THE INDEPENDENT PAYMENT ADVISORY BOARD

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

MARCH 6, 2012

Serial No. 112–HL08

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

78–590 WASHINGTON : 2013

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON WAYS AND MEANS

DAVE CAMP, Michigan, *Chairman*

WALLY HERGER, California
SAM JOHNSON, Texas
KEVIN BRADY, Texas
PAUL RYAN, Wisconsin
DEVIN NUNES, California
PATRICK J. TIBERI, Ohio
GEOFF DAVIS, Kentucky
DAVID G. REICHERT, Washington
CHARLES W. BOUSTANY, JR., Louisiana
PETER J. ROSKAM, Illinois
JIM GERLACH, Pennsylvania
TOM PRICE, Georgia
VERN BUCHANAN, Florida
ADRIAN SMITH, Nebraska
AARON SCHOCK, Illinois
LYNN JENKINS, Kansas
ERIK PAULSEN, Minnesota
KENNY MARCHANT, Texas
RICK BERG, North Dakota
DIANE BLACK, Tennessee
TOM REED, New York

SANDER M. LEVIN, Michigan
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
JIM MCDERMOTT, Washington
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
XAVIER BECERRA, California
LLOYD DOGGETT, Texas
MIKE THOMPSON, California
JOHN B. LARSON, Connecticut
EARL BLUMENAUER, Oregon
RON KIND, Wisconsin
BILL PASCRELL, JR., New Jersey
SHELLEY BERKLEY, Nevada
JOSEPH CROWLEY, New York

JENNIFER SAFAVIAN, *Staff Director*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

WALLY HERGER, California, *Chairman*

SAM JOHNSON, Texas
PAUL RYAN, Wisconsin
DEVIN NUNES, California
DAVID G. REICHERT, Washington
PETER J. ROSKAM, Illinois
JIM GERLACH, Pennsylvania
TOM PRICE, Georgia
VERN BUCHANAN, Florida

FORTNEY PETE STARK, California
MIKE THOMPSON, California
RON KIND, Wisconsin
EARL BLUMENAUER, Oregon
BILL PASCRELL, JR., New Jersey

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

THE INDEPENDENT PAYMENT ADVISORY BOARD

TUESDAY, MARCH 6, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:02 a.m., in Room 1100, Longworth House Office Building, Hon. Wally Herger [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
Tuesday, March 6, 2012
HL–08

CONTACT: (202) 225–1721

Chairman Herger Announces a Hearing on the Independent Payment Advisory Board

House Ways and Means Health Subcommittee Chairman Wally Herger (R–CA) today announced that the Subcommittee on Health will hold a hearing to examine how the Independent Payment Advisory Board (IPAB) will impact the Medicare program, its beneficiaries, and health care providers. **The hearing will take place on Tuesday, March 6, 2012 in 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing. A list of witnesses will follow.

BACKGROUND:

The health care overhaul created IPAB to "reduce the per capita growth rate in Medicare spending." This 15-member board, which will consist of unelected, Presidentially-appointed members, will make recommendations as early as January 15, 2014, to cut Medicare spending if the per capita Medicare spending rate is expected to exceed an economic growth rate over a 5-year period. IPAB's recommended Medicare cuts are "fast tracked" in Congress and will go into effect unless Congress amends IPAB's recommendations with legislation that produces the same level of savings.

In announcing the hearing, Chairman Herger stated, **"One of Congress' most important responsibilities is to oversee the Medicare program and protect its beneficiaries. When Democrats created this panel, they chose to empower unelected bureaucrats at the expense of patients and their doctors. IPAB robs Medicare beneficiaries of their voice and stifles their Constitutionally-mandated representation. Our seniors and those with disabilities deserve more than nameless political appointees who will deny care if they decide it costs too much. This hearing will allow the Subcommittee to fully understand the impact this ill-conceived rationing board will have on Medicare beneficiaries and their health care providers."**

FOCUS OF THE HEARING:

The hearing will examine the impact sections 3403 and 10320 of the "Patient Protection and Affordable Care Act" (P.L. 111–148) will have on the Medicare program, its beneficiaries, and health care providers.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*Hearings*." Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submis-*

sion for the record." Once you have followed the online instructions, submit all requested information. ***ATTACH*** your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, March 20, 2012**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman HERGER. The Subcommittee will come to order. We are meeting today to hear from those who will be directly and adversely impacted by the Independent Payment Advisory Board, or IPAB. In an era where our two political parties are best known for their deep divisions, this is one area where there appears to be bipartisan concern.

IPAB was created in the Democrat's health care overhaul, and is designed to reduce the per capita rate of growth in Medicare spending. That might sound benign, but when you peel back a couple of layers it is clear that IPAB is a real threat to Medicare beneficiaries' health. Those concerned about a government takeover of health care need look no further than IPAB.

If implemented, the board will consist of 15 unelected and unaccountable Washington appointees. IPAB is given the authority to meet in secret, make its decisions in secret, and it does not need to consider the perspective of Medicare patients or their health care providers. To top it off, IPAB's rulings cannot be challenged in a court of law. My good friend from California, the Ranking Member, Mr. Stark, characterized IPAB as a "mindless rate-cutting

machine that sets up for unsustainable cuts that would endanger the health of American seniors and people with disabilities."

Yet, despite the growing bipartisan opposition to this unaccountable board, the President once again proposed further expanding its authority in his most recent budget.

Why is IPAB so dangerous? I have heard numerous concerns from patients and doctors. But to me, nothing is more troubling than IPAB's ability to drive a wedge between Medicare beneficiaries and their doctors. There is nothing in the Democrat's health care law preventing IPAB from slashing Medicare reimbursements for services or procedures that IPAB members feel are unnecessary or ineffective to levels so low that physicians would be willing to provide such care. As long as IPAB is allowed to exist, access to care for seniors and those with disabilities will forever be in jeopardy.

IPAB supporters argue that it cannot ration care. What they won't tell you is that the term "ration" is not defined anywhere in the Medicare statute. This means that what is and is not rationing will be left to 15 faceless, unaccountable and unelected appointees to decide.

There is a better way. Rather than endangering Medicare beneficiaries, we should empower them. House Republicans have put forth such a plan. Our plan would let beneficiaries, not bureaucrats, decide the coverage they want and need. We have an excellent and diverse panel of witnesses here today who will share their thoughts and concerns about IPAB. We should all take note that when patients and providers are in agreement that access to care is in jeopardy, where those concerns exist it is our fiduciary responsibility to address them.

Before I recognize Ranking Member Stark for the purpose of an opening statement, I ask unanimous consent that all Members' written statements be included in the record.

[No response.]

Without objection, so ordered. I now recognize Ranking Member Stark for 5 minutes for the purpose of his opening statement.

Mr. STARK. Thank you, Mr. Chairman. I guess you saw how long this was so you slipped that 5 minutes in there on me. That is okay.

I am proud of what we have done with the Affordable Care Act. We have provided more than 2½ million young adults with health coverage. We have reduced prescription drug costs for nearly 4 million seniors, provided free preventative care to 86 million people of all ages. And in 2014 it will go fully into effect, and expand coverage to over 30 million uninsured Americans, providing security, permanent security, for those who already have coverage.

That said, the Affordable Care Act is a large bill with many provisions. And none of us probably agree with every single provision. To that point, the Independent Payment Advisory Board, or IPAB, is a provision I strongly oppose. Remember, the House included no similar provision in our health reform bill. It is a product of the other body and we really had no part in it.

Let me be clear. I oppose IPAB for reasons different, perhaps, from my other colleagues. Congress has always stepped in to strengthen Medicare's finances when needed. I have always worked

on this Subcommittee to protect and strengthen Medicare, and ensure that it works for its 50 million beneficiaries.

One only has to look at the Accountable Care Act, which extended solvency, slowed spending growth, lowered beneficiary costs, improved benefits, modernized the delivery system, and created new fraud-fighting tools, to see that we have done a good job on this Committee.

I see no reason why Congress should hand that authority over to the executive branch. That undermines the separation of powers. And I won't go into detail now, but I have other concerns about IPAB's process. I am sure we will hear more about that today.

No one should interpret my opposition to IPAB as a knock against the ACA. I stand by my vote there. Nor should anyone interpret Republican support to repeal IPAB as an attempt to improve or preserve Medicare. I still believe that the other side of the aisle would like to end Medicare, provide it as a voucher, and that would underfund what is needed for individuals' disabilities.

Despite my opposition to IPAB, I think it is far less dangerous than a voucher plan. It doesn't undermine Medicare's guaranteed benefits. And its ability to reduce Medicare spending has guardrails. It doesn't permit cuts to come from reduced Medicare benefits. It prohibits rationing and has annual limits on Medicare cuts. The Republican voucher plan does not have these protections.

So, I believe that the witnesses may share my confusion or skepticism, but I look forward to discussing with them, if they believe there is a better plan on the other side of the aisle for Medicare's future. And I will see what the witnesses have to say.

Thanks, Mr. Chairman.

Chairman HERGER. Thank you, Mr. Stark. Today we are joined by four witnesses: Dr. Scott Gottlieb, resident fellow at the American Enterprise Institute; Katherine Beh Neas, vice president of government relations at Easter Seals; Dr. David Penson, a practicing urologist from Nashville, Tennessee, who is vice chair of the American Urological Association Health Policy Council; and Marilyn Moon, senior vice president and director of the health program at the American Institute for Research.

You will each have 5 minutes to present your oral testimony. Your entire written statement will be made a part of the record.

Dr. Gottlieb, you are now recognized for 5 minutes.

STATEMENT OF SCOTT GOTTLIEB, M.D., RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE FOR PUBLIC POLICY RESEARCH (WASHINGTON, DC)

Dr. GOTTLIEB. Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to testify before the Committee.

IPAB was created based on the premise that decisions about the pricing of Medicare benefits are simply too contentious to be handled by a political system. But changes to the way Medicare pays for medical services affect too many people in significant ways to be made behind closed doors. How Medicare prices medical products and services has sweeping implications across the entire private market. They are some of the most important policy choices that we make in health care.

To these ends there are some considerable shortcomings with the way that IPAB is structured and how it will operate. Among these problems, IPAB has no obligation to engage in public notice and comment that is customary to regulatory agencies whose decisions have similarly broad implications. IPAB's decisions are restricted from traditional review. In creating IPAB, Congress provided effective patients, providers, and product developers no mechanism for appealing the board's pronouncements. IPAB's recommendations will be fast-tracked through Congress in a way that provides only a veneer of congressional review and consent.

And for practical purposes, IPAB has been given the authority to legislate. Moreover, there is a belief that if IPAB fails to fulfill its mandate, these decisions will default to Congress. Actually, under the law they default to the Secretary of Health and Human Services.

But most significantly, IPAB is unlikely to take the steps to actually improve the quality of medical care and the delivery of services under Medicare. That is because IPAB does not have any practical alternative to simply squeezing prices in the Medicare program.

The program we have in Medicare is a problem with the existing price controls that erode health care productivity in Medicare's outdated fee-for-service payment system. This leads to inefficient medical care. There is too little support for better, more innovative ways of delivering health care.

IPAB can pursue longer-term reforms to change incentives and behavior. These ideas—for example, aligning reimbursement with value and quality, or expanding cost sharing—don't generate savings in the short run, since they are premised on long-term changes on how efficiently doctors and patients use medical services. These proposals will not produce the kind of immediate savings that IPAB needs to achieve a narrow budget window that will be its focus. Yet these are precisely the kinds of reforms that Congress has aimed to pursue on a bipartisan basis.

By doubling down on the existing practice of simply whacking price schedules with no meaningful eye to how these changes impact long-term incentives, IPAB will put more systemic payment reform further out of reach. IPAB will be working at cross purposes to Congress' broader reform goals.

IPAB's need to focus on short-run manipulation and price schedules and coding procedures is evidenced by the fact that longer-term payment reforms don't score saving money by either the CBO or the Medicare actuary who has to sign off on IPAB's recommendations.

All of these ideas for broader payment reform also rely on changes in payment to providers, especially hospitals. IPAB can't do these kinds of structural reforms if these constituencies remain off limits until 2019.

Moreover, because IPAB has its purview narrowly targeted to specific slices of the industry to achieve its targeted savings, IPAB may be forced to implement unusually deep cuts to the limited terrain where it can operate. These deep cuts could forestall access all together to certain products and services.

Medicare must continue to implement reforms to align its coverage and payment policies with a value delivered to beneficiaries.

Congress needs to focus on real ways to get longer-term savings, like premium support, modernizing benefits in the traditional Medicare program, and paying for better outcomes. IPAB makes it even harder to do all of these things.

If Congress believes that the political process is incapable of making enduring decisions about the payment of medical benefits, then all of this is an argument for getting the government out of making these kinds of judgements in the first place. It is not, in my view, an argument for creating an insular panel that is removed from the usual scrutiny to take decisions that other Federal agencies have failed to discharge, precisely because those decisions couldn't survive public examination. Thank you.

[The prepared statement of Dr. Gottlieb follows:]

THIS TESTIMONY IS EMBARGOED UNTIL 10:00 AM, MARCH 6, 2012

AMERICAN ENTERPRISE INSTITUTE

Statement before the Committee on Ways and Means
Subcommittee on Health

IPAB: Its Impacts on Medicare, its Beneficiaries, and Healthcare Providers

March 6, 2012

Scott Gottlieb, M.D.
Resident Fellow
American Enterprise Institute

The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

Introduction

Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to testify today before the House Committee on Ways and Means, Subcommittee on Health.

The Independent Payment Advisory Board (IPAB) is premised on a belief that decisions about how we price the services offered by Medicare are simply too contentious to be adequately addressed by our political system. Politics, it's argued, inevitably stymie our ability to make hard decisions to cut prices and reduce coverage of services. As a result, it becomes impossible to shrink the growth in spending. So IPAB was designed to remove the supervision of the Medicare program, and Congress, from these choices.[i]

But judgments about how we price medical services, and how those prices affect access to care, are precisely the kinds of consequential choices that should be subject to close public scrutiny. We need to have an open, rigorous, and transparent process for making these decisions. We need to actively engage Medicare's stakeholders in these deliberations, to make sure that these policies don't create unintended consequences for beneficiaries. IPAB, instead, aims to freeze stakeholders out of this process.

Changes to the way Medicare covers and pays for medical care affect too many people in significant ways to be made behind the closed doors of an insulated committee that's not accountable to beneficiaries, providers, or even to Congress. How Medicare prices products and services have sweeping implications across the entire private marketplace precisely because of the way private health plans emulate Medicare's billing schedules.

These decisions are some of the most important policy choices that we make inside our healthcare system. There are too many unpredictable consequences from these choices to let them be made in an open process that isn't subject to close public scrutiny.

Shortcomings in IPAB's Construction

Because of the substantial flaws in IPAB's mission, and the way that the board is constructed, it's activities are going to inevitably affect patients' access to care, despite Congress' intentions to make sure that IPAB couldn't limit the "benefits".[ii]

IPAB was purposely designed to take decisions about how to cut Medicare's spending on products and services out of any public debate. The implementation of IPAB's decisions is not subject to review by the Medicare program, and only tacitly subject to approval by Congress. There is no requirement for advance notice and solicitation of public comment. The board's decisions pre-empt the entire administrative and legislative process.

Patients have no way to appeal its decisions. Affected sponsors can't sue IPAB for recourse. Yet the board has enormous power. It can re-write laws already enacted by Congress with little meaningful opportunity for Congress to intervene.

IPAB's recommendations will be fast tracked through Congress, in a way that provides for only a veneer of Congressional review and consent. This was probably a nod to Constitutional requirements for a separation of powers between the Executive and legislative branches rather than a desire for genuine Congressional input.

For practical purposes, IPAB has been given the authority to legislate. Moreover, there's a belief that if IPAB fails to fulfill its mandate, these decisions will default to Congress. Actually, under the law, they default to the Secretary of Health and Human Services.

The cumulative effect of the rules for appointing members to IPAB will almost guarantee that most of its outside members hail from the insular ranks of academia.

In short, every aspect of this board was designed to remove significant decisions about Medicare cuts from public scrutiny and open debate. This was the intention. But it's a flawed premise to believe that we will get a better result by sidestepping an open, vigorous policy debate about how we price and cover services under Medicare.

Most significantly, IPAB is unlikely to take steps that actually improve the quality of medical care and the delivery of services under Medicare.

That's because IPAB does not have any practical alternative to simply squeezing prices in the Medicare program. Owing to the way it is set up, IPAB is statutorily required to achieve its savings in the short term. This will mean IPAB can do little more than manipulate Medicare's current price schedules and its coding process.

The problem we have in Medicare is not a short-term problem that can be fixed with price squeezes. We have already been trying and failing at that for the last 45 years. It's a problem with the existing price controls that erode healthcare productivity and Medicare's outdated fee-for-service payment system that leads to inefficient medical care and inadequate support for better, more innovative ways of delivering medical care.

IPAB can't pursue longer-term reforms to change incentives and behavior. These ideas (for example, aligning reimbursement with value and quality, or expanding cost-sharing) don't generate much savings in the short run, since their premised on long-term changes in how efficiently doctors and patients use medical services.

These proposals will not produce the kind of immediate savings that IPAB needs to achieve in the narrow budget windows that'll be its focus. Yet these are precisely the kinds of reforms that Congress has aimed to pursue on a bipartisan basis. By "doubling down" on the existing practice of simply whacking existing price schedules in order to slow spending – with no meaningful eye to how these changes impact long-term

incentives -- IPAB will put more systemic payment reforms further out of reach. IPAB, in short, will be working at cross-purposes to Congress' broader reform goals.

IPAB's need to focus on short-run manipulation of price schedules and coding procedures is evidenced by the fact that longer-term payment reforms don't "score" as saving money by the Congressional Budget Office or the Medicare Actuary (who has to sign off on IPAB's recommendations). The Medicare Actuary scored most of the Affordable Care Act's provisions based on quality improvement as getting little to no savings over the full decade, even though we all remain hopeful that these provisions will lead to genuine efficiencies. All of these ideas for broader payment reform also rely on changes in payment to providers, especially hospitals. IPAB can't do these kinds of structural reforms if these constituencies remain off limits until 2019.

Almost by default, IPAB will have to settle for manipulating existing price schedules – either reducing current payment rates, tweaking codes, or importing price schedules from one market for products and services into new areas. Moreover, because IPAB had its purview narrowly targeted to specific slices of the industry, to achieve the targeted saving, IPAB may be forced to implement unusually deep cuts to the limited terrain where it can operate. These deep cuts could forestall access altogether to certain products and services. There's evidence that higher payments expand access to physicians.[iii] The opposite is also true. The Medicare Actuary estimates that Medicare rates will eventually be driven below Medicaid rates under the current budget assumptions.

Additionally, just because IPAB is exempt from limiting "benefits" doesn't mean it can't limit coverage in ways that reduce patients' access to medical care. IPAB could, in practice, still create policies that affect how particular services are covered by benefits. It seems clear that IPAB will have the power to confer the Centers for Medicare and Medicaid Services with new authorities that will enable the Medicare agency to make more granular decisions about what medical products and services it chooses to cover.

Rather than making the tough clinical judgments themselves about the relative value of individual products and services, IPAB would grant CMS authority to exert more control over benefit design, to rely on judgment of the agency's largely thin clinical staff about the coverage it will provide for competing treatments. This could have significant implications. While the new law bars IPAB from reducing the coverage of specific items, there is nothing barring IPAB from giving CMS authorities to engage in similar activities.

If Congress intended CMS to have more deliberate authorities to make decisions about what services should and shouldn't be covered by Medicare, I think many here today, on this Committee, would want the opportunity to weigh those decisions and not have them conferred by a remote agency that's removed from public oversight. These kinds of tough choices get to the very heart of what kind of benefit Medicare will ultimately become, and whether it will remain adequate medical benefit or see its practical value eroded.

For those who believe that IPAB will take a cautious, go-slow approach, the exact opposite may be true. That's because IPAB may only get a few chances during their

tenure to implement changes. When these windows open up, their institutional prejudice will be to overshoot, not undershoot. Under IPAB's charter, it only gets to make policy when the rate of Medicare growth is expected to exceed CPI by a certain measure. This means IPAB may only have the chance to legislate once every several years.

Some of its members will undoubtedly worry they may not get more than one chance to push favored ideas. So they'll try and get their proposals implemented when they have the opening. Similarly, members may decide that it's politically easier to issue proposals once every several years rather than come up with a new set of policies annually.

Impact of IPAB's Actions

Medicare is no ordinary payer. Its decisions should be subject to close scrutiny precisely because of their wide-ranging impact. Yet IPAB's entire scheme is far less transparent, rigorous, and open to challenge than the average private health plan.

This will have implications for patients and providers. It will also have significant implications for those developing new medical technologies. It will make that process more uncertain, more costly, and less attractive to new investment.

Can you imagine a private health plan making retrospective decisions about coverage and payment after it had contracted with providers and beneficiaries, and then proclaiming itself exempt from any appeals by patients, judicial review by beneficiaries or providers, and relieved of any serious political scrutiny? This is effectively how IPAB will operate, not by its own fidelity but by legislative design, according to its Congressional mandate. Congress has created the very constructs that it derides, and penalizes, when private companies undertake similar practices that deny consumers a chance for petition.

Medicare must continue to implement reforms to align its coverage and payment policies with the value being delivered to beneficiaries. The only consistent way is to develop policies that enable these decisions to be made in a de-centralized fashion, based on the actual demand from consumers and providers. We can't develop these kinds of long-term reforms by lodging these judgments into the hands of an increasingly narrow and insulated band of appointed "experts" who are beholden to short-term budget goals.

Congress needs to focus on real ways to get longer-term savings, like premium support, modernizing benefits in traditional Medicare, and paying for better outcomes. IPAB makes it even harder to do all these things. The activities of IPAB will only serve to put more meaningful, global payment reforms further out of reach.

If Congress believes that the political process is incapable of making enduring decisions about the payment of medical benefits, then this is an argument for limiting the government role in making these kinds of judgments in the first place. It's not a call for creating an insular panel, exempt from public scrutiny; to take on decisions that other Federal agencies have failed to adequately discharge. Choices about how we price and

cover medical benefits under Medicare are simply to important for Americans to remove from public scrutiny and from the close supervision of Congress.

Dr. Gottlieb is a physician and Resident Fellow at the American Enterprise Institute. He previously served as Deputy Commissioner of the Food and Drug Administration and a Senior Advisor to the Administrator of the Centers for Medicare and Medicaid Services. He consults with, and invests in healthcare companies.

---

[i] The Affordable Care Act prohibits IPAB from making any recommendations prior to December 31, 2018 that would "reduce payment rates" on items and services furnished by a Medicare provider that is scheduled "to receive a reduction in the inflationary payment updates…in excess of a reduction due to productivity" in a year in which the recommendation is to take effect. This was meant to exempt hospitals from being targeted by IPAB prior to 2019.

[ii] The law states: The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

[iii] Chapin White. A Comparison of Two Approaches to Increasing Access to Care: Expanding Coverage versus Increasing Physician Fees. February 2, 2012. DOI: 10.1111/j.1475-6773.2011.01378.x

Chairman HERGER. Thank you.

Ms. Neas, you are now recognized for 5 minutes.

STATEMENT OF KATHERINE BEH NEAS, SENIOR VICE PRESIDENT, GOVERNMENT RELATIONS, EASTER SEALS, OFFICE OF PUBLIC AFFAIRS (WASHINGTON, DC)

Ms. NEAS. Thank you, Mr. Chairman, for this opportunity to testify. I am Katy Neas, senior vice president for government relations at Easter Seals. For nearly 100 years, Easter Seals has provided exceptional services so that children and adults with disabilities in their families can live, learn, work, and play in the community. Last year, Easter Seals served 1.6 million individuals through a network of 75 affiliates across the country.

Easter Seals' experience over these many decades has solidified our belief that when people with disabilities, regardless of age, receive appropriate health care services, they live with greater independence. This experience was one of the main reasons Easter Seals supported and continues to support the Affordable Care Act. At the same time, we strongly concur that there must be cost containment within the health care system, and believe that more can and must be done to control costs within both public and private health care systems.

To achieve true cost containment, Easter Seals believes that two important steps must be in place. First, the cost containment reforms established in the ACA must be given time to be implemented. Second, any new policies must be designed to ensure that people with disabilities can attain appropriate, medically necessary services in a timely fashion as to promote overall health and wellness.

We too have concerns about the effectiveness of the IPAB that was included in the ACA. IPAB is not designed to be an instrument of delivery reform, or to improve the quality of care. The charge for this board is to reduce the per capita rate of growth in Medicare spending. For people with disabilities and chronic conditions, it is through better coordination and provision of quality care that real changes in health status can be achieved, and savings in the health care system can be realized.

The language of the Affordable Care Act so limits where the IPAB can make changes, that all that is really left is reducing reimbursements to providers. The board cannot take any action that would deny access to care, increase revenue, restrict benefits, or change reimbursements to hospitals or hospices. If circumstances bring about a mandated cut in reimbursement to providers, it is likely that access to quality care will be reduced, and cost will be shifted to the patient.

We are already experiencing a reduction in the number of health care providers who will participate in public insurance programs. The result is the same as if benefits were eliminated.

A legislative correction such as the Medicare Decisions Accountability Act would ensure transparency and an opportunity for any beneficiary to talk with their Member of Congress about how the Medicare program can reduce cost and increase quality. It would also leave on the table more options for slowing the growth of Medicare expenditures, and the support of new delivery reform

models. This seems the brighter path for people with disabilities and chronic conditions, to assure the most impact from money spent through the Medicaid program.

Again, thank you for this opportunity to speak with you today.

[The prepared statement of Ms. Neas follows:]

THIS TESTIMONY IS EMBARGOED UNTIL 10:00 AM MARCH 6, 2012

Easter Seals
Office of Public Affairs
1425 K Street, N.W.
Suite 200
Washington, DC 20005
202.347.3066 phone
202.347.7385 tty
202.737.7914 fax
www.easterseals.com

Testimony of Katy Beh Neas
Senior Vice President, Government Relations
Easter Seals

Before the House of Representatives Ways and Means Committee
Health Subcommittee

March 6, 2012

Katy Beh Neas
Senior Vice President, Government Relations
Easter Seals
Office of Public Affairs
1425 K St. NW, Suite 200
Washington, DC 20005
PH: 202.347.3066
FX: 202.737.7914
kneas@easterseals.com
www.easterseals.com

Chairman Herger and Ranking Member Stark, Members of the Health Subcommittee of the Ways and Means Committee, thank you for this opportunity to testify. I am Katy Beh Neas, Senior Vice President for Government Relations at Easter Seals.

For people with disabilities and chronic conditions of all ages, the goal of good health care is to have access to high quality, comprehensive and affordable health care that allows a person to be healthy and live as independently as possible and participate in his or her community. For the nearly 48 million qualified individuals with disabilities or who over the age of 65, the Medicare program is the primary route to that quality health care coverage.

As the principal source of health insurance for this frequently vulnerable population, the need to control cost is going to be entwined with the continued integrity of the program. The question that arises, then, is whether the proposed Independent Payment Advisory Board or IPAB is a mechanism to employ.

The Independent Payment Advisory Board was included in the Affordable Care Act as a back-up tool to reduce the cost of Medicare should that program exceed a designated target. While Easter Seals supported the passage of this legislation with the goal to increase the number of people with access to health care coverage, there are questions to be raised about the use of this tool for the purpose of cost containment for Medicare, a public medical insurance program.

Serious concerns have been raised about a 15 member, non-elected board mandating to Congress reductions to bring spending for a federal health care program into line. These policy recommendations would move through the legislative process on an accelerated track and, if the House of Representatives or Senate could not garner a simple majority vote on alternatives or 3/5 of their members to oppose the proposals, they would become law. Taking the responsibility of Medicare payment policy out of the hands of elected members of Congress reduces the access that beneficiaries and providers, who interact with the program on a regular basis, have to the development of good health care policy. The law does not require even a public hearing for the individuals most affected by the proposed changes to have a voice in the process.

The IPAB is not designed to be an instrument of delivery reform or to improve the quality of care. The charge for this Board is to reduce the per capita rate of growth in Medicare spending. For people with disabilities and chronic conditions, it is through better coordination and provision of quality care that real changes in health status can be achieved, not in the reduction of spending per person. The language of the Affordable Care Act so limits where the IPAB can make changes that all that is really left is reducing reimbursements to providers. The Board can not take any action that would deny access to care, increase revenue, restrict benefits, or change reimbursements to hospitals or hospices. If circumstances bring about a mandated cut in reimbursement to providers, it is likely that access to quality care will be reduced and costs will be shifted to private payers, which only worsens an existing problem.

For people with disabilities, the structure of care delivery systems can go a long way toward providing better and more comprehensive care. The need to track and organize the process of a patient's care, we believe, will lead to better health outcomes, but this does not happen in a visit or two, but with commitment to coordination over time. The savings, should the Independent Board act, are to be found in one "scoreable" year, not over the reasonable period of time it takes to produce a path to better care and therefore better outcomes.

A legislative correction such as the Medicare Decisions Accountability Act would ensure transparency and an opportunity for any beneficiary to talk with their member of Congress about how the Medicare program can reduce cost and increase quality. It would also leave on the table more options for slowing the growth of Medicare expenditures and the support of new delivery reform models. This seems the brighter path for people with disabilities and chronic conditions to assure the most impact from money spent through the Medicare program.

Thank you.

Easter Seals is a private, non-profit organization that provides exceptional services, education, outreach, and advocacy so that people living with disabilities or other special needs and their families can live, learn, work and play in our communities. Through a network of 75 affiliates, Easter Seals served 1.6 million children and adults with disabilities in 2010.

Chairman HERGER. Thank you.

Dr. Penson, you are now recognized for 5 minutes.

STATEMENT OF DAVID F. PENSON, M.D., MPH, VICE CHAIR, HEALTH POLICY COUNCIL, AMERICAN UROLOGICAL ASSOCIATION (NASHVILLE, TN)

Dr. PENSON. Chairman Herger, Ranking Member Stark, and other Members of the Subcommittee, I want to thank you for the opportunity to testify on the IPAB. My name is David Penson, and I am a practicing urologist from Nashville, Tennessee. I am speaking today on behalf of the American Urological Association, or the AUA, which has over 18,000 members, and has promoted the highest standards of urologic care in the United States and the world for the last 110 years. I serve as the vice chair of the AUA's health policy council. My testimony today does not represent the opinion of my primary employer of Vanderbilt University.

The AUA strongly opposes the IPAB, and calls on Congress to pass legislation that would repeal it. The AUA also participates in the IPAB Coalition and is a member of the Alliance of Specialty Medicine. Both groups support full repeal of the IPAB. We believe that the IPAB, if enacted, will result in reduced access to health care for Medicare beneficiaries.

Why do we believe this? We know the Subcommittee is keenly aware of the ongoing issues with the SGR. Despite recent action to temporarily prevent the steep cuts to the SGR, physicians now face a 32 percent cut on January 1, 2013. Clearly, this affects physicians' confidence in the Medicare program. To understand how much it affects confidence, and to determine if the cuts would impact access to health care, the Alliance of Specialty Medicine last year surveyed physicians and found that more than one-third planned to change their Medicare status to non-participating if reimbursement is significantly cut. Another third will opt out of Medicare for 2 years and privately contract with patients.

The IPAB will only make matters worse. Hospitals and other Part A providers are exempt from IPAB until 2020. In addition, the IPAB is required to make recommendations that prioritize primary care. The result will be a disproportionate share of reductions on physicians with an emphasis on specialists, including urologists.

Like the SGR, the IPAB, by its very nature, is flawed and will result in providers leaving Medicare. Specifically, the IPAB will consist of a board of unelected individuals that lacks accountability, clinical expertise, and transparency in its proceedings. In addition, the IPAB's recommendations will be precluded from administrative or judicial review, and will be enacted unless Congress specifically acts to prevent this from occurring.

To understand the negative impact that IPAB would have on Americans, we can look to the current impact of a similar body, the United States Preventative Services Task Force. The task force is an independent panel composed exclusively of primary care providers, and charged with making recommendations on the value of preventative services. The task force is not required, nor does it consult with the specialty areas relevant to the specific recommendations, and only recently added a public comment period in response to criticism.

The task force got our attention this fall when it released new draft recommendations to discourage PSA-based screening of prostate cancer, giving it a D rating, asserting that there is no net benefit, or that the harms outweigh the benefits. Based upon our review of the evidence, we strongly disagree with these draft recommendations. But the task force did not seek our opinion. In fact, the draft recommendations were developed without consultation of urologists, medical oncologists, or radiation oncologists, the very specialists who diagnose and treat prostate cancer every day.

Prior to the Affordable Care Act, the task force recommendations were advisory and non-binding. Now, however, their recommendations are tied to patient cost sharing, intended to encourage or limit access to certain provider services, preventative services. In short, the recommendations of the task force will limit Medicare beneficiaries' right to decide if they can be screened for prostate cancer, and have reduced access to health care.

You may recall a couple of years ago that the task force made similar recommendations discouraging mammograms for women in their forties. Like the task force, the IPAB is another board of unelected, unaccountable individuals that will have a similar impact on Medicare beneficiaries. However, its impact will be more severe, since the IPAB has much broader authority to alter the delivery of care. Appointed members cannot be individuals directly involved in the provision of Medicare services or have other employment. Thus, practicing clinicians, the very people who treat the patients impacted by the IPAB, are excluded from participation on the board.

Although the IPAB is argued to bend the cost curve, it only serves to ratchet down costs without clinical expertise or consideration of medical evidence. Similar to the task force, it doesn't have the research capability or accountability to examine the effects of its recommendations and determine whether the recommendations will threaten access to care.

While we are in agreement that Medicare spending growth is unsustainable and payment policies are challenging, it is your duty and responsibility as elected officials to address these issues. The care of our Nation's seniors and individuals with disabilities is far too important to leave in the hands of unelected board members.

Thank you for the opportunity to testify. I look forward to your questions.

[The prepared statement of Dr. Penson follows:]

****THIS TESTIMONY IS EMBARGOED UNTIL 10:00 AM, MARCH 6, 2012****

STATEMENT OF THE

AMERICAN UROLOGICAL ASSOCIATION

PRESENTED BY

DAVID F. PENSON, MD

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

TUESDAY, MARCH 6, 2012

"Impact of New Advisory Board on Medicare"

Chairman Herger, Ranking Member Stark and other members of the Subcommittee, I want to thank you for the opportunity to testify on the Independent Payment Advisory Board (IPAB). My name is David Penson; I am a practicing urologist from Nashville, Tennessee, and I serve as the Vice Chair of the American Urological Association's (AUA) Health Policy Council. I am speaking today on behalf of the American Urological Association, which has over 18,000 members and has promoted the highest standards of urologic care in the US and the world for the last 110 years.

I note that my testimony today reflects AUA's ongoing concerns with the IPAB; however, I call to your attention AUA's membership in the IPAB Coalition, a group of 23 medical societies representing 350,000 physicians that share our same concerns about the IPAB. In addition, the AUA is a member of the Alliance of Specialty Medicine, a 12-member coalition of medical specialty societies that opposed the creation of the IPAB and its predecessors, and support its full repeal. I must also state, however, that my testimony today does not reflect the opinion of my primary employer, Vanderbilt University.

While I am here sitting before this subcommittee to testify about the AUA's concerns about the IPAB, I am also in Washington with hundreds of my colleagues, urologists from across the country, participating as part of a Joint Advocacy Conference (JAC) among the urologic community. We are here on Capitol Hill exercising our right to engage in an important dialogue with members of Congress, including you and your staffs, about the Medicare program and its impact on our practices and our patients, Medicare beneficiaries. We bring real world experience to share what we see every day in our practices, caring for our patients. Ironically, the subject of todays hearing, the IPAB, would threaten these conversations.

The AUA strongly opposes the IPAB and calls on Congress to pass legislation that would repeal it.

Critical Issues with the IPAB

The most troubling aspect of the IPAB is the significant and immediate ramifications it will have on Medicare beneficiaries' access to care.

This subcommittee is keenly aware of the Sustainable Growth Rate (SGR) conundrum that has put Medicare physician payments in jeopardy year-to-year, and sometimes, month-to-month. Despite last minute Congressional action to prevent the steep reductions, confidence in the program by physicians is waning. This is reflected in the number of physicians limiting the number of Medicare beneficiaries they will see or accept into their practice, the number of physicians considering early retirement, and, despite the lack of hard data, anecdotal reports on the number of physicians opting out of the Medicare program. In fact, a 2011 survey of specialists represented by the Alliance of Specialty Medicine shows more than one-third plan to change their participation status to non-participating if Medicare reimbursement to physicians is significantly cut, while another third will opt out of Medicare for two years and privately contract with Medicare patients. Over the next twelve months, two-thirds said they would limit the number of Medicare patient appointments, while close to half said they would reduce time spent with Medicare patients, stop providing certain services, and reduce staff. At present, physicians face a substantial reduction–approximately 32%–on January 1, 2013, if Congress does not take action.

The IPAB only serves to worsen this problem. As you know, hospitals and other Part A providers have been exempted from the IPAB's reach until 2020. In addition, the statute explicitly states that the IPAB should give priority to recommendations that prioritize primary care. The result will be a

disproportionate share of reductions on physicians, with an emphasis on specialists, such as urologists. The impact on beneficiaries will be reduced access to highly specialized care and innovative therapies that improve beneficiary health and quality of life.

To understand the negative impact that the IPAB would have on Americans, one doesn't have to use one's imagination. Medicare beneficiaries and urologists have already experienced the havoc an unelected, unaccountable government board can wreak on access to healthcare. I am speaking specifically of the US Preventive Services Task Force.

The U.S. Preventive Services Task Force (USPSTF) is an independent panel of 16 non-Federal "experts" in prevention and evidence-based medicine, composed of primary care providers and charged with making evidence-based recommendations on a wide range of preventive services. New members are hand-selected and appointed to the task force by the Director of the Agency for Healthcare Research and Quality (AHRQ) based on loose qualification criteria.

Recently, the USPSTF dealt a strong blow to millions of American men. On October 7, 2011, the USPSTF released new draft recommendations against PSA-based screening for prostate cancer for healthy men, asserting that there is "moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits," and discouraged the use of the test by issuing a Grade "D" rating. These draft recommendations were developed without consultation with urologists–specialists who diagnose and treat prostate cancer–and are dangerous to men who may not have the opportunity to undergo a simple blood test that could facilitate diagnosis and treatment.

Prior to the Affordable Care Act, USPSTF recommendations were advisory and non-binding. Under its new authority, however, USPSTF recommendations have the force of law, restricting access to important, oftentimes life saving preventive screenings, such as the PSA test, which no longer would be provided without cost-sharing. USPSTF made similar recommendations regarding breast cancer screening with mammography for American women in their 40's. Simply put, the USPSTF's recommendations are highly questionable and ill-advised, given the evidence in both cases.

Shortcomings with the USPSTF include a lack of accountability by its members, a lack of clinical expertise in the specialty areas in which it makes recommendations, and limited transparency in its proceedings. Only recently did the USPSTF add a public comment period. This coupled with new authority that impacts access to care makes the USPSTF a dangerous, unwieldy body that can harm more patients than it helps. Sound familiar?

The similarities between the USPSTF and the IPAB are uncanny.

The ACAs establishment of a 15-member board of another unelected, unaccountable bureaucrats will have a similar impact on more than 45 million Medicare beneficiaries whose healthcare will be affected when it makes recommendations to "reduce the per capita rate of growth in Medicare spending" beginning in 2014. The IPAB may not make recommendations that would cause a reduction in patient benefits (i.e., "ration care") or increase revenues, beneficiary premiums or cost-sharing. IPAB recommendations have the force of law if Congress fails, or chooses not, to act.

Because the health care law prohibits the IPAB from "rationing" care, restricting benefits, or changing eligibility criteria, the board will be left with few options apart from making cuts to providers. These cuts could be driven so low that physician will be forced to limit the number of Medicare beneficiaries they see and accept into their practices, opt-out of the Medicare program, or be driven out of practice

all together. And, from our perspective, as well as that of like-minded opponents, this has the same effect as rationing care.

The President, with the advice and consent of the Senate, makes appointments to the IPAB. However, should the Senate be in recess, the President is empowered to unilaterally make appointments to the board if a position is vacant. Should he exercise this authority, the President could feasibly appoint 9 of the 15 member positions, tipping the scales in favor of his own political agenda.

Despite stated aims to shield what Senator Jay Rockefeller (D-WV), a key originator of the IPAB, noted as "undue influence of special interests", the IPAB creates a potential vehicle for one political party – and the President's own "special interests" – to maintain complete control of the healthcare delivery reform process.

This level of executive control over the so-called independent policy-making entity is inappropriate, and this has been reflected on both sides of the isle.

Just last week, Representative Frank Pallone (D-NJ) stated, "My opposition to the IPAB focuses on my belief that Congress must stop ceding legislative power to the executive branch…I am opposed to an independent commission playing a legislative role other than on an recommendatory basis. It is not the job of an independent commission to make decisions on health care policy for Medicare beneficiaries."

While the law states that the IPAB members are to be drawn from a wide range of backgrounds, including physicians and other health professionals, appointed members cannot be individuals directly involved in the provision or management of the delivery of Medicare items and services, or engage in any other business, vocation or employment. The explicit exclusion of providers who treat the very patients IPABs recommendations will impact is more than inappropriate; the AUA views this as negligent.

Similar to the USPSTF's recommendation on the PSA screening, which did not consider the clinical expertise of the very medical specialty that treats prostate cancer, the IPAB will not consider the clinical expertise of practicing physicians who see Medicare beneficiaries, the very patients whose care will be impacted by the IPAB's proposals.

Furthermore, the statute precludes administrative or judicial review of the implementation of IPAB recommendations and puts in place a "fast-track" process for implementation of the recommendations. Specifically, if Congress fails to find offsets to meet or exceed the Medicare cost cutting targets for that year, the Secretary must implement the IPAB recommendations. And, in the event the IPAB is not constituted or if it failed to make recommendations, the Secretary of Health and Human Services is required to devise a proposal. It is clear to us that the "end-run" around established Congressional procedures was purposefully built into the system to prevent Congress form having sufficient time to alter or override IPAB recommendations. Patients and providers are offended by these measures, and we believe a number of your colleagues are, as well.

Rep. Allyson Schwartz, D-Pa., testified before the Energy and Commerce Committee on the IPAB, noting that Congress "must assume responsibility for legislating sound health care policy for Medicare beneficiaries" and that allowing IPAB to stand essentially translates to an abdication of that duty and "would undermine our ability to represent the needs of the seniors and disabled in our communities."

Congress' establishment of the IPAB sets a dangerous precedent for overriding the normal legislative process. Congress is an accountable, representative body and, as such, must assume responsibility for legislating sound healthcare policy, including those policies related to physician payment within the Medicare and Medicaid systems. Abdicating this responsibility to an unelected and unaccountable board removes our elected officials from the decision-making process for a program upon which millions of our nation's seniors and individuals with disabilities rely, endangering the important dialogue that takes place between elected officials and their constituents.

Funding for the IPAB has already been appropriated, and reports and recommendations will be forthcoming. Before the IPAB has an opportunity to wreak any havoc on the Medicare program, it must be repealed.

Again, the IPAB is dangerous to America's seniors and must be eliminated.

Conclusion

As it has been described in statute, the IPAB serves only to ratchet down costs without clinical expertise or consideration of medical evidence; and, similar to the USPSTF, without the research capacity to examine the effects of its recommendations to ensure patients are not unduly impacted. If the IPAB has any accountability, it is only to the President who appointed its members, not to the Congress, and certainly not to the American people. The IPAB serves only to drive more physicians out of the Medicare program or limit their willingness to see and accept Medicare patients into their practice, further deteriorating access to healthcare services by this vulnerable population.

While we are in agreement that growth in Medicare spending is unsustainable and the issues that Congress face in addressing Medicare payment policy are challenging; it is the duty and responsibility of you - our nation's elected officials - to address these issues, rather than ceding this important work to a handful of government appointees.

We strongly disagree with Senator Rockefeller when he commented, "It is long past time that Medicare payment policy is determined by experts, using evidence, instead of by the undue influence of special interests." Physicians with clinical expertise in their chosen specialty and Medicare beneficiaries that rely on the Medicare program are not "special interests" – they are your constituents, the very people that have elected you into the positions you hold this very day. They deserve, and we deserve, a right to influence decisions about Medicare policy.

And, against his prior promise to the physician community that he would listen to us and collaborate to pursue health care reform that works for our patients, the President has proposed to "strengthen" IPAB through various tools and mechanisms including reducing Medicare's target growth by GDP per capita plus 0.5 percent, as well as giving IPAB the ability to automatically sequester Medicare spending.

Devising Medicare payment policy requires a broad and thorough analysis. Therefore, it would be negligent to leave these decisions in the hands of an unelected, unaccountable governmental body with minimal Congressional input that will most certainly have a negative impact on the availability of quality, efficient healthcare to Americans.

We cannot afford to disregard Congressional oversight when making decisions that impact millions of beneficiaries' ability, and indeed the ability of all Americans, to receive quality care. Democrat and Republican Members of Congress; organizations representing seniors, and other patient groups;

physicians and other healthcare providers; and a growing number of health policy experts are deeply concerned about the ramifications of the IPAB. To date, approximately 224 Members of the House of Representatives have signed on to support the bipartisan bill, H.R. 452, the Medicare Decisions Accountability Act, and growing number of healthcare professional organizations are also rallying for IPAB repeal.

Mr. Chairman, members of the subcommittee, I want to thank you again for the opportunity to testify on behalf of the 18,000 members of the AUA. I look forward to addressing your questions.

Chairman HERGER. Thank you.

Ms. Moon, you are now recognized for 5 minutes.

STATEMENT OF MARILYN MOON, PH.D., SENIOR VICE PRESIDENT AND DIRECTOR, HEALTH PROGRAM, AMERICAN INSTITUTES FOR RESEARCH (WASHINGTON, DC)

Ms. MOON. Thank you. I appreciate the opportunity to be here. My name is Marilyn Moon, and I am a long-term researcher in the area of Medicare, with a particular emphasis on the issues that affect the consumers of the program, the beneficiaries. In this testimony I address both the context and rationale for the IPAB, and some practical issues and concerns that need to be addressed.

While the IPAB raises a number of very legitimate concerns, it can be reasonable as a tool, if appropriately applied.

In addition to the Independent Payment Advisory Board which is the subject of this testimony, substantial resources have been given under the ACA to the Centers for Medicare and Medicaid Services to identify, evaluate, and introduce innovations to the delivery and payment of care. This large infusion of funds to find ways to improve delivery and quality while holding down costs is at the heart of efforts to slow growth over time.

It is only by identifying and implementing such changes that we can expect to see improvements over time, and that is the important aspect of reform that we should be focusing on. On the other hand, the IPAB can play a role here as a backstop. Until we understand better how to use our resources more effectively, and what organizations and treatments work well, it will be impossible to move forward to slow spending growth. So it is important to fully—it is fully appropriate for this to be done at the Federal level, which will ensure both a very broad look at innovations, and make the information available to all providers of care.

Research conducted by private insurers or providers is likely to remain proprietary and to not be of the needed scope to achieve the tasks that loom before us. With these other activities, the IPAB makes considerably more sense than if it had been enacted as a stand-alone gatekeeper of spending.

Moreover, it is important to contrast it with other alternatives that people talk about. For example, those who advocate decentralizing our Medicare program and turning decisionmaking over to beneficiaries place an enormous burden and risk on those beneficiaries. This is the hallmark of options that would require Medicare beneficiaries to buy insurance with a limited guarantee of subsidy from the Federal Government.

Supporters of such an approach often talk about having beneficiaries put more skin in the game as a way of improving health care decisionmaking. Despite claims that this would create better consumers of care, they are asking the most vulnerable members of our society to make decisions for which they are likely to be poorly equipped. And I believe the evidence underscores that from the RAND experiment and other places.

One positive aspect of IPAB that is often ignored, particularly when the idea is broadly challenged, is that it was explicitly set up to avoid cuts in benefits to beneficiaries and reductions in their coverage. And although the rationing aspect has some—I have

some concerns about how well it is drafted, that is part of the idea, that you are not trying to harm beneficiaries. And treating this only as a backstop after other things have not worked and as a way of providing incentives to providers to be supportive of other kinds of changes I think is the way to view the IPAB over time.

There are, nonetheless—though I have spoken somewhat positively about the IPAB—concerns I have that reflect the same kinds of concerns that you have already heard on the panel this morning.

First, setting goals on limited time horizons and then having short periods to implement change will put enormous pressure on a system that needs to change in many ways, but is not yet set up to readily adopt reforms. Fortunately, we will probably have until 2020 or 2021 before that is an issue, because the changes that were made in the ACA are likely to slow the growth of Medicare sufficiently to avoid having the IPAB have to go into effect. It could use that period of time, for example, to focus on ways to incorporate more effectively these kinds of changes in the decisionmaking that it undertakes.

Second, I have concerns about the tight conflict of interest requirements and the full-time paid status of board members that are similar to issues that other people have raised.

Finally, I think the cumulative effect of very stringent controls over a long period of time needs to also be carefully examined. Tightening up on payments, requiring coordination of care, and improving the overall delivery of care are all desirable activities.

But what happens if over a period of time these have happened and, as a society we want to see spending on health care decisions—on health care increase? The IPAB would be a penalty in that regard.

So, I think that the IPAB should certainly be changed, but I think it can be viewed as an appropriate tool in a broader context.

[The prepared statement of Ms. Moon follows:]

The Impact of the Independent Payment Advisory Board

Testimony of
Marilyn Moon
Senior Vice President and Director
American Institutes for Research (AIR)*

Before the House of Representatives
Committee on Ways and Means
Subcommittee on Health

March 6, 2012

---

* This testimony solely reflects the views of the author and not those of AIR or its Board of Trustees.

Marilyn Moon
Senior Vice President and Director
Health Program
American Institutes for Research
10720 Columbia Pike
Silver Spring, MD 20901
MMoon@air.org
301-592-2101

Providing high quality healthcare in the United States in the future depends critically upon slowing the rate of growth in the costs of that care. Such concern is relevant for all Americans, but gets particular attention in the programs funded publically. The costs of Medicare are part of the debate over the budget and the deficit as well as the future of the program itself. Contrast this with the more hidden costs of employer-provided insurance where many recipients of that coverage have little idea how much is paid on their behalf. Thus, it is not surprising that so much attention is focused on Medicare and its "sustainability" over time. It is in this context that the Independent Payment Advisory Board (IPAB) was enacted as part of the Patient Protection and Affordable Care Act (hereafter referred to as the Affordable Care Act or the ACA).

In this testimony, I address both the context and rationale for the IPAB and some practical issues and concerns that need to be addressed. While the IPAB raises a number of legitimate concerns, it can be a reasonable tool if appropriately applied.

The Context for the Independent Payment Advisory Board

In the Affordable Care Act, Medicare was singled out for a number of efforts aimed at slowing spending growth; the nature of the legislation was such that the federal government could not exercise similar controls over the private sector that will cover most Americans under the age of 65. Instead, Medicare was to be the model for instituting change in the delivery of care in the U.S.

In addition to the Independent Payment Advisory Board (IPAB) which is the subject of this testimony, substantial resources have been given to the Centers for Medicare and Medicaid Services (CMS) to identify, evaluate and introduce innovations to the delivery and payment of care. This large infusion of funds to find ways to improve delivery and quality while holding down costs is at the heart of efforts to slow growth over time. It is only by identifying and implementing such change that we can expect to see improvements over time. For the first time, substantial funding was established under the ACA which will allow for systematic investment in such change. Until we understand better how to use our resources more effectively and what organizations and treatments work well, it will be impossible to move forward to slow spending growth. It is fully appropriate for this to be done at the federal level—which will ensure both a very broad look at innovations and make the information available to all providers of care. Research conducted by private insurers or providers is likely to remain proprietary and to not be of the needed scope to achieve the tasks that loom before us. With these other activities, the IPAB makes considerably more sense than if it had been enacted as a standalone gatekeeper of spending.

In conjunction with efforts to better understand various options for change, the IPAB establishes a process to enforce cost containment in Medicare if per capita spending growth exceeds certain target rates. It attempts to employ experts and reduce the influence of special interests to minimize political gamesmanship.

Research has indicated that the rapid infusion of new technology is the a major driver of the rising costs of care; it only makes sense then that this is also the area to which we should look to find ways of mitigating growth. And once such knowledge is accumulated, how should it be applied? Medicare, as an enormous share of our health care system, is a logical place to start. Changes can be imposed, but there need to be appropriate safeguards and protections for beneficiaries. Decisions need to be applied consistently and fairly—something that cannot be assured with less direct controls. This is an enormous task and one in which the federal government, providers of care, private insurers and beneficiaries all have a stake. Efforts to reduce the ability of the federal government to bring about change in care will weaken the tools available to tackle what is likely to be a long and challenging process.

By contrast, those who advocate decentralizing our Medicare program and turning decision-making over to beneficiaries place an enormous burden and risk on those beneficiaries. This is the hallmark of options that would require Medicare beneficiaries to buy insurance with a limited guarantee of subsidy from the federal government—referred to as vouchers or premium support—that are currently being discussed. Supporters of such an approach often talk about having beneficiaries putting more "skin in the game" as a way of improving healthcare decision-making. Despite claims that this would create better consumers of care, they are asking the most vulnerable members of our society to make decisions for which they are likely to be poorly equipped. For example, proponents often cite the famous RAND experiment on this topic, but they ignore two key findings: first, that while making people more financially liable will result in lower spending, such lower spending will come both from discretionary expenditures and from expenditures that are critical to the health of the individual. Second, changes in behavior come more from those with limited resources: it is not the change in price that drives people to consume less, it is the inability to afford such care at all when deductibles or coinsurance rise.

Further, this approach shifts the risk of continuing cost growth onto beneficiaries. It lets the federal government off the hook, but expects individuals to face the tough choices between poor coverage or very expensive coverage if costs are not brought under control. There is no strong evidence that markets work to discipline the costs of healthcare, so we have no reason to be optimistic that they will indeed be able to hold down cost growth over time. Private plans will be able to alter the benefit package and cause patients to face a range of hard choices that may substantially reduce the protections that Medicare now assures. Healthcare is complicated, and decisions are often made outside the control of beneficiaries when they are very ill and unable to participate in informed decision-making. We should not put the burden of improving the healthcare system on the shoulders of individual Medicare beneficiaries.

One positive aspect of IPAB that is often ignored, particularly when the idea is broadly challenged, is that it was explicitly set up to avoid cuts in benefits to beneficiaries and reductions in their coverage. (It also has an explicit prohibition on "rationing" although that is not clearly defined.) These protections strongly affirm the goal of insulating beneficiaries and stands in stark contrast with a voucher or premium support approach to Medicare. The IPAB statute implicitly

recognizes that individuals cannot change the healthcare system, but rather that the focus needs to be on improving the delivery of care—an activity that requires research and determination to help the system change.

The role of the IPAB is to be a backstop to ensure that tough decisions do get made if costs remain out of control, and that they would be applied to everyone. Fortunately, projections of Medicare cost growth indicate that the IPAB will not need to make recommendations until at least 2021: Medicare spending is projected to remain well below the triggers for some time to come largely as a result of various parts of the ACA. The ACA made changes in provider payments and other aspects of Medicare that have substantially slowed its growth. What the Board could do in the interim is develop mechanisms for implementing change and work with the Innovations Center of CMS to identify where the most promising areas of change reside and be prepared to help that come about if there is resistance to such changes in moving forward. Viewed in this way, the IPAB could become a positive tool rather than merely a threatened approach to change.

Issues Facing the IPAB

Despite the arguments I have made above about the reasonableness of the goals of the IPAB, there are some serious challenges that ought to be addressed to improve its functioning.

First, setting goals on limited time horizons and then having short periods to implement change will put enormous pressure on a system that needs to change in many ways but is not yet set up to readily adopt reforms. Improved coordination of care, for example, is a key part of reforms but will require that individual providers and institutions make a broad range of changes in attitudes, policies, and financial arrangements. Instant savings should not be expected nor used to measure success. This may create a bias in favor of less complicated changes such as payment limits. A Board tasked with annual growth targets will find it very challenging to pursue a nuanced approach that encourages delivery system reforms. The longer time horizon of six year terms for members of the Board may help but probably is not sufficient to address this issue. The short time that the Congress has to act if it were to seek other approaches is also problematic. Overall, changes to IPAB should be made that will improve its ability to foster delivery system reform.

Second, the tight conflict of interest requirements and the fulltime paid status of Board members may make it difficult to truly attract the types of high quality members that would be desired. The salaries will not compete with what many could make on the outside and requiring Board members to give up all their other connections and affiliations may discourage many who would like to participate. It is also not clear what the activities of the members of Board would be that would require fulltime participation. Modification of these rules, while continuing the goal of attracting members not beholden to special interests, is desirable.

Third, the lack of clarity about what constitutes rationing of care is an issue. It might be viewed either too narrowly or too broadly. Nonetheless, it is important to note that the spirit of not harming beneficiaries is the stated goal in the ACA—and certainly puts the IPAB in a stronger position to protect beneficiaries than does a premium support approach to care, for example.

Fourth, the exemption of some providers of care in the early years could generate equity problems if the choices facing the Board are unduly constrained.

Fifth, if Medicare is singled out for more controls while the rest of the healthcare system grows rapidly, access and quality problems could arise. The intent is to have Medicare be a model for others to follow, but it would be appropriate to add further considerations for the Board for how Medicare is functioning relative to the rest of the healthcare system in making recommendations.

Finally, what is the cumulative effect of very stringent controls over a long period of time? Tightening up on payments, requiring coordination of care, and improving the overall delivery of care are all desirable activities. But what happens if, over a period of time, these have happened and as a society we want to see spending on healthcare increase—perhaps because of crucial but expensive advances that truly improve peoples' lives? Establishing a system that assumes that we must follow a particular trajectory indefinitely may ultimately prove not to be good policy, and we may decide it is appropriate to actually increase the revenue we need to support a worthy program. The IPAB implicitly rejects that type of recommendation.

Conclusions

The IPAB is not an ideal mechanism; it needs improvements and even then it will still reflect the fact that policymakers have decided that some decisions are just very hard to make on their own. But it should be viewed in the broader context of what it is trying to achieve and whether it is a reasonable tool among many that the ACA has created. It should not be viewed in isolation.

Moreover, the IPAB needs to be compared to alternative approaches. As compared to a privatized Medicare system, it offers many positives. It does not penalize beneficiaries first and foremost. Its intent is to explicitly avoid rationing—an advantage over a system that limits the growth in the value of the subsidy to be paid for purchase of private insurance. It uses the considerable and valuable power of the federal government to consider changes that need to be applied equitably across the U.S. And the ACA is trying to target the source of healthcare spending: what we pay for what types of services.

Chairman HERGER. Thank you for your testimony.

Dr. Gottlieb, some have suggested that IPAB could rely on information garnered from the experiments of another Democratic health care tool, the Center for Medicare and Medicaid Innovation, to develop cost-saving policies. However, many Members, including myself, have serious concerns that CMMI was given a blank check with no accountability to beneficiaries or to Congress.

Are you concerned that the interactions between IPAB and CMMI could lead to a perfect storm such as—these government bodies will have unchecked powers to change Medicare in ways that neither beneficiaries, providers, nor Congress can appeal?

Dr. GOTTLIEB. I think the interplay between IPAB and CMMI certainly—it could be significantly problematic. You know, IPAB could effectively authorize new authorities onto CMS, and then CMMI could provide the funding for it. So you basically completely sidestep Congress.

I think one can imagine IPAB skirting prohibitions on changes in cost sharing of benefit by authorizing or instructing the Innovation Center to use a more restrictive standard for what Medicare will cover, and then providing—CMMI would provide the funding to implement that. I think it is almost a foregone conclusion that, if IPAB is constituted, it will pursue some kind of reference pricing scheme like LCA authority, conferring LCA authority explicitly onto Part B drugs, something CMS has already sought and lost a number of Federal court cases in seeking that authority. And CMMI could effectively create the infrastructure to execute that. And so you would have the two entities working together to effectively accomplish what traditionally has been done by Congress, granting authority and then providing funding for it.

Chairman HERGER. Thank you. Ms. Neas, you are not alone in expressing unease about IPAB. In fact, I have heard from a number of patient groups that have shared similar concerns that IPAB need not count a single patient representative among its 15 members.

Can you discuss why you think it is important for beneficiaries to have a strong voice while this unelected board is making decisions to cut Medicare?

Ms. NEAS. Absolutely. In the disability rights movement we have a phrase, "Nothing about us without us." Patients and beneficiaries are essential in this decisionmaking process. People know what their bodies need, they know what they need. And simply having the dollars of what you pay a provider be the only factor in the decisionmaking process to us is simply missing the point. We really need people to be invested in their own health, and to make that opinion be part of this decisionmaking process.

Chairman HERGER. Thank you. Dr. Penson, the President and key officials in his Administration claim that IPAB will strengthen Medicare. The President and these officials are also quick to claim that IPAB supposedly cannot ration care, increase beneficiary cost sharing, or reduce benefits. To me, this means that the only thing that IPAB can do to cut Medicare spending is to slash payments to providers.

Do you believe that simply cutting provider payments strengthen the Medicare program? Or do you think it will weaken the program by reducing beneficiary access to care?

Dr. PENSON. I absolutely am—agree with you that I think it will weaken the program. The fact of the matter is that if you reduce reimbursements to physicians—there are many physicians out there in the community now who are struggling, particularly primary care providers. But specialists, as well. And what I think will happen is, if you reduce reimbursements, you will have providers leaving the system, leaving the program, and then that will reduce access for beneficiaries.

Chairman HERGER. Thank you. Mr. Stark is now recognized for 5 minutes.

Mr. STARK. Thank you, Mr. Chairman. We—one of the reasons that I was happy to see ACA pass is that it was successful in constraining health care spending, and extended the solvency of the Medicare trust fund, slowed the cost growth in Medicare, and growth in overall national health spending, all while lowering beneficiary cost sharing. In fact, CBO estimates that Medicare spending growth is so low, given the Accountable Care Act, that IPAB won't be triggered until after 2021, I think, as Ms. Moon indicated.

Could you tell us, Ms. Moon, how ACA is lowering the Medicare spending, and how you suspect it may continue to do that in the future? It is my understanding that the cost containment from ACA means that, as you said, IPAB won't be triggered for years. Can you elaborate on that a bit?

Ms. MOON. Certainly. A number of the changes that were made in the Medicare program will reduce the level of spending over time. There are a number of them. One of them that I think was particularly important, for example, was to try to set on an equal footing with the traditional Medicare program, the Medicare Advantage aspects of the program in which now those private plans will be paid on a level comparable to what Medicare beneficiaries and traditional Medicare will get. I think that was a very positive move forward, for example, and a substantial piece of this.

I think other areas in which the projections of lower spending are important are going to come from the innovation center of the—of this new activity by the Centers for Medicare and Medicaid Services. And unlike those who fear what it will do, I think that finally we are putting resources into looking at, very systematically and carefully, what things work to improve the delivery of care in the United States, recognizing that a lot of changes are going to have to be made.

Some of these are not going to be easy, and they are going to be tough changes, but I think they will get the kind of scrutiny that they need when they are put out there as the CMMI does, the Center for Medicare and Medicaid Innovations, and that is by doing research and analysis and then talking about the findings and how they can change over time. That is much more transparent than will happen, for example, if these changes are made by private insurance companies in their own efforts to hold down costs.

Mr. STARK. I am sure you are aware of—well, not only Canada, but I think almost all nations except Somalia and someplace else have basically an effectiveness study which would help patients

and physicians, without regard to cost, but through a study of how effective various procedures or various pharmaceuticals are—is aspirin better than Tylenol? Somebody will do a study on that and suggest to Dr. Penson that for this particular issue or that particular issue the statistics would show that this is more effective.

Should that, over time, provide better service to our—to all Americans, but in particular to the Medicare beneficiaries, if the physicians chose—it is a voluntary issue—to follow its recommendations?

Ms. MOON. I think——

Mr. STARK. I will ask Dr. Penson if that would be useful—would be helpful in his practice.

Dr. PENSON. Well, I am—as I also wear a second hat as a health services researcher who focuses on comparative effectiveness, so evidence-based medicine is very important. The AUA supports it. I support it. I will add, though, that sometimes we do a study and it clouds this issue even more so. But evidence is very important for the practice of medicine, absolutely.

Mr. STARK. Ms. Moon.

Ms. MOON. I think that that is key to the future, because we really have to understand how to use our resources wisely. And, as you indicated, this should be advisory to physicians and other providers of care. It is difficult to ask physicians in this very fast-changing world to be on top of everything. And good and reliable information about what works and what doesn't is going to be an essential piece of that.

Mr. STARK. Thank you. I want to thank the entire panel for their contribution. Mr. Chairman, thank you.

Chairman HERGER. Thank you. Mr. Johnson is recognized for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman. I am appalled by the government control of everything, and I think we need to get the government out of it. You know, unelected and unaccountable board trying to tell you docs what you can and cannot do is ridiculous.

Are you still doing Medicare?

Dr. PENSON. I am, personally. I work for a large academic medical center, so I suspect my medical center will always be in Medicare. I can tell you many of my colleagues are considering not participating, particularly if the SGR cuts go through.

Mr. JOHNSON. Yes, I know. I am aware of a couple of docs that are thinking about going to the military and getting out of private medicine. That is ridiculous.

Dr. Gottlieb, Secretary Sebelius testified before the Committee just last week and claimed IPAB is prohibited from rationing care-altering benefits. It is difficult to imagine that with this Administration and its Washington-knows-best mentality, that they could decide services and procedures aren't warranted. As a result, they might recommend slashing Medicare reimbursements for those services and procedures.

Do you see this as a possibility, and could you comment on it?

Dr. GOTTLIEB. Well, I think they are going to be forced to manipulate payment schedules and coding because they need to

achieve budget savings in the near term, and in the near term that is all you can really do, given the other constraints.

And what they are likely to do is import price schedules that exist in one aspect of the market into new aspects of the market so you can envision things like maybe VA pricing for the specialty, tier drugs in the Part D benefit, they are likely to just burn down existing payment rates, just drive them lower. And they are likely to try to do things to the coding process to try to change how certain products are reimbursed, maybe giving CMS authority to engage in forms of reference pricing.

I think that the way that IPAB is likely to ration, if you will, is by just conferring new authorities onto CMS, authorities that CMS has long wanted to be able to engage in, you know, aspects of what really amounts to reference pricing, where you would categorize products along a judgement made by CMS that products are clinically interchangeable.

So, for example, consolidating drugs with separate Orange Book listings under the same payment code, even if those drugs are paid separately, CMS could theoretically say that they think that they are clinically interchangeable. And just applying least cost, saying that within a category of approaches to a given medical problem CMS doesn't recognize the clinical difference between different approaches and is therefore going to pay for the lowest rate. I think that is what we are likely to see.

As far as rationing, I am not sure—there is no definition of rationing in the statute, so I am not sure how that is likely to be interpreted. And since you can't sue IPAB for implementations of its recommendations, I am not sure how you can challenge that.

Mr. JOHNSON. Thank you. I appreciate that. Do you think Medicare can be saved with arbitrary reimbursement cuts, or do we need more fundamental reform?

Dr. GOTTLIEB. Well, I agree with you, Congressman. I think we need more fundamental reform. I think that this endless series of just burning down payment schedules and trying to lump different treatments under the same payment code to bring sort of bureaucratic efficiency to the management of the program just makes more fundamental—far more difficult.

So, as we go through successive cycles of these arbitrary cuts, I think it makes it harder and harder to achieve something fundamental.

Mr. JOHNSON. Yes. I am seeing some docs just getting out of it, they are not accepting it any more. Do you still? You said you did.

Dr. PENSON. I do, because I am an employee of a medical center. But I will repeat what I said before, which is I know many of my colleagues have either left Medicare or are considering leaving Medicare because they are worried, frankly, about keeping the lights on.

Mr. JOHNSON. Yes, yes. It is a serious problem. Thank you, Mr. Chairman. I yield back.

Chairman HERGER. Thank you. Mr. Reichert is recognized.

Mr. REICHERT. Thank you, Mr. Chairman. Thank you all for being here. As you can see, there is some agreement on this panel this morning. And you have, I think, answered most questions

through your testimony, so some of these might be repetitive. But I think that some of the topics bear a highlighting during the questioning.

And I have only been on this Committee—this is going on my fourth year. I know some Members have been here much longer than that, and they have been struggling with health care and health care reform and lowering costs and increasing accessibility and quality versus quantity for a lot longer than I have. But it has become obvious to me in my short tenure on this Committee that there are some serious problems with this so-called Affordable Health Care Act.

We have already removed language regarding the 1099 form. We have also—the Class Act is one part of the program removed from the health care law. It is not affordable. The—there are other issues, as you know, regarding mandates. So now we have lawsuits filed as a result of this law being passed. And now we have also discovered that, if you like your health care plan, you can't keep it.

And then, so today we are here to talk about another problem that there is agreement on with this panel, at least in the beginning of this discussion, and that is this advisory board. And most of you, you have touched on this already.

But again, I want to highlight the—what Dr. Penson especially said in his testimony. The advisory board only serves to worsen the problem of physicians leaving Medicare. And Mr. Johnson just spoke briefly to this, too. Can you explain how the advisory board can restrict access to care for our Nation's seniors? You have explained, at least in one case, prostate cancer, for example. The screening has been rated now as a D rating, which is going to restrict some coverage there and some access. Patient cost sharing is designed to limit access. Can you give some other examples of how access will be limited, and why?

Dr. PENSON. Well, I think specifically with the IPAB, it is primarily going to be cutting reimbursements to physicians, and not just specific tests like the task force did with prostate cancer.

With that being said, if we continue to cut reimbursement to physicians, we are going to have a crisis, because physicians are going to leave the Medicare program. And it is going to happen not just with primary care providers, but specialists. These days doctors, particularly community physicians, are working on a very tight margin. And if you continue to cut their reimbursements, they are going to close their doors, or they are going to stop seeing Medicare patients. And effectively, you are going to have American seniors saying, "Well, maybe I need to pay out of pocket to see my doctor I have been seeing for 10 years, because he no longer will accept Medicare." I see that as a huge problem. And it effectively is rationing, depending on how you define it.

Mr. REICHERT. And just to follow up on this idea, Ms. Neas, your—I liked your "no discussions about us without us." And if you could, just elaborate a little more on that just to help us understand how Medicare changes and reforms are impacting beneficiaries, and especially if they are not there to represent their own views, thoughts, and ideas, and us as representatives have no place at the table to represent those individuals most in need that your

organization particularly represents. Can you go into some detail on that?

Ms. NEAS. Sure. And I think, if I could be so bold, I think Dr. Penson might agree with us. One of the ways that we are healthy is when we have good relationships with our health care providers. It is a two-way street. Your doctor tells you what to do, and then you are supposed to do it. And that doesn't always happen, but there needs to be direct communication with the patient and their health care provider. And when that happens in a positive way, people have better health. It is not very complicated.

If you take that patient-doctor relationship out of the delivery of health care so that it is harder to stay with your doctor, you are going to somebody new every time, it can be very, very difficult. I think you——

Mr. REICHERT. Would you say the board is sort of doing this, then?

Ms. NEAS. If you make it so doctors can't stay in the Medicare program—and we are seeing this—and I know it is not the jurisdiction of this Committee, but we are seeing this every day in the Medicaid program, where health care providers simply are no longer taking children with disabilities who are on Medicaid because they cannot afford to pay their light bill and do this. It is not that they are being inappropriate in any way. They cannot stay open if they continue to serve these patients. We fear the same thing may be true with Medicaid—with Medicare, if it is constantly—if there are fewer people.

I can give you one very quick example. I have a very dear friend who has spina bifida. She is in her mid-fifties. She has been on Medicare for times when she—and she has had over 50 surgical procedures. When she goes to a new doctor, they want a full medical history. She is 50 years old. She has had 50 surgeries. They don't want—they don't need to know if she has something wrong with her stomach when her legs were amputated. It is—but—and that is an inefficiency in the system, that if you make it harder for the people who know their patients to stay in Medicare, you are going to have less good health outcomes for patients.

Mr. REICHERT. Thank you.

Chairman HERGER. The gentleman's time has expired. Mr. Pascrell is recognized.

Mr. PASCRELL. Thank you, Mr. Chairman. It has been pointed out many times in this room, Mr. Chairman, how critical it was that health care reform included the cutting-edge delivery and payment reforms that it did. I will refer back to this in a moment.

But I have never believed that the Independent Payment Advisory Board, as it stands now, would—will effectively fulfill its stated mission to—in terms of cost containment. I never really accepted that. I have concerns with how IPAB will operate, and that it gives us important congressional authority over pricing. That is why I am cosponsor of the bill, and I intend to support it in committee and on the floor.

But let's be clear, that the IPAB was originally designed to protect beneficiaries. That was its purpose. Despite what my friends on the other side would have you believe, it is their voucher plan that they endorsed, the majority endorsed, that would end Medi-

care as we know it. That is what would end Medicare as we know it.

So, while we may be talking about repealing IPAB today, we should not lose the big picture, and that is the Affordable Care Act was entitlement reform. Nobody wants to say that on the other side. I don't know why. One-third of the Act was entitlement reform, as far as I am concerned, concerning Medicare. Very specific. Unlike their plan, it will actually contain Medicare costs while improving benefits, not ending the Medicare guarantee.

And I had a question for Dr. Moon, but I have—want a quick question, if you would, Ms. Neas. You know, the vouchers are not going to work for individuals with disabilities. Let's set the record straight here.

Ms. NEAS. That is absolutely right. Our experience, whether it has been in health care or in education, what people with disabilities need is what they need.

Mr. PASCRELL. So what the voucher program does is turn people with disabilities and senior citizens over to the private health insurance industry. It turns it over to them to determine what care and how much care they are going to receive. Can you just briefly talk about converting Medicare to a voucher and what it would do to the very people you are focused on?

Ms. NEAS. Over time, the Medicare program and others have been altered to include specific services and supports. Those were because people needed them, and we needed to spell out in very specific ways that there was a range of services that needed to be reimbursed by the Medicare program. People need those services.

And because it is a big pool, not everyone is going to need the same amount. But they need to be able to have medically necessary service available to them, as decided by their health care provider, and not say, "If you cost more than $15,000 a year, too bad for you." If you have a stroke and you need ongoing physical therapy to regain the strength in one side——

Mr. PASCRELL. Right.

Ms. NEAS [continuing]. You need that. And it is not—and you may need, depending on you as an individual, you might need physical therapy for 2 months, or you might need it for a year.

Mr. PASCRELL. Thank you. Dr. Moon, we know of the various and very specific cost containment under the Affordable Care Act—just to name a few, efforts to reduce preventable hospital re-admissions, improving payment accuracy—has an effect on what we are talking about. Promoting value-based purchasing, et cetera, encouraging innovation through the new Center for Medicare and Medicaid, establishing—and funds research on effectiveness of different clinical interventions with the Patient Centered Outcomes Research Institute. These are among many.

Now, do you think it is likely that IPAB will focus on improving quality through delivery system reforms, considering how hard CBO showed it is to create any savings in such a small timeframe?

Ms. MOON. I think that is a very legitimate concern about IPAB, and I think that if there were to be changes in the program that kept it, it should allow it to have a longer timeframe than the 1 year. I think that is a dangerous aspect of the IPAB program.

Mr. PASCRELL. What do you think would be the result of that?

Ms. MOON. I think that does bias you in favor of some of the cuts in payments, and that is something that I think you want to avoid.

Again, I see IPAB mostly as a backstop, if absolutely necessary, and I would hope it would be viewed that way, and not as a first line.

Mr. PASCRELL. Thank you. Mr.——

Chairman HERGER. The gentleman's time has expired. Thank you.

Mr. PASCRELL. Mr. Chairman, if I may?

Chairman HERGER. Yes.

Mr. PASCRELL. Mr. Chairman, I think the witnesses that we have heard over many, many weeks and many hearings are an indication. They are an indication of the concerns, legitimate concerns, of folks who are involved day in and day out with health care.

I think all sides should just back off an inch or two at least, and take a look at what we are learning might not be the causes of the major problems we are facing in health care, and that we could all take a deep breath, Mr. Chairman, all take a deep breath, and understand that we are combined in intellect here, that we need to look at reducing——

Chairman HERGER. The gentleman's time has expired. Thank you very much.

Mr. PASCRELL [continuing]. Reducing one thing and not throwing away the entire essence of the bill.

Chairman HERGER. Mr. Roskam is recognized.

Mr. ROSKAM. Thank you, Mr. Chairman. You know, in that spirit of taking a deep breath, the Democratic leader of the House, when she was the speaker, sort of famously now prophesied that we had to pass the bill in order to see what was in it. And she did, and we do. Now we are walking through this IPAB adventure.

And I think what is interesting, to the gentleman from New Jersey's point—and I accept the premise of what he is saying—and that is there is nobody here—it is interesting—no voice on this panel is defending IPAB. Nobody. We have heard, well, it didn't start in this chamber. We have heard it is not—you know, this wasn't the real purpose. But it is fascinating that, at least to date, an hour into this hearing, there has been no voice that has defended on this panel the status quo of IPAB. So let's talk about why.

Dr. Gottlieb, can I turn to you? And let me ask you this. Under IPAB, will health care providers' ability to provide care to patients be affected by reimbursements being cut for particular services?

Dr. GOTTLIEB. I think it absolutely will. I—you know, as we have been saying, I think IPAB's scope is so narrow and constrained, in terms of what it can do, and how far out it can look—getting to Ms. Moon's point—that it is going to just have to burn down payment rates. And we have seen time and time again, when payment rates get driven too low, certain services just become unavailable.

If you look even under the DRG system, when DRGs get driven down too low, certain technologies will fall out and just won't be available in a hospitalized setting. I think the same thing is likely

to happen on the Part B side in the outpatient setting, is IPAB has to just burn down payment rates and manipulate coding schedules.

Mr. ROSKAM. So the downward pressure—in a nutshell, the downward pressure is so fierce that it will have an impact.

Let me ask you this. The debate around the word "rationing" has created a high level of anxiety. You know, and so the proponents of the Affordable Care Act say, "Well, IPAB can't ration." Rationing, as you know, is not defined in the statute. Let me ask you this. Can you have, per se, rationing, based on what the Independent Payment Advisory Board makes decisions to reimburse?

Dr. GOTTLIEB. Sure. You are going to have payment driven so low in some settings that certain services just won't be available. Physicians won't be available to take patients. I think entrepreneurship is going to suffer, because you are going to have less investment in certain sectors in anticipation of the inability to get reimbursement for certain things. And I think the third leg of this is the fact that IPAB could confer authorities—give CMS new authority so CMS can engage in the rationing.

I don't see—I am not an attorney, I am a physician, but you know, I have spoken to attorneys in town. There is mixed opinion about this issue. But most people seem to agree that IPAB can confer authorities onto CMS that CMS would then use in ways to explicitly change benefit design and coverage rules.

Mr. ROSKAM. Ms. Neas, on behalf of Easter Seals, I am interested. I have a world class Easter Seals facility——

Ms. NEAS. Yes, you do.

Mr. ROSKAM [continuing]. In Villa Park, Illinois, which is doing remarkable work. And I have had the privilege of visiting, and really commend you and the vision and the mission that you have.

Can you comment on what you are hearing from, let's say, parents of children whom you are serving, and their level of concern about what patients—or what physicians might be prescribing based on an IPAB decision? In other words, if IPAB makes a decision, is the smorgasbord of options, the treatment options, possibly cut down as a result of the bureaucratic decisionmaking process?

Ms. NEAS. Yes, thank you for that. Yes, you do have one of our superstars in your district, which serves predominantly children, and children with very significant physical disabilities.

Our biggest concern is when you make it impossible for providers to stay in business and serve this population, they have no place else to go. And so the practical realities, particularly in smaller communities, where you may not have the same degree—breadth and scope of providers, if they cannot keep their doors open because reimbursement is the only thing that is keeping them afloat and that just gets cut, then, practically speaking, people are just afraid that those services, regardless of what is in the benefit package, if there is nobody to provide them, then they cannot access those services.

Mr. ROSKAM. Thank you. Dr. Penson, quickly. Can—there is a lot of discussion in this town about income inequality. You mentioned this a minute ago, but can you give us a little bit of a highlight? What happens, for example, if a person of means goes in and a physician—well, my time has expired. I will——

Chairman HERGER. Maybe he will answer it in writing. You want to finish the question?

Mr. ROSKAM. That is okay. I will follow up with you. Thank you.

Chairman HERGER. Mr. Kind is recognized.

Mr. KIND. Thank you, Mr. Chairman. Thanks for holding this important hearing. And I appreciate the witnesses' testimony here today.

I would be the first to admit that IPAB requires a leap of faith. But I supported it. I think it makes sense. I think it is a fail-safe backstop effort to constrain the largest and fastest growing area of spending in the Federal budget and State budgets and local budgets and business budgets and family budgets, which is health care costs. And if people have a better idea of how we can bend the cost curve out in the future, I am all for that as well.

But I think the key to reforming a health care system that was in desperate need of reform was through delivery system reform and through payment reform. It had to change the way health care is delivered, so it is more integrated and coordinated and patient-focused. And we have a lot of models throughout the country that have shown us ways to do that.

And then, ultimately, we have to change the way we pay for health care, so that we are paying for the value or the quality or the outcome of care that is given, and no longer the volume of care. And that has been the nemesis of the so-called fee-for-service system for years. And everyone on this panel, I think, recognizes the challenge that we are facing. Fee-for-service is not producing the type of outcomes or the bang for the buck that we need with our health care dollars. IPAB is merely—from my perspective—is a fail-safe mechanism that, if certain reforms don't lead to spending reductions and better outcomes, there is a way to address that.

And one of the big problems out there is the over-utilization of health care: more tests, more procedures, more things being done, but without the desired results. But we have competing ideas on which way to go. The other side, from what I can tell, would just as soon shift the cost on the backs of people who can least afford it.

Ms. Moon, let me start with you. For example, under the so-called Ryan budget plan that virtually all of them had supported last year, the Republican plan would end Medicare's guaranteed benefits for things like hospital stays and doctor visits. They would replace it with a cash voucher. Can IPAB do that?

Ms. MOON. No, it cannot.

Mr. KIND. Also the Republican plan would increase the cost for Medicare beneficiaries, according to the CBO analysis of it, by more than doubling out-of-pocket costs for new enrollees up to $6,000 a year when it is fully implemented. Can IPAB accomplish that?

Ms. MOON. No. Fortunately, it would not.

Mr. KIND. And finally, the latest version apparently that they are toying with and might include in their next budget resolution, is the so-called Ryan-Wyden Plan that embraces this concept of a target growth rate, that if certain spending reductions don't occur, automatic spending reductions occur under this target growth rate. Does IPAB mirror any of that?

Ms. MOON. No.

Mr. KIND. You know, so there is really a choice here of what we can do, moving forward. We can allow time to transpire for delivery of system and payment reform to take place, or there is the ACO models or medical homes for the better coordinated care, the Center for Innovation coming up with ideas on how we can get better value for the dollar, and have IPAB as a backstop for that, ultimately. Or, we can go down another route, which merely privatizes Medicare, turns it into a private voucher plan, shifts the cost on the backs of seniors, an additional $6,000.

And when I look at my congressional district, 80 percent of the seniors in western Wisconsin rely on Social Security as their sole source of retirement income, 80 percent. They can't take a $6,000 hit in Medicare. So what I think we need to be working on is what we can do together to try to reform a delivery system so we do get better value out of the dollar.

So am I wrong here, Ms. Moon? Am I missing something of what needs to be accomplished in the health care system?

Ms. MOON. No, I think that is exactly right. I think that this is a very tough problem, and the Federal Government has a role to play, along with consumers and providers, and everybody else. And to shift it off on to beneficiaries and make them responsible, I think——

Mr. KIND. Well, the way I see IPAB ultimately is a panel. Again, a backstop if cost constraints don't occur, but they would kick in, their relevancy would kick in. But their whole task is to find out what is working and what isn't, and then stop creating incentives for doing things that don't work.

I mean, in its simplicity, that is what IPAB is really all about. And I support it, because I have been around here long enough to see how reckless Congress is, trying to act on these reimbursement issues ourselves. I know there is great cause for representative democracy, but you just look back at SGR, and what an abysmal failure SGR has been throughout the years. It was a budget savings mechanism inserted in 1997 that has always been restored. And that is the problem we always have with these reimbursement issues.

Congress doesn't have the backbone or the guts to stand up and try to make these decisions ourselves, because we are not experts. And yet IPAB is supposed to be staffed with people with greater knowledge and greater expertise in order to make some of these difficult decisions. Congress can still intervene. There is still that mechanism. But I would feel more confident going down the IPAB road than not, given what we face today. Thank you, Mr. Chairman.

Chairman HERGER. Thank you. Dr. Price is recognized.

Mr. PRICE. Thank you, Mr. Chairman. There is so much misinformation in the last 5 minutes, I don't know quite where to start. But maybe I will start by saying that the SGR, which all of us agree is a disaster, in terms of its compensation of physician—reimbursements for physician services for seniors, everybody understands that. The IPAB has been called the SGR on steroids. So if you liked the SGR, you will love the IPAB.

Our whole goal here is the highest quality of care. We disagree drastically about how to get to that highest quality of care. Our side believes that patients and families and doctors ought to be making medical decisions. The other side believes that Washington ought to be influencing those medical decisions in very intimate ways, which is why I think it is important to point out, Mr. Chairman, that a list of medical entities, physician entities, folks taking care of patients, nearly 500 of them—500 of them—support repeal of the Independent Payment Advisory Board.

So, it is important to remember that we are talking about patients, and the people that are taking care of the patients are saying that this will be a disaster, a disaster.

We have heard a couple of things from our friends on the other side who say, "Oh, don't worry about it, it is 2020, 2021, not going to happen." I draw their attention to appendix A in their packet. The first date where something regarding IPAB must occur by law, April 30, 2013—2013. That is when the chief actuary has to begin to state whether or not these costs are going up at rates that are unacceptable, not according to patients, not according to any market at all, but according to Washington.

We have heard that the—words tossed around like "voluntary" and "advisory," as it relates to IPAB. There is nothing voluntary or advisory about the Independent Payment Advisory Board. It is a denial of care board. And its sole purpose is not quality of care, as my colleague just talked about. Its sole charge is to "decrease"—"recommend cuts in areas of excess cost growth." Decrease costs—excess cost growth, which—then you have to look at why the cost of health care is rising. And it is rising higher than the gross domestic product. Why? For two main reasons.

We heard this last week from the chief actuary for CMS as well as the OMB director. The 2.5 percent is due to "utilization and innovation," utilization and innovation. So if you are going to decrease the cost, what do you have to do? You have to decrease innovation—that is quality of care—and utilization—that is access to care, which brings me to my questions to, first, Dr. Penson.

There is some notion that if you decrease payment to physicians, that doesn't decrease the access to care for patients. Can you put—can you help us understand that, that mechanism, a little bit?

Dr. PENSON. Well, it is going to affect—you decrease reimbursement to physicians, it is going to affect things in two ways. First is the example I have thrown out there already, which is at a certain point physicians are going to close their doors and turn off the lights, simply because they can't make ends meet. And so, for many physicians, they will just opt out of Medicare. And we have already seen this in Medicaid.

The other thing that physicians will do is that they get paid—if the reimbursement gets paid less, if they try and keep their doors open and keep things open for Medicare, they will just try to see more patients.

Now, you say, "Okay, well, that is good. We want our doctors to see as many patients as possible." But Ms. Neas will back me up on this. There is a big difference between when you get—and you know this, as a physician—you get a good, long visit with your doc, where you get to talk with him or her, or you are sort of in and

out really quickly, because that is what he or she has to do, just to keep the office open.

Mr. PRICE. Dr. Gottlieb, I want to talk about some real-world consequences for the physicians out there trying to care for their patients, in spite of the rules that we toss upon them.

My understanding is that if a physician is continuing to try to see Medicare patients, and if a payment for a service in Medicare is not of a rate that would allow the physician to continue to keep his or her doors open, that physician can't see that Medicare patient and provide that service if they agree upon another price that the patient would want to pay to that physician to see him or her. Is that right?

Dr. GOTTLIEB. That is right. Under the law you can't balance bill the patient. You have to accept the customary rate under Medicare if you opt into the Medicare program.

I think the other caveat here, and what I am seeing in my clinical practice—I practice hospital-based medicine, but I will refer the patients to primary care providers as they are discharged from the hospital, and what I see more and more is just physicians capping how many Medicare patients——

Mr. PRICE. Exactly.

Dr. GOTTLIEB [continuing]. They will allow into their practice, and they will say, "I am closed to new Medicare patients." We have seen this in Medicaid for years now. It is very hard to get specialty care for Medicaid patients that I am discharging from the hospital, and it is quite unfortunate.

Mr. PRICE. And, therefore, huge decrease in access to care. In fact, last week, when the Secretary was here, she said 98.4 percent of physicians see Medicare patients. And I asked her specifically how many physicians are decreasing the number of Medicare patients that they are seeing, and the Secretary could not answer that. And it is a huge, huge number. Access to care is being compromised. IPAB damages access to care, and it is time to repeal it.

Thank you, Mr. Chairman.

Chairman HERGER. Thank you. Mr. Buchanan is recognized.

Mr. BUCHANAN. Thank you, Mr. Chairman. And I also want to thank the witnesses for being here today, taking your time.

I represent 170,000 seniors in southwest Florida, Sarasota and Manatee Counties. And many of the seniors that I talk to are very concerned about what this unelected board of bureaucrats will mean to Medicare, as it decides what constitutes necessary care for our seniors.

Dr. Penson, you represent doctors who are concerned about this board. How do doctors feel about President Obama's call to expand the reach, in terms of this board?

Dr. PENSON. I think, in general, the doctors who I represent in the American Urological Association are strongly opposed to this board, and they certainly wouldn't favor any expansion of it.

Mr. BUCHANAN. Dr. Gottlieb, I had a quick question. You mentioned in your testimony that the decision of this unelected board of bureaucrats is exempt from judicial review. I find this very concerning. Please explain to us what the full consequences of this exemption are.

Dr. GOTTLIEB. Well, my understanding, by talking to attorneys in town, is that the implementation of the board's provisions is exempt from judicial review. So, effectively, if you are a sponsor, if you are a company manufacturing a product or even a provider group affected by a decision of the board, you wouldn't have legal standing to challenge a decision in court. You also don't have any ability to appeal; there is no appeals mechanism.

I had my research assistant—and I don't have her with me here today—do a survey—we are going to be publishing it soon—of all the mechanisms in place on private health care plans, what they have in terms of adjudication. And, you know, I don't think Congress would ever allow a private plan to operate the way IPAB is going to operate, in terms of not allowing any mechanism for appeal, or any open process, in terms of how these decisions get made. And the private sector obviously does a much better job because—frankly, because they have to, under the law.

Mr. BUCHANAN. And let me—just a follow-on question that was brought up the other day, that if the Congress doesn't like what gets done at IPAB, what kind of reach—or what is their ability to try to overturn a decision, as you understand it? Because I have heard different comments on that.

Dr. GOTTLIEB. Well, there is sort of a veneer of congressional consent built in, right, where the proposals of IPAB go to Congress for a very limited time, and that Congress would have to come up with proposals that cut Medicare by the same magnitude, if they didn't like the proposals that IPAB put forward. I think it is unlikely Congress is going to be able to come up with competing proposals in the timeframe that they are allowed under the law.

So, it is effectively a way to fast-track the IPAB proposals into law and provide a veneer of congressional consent, I assume, because there were separation of powers issues if it didn't go before Congress.

Now, Congress can always pass a law later to repeal the IPAB provisions. But I think the whole idea here is that the idea was to make it very politically hard to do anything to stop the implementation of IPAB's proposals.

Mr. BUCHANAN. Thank you, Mr. Chairman. I yield back.

Chairman HERGER. Thank you. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I would ask unanimous consent to enter into the record an article from the *New York Times* called "Knotty Challenges in Health Care Costs."

Chairman HERGER. Without objection.

[The submission of Hon. Jim McDermott follows:]

Knotty Challenges in Health Care Costs

By GINA KOLATA

Published: March 5, 2012

New York Times

The numbers, the projections, make health economists shudder.

The average per capita cost of health care in the United States is over $8,000 annually, double the amount spent in most European countries. The Congressional Budget Office projects that unless costs are brought under control in the next decade, the nation will be spending all of its tax revenues on health care, Social Security, interest on the debt and defense — but mostly health care.

“If we solve our health care spending, practically all of our fiscal problems go away,” said Victor Fuchs, emeritus professor of economics and health research and policy at Stanford University. And if we don’t? “Then almost anything else we do will not solve our fiscal problems.”

Dr. Fuchs, who has been called the dean of American health care economists, has spent five decades studying the health care problem. In his view, what is needed is the sort of major change that comes once in a decade, perhaps, or even just once in a generation.

But change, he believes, will not bubble up from within the health care system itself.

Here, edited and condensed for space, is a recent conversation with Dr. Fuchs about the nation’s health care costs.

Why do we pay so much for health care?

We have higher administrative costs and a very complicated system for billing.

We have a 2-to-1 ratio of specialists to primary care physicians. In other countries the ratio is 50-50. Specialists spend more money and use more exotic interventions and also get paid more per hour of work.

We have more standby capacity. The United States has 4.2 times as many M.R.I. scanners as Canada. We have more malpractice claims.

We have less social support for the poor. Some of the additional spending comes about because we will take a poor sick person in the hospital, discharge them, and then they are back in the hospital for a month.

Drug prices are higher here. And physician incomes are higher.

Is there a large pent-up demand for a single-payer system?

No. Many Americans oppose a larger role for government. Many think their employer is paying for their health insurance, rather than it coming out of their wages.

Do we get anything for all the extra money we spend?

It is not without benefit that we can get a scan more quickly and more conveniently than people in other countries. It is not without benefit that we have specialists. It is not without benefit that we can choose our health plans.

So should we go after each of the contributing factors to our huge costs?

No. If we try to pick things off one by one, we will not accomplish much. Little stopgap measures will not do.

Then what is the big thing we should do to change the system?

The big thing for me is a dedicated value-added tax. It would provide universal coverage, a basic health care system for everyone. But the tax could be used only to pay for basic medical care, and basic medical care could be paid for only with the tax.

We want to subsidize the poor and the sick. The value-added tax is a function of income — the poor and the sick would pay much less. People are free to buy more health insurance, but they would do it with after-tax dollars.

We would do away with Goldman Sachs executives getting a $40,000-a-year health care plan that is tax-free. Patients would be enrolled in accountable care organizations, like the Kaiser plans in California. The plan gets a risk-adjusted capitation payment for each person enrolled.

But wouldn't that get rid of fee-for-service and private practices? Would people accept that?

I am suggesting an enormous change. It is revolutionary. I don't say it isn't. But nothing else will help solve the problem of cost, access and quality.

Do you think this sort of change could really come to pass?

American history is studded with examples of things that were not politically feasible until they were. The emancipation of slaves. Creation of a strong,

independent central bank. The replacement of the gold standard with fluctuating foreign-exchange rates. A trillion-dollar bailout of the financial industry.

Alexis de Tocqueville said that in the United States things move from the impossible to the inevitable without stopping at the probable. Because we are reaching a crisis and the only thing that will solve it is enormous change, we will have enormous change.

What would be the impetus? Wouldn't doctors and insurers and patients and politicians all be opposed to such a change?

Major changes in health care policy usually occur because of something outside of health policy — large-scale civil unrest, a depression. We cannot expect that change will be generated within a system. There is not enough desire for change, as opposed to desire on the part of many stakeholders not to change.

Given a stimulus from the outside, everything could come tumbling down. One of the things that might trigger it is if China stops buying our bonds. We are financing a huge deficit in Medicare and Medicaid by selling bonds, mostly to China.

Could it be that the current system is the way we want to spend our money? You say most people are insured and most people are perfectly happy with their health care. Why do we care if we devote so much money to health care?

Approximately 50 percent of all the health care spending is now government spending. At the state and local level it is crowding out education, crowding out maintenance and repair of bridges and roads. At the federal level we have a huge deficit financed by borrowing from abroad.

If it were private money and private spending, I would have no objection.

Mr. MCDERMOTT. This points out that the average cost of health care per capita in the United States is $8,000, which is twice what it is in every European country. So we all know there is a cost problem. I don't think anybody up here disagrees.

And the question is—I guess Bill Friske said it pretty well, in my view. He said, "Don't repeal it, fix it." So I am sitting here, trying to figure out—people don't like the IPAB. I think it is as good a mechanism as we have, and we will fix it on the way, maybe we will figure out better ways. But the question is, how do you fix—let's just take one area, doctor's fees?

Now, when we started Medicare, we said to the doctors, "You can submit your usual and customary fees." That was the deal. Doctors weren't coming in unless they got their usual and customary fees. Okay. So now, Dr. Penson, you sit out there at Vanderbilt University. Do you decide your fees?

Dr. PENSON. No, I do not.

[Laughter.]

Mr. MCDERMOTT. Well, who does?

Dr. PENSON. Well, I——

Mr. MCDERMOTT. An accountant?

Dr. PENSON. I believe the physicians and the leadership at Vanderbilt University, and I understand——

Mr. MCDERMOTT. No, wait a minute. You mean you don't set them? They are set by the university?

Dr. PENSON. And by the payers in the region.

Mr. MCDERMOTT. The payers of the regions?

Dr. PENSON. The payers in the region, the insurers.

Mr. MCDERMOTT. Ah, so United Health sits down with Vanderbilt and says, "Here is what we will pay. Send me a bill for that amount." Is that the idea?

Dr. PENSON. I don't know the exact mechanism, honestly.

Mr. MCDERMOTT. Isn't that interesting? Now, here we have a doctor who doesn't know how his pay comes. And what we have written into law right now is doctors can submit any pay—any fee they want, and then the government is supposed to write a check and pay them exactly what they ask for. Well, then somebody has to make a decision on how much doctors should be paid, right?

Now the question. Here is what I would like Ms. Moon and Dr. Penson and Mr. Gottlieb—Dr. Gottlieb to talk about. How should it be done? Should it be Members of Congress up on this dais decide? Or should it be by the doctors, the doctors should decide how much they are paid? Because doctors will always say, "I was not paid my fees." Of course you weren't paid your fees, they were too high. And Aetna or United Health or somebody said, "No, no, no, no. We are only paying this much." Or should it be done by a board that sits and talks about it?

What is the answer to this question of setting fees? How should it be done?

Dr. GOTTLIEB. Thank you, Congressman. I would just say up front we don't have a cost problem in medicine. I think we have a value problem in medicine. And the question is are we getting what we paid for? And I think most of us would agree we are not.

Mr. MCDERMOTT. Well, who decides the value?

Dr. GOTTLIEB. I know how my fees are established, and they are established, frankly, by Medicare. I mean I am paid—most of the patients I see are Medicare patients or Medicaid patients. And where I do have private-pay patients——

Mr. MCDERMOTT. What do you get—you submit——

Dr. GOTTLIEB [continuing]. I am paid off of a Medicare rate.

Mr. MCDERMOTT. You submit $100, what do you get back, $70?

Dr. GOTTLIEB. I—when I see patients in the hospital, I will fill out a sheet at the end of a day, and I will submit billing codes. They are Medicare billing codes, regardless of whether it is a Medicare patient or a private patient. The private plans use the same billing codes. And there is a fee schedule assigned to the billing codes. And that fee schedule is established by Medicare. And the private plans will pay a percentage off of that schedule.

Mr. MCDERMOTT. And——

Dr. GOTTLIEB. Medicare rates vary across the country, because doctors—because costs vary across the country. So Medicare varies the rates, based on surveys that it does of the actual cost of providing care. But that is how all physicians are paid, unless they are taking cash.

Mr. MCDERMOTT. Well, how would you fix that? You don't like that system. And it is costing us too much. We are paying twice what the French and the British and the Germans—everybody else is paying for health care, and our health statistics aren't better. So how do you fix this payment thing?

Dr. GOTTLIEB. Well, it——

Mr. MCDERMOTT. Because paying whatever we are paying isn't buying it.

Dr. GOTTLIEB. This gets to the question of, you know, do we have—do we tweak things, or do we go for a fundamental reform?

I mean, first of all, the whole coding process for how physicians are paid is done behind closed doors. AMA effectively has a monopoly on establishing the codes. And I——

Mr. MCDERMOTT. So you would be willing to look at the RUC committee.

Dr. GOTTLIEB. I think you have to open up the RUC. I think it should be a competitive process. And I think ideally you want to move as many services and products as you can into places where they can be bid in competitive markets. We have seen that bidding products in a competitive market works in Part D. Prices have been driven down. I would move other aspects of Medicare into competitive schemes where those services and products get bid in competitive markets.

Mr. MCDERMOTT. Dr. Penson.

Dr. PENSON. Well, Dr. Gottlieb is clearly smarter than I am. I am just a dumb urologist. But I will tell you, having practiced in Los Angeles before I was in Tennessee, it is a similar experience, in as far as what I get paid is set by the payer, whether it is Medicare or the private payer. And the institution I work for obviously negotiates that charge.

I don't have the fix. But the fix isn't just simply cutting physician fees. It is—you need fundamental reform. I don't have the answer. I don't think anyone does, that is why we are here.

Chairman HERGER. The gentleman's time has expired. Mr. Gerlach is recognized.

Mr. GERLACH. Thank you, Mr. Chairman. Maybe that is a good segue into a line of questioning particularly to Dr. Moon.

Thank you for testifying today, by the way, all of you on the panel.

Dr. Moon, in your written testimony, you indicate that you support the reasonableness of the goals of IPAB, but there are some "serious challenges" that ought to be addressed. And specifically, you say that setting goals on limited time horizons and then having short periods to implement change will put enormous pressure on the system. Instant savings should not be expected nor used to measure success. This may create a bias in favor of less complicated changes, such as payment limits, which is what the doctors have described and others have described, as well, that there needs to be perhaps a more nuanced approach encouraging delivery system reforms.

That leads to this whole issue of how are we finally going to attack the fraud that is in the system, in particular? We had Secretary Sebelius here last week, and she indicated in her testimony that they have undertaken health care fraud reforms that will generate $3 billion over 10 years of savings. Well, that sounds like a pretty good step in the right direction, except for the fact there is widespread agreement there is $50 billion in fraud every year in Medicare. That is $500 billion over 10 years. So, a $3 billion savings through these efforts, and a $500 billion problem over 10 years seems minuscule.

So, isn't that the area that everybody ought to start focusing in on to try to get a handle on the growth of the Medicare program—growth and spending in the Medicare program, issues like phantom billing, stolen identification of seniors' patient information, stolen unique physician identification numbers that lead to, again, fraudulent and criminal activity? Shouldn't that be the focus of this panel? Shouldn't that have been the focus of the Affordable Care Act, to really get to the real fundamental problems in the system, rather than keep setting up situations where doctors are going to get dinged for another 1 or 2 percent every year? Should that not be the focus of this panel, and everybody in the health care delivery system?

Ms. MOON. I believe that going after fraud is a very important aspect of trying to improve the health care system over time. But I also believe that a lot of the numbers that get thrown around are into the broader category of fraud, waste, and abuse. And once you get beyond fraudulent billing and some of the things that you can easily throw someone into an orange jumpsuit in a Federal penitentiary, you have more difficulty in terms of the subtleties of what is waste or abuse. You have the difficulties of patients and physicians, in some cases, wanting to do things for the right reasons but then overdoing things, doing things inappropriately. And how accountable we hold them is a difficult thing. That puts you also down the road to a lot of very tough controls that people have been reluctant to do.

In the fraud area, though, I would say some of the improvements that people are seeking in terms of the ability to track what hap-

pens, what the bills are, how large they are before the fact, before you actually pay, and going after them is a worthy thing to do. It is just going to be a little more difficult to get the big numbers, I think, because there is a sort of happy conspiracy out there that people—what may be viewed as waste by some people is viewed as someone else's very important——

Mr. GERLACH. Well, the Government Accountability Office put out a report that in 2010 there was $48 billion of improper payments. That is not just fraudulent activity, that is also just erroneous, unintentional administrative errors, but nonetheless is a waste of dollars that otherwise could be used to make sure there is quality and affordable care for the beneficiaries of the program.

So, we seem to get these reports periodically that there is massive amounts of waste, fraud, and abuse, and yet the best we can hear from the current Secretary of HHS is we are going to come up with $3 billion in savings over 10 years, and somehow, wow, we have done our job in all of this?

Don't you—has your institute—have you done any studies on how to deal with waste, fraud, and abuse, so that we tackle these very large numbers which, in turn—a portion of which could be making sure that physicians are getting a fair level of compensation for the patients they take care of?

Ms. MOON. We haven't looked at the fraud issue, but we have been focusing a lot on comparative effectiveness, and some of the kinds of things of trying to talk about getting value for your dollar.

I don't know about the recent GAO study, but an earlier one that they did that focused on fraud, waste, and abuse found that many of the—much of the amount was where the physician had not signed appropriately. And you don't know whether that is really fraud, or whether it is simply administrative error. So I think we have to be a little careful of being optimistic we can get all our dollars from there. I wish it were true, because that would keep us——

Mr. GERLACH. Okay. Well, you would agree we can hopefully get more than $3 billion over 10 years——

Ms. MOON. Yes, I hope we could do more than that.

Mr. GERLACH [continuing]. In savings than what the Secretary described?

Ms. MOON. I would like to see us get more than——

Chairman HERGER. The gentleman's time has expired.

Mr. GERLACH. Thank you. I appreciate it.

Chairman HERGER. Mr. Blumenauer is recognized.

Mr. BLUMENAUER. Thank you, Mr. Chairman. Thanks again for an opportunity to have this discussion, think through some of the issues.

I was struck by Dr. Penson saying he didn't have the answers, he has some concerns about application, and I appreciate that. But I do think that the Affordable Care Act actually incorporates most of what the answers are. Unlike Dr. Gottlieb, you know, we are not going to unwind Medicare. In fact, the Federal Government now pays about half the health care bill in this country.

And we are sort of—this is part of the system. That is not going to go away. Hearken our Tea Party friends saying, "Keep Govern-

ment's hands off our Medicare." It is ingrained in the system. What we need to do is make it work better.

And I couldn't agree more about the SGR. I thought it was bogus when I was here, I voted against it. I think an artificial formula that we can just kind of put it on autopilot and turn our back is wrong, and it is destructive.

It is interesting to note, despite sort of some of the payment limitations, expenses continue to skyrocket up because—and I think you, several of you, mentioned we need to change the system that rewards value in outcomes, not just procedures.

I agree with my friend from Pennsylvania. I don't know whether—how big the fraud piece is, but I have joined him in legislation for secure card, whether it is $10 billion, $20 billion, $40 billion, there is a chunk of money that will enable us to be able not just to prevent loss of resources, but also have better control and protection for patients, and have better data.

I don't think there is a silver bullet. I don't think there is one thing that is going to solve the problem. I know SGR isn't. And if I had my way, I would get rid of it entirely. I would, in fact, be willing to have some of the permanent tax cuts—you know, we battle over that—I would have some of the tax cuts go away, buy out the SGR, get rid of it. It is a goofy thing, and we are always going to try to stop it, except when we stub our toe. And the uncertainty, I think, does cloud the practice of medicine for patients and doctors.

But for me, the Affordable Care Act had all the elements that used to be bipartisan. You know, a mandate—the dreaded mandate—was the creation of conservative think tanks as an alternative to Hillary Care. This was touted by some of our Republican friends. It was what Governor Romney, in a bipartisan way, established in Massachusetts.

We have, you know, end of life care that came out of this Committee without dissent, strongly supported, somehow morphed into death panels and weirdness. I am hopeful that we can take this conversation about the IPAB and use it to kind of unwind some of these things.

I don't want that to be the default mechanism. I think—and I appreciate suggestions people have to try to make it better. But it is there because Congress has consistently failed. It won't take recommendations. You know, everybody wants to go to heaven, nobody wants to die. So we talk about restraint and care, but then we blink on some things that aren't particularly controversial. And even now, we have had people on the Committee talking about government problems with the health care reform, and then looking at ways to spend more money.

I am hopeful that we can work with you to find out ways that there might be some modest adjustment. But I hope it doesn't get to that point. It was specifically set up to give Congress a chance. And it isn't something that will happen unless Congress fails again.

We have the better part of a decade. Start moving. We have seen—and, Ms. Moon, I appreciate you referencing it—there is some areas where we are seeing some progress made. Health care costs have not exploded of late. There has actually been a little re-

straint, while we have been able to give some better service. I have people thank me that the kids are still on the parents' insurance policy, where kids are not going to be—have a problem with the pre-existing condition.

But we need to—Congress needs a tool like this, because otherwise we will do something really stupid, like SGR. And I hope the framework of health care reform, good suggestions from people like you, and Congress realizing that we can't continue to blink, will result in this never having to be put in effect, and we will do our job.

Thank you. Thank you, Mr. Chairman. I didn't get to my question, I am sorry.

[Laughter.]

But I feel so much better. I feel so much better.

[Laughter.]

Chairman HERGER. Good. The gentleman's time has expired.

I want to thank our witnesses for your testimony today. It is my sincere hope that, given the bipartisan concerns that were raised here today, this hearing will provide the foundation for this Committee to move forward in addressing the dangers posed by this ill-conceived board.

As a reminder, any Member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, I ask that the witnesses respond in a timely manner.

With that, the Subcommittee stands adjourned.

[Whereupon, at 11:29 a.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]

ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Testimony of

American Congress of Obstetricians and Gynecologists

Hearing

How the Independent Payment Advisory Board (IPAB) Will Impact
The Medicare Program, Its Beneficiaries, And Health Care Providers

House Committee on Ways and Means

Subcommittee on Health

March 6, 2012

The American Congress of Obstetricians and Gynecologists (ACOG), representing 57,000 physicians and partners in women's health, welcomes the opportunity to submit written testimony to the House Committee on Ways and Means Subcommittee on Health in support of repealing the Independent Payment Advisory Board (IPAB). IPAB, an unaccountable entity, will erode physician support for the Medicare program, limit patient access to needed care, and limit physicians' ability to continue to provide high quality care.

For these reasons, ACOG strongly supports swift passage of H.R. 452, the Medicare Decisions Accountability Act, a bi-partisan bill introduced by Rep. Phil Roe to repeal IPAB.

What IPAB Does

IPAB's sole job is to recommend Medicare cuts to Congress to reduce the per capita rate of growth in Medicare spending, if a yearly spending target is not met. In its first five years, beginning in 2015, IPAB can only recommend cuts to physicians and a few other provider types, while hospitals, nursing homes, and most other providers are exempt.

IPAB cannot, by law, recommend increasing Medicare premiums, co-pays, or deductibles, and can't recommend benefit changes or eligibility restrictions. IPAB's recommendations become law each year unless Congress can block or make changes to them by a short deadline, while overcoming significant procedural hurdles, and come up with other cuts of the same magnitude from within the Medicare program.

IPAB Will Harm Patients

IPAB will hurt our patients by restricting access to care. Fewer physicians will accept Medicare patients, and many more physicians capping the number of Medicare patients they will treat. IPAB recommendations will have far reaching consequences in the private insurance market as insurers use Medicare reimbursements as a benchmark for their own payments. IPAB will only make recommendations based on a yearly target, precluding thoughtful, longer-term solutions.

Power in the Hands of 15 Unelected Bureaucrats or in the Hands of 1

In the Affordable Care Act (ACA), the US Congress punted responsibility for Medicare cost-saving decisions to the IPAB. Beginning in 2015, the 15 unelected IPAB members would have tremendous power to cut Medicare payments to physicians and other health care providers.

Some assert that IPAB may never become a reality, given few volunteers to serve on the Board and the likelihood of difficult nomination fights. These assertions miss the point. Under the ACA, even if the Board never comes into being, these cuts will still be made, and still outside of the hands of our elected representatives. If not made by the 15 unelected bureaucrats, they'll be made by one: The Secretary of the Department of Health and Human Services.

Addressing Health Care Costs without IPAB

Without a doubt, our Nation's health care costs must be addressed. We recommend a serious, thoughtful, meaningful approach.

- Congress' challenge, and the challenge faced by our nation as a whole, is to reduce the rate of growth in health care costs while increasing access to high quality effective health care, getting better outcomes for our health care dollars. Many factors contribute to rising health care costs. Using IPAB to cut only a small segment of these factors is the wrong approach and will undermine innovation.

- Opportunities for cost savings must be identified across all parts of the health care system and throughout the Medicare program. In 2010, services reimbursed under the Medicare physician fee schedule only accounted for 12% of the total $514 billion in Medicare spending. Hospital in-patient services were more than double physician costs, 27% of Medicare spending.

- Alternative approaches to health care delivery that will result in better health outcomes for our health care dollars must be fully explored and tested in order to achieve true long term cost-effectiveness. The Centers for Medicare and Medicaid Innovation (CMMI) and medical societies, including ACOG, are hard at work in identifying practice and payment model innovations that reward quality and result in better access to care and better care outcomes. Testing, evaluation and implementation of these alternatives takes time. Arbitrary annual cuts in Medicare physician payments will quickly undermine this work.

- The physician Medicare experience must improve, not be further eroded. The Medicare sustainable growth rate (SGR) formula must be repealed and replaced by a reliable method of appropriately paying physicians. Health information technology is needed to implement quality measures that include high-quality, risk-adjusted data. This requires investments in individual physician practices, again requiring resources and time. Arbitrary annual IPAB cuts will cause physicians to lose faith in the Medicare program.

ACOG thanks the Subcommittee for the opportunity to provide this statement to the House Committee on Ways and Means, Subcommittee on Health on the Independent Payment Advisory Board. For questions or concerns, please contact Anna Hyde, ACOG Federal Affairs Manager, at 202-863-2512 or ahyde@acog.org

aaPM&R
American Academy of
Physical Medicine and Rehabilitation

Testimony of Peter C. Esselman, M.D., M.P.T.

Chair, Health Policy and Legislation Committee

American Academy of Physical Medicine and Rehabilitation

Rosemont, Illinois

Before the United States House of Representatives

Committee on Ways and Means

Subcommittee on Health

Hearing on the Independent Payment Advisory Board (H.R. 452)

Under the Patient Protection and Affordable Care Act

March 6, 2012

aaPM&R
American Academy of Physical Medicine and Rehabilitation

Written Statement

Subcommittee Chairman Herger, Ranking Member Stark and Members of the Committee on Ways and Means Subcommittee on Health:

Thank you for the opportunity to submit a written statement in support of H.R. 452 – the "Medicare Decisions Accountability Act". I present the following testimony on behalf of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), the national professional organization representing more than 8,000 physiatrists, physicians specializing in physical medicine and rehabilitation. Our members treat adults and children with acute and chronic pain, persons who have experienced catastrophic events resulting in paraplegia, quadriplegia, or traumatic brain injury, rheumatologic conditions, musculoskeletal injuries, and individuals with neurologic disorders or any other disease process that results in impairment and/or disability. Medicare patients constitute a very large segment of the patients served by this specialty and services are furnished in rehabilitation hospitals, skilled nursing facilities, outpatient facilities, and in physicians' offices.

The Academy is committed to working enthusiastically with members of Congress, the Administration, and other stakeholders on fine-tuning proposals to strengthen the Medicare program that result in patient-centered, high-quality health systems' reforms that serve the needs of all, especially those with disability, chronic conditions, or functional impairment. Any modifications to the program on which people with disabilities depend for their health care must not result in reduced access to needed services either directly, through eligibility restrictions or benefit cuts, or indirectly, through inadequate and unrealistic provider reimbursement rates.

As you know, the Patient Protection and Affordable Care Act (PPACA [P.L. 111-148]) created the Independent Payment Advisory Board (IPAB), a 15-member panel appointed by the president and confirmed by the Senate. Beginning in 2015,

the board is charged with making recommendations to Congress that would reduce spending in Medicare through implementation of a spending target system and an expedited legislative approval process. The IPAB was granted unprecedented authority and has the power to change laws previously enacted by Congress. In addition, under the law, administrative or judicial review of the Secretary's implementation of a recommendation contained in an IPAB proposal is specifically prohibited.

We are deeply concerned about the potential impact the IPAB, as structured, will have on patient access to quality healthcare – especially for those people with disabilities and chronic conditions. AAPM&R believes that the IPAB is a flawed approach to spending controls and, as structured would be harmful to patient care. It is the Academy's position that based on the proposed IPAB methodologies, the majority of any recommended spending reductions would come in the form of payment cuts to Medicare providers that could affect patient access to care, innovative therapies and specialty care. IPAB would intensify the existing problems caused by the current Medicare physician payment formula (sustainable growth rate), which is plaguing Medicare as well as the TRICARE military health care program with frequently scheduled cuts.

Lastly, we believe that the IPAB sets a bad precedent for superseding the normal legislative process. Congress is a representative entity that has authority to legislate on issues of public policy. Redirecting this responsibility to an unelected and unaccountable board eliminates our elected officials from the decision-making process regarding a program that millions of our nation's seniors and people with disabilities rely upon.

Thank you again and the Academy reiterates its commitment to work collaboratively with members of Congress, the Administration, and other stakeholders to ensure that people with acute and chronic disabling conditions benefit from appropriate healthcare system investments in order to live and function as independently as possible.

STATEMENT

OF THE

on the

Independent Payment Advisory Board

Committee on Ways and Means

Subcommittee on Health

US House of Representatives

March 6, 2012

On behalf of over 18,000 orthopaedic surgeons, the American Association of Orthopaedic Surgeons (AAOS) commends you for convening a hearing on the Independent Payment Advisory Board (IPAB) and its impact on Medicare. Founded in 1933, AAOS is the pre-eminent provider of musculoskeletal education to orthopaedic surgeons and others in the world. We continue to be a committed partner in providing high quality health care that focuses on patient safety and cultural competency.

AAOS strongly supports HR 452 "The Medicare Decisions Accountability Act" introduced by Congressman Phil Roe (TN-01). HR 452 currently has 228 bipartisan cosponsors and is an important step in preserving Congress' historically central and appropriate role in managing Medicare payment policy. We strongly feel that the IPAB, created by the Patient Protection and Affordable Care Act (PPACA), threatens the ability of the people's elected representatives in Congress to ensure access for Medicare and Medicaid beneficiaries to the health care they need, when they need it. Leaving payment policy decisions in the hands of an unelected, unaccountable governmental body with minimal congressional oversight will have a deleterious effect on the availability of quality, efficient health care to the millions of Medicare beneficiaries in the United States. From the beginning of Medicare, Members of Congress have always played an essential role in shaping policies to ensure the health care system is equipped to care for diverse populations across the country. Creation of the IPAB severely limits Congressional authority, eliminates the transparency of hearings, severely limits needed debate and stakeholder input, and will result in the reduced availability of quality, efficient health care to Medicare beneficiaries.

By current law, fewer than half of the IPAB members can be health care providers, and no member can be a practicing physician or otherwise employed. This makes no sense. No other federal authority is mandated to *not* include the professionals it regulates and for good reason- because all professional activities, especially the activity of medicine requires tremendously specific expertise, expertise attained through specific education and experience. Instead, the current legislation leaves decisions about patient's medical care in the hands of individuals who would not fully understand the day-to-day reality of delivering care. Physicians have the best knowledge and the most direct interest in their patient care and are the best judges of the potential effects of any physician payment model on the quality of care delivered to patients. If IPAB were allowed to come into existence as it is envisioned in current legislation, Congress and the public would lose the ability to have any say in payment decisions.

In addition to this flaw, there are other significant flaws with IPAB if it is left as is. Under current law, the IPAB will be required to recommend cuts based on unrealistic spending targets starting in 2014. Its recommendations are then to be "fast tracked" and automatically go into effect starting in fiscal year 2015 unless blocked or amended by Congress. Providers representing roughly 37 percent of all Medicare payments, including hospitals and hospice care, are exempt from IPAB cuts until 2020. However, IPAB members must still take their costs into consideration when recommending cuts. Thus, IPAB directed cuts will disproportionately fall on all other providers and suppliers, including orthopaedic surgeons. Furthermore, without a permanent solution to the Sustainable Growth Rate (SGR) formula, physicians already facing cuts in excess of 40 percent over the next decade are essentially subject to "double jeopardy" with cuts from both SGR and IPAB.

Even if Congress is unable to find qualified "experts" to sit on the IPAB panel, the law still calls for cuts to curb Medicare spending, directing the Secretary of the Department of Health and Human Services to enforce budget reductions unilaterally.

Finally, because IPAB will only be making recommendations based on a yearly target, more thoughtful, longer-term solutions are off the table. Repeal of the IPAB will allow policymakers and providers to work together to advance innovative payment methods that will achieve cost savings by incentivizing efficient, high quality care for all Americans.

AAOS recognizes the importance of lowering health care costs and is committed to providing high quality care that is also cost effective. Arbitrarily slashing reimbursement rates for Medicare providers is not likely to actually lower health care costs and most certainly will do nothing to promote or preserve quality care. Instead, AAOS recommends a series of initiatives that are already in place or can be easily implemented. The AAOS initiated and is a partner in the American Joint Replacement Registry (AJRR), is engaged in developing clinical practice guidelines, and has published a primer to help educate orthopaedic surgeons on issues related to Accountable Care Organizations.

AAOS also recommends meaningful and varied payment reform as a better way to lower Medicare costs and increase the overall health quality for Medicare beneficiaries. AAOS believes that payment reform must create a system consisting of financial incentives that reward higher quality care based on appropriate patient-centric measures of health outcomes. These measures must be risk adjusted so as to account for the medical, social, and personal co-morbidities that are beyond a provider's control. These include factors such as obesity, diminished mobility, chronic disease states, noncompliance with treatment recommendations, poor nutrition, tobacco and alcohol use and many other conditions which are beyond the control of health care providers.

Payment systems should reward physicians for developing medically innovative treatments that increase quality and reduce costs. This will keep patients healthier and out of hospitals, thereby increasing their productivity and Gross Domestic Product. Orthopaedics has long been a driver of medical innovation such as arthroscopic treatments for conditions which formerly required

open surgery and inpatient hospital stays. These types of innovative technological advances have saved employers, patients, Medicare, and other payers billions of dollars a year in reduced costs, principally though reductions in hospital stays and post operative days of patient morbidity. By tying payment to quality and to savings generated by medical innovation, Medicare can reduce overall costs and drive innovation.

AAOS believes that a tiered payment system can be built upon evidence-based guidelines, appropriate use criteria, risk-adjusted performance measures, and mandatory participation in national registries. In the last ten years, many registries have been created and disseminated by specialty societies and these deserve legislative, payor, purchaser, hospital, and health care provider support. We now have a foundation of quality measures and evolving evidence in virtually every area of medical practice. These are the best resources for a quality-focused payment system. We also have a sufficient foundation of outcomes research to begin to determine what constitutes a high quality outcome compared to a low quality outcome. These types of quality measures should be the foundation of a new delivery system that replaces our current fee-for-service system with one that increases quality of care while reducing healthcare costs.

Again, we thank you for your leadership on this issue and look forward to working with you. We stand ready to assist Members of Congress so that we can better enhance patient care.

Cc: House Ways and Means Committee

1090 Vermont Ave, Suite 500, Washington, DC 20005-4949 ph (202) 414-0140 | (800) 962-9008 | www.osteopathic.org

March 5, 2012

The Honorable Wally Herger
Chairman, Ways & Means Subcommittee on Health
U.S. House of Representatives
1101 Longworth House Office Building
Washington, D.C. 20515

The Honorable Pete Stark
Ranking Member, Ways & Means Subcommittee on Health
U.S. House of Representatives
1139E Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Herger and Ranking Member Stark:

As your Subcommittee prepares for its hearing on the Independent Payment Advisory Board (IPAB), I want to share the position of the American Osteopathic Association (AOA) for your consideration.

Without question, one of the most contested policies established by the "Patient Protection and Affordable Care Act" (PPACA) is the creation of the IPAB. PPACA authorized the creation of a 15 member panel with broad authority to make recommendations on reducing the overall growth of Medicare spending. Many Members of Congress and advocacy groups representing consumers, physicians, and hospitals have raised concerns regarding the IPAB and its proposed scope of work – including the AOA.

We recognize that the President, some Members of Congress, and several academic experts have signaled their strong support for the IPAB and have suggested why it is important to our nation's long-term fiscal health. The AOA does not disagree that we should pursue aggressive policies that "bend the cost curve" with respect to the Medicare program. In fact, we strongly support policies that would reduce the escalating costs of health care, both in public and private programs. However, we do have concerns with the IPAB approach.

Our concerns are based in our belief that fundamental delivery system and infrastructure reforms are better approaches that have the potential to make substantive and long-term changes in the Medicare program. As a point of clarification, the AOA supported the passage and enactment of PPACA, so this is not an attempt to undermine the law. Instead, it is a defense of those policies in the law that stand to promote a delivery system that we believe is essential to meeting our shared goal of improved quality and more efficient care.

Our health care delivery system suffers from fragmentation, a lack of coordination, and a population that demands more, not less, health care services. The combination of these factors results in the delivery of duplicative services, uncoordinated care, and all too often care that actually may harm patients. Fragmentation in care delivery results in excessive spending both in the short and long term. While we did not arrive in our current state intentionally, it is a fact that our fragmented, uncoordinated, and over-utilized delivery system does not always foster high quality, efficient care.

The United States Congress and the Administration recognized this and took historic steps to create and implement a better delivery system through the enactment of two transformational laws – PPACA and the HITECH Act. We are convinced that reforms included in PPACA, specifically those that are being initiated by the Center for Medicare and Medicaid Innovation (CMMI), and the HITECH Act will result in better care for patients and decreased costs for payers. Let me explain.

PPACA invested billions of dollars in delivery system reforms, such as the patient-centered medical home, accountable care organizations, care transition programs, medication management, health innovation zones, and other programs that have the ability to improve the quality and safety of care while slowing the overall cost of health care in years to come. Additionally, PPACA made a historic investment in primary care. When you couple the provisions of PPACA with those included in the HITECH Act, which creates and implements a nationwide interoperable health information infrastructure, you have the foundation for fundamental long-term reforms that will slow spending on health care by investing in infrastructure and process changes versus a one-time across the board reduction in spending.

Already, we are seeing the true benefits – both in quality and efficiency – of integrated patient-centered delivery models. Across the country physicians are transforming their practices into medical homes, implementing electronic health records, and coordinating with local hospitals to create delivery models that promote high quality and highly coordinated care. And I would be remiss if I didn't mention that they are seeing dramatic reductions in per capita spending as a result.

By comparison, the IPAB would operate under a requirement of creating savings through reductions in Medicare spending, independent of fundamental reforms that would advance long-term improvements in quality, safety, and efficiency. By prohibiting IPAB from altering coverage and benefits for beneficiaries, IPAB is largely limited to cuts in payments as a means of achieving its statutory goals. Finally, IPAB contributes to the concept of fragmentation by ignoring the growing trend of care being delivered in ambulatory versus inpatient settings. By limiting the application of IPAB's recommendations to only part of overall Medicare spending (IPAB can only recommend changes impacting Parts B, C, and D, which represent less than 50 percent of overall Medicare spending), IPAB views the Medicare program as 4 individual parts versus a comprehensive health care system. This approach, in our opinion, actually undermines the positive provisions and programs included in PPACA and the HITECH Act by creating a financial disincentive for those that would otherwise invest in systemic reforms. It is difficult to persuade physicians, hospitals, and other providers to make the necessary investments in electronic health records, practice transformation, and care coordination when they face arbitrary reductions in payments. Again, we are concerned with IPAB because we think it is the wrong approach – not the wrong goal.

Finally, it is important that we move beyond the deliberate distortion of certain policies by labeling them as "rationing." We are at a point in both science and policy development where we are able to have a meaningful debate regarding the appropriateness of various diagnostic and treatment modalities. Just because the FDA approved it or the physician fee schedule pays for it, we should not be so inflexible in our stance that it is appropriate for every patient. We should use the data and quality outcome measures

available to ensure that we are providing the appropriate care to each patient at the appropriate time. I would suggest that many patients are undertreated, but we cannot make such determinations if we remain resistant to comparative analysis of diagnosis and treatment modalities.

Congress and the Administration created the foundation for a better health care delivery system through the enactment of PPACA and the HITECH Act. These two laws included numerous provisions that strike at the heart of the nation's fragmented and uncoordinated delivery system and began the necessary process of establishing a more coordinated, patient-centric health care system that stands to improve health care for individuals, improve health for at-risk, high-need populations, and lower per capita spending. The AOA wants to see these initiatives have every opportunity to succeed and are concerned that policies, such as the IPAB, serve as a deterrent to realizing their true potential.

Sincerely,

Martin S. Levine, DO
President

C: Members, Ways & Means Subcommittee on Health

PRIVATE PRACTICE SECTION, APTA

APTA
American Physical Therapy Association

1055 N. Fairfax Street, Suite 100, Alexandria, VA 22314, TEL (703) 299-2410, (800) 517-1167 FAX (703) 299-2411 WEBSITE www.ppsapta.org

March 6, 2012

The Honorable Wally Herger
The Honorable Pete Stark
Subcommittee on Health
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Herger and Ranking Member Stark:

On behalf of the Private Practice Section (PPS) of the American Physical Therapy Association (APTA), and its over 4000 members who function as small businesses, we are pleased to offer this statement to the Health Subcommittee of the House Committee on Ways and Means germane to the March 6 hearing examining the effects of the Independent Payment Advisory Board (IPAB) under the Medicare program.

PPS members provide a valuable service to communities across the nation and they do so in a convenient, cost-effective manner. But as is typical for small businesses, narrow margins are jeopardized when a significant sector of its market cuts reimbursement without regard to the value of the service provided. Moreover, when such an action is unpredictable and is taken by an influential payer such as Medicare, the effect is to negatively influence the business environment and create an untenable situation for the providers. More importantly, the Medicare beneficiaries are left in a vulnerable position, unable to depend on the access to convenient, cost-effective, high-quality care to which they have become accustomed.

Physical therapists in private practice provide critical health care services to beneficiaries under Medicare Part B to enable individuals to return to their highest functional potential. We are pleased to submit this statement for the record in advance of the March 6 subcommittee hearing to discuss the repeal of Sec. 3403. Independent Medicare Advisory Board (as modified by sec. 10320) of the Patient Protection and Affordable Care Act.

PPS/APTA supports HR 452 the Medicare Decisions Accountability Act of 2011. This bill would repeal sections of the Patient Protection and Affordable Care (PPACA) that establishes an Independent Payment Advisory Board (IPAB) to develop and submit detailed proposals to reduce the per capita rate of growth in Medicare spending to the President for Congress to consider.

Background
In response, in part, to overall growth in Medicare program expenditures and growth in expenditures per Medicare beneficiary, the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended) created the Independent Payment Advisory Board (IPAB) and charged the Board with developing proposals to "reduce the per capita rate of growth in Medicare spending." The Secretary of Health and Human Services (the Secretary) is directed to implement the Board's proposals automatically unless Congress affirmatively acts to alter the Board's proposals or to discontinue the automatic implementation of such proposals.

Annually, starting April 30, 2013, with the Medicare Chief Actuary will calculate a Medicare per capita growth rate and a Medicare per capita target growth rate. If the Chief Actuary determines that the growth rate exceeds target growth rate, the Actuary would identify the amount by which the Board must reduce future spending. This determination by the Chief Actuary also triggers a requirement that the Board prepare a proposal to reduce the growth in the Medicare per capita growth rate by the applicable savings target. The Board cannot ration care, raise premiums, increase cost sharing, or otherwise restrict benefits or modify eligibility. In generating its proposals, the Board is directed to consider, among other things, Medicare solvency, quality and access to care, the effects of changes in payments to providers, and those dually eligible for Medicare and Medicaid. If the Board fails to act, the Secretary is directed to prepare a proposal.

Board proposals must be submitted to the Secretary by September 1 of each year and will be "fast-tracked" in Congress. More importantly, IPAB proposals go into force automatically unless Congress affirmatively acts to amend or block them within a stated period of time and under circumstances specified in the Act.[1]

The IPAB will be composed of 15 members appointed by the President with the advice and consent of the Senate, will serve six year terms, and shall have varied professional and geographic representation and include representatives of consumers and the elderly. Board members will be full time government employees.[2]

Impact
The Congressional Budget Office projects that the Board's potential impact on particular Medicare providers or suppliers including private practice physical therapists may be significant, particularly if the Board alters payment mechanisms, which is among its options. Moreover, the IPAB's impact may be larger if private insurers continue to track Medicare payment policies and adopt similar reductions in payments to their providers and suppliers,[3] such as private practice PTs, may be significant, particularly if the Board alters payment mechanisms. Finally, the IPAB's impact may be larger if private insurers continue to track Medicare payment policies and adopt similar reductions in payments to their providers and suppliers, which is typical. TriCare patients will definitely be impacted since reimbursement in that program is benchmarked to Medicare.

When Medicare growth exceeds the given target, then the IPAB must put forth a proposal to reduce Medicare spending without causing a reduction in patient benefits. This effectively means IPAB's focus will be on reductions to physician and therapist reimbursements.

Objections
The power of the IPAB to determine cuts to Medicare payment rates will remove this authority from elected officials which deprives stakeholders of normal recourse such as lobbying and petitioning members of Congress in other ways. The ultimate responsibility for the Medicare program is vested in the elected legislators and should not be delegated to appointed, unaccountable, full time government employees.

The impact of IPAB deliberations will be far more profound for Part B providers such as private practice physical therapists because hospitals, hospice, and inpatient rehabilitation facilities are exempt from the actions of the IPAB until 2020.[2] If these carve outs are left unaddressed, that means the entities responsible for two-thirds of Medicare spending are exempt from payment cuts until 2020.

Physical therapists in private practice are already subject to an expenditure target known as the sustainable growth rate and other payment reductions as the result of the Medicare physician payment formula. Creating and empowering the IPAB would subject PTPPs two separate expenditure targets while at the same time exempting large segments of Medicare providers who are subject to no target at all.

Moreover, since the IPAB is a 15-member independent body comprised of unelected officials, with broad discretionary authority to make radical changes in the structure of the Medicare program, IPAB recommendations should require an affirmative vote by Congress before they can be implemented.

To subject outpatient Part B provider and suppliers to payment cuts while holding other parts of the Medicare system harmless will have a dampening effect on the vibrancy of the physical therapy providers who function as small businesses, are more economical, more cost conscious, more convenient and more innovative. In essence, this could be seen as encouraging patients to once again seek and obtain care in institutions, a pattern that our system has been evolving from for over three decades.

The end result of this will mean a further reduction in the already below market reimbursement rates for therapists and physicians who treat Medicare and TriCare patients and make up less than 10 percent of total Medicare expenditures.

Conclusion
For the above reasons, PPS/APTA believes the inclusion of the Independent Payment Advisory Commission in the PPACA is a dangerous and unprecedented abrogation of congressional authority to an unelected, unaccountable body of so-called experts. To empower a mindless rate-cutting machine comprised of 15 unelected members, strips members of Congress of their constitutional duty and creates a volatile and unpredictable marketplace for those community-based health care providers, including physical therapists in private practice who operate as small businesses. Moreover, it sets the Medicare program up for unsustainable cuts that will endanger the health of America's seniors, people with disabilities and TriCare beneficiaries. PPS/APTA strongly urges Congress to repeal Sec. 3403. Independent Medicare Advisory Board (as modified by sec. 10320) of the Patient Protection and Affordable Care Act.

On behalf of the Private Practice Section of APTA, thank you for your continued efforts to create a more stable, predictable and effective Medicare system and for your vigilance in monitoring the effects of public policy on Medicare beneficiaries and independent physical therapists who operate as small businesses.

Sincerely,

Tom DiAngelis, PT, DPT
President
Private Practice Section / APTA

1. Patient Protection and Affordable Care Act, Section 3403(c)(2)(A)(iii).
2. Congressional Research Service, The Independent Payment Advisory Board, November 30, 2010.
3. Congressional Budget Office, Scoring of Proposed Changes to the Independent Payment Advisory Board, May 13, 2011.

American Society of Anesthesiologists

1501 M Street, N.W. • Suite 300 • Washington, D.C. 20005 • (202) 289-2222 • Fax: (202) 371-0384 • mail@ASAwash.org

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

Tuesday March 6, 2012

Statement for the Record by
Jerry A. Cohen, M.D., President, American Society of Anesthesiologists

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.

Comments for the Record

House Committee on Ways and Means

Subcommittee on Health

Independent Payments Advisory Board

Tuesday, March 6, 2012, 10:00 AM

By Michael G. Bindner

Center for Fiscal Equity

Chairman Herger and Ranking Member Stark, thank you for the opportunity to submit these comments for the record to the Subcommittee on Health of the House Ways and Means Committee. We will leave it to the scheduled witnesses to assess the impact of the Independent Payments Advisory Board and will confine our comments to alternative methods of cost control. As always, our comments will be made within the context of our tax and entitlement reform proposals. The Center for Fiscal Equity proposes a large ball solution with four major provisions:

- A Value Added Tax (VAT) to fund domestic military spending and domestic discretionary spending.
- Personal income surtaxes on joint and widowed filers with net annual incomes of $100,000 and single filers earning $50,000 per year to fund net interest payments, debt retirement and overseas and strategic military spending and other international spending, with graduated rates between 5% and 25% in either 5% or 10% increments.
- Employee contributions to Old Age and Survivors Insurance (OASI) with a lower income cap, which allows for lower payment levels to wealthier retirees without making bend points more progressive.
- A VAT-like Net Business Receipts Tax (NBRT), which is essentially a subtraction VAT with additional tax expenditures for family support, health care and the private delivery of governmental services, to fund entitlement spending and replace income tax filing for most people (including people who file without paying), the corporate income tax, business tax filing through individual income taxes and the employer contribution to OASI, all payroll taxes for hospital insurance, disability insurance, unemployment insurance and survivors under age 60. The funding of Medicare will be accomplished solely with the NBRT and any exclusions for private insurance will be as an offset to this tax.

The NBRT base is similar to a Value Added Tax (VAT), but not identical. Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

To extract health cost savings using the NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit, provided that services are at least as generous as the current programs. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but not so much that the free market is destroyed. Increasing Part B and Part D premiums also makes it more likely that an employer-based system will be supported by retirees.

Enacting the NBRT is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

If this proposal is adopted, employers would serve the function the IPAB will attempt to serve, because it will be in their interest to do so. They will have a direct incentive to pay for only treatments that have a positive effect on the well being of their retirees, especially if the NBRT also funds personal retirement accounts for employees which are invested in employer voting stock, an option we suggest. Indeed, an employee-ownership option is the best assurance that cost cutting does not include denying coverage that extends life significantly in order to minimize pension costs.

The IPAB might still have a function under such a reform as an information source for Medicare services provided to retirees from companies who do not offer alternative delivery, as well as for companies who do, but who would find the information developed by the IPAB valuable to their decision making on care.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Contact Sheet

Michael Bindner
Center for Fiscal Equity
4 Canterbury Square, Suite 302
Alexandria, Virginia 22304
571-334-8771
fiscalequity@verizon.net

Committee on Ways and Means
Subcommittee on Health
Independent Payments Advisory Board
Tuesday, March 6, 2012, 10:00 AM

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.

CONTACT INFORMATION

Mary R. Grealy
President
Healthcare Leadership Council
750 9th Street NW
Suite 500
Washington, DC 20001
(202) 452-8700
mgrealy@hlc.org

Committee on Ways and Means
Health Subcommittee
Statement for the Record
In reference to the March 6 Subcommittee hearing on
the Independent Payment Advisory Board (IPAB)

Statement
of
Mary R. Grealy, President, Healthcare Leadership Council

to the
House Ways and Means
Health Subcommittee

Independent Payment Advisory Board (IPAB) Hearing

March 6, 2012

Chairman Herger, Congressman Stark, and members of the subcommittee, I want to thank you on behalf of the members of the Healthcare Leadership Council (HLC) for the opportunity to submit a comment for the record on the Independent Payment Advisory Board (IPAB) and its potential ramifications for Medicare beneficiaries and the U.S. healthcare system.

HLC is a not-for-profit membership organization comprised of executives of the nation's leading healthcare companies and organizations. Members of HLC – hospitals, academic medical centers, health plans, pharmaceutical companies, medical device manufacturers, health product distributors, pharmacies, and other key sectors in the healthcare continuum – are dedicated to constantly improving the accessibility, affordability, and quality of American healthcare.

It is because of our commitment to patients and their access to quality healthcare that we have deep concerns about the IPAB. The Patient Protection and Affordable Care Act (PPACA [P.L. 111-148]) created the IPAB, a 15-member board that will be appointed by the President and empowered to make recommendations to cut Medicare spending if spending growth exceeds certain levels. The rationale for creating the IPAB has been clearly stated. As HHS Secretary Kathleen Sebelius explained in a published op-ed, the IPAB is an essential backstop to prevent excessive Medicare spending from endangering the program's future.

No one can argue with that goal. It is essential that we find ways to curb Medicare spending growth in order to preserve the program for future generations of beneficiaries. But, as we examine the IPAB, there are essential questions we must ask. Is this the best available means to address Medicare spending? Will the IPAB improve the program for beneficiaries or simply slash spending and, in so doing, reduce beneficiary access to care? Will the IPAB be responsive to public concerns or, for that matter, flexible enough to respond to changing demands, circumstances and capabilities within the healthcare sphere?

As we consider the answers to those questions, it is impossible to escape the conclusion that the IPAB has the potential to cause serious harm to Medicare beneficiaries and, by acting as a catalyst to shift healthcare costs to private payers, will actually make healthcare more expensive for healthcare consumers. It is, to say the least, worrisome that this board will have such extensive power over one of the country's most valued domestic programs, and will exercise that power without public input and without administrative or judicial review when its recommendations are implemented. When we weigh these and other concerns I will outline, it becomes clear that the IPAB should be repealed.

Let's begin by considering access to care for Medicare beneficiaries, the most important ramification of the IPAB if it is allowed to take effect. As a backdrop to this concern, we need to be aware that a significant number of physicians in this country are already limiting the number of Medicare beneficiaries they will see because of low reimbursement rates. According to an American Medical Association survey, 17 percent of all doctors, including almost one of every three primary care physicians, are restricting the number of Medicare patients in their practices. Furthermore, this is an escalating trend. The number of physicians unable to accept new Medicare patients has doubled over the last five years for which data is available. This is supported by a 2010 Medical Group Management Association study finding that two of every three physician practices are considering limiting the number of new Medicare patients and 27.7 percent are debating whether to cease treating Medicare patients altogether.

Additionally, a General Accounting Office report released this month, based on a 2010 national survey of physicians concerning the Medicaid and CHIP programs, found that 79 percent of doctors are accepting all privately insured children as new patients. By contrast, only 47 percent are accepting children who have Medicaid or CHIP coverage as new patients, citing low and delayed reimbursement and provider enrollment requirements. We are seeing this same trend with physicians and Medicare patients.

It is impossible to avoid the conclusion that the IPAB will only worsen this healthcare access problem. Because of the way in which the board is designed, the IPAB recommendations for spending reductions will come almost entirely in the form of provider payment cuts. If physicians are hit with IPAB-driven payment reductions, it will certainly affect patient access to care. In fact, the combination of payment cuts along with the projected shortage of physicians the nation will experience over the next several years, as 80 million baby boomers become new Medicare beneficiaries at the rate of 9,000 per day, will create a healthcare access 'perfect storm' that will hit seniors the hardest.

It has been suggested that the presence of healthcare experts on the board will actually serve to improve the Medicare program, rather than simply cut budgets. It is important to understand, though, that, irrespective of the capabilities and credentials of prospective IPAB members, the board's mandate makes it virtually impossible to develop long-term reforms to improve Medicare's value. Should Medicare spending levels send the board into action, it must make recommendations that will achieve sufficient scoreable savings within a one-year time period. Any meaningful reforms to enhance the value and cost-efficiency of the Medicare program would take more than one year to develop, implement and achieve tangible results. This leaves provider payment cuts as the default option.

The Congressional Budget Office agrees with this point of view, stating that the board is likely to focus its recommendations on changes to payment rates or methodologies for services in the fee-for-service sector by non-exempt providers. And the Kaiser Family Foundation stated in an issue brief that the one-year scoreable savings mandate "may discourage the type of longer-term policy change that could be most important for Medicare and the underlying growth in healthcare costs, including delivery system reforms that MedPAC and others have recommended which are included in the PPACA – and which generally require several years to achieve savings. If these delivery system reforms are not 'scoreable' for the first year of implementation, the IPAB may be more likely to consider more predictable, short-term scoreable savings, such as reductions in payment updates for certain providers."

These arbitrary payment cuts will have a ripple effect on the healthcare system as a whole. The PricewaterhouseCoopers Health Research Institute has already projected that Medicare and Medicaid payment reductions will be a driver of higher costs for private insurance payers, as public program payment cuts result in greater cost shifting. Should the IPAB have the opportunity to make even deeper reimbursement reductions, this won't reduce costs within the U.S. healthcare system,

but rather shift those costs from the public sector to the private sector. In summary, the IPAB structure presents a lose-lose-situation – less access to care for Medicare beneficiaries and higher costs for employers and individual consumers of private health insurance.

It is also essential to examine public accountability for the Medicare policy decisionmaking process once the IPAB goes into effect. It understates the power of this board to say that it is merely a safeguard to protect against runaway Medicare spending. Because the IPAB recommendations could have the force of law without an affirmative vote by Congress, and could only be overturned by a supermajority, the board would become the *de facto* decisionmaker for future Medicare policies.

One of the stated rationales for creating the IPAB was to remove Medicare policymaking from the political process, that Congress finds it too hard to make politically-difficult Medicare spending decisions. First, this premise is questionable given the fact that Congress enacted PPACA, which contains significant Medicare spending reductions. Beyond that, though, a measure that removes Congress's constitutional prerogatives to make critical decisions about the future of Medicare and shifts those duties to an unelected board seems, at the very least, to be a tremendous overreaction to a perceived contemporary political challenge. Medicare beneficiaries, providers and advocates should have the opportunity to have their voices heard, to be able to have meaningful input on program changes. That opportunity would be removed if Medicare decisions are being made by an unelected board that need not be responsive to the public, and can make recommendations that do not require the affirmative approval of Congress. The fact that the implementation of IPAB recommendations is exempt from judicial review only compounds this lack of accountability. It should also be noted that the IPAB members will be political appointees of the President of the United States. Thus, political considerations are not completely removed from the Medicare decisionmaking process. Rather, political accountability has simply shifted from the public to the executive branch.

Finally, there is an inherent problem with the rigidity of the IPAB provision in PPACA. Once Medicare spending levels reach a certain threshold, then the board would be compelled by law to act. This mandate does not take into consideration public health demands, such as a pandemic for example, that may necessitate greater, not reduced, Medicare spending. It does not take into consideration new innovations in healthcare that can make Medicare more cost-effective without the need for draconian provider cuts. New medicines that have the potential to help millions of Americans deal with chronic and painful illnesses can have high up-front costs and, thus, be prime targets for IPAB cuts, even though the dissemination of those innovative cures to patients can reduce healthcare costs in the long run. This lack of flexibility in the IPAB mandate can do a tremendous disservice to American healthcare and to the wellbeing of patients. Congress, by contrast, has the flexibility to respond to current healthcare circumstances, capabilities, and needs.

There are better, more patient-centered ways to curb Medicare spending. Throughout the nation, private sector healthcare providers are already demonstrating innovative ways to deliver healthcare, generating better outcomes for patients at less cost. We have barely scratched the surface in terms of determining the financial impact payment and delivery reforms can have on the Medicare program. There are significant efforts underway at CMS focused on moving away from the fee-for-service model, paying for quality instead of quantity of services, and aligning incentives within Medicare to ensure that providers are rewarded for providing high-quality, cost-efficient care. Some examples include value-based purchasing, bundling of payments, and better coordination of care through programs like PACE. It makes little sense to turn to an extreme solution like the IPAB, which is only focused on cutting spending instead of enhancing value, without giving these other approaches the opportunity to work. Extrapolating many of the private sector successes to larger Medicare populations could achieve meaningful savings without restricting access to care. We have outlined many of these cost-effective innovations in a publication, the *HLC Value Compendium*, which is available at www.hlc.org.

Some have suggested that the IPAB structure merely needs to be "fixed" in order to address the problems I've outlined in this testimony. The Healthcare Leadership Council rejects the idea that legislative tinkering can repair a fundamentally flawed concept. The essential purpose of the IPAB is to make cuts in order to bring Medicare spending within arbitrary parameters. No matter how one tries to "fix" it, the focus will still be on short-term budget reductions instead of long-term improvements to the Medicare program. This approach will never and can never be about bringing greater value to Medicare. To the contrary, payment cuts that drive more providers away from Medicare will only make it more difficult to develop much-needed quality improvements.

It must be noted that hundreds of organizations, including over 350 signing the letter available at http://www.hlc.org/blog/wp-content/uploads/2012/02/IPAB-Group-Letter.pdf, representing patients, consumers, physicians, hospitals and employers both small and large have publicly advocated the repeal of the IPAB. These groups represent all fifty states with some groups who supported PPACA as a whole and some that did not. There is widespread concern throughout the country about a mechanism that has the potential to significantly limit healthcare access for Medicare beneficiaries, that can undermine public health and that has no requirement to be responsive to public concerns. For these reasons, we believe it is essential to repeal this harmful and unnecessary provision of PPACA. Thank you for this opportunity to comment.

Sincerely,

Mary R. Grealy
President
Healthcare Leadership Council

2012 Members
(Alphabetized by Company)

HLC Chairman
Anthony Tersigni, EdD
President & CEO
Ascension Health

Thomas Freyman
Executive VP Finance & CFO
Abbott

Mark Bertolini
Chairman, CEO & President
Aetna

Todd Ebert
President & CEO
Amerinet

Steve Collis
President & CEO
AmerisourceBergen

Paul Queally
Chairman
Aptuit

Rick Willett
CEO
Ascend Learning

Tony Zook
Executive VP, Global Commercial
AstraZeneca

Joel Allison
President & CEO
Baylor Health Care System

Marc Grodman, M.D.
President, CEO
Bio-Reference Laboratories

Vicky Gregg
President & CEO
BlueCross BlueShield of Tennessee

George Barrett
Chairman & CEO
Cardinal Health

Kieran Gallahue
Chairman & CEO
CareFusion

Toby Cosgrove, M.D.
CEO & President
Cleveland Clinic Foundation

Jose Almeida
President & CEO
Covidien

Tim Ring
Chairman & CEO
C. R. Bard

Alex Azar
President, Lilly USA
Eli Lilly and Company

John Finan, Jr.
President & CEO
Franciscan Missionaries of Our Lady Health System, Inc.

Rice Powell
CEO
Fresenius Medical Care, NA

Patricia Hemingway Hall
President & CEO
Health Care Service Corporation

Ben Leedle, Jr.
President & CEO
Healthways

Daniel Tassé
President & CEO
Ikaria

William Weldon
Chairman & CEO
Johnson & Johnson

Brian Ewert, M.D.
President
Marshfield Clinic

John Noseworthy, M.D.
President & CEO
Mayo Clinic

John Hammergren
Chairman & CEO
McKesson Corporation

John Bardis
Chairman, President & CEO
MedAssets, Inc.

Chris O'Connell
EVP & President, Restorative Therapies Group
Medtronic

Barry Arbuckle, Ph.D.
President & CEO
MemorialCare Health System

Mark Timney
President, U.S. Market
Merck & Company, Inc.

Herbert Pardes, M.D.
President & CEO
NewYork-Presbyterian Hospital

Mark Neaman
President & CEO
NorthShore University HealthSystem

Jerzy Gruhn
President
Novo Nordisk, Inc.

Craig Smith
President & CEO
Owens & Minor

Adele Gulfo
President (US), Primary Care
Pfizer, Inc.

Susan DeVore
President & CEO
Premier healthcare alliance

Greg Irace
President & CEO
Sanofi US

Chris Wing
President & CEO
SCAN Health Plan

Stephen MacMillan
Chairman, President & CEO
Stryker

Harry Totonis
President & CEO
Surescripts

Doug Cole
President
Takeda Pharmaceuticals North America

Douglas Hawthorne, FACHE
CEO
Texas Health Resources

Christine Jacobs
Chairman, President & CEO
Theragenics

Jeffrey R. Balser, M.D., Ph.D.
Vice Chancellor for Health Affairs
Dean, Vanderbilt Univ. School of Medicine
Vanderbilt University Medical Center

Colleen Conway-Welch, R.N.
Professor & Dean
Vanderbilt University School of Nursing

Curt Nonomaque
President & CEO
VHA, Inc.

Heyward Donigan
President & CEO
ValueOptions

Gregory Wasson
President & CEO
Walgreens

David Kirchhoff
President & CEO
Weight Watchers International

Testimony of Burke Balch, J.D.
Director, Robert Powell Center for Medical Ethics
at the National Right to Life Committee[1]

Submitted to Committee on Ways and Means, Subcommittee on Health,
U.S. House of Representatives
March 6, 2012

IPAB: The Controversial Consequences for Medicare and Seniors

While the title of this hearing focuses on the implications that the Independent Payment Advisory Board (IPAB) will have for senior citizens in the Medicare program, it is equally important to understand IPAB's critical role in limiting the ability of Americans of all ages to obtain unrationed health care. The Obama Health Care Law requires IPAB to make recommendations, which the federal Department of Health and Human Services is given coercive power to

---

[1]Founded in 1968, the National Right to Life Committee, the federation of 50 state right-to-life affiliates and more than 3,000 local chapters, is the nation's oldest and largest grassroots pro-life organization. Recognized as the flagship of the pro-life movement, NRLC works through legislation and education to protect innocent human life from abortion, infanticide, assisted suicide and euthanasia.

Since its inception, the National Right to Life Committee has been equally concerned with protecting older people and people with disabilities from euthanasia as with protecting the unborn from abortion. We have recognized that involuntary denial of lifesaving medical treatment is a form of involuntary euthanasia, and therefore have opposed government rationing of health care.

implement, effectively to limit what resources Americans are allowed to devote to health care for their family so that they cannot even keep up with the rate of medical inflation. In short, IPAB will play a crucial role in limiting the ability of Americans of all ages to spend their own money to save their own lives.

IPAB is given the duty, on January 15, 2015 and every two years thereafter, to make "recommendations to slow the growth in national health expenditures" *below* the rate of medical inflation with regard to *private* (not just governmentally funded) health care.[1]

Under the law, the Commission's recommendations are to be ones "that the Secretary [of Health and Human Services] or other Federal agencies can implement administratively."[2] In turn, the Secretary of Health and Human Services is empowered to impose "quality and efficiency" measures on hospitals, requiring them to report on their compliance with them.[3] Doctors will have to comply with "quality" measures in order to be able to contract with any qualified health insurance plan.[4]

This will have grave effects on every family's health care. Basically, doctors, hospitals, and other health care providers will be told by Washington just what diagnostic tests and medical care are considered to meet "quality and efficiency standards" not only for federally funded programs like Medicare, but also for health care paid for by private citizens and their nongovernmental health

insurance. And these will be standards *specifically designed to limit what ordinary Americans may choose to spend on health care so that it is BELOW the rate of medical inflation.* Treatment that a doctor and patient deem needed or advisable to save that patient's life or preserve or improve the patient's health but which runs afoul of the imposed standards will be denied, *even if the patient is willing and able to pay for it.* In effect, there will be one uniform national standard of care, established by Washington bureaucrats and set with a view to limiting what private citizens are allowed to spend on saving their own lives.

It is critically important that the devastating impact of the Independent Payment Advisory Board on the right and ability of Americans of all ages to spend their own money as they judge best to preserve their lives and the lives of their family members be made more widely known. It is among the most dangerous rationing provisions of the Obama Health Care Law. We urge its repeal before it is too late.

ENDNOTES

1. Understanding the legislative language that sets the required target below the rate of medical inflation requires following a very convoluted path:

42 USCS § 1395kkk(o) states,
"Advisory recommendations for non-Federal health care programs. (1) In general. Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this title and in other Federal health care programs)… such as recommendations-- (A) that the Secretary or other Federal agencies can implement administratively;…(2) Coordination. In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c)."

The reference is to 42 USCS § 1395kkk(c)(2)(A)(i), which provides for Board reports with recommendations that
"will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year."

The "applicable savings target" is whatever is the lesser of two alternative targets [42 USCS § 1395kkk(c)(7)(B)].

First alternative: 2015 through 2017: The reduction necessary to limit the growth in medical spending to equal a percentage *halfway between* medical inflation and general inflation (using 5-year averages) [42 USCS §1395kkk(c)(6)(C)(I)].

In 2018 and later years: The reduction necessary to limit the growth in medical spending to "the nominal gross domestic product per capita plus 1.0 percentage point" [42USCS §1395kkk(c)(6)(C)(ii)].

Second alternative: The reduction necessary to force actual spending below projected spending by a specified percentage of projected medical spending; the specified percentage differs by year (in 2015, .5%; in 2016, 1%; in 2017, 1.25%; in 2018 and in subsequent years, 1.5%)[42 USCS § 1395kkk(c)(7)(C)(I)].

2. 42 USCS § 1395kkk(o)(1)(A).

3. 42 USCS § 1395l (t)(17) ["Each subsection (d) hospital shall submit data on measures selected under this paragraph to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this paragraph"….and "(A) Reduction in update for failure to report. (i) In general….a subsection (d) hospital …that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to such a year, the …fee schedule increase factor…for such year shall be reduced by 2.0 percentage points."], 1395l(i)(7) [similar language applicable to ambulatory surgical centers], 1395cc(k)(3) [similar language applicable to certain cancer hospitals], 13 1395rr(h)(2)(A)(iii) [similar language applicable to end-stage renal disease programs], 1395ww(b)(3)(B)(viii) [similar language otherwise applicable to hospitals], (j)(7)(D) [similar language applicable to inpatient rehabilitation hospitals], (m)(5)(D) [similar language applicable to long-term care hospitals], (s)(4)(D) [similar language applicable to psychiatric hospitals], and 1395fff(b)(3)(B)(v) [similar language applicable to skilled nursing facilities], 1395(i)(5)(D) [similar language applicable to hospice care], and (o)(2) [applicable to the way in which value-based incentives are paid].

4. 42 USCS § 18031(h)(1) provides, "Beginning on January 1, 2015, a qualified health plan may contract with…(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require."

PTPN
Setting The Standards in Rehabilitation

WITH NETWORKS IN:
Arizona • California • Colorado • Florida • Louisiana • Maine
Maryland • Massachusetts • Michigan • Mississippi • Missouri • New Hampshire • New Jersey
New York • Ohio • Oklahoma • Pennsylvania • Rhode Island • Tennessee • Texas • Vermont • West Virginia

March 6, 2012

The Honorable Wally Herger
The Honorable Pete Stark
Subcommittee on Health
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Herger and Ranking Member Stark:

As the nation's first and largest specialty network of rehabilitation therapists in independent practice, PTPN and its members who function as small businesses are pleased to offer this statement to the Health Subcommittee of the House Ways and Means Committee as it convenes the hearing March 6 to examine how the Independent Payment Advisory Board (IPAB) will impact the Medicare program, its beneficiaries, and health care providers.

PTPN has led the rehabilitation industry in national contracting, quality assurance and provider credentialing since 1985, elevating the standard of therapy practice. PTPN continued its role as a rehab pioneer by becoming the first organization of its kind to launch a mandatory third-party outcomes measurement program in 2006. The network has approximately 1,000 provider offices (with close to 3,000 physical therapists, occupational therapists and speech/language pathologists) in 23 states. PTPN contracts with most of the major managed care organizations in the nation, including insurers, workers' compensation companies, PPOs, HMOs, medical groups and IPAs. All members of PTPN must be independent practitioners who own their own practices.

PTPN supports HR 452 which would repeal the Independent Payment Advisory Board. We believe this legislation is needed for a number of reasons:

The Problem
The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended) created the Independent Payment Advisory Board (IPAB) and charged the Board with developing proposals to "reduce the per capita rate of growth in Medicare spending." The Secretary of Health and Human Services (the Secretary) is directed to implement the Board's proposals automatically unless Congress affirmatively acts to alter the Board's proposals or to discontinue the automatic implementation of such proposals.

Annually, beginning in April 2013, the Medicare Chief Actuary will calculate a Medicare (per capita) growth rate and a Medicare (per capita) target growth rate. If the Chief Actuary determines that the growth rate exceeds target growth rate, the Actuary would identify the amount by which the Board must reduce future spending. This determination triggers a requirement that the Board prepare a proposal to reduce the growth in the Medicare per capita growth rate by the proscribed amount. Nearly the only power the Board has is to cut payments to providers, specifically outpatient Part B providers and suppliers. If the Board fails to act, the Secretary is directed to prepare a proposal.

The 15 Board members will be full-time government employees who are not accountable to the public. If members do not perform, the public has no recourse. The IPAB will be appointed by the President with the advice and consent of the Senate; members will serve six year terms.

The Impact
The Congressional Budget Office projects that the Board's potential impact on particular Medicare providers or suppliers including private practice physical therapists may be significant, particularly if the Board alters payment mechanisms, which is among its options. Moreover, the IPAB's impact may be larger if private insurers continue to track Medicare payment policies and adopt similar reductions in payments to their providers and suppliers, such as PTPN member clinics, particularly if the Board alters payment mechanisms. TriCare patients will definitely be impacted since reimbursement in that program is benchmarked to Medicare.

When Medicare growth exceeds the given target, then the IPAB must put forth a proposal to reduce Medicare spending without causing a reduction in patient benefits. This effectively means IPAB's focus will be on reductions to physician and therapist reimbursements.

PTPN Objections
The power of the IPAB to determine cuts to Medicare payment rates will remove this authority from elected officials which deprives stakeholders of normal recourse such as lobbying and petitioning members of Congress in other ways. The ultimate responsibility for the Medicare program is vested in the elected legislators and should not be subrogated to appointed, unaccountable, full time government employees.

Because hospitals, hospice, and inpatient rehabilitation facilities are exempt from the actions of the IPAB until 2020, the impact of IPAB deliberations will be far more profound for Part B providers such as private practice rehabilitation therapists (including PTPN members). If these carve outs are left unaddressed, the entities responsible for two-thirds of Medicare spending are exempt from payment cuts for the remainder of this decade.

PTPN member clinics are already subject to an expenditure target known as the sustainable growth rate (SGR) and other payment reductions as the result of the Medicare physician payment formula. Creating and empowering the IPAB would subject PTPN members two separate expenditure targets while at the same time exempting large segments of Medicare providers who are subject to no target at all. The end result of this will mean a further reduction in the already below market reimbursement rates for rehabilitation therapists and physicians who treat Medicare and TriCare patients and yet make up less than 10 percent of total Medicare expenditures.

Moreover, since the IPAB is a 15-member independent body comprised of unelected officials, with broad discretionary authority to make radical changes in the structure of the Medicare program, IPAB recommendations should require an **affirmative vote** by Congress **before** they can be implemented.

To subject outpatient Part B provider and suppliers to payment cuts while holding other parts of the Medicare system harmless will have a dampening effect on the vibrancy of the physical therapy providers who function as small businesses, and are more economical, more cost conscious, more convenient and more innovative. In essence, this could be seen as encouraging patients to once again seek and obtain care in higher cost institutions, a pattern that our system has been evolving from for over three decades. This will lead to a spiral of having to further cut reimbursement to lower cost private practice therapy to make up the difference as more and more patients go to higher cost institutional therapy.

Conclusion
For the above reasons, PTPN believes the inclusion of the Independent Payment Advisory Commission in the PPACA is a **dangerous and unprecedented abrogation of Congressional authority** to an unelected, unaccountable body of so-called experts. Empowering a mindless rate-cutting machine of 15 unelected members, strips members of Congress of their constitutional duty and creates a volatile and unpredictable marketplace for PTPN member clinics who operate as small businesses. Moreover, it sets the Medicare program up for unsustainable cuts that will endanger the health of America's seniors, people with disabilities and TriCare beneficiaries. **PTPN strongly urges Congress to repeal Sec. 3403. Independent Medicare Advisory Board (as modified by sec. 10320) of the Patient Protection and Affordable Care Act.**

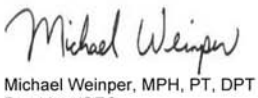
HR 452, in its present form, is a vehicle for such repeal that PTPN finds acceptable. However, we note that the legislation is a "repeal only" endeavor, thus identifying no offsets. If, at any point, offsets are added to the legislation, we reserve the right reconsider this position based on the palatability of the total legislative package.

The Honorable Wally Herger
The Honorable Pete Stark
March 6, 2012
Re: IPAB -- Page 4

Thank you for holding a hearing on the Independent Payment Advisory Board. It is important to PTPN that the statutory provision authorizing this Board be repealed.

As you proceed with your efforts to reform and ensure stability of the Medicare program -- in particular the Physician Fee Schedule -- we would urge you to be continuously mindful of the independent rehabilitation therapy providers and suppliers who function as small businesses and who are an important, integral element of our delivery system. PTPN members provide a valuable service to communities across the nation and they do so in a convenient, cost-effective manner. But as is typical for small businesses, narrow margins are jeopardized when a significant sector of its market cuts reimbursement without regard to the value of the service provided. Moreover, when such an action is unpredictable and is taken by an influential payer such as Medicare, the effect is to negatively influence the business environment and create an untenable situation for the providers. More importantly, the Medicare beneficiaries are left in a vulnerable position, unable to depend on the access to convenient, cost-effective, high-quality care to which they have become accustomed.

Sincerely,



Michael Weinper, MPH, PT, DPT
President/CEO

IPAB, Beginning a Journey to Extinction (we hope)

I have talked a lot for over two years about the Independent Payment Advisory Board (IPAB), one of the most onerous parts of Obamacare. I have been very outspoken on the need to repeal this part of Obamacare before it can harm older Americans and now, I am glad to report, I've witnessed the first step on what I hope is its journey to extinction. On February 29th, I attended the Energy and Commerce Health Subcommittee markup of HR 452, the Medicare Decisions Accountability Act. This bill will repeal the IPAB. The subcommittee voted 17 to 5 to pass the bill to full committee, where it should go this week, and hopefully be voted on by the full House by the end of March. It is our hope that this is IPAB's first step on the road to a well-deserved extinction.

The IPAB is a 15-member presidentially-appointed panel charged with reining in Medicare costs. The panel's job is to propose reductions in payments to providers such that Medicare outlays don't exceed a pre-determined level. I've discussed before the draconian, short-sighted and indiscriminate nature of this board, a board of appointed bureaucrats virtually without judicial or legislative oversight, an entity with a power and function not defined in the Constitution and without precedence in any branch of government. It is this last area on which I will focus my message. My discussion concerning the IPAB will go above Medicare, patients, doctors, hospitals and even above health care; it will focus on the basic procedural and constitutional problems with the IPAB's legislative birth and its operational powers.

The process by which the IPAB became law was dubious. It is important to remember that at the time the Patient Protection and Affordable Care Act (PPACA) legislation was introduced, the Democrats controlled both Houses of Congress. The PPACA bill was passed in the House without any IPAB language, and then sent to the Senate. The Senate traditionally makes their changes to the bill and then votes on that version of the legislation. The next traditional step after the Senate passed their version of the bill would have been to form a conference committee made up of House and Senate members to hash out a final bill (from the two separate versions) that could then pass both houses. The insidious birth of IPAB began when the language creating the IPAB was inserted in the bill --literally in the dark of night. Late in the evening, as the Senate was finishing its PPACA changes just before the Senate floor vote, the IPAB language was inserted as one of the debatable "pay-for" provisions. Even at this late hour some Senators (or their staff) read the IPAB language and voiced concerns, but were still convinced to vote for the bill anyway, to move it forward. With the IPAB language intact to satisfy the Democrat leaders, the reluctant Democrat Senators voted for it with the knowledge that the bill could be altered during the House-Senate conference committee where the offending IPAB language could be eliminated. IPAB wasn't removed, they could still vote against the final PPACA bill when it came back to the Senate floor in the form of a conference

report. The Senate passed the bill (with IPAB) and sent it back to the House where, in a surprise move, the Democratic Majority Leader convinced enough House members to vote for the Senate's version of the bill. It passed without a House-Senate conference committee being formed. The IPAB was born as a last minute addition to PPACA without the knowledge of most Members of Congress and without any substantial review or debate. Any addition to legislation with that pedigree has to come under suspicion.

The powers assigned to the IPAB are without constitutional precedent and go against the Constitution's template of checks and balances. For instance, the IPAB legislative language:

- Is essentially written such that the IPAB may make any changes in any Medicare policy "notwithstanding any provision of law . . ." it seems that the IPAB is above the law.
- Does not limit the IPAB to changes to policies under specific sections of Medicare statute; they can make changes to any part of our health care system to find their money.
- Does not include provisions that would allow Congress to alter or limit the scope of the IPAB's proposals.
- Doesn't limit the IPAB to cutting costs just to the target of that year; they can exceed those limits without oversight.
- Provides that no IPAB changes in Medicare law is subject to judicial review. The IPAB is above the judicial branch of our government.
- Does not specify what constitutes a quorum. While the law dictates a 15 member board, if only 11 have been confirmed, it could take only six votes to pass the IPAB's policies.
- Puts the IPAB's proposal process completely independent from and inconsistent with the Congressional budget process.
- Dictates that the final word on scoring the IPAB's cost cutting proposals is the Chief Actuary of CMS, an official in the executive branch, rather than the Congressional Budget Office actuaries.
- Directs the IPAB to prepare detailed legislation for introduction in Congress. Did the founding fathers fashion the constitution with the hopes that someday a Presidential appointed bureaucratic entity would be authoring detailed legislation - legislation that cannot be amended by the Congressional Member who would introduce it in the House or the Senate?
- Provides one opportunity to discontinue the IPAB in 2017 with an unprecedented super-majority of three-fifths vote in both the House and the Senate.
- Dictates that Congress can only vote to accept or reject the proposal without amending parts of the proposal.

- Forces any replacement legislation, in the case where Congress rejects the IPAB's proposal, to be passed on an unprecedented three-fifths, super-majority vote.

As you can see, the IPAB is an egregious affront to our accepted process of government, but more importantly it circumvents the very checks and balances that have allowed our constitutional based government to survive. The IPAB is not the solution to rising health care costs, nor is it a solution to any problem faced by our nation. It is a serious attack on the basic tenets of our Constitution. For this reason alone, Congress should quickly pass legislation to repeal this last minute, late-night-inserted virus that now threatens to infect our time-tested form of government.

○