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IPAB: THE CONTROVERSIAL CONSEQUENCES FOR MEDICARE AND SENIOR

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

JULY 13, 2011

Serial No. 112–73

Printed for the use of the Committee on Energy and Commerce
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U.S. GOVERNMENT PRINTING OFFICE

72–722 PDF WASHINGTON : 2012

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IPAB: THE CONTROVERSIAL CONSEQUENCES FOR MEDICARE AND SENIORS

WEDNESDAY, JULY 13, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:03 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joseph Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Whitfield, Shimkus, Myrick, Murphy, Blackburn, Gingrey, Latta, McMorris Rodgers, Lance, Cassidy, Guthrie, Pallone, Dingell, Capps, Christensen, Schakowsky, Gonzalez, Matheson, and Waxman (ex officio).

Staff present: Gary Andres, Staff Director; Jim Barnette, General Counsel; Mike Bloomquist, Deputy General Counsel; Anita Bradley, Senior Policy Advisor to Chairman Emeritus; Howard Cohen, Chief Health Counsel; Paul Edattel, Professional Staff Member, Health; Debbee Keller, Press Secretary; Ryan Long, Chief Counsel, Health; John O'Shea, Professional Staff Member, Health; Andrew Powaleny, Press Assistant; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Lyn Walker, Coordinator, Admin/Human Resources; Tom Wilbur, Staff Assistant; Jean Woodrow, Director, Information Technology; Alex Yergin, Legislative Clerk; Alli Corr, Democratic Policy Analyst; Tim Gronninger, Democratic Senior Professional Staff Member; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; and Karen Nelson, Democratic Deputy Committee Staff Director for Health.

Mr. PITTS. Everyone, please take their seats. The subcommittee will come to order. The chair recognizes himself for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Today's hearing on the Independent Payment Advisory Board comes at a crucial time. It is a crucial time for health reform in general. It has been almost 16 months since the passage of President Obama's massive overhaul of the healthcare system. And as the multitudes of provisions in the law go into effect, we are beginning to get an idea of how our healthcare system would look under PPACA. The fundamental concept underlying the administration's

approach to health reform is that the government, or a group of government-appointed experts, knows better than patients and their doctors which healthcare services are valuable.

It is also a critical time for the Medicare program in particular. A quick look at a few numbers will remind us of the importance and timeliness of today's hearing. Ten thousand seniors become eligible for Medicare every day, and according to the program's own actuaries, the program faces costs not covered by the Medicare tax of more than $30 trillion over the next 75 years. This staggering amount of money is more than double the current national debt.

One of the most worrisome provisions in PPACA and a provision that highlights the administration's fundamental approach to health reform is the creation of the Independent Payment Advisory Board or IPAB. The IPAB embodies what is objectionable in the President's healthcare system overhaul and how the administration's approach to health reform is fundamentally different from the Republican reform proposal. President Obama's health reform legislation was pushed through Congress without meaningful bipartisan debate. In like fashion, the recommendations of IPAB will be pushed through Congress with very little time for discussion or for the development of realistic alternatives to these recommendations that will then become law.

The IPAB is likely to profoundly influence the future of Medicare and even the healthcare system in general. In fact, the panel of 15 experts that will make up the board will arguably have more influence over healthcare than any person, group of people, organization, or government agency has ever had—more than patients, physicians, professional organizations, MedPAC, CMS, or even Congress.

However, we need be clear about one thing: this isn't about "death panels." The intent of creating IPAB was not to kill seniors. But Democrats do believe that the best way to cut Medicare costs is to give an unaccountable board the power to limit treatment options. We disagree. We believe the solution to fighting costs is to give patients more power, more control, and more choices. Why should anyone—especially a government-appointed expert—second-guess patients and doctors?

It is encouraging that there is widespread opposition to the IPAB. Physician groups, hospitals, consumer groups, patient advocacy groups, and others have all voiced their concern over the board. There is even bipartisan opposition in Congress. This is not surprising, since the decisions of the board will become law by a fast-track process that will bypass the usual legislative procedures, in effect superseding the customary jurisdiction of committees like this one. As Representative Pete Stark was recently quoted as saying when asked about IPAB, "Why have legislators?"

The time for substantial Medicare reform is now and the decisions about how to achieve the necessary reform are crucial and fundamental to the future of the program. The Democrats would leave these decisions to 15 unelected, unaccountable government appointees. We believe that current and future Medicare beneficiaries know better.

I want to thank the witnesses for agreeing to participate in this important hearing. I look forward to hearing their testimony. And

at this point, the chair recognizes the ranking member of the subcommittee, Mr. Pallone, for 5 minutes for his opening statement.

[The prepared statement of Mr. Pitts follows:]

Opening Statement for Chairman Joe Pitts
Energy and Commerce Committee Subcommittee on Health Hearing on
"IPAB: The Controversial Consequences for Medicare and Seniors."
July 13, 2011

Today's hearing on the Independent Payment Advisory Board comes at a crucial time. It is a crucial time for health reform in general. It has been almost 16 months since the passage of president Obama's massive overhaul of the health care system. And, as the multitudes of provisions in the law go into effect, we are beginning to get an idea of how our health care system would look under PPACA. The fundamental concept underlying the administration's approach to health reform is that the government, or a group of government appointed experts, knows better than patients and their doctors which health care services are valuable.

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I thank the witnesses for agreeing to participate in this important hearing and I look forward to their testimony.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman. And thank you for holding this very important hearing.

I am very strongly opposed to the Independent Payment Advisory Board, or IPAB, created under the Affordable Care Act. I have never supported it, and I would certainly be in favor of abolishing it. However, I do not see IPAB as a significant factor in the Affordable Care Act. As you know, I am one of the strongest advocates for the Affordable Care Act for many reasons. The Affordable Care Act has finally set our healthcare system on a path to reform. It was the most significant improvement to Medicare passed in years and will reduce costs to Medicare through a number of broad efforts—most notably, by reforming the way in which doctors deliver care, incentivizing a focus on efficiency and value rather than just the number of services performed.

Furthermore, it is important to note that the Affordable Care Act reduced projected Medicare spending growth to historically low levels. Over the past decade, Medicare cost growth per beneficiary was 7.8 percent. The most recent trustees' report projects that over the next 10 years, that growth rate will be just less than 3 percent.

Now, it is becoming increasingly clear that the Republicans will use IPAB as just another way to oppose and deface the Affordable Care Act. But this issue, from my perspective, should be the furthest thing from partisan. It is an issue that I believe all legislators from all political backgrounds should take concern. It is about the legislative and executive branches. This is about congressional prerogatives being limited. We should absolutely not, under any circumstances, seed legislative power to the executive branch. This is simply not what our founding fathers wanted or intended.

IPAB, like other independent commissions, encroaches upon our legislative authority. Indeed, I am opposed to independent commissions or outside groups playing a legislative role other than on a recommendatory basis. It is not the job of an independent commission to get involved in congressional matters—in this instance, healthcare policy for Medicare beneficiaries. We have had the counsel of MedPAC for a long time. But MedPAC is just that; it is counsel. Nothing MedPAC recommends is automatic. When Congress agrees, it enacts those recommendations. When Congress disagrees, we ignore those recommendations. This is how the process should work. This is how the process should continue.

Unfortunately, the debate of IPAB reminds me of the Base Realignment and Closure or BRAC process. IPAB is just another BRAC, only the healthcare version. In fact, during discussion over the Affordable Care Act, it was mentioned by the administration and others that they were using BRAC as an example. I strongly believe that BRAC is a monumental failure. I voted against every BRAC in my 23 years in Congress. I have seen them run up costs and waste money. And the worst part is as an elected official who was sent to Congress by my constituents to represent their best interests, then I become powerless to stop things like BRAC. I certainly tried. I fought the closure of Fort Monmouth, New Jersey, with everything that I had in more ways than I can count, but it

wasn't enough. Because like IPAB, the BRAC took away all legislative authority and prerogative, and to this day I fight to minimize its effects on my constituents.

Mr. Chairman, as I said again, this is not about IPAB or its relation to Medicare. It is about a growing imperialistic presidency. I have been here for 23 years. Whether it was the first George Bush or it was President Clinton or was the second George Bush or now President Obama, the presidency continues to try to take over the prerogatives of Congress. We have to stop it. We have to reverse it. We can't be a part of an effort to let that continue. Just because decisions are tough doesn't mean Congress shouldn't make them. I believe this committee and this Congress has the knowhow to make the tough choices that are still needed to improve our healthcare system.

And frankly, I have told the President and everybody in the executive branch I actually like dealing with MedPAC and its recommendations. I like having hearings in this subcommittee where we review the MedPAC recommendations. And most of the time we adopt them. So the idea that somehow we don't want to make the tough choices, we are not capable of making the tough choices, that is simply not true. That is why we are elected. That is why people continue to elect me in my opinion.

So instead, let us build on the Affordable Care Act's reforms and expand efforts to contain the growth and future healthcare costs. We can do it. We don't need IPAB.

I yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. I now recognize the vice chair of the subcommittee, Dr. Burgess, for 5 minutes for opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for the recognition. I want to welcome our Senator from Texas, Senator Cornyn, and my fellow OB/GYN doctor, Dr. Roe, welcome them to committee and being here today.

This healthcare law that was signed 15 months ago contains countless policies that will essentially disrupt the practice of medicine. Along with the many excesses and constrictions in the law, the Independent Payment Advisory Board represents the worst of both.

I am a doctor, a Member of Congress, I am also someone in my 60s who is soon to be Medicare-age and I am distressed by what I see happening with the Independent Payment Advisory Board. It is not accountable to any constituency. It only exists to cut provider payments to fit a mathematically-created target. Given that private insurers use Medicare as a benchmark for their own payment changes, the IPAB could have a far-reaching implication beyond Medicare for our Nation's providers.

The board exponentially and inappropriately expands the power of the executive branch, giving an unaccountable panel of 15 individuals the authority to make changes to the Medicare program. It takes the authority away from Congress. Congress has no say in

the board's reports, yet their recommendations essentially hold the power of legislation.

And yes, this board is appointed with the consent of the Senate but not necessarily because nine of these board members could be recess appointments. Nine of these board members would constitute a majority, therefore completely bypassing the legislative branch.

Now, for patients, these bureaucrats may be able to cut payments too low that it will block care to seniors. It does change the fundamental nature of the relationship with the Federal Government, and those people who are cared for by insurance provided by the Federal Government now will be able to tell you who gets care, where the care is given, when it is given, but the fundamental change is now we will be able to tell you when you have had enough.

The board is not a solution in search of a problem. Medicare's unfunded liabilities are enormous. That is why Republicans want to be able to keep Medicare for future generations by lowering the cost to the Federal Government by providing better choices.

Let me at this point yield to another doctor on the committee, Dr. Phil Gingrey.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Mr. Chairman, thank you. And I thank the gentleman for yielding.

I have got three posters I would like to share with my committee members and with the witnesses. This first poster, President Obama's chief medical officer, "Most people who have serious pain do not need advanced methods. They just need the morphine and the counseling that have been available for centuries." Again, President Obama's chief medical officer, "The decision is not whether or not we will ration care. The decision is whether we will ration with our eyes open." And the last slide, again, from President Obama's chief Medicare officer, "I cannot believe that the individual healthcare consumer can enforce through choice the proper configurations of a system as massive and complex as healthcare. That is for leaders to do."

If anyone has any questions as to why Members of Congress are opposed to what has been deemed a denial-of-care board, as you just heard, I would simply suggest you read carefully the words of the head of CMS, Dr. Donald Berwick. And it is no surprise that he will remain interim head. You might even want to refer to him as Don Corleone.

And I thank you for the time and I would now like to yield to my physician colleague from Louisiana, Dr. Bill Cassidy.

OPENING STATEMENT OF HON. BILL CASSIDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. CASSIDY. Thank you for yielding.

I am a doctor who, for the last 20 years, has worked in a hospital for the uninsured. And one of the reasons I ran for office is that well-meaning politicians would have well-sounding laws which would make the lines grow longer at my hospital for the uninsured.

I have to say, with Obamacare, it is like déjà vu all over again. Medicare is going bankrupt. Anticipating this, Obamacare has a provision of 15 appointed bureaucrats who have the ability to almost in an unfettered fashion decrease payment. Now, we say—Republicans, some Democrats—that this can decrease access. Defenders say oh, no, decreasing payment is not rationing. I ask those defenders to join me at my hospital for the uninsured and I will show you the reality.

So although I look forward to Secretary Sebelius' testimony, I feel like I have heard it before. A benign bureaucracy paternalistically looking after the interest of the individual while controlling global healthcare cost. It would be amusing if it were not so frightening. There is a better way, and the better way is to give the power to the patient and not to the bureaucrat. This is not where Obamacare is, but it is where I hope we arrive.

Thank you. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman.

There was an attack on Dr. Berwick. He was invited once to appear before our committee and was cancelled out by the committee itself. Perhaps we ought to give him the opportunity to respond to some of these statements that have been made about his past writings.

I regret to observe that this hearing today is very partisan and very hypocritical. It is partisan because this is another battle in war waged since January by the Republicans to tear down the Affordable Care Act. When the Republicans passed their repeal bill through the House in January, we were promised that a Republican replacement would be right behind it. But we are now in July and we have seen absolutely no sign of any Republican idea for addressing our Nation's problems in healthcare—skyrocketing costs, 50 million Americans without insurance, and the uneven quality of care.

This is an exercise in hypocrisy because of the utter fallacy of the pious arguments made on the issue of Medicare and costs. I have been around long enough to remember when doctors said we didn't need any government program. We take care of poor people because that is our obligation. And now we are told we can't find a doctor because they are not paid enough. They don't feel it is their obligation to take care of the poor unless they are paid adequately. I understand that, but let us skip the piety about it.

The main Republican attack on the Affordable Care Act is that we cannot afford it. Too much coverage, not enough cost reduction, they say. They ignore the CBO's estimates. They ignore the testimony from hundreds of economists and doctors and experts of all stripes. Republicans just assert it doesn't control costs. And then they attack the new law for the comprehensive approach it takes

to controlling costs. And they do it the old-fashioned way, through fear.

Dr. Burgess has called IPAB "Armageddon." Dr. Gingrey compared the Republican plan for Medicare unfavorably to "throwing grandma off a cliff," and said that IPAB is worse than that "because grandma could possibly survive the fall from a cliff but cannot survive IPAB." Well, I have some concerns about some aspects of IPAB, but I don't agree with the premise that we need IPAB to make Congress to do its job. No one should think that a hyperbole of IPAB's Republican critics—rationing, death panels, faceless bureaucrats, pulling the plug on grandma—represents reality.

It is a fact that IPAB is prohibited from rationing. It is also a fact that the savings CBO expects from IPAB over the next 10 years amounts to just $2 billion, less than 10 percent of what Republicans proposed to cut from Medicare even before they would end the program in 2022 and replace it with their voucher plan.

But the heart of the matter is Medicare and its future. What is the Republican plan for controlling costs in Medicare? Simple. End Medicare as we know it. The Republican plan shifts all of the burden for healthcare costs onto seniors, people with disabilities, onto the States. It would double costs for new enrollees in 2022 by $6,000 per person according to CBO. For people with disabilities, including people in nursing homes, Medicare cuts come almost immediately in 2013, meaning that people won't be able to pay for nursing home care or the home-based care that will keep them out of a nursing home in the first place.

Republicans are seeking to end Medicare's guaranteed benefits, leaving seniors and people with disabilities on their own in the insurance market. They want to cut the program by $20 trillion over the next few decades. Fears about IPAB are hypothetical at this point and always leave alternatives to the Congress. The harm to Medicare from the Republican plan, if enacted, would be a certainty.

With respect to IPAB, Mr. Chairman, Congress has the final say over Medicare policy. And if Congress has the final say over all IPAB recommendations, which will pass through this committee, I hope one day to return to the chairmanship of this committee, and if I do, I will certainly exercise this committee's oversight duties over IPAB thoroughly. I am sure that Mr. Upton will do the same.

So I think it is time we set aside efforts to repeal the Affordable Care Act, focus on real problems for American families in what they are facing today and stop this constant attack on anything that tries to do something about the problems that American families face, especially those who cannot buy insurance, who cannot afford insurance, who cannot pay their doctors adequately so they can be seen, and we just forget about them. We already have over 50 million uninsured. Let us don't add to the burden by taking away Medicare and Medicaid from those for whom they rely on those programs.

I yield back.

Mr. PITTS. The chair thanks the gentleman. That concludes the opening statements for the members.

I want to thank the witnesses for agreeing to appear before the committee today. We have four panels today, and your written tes-

timony will be entered into the official record. We ask that you summarize your opening statements in 5 minutes.

The first panel—and in order of presentation I will introduce them—first, the Honorable George Miller, who represents the 7th Congressional District of California; second, the Honorable John Cornyn, Senator from the State of Texas; the Honorable David Roe, who represents the 1st Congressional District of Tennessee; and I believe we have the Honorable Allyson Schwartz representing the 13th Congressional District of Pennsylvania coming.

Congressman Miller, you may begin.

STATEMENTS OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA; HON. JOHN CORNYN, A UNITED STATES SENATOR FROM THE STATE OF TEXAS; HON. DAVID P. ROE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE; AND HON. ALLYSON Y. SCHWARTZ, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

STATEMENT OF HON. GEORGE MILLER

Mr. MILLER. Thank you very much, Mr. Chairman and Ranking Member Pallone, for the opportunity to testify before the committee today.

I came to Congress in 1975, and since that time, I have been involved in the debate over national health reform proposals. Throughout these debates, lawmakers struggled with how to control costs without harming care. Unfortunately, Congress chose to kick the can down the road for a very long time. Without action, healthcare costs have continued their endless rise, well in excess of inflation. As everyone here well knows, these costs have grown to unsustainable levels for families, for businesses, and for taxpayers.

In the past decade, healthcare spending has increased an average of 6.8 percent a year and is expected to rise from 18 percent of GDP to 34 percent of GDP in 2040. At the same time, employer-provided insurance has fallen and out-of-pocket and premiums have skyrocketed for employees. The opportunity for reform finally changed with the Affordable Care Act. For the first time, Congress put in place specific, identifiable measures to make Medicare and our healthcare system more efficient. We need to give these innovations an opportunity to work.

These innovations include stronger tools to combat fraud and abuse in Medicaid and Medicare—tools that have already started to save billions of dollars; to better coordinate the care through accountable care organizations; incentives to reduce hospital readmissions, and reward the delivery of high quality and efficient care; and improved patient safety through the Partnership for Patients initiative. These reforms were included based on what was worked on in the past and what was likely to work in the future. These cost-savings ideas are beginning to work.

We did not make these decisions lightly. The debate was robust. But in the end, the majority agreed to give these ideas a chance. Our goal was to make Medicare stronger for seniors and sustainable for future generations so we wouldn't have to go down the

road of rationing or turning Medicare into a voucher program. If Congress begins to roll back these reforms, then we will not see the efficiencies, we will not see the innovations that experts agree will stabilize our healthcare system.

One of these ideas is the Independent Payment Advisory Board. This board serves as a backstop to ensure that our federal health programs operate efficiently and effectively for both seniors and for the taxpayers. Before the Affordable Care Act, Congress and other stakeholders had an unremarkable track record of controlling costs. 535 Members of Congress cannot be doctors, although it looks like an awful lot of them are. I wondered where that doctor shortage was coming from. Five hundred thirty-five Members are not capable of knowing the best science and the best practices for every medical treatment and 535 Members of Congress are subject to unrelenting lobbying by special interests that have a financial stake, and in many cases, a financial conflict of interest in many of the decisions that they make—but not necessarily the best health of our seniors in mind.

With these reasons, many experts have recommended the creation of an independent board of health experts to make the system improvement recommendations. And, as you know, Congress has often used independent boards to help with complex issues, such as MedPAC or the BRAC, which BRAC—Frank, I love you—but the fact is those bases would have never been closed and we would have been lugging the cost around for generations.

The Independent Payment Advisory Board will not usurp the Congress. It will not be unaccountable. It will not be unfettered. It simply acts as a backstop in case government spending exceeds the benchmarks. Both CBO and Medicare trustees tell us that because of the Affordable Care Act reforms, they don't expect the mandatory actions of the panel to be triggered in the immediate future. The President will nominate the doctors, health experts, and consumers to the board to examine all of the data and evidence on best practices and inefficiencies in healthcare spending. The Senate will consider and approve each nominee. The IPAB will make all of the recommendations to the Congress. The Congress can approve, disapprove, or modify each recommendation. It sounds like a heavy role for Congress.

In other words, Congress retains the role in healthcare but in an improved and more efficient fashion. Ideally, IPAB recommendations could also be a driver for innovation, not only the public sector but for the private sector.

Under the law, the Independent Payment Advisory Board guarantees the doctor-patient relationship. Doctors will retain full authority to recommend the treatments that they think are best for their patients. The law prohibits the recommendations that would ration care, change premiums, or reduce Medicare benefits.

In conclusion, I testify here today as someone who deeply cares about the delivery of healthcare to the citizens of the United States. Everyone agrees that our Nation's healthcare costs must come under control. With 76 million baby boomers just beginning to rely on Medicare, the time is now to push for innovative reforms that can help us contain the cost of the Medicare program.

The Independent Payment Advisory Board is about strengthening the Medicare program. Without the innovation and evidence-based decision-making, Medicare will be put in jeopardy. And the forces calling to end Medicare will gain the upper hand because of uncontrollable cost. The American people have firmly rejected the Republican budget plan to end Medicare, to voucherize Medicare. What they do support is accessible and affordable healthcare, and the only way we can guarantee that for future generations is by using the best science, the best medicine, the best evidence, and the best practices available for all of our citizens. We really have no alternative.

Without these innovations, our current system is unsustainable for the Nation's families, the Nation's businesses, and the Nation's taxpayers, and I strongly support IPAB and would oppose any effort by Congress to undermine it.

And thank you so very much for allowing me to testify.

[The prepared statement of Mr. Miller follows:]

U.S. Rep. George Miller (D-CA)
Testimony before the House Energy and Commerce Committee, Health Subcommittee
Hearing on the Independent Payment Advisory Board
July 13, 2011

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Thank you, Chairman Pitts and Ranking Member Pallone for the opportunity to testify today.

I came to Congress in 1975. Since that time, I've been involved in the debate over national health reform proposals.

Throughout these debates, lawmakers struggled with how to control costs without harming care.

Unfortunately, Congress chose to kick the can down the road.

Without action, health care costs have continued their endless rise, well in excess of inflation.

As everyone here well knows, these costs have grown to unsustainable levels for families, businesses and taxpayers.

In the past decade, health spending has increased an average of 6.8 percent a year. It is expected to rise from 18 percent of GDP to 34 percent in 2040.

At the same time, employer provided insurance has fallen and out of pocket and premiums have skyrocketed.

The opportunity for reform finally changed with the Affordable Care Act. For the first time, Congress put in place specific and identifiable measures to make Medicare and our health system more efficient.

We need to give these innovations a chance to work.

- These innovations include stronger tools to combat fraud and abuse in Medicare and Medicaid – tools that have already started saving billions of dollars.
- Better coordination of care through accountable care organizations.
- Incentives to reduce hospital readmissions, and reward the delivery of high quality and efficient care.
- And improved patient safety through the Partnership for Patients initiative.

These reforms were included based on what has worked in the past and what is likely to work in the future. These cost saving ideas are beginning to work.

We did not make these decisions lightly. There was robust debate.

But in the end, a majority agreed to give these ideas a chance.

Our goal was to make Medicare stronger for seniors and sustainable for future generations so we wouldn't have to go down the road of rationing or turning Medicare into a voucher program.

If Congress begins to roll back these reforms, then we will not see the efficiencies and innovations that experts agree will stabilize our health care system.

One of these ideas is the Independent Payment Advisory Board.

This board serves as a backstop to ensure that our federal health programs operate efficiently and effectively for both seniors and taxpayers.

Before the Affordable Care Act, Congress and other stakeholders had an unremarkable track record of controlling costs.

- 535 members of Congress cannot be doctors.
- 535 members of Congress are not capable of knowing the science and best practices in every medical treatment.
- And 535 members of Congress are subject to unrelenting lobbying by special interests that have a financial stake in our decisions – but not necessarily the best health of our seniors in mind.

For these reasons, many experts have recommended the creation of an independent board of health experts to make system improvement recommendations.

And, as you know, Congress often uses independent boards to help with complex issues, such as MedPAC and BRAC.

The Independent Payment Advisory Board will not usurp the role of Congress. It simply acts as a backstop in case government spending exceeds benchmarks.

Both CBO and the Medicare trustees tell us that because of Affordable Care Act reforms, they don't expect the mandatory actions of the panel to be triggered in the immediate future.

The President will nominate doctors, health experts and consumers to the board to examine all the data and evidence on best practices and inefficiencies in health care spending.

The Senate will consider and approve each nominee. IPAB will make all of its recommendations to Congress. And Congress can approve, disapprove or modify each recommendation.

In other words, Congress retains its role in health care – but in an improved, more efficient fashion

Ideally, IPAB recommendations could also be a driver for innovation in not only the public sector, but also the private sector.

Under the law, Independent Payment Advisory Board guarantees the doctor-patient relationship.

Doctors will retain full authority to recommend the treatments that they think are best for patients.

The law prohibits the recommendations that would ration care, change premiums or reduce Medicare benefits.

In conclusion, I testify here today as someone who deeply cares about the delivery of health care to the citizens of the United States.

Everyone agrees that our nation's health costs must come under control. With 76 million baby boomers just beginning to rely on Medicare, the time is now to push innovative reforms.

The Independent Payment Advisory Board is about strengthening the Medicare program.

Without innovation and evidence-based decision-making, Medicare will be put in jeopardy.

And the forces calling for ending Medicare as we know it will gain the upper hand.

The American people have firmly rejected the Republican budget plan to end Medicare.

That is why we must encourage everyone to find the sweet spot where the delivery of good health care is affordable health care.

We really have no alternative. Without innovation, our current system will be unsustainable for our nation's families, businesses and taxpayers.

I strongly support IPAB and would oppose any effort by Congress to undermine it.

Thank you for allowing me to testify.

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Mr. PITTS. The chair thanks the gentleman.

Senator Cornyn, you may begin your testimony.

STATEMENT OF HON. JOHN CORNYN

Mr. CORNYN. Chairman Pitts, Ranking Member Pallone, and members of the committee, thanks for giving me the opportunity to testify here today regarding the Independent Payment Advisory Board created by the Patient Protection Affordable Care Act. And unfortunately, this is a product that came from the Senate and not from the House. I am sorry about that.

But, of course, the goal of IPAB is one we all share, as Congressman Miller just articulated. We have to find some way to control the cost in Medicare. Medicare trustees warned Congress that the program will be insolvent in 2024, which is 5 years earlier than previously predicted. I noted that Medicare's unfunded liabilities, the gap between Medicare's future cost benefits and future taxes and premiums it expects to collect, are more than $24 trillion and growing.

The Medicare trustees have now issued a Medicare warning every year since 2006 in which they have alerted Congress that more than 45 percent of Medicare's funding will come from general revenues. The nonpartisan Congressional Budget Office issued a warning of its own in June in its 2011 long-term budget outlook. CBO projects that if current law remains in place, spending on the major mandatory healthcare programs alone will account for approximately 6 percent of our gross domestic product today to 9 percent in 2035 and would continue to increase thereafter.

So, as we all know, something has to be done about the unsustainable growth and the cost of the Medicare program. We all agree on that much. Like many Americans and many members of this committee, though, I do not believe that IPAB is the right answer. Everyone here knows how IPAB is supposed to function, but here are my specific concerns:

First, I am concerned that the only tool in the IPAB toolbox will be cutting payments to providers. And we are already seeing how government price controls are restricting access to care—on one hand saying you are covered by a government program; on the other hand saying because of restrictive payments to providers, good luck finding a doctor who will see you at that price.

The American Medical Association estimates that one of three primary care doctors limit the number of Medicare patients they see. As Dr. Burgess will confirm, in our State of Texas, 42 percent of physicians are considering opting out of Medicare completely due to low reimbursement rates. Although there is some concern recently about the rhetoric surrounding IPAB, continuously cutting reimbursement to Medicare providers will prevent access to care for Medicare beneficiaries.

Secondly, I am concerned that IPAB's enormous power will grow at the expense of Congress and the people's elected representatives. In fact—as you probably know and no doubt do know—there is litigation challenging this delegation of legislative authority to this unelected body currently pending. Why Congress would voluntarily undermine its own authority in this area is really beyond me. We are the ones who are elected, we are the ones who are accountable

to the votes, and we are the ones who should be making those decisions.

Congress created the Medicare program in 1965, and it should be Congress that is held accountable to the seniors who use Medicare as their healthcare system. But, as you know, IPAB has a different approach. Seniors subjected to IPAB recommendations cannot challenge the recommendations in court or remove members of the board. There is no accountability. The only way a member of the board can be removed is by the President for neglect of duty or malfeasance in office.

My concerns should be familiar to many of you because these are the same concerns I am hearing from you and from my constituents, which I suspect you are hearing from your constituents as well. Scott & White Healthcare in Temple, Texas, recently wrote me in support of the bill on the Senate side that I am sponsoring for repealing IPAB. They write, "Scott & White Healthcare is supportive of initiatives to identify fraud and waste in the healthcare system and incentivized high-value healthcare in this country. But we have concerns and questions about the process that will be used by IPAB to implement cost savings in Medicare."

On June the 24th, 2011, over 270 different organizations from the Pennsylvania Medical Society to the New Jersey Academy of Ophthalmology wrote Members of Congress regarding their concerns saying that "not only will IPAB severely limit Medicare beneficiaries' access to care, but also increase healthcare costs that are shifted onto the private sector." And we are all very familiar with the cost-shifting that goes on when government reimburses at a lower rate and those with private insurance or private pay have to pick up the slack. They also cited concerns about IPAB's lack of accountability and inability to improve the quality of care in the Medicare program.

I want to thank the chairman and the ranking member and this committee for being skeptical of the IPAB from the beginning and for supporting repeal now. Of course, this is not a partisan issue. This is not part of an effort to repeal the healthcare bill. This is a narrowly targeted piece of legislation designed to deal with this particular provision, which I think deserves and does have bipartisan support.

In January 2010, 72 House Democrats joined Republicans asking then-Speaker Pelosi to take IPAB out of the healthcare bill. On Monday, Congressman Pallone was quoted as he was here today saying he didn't support IPAB and certainly would be in favor of abolishing it. Congressman Roe's bill enjoys bipartisan support for the legislation in this House, and I hope some of my Democratic colleagues in the Senate will join me in our effort to repeal this particular provision in the healthcare bill.

As we repeal the IPAB, we have got to look at a better way to achieve our bipartisan goal of controlling healthcare costs in the Medicare program. One model I believe that has worked pretty darn well is the Medicare Prescription Drug program, which has come in under budget by about 40 percent by providing transparency, competition, more quality and service, which has used market forces to discipline costs. The Prescription Drug Program has achieved these results, as I say, by injecting competition and

choice into the system. Many other programs at the state level and the private sector have also cut costs without sacrificing quality or access to care, goals that we all share. And Congress should continue to take a look at those as well.

In conclusion, Mr. Chairman, let me just say that Medicare beneficiaries have paid their hard-earned money into Medicare for years and it should be these same beneficiaries, their families and providers who determine the healthcare that is right for them.

Thanks for allowing me to testify here today, and I am happy to respond to any questions you might have.

[The prepared statement of Mr. Cornyn follows:]

Testimony of Senator John Cornyn
House Energy and Commerce Committee Subcommittee on Health
July 13, 2011

Chairman Pitts, Ranking Member Pallone, and members of the Committee, thank you for the opportunity to testify before you regarding the Independent Payment Advisory Board (IPAB) created in the Patient Protection and Affordable Care Act.

The goal of the IPAB is one we all share: we must find some way to control the costs in Medicare. The Medicare Trustees' warned Congress in May that Medicare will be insolvent in 2024, five years earlier than they predicted last year. They noted that Medicare's unfunded liabilities, the gap between Medicare's future benefit costs and future taxes and premiums it expects to collect, are more than $24 trillion and growing. The Medicare Trustees' have now issued a Medicare funding warning every year since 2006, in which they have alerted Congress that more than 45 percent of Medicare's funding will come from general revenues.

The nonpartisan Congressional Budget Office (CBO) issued a warning of its own in June in its 2011 Long-Term Budget Outlook. CBO projects that, if current laws remain in place, spending on the major mandatory health care programs alone will grow from approximately 6 percent of GDP today to 9 percent in 2035 and would continue to increase thereafter.

Something must be done about the unsustainable growth rate of the Medicare program. We should all be able to agree on that. Like many Americans and many members of this committee,

however, I believe that IPAB is not the answer. Members of this committee are familiar with how the IPAB is supposed to function. Here are my concerns.

First, I am concerned that the only tool in the IPAB toolbox will be cutting payments to providers, and we are already seeing how government price controls are restricting access to care. The American Medical Association estimates that one in three primary care doctors limit the number of Medicare patients they see[1] and in my home state of Texas, 42 percent of physicians are considering opting out of Medicare completely due to reimbursement issues.[2] Although there has been some concern recently about the rhetoric surrounding the IPAB, continuously cutting reimbursement to Medicare providers will prevent access to care for Medicare beneficiaries.

Second, I am concerned that IPAB's enormous power will grow at the expense of Congress and the people's elected representatives. Congress created the Medicare program in 1965 and it should be Congress that is held accountable to the millions of seniors who use Medicare for their health care. The creation of IPAB, however, takes the accountability from the American people and Congress and places it in the hands of 15 unelected, politically appointed members. Seniors subjected to IPAB recommendations cannot challenge the recommendations in court or remove members from the Board. The only way a member of the Board can be removed is by the President for neglect of duty or malfeasance in office.

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[1] "AMA Online Survey of Physicians: The Impact of Medicare Physician Payment on Seniors Access to Care." May 2010.
[2] Texas Medical Association 2010 Physician Survey.

My concerns should be familiar to many of you because these are the same concerns I am hearing from my constituents, and which I suspect you are hearing from yours. Scott and White Healthcare located in Temple, Texas, recently wrote to me in support of repealing IPAB saying, "SWH is supportive of initiatives to identify fraud and waste in the healthcare system and to incentivize high value healthcare in this country, but we have concerns and questions about the process that will be used by the IPAB to implement cost savings in Medicare and Medicaid."

On June 24, 2011, over 270 organizations from the Pennsylvania Medical Society to the New Jersey Academy of Ophthalmology, wrote members of Congress regarding their concerns that IPAB will "not only severely limit Medicare beneficiaries' access to care but also increase healthcare costs that are shifted onto the private sector." They also cited concerns about IPAB's lack of accountability and inability to improve the quality of care in the Medicare program.

I want to thank members of the House of Representatives – both Democrats and Republicans – for being skeptical of the IPAB from the beginning, and for supporting repeal now. In January 2010, 72 House Democrats joined Republicans asking then Speaker Pelosi to take IPAB out of the health care bill. On Monday, Congressman Pallone was quoted in Politico stating, "I've never supported it [IPAB], and I would certainly be in favor of abolishing it." Congressman Roe enjoys bipartisan support for his legislation repealing IPAB and I hope some of my Democratic colleagues in the Senate will cosponsor my bill to repeal IPAB in the near future.

As we repeal the IPAB, we must find a better way to achieve our bipartisan goal of reducing the unsustainable growth rate of Medicare spending. One model is the Medicare Prescription Drug

program, which has come in under budget by over 40 percent. The Prescription Drug program has achieved these results by injecting competition and choice into the system. Many other programs at the state level and in the private sector have also cut costs without sacrificing quality or access to care, and Congress should take a look at them as well.

Medicare beneficiaries have paid their hard earned money into Medicare for years and it is should be these same beneficiaries, their families, and their providers, who determine the health care that is right for them.

Thank you for allowing me to testify today. I am happy to take any questions members of the committee may have.

Mr. PITTS. The chair thanks the gentleman and now——

Mr. BURGESS. Mr. Chairman, can I ask unanimous consent that the letters that Senator Cornyn referenced from Scott & White Clinic and New Jersey Medical Association be made part of the record here today?

Mr. PITTS. OK. Could we see those and then we will act on that if you have copies.

Mr. CORNYN. Absolutely.

Mr. PITTS. Thank you.

Congressman Roe, you are recognized for 5 minutes.

STATEMENT OF HON. DAVID P. ROE

Mr. ROE. I thank Chairman Pitts and Ranking Member Pallone and members of the subcommittee. Thank you for inviting me here to testify today. And I applaud this subcommittee's effort to shine a light on the danger posed to seniors by the Independent Payment Advisory Board, better known as IPAB.

I have practiced medicine for the past 31 years, not been in Congress. This is only my second term, and I am an OB/GYN doctor, and I found out delivering your own voters worked out pretty well for me. But I firmly in my core believe that healthcare decisions should be made between physicians, the patients, and their families, not by a board appointed by the President or anybody else, Republican or Democrat.

Created as part of the Affordable Care Act that went into effect last year, the IPAB is charged with developing proposals to reduce the per-capita rate of growth in Medicare spending. Certainly, something has got to be done to ensure that this important program remains available not only for current retirees but for the next generation as well. The Medicare trustees recently projected that the Medicare Trust Fund will go bankrupt in 2024, and it has been stated that the Congressional Budget Office says that the fund will exhaust even sooner, in 2020. We already know what President Obama's plan to save Medicare is, is the $500 billion in cuts to the program and the IPAB. The cuts speak for themselves, but the American people deserve to hear the truth about the IPAB as little more than a roadmap to potentially rationing care.

Now, some say that the Affordable Care Act expressly prohibits rationing, raising revenues or beneficiary premiums, increasing cost-sharing or other restrictions on benefits. This is highly misleading because nothing in law prohibits cutting payments to physicians. Already Medicare pays physicians between 85 and 90 cents on the actual cost of the care, which has made it more difficult for beneficiaries to access the needed care. If reimbursements continue to fall even further, it could very well become economically impossible for physicians to see Medicare patients. With millions of baby boomers becoming eligible for Medicare, IPAB cuts couldn't come at a worse time.

The IPAB could adversely impact the quality of patient care. For example, look no further than Britain's National Institute for Health and Clinical Excellence, or NICE. Decisions are based on cost, not quality or outcomes for an individual patient. Decisions regarding patient care shouldn't be made by a panel of 15 unelected bureaucrats who haven't examined the specifics of an in-

dividual's unique case. Medicine is not a one-size-fits-all discipline. What is effective for treating one patient may be harmful for another. By centralizing medical care decision-making, the IPAB would put a Washington bureaucrat squarely between patients and the care recommended by their doctor.

In addition to degrading access to and quality of care, IPAB has two significant structural problems: It is both unaccountable and unworkable. The board is empowered to make recommendations regarding Medicare without any input from Congress. Don't just take my word for it. The former OMB Director, Peter Orszag, called the IPAB the single biggest yielding of power to an independent entity since the creation of the Federal Reserve.

Even after the IPAB makes its recommendations, the hands of the Congress are still somewhat tied. The proposal would be considered under fast-track procedures and without 3/5 vote of the Senate, Congress can only modify the types of cuts, not the size. And if Congress fails to act on the board's recommendations, they automatically go into effect. This isn't government by the people. It is instead government by the bureaucrats.

Questions have also been raised regarding IPAB's ability to function as it is designed. In reference to IPAB, the CMS Chief Actuary, Richard Foster, wrote in the April 2010 memo that "limiting the cost growth for a beneficiary to a level below medical price inflation alone would represent an exceedingly difficult challenge." The CBO, on the other hand, projects no savings resulting from IPAB over the next 10 years. In both cases, these expert analyses suggest that IPAB will not yield the results promised by its proponents.

Further, the legislators who created the IPAB made it clear that they want this board to impact more than just Medicare. The Affordable Care Act requires the IPAB to make recommendations about how to restrain private-sector healthcare costs growth as well. While these recommendations do not automatically go into effect, they will no doubt serve to encourage private insurance companies to cut provider payments. Ultimately, cuts to provider insurance payments will result in even less access for Medicare beneficiaries because most providers shift cost onto private insurance to make up for Medicare losses. So everyone loses under this scenario.

While it seems that there is little that our two parties can agree on in the current environment, both sides have acknowledged that the IPAB is a terrible idea. That is why my bill to repeal IPAB—the Medical Care Decisions Accountability Act—has more than 160-plus bipartisan cosponsors, and all but one physician in U.S. Congress has signed on. The American Medical Association has endorsed my legislation, as did a broad coalition of more than 270 healthcare organizations. Even former Democratic leader Dick Gephardt called for the IPAB's repeal.

Mr. Chairman, it is time that we begin the fact-based conversation about reforming Medicare without the demagoguery that has marked recent months. I can't think of a better place to start than a bipartisan effort to repeal IPAB.

Let me finish with a couple of things. Ask yourself two things or two problems. Does this bill increase access and quality of care for seniors? And number two, how much oversight and power has Con-

gress given up? And let me just give you a brief example. If you are a family practitioner and you are seeing Medicare patients and you want to continue to do that and let us say your practice grosses $300,000 this year, which is probably what a family practice would do. About $150,000 of that—50 percent if you run a very efficient practice—is overhead. If you cut the current—SGR growth cuts are recommended to be about 30 percent the end of this year, that family practitioner is making a very comfortable living at $150,000. His or her costs stay at $150,000, but their income will be cut to 50. And how does that increase access? If IPAB basically can do that, how does that help our seniors?

I very much appreciate the bipartisan support for this, and I thank you for having me here today.

[The prepared statement of Mr. Roe follows:]

STATEMENT BY
REPRESENTATIVE DAVID P. ROE, M.D.
BEFORE THE SUBCOMMITTEE ON HEALTH
HOUSE ENERGY & COMMERCE COMMITTEE
JUNE 13, 2011

Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, thank you for inviting me to testify today. I applaud the subcommittee's efforts to shine a light on the danger posed to seniors by the Independent Payment Advisory Board, better known as IPAB.

Created as part of the Democratic health care law that went into effect last year, the IPAB is charged with developing proposals to "reduce the per capita rate of growth in Medicare spending." Certainly, something must be done to ensure that this important program remains available not only for current retirees, but for the next generation as well. The Medicare Trustees recently projected that the Medicare trust fund will go bankrupt in 2024. The Congressional Budget Office says the fund will be exhausted even sooner, in 2020.

We already know what President Obama's plan to "save" Medicare is—$500 billion in cuts to the program and the IPAB. The cuts speak for themselves, but the American people deserve to hear the truth about the IPAB, as it is little more than a roadmap to rationing.

Now, some say that PPACA expressly prohibits rationing, raising revenues or beneficiary premiums, increased cost sharing, or other restrictions on benefits. This is highly misleading, as nothing in the law prohibits cutting payments to physicians. Already, Medicare only pays physicians between 85 and 90 cents on the dollar, which has made it difficult for beneficiaries to access the care that they need. If reimbursement falls even further, it could very well become economically impossible for physicians to see Medicare patients. With millions of baby boomers becoming eligible for Medicare, IPAB's cuts couldn't come at a worse time.

The IPAB will also adversely impact the quality of patient care. For an example, look no further than Britain's National Institute for Health and Clinical Excellence, or NICE. Last year, NICE rejected the use of Avastin for treating patients with bowel cancer because it was considered too costly. Decisions regarding patient care shouldn't be made by a panel of 15 unelected bureaucrats who haven't examined the specifics of an individual's unique case. Medicine is not a one-size-fits-all discipline—what is effective for treating one patient may be harmful if applied to another. By centralizing medical decision making, the IPAB would put a Washington bureaucrat squarely between patients and the care recommended by their doctor.

In addition to degrading access to and quality of care, IPAB has two significant structural problems—it is both unaccountable and unworkable. The board is empowered to make recommendations regarding Medicare without any input from the Congress. Don't just take my word for it – former OMB Director Peter Orszag has called IPAB the "single biggest yielding of power to an independent entity since the creation of the Federal Reserve."

Even after the IPAB makes its recommendations, the hands of the legislature are still tied. The proposal would be considered under "fast-track" procedures and, without a three-fifths vote of the Senate, Congress can only modify the type of cuts, not their size. And if Congress fails to act on the board's recommendations, they automatically go into effect. This isn't government by the people; it is instead government by the technocrats.

Questions have also been raised regarding the IPAB's ability to function as it is designed. In reference to the IPAB, CMS chief actuary Richard Foster wrote in an April 2010 memo that "limiting cost growth [per beneficiary] to a level below medical price inflation alone would represent an exceedingly difficult challenge." CBO, on the other hand, projects no savings

resulting from the IPAB over the next 10 years. In both cases, these expert analyses suggest that IPAB will not yield the results promised by its proponents.

Further, the legislators who created the IPAB made clear that they want this board to impact more than just Medicare. PPACA requires the IPAB to make recommendations about how to restrain private sector health care cost growth as well. While these recommendations do not automatically go into effect, they will no doubt serve to encourage private insurance companies to cut provider payments. Ultimately, cuts to private insurance provider payments will result in even less access for Medicare beneficiaries because most providers shift costs onto private insurance to make up for Medicare losses. So everyone loses under this scenario.

While it seems that there is little that our two parties can agree on in the current environment, both sides have acknowledged that the IPAB is a terrible idea. That's why my bill to repeal the IPAB—the Medicare Decisions Accountability Act—has more than 155 bipartisan cosponsors. The American Medical Association has endorsed my legislation, as did a broad coalition of more than 270 health care-related organizations. Even former Democratic Leader Dick Gephardt has called for the IPAB's repeal.

Mr. Chairman, it's time that we begin a fact-based conversation about reforming Medicare without the demagoguery that has marked recent months. I can't think of a better place to start than a bipartisan effort to repeal the IPAB.

Mr. PITTS. The chair thanks the gentleman and now recognizes Congresswoman Schwartz for 5 minutes for her opening statement.

STATEMENT OF HON. ALLYSON Y. SCHWARTZ

Ms. SCHWARTZ. Thank you, Chairman Pitts and Ranking Member Pallone, Mr. Waxman, and members of the committee, for the opportunity to testify this morning.

First of all, let me say I have and continue to be a very strong supporter of the Affordable Care Act because it will extend access to affordable, meaningful health coverage to all Americans, strengthen Medicare, and contain costs for American families, businesses, and government. The potential for savings is significant. The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary estimates that over the course of the first 10 years the Affordable Care Act will save Medicare more than $400 billion by attacking fraud and abuse, reducing overpayments to insurance companies, reducing medical errors and unnecessary duplication of services, increasing access to cost-effective primary care services, and improving care coordination across healthcare settings and transitioning to payment systems that reward value.

CBO estimates that the law will reduce the deficit by more than $1 trillion over the next 20 years. And that is just the beginning. Healthcare reform has the potential to fundamentally transform the healthcare delivery and payment systems by creating a variety of models for improved delivery of care by incentivizing high quality, greater efficiency, and better outcomes. Successful implementation will ensure that seniors get the right care at the right time at a lower cost to taxpayers.

My decision to support repeal of the Independent Payment Advisory Board reflects my confidence in the many cost-containment measures in the law. Despite Republican claims, IPAB is not a "death panel" nor is it a "rationing board." That is merely scare tactics. IPAB is simply the wrong approach to achieving the right goal.

We all agree that the rate of growth in Medicare spending must be contained and that current Medicare payment systems are flawed and need to be reformed. But we cannot conceal fundamental flaws in our healthcare system by simply cutting reimbursements to hospitals and physicians or, even worse, ending Medicare as we know it, as the Republicans have proposed. The Republican plan to convert Medicare into a voucher program means that seniors will no longer have access to a guaranteed set of health benefits and, according to the CBO, the resulting premiums and co-insurance will increase out-of-pocket costs more than $6,000 per senior per year and increase as healthcare costs rise. This is neither better quality care nor genuine cost savings. It is merely shifting the burden of increased cost to seniors.

Congress must accept its responsibility for legislating sound health policy for Medicare beneficiaries, including reforms to the payment systems. Turning over this responsibility, whether to insurance companies as proposed by the Republicans, or to an unaccountable board, undermines our ability to represent the needs of seniors and the disabled and to ensure access to care.

Repealing IPAB—while preserving the essential health reforms in the Affordable Care Act—enables providers to focus on innovations that will achieve cost savings by incentivizing efficient, high-quality healthcare. If we do not, IPAB is structured in such a way that the board may be forced to impose cuts on a narrow sector of the healthcare system, ignoring the need for broader changes. Arbitrary cuts on spending, absent fundamental reforms to underlying cost drivers, simply shift the cost burden. Thus, IPAB has the potential to stifle implementation of the promising innovations that would address these cost drivers just as they are beginning to take shape.

The Obama Administration is already implementing healthcare reforms to reduce the rate of growth in healthcare spending by holding providers accountable for reducing costs through more coordinated care, the adoption of health information technology, improved quality, and better outcomes. Accountable Care Organizations, which create incentives for healthcare providers to work together to lower costs while meeting quality standards and putting patients first, could save up to $750 billion over the next 10 years.

The Center for Medicare and Medicaid Innovation, established under the healthcare reform law, is advancing innovations such as the Patient-Centered Medical Home, Healthcare Innovation Zones and other innovative delivery models with the potential to achieve even more significant additional savings. The Center's recently launched Partnership for Patients initiative will save costs by bringing together hospitals, physicians, and patients to dramatically reduce hospital-acquired conditions and hospitals readmissions. This program alone is expected to generate savings of up to $35 billion.

These are reforms that we should build on to achieve greater cost efficiencies without risking access or quality. It is our job to identify the cost-efficient, cost-saving innovations and ensure that they are implemented broadly and successfully across the country.

There are tough choices ahead as we work to contain the rate of growth in costs in healthcare. We should eliminate IPAB, reject the Republicans' efforts to dismantle Medicare, and focus on reshaping payment and delivery systems to reward coordination, efficiency, and value to achieve these cost savings. And in so doing, we will meet our obligation both to seniors and to taxpayers.

And I thank you for the opportunity.

[The prepared statement of Ms. Schwartz follows:]

TESTIMONY OF U.S. REPRESENTATIVE ALLYSON SCHWARTZ

House Energy & Commerce Committee

IPAB: The Controversial Consequences for Medicare and Seniors

July 13, 2011

Chairman Pitts, Ranking Member Pallone, thank you for the opportunity to testify today on an issue of great importance to the health care community and the patients they serve.

I have been and continue to be a strong supporter of the Affordable Care Act. The potential for savings is significant. The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary estimates that – over the course of 10 years – the Affordable Care Act will save the Medicare program more than $400 billion by reducing medical errors and unnecessary duplication of services, attacking fraud and abuse, reducing overpayments to insurance companies, increasing access to cost-effective primary care services, improving care coordination across health care settings and transitioning to payment systems that reward value. In the long-term, the Congressional Budget Office (CBO) estimates that the law will reduce the deficit by more than $1 trillion over the next 20 years. And that's just the beginning.

My decision to support repeal of the Independent Payment Advisory Board (IPAB) reflects my confidence in the many cost-containment measures in the law. Health care reform has the potential to fundamentally transform the health care delivery and payment systems by creating a variety of models for improved delivery of care by incentivizing high quality, greater efficiency, and better outcomes. Successful implementation will ensure that seniors get the right care at the right time at a lower cost to taxpayers.

Despite Republican claims, IPAB is not a "death panel" or a "rationing board." These are merely scare tactics. IPAB is simply the wrong approach to achieving the right goal.

We all agree that the rate of growth in Medicare spending must be contained and that current Medicare payment systems are flawed and need to be reformed. But, we cannot conceal fundamental flaws in our health care system by simply cutting reimbursements to hospitals and physicians or, even worse, ending Medicare as we know it, as Republicans have proposed. Changing Medicare into a voucher program

means that seniors will no longer have access to a guaranteed set of health benefits and, according to CBO, the resulting increased premiums and co-insurance would increase individual seniors' out-of-pockets costs more than $6,000 per year. This is neither better quality care nor genuine cost savings – it is merely shifting the cost to seniors.

Congress must accept its responsibility for legislating sound health care policy for Medicare beneficiaries, including reforms to payment systems. Turning over this responsibility, whether to insurance companies as proposed in the Republican plan, or to an unaccountable board, undermines our ability to represent the needs of seniors and the disabled and ensure their access to care.

Repealing IPAB – while preserving essential health care reforms in the Affordable Care Act – enables providers and us to focus our efforts on thoughtful innovations that will achieve cost savings by incentivizing efficient, high-quality health care. If we do not, IPAB is structured in such a way that the Board may be forced to impose cuts on a narrow sector of the health care system, ignoring the need for broader changes. Arbitrary caps on spending, absent fundamental reforms to underlying cost drivers, simply shift the cost burden. Thus, IPAB has the potential to stifle implementation of promising innovations that would address those cost drivers just as they are beginning to take shape.

The Obama administration is already implementing health care reforms to reduce the rate of growth in health care spending by holding providers accountable for reducing costs through more coordinated care, the adoption of health information technology, improved quality, and better outcomes. Accountable Care Organizations, which create incentives for health care providers to work together to lower costs while meeting quality standards and putting patients first, could save up to $750 billion over the next 10 years.

The Center for Medicare and Medicaid Innovation, established under health care reform, is advancing initiatives such as the Patient-Centered Medical Home, Healthcare Innovation Zones and other innovative delivery models with the potential to achieve significant additional savings. The Center's recently launched Partnership for Patients initiative will save costs by bringing together hospitals, physicians and patients to dramatically reduce hospital-acquired conditions and hospitals readmissions. This program alone is expected to generate savings of up to $35 billion. These are reforms that we should build upon to achieve greater cost efficiencies without risking access or quality. It is our job to

identify the most effective cost saving innovations and ensure that they are implemented broadly and successfully implemented across the nation.

There are tough choices ahead as we work to contain the rate of growth in health care costs. We should eliminate IPAB, reject Republicans' efforts to dismantle Medicare and focus on reshaping payment and delivery systems to reward coordination, efficiency and value to achieve cost savings. In so doing, we can meet our obligations to both seniors and taxpayers.

Mr. PITTS. The chair thanks the gentlelady. The chair thanks the witnesses of our first panel—very informative. I appreciate the bipartisan nature of it. And we will dismiss the first panel at this time and call the——

Mr. BURGESS. Mr. Chairman, did we rule on my unanimous consent request?

Mr. PITTS. If the Senator can give us the documents, then we will rule on it. Can you make sure we get that? Not yet? We will act on it later.

The second panel consists of a single witness. The Honorable Kathleen Sebelius is the United States Secretary of Health and Human Services. We welcome the Secretary to the hearing.

Madam Secretary, your written testimony will be made part of the official record. Welcome. And we ask that you summarize your statement in 5 minutes and then be available after 5 minutes for questions. Could you hear me? I am sorry. We have had some problems with our mikes. Your written testimony will be made part of the official record. We ask that you summarize your opening statement in 5 minutes. So welcome, Madam Secretary. You may begin your testimony.

STATEMENT OF KATHLEEN SEBELIUS, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. SEBELIUS. Well, thank you, Chairman Pitts and Ranking Member Pallone and members of the committee. I appreciate the opportunity to come today to discuss how the Affordable Care Act is strengthening Medicare for seniors today and tomorrow.

My written testimony does provide more detail, but I want to highlight some of the steps we are taking as part of the healthcare law to fill the gaps in Medicare coverage, to improve care, and make the program more sustainable for the future while preserving the guarantees for seniors and those with disabilities.

When Medicare became law in 1965, it served as a national promise that seniors wouldn't go broke because of a hospital bill. In 2006, Medicare added coverage for prescription drugs, which make up a growing share of beneficiaries' healthcare costs. But we know that too many seniors still struggle to afford their medications, and that is why the Affordable Care Act moved to assist the seniors falling into the donut hole with a one-time $250 check in 2010 and this year starts a 50 percent discount for the approximately 4 million beneficiaries who now will get some assistance with the purchase of brand-name drugs. By 2020, that gap will be closed completely.

We also know that too many seniors were going without the preventive care that can help prevent an illness before they occur, in some cases, because of expensive co-pays. And that shouldn't happen. So beginning this year, the law allows Medicare beneficiaries to receive recommended preventive services like screenings for colon or breast cancer, as well as an annual wellness visit without paying a co-pay or deductible. It is the right thing to do and it is the smart thing to do because it helps physicians catch small health problems before they turn into big ones.

The law is also helping to improve the quality and safety of care for people with Medicare. We know that there are model hospitals

across the country that have adopted best practices to dramatically increase the quality of care. In fact, for almost every major common medical error, we have examples of health systems that have significantly reduced or even eliminated them altogether. There is no reason why all Medicare beneficiaries shouldn't enjoy that same high quality of care wherever they receive it. And that is why the Affordable Care Act provides unprecedented support to help those best practices spread.

In March, we launched the Partnership for Patients, an historic partnership with employers, unions, hospital leaders, physicians, nurses, pharmacists, and patient advocates to reduce harm and error in our Nation's hospitals. Last week, we announced that more than 2,000 hospitals have already signed up and are taking critical steps to improve care. They are aimed at two goals: reducing preventable readmissions and reducing hospital-acquired conditions.

Under the law, we have also established the first of its kind, Medicare/Medicaid Coordination Office, working with States to improve care for those beneficiaries who are enrolled both in Medicare and Medicaid and often receive fragmented or duplicative care as a result.

Through the new Medicare and Medicaid Innovation Center created by the law, we are testing a wide range of additional models for increasing the quality of care from strategies of helping seniors manage their chronic conditions to new models in which hospitals and doctors who keep their patients healthy and out of the hospital can share in the cost savings they create.

Together, these reforms are beginning to dramatically strengthen Medicare today for seniors and Americans with disabilities. We also have the responsibility to preserve the promise of Medicare for future generations, and we can't do that if costs continue to rise unchecked. Because doing care the right way often costs less than doing it the wrong way, many of the laws reforms to improve care also reduce Medicare costs. For example, the Partnership for Patients alone is estimated to save Medicare as much as $50 billion over the next 10 years by reducing errors and unnecessary care.

But the law doesn't stop there. It contains important new tools to stamp out waste, fraud, and abuse. And in fiscal year 2010, as we are beginning to build this new system, our anti-fraud efforts returned a record $4 billion to taxpayers. And the new tools will help us build on that progress. The Medicare trustees estimate that these reforms in the Affordable Care Act have already extended the solvency of the trust fund until 2024. Without the reforms, the trust fund would have been insolvent 5 years from now.

But when it comes to Medicare's future, we can't take any chances, and that is why the law also creates the Independent Payment Advisory Board, or IPAB, a backstop, a failsafe to ensure Medicare remains solvent for years to come. IPAB is comprised of 15 health experts, including doctors, other healthcare professionals, employers, economists, and consumer representatives. The Affordable Care Act provides for consultation between the President and congressional leadership on appointing members of the board, and appointments are subject to the advice and consent of the Senate.

Each year, the board recommends improvements to Medicare. The recommendations must improve care and help controls costs.

For example, the board can recommend additional ways for Medicare to reduce medical errors and crack down on waste and fraud. And contrary to what some have said, IPAB by law is not allowed to ration care or shift costs to beneficiaries. In fact, it is specifically forbidden from making any recommendations that would ration care, reduce benefits, raise premiums or cost-sharing, or alter eligibility for Medicare. It leaves all final decisions in the hands of Congress.

If Medicare spending begins to threaten the program's future, IPAB is charged with making recommendations to Congress to create necessary savings without shifting the cost of care to seniors and those with disabilities. But then it is up to Congress to decide whether to accept those recommendations or come up with recommendations of its own to put Medicare on a stable, sustainable path. In other words, IPAB's recommendations are only implemented when excessive spending growth is not addressed and no actions are being taken to put spending in line.

The nonpartisan Congressional Budget Office and the independent Medicare Actuary both predict that IPAB is unnecessary anytime soon—indeed in the next decade—thanks to the work that we are already doing to slow rising costs. But we don't know about the future, which why experts across the country, including independent economists and the CBO believe that IPAB is needed as a safeguard. And we agree. We believe the best way to strengthen Medicare for today and tomorrow is to fill the gaps in coverage, crack down on waste and fraud, and bring down costs by improving care, changing the underlying delivery system. And that is what we are working to do under the healthcare law.

Over the last 16 months, our department has focused on working with Congress and our partners across the country to implement the law quickly and effectively, and in the coming months, I look forward to working with all of you to continue those efforts.

Thank you again, Mr. Chairman, and I would be pleased to take your questions.

[The prepared statement of Ms. Sebelius follows:]

Summary of Statement by Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services, on the Independent Payment Advisory Board

July 12, 2011, before the Committee on Energy and Commerce Subcommittee on Health

The Affordable Care Act fills gaps in Medicare coverage, improves care, and makes the program more sustainable for the future, while preserving its guarantees for seniors and people with disabilities.

Today the Affordable Care Act is giving seniors immediate relief with a 50% discount on covered name brand drugs for those in the prescription drug donut hole, a step towards 2020, when we will close that coverage gap completely. And the law also now allows Medicare beneficiaries to receive recommended preventive services, as well as an annual wellness visit, without paying a co-pay or deductible.

At the same time, the law is helping to improve the quality and safety of care for people with Medicare. In March, we launched the Partnership for Patients, a historic partnership to reduce harm and error in care that has already signed up 2,000 hospitals. And through the Medicare and Medicaid Innovation Center, we are testing a wide range of additional models for increasing the quality of care.

The law also preserves the promise of Medicare for future generations. The Medicare Trustees have estimated that reforms in the law that improve care, eliminate wasteful payments, and crack down on fraud have extended the life of the Medicare trust fund until 2024. Without these reforms, the trust fund would be insolvent just five years from now in 2016.

But when it comes to Medicare's future, we can't take any chances. That's why the law created the Independent Payment Advisory Board (IPAB) as a backstop to ensure Medicare remains solvent for years to come.

The IPAB will be made up of 15 health experts. The Affordable Care Act provides for consultation between the President and Congressional leadership in appointing members of the Board, and appointments are subject to the advice and consent of the Senate. Each year, the board will recommend improvements to Medicare that improve care and help control costs.

The IPAB is specifically forbidden from making any recommendations that would ration care, reduce benefits, raise premiums or cost-sharing, or alter eligibility for Medicare.

And all final decisions remain in the hands of Congress. If Medicare costs are rising at an unsustainable rate, it's Congress's choice whether to accept those recommendations, or come up with recommendations of its own to put Medicare spending on a stable, sustainable path.

The non-partisan Congressional Budget Office and the independent Medicare Actuary both predict that the IPAB is unlikely to be necessary anytime soon thanks to the work we're already doing to slow rising costs. But we can't know the future, which is why experts across the country believe the IPAB is a needed safeguard.

We believe that the best way to strengthen Medicare for today and tomorrow is to fill in gaps in coverage, crack down on waste and fraud, and bring down costs by improving care. That's what we're working to do under the health care law, and IPAB is an important part of that.

STATEMENT OF

KATHLEEN SEBELIUS

SECRETARY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

"IPAB: THE CONTROVERSIAL CONSEQUENCES FOR MEDICARE AND SENIORS"

BEFORE THE

ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH

UNITED STATES HOUSE OF REPRESENTATIVES

JULY 13, 2011

Chairman Pitts, Ranking Member Pallone, and Members of the Committee, thank you for the opportunity to discuss our Department's implementation of the Affordable Care Act. Millions of Americans across the country are already benefiting from this law, including more than 100 million people currently enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Over the past 16 months, we have worked closely with doctors, nurses, other health care providers, consumer and patient advocates, employers, Governors, State Insurance Commissioners, health plans, and interested citizens to deliver many of the law's key benefits to the American people, including Medicare beneficiaries. These benefits include improving seniors' access to affordable, life-saving medications; offering new preventive care benefits for Medicare beneficiaries; improving care coordination for beneficiaries eligible for both Medicare and Medicaid; and implementing new tools to fight fraud and return money to the Medicare Trust Funds and Treasury.

I am proud to say that we have met deadlines, established strong working partnerships, and begun laying the groundwork for reforms that will have lasting effects in the years to come. This law means real improvements for the care of Medicare beneficiaries now, and a stronger and more fiscally sound Medicare program in the future.

Making Medicare sustainable is not about cutting program benefits or shifting costs onto seniors. Sustainability for Medicare requires fundamental changes to the way that health care is delivered – changes that will lead to better health, better care, and lower costs. The Affordable Care Act includes new policies and authorities that will make critically needed delivery system reforms while preserving Medicare's guarantees for seniors and people with disabilities.

Improved Value for Seniors and People with Disabilities

Thanks to the Affordable Care Act, Medicare beneficiaries will enjoy better quality care, better access to care, and a more innovative care delivery system that will help to improve outcomes and reduce cost. People with Medicare have already experienced improved benefits that help to keep them healthy and make prescription drugs more affordable. The important changes called for in the Affordable Care Act will also produce savings for taxpayers and extend the solvency of the Medicare Trust Fund. Medicare's long-term outlook is improved as a result of the development of new systems of health care delivery that will improve health care outcomes and cost efficiency, and provide more effective tools to reduce waste and fraud. These measures will also help people with Medicare by slowing the growth of their monthly premiums, and by keeping their copayments and deductibles lower than they would have been under previous law.

Here are just a few examples:

- **Improving Medicare beneficiaries' access to life-saving medicines:** As a result of new provisions in the Affordable Care Act, people with Medicare have already received immediate relief from the cost of their prescription medications. Nearly 4 million beneficiaries received a one-time, tax-free check for $250 after reaching the Part D coverage gap, or "donut hole," during 2010. In 2011, this benefit has improved dramatically. Beneficiaries now automatically receive a 50 percent discount on covered brand-name drugs in the coverage gap. Among beneficiaries who have reached the coverage gap, the average beneficiary has saved $545, for total savings of more than $260 million in the first five months this year. Further, people with Medicare Part D will

pay a smaller share of their prescription drug costs in the coverage gap every year from now until 2020, when the coverage gap will be closed.

- **Increased access to preventive care:** Thanks to the Affordable Care Act, people with Medicare now are eligible to receive critical preventive care, like mammograms and colonoscopies, with no coinsurance or deductible. Beneficiaries also have access to a new annual wellness visit starting this year that provides a focus on preventive care. As of June 10, about 5.5 million people with Medicare have accessed one or more of these preventive measures. At the end of June, we launched a new awareness effort– *Share the News, Share the Health* – to highlight Medicare's preventive benefits and encourage more Medicare beneficiaries to take advantage of these potentially lifesaving services. Improving access to preventive care can improve early detection and treatment options, potentially reducing the cost of care and improving the health of our Medicare population in the long run.
- **High quality Medicare Advantage benefits:** This year, HHS has improved its oversight and management of the Medicare Advantage (MA) program. The results for the 2011 plan year show that these efforts are paying off: seniors and people living with disabilities have clearer plan choices that, on average, offer improved protections and stable benefits at lower premiums. Contrary to predictions of enrollment decline, 2011 MA enrollment is up six percent and average premiums are down six percent compared to 2010, while benefit and cost-sharing levels remain roughly the same. Access to MA remains strong, as more than 99 percent of Medicare beneficiaries have a choice of MA plans as an alternative to traditional Medicare. As part of the Administration's national strategy for implementing quality improvement in health care, CMS is also working to create new

incentives for all MA plans to improve the care they offer to Medicare beneficiaries. Beginning in 2012, CMS will implement a demonstration that builds on the quality bonus payments authorized in the Affordable Care Act by providing stronger incentives for plans to improve their performance, thereby accelerating quality improvements. These enhanced incentives will help provide a smooth transition as MA payments are gradually aligned more closely with costs in the Medicare fee-for-service program.

- **Increased support for primary care:** Thanks to the Affordable Care Act, physicians have better incentives to provide vital primary care services to Medicare beneficiaries. Beginning January 1, 2011, the Affordable Care Act provides for new 10 percent bonus payments for primary care services furnished by a primary care practitioner and for major surgical procedures furnished by a general surgeon in a health professional shortage area. Primary care practitioners in family medicine, internal medicine, geriatric medicine or pediatric medicine, as well as general surgeons, nurse practitioners, clinical nurse specialists, and physician assistants are eligible for these new incentive payments.

- **Specific focus on Hospital-Acquired Conditions (HACs):** These conditions consist of complications, including infections, that patients acquire while receiving care that is supposed to help them. Not all HACs are preventable, but a great number can be avoided. For example, the Centers for Disease Control and Prevention (CDC) has estimated that each year, almost 100,000 Americans die and millions suffer from hospital-acquired infections alone. In addition to pain, suffering, and sometimes death, these HAC complications could add as much as $45 billion to hospital costs paid each

year by taxpayers, insurers, and consumers.[1] The Department of Health & Human Services' Office of the Inspector General has reported that 44 percent of adverse events experienced by Medicare beneficiaries in the October 2008 sample month were preventable, and that these complications cost the Medicare program an extra $119 million in that one month alone.[2]

We know of hospitals in this country that, through improvements in their health care processes, have virtually eliminated some forms of infections that other hospitals still think are inevitable. To create incentives for hospitals to prevent such infections and other adverse conditions, the Affordable Care Act includes a Medicare payment reduction for hospitals in the top quartile of all hospitals with regards to selected hospital-acquired conditions under the inpatient prospective payment service system beginning in fiscal year 2015. Consistent with our commitment to transparency, information for consumers, and the Affordable Care Act, the Secretary will publically report information regarding HACs of each affected hospital on the Hospital Compare website. Those hospitals will have an opportunity to review, and submit corrections for, the information to be made public prior to the information being publically reported.

- **Reducing unnecessary hospital readmissions:** We know that about one in every five Medicare beneficiaries discharged from the hospital will be re-admitted within 30 days of discharge. The Medicare Payment Advisory Commission (MedPAC) estimates that Medicare spends $12 billion annually on potentially preventable readmissions.[3] Proper

[1] The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention, March 2009, http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.
[2] Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, November 2010, http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.
[3] Medicare Payment Advisory Commission (MedPAC) Report to the Congress, June 2007. (2005 data).

attention to care transitions, coordination, outreach, and patient education and support could all prevent unnecessary readmissions and allow at-risk patients to recover at home, where they would prefer to be, rather than reentering the hospital with complications. The Affordable Care Act provides for a payment adjustment for inpatient hospital services to encourage the reduction of certain readmission rates and also provides financial incentives for certain hospitals partnering with community-based organizations to improve transitional care processes. Per the Affordable Care Act, the readmission rate information for all patients in each hospital participating in the program will publicly available online.

Better Care: A Partnership with States

The Affordable Care Act is beginning to improve the way care is delivered to Medicare beneficiaries. Too often, health care takes place in disconnected fragments. Instead, we should make it possible for new levels of coordination and cooperation to take place among the people and the entities that provide health care, in order to smooth the journeys of patients and families – especially those coping with chronic illness – through their care over time and in different places.

For example, coordination is critically needed in providing care to more than 9 million beneficiaries who are eligible for both Medicare and Medicaid, also known as dual eligibles. The Affordable Care Act established a Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office, to improve coordination of the care provided to these beneficiaries. This population is among the most vulnerable and chronically ill beneficiaries:

though they represent only 15 percent of Medicaid enrollees, they account for 39 percent of Medicaid expenditures. Similarly, they are 16 percent of Medicare enrollees but account for 27 percent of Medicare expenditures. Dual eligibles must navigate two separate systems: Medicare for coverage of basic health care services, and Medicaid for coverage of long-term care supports and services and help with Medicare premiums and cost-sharing.

The Medicare-Medicaid Coordination Office is working to better streamline care for dual eligibles by improving alignment between the two programs, sharing data that is critical to States' ability to manage care for these individuals, and supporting States' innovative approaches to coordinating care for dual eligibles. The office has been hard at work. Some of its initiatives include:

- On May 11, 2011, the Medicare-Medicaid Coordination Office launched the Alignment Initiative, an effort to more effectively integrate benefits under the Medicare and Medicaid programs. Better alignment of the two programs can reduce costs by improving health outcomes and more effectively and efficiently coordinating care.
- Also on May 11, the Office announced a new process to provide States access to Medicare data to support care coordination for individuals enrolled in both Medicare and Medicaid. The ability to access both sets of information on beneficiaries covered by both programs enables States to better analyze, understand, and coordinate a person's experience.
- Partnering with the Center for Medicare and Medicaid Innovation, the Office has awarded contracts of up to $1 million each to 15 States to design person-centered approaches to coordinate care across primary, acute, behavioral health and long-term

supports and services for Medicare-Medicaid enrollees.[4] The overall goal of this contracting opportunity is to identify delivery system and financial models that can be rapidly tested and, upon successful demonstration, replicated in other States.

On July 8, 2011, HHS announced new opportunities for partnering with States to improve quality and costs for Medicare-Medicaid beneficiaries. Specifically, we announced a demonstration program to test two new financial models designed to help States improve quality and share in the lower costs that result from better coordinating care for individuals enrolled in Medicare and Medicaid; a demonstration program to help States improve the quality of care for people in nursing homes by providing these individuals with the treatment they need without having to unnecessarily go to a hospital; and a technical resource center available to help them improve care for high-need high-cost beneficiaries.

Program Integrity

As we move forward with new and exciting benefits and care models, we are redoubling our efforts to minimize waste, fraud, and abuse in Federal health care programs. This Administration has put an unprecedented focus on reducing fraud and improper payments, and is making progress towards that end. A greater focus on program integrity is integral to the success of Medicare reform. In 2010, our collective efforts returned over $4 billion in health care fraud resources to the Medicare Trust Fund, victim programs, and others. The Affordable Care Act offers additional front-end protections to keep those who commit fraud out of Federal health care

[4] http://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp#TopOfPage

programs, as well as new tools for deterring wasteful and fiscally abusive practices, promptly identifying and addressing fraudulent payment issues, and ensuring the integrity of our programs. Recently, CMS consolidated Medicare and Medicaid program integrity efforts into one office, the Center for Program Integrity.

This organizational change, coupled with the new tools provided by the Affordable Care Act, enhances CMS's ability to improve its program integrity capabilities and jointly develop Medicare, Medicaid and CHIP anti-fraud and abuse policies. For example, many Affordable Care Act provisions, such as enhanced screening requirements for new providers and suppliers, apply across the programs. In addition, oversight controls such as authority for temporary enrollment moratoria and authority for a temporary withhold on payment of claims for new durable medical equipment suppliers based on risk, will allow us to better focus our resources on addressing the areas of greatest risk and highest dollar impact.

Further, on July 1, 2011, CMS implemented a new predictive modeling technology developed with private industry experts to fight Medicare fraud. Similar to the technology used by credit card companies, predictive modeling will help identify fraudulent Medicare claims prior to payment on a nationwide basis so we can begin to take action to stop fraudulent claims early on. This initiative builds on the new anti-fraud tools and resources provided by the Affordable Care Act. Together, these tools are helping us move beyond "pay and chase" recovery operations to an approach that prevents fraud and abuse.

Finally, through the Health Care Fraud Prevention and Enforcement Action Team, or "HEAT," CMS has joined forces with our law-enforcement partners at the Department of Justice and the

Department of Health and Human Services' Office of Inspector General to collaborate and streamline our efforts to prevent, identify, and prosecute health care fraud.

Independent Payment Advisory Board

All of this work reflects this Administration's vision for improving the health of seniors and securing Medicare finances for the future. By reducing the underlying costs of the health care system and by improving the care our seniors receive, we can continue to serve today's beneficiaries while preparing for tomorrow's.

We also know that the future of Medicare requires continued vigilance and careful oversight, which is why we support the creation of a backstop mechanism to ensure Medicare remains solvent for years to come. The Independent Payment Advisory Board (IPAB) builds on the commitment we have made to our seniors' health.

The IPAB will consist of 15 health experts, including health care providers, patient advocates, employers, and experts in health economics. The Affordable Care Act provides for consultation between the President and Congressional leadership in appointing members of the Board, and appointments are subject to the advice and consent of the Senate. Their work will be objective and transparent.

The Board's primary responsibility will be to recommend improvements to Medicare. Recommendations of the IPAB will focus on ways to improve health care while lowering the growth in Medicare spending. For example, the Board could recommend approaches that would

build on and strengthen the initiatives mentioned above, from reducing medical errors, to strengthening prevention and improving care coordination, or targeting waste and fraud.

At the same time, the law contains important limitations on what the Board can recommend. The statute is very clear: the IPAB cannot make recommendations that ration care, raise beneficiary premiums or cost-sharing, reduce benefits, or change eligibility for Medicare. The IPAB cannot eliminate benefits or decide what care Medicare beneficiaries can receive. Given the long list of additional considerations the statute imposes on the Board, we expect the Board will focus on ways to find efficiencies in the payment systems and align provider incentives to drive down costs without affecting our seniors' access to the care and treatment they need. The Board's recommendations are also just that – recommendations – unless Congress fails to act. Congress still has the authority to make final decisions.

Starting in 2014, Medicare will have specific benchmarks for per capita spending increases. These benchmarks will initially be set at the average of the increases in CPI and CPI-Medical. Beginning in 2020, the benchmark will be set at the rate of growth of GDP per capita + 1 percentage point. Given these benchmarks, the Medicare Actuary predicts that the IPAB will be needed mainly as a backstop. Through the Affordable Care Act and our program integrity efforts, we have already substantially reduced the rate of growth in projected Medicare spending. The Office of the Actuary predicts that per beneficiary spending in the Medicare program will grow at a rate below the GDP+1 percentage point benchmark throughout the 75 year projection period. Indeed, the Office of the Actuary predicts that over the next decade per beneficiary Medicare spending will grow at about the same rate as GDP per capita, including an allowance to raise future physician payments to avoid the cuts mandated by the Sustainable Growth Rate formula. That would be a substantially slower rate of growth in expenditures per beneficiary,

over a 10 year period, than has ever before been seen in the Medicare program. In addition, the current Medicare spending baseline prepared by the Congressional Budget Office assumes that Medicare spending growth will not exceed the benchmark amounts over the next 10 years.

Of course, predictions are just that – predictions – and predictions are not always certain. Health care spending patterns – or the rate of growth in the benchmarks – could change. The IPAB backstop means that if Medicare spending growth does exceed growth in the benchmarks, the IPAB will make specific recommendations, and Congress will then have the opportunity to take action. If Congress rejects IPAB recommendations, they will replace them with reforms that bring Medicare spending growth to or below the benchmark – achieving the same savings. The Board's recommendations will only go into effect if Congress accepts them, or if Congress fails to act. In other words, the IPAB recommendations are only implemented when excessive spending growth is not addressed, and other actions being taken are insufficient to bring spending to levels at or below the benchmark.

Experts across the country, including independent economists and the Congressional Budget Office, believe the IPAB is a needed safeguard. We agree, which is why the President's deficit reduction framework strengthens the Board. This will ensure that we protect Medicare's future without resorting to radical benefit cuts or cost-shifting to seniors and people with disabilities.

Conclusion

The accomplishments listed above are just some of the many benefits that the Affordable Care Act has provided. The Affordable Care Act has already had a positive impact on Medicare beneficiaries, as well as on the millions more who now have greater options and protections in

their private health insurance. Our Department has worked hard to implement the many new programs and authorities that the Act has provided us. We take very seriously our responsibility to improve access, quality, and efficiency of care for all our Medicare beneficiaries, while protecting the long-term fiscal integrity of the Medicare program.

Mr. PITTS. The chair thanks the Secretary for your opening statements. I will now begin the questioning and recognize myself for 5 minutes for that purpose.

And I have a couple of questions. I would like to ask you to respond yes or no. I am very concerned about IPAB. And assuming the cap is reached, suppose we reach a situation where IPAB then kicks in, I would like to walk through a couple of potential scenarios.

Is it possible for IPAB to cut provider payments for dialysis, yes or no, if we reach that situation?

Ms. SEBELIUS. Mr. Chairman, I have had this directed by law to take into account any cut in provider services before they make recommendations.

Mr. PITTS. But the answer is yes, they may cut provider payments for dialysis?

Ms. SEBELIUS. They don't make any cuts whatsoever. They make recommendations to Congress.

Mr. PITTS. For cuts in dialysis. So if they make a recommendation for cuts for payments for dialysis, if those occurred, would at least some providers no longer be able to provide dialysis services? Yes or no?

Ms. SEBELIUS. Mr. Chairman, I have no idea what the scenario is, what the recommendations are, and what Congress would do with those recommendations, but I assume that we would have that information if we had a real example.

Mr. PITTS. If the recommendations took place, would some——

Ms. SEBELIUS. What are the recommendations, sir, and what is the payment cut and what is the rate at which providers would be repaid and what scenario and over what kind of period of time? I have no idea.

Mr. PITTS. Is it possible that some providers could be cut?

Ms. SEBELIUS. By?

Mr. PITTS. If those recommendations took place.

Ms. SEBELIUS. If Congress accepted the recommendations and made a decision that cuts in dialysis were appropriate, I assume that there could be some providers who would decide that that would not be a service they would any longer delivery, the same way they do with insurance coverage each and every day that providers make determinations whether it be part of the network.

Mr. PITTS. If that occurred, would fewer providers, as you have suggested could occur, mean that some seniors would have to wait longer for dialysis? Yes or no?

Ms. SEBELIUS. Mr. Chairman, as you know, any cut in services, certainly cost-shifting to beneficiaries could mean huge reductions in care that seniors would have the opportunity to receive. What we have right now is guaranteed benefits. What I think the House Republican plan would do is shift that to a guaranteed contribution, which would dramatically change the ability of seniors to access care.

Mr. PITTS. In this case we are talking about the law, not a proposal in the Republican budget. IPAB is commanded to save money by cutting reimbursements. They will have to make the decisions about which services are more or less critical, what patients can wait longer. Is that not rationing?

Ms. SEBELIUS. Mr. Chairman, IPAB is not directed to make recommendations based on cuts in reimbursements. It is directed to make recommendations based on ways to reduce costs overall if, indeed, the Medicare spending targets per capital exceed what the actuary hits as a target goal. I think that there are a variety of areas, and one is the work we are currently doing in the Partnership for Patients where you actually go after costs that are unnecessary and being paid right now in the system, $50 billion worth of costs for care that should have never been realized in the first place. Those are the kinds of recommendations I think that are significant and could make a huge impact.

Mr. PITTS. Let me ask you about, again, the statute. Where in the statute is there prohibition on IPAB making recommendations that could reduce access to breast cancer treatment, say, mammograms?

Ms. SEBELIUS. Well, IPAB is forbidden by law to make recommendations that would ration care and I would say any kind of prohibition on accessing treatment would be rationing care.

Mr. PITTS. Are there any provisions in the law that explicitly state IPAB cannot reduce access to the treatments like that?

Ms. SEBELIUS. They may not by law ration care. And I think anyone would suggest that a reduction or an elimination of a treatment is rationing care. That is forbidden by law.

Mr. PITTS. Suppose someone believes that IPAB has, in fact, rationed care. What redress does that person have to challenge the board's decisions?

Ms. SEBELIUS. A court challenge.

Mr. PITTS. Are the board's recommendations exempt from judicial or administrative review?

Ms. SEBELIUS. The judicial oversight that is limited is really, I think, regarding my or any future Secretary of HHS implementation of recommendations when they have followed the law. I don't think anyone—certainly our general counsel feels very strongly that nothing in that language is consistent with language that is currently in the Medicare statutes as they move forward. Nothing would certainly give either the IPAB board or a future Secretary of HHS or the current Secretary of HHS any ability to violate the law, and that would always be subject to judicial review.

Mr. PITTS. The chair thanks the gentlelady and recognizes the ranking member, Mr. Pallone, for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

Madam Secretary, while today's hearing is on IPAB and its consequences to seniors, we have yet to hold a hearing in this subcommittee on the Republican plan for Medicare, even though I have asked for that many times. And as you recall, the Republican budget ends the Medicare program. IPAB's effects do not compare to the consequences for seniors of the Republican budget. Over the next 10 years, the Republican budget proposes to cut Medicare by $32 billion. CBO believes that IPAB will save about $2 billion over that same time period. So the Republican budget would cut 13 times as much in the next decade, and that is even before they begin their plan to end Medicare starting in 2022.

I hear the Republicans accuse the Affordable Care Act of rationing care. First, it was the death panels, then the government take-

over, and now it is IPAB. But the Republican plan for Medicare is so destructive it would actually end Medicare's guaranteed hospital benefit. It would actually end Medicare's coverage for surgical care and for chemotherapy, and coverage for all those services would be entirely dependent on whether you could first convince the plan to cover you and then on whether the plan includes hospital services or chemotherapy in its benefit package. And as you know, these kinds of problems are endemic in the individual insurance market, and that is why we have so many uninsured today and that is why we passed the Affordable Care Act to guarantee a good benefit package and eliminate a lot of the discrimination.

I just wanted to ask you what do you think the Republican budget plan would mean for beneficiaries who would no longer have their Medicare benefits?

Ms. SEBELIUS. Well, Congressman, I don't know and I don't know that anyone knows all the details of what the Republican plan is. What we do know is what is there in terms of numbers, that the current plan of giving a senior or someone with a disability an $8,000 voucher beginning in 2022 and having that voucher purchase whatever coverage is available in the private market would shift costs to beneficiaries. So beneficiaries would be paying for about 61 percent of their cost of care. Currently, they pay under 30 percent. Within 8 years they would pay closer to 70 percent of the cost of care. In fact, an average senior who is relying on Social Security would be paying about 60 percent of that Social Security check in 2022 for healthcare. Right now, it is about a quarter of the Social Security check. So there would be a huge cost shift.

It is unclear what the benefits actually would be available and who makes that determination. I gather that the Office of Personnel Management would negotiate some kind of package, but what kind of a benefit package would be mandated or not mandated is a little unclear at this point. What we know is that without controlling the underlying costs and continuing down this path, what the Republican plan does is shift costs onto seniors, and frankly, insurance companies are pretty adept at making decisions about what care is granted and what care isn't granted, eliminating benefit packages. And that is done in a day-in and day-out basis, as well as determining what providers get paid, for what services, over what kind of period of time.

Mr. PALLONE. Well, you know, the point I am trying to make is the Republican cuts to Medicare in the future far outstrip anything proposed in the Affordable Care Act, including IPAB, and we have to remember that Republicans objected to all of the savings in the Affordable Care Act, not just the IPAB. And despite that, their budget, amazingly enough, proposed to incorporate 96 percent of the Affordable Care Act savings, all of them essentially except for the IPAB.

I just wanted to ask you, as I mentioned before, you know, we are talking a Republican budget that proposes to cut Medicare by 32 billion. CBO says that IPAB will save about 2 billion over that same time period. So the Republican budget cut is 13 times as much. I just wanted you to comment on that or confirm that if you will.

Ms. SEBELIUS. Well, again, Mr. Chairman, I think there is no question that the Republican budget does contemplate an end to Medicare as know it, an end to the commitment that seniors will have benefits guaranteed once they turn 65, be able to choose their own doctor, be able to choose the health system that they find best treats their situation, and reliably understand that they won't go bankrupt because of care delivery. So that period would come to an end and it would be a voucher system and a private insurance market, which is a very different kind of care delivery and a very different kind of commitment.

Mr. PALLONE. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and recognizes the vice chairman of the subcommittee, Dr. Burgess, for 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

Let me just continue on that for just a moment. You said that the Ryan plan would define the end of Medicare as we know it. Why does the IPAB not provide a similar definition?

Ms. SEBELIUS. Well, I think, Congressman, the Independent Payment Advisory Board makes recommendations to Congress. It is forbidden by law to do exactly what the Republican budget plans do.

Mr. BURGESS. Let me ask you a question.

Ms. SEBELIUS. They may not shift cost to seniors. They may not change benefits——

Mr. BURGESS. Yes, as we——

Ms. SEBELIUS [continuing]. They may not——

Mr. BURGESS [continuing]. Know from reading the law, it is very, very difficult for people to appeal those decisions, and in fact we won't even know because no one currently has standing until there is actually implementation of the board, which has not happened yet and care is denied and they take it through the courts. But I think we are going to find it is very, very difficult to overturn a decision of this board.

Can you tell us the difference between a voucher and premium support?

Ms. SEBELIUS. The difference between a voucher and premium support?

Mr. BURGESS. Mr. Ryan's articulated aspirational document in the Republican budget talked about premium support, a concept actually introduced during the Clinton Administration with the Commission to Save Medicare, the Bill Frist Commission. On the other side, the talking point is that he is going to give a voucher.

Ms. SEBELIUS. A voucher is basically in, I think, insurance terms a guaranteed contribution as opposed to a guaranteed benefit.

Mr. BURGESS. OK.

Ms. SEBELIUS. Those are very different concepts. On one hand, in the current Medicare program, seniors and those with disabilities have guaranteed benefits. That would switch if it becomes a voucher in the——

Mr. BURGESS. And then what would premium support look like in that world?

Ms. SEBELIUS. Pardon me?

Mr. BURGESS. What would premium support look like in that world?

Ms. SEBELIUS. I am not as familiar with that term. I know what guaranteed contribution is. I know what a voucher is. I don't——

Mr. BURGESS. So it is incorrect to use the terms interchangeably as so often happens in this committee? Premium support is a different phenomenon than a voucher? Premium support would be a request for proposals going out to insurance companies to provide the coverage, must as in Medicare Part D, so you should have some familiarity with it.

Ms. SEBELIUS. Well, if you are assuming, Congressman, let me just ask if you are assuming that $8,000 provides the total benefit——

Mr. BURGESS. No, I am asking the questions, Madam Secretary. This is my brief time to be able to ask you questions, so I have got to insist upon that.

Now, the budget for the Independent Payment Advisory Board begins October 1, correct, $15 million?

Ms. SEBELIUS. It is available, yes, sir.

Mr. BURGESS. Now, who has been nominated to that board and is awaiting confirmation?

Ms. SEBELIUS. No one.

Mr. BURGESS. And why is that?

Ms. SEBELIUS. Well, I think, Congressman, the board is not activated until 2014 and I know that the President is in discussion with a number of potential nominees and I know he has consulted with various Members of Congress, but it will be appointed and up and running at the time——

Mr. BURGESS. So should we keep that $15 million that is due October 1 because you apparently don't need it to set up the board because——

Ms. SEBELIUS. We have no intention of using money before there is a board up and running.

Mr. BURGESS. Well, who does the check go to?

Ms. SEBELIUS. I don't think there is a check. I think there is money available that we draw down.

Mr. BURGESS. Who cashes the check? Can we have that money back? We are in a debt crisis. You may have heard.

Ms. SEBELIUS. I understand. I can assure you there will be no drawdown on the treasury of $15 million until there is a board and a functioning operation.

Mr. BURGESS. Now, on this board, are they available to be a recess appointment by the President so that they would not be subject to Senate confirmation like your head of CMS is?

Ms. SEBELIUS. I am not a lawyer. I can't answer that question.

Mr. BURGESS. Well, the CRS report that is available on this indicates that there would be the availability of a recess appointment. I count nine that wouldn't require input from either the Speaker of the House or the minority leader on the Senate's side. So nine would be a majority but in fact you don't even need a numbers majority. You just need a majority of those who have been appointed, is that correct?

Ms. SEBELIUS. That is correct.

Mr. BURGESS. Let me ask you this. It looks like in statute that you could not have a majority of the board made up as physicians. Is that correct?

Ms. SEBELIUS. My understanding is that the prohibition is yes, that a majority could not be practicing physicians.

Mr. BURGESS. Well, who can make up the majority? I mean the definition of who can be the members is actually a little bit vague. It is with people with national recognition for their expertise in health finance. That is an odd pool, but they can actually make up the majority?

Ms. SEBELIUS. Well, I think, Congressman, the characteristics——

Mr. BURGESS. So think tanks can be the majority of this board.

Ms. SEBELIUS. The characteristics of the board members are modeled after the characteristics that were defined for the MedPAC board members, which have very similar kinds of backgrounds and abilities but very significant differences that there is a very strong conflict of interest barrier for the IPAB where they could not be receiving payment from the system and making recommendations at the same time.

Mr. BURGESS. The man who would have been your predecessor but he actually didn't get confirmed, Tom Daschle, wrote a book called Critical. I don't recommend anyone buy it, but he talks about this board. This board was something that he extolled in this book to a great degree, but it was actually patterned more after the Federal Employee Health Benefits program, which is, in fact, employer-sponsored insurance. Is it your vision that one day this board can be spread to further than just the Medicare world but could actually control the private health insurance world, much as the Center for Consumer Information Insurance Oversight now envisions controlling the private insurance market as well?

Ms. SEBELIUS. Again, Congressman, the board doesn't control anything. They make recommendations to Congress in the event that Congress has not acted to keep Medicare solvent. That is a recommendation board. They don't control the Medicare program. Congress is in the driver seat. They make recommendations and I think that could be very helpful as look for ways to preserve beneficiaries' right to health insurance and look for a program to be solvent on into the future.

Mr. PITTS. The chair thanks the gentleman and recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes.

Mr. WAXMAN. Thank you, Mr. Chairman. Madam Secretary, I am pleased to see you even if you don't see me. Now you do.

You have been pressed on whether this is a premium support or a voucher. It is hard to distinguish it, but as I understand, premium support would keep increasing the amount of money that would be available for people to buy insurance, like Part D Medicare so that the amount of money would keep up with the costs. A voucher, as I understand being proposed by the Republicans—although we haven't seen detail—is a defined contribution with no increase no matter what the cost increases may be in medical care.

But I want to explore with you a different issue. We are hearing a lot today about all the things that IPAB is allegedly going to do to the Medicare program. I have also heard you describe all the

things IPAB can't do like denying benefits and increasing costs for beneficiaries. I would like to know how the Republican plan for Medicare stacks up against all of the things that IPAB can and cannot do. For example, the Republican plan would end Medicare's guaranteed benefits, the things like hospital stays and doctor visits. They would replace it with a cash voucher. Can IPAB do that?

Ms. SEBELIUS. No, they cannot.

Mr. WAXMAN. The Republican plan would increase cost-sharing for Medicare beneficiaries, more than doubling their out-of-pocket costs for new enrollees. Can IPAB do that?

Ms. SEBELIUS. Well, no, the IPAB board cannot make recommendations that would do that kind of cost-shifting.

Mr. WAXMAN. The Republican plan proposes to increase premiums and force people to negotiate their care with private plans on their own. Can IPAB do that?

Ms. SEBELIUS. There is no ability in the law, I think, to make those kinds of recommendations that would change the beneficiaries' benefits. No.

Mr. WAXMAN. In fact, IPAB is prohibited from making all of these changes that would be harmful to beneficiaries, but the Republican plan enacts them all. Are you aware of any proposals in the Republican plan that would save money by reducing costs and not by shifting them to the beneficiaries?

Ms. SEBELIUS. I have no seen any details of delivery system changes or cost reductions, no, sir.

Mr. WAXMAN. Well, I think the right way to reform Medicare is to make care more efficient the way we have started to do under the Affordable Care Act. The wrong way is to wash our hands of the problem putting all of the costs onto the Medicare beneficiaries.

Secretary Sebelius, at yesterday's hearing before the House Budget Committee, there was a major topic of conversation about the ability of Medicare patients to see their doctors when they need to, and that is an important issue for all of us to monitor. But the premise of many Republican questions seems to be that Medicare patients are unable to see their doctors today. This is similar to their bizarre claim that it is better to be uninsured than to have Medicaid. Are you aware of any information on whether Medicare patients are more or less able than private patients to see doctors of their choice?

Ms. SEBELIUS. No, sir. In fact, about 98 percent of the physicians in this country are enrolled in Medicare. I know that there are pockets in communities where doctors are just overbooked, but that would apply to private pay and Medicare patients.

Mr. WAXMAN. Surveys from the Medicare Payment Advisory Commission and numerous other independent surveys all confirm Medicare patients have access to care, at least as good as the access private insurance patients enjoy, if not better. That is for primary care and for specialists. Now, certainly, we need to address the SGR if we are really going to guarantee access in Medicare for the future, but that problem exists whether we repeal IPAB or not.

There is another problem with the Republican claims about access problems under the Affordable Care Act Medicare Savings. Republicans adopted all of those savings provisions in their own plan. Until they end the program in 2022, the Affordable Care Act is the

Republican plan for Medicare excluding IPAB. Do you know, Madam Secretary, how much of the act's Medicare savings was from the IPAB? Well, I will tell you because you may not know. It was 4 percent.

Ms. SEBELIUS. Yes.

Mr. WAXMAN. Four percent. So the Republicans embraced 96 percent of the act's cost savings in Medicare. They pile on trillions in cuts over the next several decades when they end the Medicare program, and they suggested Affordable Care Act will cause access problems but that their voucher plan won't. It doesn't add up and it doesn't make sense.

I want to ask you one last thing about—well, tell you what, I would go over my time and I would like to give other members their opportunity to ask questions. Thank you for being here. Thanks for responding to the questions.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Georgia, Dr. Gingrey, for 5 minutes for questions.

Mr. GINGREY. Mr. Chairman, thank you. Madam Secretary, thank you for appearing.

You know, we are here to talk about IPAB, Independent Payment Advisory Board, not today at least to express our outrage over Obamacare in general, but it seems like the discussion has expanded a bit, maybe on both sides of the aisle. I must say I am a little bit surprised of the questioning in regard to the difference in a voucher and premium support. You seemed to struggle just a tad over that. A voucher, as I understand it, is sending someone a check on a monthly basis to spend on healthcare at their own volition. They could basically, I guess, sign up for holistic medicine. They could have an acifidity bag around their neck.

They could essentially do anything they wanted to with that voucher whereas premium support in the plan for prosperity, the Republican plan to reform and save Medicare for our current seniors and our future generations is talking about premium support where the Center for Medicare and Medicaid Services basically where the senior designates, they want to purchase their health insurance, a plan that best fits their needs, that premium is advanced to an insurance company as payment for those services. It doesn't go directly to the patient. So that is a big difference in a voucher versus premium support. And I think we should describe it accurately.

IPAB, in its report to Congress, is charged under Obamacare with including "recommendations that target reductions in Medicare program spending to sources of excess cost growth." Madam Secretary, can you tell us where in Obamacare the term "excess cost growth" is defined?

Ms. SEBELIUS. Sir, I don't know if there is a statutory definition. I do want to respond briefly to your premium support issue because——

Mr. GINGREY. We are beyond that and my time is limited and I am just going to help you on this second question. It is not defined. "Excessive cost growth" in Obamacare is not defined. Peter Orszag, in fact, President Obama's former OMB director has defined the "excessive cost growth" in Medicare as principally the result of new medical technologies and services and their widespread use by the

U.S. heath system. That is what Peter Orszag thinks in regard to excessive cost.

Let me ask you this question. The head of CMS, Dr. Donald Berwick, interim head of CMS and it is likely that he will remain interim, has been quoted as saying "most people who have serious pain do not need advanced methods. They just need the morphine and counseling that have been available for centuries." Madam Secretary, do you believe that limiting advanced methods to sick seniors in favor of morphine and counseling is an appropriate way to reduce Medicare costs? Yes or no?

Ms. SEBELIUS. Congressman, I believe that seniors have a right to make choices with their doctors, which is what they do now under the Guaranteed Benefit program under the Medicare system. Under an insurance plan, that would no longer exist and I would also suggest that premium support typically means that there is an enhanced benefit and as a result——

Mr. GINGREY. Well, Madam Secretary, I agree with the first part of your response. It should be between the doctor and the patient and you don't get that with IPAB.

Madam Secretary, I am aware that the statute states that IPAB cannot propose plans that ration care. Can you tell me where the word rationing is defined in the Obamacare statute?

Ms. SEBELIUS. It is not defined, sir.

Mr. GINGREY. Well, you are absolutely correct on that. It is not defined.

During questioning before the House Budget Committee yesterday, you referred to IPAB as merely a safeguard and a stopgap noting that it will only come into play if Congress failed to reduce Medicare spending, in fact, wouldn't be recommending any cuts until the 10 years. Yet on Wednesday, April 13, President Obama in laying out his plan to reduce healthcare spending to the American people stated that IPAB was a major plank in his plan to make additional savings in Medicare. Madam Secretary, if President Obama had stated publicly that IPAB is a major plank of his plan to save Medicare and you are saying that IPAB, it is just a backstop to Congress coming up with a plan, should the American people infer from that that Obamacare is the President's grand plan to save Medicare? Give me a yes or no or if you want to expand a little bit and the chairman will allow, I would like to hear your opinion on that.

Ms. SEBELIUS. I don't think there is any disagreement between the President and my statement. The way that the Independent Payment Advisory Board is structured is that recommendations are made on a yearly basis and recommendations are only impactful if, indeed, Congress has not taken the advice of the independent actuary that per capita spending has exceeded a targeted goal. If, indeed, the IPAB recommendations are not ones that Congress chooses to accept, they change the recommendations or move in a different direction and the recommendations never have any impact if, indeed, cost trends are below the independent actuary's targeted goal.

It is a backstop. It is a backstop for Congress taking the responsibility to keep Medicare solvent into the future. If, indeed, they

don't act, there is a mechanism where these recommendations become law absent Congress rejecting the recommendation.

Mr. GINGREY. Well, I have gone way over my time and I will just close out by saying I agree with Mr. Pallone and Ms. Schwartz that we ought to repeal IPAB. It is wrongheaded. It is boneheaded. And I yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentlelady from California, Mrs. Capps, for 5 minutes.

Mrs. CAPPS. Thank you, Mr. Chairman. And thank you, Madam Secretary, for being here today.

You know, I have been listening to this discussion. I have met with advocates in the past few months on both sides of the IPAB issue. The one thing they share is a concern for the unknown. One common concern is that due to protections for hospitals and other groups from IPAB changes before 2020, the only thing left would be to cut provider rates. Others note that this is not true. We have heard the same kind of discussion today. Can you please address this issue? What could IPAB recommend other than provider payment cuts?

Ms. SEBELIUS. Well, I can give you a few quick examples of things that are on the table as we speak. For years there was a recommendation out of MedPAC, who can only, you know, make recommendations that we look at the overpayment to Medicare Advantage plans. That was never accepted by the United States Congress and yet when the Affordable Care Act was put together, Congress decided that that was an appropriate area to look at.

Medicare Advantage, the private market strategy for Medicare which was supposed to introduce competition and choice and drive down costs, now runs at about 113 percent of the fee-for-service plan with no health benefits. So Congress implemented the changes recommended by MedPAC for years, and over the course of the next 10 years, the Congressional Budget Office says about $140 billion will be saved. That is an example of the kind of strategy that has been on the table. If it had been implemented years ago, $140 billion less would have been paid out over the last decade.

But an overpayment, no health benefits, seniors will still have choices. We have a very robust program. We have begun to decrease the overpayment to Medicare Advantage plans. But I think that is a strategy that is in the Affordable Care Act. It is exactly the kind of strategy that I think is anticipated by this independent board.

Mrs. CAPPS. Thank you. Conversely, the Republican majority has voted unanimously to essentially end the current Medicare program. The not hypothetical but known result would be a doubling in out-of-pocket costs for beneficiaries who would get a limited-amount voucher to cover a fraction of the cost of private insurance. It would leave our seniors and persons with disabilities on their own to haggle with insurance companies without any guarantee that there would be any policies available to them, let alone that they would be affordable.

Madam Secretary, some talk about the Republican plan as a way to cut cost, but all I see is a huge cost shift placing the financial burden on seniors with limited incomes without any meaningful re-

forms in the plan to actually address the overall costs of healthcare. As you have analyzed the Ryan budget plan, are there any cost-containment strategies in it to privatize Medicare? Does that privatizing include any cost containment that you notice?

Ms. SEBELIUS. Congresswoman, we have not been able to identify cost-containment strategies. And as I say, the case in point, Medicare Advantage, which has been in existence for years which was specifically put on the table to introduce cost and competition, was anticipated to drive down costs has done just the opposite. It is running at about 113 percent and every Medicare beneficiary, all 49 million beneficiaries pay an extra $3.66 per member per month to pay for the additional supports for Medicare Advantage program that will, again, be gradually over time decreased. And I think thanks to the Affordable Care Act, that excess payment will cease to exist.

Mrs. CAPPS. I think all of us in Congress understand the need to reign in healthcare spending. In fact, that is what so many innovations in the Affordable Care Act are set up to do, just that. I just have a few seconds. You have a few seconds. If you could talk about some of those aspects of the law. You mentioned Medicare Advantage. What are some of the other parts of the Affordable Care Act, particularly as it relates to Medicare, that are opportunities for cost containment?

Ms. SEBELIUS. Well, I think, Congresswoman, certainly through the Innovation Center, we are already seeing some very exciting delivery system reform, which is really the underlying healthcare delivery system. So the Partnership for Patients goals, which I think are very on point, and not only impact Medicare but impact everyone that goes in and out of the hospital, reducing hospital-acquired infections, which kill 100,000 people in America every year, cause hundreds of thousands of people to stay in the hospital longer and put them in worse physical condition, but cost billions of dollars, and reduce unnecessary readmissions where one out of five Medicare patients cycles back to the hospital within 30 days. Many of them have never seen a healthcare provider.

Those two initiatives, which already 2,000 hospitals and countless other partners have signed up to participate in will reduce Medicare spending by $50 billion. Better healthcare, lower cost.

Mrs. CAPPS. Thank you very much. I yield back.

Mr. PITTS. The chair thanks the gentlelady, recognizes the gentleman from Ohio, Mr. Latta, for 5 minutes for questions.

Mr. LATTA. Well, thank you very much, Mr. Chairman. And Secretary, thank you very much for being with us today. If I can just go back on the line of questioning that Dr. Burgess had. Is there anything in the law that says how many members have to be appointed before the board starts functioning?

Ms. SEBELIUS. Not to my knowledge, sir, but I can——

Mr. LATTA. Well, the reason I ask that with 15 members could 3 members actually be appointed and start functioning as a board? Because just looking at what the law says here——

Ms. SEBELIUS. I am sorry. I am really having a very hard time hearing you.

Mr. LATTA. I can probably talk louder than this microphone is picking this up.

Ms. SEBELIUS. I can put my ear to the microphone but that really doesn't help.

Mr. LATTA. That might help. This is the Energy and—you know, this is the technology here, too.

Ms. SEBELIUS. Sorry.

Mr. LATTA. But it says under the act, it says, "Quorum: a majority of the appointed members of the board shall constitute a quorum for the transaction of business, but a lesser number of members may hold hearings." But again, I guess the question is if you have got only three members appointed, can they start functioning as the board? And then actually you could have fewer members of that three actually start holding hearings. Is that possible?

Ms. SEBELIUS. Well, I certainly think fewer than a quorum could start holding hearings and I would think that that outreach function is critically important for any board who is going to make recommendations. I would be happy to get you the answer in writing.

Mr. LATTA. I appreciate that.

Ms. SEBELIUS. I don't want to speak outside of the——

Mr. LATTA. Yes, I would appreciate that if you could.

And if I can just go to your testimony on page 12, you said that the "IPAB cannot make recommendations that ration care, raise beneficiary premiums or cost-sharing, reduce benefits, or change eligibility for Medicare. The IPAB cannot eliminate benefits or decide what care Medicare beneficiaries can receive. Given a long list of additional considerations the statute imposes on the board, we expect the board will focus on ways to find efficiencies in the payment systems and align provider incentives to drive down those costs without affecting our seniors' access to care and treatment." OK. So what we are saying is, then, they are going to have pretty much the power of the purse. Would you say that would be the recommendations that they would have in this case and that they would have that power of the purse to say if they are not making the recommendations as to what care that a person would be receiving but they are going to be able to say how much money is going to be expended? Would that be a correct statement?

Ms. SEBELIUS. I think, Congressman, again, they are recommendations that come to Congress. They are triggered at a point where the independent actuary sets a per capita spending target. Actions have not reached that spending target so they will make recommendations about appropriate ways to reach that within the bounds of the law.

Mr. LATTA. OK. So going along those same lines, though, again, if someone has the recommendations of the power of the purse and they are saying well, we are going to have to reduce that—you already mentioned a little earlier in some other questions—how are we going to make up for those doctors and hospitals if their payments are going down? Wouldn't they, then, have to cut back on the patients they see and the care that they provide?

Ms. SEBELIUS. Well, again, I think, Congressman, I tried to give with Congresswoman Capps an example of the kind of strategy that can yield enormous cost savings without jeopardizing care or jeopardizing the kind of relationship between doctors and their patients. And that is really what is envisioned. I think a fundamental tenet of the current Medicare commitment to seniors and those

with disabilities is the ability to choose one's own doctor, the ability to choose one's own care system, and the knowledge that you have benefits that are available to you. That ceases to exist under the plan supported by the House Republicans, and I think that IPAB serves as an ongoing yearly group of experts who are not being paid by the system to make recommendations to Congress who can act on those recommendations or not.

Mr. LATTA. Because, again, I represent a rather large area in the State of Ohio, a lot of rural areas that have a lot of community hospitals. You know, they are all very, very concerned about reimbursement. I have got a lot of my doctors that are very concerned about reimbursement and so, you know, as we are looking at this, they are reading this, too, and, you know, as they read the testimony about, you know, driving down costs and trying to, you know, for payment systems align provider incentives, they are nervous about their other payment.

And Mr. Chairman, I see that my time has expired and I yield back. Thank you.

Mr. PITTS. The chair thanks the gentleman and yields 5 minutes to the ranking member emeritus, the gentleman from Michigan, Mr. Dingell.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy. Welcome back to the committee, Madam Secretary.

Ms. SEBELIUS. Thank you, sir.

Mr. DINGELL. Your father served here with distinction. It is particular pleasure to see you here this morning.

Madam Secretary, do you believe that the emphasis on annual recommendations will limit the board's focus to short-term fixes rather than lowering our Nation's healthcare spending in long term? Yes or no?

Ms. SEBELIUS. No.

Mr. DINGELL. Madam Secretary, under the Republican plan, nothing will prevent private insurance companies from rationing care. Is that right?

Ms. SEBELIUS. I am sorry. Nothing——

Mr. DINGELL. Under the Republican plan, nothing would prevent private insurance companies from rationing care, yes or no?

Ms. SEBELIUS. That is correct. There is no prohibition.

Mr. DINGELL. All right. Now, IPAB is legally prohibited in the legislation from making recommendations that would ration healthcare, is that right?

Ms. SEBELIUS. Yes, sir. There is a prohibition for rationing care, shifting costs to beneficiaries, eliminating benefits.

Mr. DINGELL. Now, Madam Secretary, who is in charge? Under the Republican plan, the insurance companies, is that right?

Ms. SEBELIUS. If I understand it correctly, yes, the voucher would be paid to an insurance company.

Mr. DINGELL. All right. The Republican plan also ends Medicare as we know it and repeals the Affordable Care Act giving free reign to the insurance companies to decide what care you could get and when with no clear limits to protect consumers or prevent insurance companies from taking in exorbitant profits, is that right?

Ms. SEBELIUS. Well, the various features, including the medical loss ratio and consumer protections and rate review would all be

eliminated with the Affordable Care Act and companies would then be in charge of seniors——

Mr. DINGELL. And under the Affordable Care Act the individual and that individual's doctor would be in control of matters and the President's plan maintains Medicare as we know it. Is that right?

Ms. SEBELIUS. Well, it is a—yes, a plan that maintains the Medicare benefit package understanding we need to look serious at outgoing costs.

Mr. DINGELL. And the plan remains a defined benefit plan. Is that right?

Ms. SEBELIUS. That is correct.

Mr. DINGELL. Which, under the Republican plan, it is not? It is a defined payment plan, is that right?

Ms. SEBELIUS. Yes, sir.

Mr. DINGELL. All right. Now, the Republican plan would eliminate Medicare's guaranteed benefits and limits on cost-sharings and premiums, is that right, yes or no?

Ms. SEBELIUS. Yes.

Mr. DINGELL. Instead, insurance companies could determine which benefits seniors on Medicare would receive and how much they would pay, is that right?

Ms. SEBELIUS. I assume so, sir. I don't think there is any written language about what the benefits would look like.

Mr. DINGELL. OK. IPAB is, under the President's plan, the President—or rather IPAB is legally prohibited from cutting premiums or increasing premiums and copayments. Is that right?

Ms. SEBELIUS. Yes. There cannot be cost-shifting onto beneficiaries.

Mr. DINGELL. Now, under the Republican plan, healthcare costs would rise which turns Medicare over to private insurance that have higher administrative costs and profits, is that right?

Ms. SEBELIUS. Yes, sir. Currently, the Medicare program runs at under 2 percent administrative costs and I think the most efficient private insurers are at about 12 to 15 percent.

Mr. DINGELL. Now, IPAB will make decisions based on what is best for seniors and Medicare and not who spends the most money in Washington, is that right?

Ms. SEBELIUS. By law they are directed to protect the beneficiaries as they make recommendations.

Mr. DINGELL. All right. Now, Madam Secretary, how will you and the board insure that consumers' and patients' views will be taken into consideration as the board drafts its recommendations?

Ms. SEBELIUS. Well, Congressman, I think that there is no question that the President will look for members of this board who are eager to not only participate in the long-term solvency of Medicare but also pay close attention to the protection of the beneficiary, which is part of the fundamental direction——

Mr. DINGELL. We also hold public hearings on these matters, right?

Ms. SEBELIUS. Public hearings, I think the appointment of people who don't have a conflict——

Mr. DINGELL. Well, Madam Secretary, is it your belief that the board would benefit from soliciting public comment prior to issuing its recommendations——

Ms. SEBELIUS. Absolutely.

Mr. DINGELL [continuing]. In a manner similar to that specified in the Administrative Procedures Act?

Ms. SEBELIUS. Yes, sir.

Mr. DINGELL. I guess we could say that is a commitment on the part of the department, is that right?

Ms. SEBELIUS. Yes, very much so.

Mr. DINGELL. Madam Secretary, it is always a privilege to see you.

Thank you, Mr. Chairman, for your courtesy.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Louisiana, Dr. Cassidy, for 5 minutes.

Mr. CASSIDY. Thank you for being here, Secretary Sebelius. And if every now and then I cut you off, I am not being rude, but it is so valuable to have you here I am just trying to stay focused and I apologize at the outset.

I will also say to my Democratic colleagues, Republicans do retain the savings, yes, 96 percent of them but we put them back into Medicare as opposed to spending them on another entitlement, and I think that is the difference between the two of us.

Secretary, I am a doctor who works in a hospital for the uninsured but 20 to 50 percent of my patients have Medicaid. So I think it is fair to stipulate that when public insurance programs pay physicians below cost, then they really don't have access. It may be access on paper but it is not access in power. Now, that said, Richard Foster currently estimates that under current law in 9 years, Medicare will pay physicians below what they receive on average from Medicaid. Now, is it fair to accept with the given stipulation that that will hurt access of Medicare patients to their physician?

Ms. SEBELIUS. Well, I don't think there is any question, Congressman, that underpayment of any kind of provider certainly jeopardizes an adequate network, whether it is a private insurer or a public payer.

Mr. CASSIDY. Now, if MedPAC already knowing that under current law—under current law physician reimbursement is cut by 21 percent in the near future, I am sure you will agree that that would have disastrous effects upon a patient's access.

Ms. SEBELIUS. You mean failing to fix the SGR.

Mr. CASSIDY. And of course part of the savings of SGR is into the trillion dollars of savings that the other side of the aisle claims for Obamacare. So I will tell you as a patient that sees Medicaid patients at a hospital for the uninsured, when I read that this board has the limited ability to cut but where they can cut is reimbursement to providers, I actually see that what we are really doing is effectively denying access. Now, I will also say that I have learned that rarely do government institutions admit that they are rationing. Rather, the queue gets longer. Would you disagree with that or do you think I am wrong?

Ms. SEBELIUS. Well, Congressman, I think that there is no question that, again, I think the Republican budget plan on Medicaid——

Mr. CASSIDY. Well, I am speaking about current law. I am really——

Ms. SEBELIUS [continuing]. Since you raised Medicaid in hospitals——

Mr. CASSIDY [continuing]. I see that you are pivoting here——

Ms. SEBELIUS [continuing]. Cutting $770 billion——

Mr. CASSIDY [continuing]. Again, when we speak of a board which has limited ability to save money except by cutting payments to providers——

Ms. SEBELIUS. Well, that is not accurate, sir.

Mr. CASSIDY. OK. So it can also do Medicare Part A and it can also do pharmacy coverage for dual eligibles. But clearly, a significant portion of it is cutting payments to providers. Now, again, under current law Medicare will be paying providers less than Medicaid per Richard Foster as well documented Medicaid patients have trouble gaining access. So where do we part in our analysis?

Ms. SEBELIUS. Well, again, I think that there are lots of opportunities in the delivery system where we are paying or overpaying for care that probably should never have been——

Mr. CASSIDY. So if I may summarize, you are saying that there will be savings that will keep this mechanism from being—I gather—keep this mechanism, this IPAB, this denial-of-care board from having to act. I will say parenthetically that the New England Journal of Medicine article which I am sure you are aware of shows that Accountable Care Organizations have not saved money under the more favorable rules in which the pilot studies have been done.

But going back to my point——

Ms. SEBELIUS. Some of them did, some didn't.

Mr. CASSIDY. Three out of ten did, seven didn't. So coming back to the current law——

Ms. SEBELIUS. So we learn from them and go on.

Mr. CASSIDY. Coming back to current law because we really can't say oh, don't worry. If this works out, this would never happen. Let us just assume that it does happen. Again, if we decrease payment to providers and we know from experience that that will decrease access, does that not trouble you?

Ms. SEBELIUS. It does, which is why I think Congress carefully wrote also into the parameters for the Independent Payment Advisory Board that at every step along the way, provider access had to be part of their overall recommendations.

Mr. CASSIDY. It has to be part of the overall——

Ms. SEBELIUS. They make recommendations to Congress.

Mr. CASSIDY. Clearly, Medicaid by law has to provide access for pregnant women and pediatrics. By law they are supposed to pay adequately to give that access. And yet there is a recent New England Journal of Medicine study that shows that those with Medicaid or CHIP actually are more likely to be denied access to an appointment. In fact, 2/3 of the time they are denied such access. Doesn't that give us pause that despite that law that they are guaranteed access, for the privately insured it is only 11 percent that you can't get an appointment? For the publicly insured it is 2/3. I mean do you not see a danger that this would be the case with this IPAB board?

Ms. SEBELIUS. Well, again, IPAB has no authority to cut anything. They make recommendations and——

Mr. CASSIDY. And 4/5 of Congress will return.

Ms. SEBELIUS [continuing]. Secondly, as you know, sir, that governors of various States set provider rates in their Medicaid programs. They are vastly different in Louisiana than they are in——

Mr. CASSIDY. This is on average and I think New York Times has well documented that in States as desperate as Louisiana and Michigan that is the case. It is disingenuous to think otherwise.

But that is OK. I am out of time and I yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes for questions.

Ms. SCHAKOWSKY. I think this discussion is just really ironic, this attack on IPAB given the fact that the Republican plan would instead turn over the Medicare program to private insurance who would have no constraints whatsoever in raising their rates and doubling of out-of-pocket costs for beneficiaries. And this semantic debate whether it is vouchers or premium supports, the only difference is where the check is sent to, where the inadequate check is sent to. And if we want to have a semantic debate, we ought to change the—because what they are proposing is not Medicare. We could call it Sortacare or Maybecare or Idon't care. But it is not Medicare anymore according to what my understanding of Medicare, which, as you pointed out, Madam Secretary, is a guaranteed benefit plan. That is the essence of Medicare.

The other thing is I don't know for sure if you know the answer to this, but my understanding is that the Republican budget includes all of the Medicare savings provisions that you so wisely helped to navigate and talked about from the Affordable Care Act with the exception of IPAB. Isn't that true?

Ms. SEBELIUS. That is my understanding.

Ms. SCHAKOWSKY. And those include those kinds of changes that have been made that they accuse the Democrats of, you know, cutting Medicare and, you know, these are reasonable savings. Is it also true that there was a May 26, 2011, letter to Representative Waxman from the CBO projecting the Medicare will not exceed the specified targets during the 2012 to 2021 period, and therefore, that IPAB will not be triggered during that period? I know you said that. I would like for you to restate that expectation.

Ms. SEBELIUS. Well, I think thanks to the impact already of some of the strategies in the Affordable Care Act and some really unprecedented new tools not only in fraud and abuse but in delivery system ability to align payments with high-quality, lower-cost care, we are already seeing a cost trend that is diminishing. And the actuary has projected that at no time—there is a slight possibility that in 2018 there would be a brief recommendation period, but he basically says that for that 10-year period, it is very unlikely that IPAB ever have—they will be meeting and making recommendations but in terms of having to meet a spending target will not occur.

Ms. SCHAKOWSKY. Once again, I frankly was really a bit surprised and happy to see that there is this new study that says that 93 percent of physicians are taking new Medicare patients but only 88 percent of physicians are taking new private patient plans, new private plans. The issue of access I think, you know, is on every-

one's mind, and clearly we do not want to see doctors refusing to take Medicare patients. So let me ask you to—again, I think it is once again, but address this issue of access to care with IPAB.

Ms. SEBELIUS. Well, again, I think that the goal is to make sure that Medicare is solvent not only for the next number of years—and as you know, the Affordable Care Act has already extended the solvency projections—but on into the future. And so the strategies really are aimed at trying to make sure that we not only have patients' ability to choose his or her own doctor, a fundamental tenet of the current Medicare plan, very different than if you are in a private insurance plan where that physician, that hospital system, that pharmacy, that set of benefits is pre-chosen for you. So access to your own doctor, having, you know, patient-driven strategies and making sure that as recommendations are made about any kind of cost reduction on into the future that we pay close attention to patient access to providers. That is part of the framework of the Independent Payment Advisory Board, and it is one that I think the board would follow very seriously. Certainly, we would at the Department of Health and Human Services pay very careful attention to anything that jeopardized care delivery and certainly having access to a physician jeopardizes care delivery.

Ms. SCHAKOWSKY. Thank you. And let me just say that I want to thank you so much for your leadership in making sure that we can finally reach a time when all Americans have access to quality healthcare. Thank you.

Mr. PITTS. The chair thanks the gentlelady and recognizes the gentleman from New Jersey, Mr. Lance for 5 minutes.

Mr. LANCE. Thank you very much, Mr. Chairman. And good morning to you, Madam Secretary.

Ms. SEBELIUS. Good morning.

Mr. LANCE. I am interested in the process regarding the IPAB because in my judgment oftentimes process relates fundamentally to policy. And you have indicated, Madam Secretary, that the President has not yet chosen to appoint any members of IPAB. Might you give the committee a time frame when in your opinion the President might begin to appoint members to the board?

Ms. SEBELIUS. Sir, I don't know about a specific timetable. I know it is absolutely the President's intention that by the time the IPAB provision would begin to operate there will be members of the board. As you know, the independent actuary doesn't make a target recommendation until 2013——

Mr. LANCE. 2013.

Ms. SEBELIUS [continuing]. Comes to Congress in 2014.

Mr. LANCE. But it is your best judgment that President Obama intends to make appointments in his term of office, the term of office ending in the end of 2012.

Ms. SEBELIUS. I think President Obama intends to make appointments so that the IPAB can be operational at the time that it is operational.

Mr. LANCE. Thank you. The law suggests that he makes several of the appointments in consultation with the leaders, Speaker Boehner, Leader Pelosi, Leader Reid, and Leader McConnell. Is that accurate?

Ms. SEBELIUS. Yes, sir.

Mr. LANCE. And is he required to appoint those whom the leaders have suggested or is it merely consultative?

Ms. SEBELIUS. It is consultative.

Mr. LANCE. So, for example, he would not be required to follow through on the suggestions of any of the four leaders?

Ms. SEBELIUS. That is correct, although the Senate has a confirmation ability and I would feel that their consultation might be fundamental in getting folks confirmed.

Mr. LANCE. Perhaps that is so. That is obviously for the other House of Congress. Now, regarding how we in the legislative branch can discontinue the automatic implementation process for recommendations of IPAB—and this is down the road, for example, in 2017—as I understand it, a joint resolution discontinuing the process must meet several conditions, including the fact that it would require approval by a super majority of 3/5 of the Members of the Senate. Is that accurate?

Ms. SEBELIUS. No, sir. The recommendations to be changed by Congress operate in the normal rules of the congressional structure. Now, the Senate seems to do everything by a vote of 60, but there is certainly no requirement that IPAB be rejected and substitute recommendations be made by a super majority. I think it is only to repeal IPAB itself, to get rid of the board. It is my understanding that that is a super majority written into the law, but not to accept or reject the recommendations.

Mr. LANCE. So to follow through on your expertise and you are obviously expert on this. To get rid of IPAB, the underlying PPACA law requires a super majority in the Senate?

Ms. SEBELIUS. Well, in the repeal of the Affordable Care Act——

Mr. LANCE. Yes.

Ms. SEBELIUS [continuing]. The House has taken action to repeal the Independent Payment Advisory Board——

Mr. LANCE. Yes.

Ms. SEBELIUS [continuing]. And again, I apologize. I don't want to misspeak. It is my understanding that if that were done independently, that that would require some kind of super majority. Just in 2017. I am sorry.

Mr. LANCE. Yes, in 2017.

Ms. SEBELIUS. Just that 1 year——

Mr. LANCE. Yes.

Ms. SEBELIUS [continuing]. It would require super majority.

Mr. LANCE. Well, in my judgment that is unconstitutional and I am wondering whether the lawyers at your department opined on whether that provision is constitution or unconstitutional, recognizing that we all rely on the advice of those who serve us in legal capacities?

Ms. SEBELIUS. I have been advised, Congressman, that our lawyers feel that the structure and the operation as described by law of IPAB is constitutional. I would be happy to go back and get a very specific answer for that question.

Mr. LANCE. Thank you. My time is up. It is my judgment that that provision at the very least is unconstitutional and not in accordance with the current provisions of the American Constitution.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Texas, Mr. Gonzalez, for 5 minutes for questions.

Mr. GONZALEZ. Thank you very much, Mr. Chairman. Welcome, Madam Secretary.

This is a quote and since this is a discussion now about the benefits and such of competing plans, the Affordable Care Act has already been repealed in the House of Representatives. This is the quote. "First, I fear that as health inflation rises, the cost of private plans will outgrow the government premium support. The elderly will be forced to pay even higher deductibles and co-pays. Protecting those who have been counting on the current system their entire lives should be the key principle of reform." Would you agree with that statement?

Ms. SEBELIUS. From what I could hear of it, I do agree.

Mr. GONZALEZ. Well, you just agreed with a Republican Senator Scott Brown. I just thought I would throw out a Republican out there that agrees with the position that we have been taking as to the competing plans. And so to give some things some context as I lead to my second question would be that 1/2 of Medicare beneficiaries have incomes of less than $21,000, 1/2 have less than $2,095 in retirement assets, 1/2 have less than 30,000 in financial assets, 1 in every 4 Medicare Part D beneficiaries reaches the donut hole. So we have had the Affordable Care Act, and something that I believe has gone unnoticed—and you may have covered it in your statement and I apologize, I got here late—what went into effect this year that will result and has already resulted I believe in about $260 million in savings to Part D beneficiaries when it comes to name-brand pharmaceuticals and generics?

Ms. SEBELIUS. A 50 percent discount did begin in 2010 for those 4 million approximately beneficiaries who will see a 50 percent decrease in the brand-name drugs that they purchase once they hit the donut hole gap.

Mr. GONZALEZ. That is already in place?

Ms. SEBELIUS. It is.

Mr. GONZALEZ. Can you contrast what we presently have in the way of Medicare Part D and within the Affordable Care Act but what we have had in place as opposed to what is being proposed by the Republicans and of course what we refer to as the Ryan budget, the Ryan plan, RyanCare, whatever you want to call it? Is there a significant difference in the very nature of the benefit that is being provided?

Ms. SEBELIUS. Well, I certainly think that the repeal of the Affordable Care Act would eliminate the donut hole closing, the gap coverage that now anticipates being closed. But beyond that, it is my understanding, Congressman, that there would be a significant change in the poorest seniors who now qualify for both Medicare and Medicaid benefits. With the Republican budget as it deals with Medicaid, as you know right now, there is help and support for another approximately 4 million seniors who actually are income-eligible. They don't ever hit the so-called donut hole and pay out-of-pocket costs because their costs are supported by the Federal Government.

And there would be a major shift in the kinds of support for the poorest seniors. It would shift from, again, price supports for every-

thing from nursing home care to prescription drug care and shift to a fixed income, a fixed amount of money in a medical savings account that those seniors could try to use to navigate what are often very substantial healthcare costs. So I think in terms of the drug plan, there are about 4 million seniors right now who are actually supported with wraparound care. And that would cease to exist also.

Mr. GONZALEZ. The way it has been explained to me—and I am surely not the expert in the area—and I am just going to go ahead and read basically. "Part D is a defined benefit, so services are specified in law and covered by plans. The Republican plan would leave benefits up to the beneficiaries' negotiation with the insurers. Part D's federal contribution keeps pace with drug costs, so beneficiaries and the government split the growth in health cost, and the Republican budget beneficiaries would bear all of the burden." Is that an accurate description of the situation and the contrast between what we have, what the Democrats have been proposing and supporting, and then the latest proposal from the Republicans?

Ms. SEBELIUS. I think so, sir.

Mr. GONZALEZ. Thank you very much. I yield back.

Mr. PITTS. The chair thanks the gentleman. Before I yield to Mr. Guthrie, you mentioned there would be a judicial review for the implementation of IPAB recommendations. Before I yield to Mr. Guthrie, I would like the record to show on page 420 of the act, Section 3403(e)(5) states there should be "no administrative or judicial review under Sections 1869, Section 1978, or otherwise of the implementation by the Secretary." That means there is no judicial review of IPAB's recommendations.

Ms. SEBELIUS. Mr. Chairman, the question that was posited to me was a question that assumed that IPAB operated outside the scope of their authority, outside the scope of the law. In that case, our general counsel feels very strongly that there absolutely is a judicial review right. So in the implementation that falls within the scope of the law, that is the case that you——

Mr. PITTS. The chair thanks the gentlelady and recognizes Mr. Guthrie for 5 minutes.

Mr. GUTHRIE. Thanks, Madam Secretary, for coming. I appreciate you being here. The question first you seem well versed in the Republican budget. How many people that are 65 years old today and older are affected by that budget? How many people will be affected that are elderly on Medicare today?

Ms. SEBELIUS. Well, I think the Republican budget would dramatically affect the poorest seniors in its impact on——

Mr. GUTHRIE. What will Medicare——

Ms. SEBELIUS [continuing]. The dual eligible seniors who are over 65 today will immediately see a cut in their benefits and in their payments going forward.

Mr. GUTHRIE. People would see the Medicare they wouldn't be affected——

Ms. SEBELIUS. Well, those seniors are on Medicare today. The poorest seniors in this country would be immediately affected by the Republican budget.

Mr. GUTHRIE. But on that the President today is talking about raising taxes on people making 200,000, $250,000 or more and sup-

ports that. The administration supports that. If somebody is 54 years old today, when they are 65 if their income is $250,000 or more, why should they not pay more for their healthcare? We want them to pay more taxes or the administration does; why shouldn't they be more responsible for their healthcare? Why should they be treated the same as the dual eligibles? Why should they have the same payment as that?

Ms. SEBELIUS. Well, I think the President's concept of shared sacrifice is that people contribute a fair share.

Mr. GUTHRIE. But not in healthcare? Not in terms of their Medicare?

Ms. SEBELIUS. In terms of Medicaid, no one qualifies for Medicaid who is making $250,000 a year.

Mr. GUTHRIE. But if somebody is 65 years old they qualify for Medicare regardless of income. If somebody is 65 years old——

Ms. SEBELIUS. Everyone who reaches the age of 65 in America qualifies for Medicare, correct.

Mr. GUTHRIE. So my question is why shouldn't somebody that is 54 today, 11 years from now when our budget would go into effect not be required to pay more for their healthcare if you talk about shared sacrifice?

Ms. SEBELIUS. Well, the current Medicare structure has income-related premiums in a variety of the programs. That is part of the program right now.

Mr. GUTHRIE. But right now currently there is a study out of the Urban Institute. I think you have seen it. It is about 1 to 3 what people pay into Medicare, what they take out. The average of the Urban Institute said I think it is $109,000 the average couple pays into Medicare and takes out or will expend $343,000 in healthcare costs over the course of their lifetime. And I don't think it should be 1 for 1, $1 you get in, $1 you get out. But given that the baby boomers are retiring, 1946 they turn 65 this year. I am 1964, the end of it. Just demographically, these kinds of costs just can't be withstood in this system. And the system as it is, if you are saying we are going to leave the system as it is and try to make it up in efficiencies or provider reimbursements, I don't see when we get to 2024, which is the point where it—how it becomes sustainable without reforming and changing the program, not just trying to make it on pure efficiencies. I don't see where you can make that kind of difference.

Ms. SEBELIUS. Well, I would agree that I think we certainly understand that Medicare as it is right now as a fee-for-service, pay-for-volume program is unsustainable and certainly unsustainable at the point as you suggest that we have a looming influx of baby boomers.

Mr. GUTHRIE. Um-hum.

Ms. SEBELIUS. I think there is a very dramatic difference of approaches between the Republican plan, which shifts those costs onto seniors. It doesn't really lower costs. It just says you will pay 61 percent of your own healthcare up to 70 percent. A direct opposition——

Mr. GUTHRIE. Well, I would argue that implementing the system would lower costs and kind of—the proof in the pudding that was Medicare Part D. It is one of the programs I think it is 40 percent

under estimates performing because of competition within health plans for people's business. So I would argue it does lower cost. But go ahead.

Ms. SEBELIUS. Well, I just wanted to say that is one vision of the system that you shift those costs to private insurers and somehow achieve something along the way.

Mr. GUTHRIE. The differences are so great. Matter of fact, in 30 years, the entire federal budget is going to be Medicare, Medicaid, and Social Security.

Ms. SEBELIUS. If nothing changes.

Mr. GUTHRIE. So the differences are so great and so just saying we are going to cut back our reimbursements or create efficiencies, I don't see where you make that difference. That is my question.

Ms. SEBELIUS. Well, I think that again——

Mr. GUTHRIE. Without completely reforming the system.

Ms. SEBELIUS. I think we do need a complete reform of the system, and I think the Republican budget chooses to do that with beneficiaries and just shift costs of who pays what——

Mr. GUTHRIE. Instead of shifting it to my 17-year-old——

Ms. SEBELIUS [continuing]. And the Affordable Care Act says——

Mr. GUTHRIE [continuing]. To pay it for the rest of their life.

Ms. SEBELIUS [continuing]. We need to look at the underlying healthcare costs not just for Medicare but if affects every private employer, it affects everybody who goes to the hospital, it affects every doctor, and the kinds of underlying healthcare shifts—and let me give you another example, Congressman, if I may. We have finally started down the road of competitive bidding, a market strategy, for durable medical equipment. It was started in 2003, pulled back in 2008, restarted this year in the test market where it is implemented. There is a 34 percent decrease in durable medical equipment without any jeopardizing of benefits.

Mr. GUTHRIE. I lost my time but with that level of savings required to make it work unsustainable can just come from efficiencies alone.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentlelady from Tennessee, Ms. Blackburn, for 5 minutes.

Mrs. BLACKBURN. Thank you, Madam Secretary, for your patience. And three of us are going to try to share the balance of your time and get our questions in.

I would remind my colleagues, one of my colleagues from Illinois was making comments about what Medicare would be called going forward. I would remind my colleagues it was Obamacare or PPACA, whatever we want to call it, that cut $575 billion out of Medicare. It was a conscious decision to make those cuts. I would also remind my colleagues that Medicare is a trust fund, and the Federal Government has had first right of refusal on the paychecks of the workers of this country. And so therefore, making that kind of cut I think is a breach of what has been promised to those enrollees.

Madam Secretary, I looked at some of your comments from the budget committee yesterday and I feel like we are kind of doing a session of kick the can. And you know as well as I do that as we have been with you time and again on these hearings, we have looked at access to affordable care and have tried to get some defi-

nitions from you, and IPAB is one of those that we are very concerned about how it is going to restrict or affect access to healthcare and what IPAB is going to end up doing. We know that supposedly some of the 15 experts coming to IPAB are supposed to be pharmaca, economics, health economists, insurers, and actuaries. We know that the President, he has an initiative to achieve savings. So if they are not there to achieve savings, what are they there for?

Ms. SEBELIUS. They are there, Congresswoman, to recommend to Congress ways that Medicare can be solvent on into the future.

Mrs. BLACKBURN. So you see it strictly as a solvency issue?

Ms. SEBELIUS. That is their direction, yes.

Mrs. BLACKBURN. That is their direction. OK.

Ms. SEBELIUS. They are only triggered when the independent actuary——

Mrs. BLACKBURN. Let me ask you another question, then, because we know the GAO is supposed to do a study by January 1, 2015, on access, affordability, and quality. This is of IPAB. And then Kaiser Foundation recently noted that, "IPAB would be required to continue to make annual recommendations to further constrain payments if the CMS actuary determine that Medicare spending exceeded targets, even if evidence of access or quality concerns surface." And I am quoting Kaiser Foundation. So how do you reconcile the statements made by the administration that IPAB will not impact access, affordability, and quality with the statements made by the Kaiser Family Foundation that IPAB is required to continue cutting even if evidence of quality-of-access problems arise?

Ms. SEBELIUS. Congresswoman, I am not familiar with that Kaiser quote, but as you know——

Mrs. BLACKBURN. Well, in the interest of time, then, if you are not familiar with it, would you——

Ms. SEBELIUS. I am not familiar with what Kaiser said. I am familiar with the law and I am familiar with the way it works and I am familiar with the fact that what they are directed to do is when the independent actuary, on a yearly basis—which he does year in and year out—recommends a target goal for spending, assuming that Congress ignores that, doesn't act, they are directed to recommend ways to meet that spending target to Congress. Again, if Congress does not act, chooses to ignore, chooses not to change it, then those cuts go into——

Mrs. BLACKBURN. OK. Well, let me reclaim my time so that I can yield to Mr. Shimkus, but I would also like to highlight that I am still waiting for a response from you on addressing waste, fraud, and abuse from the last hearing. And with that, I yield to Mr. Shimkus.

Mr. SHIMKUS. Thank you. Thank you, Madam Secretary. Welcome. And we are going to try to get you out of here. This is our last couple of questions. We are not going to match our greatest hits of the last time so I am not intent to do that.

But our 2024 time frame for the expansion of the solvency of Medicare, is that based upon the——

Ms. SEBELIUS. 2024——

Mr. SHIMKUS. The 2024 expansion of the Medicare Trust Fund is based upon the——

Ms. SEBELIUS. Expansion or——

Mr. SHIMKUS. The solvency.

Ms. SEBELIUS. The solvency, yes.

Mr. SHIMKUS. The solvency is based upon the $575 billion cut in Medicare, is that correct, for the most part?

Ms. SEBELIUS. It is based on projecting what the trends are right now on into——

Mr. SHIMKUS. And based upon the double counting that we talked about last time. And I would just ask your individual health insurance policy, do you have under the Federal Employees' Health Benefit plan?

Ms. SEBELIUS. I do.

Mr. SHIMKUS. And in the D.C. area there is probably around 42 difference choices for health insurance policies? I mean in St. Louis area is 21. I think D.C. is almost double that amount. It is operated by OPM. They negotiate it. We have a premium support plan that you are participant of and that I am a participant of.

Ms. SEBELIUS. And the Federal Government pays about 70 percent of the cost——

Mr. SHIMKUS. All that premium support is a——

Ms. SEBELIUS. And it rises——

Mr. SHIMKUS [continuing]. Negotiated contractual relationship with private insurance to provide insurance just like you receive and just like we receive. So it is the same plan so any——

Ms. SEBELIUS. Well, it is——

Mr. SHIMKUS. The voucher debate is not correct.

Ms. SEBELIUS. Well——

Mr. SHIMKUS. It is the same plan that you have. And I yield my time to Dr. Murphy.

Mr. MURPHY. Thank you. I am just trying to find out some answers here. And if you don't have the information, could you please get back to me.

What is an estimate of how much you think working on fraud issues will save Medicare overall, again, 1 or 5 or 10 years?

Two, is you are working on a number of issues about quality improvement. You did mention the issue about infections. There has been bills we have moved through this committee, a bill that I wrote to ask for transparency on infection reporting. I understand from speaking with the head of Center for Disease Management that it has been about 27,000 lives have been saved by having the transparency. And I appreciate everybody who worked on that. If you could get us some accurate numbers of how much money that will save, too, over time, I would appreciate that, too.

So yes, fraud, improvement of quality, and there is a number of issues there. Another option, too, to reduce Medicare costs is the ongoing issue we have of reducing payments, which is the SGR, et cetera, and also means testing has been kicked around, too. But I do want to ask this and tie in with some other issues. Medicare Part D, the actual part that is a donut hole—and, again, I don't expect you to know these numbers—but there is a percentage of seniors that never got to that level because they never needed that much prescriptions. Do you have information on what percentage

of seniors that was or how many that was who, you know, spending for prescription drugs never got there?

Ms. SEBELIUS. I know that about 8 million hit it. I don't know how many enrollees we have.

Mr. MURPHY. Um-hum.

Ms. SEBELIUS. I don't know how many are enrolled but I can get you that number.

Mr. MURPHY. Let me lay out because I don't want to play games and I am sure you don't like them either. I am just trying to find this out. In terms of the number of seniors who actually had a donut hole problem, some never purchased a plan but never hit that level. Some did purchase a donut hole coverage plan and helped them through that next level. And some did not have coverage and those are the ones we all share a concern about. So what I am trying to find out as we are looking at honest numbers on this is what was the difference in impact upon cost and quality of care? You are probably familiar with the study that came out that said about 50 to 75 percent of people who were prescribed medication do not take it correctly. Either they never fill the prescription, they don't take it, they mix it with other drugs, and that leads to returns to physicians' offices, re-hospitalizations, extended hospital visits, and emergency room visits.

In the context of this, as we really try and look at honest quality—and I get real tired of this Republican-Democrat battle. I just want to talk about patients here. The issue is if we get down to the concrete levels of this, what does it really save if we focus on how we can do such things as disease management and care management, because you know right now that is not paid for. And that is a big frustration for me that someone who may have a chronic illness such as diabetes or cancer or heart disease, if they are not helped through this and physicians aren't paid for this, so we don't pay a nurse to make the call and monitor this, it is a serious cost problem. And I hope that is something as we get through this you can help us with some real numbers. I don't know if the IPAB board is authorized to work on these things. I tend to not think so but correct me if I am wrong. I would deeply appreciate further discussions with you on this outside of this artificial setting here and to work further on this.

Ms. SEBELIUS. Well, I would very much appreciate that. We can get you some numbers. I am not sure—since Medigap plans are sold at the state level and some cover additional prescription drugs but a lot don't—how accurate I can—but we will get you the donut hole numbers as much as we can. And we would love to work with you on coordinated care strategies, particularly for the chronically ill. I think that is an enormous opportunity for better care delivery at significantly lower costs.

Mr. MURPHY. Thank you. And I might add my closing part here is that I know that a lot of private plans end up paying these out of pocket now where they will cover heart disease and diabetes, and I want to make sure we don't leave this hearing saying that everything the government does is bad and everything private insurance does is bad. I think there is a lot mistakes on both, but I would hope we would not get into that finger-pointing and blame game but instead say let us look at how we can use disease man-

agement. And I want to hear how this is going to be done better. Thank you. I yield back.

Ms. SEBELIUS. Thank you.

Mr. PITTS. The chair thanks the gentleman. Madam Secretary, we will submit questions for the record and ask that you please respond promptly to those. You have been very generous with your time. Thank you for your testimony. We will take a 5-minute break as we set up the third panel.

[Recess.]

Mr. PITTS. The subcommittee will come to order. I will ask our guests to please take their seats. The chairman has a unanimous consent request that the following documents be entered into the record: statement of Burke Balch, Director of the Robert Powell Center for Medical Ethics of the National Right to Life Committee; second, a letter from Sandra Schneider, President of American College of Emergency Physicians to Chairman Pitts and Ranking Member Pallone; thirdly, statement of Thair Phillips, President of RetireSafe; fourth, a letter from 283 healthcare organizations opposing the Independent Payment Advisory Board; fifth, statement of Karen Zinka, Health Educator for Men's Health Network; sixth, a statement of Richard Waldman, President of American College of Obstetricians and Gynecologists; seventh, a letter from Tim Laing, Chair of the Government Affairs Committee, American College of Rheumatology; eighth, statement of the American College of Radiology; ninth, a letter from Cecil Wilson, past president of the American Medical Association; tenth, testimony from Bob Blancato, National Association of Nutrition and Aging Services Programs. I think you have all copies of these. Without objection, so ordered.

[The information follows:]

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 Energy and Commerce, Subcommittee on Health,
U.S. House of Representatives
June 14, 2011

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."

American College of Emergency Physicians
ADVANCING EMERGENCY CARE

July 8, 2011

The Honorable Joe Pitts
Chairman
Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives
2125 RHOB
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives
2322A RHOB
Washington, DC 20510

Dear Chairman Pitts and Ranking Member Pallone:

On behalf of the American College of Emergency Physicians (ACEP), our 29,000 members and the nearly 124 million patients we treat every year, we appreciate the committee's efforts to bring greater attention to the potential consequences of the Independent Payment Advisory Board (IPAB) that was created in the 2010 Affordable Care Act. ACEP is a strong supporter of H.R. 452, the "Medicare Decisions Accountability Act," which would repeal the IPAB and we urge the Health Subcommittee to focus on the aspects of the IPAB that will negatively harm health care providers and subsequently impair Medicare patients' access to care during the upcoming hearing.

As constructed in the Affordable Care Act, the IPAB will have 15 full-time members, appointed by the president and confirmed by the Senate, who, once approved, will have no accountability to Congress, health care providers or the public. IPAB decisions on how to implement Medicare cuts would force Congress to adopt the recommendations or find comparable savings and, without congressional action, the cuts will automatically be implemented by Health and Human Services (HHS).

Since hospitals and nursing homes (Medicare Part A) are not subject to IPAB's cost-cutting recommendations until at least fiscal year 2020, ACEP warns that IPAB's mandate to reduce spending would be primarily focused on Medicare Part B services, which will potentially reduce physician payments even further and cause even more health care providers to question the value of participating in the Medicare program.

We also find it very disconcerting that only a minority of the commissioners can be health care providers, none of whom may be participating in the Medicare program. We question the fundamental wisdom and fairness of having individuals make significant policy decisions about a program that they neither have a stake in nor understand the ramifications of how their decisions will affect the physician-patient relationship and, ultimately, treatment decisions.

Furthermore, the distribution and balancing of power among the different branches of government is an important principle. It ensures that no one branch is able to dominate the others. Unfortunately, when Congress allowed the IPAB provision to become law, it was a serious abdication of their responsibility to provide oversight of the Executive Branch.

The very real potential for future Medicare physician reimbursement cuts (or freezes in payments that do not keep pace with the rising cost of providing care) due to inequities in the Sustainable Growth Rate (SGR) formula coupled with further health care provider cuts assigned by the IPAB, many Medicare beneficiaries could be turned away from their regular physicians.

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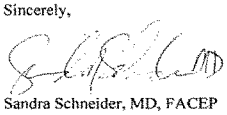
This disruption in the coordination of care could lead more patients to the Emergency Department.

This year marks the beginning of Medicare eligibility for 78 million baby boomers. America's Emergency Departments already treat nearly 124 million patients a year and nearly 20 percent of those visits are by Medicare beneficiaries. Making additional reductions to Medicare at this time would not be wise public policy and could devastate the coordination of patient care. We sincerely hope you thoughtfully consider the long-term consequences of how IPAB decisions will impact patient care.

We look forward to working with the Energy and Commerce Committee and the Health Subcommittee as it works towards sustainable Medicare reforms.

Sincerely,



Sandra Schneider, MD, FACEP
President

CC: House Energy and Commerce Health Subcommittee Members

RetireSafe

Standing Up For America's Seniors!

The Honorable Joseph R. "Joe" Pitts Chairman,
Energy and Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Chairman:

RetireSafe, an almost 400,000-supporter-strong nationwide advocate for older Americans, is pleased that the Energy and Commerce Subcommittee on Health is holding a hearing to discuss the Independent Payment Advisory Board (IPAB), and wishes to submit a statement for the record at that hearing.

The facts are well documented on the process used by the majority party to insert the IPAB, at the eleventh hour, without debate or review, into the Patient Protection and Affordable Care Act. It is also well documented on how this board circumvents the legislative process and the powers outlined in the Constitution by granting unprecedented powers to an unelected entity. We find this abdication to unelected bureaucrats reprehensible and consider the only true remedy to be repeal of this portion of the Affordable Care Act or Obamacare. Thus RetireSafe wholeheartedly supports HR 452 to accomplish that very thing.

We think it is also important that the Health Subcommittee consider the short-sighted nature of the IPAB and the impact it will have on both the quality and availability of care for older Americans. The methods available to the IPAB for cutting costs work against all the long-term solutions of competition, making the patient the customer, encouraging prevention and wellness, encouraging the discovery of new cures, and reducing the practice of defensive health care. It instead uses a meat axe approach to cost control which will serve only to reduce access and quality to solve near term cost problems. As drug, device, and provider costs are cut through IPAB edicts, the odds will be even more against the use of quality home health care, and the development of cures for Diabetes, Alzheimer's disease, and other age related illnesses. Both factors will fill hospitals and other institutions with seniors desperately in need of care. Medicare Part A will go broke even sooner, and Medicaid will face an avalanche of institutionalized seniors, all due to IPAB bureaucrats.

Medicare is a promise the government made to older Americans decades ago. As working citizens these same people paid month after month, year after year into a system on the belief that they would receive quality health care when they got older. Using a backroom created board of unelected bureaucrats to ration care is not what they were promised. There are ways to begin solving the fraud, abuse and inefficiencies in Medicare; the IPAB is not one of them.

Thair Phillips,
President

1616 H Street NW, Suite 902, Washington D.C. 20006
www.retiresafe.org

June 24, 2011

Dear Member of Congress:

The organizations listed below represent a breadth of entities including all sectors of the healthcare industry, employers of different sizes and geographic locations, as well as purchasers of care, consumers and patients. We all share the conviction that the Independent Payment Advisory Board (IPAB) will not only severely limit Medicare beneficiaries' access to care but also increase healthcare costs that are shifted onto the private sector. While we all recognize the need for more sustainable healthcare costs, we do not believe the IPAB is the way to, or will, accomplish this goal.

As you know, the Patient Protection and Affordable Care Act (PPACA [P.L. 111-148]) created the IPAB, a board appointed by the President and empowered to make recommendations to cut spending in Medicare if its spending growth reaches certain measures. The IPAB will have unprecedented power with little oversight, even though it has the power to literally change laws previously enacted by Congress. Further, the law specifically prohibits administrative or judicial review of the Secretary's implementation of a recommendation contained in an IPAB proposal.

We are deeply concerned about the impact the IPAB will have on patient access to quality healthcare. The bulk of any recommended spending reductions will almost certainly come in the form of payment cuts to Medicare providers. This will affect patient access to care and innovative therapies. In the past five years for which data is available, the number of physicians unable to accept new Medicare patients because of low reimbursement rates has more than doubled. According to an American Medical Association survey, current reimbursement rates have already led 17 percent of all doctors, including 31 percent of primary care physicians, to restrict the number of Medicare patients in their practices. In all likelihood, the IPAB will only exacerbate this problem.

While we are all supportive of improving the quality of care in this country, we are concerned that the IPAB will not be able to focus on improving healthcare and delivery system reforms, as some of its proponents have suggested. Requiring the IPAB to achieve scoreable savings in a one-year time period is not conducive to generating savings through long-term delivery system reforms. According to a recent Kaiser Family Foundation issue brief, "[w]hile the requirement to achieve Medicare savings for the implementation year provides a clear direction and target for the Board, it may discourage the type of longer-term policy change that could be most important for Medicare and the underlying growth in health care costs, including delivery system reforms that MedPAC and others have recommended which are included in the ACA – 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." The Congressional Budget Office (CBO) has in fact stated 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. Again, this will have a severe, negative impact on Medicare beneficiaries.

Last, we believe that the IPAB sets a dangerous precedent for overriding the normal legislative process. Congress is a representative body that has a duty to legislate on issues of public policy.

Abdicating this responsibility to an unelected and unaccountable board removes our elected officials from the decision-making process for a program that millions of our nation's seniors and disabled individuals rely upon, endangering the important dialogue that takes place between elected officials and their constituents.

We do not believe the IPAB is the right way to achieve savings in Medicare and strongly urge Congress to eliminate this provision.

Sincerely,

Abigail Alliance

Action CF

AdvaMed

Advocates for Responsible Care

AIDS Delaware

AIDS Drug Assistance Programs Advocacy Association

AIDS Housing Association of Tacoma

AIDS Institute

Alabama Orthopaedic Society

Alder Health Services, Inc.

Alliance for Aging Research

Alliance of Specialty Medicine

ALung Technologies, Inc.

Alzheimer's & Dementia Resource Center

Alzheimer's Arkansas

American Academy of Facial Plastic & Reconstructive Surgery

American Academy of Neurology

American Academy of Otolaryngology – Head and Neck Surgery

American Academy of Physical Medicine and Rehabilitation

American Association for the Study of Liver Diseases

American Association of Clinical Endocrinologists

American Association of Clinical Urologists

American Association of Homecare

American Association of Neurological Surgeons

American Association of Orthopaedic Executives

American Association of Orthopaedic Surgeons
American Autoimmune Related Diseases Association
American College of Emergency Medicine - Indiana Chapter
American College of Emergency Physicians
American College of Mohs Surgeons
American College of Osteopathic Surgeons
American College of Radiology
American College of Surgeons - Missouri Chapter
American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Liver Foundation - Allegheny Division
American Osteopathic Academy of Orthopedics
American Physical Therapy Association
American Podiatric Medical Association
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Cataract and Refractory Surgery
American Society of General Surgeons
American Society of Plastic Surgeons
American Society of Radiation Oncology
American Urological Association
Amigos por la Salud
Arizona Medical Association
Arizona Urological Society
Arkansas Medical Society
Arkansas Orthopaedic Society
Associated Industries of Florida
Association for Behavioral Healthcare
Association of Nurses in AIDS Care
Asthma & Allergy Foundation of America - California Chapter
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California Rheumatology Alliance
California Urological Association
Children's Rare Disease Network
Coalition for Affordable Health Coverage
Coalition of State Rheumatology Organizations
Colorado Academy of Family Physicians
Colorado BioScience Association
Colorado Cross-Disability Association
Colorado Gerontological Society
Colorado Retail Council
Colorado Springs Health Partners
Community Health Charities of Florida
Community Health Charities of Nebraska
Congress of Neurological Surgeons
Connecticut Orthopaedic Society
Connecticut State Urology Society
Delaware Academy of Medicine
Delaware Ecumenical Council on Children and Families
Delaware HIV Consortium
Delaware State Orthopaedic Society
Easter Seals
Easter Seals Crossroads
Easter Seals of Arkansas
Easter Seals of Maine
Easter Seals of Massachusetts
Easter Seals of New Jersey

Easter Seals of South Florida
Elder Care Advocacy of Florida
Florida Chamber of Commerce
Florida Medical Association
Florida Society of Rheumatology
Florida Society of Thoracic & Cardiovascular Surgeons
Florida State Hispanic Chamber of Commerce
Florida Transplant Survivor's Coalition
Florida Urological Society
Georgia Association for Home Health Agencies
Georgia Bio
Georgia Orthopaedic Society
Global Genes
HEALS of the South
Healthcare Leadership Council
HealthHIV
Heart Rhythm Society
Hoosier Owners and Providers for the Elderly
Illinois Association of Orthopaedic Surgeons
Illinois Biotechnology Industry Organization—iBIO®
Illinois Chamber of Commerce
Indiana Association of Cities and Towns
Indiana Health Care Association
Indiana Health Industry Forum
Indiana Neurological Society
InterAmerican College of Physicians & Surgeons
International Franchise Association
International Institute for Human Empowerment
Iowa Orthopaedic Society
Kansas Urological Association
Kentucky BioAlliance
Kentucky Medical Association

Kidney Cancer Association of Illinois
Large Urology Group Practice Association
Latino Diabetes Association
Licensed Professional Counselors Association of Georgia
Louisiana State Medical Society
Lupus Alliance of America - Hudson Valley Affiliate
Lupus Alliance of America - Queens and Long Island Affiliate
Lupus Alliance of America - Southern Tier Affiliate
Lupus Alliance of America - Upstate New York Affiliate
Lupus Foundation of Arkansas
Lupus Foundation of Florida
Lupus Foundation of Mid and Northern New York
Lupus Foundation of the Genesee Valley
Mabel Wadsworth Women's Health Center
Maine Health Care Association
Maine Osteopathic Association
Maine State Council of Vietnam Veterans of America
Maryland Orthopaedic Association
Maryland State Medical Society
Massachusetts Association for Behavioral Health Systems
Massachusetts Association for Mental Health
Massachusetts Biomedical Initiatives
Massachusetts Medical Device Industry Council
Massachusetts Orthopaedic Association
Medical Association of Georgia
Medical Association of the State of Alabama
Medical Society of Delaware
Medical Society of the District of Columbia
Medical Society of the State of New York
Men's Health Network
Mental Health America of Indiana
Michigan Bio

Michigan Chamber of Commerce
Michigan College of Emergency Physicians
Michigan Orthopaedic Society
Michigan Society of Anesthesiologists
Mississippi Arthritis and Rheumatism Society
Mississippi Orthopaedic Society
Missouri State Medical Association
Missouri Urological Association
Montana Orthopaedic Society
National Alliance on Mental Illness
National Alliance on Mental Illness Colorado
National Alliance on Mental Illness Florida
National Alliance on Mental Illness Georgia
National Alliance on Mental Illness Indiana
National Alliance on Mental Illness Maine
National Association for Home Care & Hospice
National Association for Home Care & Hospice - Indiana Chapter
National Association for Home Care & Hospice - Ohio Chapter
National Association for Uniformed Services
National Association of Manufacturers
National Association of Nutrition and Aging Services Programs
National Association of People with AIDS
National Association of Spine Specialists
National Council of Negro Women
National Council of Negro Women - Los Angeles View Park Section
National Grange
National Health Foundation
National Hemophilia Foundation - Delaware Valley Chapter
National Kidney Foundation - Ohio Chapter
National Medical Association
National Minority Quality Forum
National Retail Federation

Nebraska Academy of Physician Assistants
Nebraska Medical Association
Nebraska Orthopaedic Society
Nebraska Urological Association
Neurofibromatosis Mid-Atlantic
Nevada Orthopaedic Society
Nevada State Medical Association
New Horizons Home Health Services
New Jersey Academy of Ophthalmology
New Jersey Mayors Committee of Life Science
New York State Rheumatologists Society
New York State Urological Society
North Carolina Urological Association
Northwest Urological Society
Ohio Association of Ambulatory Surgery Centers
Ohio Association of County Behavioral Health Authorities
Ohio Association of Medical Equipment Services
Ohio Hospital Association
Ohio Orthopaedic Society
Ohio State Grange
Ohio State Medical Association
Ohio Urological Society
Oklahoma State Medical Association
Oklahoma State Orthopaedic Society
Oklahoma State Urologic Association
Oregon Medical Association
Partners in Care Foundation
Pennsylvania BIO
Pennsylvania Medical Society
Pennsylvania Orthopaedic Society
Personal Coaching & Psychotherapy for Women
PhRMA

RARE Project
RetireSafe
Rhode Island Medical Society
Rocky Mountain Stroke Center
Rural Health IT
Sanfilippo Foundation for Children
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Gynecologic Oncology
Society of Urologic Oncology
South Carolina BIO
South Carolina HIV/AIDS Care Crisis Task Force
South Carolina Medical Association
South Carolina Podiatric Medical Association
South Carolina Urological Association
South Dakota State Orthopaedic Society
South Jersey Geriatric Care PC
South Jersey Senior Networking Group
Stockton Center on Successful Aging
Syndicus Scientific Services
Team Sanfilippo Foundation
Tennessee Medical Association
Tennessee Orthopaedic Society
Texas Healthcare & Bioscience Institute
Texas Urological Society
The Capital Region Action Against Breast Cancer!
The G.R.E.E.N. Foundation
The Global Healthy Living Foundation
U.S. Chamber of Commerce
U.S. Pain Foundation
Urology Society of New Jersey
Utah Medical Association

Utah State Orthopaedic Society
Vascular Society of New Jersey
Vermont Medical Society
Veterans Health Council
VHA Inc.
Vietnam Veterans of America
Virginia Biotechnology Association
Visiting Nurse Association of Ohio
Washington Free Clinic Association
Washington Osteopathic Medical Association
Washington Rheumatology Association
Washington State Medical Association
Washington State Urology Society
WERAK Foundation
West Virginia Academy of Otolaryngology
West Virginia Chapter of the American College of Cardiology
West Virginia Manufacturer's Association
West Virginia Orthopaedic Society
West Virginia State Medical Association
William "Hicks" Anderson Community Center
Wisconsin Urological Society
Women Against Prostate Cancer

House Energy and Commerce Committee

Subcommittee on Health

IPAB: The Controversial Consequences for Medicare and Seniors

July 13, 2011

Statement of

Karen Zinka

Men's Health Network
P.O. Box 75972
Washington, DC 20013
www.menshealthnetwork.org

Men's Health Network Addresses Medicare Costs and Improvements

We welcome this opportunity to express our concerns about patient care and the costs associated with same.

In a recent address at George Washington University, President Obama said, "We will slow the growth of Medicare costs by strengthening an independent commission of doctors, nurses, medical experts and consumers who will look at all the evidence and recommend the best ways to reduce unnecessary spending while protecting access to the services seniors need."

We share the President's concern, and that of Congress, for the escalating burden of health care costs in Medicare and Medicaid, but differ on how best to address those costs. However, we are concerned that the Independent Payment Advisory Board will limit access to necessary therapies while taking the decision about how to improve Medicare away from our elected officials.

Specifically:

- We are concerned that there is minimal, if any, patient representation on the Independent Payment Advisory Board (IPAB) and that the Board is being given powers that should reside with Congress, where patients', caregivers', and families' voices can be heard.

- We are concerned that the IPAB will limit access to life saving drugs, thereby endangering the lifestyles of retirees while causing Medicare costs to rise due to increased hospitalizations from advanced health conditions that would have been treatable or preventable.

- We are concerned for the future of drug innovation in this country. We are the leader in developing new products that promise and deliver better health outcomes for our citizens, seniors included, and we want to continue that leadership. If payment for a drug or treatment is denied based on cost, what message does that sent to companies that might be working on new, life-saving or life-extending drugs or treatments that might be expensive?

The best way to hold down medical costs is not to make it harder for patients, including seniors, to access life-saving drugs that allow a person to enjoy a healthy lifestyle well into their old age. Instead, we should insure that Medicare focuses on prevention and early detection, and timely treatment with innovative and effective therapies.

The President was correct in addressing the number of days spent in a hospital, and the expense associated with those stays. The Medicare Part D program has been amazingly successful, coming in well under expected budget. Medicare Part D has made the pharmaceutical products that allow retirees to continue a healthy lifestyle available at reasonable cost. By doing so, it has provided for the treatment of potentially life threatening or crippling health conditions before they advance, forestalling the need for expensive hospital stays.

Medicare will best serve the aging population by insuring that every person entering Medicare receives a Welcome to Medicare Physical, unless they choose not to participate, that will provide guidance for their health maintenance as they age. Unfortunately, due to failure to adequately inform retirees, less than 10% of those eligible receive this life-saving examination and consultation.

The Welcome to Medicare Physical was passed by Congress as part of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. According to the law passed by Congress, the Welcome to Medicare Physical "...means physicians' services consisting of a physical examination...with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to screening and other preventive services."

This CMS description of this critical benefit should provide guidance for the Administration's prevention initiatives in Medicare. "The 'Welcome to Medicare' physical exam...(is)...an easy way for you and your doctor to get an accurate benchmark for your health now and in the future. During the exam, you and your physician will review your medical and family history, assess current health conditions and prescriptions, and conduct screenings to establish a baseline for future, personalized care. You will also have an opportunity to talk about short- and long-term steps to improve your health and stay well under the care of doctors participating in the Medicare program."

Catching health problems, or the signs of developing health problems, early when they are treatable or preventable is the best way to ensure healthy retirement years with less expense to Medicare. Treating those conditions with drugs and other therapies before there is a need for hospitalization and possible rehabilitation is the most cost effective way to provide for the health of our seniors.

We call on the Administration to make real improvements in Medicare by ensuring that every available person entering Medicare receive their Welcome to Medicare Physical, the life saving prevention consultation that they deserve, and have paid for. It is through prevention and innovation that we can reduce unnecessary spending while protecting access to the services and therapies seniors need.

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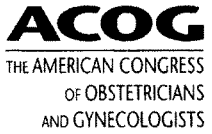

Office of the President
Richard N. Waldman, MD, FACOG
770 James St.
Syracuse, NY 13203-2117

March 11, 2011

The Honorable Phil Roe, MD, FACOG
419 Cannon House Office Building
Washington, DC 20515

Dear Dr. Roe,

On behalf of the American Congress of Obstetricians and Gynecologists (ACOG), representing over 54,000 physicians and partners in women's health, thank you for introducing HR 452, the Medicare Decisions Accountability Act, to repeal the Indpendent Payment Advisory Board (IPAB) in the Patient Protection and Affordable Care Act (ACA). ACOG strongly supports enactment of this legislation.

IPAB is a bad idea, and one of the reasons why ACOG was unable to support the final passage of the ACA. Congress needs to act before this Board meets for the first time. IPAB would be composed of 15 unelected members, wholly not accountable to taxpayors, health care providers, Congressional oversight and responsibility, or even judicial review. Under the ACA, IPAB is charged with recommending health spending cuts, and only cuts, primarily focused on physicians in the first years of its existence. This narrow focus distorts the full picture of health care spending in America. The Board's recommendations would easily become law under the procedures created in the ACA.

As a physician and an ob-gyn, you already know the frustration physicians feel in dealing with the Medicare program. IPAB can seriously erode physician support for the Medicare program, limit patient access to needed care, and limit physicians' ability to continue to provide high quality care.

Your bill, HR452, will put a quick end to this bad idea, and help restore regular order and Congressional oversight and responsibility, which the American taxpayers expect.

Again, thank you for introducing HR 452 repealing the IPAB. We look forward to working closely with you to bring this bill toenactment. I hope you won't hesitate to contact me or ACOG Government Relations staff, Anna Hyde, at 202-863-2512 or ahyde@acog.org if we can be of any assistance.

Sincerely,

Richard N. Waldman, MD, FACOG
President

AMERICAN COLLEGE OF RHEUMATOLOGY
EDUCATION • TREATMENT • RESEARCH

Specialists in Arthritis Care & Research
2200 Lake Boulevard NE • Atlanta, GA 30319
Phone: (404) 633-3777 • Fax: (404) 633-1870
www.rheumatology.org • info@rheumatology.org

July 12, 2011

The Honorable Fred Upton
Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Henry Waxman
Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Upton and Ranking Member Waxman:

The American College of Rheumatology representing over 7,000 rheumatologists and rheumatology health professionals would like to commend the Energy & Commerce Committee for holding a scheduled hearing entitled, *IPAB: The Controversial Consequences for Medicare and Seniors.* This hearing will hopefully shed light on the harm that will occur when Congress places Medicare decisions in the hands of bureaucrats through the Independent Payment Advisory Board. We hope the hearing's testimonies will prompt Congress to repeal this problematic board.

The ACR understands concerns with the rising costs of health care. However, the IPAB is not the appropriate response to curb health care spending. The IPAB would remove congressional oversight and place responsibility in the hands of bureaucrats who do not have the clinical expertise to determine the adverse impact that proposed recommendations would have on patient care. With these concerns, the ACR strongly supports H.R. 452, the *Medicare Decisions Accountability Act of 2011,* legislation introduced by Rep. Phil Roe, MD that would repeal the IPAB. As of today, 162 House Republicans and Democrats support IPAB repeal.

The ACR appreciates your leadership and willingness to gather information regarding the IPAB. We hope that the results of the hearing will clarify that the IPAB will not appropriately accomplish the cost saving goals in the Medicare system set out by Congress. We look forward to working with both of you to ensure patient access to care is protected.

If you have any questions, please contact the ACR's Government Affairs Director, Aiken Hackett, at (404) 633-3777 or *ahackett@rheumatology.org* for more information.

Sincerely,

Tim Laing, MD
Chair, Government Affairs Committee
American College of Rheumatology

CC: The Honorable Joseph Pitts
The Honorable Frank Pallone

Statement of the
American College of Radiology
To the
House Energy and Commerce Health Subcommittee's
Hearing "IPAB: the Controversial Consequences for Medicare and Seniors."

Wednesday, July 13, 2011

The American College of Radiology (ACR), representing 36,000 radiologists, radiation oncologists, medical physicists, interventional radiologists and nuclear medicine physicians, would like to express our strong opposition to the Independent Payment Advisory Board (IPAB).

Created by the *Patient Protection and Affordable Care Act*, the 15 member IPAB is intended to control Medicare spending through the use of targeted spending reductions and a fast-track legislative process. Since the beginning of the health care reform debates in 2009, ACR has consistently expressed opposition to the creation of this entity.

We are deeply troubled by the Board's composition of unelected officials which would eliminate the opportunity for patients and physicians to raise grievances with Congress regarding Medicare payment rates. We believe that IPAB sets a dangerous precedent for overriding the normal legislative process and we strongly protest a process in which elected officials would shed their ability to adequately represent patients and constituents. Furthermore, IPAB's recommendations will unfairly target physician costs within the overall health care system, potentially prompting physicians to no longer accept Medicare patients, thus threatening patient access to care. Although we applaud efforts by Congress to control the ever-increasing cost of health care in the United States, the ACR is gravely concerned that IPAB will become an unregulated autonomous seat of power with the ability to influence medical care, without answering to the very people whose lives it will affect.

The American College of Radiology stands united with our colleagues in the House of Medicine in opposition to IPAB. We urge Congress to take decisive action to repeal this harmful entity and we applaud the House Energy and Commerce Committee's attempts to review this policy.

July 6, 2011

The Honorable David P. Roe, MD
U.S. House of Representatives
419 Cannon House Office Building
Washington, DC 20515

Dear Dr. Roe:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express our support for H.R. 452, which would repeal the Independent Payment Advisory Board (IPAB). Throughout and since the health care reform debate, the AMA has continually expressed its opposition to the IPAB on several grounds.

The IPAB puts important health care payment and policy decisions in the hands of an independent body that has far too little accountability. Major changes in the Medicare program should be decided by elected officials. We have already seen first-hand the ill effects of the flawed sustainable growth rate (SGR) physician target and the steep cuts that Congress has had to scramble each year to avoid, along with the significant price tag of a long-term SGR solution. The IPAB would subject physicians to double jeopardy in the form of two separate targets. At the same time, it would exempt for a significant period of time, large segments of Medicare providers who are subject to no target at all, leaving physicians in a position in which they could bear a disproportionate burden of any cuts under the IPAB.

The experience with the SGR also raises concerns about policy decisions based on projections that require subsequent adjustments to reflect more accurate data. In 2003, Congress had to take action to allow the Centers for Medicare & Medicaid Services to correct $54 billion in projection errors under the SGR target. The IPAB also imposes a rigid budget target that is prone to "projection errors" that would force Congress to produce billions of dollars in offsets due to inaccurate calculations.

We appreciate the need to reduce the federal budget deficit and control the growth of spending in Medicare. However, we believe that this can best be achieved by Congress working in a bipartisan manner to reform the delivery system and improve quality, access, and efficiency. At a time in which Congress is struggling to eliminate the SGR, it does not make sense to allow another rigid formula to be implemented that risks a bigger set of problems for a broader cross-section of Medicare services.

We thank you for your leadership on this issue, and look forward to working with you to repeal the IPAB and preserve access for seniors to their physicians.

Sincerely,

Cecil B. Wilson

Cecil B. Wilson, MD
Immediate Past President

American Medical Association 515 N. State St. Chicago IL 60654
(312) 464-5000 www.ama-assn.org

National Association of Nutrition and Aging Services Programs
1612 K Street, NW Suite 400 Washington, DC 20006
(202) 682-6899 (202) 223-2099 fax
www.nanasp.org

Wednesday, July 13, 2011

Testimony of Bob Blancato
Hearing of the House Energy and Commerce Health Subcommittee
Chairman- Congressman Joe Pitts (PA)
Ranking Member- Congressman Frank Pallone, Jr. (NJ)

Chairman Pitts, Congressman Pallone:

Thank you for the opportunity to submit testimony addressing IPAB, the Independent Payment Advisory Board. My name is Bob Blancato and I am the Executive Director of the National Association of Nutrition and Aging Services Programs, NANASP. We are a national membership organization representing community-based providers of congregate and home-delivered nutrition services for the elderly as well as other professionals in the aging network.

In addition to senior nutrition issues, our members are concerned with the numerous issues affecting the seniors they serve, especially Medicare. Throughout the 46 year history of Medicare, decisions about Medicare spending and coverage have resided with Congress. NANASP is extremely concerned about the IPAB as it is largely unaccountable to Congress and the American public and could make major cuts to Medicare, directly affecting the medical care of seniors. While IPAB is not necessarily allowed to ration care, it is allowed to cut reimbursement rates to participating doctors and a growing number of physicians have already stopped accepting new Medicare patients.

While NANASP is sensitive to the need for entitlement reform, spending cuts and the deficit, IPAB would be made up of a 15 member unelected and unaccountable board, appointed by the President to reduce the growth of Medicare if it exceeds a certain level in a calendar year. Elected representatives should be charged with controlling spending in entitlement programs not IPAB. NANASP urges Congress to repeal or replace IPAB and we urge Congress to act during this Session before implementation of IPAB proceeds.

Respectfully Submitted,

Robert B. Blancato

Robert B. Blancato

***NANASP's vision is to** reshape the future of nutrition and healthy aging.*
***NANASP's mission is to** strengthen through advocacy and education those who help older Americans.*

Mr. PITTS. I will introduce our third panel at this time. Testifying in our third panel are Christopher Davis, who is an analyst on Congress and the legislative process for the Congressional Research Service; David Newman is a specialist in healthcare financing at the Congressional Research Service; Avik Roy is a healthcare analyst with the firm Monness, Crespi, Hardt, and Company in New York City; Stuart Guterman is vice president for Payment and System Reform, executive director for the Commission on High Performance Health System at the Commonwealth Fund; Judy Feder is professor public policy at Georgetown University; and Dr. Scott Gottlieb is a practicing physician and is currently a resident fellow in health policy at the American Enterprise Institute.

Mr. Davis, you may begin your testimony.

STATEMENTS OF CHRISTOPHER M. DAVIS, ANALYST ON CONGRESS AND THE LEGISLATIVE PROCESS, CONGRESSIONAL RESEARCH SERVICE, ACCOMPANIED BY DAVID NEWMAN, SPECIALIST IN HEALTH CARE FINANCING, CONGRESSIONAL RESEARCH SERVICE; DIANE COHEN, SENIOR ATTORNEY, SCHARF–NORTON CENTER FOR CONSTITUTIONAL LITIGATION, GOLDWATER INSTITUTE; JUDITH FEDER, PROFESSOR AND FORMER DEAN, GEORGETOWN PUBLIC POLICY INSTITUTE; AVIK S. ROY, HEALTHCARE ANALYST, MONNESS, CRESPI, HARDT AND CO.; STUART GUTERMAN, SENIOR PROGRAM DIRECTOR, PROGRAM ON MEDICARE'S FUTURE, THE COMMONWEALTH FUND; AND SCOTT GOTTLIEB, RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE

STATEMENT OF CHRISTOPHER M. DAVIS

Mr. DAVIS. Thank you, Mr. Chairman. Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, on behalf of the Congressional Research Service I appreciate the opportunity to testify about the "fast-track" parliamentary procedures relating to the Independent Payment Advisory Board.

I am accompanied today by my CRS colleague, David Newman, who is a specialist in healthcare financing. While I will limit my testimony to the parliamentary aspects of the IPAB, at the request of the subcommittee, David is available to answer questions if desired on the healthcare policy aspects of the board.

Expedited or "fast-track" procedures are special parliamentary procedures Congress sometimes adopts to promote timely action on legislation. As the name implies, fast-track procedures differ from the usual procedures of the House and Senate because they generally allow the legislation in question to be considered more quickly and to avoid some of the parliamentary hurdles which face most bills.

The Patient Protection and Affordable Care Act established two fast-track procedures related to the IPAB. The first governs consideration of a bill implementing the recommendations of the IPAB related to future rates of Medicare spending. The second procedure governs consideration of a joint resolution discontinuing the automatic implementation of the IPAB's recommendations. I will briefly describe both procedures.

As others have testified, under PPACA the IPAB will, under certain circumstances, propose an implementing bill containing recommendations designed to reduce the rate of Medicare spending growth. The Secretary is to automatically implement these recommendations on August 15 unless legislation is enacted before then which supersedes the IPAB proposals.

The procedures established by PPACA permit Congress to amend the IPAB-implementing legislation but only in a manner that achieves at least the same level of targeted reductions in spending growth as the IPAB plan. The act bars Congress from changing the IPAB fiscal targets in any other legislation it considers as well and creates a super majority vote in the Senate to wave this requirement.

PPACA establishes special fast-track procedures governing House and Senate committee consideration and Senate Floor consideration of an IPAB-implementing bill. Under these procedures, the bill is automatically introduced and referred to the House Committees on Energy and Commerce and Ways and Means and to the Senate Committee on Finance. Not later than April 1, each committee may report the bill with committee amendments related to the Medicare program. If a committee has not reported by April 1, it is discharged.

PPACA does not establish special procedures for Floor consideration of an IPAB-implementing bill in the House. It does for the Senate. PPACA creates an environment for Senate Floor consideration of an IPAB-implementing bill which is similar to that which exists after the Senate has invoked cloture. There is a maximum of 30 hours of consideration and all amendments must be germane. A final vote on the bill is assured.

PPACA establishes a second fast-track procedure governing consideration of a joint resolution discontinuing the automatic implementation process of the IPAB recommendations. Such a joint resolution is in order only in the year 2017 and its consideration is also expedited in committee and on the Senate Floor. Passage of a joint resolution discontinuing the automatic IPAB process requires a 3/5 vote of Members of both the House and the Senate. Both the IPAB-implementing bill and the joint resolution I have described must be signed by the President to become law. should either measure be vetoed, overriding the veto would require a 2/3 vote in both chambers. The arguable effect of these provisions is to favor the continuation of the IPAB and its recommendations possibly even in the face of congressional majority supporting a different policy approach.

While the fast-track parliamentary procedures governing consideration of an IPAB-implementing bill are expedited, they do not in themselves guarantee that Congress will agree on a bill and present it to the President. Because it is not possible to force the House and Senate to agree on the same bill text, whether Congress can pass an implementing bill which will supersede the recommendations of the IPAB is subject to the deliberative process.

Finally, as I detail in my written testimony, questions about certain mechanics of these two fast-track procedures, such as how certain points of order under the act will be enforced will likely re-

quire clarification by the House and Senate in close consultation with each chamber's parliamentarian.

The Congressional Research Service appreciates the opportunity to assist the subcommittee as it examines these matters. My colleague and I are happy to answer any questions you may have.

[The prepared statement of Mr. Davis follows:]

July 13, 2011

"FAST TRACK" PARLIAMENTARY PROCEDURES RELATING TO THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB):
SUMMARY OF MAJOR POINTS

Hearing Before the House Committee on Energy and Commerce
Subcommittee on Health

Christopher M. Davis
Analyst on Congress and the Legislative Process
Congressional Research Service, Library of Congress

- The Independent Payment Advisory Board (IPAB) established by the Patient Protection and Affordable Care Act (PPACA) is made of up 15 individuals, appointed by the President, each subject to the Senate confirmation process. This means that IPAB nominees face the potential of extended Senate debate, the cloture process, and, under certain limited parliamentary circumstances, might be recess appointed.

- Under PPACA, the IPAB is, beginning in 2014, required to put forth recommendations on ways to reduce future rates of Medicare spending, along with legislation implementing these recommendations. The Secretary of Health and Human Services is required to automatically implement IPAB's recommendations by August 15 of the year they are submitted, unless legislation is enacted superseding them.

- PPACA permits Congress to amend the IPAB-implementing legislation, but only in a manner that achieves at least the same level of targeted reductions in Medicare spending growth as are contained in the IPAB plan. The Act bars Congress from changing the IPAB fiscal targets in any other legislation it considers as well, and establishes a super-majority vote requirement in the Senate to waive this provision.

- The Act establishes special "fast track" parliamentary procedures governing House and Senate committee consideration, and Senate floor consideration, of legislation implementing the IPAB's proposal. These mandates the immediate introduction of the legislation in Congress, and establish deadlines for committee and Senate floor consideration, as well as limit the amending process. PPACA establishes a second "fast track" procedure governing the consideration of a joint resolution discontinuing the automatic IPAB implementation process described above. This joint resolution requires a supermajority for passage.

- The fast track procedures make it more likely, but do not guarantee that Congress will be able to act to send a bill to the President superseding the IPAB's recommendations.

- The arguable effect of these provisions of PPACA is to favor the continuation of the IPAB and its recommendations.

- Either the House and Senate can change the "fast track" procedures, but in practice, the Senate may find it difficult to do so if it cannot achieve unanimous consent.

- Some questions exist about the enforceability and mechanics of these fast track procedures, which will likely require clarification by the House and Senate in close consultation with each chamber's Parliamentarian.

July 13, 2011

STATEMENT ON "FAST TRACK" PARLIAMENTARY PROCEDURES RELATING TO THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)
Hearing Before the House Committee on Energy and Commerce
Subcommittee on Health

Christopher M. Davis
Analyst on Congress and the Legislative Process
Congressional Research Service, Library of Congress

Chairman Pitts, Ranking Member Pallone, and Members of the Health Subcommittee:

I appreciate the opportunity to testify before you on behalf of the Congressional Research Service about the "fast track" parliamentary procedures relating to the Independent Payment Advisory Board (IPAB) which were established by Sections 3403 and 10320 of the Patient Protection and Affordable Care Act (PPACA).[1]

This testimony begins with a discussion of expedited parliamentary procedures, generally. It then briefly describe the structure and establishment of the IPAB. The testimony then detail the two "fast track" parliamentary mechanisms established by PPACA related to the Independent Payment Advisory Board. This testimony concludes by raising considerations for policymakers related to these two parliamentary mechanisms.

EXPEDITED PROCEDURES GENERALLY

So-called expedited or "fast-track" legislative procedures are special procedures that Congress adopts to promote timely committee and floor action on a specifically-defined type of legislation. Congress does not adopt expedited procedures as part of the standing rules of the House or

[1] P.L. 111-148. 124 Stat. 489, 125 Stat 949.

Senate, but instead includes them in measures that are enacted into law, usually in the same measure that defines the kinds of bill or resolution that are subject to the expedited procedures. Congress sometimes chooses to enact expedited procedures because the regular legislative processes of the House and Senate can be time-consuming, and provide no guarantee that a bill or resolution will be considered quickly, or at all, in committee and on the floor. Although expedited procedures are enacted in law, they have the same force and effect as standing House or Senate rules, and accordingly, statutes that contain them are sometimes referred to as "rulemaking" statutes. Well-known examples of rulemaking statutes which include expedited parliamentary procedures for the consideration of legislation are the Trade Act of 1974[2], the War Powers Resolution[3], the Congressional Budget Act of 1974[4], and the Defense Base Closure and Realignment Act of 1990.[5]

Because Article I, Section 5 of the Constitution gives each chamber of Congress the power to determine the rules of its own proceedings, expedited procedure statutes can (like all rules of the House or Senate) be set aside, altered, or amended by either chamber at any time insofar as the procedure in that chamber is concerned.[6] In order to change the way in which the features of an expedited procedure apply in either chamber, it is sufficient that the chamber decides to ignore or alter the expedited procedure through any of the same means by which it normally alters or overrides its rules. In the House, this can be accomplished through the adoption of a special rule reported by the Committee on Rules, by suspension of the rules, or by unanimous consent.[7]

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[2] 19 U.S.C. 2191-2194.

[3] 50 U.S.C. 1544-1546.

[4] 2 U.S.C. 601-688.

[5] 10 U.S.C. 2908.

[6] William Holmes Brown and Charles W. Johnson, *House Practice, A Guide to the Rules, Precedents and Procedures of the House* (Washington: GPO, 2003), ch. 50, §4, p. 826.

[7] Prior research undertaken by CRS suggests that the House of Representatives almost always supplants the terms of rulemaking statutes by adopting special rules by majority vote which establish terms for consideration which may resemble in whole or in part those included in law. CRS Memorandum, Use of Privileged Resolution of Disapproval and Approval, 1989-1998, by Richard S. Beth, Mar. 13, 2000, p. 13.

In recent years, many rulemaking statutes have focused mostly or exclusively on the Senate, where, unlike in the House, the Standing Rules do not ensure a voting majority the ability to bring consideration of a measure or matter to a vote or even to guarantee it will be considered at all. Although the same constitutional authority to determine its own rules resides equally in both houses of Congress, expedited procedures are, in a sense, more binding on the Senate than they are on the House of Representatives. The Senate most often operates under terms established by the unanimous consent of all Senators. If unanimous consent could not be achieved, altering the terms of a rulemaking statute for the consideration of a specified measure would, in all likelihood, require either the vote of three-fifths of Senators chosen and sworn necessary to invoke cloture or the concurrence of two-thirds present and voting necessary to suspend the rules. Motions to suspend the rules also require written notice one calendar day in advance, and are themselves fully debatable.[8] In short, while the House and Senate can each choose to alter a statutory rule, in practice, once established, such fast track rules are potentially difficult for the Senate to change.

Section 1130 of the most recent edition of the *House Rules and Manual* lists 31 statutes which establish expedited parliamentary procedures applicable to the House of Representatives. Some of the listed statutes, such as the Trade Act of 1974 and the Arms Export Control Act, establish more than one set of expedited House procedures.[9] The rulemaking statutes listed in the *House Manual* can generally be described as falling into two broad categories. The first category includes procedures which allow the House and Senate promptly to consider a measure (typically a joint resolution) that either approves or disapproves some action taken or policy established by the executive branch. Such procedures tend to be fully expedited when compared to the regular

[8] Floyd M. Riddick and Alan S. Frumin, Riddick's *Senate Procedure: Precedents and Practices*, 101st Cong., 1st sess., S.Doc. 101-28 (Washington: GPO, 1992), p. 1266.

[9] The House Manual lists most, but not all rulemaking statutes. It does not include statutes enacted subsequent to the publication of the Manual, and generally does not include expedited procedure statutes which apply exclusively to the Senate.

procedures of the House and Senate, calling for mandatory introduction of a joint resolution, its timely reporting or automatic discharge from committee, a finite period of floor debate and an automatic "hookup" between joint resolutions considered by the two chambers. Such procedures almost always bar the consideration of amendments altogether, including committee amendments, as well as preclude other motions which might delay or prevent a final vote.

A second broad category of rulemaking statute establishes special procedures for congressional consideration of legislation, often submitted to Congress by the President, and may apply to one or both chambers of Congress. Such procedures also tend to be more expedited than normal House or Senate procedures, but otherwise may vary in the extent that they place limits on debate and amendment of a given measure or class of measure. Some procedures in this second category bar amendments entirely, while others permit only germane amendments, or allow Congress to offer counterproposals to legislation forwarded by the executive branch which meet the same general policy criteria established by the President's bill. Most procedures falling into this second broad category require automatic introduction by request, limit committee consideration, and include some limits on floor debate and motions. Many of the procedures also include elements which are intended to expedite consideration of a conference report or amendment exchange between the House and Senate. Some of these procedures might be described as establishing an only partially expedited legislative process. They may, for example, create a "fast track" in one chamber but not the other, or guarantee floor consideration, but not ensure final action.

It is difficult to establish fully expedited procedures for measures to which amendments are permitted, because the existence of an amendment process creates the possibility of a need to resolve bicameral differences. Because it is not possible to force the House and Senate to reach ultimate agreement on a legislative text, procedures of this type generally expedite some, but not all, aspects of congressional consideration.

ESTABLISHING THE INDEPENDENT PAYMENT ADVISORY BOARD

The Independent Payment Advisory Board was established by Sections 3403 and 10320 of the Patient Protection and Affordable Care Act.[10] The IPAB is charged by that law with developing proposals to "reduce the per capita rate of growth in Medicare spending."[11]

Under the terms of the Act, the IPAB is to be composed of 15 members appointed by the President with the advice and consent of the Senate.[12] The Act requires the President to consult with the Speaker of the House, the House minority leader, and the Senate majority and minority leaders, each on the appointment of three IPAB members. The remaining three IPAB appointments are presumably the selections of the President alone. The Chairman of the IPAB is appointed by the President from among the 15 members of the Board and the position is also subject to Senate confirmation. In addition to the President's 15 IPAB appointments, the Secretary of Health and Human Services, the Administrator of the Centers for Medicare and Medicaid Services (CMS), and the Administrator of the Health Resources and Services Administration (HRSA) serve as *ex-officio* nonvoting members of the Board.[13]

The Act requires the appointed membership of the IPAB to include individuals who enjoy "national recognition" in several stated aspects of health policy, including health finance and economics, and further stipulates occupations which should be represented on the Board, including physicians and "experts in pharmaco-economics." The Act specifies that the appointed IPAB members have broad geographic representation and that the Board be balanced between

[10] P.L. 111-148. 124 Stat. 489, 125 Stat 949.

[11] For more information on the duties of the IPAB and associated health policy issues, see: CRS Report R41511, *The Independent Payment Advisory Board*, by David Newman and Christopher M. Davis.

[12] §3403(g)(1). This citation and similar citations in this section are citations to the text of P.L. 111-148, as amended.

[13] Ibid.

urban and rural representatives. In order to minimize conflicts of interest, the Act stipulates that a majority of the appointed members of the IPAB are not be persons "directly involved" in the provision or management of the delivery of items and services covered by Medicare.[14]

Each individual appointed to the IPAB will hold office for a term of six years, except that the initial appointments have staggered terms: Five are appointed for a term of one year, five are appointed for a term of three years, and five for a term of six years.[15] With the exceptions noted below, an IPAB member may not serve more than two full consecutive terms. Members appointed to fill a vacancy occurring prior to the expiration of the term for which that Member's predecessor was appointed shall be appointed for the remainder of that term. Members appointed to complete the remaining term of a vacancy in this way are eligible to serve two additional consecutive full terms. Additionally, members appointed to the IPAB may continue to serve beyond the expiration of their term until their successor has taken office.
Under the terms of the Act, a majority of the 15 appointed members of the IPAB constitute a quorum for the transaction of business, although a lesser number may hold hearings. The statute further stipulates that no vacancy on the Board will impair the right of the remaining IPAB members to exercise all of the powers of the Board.[16] Finally, the members of the IPAB may only be removed by the President for cause.

As noted, the Members of IPAB require Senate confirmation. Unless the confirmation process is altered in the Senate by unanimous consent, the consideration of these nominations would take place under the normal parliamentary procedures the Senate uses to consider presidential nominations. That is, the nominations are potentially subject to extended debate and to the cloture

[14] §3403(g)(1)(B).
[15] §3403(g)(2).
[16] §3403(g)(4).

process. Additionally, the President, under certain procedural circumstances, might be able to recess appoint some or all IPAB members should their confirmation be blocked in the Senate, an eventuality which might also be precluded by the Senate under certain circumstances.

TWO EXPEDITED OR "FAST TRACK" PROCEDURES RELATED TO IPAB

Under the terms of PPACA, if future Medicare spending is expected to exceed certain targets established by the Act, the Independent Payment Advisory Board will propose recommendations to Congress and the President to reduce the Medicare growth rate. The IPAB's first set of recommendations would be proposed on Jan. 15, 2014. The Secretary of Health and Human Services must implement the Board's recommendations unless Congress affirmatively acts to amend or block them within a stated period of time and under circumstances specified in the Act.

As noted above, PPACA requires the Board to submit its proposal to both Congress and the President. The proposal is to be accompanied by, among other things, implementing legislation. The Secretary is required to automatically implement the proposals contained in the IPAB legislation on August 15 of the year such a proposal is submitted, unless:

- prior to that date, legislation is enacted that includes the statement, "This Act supersedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act," or
- in 2017, a joint resolution discontinuing the automatic IPAB implementation process has been enacted.[17]

[17] Such a joint resolution and the procedures for its consideration are described below.

To begin, § 3403(d) of the Act establishes special "fast track" parliamentary procedures governing House and Senate committee consideration, and Senate floor consideration, of legislation implementing the Board's proposal. The Act mandates the immediate introduction of the legislation in Congress, and by establishing strict deadlines for committee and Senate floor consideration, as well as by placing certain limits on the amending process. The procedures established by the Act permit Congress to amend the IPAB-implementing legislation, but only in a manner that achieves at least the same level of targeted reductions in Medicare spending growth as are contained in the IPAB plan. The Act bars Congress from changing the IPAB fiscal targets in any other legislation it considers as well, and establishes procedures whereby a super-majority vote is required in the Senate to waive this requirement.

The Act establishes a second set of "fast track" procedures governing the consideration of a joint resolution discontinuing the automatic IPAB implementation process described above. This joint resolution requires a super-majority vote of both chambers and either the signature of the President or overriding his veto by a two-thirds vote in each house to enter into force.

PROCEDURES FOR CONSIDERING IPAB-IMPLEMENTING BILL

House and Senate Introduction of IPAB-Implementing Bill

On the day that the IPAB-implementing legislation is submitted to Congress by the President, it is to be introduced "by request" in each chamber by the House and Senate majority leaders or by a designee.[18] If a house is not in session on the day the proposal is submitted, the measure is to be

[18] The term "by request" indicates that the measure is being introduced as a courtesy to the President, who can not introduce legislation, and that the sponsor of the bill does not necessarily favor it.

introduced on the first day the chamber is in session thereafter. In the event that the House and Senate majority leaders fail to introduce the legislation within five days after the date on which the proposal is submitted to Congress (or after that chamber came into session after the proposal's submission), any Member may introduce the bill in his or her respective chamber.[19]

House and Senate Committee Referral, Report, and Discharge

When introduced in the House, an implementing bill is to be referred to the House Committees on Energy and Commerce and on Ways and Means. In the Senate, the measure is to be referred to the Committee on Finance. Not later than April 1 in any year in which a proposal is submitted, the committees of referral each may report the bill "with committee amendments related to the Medicare program." Rule XV of the Standing Rules of the Senate, which bars the Senate from considering a committee amendment containing any "significant matter" not in the jurisdiction of the committee recommending the amendment, does not apply to the IPAB legislation. The effect of the exemption is that the Committee on Finance may report committee amendments to the IPAB-implementing bill that include matter not in its jurisdiction "if that matter is relevant to a proposal contained" in the IPAB plan.[20]

If a committee of referral has not reported the IPAB-implementing bill to its respective chamber by April 1, the committee will be automatically discharged of further consideration of the legislation.

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[19] Several existing expedited procedure statutes contain provisions for the mandatory introduction of legislation by House and/or Senate leaders. CRS is unaware of any instance in which a House or Senate officer failed to introduce legislation by request when directed to do so by such a statutory rule. For examples of such statutes, see U.S. Congress, House, *Constitution, Jefferson's Manual, and Rules of the House of Representatives*, H.Doc. 110-162, 110th Cong., 2nd sess. (Washington: GPO, 2009), §1130.

[20] Unlike germaneness, any requirement that amendments be "relevant" does not stem from the Senate's standing rules. It is a limitation that is traditionally only imposed on the amendment process by unanimous consent. In cases in which such a requirement has been imposed by unanimous consent, it has traditionally meant that the subject of an amendment must relate to the subject of the text it proposes to amend, and does not contain any significant subject matter not addressed by that underlying text.

Congress Can Consider Only Legislation That Meets the Same Fiscal Targets as Those Recommended by the IPAB

The special parliamentary procedures established by the Act attempt to bar the House or Senate from considering any bill, resolution, amendment, or conference report pursuant either to the special fast track procedures contained in the Act *or by any other legislative mechanism*, which would repeal or change the recommendations of the IPAB if that change would fail to achieve the same targeted reductions in Medicare spending growth achieved by the IPAB proposal. In other words, the procedures propose to bar Congress (including future Congresses) from considering, in any legislation (not just the IPAB-implementing bill), changes to the Board's recommendations that fail to meet at least the same fiscal targets as those forwarded by IPAB.

The Act attempts to "entrench" this limitation on congressional action by stating that the provision can be waived in the Senate only by an affirmative vote of three-fifths of Senators chosen and sworn (60 votes if there is no more than one vacancy), the same threshold required to invoke cloture on most measures and matters. An appeal of a ruling on a point of order under this provision carries the same super-majority vote threshold to overturn the ruling of the Senate's presiding officer.[21]

Initial House Floor Consideration

[21] While the Chief Actuary of the Centers for Medicare and Medicaid Services is to determine whether the IPAB proposal meets certain fiscal targets laid out by the Act, it is not specified how such a determination is to be made for other legislation Congress considers. How the Senate's presiding officer, for example, might rule on a point of order alleging that a given bill or amendment violates this provision, is unclear. This question would likely require additional clarification by the Senate, no doubt made after close consultation with its Parliamentarian.

The Act does not establish fast track parliamentary procedures governing initial floor consideration of an IPAB-implementing bill in the U.S. House of Representatives. That means that it could not be forced to the floor by individual Members in conflict with the schedule of the majority party leadership. Should the House choose to act on such legislation, it would presumably do so under its usual procedures, most likely by adopting a special rule reported from the House Committee on Rules to establish terms for considering the bill.

Initial Senate Floor Consideration

The special parliamentary procedures established by the Act create an environment for Senate floor consideration of an IPAB-implementing bill which is similar to that which exists after the Senate has chosen to invoke cloture on legislation.

Under most parliamentary circumstances, a motion to proceed to consider legislation in the Senate is fully debatable.[22] Under the special procedures established by the Act, however, once an IPAB-implementing bill is on the Senate Calendar of Business, a non-debatable motion to proceed to its consideration is in order.[23] If the Senate chooses to take up the implementing bill by adopting this motion, consideration of the implementing legislation is limited to a total of 30 hours equally divided between the two party leaders, and a non-debatable motion to further limit debate is in order. This is a departure from Senate practice under its Standing Rules, during which debate on legislation is generally limited only by unanimous consent or by invoking cloture.[24]

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[22] A motion to proceed to consider is non-debatable in the Senate under certain limited circumstances, including under specific procedural statutes such as the Congressional Budget Act, when made during the Morning Hour, and when dealing with treaties, nominations and conference reports.

[23] The Act does not specify who can make the motion to proceed, and under the chamber's Standing Rules, any Senator may in theory lodge such a motion. By long-standing practice, however, Senators almost always defer to the majority leader or his designee to make such scheduling motions.

[24] For more information on cloture, see CRS Report 98-425, *Invoking Cloture in the Senate*, by Christopher M. Davis.

Likewise, under the regular procedures of the Senate, debate on amendments is unlimited and there is no general requirement that amendments be germane.[25] Any amendments offered to the implementing bill in the Senate under the special procedures established by the Act, however, must be germane, and debate on each amendment is limited to one hour, equally divided between the bill manager and the offerer of the amendment. Debate on second-degree amendments, debatable motions, and appeals is limited to 30 minutes each, similarly divided.[26] The party floor leaders may yield time they control under the overall 30-hour cap to Senators during the consideration of any amendment, debatable motion, or appeal, should they choose to do so; however, debate on any may not exceed one hour.

Not only must amendments be germane, but, as is noted above, the procedure established by the Act bars the consideration of any amendment (including committee amendment), which would cause the bill to result in a net reduction in the total Medicare program spending in the implementation year that is less than the applicable savings target established for that year and contained in the IPAB proposal. This limitation can only be waived by a vote of three-fifths of Senators chosen and sworn, and successfully appealing a point of order under this provision carries the same super-majority vote requirement.

After 30 hours of consideration, the Senate proceeds to vote on any pending amendments and then, once they are disposed of, on the measure itself, as amended, if amended. Prior to final passage, a motion to table or to reconsider is in order, as is a demand for a live quorum call.

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[25] The Senate requires germaneness of amendments when offered to general appropriations bills, under some statutory rules (such as the Congressional Budget Act of 1974), to any legislation considered post-cloture, and when Senators agree to such a requirement by unanimous consent. Although the time for debate on amendments is unlimited in most circumstances, a non-debatable motion to table an amendment is in order in the Senate, and the effect of adopting such a motion would be to kill the amendment.

[26] If the bill manager favors the amendment, motion, or appeal, then the time in opposition will be controlled by the Senate minority leader or his designee.

Automatic "Hookup" of House and Senate Bill

The Act's special parliamentary procedures include provisions that are intended to facilitate the exchange of implementing legislation between the House and Senate.

The expedited procedures governing the Senate apply to a bill received from the House only if the same bill has been introduced in the Senate. In addition, the expedited procedures apply in the Senate only if the bill received from the House is related only to the programs under the Act and has satisfied the same fiscal targets as the IPAB-implementing bill. Such limitations are intended to prevent the special fast track procedures from being used to obtain expedited Senate consideration of unrelated legislation or legislative provisions.

In particular, the Act establishes "hookup" procedures to ensure that the chambers will, in the end, act on the same measure. If, before voting on its own implementing bill, a chamber receives an implementing bill passed by the other chamber, that engrossed legislation will automatically be amended by the text of the second chamber's bill and become the measure the receiving chamber votes on for final passage. If, after passing its own measure, a chamber receives an implementing bill passed by the other chamber, the vote on the receiving chamber's bill shall be considered to be the vote on the measure received from the other house as amended by the receiving chamber's implementing bill.

Consideration of a Conference Report or Amendment Exchange

The Act also establishes special parliamentary procedures for the expedited consideration of conference reports or amendments between the chambers intended to resolve bicameral differences on an IPAB-implementing bill. In the Senate, where the process of going to

conference may be subjected to filibuster, the Act does not appear to expedite this process, which would presumably occur under normal Senate procedures. The Act limits consideration of a proposed resolution of differences, whether in the form of a conference report or amendments between the chambers, to 10 hours of consideration in each chamber, equally divided between Senate party leaders, and in the House, between the Speaker of the House and its minority leader. Debate on any amendment under these procedures is limited to one hour and on second-degree amendments, motions, and appeals, to 30 minutes each. Here also, the expedited procedures apply only if the legislation is related only to the program under the Act and satisfies the same fiscal targets required of the IPAB bill.

Consideration of Veto Message

Should the President veto an IPAB-implementing bill, debate on the veto message in the Senate, which would under normal circumstances be unlimited, is confined to one hour, equally divided. There is no similar provision established for the House of Representatives, and it would presumably consider such a veto message under its regular parliamentary mechanisms.[27]

PROCEDURES FOR CONSIDERING JOINT RESOLUTION DISCONTINUING THE INDEPENDENT PAYMENT ADVISORY BOARD PROCESS

Section 3403 of P.L. 111-148 establishes a second "fast track" parliamentary mechanism for consideration of legislation discontinuing the automatic implementation process for the recommendations of the Independent Payment Advisory Board described above.

[27] See CRS Report RS22654, *Veto Override Procedure in the House and Senate*, by Elizabeth Rybicki.

Under the terms of the Act, in order to qualify for consideration under "fast track" procedures, a joint resolution discontinuing the process must meet several conditions:

- It must be introduced in 2017 by not later than February 1 of that year.
- It may not have a preamble.[28]
- It must have the title, "Joint resolution approving the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act."
- It must have the sole text, "That Congress approves the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act."

Introduction, Referral, and Automatic Discharge

Under the terms of the Act, such a joint resolution may be introduced by any Member in either chamber. When introduced, the joint resolution is referred to the Committees on Ways and Means and on Energy and Commerce in the House, and to the Committee on Finance in the Senate. In the Senate, if the Committee on Finance has not reported this joint resolution (or an identical joint resolution) by the end of 20 days of continuous session after its introduction, the committee may be discharged from its further consideration of the measure upon a petition signed by 30

[28] A preamble is a series of "whereas" clauses at the beginning of a measure describing the reasons for and intent of the legislation.

Senators.[29] The committee could also mark up and report the joint resolution, although it is not required to do so, but if it does, it may not report amendments to it.

House Floor Consideration

The Act does not establish special parliamentary procedures governing initial floor consideration of a joint resolution discontinuing the IPAB-implementing process in the House of Representatives. Should the House choose to act on such legislation, it would presumably do so under its regular procedures, most likely by adopting a special rule reported from the House Committee on Rules. Passage of the joint resolution in the House does, however, require a super-majority of three-fifths of Members, duly chosen and sworn, the same as in the Senate.

Senate Floor Consideration

At any time after a qualifying joint resolution has been placed on the Senate's Calendar of Business, it is in order to make a non-debatable motion to proceed to its consideration. Such a motion to proceed may be made even if one has been previously been rejected. As with the IPAB-implementing bill procedure described above, the Act does not specify who may make this motion.

Points of order against the joint resolution and its consideration, with the exception of points of order established by the Congressional Budget Act of 1974 or any budget resolution enacted pursuant to the Budget Act, are waived. If the Senate agrees to the motion to proceed,

[29] Days of continuous session are calculated by counting every calendar day, including Saturdays and Sundays, and pausing the count only at times when either chamber has adjourned for more than three days pursuant to a concurrent adjournment resolution.

consideration of the legislation is "locked in"; the joint resolution remains the unfinished business of the Senate until it is disposed of.

Debate on a joint resolution discontinuing the automatic IPAB-implementing process and on all debatable motions and appeals in connection with the measure is limited to 10 hours in the Senate, with the time divided between the majority and minority leaders or their designees. A non-debatable motion to further limit debate is available.

No amendment (including committee amendment), motion to postpone, motion to proceed to the consideration of other business, or to recommit the joint resolution, may be made. At the conclusion of consideration, and after a single live quorum call, if requested, the Senate votes on the joint resolution. Passage of a joint resolution discontinuing the automatic IPAB process requires a supermajority of three-fifths of Senators, duly chosen and sworn.

Automatic "Hookup" with Other Chamber

As with the special procedures established for considering IPAB-implementing bills described above, the Act also establishes "hookup" procedures to facilitate the consideration in one chamber of a joint resolution passed by the other. If, before the passage by one house of a joint resolution discontinuing the IPAB-implementation process, that house receives an identical joint resolution from the other, that engrossed joint resolution will not be referred to committee, but will become the one on which the receiving chamber takes its final vote. Such provisions are designed to ensure that the House and Senate act on the same legislation.

ADDITIONAL CONSIDERATIONS FOR POLICYMAKERS

Legislation May Face a High Bar

Both the implementing bill and the joint resolution described above are law-making forms of legislation, which must be signed by the President or enacted over his veto to become effective. Should either type of measure be vetoed by the President, overriding the veto would require a super-majority vote of two-thirds in both chambers for the measure to become law. The arguable and perhaps intended effect of the procedures in the Act is to favor the continuation of the IPAB and its recommendations even in the face of significant opposition in both chambers of Congress. This is why some observers have argued that statutory disapproval mechanisms of the type contained in the Act shift the power balance to the executive branch and away from Congress.[30]

Do the Fast Track Procedures Guarantee Congress Can Act?

Supporters argue that the fast track procedures relating to IPAB make it far more likely that a congressional majority will be able to succeed in sending a bill to the President which they support. Others argue that, while the parliamentary procedures governing consideration of an IPAB implementing bill are expedited, they do not in themselves guarantee that Congress will agree on a bill and present it to the President for his consideration. Because it is not possible to "force" the House and Senate to agree on the same bill text, whether Congress can pass an implementing bill which would supersede the recommendations of the IPAB, they argue, remains within the control of Congress itself. Questions may also exist about whether the expedited procedure governing Senate consideration of an IPAB implementing bill precludes all opportunities for opponents to delay such a bill's progress.

[30] See, for example, Rep. Claude D. Pepper, remarks in the House, *Congressional Record*, vol. 134, July 7, 1988, p. 17071.

Either Chamber May Change the Parliamentary Procedure

The "fast track" parliamentary procedures established by the Act for the consideration of both types of IPAB legislation are considered to be rules of the respective houses of Congress even though they are codified in statute. As such, Congress has traditionally viewed them as subject to change in the same manner and to the same extent that any House or Senate rule can be altered by the Members of that chamber. In other words, Congress is not required to amend or repeal the statute to change the procedures. The House or Senate can change the procedures by unanimous consent or by suspension of the rules. The House may also adopt a special rule reported by the House Committee on Rules. In practice, however, as has been noted, altering the statutory procedures in the Senate is potentially difficult if there is not unanimous consent to do so.

Questions Exist About the Mechanics of the Procedures

As is described above, the terms of the Act attempt to "entrench" the procedures themselves against change by requiring a super majority to amend them, as well as to discontinue the automatic IPAB-implementation process. The Act also purports to restrict the ability of future Congresses to enact certain policy changes related to Medicare in other legislation, not just the IPAB-implementing measure. How these entrenching provisions will be reconciled with the well-established constitutional right of each chamber of Congress to make the rules of its own proceeding,[31] and how or if one Congress can broadly regulate the actions of a future Congress in this way, will likely only be clarified in practice.

Questions about the enforcement of these provisions are highlighted when one imagines how the consideration of IPAB legislation might play out in a future Congress. As has been noted, the

[31] U.S. Constitution, Article I, sec. 5.

House of Representatives normally brings major legislation to the floor under the terms of a special rule reported by its Committee on Rules. This is likely to be the method used by a future House of Representatives to consider IPAB-implementing legislation or other bill dealing with rates of Medicare spending.

A special rule establishes unique terms for the consideration of a specific measure and routinely waives all points of order against the measure in question and its consideration. As such, it is unclear if there will be any parliamentary opportunity for a House Member to make a point of order against some future IPAB-implementing bill, for example, that the legislation violates the Act's stricture on changing targeted rates of Medicare spending. While one can certainly envision a Member making a rhetorical argument to that effect, a special rule which waives all points of order against such a bill and its consideration would effectively preclude enforcement of these terms of the Act. For example, a "rider" discontinuing the automatic IPAB process entirely, if included in the conference report on an appropriations bill would similarly be unreachable by points of order if the report were considered under such a special rule or under the House's suspension of the rules procedure.

Questions about the enforcement of the Act's provisions similarly exist in the Senate. Again, traditionally, "fast track" procedures like those contained in the Act have been, in practice, more binding on the Senate than on the House, because the Senate views itself as a "continuing body" having rules that are continually in force. Additionally, altering such statutory procedures has arguably been more difficult in the Senate than in the House, because to change its rules (including statutory rules) the Senate must effectively get all its Members to agree to waive them by unanimous consent or muster a super-majority vote to suspend or to limit debate on a proposal to amend them.

Unlike other statutory fast track procedures now in force, the Act establishes wide-ranging procedures which purport to regulate the consideration of not just one bill, but any legislation violating the Medicare spending goals established by IPAB. To what extent a future Congress will view itself as bound by these broad terms, how the Senate's presiding officer will rule on certain points of order established by the Act, among other questions, will likely require additional clarification by the House and Senate in close consultation with each chamber's Parliamentarian.

CONCLUSION

I am happy to answer any questions you may have about my testimony. Additionally, my colleagues and I at the Congressional Research Service are available to provide additional analytical and research assistance to the subcommittee as it continues its examination of this subject.

Mr. PITTS. The chair thanks the gentleman.

Mr. Newman, you are recognized for 5 minutes for an opening statement.

Mr. NEWMAN. I have no independent testimony.

Mr. PITTS. Ms. Cohen, I apologize to you. I failed to introduce you in the introduction. Diane Cohen, Senior Attorney for Goldwater Institute. You are recognized for 5 minutes.

STATEMENT OF DIANE COHEN

Ms. COHEN. Thank you, Chairman, and thank you, Ranking Member Pallone. I really appreciate the opportunity to come here all the way from Arizona and to discuss with you the unprecedented constitutional issues raised by Congress' establishment of the Independent Payment Advisory Board and the real-world consequences that this unprecedented independent agency will have on the lives of citizens and especially seniors.

The Goldwater Institute's legal challenge to the Patient Protection and Affordable Care Act is unique among the lawsuits challenging the act because ours is the only one that challenges the constitutionality of IPAB. We believe the creation of IPAB represents the most sweeping delegation of Congressional authority in history, a delegation that is anathema to our constitutional system of separation of powers and to responsible, accountable, and democratic lawmaking. IPAB is insulated from congressional, presidential, and judicial accountability to a degree never before seen. It is the totality of these factors that insulate IPAB from our Nation's system of checks and balances that renders it constitutionally objectionable.

Specifically, IPAB is an unelected board of bureaucrats whose proposals can become law without the approval of Congress, without the approval of the President, and they are insulated from rulemaking, administrative and judicial review, and any meaningful congressional oversight. Far from representing Medicare reform, IPAB is an abdication of what has been historically a congressional responsibility. Indeed, it is an unconstitutional delegation of Congress' legislative duties and is unaccountable to the electorate and immune from checks and balances.

And I just want to follow up on what the Secretary testified about earlier this morning. Let us be clear, Section (e)(5), the act specifically prohibits judicial review. And what that means is that the act prohibits judicial review. If the Secretary acts outside the law, there is no judicial review. There is no accountability for her actions. Secondly, these are not mere proposals or recommendations. These are legislative proposals that can become law.

We also heard talk about while one provision says there is no judicial review but we are not supposed to believe that, another provision says a joint resolution is required to dissolve the board, but we are not supposed to believe that, and then another provision prohibits rationing, but we are supposed to believe that.

IPAB is independent in the worst sense of the word. It is independent of Congress, independent of the President, independent of the judiciary, and independent of the will of the American people. Thank you, Mr. Chairman.

[The prepared statement of Ms. Cohen follows:]

Testimony of Diane Cohen

Senior Attorney

Goldwater Institute

Phoenix, Arizona

Before the

United States House of Representatives

Committee on Energy and Commerce

Subcommittee of Health

"IPAB: The Controversial Consequences for Medicare and Seniors"

July 14, 2011

Summary

I appreciate the opportunity to discuss the unprecedented constitutional issues raised by Congress's establishment of the Independent Payment Advisory Board (IPAB) and the real world consequences that this unprecedented independent agency will have on the lives of citizens and particularly seniors.

The Goldwater Institute's legal challenge to the "Patient Protection and Affordable Care Act," is unique among the lawsuits challenging the Act because ours is the only one that challenges the constitutionality of IPAB. We believe the creation of IPAB represents the most sweeping delegation of congressional authority in history, a delegation that is anathema to our constitutional system of Separation of Powers and to responsible, accountable, democratic lawmaking.

IPAB is insulated from congressional, presidential and judicial accountability to a degree never before seen. It is the totality of the factors insulating IPAB from our nation's system of checks and balances that renders it constitutionally objectionable. Specifically, IPAB is an unelected board of bureaucrats, whose proposals can become law without approval of Congress and the President, and are insulated from rulemaking, administrative and judicial review, and any meaningful congressional oversight. Far from representing Medicare reform, IPAB is abdication of what historically has been a congressional responsibility. Indeed, it is an unconstitutional delegation of Congress's legislative duties and responsibilities to an agency that is unaccountable to the electorate and immune from checks or balances.

IPAB is "independent" in the worst sense of the word: it is independent of Congress, independent of the President, independent of the judiciary and independent of the will of the people.

INTRODUCTION

Good afternoon Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee. Thank you for inviting me here today. My name is Diane Cohen and I am Senior Attorney at the Goldwater Institute in Phoenix, Arizona. The Goldwater Institute is an independent government watchdog organization supported by people who are committed to expanding free enterprise and protecting liberty. The Institute develops innovative, principled solutions to pressing issues facing the states and enforces constitutionally limited government through litigation. The Institute focuses its work on expanding economic freedom and educational opportunity, bringing transparency to government and protecting the rights guaranteed to Americans by the federal and state constitutions. I represent plaintiffs Nick Coons and Dr. Eric Novack, in a lawsuit now pending in the federal district court for Arizona that challenges the constitutionality of PPACA and specifically the Independent Payment Advisory Board (IPAB), which is the subject of today's hearing.

I appreciate the opportunity to appear before you today to discuss this legal challenge.[1] Dr. Eric Novack is an orthopaedic surgeon from Glendale, Arizona, who treats Medicare patients. He is challenging IPAB on Separation of Powers grounds, arguing that PPACA vests IPAB with authority to legislate changes to Medicare policy – not merely to "recommend," a euphemism the statute uses – and

also to legislate changes to an undefined sector of the American health care market. Specifically, the statute creates and empowers IPAB to reduce – but not to increase – physician Medicare reimbursements in order to achieve a net reduction in total Medicare spending. This agency enjoys an unprecedented power to make public policy free of meaningful oversight by the legislative, executive or judicial branches. As the Supreme Court reminded us last month, "Separation-of-powers principles are intended, in part, to protect each branch of government from incursion by others. Yet the dynamic between and among the branches is not the only object of the Constitution's concern. The structural principles secured by the separation of powers protect the individual [such as Dr. Novack] as well."[2] This system of checks and balances is critical to our constitution as a precaution against tyranny.[3] Here I want to explain how IPAB enjoys lawmaking power; how congressional, presidential and judicial oversight are lacking; and how IPAB's enabling legislation purports to be unrepealable.

The Supreme Court has explained that Congress may not "abdicate, or . . . transfer to others, the essential legislative functions with which it is vested."[4] Likewise, the Court has recognized that while Congress may create administrative agencies and commissions, it may not yield to another authority the ultimate power to make law. Determining whether Congress has illegitimately given up its lawmaking role or simply delegated power to a subordinate agency is not always

easy, but the Supreme Court has indicated that the "true distinction" between legitimate and illegitimate delegations of authority is that an agency may not exercise the power to make law, but may be given the "authority or discretion as to its execution, to be exercised under and in pursuance of the law."[5] This is a distinction "of degree,"[6] and "varies according to the scope of the power congressional conferred."[7] In other words, the broader the authority conferred on an agency, the more tightly it must be bound by legislative, judicial or executive oversight, and the more precise and narrow its instructions from Congress must be.

Accordingly, the Supreme Court held that unless Congress "lay[s] down by legislative act an intelligible principle to which the person or body authorized to [exercise delegated authority] is directed to conform, such legislative action is . . . a forbidden delegation of legislative power."[8] This "intelligible principles" test is one that examines the totality of the circumstances, "standards, definitions, context, and reference to past administrative practice" in the statute empowering the agency in order to determine whether the agency's decisionmaking is properly guided and confined.[9]

IPAB fails this test. This agency is an unelected, unaccountable independent authority, which is "independent" in the worst sense of the word: it is independent of Congress, independent of the President, independent of the judiciary and independent of the will of the people.

IPAB is composed of fifteen members appointed by the President with the advice and consent of the Senate.[10] The statute does not require the Board to be bi-partisan in make-up, as is required for other independent agencies, such as the Sentencing Commission, Federal Communications Commission, Equal Employment Opportunity Commission, Federal Elections Commission, Federal Trade Commission, Securities and Exchange Commission, Commodities Futures Trading Commission, International Trade Commission, and National Transportation Safety Board.

Beginning on January 15, 2014, and every year thereafter, IPAB must make "detailed and specific" "*legislative* proposals" that are "*related to the Medicare program.*"[11] It is wrong, however, to call these "proposals" or "recommendations," because with one virtually insurmountable exception I will describe shortly, the Secretary of Health and Human Services is required to implement these proposals, effectively making them law without the approval of Congress or signature of the President.[12]

There are few limitations on the scope of IPAB's authority to legislate. The Act provides that Congress is prohibited from amending IPAB's proposals to "ration health care, raise revenues or increase Medicare beneficiary cost sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility requirements."[13] But although the Act specifically prohibits

"rationing," *de facto* rationing is what may in fact result as the practical impact of what IPAB will do: cut physician (and in 2020 hospital) reimbursement rates.

PPACA also strictly constrains the Senate's ability to alter IPAB proposals, such as requiring a 3/5 super-majority to change the Board's proposals or otherwise consider any bill, resolution, amendment or conference report that would repeal or otherwise change a recommendation of the Board, if that change would fail to meet the Act's requirements.[14] Thus, Congress lacks any authority within the Act to alter or reverse IPAB's proposals.

The only way an IPAB proposal does not become law is if 1. Congress successfully amends an IPAB proposal pursuant to the truncated legislative rules and procedures allowed by the statue;[15] or 2. the implementation year is 2020 and a joint resolution described in the Act is enacted not later than August 15, 2017.[16] IPAB's anti-repeal provision is not merely an internal house procedure, but a statute passed by both houses and signed by the president. IPAB's anti-repeal provision is not consistent with fast-track legislation, either from procedural or conceptual standpoints. As my panel colleague Christopher Davis, Congressional Analyst on Congress and the Legislative Process can more fully explain, "fast-track" legislative procedures provide for expedited procedures for committee and floor action on specifically defined types of bills or resolutions. But certainly, a statutory provision that prohibits the introduction of a resolution until 2017, and

then only during a fifteen-day window in that year, and further provides that even if the resolution is passed and signed into law by the President, it would not take effect until 2020, cannot be described as an "expedited" or fast-track procedure under any stretch of the imagination.

Augmenting IPAB's striking degree of autonomy, PPACA expressly prohibits administrative and judicial review of IPAB's legislative proposals that become law.[17] IPAB is also exempt from administrative rulemaking requirements (which are present in the other aforementioned independent agencies).[18] However, rulemaking requirements are essential to the democratic process because they are the only means whereby members of the public can provide input, data and analysis on whether the agency should reject, approve or modify a proposed rule. Indeed, Congress passed the Administrative Procedures Act[19] for this very purpose.

While the absences of judicial review and rulemaking requirements do not in themselves mean IPAB is unconstitutional under the intelligible principles test, they are factors the Supreme Court has used to analyze the constitutionality of congressional delegation. In *Hampton,* the Court noted that the Tariff Commission issued recommendations only *after giving notice and an opportunity to be heard.*[20] Likewise, in *Mistretta,*[21] the Court emphasized that the Sentencing Commission engaged in APA notice-and-comment rulemaking and was fully accountable to Congress, "which can revoke or amend any or all of the [Commission's]

Guidelines as it sees fit either within the 180-day waiting period."[22] None of these compensating forms of constraint are present in PPACA.

Although IPAB purports to regulate only Medicare expenditures, it actually goes much further. IPAB has the potential to regulate private health care markets. For example, the Act *requires* IPAB to produce a "public report" containing "standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the program under this title."[23] IPAB must include in its report "[a]ny other areas that the Board determines affect overall spending and quality of care in the *private sector*."[24] But these are not merely reports, because IPAB is *required* to rely on them when formulating its so-called proposals.[25]

Additionally, PPACA requires IPAB to submit to Congress and the President recommendations to "slow the growth in national health expenditures" in "Non-Federal Health Care Programs,"[26] which includes recommendations that may "require legislation to be enacted by Congress in order to be implemented" or that may "require legislation to be enacted by State or local governments in order to be implemented." [27]

In other words, IPAB has broad powers to regulate *private* health care and insurance markets, so long as such action is "related to the Medicare program" and

"improv[es] health care outcomes," and serves IPAB's other stated goals.[28] Timothy Jost, a leading expert on PPACA, has recently written that it may not be possible to cap Medicare expenditures as IPAB is required to do without addressing private expenditures, and that IPAB is likely to end up setting prices for *all* medical services in the private health care market.[29]

Moreover, in creating IPAB, Congress yields its historic role in legislating Medicare reimbursement rates. The *Bowsher* Court examined Congress's historical view of the Comptroller General as an officer of the legislative branch in determining whether enforcement powers delegated to him were a violation of the Separation-of-Powers doctrine.[30] The Court looked to prior statutes that discussed the role of the Comptroller General, showing that the Comptroller was part of the legislative branch and an "agent of Congress."[31]

Far more than was the case in *Bowsher*, PPACA gives this independent agency autonomous lawmaking power over subjects traditionally legislated upon by Congress. Over the last two decades, Congress has set Medicare reimbursement rates. Yet PPACA transfers this traditionally congressional power to the autonomous jurisdiction of IPAB.[32]

It is true, of course, that Congress has at times transferred some of its traditional powers to independent agencies, subject only to lenient congressional

oversight, but none of those precedents even approach the extreme degree of independence that IPAB enjoys.

Some have compared IPAB to the Defense Base Closure and Realignment Commission (BRAC),[33] for example, and to the Congressional Review Act (CRA),[34] both of which establish "fast track" procedures for Congress's "disapproval of agency regulations." However, like the Sentencing Commission, both of these statutes included provisions for congressional oversight and constraint, which IPAB lacks. Further, neither BRAC nor CRA contain anti-repeal provisions.

BRAC was established to issue recommendations regarding the closure and realignment of military installations, through what the Supreme Court has described as an "elaborate process." [35] But unlike IPAB, BRAC's task did not even begin until *after* the Secretary of Defense prepared closure and realignment recommendations, based on statutorily set selection criteria, which he established *after* notice and an opportunity for public comment. BRAC was required to hold public hearings and prepare a report on those recommendations and then issue its own recommendations for base closures and realignments. [36] The Commission then submitted its report to the President, who could approve or disapprove them. If the recommendations were approved, they were submitted to Congress but Congress then had the opportunity to enact a resolution to disapprove the

recommendations and bar the closures.[37] PPACA contains no similar mechanisms for presidential or congressional review of IPAB's "recommendations" before they become law.

The CRA is also entirely different from IPAB's enabling legislation. It establishes expedited procedures allowing Congress to disapprove agency regulations. While it establishes a "fast-track" procedure for review of regulations, it does nothing to alter administrative rule-making or judicial review of regulations, nor does it entrench regulations from repeal or amendment. Neither BRAC nor CRA shares anything in common with IPAB, in terms of purpose, policy, procedure or scope of independence from Congress and the Courts.

Indeed, several provisions, subsections (d) and (f)(2), are designated "fast track" because they contain numerous limitations on congressional debate and consideration of IPAB proposals.[38] These so-called "fast tracks" are the only provisions specifically enacted as an exercise of Congress' rulemaking power. The anti-repeal provision (contained in subsections (f) and (f)(1)), is *not* one of these two subsections. Furthermore, IPAB's anti-repeal provision is designed to *decrease* Congressional control, not to increase it.

IPAB is not only immune from meaningful congressional oversight and judicial review, it is also insulated from executive control. By mandating that the President "*shall*" submit IPAB proposals to Congress,[39] PPACA unconstitutionally

restricts the President's powers to "recommend to [Congress's] Consideration such Measures as he shall judge necessary and expedient."[40] Indeed, Presidents have routinely asserted their authority under the Recommendations Clause, including President Obama.[41]

PPACA also entrenches IPAB from repeal. In order to repeal IPAB pursuant to the Act, Congress is *required* to enact a Joint Resolution to that effect,[42] but is prohibited from even introducing such a resolution until 2017, *and* no later than February 1, 2017, *and* the Resolution must be enacted no later than August 15, 2017, or Congress is foreclosed from repealing the Board.[43] If such a resolution is introduced, the Act mandates an unprecedented super-majority vote to pass the resolution: 3/5 *of all elected members of Congress*, a more severe supermajority requirement than any of which I am aware in the history of American law.[44] And even in the event such a resolution could clear these hurdles, the dissolution would not become effective until 2020.[45]

It is a maxim of representative government that one Congress does not have the power to bind the hands of a future Congress, which is precisely what IPAB's anti-repeal provision does. The Constitution states that "All legislative Powers herein granted shall be vested in a Congress of the United States."[46] IPAB's anti-repeal provision denies future congresses these basic legislative powers, thereby diminishing Congress' constitutional powers via statute. That Congress may not

supersede the Constitution by statute was recognized by the great Justice John Marshall as being "one of the fundamental principles of our society."[47] Although scholars throughout history have addressed the notion of entrenchment, this "most familiar and fundamental principle[]" has long been perceived as "so obvious as rarely to be stated."[48] Thomas Jefferson noted that if a present legislature were to "pass any act, and declare it shall be irrevocable by subsequent assemblies, the declaration is merely void, and the act repealable, as other acts are."[49]

Indeed, the Supreme Court has long recognized that "a general law . . . may be repealed, amended or disregarded by the legislature which enacted it," and "is not binding upon any subsequent legislature." [50]To be sure, there are times when Congress may bind its successors by entering into contracts whose duration outlives the current legislature. But this does not undermine the underlying rationale against entrenchment; rather, it strengthens it.

A closer look at IPAB exposes its virtually limitlessness powers to legislate. In sum, the following factors in their totality reveal an unprecedented delegation of legislative authority in violation of the Separation-of-Powers doctrine:

- IPAB's "legislative proposals" are insulated from the APA notice and comment requirements;
- The Secretary is required to implement these "legislative proposals" without regard for congressional or presidential approval;
- PPACA prohibits administrative and judicial review of IPAB proposals;

- Congress is restricted from meaningful oversight through fast-track procedures that limit consideration and debate of IPAB's legislative proposals;

- PPACA prevents Congress from altering or amending IPAB's proposals in any way except to add provisions that IPAB could have itself added but for some reason failed to do;

- Congress may only bar IPAB'S "legislative proposals" from automatically becoming law if 3/5 of all sworn members of Congress pass a joint resolution to dissolve IPAB during a short window in 2017; and

- PPACA curtails the presidential constitutional power to recommend such measures as he considers expedient pursuant to Article II, sec. 3.

Not long ago, Justice Scalia predicted that, unless the constitutional prohibition on delegations of legislative power was rigorously enforced, Congress could create:

> "expert" bodies, insulated from the political process, to which Congress will delegate various portions of its lawmaking responsibility. How tempting to create an expert Medical Commission (mostly M.D.s, with perhaps a few Ph.D.s in moral philosophy) to dispose of such thorny, "no-win" political issues as the withholding of life-support systems in federally funded hospitals. The only governmental power the Commission possesses is the power to make law; and it is not the Congress.[51]

Unfortunately, the "Medical Commission" Justice Scalia warned of now exists: its name is IPAB.

Respectfully submitted,

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[1]PPACA was amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 ("HCERA"). All citations are to PPACA as amended by HCERA.
[2]*Bond v. United States*, 2011 WL 2369334 *8 (June 16, 2011).
[3]*Loving v. United States,* 517 U.S. 748, 756 (1996).
[4]*Currin v. Wallace*, 306 U.S. 1, 15 (1939).
[5]*Loving*, 517 U.S. at 758-59.
[6]*Mistretta v. United States*, 488 U.S. 361, 415 (1989) (Scalia, J. dissenting).
[7]*Whitman v. Am. Trucking Ass'ns, Inc.*, 531 US. 457, 475 (2001).
[8]*J.W. Hampton v. United States*, 276 U.S. 394, 409 (1928).
[9]*Bowsher v. Synar*, 478 U.S. 714, 720 (1986).
[10]42 U.S.C. § 1395kkk(g)(1)-(4).
[11]§ 1395kkk(b)(1)(3); (c)(1)(A) and (c)(2)(A)(vi); (d)(1)(A), (B), (C), (D); and (e)(1) and (3) (emphasis added).
[12]*See*, §1395kkk(e)(1).
[13]§ 1395kkk(d)(3)(A).
[14]§ 1395kkk(d)(3)(A)-(E).
[15]§ 1395kkk(e)(3)(A) (i).
[16]§ 1395kkk(e)(3)(A)(ii).
[17]§ 1395kkk(e)(5).
[18]IPAB merely *permits* the Secretary to engage in *interim final* rulemaking. *See* § 1395kkk(e)(2)(B). Likewise, the Act *permits* but does not require IPAB to hold hearings, take testimony and receive such evidence as the Board considers advisable. §1395 (h)(i)(1).
[19]5 U.S.C. § 552, *et seq*.
[20]*Hampton*, 276 U.S. at 405.
[21]488 U.S. at 394.

[22]*See also United States v. Lopez*, 938 F.2d 1293, 1297 (D.C. Cir. 1991) (the lack of judicial review in the Sentencing Reform Act was offset by "ample provision for review of the guidelines by the Congress and the public" and, thus, "no additional review of the guidelines as a whole is either necessary or desirable"); Sentencing Act, 28 U.S.C. § 994(p).
[23]§ 1395kkk(n)(1).
[24]§ 1395kkk(n)(1)(E) (emphasis added).
[25] *See* § 1395kkk(c)(2)(B)(vii).
[26]§ 1395kkk(o)(1).
[27]§ 1395 (o)(A)-(E).
[28]*See generally* §1395kkk(c)(2)(B)(i-vii).
[29]Timothy Jost, *The Independent Medicare Advisory Board,* 11 YALE J. HEALTH POL'Y L. & ETHICS 21, 43 (2011).
[30]*Bowsher*, 478 U.S. at 731.
[31]*Id.*
[32]*See, e.g.*, the 1989 Omnibus Budget Reconciliation Act (PL 101-239), which introduced the resource-based relative value scale fee schedule (RB-RVS) and was the first change to the original Medicare Part B system that paid physicians based on usual, customary, and reasonable charges; the 1997 Balanced Budget Act (PL 105-33), which introduced the sustainable growth rate (SGR) that was designed to act as a restraint on Medicare spending and sets a "sustainable" growth rate for spending on Medicare services starting in April 1996 ; the 2003 Consolidated Appropriations Resolution of 2003 (108-7), which resulted in a 1.4% increase in reimbursement rates, when the scheduled reduction was 4.4%; the Medicare Modernization Act of 2003 (PL 108-173), which resulted in a 1.5% increase in reimbursement rates, when the scheduled reduction was 4.5%; the 2010 Department of Defense Appropriates Act (PL 111-118), which canceled a 21.3% decrease in the reimbursement rate; and the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, which resulted in 2.2% increase in reimbursements.
[33]10 U.S.C. § 2687.
[34]5 U.S.C. §§ 801-808.
[35]*See Dalton v. Specter*, 511 U.S. 462, 464-465 (1994).
[36]*Id.* at 465.
[37]*Id.*
[38]*See* § 1395kkk (d)(3)(A)-(E) and (d)(4)(A)-(F).
[39]§ 1395kkk(c)(4).
[40]U.S. Const. art. I § 3.

[41]*See*, Statement by President Obama on H.R. 1105, Omnibus Appropriations Act, March 11, 2009 ("Several provisions of the Act . . . effectively purport to require me and other executive officers to submit budget requests to Congress in particular forms. Because the Constitution gives the President the discretion to recommend only 'such Measures as he shall judge necessary and expedient' . . . I shall treat these directions as precatory."); *see also*, Statement by President Clinton on S. 2327, Oceans Act of 20000, Aug. 7, 2000 ("The Recommendations Clause . . . protects the President's authority to formulate and present his own recommendations [to Congress.]" President Clinton construed the statute so as not to extend to proposals or responses that he did not wish to present.
[42]§ 1395kkk(f)(1)(C) and (D).
[43]*See* § 1395kkk(f)(3).
[44]By comparison, only two-thirds of Senators *present* need to vote to remove a sitting president, U.S. Const. art. I, § 4, or to make a treaty the supreme law of the land. U.S. Const. art. II, § 2.
[45]§ 1395kkk(e)(3)(A); but *see*, due to an apparent scrivener's error, § 1395kkk(f)(1) should cross-reference subsection (e)(3)(A), not (e)(3)(B).
[46]U.S. Const. art. I, § 1.
[47]*Id.*
[48]Charles L. Black, Jr., *Amending the Constitution: A Letter to a Congressman*, 82 Yale L.J. 189, 191 (1972).
[49]Thomas Jefferson, Notes on the State of Virginia 126 (Wells and Lilly 1829)(cktj).
[50]*Manigault v. Springs*, 199 U.S. 473, 487 (1905); *see also Street v. United States*, 133 U.S. 299, 300 (1890) (holding that an act of Congress "could not have . . . any effect on the power of a subsequent Congress").
[51]*Mistretta*, 488 U.S. at 422 (Scalia, J. dissenting).

Mr. PITTS. The chair thanks the gentlelady and recognizes Dr. Feder for 5 minutes.

STATEMENT OF JUDITH FEDER

Ms. FEDER. Thank you, Chairman Pitts, Ranking Member Pallone, members of the committee.

Mr. PITTS. Pull your mike—or push it on. Yes.

Ms. FEDER. OK?

Mr. PITTS. That is better.

Ms. FEDER. I will start again. Chairman Pitts, Ranking Member Pallone, members of the committee, I am glad to be with you this morning as you consider the role of the Independent Payment Advisory Board established by the Affordable Care Act.

I would like to start in thinking about how to approach that by calling your attention to the fact that Medicare is an enormously successful program, more successful than private health insurance in pooling risk and controlling costs. Medicare has historically achieved slower spending growth than private insurance, and the ACA extends its relative advantage. Action taken in the Affordable Care Act achieves an average annual growth rate of 2.8 percent per Medicare beneficiary for 2010 to 2021, 3 percentage points slower than per capital national health spending. National health spending is projected to grow faster than GDP growth per capital by close to 2 percentage points, but Medicare's projected per beneficiary spending growth will be a full percentage point below growth in per capital GDP.

Growing slower than the private sector is good but not good enough since both public and private insurers pay too much for too many services and fail to assure sufficiently delivered quality care. That is why the Affordable Care Act goes beyond tightening fee-for-service payments to pursue a strategy of payment and delivery reform and creates the IPAB to assure effective results. The strategy includes payment reductions for overpriced or undesirable behavior and bonuses or rewards for good behavior, most especially for payment arrangements that reward providers for coordinated integrated care efficiently delivered.

These reforms have the potential to transform both Medicare and, by partnership and example, the Nation's healthcare delivery system to provide better quality care at lower cost. But their achievement in implementation cannot be assumed. That is why the IPAB exists, to recommend ways to achieve specified reductions in Medicare spending by changing payments to healthcare providers. In essence, IPAB serves to inform and assure congressional action to keep Medicare spending under control.

Some legislators have proposed to repeal the IPAB, but along with about 100 health policy experts who recently wrote congressional leaders in support of IPAB, I see that effort as sorely misguided. As we wrote, the IPAB enables Congress to mobilize the expertise of professionals to assemble evidence and assure that the Medicare program acts on the lessons of the payments and delivery innovations the Affordable Care Act seeks to promote.

I contrast the ACA strategy to strengthen Medicare with the inclusion of IPAB with the alternative strategy not only to repeal IPAB but also to eliminate Medicare for future beneficiaries, re-

placing it with vouchers for the purchase of private insurers, vouchers that take advantage of all Medicare payment reductions included in the Affordable Care Act. The Congressional Budget Office analysis shows that such action would not slow healthcare cost growth. Rather, it would increase insurance costs and shift responsibility for paying most of them onto seniors, doubling out-of-pocket costs for the typical 65-year-old from about 6 to $12,000 in 2022 with out-of-pocket spending for beneficiaries growing even further in the future as the gap between Medicare—slower cost growth—and private insurance—more faster cost growth—would increase.

Given Medicare's track record relative to private insurance in delivering benefits and controlling costs, morphing Medicare into a private insurance market simply makes no sense. Medicare is clearly doing its part to control spending and to bring the rate of spending growth under control. But healthcare spending growth is not fundamentally a Medicare problem. It is a health system problem. Medicare can only go so far on its own to promote efficiencies without partnership with the private sector. Effective payment and delivery reform requires an all-payer partnership to assure that providers actually change their behavior rather than looking to favor some patients over others or to pit one pair against another.

Rather than moving to abandon IPAB which supports Medicare's continued and improved efficiency, Congress should therefore modify IPAB's current spending target to apply not just to Medicare but to private insurance, indeed, to all healthcare spending and extend its authorities to trigger recommendations for all payer payment reform if the target is breached. Only payment efficiencies that apply to all payers can assure Medicare and all Americans the affordable quality care we deserve.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Feder follows:]

Testimony

by

Judith Feder, Ph.D.

Professor and former Dean, Georgetown Public Policy Institute, and Urban Institute Fellow

Before the

HEALTH SUBCOMMITTEE
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES

July 13, 2011

Chairman Upton, Ranking Member Pallone and members of the committee, I appreciate the opportunity to appear before you today as you consider the role of the Independent Payment Advisory Board established by the Affordable Care Act (ACA). Along with its extension of essential health insurance coverage to tens of millions of Americans, the ACA reduces the federal deficit—in large part because of measures the law takes to responsibly slow the growth in Medicare and overall health spending. Establishment of the Independent Payment Advisory Board (IPAB) is one such measure. The IPAB serves as a guarantor of the ACA's investment in cost-containment.

Having IPAB as a backstop to sustain Medicare's financing is not only critical to securing this vital program that makes health care affordable for older and many disabled Americans; but also to assure that Medicare leads the much-needed transformation of the nation's entire health care payment system—moving from reliance on mechanisms that reward the delivery of ever more, and ever more expensive services, regardless of their contribution to health, to mechanisms that reward high quality care, efficiently provided. In short, the IPAB is part of the Affordable Care Act's commitment to assuring all Americans quality care at lower cost.

As you consider the role of the IPAB, I urge you to consider that:

- Medicare is an enormously successful program—more successful than private insurance in pooling risk and controlling costs.
- Medicare's per capita cost growth has historically been slower than per capita growth in private insurance. But, as a result of measures taken in the Affordable Care Act, Medicare's relative advantage grows dramatically in the coming decade. Its projected 2.8 percent average annual growth rate in spending per beneficiary is projected to be a full percentage point below per capita growth in GDP and three percentage points below growth in national health expenditures per capita. ACA-initiated payment reforms, already under way, have the potential to improve quality and reduce spending growth even further. The IPAB provides a back-up to assure that these savings and efficiencies are actually achieved.
- Medicare is clearly doing its part to control health care cost growth. But spending growth is not, fundamentally, a Medicare problem; it's the problem of the entire health care system. Medicare can only go so far on its own in promoting efficiencies, without partnership with the private sector. Effective payment and delivery reform requires an all-payer partnership to assure that providers' actually change their behavior, rather than looking to favor some patients over others or pit one payer against another. .
- What's needed, therefore, is not to abandon IPAB—and certainly not to morph Medicare into less effective private insurance. Rather, we should extend the expertise and authority IPAB focuses on Medicare to apply to all payers—with a system-wide spending target

that triggers all-payer payment reform to assure Medicare beneficiaries and all Americans the high quality, efficiently delivered care we deserve.

The importance of securing Medicare cannot be overstated. From its inception, Medicare was designed to avoid the problems that plague the private health insurance market. Unlike private insurers, for whom administration, marketing and profits may absorb 15-20 percent of health care premiums, Medicare spends only 3 percent on program administration. While private insurers compete to enroll the healthy and avoid the sick, Medicare pools the overwhelming majority of beneficiaries in a single program—avoiding discrimination based on pre-existing conditions and denials of coverage when people are sick. And, when it comes to costs, Medicare's ability to purchase care from hospitals, doctors and other providers on behalf of virtually all its beneficiaries—rather than having individual beneficiaries or even several insurers negotiate on their own—has historically kept its rate of cost growth per beneficiary below premium growth in private insurance.

The Affordable Care Act promotes cost containment for the future in multiple ways, beginning by setting future payment rates to hold hospitals and other institutional health care providers accountable for productivity gains on a par with those achieved by every other sector of our economy over the past several decades. The result is an average annual per beneficiary growth rate of 2.8 percent for 2010 to 2021—3 percentage points slower than per capita national health expenditures. A this growth rate (3.9 percent per year), national health spending will actually exceed average annual GDP growth per capita by close to 2 percentage points. By contrast, Medicare's projected per beneficiary spending growth will be a full percentage point below growth in per capita GDP. With per capita cost growth slowed, for the first time in the program's history, enrollment growth has become a major driver of overall Medicare spending.

A slower spending increase than the private sector's, however, does not mean that Medicare uses its dollars as efficiently and effectively as it can—particularly as the aging of the baby boomers and expanded enrollment become a significant driver of its overall costs. Public and private insurers alike pay too much for too many services and fail to assure efficiently delivered, quality care. That's why the Affordable Care Act goes beyond tightening fee-for-service payments to pursue a strategy of payment and delivery reform—and creates the IPAB to assure effective results. Payment reform involves a mix of strategies to support not just cheaper but better care:

- **No rewards for 'bad' behavior**. The ACA authorizes the Secretary of Health and Human Services to review and alter "misvalued" fees, such as paying more for services than they're worth, and to reduce payments for clearly undesirable behavior, such as hospital-acquired infections or conditions, inappropriate hospital readmissions, and, even more egregious, outright fraud.
- **Bonuses for 'good' behavior.** Alongside what might be considered these "sticks" to change behavior, the ACA authorizes a set of "carrots," or rewards to delivery of more

effective and efficient care. At the most basic level, these rewards are extra payments to providers for doing "good" things—say, meeting a set of efficiency standards while maintaining quality care. But more importantly, these rewards reside in alternative payment mechanisms to replace today's fee-for-service payment system.

- **Payment reforms.** Among the new payment systems the new health law encourages are "accountable care organizations", collaboratives of inpatient and outpatient providers who will be rewarded for delivering quality care to a defined set of patients at lower-than-projected costs; "patient-centered medical homes" to promote the financial and health benefits of primary care and chronic care management; and "bundling" separate fees surrounding a hospital episode into a single payment for services associated with a specific condition, such as a hip fracture, which today would include separate fees for diagnosis, surgery, and postoperative care.

These reforms have the potential to transform both Medicare and, by example and in partnership, the nation's health care delivery system to provide better quality care at lower costs. But their achievement and implementation cannot be assumed. To assure that its savings objectives are actually achieved, the ACA's cost containment strategy includes a back-up enforcement mechanism—the Independent Payment Advisory Board or IPAB. The board consists of 15 members, appointed by the President and confirmed by the Senate, to include experts in health economics and insurance, as well as consumer representatives.

The Board is empowered to undertake analysis on ways to promote efficiency in both Medicare and national care spending, and to make recommendations accordingly. But, with respect to Medicare, if spending is projected to exceed the annual Medicare per capita cost-growth target specified in the ACA, the IPAB is required to recommend ways to achieve specified reductions in Medicare spending by changing payments to health care providers, and Congress is required to fast-track consideration of those proposals in the legislative process. Unless Congress votes to reject the proposal (with 60 votes in the Senate) or passes an alternative proposal that achieves similar savings, the Secretary of Health and Human Services must implement the IPAB recommendations. In essence, IPAB serves to inform and assure congressional action to keep provider payment under control.

Some legislators have proposed to repeal the IPAB. But along with about a hundred health policy experts who recently wrote congressional leaders in support of IPAB, I see that effort as sorely misguided. As we wrote, the IPAB enables Congress to mobilize the expertise of professionals to assemble evidence on how payment incentives affect care delivery and to use that evidence to suggest sensible improvements. As an independent, expert, evidence-driven body, we argued, the IPAB will support, not diminish, the Congress' capacity to assure that the Medicare program acts on the lessons of the payment and delivery innovations the Affordable Care Act seeks to promote.

Rather than support this strategy to strengthen Medicare and, indeed, the overall health care system by promoting better care at lower costs, opponents of the Affordable Care Act have proposed not only to repeal IPAB but also to eliminate Medicare for future beneficiaries—replacing it with vouchers for the purchase of private insurance. As analysis of that proposal by the Congressional Budget Office makes crystal clear that strategy would not slow health care cost growth. Instead, it would increase insurance costs and shift responsibility for paying most of them onto seniors. The cost of private insurance is, to start with higher than the cost of Medicare, and, as noted above is growing considerably faster. A voucher set equal to Medicare costs in 2022, when the proposed change would begin, would be insufficient to buy Medicare benefits in private insurance. With this voucher, a typical 65 year old's out-of-pocket spending would be about twice what it's projected to be under traditional Medicare—an additional $6000 in out-of-pocket spending—in 2022. And as the gap between Medicare costs and private premiums continues to grow—extra out-of-pocket spending would rise to $11,000 in 2030. Given Medicare's track record relative to private insurance in delivering benefits and controlling costs, morphing Medicare into a private insurance market simply makes no sense.

Rather than replace the IPAB, let alone Medicare, what does make sense is to use the IPAB to align the private sector with the public sector's commitment to health care payment reform and slower cost growth. Medicare payment changes have already brought its spending per capita well below both per capita growth in GDP and per capita private health care costs. And its emphasis on payment and delivery reform can achieve even more. But success in that effort depends on more than Medicare. Medicare can only go so far on its own to promote efficiencies, without partnership with the private sector. Effective payment and delivery reform requires an all-payer partnership to assure that providers actually change their behavior, rather than looking to favor some patients or others or pit one payer against another. Rather than moving to abandon IPAB, which supports Medicare's continued and improved efficiency, Congress should therefore modify IPAB's current spending target to apply not just to Medicare but to private insurance—all health care spending, and extend its authorities to trigger recommendations for all-payer payment reform if the target is breached.

Health care cost growth is not, fundamentally, a Medicare problem—though Medicare is doing its part to control it; it's a health care system problem—and it's the private sector that needs to become a full-fledged partner in Medicare's efforts. As you address concerns about Medicare's future and the fiscal future of the nation, I therefore urge you not simply to recognize IPAB's value in helping slow Medicare cost growth, but also to take action to extend the expertise and authority IPAB provides to move all payers in partnership toward reforms that will deliver better quality care at lower costs. Only payment efficiencies that apply to all payers can assure Medicare and all Americans the affordable, quality care we deserve.

Mr. PITTS. The chair thanks the gentlelady and recognizes the gentleman, Mr. Roy, for 5 minutes.

STATEMENT OF AVIK S. ROY

Mr. ROY. Chairman Pitts, Ranking Member Pallone, and members of the Health Subcommittee——

Mr. PITTS. Is your mike on?

Mr. ROY. Chairman Pitts—there we go—Ranking Member Pallone, members of the Health Subcommittee, thanks for inviting me to speak with you today about IPAB.

My name is Avik Roy and I am a healthcare analyst at Monness, Crespi, Hardt, and Company, a securities firm in New York. In that capacity, I recommend healthcare investments to our clients who represent the largest investment firms in the world. In addition, I am a senior fellow in healthcare at the Heartland Institute in which capacity I conduct research on health policy with an emphasis on entitlement reform.

In my remarks today I will focus on four questions: first, why is Medicare so expensive? Second, what is the best way to adjust the growth of Medicare spending while preserving high-quality care for seniors? Third, is IPAB likely to aid these goals? Fourth, is IPAB perfect as it is? Is it possible to reform or improve IPAB or should Congress scratch the whole thing and try something else?

Why has Medicare spending gone through the roof? Many trees have been killed in search of answers to the questions. Well, while there are many plausible drivers of Medicare spending growth, the single-biggest problem is this: it is easy to waste other people's money. It is like the difference between a cash bar and an open bar. At a cash bar, I might order a beer or a house wine, but at the open bar, I would probably ask for a fine Kentucky bourbon, especially if Congressman Guthrie and Whitfield come back. Price becomes no object in such a system. And Medicare is more like that open bar. As a result, seniors tend to be entirely unaware of how expensive their treatments are and have no incentive to avoid unnecessary or overpriced care. Studies show that spending has increased most rapidly in those areas of healthcare where individuals bear the least responsibility for their own expenses.

So what should Congress do? There are three ways to deal with the Medicare cost problem. The first, which is what we do now, is to avoid hard choices by promising that we will cover nearly every treatment but underpay doctors and hospitals in compensation. The second approach, which we call rationing, is for Medicare to determine either by congressional order or an expert panel that certain treatments aren't cost-effective and deny them to seniors who seek them out. The third option would be to let seniors decide by granting them more control over their own health dollars either by increased cost-sharing and/or by allowing them to choose between different insurance plans with different benefit packages.

Our current approach, underpaying doctors and hospitals, is leading more and more doctors to drop out of Medicare. We already see this problem in Medicaid where internists are almost nine times as likely to reject all Medicaid patients for new appointments than those with private insurance. According to Medicare Actuary Richard Foster, Medicare reimbursement rates will become worse

than those of Medicaid within the next 9 years. And studies show that health outcomes for many Medicaid patients are worse than those who have no insurance at all.

As you know, after objections at rationing care through IPAB would resemble a death panel, Congress severely constrained IPAB's authority preventing the board from including any recommendation to ration care, raise premiums, increase cost-sharing, restrict benefits, or alter eligibility requirements. I know that you are all very familiar with the endless tussle over the Medicare sustainable growth rate, or SGR, which has caused significant fiscal headaches because Congress routinely overrides the SGR's requirements for reduced payments to doctors and hospitals. But IPAB, as it is currently designed, is similar to SGR in that its primary approach to cost control involves reducing payments to physicians. These global reimbursement cuts haven't worked in the past and they won't work in the future. Hence, we should be seriously concerned that IPAB as it is currently designed will reduce seniors' access to doctors and healthcare services, thereby worsening the quality and outcome of their care.

So the question we must then ponder is can IPAB be fixed or should Congress wholly repeal it? It is conceivable that a differently designed IPAB could help Medicare spending more efficient. For example, an IPAB that was empowered to make changes to Medicare premiums, cost-sharing provisions, and eligibility requirements could assist Congress in enacted much-needed reforms to the program.

I know that both IPAB's proponents and its opponents see the board as a foot in the door for government rationing. But let us remember that for 45 years we have misled the public into thinking that we could provide seniors with unlimited taxpayer-funded healthcare with no constraints. IPAB, to its credit, is an attempt at intellectual honesty because government rationing is a logical and necessary consequence of single-payer systems like Medicare.

Between IPAB and the 2012 House budget, Congress can now have an honest debate. Should we move to a more British-style system of rationing under single-payer healthcare or should we move to a more Swiss-style system of individual choice and diverse options? In the diversity-and-choice approach, if you don't like how your health plan restraints costs, you can switch to another plan or spend your own money on a more generous plan. In the government-driven approach, you have to accept what the government tells you to accept or pay onerous economic penalties.

It is certainly my view that diversity and choice is more appealing and also more likely to work.

Thanks again for having me. As an addendum to my written testimony, I am including an article from the latest issue of National Affairs in which I further expand on these issues. I look forward to your questions.

[The prepared statement of Mr. Roy follows:]

Testimony before the Health Subcommittee of the House Energy & Commerce Committee

July 13, 2011

IPAB: The Controversial Consequences for Medicare and Seniors

Avik Roy
Senior Analyst, Monness, Crespi, Hardt & Co.
Senior Fellow, Heartland Institute

Summary

Because Medicare spending is growing far more quickly than the tax base that supports it, it is simply not possible to address our fiscal problems only by increasing the taxes that fund Medicare. We must find a way to ensure that Medicare spending grows at a rate that is similar to that of the economy as a whole.

Medicare is expensive because seniors have no incentive to shop for value. The single largest driver of Medicare cost inflation is the fact that retirees bear little of the expense for their own care. As a result of this arrangement, seniors tend to be entirely unaware of how expensive their treatments are, and have no incentive to avoid unnecessary or overpriced care. Although Medicare was originally designed with cost-sharing in mind, in the form of deductibles, coinsurance, and copays, "Medigap" and other supplemental policies are a significant driver of Medicare spending growth, because they eliminate the cost-sharing provisions in the Medicare program.

We have three choices: underpaying providers, rationing care, or reforming cost-sharing. There are three ways to deal with this problem. The first, which is what we do now, is to avoid hard choices by promising that we'll cover nearly every treatment, but underpaying doctors and hospitals for their work. The second approach, which we call "rationing," is for Medicare to determine, either by Congressional order or an expert panel, that certain treatments aren't cost effective, and deny them to seniors who seek them out. The third option would be to let seniors decide what treatments to pay for, by granting retirees more control over their own health dollars: either by giving them more skin in the game, through increased cost-sharing, and/or by allowing them to choose between different insurance plans with different benefit packages.

IPAB focuses on reducing provider payments, which is unlikely to work. Global reimbursement cuts, of the kind mandated by the Sustainable Growth Rate and by IPAB, are highly unlikely to work. We all know that Congress has repeatedly overridden the SGR provisions with so-called "doc fix" legislation. In addition, doctors and hospitals undermine these reimbursement cuts by performing more procedures in less time, or by dropping out of the program. We are already seeing harmful effects from this approach on Medicare's health outcomes. Hence, we should be seriously concerned that IPAB, as it is currently designed, will reduce seniors' access to doctors and health care services, thereby worsening the quality of their care.

IPAB could be improved with a different mandate, but a better approach would be to move to a premium support model with stronger cost-sharing. It is conceivable that a differently designed IPAB could help make Medicare spending more efficient. For example, an IPAB that was empowered to make changes to Medicare premiums, cost-sharing provisions, and eligibility requirements could assist Congress in enacting much-needed reforms to the program. However, a more attractive approach would be to give seniors more control and more responsibility for their own health spending. The 2012 House budget is a promising move in that direction, as is the Lieberman-Coburn proposal in the Senate. I hope that Congress can find a way to advance both.

Written Statement

Chairman Pitts, Ranking Member Pallone, and members of the Health Subcommittee of the House Energy and Commerce Committee: thanks for inviting me to speak with you about Medicare's new Independent Payment Advisory Board, and about the broader challenge of making Medicare affordable for future generations. I'm especially pleased to be speaking before three representatives of my home state of Michigan.

My name is Avik Roy, and I'm a health care analyst at Monness, Crespi, Hardt & Company, a securities firm in New York. In that capacity, I make investment recommendations within the health care sector for our clients, who are among the largest investment funds in the world. In addition, I am a Senior Fellow in Health Care at the Heartland Institute, in which capacity I conduct research on health policy, with an emphasis on entitlement reform. I've written extensively on the topic of Medicare's rapidly increasing expenditures, and also on the concept of using government-appointed experts to curb those expenditures.

In my remarks today, I'll focus on four questions. First, why is Medicare so expensive? Second, what is the best way to adjust the growth of Medicare spending, while preserving high-quality health care for seniors? Third, is IPAB likely to achieve these goals? Fourth, is IPAB perfect as is, is it possible to reform or improve IPAB, or should Congress scratch the whole thing and try something else?

Introduction

As all of you know, per-capita spending on Medicare has been growing at nearly twice the rate of the economy. On top of that, because of the retirement of the Baby Boom generation, the number of people on Medicare is set to grow from 47 million today to 77 million in 2030, 19 years from now.

Because Medicare spending is growing far more quickly than the tax base that supports it, it is simply not possible to address our fiscal problems only by increasing the taxes that fund Medicare. As Andrew Rettenmaier and Thomas Saving have shown, Medicare payroll taxes would need to quadruple today in order to cover the program's unfunded liabilities; alternatively, income-tax rates would have to increase by 57%. And even this would be sufficient only if we made the generous, but dubious, assumption that dramatic tax increases would not retard future economic growth (and thereby future tax revenues).

So we must find another way, and soon. If Washington fixes Medicare only after a debt-driven economic disruption, the likely outcome will involve draconian across-the-board cuts in benefits to retirees, painful rationing of medical services, and restricted access to doctors and hospitals. In that scenario, the wealthy will be affected the least, as they will be the ones most able to purchase supplemental insurance to address their needs. It will be the poorest, and the sickest, of Medicare's enrollees who will get left behind.

Why is Medicare so expensive?

There have been many books published, papers penned, and trees killed in search of answers to the question of why Medicare spending has gone through the roof. In 1965, Congress projected that Medicare would cost 12 billion dollars in 1990, accounting for inflation. But in 1990, the program cost not $12 billion but $110 billion. In 2010, we spent more than $520 billion on Medicare alone.

But while there are many plausible drivers of Medicare's spending growth—including its obsolete fee-for-service payment system; its poor controls against fraud and abuse; and its outdated eligibility requirements—the single biggest problem is this: it's easy to waste other people's money. It's like the difference between a cash bar and an open bar: at a cash bar, I might order a beer or a house wine; but at the open bar, I'd probably ask for a fine Kentucky bourbon.

The single largest driver of Medicare cost inflation is the fact that Medicare is more like an open bar: retirees bear little of the expense for their own care. As a result of this arrangement, seniors tend to be entirely unaware of how expensive their treatments are, and have no incentive to avoid unnecessary or overpriced care. From 1960 to 1985, consumers paid for 11% of American hospital care expenses. During that time frame, real per-capita hospital expenses grew 286%. By contrast, during that period, Americans paid for 80% of American prescription drug expenses, limiting real per-capita growth to 74%. Rettenmaier and Saving have shown that this pattern

holds true elsewhere as well: that spending has increased most rapidly in those areas of health care where individuals bore the least responsibility for their own expenses.

It's not obvious today, but Medicare was designed with cost-sharing in mind. Retirees, in theory, pay an increasing deductible over time for hospital care in Medicare Part A, and are liable for all costs beyond 150 hospital days. For physician services under Part B, seniors pay a modest deductible, and then 20 percent of all costs beyond the deductible.

The problem is that the theory of cost-sharing in Medicare doesn't play out in practice. Over 90 percent of seniors obtain so-called "Medigap" plans or other supplemental policies, which wipe out Medicare's deductibles, co-pays, and coinsurance provisions. These plans cost very little, and are highly profitable to the insurers who provide them. Studies show that retirees with Medigap plans consume substantially more health care services, with little added benefit, compared to those who don't.

What is the best way to curb spending growth while preserving high-quality care?

As I said earlier, the fundamental challenge for Medicare, and other similarly structured kinds of health insurance, is that it's easy to waste other people's money. Nearly all of us are more mindful if it's our money we're spending, as opposed to someone else's.

Let me give a real-world example. Recently, there has been a lot of controversy around the use of Avastin, a pioneering biotechnology drug, in breast cancer. Clinical trials have shown that

Avastin doesn't help breast cancer patients live longer, which is the gold standard for benchmarking cancer drugs. As a result, the FDA rescinded Avastin's approval for breast cancer. But Medicare announced that they would continue to pay for the drug in that setting, regardless of the FDA's input or the actual clinical data. In effect, Medicare has decided to continue to pay for a very expensive drug that hasn't shown a clear benefit in breast cancer patients. As a result, there are many people who are getting Avastin who won't benefit from it at all, at a taxpayer cost in the hundreds of millions.

So what should Medicare do? There are three ways to deal with this problem. The first, which is what we do now, is to avoid hard choices by promising that we'll cover nearly every treatment, but underpaying doctors and hospitals for their work. The second approach, which we call "rationing," is for Medicare to determine, either by Congressional order or an expert panel, that certain treatments aren't cost effective, and deny them to seniors who seek them out. The third option would be to let seniors decide, by granting them more control over their own health dollars: either by giving them more skin in the game, through increased cost-sharing, and/or by allowing them to choose between different insurance plans with different benefit packages.

Our current approach, underpaying doctors and hospitals, will increasingly lead doctors to stop treating Medicare patients. We already see this problem in the Medicaid program, where internists are 8.5 times as likely to reject all Medicaid patients than those with private insurance. Studies show that health outcomes for many Medicaid patients are worse than those who have no insurance at all. According to Medicare Actuary Richard Foster, Medicare reimbursement rates are set to fall below those of Medicaid at the end of this decade.

The United Kingdom has attempted the second approach: having government experts deny beneficiaries from receiving unneeded care. Their approach has, no doubt, resulted in less wasteful spending in some areas, but it also prevents patients from benefiting from effective therapies that the government deems too expensive. And it's not clear that Britain's approach has worked: from 1999 to 2008, British health expenditures grew at an average rate of 7.2 percent, compared to 5.9 percent for the United States.

The third approach has the most appeal. Take the example of Switzerland. Switzerland has universal health coverage and outstanding health outcomes, but the Swiss government spends only 2.7 percent of GDP on health care, compared to 7.4 percent in the U.S. They do it by using a premium support model: the government gives Swiss citizens a subsidy, on a sliding scale based on income, to purchase insurance on the private market. Individuals thereby have an incentive to buy plans that have the benefits they most want, delivered in the most cost-effective manner.

In America, we have done something similar with Medicare Part D, the prescription drug benefit. Seniors are given a subsidy to buy plans of their own choosing, but until the passage of the Affordable Care Act, Part D plans were required to have significant cost-sharing provisions in the form of the so-called "donut hole." In addition, seniors are not allowed to purchase supplemental policies for prescription drug coverage if they participate in Part D. These features explain why Part D has come in more than 30 percent under budget—a remarkable achievement.

Is IPAB likely to achieve these goals?

The designers of IPAB, in many ways, hoped to replicate the British approach: by giving 15 government officials the power to make changes that will restrain the growth of Medicare spending. However, after objections that IPAB resembled a "death panel," Congress severely constrained IPAB's authority, preventing the Board from including any recommendation to ration care, raise premiums, increase cost-sharing, restrict benefits, or alter eligibility requirements.

Indeed, from now until 2020, the primary method by which IPAB will be empowered to reduce costs is by reducing Medicare payments under parts C and D. That is to say, the aspects of Medicare that most involve individual choice and prudent cost-sharing are the ones that appear to be the most likely to wither under IPAB, as it is currently structured.

I know that you all are very familiar with the endless tussle over the Medicare Sustainable Growth Rate, or SGR, which has created significant fiscal problems because Congress has routinely overridden the SGR's requirements for reduced payments to doctors and hospitals. But IPAB, as it is currently designed, is similar to SGR in that its primary approach to cost control involves reducing payments to physicians.

Global reimbursement cuts, of the kind mandated by the SGR and by IPAB, are highly unlikely to work. We all know that Congress has repeatedly overridden the SGR provisions with so-called

"doc fix" legislation. In addition, doctors and hospitals undermine these reimbursement cuts by performing more procedures in less time, or by dropping out of the program. We are already seeing harmful effects from this approach on Medicare's health outcomes.

Hence, we should be seriously concerned that IPAB, as it is currently designed, will reduce seniors' access to doctors and health care services, thereby worsening the quality of their care. In addition, the Board may cause disproportionate harm to Medicare Parts C and D, the most attractive aspects of the Medicare program.

Can IPAB be improved?

It is fairly clear, then, that IPAB in its current form is unlikely to achieve its goal of bending Medicare's cost curve. The question we must then ponder is: can IPAB be fixed, or should Congress wholly repeal it?

It is conceivable that a differently designed IPAB could help make Medicare spending more efficient. For example, an IPAB that was empowered to make changes to Medicare premiums, cost-sharing provisions, and eligibility requirements could assist Congress in enacting much-needed reforms to the program.

Many of IPAB's opponents are concerned that the board represents a "foot in the door" for a more pernicious form of rationing, in which Medicare stops paying for beneficial treatments that the Board thinks are too expensive. And indeed, there is something distasteful and clumsy about

one-size-fits-all, government-driven rationing. Take the example of Lucentis, an important new treatment for age-related macular degeneration, the leading cause of blindness in the elderly. Britain's rationing board, the National Institute for Health and Clinical Excellence, or NICE, decided that Lucentis was too expensive, and decided to only recommend its use in patients who were already blind in one eye, on the premise that going blind in one eye is no big deal, but going blind in two eyes is.

However distasteful rationing might be, for 45 years, we've misled the American public into thinking that we could provide seniors with unlimited, taxpayer-funded health care with no constraints. IPAB, to its credit, is an attempt at intellectual honesty, because government rationing is a logical and necessary consequence of single-payer health care systems like Medicare.

IPAB is therefore an unwitting agent of superior Medicare reforms, like those contained in the 2012 House Budget. That budget would give seniors the tools to make their own decisions about which benefits and services they most want to pay for. Thanks to IPAB, retirees now have an honest choice: should we move to a more British-style system of rationing under a single-payer health care system, or should we move more to a Swiss-style system of diverse options and individual decisions?

In the diversity-and-choice approach, if you don't like how your health plan restrains costs, you can switch to another plan, or spend your own money on a more generous one. In the

government-driven approach, you have to accept what the government tells you to accept, or pay onerous economic penalties.

It is certainly my view that giving seniors more choice and more responsibility is the most effective way to bring down the growth of Medicare spending. The 2012 House budget is a promising move in that direction, as is the Lieberman-Coburn proposal in the Senate. I hope that Congress can find a way to advance both.

Thank you again for having me. I look forward to your questions, and to being of further assistance to this Subcommittee. As an addendum to this testimony, I am including an article entitled "Saving Medicare from Itself," which further expands on these issues, and appears in the Summer 2011 issue of *National Affairs*.

Addendum: Saving Medicare from Iteslf

At the heart of America's fiscal crisis is the looming collapse of our entitlement system. And the primary cause of that looming collapse is the explosion of costs in Medicare, the federal program that provides health insurance to every American over 65. Without major reforms of the program, there is simply no way for us to address the federal deficit, contain the national debt, or save Medicare itself from collapse.

Medicare's woes are partly demographic. In 2030, when the last of the Baby Boomers retires, there will be 77 million people on Medicare, up from 47 million today. But there will be fewer

working people funding the benefits of this much larger retiree population: In 2030, there will be 2.3 workers per retiree, compared to 3.4 today and about 4 when the program was created.

But a bigger part of Medicare's troubles is the rapid inflation of health-care costs. In 2010, the per capita cost of providing health-care services in America increased by 6.1%, according to Standard & Poor's, while overall inflation increased by only 1.5%. Over the past decade, health-care inflation has risen 48%, while inflation in the broader economy has increased by only 26%, according to the Department of Labor.

Providing an increasingly expensive service to a rapidly growing population while drawing on a fast-declining pool of taxpayers is, of course, a recipe for fiscal doom. The Congressional Budget Office now projects that the Medicare program will be effectively bankrupt in 2021, and its continuing growth will increasingly burden the federal budget, sinking the nation deeper into debt. The program's trustees report that its unfunded long-term liability — the gap between the benefits that will need to be paid out and the revenues available to pay for them over the coming decades — is more than $30 trillion.

It is simply not possible to address this problem only by increasing the taxes that fund Medicare. Medicare spending is growing at a much faster rate than the economy (and therefore faster than the tax base). As Andrew Rettenmaier and Thomas Saving have shown, Medicare payroll taxes would need to quadruple today in order to cover the program's unfunded liabilities; alternatively, income-tax rates would need to increase by 57%. And even this would be sufficient only if we made the generous, but dubious, assumption that dramatic tax increases would not retard future economic growth (and thereby future tax revenues).

Another solution must be found, and soon. If Washington fixes Medicare only after a debt-driven economic disruption, the likely outcome will involve draconian across-the-board cuts in benefits to retirees, painful rationing of medical services, and restricted access to doctors and hospitals. In such a scenario, the wealthy will be affected the least, as they will be the ones most able to purchase supplemental insurance to address their needs. It will be the poorest, and the sickest, of Medicare's enrollees who will get left behind.

If Medicare reform is urgent for the sake of our most vulnerable retirees, it is also necessary for the sake of our health-care system. By subsidizing the massive over-utilization of health-care resources, and by underpaying doctors and physicians (who must pass on the costs to patients with private insurance), Medicare drives up the cost of health care not only for the elderly but for everyone. Rising costs, in turn, make health care unaffordable for tens of millions of middle-class Americans. And these problems will only get worse as the elderly become a larger share of the population.

An effective reform of the program would have to both restructure the way Medicare itself works and help to restrain the growth of health-care costs more generally. That seems like a monumental task, but ironically the poor design of Medicare actually makes that task more achievable, by making the key problems with the program readily apparent and addressable.

Legislators have understandably been reluctant to take on the task of reform, given that Medicare is popular with its recipients and that those recipients are a large and powerful constituency. But if Medicare reforms seem politically difficult now, they will be nearly impossible when the elderly population reaches 80 million. We can be certain that the retirees of the future, too, will vote in large numbers.

The time to take up meaningful Medicare reform must therefore be now. By considering the history and design of the program, as well as the reasons why past efforts to fix it have failed, we can better see our way toward a politically plausible and economically sustainable set of solutions.

WHAT IS MEDICARE?

We Americans have lived with Medicare for 45 years, so such a program may seem to us a standard component of modern government. But it is worth remembering that ours is the only developed country that makes age-based distinctions in its provision of government health coverage.

In many other countries, state-funded health insurance began with the poor, and was gradually extended up the income ladder. But in mid-20th-century America, there was still a significant stigma attached to being "on the dole," and income tests were considered demeaning.

Policymakers who sought an expanded role for government in health care thus believed that starting with the elderly would be more politically palatable. After all, the elderly were a far more sympathetic group in the public's eyes: Older Americans had less opportunity to earn their own money in order to fund their health care, and were therefore generally poorer than other Americans (along with being less healthy). Being both relatively poor and relatively unhealthy, they were in turn also less likely to have health insurance. And policymakers believed that the model of Social Security as a "self-financed" program for the elderly, paid for with a dedicated payroll tax, could easily be extended to health insurance.

For many years, however, federal health-care initiatives were successfully opposed by a coalition of Republicans and conservative Democrats, as well as by the organized force of American doctors, who feared that socialized medicine would restrict their freedom to serve their patients as they thought best. But this dynamic shifted dramatically in 1964, when Barry Goldwater challenged Lyndon Johnson for the presidency.

The 1964 election, which many on the right fondly recall as the dawn of modern conservatism, was in fact the greatest victory for the left in American history. Democrats gained 36 seats in the House of Representatives — giving them an astonishing 155-seat majority — and increased their already huge Senate majority by two seats, nudging them up to a 36-seat majority. (By comparison, the substantial Democratic majorities held after the 2008 election were merely 79 seats in the House and 20 seats in the Senate.) Even taking conservative-leaning Democrats into account, liberals were utterly in control of Washington in 1965. Suddenly, Democrats found themselves with a mandate to enact far-reaching reforms, and they did not waste the opportunity.

The very first bill of the 1965 congressional session — H.R. 1 in the House and S 1 in the Senate — was titled "Hospital Insurance for the Aged through Social Security." The focus on hospital insurance reflected the fact that hospitalization costs represented the greatest financial burden on the elderly at the time. As the so-called "Medi-care" bill zipped through Congress, Republican leaders, still reeling and disoriented from their painful defeat, criticized the proposal from the *left*, arguing that the legislation was inadequate because it covered neither physician services nor prescription drugs.

They proposed instead a more comprehensive but voluntary plan, comparable to the one that was at the time administered by Aetna for federal employees. But Democrats were perfectly happy to

accommodate these objections within their more ambitious non-voluntary program, and the final bill included a new entitlement composed of two Medicare programs for the elderly — Part A and Part B — along with a separate health-care entitlement for the poor called Medicaid.

Medicare Part A covered hospital expenses — 60 days of hospital care after the beneficiary paid a deductible of $40 and an additional 30 days of hospital expenses for which the beneficiary would pay $10 per day. The program would be financed through a payroll tax similar to the one that paid for Social Security, though at a lower rate — a flat rate that was originally 0.7%, half of which was paid by the employee and half by the employer. Part B provided coverage for outpatient physician and nursing services, outpatient diagnostic services, medical equipment, and drugs administered by physicians (but not prescription drugs purchased by the patient). Unlike Part A, Part B would be funded by premiums from retirees, along with federal subsidies equal to those premiums.

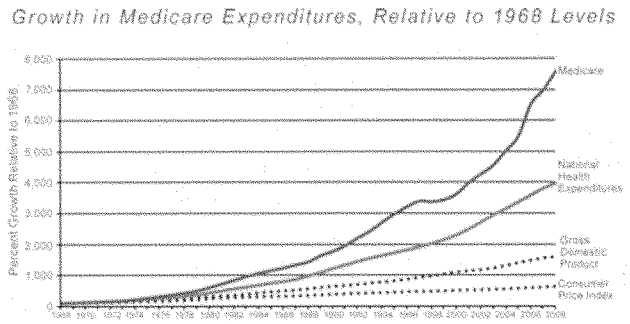
These two parts of Medicare still constitute the bulk of the program today, and they have not changed all that much — though the deductibles have of course grown with inflation. This year, Part A covers 60 days of hospital care with a total deductible of $1,132, an additional 30 days with a deductible of $283 per day, 60 more days at $566 per day, and then all costs beyond that period. These figures would suggest some significant cost-sharing after the first two months in a hospital, but, as we shall see, the great majority of seniors have private supplemental insurance coverage that leaves them with essentially no deductible costs for Medicare at all. The payroll tax that still funds this program is now 2.9% — still shared equally between employer and employee — though the health-care law enacted last year stands to increase the employee share for wealthier workers (those earning over $200,000) by a further 0.9% starting in 2013.

Part B is also much as it was at the outset, covering physician services, outpatient care, and medical equipment. Seniors today pay a $162 deductible for such services, in addition to 20% of all costs beyond the deductible for most services — though again, supplemental insurance often covers that amount for them. In 1982, a third component was added — which came to be known as Medicare Part C, and later Medicare Advantage — under which seniors have the option of allowing private insurers to manage their Part A and Part B benefits (as discussed below). And in 2003, President George W. Bush and Congress added a prescription-drug benefit, known as Medicare Part D, in which seniors choose from a menu of approved private coverage options for drugs. Parts A and B of the program, however, remain by far its most significant and most expensive components (accounting for roughly 90% of its costs), and are the keys to Medicare's fiscal woes.

The cost overruns started very early, and were in large part an unintended function of Medicare's original design. The fact that Part B included coverage of physician services outside of hospitals meant that the great bulk of American doctors would come to interact with this new federal program — since older Americans are the ones who most frequently visit most doctors. In an effort to avoid a fight with the American Medical Association over this transformation in the lives of the nation's physicians, Medicare's designers opted not to specify any particular limits on physician-reimbursement rates. Instead, the legislation stated that doctors were to be paid according to so-called "usual, customary, and reasonable" rates — a vague reference to a system of determining payment rates that a few Blue Shield plans had been trying out in the 1960s.

The law provided no specific definition of "usual, customary, and reasonable," and essentially no guidance regarding how such a definition should be arrived at by Medicare's administrators.

Medicare would pay health-care providers on a per-service basis — creating a major incentive to provide more services to patients in order to tap into this massive new source of funds — and the fee per service was left largely undefined. The program was thus launched with no clear plan for keeping its costs under control, and it included no real incentives for doctors, patients, or administrators to do so themselves.



The consequences were immediate and dramatic. The annual growth of physician fees in America went from 3.8% in 1965 to 7.8% in 1966. In that same first year of Medicare's existence, hospital costs increased by 21.9%; over the subsequent five years, they grew by an average of 14% each year. These figures flummoxed government forecasters, who had projected that growth in hospital costs would actually *slow* after the enactment of Medicare. Instead, costs continued to grow rapidly. When Medicare was enacted, the staff of the House Ways and Means Committee (which was responsible for estimating the program's costs and effects, since the Congressional Budget Office had yet to be created) projected that its cost would grow from under $5 billion in its first year to $12 billion in 1990 — accounting for inflation — because they expected that hospital-cost growth would not exceed wage growth from 1975 onward. Instead,

Medicare expenditures grew at roughly 2.4 times the rate of inflation over that period, and in 1990 reached not $12 billion but $110 billion. By 2000, the program cost $219 billion. Last year, it cost just over $520 billion. According to the Congressional Budget Office, if Medicare is not reformed, by 2020 it will cost about a trillion dollars a year.

Health-care costs beyond Medicare have also exploded in this period, and without question that has helped to drive Medicare's growth. But Medicare spending has increased faster than overall inflation in the health sector, and appears in many respects to have driven that inflation.

So what happened? Why have Medicare's costs gotten so out of control?

PUSHING COSTS UP

The largest driver of Medicare cost inflation is the fact that retirees bear little of the expense for their own care. As a result, seniors have no incentive to avoid unnecessary or overpriced treatments. Rettenmaier and Saving have shown that, between 1960 and 1985, growth in health expenditures was highest in those categories of spending in which consumer cost-sharing was lowest (such as hospital care), and lowest where consumers were most responsible for their own expenses (like prescription drugs, which were not covered by Medicare during that period).

The same holds true for all consumers of health care — not just the elderly. Medicaid and the system of employer-based health insurance both provide a great deal of first-dollar insurance coverage, meaning that consumers do not pay directly for services they receive and therefore have no clear sense of relative costs and values. In 1960, individuals paid directly for 52% of national health expenditures, but by 2008 that share had declined to just 12%. Americans are shielded from the real costs of their health care; as a result, it costs too much.

Cost-Sharing and Health-Care Spending Growth, 1960-1985		
Spending Category	Percent Paid by Consumers	Percent Real Per Capita Spending Growth
Hospital Care	10.5%	286%
Physician Services	42.8%	259%
Prescription Drugs	70.9%	74%

Source: Rettenmaier and Saving, *The Diagnosis and Treatment of Medicare*, 2007

In theory, Medicare does include some cost-sharing provisions, especially for physician payments under Part B. But over time, private insurance companies began to realize that Medicare's design allowed them to provide seniors with supplemental coverage to pay for the deductible and co-insurance requirements of the program — a good deal for insurers (for whom costs are finite and low), as well as for the seniors who purchase such plans (and are thereby freed from any direct cost for health care). Today, almost 90% of seniors have supplemental coverage plans, which means in effect that they have unlimited health coverage for a low and fixed cost, and thereby every incentive to seek generous, and even unneeded, care.

Combined with the fact that Medicare generally pays health-care providers on a per-service basis rather than on a per-patient or per-outcome basis, this means that Medicare creates an enormous incentive for everyone involved to provide *more* services to seniors. Volume, more than the cost of individual services, has been Medicare's fiscal downfall. And, as discussed below, reformers trying to fix the program's finances — from the 1970s through the health-care bill enacted last year — have sought to do so through price controls that reduce the amount the program pays for each service provided, which actually creates an even greater incentive for physicians and hospitals to provide a greater *number* of services to make up the lost revenue.

In a detailed study of this phenomenon conducted in 2007, the Congressional Budget Office found that, between 1997 and 2005, the fees paid by Medicare for individual physician services actually declined by 5%, but the total amount spent on such services by the program increased by an astonishing 35% — because of enormous growth in volume.

Beyond the skewed incentives it creates, Medicare also inflates costs as a result of its byzantine structure, which hampers efficiency. Many people wrongly believe that Medicare is more efficient than private insurance; that view was often stated by champions of Obamacare during the debate preceding the law's enactment. These advocates argued that Medicare's administrative costs — the money it spends on expenses other than patient care — are just 3% of total costs, compared to 15% to 20% in the case of private, employer-sponsored insurance. But these figures are highly misleading, for several reasons.

First, other government agencies help administer the Medicare program. The Internal Revenue Service collects the taxes that fund the program; the Social Security Administration helps collect some of the premiums paid by beneficiaries (which are deducted from Social Security checks); the Department of Health and Human Services helps to manage accounting, auditing, and fraud issues and pays for marketing costs, building costs, and more. Private insurers obviously don't have this kind of outside or off-budget help. Medicare's administration is also tax-exempt, whereas insurers must pay state excise taxes on the premiums they charge; the tax is counted as an administrative cost. In addition, Medicare's massive size leads to economies of scale that private insurers could also achieve, if not exceed, were they equally large.

But most important, because Medicare patients are older, they are substantially sicker than the average insured patient — driving up the denominator of such calculations significantly. For

example: If two patients cost $30 each to manage, but the first requires $100 of health expenditures and the second, much sicker patient requires $1,000, the first patient's insurance will have an administrative-cost ratio of 30%, but the second's will have a ratio of only 3%. This hardly means the second patient's insurance is more efficient — administratively, the patients are identical. Instead, the more favorable figure is produced by the second patient's more severe illness.

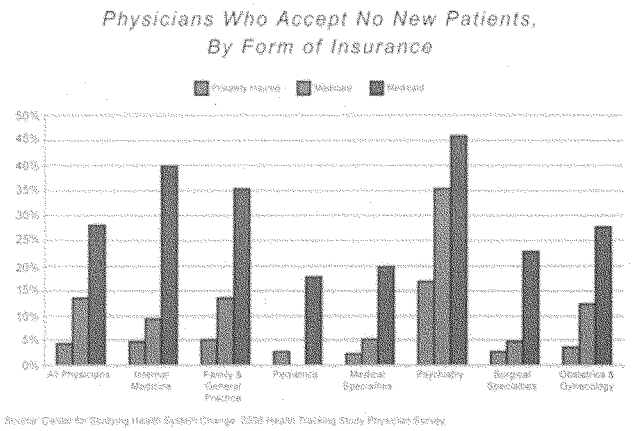
A more accurate measure of overhead would therefore be the administrative costs per patient, rather than per dollar of medical expenses. And by that measure, even with all the administrative advantages Medicare has over private coverage, the program's administrative costs are actually significantly *higher* than those of private insurers. In 2005, for example, private insurers spent $453 per beneficiary on administrative costs, compared to $509 for Medicare.

Medicare's fragmentary, piecemeal character leads to other problems as well. The static nature of government benefits means that Medicare remains largely stuck in the health-care models of 1965, even though considerable innovation in health insurance has taken place since then. For instance, retirees pay almost nothing for inpatient hospitalization costs in the first two months, but do pay more for outpatient physician care. As a result, the elderly have an incentive to seek expensive hospital care when less expensive outpatient care might suffice. By law, traditional Medicare is not allowed to steer patients to more cost-efficient hospitals and doctors, the way private plans can.

As already noted, repeated attempts at reducing the growth of Medicare spending have taken the form of price controls to restrict fees paid for individual services. These controls, by paying relatively more for certain diagnoses than for others, incentivize doctors to game the system

instead of providing optimal care. Overall, Medicare pays doctors and hospitals about 80% of what they receive from private insurers; many providers overcharge younger patients with private insurance in order to make up the difference.

As a result of such price controls and of the program's tangled web of rules and requirements, doctors are increasingly dropping out of the Medicare program. According to a 2008 survey from the Center for Studying Health System Change, more than one-quarter of all physicians actively restrict the number of Medicare patients in their practices. The American Academy of Family Physicians says that 13% of its members did not accept Medicare patients at all in 2009 — up from 8% in 2008 and 6% in 2004.



If Medicare continues to cut physician reimbursements without fundamental reform, it will become even more difficult for retirees to find doctors who will see them. This problem has been apparent for years in the Medicaid program, which restricts physician payments even more severely than Medicare in most states. Studies show that many Medicaid patients fare worse in

terms of basic health outcomes than those with no insurance at all. But thanks to last year's health-care law, Medicare payment rates are set to fall *below* those of Medicaid in the latter part of this decade, according to Medicare's chief actuary, Richard Foster. Unless the program is reformed to rely less on such price controls, Medicare patients will find it increasingly difficult to get care.

Without a doubt, the growth of the retiree population is also an important source of stress on Medicare's finances. That growth is driven by two factors: the aging of the Baby Boomers, and increasing life expectancy. When Medicare was enacted in 1965, the average life expectancy at birth was 70.2 years. In other words, it was anticipated that Medicare would cover an average person's health expenditures for the last 5.2 years of his life. In 2010, the average American lived to the age of 78.4; Medicare thus covered the last 13.4 years of his life — a 158% increase in the coverage period. The U.S. Census Bureau projects that, in the coming decades, American life expectancy will continue to elongate by approximately one year for every eight years that pass.

Of course, unlike the growth of costs due to the incentive structure of Medicare, the extension of life expectancies is not bad news. The overall story of Medicare is not entirely bad, either. The program has provided the elderly with health insurance for more than four decades. Seniors rely on it and like it; the program is extremely popular. But along the way, it has done grave damage to our broader health-care sector — contributing to an unsustainable inflation of costs that puts the program itself in jeopardy, and that makes it harder for younger Americans to afford insurance for themselves and their families.

Today, the program's finances are completely out of control. And the illusion of pre-funded benefits — the notion that Americans pay into the system while they work and then merely

withdraw the funds they put in when they retire — no longer bears any relation to reality. According to calculations published earlier this year by Eugene Steuerle and Stephanie Rennane of the Urban Institute, the average two-earner married couple retiring in 2010 had paid $109,000 in Medicare taxes while working, but will receive $343,000 in benefits during retirement. A similar couple retiring in 2030 will have paid $167,000 in taxes and will receive $530,000 in benefits. Medicare is simply a massive (and growing) transfer of resources from younger to older Americans. And since the elderly are no longer the poorest Americans — on the contrary; Americans over the age of 65 are now significantly wealthier than younger Americans — that often means that Medicare is a transfer of resources from poorer to wealthier Americans. The illusion of an earned benefit, like the illusion of Medicare as a self-sustaining program, must be overcome if we are to address Medicare's woes.

Clearly, it is well past time to save Medicare from itself. But how?

FAILED FIXES

Because the problem of cost overruns became apparent so soon after Medicare's enactment, almost every president after Lyndon Johnson tried his hand at restraining the program's growing expense. In 1972, under Richard Nixon, Congress allowed for the creation of Medicare health-maintenance organizations, in the hope that private managed care might help keep down the program's costs. Consumers had little incentive to use them, however, and the experiment was a failure. Nixon's other Medicare adjustment undermined his efforts: He also expanded Medicare to include people under 65 who qualified for Social Security disability benefits and had received them for two years, which of course only further swelled Medicare's budget.

In 1977, under Jimmy Carter, the Health Care Financing Administration was created to more efficiently administer Medicare and Medicaid, setting the programs apart from Social Security. In 1983, under Ronald Reagan, HCFA imposed a "prospective payment system" whereby hospitals and physicians would be reimbursed at a set rate for a specific diagnosis — Medicare's first price controls.

But after a few years, hospitals and physicians grew wise to the new system, and found ways to shift patients from poorly paying "diagnosis-related groups" to higher-paying ones — a practice called "upcoding." So in 1988, a team led by William Hsiao, an economist at the Harvard School of Public Health, proposed a new system of price controls for Medicare called the Resource-Based Relative Value Scale, or RBRVS. Hsiao invented a complex formula that combined the time, effort, judgment, skill, and stress of addressing a specific medical problem (the "physician work" factor) with local medical-practice costs and related considerations. The formula was adopted by Congress as part of the 1989 budget deal in an effort to manage Medicare's costs. But few of Hsiao's factors had anything to do with the way in which economies normally price goods and services, and the RBRVS system did little to improve the economic value of health-care decisions, or Medicare's finances.

Also in 1988, Congress passed the short-lived Medicare Catastrophic Coverage Act, which expanded Medicare Part A to cover an unlimited number of hospital days, eliminated the daily co-insurance requirement for stays longer than 30 days, and provided a benefit for outpatient prescription drugs, among numerous other perks. President Reagan had insisted that the MCCA be deficit-neutral; it therefore incorporated a means-tested supplemental premium of up to $800

to pay for these extra benefits. But that supplemental premium proved to be extremely unpopular with retirees, and the entire law was repealed in 1989.

The next major push for Medicare reform began in the mid-1990s. The new Republican Congress proposed reducing projected Medicare spending by $270 billion, along with a package of tax cuts; President Clinton accused Republicans of fleecing Medicare to aid the wealthy, and counter-proposed $128 billion in reductions with no tax cuts.

Eventually, in 1997, the two sides produced the Balanced Budget Act, which included an important Medicare reform. The law created the Sustainable Growth Rate, a formula that tied physician reimbursements to GDP growth as a way of keeping costs under control. While the SGR may have helped to hold down costs in the short term — Medicare expenditures were essentially flat in 1998 and '99 — by 2001, those costs had resumed their historical growth rate. The 1997 law would thus have required significant cuts in doctor fees, but doctors protested, and Congress began passing so-called "doc fix" legislation to increase physician reimbursements above their SGR-mandated levels — essentially ignoring the law's requirement on an annual basis almost every year since 2003. As a result of politics and interest-group concerns (not to mention the basic economics of health care), price controls have thus proven a thoroughly inadequate means of holding down Medicare costs.

Unfortunately, Obamacare only doubles down on this failed approach. Like prior attempts to limit costs through price controls, the new law simply caps annual Medicare growth but fails to fundamentally transform the system to allow it to live within such caps. Starting in 2015, per capita Medicare spending growth will be limited to a fixed rate set between the general rate of inflation and health-care-cost inflation. Then, starting in 2018, that rate will be set permanently

at per capita GDP growth plus one percentage point — a rate far lower than Medicare's growth in recent decades. And just how will costs be kept within these boundaries? The law establishes a board of experts — the 15-member Independent Payment Advisory Board — that will be charged with making the necessary changes to Medicare's payment rates and practices. But the board is prohibited from requiring greater cost-sharing by Medicare recipients, and from changing the basic "fee-for-service" structure of the program. So it cannot pursue market-based reforms. All it can do is tweak the program's price controls, in the hope that just the right mix of cuts in payments to doctors and hospitals will cause those doctors and hospitals to become more efficient.

This is exactly the approach that has failed to control prices in the past, and the one that Congress has had to override each year through the "doc fix." It simply pays doctors less and less for the same services without giving them any incentive to improve their efficiency or productivity by changing how they work. There is no reason to imagine this oft-failed approach will succeed this time around. Indeed, in May, the Medicare program's own actuary explained why he expects Obamacare's price controls to fail:

By the end of the long-range projection period, Medicare prices for hospital, skilled nursing facility, home health, hospice, ambulatory surgical center, diagnostic laboratory, and many other services [under the new law] would be less than half of their level under the prior law. Medicare prices would be considerably below the current relative level of Medicaid prices, which have already led to access problems for Medicaid enrollees, and far below the levels paid by private health insurance. Well before that point, Congress would have to intervene to prevent the withdrawal of providers from the Medicare market and the severe problems with beneficiary

access to care that would result. Overriding the productivity adjustments, as Congress has done repeatedly in the case of physician payment rates, would lead to far higher costs for Medicare in the long range than those projected under current law.

Medicare's future under Obamacare thus looks much like its past — only worse.

MARKET REFORMS

But if price controls have been a failure, most attempts at market-oriented reforms have not fared much better. In 1982, Congress introduced Medicare Part C, which allows private insurers to administer Medicare plans at 95% of the combined cost of Part A and Part B. The idea was that these private plans could save money because they would integrate Part A and Part B coverage into a single benefit package, and would thus be managed more efficiently by private entities. Part C was popular with retirees; enrollment grew at 30% a year in the mid-1990s, peaking at 16% of Medicare enrollees in 1999. But unfortunately, this system strongly incentivized private plans to "cherry-pick" younger and healthier retirees, leaving the rest to traditional Medicare — thereby raising, rather than reducing, overall costs (because the larger traditional Medicare program still dominated the health-care market, and so its higher costs meant higher health-care costs overall).

Things changed in 1997, when the Balanced Budget Act introduced a more sophisticated risk-adjustment system so as to curtail cherry-picking. As a result, insurers started to drop out of Part C (since their costs were going to rise), and enrollment stalled. It turned out that, for beneficiaries of equivalent health and age, private plans were slightly *more* costly than traditional Medicare, because the fragmented community of private insurers lacked the government's market

power to negotiate lower rates. The fact that private insurers had to compete in the same market with traditional Medicare put them at an immense disadvantage, yet Medicare's market advantage did not make it any more efficient or cost-effective.

This problem was revisited in 2003, when President Bush signed the Medicare Modernization Act. The MMA increased reimbursements to private insurers in order to compensate for their lack of market power; by 2009, Part C plans (rechristened "Medicare Advantage" plans) were paid 14% more per patient on average than traditional Medicare. In return, private insurers reduced premiums. These changes increased the popularity of privately-managed Medicare plans; by 2010, Medicare Advantage enrolled 11 million retirees, or nearly 25% of all Medicare participants. But again, they did not significantly reduce costs, as they were still playing in a field dominated by a highly inefficient fee-for-service Medicare program.

Market-based reforms cannot have their desired effect — introducing meaningful competition and consumer pressures to bring down costs — as long as this traditional fee-for-service structure of Medicare remains the dominant force in the market, because providers still have a powerful incentive to conform their behavior to Medicare's inefficient design. For a market reform to work, it seems, it has to be comprehensive — either replacing traditional Medicare or turning it into just one option among many. Today's reformers would be wise to keep this lesson in mind.

The most successful cost-control experiment in Medicare — the relatively new prescription-drug component called Part D — has been proving this point. The Part D benefit, added in 2003, is a so-called "premium support" program. Seniors are given a set amount of money to apply toward their choice of plan, selected from a menu of private prescription-drug coverage options. If they

prefer a more expensive plan, they can make up the difference themselves. Because this premium-support program is the only source of prescription-drug funding in Medicare, it is able to bring real market forces to bear.

The program also contains a further cost-control mechanism that has come to be known as the "donut hole," by which recipients are required to pay for all drug costs above a certain minimum level and below a ceiling — a design intended to simultaneously make seniors sensitive to prices yet shield them from catastrophic costs. In 2009, the donut hole required retirees to pay 100% of prescription-drug costs above $2,700 and below $6,154, in order to discourage unnecessary spending. (Obamacare would eliminate this element of the program as well — sparing seniors from the donut hole, but thereby also shielding them from market forces that can help restrain costs.)

These two market-based elements have indeed kept costs down for this component of Medicare. While Medicare Part D has provided drug coverage to most Medicare recipients and is very popular with seniors, it has so far come in more than 30% *below* the original cost expectations of the Congressional Budget Office. In a recent report, the actuary of Medicare projects that Part D's cost over its first decade will likely be more than 40% below those original estimates.

Some market-based reforms, then, can work. The premium-support model of Medicare Part D has been a great success. But its application has been limited, and overall Medicare costs continue to climb.

PREMIUM SUPPORT

Could there be a way to apply the lessons of this "premium support" and cost-sharing approach to the broader program? The history of failed reform efforts includes one intriguing twist that suggests there just might be.

In 1997, as a result of the Balanced Budget Act, Congress organized the National Bipartisan Commission on the Future of Medicare, under the leadership of Democratic senator John Breaux and Republican representative Bill Thomas. The commission's final recommendation, supported by members of both parties, was that Medicare should be converted to a "market-based Premium Support model" similar to the one used in the Federal Employees Health Benefits Program.

Under the commission's proposed system, retirees would have been able to choose between private health plans and a traditional government-run fee-for-service plan (a consolidation of Medicare Parts A, B, and C). Thus traditional Medicare would have become one option among many, competing for business. Regardless of what option they chose, beneficiaries would have been expected to pay a premium equal to 12% of per capita health costs, but would have paid no premium at all if they bought a plan that was at least 15% cheaper than the average one. In addition, the commission recommended increasing the Medicare eligibility age from 65 to 67, in harmony with Social Security.

After the commission made its proposal, President Clinton made a counter-proposal, shaped in large part by his Treasury secretary, Lawrence Summers. He proposed "managed competition" for Medicare, in which private insurers would have engaged in competitive bidding for health coverage of the elderly. Retirees who chose plans that cost less than the average bid would have retained three-fourths of the savings. Clinton also proposed new subsidies to encourage

employers to retain private-sector health coverage for their retirees, taking some of the burden off of Medicare.

These two sets of proposals were, in many ways, quite compatible. Indeed, according to historian Steven Gillon, President Clinton and House Speaker Newt Gingrich, along with several prominent Senate Democrats, were close in 1997 to a historic agreement for reforming Medicare along these lines. But after the Monica Lewinsky scandal erupted in early 1998, Clinton was focused on defending himself from impeachment, and this required currying the favor of ideological Democrats over pragmatic ones. Thus no serious effort was made to bridge the various reform proposals, and Medicare's problems went unresolved.

Even though it went by the wayside, the basic structure of the Breaux-Thomas commission's proposal — transforming Medicare into a premium-support system in which retirees have a pre-set benefit they can use toward the purchase of approved private insurance plans — remains the most plausible approach to addressing Medicare's immense and growing problems. A number of reform proposals offered in the years since the commission's report have followed its lead in general terms, though always with particular tweaks or additions.

The most prominent, and surely the most important, of these is the 2012 budget resolution recently passed (by the Republican majority on a party-line vote) in the House of Representatives. Proposed by House Budget Committee chairman Paul Ryan, the budget included a plan to transform Medicare into a premium-support system beginning in 2022. This would mean that all current retirees, as well as people who will retire by that year, would be left in the existing Medicare system (unless he chooses to, no American now over the age of 55

would be transitioned into the system of premium support); a new structure, however, would be established for new retirees from 2022 onward.

Rather than pay all providers a set fee directly, this approach would let retirees use the money (in the form of a premium-support payment that would start at current Medicare rates and grow with overall inflation) to choose insurance plans from a menu of private coverage options. To participate, private insurers would have to agree to accept all Medicare recipients, to charge the same premiums to all beneficiaries of the same age, and to provide at least a minimum benefits package required by the Office of Personnel Management (which runs the Federal Employee Health Benefit Plan), with the idea of providing all seniors with guaranteed affordable comprehensive coverage.

The level of premium support would increase with age, and poor seniors and those in the worst health would also get significantly greater support, while the wealthiest would receive less and so need to use more of their own money to buy coverage. And the premium-support model would not be a small experiment overshadowed by traditional Medicare (and thus unable to really change the way insurers and providers do business): It would be the core of the new Medicare system, and the means by which seniors would be guaranteed coverage.

This approach, then, would work like the Medicare prescription-drug benefit (and like the health-insurance program made available to federal employees). Insurers and providers would need to compete for seniors' dollars, and to do so they would be free to find innovative ways to offer better quality at lower costs. That's how markets produce efficiency: by letting sellers find ways to offer buyers what they want at prices they are willing to pay.

Although the precise effect of this approach on overall health-care costs is difficult to predict, there is no question that such a reform would dramatically improve Medicare's fiscal prospects and reduce the burdens it would place on the broader federal budget.

FIXING MEDICARE

Something like the Ryan approach will be crucial to the future of Medicare. The program is set to go bankrupt in a decade, and seems past the point of small fixes or yet another tweak to the price-control formula (as proposed under Obamacare). A broader reform must come. Medicare's history, its importance to the seniors who depend on it, and the nature of its fiscal problems suggest that such a reform must take account of six factors.

First, we must remember that Medicare's primary achievement — protecting economically vulnerable retirees — is a salutary one, the preservation of which must be the cornerstone of reform. We must also promise current and soon-to-be retirees that their benefits will not change. As many have suggested (and as the Ryan budget proposes), reforms should be implemented only for future enrollees age 55 or younger, in order to allow for a gradual transition into a reformed system, and to preserve benefits for those who have long planned their retirements around the existing system.

Second, we must appreciate the power of cost-sharing. When patients are aware of the costs of their care, and assume partial responsibility for higher expenditures, they are more likely to make sensible decisions about whether to pursue treatment. This can do much more to curb health-care cost inflation than can crude price controls or benefit cuts. As discussed above, from 2003 to 2010, Medicare's prescription-drug benefit contained significant cost-sharing provisions, in plans

administered entirely by private insurers, and the program came in under budget as a result. Most important, so long as Medicare remains in its current form, the role of supplemental "Medigap" plans must be seriously re-examined. These plans do much to undermine value-oriented health-care consumption by shielding seniors from all cost-sharing.

Third, we must introduce means-testing into Medicare. Some conservatives, because of their aversion to wealth redistribution, have opposed means tests; some liberals have opposed them because they fear that Medicare will lose political support if its benefits are not uniform. Both of these arguments fail to stand up to scrutiny. If we raise taxes to bridge our enormous deficits instead of reducing Medicare spending, those taxes will fall disproportionately on the wealthy and discourage economic growth. Spending less is a better solution, because taxes cannot be increased as quickly as Medicare expenditures will rise. As to Medicare's political support, the explosive growth of Medicaid shows that welfare programs can have just as much support as entitlements do. Either way, the political concerns of the left and right pale in comparison to the fiscal crisis we now face.

Fourth, we should index the Medicare retirement age to life expectancy, as tabulated by the Census Bureau each year. This would ensure that the program is not exposed to increases — expected or unexpected — in American longevity. Once again, the Bipartisan Medicare Commission of the late 1990s offered a framework for thinking about how to adjust the eligibility age for Medicare. Improving our age-dependency ratio — the number of retirees per worker — must come in part through normalizing our retirement age, inducing more middle-aged people to remain in the work force, and from restoring the tax subsidies (eliminated by Obamacare) that encourage employers to maintain private health coverage for retirees.

Fifth, we must address the substantial problem of Medicare fraud. It is estimated that $60 to $100 billion of annual Medicare spending — between 8% and 13% of the total — is fraudulent. Medicare processes over one billion claims per year, and is required by law to reimburse claims within 15 to 30 days. This makes it almost impossible to prevent criminal activity. Private administration of the program would do much to incentivize the development of more thorough auditing practices.

Finally, Medicare must evolve into a system in which individuals can shop for value in insurance plans. They already have the ability to do this with Medicare Parts C and D, but not with A and B. As discussed above, the Breaux-Thomas commission proposed a premium-support system in which Medicare would subsidize retirees in purchasing insurance. The Ryan budget suggested a similar approach, as did the deficit-reduction task force of the Bipartisan Policy Center, headed by former Republican senator Pete Domenici and former Congressional Budget Office director Alice Rivlin, a Democrat, earlier this year. Some of the specifics of their plans differed, of course, but they shared the conviction that a transition to premium support is essential to Medicare's future.

MEDICARE IN CONTEXT

Important as these reforms of the structure of Medicare would be, an enduring solution to Medicare's problems would also require a reform of the broader health-care system.

Until our whole system moves in the direction of an individual market for health insurance, we will have no voluntary mechanism by which to encourage Americans to shop for value in health care. If overall health spending for Americans below the age of 65 continues to rise at a much

faster pace than inflation (because of the perverse incentives of the employer-based insurance system and of Medicaid), Medicare's expenditures will rise with it.

Addressing this problem would require reforming and integrating Medicare, Medicaid, the employer-sponsored system, and the individual market (and would therefore require replacing Obamacare with a very different set of health-care reforms well beyond Medicare). It would involve addressing the runaway costs of defensive medicine and medical-malpractice litigation. Such changes would of course be extremely difficult to undertake, as the heated ongoing health-care debate amply demonstrates. But a meaningful and effective reform of Medicare could offer a plausible first step along such a path — addressing some of the most significant causes of the cost-inflation problem, and offering proof that sensible market-based reforms can work.

This moment in our politics — when our long-term fiscal situation has suddenly captured public attention — might just offer the opportunity to attempt such a step. It is an opportunity we must not allow to slip by.

Mr. PITTS. The chair thanks the gentleman and recognizes Dr. Guterman for 5 minutes.

STATEMENT OF STUART GUTERMAN

Mr. GUTERMAN. Thank you, Chairman Pitts, Vice Chairman Burgess, Ranking Member Pallone, and members of the subcommittee, for this invitation to testify on the Independent Payment Advisory Board.

I am Stuart Guterman, Vice President for Payment and System Reform with the Commonwealth Fund, which is a private foundation that aims to promote a high-performance health system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable members, including those with low incomes, the uninsured, young children, and elderly adults. I am particularly glad to be able to speak to you on this topic because I have been working on Medicare issues, particularly payment policy, for a long time at CMS, MedPAC and CBO.

I have seen the problems faced by the program persist over time despite continuous efforts to address and remediate them. I believe we have an unprecedented opportunity and an historic imperative now to address these problems in a comprehensive way, which is the only way they can be solved. The Congress faces a challenging dilemma in addressing the growth of Medicare spending. Achieving an appropriate balance between controlling costs and continuing to achieve the objectives of the program is a difficult task but one that is of the utmost importance.

An important factor to considering policies to control Medicare and other federal health spending is the fact that it is largely driven by factors that apply across the healthcare system, putting pressure not only on the public sector, including both the Federal Government and state and local governments but the private sector as well, including both large and small businesses, workers and their families, and others who need or may need healthcare. Treating healthcare cost growth only as a Medicare issue can lead to inappropriate policies that fail to address the underlying cause of the problem and lead to increasing pressure not only on Medicare and its beneficiaries but on the rest of the health system and the people it serves. In other words, I guess I would say that the open bar extends not only to Medicare beneficiaries but to all patients who make choices about how much healthcare to use—and their providers.

The IPAB, if used appropriately, can serve as a helpful tool in attempting to address these issues. It should be viewed as an opportunity to focus the attention of policymakers both in the executive branch and the legislative branch and in fact if stakeholders and state and local governments in the private sector as well, an action that in the end needs to be taken to avoid an alternative that everybody should agree will be unpalatable.

I have described some of these actions in my written testimony, which I won't go into detail here, but suffice it to say, this will require a broader view of the role of IPAB and all other available mechanisms as well. It is not a question of whether Congress or the IPAB should be trusted to solve this problem but the issue that

it will take, collaboration among Congress, the administration, and all parties involved in the healthcare system to solve it.

While the board is currently charged with identifying areas of overpayment in Medicare, its scope of authority also includes issuing recommendations for Medicaid and private insurer payment policies. And the combined leverage of multiple payers could in fact yield prices closer to competitive market prices, as well as greatly reduce administrative burdens on physician practices and hospitals, all while stimulating delivery system improvement and innovation. To be sure, how much we pay for healthcare is very important, but how we pay and what we pay for is even more important. The IPAB should be looked at as a tool to be used to improve health system performance in this way.

An array of payment approaches can be designed to encourage providers to become more accountable for the quality and cost of care beneficiaries receive and reward them rather than punishing them as the current system often does for providing that type of care. In this regard, the IPAB can and should work closely with the new CMS Innovation Center. These innovations should be developed both from the top down with the Federal Government leading the way, as well as from the bottom up with Federal Government joining in initiatives developed and implemented by local stakeholders.

The Affordable Care Act provides for testing innovative payment strategies, including broad authority for the Innovation Center to pilot test a broad array of payment and delivery system reforms. The IPAB should have the flexibility to work with the Innovation Center to quickly adopt and spread successful innovations throughout the Medicare and Medicaid programs and work to encourage their spread and align improvement efforts throughout the healthcare system.

Finally, and perhaps most importantly, the scope of the IPAB should include working with private sector payers on ways to foster collaboration between the public and private initiatives to improve organization and delivery of healthcare and slow cost growth. Given the CBO's finding of 55 percent of projected increase in federal health spending over the next 25 years can be attributed to excess growth in healthcare costs throughout the healthcare sector. This problem plagues businesses, households, federal, state, and local government alike. And it seems clear the only way to reduce growth in federal health spending is to address the growth of total health spending.

Summing up, the emphasis of IPAB as part of a broader process should be on total healthcare costs rather than only federal spending, enhancing access and quality, being sensitive to distributional impact, including protecting the most vulnerable, emphasizing the need the improve performance, encouraging coherence and alignment of incentives across the entire healthcare system. Again, the IPAB can be useful as a vehicle for focusing attention on these most critical issues if all the public and private sector stakeholders can work together to make it so.

Thanks for inviting me to participate in this hearing, and I am honored to be here before the subcommittee and with these distinguished panels and look forward to the rest of the discussion.

[The prepared statement of Mr. Guterman follows:]

THE INDEPENDENT PAYMENT ADVISORY BOARD AS A VEHICLE FOR SAVINGS THROUGH SYSTEM IMPROVEMENT

Stuart Guterman

Vice President, Payment and System Reform

Executive Director, Commission on a High Performance Health System

The Commonwealth Fund

Invited testimony

Committee on Energy and Commerce

Subcommittee on Health

U.S. House of Representatives

Hearing on "IPAB: The Controversial Consequences for Medicare and Seniors"

July 13, 2011

This testimony draws heavily on Commonwealth Fund publications written by or co-authored with my colleagues, and I would like to thank Karen Davis, John Craig, Anthony Shih, Cathy Schoen, Barry Scholl, Mark Zezza, and Rachel Nuzum in particular for their helpful comments and suggestions.

The views presented here are those of the author and not necessarily those of the Commonwealth Fund or its directors, officers, or staff, or the members of the Commission on a High Performance Health System.

THE INDEPENDENT PAYMENT ADVISORY BOARD AS A VEHICLE FOR SAVINGS THROUGH SYSTEM IMPROVEMENT

SUMMARY OF MAJOR POINTS

Addressing the growth of Medicare spending is a challenging dilemma, on one hand, Medicare is extremely popular and effective, but on the other, Medicare spending growth threatens its continued ability to fulfill its mission.

Medicare spending is driven primarily by excess cost growth throughout the health system—which also is putting pressure on state and local governments, businesses, and households—so treating it only as a Medicare issue can lead to inappropriate policies that will fail to address the problem.

The Independent Payment Advisory Board can serve as a useful tool to address these issues, by focusing attention on broader consideration of policy imperatives.

This will require a broader view of the role of IPAB and collaboration across the executive and legislative branches, but also with state and local governments, providers, patients, and private sector payers and purchasers.

The emphasis should be on:

- Total health care costs, rather than only federal spending.
- Enhancing access and quality.
- Being sensitive to distributional impacts.
- Emphasizing the need to improve performance.
- Establishing coherence and alignment of incentives across the entire health system.

THE INDEPENDENT PAYMENT ADVISORY BOARD AS A VEHICLE FOR SAVINGS THROUGH SYSTEM IMPROVEMENT

Thank you, Chairman Pitts, Vice Chairman Burgess, Congressman Pallone, and Members of the Subcommittee, for this invitation to testify on the Independent Payment Advisory Board (IPAB). I am Stuart Guterman, Vice President for Payment and System Reform at the Commonwealth Fund. The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Fund carries out this mission by supporting independent research on health care issues and making grants to improve health care practice and policy.

I am glad to be able to speak to you on this topic, because I have been working on Medicare issues—particularly payment policy—for a long time, at the Centers for Medicare and Medicaid Services (CMS, and its predecessor, the Health Care Financing Administration) in the mid-1980s and again from 2002 to 2005, and at the Medicare Payment Advisory Commission (MedPAC, and its predecessor, the Prospective Payment Assessment Commission) from 1988 to 1999, as well as at the Congressional Budget Office (CBO). I have seen the problems faced by the program persist over time, despite continuous efforts to address and remediate them. I believe that we have an unprecedented opportunity—and an historic imperative—now to address these problems in a comprehensive way, which is the only way they can be solved.

The Congress faces a challenging dilemma in addressing the growth of Medicare spending: on one hand, Medicare is an extremely popular and effective federal program, and some 47 million aged and disabled beneficiaries depend on it for access to the health care they need; on the other, Medicare spending is rising at a rate that threatens the program's continued ability to fulfill its mission, and this growth is putting increasing pressure on the federal budget as well. Achieving an appropriate balance between controlling costs and continuing to achieve the objectives of the program is a difficult task, but one that is of the utmost importance.

An important factor in considering policies to control Medicare and other federal health spending is the fact that it is largely driven by factors that apply across the health system—putting pressure not only on the public sector, including both the federal government and state and local governments, but the private sector as well, including both large and small businesses, their workers and their families, and others who need or may need health care. Treating health care cost growth only as a Medicare issue can lead to inappropriate policies that fail to address the underlying cause of the problem and lead to increasing pressure not only on Medicare and its beneficiaries but on the rest of the health system and the people it serves.[1]

The IPAB, if used appropriately, can serve as a useful tool in attempting to address these issues. Rather than a usurpation of Congressional authority, it should be viewed as an opportunity to focus the attention of policymakers in both the executive and legislative branches (and, in fact, of stakeholders in state and local governments and the private sector, as well) on action that, in the end, has to be taken to avoid an alternative

that everybody should agree will be unpalatable: what will happen if no constructive action is taken and health care costs are allowed to continue to rise as currently projected, with no change the way that health care is financed and delivered and no improvement in health system performance. This will require a broader view of the role of IPAB (and all other available mechanisms), and collaboration among Congress, the Administration, and all parties involved in the health system—a difficult proposition, but one that we have no choice but to attempt. The alternative is not the status quo, but the calamitous situation toward which we are headed if we do not take appropriate action.

In this testimony, I first discuss the growth of Medicare spending in this broader context. I then describe alternative approaches that have been proposed to achieve savings in Medicare spending, and finally consider the role that the IPAB might play in facilitating the implementation of policies that could slow both Medicare and overall spending growth by changing the way we pay for and deliver health care.

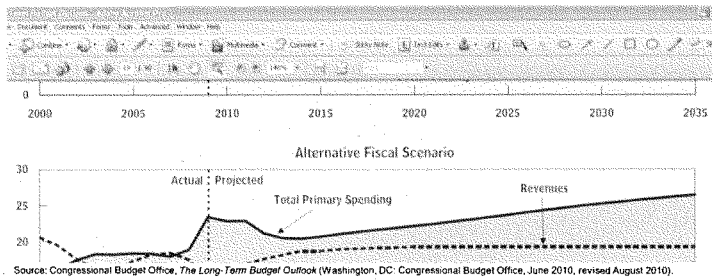
THE FEDERAL BUDGET, MEDICARE SPENDING, AND HEALTH CARE COST GROWTH

The federal budget faces increasing pressure, with a gap between outlays and revenues that is projected to persist or even grow over time (Figure 1). Federal expenditures on health programs play a major role in total federal spending: in 2010, the federal government spent an estimated $820 billion on Medicare, Medicaid, and the Children's Health Insurance Program (CHIP)[2] – accounting for 24 percent of all federal non-interest

spending.[3] Moreover, the cost of these programs is projected to increase sharply over time, driving federal spending to unprecedented levels.

Figure 1. Federal Revenues and Primary (Non-Interest) Spending, by Category, Under CBO's Alternative Long-Term Budget Scenario, 2000-2035

Percent of GDP



Source: Congressional Budget Office, *The Long-Term Budget Outlook* (Washington, DC: Congressional Budget Office, June 2010, revised August 2010).

Note: This alternative fiscal scenario adheres closely to current law, following CBO's 10-year baseline budget projections through 2020 and extending the baseline concept through 2035; however, this estimate incorporates a number of assumed exceptions to current law as of the August 2010 revision, including: (1) Medicare physician payment rates continue to grow at the Medicare economic index rather than following the SGR, (2) several policies to restrain spending after 2020 (e.g., IPAB recommendations) do not go into effect, (3) health insurance premium subsidy cuts scheduled for 2020 do not take effect, and (4) the tax relief policies in effect in 2010 are extended through 2020, after which individual income taxes are adjusted to keep total revenue constant as a share of GDP.

CHIP = Children's Health Insurance Program.

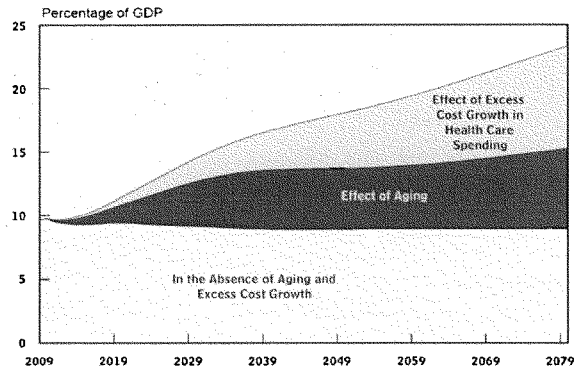
Three things are important to remember, however, in considering policies to reduce the growth of federal spending on health programs. One is that Medicare, Medicaid, and CHIP are not merely line items in the federal budget—they are social programs that provide access to needed health care to vulnerable groups of Americans: the elderly and disabled, families with low incomes, and poor children. Without these programs, many of these people would not be able to get the care they need—subjecting them to increased suffering and imposing costs on society in general in other ways.

Another is that the out-of-pocket cost of health care to Medicare beneficiaries can be substantial: they pay premiums for Part B (Supplementary Medical Insurance, which since 2007 has been indexed to beneficiaries' incomes) and (except for those who qualify

for the low-income subsidy) Part D (Prescription Drug Plan) coverage; in addition, beneficiaries who use most Medicare-covered services must pay deductible and coinsurance amounts; most beneficiaries also contribute to their Part D costs, as well, with the deductible and coinsurance or copayment amounts depending on the plan. These Medicare deductibles and copayments, along with payments for services that are not covered by Medicare, can exact a high cost on beneficiaries—particularly those with low incomes or in poor health. Currently, Medicare covers less than 75 percent of the average beneficiary's total health expenditures, with Medicare beneficiaries with poor health status or low incomes vulnerable to significant financial burdens.[4] Cutting back on Medicare coverage or increasing beneficiaries' responsibilities to pay for their health care costs would exacerbate this situation.

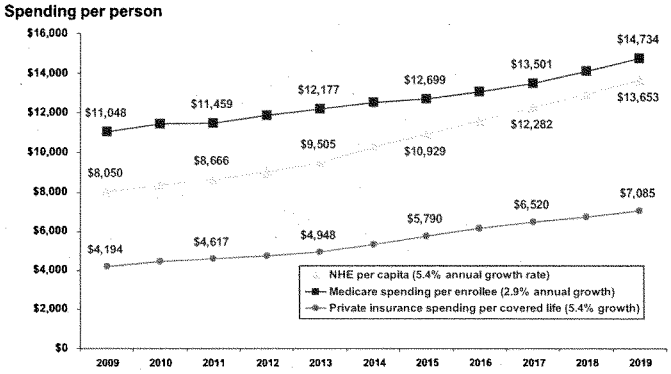
Thirdly, most of the growth in federal health spending is attributable to increasing costs across the health system (Figure 2). Although the aging of the post-war "baby boom" generation into retirement often has been cited as the reason for concern about the solvency of the Medicare program, the Congressional Budget Office estimates that, in the long run, it is excess health care cost growth (cost growth per person that exceeds the growth in per capita gross domestic product) that accounts for most of the increase in federal health care spending—56 percent of the increase in Medicare, Medicaid, and Social Security combined, but 71 percent of the increase in Medicare and Medicaid only (excluding Social Security, since it is affected by aging but not health care costs).[5] In fact, private insurance spending per insured person is projected to increase at a faster pace than federal health spending per person over the next decade (Figure 3).

Figure 2. Sources of Growth in Projected Federal Spending on Medicare, Medicaid and Social Security, 2010 to 2080



NOTE: Excess cost growth refers to the extent to which growth in health spending per Medicare or Medicaid beneficiary exceeds the growth rate of per capita GDP.
SOURCE: Presentation by Robert A. Sunshine, CBO Deputy Director, in a presentation on Mandatory Spending to the National Commission on Fiscal Responsibility and Reform, May 12, 2010.

Figure 3. Projected Growth In Medicare and Private Spending per Person, 2009-2019



Source: Commonwealth Fund analysis of data from CMS, Office of the Actuary, National Health Statistics Group, National Health Expenditures Projections 2009-2019, September 2010.

The challenge, then, is not just to reduce the amount that the federal government spends on health care—although reducing health spending growth and the federal budget

deficit that it plays a major part in driving is an important policy imperative. Health care costs are putting pressure not only on the federal budget, but also on:

- State budgets, as Medicaid has become the largest single line item for states, accounting for an average 22 percent of total spending in fiscal 2010 (with wide variation around that average across states);[6]
- Businesses, as large employers' health care costs doubled between 2001 and 2009, while small employers struggle to provide health care coverage at all;[7]
- Workers, whose insurance premiums have more than doubled between 2001 and 2009—more than three times as fast as their earnings;[8] and
- The unemployed, who face the loss of their coverage—60 percent of working age adults who were uninsured at any time during 2010 reported having medical bill problems or accrued medical debt.[9]

The implications of bringing health care costs under control therefore are much broader than the federal budget, and efforts to do so will require concerted efforts across the public and private sectors to elicit changes in the way health care is financed and delivered—not only for Medicare beneficiaries but for all Americans.

APPROACHES FOR ACHIEVING SAVINGS

There are three basic approaches for achieving savings in health spending:

1. Eligibility or benefits—that is, affecting the number of people, the range of services, or the share of spending covered by the programs;

2. Payments—that is, modifying the prices paid for some or all covered services; and
3. Utilization—that is, reducing the number of services provided or changing the mix of services to substitute less intensive for more intensive care.

Various policies in each of these categories have been proposed to slow the growth of Medicare spending, with some very different implications for the participants in public programs and for the providers who serve them. These types of policies also are being developed in the private sector, involving many of the same considerations.

Eligibility or Benefits

In the deliberations on how to address the federal deficit, a number of proposals have been advanced that would reduce Medicare spending by cutting eligibility or benefits. These include proposals to:

- Raise the age of eligibility for Medicare to age 67.
- Income-test eligibility, premiums, or cost-sharing for Medicare beneficiaries.
- Increase Medicare cost-sharing, by instituting increased out-of-pocket requirements and/or prohibiting first-dollar coverage under private supplemental policies.
- Convert Medicare to a high-deductible health plan tied to a health savings account.

- Convert Medicare to a voucher for the purchase of private insurance, with the value of the voucher set below what Medicare would otherwise be projected to spend.

These policies should be examined carefully for their potential effects particularly on the sickest and poorest beneficiaries.

For example, raising the eligibility age to 67 leaves a large number of 65 and 66 year olds with the burden of obtaining other coverage. It has been estimated that, in the pre-reform environment, 200,000 Americans would become uninsured—the Affordable Care Act likely would reduce that number substantially, but the ability to obtain comparable coverage is a concern because of the high premiums that they would face.[10] In any case, out-of-pocket costs would increase for most of the individuals who would be affected.[11] The cost of coverage available through the health insurance exchanges also would increase, because of the addition of older adults into that pool of covered lives, as would costs for employers, with older workers staying in employer-sponsored coverage, and states, with low-income individuals staying in full Medicaid coverage until they are eligible for Medicare. Finally, per beneficiary costs in Medicare would increase, as what currently are the youngest—and healthiest—beneficiaries would not be entering the program until they were older.

Increasing Medicare cost-sharing or converting the program to a high-deductible health plan would shift costs onto the beneficiaries who use the most services. Raising out of pocket costs has been shown to reduce utilization of both unnecessary and necessary care;[12] moreover, 58 percent of total program spending is accounted for by 10

percent of Medicare beneficiaries, who incur an average of $48,000 in Medicare costs; these beneficiaries incur such high costs because they are very sick—not because they are not careful shoppers.[13]

Converting Medicare to a voucher program is a radical approach to slowing Medicare spending, the effects of which are extremely dependent on the level and rate of increase of the voucher that would be given to beneficiaries: the lower the voucher, the more savings could be generated by the proposal—but the more difficult it would be for Medicare beneficiaries to find adequate private coverage without contributing a substantial portion of their own resources. CBO has estimated that the proposal adopted by the House Budget Committee would substantially reduce Medicare program spending and make it more predictable, but beneficiaries would spend considerably more than under the current program, threatening their access to adequate coverage and, consequently, the care they need.[14] By 2022, new enrollees would have to pay at least $6,400 more out-of-pocket to buy coverage comparable to traditional Medicare, and by 2030, the portion of a typical 65-year-old's health care expenses he or she would have to pay out of his or her own resources would increase from 30 percent to 68 percent.[15]

Other policies could be used to deter use of unnecessary or duplicative care and encourage use of lower cost sources of care, structured in a way that would avoid merely shifting costs to beneficiaries by reformulating existing cost-sharing requirements to guide wiser patient choices. Policies along this line could include:

- Targeting Medicare cost-sharing on discretionary care, by reducing or eliminating copayments for essential services while increasing cost-sharing

for services that are supply-sensitive (i.e., elective services the utilization of which is substantially dependent on their level of availability).

- Reducing Medicare cost-sharing on services over which patients have little discretion (e.g., hospitalization), while instituting modest copayments on services such as home health visits (for which there currently is no copayment).
- Value-based benefit design—that is, eliminating or reducing cost sharing for primary care, prescription drugs essential for the control of chronic conditions, and other services that have been shown to be beneficial and highly cost-effective.
- Reference pricing—that is, paying a price that covers the cost of the most cost-effective drug, device, or treatment for each patient's condition, and giving patients the option of obtaining other drugs, devices, or treatments if they are willing to pay the difference in cost out-of-pocket.
- Tiered networks—that is, reducing the cost to the patient for obtaining care from physicians and hospitals that have the same or better outcomes (e.g., lower mortality or fewer complications), but have lower costs over an episode of care.

All of these policies increasingly are being used in the private sector to encourage providers, suppliers, and subscribers to make better choices as to what care is provided and what treatments, drugs, and devices are chosen.

Although the IPAB currently is prohibited from addressing issues of Medicare eligibility or benefits, it could serve as a vehicle for considering how these policies could be developed and implemented not only in Medicare but throughout the health system—pulling together evidence produced by entities like the CMS Innovation Center and the Patient-Centered Outcomes Research Institute (PCORI), and in consultation with MedPAC, the Medicaid and CHIP Payment and Access Commission (MACPAC), organizations of private payers and providers, and patient advocacy organizations, as well as Members of Congress and the Administration.

Payments

A second category of policies that have been proposed to achieve program savings is provider payments. On average—although the relationship between Medicare and private insurers' payment rates varies widely—private insurers typically pay providers more.[16] Providers and private insurers have argued that prices to private insurers are higher to compensate for lower rates from Medicare and Medicaid. Recent evidence, however, suggests that hospitals that face constrained revenues from private insurers operate more efficiently and realize higher margins from Medicare as a result.[17] Under the current mechanism, while Medicare prices are administratively set, prices paid by individual private insurers can vary widely across providers in a given market area and prices paid by different payers to individual providers can vary widely as well (Figure 4).

Figure 4. Wide Variation in Prices within the U.S.: Example of New Hampshire Insurers' Payments for Selected Procedures

	Colonoscopy	Mammogram	MRI (back) (Outpatient)
Insurer A	$1,353 - $4,611	$227 - $881	$645 - $2,790
Insurer B	$1,270 - $3,121	$161 - $564	$640 – $2,292
Insurer C	$1,195 - $3,524	$129 - $612	$732 - $2,659

Source: http://www.nhhealthcost.org/cost/RxProcedure.aspx
Retrieved 14 October, 2010

This wide array of prices for what appear to be similar services—along with precious little information about the price, true production cost, or value of alternative services—makes it difficult for the health care market to send appropriate signals to providers and consumers about how resources should be allocated, what services are valuable, and what providers can best provide them. This may indicate that policies that help the market work better—such as the promotion of greater price transparency and more information about the quality and value of alternative health care strategies, as well as other policies to address the consolidation of market power in the markets for both health care and health coverage—could be required to make sure we obtain maximum value from our health care dollars.

For example, the identification of services for which prices are high relative to what a competitive market price would be can help bring prices in line with efficient

provision of care. One instance of this is brand name drugs and medical devices such as hip replacements, the prices for which in the U.S. are about twice those in other countries. Policies to address this issue might include price negotiation for prescription drugs, medical devices, and durable medical equipment.

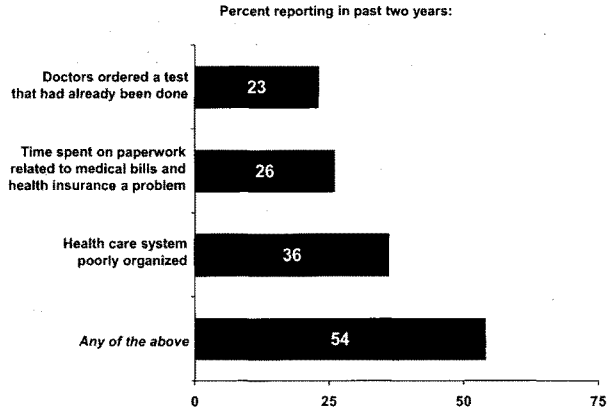
Variation in prices, as well as utilization, also may play an important role in driving variation in spending. Research indicates that a large portion of the difference between spending levels in the U.S. and in other countries can be attributed to price differences[18] and, given the emerging evidence about the wide array of prices for the same services even within the same markets in this country, analysis of the role of prices in driving health spending should be conducted. With the concern about consolidation of market power—even before the advent of the Accountable Care Organization—the development of policies to deal with that trend, and to use it constructively to promote coordinated care, may be an important focus.[19]

The IPAB can play an important role in bringing these considerations together—again, focusing not just on Medicare but as these issues apply more broadly across the entire health system.

Utilization

Proposals to reduce utilization of services is often characterized as rationing and portrayed as denying patients to the right to life-saving care. Yet, the American public indicates in surveys that more than half (54 percent) of all patients experience duplicative tests or poorly organized care (Figure 5).

Figure 5. Potential Waste and Inefficiency: More Than Half of Adults Experience Wasteful and Poorly Organized Care



Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2011.

A significant body of research points to significant misuse (i.e., medical errors) and overuse (e.g., duplication of tests or unnecessary care) of services, as well as to underuse of some services (e.g., preventive services, management of chronic conditions, and other forms of primary care that can reduce ambulatory care sensitive hospital and emergency room use), especially by low-income and other vulnerable populations.[20] The Institute of Medicine estimated that as many as 98,000 patients die in hospitals each year as a result of medical errors that could have been prevented.[21] MedPAC estimated that 13.3 percent of hospital readmissions within 30 days of discharge are avoidable.[22] Another study estimated that 30 percent of payments for patients with acute myocardial infarctions and 60 percent of payments for diabetes care were attributable to potentially avoidable complications.[23] Researchers at the Rand Corporation found that patients, on average, receive only 55 percent of recommended care for their health conditions.[24]

Ensuring the right care can not only reduce the cost of care but also improve access, quality, and outcomes.

One way to guide the health system toward more appropriate utilization, as well as invest in services that could reduce hospitalization or hospital readmissions is to give physicians and hospitals incentives to better coordinate care, improve patient outcomes and reduce the resources used in caring for patients. Policies that embrace this strategy include:

- Incentives for primary care practices, community health centers, and health clinics to convert to patient-centered medical homes.
- Shared savings for accountable care organizations.
- Value-based purchasing with rewards for better quality or better patient outcomes.
- Bundled acute and post-acute care global fees.
- Gain-sharing for hospital inpatient physicians which align inpatient physician incentives with hospital incentives.

The Affordable Care Act includes all of these policies, including broad authority for the CMS Innovation Center to pilot test a broad array of payment and delivery system reforms. Continued funding, acceleration, and expansion of this work should be supported.

The IPAB should have the flexibility to quickly adopt and spread successful innovations throughout the Medicare and Medicaid programs and to work with private payers and other stakeholders to encourage broader adoption of initiatives that promise to

reduce cost growth while improving system performance. The challenge is not the absence of creative ideas for achieving savings while improving care, but the distractions of arguments along ideological lines contrasting market-based versus government-based solutions, while in truth a concerted effort by public programs and private payers could reduce administrative costs, leverage change, and yield more rapid transformation of the health care system.

The Independent Payment Advisory Board

In the context of these issues, the IPAB can be a useful tool to effectively address both federal and total health system spending. While the board is currently charged with identifying areas of overpayment in Medicare, its scope of authority could be broadened to include recommendations for Medicaid and private insurer payment policies. The combined leverage of multiple payers could yield price levels and distribution that are closer to what would be offered in competitive markets, as well as greatly reduce administrative burdens on physician practices and hospitals and stimulate delivery system improvement and innovation, such as better care coordination.

Similarly, the IPAB could explore the potential of reference pricing to both lower spending and improve the quality and effectiveness of care that beneficiaries receive. Under reference pricing, new high-priced devices, procedures, and treatment regimens that are not shown to be more effective than existing lower-priced technologies are paid at the same level as those existing equally-effective technologies. Other countries

commonly use this approach not only to save money but also to provide appropriate incentives to innovate in ways that are productive in terms of clinical outcomes. Another set of policies currently within the IPAB's purview is an array of payment approaches designed to encourage providers to become more accountable for the quality and cost of care beneficiaries receive. Promising examples include bundled payment as well as strategies that facilitate closer and more effective management of patients with multiple chronic conditions. In this regard, the IPAB can and should work closely with the new CMS Innovation Center. Previous work that my colleagues and I have published has discussed how these collaborations can be pursued both from the "top down" (that is, with others joining in initiatives developed and implemented by the federal government) and the "bottom up" (with the federal government joining in initiatives developed and implemented by local stakeholders).[25] Collaboration with MedPAC and MACPAC, as well as entities like PCORI, organizations of private payers and providers, and patient advocacy organizations, as well as Members of Congress and the Administration, is critical to the success of this endeavor.

On this score, the IPAB should be considered not as a mechanism for imposing specific policies on the Congress, but instead as a vehicle for focusing attention on a set of issues that are critical, and that everyone agrees are of the utmost importance if we are to preserve not only the solvency of the Medicare program and the federal government, but also the ability of American businesses to continue to compete in increasingly competitive international markets and the access of Medicare beneficiaries and all

Americans to a health system that produces appropriate and effective care when they need it.

To play this role usefully, the scope of the IPAB's authority could be broadened to include working with private sector payers to develop policies that would involve a collaboration of public and private sector initiatives to improve the organization and delivery of health care and slow cost growth. Given that the biggest driver of the projected increase in federal health spending over the coming years is excess health care cost growth—which is a problem that plagues the private sector (businesses and households) as well as the public sector (including both the federal government and state and local governments)—it seems clear that the only way to control federal health spending is to control total health care costs.

Conclusion

The set of policies discussed here is intended to keep the discussion of health care's role in reducing the federal deficit focused where it should be: on pursuing the kinds of improvements in health care organization and delivery that can address the underlying cause of both federal and private health spending growth. By focusing more broadly on the general increase in health care costs, policymakers can alleviate the pressure that health spending has put not only on the federal government, but also state and local governments, businesses, and families.

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Mr. PITTS. The chair thanks the gentleman and recognizes Dr. Gottlieb for 5 minutes.

STATEMENT OF SCOTT GOTTLIEB

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

IPAB was created based on a premise that decisions about the pricing of Medicare's benefits are simply too contentious to be handled by a political process. 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 healthcare. 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 judicial review. In creating IPAB, Congress provided affected patients, providers, and product developers with no mechanism for appealing the board's decisions. IPAB's recommendations will be fast-tracked through Congress in way that provides for only a veneer of congressional review and consent. 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. But most significantly, IPAB is unlikely to take steps that 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 problem we have in Medicare is a problem with the existing price controls that erode healthcare productivity and 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 healthcare.

So what is IPAB likely to do besides simply squeeze prices? They will also try to confer CMS with new authorities to enable the agency to make more granular decisions about what products and services CMS chooses to cover. IPAB could well confer CMS with constructs such as Least Costly Alternative authority or the authority to consolidate drugs, devices, equipment, or services under the same payment code. The combined effect of these new powers would effectively give CMS the ability to engage in tacit forms of reference pricing.

The problem is that CMS has no tradition of making these kinds of decisions. As a consequence, it has little capacity to make the required clinical judgments. I believe many in Congress realize this and I know many stakeholders recognize it. This isn't just a question of expertise. It is also a question of whether these kinds of personal medical choices should be made in the first place by a remote agency that is far removed from the circumstances that influence clinical decision-making. This will have implications for patients and providers. It will also have implications for those developing

new medical technologies making that process more uncertain, more costly, and less attractive to new investment.

Medicare must continue to implement reforms to align its coverage and payment policies with the value delivered to beneficiaries. Congress needs to focus on real ways to get longer-term savings like premium support, modernizing benefits in tradition Medicare, and paying for better outcomes. IPAB makes it even harder to do all these things.

In closing, 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 judgments in the first place. It is not an argument for creating an insular panel that is removed from the usual scrutiny to take decisions that other federal entities have failed to adequately discharge precisely because those decisions could not survive public examination.

Thank you.

[The prepared statement of Mr. Gottlieb follows:]

AMERICAN ENTERPRISE INSTITUTE

Statement before the Committee on Energy and Commerce
Subcommittee on Health

IPAB: The Controversial Consequences for Medicare and Seniors

July 13, 2011

Scott Gottlieb, M.D.
Resident Fellow
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The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to testify today before the Committee. I have a longer working paper that contains some supporting details to my oral testimony today that I would like to submit for the record.

The Independent Payment Advisory Board (IPAB) was created based on the premise that decisions about the pricing of health benefits offered by Medicare are simply too contentious to be adequately handled by our present political system.

But these decisions are precisely the kinds of consequential choices that should be subject to close public scrutiny and an open, rigorous, and transparent decision-making process that engages with Medicare's stakeholders.

Changes to the way Medicare pays for and covers medical services affect too many people in significant ways to be made behind the closed doors of an insulated committee. How Medicare prices medical products and services has sweeping implications across the entire private marketplace. These decisions are some of the most important policy choices that we make inside our healthcare system.

Problems with IPAB's Construction

IPAB is not the right body to discharge these kinds of matters. There are some considerable shortcomings with the way that IPAB is structured, and the manner in which the board is tasked with operating under current law.

IPAB was purposely construed in legislation to take decisions about how to cut Medicare's spending on medical products and services out of any public debate and, instead, vest them in the hands of a sequestered board of appointed individuals.

The board has no obligation to engage in public notice and comment that is customary to regulatory agencies whose decisions have similarly broad implications for patients, healthcare providers, and medical product developers.

IPAB's decisions are restricted from judicial review.

In creating IPAB, Congress provided affected patients, providers, or product developers with no mechanism for appealing the board's pronouncements.

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 issues related to the separation of powers between the Executive and legislative branches rather than a desire for genuine Congressional input.[i] For practical purposes, the IPAB has been given the authority to legislate.

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 cleverly designed to remove significant decisions about Medicare cuts from public debate and scrutiny.

But 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. 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 is 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 healthcare services.

IPAB is an unsuitable solution tilting at the wrong problem. If the architects of government-run health programs bemoan that fact that it is hard to achieve unpopular cuts to the program because the political process often stymies these efforts, I would submit that this is an argument against running these health programs out of Washington. It is not an indictment of the open, transparent, and vigorous process that traditionally governs serious policymaking.

IPAB's Likely Pursuits

The first question is: "What is IPAB likely to do?" Will its decisions have perverse impacts on some of Medicare's constituents precisely because IPAB's decisions sidestep the checks that normally protect against regulatory over-reaching?

Because of IPAB's mandate to come up with potentially big savings, and its composition of largely generalist academics, IPAB will not have the opportunity or capacity to adjudicate individual medical treatments and services. IPAB will operate at a higher level, confining its work to one of three broader areas of policymaking:

First, it will lower the price Medicare pays for services closer to Medicaid rates.[ii]

Second, it will extend government price schedules that currently exist in one aspect of the market to new places inside the Medicare program. Since hospitals and other service providers have gotten themselves politically excluded from IPAB's initial reach, the board's payment cuts will fall disproportionally on the reimbursement of, and in turn access to, medical technology such as drugs and medical devices.

If you want a better indication of what these proposals might comprise, I would look to the recommendations made by MedPAC that CMS failed to implement (often because of political resistance) as a guide to the ideas IPAB is likely to pursue.[iii]

Third, and finally, IPAB will confer CMS 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, the IPAB would grant CMS authority to rely on judgment of the agency's largely thin clinical staff about the relative benefits of competing treatments.

It is this last area of policymaking that could have the most significant implications. While the new law bars IPAB from reducing the coverage of specific benefits, there is nothing barring IPAB from giving CMS authorities to engage in similar activities.

So IPAB could well confer CMS with constructs such as Least Costly Alternative (LCA) authority, or the authority to consolidate drugs, devices, equipment, or services, under the same payment code. The combined effect of these new powers would effectively give CMS the ability to engage in tacit forms of reference pricing for a wide range of medical products and services.

In effect, CMS would be able to say, among a variety of therapeutic options, we think the different approaches are clinically interchangeable. We – CMS -- will only reimburse at a rate that pays for the cheapest alternative. Low reimbursement rates for higher-priced technology or services would effectively bar their use. CMS has long wanted these powers. The agency went to federal court three times – in both Republican and Democratic administrations – seeking LCA authority, for example.[iv]

These authorities have the effect of making CMS a clinical arbiter, deciding what treatments are sufficiently similar that they can be used interchangeably for one another. The problem is that CMS has no tradition of making these kinds of decisions. As a consequence, it has little capacity to make the required judgments. I believe many in Congress realize this, and I know many stakeholders recognize it.

This isn't just a question of expertise. It is also a question of whether these kinds of personal medical choices should be made in the first place by a remote agency that is far removed from circumstances that influence clinical decision-making.

Moreover, under IPAB's current charter, it only gets to make recommendations 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.

As a result, the institutional instinct of the board will be to over-reach as opposed to moderate its positions – to achieve a higher degree of savings. Some members will worry they may not get another chance to push favored ideas so they will try and get their recommendations implemented when they have the opportunity. Similarly, members may decide that it is politically easier to issue proposals once every several years rather than have to come up with a new set of policies every year.

The Consequences of IPAB's Actions

So at a broad level, this is how I see IPAB flexing its powers. The final question is: What are the consequences of these policies that IPAB is likely to pursue?

The requirement for public scrutiny of regulatory decisions affords a measure of thoughtfulness, rigor, and moderation that I believe are essential to making decisions as important as how we cover health benefits in this nation.

Moreover, because Medicare affects so many people, and drives so much of the coverage decisions made in the private market, its actions have wide impact.

In short, Medicare is no ordinary payer. Its decisions should be more transparent, more expertly guided, and more subject to debate and public scrutiny and opportunities for appeal precisely because of the wide-ranging impact.

Yet the constitution of IPAB, and the staffing of CMS, renders this entire scheme far less transparent and rigorous and open 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.

Similar processes in Europe show that these kinds of schemes make it far less likely that entrepreneurs can develop new therapies that effectively re-price the initial treatment of significant diseases, no matter how much benefit those treatments may potentially deliver. Prices inside different therapeutic areas become arbitrarily capped, reducing incentives to significant new investment.

Already, it can take years for effective new therapies to win reimbursement in Europe; long after they are paid for by private health plans here in the U.S. Market access to new treatments in Europe lag the U.S. as a consequence. The new authorities IPAB will confer on CMS will bring our process far closer to Europe.[v] [vi]

Combined with increasing regulatory requirements at FDA that have made early discovery and development far more costly (front-loading many of the costs of drug development) IPAB's additional costs and uncertainties could leave more investors with the view that biomedicine is not a viable opportunity for early stage investment. Here is the U.S., we are already seeing less new company formation in the biotech sector, as business models adjust to the challenges of the regulatory and reimbursement climate. Look no further than San Diego, which was once a bustling hub of biotech entrepreneurship. Today it looks more like a biotech ghost town.

Conclusion

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 them.

Medicare must continue to implement reforms to align its coverage and payment policies with the value 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 of consumers and providers. It's not to consolidate these judgments into an increasingly narrow band of government actors.

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.

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 judgments in the first place.

It is not an argument for creating some kind of paramount and insular panel that is cloistered from the usual scrutiny, to take decisions that other Federal entities have failed to adequately discharge -- precisely because those decisions couldn't survive public examination, scientific questioning, and close political inspection.

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[i] "The terms of the Act attempt to "entrench" the procedures themselves against change by requiring a super majority to amend them, as well as to discontinue the automatic IPAB-implementation process. The Act also purports to restrict the ability of future Congresses to enact certain policy changes related to Medicare in other legislation, not just the IPAB-implementing measure. How these entrenching provisions will be reconciled with the well- established constitutional right of each chamber of Congress to make the rules of its own proceeding, and how or if one Congress can broadly regulate the actions of a future Congress in this way, will likely only be clarified in practice." From the Congressional Research Service, CRS Report for Congress. The Independent Payment Advisory Board David Newman and Christopher M. Davis, November 30, 2010

[ii] https://www.cms.gov/ReportsTrustFunds/Downloads/2011TRAlternativeScenario.pdf. See figures 1 and 2. By the end of the projection period, Medicare and Medicaid payment rates for inpatient hospital services would both represent roughly 33% of the average level for private health insurance. Under current law, Medicare rates for physician services would eventually fall to 27% of private health insurance levels by 2085 and to less than half of the projected Medicaid rates. The continuing slower growth would occur as a result of negative update adjustment factors caused by growth in the volume and intensity of physician services that exceeds the increase specified by the SGR formula.

[iii] See attached document outlining MedPAC's never implemented recommendations

[iv] Gottlieb, Scott. How the U.S. Government Rations Health Care. The Wall Street Journal, October 1, 2009. P A24

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[vi] Cristian Vladescu, Simona Baculea, Nona Chirac. The Burden of Cancer and Market Access for New Oncology Drugs in European Countries. Management in Health, Vol 13, No 2 (2009) Available at http://journal.managementinhealth.com/index.php/rms/article/view/23/76

Mr. PITTS. The chair thanks the gentleman. I will now begin the questioning and recognize myself for 5 minutes for that purpose.

Mr. Roy, changes that reduce cost by improving the healthcare delivery system and health outcomes often require several years before savings may occur and the board may have to find immediate savings. Therefore, isn't there a real concern that board proposals may skew towards changes in payments, which are likely to result in de facto rationing of care and ignore the more important aspects of long-term reform?

Mr. ROY. In fact, it appears that that is almost certain to be the likely consequence of IPAB's decisions.

Mr. PITTS. Thank you.

Ms. Cohen, can you expand on how difficult it would be for Congress to stop or override the decisions made by the 15 experts on this board once the process is put into motion?

Ms. COHEN. Certainly. Well, first of all, it is not a matter of Congress being able to come up with an alternative. The alternative would actually have to be exactly what IPAB would have already done. They have to make the same cuts or an alternative couldn't even be viable pursuant to the statute. There can be no amendments to IPAB's proposal, again, unless it meets the very strict requirements of IPAB's statute. So basically, Congress can do nothing but do more than what IPAB has done. It certainly couldn't do less.

But more than that, we have talked about the spending targets, but IPAB's power is much broader than that. IPAB also has powers that could affect the private market, and it is very unclear about if a proposal came by that came from IPAB that included recommendations for the private market—or legislative proposals, as they are called in the act—whether Congress could actually override that. And then, of course, there is the super majority voting requirement in the Senate. And that, of course, is a very difficult hurdle.

Mr. PITTS. Thank you. Anyone can respond to this question. Savings attributable to the IPAB have varied considerably. The CBO's scoring for the IPAB has changed several times. Initially, the CBO estimated that savings attributable to the board would be $15.5 billion over the 5-year period from 2015 to 2019. In March 2011, realizing that under current law the IPAB mechanism will not affect Medicare spending during the 2011–2021 period, CBO scored repeal of the IPAB at zero. In April, using an obscure statistical methodology called the one-sided bet, the CBO revised this estimate again and now says that full repeal of the IPAB would cost $2.4 billion. Can anyone explain why this has been so difficult to score? Mr. Davis, do you want to try?

Mr. DAVIS. Mr. Chairman, I would like to, if I can, defer to my colleague, Mr. Newman.

Mr. PITTS. All right. Mr. Newman?

Mr. NEWMAN. I think basically we have got a varying set of assumptions going forward in that these estimates are likely to change in future years, too. If Congress fixes the SGR, the baseline estimate with respect to what program expenditures are going to be will change, and once that changes, the targets will change and the potential savings resulting from board recommendations will

change, too. I think what you are doing is looking at snapshots at these estimates over time.

Mr. PITTS. All right. Thank you.

Dr. Guterman, regarding the IPAB, the CBO stated 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 nonexempt providers. And the Kaiser Family Foundation recently stated in an issue brief that the 1-year scorable savings mandate may discourage the type of longer-term policy change that could be most important for Medicare, and the underlying growth in healthcare cost, including delivery system reforms that MedPAC and others have recommended, which are included in the ACA and which generally require several years to achieve savings. Would you agree with this assessment from both the CBO and the Kaiser Foundation?

Mr. GUTERMAN. I would suggest that the IPAB, since it doesn't exist yet, what it focuses on will depend a lot on the environment in which it operates. And I would envision IPAB as working closely with the Innovation Center to incorporate some of the best policies that were enacted in the Affordable Care Act and other policy ideas as well. So I would hope that IPAB wouldn't be an either-or proposition, that you would either take IPAB or the Congress or some other party but that it would be people working together to try to find the best policies available to accomplish the goals that IPAB was established for, which is to slow Medicare spending and more broadly to slow healthcare spending.

Mr. PITTS. The chair thanks the gentleman. My time has expired. The chair recognizes Ms. Schakowsky for 5 minutes for questions.

Ms. SCHAKOWSKY. I thank you, Mr. Chairman and Mr. Pallone, for letting me go out of order.

Mr. Roy, I have to say that I am deeply offended by your open-bar analogy. It is like saying oh, honey, now that we are 65, I can get breast cancer and you can have that heart attack. And we are now able to get—I can now get a PET scan and an MRI and a CAT scan as if older Americans are making those kinds of decisions or—as I think Dr. Guterman pointed out—as if they are making those decisions differently from people who have insurance who also, you know, go about their business knowing that they are insured and get the healthcare. I mean, really. And also that Medicare has exploded. It has not, in fact, exploded more than healthcare costs in the private sector. Is that true, Dr. Feder?

Ms. FEDER. That is true, Congresswoman, that Medicare spending per capita grows more slowly than in the private sector.

Ms. SCHAKOWSKY. More slowly. The other thing is you must not have seen the recent Medicaid study, a scientific study done out of Oregon that absolutely showed—the first actual scientific study that was able to take 10,000 people who got Medicaid, 10,000 who did not and had profound improvements in the healthcare of people—you ought to check it out. It is a very important study.

So I think it is insulting to older Americans to say that now they are just spending their days just having a great time at the doctor. You know, mostly I think people are trying to figure out, you know, perhaps have a little vacation or something or pay for their medications is more likely.

So Dr. Feder, what you are saying in your testimony is that because the problem is system-wide that this will—and you mentioned how consumers should have choices and mentioned Switzerland, you know, Switzerland says in the basic package, insurance companies can't make any profit. Did you know that?

Mr. ROY. Yes, they are nonprofit companies.

Ms. SCHAKOWSKY. They are nonprofit companies. That makes a rather big difference between the U.S. system that anyone has proposed and the Swiss system, which I think was sort of glossed over in your saying that, you know, we should have more—I think it is—I would like that. That would be just fine.

But Dr. Feder, I want to get back to you and say so how exactly would that work if we were to bring everyone under this system?

Ms. FEDER. Ms. Schakowsky, as you know, the Independent Payment Advisory Board is now authorized to make recommendations for the private sector but they are not binding. There is not an overall target. There is a target on Medicare alone. And since, as you say and I agree, the problem is system-wide. We could modify that is a target that authorization to apply to all of healthcare spending because Medicare and private spending are driven by the same factors and can be most effective if their payment mechanisms are aligned. And a way to do that is as the IPAB examines the evidence, as Dr. Guterman said, works with the Innovation Center and looks for ways to improve payments in both the public and private sector, adoption of those improved payment mechanisms could be applied, recommended to the Congress for application not only to Medicare but as conditions we could say for favorable tax preferences under current law. So we have the capacity to apply these mechanisms across the board.

Ms. SCHAKOWSKY. And there could be some carrots you put out, as well as sticks.

Ms. FEDER. I beg your pardon? There could be?

Ms. SCHAKOWSKY. The carrots as well as sticks.

Ms. FEDER. Absolutely. I think the goal is to actually change the way in which we pay consistent with—I believe it was Mr. Murphy was asking the Secretary about coordinating care. The goal is to move away from rewarding providers for delivering ever more and expensive service and more expensive services toward delivering good care, efficient higher-quality care, coordinated and efficiently delivered and rewarding providers accordingly.

Ms. SCHAKOWSKY. OK. Would anybody want to comment on the issue of access to care? Is it really a concern that we—and I will leave that to—that if Medicare reimbursements are too low as a result of a decision by IPAB that doctors simply won't take Medicare patients.

Mr. ROY. That is already happening. So if you look at consistent surveys, the rate of the difficulty for Medicare beneficiaries gaining access to care is higher than it is for people in private insurance.

Ms. SCHAKOWSKY. Actually, I saw an opposite study. Maybe you haven't seen a more recent study that has 93 percent of Medicare patients were able to access care as opposed to 88 percent of people who had private insurance.

Mr. ROY. The consistent consensus of all the data is access to care for Medicare beneficiaries is worse, and I recommend that you talk to the physicians in your district and I think they will agree.

Ms. FEDER. Actually, I have to take issue with that. It is not consistent. The MedPAC finds through the surveys that they do that the access that Medicare beneficiaries have access in the vast majority of communities around the country. There are variations and that in many respects if not most or if not all it is that the access is superior to those for private insurers.

Ms. SCHAKOWSKY. Thank you. My time has actually run out. I don't know, Mr. Chairman, if Dr. Guterman——

Mr. GUTERMAN. If I can add one more comment. Any issues there are with current or future access problems for Medicare beneficiaries is probably attributable to the sustainable growth rate mechanism, which is kind of a separate issue from the IPAB. And I would also point out that CBO's estimate of the impact of the whole Affordable Care Act on Medicare spending was that the projected increase pre the ACA of 94 percent over the next 10 years would be reduced to an increase of 71 percent over the next 10 years in Medicare spending. I think that could hardly be described as rationing care or starving providers.

Mr. PITTS. OK.

Ms. SCHAKOWSKY. Thank you.

Mr. PITTS. The chair thanks the gentlelady and recognizes Dr. Burgess for 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

Let me just say on the issue of access to care, Mr. Roy, I have talked to the doctors in Ms. Schakowsky's district and they tell me to a man and a woman that they are in deep trouble because they cannot afford the cost of delivering their care. Now, true enough MedPAC came to this panel, I think it was the last Congress, testified to us that there were not access issues that they had identified and then Glenn Hackbarth has visited with me since then saying he is becoming concerned about people, particularly seniors who move, and when does that happen? I want to be closer to the grandkids, so they move to a new city or location and there they find the door is closed. And if this Congress continues to bury its head in the sand about that, we are going to find that the world becomes very, very hostile.

Now, Mr. Roy, let me just tell you I was not offended by your open-bar analogy.

Mr. ROY. Thank you.

Mr. BURGESS. I do not drink myself but I thought it was apropos. And, you know, the President of the United States, when he had the Republicans down 3 or 4 or 5 weeks ago to the White House, big reception in the East Room, and he wanted to drive a point home with us. And I think the point he wanted to make was that drugs cost too much.

But the point he made was that during the—and it is not a HIPAA violation because he told us in an open forum—in the election he developed a rash on his back and he was concerned about it. So he went to a doctor who prescribed some goop to put on it. And he put the goop—he didn't use the word goop; I made that up—but he put this cream on it for the prescribed time and it

might have helped a little bit but not so much so he had it refilled. He had a little prescription card and it cost him 5 bucks to get it refilled. So he went down and had it refilled.

And then he was on the campaign trail and he ran out. So what to do? He went to a pharmacist, explained to the pharmacist his dilemma, got the prescription transferred via the miracle of electronic records and the pharmacist bagged it up for him and said that will be $400. And the President looked at the pharmacist and said, you know, this rash is not that bad. And at that point, the President became an informed consumer and was spending his healthcare dollars wisely. Now, people do argue that well, wait a minute. You go into that sort of system and people will not get healthcare when they need it.

He also pointed out to us, and I did not know this, but apparently one of his daughters was gravely ill when she was very young and he went to the emergency room with her and the doctor explained the diagnoses and what would have to be done and what he proposed and the President—then not the President—he said do whatever it takes. And of course he did. He behaved in a rational fashion that you would expect a father to do when their child is gravely ill. He did not question cost.

So I guess the point I am trying to make is the President actually articulated a strategy for consumer-directed healthcare that I thought was phenomenal for him to admit. Now, we had some hearings leading up to the Affordable Care Act. We didn't have hearings that I thought really would have gotten to the issue of the cost of delivering care. If we were serious about that, we should have invited Mitch Daniels in here and said how did you do it with your Healthy Indiana plan? Now, Dr. Feder is saying that the cost of Medicare grows more slowly than other areas. I don't think that is accurate and I would like to hear Dr. Gottlieb, perhaps Ms. Cohen weigh in on that, and you, too, Mr. Roy, but we never heard from someone who is actually making it happen on the ground. Healthy Indiana program costs went down by 11 percent over 2 years. So even if we accept the figures that I believe are wrong that Dr. Feder is talking about, why wouldn't we do something that is even better than that, which was look into consumer-directed healthcare? Because as the President so correctly articulated, something magic happens when people spend their own money.

Now, we are left with this Independent Payment Advisory Board that is going to tell us how to magically spend less money, and it just takes me back to a speech that Ronald Reagan gave in 1964, and he talked then about some of the issues that were ahead and whether or not this country still believes in this capacity for self-government or whether we abandon the American Revolution and confess that it is a little intellectual elite in a far-distant Capitol that can plan our lives for us better than we can plan them ourselves. Ronald Reagan was describing the Independent Payment Advisory Board.

I have gone on too long, but Dr. Gottlieb, do you have an impression as to whether or not the cost of delivering care is rising more slowly in Medicare than in other areas?

Mr. GOTTLIEB. I would defer to Mr. Roy on an analysis of numbers. I haven't seen any apples-to-apples comparisons on senior care because everyone is in Medicare.

Mr. ROY. That is correct so you can't really analyze the numbers directly because seniors, of course, are almost all on Medicare. Not all of them but—and they are also over 65 so they have higher medical expenditures.

Mr. BURGESS. Well, let me ask you a question. Regardless of whether you are for-profit or not-for-profit insurance company, you need to have access to capital, so the cost of that capital is the cost of what the cost of the capital is on the open market, but does Medicare have a cost of capital that they have to put on their balance sheet?

Mr. ROY. No, in fact there are a number——

Mr. BURGESS. Do they have a cost for advertising they need to put on their balance sheet?

Mr. ROY. There are a number of different aspects of Medicare administrative costs that are off the HHS or Medicare——

Mr. BURGESS. And on that general administrative side to the balance sheet, what about all the administration that goes on in the Department of Health and Human Services that is appropriated through a discretionary appropriation, which is the largest appropriation that occurs every year that the Congress deigns to do appropriations bills?

Mr. GOTTLIEB. I would just add, you know, the most significant cost to Medicare is the cost of compliance with the Medicare program, which is a cost that isn't estimated. If you look at what goes on in medical practice, a good percentage of the expenditures in any medical practice or in the hospital is on trying to comply with the Medicare program because of the threat of, you know, a Justice Department audit or a Medicare audit. Hospitals, medical practices overspend on that. That doesn't get calculated in the cost of the overall program, if you will. Private healthcare plans have to actually hire staff to do that kind of work. Medicare can just foist rules on the private sector and back it up with the threat of litigation or criminal penalty, and those costs don't get estimated in the cost of the program.

Mr. BURGESS. Very well. Thank you.

Mr. ROY. Roughly speaking, the administrative costs are double when you count all the off-budget expenditures of Medicare, and that doesn't also include the cost of fraud, which is very significant in the Medicare program relative to that for private insurers. If you add all that up, the administrative cost per beneficiary for Medicare between fraud and the actual administrative costs is arguably double to three times that of private insurers. If you leave fraud out, it is about 20 percent higher.

Mr. BURGESS. Thank you. Thank you all for being on the panel today.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman, Mr. Pallone, for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. I am going to try to divide my time between asking Dr. Guterman about the Affordable Care Act and asking Mr. Davis about IPAB. So just bear that in mind if I cut you off.

You heard me in the beginning that I am against IPAB. I think it is a usurpation of, you know, congressional authority and, you know, I have never been in favor. I spent a lot of time trying to make sure it wasn't in the House bill, which it wasn't. But a lot of my concern is that it is very much like the BRAC, which I think is a disaster. And the concern about the BRAC is that it is totally stacked against Congress. I mean I don't like the idea to begin with because it takes away congressional authority and gives it to the executive or independent commission, but I also think it is stacked. There is no way we are ever going to overturn a BRAC decision. We have had three BRACs since I have been here. Every time we try to overturn it we fail, and that is it. There is no congressional input.

What I wanted to ask Mr. Davis quickly is to what extent is IPAB the same? In other words, we have been operating with MedPAC, they make recommendations, we usually adopt them. I think we have been very effective. I don't see any need to change MedPAC. With BRAC, you know, it is one deal. You either vote it up or down. You need a super majority, which we never get. Is the process similar and stacked in a way that it is going to be virtually impossible as it is with the BRAC to overturn?

Mr. DAVIS. Thank you, Mr. Pallone.

Mr. PALLONE. And I am asking him as opposed to the D or R witnesses because I am trying to be—not that you are biased but I am trying to get an unbiased opinion. Go ahead.

Mr. DAVIS. Yes, Mr. Pallone. As you said in your opening comments, there are very many similarities between the IPAB model and the base-closure commission. Principally is, as you indicated, that this is a commission that makes recommendations that go into force unless Congress stops them. That is also, of course, the case with IPAB. And whether under this procedure there are certain super majorities that are required to overturn IPAB and some of them, frankly, are de facto super majorities as they are with BRAC, the idea that if Congress were to put forward something different it would be vetoed and require a 2/3 override in both chambers. So in that way it is similar to the base closure process.

There are two differences I would highlight, though. The first is is that Congress, unlike under BRAC, can change the procedures—or rather change the recommendations of IPAB as long as they fit within the same fiscal targets. That, as you know, is not the case with BRAC where it is simply an up-or-down vote. Others have pointed out another difference, frankly, with BRAC in simply that it is related only to facilities while, of course, very important, can be thought of as very different to a sweeping policy area such as Medicare or healthcare reform. So I think in sum there is similarities and differences.

Mr. PALLONE. All right. Thank you. I appreciate that.

Now, let me ask Dr. Guterman, I don't know if I was going to ask Judy Feder to jump in, too, but I don't know if we have time. I believe very strongly—I am opposed to IPAB, but one of the reasons I also was opposed to it was because I thought that in the Affordable Care Act that we did a very good job about keeping costs down and that we put together under Medicare, under the Affordable Care Act a sustainable trajectory if you will for the next gen-

eration with all the things that we did and we don't need IPAB, not necessary.

So what I wanted to ask you is if you could outline how the Affordable Care Act's approach to reducing health costs is affective. You know, don't get into IPAB. I mean to what extent did we set up a sustainable Medicare program here and get towards the cost without IPAB, with the other things. In 1 minute or so.

Mr. DAVIS. The Affordable Care Act laid out a number of tools that one could use to build a better healthcare system, and that is really the answer. It is not a matter of how much we pay so much as how we pay and what we pay for in healthcare and how healthcare is organized and delivered that needs to be addressed. And the Affordable Care Act, through the Innovation Center, through the Medicare/Medicaid Coordination Office. Those are two big steps because the Innovation Center is supposed to develop in collaboration with outside parties innovations that help improve the delivery of care and save money in Medicare and Medicaid and across the healthcare sector.

And they have already begun to initiate projects that involve States in broader initiatives. They are working with private payers. The ACO model that they are working on is one that has been picked up by the private sector, and in fact there are a number of private sector initiatives that are ongoing to try to achieve the Accountable Care Organization model that has been put forward in the ACA.

And also having Medicare and Medicaid work together for a change, there are 9 million beneficiaries who are eligible for both programs, and right now the two programs just aren't well aligned to serve those beneficiaries' needs or to make sure that the money that is spent is well spent for those beneficiaries.

Mr. PALLONE. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Georgia, Dr. Gingrey, for 5 minutes for questions.

Mr. GINGREY. Mr. Chairman, thank you very much and I thank the panel. I am sorry I had to step out to give a little quick speech and I missed all of your testimony but I certainly intend to read it all because what I heard was extremely interesting, a little bit diverse, which is to be expected.

Before I go into questions, I want to raise one very important point today. In the press, Secretary Sebelius has often chided opponents of IPAB for suggesting that it has the power to restrict access to physicians' services or life-saving drugs and treatments, otherwise known as rationing. And yet under oath here today she has admitted that IPAB is charged with reducing excessive growth areas of Medicare spending when President Obama's own OMB director states that excessive growth in Medicare spending is due to the availability and adoption of new, high-cost drugs and treatments.

Finally, nowhere in Obamacare are the words rationing or excessive growth areas defined in statute, which means it is up to the Secretary and the IPAB board to ultimately decide what is rationing and what cutting excessive growth areas means. It is up to them. And if the American public disagrees with how the Secretary

or IPAB define rationing, they are, as I got from her testimony, prohibited from suing in court to stop it.

So my concern here is simple. What one person considers rationing, another might refer to as reducing excessive growth areas of Medicare, known here as new treatments or drugs. And I believe the Secretary of Health and Human Services owes this committee and owes the American people a lot more clarity on this issue.

Now, let me in the remaining time get to my questions and I will go to Dr. Gottlieb, yes, and Mr. Roy. I am interested in your thoughts on the lack of clarity in the law with regards to, one, rationing and reductions in excessive growth areas, along with the lack of judicial review, as I mentioned, for patients who feel the board is in fact denying them the benefits that they need to survive.

Mr. GOTTLIEB. Well, I think the issue of rationing versus squeezing payments is a distinction without a difference because we have seen it already that when you squeeze payments, it effectively closes off access to care, and there is some debate about what is happening in the Medicare program, and I would submit there has been some recent studies, one out of Massachusetts that shows that Medicare beneficiaries are having a hard time getting access to providers up there. There is certainly no debate around Medicaid and whether or not patients under the Medicaid program have a difficult time getting access to medical care because of how low rates have been squeezed in that program. So, so long as IPAB is going to squeeze down payments, it is going to ration care, and I think, you know, the distinction is just semantics.

What was the second question, Congressman? I am sorry.

Mr. GINGREY. Well, let me do this, Dr. Gottlieb. Thank you. And I would like to get Mr. Roy's opinion on that same thing if he can.

Mr. ROY. I think that I would echo Dr. Gottlieb's comments. I think that the importance of access to a physician cannot be understated. It is the most important thing. If you have a problem and you can't see a doctor for that problem and that problem festers, you could have a much more serious medical condition. Children die of toothaches on Medicaid because they can't see a dentist and have their abscesses removed. There are serious, serious medical problems of healthcare that if you can't have access to a physician, you can't do anything. So the fact that the IPAB is explicitly restricted from changing the mix of benefits really doesn't matter if somebody can't actually see a doctor in the first place.

Mr. GINGREY. Right. Right. Well, I thank you both for that answer to that question. And I have got one more, Mr. Chairman.

Secretary Sebelius in her statements today said that the administration has begun outreach efforts to fill these 15 seats on the Independent Payment Advisory Board. I would just be curious to know among this distinguished panel whether or not any of you have been contacted, and I very specifically ask Ms. Cohen. Has anyone from the administration contacted you about serving on our IPAB?

Ms. COHEN. No, probably because I am suing them.

Mr. GINGREY. Ms. Feder, Judy Feder, has anyone from the administration asked you—contacted you about this?

Ms. FEDER. I have actually had lots of discussions about various aspects of the Affordable Care Act with the administration and indicated that I would be proud to serve on the Independent Payment Advisory Board.

Mr. GINGREY. So the answer is yes? That sounds like a yes to me.

Ms. FEDER. Asked would be grossly overstating.

Mr. GINGREY. Yes. I take that as a yes. Mr. Roy, how about yourself? Have you been asked?

Mr. ROY. I am afraid not. I like my current job, so I am OK.

Mr. GINGREY. Dr. Gottlieb?

Mr. GOTTLIEB. I have been asked by some Senate staff and I indicated that I would be interested in being nominated but I wouldn't want to serve. My only reason for being nominated is I want to write an op ed. outlining why the President shouldn't pick me to serve on the board.

Mr. GINGREY. So the response, Mr. Chairman, is that two of our panelists have been at least approached and one is enthusiastic about the possibility of serving and the other one is not. I thank you all very much for your response and I yield back my time.

Ms. FEDER. If I might just clarify, the approach was mine I just want to say.

Mr. GINGREY. Mr. Chairman, would you yield me another 15 seconds?

Mr. PITTS. Go ahead.

Mr. GINGREY. Did I not ask Dr. Guterman?

Mr. GUTERMAN. No, you didn't.

Mr. GINGREY. I apologize, Dr. Guterman. Have you been approached?

Mr. GUTERMAN. You don't need 15 seconds. No, I have not.

Mr. GINGREY. You have not. OK. Thank you. And I yield back.

Mr. PITTS. All right. The chair thanks the gentleman and recognizes the gentlelady from California, Mrs. Capps, for 5 minutes for questioning.

Mrs. CAPPS. Thank you, Mr. Chairman.

Well, welcome to all of you and thank you. This is a big panel and thank you to each of you for your testimony. I am in and out today but my computer and my television set are all locked in so I could watch and listen.

Dr. Feder, the Republican plan for Medicare is to end it in 2022 and replace it with a limited voucher, whatever it needs to be called, with which to purchase coverage on their own. Each senior, then, would have this opportunity or responsibility. It would solve the Federal Government's healthcare cost problems by asking seniors and those with disabilities to make sure that all the costs were covered and using their voucher or subsidy or premium support to help them do this. The Congressional Budget Office estimates that the Republican budget would double annual costs. Despite this cost-saving or cost-shifting in the Ryan budget plan, the Republican budget would actually double the annual cost for Medicare by 2022 and nearly triple them by 2030. But this isn't just a problem for the future. Costs that large cannot be covered by our future seniors overnight.

The Center for Economic and Policy Research looked into what these changes would mean for the retirement planning of people who are 54 or under today, which will be the first cohort of people who will live under—should the Ryan plan become actualized. They found that this plan would require that each senior would have to save about $182,000 for retirement over whatever they would be currently planning to save. Does this lead you to question the claim that the Republican budget doesn't hurt people today, only in the future?

Ms. FEDER. It does, indeed, Ms. Capps, and I appreciate your drawing attention to the fact that it is not just about the future. It is about the current period. And I would add to it the concern that you have raised about people becoming uncertain as to what they would have to pay for insurance. And at the time when they are struggling to put aside pensions for the future, as well as take care of their kids, get them started and educated, that they would have to be putting money away to deal with future insurance costs seems to me an outrage.

In addition to that, those who were talking about the repeal of the IPAB are also talking about the repeal of the Affordable Care Act. And so the protections that have been added for prescription drug costs, for preventive benefits, and other advantages that are available to current seniors, current beneficiaries would also disappear.

In addition, there would be an enormous—as this proposal has set up—there would be a huge cliff that occurs at that year when that goes into effect. And that seems an enormous burden to put on people into the future.

Mrs. CAPPS. I would like to shift to a topic of Medicaid in just a minute, but I want you to respond briefly to many concerns that current seniors—today's Medicare recipients are the ones who are voicing their concerns about this change in plan, even though they have been reassured that nothing will happen to them. There is a concern, and I haven't been able to address it—I wondered if you could—about what is to stop, you know, the majority from pushing forward this time. I mean if it is going to be that kind of cost shift to start, you know, for those who are 54 now, what is there sacred about this contract that the current seniors now have with their government?

Ms. FEDER. The people that would be affected in 2022 are paying into Medicare for Medicare benefits as we speak and they are expecting them. If the Congress changes that contract, there is nothing to say that they couldn't change the contract for those currently on Medicare.

Mrs. CAPPS. Now, similarly, the Republican plan for Medicaid would also slash payments to States starting in just 2 years. It would be sort of a block-grant approach to Medicaid—the match that is now guaranteed, the federal portion of it would no longer be in the same way. I am from California, and boy, there is tremendous concern about this because our State has terrific economic challenges. We have lots of people receiving Medicaid benefits, and to have this double whammy to the State of having to pick up more of the piece, which is apparently what is intended. Maybe you will

explain what the cuts to Medicaid would have any effect on Medicare beneficiaries, some of them being dually eligible.

Ms. FEDER. The Republican budget calls for a cut in federal funding to the States for Medicaid of about 3/4 of a trillion dollars. It is a huge cut in the resources going to States to support a population which, as we all know and are discussing with respect to Medicare is aging and then becoming increasingly in need of care. About a third of Medicaid spending is for long-term care services, long-term services and support, some in nursing homes, some outside nursing homes. The elderly along with younger people with disabilities but the elderly are primary beneficiaries. They are also beneficiaries of Medicare.

We have improved services in recent years to try to get people who need long-term care services at home and in the community where they want to stay and not go into nursing homes, those as well as a host of other services who are dual eligibles. Medicare beneficiaries who are also dependent on Medicaid would be tremendously at risk as we know from what States are already considering as cuts in benefits.

Mrs. CAPPS. Thank you, Dr. Feder.

Mr. PITTS. The chair thanks the gentlelady and recognizes the gentleman from Kentucky, Mr. Guthrie, for 5 minutes.

Mr. GUTHRIE. Thank you, Mr. Chairman. Thank you for coming.

I talked with the Secretary earlier today and here is my concern. And people have paid into Medicare and it is not a dollar in, you get a dollar out. I understand that. But we have a study from the Urban Institute says people average about 100,000 or a little more into Medicare and take out about 300,000. And people might say that is not a correct study or not. I know. And I have seen other studies about three to one what you pay and what you receive. And I am 1964 into the baby boomer. Beginning of the baby boomer is 1946. We are all retiring starts now. It starts now. We know in 2024 I think the President even said Medicare is unsustainable. Now, they say during the Obama healthcare plan, President Obama's healthcare plan they preserve Medicare, but he even said yesterday that it is unsustainable the path that it is on. And what we are trying to do is offer a solution, a reform that preserves it for those who have it and to have it for people that are—I am 47. I am affected by it—to move forward. And to say that we paid into Medicare and it is not going to be there. That is just incorrect. That is absolutely incorrect because it is a government-sponsored program that we are offering that uses Medicare dollars to move forward.

So my question is—and Dr. Feder, with the vast of baby boomers moving—taking out $3 for every $1 we put in, how do you keep the system as it is for people in the future? You can't just—you know, they talked about DME medical equipment. If you stopped people from buying the scooters—the free advertising, I will get you a scooter on television—you can't save enough money to make up for the demographic move, the wave that is coming of baby boomers. And it starts today. It has started today.

Ms. FEDER. Mr. Guthrie, I am an earlier baby boomer. I will be 65 next year, so I am at the point of the pressure here. And there is no question that it is growth in population that is what is driv-

ing Medicare spending, total spending much more than any other period in the history of the program as the enrollment grows because the per capital spending growth, remember, for Medicare is much slower than private sector growth, but what is now come to drive along with that spending growth, cost per beneficiary, is the number of beneficiaries.

Mr. GUTHRIE. Right.

Ms. FEDER. And it is true for all of us that we don't want 1965 healthcare or in 1985 or in 2020. We want the healthcare that is available today.

Mr. GUTHRIE. Right. So how do you have the fee-for-services as it exists today with the vast baby boomers retiring and not—talk about cost-shifting. I have a 17-year-old daughter who in 30 years will be 47 years old, which is my age. And in 40 years, according to the CBO, 100 percent—if you have 18 percent of revenue GDP—coming to the Federal Government will be for Medicare, Medicaid, and Social Security. So the greatest generation who provided the interstate highways, fought World War II, did everything to give my generation the opportunities, my generation, if we don't address it—I know everybody is here criticizing everything we are doing—but if we do not address it, my child will go to work when she is my age for me to be retired, solely for me to be retired.

Ms. FEDER. Well, I understand your concern and I share it. I have 4-year-old twin granddaughters, and I am doing my best to guarantee affordable healthcare for them well into the future when they are my age and older. And what we are all concerned about here is how to do that. And the way to do that is to change the overall healthcare system. The Affordable Care Act gave Medicare the lead in changing the way we pay for healthcare and making the whole system more efficient. And that is what we need to do because an alternative is simply to deny care to those who don't have the resources to pay a cost that is going up.

Mr. GUTHRIE. The Republican plan doesn't deny care. And just like Medicare Part D, it is 40 percent under estimate because health plans have to compete. Anybody can answer what I just—I am just not asking the one question——

Ms. FEDER. Well, if I may stay with you, I don't think Medicare Part D offers you the answer there, sir, and the cost of prescription drugs are rising as well. We need to make the system more efficient——

Mr. GUTHRIE. Well, let me ask—Mr. Roy, I am about out of time. I am sorry to cut you off but I only have 40 seconds left.

Mr. ROY. No, I think that one of the things that we see with the CBO projections is the CBO consistently underestimates the importance of cost-shifting in medical expenditures, so Medicare Part D has a significant cost-sharing component, which is the so-called donut hole, which is now going away. But that donut hole is a big part of the reason, along with the choice and plans, that Medicare Part D is coming 40 percent under budget, whereas with the conventional, traditional parts of the program, expenditures have skyrocketed out of control because there has been minimal cost-sharing.

Mr. GUTHRIE. And the administration wants people making $250,000 or more to pay more taxes but they don't want them to

pay more for their healthcare. And what our plan does is if you are at the lower end, you still get covered, and at the higher end you would pay more. And so instead of a $250,000-a-year person at 65 years old paying more for their healthcare, they are going to send the bill to my 17-year-old daughter and my 16-year-old son and my 13-year-old daughter.

Mr. ROY. I would make a point about that which is that because medical expenditures grow at faster than the rate of GDP, you can never raise taxes fast enough to compensate for the rise in healthcare spending. So it is always much more efficient if you want a means test to means test on a spending side rather than on the taxation side.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Texas, Mr. Gonzalez, for 5 minutes.

Mr. GONZALEZ. Well, thank you very much, Mr. Chairman. And I really appreciate the testimony of all the witnesses. I may not agree with a few of you but I do think that IPAB is actually one of the best approaches as trying to get a handle on what are exploding healthcare costs. And I think we all acknowledge that healthcare costs consume too much of our GDP, that employers are no longer providing it to the degree that they used to provide it to their employees, that individuals in this country very likely cannot afford healthcare. It is that simple. That 50 cents out of every dollar spent on healthcare comes from some entity of government.

And I do—I share some of the real concerns of my colleagues on the other side of the aisle about where we are going to be and such. A generation that may have provided great opportunity for us, the interstate highway system, but I remind everybody that what Eisenhower and others did in the '50s to give us that interstate highway system was to, in essence, raise the gasoline tax what would be the equivalent of 96 cents a gallon today. There is not one of my colleagues—and I hate to say it—I don't think I would vote on that myself today. So there is a difference that is going on out there as to what people are willing to pay for in this country and still expect to receive the benefit.

I am concerned about something you said, Mr. Roy, and because in the United States either the government is subsidizing the payment for healthcare or the private sector is. But the individual consumer—and there is no other product or service that has that kind of status in this country that I am aware of. But I am somewhat disturbed by the fact that it must be all of the patient's fault.

And I am concerned about some aspects of IPAB. I share the concerns of my physicians in my district that are saying where will our input—how are we guaranteed that we have something to say as far as the information that is going to be considered by the members of this board? I am really worried about that. But where does the responsibility lie? I will tell you right now, if I go into my doctors—and I have been going to them for a number of years—and if they tell me I need a certain procedure or certain test, I really don't question it.

Now, let us just say I didn't have Blue Cross/Blue Shield because it is employer-sponsored. I am a Member of Congress. But I was going to pay that out of my own pocket. I am still not real sure—your premise is that I am going to shop around and I am going to

go around and say well, I am not sure that I really need that test. I think I will go and see another doctor and get another opinion, which is going to cost me money and such. So where does the responsibility lie? Do you believe that maybe the physicians have a responsibility only to provide that service which is absolutely necessary? I am not going to get into the argument of unnecessary testing and everything else because I have got the gold standard in the State of Texas, and it has not brought down the cost of healthcare in the State of Texas. It has brought down the cost of insurance policies for certain specialties. So where is this shared responsibility? How do we get a handle on this? And isn't IPAB maybe a method of achieving that goal?

Mr. ROY. If one looks at a number of studies around the behavior of patients and physicians with high deductible health plans and health savings accounts where there is more consumerism, where there is more ability to shop for procedures and tests and office visits, you see a lot more intelligent consumption.

I think in Washington we have an excessively pessimistic view of the ability of individuals to make intelligent decisions about their own care. Especially in the days of the internet, people do a lot of research; people have a lot of knowledge. If we had a system where consistently across the system for everyone there were more and more people who could shop for care, who bought insurance for themselves instead of having it provided by someone else, you have more of the ability to start thinking in the way that people need to think about well, do I really need that test? And if a doctor says, yes, I really do think you need that test even though it costs $2,000, the patient might say yes. But maybe the doctor will say you know what? That test is $2,000. I think it might benefit you a little bit but maybe it is not worth paying for for you right now because it is $2,000 and you are very unlikely to benefit from it.

Mr. GONZALEZ. Don't you think the determining factor, though, really in most tests—and I know this is going to be controversial—is whether it is covered or not?

Mr. ROY. Could you repeat the question?

Mr. GONZALEZ. What I am saying is whether you have access to a number of tests or not is whether that test is going to be paid for through some subsidy, either through private insurance or government. Isn't that the truth?

Mr. ROY. Not necessarily because, again, if you have co-pays, deductibles, health savings accounts, and other mechanisms by where the patient shares in the expenditure, the patient has more of an incentive to monitor those expenditures and make sure they are being executed intelligently.

Mr. GONZALEZ. And Mr. Chairman, I am going to ask your indulgence just to give Dr. Guterman a couple of minutes to respond to some of the comments.

Mr. PITTS. Dr. Guterman?

Mr. GUTERMAN. I promise this will be brief. I wanted to point out that in my written testimony, I point out that 58 percent of total Medicare spending is accounting for by 10 percent of Medicare beneficiaries, who account for an average of $48,000 in Medicare costs. These are people who are very sick. It is not that they are incurring those costs because they are bad shoppers. The other

thing I would point out is that there was a large-scale experiment on the impact of out-of-pocket costs on the utilization of healthcare and what it found was that, indeed, higher out-of-pocket costs reduced the utilization of healthcare both desirable and undesirable healthcare. So putting the onus on the back of Medicare beneficiaries, especially ones who are sick who are the ones who are spending the money is kind of a difficult way to make sure that the system runs efficiently.

Mr. PITTS. The chair thanks the gentleman. That completes this round of questioning. We will have one follow-up for each side. Dr. Burgess?

Mr. BURGESS. Thank you, Mr. Chairman.

Dr. Guterman, I recognize one size fits all doesn't work and that is one of the reasons I have got some concerns about what we have done, what Congress has done with the Affordable Care Act. But I am a big believer and letting people spend their own money for healthcare, but I also recognize that there are populations out there where this would not be the wisest course of action.

Now, when I practice medicine, I kind of considered myself to be—well, what I have learned now—we call it a medical home—but I mean I was always the one that arranged things for my patient. I always went the extra mile to do things that were not necessarily reimbursed but were required as part of giving good care. And I don't remember if you were there at the Commonwealth meeting in January but it came up during the course of that meeting that one of the Members of Congress who was there said that healthcare is so complicated I have to use a concierge doctor to sort of sort things out for me. And this was not a Republican Member who said it. So it was kind of a shock to hear this come from a Member of Congress. And I asked Don Berwick. Dr. Berwick was there and he was on that panel, and I said, so Don, you just complained about 20 percent of your patients consuming 80 percent of your resources. Why don't you buy these folks a concierge doctor? Or why don't you directly contract with a physician to be responsible for a pool or panel of patients in the dual eligible world. And we all know who those patients are. They are readily identifiable. They don't move around a lot. They stay in one place. So wouldn't that be a population that would be amenable to a different type of practice model? You talk about wanting to change the payment structure for everyone and maybe that is not necessary.

Maybe we could look at this defined population and say we want to do a better job for these patients. And we know that they are not served by having to go from doctor to doctor to doctor to doctor. Why don't we put one person in charge? We used to have a saying when I was in practice too many doctors means no doctor and that is exactly true. So if you had one person who was directly accountable to that arguably very complicated and very ill and multiple-medical-conditions patient, if you have one doctor, don't you think you would get a better return on investment for that money that you spend?

Mr. GUTERMAN. Dr. Burgess, I agree with everything you said, and I think that is the underlying philosophy of the medical home model. I think it is the underlying philosophy of the Accountable Care Organization. And I think, you know, what this represents is

that I think we all agree that the healthcare system needs to work better to provide care, especially for those with multiple chronic illnesses and the people who are sickest. And I think whatever approach you take, whether it is a——

Mr. BURGESS. But, sir, that is not new information. You said you have been working on this for 30 years. Where is the beef?

Mr. GUTERMAN. The medical home model has been one that has been talked about and tried in limited, you know, scale, but——

Mr. BURGESS. And yet, I am the kind of doctor who was providing that type of care and you basically ran me out of business——

Mr. GUTERMAN. Right.

Mr. BURGESS [continuing]. By not paying the freight, by not paying for these activities.

Mr. GUTERMAN. The problem is that in our current fee-for-service system, people get punished for doing the kind of care that you would like to provide. And, you know, we hear people from various systems around the country, you know, that can enumerate the way they get punished for doing good things for their patients, but under the current payment system, those good things are rewarded with lower payment, so in a sense they are punished for doing what they would like to do for their patients. So I think we can agree—and maybe this is a platform for kind of collaboration, you know, across the aisle that we agree, I think, on the kind of care we would like to see and we agree that getting to that kind of care is what we really need to solve the problems that we are all concerned with.

Mr. BURGESS. And I would just submit the obstacle so far has been CMS. They haven't been a facilitator; they have been an obstacle. But I welcome the opportunity to work with you on this. Obviously, I have got some discussions going on with other people and I would welcome the Commonwealth Fund being part of that discussion as well.

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

Mr. PITTS. The chair thanks the gentleman. Mr. Pallone for a follow-up?

Mr. PALLONE. Thank you, Mr. Chairman. I am going to ask Dr. Guterman. You know, before I was asking you questions about how the Affordable Care Act would save money even without IPAB, and I believe very strongly that it saves money, particularly for not only the government but also for beneficiaries as opposed to the Republican budget, which I think is going to cost, you know, Medicare beneficiaries a lot more. So I just want to ask you to compare and contrast the Affordable Care Act's approach to saving money and that of the Republican budget, particularly as beneficiaries are affected if you would.

Mr. GUTERMAN. Let me start by adding something I omitted in my answer to your previous question and that is the Patient-Centered Outcomes Research Institute, which is a public-private organization that is charged with producing evidence to help make better clinical decisions in the healthcare sector, which I think can only help. It is not like those decisions aren't being made every day millions of times. It is just they are being made with too little information. But I guess rather than contrast the two approaches, I

would say that under both approaches the problem is not solved unless we change the way healthcare is delivered and paid for because in the end you need to control the cost of healthcare and you need to control the way healthcare is delivered and the way it is targeted at the people who need it most and providing the services that benefit people most.

And if you provide people with premium support, if the cost of healthcare isn't controlled, they are going to find themselves more and more left out of the market for health insurance. If you just rely on cutting payments alone, you are going to make access more difficult for Medicare beneficiaries. If you address broader issues either through the IPAB or other mechanisms that are already in place with the Affordable Care Act, then I think you achieve what you want to achieve and then, you know, even perhaps make the Independent Payment Advisory Board unnecessary because you have controlled costs already and met their targets.

Mr. PALLONE. Thank you.

Mr. PITTS. Dr. Cassidy, you came in and missed the first round. Do you have questions?

Mr. CASSIDY. Yes.

Mr. PITTS. You are recognized for 5 minutes.

Mr. CASSIDY. I apologize for having to leave.

Dr. Guterman, I kind of had a schizophrenic approach to your testimony. Part of it I liked and part of it I am thinking what is the guy thinking? So the part that I liked is where you mention that we have to take a global view. History clearly shows that Medicare and Medicaid will do a downward pressure upon their cost and shift that to the private sector. I mean there is no mystery about that. I could almost stipulate that. There is a good article by one of the—maybe McKinsey, maybe somebody else about the hydraulic effect. The more Medicare, the more Medicaid you have in your book of business, the greater the upward impact upon costs for small businesses and the private health insurance market.

So what gives you kind of encouragement that IPAB—which is really just looking after the Medicare book of business—will not succumb to that same temptation that Medicare always has and Medicaid specifically really has to shift cost to the private sector?

Mr. GUTERMAN. Let me first—the term cost-shifting is often misunderstood partly because it assumes that the cost of healthcare is somehow immutable and can't be reduced by better examination of what is appropriate to——

Mr. CASSIDY. I will give you that we can do a better job with what we have, but if Medicaid pays 60 percent of cost, then clearly there has to be a makeup someplace.

Mr. GUTERMAN. Well, but that depends on whether you think costs are right. But beyond that, what I think is important to think of IPAB in the context of is the broader set of tools that are available to us, that I think there is more really unprecedented push to use to address the problems that we are facing now. And I think, you know, looking at IPAB alone—IPAB alone is not going to solve the problem. But IPAB is in the context of a broad array of policies that are on the table that may in fact be able to solve the problem. And it is also part of a process that I think the Congress has to be involved in. You know, sometimes——

Mr. CASSIDY. Let me pause you there because I have limited time.

Mr. Roy, what would you—I think we know where Dr. Guterman is going. What would be your thoughts?

Mr. ROY. Yes, so I think you actually, Dr. Cassidy, bring up the most important point around this faulty idea that somehow Medicare expenditures are growing more slowly than private sector because what happened is Medicare shifts costs to private insurers, so if I have two Chevys that I paid $10,000 each for and the government comes to me and says I am buying that one Chevy from you for $5,000 and I lose 5,000 on that, maybe I charge the other guy 15,000 to make it up. And that is effectively what cost sharing is. It is more complicated than that in reality, but that is basically what Medicare does. Medicare cheats by underpaying for care and restricting access. And these are the problems that, unfortunately, have a significant—what IPAB is all about.

Mr. CASSIDY. Dr. Gottlieb, your thoughts, please?

Mr. GOTTLIEB. I think IPAB has no alternative but to try to squeeze payments in the short term because anything it could do to try to fundamentally reform payment systems or the way care is delivered isn't going to score well at CBO. They are going to have to achieve immediate savings.

I think one of the larger problems here is that a lot of the reforms in the Accountable Care Act and a lot of things we are talking about here today are predicated on changing the delivery model, getting better coordination of care. Those require investments in innovation and how care is delivered, and the only that providers, hospitals, doctors are going to invest money to better coordinate care is if they can earn an above-market rate of return for a sustainable period of time on their invested capital. And the problem is that the administration's legislation, the regulations don't allow for that. And that is why is you are seeing the adverse reaction to the regulations on the Accountable Care Organizations.

I could tell you I have seen a lot of business plans floated with venture capitalists on creating new Accountable Care Organizations or services that would provide services to the Accountable Care Organizations. I haven't seen a single one yet funded for that precise reason that the presumption out there is that you are not going to be able to earn a return on capital. If you do earn an above-market rate of return on capital for any length of time, it is going to be regulated. If you continue to earn an above-market rate of return, it is going to be taxed. And if you continue to earn it after it is taxed, you are going to be criminalized.

Mr. CASSIDY. But on the other hand, if you don't, you will be subsidized.

Mr. GOTTLIEB. And when it is gone, you subsidize it.

Mr. CASSIDY. And that is without saying that, again, as I mentioned earlier, the New England Journal of Medicine article that reflected upon the 10 Accountable Care Organization pilot studies, places specifically chosen so that they would be more likely to succeed did not.

Now, Dr. Guterman, you must have some thoughts about that.

Mr. GUTERMAN. In fact, as I was saying when we started up those demonstrations, and in fact I would describe that demonstra-

tion as a rousing success for several reasons. One is that half of those 10 sites were able to achieve measurable savings according to the rules of the demonstration and received bonus payments for saving Medicare millions of dollars compared to the targets that they were working under.

Mr. CASSIDY. Now, in fairness, it was a 3-year demonstration project and I think 3 did and it was not every year and several did not.

Mr. GUTERMAN. But in the last 3 years there were 5 of them. And all of the sites achieved noticeable increases in the quality of care, which perhaps was even more important, certainly without spending more money. And there were some—as there will be—and I think something that the IPAB or any other mechanism is going to have to deal with is compared to what? And how you deal with getting either CBO scoring or the Office of the Actuary in CMS to agree that a particular project is going to save money. But that is going to have to be dealt with. That is a methodological issue that I think needs to be dealt with.

Mr. CASSIDY. I am out of time. I yield back. Thank you all.

Mr. PITTS. The chair thanks the gentleman. Did you——

Mr. BURGESS. But Mr. Chairman?

Mr. PITTS. Go ahead.

Mr. BURGESS. Did you rule on my unanimous consent request for Senator Cornyn's letters from Scott & White?

Mr. PITTS. Without objection, so ordered.

[The information follows:]

May 23, 2011

The Honorable John Cornyn
United States Senate
517 Hart Building
Washington, D.C. 20510

Dear Senator Cornyn:

I am writing today in regards to the proposed Independent Payment Advisory Board (IPAB) created by the Patient Protection and Affordable Care Act (PPACA) and potential impact on our healthcare system.

Scott & White Healthcare (SWH) is a Central Texas based, non-profit healthcare system with 12 hospitals, more than 60 clinics, and an 240,000+ member health plan. Scott & White Healthcare is the principal research and education campus for the Texas A&M Health Science Center College of Medicine.

SWH is supportive of initiatives to identify fraud and waste in the healthcare system and to incentivize high value healthcare in this country, but we have concerns and questions about the process that will be used by the IPAB to implement cost savings in Medicare and Medicaid.

Although hospitals are exempt from the IPAB jurisdiction initially, we have concerns about the immediate uncertainty at hand with regard to physician payments. With the double jeopardy of the unsustainable SGR formula for Medicare Part B physician payments and the proposed IPAB cost reductions goals, we are uncertain what the future holds for physician payments. With over 800 physicians providing healthcare within our system, what seems a small change to the payment structure is magnified.

Additionally, an integrated system such as Scott & White Healthcare is subject to payment reductions through IPAB on both the hospital side and the physician side. With 12 hospitals and 800+ physicians, these payment reductions could have a great impact on our system. While payments may be cut from both sides by IPAB, we are still required to screen and stabilize each person who enters an emergency department in our system through EMTALA, regardless of these cuts.

Thank you for your consideration of these comments.

Sincerely,

Robert Pryor, M.D., M.B.A.
President & CEO

J. James Rohack, M.D.
Director, Scott & White Center for Healthcare Policy

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sw.org

Mr. BURGESS. Thank you.

Mr. PITTS. Thank you and thank you to the panel. Very informative. I appreciate your patience.

We will now change panels to a fourth panel, and I will introduce the fourth panel as they come to the table.

Joining us on our fourth panel is Dr. Alex Valadka, a neurosurgeon. He is the chief executive officer at the Seton Brain and Spine Institute, Austin, Texas. He represents the Alliance for Specialty Medicine. Secondly, we have Mary Grealy, who is the president of the Healthcare Leadership Council in Washington, D.C. Then we have Dr. Jack Lewin, Chief Executive Officer of the American College of Cardiology. And fourthly, we have Teresa Morrow, who is the cofounder and president of Women Against Prostate Cancer.

Your written testimony will be entered into the record. We ask that you summarize your opening statements in 5 minutes each.

Dr. Valadka, you may begin your opening statement.

STATEMENTS OF ALEX B. VALADKA, REPRESENTING THE ALLIANCE OF SPECIALTY MEDICINE; MARY R. GREALY, PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL; JACK LEWIN, CHIEF EXECUTIVE OFFICER, AMERICAN COLLEGE OF CARDIOLOGY; AND TERESA MORROW, COFOUNDER AND PRESIDENT, WOMEN AGAINST PROSTATE CANCER

STATEMENT OF ALEX B. VALADKA

Mr. VALADKA. Thank you, Chairman Pitts, Ranking Member Pallone, members of the subcommittee, for allowing me to testify about the Independent Payment Advisory Board. My name is Alex Valadka. I am a practicing neurosurgeon from Austin, Texas, and as far as I can tell, I am the only practicing physician who has the privilege of testifying before you here today.

I am pleased to be here today on behalf of the Alliance of Specialty Medicine which was founded in 2001 with the mission to develop sound federal healthcare policy that fosters patient access to the highest quality specialty care and improves timely access to high-quality medical care for all Americans. As advocates for patients and physicians, the alliance and its members welcome the opportunity to contribute to the ongoing debate regarding IPAB, or as we think about it, the Impacts Patients Adversely Board.

We are deeply concerned about the unintended consequences that will result from the establishment of IPAB. We oppose its creation and we are now urging Congress to immediately act to repeal IPAB. Now, I realize that by this time in our IPAB-athon here today, you have had an earful and I don't to be overly repetitive, but I do want to make you aware that America's specialty physicians have numerous concerns at both the concept of IPAB and its structure.

First and foremost, the alliance believes that under the IPAB, access to specialty care will be severely limited due in part to the additional payment cuts that it will impose on physicians. Medicare physician payments are already well below market rates, as you heard earlier today, and they continue to be subject to deep cuts as a result of the flawed SGR formula. Cuts to physician reim-

bursement under IPAB will only exacerbate those already imposed on physicians as a result of SGR cuts and other cuts that are going to occur each year as part of the Medicare physician fee schedule for things like problems with the electronic health record, value of base quality modifiers, meaningful use requirements, and things of that type.

Our physician survey data demonstrates that these cuts, including those imposed by IPAB, may ultimately force specialists out of the Medicare program severely threatening Medicare access to its beneficiaries to innovative therapies and quality of care. And to echo something that was said earlier today, participation in Medicare is not on or off. Many physicians still continue to participate but they have to limit the number of Medicare patients they can see in their offices or otherwise provide access to.

Our second concern is that IPAB lacks accountability and sets a dangerous precedent for overriding the normal legislative process. As drafted, the IPAB has little if any accountability to the Medicare beneficiaries whose healthcare will be affected by its decisions. And yet its recommendations will have the force of law if Congress fails or chooses not to act. The alliance maintains that Congress should be the entity to legislate healthcare policy, not an independent board.

An additional concern is that the limited transparency of IPAB proceedings severely limits congressional oversight of the Medicare program and replaces the transparency of hearings like this one with the less transparent process overseen by the executive branch, not the legislative branch.

The IPAB statute also provides fast-track procedures for IPAB proposals, which will automatically become law unless Congress can act very quickly to amend the proposal. Congress already faces significant challenges in moving legislation through the regular legislative process and we seriously doubt its ability to jump through all the procedural hoops within the required 7 months to override IPAB recommendations.

Although its proponents argue that the IPAB is critical to holding down the growth in healthcare spending, providers representing nearly 40 percent of Medicare expenditures, including hospitals and nursing homes, are exempt from the reach of IPAB for several years. We agree with the CBO that this would place greater pressures to achieve saving on physicians which, as I previously noted, will ultimately curtail seniors' timely access to specialty care.

Finally—and again as discussed earlier today—the process for making appointments to the IPAB isn't balanced because appointments are made solely by the President. This structure also ensures that the board will have inadequate expertise since it fails to include practicing clinicians like me who can draw from firsthand experience when considering how proposed recommendations could impact the delivery of healthcare for both the patient and provider perspective.

Although the alliance recognizes the need to hold down the growth of Medicare costs, the IPAB is simply the wrong way to go. But the more than 100,000 physicians represented by the alliance reiterate our pledge to work with Congress to identify more appro-

priate ways to achieve this goal. I ask that you make the same commitment and work with the medical community to meet the challenges facing our healthcare system and not leave these very important decisions to a group of 15 unelected and largely unaccountable individuals.

Mr. Chairman, thank you again for allowing the alliance to testify, and I would be happy to answer any questions.

[The prepared statement of Mr. Valadka follows:]

STATEMENT OF THE

ALLIANCE OF SPECIALTY MEDICINE

PRESENTED BY

ALEX B. VALADKA, MD

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES

WEDNESDAY, JULY 13, 2011

"IPAB: The Controversial Consequences for Medicare and Seniors"

Alliance of Specialty Members Include:

American Academy of Facial Plastic and Reconstructive Surgery • American Association of Neurological Surgeons • American Gastroenterological Association • American Society of Cataract & Refractive Surgery • American Society of Plastic Surgeons • American Urological Association • Coalition of State Rheumatology Organizations • Congress of Neurological Surgeons • Heart Rhythm Society • National Association of Spine Specialists • Society for Cardiovascular Angiography and Interventions

For more information about the Alliance visit: http://www.specialtydocs.org/

EXECUTIVE SUMMARY

The Alliance of Specialty Medicine is deeply concerned about the potential, unintended consequences that will likely result from the establishment of the Independent Payment Advisory Board (IPAB). We opposed its creation and we are now urging Congress to immediately act and repeal the IPAB.

The Alliance believes that under the IPAB access to specialty care will be severely limited due, in part, to the additional payment cuts it will impose on physicians. Medicare physician payments are already well below market rates and continue to be subject to deep cuts as a result of the flawed sustainable growth rate (SGR) formula. Cuts to physician reimbursement under the IPAB will only exacerbate those already imposed on physicians as a result of the SGR cuts as well as other changes that occur each year as part of the Medicare physician fee schedule. Physician survey data demonstrates that these cuts, including those imposed by IPAB, may ultimately force specialists out of the Medicare program, severely threatening Medicare beneficiary access to innovative therapies and specialty care.

The Alliance has numerous concerns with both the concept of the IPAB as well as its structure. Our primary criticisms include the following:

- The IPAB lacks accountability and sets a dangerous precedent for overriding the normal legislative process. As drafted, the IPAB has little, if any, accountability to the Medicare beneficiaries whose healthcare will be affected by such decisions. Yet, its recommendations have the force of law if Congress fails, or chooses not, to act. The Alliance maintains that Congress should be the entity to legislate healthcare policy, not the IPAB.
- The limited transparency of IPAB proceedings severely limits Congressional oversight of the Medicare program and replaces the transparency of Congressional hearings and debate with a less transparent process overseen by the executive branch, with at best, minimal accountability for the healthcare decisions it makes.
- The statute provides "fast-track" procedures for IPAB proposals, which automatically become law if Congress is unable to quickly amend the proposal. These expedited procedures vary significantly from the procedures the House and Senate usually follow to consider most legislation.
- The breadth of IPAB's authority is unfairly limited and does not treat all providers equally since the statute specifically exempts some providers, such as hospitals and nursing homes, from IPAB cuts for several years. We contend, as does the Congressional Budget Office (CBO), that this will place greater pressures to achieve savings from physicians.
- The process for making appointments to the IPAB is imbalanced as appointments are made solely by the President. Furthermore, the structure ensures that the board will have inadequate expertise since it fails to include practicing clinicians who can draw from firsthand experience when considering how proposed recommendations could impact the delivery of healthcare from both the provider and patient perspective.

Thank you Chairman Pitts, Ranking Member Pallone and other distinguished members of the Subcommittee, for allowing me to testify on the Independent Payment Advisory Board. My name is Alex Valadka, and I am a practicing neurosurgeon from Austin, Texas. I serve as the chair of the American Association of Neurological Surgeons' and the Congress of Neurological Surgeons' Washington Committee, as well as the spokesperson for the Alliance of Specialty Medicine, which I am here representing today.

The Alliance of Specialty Medicine was founded in 2001, with a mission to develop sound federal healthcare policy that fosters patient access to the highest quality specialty care and improves timely access to high quality medical care for all Americans.

As patient and physician advocates, the Alliance welcomes the opportunity to contribute to the ongoing debate regarding the Independent Payment Advisory Board (IPAB). For the reasons I will discuss today, we opposed the creation of the IPAB and support its full repeal.

ONGOING OPPOSITION TO THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

As discussions ensued during healthcare reform over the development of an executive branch board that would divest Congress of its authority for Medicare payment policy – specifically, proposals that would have expanded the Medicare Payment Advisory Commission's (MedPAC) authority or established the Independent Medicare Advisory Council (IMAC) – the Alliance of Specialty Medicine voiced serious concerns over potential, unintended consequences that would likely result from its establishment. Despite numerous communications to Congressional leadership voicing concern about such a board, the Senate included the Independent Payment Advisory Board, referred to as the "IPAB," as part of the now-enacted Patient Protection and Affordable Care Act (PPACA).

Starting in 2014, the IPAB will require a 15-member board of non-elected officials to recommend Medicare spending reductions to reduce the per capita rate of growth in Medicare in years when spending exceeds a targeted growth rate, without causing a reduction in patient benefits or an increase in revenues, beneficiary premiums or cost-sharing. In addition, if targeted growth rates are not surpassed, the IPAB could still submit an advisory report recommending additional cuts or alterations to payment policies. The Alliance believes these cuts will further pressure more and more specialty physicians to stop seeing Medicare patients and jeopardize an already vulnerable Medicare program.

Growing concerns over the rising costs of healthcare are shared by physicians, but we are confident that the IPAB is the wrong solution. The IPAB, as it has been described in statute, will simply ratchet down costs in the absence of adequate clinical expertise or the research capacity to examine the national and regional effects of proposed recommendations to ensure patients are not unduly impacted.

Without regard for the physician community's concerns – concerns raised by those who understand our healthcare delivery system best – 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.

To be blunt, Alliance member organizations and the specialists they represent -- me included -- are just as concerned about the negative impact of the IPAB as we are about the flawed Medicare physician payment system – which we have asked you to correct for more than 10 years. This should tell you something – the IPAB is dangerous and must be eliminated.

As you know, funding for the IPAB will be appropriated beginning with fiscal year 2012 -- less than 3 months from today. This committee should make every effort to repeal the IPAB before it even gets off the ground.

I will now highlight some of the most troubling aspects of the IPAB for Medicare and America's seniors.

RESTRICTED ACCESS TO SPECIALTY CARE

As this subcommittee is fully aware, Medicare physician payments are already well below market rates and continue to be subject to substantial, unprecedented cuts as a result of the flawed sustainable growth rate (SGR) formula. Congress has typically stepped in to delay the SGR cuts, but the threat of reimbursement reductions remains very real. Indeed, the SGR requires physician payment rates to be reduced by nearly 30 percent on January 1, 2012 and by more than 40 percent over the next decade.

In addition, each year as part of the annual Medicare physician fee schedule (MPFS), physicians are subject to further reductions as a result of changes in payment policies for the services they provide. For example, in the 2012 MPFS that was released less than two weeks ago, CMS proposes deep cuts to certain imaging services paid under the physician fee schedule by applying a multiple procedure payment reduction (MPPR). CMS also proposes a number of changes to the relative value units, or RVUs, for several procedures, as well as continuing to implement changes to the practice expense values.

Moreover, the IPAB has unfettered authority to achieve targeted spending reductions as it sees fit, which could include targeting more spending cuts from certain healthcare providers rather than others. The statute explicitly states that the IPAB should give priority to recommendations that prioritize primary care. Effectively, this means that the IPAB could hold certain medical specialties, such as primary care, harmless, while significantly cutting specialists.

Thus, under the IPAB, the cuts resulting from the SGR and changes to Medicare's payment policies will be exacerbated – subjecting physicians to potential double jeopardy. As hospitals and other Part A providers have been exempted from the IPAB's reach until 2020, this effectively means IPAB will place a disproportionate focus on reductions to physician reimbursements. Even the Congressional Budget Office (CBO) has stated that the IPAB 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 -- that is, physicians.

Beneficiary access to care has already been hindered as a result of the instability and inequities in Medicare physician payments. The number of physicians who no longer accept new Medicare patients because of low reimbursement rates has more than doubled, and we believe this number will continue to grow. In fact, a recent survey of specialists represented by the Alliance 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.

In addition, an American Medical Association survey shows that current reimbursement rates have already led close to one-fifth of all doctors, including a third of primary care physicians, to restrict the number of Medicare patients in their practices. Beneficiaries are at risk of losing the doctor of their choice as more physicians are forced to limit the number of Medicare patients they see.

The threat of the IPAB, particularly if it is coupled with the flawed SGR formula, may ultimately force specialists out of the Medicare program, which will severely threaten Medicare beneficiary access to innovative therapies and specialty care.

LACK OF ACCOUNTABILITY

As drafted, the IPAB has little, if any, accountability to the more than 45 million Medicare beneficiaries whose healthcare will be affected by such decisions. Yet, its recommendations have the force of law if Congress fails, or chooses not, to act.

Over the past several years, Congress has long looked to MedPAC and its predecessor, the Physician Payment Review Commission (PPRC), for recommendations and expertise in Medicare policy changes. Congress admittedly struggles to make the "hard decisions" to control rising costs in Medicare expenditures.

To deal with the challenge, Congress has put forward several proposals to create an independent policy-making entity that would be able to control the growth in Medicare expenditures, and be insulated from special interests and lobbyists. Ironically, the IPAB fails to remove politics from Medicare payment policy; rather, by failing to provide balance in the appointment process, it 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.

Recently, Secretary Sebelius published an article on Politico's website, describing IPAB as an "advisory board" whose "work will be transparent, independent and accountable to Congress and the President." It is unclear how this advisory board can be both independent and accountable. Indeed, it is independent and it is certainly not merely advisory, as the IPAB enjoys totally unreviewable and unaccountable power to change the law. If it has any accountability, it is only to the President who appointed its members, not to the Congress, and certainly not to the American people.

Furthermore, the law precludes administrative or judicial review of the implementation of IPAB recommendations and Congress, which under certain conditions may amend IPAB recommendations, is given very little time to do so. Specifically, under the "fast-track" process, if Congress fails to find off-sets to meet or exceed the Medicare cost cutting targets for that year, the Secretary must implement the IPAB recommendations. In the event that the IPAB is not constituted or if it fails to make recommendations for reducing spending in Medicare, the Secretary of Health and Human Services is required to come up with a detailed and specific proposal of her own.

The Alliance is extremely concerned that the timeframe for Congress to act under the fast-track procedure is frightfully short. As described in statute, the IPAB must submit a proposal to Congress and the President for achieving Medicare savings targets in the following year, by January 15 of each year beginning in 2014. In the event this deadline is missed, the Secretary must submit a proposal, meeting the same targets, to the President and MedPAC 10 days later. Then, the proposal must be delivered to Congress within 48 hours, whereby it must be immediately introduced and referred to the appropriate committees of jurisdiction for consideration, which must complete their action by April 1. Congress is prohibited from considering any bill or amendment that would not meet or exceed the IPAB targets. If Congress does not pass an alternative proposal to that of the IPAB before August 15, or if the President vetoes the proposal as passed by Congress, the original IPAB recommendations would be implemented by the HHS Secretary on January 1 of the following year.

These expedited procedures vary significantly from the parliamentary mechanism the House and Senate usually follow to consider most legislation and we believe was intentionally designed to ensure that Congress will have insufficient time to alter or override IPAB recommendations.

Congress' establishment of the IPAB sets a dangerous precedent for overriding the normal legislative process. Congress is a 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 disabled individuals rely, endangering the important dialogue that takes place between elected officials and their constituents.

We agree that growth in Medicare spending is unsustainable and the issues that Congress faces in addressing Medicare payment policy are difficult; however, we contend that it is the duty and responsibility of our nation's elected officials to address these issues rather than ceding this important work to a handful of government appointees.

LIMITED TRANSPARENCY IN IPAB PROCEEDINGS

In its current role, MedPAC serves an important function as an advisory committee to elected decision makers in Congress. Using MedPAC's recommendations, Congressional leaders are currently able to consider the realities facing Medicare beneficiaries and providers through an open legislative process. The Alliance appreciates the continued role MedPAC will play regarding review of recommendations made by the IPAB. However, the IPAB severely limits Congressional oversight of the Medicare program and replaces the transparency of Congressional hearings and debate with a

less transparent process overseen by the executive branch with at best minimal accountability for the healthcare decisions it makes. Additionally, there is no notice and comment process to solicit public input prior to the IPAB sending its recommendations to the President and Congress. Notice and comment is a fundamental aspect of the federal rulemaking process to ensure transparency and accountability. The failure to include a mechanism for the public to have a meaningful opportunity to be heard further isolates the IPAB.

FAILURE TO MAINTAIN EQUALITY

The breadth of IPAB's authority is unfairly limited and does not treat all providers equally.

For its first 5 years, IPAB's potential cuts are primarily limited to Medicare Parts B, C, and D. Most Medicare Part A providers, including hospitals, long term care facilities, and clinical laboratory services, are exempt, despite the fact that these providers comprise over a third of all Medicare spending. Shielding Part A providers from the IPAB's cost reductions until 2020 effectively means IPAB's focus will be on reductions to physician reimbursements while ignoring that physicians already are subject to cost and volume controls under Medicare.

Exempting some groups places greater pressure to achieve savings from a more limited pool of providers. If these carve outs are left unaddressed, and the entities responsible for the bulk of Medicare spending remain exempt from payment cuts until 2020, the end result of this will mean a further reduction in the already below market reimbursement rates for physicians who treat Medicare patients. The Congressional Budget Office (CBO) has verified that the IPAB 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; that is, physicians.

IMBALANCE IN APPOINTMENTS

The Alliance is concerned about the manner in which appointments to the IPAB will be made.

As enacted, the IPAB will be composed of 15 members appointed by the President with the advice and consent of the Senate. In addition, the PPACA requires the President to consult with the Speaker of the House, the House minority leader, and the Senate majority and minority leaders, each on the appointment of three IPAB members. Presumably, the remaining three IPAB appointments will be the selections of the President alone, without any advice or counsel. The Chairman of the IPAB is appointed by the President from among the 15 members of the Board and is also subject to Senate confirmation.

Most concerning is that, should the Senate be in recess, the President is empowered to unilaterally make appointments to the board if a position is vacant. The Alliance maintains that this level of executive control over the so-called independent policy-making entity is inappropriate.

Were the President to make recess appointments to the IPAB, he could fill whichever positions on the board he chose to without ensuring that his appointments result in a politically balanced board. In

fact, the President could make recess appointments to those membership slots that are likely to be filled by members of his own party: the three filled in consultation with the Senate majority leader, the three filled in consultation with the House minority leader, and the three filled without consultation. Indeed, 9 of the 15 member positions could feasible be filled by the President allowing him to "stack the deck" in favor of his own political agenda. And, as we understand, this number would be sufficient to provide a quorum for the board to conduct business, thereby submitting proposals and making recommendations of a partisan nature.

Furthermore, the President could use his recess appointment power to appoint one of his nine "hand-picked" members as chair.

Regardless of the President's statutory mandate to consult with House and Senate leadership on his recommendation, it is still the President who is solely and explicated authorized to make IPAB appointments. The imbalance appears to have been purposefully built into the IPAB and is concerning.

INADEQUATE EXPERTISE OF IPAB OFFICIALS

The qualifications to serve as a member of the IPAB as they are written are of great concern to the Alliance. According to the law, appointed members of the Board are to provide varied professional and geographic representation and possess recognized expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, and reimbursement of health facilities.

IPAB Commissioners should have current clinical expertise; that is, they should be practicing physicians and other healthcare providers with the ability to draw from firsthand experience when considering how proposed recommendations could impact the delivery of healthcare from both the provider and patient perspective.

While the law states that the board members are to be drawn from a wide range of backgrounds, including physicians and other health professionals, the law further states that appointed members cannot be individuals directly involved in the provision or management of the delivery of Medicare items and services. The statute also specifies that the majority of IPAB members cannot constitute healthcare providers. Further, the law states that no individual may serve as an appointed member if they engage in any other business, vocation or employment. This explicit exclusion of providers who treat the very patients this board will impact is inappropriate. Only practicing physicians who see Medicare beneficiaries have the current and necessary, in-depth perspectives of the patients whose care will be impacted by the IPAB's proposals.

CONCLUSION

While we all recognize the need for more sustainable healthcare costs, we do not believe that IPAB is the way to, or will, accomplish this goal. The IPAB, particularly if it is coupled with the SGR crisis, will severely threaten Medicare beneficiary access to innovative therapies and specialty care.

Furthermore, IPAB-related cuts have the potential to drive many physicians out of business, putting thousands of jobs at risk -- from the staff that they employ, to those employed by support and referral entities, such as medical billing companies and clinical ancillary services.

No one can argue that Medicare payment policy requires a broad and thorough analysis; thus leaving these decisions in the hands of an unelected, unaccountable governmental body with minimal Congressional input will most certainly have a negative impact 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, the disabled and other patient groups; physicians and other healthcare providers; and health policy experts all agree. To date, approximately 150 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 (at least 300 at present) of physician and patient organizations are also rallying for IPAB repeal.

You have chosen to become elected officials, as I have chosen to be a neurosurgeon. We both have a duty and responsibility – I to my patients, and you to your constituents and all Americans. I am committed to serving my patients and providing the highest quality care possible. I ask that you make the same commitment, and work with the medical community to meet the challenges facing our healthcare system.

In June 2009, President Obama gave a speech at the American Medical Association's House of Delegates meeting to an audience of physicians who are dedicated to seeing through positive reforms for the American healthcare delivery system. The President said, "I need your help. Doctors, to most Americans, you are the healthcare system... That's why I will listen to you and work with you to pursue reform that works for you."

Today, the more than 100,000 doctors represented by the Alliance are reiterating our pledge to work with Congress to make the necessary improvements in our healthcare system that will ensure that patients receive the right care at the right time. A significant step in that direction will be to repeal the IPAB so millions of Medicare beneficiaries' access to care will not be at risk.

Mr. Chairman, thank you again for including the Alliance of Specialty Medicine as a witness. I am happy to answer any questions.

Mr. PITTS. The chair thanks the gentleman and recognizes Ms. Grealy for 5 minutes for an opening statement.

STATEMENT OF MARY R. GREALY

Ms. GREALY. Chairman Pitts, Ranking Member Pallone, members of the subcommittee, on behalf of the members of the Healthcare Leadership Council, I want to thank you for the opportunity to testify on the ramifications of the Independent Payment Advisory Board, or IPAB, for patients and the U.S. healthcare system.

Now, already today you have heard a number of perspectives on IPAB. While I request to submit my full testimony for the record, I would like to briefly share the point of view of HLC members who are chief executives of the Nation's leading healthcare companies and organizations. The views I express today reflect the conclusions of hospitals, academic health centers, insurers, pharmaceutical and medical device innovators, distributors, pharmacies, and other sectors within our healthcare system.

Mr. Chairman, we fully agree that it is imperative to make Medicare a more cost-efficient program, that its current spending growth rates are unsustainable. The question is how to address this challenge in a way that strengthens and does not undermine the accessibility, the affordability, and quality of healthcare for Medicare beneficiaries and for all Americans.

Now, there are different approaches available to Congress in pursuing this objective. On one hand, you have the direction embodied in IPAB to simply slash expenditures whenever spending exceeds a certain arbitrary level. Now, we can talk all we want about the expertise of those who conceivably would be serving on IPAB, but those credentials are largely irrelevant. IPAB isn't designed to develop meaningful long-term reforms to strengthen the value of the Medicare program. Rather, its mandate is to achieve immediate scorable savings.

Now, according to analysis from the Congressional Budget Office and the Kaiser Family Foundation, this imperative to make immediate reductions means that IPAB's course of action will likely focus on reducing payments to providers. The impact of this action is easy to predict. Today, as we have heard, an increasing number of physicians are restricting the number of Medicare patients that they see in their practice because of low payment rates. According to a survey of the American Medical Association's members, that number includes one of every three primary care physicians.

Now, if IPAB is expected to cut the payment rates to even lower levels, then we will almost certainly see more physicians unable to treat Medicare beneficiaries and access will become a more critical issue. With those 80 million baby boomers entering the Medicare program at an average of 9,000 per day and the projected physician shortages already on the horizon, we could find ourselves on the verge of a healthcare access perfect storm that will hit seniors the hardest.

These payment cuts also will likely result in greater cost-shifting to private payers and their beneficiaries. It should also be noted that IPAB will function much as that deadly robot in the "Terminator" movies. It will have a single-minded, relentless focus on

achieving its cost-cutting function. There is no statutory latitude to take into consideration unforeseen public health concerns that may, in the short term, necessitate more, not less, healthcare spending. It does not take into consideration the potential of new medicines and devices that may have high upfront cost but that will reduce Medicare spending in the long run.

Now, there is no question that Congress has more flexibility than the IPAB in being responsive to healthcare's circumstances, capabilities, and needs and will certainly be more responsive to public concerns than an unelected board ever will be. There are far more preferable approaches to making Medicare more cost-efficient. There are multiple provisions, for example, as we have heard today, within the Patient Protection and Affordable Care Act that are focused on moving away from the fee-for-service model and aligning incentives to reward providers for high-quality cost-effective care. We should give these reforms an opportunity to work before we think of turning to an approach as extreme as the IPAB.

Also, throughout the country, private-sector healthcare providers are demonstrating innovative ways to generate better health outcomes with less cost. We have documented many of these successes in our HLC value compendium, which we provided to CMS and I would like to submit for the record.

Mr. Chairman, thank you again for this opportunity to present our views.

In summary, the members of the Healthcare Leadership Council believe that the IPAB mandate and inherent inflexibility will inevitably result in reduced healthcare access for seniors. We need, instead, to turn to payment and delivery reforms that will actually improve care while reducing costs.

Thank you, and I will be happy to answer any questions.

[The prepared statement of Ms. Grealy follows:]

Committee on Energy & Commerce Subcommittee on Health
Hearing on IPAB: The Controversial Consequences for Medicare and Seniors
Wednesday, July 13, 2011

Chairman Pitts, Congressman Pallone 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 testify on the Independent Payment Advisory Board (IPAB) and its potential ramifications for Medicare beneficiaries and the U.S. healthcare system.

My name is Mary Grealy and I am president of the HLC, 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 discussing 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. By the way, 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. Let's 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 ACA – 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, Mr. Chairman, 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 I am submitting with my testimony.

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 280 signing the letter I have attached to my testimony, representing patients, consumers, physicians, hospitals and employers both small and large have publicly advocated the repeal of the IPAB.

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, Mr. Chairman, we believe it is essential to repeal this harmful and unnecessary provision of PPACA. Thank you for this opportunity to testify and I will be happy to answer your questions.

Mr. PITTS. The chair thanks the gentlelady and recognizes Dr. Lewin for 5 minutes.

STATEMENT OF JACK LEWIN

Mr. LEWIN. Thank you very much, Chairman Pitts, Ranking Member Pallone, and Vice Chair Dr. Burgess. It is a pleasure to be here today representing the American College of Cardiology, all of America's cardiologists, and the many cardiovascular nurses and researchers.

Cardiovascular medicine represents 43 percent of Medicare costs today, still, unfortunately the number one killer in America, yet we have made some real progress. In the last decade, morbidity and mortality for cardiovascular disease has gone down by 30 percent in the United States, and that is because of new imaging techniques, new procedures, new therapeutics, new approaches to prevention, but also because for the last decade we have been able to take electronic tools, guidelines, performance measures, appropriate-use criteria and apply them closer and closer to the point of care to measure best evidence and get the best results reducing unnecessary spending and activities.

The Door-to-Balloon Campaign is one approach where we have been able to speed the treatment of heart attacks in hospitals through system improvement using the data we collect in the registries we have in 2,500 U.S. hospitals. We have reduced the variation for heart attack treatment by a factor of 3, the length of stay from 5 to 3 days, the costs by 30 percent across the United States just in the last 3 to 4 years. Unbelievable.

But here is the thing. We got no reward for that, no incentives for that. It happened because we believe in it. The IPAB, as proposed, is going to fail. Its price controls won't work. It is a mechanism that represents the past, not the future. And we are very concerned about that. In fact, you know, we probably ought to get rid of the existing flawed price-control mechanism, the SGR that you have on the books right now. It hasn't worked very well, has it? We get rid of that one before we launch the next one, please.

We need an immediate and different approach or a very different IPAB to bend the cost curve. In the last 40 years, amazingly enough, the healthcare costs have gone up, you know, multiples of the GDP 40 years in a row. This is really amazing. If we got the GDP—if healthcare costs were GDP plus 1 percent, the U.S. national deficit would go away in 20 years. So, you know, it is a patriotic kind of thing calling for me at least for the profession of medicine, physicians, hospitals, and others to get on this. We really have to bend the cost curve. And can we do it? Yes, we can. If we get the unnecessary spending out of the system, we can get this done.

Now, I think to do that we have got to go back to using those tools at the point of care, the guidelines, the appropriate-use criteria. These measure not only quality but for appropriate use, effectiveness in terms of efficiency and spending, getting the right test the first time, getting the right procedure the first time, et cetera. We can now measure comparative outcomes. We couldn't do that 10 years ago. We didn't have the electronic means to do that. We couldn't tell doctors and hospitals how they are doing as to whether

they are spending the money efficiently, providing patients with the best care. Now, we can.

So let us provide the incentives for consistent best evidence at the point of care, let us systematically reduce variation, get rid of the unnecessary tests and procedures, unnecessary admissions and costs. Let us use that kind of a price-control approach. That is not the IPAB, folks. If we want to IPAB to work, it is going to have to be so radically modified to do the following: it has got to develop incentives for doctors and hospitals to reward quality and not volume. Setting price controls on volume is not going to solve our problem. We already know that. It needs to apply to healthcare sectors, not just the doctors, and wait a few years and add the hospitals later. It needs to be flexible to attract people who really understand the healthcare system and are in it and see it from various perspectives. And it is currently designed so that it can't do that in terms of the 15 members it is going to attract to be full-time parties as it is designed now.

So, you know, we are committed to the cause of the IPAB. We think its purpose is absolutely right on. We believe in that purpose. We see it as, in fact, a national kind of patriotism. Let us compete in a global economy and get healthcare costs down without destroying innovation in healthcare and without destroying patient care itself.

So let us rethink the IPAB or amend it so that it can achieve the kinds of targets that will provide viable Medicare—well, the targets for Medicare spending that will keep the healthcare system viable but that won't stifle innovation and won't harm patient care.

Thank you very much.

[The prepared statement of Mr. Lewin follows:]

Statement for the Record

Presented to the

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
HEALTH SUBCOMMITTEE

Hearing on

IPAB: The Controversial Consequences for Medicare and Seniors

July 13, 2011

The American College of Cardiology (ACC) is pleased to submit a statement for the record for the Energy and Commerce Health Subcommittee hearing, **"IPAB: The Controversial Consequences for Medicare and Seniors."**

The ACC is a professional medical society and teaching institution made up of 40,000 cardiovascular professionals from around the world – including over 90 percent of practicing cardiologists in the United States and a growing number of registered nurses, clinical nurse specialists, nurse practitioners, physician assistants and clinical pharmacists.

The College is committed to working with Congress, the physician community, the Center for Medicare and Medicaid Services (CMS), and the Administration to strengthen the Medicare program and to ensure that Medicare patients can benefit from the life-saving and life-enhancing care that cardiovascular specialists provide.

The ACC strongly supports efforts to align financial incentives to inspire greater focus on providing care that is patient-centered, evidence-based and cost-effective. Early in the health reform debate, the College hoped the Independent Payment Advisory Board (IPAB) concept would offer an opportunity to break down the silos of parts A and B in Medicare and modernize the program by focusing on quality improvement. Unfortunately, the ACC believes that the IPAB as enacted in the Affordable Care Act (ACA) is a flawed way to control spending and will be harmful to patient care. Significant modifications to the current model are necessary.

Reforming the Flawed Medicare Physician Reimbursement Formula

First and foremost, Congress must act to permanently repeal the flawed sustainable growth rate (SGR) formula used to set Medicare physician payment rates prior to implementation of IPAB. Physicians are already subject to an expenditure target and other potential payment reductions as the result of the Medicare physician payment formula. The College believes it does not make sense to subject physicians to expenditure targets while at the same time exempting from IPAB's recommendations large segments of Medicare providers who are subject to no target at all. Until the SGR is replaced, the ACC cannot support implementation of IPAB.

Since the formula was established, Congress has repeatedly stepped in and stopped pending cuts but did not address the underlying problems with the formula. Each time Congress has passed a short-term intervention it has only created practice instability, deepened the payment cuts in future years, and increased the cost of permanently resolving the problem.

It is widely known that the current reimbursement formula is severely flawed. It does not accurately reflect the cost of providing care to Medicare beneficiaries, nor does it account for changes and improvements in technology, shifts in the site of service, and the changing demographics of the Medicare population.

Congress must act this year to stop the 29.5 percent Medicare physician payment cut scheduled for January 1, 2012. The ACC strongly urges Congress to repeal the SGR, provide stable payments for a period of several years to allow testing of different payment models, and then allow for a transition to new payment models.

Re-Aligning Incentives to Reward Quality Instead of Volume

The ACC believes IPAB must place more emphasis on payment reforms that improve quality and lower costs rather than price controls that could hurt access—and as history proves---won't work.

Through its national cardiovascular data registry, clinical guidelines, appropriate use criteria, and other quality initiatives, the ACC is committed to providing its members with tools to help ensure that the highest quality of care is provided to patients with cardiovascular disease, leading to better outcomes and more responsible use of limited health care resources.

With more than 2 million patient records, the ACC's PINNACLE Outpatient Registry is an example of a quality of care monitoring and feedback system. This ambulatory registry can be an invaluable resource in terms of identifying variations in care, reducing disparities, and measuring performance and providing opportunities for performance improvement at the practice level. The suite of other National Cardiovascular Data Registries (NCDR®) is also important for measuring outcomes at the hospital level, with more than 14 million patient records. Measuring cardiovascular quality across the care continuum will allow a thorough tracking of these new payment initiatives to ensure that quality is improved at the same time that spending is reduced.

Given the important role guidelines play in bridging the gaps between science and practice, the ACC is also committed to increasing adherence to guidelines and appropriate use criteria through the use of clinical decision support tools; development of educational tools and programs; and the creation of a network of hospitals and practices committed to quality improvement. In

addition, the ACC is piloting ways to increase primary and secondary prevention through the development of tools to monitor and encourage patient adherence to medications, as well as patient involvement and understanding of cardiovascular disease and impacts of lifestyle choices. As a part of building this understanding, ACC believes in engaging patients with shared decision making, providing individualized patient risk profiles and care support information.

Based on the College's experience, deficiencies in quality and efficiency are not generally the result of uneducated or recalcitrant physicians, but rather the result of misaligned incentives and inadequate feedback systems. The use of claims data instead of clinical data will go a long way to educate physicians about their quality of care and change their care patterns. Blunt cuts to reimbursement for services do not change behavior. The ACC strongly supports moving the current Medicare physician payment system away from a volume-based system and toward a value-driven system that aligns financial incentives with performance of evidence-based medicine and with improving care delivery systems.

The College strongly supports the testing of new models for delivering and reimbursing care through the CMS Innovation Center, private payers, and other initiatives, with priority placed on high cost, high impact conditions. Models are needed that work for a variety of settings, and must address the infrastructure challenges of private practice and rural areas.

While there are many clinical reasons to implement these changes, the financial impact will be substantial. The current system wastes substantial costs on inefficient or unnecessary care.

Table 1 represents just some of the potential savings:

Table 1. Projected Annual Savings by Avoiding Low Value Care and Inefficient Utilization Review

Current Practice	Savings
Inefficient Radiology Benefit Management Utilization Reviews in Private Health Plans	$271 - $869 million
1% reduction in stenting not meeting appropriate use	$44 million (10% reduction = $490 million)
1% reduction in ICD not meeting guidelines	$10 million (10% reduction = $100 million)

The experience gained by testing models should be seriously considered by IPAB.

Other Necessary IPAB Improvements

In addition to permanently replacing the SGR formula and placing more emphasis on quality improvement, the College urges Congress to work in a bipartisan manner to enact the following improvements to the IPAB framework and authority:

- IPAB must apply to all sectors of health care at the same time (segments of health care should not be carved out till later dates)
- Flexibility should be provided to help recruit high quality Board candidates
- Congress should retain the ability to achieve a different level of savings than proposed by the IPAB to adjust for new innovations that warrant spending growth
- Congress should maintain its ultimate accountability for the sustainability and stability of the Medicare program
- Recommendations should require an affirmative vote by Congress before they can be implemented

Conclusion

Thank you for the opportunity to share the College's views on the IPAB. ACC's CEO John C. (Jack) Lewin, M.D., and Senior VP for Advocacy James (Jim) Fasules, M.D., F.A.C.C., offer the ACC as a resource to you and your colleagues as you work to strengthen the Medicare program to ensure that Medicare beneficiaries have access to high quality care.

Summary

The American College of Cardiology (ACC) strongly supports efforts to align financial incentives to inspire greater focus on providing care that is patient-centered, evidence-based and cost-effective. Early in the health reform debate, the College hoped the Independent Payment Advisory Board (IPAB) concept would offer an opportunity to break down the silos of parts A and B in Medicare and modernize the program by focusing on quality improvement. Unfortunately, the ACC believes significant modifications are necessary to the IPAB as enacted in the Affordable Care Act (ACA).

First and foremost, Congress must act to permanently repeal the flawed sustainable growth rate (SGR) formula used to set Medicare physician payment rates prior to implementation of IPAB. Physicians are already subject to an expenditure target and other potential payment reductions as the result of the Medicare physician payment formula. The College believes it does not make sense to subject physicians to expenditure targets while at the same time exempting from IPAB's recommendations large segments of Medicare providers who are subject to no target at all. Until the SGR is replaced, the ACC cannot support implementation of IPAB.

In addition to permanently replacing the SGR formula, the College urges Congress to work in a bipartisan manner to enact the following improvements to the IPAB framework and authority:

- IPAB must apply to all health sectors at the same time (hospitals and other segments of health care should not be carved out)
- Flexibility should be provided to help recruit high quality Board candidates
- More emphasis should be placed on payment reforms that improve quality and lower costs rather than price controls that could hurt access
- Congress should retain the ability to achieve a different level of savings than proposed by the IPAB to adjust for new innovations that warrant spending growth
- Congress should maintain its ultimate accountability for the sustainability and stability of the Medicare program
- Recommendations should require an affirmative vote by Congress before they can be implemented

Mr. PITTS. The chair thanks the gentleman and recognizes Ms. Morrow for 5 minutes.

STATEMENT OF TERESA MORROW

Ms. MORROW. Thank you. I would like to thank Chairman Pitts and Ranking Member Pallone and the committee for holding this important hearing today and I appreciate the opportunity to submit my testimony on a topic that will definitely have significant implications on the lives of thousands of men, women, and families.

My name is Teresa Morrow, and I am cofounder and president of Women Against Prostate Cancer. Our mission is to unite the voices and provide support for the millions of women affected by prostate cancer. As healthcare leaders of the household, the role that women play in all phases of prostate cancer from preventative screenings to treatment and follow-up care is critical.

As you know, prostate cancer, as with any cancer, impacts the entire family. Our own cofounder, Betty Gallo, experienced the impact of this firsthand when her husband and your former colleague, Representative Dean Gallo, was diagnosed with prostate cancer in 1992 and subsequently died from the disease in 1994. Since his passing, many advancements in treatment and access to screenings and quality healthcare have saved the lives of thousands of men diagnosed with prostate cancer and fewer families have to suffer the loss of their loved ones as the Gallo family did.

We are here today because we are concerned about the effect that implementation of the Independent Payment Advisory Board will have on Medicare patients and families, including the large number of seniors that are diagnosed with prostate cancer each year. We share your concerns for more sustainable healthcare costs but do not believe that IPAB is the best way to achieve this goal.

We believe that IPAB will have a negative impact on patient access to quality care. IPAB's power to dramatically cut payments to healthcare providers and physicians who provide services to beneficiaries will likely result in fewer providers being willing to accept new Medicare patients and limiting senior's access to quality providers. We are concerned that IPAB could ultimately limit access to certain treatments or medications. While IPAB may be specifically prohibited from rationing care, reduced payments for certain medical services and providers could lead to the unintended consequence that beneficiaries should have access to certain treatments and therapies but not to others.

As a prostate cancer organization, we are particularly concerned that patients may not have access to new and innovative therapies to treat cancer that can ultimately improve and save lives. Treatment decisions should be made between a healthcare provider and a patient and his or her family and not be limited by an unelected board.

I recently spoke with a prostate cancer patient named Doug Magill from Northeast Ohio, and when he was diagnosed with prostate cancer, he began his quest to determine which treatment to pursue. He did all the things an informed patient would do—got a second opinion, spoke with other patients, family and friends, and he did a lot of research. Ultimately, he chose to travel across the country to Loma Linda University Medical Center to receive proton

radiation therapy. He chose proton therapy because of his fear of the side effects such as impotence and incontinence that other treatments may cause.

Doug expressed his concern to me that an entity like IPAB may have restricted his right to choose his treatment. By limiting his access to certain providers, he may have been forced to choose surgery instead of proton therapy and possibly left incontinent and impotent for the rest of his life.

Like Doug, each prostate cancer patient is unique and that should come into play when determining a treatment path. Patients and providers should have the right to choose what is best for them.

Another negative impact to seniors will be IPAB's requirement to achieve savings in 1-year periods. This means that the focus will largely be on cutting payments and other short-term savings rather than on long-term savings and reforms that could save money or help patients avoid unnecessary care in the future.

More emphasis should be placed on prevention. Catching health problems in their early stages while they are still treatable and preventable is the best way to ensure that seniors stay healthy and incur less expense to Medicare in the long run. More emphasis should be placed on participation in benefits like the Welcome to Medicare physical. Currently, less than 10 percent of those eligible to participate in this screening do so even though it can serve to provide guidance for seniors' health maintenance as they age.

Finally, we are concerned about the lack of oversight of IPAB. The board has the power to change laws previously enacted by Congress without actually needing congressional approval. Furthermore, the Secretary's implementation of IPAB's recommendations is exempt from judicial and administrative review.

We are also troubled that there is no patient representation on the board and that IPAB is not required to hold public meetings where the voices of patients, caregivers, and families can be heard. Important healthcare decisions that can dramatically impact patients will be made by an unelected board without accountability to the public.

In conclusion, I would like to thank the committee and just reiterate that while we agree that healthcare costs do need to be reigned in, we do not believe that IPAB is the right way to do so. Thank you.

[The prepared statement of Ms. Morrow follows:]

FOR THE RECORD

House of Representatives

Energy and Commerce Committee

Hearing on:

"IPAB: The Controversial Consequences for Medicare and Seniors"

9:00 a.m.

Rayburn 2123

Wednesday, July 13, 2011

Statement Submitted for Consideration by the Committee

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Hearing on: "IPAB: The Controversial Consequences for Medicare and Seniors"

Summary of testimony of

Theresa Morrow, Co-Founder & President, Women Against Prostate Cancer

We are here today because we are concerned about the affect that implementation of the Independent Payment Advisory Board (IPAB) will have on Medicare patients and families. We do not believe that IPAB is the best way to achieve sustainable healthcare costs.

We believe that IPAB will have a negative impact on patient access to quality care. IPAB's power to dramatically cut payments to healthcare providers and physicians who provide services to Medicare beneficiaries, will likely mean that that fewer providers would be willing to accept new Medicare. IPAB also has the power to decide that Medicare will not cover certain treatments or medications purely based on their cost and that patients may not have access to new and innovative therapies to treat cancer that can ultimately improve and save lives.

IPAB's requirement to achieve savings in one-year periods means that the focus will largely be on cutting payments and other short-term savings rather than on long-term savings and reforms that could save money or help patients avoid unnecessary care in the future. More emphasis should be placed on prevention to ensure that seniors stay healthy and incur less expense to Medicare in the long run.

Finally, we are concerned by the lack of oversight of IPAB. Ultimately, IPAB proposals do not need Congressional approval to go into effect and the Secretary's implementation of IPAB's recommendations is exempt from judicial and administrative review. We are also troubled that there is no patient representation on the Board and that IPAB is not required to hold public meetings where the voices of patients, caregivers and families can be heard.

Energy and Commerce Committee

Hearing on: "IPAB: The Controversial Consequences for Medicare and Seniors"

Wednesday, July 13, 2011

Testimony of

Theresa Morrow, Co-Founder & President, Women Against Prostate Cancer

I would like to thank Chairman Upton and the Committee for holding this important hearing. I appreciate the opportunity to submit testimony on a topic that will have significant implications on the lives of thousands of men, women, and families.

Women Against Prostate Cancer's mission is to unite the voices and provide support for the millions of women affected by prostate cancer. Our membership is made up of the wives, partners, mothers, daughters, sisters, widows and caregivers of prostate cancer patients.

As health care leaders of the household, the role that women play in all phases of prostate cancer, from preventive screenings to treatment and follow-up care is critical. As you know, prostate cancer, as with any cancer, impacts the entire family emotionally, financially, physically and spiritually. Our own co-founder Betty Gallo, experienced the impact of this disease first hand when her husband, your former colleague, Representative Dean Gallo was diagnosed with prostate cancer in 1992 and subsequently died from the disease in 1994. Unfortunately by the time Mr. Gallo was diagnosed the cancer had already spread beyond his prostate and had metastasized in his bones. Since his passing, many advancements in treatment and access to screenings and quality healthcare have saved the lives of thousands of men diagnosed with prostate cancer and fewer families have to suffer the loss of their loved ones as the Gallo family did.

We are here today because we are concerned about the affect that implementation of the Independent Payment Advisory Board (IPAB) will have on Medicare patients and families, including the large number of seniors that are diagnosed with prostate cancer each year. We share your concerns for more sustainable healthcare costs, but do not believe that IPAB is the best way to achieve this goal.

We believe that IPAB will have a negative impact on patient access to quality care. IPAB has the power to dramatically cut payments to healthcare providers and physicians who provide services to Medicare beneficiaries. As a result, it is likely that fewer providers would be willing to accept new Medicare patients therefore limiting seniors' access to quality providers.

IPAB also has the power to decide that Medicare will not cover certain treatments or medications purely based on their cost. As a prostate cancer organization, we are particularly concerned that patients may not have access to new and innovative therapies to treat cancer that can ultimately improve and save lives. By targeting such treatments, IPAB decisions could lead to slower investment and development of new innovations in the US that deliver better health outcomes to our citizens, including seniors. Treatment decisions should be made between a health care provider and a patient and his or her family and not be limited by an unelected Board.

I recently spoke with a prostate cancer patient named Doug Magill from Northeast Ohio. When Doug was diagnosed with prostate cancer he began his quest to determine which treatment to pursue, he did all the things an informed patient would do; he got a second opinion, spoke with other patients, family, and friends and did a lot of research. Ultimately Doug chose to travel across the country to Loma Linda University Medical Center in Southern California to receive

proton radiation therapy. He chose proton therapy because of his fear of the side effects, such as impotence and incontinence, that may be caused by other treatments.

Doug expressed his concern to me that an entity like IPAB would have restricted his right to choose his treatment. He may have been to forced to choose surgery instead of proton therapy and been left incontinent and impotent for the rest of his life. His quality of life would be of no consequence when considering how to keep the costs down.

Like Doug, each prostate cancer patient is unique and there are a number of factors that come into play when determining a treatment path; patients and providers should have the right to choose what is best for them.

IPAB could even go so far as to say that any man diagnosed with prostate cancer over the age of 85 will not receive any treatment, but rather recommend that these men should get watchful waiting with the perception that prostate cancer is only a slow growing disease that will not affect an older man in his lifetime. The Board should not have the authority to make overarching decisions that do not take into account whether a man is in poor health with a short life expectancy or if he is completely healthy and can expect to spend 15 more years with his wife and grandkids.

Another negative impact to seniors will be IPAB's requirement to achieve savings in one-year periods. This means that the focus will largely be on cutting payments and other short-term savings rather than on long-term savings and reforms that could save money or help patients avoid unnecessary care in the future.

Instead more emphasis should be placed on prevention. Catching health problems, or signs of

developing health problems, in their early stages, when they are still treatable or preventable is the best way to ensure that seniors stay healthy and incur less expense to Medicare in the long run. More emphasis should be placed on participation in benefits like the Welcome to Medicare Physical which was passed by Congress in 2003 as part of the Medicare Prescription Drug, Improvement and Modernization Act (MMA). Currently, less than 10% of those eligible participate in this health screening even though it can serve to provide guidance for seniors' health maintenance as they age.

Finally, we are concerned by the lack of oversight of IPAB. The Board has the power to change laws previously enacted by Congress. IPAB proposals must be accepted unless Congress can submit a proposal with the same cost savings. If Congress fails to adopt a substitute proposal, IPAB's proposal must be implemented, meaning that IPAB's proposal does not need Congressional approval to go into effect. Furthermore, the Secretary's implementation of IPAB's recommendations is exempt from judicial and administrative review.

We are also troubled that there is no patient representation on the Board and that IPAB is not required to hold public meetings where the voices of patients, caregivers and families can be heard. Important health care decisions that can dramatically impact patients will be made by an unelected Board without accountability to the public.

Our organization is dedicated to ensuring that prostate cancer patients and their families have access to quality care and can achieve healthy, happy lives after diagnosis. And while we share the concerns of the President and Congress for the increasing burden of healthcare costs in Medicare, we do not believe that IPAB is the right way to do so.

In conclusion, I would like to thank the Committee for all of its work on this issue and allowing

the opportunity for me to provide input into this important discussion whose outcome will surely have an impact on prostate cancer patients and their families.

Mr. PITTS. The chair thanks the gentlelady and thanks the panel for your testimony. We will now begin questioning and I will recognize myself for 5 minutes for that purpose.

Dr. Valadka, you state that the IPAB as it has been described in statute will simply ratchet down costs in the absence of adequate clinical expertise or the research capacity to examine the national and regional effects of proposed recommendations to ensure patients are not unduly impacted. Are you concerned that the IPAB's mandate to cut spending in the short-term will undermine longer-term improvements to Medicare and the healthcare system in general? Would you elaborate?

Mr. VALADKA. Yes, thank you for the question.

One aspect of this which has not been addressed much this morning is the fact that Medicare not only funds a lot of practitioners in the private sector but also is a huge contributor to medical schools and other places that do research. And that margin is getting thinner and thinner. As someone who spent over 12 years as a medical school faculty member, I can attest to that firsthand.

So if Medicare reimbursements to all the physicians participating in medical schools are going down, that leaves very little excess room for research to develop new treatments, as well as for education of medical students and residents who are going to be the next generation of practitioners. And those are the most fertile source for new innovations, ideas coming forward for the several decades following their training.

And moving to people who are already in practice, there is a lot of very clever people practicing out there who come up with better ways to do a procedure or treat a patient or to treat a disease. But again, if there is less excess capital flowing into their practices, they are not going to have the luxury of that time to develop new and better treatments.

Mr. PITTS. Thank you.

Ms. Grealy, many if not most healthcare analysts think that meaningful health reform will occur over a number of years. Are the short-term scorable proposals that the board is likely to have to make consistent with meaningful health reform in your opinion?

Ms. GREALY. Well, actually, I think it could be a barrier to that long-term meaningful reform. I think as you have heard among this panel that things that could save Medicare money in the long run may require a capital investment up front. We look at the current development of Accountable Care Organizations. It requires investment. As Dr. Lewin has pointed out, we need to have health information technology as an important tool. Again, these are things that in the short-term could increase spending, and this idea of having a year-by-year, 1-year budget reduction requirement I think really could impede some of those longer-term savings that would improve quality as well as reduce the cost of care.

Mr. PITTS. Thank you.

Dr. Lewin, in your testimony you state that "until the SGR is replaced, you cannot support implementation of the IPAB." Does that mean that if the SGR is replaced, you would then support the IPAB?

Mr. LEWIN. Thank you for the question, Mr. Chairman.

No, I think the SGR needs to be replaced and that is going to be exceedingly difficult as you well know because of the accumulated debt that it has accrued.

I think that we need something different from the IPAB and the SGR, something that is not a price-control approach. In fact, let us move away from the past and really innovate in health system reform to a new future where we start rewarding for better quality, more efficient care rather than the volume of care. And so, you know, we need to get on this now. We may not get the SGR fixed for years as far as I know. So we need to develop a new mechanism.

And sir, the IPAB, while the goal is right, the method is wrong. And so we will work with you to develop something that really will bend the cost curve, really will achieve those spending targets but to do so in a fashion that could actually work.

Mr. PITTS. Thank you.

Ms. Morrow, how could the IPAB affect the development of newer treatment modalities for prostate cancer as they are developed in the future? Does the IPAB have the potential to limit care for future patients as well as current patients in your opinion?

Ms. MORROW. Yes, we do believe that, you know, IPAB is charged to reduce excessive growth rates and Medicare spending and, you know, that could be defined as reducing payments for new, high-priced drugs and yes, we are very concerned about that taking prostate cancer.

Mr. PITTS. Thank you. The chair yields to Mr. Pallone for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask Dr. Lewin one of the many ideas put into place by the Affordable Care Act was the Center for Medicare and Medicaid Innovation. It is a new effort by CMS to research and develop ideas to save money and improve quality in Medicare and Medicaid more quickly than before. Last week, the Innovations Center announced projects to improve the coordination of care for dual eligibles—for instance, in cooperation with the States. Do you believe that the Innovations Center is a good idea? Would you just comment on it and why you might think that it is a good idea?

Mr. LEWIN. We heartily applaud the Innovation Center idea. We think that this is exactly what we need, a part of the CMS agency that really starts rewarding and funding innovation and new idea. I mean, we want to continue to have the best healthcare for all people in this country, including those who don't have access right now, and we want to continue innovating. But we are going to have to cut spending. Fortunately, you know, we can do this because there is so much waste in the current healthcare system.

The Innovation Center moving toward the triple aim—things that improve health, improve healthcare, and lower costs at the same time are possible. The Door-to-Balloon, the speeding up of heart attack treatment is an example. And I could give you numerous more that we are working on in cardiology. So if we could start funding models and show people out there what best practices are and then diffuse those across the healthcare system with a new kind of payment incentive process, I think we can solve this prob-

lem, have the best healthcare system in the world, and do it at GDP plus 1 percent.

Mr. PALLONE. Thank you.

Did you want to comment, Ms. Grealy, on the Innovation Center as well?

Ms. GREALY. Yes, I think this is a real opportunity for a public-private partnership. I think Jack has given some great models of what is being done in the private sector now against the financial incentives in the current Medicare program. They are doing the right thing despite not really getting rewarded for it. The value compendium that we have submitted will show you other examples of that. So I think it is an opportunity for the Medicare and Medicaid programs to learn from the private sector and to test pilot these things as opposed to this board of 15 people coming up with a number, making some recommendations that perhaps haven't even been test piloted. And I think that is the real advantage of having the Center for Innovation.

Mr. PALLONE. Thank you. I was going to ask you also, Ms. Grealy, this is a quote from the CBO analysis of the Republican plan for Medicare and Medicaid in their budget. It says, "Under the Republican budget proposal, the gradually increasing number of Medicare beneficiaries participating in the new premium-support program would bear a much larger share of their healthcare costs than they would under the traditional program, and that greater burden would require them to reduce their use of healthcare services, spend less on other goods and services, or save more in advance of retirement than they would under current law."

Now, in your testimony, you said that "IPAB has the potential to cause serious harm to Medicare beneficiaries" but, you know, I would like to know what your views would be of the Republican budget plan and its effect on beneficiaries. Do you agree with the CBO's characterization of the Republican plan?

Ms. GREALY. The Healthcare Leadership Council for over a decade has supported the concept of moving to a premium-support model for the Medicare program to give seniors more choice, to have those private plans competing, much as they do in the Medicare Part D program. I think what we need to do is to look at the premium-support model. There are many components to it. We probably would recommend using a different inflation factor. Much like Alice Rivlin, we would probably recommend maintaining for a period of time the traditional Medicare program. So I think there is a lot of merit to the concept. I think there are some modifications that we would make to the proposal that was put forward.

Mr. PALLONE. Thank you.

Let me ask—I guess I have another 50 seconds here. I wanted to ask Ms. Morrow, you know, again you made your concerns about IPAB clear but as you know, this was developed as a backstop mechanism to address to growing costs of healthcare. In the Republican approach in the budget is very different. They would simply slash existing programs. They would end Medicare as we know it, and they would slash medical research. And I am concerned about the impact on medical research of the Republican budget. The NIH budget was actually cut under the continuing resolution for this year, and for 2012 it doesn't look any better. If you would just com-

ment on it. I mean I am just concerned where are we going with research with what happened with the CR and what is in the Republican budget for the future?

Ms. MORROW. Yes, continuing research in cancer is extremely important to us and we do advocate for increased funding for research. And I am not familiar with everything that is in the Republican plan but, I mean, we will continue to support more increased funding for research.

Mr. PALLONE. OK. Thank you very much. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and recognizes the vice chairman of the subcommittee, Dr. Burgess, for 5 minutes.

Mr. BURGESS. Well, thank you, Mr. Chairman. And I thank you all for being here. This has been an interesting—although, Dr. Valadka, you are correct that this was—what did you call it? The IPAB-alooza of—IPAB-ulous?

Mr. VALADKA. IPAB-athon, but IPAB-alooza applies as well.

Mr. BURGESS. I do so welcome the comments of all of you. I think they have been very helpful.

Ms. Grealy, I hope that you will take some time and take the Secretary of Health and Human Services perhaps to lunch and explain to her what premium support actually is. You might even want to include Ranking Member Waxman in that discussion because he seems to have some difficulty and even the President of the United States required a little remedial education of the difference between a voucher and a premium-support system.

Dr. Valadka, let me just ask you, we hear a lot about the IPAB. We have heard a lot about it today, but I get the general impression that doctors and patients and patient-advocacy groups do not support the IPAB. Is that a fair assessment, and if that is fair, why do you suppose that is?

Mr. VALADKA. To borrow a line from a high-ranking member of this body, when the healthcare debate was going on a couple of years ago, you have to pass the bill to find out what is in it.

Mr. BURGESS. Now, we know.

Mr. VALADKA. I have had that same conversation with many of my colleagues in the operating room and the ICU in the hallways where they don't really quite know what IPAB is. And the more you talk to them and educate them, I don't think anyone thinks it is a good idea. And I think it has been gratifying to see this started as a very obscure issue that only policy wonks knew about, and now I understand they get discussed in the New York Times, Wall Street Journal, CNN, mainstream media outlets like that. So I do think that the more people learn about it, the less they are going to support it.

Mr. BURGESS. And I think that is in general true.

Now, Dr. Lewin, you talked about repeal the SGR before you do the IPAB. I got to believe that really you are the membership of the American College of Cardiology would not support either of those control mechanisms. Is that correct? Now, the AMA did—you know, unlike Mr. Pallone, who voted for that bill, I voted against it. I thought the AMA was wrong to support it. What does your membership say?

Mr. LEWIN. Well, we certainly don't have any affinity for the SGR. It clearly doesn't work and it is too bad we didn't deal with it 10 years ago, right? We all wish we had. But that said, I think the IPAB as it is currently designed we don't believe will be effective in any way, shape, or form. It is going to be another price-control mechanism. So we would like to get on with the challenge that we have as a Nation of, you know, creating the healthcare system of the future that provides access to everybody, that continues to reward innovation and improve quality. And we think we need a different approach than the IPAB.

Mr. BURGESS. Well, let me tell you the problem, though, because you reference the SGR and your pessimism of the SGR that anything meaningful will happen, and I actually—this here I am more optimistic that something can happen to the SGR than any time previous in my 9 years here.

But here is the deal. You are exactly right. What if in 1998 someone had had the courage to say oh, this SGR thing is going to be a disaster in 10 years' time and I want to fix it. We have that opportunity with the IPAB now. Once the IPAB begins that cumulative effect of, you know, this specious thing of a dollar saved, then there is going to be a CBO-directed cost associated with its repeal. And it won't be too terribly long before that cost becomes a mountain too tall to climb just as the SGR is today.

So yes, we got to kill one that is mature, which is the SGR, but the other one, we do need to get a handle on it before it ever gets out of the box. And I would say the time is now to repeal the Independent Payment Advisory Board, and I would encourage Mr. Pallone to join with us on that because once this thing gets away from you, it is Katy bar the door. It would be impossible to undo it.

And I think honestly that is what the administration is banking on. They want to get this thing up and running and it is another method—but let us be honest, this thing was not about healthcare, never was. It is a tax bill, but bottom line, it is about control. They want to control you. They want to control Dr. Valadka. They want to control what you do. They want you to do only what they tell you you can do and they want to be able to tell you when to stop, don't do anymore. That patient has had enough. That is where this thing is going.

Ms. Morrow, let me just thank you for being here. I don't have a question for you as relates to the IPAB on prostate cancer, but I do remember in the discussion of healthcare reform as it was going through, I read somewhere where some healthcare thinker said we will be able to tell if Congress was serious about reforming healthcare as to what they do with prostate cancer because the implication was we over-treat prostate cancer in the United States of America. However, recent studies comparing survival rates for prostate cancer in the United States versus Europe, it is like 99 versus 77 percent. I would rather be here with all our faults than anywhere else in the world. Do you have any comments on that?

Ms. MORROW. I have seen those same statistics and, you know, as far overtreatment, we strongly disagree with that term. You know, it is up to the patient. The doctor and the patient can have an informed discussion about the person's prostate cancer and

whether it is going to grow and affect them in their lifetime, but the decision should be between the patient and the provider.

Mr. BURGESS. And not the IPAB and the provider.

Ms. MORROW. Exactly.

Mr. BURGESS. Thank you.

Mr. PITTS. The chair thanks the gentleman and recognizes Dr. Cassidy for 5 minutes.

Mr. CASSIDY. Dr. Valadka, a friend emailed me and said how come you don't have a practicing physician on the panels, one passionate about our practices? And so I will have to email her back and say although I didn't pick it, we have one.

My question for you is that when you look at the CBO score that Mr. Pallone referenced, it says the reason that traditional Medicare scores less than a private insurance plan is that traditional Medicare pays physicians less. Indeed, the way CBO scored it is although they don't assume the SGR cuts go through, they also have no inflation adjustment. Now, that has been the case since 2002, and effectively, Medicare is paying physicians significantly less now than they were in 2002, so much so that Richard Foster says that within 9 years Medicare will pay less on average than Medicaid. You are a practicing physician. Secretary Sebelius avoided answering this question every which way. But if Medicare is now paying less than Texas Medicaid, what will that do for access to services for those who have Medicare?

Mr. VALADKA. In one word, cost-shifting. As we discussed here earlier today——

Mr. CASSIDY. Now, let me say this. You are saying that as a specialist who sees people coming through the ER and almost have no choice but to see the patient. So speak first as a specialist and then imagine what it would do for access to primary care.

Mr. VALADKA. Well, as you well know, when patients come through the emergency room, we take care of them first and oftentimes we don't even know their name. You know, they are in the computer as unknown, number something, we operate and take care of them and then later figure out who they are, who the family is, you know, if they have any resources. That is a hospital administration issue. But that is time that takes away from your practice. And as you know, time is a very precious thing. So you are going to have to make up the gap in other ways because you are going to have pay your secretary, your nurses, your——

Mr. CASSIDY. You have a fixed overhead?

Mr. VALADKA. Absolutely.

Mr. CASSIDY. Now, I know you are not primary care, but if you are primary care and you are spending 50 percent of your receipts on fixed overhead and you got a choice of which patients that you can afford to take—New York Times documented this very well with an oncologist in Michigan getting paid below cost by Michigan Medicaid at some point could no longer afford to take more Michigan Medicaid patients, would you accept that it is going to hurt access to primary care?

Mr. VALADKA. Well, I think you used the word choice as to what patients are going to have to take, and I would quibble with you a little bit. You don't have a choice. You have to take more patients with commercial insurance just to subsidize all of the activity you

are spending taking care of the patients with no insurance or Medicaid.

Mr. CASSIDY. Or limit what you—now, in this case, if Medicare is paying less than Medicaid, you would now put the Medicare patient in the same boat if you will as that Michigan Medicaid cancer patient who could not find a provider?

Mr. VALADKA. That is exactly right.

Mr. CASSIDY. Yes. And again, in 9 years under the provision that CBO describes is saving money for traditional fee-for-service Medicare, we and Medicare as we know it because seniors will not be able to access care, that is a little—and you raised something, just kind of—I thought about it but the way you phrase it kind of ticked my mind a little bit. So IPAB can only cut among providers, physicians.

Mr. VALADKA. Yes.

Mr. CASSIDY. So really we could have a hole in the bucket for hospitals. There could be a hole in the bucket for hospitals with just an inordinate amount of cost going there, but physicians would have to make up the difference, correct?

Mr. VALADKA. As it is now, yes, because hospitals have I think until 2018 or 2019. Yes. They are out of the loop. They kind of negotiated themselves out. I just can't stress it enough—it is like a broken record—we have to do something different than this. We need to deal with the rising costs of Medicare. We can but we need help from Congress to do that with a different approach than this design. This isn't going to work and if this is health reform, then let us start off and do something the right way and reward incentives for quality and efficiency and improved care. That we can do. We now have the tools to do that. We couldn't have done that in the '90s when health reform was proposed. We can do that now. And physicians want to do this. We still want—clinical judgments are still going to be important and we want to protect the patient-physician relationship in this process.

Mr. CASSIDY. I like the way you emphasize the practicing physician's role in controlling healthcare costs. I note in IPAB I don't think you are allowed to continue to practice and still serve on the board, which gives me kind of pause. Wait a second. If the person who is in the mix, if she is the one who knows best how to do it but she is the one who, by statute, is not allowed to serve, it seems kind of odd.

Mr. VALADKA. Certainly. And especially a full-time occupation to be on the board. We are going to attract people that are going to be retired people. So this is not the design for a system that is really going to innovatively improve Medicare.

Mr. CASSIDY. There is a system designed by staffers, not by people involved in healthcare.

I am out of time. I yield back. I thank you all.

Mr. VALADKA. Thank you.

Mr. PITTS. The chair thanks the gentleman. That completes the first round. We will have one follow-up on each side. Dr. Burgess?

Mr. BURGESS. Dr. Lewin, you referenced that setting price controls on volume doesn't work, and I think we have seen that with the SGR rather eloquently. You reduce the amount you pay and you drive up volume because, as Dr. Cassidy pointed out, overhead

costs are fixed so you have got to do more if you are going to keep those overhead costs met and continue to earn a salary if you are at an individual or a small-group practice, which I was.

Now, fee-for-service medicine gets a bad rap in all of this and we are told by all the great thinkers in healthcare that the fee-for-service system is the culprit. But really the culprit is the administrative pricing brought to us by the Center for Medicare and Medicaid Services and your specialty in particular. I mean, I have had deans of medical schools who are cardiologists come to me and say the big problem is the overutilization of our specialty, you know, Door-to-Balloon time studies that you have done, that is great and a great metric, but if these guys are accurate and more balloons are being done than are necessary, then it doesn't matter that you do them quickly. It is still going to be a cost driver. And yet because of administrative pricing, we have favored that type of activity in the Medicare system.

You know, you would ask yourself the big problem that everyone talks about is childhood obesity. You have got the First Lady working on that is her main cause. You would think that with childhood obesity under the raft of childhood diabetes that will follow that we will be churning up pediatric endocrinologists right, left, and center. And yet we turn them out a handful a year. And cardiologists know we turn out a lot. So as the leader of your professional organization, how are you proposing to deal with this? Forget SGR and IPAB for a moment. You guys have a responsibility here.

Mr. LEWIN. Yes, you know, just as a quick aside with the tsunami of obesity and diabetes, you know, we won't have enough cardiologists to deal with what is coming up in the future. But, you know, we really have the tools now to make sure that people who have chronic stable angina who are approaching the system for care don't get a stent when it really wasn't needed or don't get bypass surgery where a stent would have been better or get to optimal medical therapy when the data shows the results will be better and they will have no risk of complications in the meantime. We have these tools, we have the science, but there are no incentives to apply them in hospitals across the country.

We have incentives to reduce the use of implantable defibrillators for people for whom the science says shouldn't have gotten them. We published it. We published our data. We have 100 percent—thanks to—Medicare requires the use of our registry. We have 100 percent of the implantable defibrillator data in the United States. We pointed out 23 percent of them apparently were placed without the best guideline evidence being present. And we want to go around and educate everybody, but the incentives are not there to say to the hospitals and the doctors we are going to reward those who start to reduce that variation, not pay for the volume.

Mr. BURGESS. Well, how will IPAB reduce that variation?

Mr. LEWIN. It won't. It will not. IPAB just has no way to do that. We need a different mechanism and that is payment incentives for improved quality and outcomes and efficiency. And you have to measure to manage. So you have got to have systems out there to give doctors and hospitals feedback, dashboards of feedback on how they are doing as compared to all their peers. When they have that information, they will change.

Mr. BURGESS. And Dr. Valadka, let me just ask you to, you know, you are the only practicing physician we have heard from all day. What about how does medical liability reform factor into what Dr. Lewin was just talking about?

Mr. VALADKA. I think liability reform is a huge way to try to bring down costs in the healthcare system. Now, that is not part of IPAB. Of course, we would beginning far afield. But you are a Texan. You have heard about the Texas miracle following tort reform there in 2003. It did everything that its proponents said it would. It lowered the cost of professional liability insurance. It brought more PLI carriers into the State, and most importantly, it brought a lot more physicians into the State. And those guys are going to the rural and underserved areas just as much as going to the major metropolitan centers. The only downside has been the flood of applications to the Texas Medical Board because——

Mr. BURGESS. Yes, the Texas Medical Board is in trouble. But Dr. Lewin referenced, you know, the fact that sometimes a stent might do instead of a bypass or maybe maximum medical therapy. But it could be tough if you are the doctor on the frontline who is worried about the appearance of did I do everything possible if this patient walks out of the office and crashes and burns in my parking lot, did I do everything possible to prevent that from happening? And that is a burden with which we live as practicing physicians every day, is it not?

Mr. VALADKA. Well, that is absolutely true. And again, to put that in perspective, that is going to happen a certain percentage of the time even if you do everything right. So now you are thinking, OK, did I do everything right? Someone is going to be looking over my shoulder in 6 months or 12 months if there is a bad outcome. And again, you know, Abraham Lincoln said even if you did everything right and events prove you wrong, a thousand angels swearing you were right won't make a difference. So that is a huge concern for all practicing physicians.

Mr. BURGESS. Thank you for being here today, all of you. Thank you.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Michigan, the ranking member emeritus, Mr. Dingell, for 5 minutes of questions.

Mr. DINGELL. Mr. Chairman, you are most courteous. Thank you.

Dr. Lewin, welcome to today's hearing. I would like to begin to discuss your recommended improvements to IPAB. You mentioned in your testimony that flexibility should be provided to help recruit high-quality board candidates. Do you believe, then, that under the current statute the board will be unable or will be able to recruit high candidates?

Mr. LEWIN. Congressman Dingell, thank you for the question. I don't believe the way it is currently constructed the IPAB will recruit the kind of people that we want. First of all, the IPAB membership is a full-time, if you will, occupation. It means that we can't bring in the best and the brightest from throughout the health sector with various perspectives to help guide this process. We are almost destined with that approach to bring in retired people.

Mr. DINGELL. My next question, you have gotten a bit ahead, but one, what will be the barriers to recruiting candidates; and two,

what should we do to eliminate those barriers to enable us to recruit the strongest candidates?

Mr. LEWIN. My guess is that the importance of this process is that some excellent candidates may come to serve just with their expenses covered, but I think this shouldn't have to be a full-time commitment on the part of those individuals. We need people who are the best and the brightest in the healthcare sector who understand the economics as well as the clinical realities of this and the patient perspective part of this to be sitting around this table. So I think that the way that it is designed in terms of the pay and the requirement that it be a full-time occupation will make it very untenable.

Mr. DINGELL. OK. Now, Doctor, IPAB establishes a Consumer Advisory Council to advise the board on how payment policies impact consumers. However, this is an advisory capacity only and does not include patient representation. Now, as a physician, how would you recommend addressing this problem and encouraging patients' participation to help in decision-making necessary for the board to issue the best recommendations?

Mr. LEWIN. Well, I think the IPAB ought to have patient representation sitting right there on the board itself if it was to exist. Patient representation should have been part of the process of the IPAB. But I would say, Congressman Dingell, that I think we have to reconstruct what we consider this IPAB model if we want it to actually achieve cost containment over time by systematic improving quality of care. I think the way it is designed isn't going to work so I am not so concerned about how we get the members on it right now. I would like to see a design of a system that might actually reduce costs and improve quality.

Mr. DINGELL. I notice you, Dr. Valadka, were nodding yes?

Mr. VALADKA. Yes, I agree completely. It seems like we have gotten a little bit ahead of the conversation when we are talking about how to structure IPAB and how it should be set up in advisory committees, but I think a more fundamental question is really will it achieve the aims it sets out to do without creating too many adverse events like limiting access to care for our seniors.

Mr. DINGELL. Thank you.

Now, again, coming back to our first witness here. Your testimony suggests the use of data registries as one way to ensure high-quality care while identifying areas to reduce spending. In particular, Doctor, you mentioned the ACC's Pinnacle outpatient registry. I happen to believe that the technology advances like electronic health records and registries can create savings but also know that there could be a resistance to implementing such technologies. How many providers participate in this registry currently, Dr. Lewin?

Mr. LEWIN. Thank you for that question, Congressman Dingell. Nearly all the major hospitals in the United States participate in the registries and they pay us for the data, and that allows us to actually keep this very expensive operation going. In the physician outpatient setting, it is really hard to ask the doctors to pay us for collection of data at this time, but a thousand practices have signed up. We have two million patient records already with this relatively new system. And we can see measured improvement in

quality across the entire Pinnacle network. I might add that 100 percent of the Pinnacle participants received the full PQRS reward and the e-prescribing reward, and we were able to file for them. So there is some small reward. But if we were to use payment reform to provide real incentives for improved outcomes and quality, this would go rapidly across the entire environment. It needs to reach to internal medicine and family practice and others who share in the care of cardiology patients with us in the outpatient setting.

Mr. DINGELL. My time is up, Doctor, but with the patience of the chair, I am going to ask you can you give me an example of how a member of ACC has used the registry to bring down the costs of their practice?

Mr. LEWIN. Absolutely. The one thing I can give you is that they got an average of 8 to $10,000 back from the rather pitifully small reward program called PQRS that Medicare uses today by just by participating in the registry. They got the rewards from Bridges to Excellence and from other employer-based private insurance approaches. And some of them are now going to receive a bypass of having to go through, you know, call a nurse to get permission for a procedure because they can demonstrate to the insurance company that they are making the right decisions using the clinical decision support tools embedded in the registry. So it is a hassle factor improvement for the doctor, and time is worth money. So even though the payment incentives aren't really aligned yet to improve quality, even now, this Pinnacle registry is offering some benefits to people in the current environment.

Mr. DINGELL. Thank you, Doctor.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. We are voting on the floor. We have 11 minutes to go. We have time for follow-up from Mr. Pallone.

Mr. PALLONE. I will be quick. I know that both Dr. Burgess and you, Dr. Lewin, brought up the SGR and I do think that certainly when I hear from the doctors, you know, they see the SGR and, again, the cliff we faced in January as the biggest threat to Medicare, more so than IPAB. And you know, I am opposed to IPAB but I just wanted you to comment on that. I mean, isn't this SGR a major threat, more so than IPAB and what are the doctors telling you about it?

Mr. LEWIN. We would have to think that it is a major threat. It is certainly a threat to access. If more doctors can't afford to accept Medicare patients, clearly it is going to pose a nightmare for our healthcare system, for emergency rooms and for the entire system. So we are very, very worried about it and particularly because it is a big, big price tag to try to fix it.

Mr. PALLONE. The cut.

Mr. LEWIN. And I honestly don't know how it is going to happen given the conversation on, you know, the debt ceiling and the deficit. So, you know, I assume we might end up kicking that can down the road again, and I am very, very worried about that, much more worried than I am about the IPAB.

Mr. PALLONE. Well, I just wanted to say I know that Dr. Burgess mentioned that, you know, he hopes that we can get to it and do a long-term fix this year. And I am very much supportive of that.

I always kid him because he was I think the only Republican who voted for the Democrat long-term fix that we passed a couple years ago. So I have to commend him for that although maybe he doesn't like to be commended for that.

But I would just ask, Mr. Chairman, that I know that we have already had a hearing on it, but I would urge that we do try to address it and not wait until the last minute and kick the can down the road.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and for the information of the panel. We are going to deal with the SGR this year. We intend to do a long-term fix. We are in the process. We have collected information from all the doctor groups. We have had meetings, many meetings, and we are in the process of developing a vehicle, but it will probably be after the break in the fall before we get to it. But we intend to deal with it on a permanent basis before the end of the year.

This has been an excellent panel. Thank you for the information you have shared.

That concludes today's hearing. I remind members that they have 10 business days to submit questions for the record, and I ask the witnesses to please agree to respond promptly to these questions. With that, this subcommittee is adjourned.

[Whereupon, at 2:06 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Opening Statement of Chairman Fred Upton
Energy and Commerce Health Subcommittee Hearing on
IPAB: The Controversial Consequences for Medicare and Seniors
Wednesday, July 13, 2011
(Remarks as Prepared for Delivery)

As we continue to discuss the many pressing issues in health care, there are few issues with greater urgency than Medicare reform. This has been highlighted by the most recent Medicare Trustee's report predicting that the Medicare Trust Fund will be bankrupt in 2024, five years earlier than reported one year ago.

The health reform law took $575 billion out of the program – not to strengthen Medicare, but to spend on new entitlements. The law also gave an unelected, unaccountable panel of 15 experts and academics, known as the Independent Payment Advisory Board, the power to make seniors' health care decisions. That controversial board is the subject of today's hearing.

Last month, during the markup of our Semi-Annual Committee Activity Report, we approved an amendment instructing the committee to examine the health care law's rationing board, the IPAB, and its effects on seniors' access to care. And as Congress reviews the future of Medicare, we must also examine the devastating effects on seniors' health care if the program goes bankrupt in 2024.

Day after day, unnerving new details of the health care law are uncovered. The IPAB can certainly be counted among the issues that have only increased in controversy as lawmakers, patients, and doctors learn more about it's vast power and potentially devastating consequences.

I thank the witnesses for being here today for what is perhaps the most comprehensive congressional review yet of the IPAB. I am particularly interested in hearing from Secretary Sebelius about the future of this

board and the power it bestows. Although the members of IPAB must be appointed by the president and confirmed by the Senate, the administration has yet to nominate a single person to serve with this controversial panel. This prompts troubling new questions.

First, what will happen to the $15 million that will be given to the board – which currently has no members – on October 1 of this year to begin its work?

And second, will the secretary take on the IPAB's treatment denial duties if no members are appointed and confirmed? The health law gave the secretary the power to make binding payment reductions in Medicare if the board does not do so. I'd like to hear from the secretary about her interpretation of this authority and how she might use it.

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Opening Statement of the Honorable Joe Barton
Chairman Emeritus, Committee on Energy and Commerce
Subcommittee on Health
"IPAB: The Controversial Consequences for Medicare and Seniors"
July 13, 2011

Thank you, Mr. Chairman, for bringing the issues surrounding the Independent Payment Advisory Board (IPAB) before this Subcommittee today. I think we all agree that we need to find ways to control the costs in Medicare; however, I am deeply troubled by the Administration's decision to select 15 unelected, unaccountable, "experts" to decide how and where to implement spending cuts.

What is even more worrisome is this board's ability to "fast track" their proposals to avoid the usual system of checks and balances. Any decision that IPAB makes can automatically become law, and there is no administrative process that will allow doctors or citizens to provide input or challenge the board's decisions. I believe that doctors and their patients should decide the value of medical services, not some group of politically appointed "experts".

President Obama has said time and time again that he is committed to establishing a system of transparency, public participation, and collaboration. Unfortunately, he has made the mistake of not delivering on his promise.

I am afraid that if we do not eliminate IPAB, we will be following in the President's footsteps by making this same mistake.

Thank you, I yield back.

Congressman Marsha Blackburn
Opening Statement for Energy and Commerce
Health Subcommittee Hearing
"IPAB: The Controversial Consequences for Medicare and Seniors"
July 13, 2011

I would like to thank the Chairman for calling this hearing to examine what in my mind is one of the most potentially harmful provisions of the ObamaCare bill.

Over the past year, seniors and health care providers from across my district all have shared with me their opposition to the Independent Payment Advisory Board. They know the IPAB's only option to curb Medicare spending will be to effectively refuse treatments to patients by severely cutting provider fees.

Seniors have spent their entire working lives giving the government first right of refusal on their paycheck in order to receive health care coverage when they turn 65.

Physicians are already restricting how many Medicare patients they treat. Thanks to the IPAB, this problem will only get worse – leaving our seniors without the necessary access to physicians they deserve.

In my mind, the IPAB acts as a medical IRS by inserting itself firmly in between a patients and their doctor, just as the IRS does between our constituents and their paychecks.

Instead of giving patients control of their health care decisions, the President and his allies in Congress chose to delegate this power to a commission of 15 unelected bureaucrats in Washington.

Health care decisions should be made by patients and their physicians – not bureaucrats. That is why I oppose the IPAB and that is why I support Dr. Roe's bill, H.R. 452.

I yield back.

07.13.2011 - E&C Health Subcommittee Hearing - Independent Payment Advisory Board - Opening Statement

Thank you Mr. Chairman.

I am a strong supporter of Medicare. Like millions of seniors both my late father and late mother-in-law depended upon Medicare so I know how important it is to strengthen this important safety net program now and in the future. But the truth is Medicare is in financial trouble.

Evidence from the Medicare Trustees, the Medicare Actuary, the Congressional Budget Office and others show that without reform, Medicare will go bankrupt in a few short years.

The U.S. House passed a budget blueprint plan that attempts to protect, preserve and save Medicare not only for today's seniors but also for future generations. Under the plan current Medicare beneficiaries would see no change to their current benefits.

The Democrats under the leadership of President Obama have a different plan for Medicare.

Last year's health care law raided the Medicare Trust Fund to the tune of $500 billion to help pay for the President's signature domestic issue further exacerbated Medicare's solvency.

The President's health care law also created something called the "Independent Payment Advisory Board," or the IPAB. Most Americans have never heard of IPAB.

Beginning in fiscal year 2015 this new federal agency call the IPAB will be made up of 15 unelected bureaucrats who will have the power to make major cost-cutting decisions about Medicare with little oversight or accountability.

This year President Obama has proposed strengthening the IPAB agency as a way to lower Medicare costs.

I oppose the President's Independent Payment Advisory Board because I fear it will lead to the rationing of care for Medicare beneficiaries.

The board's unprecedented authority to alter Medicare policy could ultimately reduce seniors' access to health care and put the government – rather than the patient – at the center of our health care system.

I hope today's hearing will closely examine the President's Independent Payment Advisory Board and whether health care decisions should be controlled by patients and their doctors, or by a board of unaccountable government bureaucrats.

Thank you.

Statement from Representative John D. Dingell
House Committee on Energy and Commerce
Subcommittee on Health
"IPAB: The Controversial Consequences for Medicare and Seniors"
July 13, 2011

Thank you Mr. Chairman for holding today's hearing.

I find it ironic that today's hearing is entitled: "IPAB: The Controversial Consequences for Medicare and Seniors." This seems to be a more fitting title for Chairman Ryan's voucher plan for Medicare.

While I would hope that my Republican colleagues are truly concerned about ensuring Medicare is accessible to seniors in need, their support and defense of ending Medicare as we know it leaves me doubtful.

You can understand then why I find it hypocritical that my Republican friends are voicing disdain for the Independent Payment Advisory Board, or IPAB, which will recommend improvements to Medicare designed to lower health care costs, when the Republican Medicare plan irresponsibly chooses to recklessly slash and burn away the program rather than bothering to improve it.

The Republican Medicare plan chooses to find savings in Medicare by cutting the program in half by 2050. These proposed savings will be found through eliminating benefits and shifting costs to seniors. On the contrary, IPAB is explicitly prohibited from making any recommendations that would raise premiums, reduce benefits or change eligibility for Medicare.

The Republican Medicare plan chooses to improve Medicare by actually ending it in favor of a complex voucher system for seniors to purchase costly health insurance coverage in the private market. Under this convoluted plan, the average senior would pay $6,400 out of pocket in the first year of the plan, and by the tenth year seniors would end up paying 70 percent of their own health care bills. IPAB on the other hand is explicitly prohibited from increasing cost-sharing for seniors and is directed to protect access to services for Medicare beneficiaries.

The solvency of the Medicare program is of the utmost importance to me and the thousands of seniors across this country, and I urge my colleagues to prioritize this issue especially during our country's economic struggles. These seniors have had to make tough choices to pay for their prescriptions or their gas bill, and they expect that the federal government will make the tough choices necessary to keep the promise Medicare has made to those nearing, planning for in retirement.

Today's hearing should not be used to exercise partisan soapbox rhetoric, rather this Committee should use today as an opportunity to learn about how IPAB can best be implemented to keep the historic promise we made to our seniors that their health care will be accessible and affordable long after they leave the workplace.

Secretary Sebelius Questions for the Record
House Committee on Energy and Commerce
Subcommittee on Health
July 13, 2011

The Honorable Joseph R. Pitts

1. In your testimony before the House Budget Committee yesterday, you went to great lengths to make the point that the IPAB is unlikely to be triggered and, therefore, will not have to make spending cuts. You even cited a CBO estimate that says that the Board is unlikely to be triggered over the next decade. However, in 2010, in an attempt to assess the impact of the ACA, the CMS Chief Actuary performed calculations using historic data to better understand the potential impact of the Board. The Chief Actuary reported that "actual Medicare cost growth per beneficiary was below the target level in only four of the last 25 years, with three of those years immediately following the Balanced Budget Act of 1997." Thus, in most recent years past, the Chief Actuary would have made a determination that triggered a Board proposal. How do you reconcile these findings with your claim that the Board is unlikely to be triggered? It sounds to me like the Board is virtually certain to be triggered, at least according to 25 years worth of data.

Answer: The Affordable Care Act included historic investments in routing out fraud, waste, and abuse in the Medicare program – including hundreds of billions of dollars of overpayments to Medicare Advantage plans – as well as important provider payment changes designed to improve quality and incentivize efficient delivery of health care services. The HHS Health Care Fraud and Abuse Control program alone in 2010 returned $2.86 billion to the Medicare trust funds and $683 million to the Federal Treasury from Medicaid Recoveries. The creation of the Partnership for Patients has the potential to save Medicare up to $50 billion over the next decade by reducing patient harm in hospitals and preventing unnecessary hospital readmissions. Based on the long-term savings to the Medicare program that will accrue from these and other Affordable Care Act initiatives, the Congressional Budget Office does not project a triggering of IPAB proposals in the coming decade.

2. In May the Administration proposed requiring state Medicaid programs to obtain public comments before reducing provider reimbursement levels. Why is the Obama Administration imposing public comment requirements on state Medicaid programs, but not imposing a similar requirement on its controversial IPAB?

Answer: Congress created IPAB as an independent Board with flexibility in how it interacts with health care stakeholders and the public at large. However, IPAB is also accountable to Congress in that its recommendations are subject to review, assessment, and amendment by Congress. In addition, once IPAB makes its proposals, Congress can provide opportunities for public input prior to its decisions on how to address excess cost growth in the Medicare program. Finally, members of the IPAB board cannot hold outside employment; must adhere to strict conflict-of-interest requirements (prohibiting members from holding outside employment); and are subject to a lobbying cooling off period after their service on the board concludes – all of which would likely result in the Board seeking to do its work in a manner that is open and transparent.

3. The Administration has stated that IPAB will recommend policies to reduce Medicare spending while "not harming beneficiaries' access to needed services" – how is this guarantee enforced? What can a beneficiary who believes their health care has suffered due to an IPAB recommendation do since the implementation of IPAB recommendations are not reviewable in a court of law?

Answer: IPAB is expressly prohibited from making proposals that would ration health care, raise revenues or Medicare beneficiary premiums, increase beneficiary cost sharing (including deductibles, coinsurance, and co-payments), or otherwise restrict benefits or modify eligibility criteria. We do not believe the statute precludes judicial review of HHS's implementation of an IPAB recommendation that is clearly outside the authority conferred by the statute.

This view is consistent with existing case law.[1] Thus, while we cannot offer advice on hypothetical cases, we believe such case law would support a legal challenge to an implemented IPAB recommendation that clearly violated one or more of the statutory restrictions set forth above (such as a recommendation to increase beneficiary co-payment amounts), assuming Congress were to fail to override that recommendation. Of course, we don't have any reason to believe IPAB will issue recommendations exceeding its statutory authority, and Congress could exercise its authority to preempt or override an unlawful recommendation, making a legal challenge unnecessary.

4. In a Senate hearing earlier this year you testified that rural critical-access hospitals are in "precarious territory" in terms of the future cuts they could face from IPAB beginning in 2014. That is because these hospitals, unlike most other hospitals, would fall under the immediate jurisdiction of IPAB. There are concerns that rural critical access hospitals and health care providers are going to be disproportionately impacted by IPAB's cuts. Given the high proportion of critical access hospitals in rural states, along with high physician shortages in rural communities across this country, subjecting rural providers to additional cuts will undermine access to care in these areas. What is being done by the Administration on this issue?

Answer: Congress directed IPAB to include recommendations that, to the extent feasible, both "protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas." Given such language and the broad and important role that critical access hospitals (CAHs) play in serving seniors in rural areas, we believe that the IPAB's proposals will preserve access to care in rural and frontier areas, including CAHs. Moreover, the Administration is taking action to protect the rural safety net, including a number of grant programs and initiatives through the Health Resources and Services Administration (HRSA).

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[1] See, e.g., Hanauer v. Reich, 82 F.3d 1304, 1307 (4th Cir. 1996) ("[E]ven when the statutory language bars judicial review, courts have recognized that an implicit and narrow exception to the bar on judicial review exists for claims that the agency exceeded the scope of its delegated authority or violated a clear statutory mandate."); Griffith v. Fed. Labor Relations Auth., 842 F.2d 487, 492 (D.C. Cir. 1988) ("Even where Congress is understood generally to have precluded review, the Supreme Court has found an implicit but narrow exception, closely paralleling the historic origins of judicial review for agency actions in excess of jurisdiction.").

One such program, the Medicare Rural Hospital Flexibility (Flex) Program, provides funding to state governments to work with CAHs in their States to spur quality and performance improvement activities, stabilize rural hospital finance, and integrate emergency medical services (EMS) into their health care systems. The Flex Program is also beginning a new special project, the Medicare Beneficiary Quality Improvement Project (MBQIP) focused on Medicare Beneficiary Health Status improvement at CAHs.

Two other valuable programs managed by the Office of Rural Health Policy are the Rural Health Services Outreach (Outreach) Grant Program and the State Office of Rural Health (SORH) Grant Program. These programs play important parts in protecting the rural safety net and working with CAHs and other rural providers. The Outreach Program promotes rural health care services outreach by expanding the delivery of health care services to include new and enhanced services in rural areas. CAHs are eligible to apply for this grant program. The SORH Grant Program creates a focal point within each State for rural health issues; strengthens Federal, State, and partnerships in rural health; and promotes recruitment and retention of a competent health care workforce for rural safety net providers.

CAHs are also eligible providers for the 340B Drug Pricing Program which is managed by the Office of Pharmacy Affairs (OPA) at HRSA. The 340B Program limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes and qualified hospitals. Participation in the program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers.

The Centers for Medicare & Medicaid Services (CMS) is also working to protect the rural safety net. The Medicare program finances over $60 billion in hospital, physician, and preventive care and other health services to nearly 9.5 million Americans residing in rural areas across the U.S. in 2009. The Affordable Care Act expanded and extended the Medicare Rural Community Hospital Demonstration to provide an estimated $52 million in enhanced reimbursement for inpatient services at 25 rural hospitals in several States. The Affordable Care Act also included important provisions to help rural hospitals, doctors and home health care providers. The law provided a 10 percent bonus payment for qualifying primary care providers in health professional shortage areas. Home health agencies serving Medicare beneficiaries in rural areas received a 3 percent increase in payments for five years in recognition of the challenges, including geographic distances, they face in delivering care. The Affordable Care Act also included a provision to redistribute unfilled medical residency positions, making hospitals with a rural training track a priority for obtaining new positions. The goal is to increase beneficiary access to physician services in rural areas, especially to physicians training in primary care. Finally, CMS streamlined the process hospitals and CAHs can use for credentialing and granting privileges to physicians and practitioners who deliver care through telemedicine. The goal is to reflect the most innovative approaches in delivering care to all patients, especially those in rural or remote parts of the country through telemedicine practices.

The Honorable Tim Murphy

1. Can the Secretary provide an overall savings estimate for the next 5-10 years for addressing Medicare fraud?

Answer: CMS actuaries conservatively project that for every new dollar spent by HHS to combat health care fraud about $1.50 is saved or averted. Based on these projections, the $581 million in Health Care Fraud and Abuse Control Program discretionary funding in the President's FY 2012 budget request, as part of a multi-year investment, is expected to yield Medicare and Medicaid savings of $4.6 billion over 5 years and $10.3 billion over ten years.

2. Hospitals reporting infections through the Centers for Disease Control database has been linked to saving 27,000 lives in the past ten years, the centers report. With new requirements that hospitals report infections rates, how much money will this save in healthcare costs over time?

Answer: Hospital-Acquired Conditions (HACs) consist of complications, including infections, that patients acquire while receiving care that is supposed to help them. The Centers for Disease Control and Prevention (CDC) has estimated that each year, almost 100,000 Americans die and millions suffer from hospital-acquired infections alone.[1] In addition to pain, suffering, and sometimes death, these HAC complications could add as much as $45 billion to hospital costs paid each year by taxpayers, insurers, and consumers.[2] The Department of Health & Human Services' Office of the Inspector General has reported that 44 percent of adverse events experienced by Medicare beneficiaries in the October 2008 sample month were preventable, and that these complications cost the Medicare program an extra $119 million in that one month alone.[3]

A variety of initiatives are being undertaken by the Department to address this very serious and harmful problem in our healthcare system with the goal of saving lives, preventing complications, and reducing associated healthcare costs. The Partnership for Patients is a public-private partnership that will help improve the quality and safety of health care for all Americans. The goals of this initiative are to reduce preventable injuries in hospitals, including healthcare-associated infections, by 40 percent and reduce readmissions by 20 percent. If successful, we believe that this initiative has the potential to reduce 1.8 million incidents of harm, save 60,000 lives, and prevent 1.6 million unnecessary readmissions to the hospital during the next 3 years, reducing costs by up to $10 billion in Medicare during this 3 year time period. This will require replicating on a large scale what has been done on a small scale in several exemplary facilities. With respect to infections, under the Medicare Inpatient Quality Reporting program, hospitals are beginning this year to report information on central line-associated bloodstream infections through the Centers for Disease Control's National Health Safety Network. This reporting will

[1] Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. March 2007. http://www.cdc.gov/ncidod/dhqp/pdf/hicpac/infections_deaths.pdf
[2] The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention, March 2009, http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.
[3] Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, November 2010, http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.

be expanded over the next two year, and hospitals will begin reporting on surgical site infections, catheter-associated urinary tract infections, MRSA, and C-Difficile.

In addition, to create incentives for hospitals to prevent such infections and other adverse conditions, the Affordable Care Act includes a Medicare payment reduction for hospitals in the top quartile of all hospitals with regards to selected hospital-acquired conditions (which include infections) under the inpatient prospective payment service system beginning in fiscal year 2015. Consistent with our commitment to transparency, information for consumers, and the Affordable Care Act, the Secretary will publicly report information regarding HACs of each affected hospital on the Hospital Compare website.

3. Is IPAB authorized to exact changes in Medicare that will permit reimbursement to doctors, nurses, specialists, etc who find savings performing coordinated care for patients?

Answer: IPAB's statutory direction is clear: to make recommendations to Congress that, to the extent feasible, will improve the quality of care Medicare beneficiaries receive while lowering the growth in program spending. Congress gave IPAB further direction to consider recommendations that, among other things, promote "care coordination, prevention and wellness." While we cannot offer advice on hypothetical cases, IPAB's recommendations could include ways to build upon the Administration's current efforts to enhance and incentivize care coordination for the most vulnerable Medicare beneficiaries.

4. I have a question about Medicare Part D and the donut hole, the percentage of seniors that never really need it. They never got to that level because they never needed that many prescriptions. Do you have information on what percentages of seniors that was or how many that was who, you know, spending for prescription drugs and never got there?

Answer: In 2010, about 14 million Part D enrollees who did not qualify for the low income subsidy had prescription drug spending that was below the "donut hole" or coverage gap. About 4 million non-low income subsidy beneficiaries hit the gap with spending above $2700, and qualified for the $250 rebate check.

In 2010, about 14 million Part D enrollees who did not qualify for the low income subsidy had spending that did not reach the coverage gap. About 4 million non-low income subsidy beneficiaries hit the gap and qualified for the $250 rebate check.

The Honorable Leonard Lance

Procedure for amending IPAB Proposals:
1. Section 3403(d) outlines the limitations on altering IPAB's recommendations. Congress is barred from making alterations that would exceed the savings targets set by the Chief Actuary of CMS without a three-fifths vote by the Senate. [subsection (d)(3)(D)] Additionally Congress is prohibited from making changes that would result in a net reduction in total Medicare program spending without a three-fifths vote by the Senate. [subsection (d)(4)(B)(v)] It is my opinion that these sections are unconstitutional and I would like to know if the general counsel at HHS had opined or offered guidance on those sections and their constitutionality.

Answer: Litigation involving this issue is pending in the United States District Court for the District of Arizona (Coons v. Geithner, Case No. CV-10-1714). The Administration's position, as reflected in pleadings filed in connection with this litigation, is that these sections of the Affordable Care Act are constitutionally sound. The legal arguments underlying this position are described in a Motion to Dismiss filed in this case by the Department of Justice on May 31, 2011. HHS would be pleased to provide you a copy of this Motion upon request.

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