it entirely offset the undervalued Medicare payment. While other medical specialties can unilaterally adjust patient and payer mixes, and can more easily rebalance lines of service, anesthesiologists do not have this same flexibility. As a result, most anesthesiology practices *are far more vulnerable* to revenue reductions than are other medical specialties.

The anesthesiology underpayment is also set against the broader backdrop of Medicare's inability to keep pace with the rising costs of care. Medicare's rate-setting methodology for physician services prevents Medicare payments from scaling with ever-rising practice costs. First, the physician services rate-setting methodology does not take inflation into account, resulting in *de facto* reductions over time. The Medicare Access and CHIP Reauthorization Act (MACRA) also instituted a six-year freeze on physician payment updates, beginning in 2020 and ending after 2025. Other statutory cuts, such as the 2 percent Medicare sequestration, reduce physician payments even further.

A public option payment design that simply ties rates to a given multiple of Medicare may seem like an attractive policy choice. However, structuring payments in this way would have dramatically different impacts across medical specialties. According to our research, even if payment rates under a public option are based on a certain multiple of Medicare payments, anesthesiologists would experience significant adverse impacts. Even with payments set at 200

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[4] *ASA Survey Results: Commercial Fees Paid for Anesthesia Services, 2020*, ASA Monitor, October 2020, Vol. 84, 1–29, available at https://pubs.asahq.org/monitor/article/84/10/1/110713/ASA-Survey-Results-Commercial-Fees-Paid-for.

[5] The CY2021 Medicare Physician Fee Schedule final rule (available here) notes that anesthesiologists can expect an 8 percent reduction in revenue under Medicare if the changes are fully phased-in, in accordance with current law.

percent of Medicare rates, anesthesiologists would still see a 33 percent reduction in practice revenue. At 125 percent, the reduction would worsen to 58 percent. In short, linking any public option payments to Medicare rates, *without taking into consideration anesthesiology's unique legacy payment disparity*, would have devastating consequences for anesthesiology practices across the country.

Tying public option payment rates to Medicare rates would have unintended negative consequences, including increasing pressure for market consolidation. A greater percentage of payments based on inadequate Medicare rates would make anesthesiology practices more reliant on commercial payments. As a result, anesthesiology practices would feel even more pressure to consolidate, to create economies of scale and to increase negotiating leverage in the commercial market.

At ASA, we are dedicated to raising the standards of the medical practice of anesthesiology and to improving patient care. Since 1905, we have advocated for all patients who require anesthesia or relief from pain. We believe that all patients should have access to affordable health insurance, but we are also committed to reform that preserves the strength and vitality of our specialty.

To that end, we respectfully urge that any public option payment design should not be tied to Medicare payment rates. If Congress does decide to base a public option payment system upon Medicare rates, it is vitally important that such a design consider our unique position and the potential unintended consequences of a one-size-fits-all approach.

We continue to perform research into public option payment design, and we are happy to share any additional insights as we complete our analyses. We commend Congress for continuing to work toward affordable health insurance coverage for all patients, and we welcome the opportunity to continue to engage with you on these important issues.

Sincerely,

Beverly Philip, MD, FACA, FASA
President, American Society of Anesthesiologists