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ANTITHESIS OF 33% PROBLEM

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ANTITHESIS OF 33% PROBLEM

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My opinion

When I first heard about 33% problem [1-3], I thought that 33% problem is going to haunt me despite moving from India to the United States (U.S.). When graduating to practice anesthesia in India, I had often heard that we as anesthesiologists in India must ensure that we get paid for our anesthesia services at least at 33% of what our surgical colleagues are getting paid for their surgical services. However, that was when there was self-pay model in India before healthcare insurance turned reimbursements translucent-to-opaque like in the U.S. We do not know anymore what our surgical colleagues are charging or getting reimbursed for their surgical services [4-5], even though it may be interesting for national databases to compare what anesthesia providers are charging the third-party payers as compared to what surgical colleagues are charging the third-party payers for services delivered to the patients covered by those third-party payers [6]. Even healthcare facilities' charges can also be drawn into comparison by those national databases. However, the national databases may not be interested in deciphering and contrasting these comparative charges because everyone may say that those charges submitted to third-party payers do not represent the actual reimbursements by those third-party payers. However, that is the multi-trillion-dollar question born as genie out of the bottled lamp calledÂ translucent-to-opaqueÂ healthcare industry because the charges we are submitting as anesthesia providers, surgical colleagues and healthcare facilities may be too exorbitant that they may appear funny whenever quotedÂ to the onlookers [7-10],Â and we all know that those quoted charges are meant to be jokes so that the third-party payers can at least pay reasonable fractions of those quoted jokes and still be happy about their own negotiation skills. Even the largest public payer in the U.S., Centers for Medicare & Medicaid Services, may fail to disclose what they were charged for healthcare annually [11], because they may only disclose what they reimbursed for healthcare delivered knowing that if they may disclose the healthcare charges billed, it may be well above the gross domestic product of the U.S. and joke will be on the society that has allowed healthcare charges to turn into creeping creepy jokes. However, these creeping creepy jokes can become weeping weepy nightmares when the sky comes crashing down upon the uninsured thus reluctantly self-paying patients because the way healthcare charges are being designed even the sky may no longer be the limit considering that they are designed to be never get paid unless one is an uninsured thus reluctantly self-paying patient who may have to plead to anesthesia personnel, surgical colleagues, healthcare facilities and their debt collection agencies to get their payable healthcare charges reduced or maybe forgiven but may never achieve the grade of deductions as achievable by the negotiating power rendered to third-party payers by their mammoth sizes [12].

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Coming back to 33% problem for anesthesiologists in the U.S., the first question arises whether 33% problem also exists for non-physician anesthesia providers like certified registered nurse anesthetists (CRNAs) and certified anesthesiologist assistants (CAAs) when per mean annual wages reported byÂ U.S. bureau of labor statistics, the anesthesiologists' wages have outclassed all other medical and surgical specialists' wages except for cardiologists' wages [13]. Before delving further, we should perform some simple mathematics.Â

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Assuming that anesthesiologists working as partners/employees in groups/hospitals draw say 350,000 USD as annual salaries, their non-salary benefits cost their groups/hospitals say 50,000 USD per anesthesiologist annually. Considering that theirÂ groups/hospitals may need say 20% as administrative costs (say 100,000 USD per anesthesiologist) for their own sustenance, the total cost of delivering anesthesia will be say 500,000 USD per anesthesiologist annually which will have to be reimbursed by third-party payers. The third-party payers will be the mix of public payers and private payers while the payments will be the mix of direct payments and indirect payments [14-15]. Assuming that the mix of public payers and private payers is 50-50 and assuming that 33% problem exists in its truest fullest sense, the anesthesiologists will be delivering anesthesia care to patients covered by public payers and to patients covered by private payers in a 3:1 ratio so that theirÂ groups/hospitalsÂ can draw say 250,000 USD

per anesthesiologist annually from public payers and sayÂ 250,000 USD per anesthesiologist annually from private payers. If work-life balancing anesthesiologists deciding to halve their annual patient loads will choose toÂ deliver anesthesia care to patients covered by public payers and to patients covered by private payers in a 1:1 ratio only,Â theirÂ groups/hospitalsÂ will onlyÂ draw say 83,333 USD per anesthesiologist annually from public payers and sayÂ 250,000 USD per anesthesiologist annually from private payers whereafter anesthesiologists' annual salaries will get reduced by say 166,667 USD to become say 183,333 USD because neither non-salary benefits nor administrative costs may get reduced to share the burden of dwindling revenues/reimbursements. Thereafter, the option forÂ theirÂ groups/hospitalsÂ will be to either indirectly channelize reimbursed facility charges from third-party payers to neutralizeÂ say 166,667 USD salary reduction per anesthesiologist thus indirectly implicating the underpaid anesthesiologist services within healthcare facilities as their facilities' costs or look into non-physician anesthesia providers working at dwindled annual salaries at which rates it will be non-negotiable for anesthesiologists who will thus become non-available to deliver anesthesiologist services [16-17]. The question will then become whether non-physician anesthesia providers will take the lead to either directly deal with third-party payers to resolve 33% problem for themselves or indirectly neutralize 33% problem by getting paid at overtime surcharges while working over and above 40 work-hours per week [18]. The second option may be the best bet because what else can explain mean annual wages for anesthesiologists (331,190 USD) being just 1.64 times that of mean annual wages of nurse anesthetists (202.470 USD) [19-20], when revenues/reimbursements per anesthesiologist should be >4 times the revenues/reimbursements per nurse anesthetist considering that each anesthesiologist aims to medically direct four nurse anesthetists at a time for 200% of high-end maximum allowable amounts' collections as compared to 50% of low-endÂ maximum allowable amounts'Â collectionsÂ per nurse anesthetist [21], unless either each anesthesiologist in reality is medically directing only 1.64 nurse anesthetists as averaged annually orÂ groups/hospitalsÂ partnering/employing anesthesiologists are keeping the most of the above and beyond generatedÂ revenues/reimbursementsÂ for their own sustenance.

In a nutshell, it may be worth pondering what actually may be happening. Firstly, anesthesiologists are making as much or even better than surgeons because anesthesiologists are getting paid for higher revenue-rated perioperative services year in and year out while surgeons have to variably distribute their time between higher revenue-rated perioperative services and lower revenue-rated inpatient and outpatient services [22-24]. Secondly, increased administrative burden to keep up with increasing regulatory burden in translucent-to-opaque healthcare revenue generating industry may be forcingÂ groups/hospitals toÂ keep a major piece of pie for their own sustenance [25-26]. Finally, without constant pressure by anesthesiologists reminding third-party payers about 33% problem, any number of third-party payers in their right minds may gear up to drive anesthesiologists' revenues/reimbursements further down where-after futureÂ medical students may choose some other specialty rather than anesthesiology [27], so that 33% problem no longer haunts physician anesthesiologists thus leaving it up to non-physician anesthesia providers and third-party payers to sort out 33% problem among themselves.

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