



Independent Payment Advisory Board Hearing
House Committee on Ways and Means
Subcommittee on Health

Tuesday March 6, 2012

Statement for the Record by
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On behalf of the over 48,000 members of the American Society of Anesthesiologists, I would like to thank Chairman Herger and Ranking Member Stark for holding this hearing on the Independent Payment Advisory Board (IPAB). I greatly appreciate the opportunity to submit a statement for the record and your willingness to bring this important topic before the Committee.

ASA realizes that Congress is examining ways to keep the Medicare program sustainable for future generations. As a physician, I have an interest in seeing that the Medicare program remains viable for my patients. As a representative of a national physician organization, I believe that adequate physician payment is essential to ensuring that Medicare patients have access to safe and effective care. IPAB fails on both fronts. **Simply put, IPAB is an unelected board whose sole purpose is to cut Medicare payments.**

Anesthesiology's role as leaders in improving quality care and our longstanding Medicare payment problems give us a unique perspective on IPAB. Anesthesiologists are recognized by the Institute of Medicine as the leader in patient safety,¹ and we have done more than our fair share to control costs. Through quality improvements anesthesiologists have reduced their liability costs over the years.² And, the Congressional Budget Office (CBO) has determined that anesthesia services do not drive volume or growth.³ However, as many on this Committee know, anesthesiologists suffer from a significant payment disparity under the Medicare system known as the "33% problem." While modest disparities between Medicare and commercial physician payment rates are longstanding and well-recognized for other medical specialties, the disparity in payments for anesthesia services is unique. In July 2007, a Government Accountability Office (GAO) report confirmed for the public and Congress what anesthesiologists have known and

¹ *To Err is Human: Building a Safer Health System*, Institute of Medicine, 2000.

² Newman, David. Vivian S. Chu and Baird Webel. *Medical Malpractice: Background and Examination of the Issues Before Congress*. Congressional Research Service. June 27, 2011.

³ "Budget Options Volume I Health Care" Congressional Budget Office. December 2008:
<http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf>.

struggled with for years: Medicare payments for anesthesia services are drastically low.⁴ According to the GAO, Medicare payments for Anesthesia services represent only 33 percent of the prevailing commercial insurance payment rates for the same service. In contrast, the Medicare Payment Advisory Commission (MedPAC) consistently reports Medicare's payments for other physician services represent approximately 80 percent of commercial rates when averaged across all physician services and geographic areas. Further, the anesthesia payment differential continues and may be expanding. Based on ASA's annual survey data, the 2011 Medicare anesthesia conversion factor was only 31 percent of even the lowest average commercial conversion factor for anesthesia.⁵ It is against this backdrop that it is unthinkable for those in my profession that an unaccountable and unelected board could make cuts to Medicare payments for the services of our medical specialty.

ASA remains very concerned about IPAB's statutory authority which effectively usurps a significant and meaningful part of Congress' authority over the Medicare program. Longstanding payment policies with broad support in Congress and enacted into law could be reversed or changed by the Board. Moreover, lawmakers would effectively be thwarted by barriers created by the IPAB statute from holding the board to any level of accountability. Currently, Medicare beneficiaries, advocates, and physicians have the ability to work with Congress to improve the program. The implementation of IPAB would largely remove Congress from the process with negative consequences for the nation's Medicare system.

In 2010, the House passed the Senate's Affordable Care Act, which included the IPAB provision. Many Members of Congress that voted for the Senate bill, including members of this Committee, pledged to improve the Affordable Care Act. In that vein, ASA strongly urges Congress to repeal IPAB immediately. **The time for repealing IPAB is today and the momentum is growing.** In a show of bipartisanship, the House Ways and Means Committee and the House Energy and Commerce Committee voted in support of Congressman Phil Roe's legislation, H.R. 452, to repeal IPAB. Currently, 234 bipartisan House Members have cosponsored H.R. 452, including members of this Committee. We thank them for their support and urge swift passage of this legislation.

⁴ U.S. Government Accountability Office. *Medicare and Private Payment Differences for Anesthesia Services*, GAO-07-463, Washington, DC: Government Accountability Office, 2007.

⁵ Byrd, Jason R. Loveleen Singh. *ASA Survey Results for Commercial Fees Paid for Anesthesia Services*, 2011. American Society of Anesthesiologists Newsletter. October 2011. Vol. 75. Number 10: 38-41.