TESTIMONY TO PRACTICING PHYSICIANS ADVISORY COMMISSION

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Good morning, I am Dr. Alexander Hannenberg and I represent the American Society of Anesthesiologists. Our specialty has a special place in the Medicare Fee Schedule, largely because we have used a Relative Value Scale for payment in anesthesia since 1962. When the Medicare Fee Schedule was introduced thirty years later, the anesthesia system was preserved and aligned, through adjustment of the anesthesia conversion factor, with the other 5000 physician services. Our relative value system uses a different scale of units and a different conversion factor than the remainder of RBRVS. The anesthesia conversion factor today is almost 20% lower than it was in 1990.

Critical to the willingness of physicians to provide care to Medicare beneficiaries is the competitiveness of Medicare's rates compared to the private insurance marketplace. Since the early days of the fee schedule, several groups have tracked this relationship including the Physician Payment Review Commission, MedPAC and the American Medical Association. The most recent data from AMA indicates that Medicare's conversion factor for physician services is approximately 83% of private conversion factors. Thus, there is a relatively small gradient to draw physicians from Medicare to private patients. A similar comparison of conversion factors in anesthesiology demonstrates a vastly greater differential: Medicare rates are less than 40% of private conversion factors in our specialty. Indeed, our recent national survey of welfare conversion factors showed that the national average Medicaid rate was slightly more than $17 per unit at a time when the national average Medicare anesthesia rate was $16.60. Therefore, not

only do private insurers pay nearly three times Medicare's fees, but many welfare programs pay more than Medicare, too.

Were it not for the obligation of anesthesiologists to care for all those appearing in our operating rooms, I think it is fair to say that anesthesiologists' Medicare participation rates under these circumstances would be in single digits. While we take "all comers" where we practice, our members respond to financial incentives with their feet, especially in the face of a serious and unremitting provider shortage in the specialty. Institutions serving large numbers of Medicare beneficiaries either subsidize the clinical practice revenues of their anesthesiologists or lose them. For example, Sun Health of Arizona has a 90% Medicare caseload and, according to CEO Leland Peterson, spent more than $1 million in subsidy and locum tenens coverage to keep its ORs running. One of the Sun Health facilities in Sun City lost its entire anesthesia group and another lost 65% of its anesthesiologists in the same year to more lucrative, lower Medicare practices. Sun Health is a good example of the dramatic cost shifting from Part B to Part A driven by the inadequacy of the Medicare rate in anesthesiology. A recent Tarrance Group survey of hospital administrators demonstrated that more than a third of hospitals are subsidizing anesthesiologists.

ASA has twice presented its case for adjustment to the conversion factor to the AMA Specialty Society Relative Value Update Committee (RUC), but the problem persists. The viability of anesthesia practice under Medicare rates is not a consideration in the RUC's review of the issue. The RUC was never designed to assess the impact of the fee schedule on provision of medical services. There is, in fact, no place in the update mechanism where the <u>adequacy</u> of reimbursement addressed. Even though the RUC recently found consistent undervaluation of physician work in many common anesthesia services, in the 2003 fee schedule

CMS took an excrutiatingly narrow interpretation of the RUC study and made a miniscule adjustment. Measures such as this will clearly do nothing to make anesthesiologists available to communities like Sun City and don't begin to relieve the burden on hospitals in such areas. The RUC can't see the forest for the trees and CMS appears unable to do any better. We hope the Commission will help CMS create a fee schedule that makes the self-sustaining practice of my specialty possible under Medicare.