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4 HEARING ON ``IPAB: THE CONTROVERSIAL CONSEQUENCES FOR  
5 MEDICARE AND SENIORS''  
6 WEDNESDAY, JULY 13, 2011  
7 House of Representatives,  
8 Subcommittee on Health  
9 Committee on Energy and Commerce  
10 Washington, D.C.

11 The Subcommittee met, pursuant to call, at 9:03 a.m.  
12 a.m., in Room 2123 of the Rayburn House Office Building, Hon.  
13 Joseph Pitts [Chairman of the Subcommittee] presiding.

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

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

|  
35           Mr. {Pitts.} Everyone, please take their seats. The  
36 subcommittee will come to order. The chair recognizes  
37 himself for 5 minutes for an opening statement.

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

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

57           One of the most worrisome provisions in PPACA and a

58 provision that highlights the administration's fundamental  
59 approach to health reform is the creation of the Independent  
60 Payment Advisory Board or IPAB. The IPAB embodies what is  
61 objectionable in the President's healthcare system overhaul  
62 and how the administration's approach to health reform is  
63 fundamentally different from the Republican reform proposal.  
64 President Obama's health reform legislation was pushed  
65 through Congress without meaningful bipartisan debate. In  
66 like fashion, the recommendations of IPAB will be pushed  
67 through Congress with very little time for discussion or for  
68 the development of realistic alternatives to these  
69 recommendations that will then become law.

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

77         However, we need be clear about one thing: this isn't  
78 about ``death panels.'' The intent of creating IPAB was not  
79 to kill seniors. But Democrats do believe that the best way  
80 to cut Medicare costs is to give an unaccountable board the  
81 power to limit treatment options. We disagree. We believe

82 the solution to fighting costs is to give patients more  
83 power, more control, and more choices. Why should anyone--  
84 especially a government-appointed expert--second-guess  
85 patients and doctors?

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

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

102 I want to thank the witnesses for agreeing to  
103 participate in this important hearing. I look forward to  
104 hearing their testimony. And at this point, the chair  
105 recognizes the ranking member of the subcommittee, Mr.

106 Pallone, for 5 minutes for his opening statement.

107 [The prepared statement of Mr. Pitts follows:]

108 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
109 Mr. {Pallone.} Thank you, Mr. Chairman. And thank you  
110 for holding this very important hearing.

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

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

130 Now, it is becoming increasingly clear that the  
131 Republicans will use IPAB as just another way to oppose and

132 deface the Affordable Care Act. But this issue, from my  
133 perspective, should be the furthest thing from partisan. It  
134 is an issue that I believe all legislators from all political  
135 backgrounds should take concern. It is about the legislative  
136 and executive branches. This is about congressional  
137 prerogatives being limited. We should absolutely not, under  
138 any circumstances, seed legislative power to the executive  
139 branch. This is simply not what our founding fathers wanted  
140 or intended.

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

154 Unfortunately, the debate of IPAB reminds me of the Base  
155 Realignment and Closure or BRAC process. IPAB is just

156 another BRAC, only the healthcare version. In fact, during  
157 discussion over the Affordable Care Act, it was mentioned by  
158 the administration and others that they were using BRAC as an  
159 example. I strongly believe that BRAC is a monumental  
160 failure. I voted against every BRAC in my 23 years in  
161 Congress. I have seen them run up costs and waste money.  
162 And the worst part is as an elected official who was sent to  
163 Congress by my constituents to represent their best  
164 interests, then I become powerless to stop things like BRAC.  
165 I certainly tried. I fought the closure of Fort Monmouth,  
166 New Jersey, with everything that I had in more ways than I  
167 can count, but it wasn't enough. Because like IPAB, the BRAC  
168 took away all legislative authority and prerogative, and to  
169 this day I fight to minimize its effects on my constituents.

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

180 the knowhow to make the tough choices that are still needed  
181 to improve our healthcare system.

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

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

194         I yield back, Mr. Chairman.

195         [The prepared statement of Mr. Pallone follows:]

196 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
197           Mr. {Pitts.} The chair thanks the gentleman. I now  
198 recognize the vice chair of the subcommittee, Dr. Burgess,  
199 for 5 minutes for opening statement.

200           Dr. {Burgess.} I thank the chairman for the  
201 recognition. I want to welcome our Senator from Texas,  
202 Senator Cornyn, and my fellow OB/GYN doctor, Dr. Roe, welcome  
203 them to committee and being here today.

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

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

218           The board exponentially and inappropriately expands the  
219 power of the executive branch, giving an unaccountable panel

220 of 15 individuals the authority to make changes to the  
221 Medicare program. It takes the authority away from Congress.  
222 Congress has no say in the board's reports, yet their  
223 recommendations essentially hold the power of legislation.

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

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

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

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

244 [The prepared statement of Dr. Burgess follows:]

245 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
246 Dr. {Gingrey.} Mr. Chairman, thank you. And I thank  
247 the gentleman for yielding.

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

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

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

269 Cassidy.

270 [The prepared statement of Dr. Gingrey follows:]

271 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
272 Dr. {Cassidy.} Thank you for yielding.

273 I am a doctor who, for the last 20 years, has worked in  
274 a hospital for the uninsured. And one of the reasons I ran  
275 for office is that well-meaning politicians would have well-  
276 sounding laws which would make the lines grow longer at my  
277 hospital for the uninsured. I have to say, with ObamaCare,  
278 it is like déjà vu all over again. Medicare is going  
279 bankrupt. Anticipating this, ObamaCare has a provision of 15  
280 appointed bureaucrats who have the ability to almost in an  
281 unfettered fashion decrease payment. Now, we say--  
282 Republicans, some Democrats--that this can decrease access.  
283 Defenders say oh, no, decreasing payment is not rationing. I  
284 ask those defenders to join me at my hospital for the  
285 uninsured and I will show you the reality.

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

294 Thank you. I yield back.

295 [The prepared statement of Dr. Cassidy follows:]

296 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
297           Mr. {Pitts.} The chair thanks the gentleman and now  
298 recognizes the ranking member of the full committee, Mr.  
299 Waxman, for 5 minutes for opening statement.

300           Mr. {Waxman.} Thank you very much, Mr. Chairman.

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

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

317           This is an exercise in hypocrisy because of the utter  
318 fallacy of the pious arguments made on the issue of Medicare  
319 and costs. I have been around long enough to remember when

320 doctors said we didn't need any government program. We take  
321 care of poor people because that is our obligation. And now  
322 we are told we can't find a doctor because they are not paid  
323 enough. They don't feel it is their obligation to take care  
324 of the poor unless they are paid adequately. I understand  
325 that, but let us skip the piety about it.

326         The main Republican attack on the Affordable Care Act is  
327 that we cannot afford it. Too much coverage, not enough cost  
328 reduction they say. They ignore the CBO's estimates. They  
329 ignore the testimony from hundreds of economists and doctors  
330 and experts of all stripes. Republicans just assert it  
331 doesn't control costs. And then they attack the new law for  
332 comprehensive approach it takes to controlling costs. And  
333 they do it the old-fashioned way, though fear.

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

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

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

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

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

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

386           I yield back.

387           [The prepared statement of Mr. Waxman follows:]

388           \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
389           Mr. {Pitts.} The chair thanks the gentleman. That  
390 concludes the opening statements for the members.

391           I want to thank the witnesses for agreeing to appear  
392 before the committee today. We have four panels today and  
393 your written testimony will be entered into the official  
394 record. We ask that you summarize your opening statements in  
395 5 minutes.

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

404           Congressman Miller, you may begin.

|  
405 ^STATEMENTS OF HON. GEORGE MILLER, A REPRESENTATIVE IN  
406 CONGRESS FROM THE STATE OF CALIFORNIA; HON. JOHN CORNYN, A  
407 UNITED STATES SENATOR FROM THE STATE OF TEXAS; HON. PHIL ROE,  
408 A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE; AND  
409 HON. ALLYSON Y. SCHWARTZ, A REPRESENTATIVE IN CONGRESS FROM  
410 THE STATE OF PENNSYLVANIA

|  
411 ^STATEMENT OF HON. GEORGE MILLER

412 } Mr. {Miller.} Thank you very much, Mr. Chairman and  
413 Ranking Member Pallone, for the opportunity to testify before  
414 the committee today.

415 I came to Congress in 1975, and since that time, I have  
416 been involved in the debate over national health reform  
417 proposals. Throughout these debates, lawmakers struggled  
418 with how to control costs without harming care.

419 Unfortunately, Congress chose to kick the can down the road  
420 for a very long time. Without action, healthcare costs have  
421 continued their endless rise, well in excess of inflation.  
422 As everyone here well knows, these costs have grown to  
423 unsustainable levels for families, for businesses, and for  
424 taxpayers.

425 In the past decade, healthcare spending has increased an

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

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

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

450 into a voucher program. If Congress begins to roll back  
451 these reforms, then we will not see the efficiencies, we will  
452 not see the innovations that experts agree will stabilize our  
453 healthcare system.

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

469 With these reasons, many experts have recommended the  
470 creation of an independent board of health experts to make  
471 the system improvement recommendations. And, as you know,  
472 Congress has often used independent boards to help with  
473 complex issues, such as MedPAC or the BRAC, which BRAC--

474 Frank, I love you--but the fact is those bases would have  
475 never been closed and we would have been lugging the cost  
476 around for generations.

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

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

495         Under the law, the Independent Payment Advisory Board  
496 guarantees the doctor-patient relationship. Doctors will  
497 retain full authority to recommend the treatments that they

498 think are best for their patients. The law prohibits the  
499 recommendations that would ration care, change premiums, or  
500 reduce Medicare benefits.

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

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

520 Without these innovations, our current system is  
521 unsustainable for the Nation's families, the Nation's

522 businesses, and the Nation's taxpayers, and I strongly  
523 support IPAB and would oppose any effort by Congress to  
524 undermine it.

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

526           [The prepared statement of Mr. Miller follows:]

527           \*\*\*\*\* INSERT 1 \*\*\*\*\*

|

528 Mr. {Pitts.} The chair thanks the gentleman.

529 Senator Cornyn, you may begin your testimony.

|  
530 ^STATEMENT OF HON. JOHN CORNYN

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

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

546 The Medicare trustees have now issued a Medicare warning  
547 every year since 2006 in which they have alerted Congress  
548 that more than 45 percent of Medicare's funding will come  
549 from general revenues. The nonpartisan Congressional Budget  
550 Office issued a warning of its own in June in its 2011 long-  
551 term budget outlook. CBO projects that if currently law

552 remains in place, spending on the major mandatory healthcare  
553 programs alone will account for approximately 6 percent of  
554 gross domestic product today to 9 percent in 2035 and would  
555 continue to increase thereafter.

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

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

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

576 Medicare providers will prevent access to care for Medicare  
577 beneficiaries.

578         Secondly, I am concerned that IPAB's enormous power will  
579 grow at the expense of Congress and the people's elected  
580 representatives. In fact--as you probably know and no doubt  
581 do know--there is litigation challenging this delegation of  
582 legislative authority to this unelected body currently  
583 pending. Why Congress would voluntarily undermine its own  
584 authority in this area is really beyond me. We are the ones  
585 who are elected, we are the ones who are accountable to the  
586 votes, and we are the ones who should be making those  
587 decisions.

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

597         My concerns should be familiar to many of you because  
598 these are the same concerns I am hearing from you and from my  
599 constituents, which I suspect you are hearing from your

600 constituents as well. Scott and White Healthcare in Temple,  
601 Texas, recently wrote me in support of the bill on the Senate  
602 side that I am sponsoring for repealing IPAB. They write,  
603 ``Scott and White Healthcare is supportive of initiatives to  
604 identify fraud and waste in the healthcare system and  
605 incentivized high-value healthcare in this country. But we  
606 have concerns and questions about the process that will be  
607 used by IPAB to implement cost savings in Medicare.''

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

620         I want to thank the chairman and the ranking member and  
621 this committee for being skeptical of the IPAB from the  
622 beginning and for supporting repeal now. Of course, this is  
623 not a partisan issue. This is not part of an effort to

624 repeal the healthcare bill. This is a narrowly-targeted  
625 piece of legislation designed to deal with this particular  
626 provision, which I think deserves and does have bipartisan  
627 support.

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

637         As we repeal the IPAB, we have got to look at a better  
638 way to achieve our bipartisan goal of controlling healthcare  
639 costs in the Medicare program. One model I believe that has  
640 worked pretty darn well is the Medicare Prescription Drug  
641 program, which has come in under budget by about 40 percent  
642 by providing transparency, competition, more quality and  
643 service, which has used market forces to discipline costs.  
644 The Prescription Drug Program has achieved these results, as  
645 I say, by injection competition and choice into the system.  
646 Many other programs at the state level and the private sector  
647 have also cut costs without sacrificing quality or access to

648 care, goals that we all share. And Congress should continue  
649 to take a look at those as well.

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

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

657 [The prepared statement of Mr. Cornyn follows:]

658 \*\*\*\*\* INSERT 2 \*\*\*\*\*

|  
659 Mr. {Pitts.} The chair thanks the gentleman and now--

660 Dr. {Burgess.} Mr. Chairman, can I ask unanimous  
661 consent that the letters that Senator Cornyn referenced from  
662 Scott and White Clinic and New Jersey Medical Association be  
663 made part of the record here today.

664 Mr. {Pitts.} Okay. Could we see those and then we will  
665 elect on that if you have copies.

666 Mr. {Cornyn.} Absolutely.

667 Mr. {Pitts.} Thank you.

668 Congressman Roe, you are recognized for 5 minutes.

|  
669 ^STATEMENT OF HON. PHIL ROE

670 } Dr. {Roe.} I thank Chairman Pitts and Ranking Member  
671 Pallone and members of the subcommittee. Thank you for  
672 inviting me here to testify today. And I applaud this  
673 subcommittee's effort to shine a light on the danger posed to  
674 seniors by the Independent Payment Advisory Board, better  
675 known as IPAB.

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

684 Created as part of the Accountable [sic] Care Act that  
685 went into effect last year, the IPAB is charged with  
686 developing proposals to reduce the per-capita rate of growth  
687 in Medicare spending. Certainly, something has got to be  
688 done to ensure that this important program remains available  
689 not only for current retirees but for the next generation as  
690 well. The Medicare trustees recently projected that the

691 Medicare Trust Fund will go bankrupt in 2024, and it has been  
692 stated that the Congressional Budget Office says that the  
693 fund will exhaust even sooner in 2020. We already know what  
694 President Obama's plan to save Medicare is, is the \$500  
695 billion in cuts to the program and the IPAB. The cuts speak  
696 for themselves, but the American people deserve to hear the  
697 truth about the IPAB as little more than a roadmap to  
698 potentially rationing care.

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

711         The IPAB could adversely impact the quality of patient  
712 care. For example, look no further than Britain's National  
713 Institute for Health and Clinical Excellence or NICE.  
714 Decisions are based on cost, not quality or outcomes for an

715 individual patient. Decisions regarding patient care  
716 shouldn't be made by a panel of 15 unelected bureaucrats who  
717 haven't examined the specifics of an individual's unique  
718 case. Medicine is not a one-size-fits-all discipline. What  
719 is effective for treating one patient may be harmful for  
720 another. By centralizing medical care decision-making, the  
721 IPAB would put a Washington bureaucrat squarely between  
722 patients and the care recommended by their doctor.

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

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

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

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

760           While it seems that there is little that our two parties  
761 can agree on in the current environment, both sides have  
762 acknowledged that the IPAB is a terrible idea. That is why

763 my bill to repeal IPAB--the Medical Care Decisions  
764 Accountability Act--has more than 160-plus bipartisan  
765 cosponsors with all but one physician in U.S. Congress has  
766 signed on. The American Medical Association has endorsed my  
767 legislation, as did a broad coalition of more than 270  
768 healthcare organizations. Even former Democratic leader Dick  
769 Gephardt called for the IPAB's repeal.

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

774 Let me finish with a couple of things. Ask yourself two  
775 things or two problems. Does this bill increase access and  
776 quality of care for seniors? And number two, how much  
777 oversight and power has Congress given up? And let me just  
778 give you a brief example. If you are a family practitioner  
779 and you are seeing Medicare patients and you want to continue  
780 to do that and let us say your practice grosses 300,000 this  
781 year, which is probably what a family practice would do.  
782 About 150,000 of that--50 percent if you run a very efficient  
783 practice--is overhead. If you cut the current SGR growth  
784 cuts are recommended to be about 30 percent the end of this  
785 year, that family practitioner is making a very comfortable  
786 living at \$150,000. His or her costs stay at 150,000, but

787 their income will be cut to 50. And how does that increase  
788 access? If this IPAB basically can do that, how does that  
789 help our seniors?

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

792 [The prepared statement of Dr. Roe follows:]

793 \*\*\*\*\* INSERT 3 \*\*\*\*\*

|  
794           Mr. {Pitts.} The chair thanks the gentleman and now  
795 recognizes Congresswoman Schwartz for 5 minutes for her  
796 opening statement.

|  
797 ^STATEMENT OF HON. ALLYSON Y. SCHWARTZ

798 } Ms. {Schwartz.} Thank you, Chairman Pitts and Ranking  
799 Member Pallone, Mr. Waxman, and members of the committee, for  
800 the opportunity to testify this morning.

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

816 CBO estimates that the law will reduce the deficit by  
817 more than \$1 trillion over the next 20 years. And that is  
818 just the beginning. Healthcare reform has the potential to

819 fundamentally transform the healthcare delivery and payment  
820 systems by creating a variety of models for improved delivery  
821 of care by incentivizing high quality, greater efficiency,  
822 and better outcomes. Successful implementation will ensure  
823 that seniors get the right care at the right time at a lower  
824 cost to taxpayers.

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

831         We all agree that the rate of growth in Medicare  
832 spending must be contained and that current Medicare payment  
833 systems are flawed and need to be reformed. But we cannot  
834 conceal fundamental flaws in our healthcare system by simply  
835 cutting reimbursements to hospitals and physicians or, even  
836 worse, ending Medicare as we know it, as the Republicans have  
837 proposed. The Republican plan to convert Medicare into a  
838 voucher program means that seniors will no longer have access  
839 to a guaranteed set of health benefits and, according to the  
840 CBO, the resulting premiums and co-insurance will increase  
841 out-of-pocket costs more than \$6,000 per senior per year and  
842 increase as healthcare costs rise. This is neither better

843 quality care nor genuine cost savings. It is merely shifting  
844 the burden of increased cost to seniors.

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

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

864 The Obama Administration is already implementing  
865 healthcare reforms to reduce the rate of growth in healthcare  
866 spending by holding providers accountable for reducing costs

867 through more coordinated care, the adoption of health  
868 information technology, improved quality, and better  
869 outcomes. Accountable Care Organizations, which create  
870 incentives for healthcare providers to work together to lower  
871 costs while meeting quality standards and putting patients  
872 first, could save up to \$750 billion over the next 10 years.

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

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

889         There are tough choices ahead as we work to contain the  
890 rate of growth in costs in healthcare. We should eliminate

891 IPAB, reject the Republicans' efforts to dismantle Medicare,  
892 and focus on reshaping payment and delivery systems to reward  
893 coordination, efficiency, and value to achieve these cost  
894 savings. And in so doing, we will meet our obligation both  
895 to seniors and to taxpayers.

896 And I thank you for the opportunity.

897 [The prepared statement of Ms. Schwartz follows:]

898 \*\*\*\*\* INSERT 4 \*\*\*\*\*

|  
899 Mr. {Pitts.} The chair thanks the gentlelady. The  
900 chair thanks the witnesses of our first panel, very  
901 informative. Appreciate the bipartisan nature of it. And we  
902 will dismiss the first panel at this time and call the--

903 Dr. {Burgess.} Mr. Chairman, did we rule on my  
904 unanimous consent request?

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

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

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

|  
921 ^STATEMENT OF KATHLEEN SEBELIUS, SECRETARY, U.S. DEPARTMENT  
922 OF HEALTH AND HUMAN SERVICES

923 } Secretary {Sebelius.} Well, thank you, Chairman Pitts  
924 and Ranking Member Pallone and members of the committee. I  
925 appreciate the opportunity to come today to discuss how the  
926 Affordable Care Act is strengthening Medicare for seniors  
927 today and tomorrow.

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

934 When Medicare became law in 1965, it served as a  
935 national promise that seniors wouldn't go broke because of a  
936 hospital bill. In 2006, Medicare added coverage for  
937 prescription drugs, which make up a growing share of  
938 beneficiaries' healthcare costs. But we know that too many  
939 seniors still struggle to afford their medications, and that  
940 is why the Affordable Care Act moved to assist the seniors  
941 falling into the donut hole with a one-time \$250 check in  
942 2010 and this year starts a 50 percent discount for the

943 approximately 4 million beneficiaries who now will get some  
944 assistance with the purchase of brand-name drugs. By 2020,  
945 that gap will be closed completely.

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

956 The law is also helping to improve the quality and  
957 safety of care for people with Medicare. We know that there  
958 are model hospitals across the country that have adopted best  
959 practices to dramatically increase the quality of care. In  
960 fact, for almost every major common medical error, we have  
961 examples of health systems that have significantly reduced or  
962 even eliminated them altogether. There is no reason why all  
963 Medicare beneficiaries shouldn't enjoy that same high quality  
964 of care wherever they receive it. And that is why the  
965 Affordable Care Act provides unprecedented support to help  
966 those best practices spread.

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

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

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

987           Together, these reforms are beginning to dramatically  
988 strengthen Medicare today for seniors and Americans with  
989 disabilities. We also have the responsibility to preserve  
990 the promise of Medicare for future generations, and we can't

991 do that if costs continue to rise unchecked. Because doing  
992 care the right way often costs less than doing it the wrong  
993 way, many of the laws reforms to improve care also reduce  
994 Medicare costs. For example, the Partnership for Patients  
995 alone is estimated to save Medicare as much as \$50 billion  
996 over the next 10 years by reducing errors and unnecessary  
997 care.

998         But the law doesn't stop there. It contains important  
999 new tools to stamp out waste, fraud, and abuse. And in  
1000 fiscal year 2010, as we are beginning to build this new  
1001 system, our anti-fraud efforts returned a record \$4 billion  
1002 to taxpayers. And the new tools will help us build on that  
1003 progress. The Medicare trustees estimate that these reforms  
1004 in the Affordable Care Act have already extended the solvency  
1005 of the trust fund until 2024. Without the reforms, the trust  
1006 fund would have been insolvent 5 years from now.

1007         But when it comes to Medicare's future, we can't take  
1008 any chances, and that is why the law also creates the  
1009 Independent Payment Advisory Board, or IPAB, a backstop, a  
1010 failsafe to ensure Medicare remains solvent for years to  
1011 come. IPAB is comprised of 15 health experts, including  
1012 doctors, other healthcare professionals, employers,  
1013 economists, and consumer representatives. The Affordable  
1014 Care Act provides for consultation between the President and

1015 congressional leadership on appointing members of the board,  
1016 and appointments are subject to the advice and consent of the  
1017 Senate.

1018         Each year, the board recommends improvements to  
1019 Medicare. The recommendations must improve care and help  
1020 controls costs. For example, the board can recommend  
1021 additional ways for Medicare to reduce medical errors and  
1022 crack down on waste and fraud. And contrary to what some  
1023 have said, IPAB by law is not allowed to ration care or shift  
1024 costs to beneficiaries. In fact, it is specifically  
1025 forbidden from making any recommendations that would ration  
1026 care, reduce benefits, raise premiums or cost-sharing, or  
1027 alter eligibility for Medicare. It leaves all final  
1028 decisions in the hands of Congress.

1029         If Medicare spending begins to threaten the program's  
1030 future, IPAB is charged with making recommendations to  
1031 Congress to create necessary savings without shifting the  
1032 cost of care to seniors and those with disabilities. But  
1033 then it is up to Congress to decide whether to accept those  
1034 recommendations or come up with recommendations of its own to  
1035 put Medicare on a stable, sustainable path. In other words,  
1036 IPAB's recommendations are only implemented when excessive  
1037 spending growth is not addressed and no actions are being  
1038 taken to put spending in line.

1039           The nonpartisan Congressional Budget Office and the  
1040 independent Medicare Actuary both predict that IPAB is  
1041 unnecessary anytime soon--indeed in the next decade--thanks  
1042 to the work that we are already doing to slow rising costs.  
1043 But we don't know about the future, which why experts across  
1044 the country, including independent economists and the CBO  
1045 believe that IPAB is needed as a safeguard. And we agree.  
1046 We believe the best way to strengthen Medicare for today and  
1047 tomorrow is to fill the gaps in coverage, crack down on waste  
1048 and fraud, and bring down costs by improving care, changing  
1049 the underlying delivery system. And that is what we are  
1050 working to do under the healthcare law.

1051           Over the last 16 months, our department has focused on  
1052 working with Congress and our partners across the country to  
1053 implement the law quickly and effectively, and in the coming  
1054 months, I look forward to working with all of you to continue  
1055 those efforts.

1056           Thank you again, Mr. Chairman, and I would be pleased to  
1057 take your questions.

1058           [The prepared statement of Ms. Sebelius follows:]

1059 \*\*\*\*\* INSERT 5 \*\*\*\*\*

|  
1060           Mr. {Pitts.} The chair thanks the secretary for your  
1061 opening statements. I will now begin the questioning and  
1062 recognize myself for 5 minutes for that purpose.

1063           And I have a couple of questions I would like to ask you  
1064 to respond yes or no. I am very concerned about IPAB. And  
1065 assuming the cap is reached, suppose we reach a situation  
1066 where IPAB then kicks in, I would like to walk through a  
1067 couple of potential scenarios.

1068           Is it possible for IPAB to cut provider payments for  
1069 dialysis, yes or no, if we reach that situation?

1070           Secretary {Sebelius.} Mr. Chairman, I have had this  
1071 directed by law to take into account any cut in provider  
1072 services before they make recommendations.

1073           Mr. {Pitts.} But the answer is yes, they may cut  
1074 provider payments for dialysis?

1075           Secretary {Sebelius.} They don't make any cuts  
1076 whatsoever. They make recommendations to Congress.

1077           Mr. {Pitts.} For cuts in dialysis. So if they make a  
1078 recommendation for cuts for payments for dialysis, if those  
1079 occurred, would at least some providers no longer be able to  
1080 provide dialysis services? Yes or no?

1081           Secretary {Sebelius.} Mr. Chairman, I have no idea what  
1082 the scenario is, what the recommendations are, and what

1083 Congress would do with those recommendations, but I assume  
1084 that we would have that information if we had a real example.

1085 Mr. {Pitts.} If the recommendations took place, would  
1086 some--

1087 Secretary {Sebelius.} What are the recommendations,  
1088 sir, and what is the payment cut and what is the rate at  
1089 which providers would be repaid and what scenario and over  
1090 what kind of period of time? I have no idea.

1091 Mr. {Pitts.} Is it possible that some providers could  
1092 be cut?

1093 Secretary {Sebelius.} By?

1094 Mr. {Pitts.} If those recommendations took place.

1095 Secretary {Sebelius.} If Congress accepted the  
1096 recommendations and made a decision that cuts in dialysis  
1097 were appropriate, I assume that there could be some providers  
1098 who would decide that that would not be a service they would  
1099 any longer delivery, the same way they do with insurance  
1100 coverage each and every day that providers make  
1101 determinations whether it be part of the network.

1102 Mr. {Pitts.} If that occurred, would fewer providers,  
1103 as you have suggested could occur, mean that some seniors  
1104 would have to wait longer for dialysis? Yes or no?

1105 Secretary {Sebelius.} Mr. Chairman, as you know, any  
1106 cut in services, certainly cost-shifting to beneficiaries

1107 could mean huge reductions in care that seniors would have  
1108 the opportunity to receive. What we have right now is  
1109 guaranteed benefits. What I think the House Republican plan  
1110 would do is shift that to a guaranteed contribution, which  
1111 would dramatically change the ability of seniors to access  
1112 care.

1113 Mr. {Pitts.} In this case we are talking about the law,  
1114 not a proposal in the Republican budget. IPAB is commanded  
1115 to save money by cutting reimbursements. They will have to  
1116 make the decisions about which services are more or less  
1117 critical, what patients can wait longer. Is that not  
1118 rationing?

1119 Secretary {Sebelius.} Mr. Chairman, IPAB is not  
1120 directed to make recommendations based on cuts in  
1121 reimbursements. It is directed to make recommendations based  
1122 on ways to reduce costs overall if, indeed, the Medicare  
1123 spending targets per capital exceed what the actuary hits as  
1124 a target goal. I think that there are a variety of areas,  
1125 and one is the work we are currently doing in the Partnership  
1126 for Patients where you actually go after costs that are  
1127 unnecessary and being paid right now in the system, \$50  
1128 billion worth of costs for care that should have never been  
1129 realized in the first place. Those are the kinds of  
1130 recommendations I think that are significant and could make a

1131 huge impact.

1132 Mr. {Pitts.} Let me ask you about, again, the statute.  
1133 Where in the statute is there prohibition on IPAB making  
1134 recommendations that could reduce access to breast cancer  
1135 treatment, say, mammograms?

1136 Secretary {Sebelius.} Well, IPAB is forbidden by law to  
1137 make recommendations that would ration care and I would say  
1138 any kind of prohibition on accessing treatment would be  
1139 rationing care.

1140 Mr. {Pitts.} Are there any provisions in the law that  
1141 explicitly state IPAB cannot reduce access to the treatments  
1142 like that?

1143 Secretary {Sebelius.} They may not by law ration care.  
1144 And I think anyone would suggest that a reduction or an  
1145 elimination of a treatment is rationing care. That is  
1146 forbidden by law.

1147 Mr. {Pitts.} Suppose someone believes that IPAB has, in  
1148 fact, rationed care. What redress does that person have to  
1149 challenge the board's decisions?

1150 Secretary {Sebelius.} A court challenge.

1151 Mr. {Pitts.} Are the board's recommendations exempt  
1152 from judicial or administrative review?

1153 Secretary {Sebelius.} The judicial oversight that is  
1154 limited is really, I think, regarding my or any future

1155 Secretary of HHS implementation of recommendations when they  
1156 have followed the law. I don't think anyone--certainly our  
1157 general counsel feels very strongly that nothing in that  
1158 language is consistent with language that is currently in the  
1159 Medicare statutes as they move forward. Nothing would  
1160 certainly give either the IPAB board or a future Secretary of  
1161 HHS or the current Secretary of HHS any ability to violate  
1162 the law, and that would always be subject to judicial review.

1163 Mr. {Pitts.} The chair thanks the gentlelady and  
1164 recognizes the ranking member, Mr. Pallone, for 5 minutes for  
1165 questions.

1166 Mr. {Pallone.} Thank you, Mr. Chairman.

1167 Madam Secretary, while today's hearing is on IPAB and  
1168 its consequences to seniors, we have yet to hold a hearing in  
1169 this subcommittee on the Republican plan for Medicare, even  
1170 though I have asked for that many times. And as you recall,  
1171 the Republican budget ends the Medicare program. IPAB's  
1172 effects do not compare to the consequences for seniors of the  
1173 Republican budget. Over the next 10 years, the Republican  
1174 budget proposes to cut Medicare by \$32 billion. CBO believes  
1175 that IPAB will save about \$2 billion over that same time  
1176 period. So the Republican budget would cut 13 times as much  
1177 in the next decade, and that is even before they begin their  
1178 plan to end Medicare starting in 2022.

1179 I hear the Republicans accuse the Affordable Care Act of  
1180 rationing care. First, it was the death panels, then the  
1181 government takeover, and now it is IPAB. But the Republican  
1182 plan for Medicare is so destructive it would actually end  
1183 Medicare's guaranteed hospital benefit. It would actually  
1184 end Medicare's coverage for surgical care and for  
1185 chemotherapy, and coverage for all those services would be  
1186 entirely dependent on whether you could first convince the  
1187 plan to cover you and then on whether the plan includes  
1188 hospital services or chemotherapy in its benefit package.  
1189 And as you know, these kinds of problems are endemic in the  
1190 individual insurance market, and that is why we have so many  
1191 uninsured today and that is why we passed the Affordable Care  
1192 Act to guarantee a good benefit package and eliminate a lot  
1193 of the discrimination.

1194 I just wanted to ask you what do you think the  
1195 Republican budget plan would mean for beneficiaries who would  
1196 no longer have their Medicare benefits?

1197 Secretary {Sebelius.} Well, Congressman, I don't know  
1198 and I don't know that anyone knows all the details of what  
1199 the Republican plan is. What we do know is what is there in  
1200 terms of numbers, that the current plan of giving a senior or  
1201 someone with a disability an \$8,000 voucher beginning in 2022  
1202 and having that voucher purchase whatever coverage is

1203 available in the private market would shift costs to  
1204 beneficiaries. So beneficiaries would be paying for about 61  
1205 percent of their cost of care. Currently, they pay under 30  
1206 percent. Within 8 years they would pay closer to 70 percent  
1207 of the cost of care. In fact, an average senior who is  
1208 relying on Social Security would be paying about 60 percent  
1209 of that Social Security check in 2022 for healthcare. Right  
1210 now, it is about a quarter of the Social Security check. So  
1211 there would be a huge cost shift.

1212         It is unclear what the benefits actually would be  
1213 available and who makes that determination. I gather that  
1214 the Office of Personnel Management would negotiate some kind  
1215 of package, but what kind of a benefit package would be  
1216 mandated or not mandated is a little unclear at this point.  
1217 What we know is that without controlling the underlying costs  
1218 and continuing down this path, what the Republican plan does  
1219 is shift costs onto seniors, and frankly, insurance companies  
1220 are pretty adept at making decisions about what care is  
1221 granted and what care isn't granted, eliminating benefit  
1222 packages. And that is done in a day-in and day-out basis, as  
1223 well as determining what providers get paid, for what  
1224 services, over what kind of period of time.

1225         Mr. {Pallone.} Well, you know, the point I am trying to  
1226 make is the Republican cuts to Medicare in the future far

1227 outstrip anything proposed in the Affordable Care Act,  
1228 including IPAB, and we have to remember that Republicans  
1229 objected to all of the savings in the Affordable Care Act,  
1230 not just the IPAB. And despite that, their budget, amazingly  
1231 enough, proposed to incorporate 96 percent of the Affordable  
1232 Care Act savings, all of them essentially except for the  
1233 IPAB.

1234 I just wanted to ask you, as I mentioned before, you  
1235 know, we are talking a Republican budget that proposes to cut  
1236 Medicare by 32 billion. CBO says that IPAB will save about 2  
1237 billion over that same time period. So the Republican budget  
1238 cut is 13 times as much. I just wanted you to comment on  
1239 that or confirm that if you will.

1240 Secretary {Sebelius.} Well, again, Mr. Chairman, I  
1241 think there is no question that the Republican budget does  
1242 contemplate an end to Medicare as know it, an end to the  
1243 commitment that seniors will have benefits guaranteed once  
1244 they turn 65, be able to choose their own doctor, be able to  
1245 choose the health system that they find best treats their  
1246 situation, and reliably understand that they won't go  
1247 bankrupt because of care delivery. So that period would come  
1248 to an end and it would be a voucher system and a private  
1249 insurance market, which is a very different kind of care  
1250 delivery and a very different kind of commitment.

1251 Mr. {Pallone.} Thank you. Thank you, Mr. Chairman.

1252 Mr. {Pitts.} The chair thanks the gentleman and  
1253 recognizes the vice chairman of the subcommittee, Dr.  
1254 Burgess, for 5 minutes for questions.

1255 Dr. {Burgess.} Thank you, Mr. Chairman.

1256 Let me just continue on that for just a moment. You  
1257 said that the Ryan plan would define the end of Medicare as  
1258 we know it. Why does the IPAB not provide a similar  
1259 definition?

1260 Secretary {Sebelius.} Well, I think, Congressman, the  
1261 Independent Payment Advisory Board makes recommendations to  
1262 Congress. It is forbidden by law to do exactly what the  
1263 Republican budget plans do.

1264 Dr. {Burgess.} Let me ask you a question.

1265 Secretary {Sebelius.} They may not shift cost to  
1266 seniors. They may not change benefits--

1267 Dr. {Burgess.} Yeah, as we--

1268 Secretary {Sebelius.} --they may not--

1269 Dr. {Burgess.} --know from reading the law, it is very,  
1270 very difficult for people to appeal those decisions, and in  
1271 fact we won't even know because no one currently has standing  
1272 until there is actually implementation of the board, which  
1273 has not happened yet and care is denied and they take it  
1274 through the courts. But I think we are going to find it is

1275 very, very difficult to overturn a decision of this board.

1276 Can you tell us the difference between a voucher and  
1277 premium support?

1278 Secretary {Sebelius.} The difference between a voucher  
1279 and premium support?

1280 Dr. {Burgess.} Mr. Ryan's articulated aspirational  
1281 document in the Republican budget talked about premium  
1282 support, a concept actually introduced during the Clinton  
1283 Administration with the Commission to Save Medicare, the Bill  
1284 Frist Commission. On the other side, the talking point is  
1285 that he is going to give a voucher.

1286 Secretary {Sebelius.} A voucher is basically in, I  
1287 think, insurance terms a guaranteed contribution as opposed  
1288 to a guaranteed benefit.

1289 Dr. {Burgess.} Okay.

1290 Secretary {Sebelius.} Those are very different  
1291 concepts. On one hand, in the current Medicare program,  
1292 seniors and those with disabilities have guaranteed benefits.  
1293 That would switch if it becomes a voucher in the--

1294 Dr. {Burgess.} And then what would premium support look  
1295 like in that world?

1296 Secretary {Sebelius.} Pardon me?

1297 Dr. {Burgess.} What would premium support look like in  
1298 that world?

1299 Secretary {Sebelius.} I am not as familiar with that  
1300 term. I know what guaranteed contribution is. I know what a  
1301 voucher is. I don't--

1302 Dr. {Burgess.} So it is incorrect to use the terms  
1303 interchangeably as so often happens in this committee?  
1304 Premium support is a different phenomenon than a voucher?  
1305 Premium support would be a request for proposals going out to  
1306 insurance companies to provide the coverage, must as in  
1307 Medicare Part D, so you should have some familiarity with it.

1308 Secretary {Sebelius.} Well, if you are assuming,  
1309 Congressman, let me just ask if you are assuming that \$8,000  
1310 provides the total benefit--

1311 Dr. {Burgess.} No, I am asking the questions, Madam  
1312 Secretary. This is my brief time to be able to ask you  
1313 questions, so I have got to insist upon that.

1314 Now, the budget for the Independent Payment Advisory  
1315 Board begins October 1, correct, \$15 million?

1316 Secretary {Sebelius.} It is available, yes, sir.

1317 Dr. {Burgess.} Now, who has been nominated to that  
1318 board and is awaiting confirmation?

1319 Secretary {Sebelius.} No one.

1320 Dr. {Burgess.} And why is that?

1321 Secretary {Sebelius.} Well, I think, Congressman, the  
1322 board is not activated until 2014 and I know that the

1323 President is in discussion with a number of potential  
1324 nominees and I know he has consulted with various Members of  
1325 Congress, but it will be appointed and up and running at the  
1326 time--

1327 Dr. {Burgess.} So should we keep that \$15 million that  
1328 is due October 1 because you apparently don't need it to set  
1329 up the board because--

1330 Secretary {Sebelius.} We have no intention of using  
1331 money before there is a board up and running.

1332 Dr. {Burgess.} Well, who does the check go to?

1333 Secretary {Sebelius.} I don't think there is a check.  
1334 I think there is money available that we draw down.

1335 Dr. {Burgess.} Who cashes the check? Can we have that  
1336 money back? We are in a debt crisis. You may have heard.

1337 Secretary {Sebelius.} I understand. I can assure you  
1338 there will be no drawdown on the treasury of \$15 million  
1339 until there is a board and a functioning operation.

1340 Dr. {Burgess.} Now, on this board, are they available  
1341 to be a recess appointment by the President so that they  
1342 would not be subject to Senate confirmation like your head of  
1343 CMS is?

1344 Secretary {Sebelius.} I am not a lawyer. I can't  
1345 answer that question.

1346 Dr. {Burgess.} Well, the CRS report that is available

1347 on this indicates that there would be the availability of a  
1348 recess appointment. I count nine that wouldn't require input  
1349 from either the Speaker of the House or the minority leader  
1350 on the Senate's side. So nine would be a majority but in  
1351 fact you don't even need a numbers majority. You just need a  
1352 majority of those who have been appointed, is that correct?

1353 Secretary {Sebelius.} That is correct.

1354 Dr. {Burgess.} Let me ask you this. It looks like in  
1355 statute that you could not have a majority of the board made  
1356 up as physicians. Is that correct?

1357 Secretary {Sebelius.} My understanding is that the  
1358 prohibition is yes, that a majority could not be practicing  
1359 physicians.

1360 Dr. {Burgess.} Well, who can make up the majority? I  
1361 mean the definition of who can be the members is actually a  
1362 little bit vague. It is with people with national  
1363 recognition for their expertise in health finance. That is  
1364 an odd pool, but they can actually make up the majority?

1365 Secretary {Sebelius.} Well, I think, Congressman, the  
1366 characteristics--

1367 Dr. {Burgess.} So think tanks can be the majority of  
1368 this board.

1369 Secretary {Sebelius.} The characteristics of the board  
1370 members are modeled after the characteristics that were

1371 defined for the MedPAC board members, which have very similar  
1372 kinds of backgrounds and abilities but very significant  
1373 differences that there is a very strong conflict of interest  
1374 barrier for the IPAB where they could not be receiving  
1375 payment from the system and making recommendations at the  
1376 same time.

1377         Dr. {Burgess.} The man who would have been your  
1378 predecessor but he actually didn't get confirmed, Tom  
1379 Daschle, wrote a book called Critical. I don't recommend  
1380 anyone buy it, but he talks about this board. This board was  
1381 something that he extolled in this book to a great degree,  
1382 but it was actually patterned more after the Federal Employee  
1383 Health Benefits program, which is, in fact, employer-  
1384 sponsored insurance. Is it your vision that one day this  
1385 board can be spread to further than just the Medicare world  
1386 but could actually control the private health insurance  
1387 world, much as the Center for Consumer Information Insurance  
1388 Oversight now envisions controlling the private insurance  
1389 market as well?

1390         Secretary {Sebelius.} Again, Congressman, the board  
1391 doesn't control anything. They make recommendations to  
1392 Congress in the event that Congress has not acted to keep  
1393 Medicare solvent. That is a recommendation board. They  
1394 don't control the Medicare program. Congress is in the

1395 driver seat. They make recommendations and I think that  
1396 could be very helpful as look for ways to preserve  
1397 beneficiaries' right to health insurance and look for a  
1398 program to be solvent on into the future.

1399 Mr. {Pitts.} The chair thanks the gentleman and  
1400 recognizes the ranking member of the full committee, Mr.  
1401 Waxman, for 5 minutes.

1402 Mr. {Waxman.} Thank you, Mr. Chairman. Madam  
1403 Secretary, I am pleased to see you even if you don't see me.  
1404 Now you do.

1405 You have been pressed on whether this is a premium  
1406 support or a voucher. It is hard to distinguish it, but as I  
1407 understand, premium support would keep increasing the amount  
1408 of money that would be available for people to buy insurance,  
1409 like Part D Medicare so that the amount of money would keep  
1410 up with the costs. A voucher, as I understand being proposed  
1411 by the Republicans--although we haven't seen detail--is a  
1412 defined contribution with no increase no matter what the cost  
1413 increases may be in medical care.

1414 But I want to explore with you a different issue. We  
1415 are hearing a lot today about all the things that IPAB is  
1416 allegedly going to do to the Medicare program. I have also  
1417 heard you describe all the things IPAB can't do like denying  
1418 benefits and increasing costs for beneficiaries. I would

1419 like to know how the Republican plan for Medicare stacks up  
1420 against all of the things that IPAB can and cannot do. For  
1421 example, the Republican plan would end Medicare's guaranteed  
1422 benefits, the things like hospital stays and doctor visits.  
1423 They would replace it with a cash voucher. Can IPAB do that?

1424 Secretary {Sebelius.} No, they cannot.

1425 Mr. {Waxman.} The Republican plan would increase cost-  
1426 sharing for Medicare beneficiaries, more than doubling their  
1427 out-of-pocket costs for new enrollees. Can IPAB do that?

1428 Secretary {Sebelius.} Well, no, the IPAB board cannot  
1429 make recommendations that would do that kind of cost-  
1430 shifting.

1431 Mr. {Waxman.} The Republican plan proposes to increase  
1432 premiums and force people to negotiate their care with  
1433 private plans on their own. Can IPAB do that?

1434 Secretary {Sebelius.} There is no ability in the law, I  
1435 think, to make those kinds of recommendations that would  
1436 change the beneficiaries' benefits. No.

1437 Mr. {Waxman.} In fact, IPAB is prohibited from making  
1438 all of these changes that would be harmful to beneficiaries,  
1439 but the Republican plan enacts them all. Are you aware of  
1440 any proposals in the Republican plan that would save money by  
1441 reducing costs and not by shifting them to the beneficiaries?

1442 Secretary {Sebelius.} I have no seen any details of

1443 delivery system changes or cost reductions, no, sir.

1444 Mr. {Waxman.} Well, I think the right way to reform  
1445 Medicare is to make care more efficient the way we have  
1446 started to do under the Affordable Care Act. The wrong way  
1447 is to wash our hands of the problem putting all of the costs  
1448 onto the Medicare beneficiaries.

1449 Secretary Sebelius, at yesterday's hearing before the  
1450 House Budget Committee, there was a major topic of  
1451 conversation about the ability of Medicare patients to see  
1452 their doctors when they need to, and that is an important  
1453 issue for all of us to monitor. But the premise of many  
1454 Republican questions seems to be that Medicare patients are  
1455 unable to see their doctors today. This is similar to their  
1456 bizarre claim that it is better to be uninsured than to have  
1457 Medicaid. Are you aware of any information on whether  
1458 Medicare patients are more or less able than private patients  
1459 to see doctors of their choice?

1460 Secretary {Sebelius.} No, sir. In fact, about 98  
1461 percent of the physicians in this country are enrolled in  
1462 Medicare. I know that there are pockets in communities where  
1463 doctors are just overbooked, but that would apply to private  
1464 pay and Medicare patients.

1465 Mr. {Waxman.} Surveys from the Medicare Payment  
1466 Advisory Commission and numerous other independent surveys

1467 all confirm Medicare patients have access to care, at least  
1468 as good as the access private insurance patients enjoy, if  
1469 not better. That is for primary care and for specialists.  
1470 Now, certainly, we need to address the SGR if we are really  
1471 going to guarantee access in Medicare for the future, but  
1472 that problem exists whether we repeal IPAB or not.

1473         There is another problem with the Republican claims  
1474 about access problems under the Affordable Care Act Medicare  
1475 Savings. Republicans adopted all of those savings provisions  
1476 in their own plan. Until they end the program in 2022, the  
1477 Affordable Care Act is the Republican plan for Medicare  
1478 excluding IPAB. Do you know, Madam Secretary, how much of  
1479 the act's Medicare savings was from the IPAB? Well, I will  
1480 tell you because you may not know. It was 4 percent.

1481         Secretary {Sebelius.} Yeah.

1482         Mr. {Waxman.} Four percent. So the Republicans  
1483 embraced 96 percent of the act's cost savings in Medicare.  
1484 They pile on trillions in cuts over the next several decades  
1485 when they end the Medicare program, and they suggested  
1486 Affordable Care Act will cause access problems but that their  
1487 voucher plan won't. It doesn't add up and it doesn't make  
1488 sense.

1489         I want to ask you one last thing about--well, tell you  
1490 what, I would go over my time and I would like to give other

1491 members their opportunity to ask questions. Thank you for  
1492 being here. Thanks for responding to the questions.

1493 Mr. {Pitts.} The chair thanks the gentleman and  
1494 recognizes the gentleman from Georgia, Dr. Gingrey, for 5  
1495 minutes for questions.

1496 Dr. {Gingrey.} Mr. Chairman, thank you. Madam  
1497 Secretary, thank you for appearing.

1498 You know, we are here to talk about IPAB, Independent  
1499 Payment Advisory Board, not today at least to express our  
1500 outrage over ObamaCare in general, but it seems like the  
1501 discussion has expanded a bit, maybe on both sides of the  
1502 aisle. I must say I am a little bit surprised of the  
1503 questioning in regard to the difference in a voucher and  
1504 premium support. You seemed to struggle just a tad over  
1505 that. A voucher, as I understand it, is sending someone a  
1506 check on a monthly basis to spend on healthcare at their own  
1507 volition. They could basically, I guess, sign up for  
1508 holistic medicine. They could have an acifidity bag around  
1509 their neck.

1510 They could essentially do anything they wanted to with  
1511 that voucher whereas premium support in the plan for  
1512 prosperity, the Republican plan to reform and save Medicare  
1513 for our current seniors and our future generations is talking  
1514 about premium support where the Center for Medicare and

1515 Medicaid Services basically where the senior designates, they  
1516 want to purchase their health insurance, a plan that best  
1517 fits their needs, that premium is advanced to an insurance  
1518 company as payment for those services. It doesn't go  
1519 directly to the patient. So that is a big difference in a  
1520 voucher versus premium support. And I think we should  
1521 describe it accurately.

1522 IPAB, in its report to Congress, is charged under  
1523 ObamaCare with including ``recommendations that target  
1524 reductions in Medicare program spending to sources of excess  
1525 cost growth.'' Madam Secretary, can you tell us where in  
1526 ObamaCare the term ``excess cost growth'' is defined?

1527 Secretary {Sebelius.} Sir, I don't know if there is a  
1528 statutory definition. I do want to respond briefly to your  
1529 premium support issue because--

1530 Dr. {Gingrey.} We are beyond that and my time is  
1531 limited and I am just going to help you on this second  
1532 question. It is not defined. ``Excessive cost growth'' in  
1533 ObamaCare is not defined. Peter Orszag, in fact, President  
1534 Obama's former OMB director has defined the ``excessive cost  
1535 growth'' in Medicare as principally the result of new medical  
1536 technologies and services and their widespread use by the  
1537 U.S. health system. That is what Peter Orszag thinks in  
1538 regard to excessive cost.

1539           Let me ask you this question. The head of CMS, Dr.  
1540 Donald Berwick, interim head of CMS and it is likely that he  
1541 will remain interim, has been quoted as saying ``most people  
1542 who have serious pain do not need advanced methods. They  
1543 just need the morphine and counseling that have been  
1544 available for centuries.'' Madam Secretary, do you believe  
1545 that limiting advanced methods to sick seniors in favor of  
1546 morphine and counseling is an appropriate way to reduce  
1547 Medicare costs? Yes or no?

1548           Secretary {Sebelius.} Congressman, I believe that  
1549 seniors have a right to make choices with their doctors,  
1550 which is what they do now under the Guaranteed Benefit  
1551 program under the Medicare system. Under an insurance plan,  
1552 that would no longer exist and I would also suggest that  
1553 premium support typically means that there is an enhanced  
1554 benefit and as a result--

1555           Dr. {Gingrey.} Well, Madam Secretary, I agree with the  
1556 first part of your response. It should be between the doctor  
1557 and the patient and you don't get that with IPAB.

1558           Madam Secretary, I am aware that the statute states that  
1559 IPAB cannot propose plans that ration care. Can you tell me  
1560 where the word rationing is defined in the ObamaCare statute?

1561           Secretary {Sebelius.} It is not defined, sir.

1562           Dr. {Gingrey.} Well, you are absolutely correct on

1563 that. It is not defined.

1564           During questioning before the House Budget Committee  
1565 yesterday, you referred to IPAB as merely a safeguard and a  
1566 stopgap noting that it will only come into play if Congress  
1567 failed to reduce Medicare spending, in fact, wouldn't be  
1568 recommending any cuts until the 10 years. Yet on Wednesday,  
1569 April 13, President Obama in laying out his plan to reduce  
1570 healthcare spending to the American people stated that IPAB  
1571 was a major plank in his plan to make additional savings in  
1572 Medicare. Madam Secretary, if President Obama had stated  
1573 publicly that IPAB is a major plank of his plan to save  
1574 Medicare and you are saying that IPAB, it is just a backstop  
1575 to Congress coming up with a plan, should the American people  
1576 infer from that that ObamaCare is the President's grand plan  
1577 to save Medicare? Give me a yes or no or if you want to  
1578 expand a little bit and the chairman will allow, I would like  
1579 to hear your opinion on that.

1580           Secretary {Sebelius.} I don't think there is any  
1581 disagreement between the President and my statement. The way  
1582 that the Independent Payment Advisory Board is structured is  
1583 that recommendations are made on a yearly basis and  
1584 recommendations are only impactful if, indeed, Congress has  
1585 not taken the advice of the independent actuary that per  
1586 capita spending has exceeded a targeted goal. If, indeed,

1587 the IPAB recommendations are not ones that Congress chooses  
1588 to accept, they change the recommendations or move in a  
1589 different direction and the recommendations never have any  
1590 impact if, indeed, cost trends are below the independent  
1591 actuary's targeted goal.

1592 It is a backstop. It is a backstop for Congress taking  
1593 the responsibility to keep Medicare solvent into the future.  
1594 If, indeed, they don't act, there is a mechanism where these  
1595 recommendations become law absent Congress rejecting the  
1596 recommendation.

1597 Dr. {Gingrey.} Well, I have gone way over my time and I  
1598 will just close out by saying I agree with Mr. Pallone and  
1599 Ms. Schwartz that we ought to repeal IPAB. It is  
1600 wrongheaded. It is boneheaded. And I yield back.

1601 Mr. {Pitts.} The chair thanks the gentleman and  
1602 recognizes the gentlelady from California, Mrs. Capps, for 5  
1603 minutes.

1604 Mrs. {Capps.} Thank you, Mr. Chairman. And thank you,  
1605 Madam Secretary, for being here today.

1606 You know, I have been listening to this discussion. I  
1607 have met with advocates in the past few months on both sides  
1608 of the IPAB issue. The one thing they share is a concern for  
1609 the unknown. One common concern is that due to protections  
1610 for hospitals and other groups from IPAB changes before 2020,

1611 the only thing left would be to cut provider rates. Others  
1612 note that this is not true. We have heard the same kind of  
1613 discussion today. Can you please address this issue? What  
1614 could IPAB recommend other than provider payment cuts?

1615 Secretary {Sebelius.} Well, I can give you a few quick  
1616 examples of things that are on the table as we speak. For  
1617 years there was a recommendation out of MedPAC, who can only,  
1618 you know, make recommendations that we look at the  
1619 overpayment to Medicare Advantage plans. That was never  
1620 accepted by the United States Congress and yet when the  
1621 Affordable Care Act was put together, Congress decided that  
1622 that was an appropriate area to look at.

1623 Medicare Advantage, the private market strategy for  
1624 Medicare which was supposed to introduce competition and  
1625 choice and drive down costs now runs at about 113 percent of  
1626 the fee-for-service plan with no health benefits. So  
1627 Congress implemented the changes recommended by MedPAC for  
1628 years, and over the course of the next 10 years, the  
1629 Congressional Budget Office says about \$140 billion will be  
1630 saved. That is an example of the kind of strategy that has  
1631 been on the table. If it had been implemented years ago,  
1632 \$140 billion less would have been paid out over the last  
1633 decade.

1634 But an overpayment, no health benefits, seniors will

1635 still have choices. We have a very robust program. We have  
1636 begun to decrease the overpayment to Medicare Advantage  
1637 plans. But I think that is a strategy that is in the  
1638 Affordable Care Act. It is exactly the kind of strategy that  
1639 I think is anticipated by this independent board.

1640 Mrs. {Capps.} Thank you. Conversely, the Republican  
1641 majority has voted unanimously to essentially end the current  
1642 Medicare program. The not hypothetical but known result  
1643 would be a doubling in out-of-pocket costs for beneficiaries  
1644 who would get a limited-amount voucher to cover a fraction of  
1645 the cost of private insurance. It would leave our seniors  
1646 and persons with disabilities on their own to haggle with  
1647 insurance companies without any guarantee that there would be  
1648 any policies available to them, let alone that they would be  
1649 affordable.

1650 Madam Secretary, some talk about the Republican plan is  
1651 a way to cut cost but all I see is a huge cost shift placing  
1652 the financial burden on seniors with limited incomes without  
1653 any meaningful reforms in the plan to actually address the  
1654 overall costs of healthcare. As you have analyzed the Ryan  
1655 budget plan, are there any cost-containment strategies in it  
1656 to privatize Medicare? Does that privatizing include any  
1657 cost containment that you notice?

1658 Secretary {Sebelius.} Congresswoman, we have not been

1659 able to identify cost-containment strategies. And as I say,  
1660 the case in point, Medicare Advantage, which has been in  
1661 existence for years which was specifically put on the table  
1662 to introduce cost and competition, was anticipated to drive  
1663 down costs has done just the opposite. It is running at  
1664 about 113 percent and every Medicare beneficiary, all 49  
1665 million beneficiaries pay an extra \$3.66 per member per month  
1666 to pay for the additional supports for Medicare Advantage  
1667 program that will, again, be gradually over time decreased.  
1668 And I think thanks to the Affordable Care Act, that excess  
1669 payment will cease to exist.

1670 Mrs. {Capps.} I think all of us in Congress understand  
1671 the need to reign in healthcare spending. In fact, that is  
1672 what so many innovations in the Affordable Care Act are set  
1673 up to do just that. I just have a few seconds. You have a  
1674 few seconds. If you could talk about some of those aspects  
1675 of the law, you mentioned Medicare Advantage. What are some  
1676 of the other parts of the Affordable Care Act, particularly  
1677 as it relates to Medicare, opportunities for cost  
1678 containment?

1679 Secretary {Sebelius.} Well, I think, Congresswoman,  
1680 certainly through the Innovation Center, we are already  
1681 seeing some very exciting delivery system reform, which is  
1682 really the underlying healthcare delivery system. So the

1683 Partnership for Patients goals, which I think are very on  
1684 point, and not only impact Medicare but impact everyone that  
1685 goes in and out of the hospital, reducing hospital-acquired  
1686 infections, which kill 100,000 people in America every year,  
1687 cause hundreds of thousands of people to stay in the hospital  
1688 longer and put them in worse physical condition, but cost  
1689 billions of dollars, and reduce unnecessary readmissions  
1690 where one out of five Medicare patients cycles back to the  
1691 hospital within 30 days. Many of them have never seen a  
1692 healthcare provider.

1693 Those two initiatives, which already 2,000 hospitals and  
1694 countless other partners have signed up to participate in  
1695 will reduce Medicare spending by \$50 billion. Better  
1696 healthcare, lower cost.

1697 Mrs. {Capps.} Thank you very much. I yield back.

1698 Mr. {Pitts.} The chair thanks the gentlelady,  
1699 recognizes the gentleman from Ohio, Mr. Latta, for 5 minutes  
1700 for questions.

1701 Mr. {Latta.} Well, thank you very much, Mr. Chairman.  
1702 And Secretary, thank you very much for being with us today.  
1703 If I can just go back on the line of questioning that Dr.  
1704 Burgess had. Is there anything in the law that says how many  
1705 members have to be appointed before the board starts  
1706 functioning?

1707 Secretary {Sebelius.} Not to my knowledge, sir, but I  
1708 can--

1709 Mr. {Latta.} Well, the reason I ask that with 15  
1710 members could 3 members actually be appointed and start  
1711 functioning as a board? Because just looking at what the law  
1712 says here--

1713 Secretary {Sebelius.} I am sorry. I am really having a  
1714 very hard time hearing you.

1715 Mr. {Latta.} I can probably talk louder than this  
1716 microphone is picking this up.

1717 Secretary {Sebelius.} I can put my ear to the  
1718 microphone but that really doesn't help.

1719 Mr. {Latta.} That might help. This is the Energy and--  
1720 you know, this is the technology here, too.

1721 Secretary {Sebelius.} Sorry.

1722 Mr. {Latta.} But it says under the act it says  
1723 ``Quorum: a majority of the appointed members of the board  
1724 shall constitute a quorum for the transaction of business,  
1725 but a lesser number of members may hold hearings.'' But  
1726 again, I guess the question is if you have got only three  
1727 members appointed, can they start functioning as the board?  
1728 And then actually you could have fewer members of that three  
1729 actually start holding hearings. Is that possible?

1730 Secretary {Sebelius.} Well, I certainly think fewer

1731 than a quorum could start holding hearings and I would think  
1732 that that outreach function is critically important for any  
1733 board who is going to make recommendations. I would be happy  
1734 to get you the answer in writing.

1735 Mr. {Latta.} I appreciate that.

1736 Secretary {Sebelius.} I don't want to speak outside of  
1737 the--

1738 Mr. {Latta.} Yeah, I would appreciate that if you  
1739 could.

1740 And if I can just go to your testimony on page 12, you  
1741 said that the ``IPAB cannot make recommendations that ration  
1742 care, raise beneficiary premiums or cost-sharing, reduce  
1743 benefits, or change eligibility for Medicare. The IPAB  
1744 cannot eliminate benefits or decide what care Medicare  
1745 beneficiaries can receive. Given a long list of additional  
1746 considerations the statute imposes on the board, we expect  
1747 the board will focus on ways to find efficiencies in the  
1748 payment systems and align provider incentives to drive down  
1749 those costs without affecting our seniors' access to care and  
1750 treatment.'' Okay. So what we are saying is, then, they are  
1751 going to have pretty much the power of the purse. Would you  
1752 say that would be the recommendations that they would have in  
1753 this case and that they would have that power of the purse to  
1754 say if they are not making the recommendations as to what

1755 care that a person would be receiving but they are going to  
1756 be able to say how much money is going to be expended? Would  
1757 that be a correct statement?

1758 Secretary {Sebelius.} I think, Congressman, again, they  
1759 are recommendations that come to Congress. They are  
1760 triggered at a point where the independent actuary sets a per  
1761 capita spending target. Actions have not reached that  
1762 spending target so they will make recommendations about  
1763 appropriate ways to reach that within the bounds of the law.

1764 Mr. {Latta.} Okay. So going along those same lines,  
1765 though, again, if someone has the recommendations of the  
1766 power of the purse and they are saying well, we are going to  
1767 have to reduce that--you already mentioned a little earlier  
1768 in some other questions--how are we going to make up for  
1769 those doctors and hospitals if their payments are going down?  
1770 Wouldn't they, then, have to cut back on the patients they  
1771 see and the care that they provide?

1772 Secretary {Sebelius.} Well, again, I think,  
1773 Congressman, I tried to give with Congresswoman Capps an  
1774 example of the kind of strategy that can yield enormous cost  
1775 savings without jeopardizing care or jeopardizing the kind of  
1776 relationship between doctors and their patients. And that is  
1777 really what is envisioned. I think a fundamental tenet of  
1778 the current Medicare commitment to seniors and those with

1779 disabilities is the ability to choose one's own doctor, the  
1780 ability to choose one's own care system, and the knowledge  
1781 that you have benefits that are available to you. That  
1782 ceases to exist under the plan supported by the House  
1783 Republicans, and I think that IPAB serves as an ongoing  
1784 yearly group of experts who are not being paid by the system  
1785 to make recommendations to Congress who can act on those  
1786 recommendations or not.

1787       Mr. {Latta.} Because, again, I represent a rather large  
1788 area in the State of Ohio, a lot of rural areas that have a  
1789 lot of community hospitals. You know, they are all very,  
1790 very concerned about reimbursement. I have got a lot of my  
1791 doctors that are very concerned about reimbursement and so,  
1792 you know, as we are looking at this, they are reading this,  
1793 too, and, you know, as they read the testimony about, you  
1794 know, driving down costs and trying to, you know, for payment  
1795 systems align provider incentives, they are nervous about  
1796 their other payment.

1797       And Mr. Chairman, I see that my time has expired and I  
1798 yield back. Thank you.

1799       Mr. {Pitts.} The chair thanks the gentleman and yields  
1800 5 minutes to the ranking member emeritus, the gentleman from  
1801 Michigan, Mr. Dingell.

1802       Mr. {Dingell.} Mr. Chairman, I thank you for your

1803 courtesy. Welcome back to the committee, Madam Secretary.

1804 Secretary {Sebelius.} Thank you, sir.

1805 Mr. {Dingell.} Your father served here with  
1806 distinction. It is particular pleasure to see you here this  
1807 morning.

1808 Madam Secretary, do you believe that the emphasis on  
1809 annual recommendations will limit the board's focuses to  
1810 short-term fixes rather than lowering our Nation's healthcare  
1811 spending in long term? Yes or no?

1812 Secretary {Sebelius.} No.

1813 Mr. {Dingell.} Madam Secretary, under the Republican  
1814 plan, nothing will prevent private insurance companies from  
1815 rationing care. Is that right?

1816 Secretary {Sebelius.} I am sorry. Nothing--

1817 Mr. {Dingell.} Under the Republican plan, nothing would  
1818 prevent private insurance companies from rationing care, yes  
1819 or no?

1820 Secretary {Sebelius.} That is correct. There is no  
1821 prohibition.

1822 Mr. {Dingell.} All right. Now, IPAB is legally  
1823 prohibited in the legislation from making recommendations  
1824 that would ration healthcare, is that right?

1825 Secretary {Sebelius.} Yes, sir. There is a prohibition  
1826 for rationing care, shifting costs to beneficiaries,

1827 eliminating benefits.

1828 Mr. {Dingell.} Now, Madam Secretary, who is in charge?

1829 Under the Republican plan, the insurance companies, is that  
1830 right?

1831 Secretary {Sebelius.} If I understand it correctly,  
1832 yes, the voucher would be paid to an insurance company.

1833 Mr. {Dingell.} All right. The Republican plan also  
1834 ends Medicare as we know it and repeals the Affordable Care  
1835 Act giving free reign to the insurance companies to decide  
1836 what care you could get and when with no clear limits to  
1837 protect consumers or prevent insurance companies from taking  
1838 in exorbitant profits, is that right?

1839 Secretary {Sebelius.} Well, the various features,  
1840 including the medical loss ratio and consumer protections and  
1841 rate review would all be eliminated with the Affordable Care  
1842 Act and companies would then be in charge of seniors--

1843 Mr. {Dingell.} And under the Affordable Care Act the  
1844 individual and that individual's doctor would be in control  
1845 of matters and the President's plan maintains Medicare as we  
1846 know it. Is that right?

1847 Secretary {Sebelius.} Well, it is a--yes, a plan that  
1848 maintains the Medicare benefit package understanding we need  
1849 to look serious at outgoing costs.

1850 Mr. {Dingell.} And the plan remains a defined benefit

1851 plan. Is that right?

1852 Secretary {Sebelius.} That is correct.

1853 Mr. {Dingell.} Which, under the Republican plan, it is  
1854 not? It is a defined payment plan, is that right?

1855 Secretary {Sebelius.} Yes, sir.

1856 Mr. {Dingell.} All right. Now, the Republican plan  
1857 would eliminate Medicare's guaranteed benefits and limits on  
1858 cost-sharings and premiums, is that right, yes or no?

1859 Secretary {Sebelius.} Yes.

1860 Mr. {Dingell.} Instead, insurance companies could  
1861 determine which benefits seniors on Medicare would receive  
1862 and how much they would pay, is that right?

1863 Secretary {Sebelius.} I assume so, sir. I don't think  
1864 there is any written language about what the benefits would  
1865 look like.

1866 Mr. {Dingell.} Okay. IPAB is, under the President's  
1867 plan, the President--or rather IPAB is legally prohibited  
1868 from cutting premiums or increasing premiums and copayments.  
1869 Is that right?

1870 Secretary {Sebelius.} Yes. There cannot be cost-  
1871 shifting onto beneficiaries.

1872 Mr. {Dingell.} Now, under the Republican plan,  
1873 healthcare costs would rise which turns Medicare over to  
1874 private insurance that have higher administrative costs and

1875 profits, is that right?

1876 Secretary {Sebelius.} Yes, sir. Currently, the  
1877 Medicare program runs at under 2 percent administrative costs  
1878 and I think the most efficient private insurers are at about  
1879 12 to 15 percent.

1880 Mr. {Dingell.} Now, IPAB will make decisions based on  
1881 what is best for seniors and Medicare and not who spends the  
1882 most money in Washington, is that right?

1883 Secretary {Sebelius.} By law they are directed to  
1884 protect the beneficiaries as they make recommendations.

1885 Mr. {Dingell.} All right. Now, Madam Secretary, how  
1886 will you and the board insure that consumers' and patients'  
1887 views will be taken into consideration as the board drafts  
1888 its recommendations?

1889 Secretary {Sebelius.} Well, Congressman, I think that  
1890 there is no question that the President will look for members  
1891 of this board who are eager to not only participate in the  
1892 long-term solvency of Medicare but also pay close attention  
1893 to the protection of the beneficiary, which is part of the  
1894 fundamental direction--

1895 Mr. {Dingell.} We also hold public hearings on these  
1896 matters, right?

1897 Secretary {Sebelius.} Public hearings, I think the  
1898 appointment of people who don't have a conflict--

1899 Mr. {Dingell.} Well, Madam Secretary, is it your belief  
1900 that the board would benefit from soliciting public comment  
1901 prior to issuing its recommendations--

1902 Secretary {Sebelius.} Absolutely.

1903 Mr. {Dingell.} --in a manner similar to that specified  
1904 in the Administrative Procedures Act?

1905 Secretary {Sebelius.} Yes, sir.

1906 Mr. {Dingell.} I guess we could say that is a  
1907 commitment on the part of the department, is that right?

1908 Secretary {Sebelius.} Yes, very much so.

1909 Mr. {Dingell.} Madam Secretary, it is always a  
1910 privilege to see you.

1911 Thank you, Mr. Chairman, for your courtesy.

1912 Mr. {Pitts.} The chair thanks the gentleman and  
1913 recognizes the gentleman from Louisiana, Dr. Cassidy, for 5  
1914 minutes.

1915 Dr. {Cassidy.} Thank you for being here, Secretary  
1916 Sebelius. And if every now and then I cut you off, I am not  
1917 being rude, but it is so valuable to have you here I am just  
1918 trying to stay focused and I apologize at the outset.

1919 I will also say to my Democratic colleagues, Republicans  
1920 do retain the savings, yes, 96 percent of them but we put  
1921 them back into Medicare as opposed to spending them on  
1922 another entitlement, and I think that is the difference

1923 between the two of us.

1924 Secretary, I am a doctor who works in a hospital for the  
1925 uninsured but 20 to 50 percent of my patients have Medicaid.  
1926 So I think it is fair to stipulate that when public insurance  
1927 programs pay physicians below cost, then they really don't  
1928 have access. It may be access on paper but it is not access  
1929 in power. Now, that said, Richard Foster currently estimates  
1930 that under current law in 9 years, Medicare will pay  
1931 physicians below what they receive on average from Medicaid.  
1932 Now, is it fair to accept with the given stipulation that  
1933 that will hurt access of Medicare patients to their  
1934 physician?

1935 Secretary {Sebelius.} Well, I don't think there is any  
1936 question, Congressman, that underpayment of any kind of  
1937 provider certainly jeopardizes an adequate network, whether  
1938 it is a private insurer or a public payer.

1939 Dr. {Cassidy.} Now, if MedPAC already knowing that  
1940 under current law--under current law physician reimbursement  
1941 is cut by 21 percent in the near future, I am sure you will  
1942 agree that that would have disastrous effects upon a  
1943 patient's access.

1944 Secretary {Sebelius.} You mean failing to fix the SGR.

1945 Dr. {Cassidy.} And of course part of the savings of SGR  
1946 is into the trillion dollars of savings that the other side

1947 of the aisle claims for ObamaCare. So I will tell you as a  
1948 patient that sees Medicaid patients at a hospital for the  
1949 uninsured, when I read that this board has the limited  
1950 ability to cut but where they can cut is reimbursement to  
1951 providers, I actually see that what we are really doing is  
1952 effectively denying access. Now, I will also say that I have  
1953 learned that rarely do government institutions admit that  
1954 they are rationing. Rather, the queue gets longer. Would  
1955 you disagree with that or do you think I am wrong?

1956 Secretary {Sebelius.} Well, Congressman, I think that  
1957 there is no question that, again, I think the Republican  
1958 budget plan on Medicaid--

1959 Dr. {Cassidy.} Well, I am speaking about current law.  
1960 I am really--

1961 Secretary {Sebelius.} --since you raised Medicaid in  
1962 hospitals--

1963 Dr. {Cassidy.} --I see that you are pivoting here--

1964 Secretary {Sebelius.} --cutting \$770 billion--

1965 Dr. {Cassidy.} --again, when we speak of a board which  
1966 has limited ability to save money except by cutting payments  
1967 to providers--

1968 Secretary {Sebelius.} Well, that is not accurate, sir.

1969 Dr. {Cassidy.} Okay. So it can also do Medicare Part A  
1970 and it can also do pharmacy coverage for dual eligibles. But

1971 clearly, a significant portion of it is cutting payments to  
1972 providers. Now, again, under current law Medicare will be  
1973 paying providers less than Medicaid per Richard Foster as  
1974 well documented Medicaid patients have trouble gaining  
1975 access. So where do we part in our analysis?

1976 Secretary {Sebelius.} Well, again, I think that there  
1977 are lots of opportunities in the delivery system where we are  
1978 paying or overpaying for care that probably should never have  
1979 been--

1980 Dr. {Cassidy.} So if I may summarize, you are saying  
1981 that there will be savings that will keep this mechanism from  
1982 being--I gather--keep this mechanism, this IPAB, this denial-  
1983 of-care board from having to act. I will say parenthetically  
1984 that the New England Journal of Medicine article which I am  
1985 sure you are aware of shows that Accountable Care  
1986 organizations have not saved money under the more favorable  
1987 rules in which the pilot studies have been done.

1988 But going back to my point--

1989 Secretary {Sebelius.} Some of them did, some didn't.

1990 Dr. {Cassidy.} Three out of ten did, seven didn't. So  
1991 coming back to the current law--

1992 Secretary {Sebelius.} So we learn from them and go on.

1993 Dr. {Cassidy.} Coming back to current law because we  
1994 really can't say oh, don't worry. If this works out, this

1995 would never happen. Let us just assume that it does happen.  
1996 Again, if we decrease payment to providers and we know from  
1997 experience that that will decrease access, does that not  
1998 trouble you?

1999 Secretary {Sebelius.} It does, which is why I think  
2000 Congress carefully wrote also into the parameters for the  
2001 Independent Payment Advisory Board that at every step along  
2002 the way, provider access had to be part of their overall  
2003 recommendations.

2004 Dr. {Cassidy.} It has to be part of the overall--

2005 Secretary {Sebelius.} They make recommendations to  
2006 Congress.

2007 Dr. {Cassidy.} Clearly, Medicaid by law has to provide  
2008 access for pregnant women and pediatrics. By law they are  
2009 supposed to pay adequately to give that access. And yet  
2010 there is a recent New England Journal of Medicine study that  
2011 shows that those with Medicaid or CHIP actually are more  
2012 likely to be denied access to an appointment. In fact, 2/3  
2013 of the time they are denied such access. Doesn't that give  
2014 us pause that despite that law that they are guaranteed  
2015 access, for the privately insured it is only 11 percent that  
2016 you can't get an appointment? For the publicly insured it is  
2017 2/3. I mean do you not see a danger that this would be the  
2018 case with this IPAB board?

2019 Secretary {Sebelius.} Well, again, IPAB has no  
2020 authority to cut anything. They make recommendations and--

2021 Dr. {Cassidy.} And 4/5 of Congress will return.

2022 Secretary {Sebelius.} --secondly, as you know, sir,  
2023 that governors of various States set provider rates in their  
2024 Medicaid programs. They are vastly different in Louisiana  
2025 than they are in--

2026 Dr. {Cassidy.} This is on average and I think New York  
2027 Times has well documented that in States as desperate as  
2028 Louisiana and Michigan that is the case. It is disingenuous  
2029 to think otherwise.

2030 But that is okay. I am out of time and I yield back.

2031 Mr. {Pitts.} The chair thanks the gentleman and  
2032 recognizes the gentlelady from Illinois, Ms. Schakowsky, for  
2033 5 minutes for questions.

2034 Ms. {Schakowsky.} I think this discussion is just  
2035 really ironic, this attack on IPAB given the fact that the  
2036 Republican plan would instead turn over the Medicare program  
2037 to private insurance who would have no constraints whatsoever  
2038 in raising their rates and doubling of out-of-pocket costs  
2039 for beneficiaries. And this semantic debate whether it is  
2040 vouchers or premium supports, the only difference is where  
2041 the check is sent to, where the inadequate check is sent to.  
2042 And if we want to have a semantic debate, we ought to change

2043 the--because what they are proposing is not Medicare. We  
2044 could call it Sortacare or Maybecare or I don't care. But it  
2045 is not Medicare anymore according to what my understanding of  
2046 Medicare, which, as you pointed out, Madam Secretary, is a  
2047 guaranteed benefit plan. That is the essence of Medicare.

2048         The other thing is I don't know for sure if you know the  
2049 answer to this, but my understanding is that the Republican  
2050 budget includes all of the Medicare savings provisions that  
2051 you so wisely helped to navigate and talked about from the  
2052 Affordable Care Act with the exception of IPAB. Isn't that  
2053 true?

2054         Secretary {Sebelius.} That is my understanding.

2055         Ms. {Schakowsky.} And those include those kinds of  
2056 changes that have been made that they accuse the Democrats  
2057 of, you know, cutting Medicare and, you know, these are  
2058 reasonable savings. Is it also true that there was a May 26,  
2059 2011, letter to Representative Waxman from the CBO projecting  
2060 the Medicare will not exceed the specified targets during the  
2061 2012 to 2021 period, and therefore, that IPAB will not be  
2062 triggered during that period? I know you said that. I would  
2063 like for you to restate that expectation.

2064         Secretary {Sebelius.} Well, I think thanks to the  
2065 impact already of some of the strategies in the Affordable  
2066 Care Act and some really unprecedented new tools not only in

2067 fraud and abuse but in delivery system ability to align  
2068 payments with high-quality, lower-cost care, we are already  
2069 seeing a cost trend that is diminishing. And the actuary has  
2070 projected that at no time--there is a slight possibility that  
2071 in 2018 there would be a brief recommendation period, but he  
2072 basically says that for that 10-year period, it is very  
2073 unlikely that IPAB ever have--they will be meeting and making  
2074 recommendations but in terms of having to meet a spending  
2075 target will not occur.

2076 Ms. {Schakowsky.} Once again, I frankly was really a  
2077 bit surprised and happy to see that there is this new study  
2078 that says that 93 percent of physicians are taking new  
2079 Medicare patients but only 88 percent of physicians are  
2080 taking new private patient plans, new private plans. The  
2081 issue of access I think, you know, is on everyone's mind, and  
2082 clearly we do not want to see doctors refusing to take  
2083 Medicare patients. So let me ask you to--again, I think it  
2084 is once again, but address this issue of access to care with  
2085 IPAB.

2086 Secretary {Sebelius.} Well, again, I think that the  
2087 goal is to make sure that Medicare is solvent not only for  
2088 the next number of years--and as you know, the Affordable  
2089 Care Act has already extended the solvency projections--but  
2090 on into the future. And so the strategies really are aimed

2091 at trying to make sure that we not only have patients'  
2092 ability to choose his or her own doctor, a fundamental tenet  
2093 of the current Medicare plan, very different than if you are  
2094 in a private insurance plan where that physician, that  
2095 hospital system, that pharmacy, that set of benefits is pre-  
2096 chosen for you. So access to your own doctor, having, you  
2097 know, patient-driven strategies and making sure that as  
2098 recommendations are made about any kind of cost reduction on  
2099 into the future that we pay close attention to patient access  
2100 to providers. That is part of the framework of the  
2101 Independent Payment Advisory Board, and it is one that I  
2102 think the board would follow very seriously. Certainly, we  
2103 would at the Department of Health and Human Services pay very  
2104 careful attention to anything that jeopardized care delivery  
2105 and certainly having access to a physician jeopardizes care  
2106 delivery.

2107 Ms. {Schakowsky.} Thank you. And let me just say that  
2108 I want to thank you so much for your leadership in making  
2109 sure that we can finally reach a time when all Americans have  
2110 access to quality healthcare. Thank you.

2111 Mr. {Pitts.} The chair thanks the gentlelady and  
2112 recognizes the gentleman from New Jersey, Mr. Lance for 5  
2113 minutes.

2114 Mr. {Lance.} Thank you very much, Mr. Chairman. And

2115 good morning to you, Madam Secretary.

2116 Secretary {Sebelius.} Good morning.

2117 Mr. {Lance.} I am interested in the process regarding  
2118 the IPAB because in my judgment oftentimes process relates  
2119 fundamentally to policy. And you have indicated, Madam  
2120 Secretary, that the President has not yet chosen to appoint  
2121 any members of IPAB. Might you give the committee a time  
2122 frame when in your opinion the President might begin to  
2123 appoint members to the board?

2124 Secretary {Sebelius.} Sir, I don't know about a  
2125 specific timetable. I know it is absolutely the President's  
2126 intention that by the time the IPAB provision would begin to  
2127 operate there will be members of the board. As you know, the  
2128 independent actuary doesn't make a target recommendation  
2129 until 2013--

2130 Mr. {Lance.} 2013.

2131 Secretary {Sebelius.} --comes to Congress in 2014.

2132 Mr. {Lance.} But it is your best judgment that  
2133 President Obama intends to make appointments in his term of  
2134 office, the term of office ending in the end of 2012.

2135 Secretary {Sebelius.} I think President Obama intends  
2136 to make appointments so that the IPAB can be operational at  
2137 the time that it is operational.

2138 Mr. {Lance.} Thank you. The law suggests that he makes

2139 several of the appointments in consultation with the leaders,  
2140 Speaker Boehner, Leader Pelosi, Leader Reid, and Leader  
2141 McConnell. Is that accurate?

2142 Secretary {Sebelius.} Yes, sir.

2143 Mr. {Lance.} And is he required to appoint those whom  
2144 the leaders have suggested or is it merely consultative?

2145 Secretary {Sebelius.} It is consultative.

2146 Mr. {Lance.} So, for example, he would not be required  
2147 to follow through on the suggestions of any of the four  
2148 leaders?

2149 Secretary {Sebelius.} That is correct, although the  
2150 Senate has a confirmation ability and I would feel that their  
2151 consultation might be fundamental in getting folks confirmed.

2152 Mr. {Lance.} Perhaps that is so. That is obviously for  
2153 the other House of Congress. Now, regarding how we in the  
2154 legislative branch can discontinue the automatic  
2155 implementation process for recommendations of IPAB--and this  
2156 is down the road, for example, in 2017--as I understand it, a  
2157 joint resolution discontinuing the process must meet several  
2158 conditions, including the fact that it would require approval  
2159 by a super majority of 3/5 of the Members of the Senate. Is  
2160 that accurate?

2161 Secretary {Sebelius.} No, sir. The recommendations to  
2162 be changed by Congress operate in the normal rules of the

2163 congressional structure. Now, the Senate seems to do  
2164 everything by a vote of 60, but there is certainly no  
2165 requirement that IPAB be rejected and substitute  
2166 recommendations be made by a super majority. I think it is  
2167 only to repeal IPAB itself, to get rid of the board. It is  
2168 my understanding that that is a super majority written into  
2169 the law, but not to accept or reject the recommendations.

2170 Mr. {Lance.} So to follow through on your expertise and  
2171 you are obviously expert on this. To get rid of IPAB, the  
2172 underlying PPACA law requires a super majority in the Senate?

2173 Secretary {Sebelius.} Well, in the repeal of the  
2174 Affordable Care Act--

2175 Mr. {Lance.} Yes.

2176 Secretary {Sebelius.} --the House has taken action to  
2177 repeal the Independent Payment Advisory Board--

2178 Mr. {Lance.} Yes.

2179 Secretary {Sebelius.} --and again, I apologize. I  
2180 don't want to misspeak. It is my understanding that if that  
2181 were done independently, that that would require some kind of  
2182 super majority. Just in 2017. I am sorry.

2183 Mr. {Lance.} Yes, in 2017.

2184 Secretary {Sebelius.} Just that one year--

2185 Mr. {Lance.} Yeah.

2186 Secretary {Sebelius.} --it would require super

2187 majority.

2188           Mr. {Lance.} Well, in my judgment that is  
2189 unconstitutional and I am wondering whether the lawyers at  
2190 your department opined on whether that provision is  
2191 constitution or unconstitutional, recognizing that we all  
2192 rely on the advice of those who serve us in legal capacities?

2193           Secretary {Sebelius.} I have been advised, Congressman,  
2194 that our lawyers feel that the structure and the operation as  
2195 described by law of IPAB is constitutional. I would be happy  
2196 to go back and get a very specific answer for that question.

2197           Mr. {Lance.} Thank you. My time is up. It is my  
2198 judgment that that provision at the very least is  
2199 unconstitutional and not in accordance with the current  
2200 provisions of the American Constitution.

2201           Thank you, Mr. Chairman.

2202           Mr. {Pitts.} The chair thanks the gentleman and  
2203 recognizes the gentleman from Texas, Mr. Gonzalez, for 5  
2204 minutes for questions.

2205           Mr. {Gonzalez.} Thank you very much, Mr. Chairman.  
2206 Welcome, Madam Secretary.

2207           This is a quote and since this is a discussion now about  
2208 the benefits and such of competing plans, the Affordable Care  
2209 Act has already been repealed in the House of  
2210 Representatives. This is the quote. ``First, I fear that as

2211 health inflation rises, the cost of private plans will  
2212 outgrow the government premium support. The elderly will be  
2213 forced to pay even higher deductibles and co-pays.  
2214 Protecting those who have been counting on the current system  
2215 their entire lives should be the key principle of reform.''  
2216 Would you agree with that statement?

2217 Secretary {Sebelius.} From what I could hear of it, I  
2218 do agree.

2219 Mr. {Gonzalez.} Well, you just agreed with a Republican  
2220 Senator Scott Brown. I just thought I would throw out a  
2221 Republican out there that agrees with the position that we  
2222 have been taking as to the competing plans. And so to give  
2223 some things some context as I lead to my second question  
2224 would be that 1/2 of Medicare beneficiaries have incomes of  
2225 less than \$21,000, 1/2 have less than \$2,095 in retirement  
2226 assets, 1/2 have less than 30,000 in financial assets, 1 in  
2227 every 4 Medicare Part D beneficiaries reaches the donut hole.  
2228 So we have had the Affordable Care Act, and something that I  
2229 believe has gone unnoticed--and you may have covered it in  
2230 your statement and I apologize, I got here late--what went  
2231 into effect this year that will result and has already  
2232 resulted I believe in about \$260 million in savings to Part D  
2233 beneficiaries when it comes to name-brand pharmaceuticals and  
2234 generics?

2235 Secretary {Sebelius.} A 50 percent discount did begin  
2236 in 2010 for those 4 million approximately beneficiaries who  
2237 will see a 50 percent decrease in the brand-name drugs that  
2238 they purchase once they hit the donut hole gap.

2239 Mr. {Gonzalez.} That is already in place?

2240 Secretary {Sebelius.} It is.

2241 Mr. {Gonzalez.} Can you contrast what we presently have  
2242 in the way of Medicare Part D and within the Affordable Care  
2243 Act but what we have had in place as opposed to what is being  
2244 proposed by the Republicans and of course what we refer to as  
2245 the Ryan budget, the Ryan plan, RyanCare, whatever you want  
2246 to call it? Is there a significant difference in the very  
2247 nature of the benefit that is being provided?

2248 Secretary {Sebelius.} Well, I certainly think that the  
2249 repeal of the Affordable Care Act would eliminate the donut  
2250 hole closing, the gap coverage that now anticipates being  
2251 closed. But beyond that, it is my understanding, Congressman,  
2252 that there would be a significant change in the poorest  
2253 seniors who now qualify for both Medicare and Medicaid  
2254 benefits. With the Republican budget as it deals with  
2255 Medicaid, as you know right now, there is help and support  
2256 for another approximately 4 million seniors who actually are  
2257 income-eligible. They don't ever hit the so-called donut  
2258 hole and pay out-of-pocket costs because their costs are

2259 supported by the Federal Government.

2260           And there would be a major shift in the kinds of support  
2261 for the poorest seniors. It would shift from, again, price  
2262 supports for everything from nursing home care to  
2263 prescription drug care and shift to a fixed income, a fixed  
2264 amount of money in a medical savings account that those  
2265 seniors could try to use to navigate what are often very  
2266 substantial healthcare costs. So I think in terms of the  
2267 drug plan, there are about 4 million seniors right now who  
2268 are actually supported with wraparound care. And that would  
2269 cease to exist also.

2270           Mr. {Gonzalez.} The way it has been explained to me--  
2271 and I am surely not the expert in the area--and I am just  
2272 going to go ahead and read basically. ``Part D is a defined  
2273 benefit, so services are specified in law and covered by  
2274 plans. The Republican plan would leave benefits up to the  
2275 beneficiaries' negotiation with the insurers. Part D's  
2276 federal contribution keeps pace with drug costs, so  
2277 beneficiaries and the government split the growth in health  
2278 cost, and the Republican budget beneficiaries would bear all  
2279 of the burden.'' Is that an accurate description of the  
2280 situation and the contrast between what we have, what the  
2281 Democrats have been proposing and supporting, and then the  
2282 latest proposal from the Republicans?

2283 Secretary {Sebelius.} I think so, sir.

2284 Mr. {Gonzalez.} Thank you very much. I yield back.

2285 Mr. {Pitts.} The chair thanks the gentleman. Before I  
2286 yield to Mr. Guthrie, you mentioned there would be a judicial  
2287 review for the implementation of IPAB recommendations.

2288 Before I yield to Mr. Guthrie, I would like the record to  
2289 show on page 420 of the act, Section 3403(e)5 states there  
2290 should be ``no administrative or judicial review under  
2291 Sections 1869, Section 1978, or otherwise of the  
2292 implementation by the Secretary.'' That means there is no  
2293 judicial review of IPAB's recommendations.

2294 Secretary {Sebelius.} Mr. Chairman, the question that  
2295 was posited to me was a question that assumed that IPAB  
2296 operated outside the scope of their authority, outside the  
2297 scope of the law. In that case, our general counsel feels  
2298 very strongly that there absolutely is a judicial review  
2299 right. So in the implementation that falls within the scope  
2300 of the law, that is the case that you--

2301 Mr. {Pitts.} The chair thanks the gentlelady and  
2302 recognizes Mr. Guthrie for 5 minutes.

2303 Mr. {Guthrie.} Thanks, Madam Secretary, for coming. I  
2304 appreciate you being here. The question first you seem well  
2305 versed in the Republican budget. How many people that are 65  
2306 years old today and older are affected by that budget? How

2307 many people will be affected that are elderly on Medicare  
2308 today?

2309 Secretary {Sebelius.} Well, I think the Republican  
2310 budget would dramatically affect the poorest seniors in its  
2311 impact on--

2312 Mr. {Guthrie.} What will Medicare--

2313 Secretary {Sebelius.} --the dual eligible seniors who  
2314 are over 65 today will immediately see a cut in their  
2315 benefits and in their payments going forward.

2316 Mr. {Guthrie.} People would see the Medicare they  
2317 wouldn't be affected--

2318 Secretary {Sebelius.} Well, those seniors are on  
2319 Medicare today. The poorest seniors in this country would be  
2320 immediately affected by the Republican budget.

2321 Mr. {Guthrie.} But on that the President today is  
2322 talking about raising taxes on people making 200,000,  
2323 \$250,000 or more and supports that. The administration  
2324 supports that. If somebody is 54 years old today, when they  
2325 are 65 if their income is \$250,000 or more, why should they  
2326 not pay more for their healthcare? We want them to pay more  
2327 taxes or the administration does; why shouldn't they be more  
2328 responsible for their healthcare? Why should they be treated  
2329 the same as the dual eligibles? Why should they have the  
2330 same payment as that?

2331 Secretary {Sebelius.} Well, I think the President's  
2332 concept of shared sacrifice is that people contribute a fair  
2333 share.

2334 Mr. {Guthrie.} But not in healthcare? Not in terms of  
2335 their Medicare?

2336 Secretary {Sebelius.} In terms of Medicaid, no one  
2337 qualifies for Medicaid who is making \$250,000 a year.

2338 Mr. {Guthrie.} But if somebody is 65 years old they  
2339 qualify for Medicare regardless of income. If somebody is 65  
2340 years old--

2341 Secretary {Sebelius.} Everyone who reaches the age of  
2342 65 in America qualifies for Medicare, correct.

2343 Mr. {Guthrie.} So my question is why shouldn't somebody  
2344 that is 54 today, 11 years from now when our budget would go  
2345 into effect not be required to pay more for their healthcare  
2346 if you talk about shared sacrifice?

2347 Secretary {Sebelius.} Well, the current Medicare  
2348 structure has income-related premiums in a variety of the  
2349 programs. That is part of the program right now.

2350 Mr. {Guthrie.} But right now currently there is a study  
2351 out of the Urban Institute. I think you have seen it. It is  
2352 about 1 to 3 what people pay into Medicare, what they take  
2353 out. The average of the Urban Institute said I think it is  
2354 109,000 the average couple pays into Medicare and takes out

2355 or will expend \$343,000 in healthcare costs over the course  
2356 of their lifetime. And I don't think it should be 1 for 1,  
2357 \$1 you get in, \$1 you get out. But given that the baby  
2358 boomers are retiring, 1946 they turn 65 this year. I am  
2359 1964, the end of it. Just demographically, these kinds of  
2360 costs just can't be withstood in this system. And the system  
2361 as it is, if you are saying we are going to leave the system  
2362 as it is and try to make it up in efficiencies or provider  
2363 reimbursements, I don't see when we get to 2024, which is the  
2364 point where it--how it becomes sustainable without reforming  
2365 and changing the program, not just trying to make it on pure  
2366 efficiencies. I don't see where you can make that kind of  
2367 difference.

2368         Secretary {Sebelius.} Well, I would agree that I think  
2369 we certainly understand that Medicare as it is right now as a  
2370 fee-for-service, pay-for-volume program is unsustainable and  
2371 certainly unsustainable at the point as you suggest that we  
2372 have a looming influx of baby boomers.

2373         Mr. {Guthrie.} Um-hum.

2374         Secretary {Sebelius.} I think there is a very dramatic  
2375 difference of approaches between the Republican plan, which  
2376 shifts those costs onto seniors. It doesn't really lower  
2377 costs. It just says you will pay 61 percent of your own  
2378 healthcare up to 70 percent. A direct opposition--

2379 Mr. {Guthrie.} Well, I would argue that implementing  
2380 the system would lower costs and kind of the proof in the  
2381 pudding that was Medicare Part D. It is one of the programs  
2382 I think it is 40 percent under estimates performing because  
2383 of competition within health plans for people's business. So  
2384 I would argue it does lower cost. But go ahead.

2385 Secretary {Sebelius.} Well, I just wanted to say that  
2386 is one vision of the system that you shift those costs to  
2387 private insurers and somehow achieve something along the way.

2388 Mr. {Guthrie.} The differences are so great. Matter of  
2389 fact, in 30 years, the entire federal budget is going to be  
2390 Medicare, Medicaid, and Social Security.

2391 Secretary {Sebelius.} If nothing changes.

2392 Mr. {Guthrie.} So the differences are so great and so  
2393 just saying we are going to cut back our reimbursements or  
2394 create efficiencies, I don't see where you make that  
2395 difference. That is my question.

2396 Secretary {Sebelius.} Well, I think that again--

2397 Mr. {Guthrie.} Without completely reforming the system.

2398 Secretary {Sebelius.} I think we do need a complete  
2399 reform of the system, and I think the Republican budget  
2400 chooses to do that with beneficiaries and just shift costs of  
2401 who pays what--

2402 Mr. {Guthrie.} Instead of shifting it to my 17-year-

2403 old--

2404 Secretary {Sebelius.} --and the Affordable Care Act

2405 says--

2406 Mr. {Guthrie.} --to pay it for the rest of their life.

2407 Secretary {Sebelius.} --we need to look at the

2408 underlying healthcare costs not just for Medicare but if

2409 affects every private employer, it affects everybody who goes

2410 to the hospital, it affects every doctor, and the kinds of

2411 underlying healthcare shifts--and let me give you another

2412 example, Congressman, if I may. We have finally started down

2413 the road of competitive bidding, a market strategy, for

2414 durable medical equipment. It was started in 2003, pulled

2415 back in 2008, restarted this year in the test market where it

2416 is implemented. There is a 34 percent decrease in durable

2417 medical equipment without any jeopardizing of benefits.

2418 Mr. {Guthrie.} I lost my time but with that level of

2419 savings required to make it work unsustainable can just come

2420 from efficiencies alone.

2421 Mr. {Pitts.} The chair thanks the gentleman and

2422 recognizes the gentlelady from Tennessee, Ms. Blackburn, for

2423 5 minutes.

2424 Mrs. {Blackburn.} Thank you, Madam Secretary, for your

2425 patience. And three of us are going to try to share the

2426 balance of your time and get our questions in.

2427 I would remind my colleagues, one of my colleagues from  
2428 Illinois was making comments about what Medicare would be  
2429 called going forward. I would remind my colleagues it was  
2430 ObamaCare or PPACA, whatever we want to call it, that cut  
2431 \$575 billion out of Medicare. It was a conscious decision to  
2432 make those cuts. I would also remind my colleagues that  
2433 Medicare is a trust fund, and the Federal Government has had  
2434 first right of refusal on the paychecks of the workers of  
2435 this country. And so therefore, making that kind of cut I  
2436 think is a breach of what has been promised to those  
2437 enrollees.

2438 Madam Secretary, I looked at some of your comments from  
2439 the budget committee yesterday and I feel like we are kind of  
2440 doing a session of kick the can. And you know as well as I  
2441 do that as we have been with you time and again on these  
2442 hearings, we have looked at access to affordable care and  
2443 have tried to get some definitions from you, and IPAB is one  
2444 of those that we are very concerned about how it is going to  
2445 restrict or affect access to healthcare and what IPAB is  
2446 going to end up doing. We know that supposedly some of the  
2447 15 experts coming to IPAB are supposed to be pharmaca,  
2448 economics, health economists, insurers, and actuaries. We  
2449 know that the President, he has an initiative to achieve  
2450 savings. So if they are not there to achieve savings, what

2451 are they there for?

2452 Secretary {Sebelius.} They are there, Congresswoman, to  
2453 recommend to Congress ways that Medicare can be solvent on  
2454 into the future.

2455 Mrs. {Blackburn.} So you see it strictly as a solvency  
2456 issue?

2457 Secretary {Sebelius.} That is their direction, yes.

2458 Mrs. {Blackburn.} That is their direction. Okay.

2459 Secretary {Sebelius.} They are only triggered when the  
2460 independent actuary--

2461 Mrs. {Blackburn.} Let me ask you another question,  
2462 then, because we know the GAO is supposed to do a study by  
2463 January 1, 2015, on access, affordability, and quality. This  
2464 is of IPAB. And then Kaiser Foundation recently noted that,  
2465 ``IPAB would be required to continue to make annual  
2466 recommendations to further constrain payments if the CMS  
2467 actuary determine that Medicare spending exceeded targets,  
2468 even if evidence of access or quality concerns surface.''   
2469 And I am quoting Kaiser Foundation. So how do you reconcile  
2470 the statements made by the administration that IPAB will not  
2471 impact access, affordability, and quality with the statements  
2472 made by the Kaiser Family Foundation that IPAB is required to  
2473 continue cutting even if evidence of quality-of-access  
2474 problems arise?

2475 Secretary {Sebelius.} Congresswoman, I am not familiar  
2476 with that Kaiser quote, but as you know--

2477 Mrs. {Blackburn.} Well, in the interest of time, then,  
2478 if you are not familiar with it, would you--

2479 Secretary {Sebelius.} I am not familiar with what  
2480 Kaiser said. I am familiar with the law and I am familiar  
2481 with the way it works and I am familiar with the fact that  
2482 what they are directed to do is when the independent actuary,  
2483 on a yearly basis--which he does year in and year out--  
2484 recommends a target goal for spending, assuming that Congress  
2485 ignores that, doesn't act, they are directed to recommend  
2486 ways to meet that spending target to Congress. Again, if  
2487 Congress does not act, chooses to ignore, chooses not to  
2488 change it, then those cuts go into--

2489 Mrs. {Blackburn.} Okay. Well, let me reclaim my time  
2490 so that I can yield to Mr. Shimkus, but I would also like to  
2491 highlight that I am still waiting for a response from you on  
2492 addressing waste, fraud, and abuse from the last hearing.  
2493 And with that, I yield to Mr. Shimkus.

2494 Mr. {Shimkus.} Thank you. Thank you, Madam Secretary.  
2495 Welcome. And we are going to try to get you out of here.  
2496 This is our last couple of questions. We are not going to  
2497 match our greatest hits of the last time so I am not intent  
2498 to do that.

2499 But our 2024 time frame for the expansion of the  
2500 solvency of Medicare, is that based upon the--  
2501 Secretary {Sebelius.} 2024--  
2502 Mr. {Shimkus.} The 2024 expansion of the Medicare Trust  
2503 Fund is based upon the--  
2504 Secretary {Sebelius.} Expansion or--  
2505 Mr. {Shimkus.} The solvency.  
2506 Secretary {Sebelius.} The solvency, yeah.  
2507 Mr. {Shimkus.} The solvency is based upon the \$575  
2508 billion cut in Medicare, is that correct, for the most part?  
2509 Secretary {Sebelius.} It is based on projecting what  
2510 the trends are right now on into--  
2511 Mr. {Shimkus.} And based upon the double counting that  
2512 we talked about last time. And I would just ask your  
2513 individual health insurance policy, do you have under the  
2514 Federal Employees' Health Benefit plan?  
2515 Secretary {Sebelius.} I do.  
2516 Mr. {Shimkus.} And in the D.C. area there is probably  
2517 around 42 difference choices for health insurance policies?  
2518 I mean in St. Louis area is 21. I think D.C. is almost  
2519 double that amount. It is operated by OPM. They negotiate  
2520 it. We have a premium support plan that you are participant  
2521 of and that I am a participant of.  
2522 Secretary {Sebelius.} And the Federal Government pays

2523 about 70 percent of the cost--

2524 Mr. {Shimkus.} All that premium support is is a--

2525 Secretary {Sebelius.} And it rises--

2526 Mr. {Shimkus.} --negotiated contractual relationship

2527 with private insurance to provide insurance just like you

2528 receive and just like we receive. So it is the same plan so

2529 any--

2530 Secretary {Sebelius.} Well, it is--

2531 Mr. {Shimkus.} The voucher debate is not correct.

2532 Secretary {Sebelius.} Well--

2533 Mr. {Shimkus.} It is the same plan that you have. And

2534 I yield my time to Dr. Murphy.

2535 Mr. {Murphy.} Thank you. I am just trying to find out

2536 some answers here. And if you don't have the information,

2537 could you please get back to me.

2538 What is an estimate of how much you think working on

2539 fraud issues will save Medicare overall, again, 1 or 5 or 10

2540 years?

2541 Two, is you are working on a number of issues about

2542 quality improvement. You did mention the issue about

2543 infections. There has been bills we have moved through this

2544 committee, a bill that I wrote to ask for transparency on

2545 infection reporting. I understand from speaking with the

2546 head of Center for Disease Management that it has been about

2547 27,000 lives have been saved by having the transparency. And  
2548 I appreciate everybody who worked on that. If you could get  
2549 us some accurate numbers of how much money that will save,  
2550 too, over time, I would appreciate that, too.

2551 So yeah, fraud, improvement of quality, and there is a  
2552 number of issues there. Another option, too, to reduce  
2553 Medicare costs is the ongoing issue we have of reducing  
2554 payments, which is the SGR, et cetera, and also means testing  
2555 has been kicked around, too. But I do want to ask this and  
2556 tie in with some other issues. Medicare Part D, the actual  
2557 part that is a donut hole--and, again, I don't expect you to  
2558 know these numbers--but there is a percentage of seniors that  
2559 never got to that level because they never needed that much  
2560 prescriptions. Do you have information on what percentage of  
2561 seniors that was or how many that was who, you know, spending  
2562 for prescription drugs never got there?

2563 Secretary {Sebelius.} I know that about 8 million hit  
2564 it. I don't know how many enrollees we have.

2565 Mr. {Murphy.} Um-hum.

2566 Secretary {Sebelius.} I don't know how many are  
2567 enrolled but I can get you that number.

2568 Mr. {Murphy.} Let me lay out because I don't want to  
2569 play games and I am sure you don't like them either. I am  
2570 just trying to find this out. In terms of the number of

2571 seniors who actually had a donut hole problem, some never  
2572 purchased a plan but never hit that level. Some did purchase  
2573 a donut hole coverage plan and helped them through that next  
2574 level. And some did not have coverage and those are the ones  
2575 we all share a concern about. So what I am trying to find  
2576 out as we are looking at honest numbers on this is what was  
2577 the difference in impact upon cost and quality of care? You  
2578 are probably familiar with the study that came out that said  
2579 about 50 to 75 percent of people who were prescribed  
2580 medication do not take it correctly. Either they never fill  
2581 the prescription, they don't take it, they mix it with other  
2582 drugs, and that leads to returns to physicians' offices, re-  
2583 hospitalizations, extended hospital visits, and emergency  
2584 room visits.

2585         In the context of this, as we really try and look at  
2586 honest quality--and I get real tired of this Republican-  
2587 Democrat battle. I just want to talk about patients here.  
2588 The issue is if we get down to the concrete levels of this,  
2589 what does it really save if we focus on how we can do such  
2590 things as disease management and care management, because you  
2591 know right now that is not paid for. And that is a big  
2592 frustration for me that someone who may have a chronic  
2593 illness such as diabetes or cancer or heart disease, if they  
2594 are not helped through this and physicians aren't paid for

2595 this, so we don't pay a nurse to make the call and monitor  
2596 this, it is a serious cost problem. And I hope that is  
2597 something as we get through this you can help us with some  
2598 real numbers. I don't know if the IPAB board is authorized  
2599 to work on these things. I tend to not think so but correct  
2600 me if I am wrong. I would deeply appreciate further  
2601 discussions with you on this outside of this artificial  
2602 setting here and to work further on this.

2603 Secretary {Sebelius.} Well, I would very much  
2604 appreciate that. We can get you some numbers. I am not  
2605 sure--since Medigap plans are sold at the state level and  
2606 some cover additional prescription drugs but a lot don't--how  
2607 accurate I can--but we will get you the donut hole numbers as  
2608 much as we can. And we would love to work with you on  
2609 coordinated care strategies, particularly for the chronically  
2610 ill. I think that is an enormous opportunity for better care  
2611 delivery at significantly lower costs.

2612 Mr. {Murphy.} Thank you. And I might add my closing  
2613 part here is that I know that a lot of private plans end up  
2614 paying these out of pocket now where they will cover heart  
2615 disease and diabetes, and I want to make sure we don't leave  
2616 this hearing saying that everything the government does is  
2617 bad and everything private insurance does is bad. I think  
2618 there is a lot mistakes on both, but I would hope we would

2619 not get into that finger-pointing and blame game but instead  
2620 say let us look at how we can use disease management. And I  
2621 want to hear how this is going to be done better. Thank you.  
2622 I yield back.

2623 Secretary {Sebelius.} Thank you.

2624 Mr. {Pitts.} The chair thanks the gentleman. Madam  
2625 Secretary, we will submit questions for the record and ask  
2626 that you please respond promptly to those. You have been  
2627 very generous with your time. Thank you for your testimony.  
2628 We will take a 5-minute break as we set up the third panel.

2629 [Recess.]

2630 Mr. {Pitts.} The subcommittee will come to order. I  
2631 will ask our guests to please take their seats. The chairman  
2632 has a unanimous consent request that the following documents  
2633 be entered into the record: statement of Burke Balch,  
2634 Director of the Robert Powell Center for Medical Ethics of  
2635 the National Right to Life Committee; second, a letter from  
2636 Sandra Snyder, President of American College of Emergency  
2637 Physicians to Chairman Pitts, Ranking Member Pallone;  
2638 thirdly, statement of Thair Phillips, President of  
2639 RetireSafe; fourth, a letter from 283 healthcare  
2640 organizations opposing the Independent Payment Advisory  
2641 Board; fifth, statement of Karen Zinca, Health Educator for  
2642 Men's Health Network; sixth, a statement of Richard Waldman,

2643 President of American College of Obstetricians and  
2644 Gynecologists; seventh, a letter from Tim Lang, Chair of the  
2645 Governor Affairs Committee, American College of Rheumatology;  
2646 eighth, statement of the American College of Radiology;  
2647 ninth, a letter from Cecil Wilson, past president of the  
2648 American Medical Association; tenth, testimony from Bob  
2649 Blancato, National Association of Nutrition and Aging  
2650 Services Programs. I think you have all copies of these.

2651 Without objection, so ordered.

2652 [The information follows:]

2653 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|

2654           Mr. {Pitts.} I will introduce our third panel at this  
2655 time. Testifying in our third panel are Christopher Davis,  
2656 who is an analyst on Congress and the legislative process for  
2657 the Congressional Research Service; David Newman is a  
2658 specialist in healthcare financing at the Congressional  
2659 Research Service; Avik Roy is a healthcare analyst with the  
2660 firm Monness, Crespi, Hardt, and Company in New York City;  
2661 Stuart Guterman is vice president for Payment and System  
2662 Reform, executive director for the Commission on High  
2663 Performance Health System at the Commonwealth Fund; Judy  
2664 Feder is professor public policy at Georgetown University;  
2665 and Dr. Scott Gottlieb is a practicing physician and is  
2666 currently a resident fellow in health policy at the American  
2667 Enterprise Institute.

2668           Mr. Davis, you may begin your testimony.

|  
2669 ^STATEMENTS OF CHRISTOPHER M. DAVIS, ANALYST ON CONGRESS AND  
2670 THE LEGISLATIVE PROCESS, CONGRESSIONAL RESEARCH SERVICE,  
2671 ACCOMPANIED BY DAVID NEWMAN, SPECIALIST IN HEALTH CARE  
2672 FINANCING, CONGRESSIONAL RESEARCH SERVICE; DIANE COHEN,  
2673 SENIOR ATTORNEY, SCHARF-NORTON CENTER FOR CONSTITUTIONAL  
2674 LITIGATION, GOLDWATER INSTITUTE; JUDITH FEDER, PROFESSOR AND  
2675 FORMER DEAN, GEORGETOWN PUBLIC POLICY INSTITUTE; AVIK S. ROY,  
2676 HEALTHCARE ANALYST, MONNESS, CRESPI, HARDT AND CO.; STUART  
2677 GUTERMAN, SENIOR PROGRAM DIRECTOR, PROGRAM ON MEDICARE'S  
2678 FUTURE, THE COMMONWEALTH FUND; AND DR. SCOTT GOTTLIEB,  
2679 RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE

|  
2680 ^STATEMENT OF CHRISTOPHER M. DAVIS

2681 } Mr. {Davis.} Thank you, Mr. Chairman. Chairman Pitts,  
2682 Ranking Member Pallone, and members of the subcommittee, on  
2683 behalf of the Congressional Research Service I appreciate the  
2684 opportunity to testify about the ``fast-track'' parliamentary  
2685 procedures relating to the Independent Payment Advisory  
2686 Board.

2687 I am accompanied today by my CRS colleague, David  
2688 Newman, who is a specialist in healthcare financing. While I  
2689 will limit my testimony to the parliamentary aspects of the

2690 IPAB, at the request of the subcommittee, David is available  
2691 to answer questions if desired on the healthcare policy  
2692 aspects of the board.

2693 Expedited or ``fast-track'' procedures are special  
2694 parliamentary procedures Congress sometimes adopts to promote  
2695 timely action on legislation. As the name implies, fast-  
2696 track procedures differ from the usual procedures of the  
2697 House and Senate because they generally allow the legislation  
2698 in question to be considered more quickly and to avoid some  
2699 of the parliamentary hurdles which face most bills.

2700 The Patient Protection and Affordable Care Act  
2701 established two fast-track procedures related to the IPAB.  
2702 The first governs consideration of a bill implementing the  
2703 recommendations of the IPAB related to future rates of  
2704 Medicare spending. The second procedure governs  
2705 consideration of a joint resolution discontinuing the  
2706 automatic implementation of the IPAB's recommendations. I  
2707 will briefly describe both procedures.

2708 As others have testified, under PPACA the IPAB will,  
2709 under certain circumstances, propose an implementing bill  
2710 containing recommendations designed to reduce the rate of  
2711 Medicare spending growth. The secretary is to automatically  
2712 implement these recommendations on August 15 unless  
2713 legislation is enacted before then which supersedes the IPAB

2714 proposals.

2715           The procedures established by PPACA permit Congress to  
2716 amend the IPAB-implementing legislation but only in a manner  
2717 that achieves at least the same level of targeted reductions  
2718 in spending growth as the IPAB plan. The act bars Congress  
2719 from changing the IPAB fiscal targets in any other  
2720 legislation it considers as well and creates a super majority  
2721 vote in the Senate to waive this requirement.

2722           PPACA establishes special fast-track procedures  
2723 governing House and Senate committee consideration and Senate  
2724 Floor consideration of an IPAB-implementing bill. Under  
2725 these procedures, the bill is automatically introduced and  
2726 referred to the House Committees on Energy and Commerce and  
2727 Ways and Means and to the Senate Committee on Finance. Not  
2728 later than April 1, each committee may report the bill with  
2729 committee amendments related to the Medicare program. If a  
2730 committee has not reported by April 1, it is discharged.

2731           PPACA does not establish special procedures for Floor  
2732 consideration of an IPAB-implementing bill in the House. It  
2733 does for the Senate. PPACA creates an environment for Senate  
2734 Floor consideration of an IPAB-implementing bill which is  
2735 similar to that which exists after the Senate has invoked  
2736 cloture. There is a maximum of 30 hours of consideration and  
2737 all amendments must be germane. A final vote on the bill is

2738 assured.

2739           PPACA establishes a second fast-track procedure  
2740 governing consideration of a joint resolution discontinuing  
2741 the automatic implementation process of the IPAB  
2742 recommendations. Such a joint resolution is in order only in  
2743 the year 2017 and its consideration is also expedited in  
2744 committee and on the Senate Floor. Passage of a joint  
2745 resolution discontinuing the automatic IPAB process requires  
2746 a 3/5 vote of Members of both the House and the Senate. Both  
2747 the IPAB-implementing bill and the joint resolution I have  
2748 described must be signed by the President to become law.  
2749 should either measure be vetoed, overriding the veto would  
2750 require a 2/3 vote in both chambers. The arguable effect of  
2751 these provisions is to favor the continuation of the IPAB and  
2752 its recommendations possibly even in the face of  
2753 congressional majority supporting a different policy  
2754 approach.

2755           While the fast-track parliamentary procedures governing  
2756 consideration of an IPAB-implementing bill are expedited,  
2757 they do not in themselves guarantee that Congress will agree  
2758 on a bill and present it to the President. Because it is not  
2759 possible to force the House and Senate to agree on the same  
2760 bill text, whether Congress can pass an implementing bill  
2761 which will supersede the recommendations of the IPAB is

2762 subject to the deliberative process.

2763           Finally, as I detail in my written testimony, questions  
2764 about certain mechanics of these two fast-track procedures,  
2765 such as how certain points of order under the act will be  
2766 enforced will likely require clarification by the House and  
2767 Senate in close consultation with each chamber's  
2768 parliamentarian.

2769           The Congressional Research Service appreciates the  
2770 opportunity to assist the subcommittee as it examines these  
2771 matters. My colleague and I are happy to answer any  
2772 questions you may have.

2773           [The prepared statement of Mr. Davis follows:]

2774 \*\*\*\*\* INSERT 6 \*\*\*\*\*

|  
2775 Mr. {Pitts.} The chair thanks the gentleman.

2776 Mr. Newman, you are recognized for 5 minutes for an  
2777 opening statement.

2778 Mr. {Newman.} I have no independent testimony.

2779 Mr. {Pitts.} Ms. Cohen, I apologize to you. I failed  
2780 to introduce you in the introduction. Diane Cohen, Senior  
2781 Attorney for Goldwater Institute. You are recognized for 5  
2782 minutes.

|  
2783 ^STATEMENT OF DIANE COHEN

2784 } Ms. {Cohen.} Thank you, Chairman, and thank you,  
2785 Ranking Member Pallone. I really appreciate the opportunity  
2786 to come here all the way from Arizona and to discuss with you  
2787 the unprecedented constitutional issues raised by Congress'  
2788 establishment of the Independent Payment Advisory Board and  
2789 the real-world consequences that this unprecedented  
2790 independent agency will have on the lives of citizens and  
2791 especially seniors.

2792 The Goldwater Institute's legal challenge to the Patient  
2793 Protection and Affordable Care Act is unique among the  
2794 lawsuits challenging the act because ours is the only one  
2795 that challenges the constitutionality of IPAB. We believe  
2796 the creation of IPAB represents the most sweeping delegation  
2797 of Congressional authority in history, a delegation that is  
2798 anathema to our constitutional system of separation of powers  
2799 and to responsible, accountable, and democratic lawmaking.  
2800 IPAB is insulated from congressional, presidential, and  
2801 judicial accountability to a degree never before seen. It is  
2802 the totality of these factors that insulate IPAB from our  
2803 Nation's system of checks and balances that renders it  
2804 constitutionally objectionable.

2805           Specifically, IPAB is an unelected board of bureaucrats  
2806 whose proposals can become law without the approval of  
2807 Congress, without the approval of the President, and they are  
2808 insulated from rulemaking, administrative and judicial  
2809 review, and any meaningful congressional oversight. Far from  
2810 representing Medicare reform, IPAB is an abdication of what  
2811 has been historically a congressional responsibility.  
2812 Indeed, it is an unconstitutional delegation of Congress'  
2813 legislative duties and is unaccountable to the electorate and  
2814 immune from checks and balances.

2815           And I just want to follow up on what the secretary  
2816 testified about earlier this morning. Let us be clear,  
2817 Section (e)5, the act specifically prohibits judicial review.  
2818 And what that means is that the act prohibits judicial  
2819 review. If the secretary acts outside the law, there is no  
2820 judicial review. There is no accountability for her actions.  
2821 Secondly, these are not mere proposals or recommendations.  
2822 These are legislative proposals that can become law.

2823           We also heard talk about while one provision says there  
2824 is no judicial review but we are not supposed to believe  
2825 that, another provision says a joint resolution is required  
2826 to dissolve the board, but we are not supposed to believe  
2827 that, and then another provision prohibits rationing, but we  
2828 are supposed to believe that.

2829 IPAB is independent in the worst sense of the word. It  
2830 is independent of Congress, independent of the President,  
2831 independent of the judiciary, and independent of the will of  
2832 the American people. Thank you, Mr. Chairman.

2833 [The prepared statement of Ms. Cohen follows:]

2834 \*\*\*\*\* INSERT 7 \*\*\*\*\*

|  
2835           Mr. {Pitts.} The chair thanks the gentlelady and  
2836 recognizes Dr. Feder for 5 minutes.

|  
2837 ^STATEMENT OF JUDITH FEDER

2838 } Ms. {Feder.} Thank you, Chairman Pitts, Ranking Member  
2839 Pallone, members of the committee.

2840 Mr. {Pitts.} Pull your mike--or push it on. Yeah.

2841 Ms. {Feder.} Okay?

2842 Mr. {Pitts.} That is better.

2843 Ms. {Feder.} I will start again. Chairman Pitts,  
2844 Ranking Member Pallone, members of the committee, I am glad  
2845 to be with you this morning as you consider the role of the  
2846 Independent Payment Advisory Board established by the  
2847 Affordable Care Act.

2848 I would like to start in thinking about how to approach  
2849 that by calling your attention to the fact that Medicare is  
2850 an enormously successful program, more successful than  
2851 private health insurance in pooling risk and controlling  
2852 costs. Medicare has historically achieved slower spending  
2853 growth than private insurance, and the ACA extends its  
2854 relative advantage. Action taken in the Affordable Care Act  
2855 achieves an average annual growth rate of 2.8 percent per  
2856 Medicare beneficiary for 2010 to 2021, 3 percentage points  
2857 slower than per capital national health spending. National  
2858 health spending is projected to grow faster than GDP growth

2859 per capital by close to 2 percentage points, but Medicare's  
2860 projected per beneficiary spending growth will be a full  
2861 percentage point below growth in per capital GDP.

2862 Growing slower than the private sector is good but not  
2863 good enough since both public and private insurers pay too  
2864 much for too many services and fail to assure sufficiently  
2865 delivered quality care. That is why the Affordable Care Act  
2866 goes beyond tightening fee-for-service payments to pursue a  
2867 strategy of payment and delivery reform and creates the IPAB  
2868 to assure effective results. The strategy includes payment  
2869 reductions for overpriced or undesirable behavior and bonuses  
2870 or rewards for good behavior, most especially for payment  
2871 arrangements that reward providers for coordinated integrated  
2872 care efficiently delivered.

2873 These reforms have the potential to transform both  
2874 Medicare and, by partnership and example, the Nation's  
2875 healthcare delivery system to provide better quality care at  
2876 lower cost. But their achievement in implementation cannot  
2877 be assumed. That is why the IPAB exists, to recommend ways  
2878 to achieve specified reductions in Medicare spending by  
2879 changing payments to healthcare providers. In essence, IPAB  
2880 serves to inform and assure congressional action to keep  
2881 Medicare spending under control.

2882 Some legislators have proposed to repeal the IPAB, but

2883 along with about 100 health policy experts who recently wrote  
2884 congressional leaders in support of IPAB, I see that effort  
2885 as sorely misguided. As we wrote, the IPAB enables Congress  
2886 to mobilize the expertise of professionals to assemble  
2887 evidence and assure that the Medicare program acts on the  
2888 lessons of the payments and delivery innovations the  
2889 Affordable Care Act seeks to promote.

2890 I contrast the ACA strategy to strengthen Medicare with  
2891 the inclusion of IPAB with the alternative strategy not only  
2892 to repeal IPAB but also to eliminate Medicare for future  
2893 beneficiaries, replacing it with vouchers for the purchase of  
2894 private insurers, vouchers that take advantage of all  
2895 Medicare payment reductions included in the Affordable Care  
2896 Act. The Congressional Budget Office analysis shows that  
2897 such action would not slow healthcare cost growth. Rather,  
2898 it would increase insurance costs and shift responsibility  
2899 for paying most of them onto seniors, doubling out-of-pocket  
2900 costs for the typical 65-year-old from about 6 to \$12,000 in  
2901 2022 with out-of-pocket spending for beneficiaries growing  
2902 even further in the future as the gap between Medicare--  
2903 slower cost growth--and private insurance--more faster cost  
2904 growth--would increase.

2905 Given Medicare's track record relative to private  
2906 insurance in delivering benefits and controlling costs,

2907 morphing Medicare into a private insurance market simply  
2908 makes no sense. Medicare is clearly doing its part to  
2909 control spending and to bring the rate of spending growth  
2910 under control. But healthcare spending growth is not  
2911 fundamentally a Medicare problem. It is a health system  
2912 problem. Medicare can only go so far on its own to promote  
2913 efficiencies without partnership with the private sector.  
2914 Effective payment and delivery reform requires an all-payer  
2915 partnership to assure that providers actually change their  
2916 behavior rather than looking to favor some patients over  
2917 others or to pit one pair against another.

2918         Rather than moving to abandon IPAB which supports  
2919 Medicare's continued and improved efficiency, Congress should  
2920 therefore modify IPAB's current spending target to apply not  
2921 just to Medicare but to private insurance, indeed, to all  
2922 healthcare spending and extend its authorities to trigger  
2923 recommendations for all payer payment reform if the target is  
2924 breached. Only payment efficiencies that apply to all payers  
2925 can assure Medicare and all Americans the affordable quality  
2926 care we deserve.

2927         Thank you, Mr. Chairman.

2928         [The prepared statement of Ms. Feder follows:]

2929 \*\*\*\*\* INSERT 8 \*\*\*\*\*

|  
2930           Mr. {Pitts.} The chair thanks the gentlelady and  
2931 recognizes the gentleman, Mr. Roy, for 5 minutes.

|  
2932 ^STATEMENT OF AVIK S. ROY

2933 } Mr. {Roy.} Chairman Pitts, Ranking Member Pallone, and  
2934 members of the Health Subcommittee--

2935 Mr. {Pitts.} Is your mike on?

2936 Mr. {Roy.} Chairman Pitts--there we go--Ranking Member  
2937 Pallone, members of the Health Subcommittee, thanks for  
2938 inviting me to speak with you today about IPAB.

2939 My name is Avik Roy and I am a healthcare analyst at  
2940 Monness, Crespi, Hardt, and Company, a securities firm in New  
2941 York. In that capacity, I recommend healthcare investments  
2942 to our clients who represent the largest investment firms in  
2943 the world. In addition, I am a senior fellow in healthcare  
2944 at the Heartland Institute in which capacity I conduct  
2945 research on health policy with an emphasis on entitlement  
2946 reform.

2947 In my remarks today I will focus on four questions:  
2948 first, why is Medicare so expensive? Second, what is the  
2949 best way to adjust the growth of Medicare spending while  
2950 preserving high-quality care for seniors? Third, is IPAB  
2951 likely to aid these goals? Fourth, is IPAB perfect as it is?  
2952 Is it possible to reform or improve IPAB or should Congress  
2953 scratch the whole thing and try something else?

2954           Why has Medicare spending gone through the roof? Many  
2955 trees have been killed in search of answers to the questions.  
2956 Well, while there are many plausible drivers of Medicare  
2957 spending growth, the single-biggest problem is this: it is  
2958 easy to waste other people's money. It is like the  
2959 difference between a cash bar and an open bar. At a cash  
2960 bar, I might order a beer or a house wine, but at the open  
2961 bar, I would probably ask for a fine Kentucky bourbon,  
2962 especially if Congressman Guthrie and Whitfield come back.  
2963 Price becomes no object in such a system. And Medicare is  
2964 more like that open bar. As a result, seniors tend to be  
2965 entirely unaware of how expensive their treatments are and  
2966 have no incentive to avoid unnecessary or overpriced care.  
2967 Studies show that spending has increased most rapidly in  
2968 those areas of healthcare where individuals bear the least  
2969 responsibility for their own expenses.

2970           So what should Congress do? There are three ways to  
2971 deal with the Medicare cost problem. The first, which is  
2972 what we do now, is to avoid hard choices by promising that we  
2973 will cover nearly every treatment but underpay doctors and  
2974 hospitals in compensation. The second approach, which we  
2975 call rationing, is for Medicare to determine either by  
2976 congressional order or an expert panel that certain  
2977 treatments aren't cost-effective and deny them to seniors who

2978 seek them out. The third option would be to let seniors  
2979 decide by granting them more control over their own health  
2980 dollars either by increased cost-sharing and/or by allowing  
2981 them to choose between different insurance plans with  
2982 different benefit packages.

2983 Our current approach, underpaying doctors and hospitals,  
2984 is leading more and more doctors to drop out of Medicare. We  
2985 already see this problem in Medicaid where internists are  
2986 almost nine times as likely to reject all Medicaid patients  
2987 for new appointments than those with private insurance.  
2988 According to Medicare Actuary Richard Foster, Medicare  
2989 reimbursement rates will become worse than those of Medicaid  
2990 within the next 9 years. And studies show that health  
2991 outcomes for many Medicaid patients are worse than those who  
2992 have no insurance at all.

2993 As you know, after objections at rationing care through  
2994 IPAB would resemble a death panel, Congress severely  
2995 constrained IPAB's authority preventing the board from  
2996 including any recommendation to ration care, raise premiums,  
2997 increase cost-sharing, restrict benefits, or alter  
2998 eligibility requirements. I know that you are all very  
2999 familiar with the endless tussle over the Medicare  
3000 sustainable growth rate, or SGR, which has caused significant  
3001 fiscal headaches because Congress routinely overrides the

3002 SGR's requirements for reduced payments to doctors and  
3003 hospitals. But IPAB, as it is currently designed, is similar  
3004 to SGR in that its primary approach to cost control involves  
3005 reducing payments to physicians. These global reimbursement  
3006 cuts haven't worked in the past and they won't work in the  
3007 future. Hence, we should be seriously concerned that IPAB as  
3008 it is currently designed will reduce seniors' access to  
3009 doctors and healthcare services, thereby worsening the  
3010 quality and outcome of their care.

3011         So the question we must then ponder is can IPAB be fixed  
3012 or should Congress wholly repeal it? It is conceivable that  
3013 a differently designed IPAB could help Medicare spending more  
3014 efficient. For example, an IPAB that was empowered to make  
3015 changes to Medicare premiums, cost-sharing provisions, and  
3016 eligibility requirements could assist Congress in enacted  
3017 much-needed reforms to the program.

3018         I know that both IPAB's proponents and its opponents see  
3019 the board as a foot in the door for government rationing.  
3020 But let us remember that for 45 years we have misled the  
3021 public into thinking that we could provide seniors with  
3022 unlimited taxpayer-funded healthcare with no constraints.  
3023 IPAB to its credit is an attempt at intellectual honesty  
3024 because government rationing is a logical and necessary  
3025 consequence of single-payer systems like Medicare.

3026           Between IPAB and the 2012 House budget, Congress can now  
3027 have an honest debate. Should we move to a more British-  
3028 style system of rationing under single-payer healthcare or  
3029 should we move to a more Swiss-style system of individual  
3030 choice and diverse options? In the diversity-and-choice  
3031 approach, if you don't like how your health plan restraints  
3032 costs, you can switch to another plan or spend your own money  
3033 on a more generous plan. In the government-driven approach,  
3034 you have to accept what the government tells you to accept or  
3035 pay onerous economic penalties.

3036           It is certainly my view that diversity and choice is  
3037 more appealing and also more likely to work.

3038           Thanks again for having me. As an addendum to my  
3039 written testimony, I am including an article from the latest  
3040 issue of National Affairs in which I further expand on these  
3041 issues. I look forward to your questions.

3042           [The prepared statement of Mr. Roy follows:]

3043 \*\*\*\*\* INSERT 9 \*\*\*\*\*

|  
3044           Mr. {Pitts.} The chair thanks the gentleman and  
3045 recognizes Dr. Guterman for 5 minutes.

|  
3046 ^STATEMENT OF STUART GUTERMAN

3047 } Mr. {Guterman.} Thank you, Chairman Pitts, Vice  
3048 Chairman Burgess, Ranking Member Pallone, and members of the  
3049 subcommittee, for this invitation to testify on the  
3050 Independent Payment Advisory Board.

3051 I am Stuart Guterman, Vice President for Payment and  
3052 System Reform with the Commonwealth Fund, which is a private  
3053 foundation that aims to promote a high-performance health  
3054 system that achieves better access, improved quality, and  
3055 greater efficiency, particularly for society's most  
3056 vulnerable members, including those with low incomes, the  
3057 uninsured, young children, and elderly adults. I am  
3058 particularly glad to be able to speak to you on this topic  
3059 because I have been working on Medicare issues, particularly  
3060 payment policy, for a long time at CMS, MedPAC and CBO.

3061 I have seen the problems faced by the program persist  
3062 over time despite continuous efforts to address and remediate  
3063 them. I believe we have an unprecedented opportunity and an  
3064 historic imperative now to address these problems in a  
3065 comprehensive way, which is the only way they can be solved.  
3066 The Congress faces a challenging dilemma in addressing the  
3067 growth of Medicare spending. Achieving an appropriate

3068 balance between controlling costs and continuing to achieve  
3069 the objectives of the program is a difficult task but one  
3070 that is of the utmost importance.

3071         An important factor to considering policies to control  
3072 Medicare and other federal health spending is the fact that  
3073 it is largely driven by factors that apply across the  
3074 healthcare system, putting pressure not only on the public  
3075 sector, including both the Federal Government and state and  
3076 local governments but the private sector as well, including  
3077 both large and small businesses, workers and their families,  
3078 and others who need or may need healthcare. Treating  
3079 healthcare cost growth only as a Medicare issue can lead to  
3080 inappropriate policies that fail to address the underlying  
3081 cause of the problem and lead to increasing pressure not only  
3082 on Medicare and its beneficiaries but on the rest of the  
3083 health system and the people it serves. In other words, I  
3084 guess I would say that the open bar extends not only to  
3085 Medicare beneficiaries but to all patients who make choices  
3086 about how much healthcare to use--and their providers.

3087         The IPAB, if used appropriately, can serve as a helpful  
3088 tool in attempting to address these issues. It should be  
3089 viewed as an opportunity to focus the attention of  
3090 policymakers both in the executive branch and the legislative  
3091 branch and in fact if stakeholders and state and local

3092 governments in the private sector as well, an action that in  
3093 the end needs to be taken to avoid an alternative that  
3094 everybody should agree will be unpalatable.

3095 I have described some of these actions in my written  
3096 testimony, which I won't go into detail here, but suffice it  
3097 to say, this will require a broader view of the role of IPAB  
3098 and all other available mechanisms as well. It is not a  
3099 question of whether Congress or the IPAB should be trusted to  
3100 solve this problem but the issue that it will take,  
3101 collaboration among Congress, the administration, and all  
3102 parties involved in the healthcare system to solve it.

3103 While the board is currently charged with identifying  
3104 areas of overpayment in Medicare, its scope of authority also  
3105 includes issuing recommendations for Medicaid and private  
3106 insurer payment policies. And the combined leverage of  
3107 multiple payers could in fact yield prices closer to  
3108 competitive market prices, as well as greatly reduce  
3109 administrative burdens on physician practices and hospitals,  
3110 all while stimulating delivery system improvement and  
3111 innovation. To be sure, how much we pay for healthcare is  
3112 very important, but how we pay and what we pay for is even  
3113 more important. The IPAB should be looked at as a tool to be  
3114 used to improve health system performance in this way.

3115 An array of payment approaches can be designed to

3116 encourage providers to become more accountable for the  
3117 quality and cost of care beneficiaries receive and reward  
3118 them rather than punishing them as the current system often  
3119 does for providing that type of care. In this regard, the  
3120 IPAB can and should work closely with the new CMS Innovation  
3121 Center. These innovations should be developed both from the  
3122 top down with the Federal Government leading the way, as well  
3123 as from the bottom up with Federal Government joining in  
3124 initiatives developed and implemented by local stakeholders.

3125         The Affordable Care Act provides for testing innovative  
3126 payment strategies, including broad authority for the  
3127 Innovation Center to pilot test a broad array of payment and  
3128 delivery system reforms. The IPAB should have the  
3129 flexibility to work with the Innovation Center to quickly  
3130 adopt and spread successful innovations throughout the  
3131 Medicare and Medicaid programs and work to encourage their  
3132 spread and align improvement efforts throughout the  
3133 healthcare system.

3134         Finally, and perhaps most importantly, the scope of the  
3135 IPAB should include working with private sector payers on  
3136 ways to foster collaboration between the public and private  
3137 initiatives to improve organization and delivery of  
3138 healthcare and slow cost growth. Given the CBO's finding of  
3139 55 percent of projected increase in federal health spending

3140 over the next 25 years can be attributed to excess growth in  
3141 healthcare costs throughout the healthcare sector. This  
3142 problem plagues businesses, households, federal, state, and  
3143 local government alike. And it seems clear the only way to  
3144 reduce growth in federal health spending is to address the  
3145 growth of total health spending.

3146         Summing up, the emphasis of IPAB as part of a broader  
3147 process should be on total healthcare costs rather than only  
3148 federal spending, enhancing access and quality, being  
3149 sensitive to distributional impact, including protecting the  
3150 most vulnerable, emphasizing the need the improve  
3151 performance, encouraging coherence and alignment of  
3152 incentives across the entire healthcare system. Again, the  
3153 IPAB can be useful as a vehicle for focusing attention on  
3154 these most critical issues if all the public and private  
3155 sector stakeholders can work together to make it so.

3156         Thanks for inviting me to participate in this hearing,  
3157 and I am honored to be here before the subcommittee and with  
3158 these distinguished panels and look forward to the rest of  
3159 the discussion.

3160         [The prepared statement of Mr. Guterman follows:]

3161 \*\*\*\*\* INSERT 10 \*\*\*\*\*

|  
3162           Mr. {Pitts.} The chair thanks the gentleman and  
3163 recognizes Dr. Gottlieb for 5 minutes.

|  
3164 ^STATEMENT OF DR. SCOTT GOTTLIEB

3165 } Dr. {Gottlieb.} Mr. Chairman, Ranking Member, thank you  
3166 for the opportunity to testify before the committee.

3167 IPAB was created based on a premise that decisions about  
3168 the pricing of Medicare's benefits are simply too contentious  
3169 to be handled by a political process. But changes to the way  
3170 Medicare pays for medical services affect too many people in  
3171 significant ways to be made behind closed doors. How  
3172 Medicare prices medical products and services has sweeping  
3173 implications across the entire private market. They are some  
3174 of the most important policy choices that we make in  
3175 healthcare. To these ends, there are some considerable  
3176 shortcomings with the way that IPAB is structured and how it  
3177 will operate.

3178 Among these problems, IPAB has no obligation to engage  
3179 in public notice and comment that is customary to regulatory  
3180 agencies whose decisions has similarly broad implications.  
3181 IPAB's decisions are restricted from judicial review. In  
3182 creating IPAB, Congress provided affected patients,  
3183 providers, and product developers with no mechanism for  
3184 appealing the board's decisions. IPAB's recommendations will  
3185 be fast-tracked through Congress in way that provides for

3186 only a veneer of congressional review and consent. The  
3187 cumulative effect of the rules for appointing members to IPAB  
3188 will almost guarantee that most of its outside members hail  
3189 from the insular ranks of academia. But most significantly,  
3190 IPAB is unlikely to take steps that actually improve the  
3191 quality of medical care and the delivery of services under  
3192 Medicare. That is because IPAB does not have any practical  
3193 alternative to simply squeezing prices in the Medicare  
3194 program.

3195         The problem we have in Medicare is a problem with the  
3196 existing price controls that erode healthcare productivity  
3197 and Medicare's outdated fee-for-service payment system. This  
3198 leads to inefficient medical care. There is too little  
3199 support for better, more innovative ways of delivering  
3200 healthcare.

3201         So what is IPAB likely to do besides simply squeeze  
3202 prices? They will also try to confer CMS with new  
3203 authorities to enable the agency to make more granular  
3204 decisions about what products and services CMS chooses to  
3205 cover. IPAB could well confer CMS with constructs such as  
3206 Least Costly Alternative authority or the authority to  
3207 consolidate drugs, devices, equipment, or services under the  
3208 same payment code. The combined effect of these new powers  
3209 would effectively give CMS the ability to engage in tacit

3210 forms of reference pricing.

3211           The problem is that CMS has no tradition of making these  
3212 kinds of decisions. As a consequence, it has little capacity  
3213 to make the required clinical judgments. I believe many in  
3214 Congress realize this and I know many stakeholders recognize  
3215 it. This isn't just a question of expertise. It is also a  
3216 question of whether these kinds of personal medical choices  
3217 should be made in the first place by a remote agency that is  
3218 far removed from the circumstances that influence clinical  
3219 decision-making. This will have implications for patients  
3220 and providers. It will also have implications for those  
3221 developing new medical technologies making that process more  
3222 uncertain, more costly, and less attractive to new  
3223 investment.

3224           Medicare must continue to implement reforms to align its  
3225 coverage and payment policies with the value delivered to  
3226 beneficiaries. Congress needs to focus on real ways to get  
3227 longer-term savings like premium support, modernizing  
3228 benefits in tradition Medicare, and paying for better  
3229 outcomes. IPAB makes it even harder to do all these things.

3230           In closing, if Congress believes that the political  
3231 process is incapable of making enduring decisions about the  
3232 payment of medical benefits, then all of this is an argument  
3233 for getting the government out of making these kinds of

3234 judgments in the first place. It is not an argument for  
3235 creating an insular panel that is removed from the usual  
3236 scrutiny to take decisions that other federal entities have  
3237 failed to adequately discharge precisely because those  
3238 decisions could not survive public examination.

3239 Thank you.

3240 [The prepared statement of Dr. Gottlieb follows:]

3241 \*\*\*\*\* INSERT 11 \*\*\*\*\*

|  
3242           Mr. {Pitts.} The chair thanks the gentleman. I will  
3243 now begin the questioning and recognize myself for 5 minutes  
3244 for that purpose.

3245           Mr. Roy, changes that reduce cost by improving the  
3246 healthcare delivery system and health outcomes often require  
3247 several years before savings may occur and the board may have  
3248 to find immediate savings. Therefore, isn't there a real  
3249 concern that board proposals may skew towards changes in  
3250 payments, which are likely to result in de facto rationing of  
3251 care and ignore the more important aspects of long-term  
3252 reform?

3253           Mr. {Roy.} In fact, it appears that that is almost  
3254 certain to be the likely consequence of IPAB's decisions.

3255           Mr. {Pitts.} Thank you.

3256           Ms. Cohen, can you expand on how difficult it would be  
3257 for Congress to stop or override the decisions made by the 15  
3258 experts on this board once the process is put into motion?

3259           Ms. {Cohen.} Certainly. Well, first of all, it is not  
3260 a matter of Congress being able to come up with an  
3261 alternative. The alternative would actually have to be  
3262 exactly what IPAB would have already done. They have to make  
3263 the same costs or an alternative couldn't even be viable  
3264 pursuant to the statute. There can be no amendments to

3265 IPAB's proposal again unless it meets the very strict  
3266 requirements of IPAB's statute. So basically, Congress can  
3267 do nothing but do more than what IPAB has done. It certainly  
3268 couldn't do less.

3269 But more than that, we have talked about how the  
3270 spending targets, but IPAB's power is much broader than that.  
3271 IPAB also has powers that could affect the private market,  
3272 and it is very unclear about if a proposal came by that came  
3273 from IPAB that included recommendations for the private  
3274 market or legislative proposals as they are called in the act  
3275 whether Congress could actually override that. And then, of  
3276 course, there is the super majority voting requirement in the  
3277 Senate. And that, of course, is a very difficult hurdle.

3278 Mr. {Pitts.} Thank you. Anyone can respond to this  
3279 question. Savings attributable to the IPAB have varied  
3280 considerably. The CBO's scoring for the IPAB has changed  
3281 several times. Initially, the CBO estimated that savings  
3282 attributable to the board would be \$15.5 billion over the 5-  
3283 year period from 2015 to 2019. In March 2011, realizing that  
3284 under current law the IPAB mechanism will not affect Medicare  
3285 spending during the 2011-2021 period, CBO scored repeal of  
3286 the IPAB at zero. In April, using an obscure statistical  
3287 methodology called the one-sided bet, the CBO revised this  
3288 estimate again and now says that full repeal of the IPAB

3289 would cost \$2.4 billion. Can anyone explain why this has  
3290 been so difficult to score? Mr. Davis, do you want to try?

3291 Mr. {Davis.} Mr. Chairman, I would like to, if I can,  
3292 defer to my colleague, Mr. Newman.

3293 Mr. {Pitts.} All right. Mr. Newman?

3294 Mr. {Newman.} I think basically we have got a varying  
3295 set of assumptions going forward in that these estimates are  
3296 likely to change in future years, too. If Congress fixes the  
3297 SGR, the baseline estimate with respect to what program  
3298 expenditures are going to be will change, and once that  
3299 changes, the targets will change and the potential savings  
3300 resulting from board recommendations will change, too. I  
3301 think what you are doing is looking at snapshots at these  
3302 estimates over time.

3303 Mr. {Pitts.} All right. Thank you.

3304 Dr. Guterman, regarding the IPAB, the CBO stated that  
3305 the board is likely to focus its recommendations on changes  
3306 to payment rates or methodologies for services in the fee-  
3307 for-service sector by nonexempt providers. And the Kaiser  
3308 Family Foundation recently stated in an issue brief that the  
3309 1-year scorable savings mandate may discourage the type of  
3310 longer-term policy change that could be most important for  
3311 Medicare and the underlying growth in healthcare cost,  
3312 including delivery system reforms that MedPAC and others have

3313 recommended, which are included in the ACA and which  
3314 generally require several years to achieve savings. Would  
3315 you agree with this assessment from both the CBO and the  
3316 Kaiser Foundation?

3317 Mr. {Guterman.} I would suggest that the IPAB, since it  
3318 doesn't exist yet, what it focuses on will depend a lot on  
3319 the environment in which it operates. And I would envision  
3320 IPAB as working closely with the Innovation Center to  
3321 incorporate some of the best policies that were enacted in  
3322 the Affordable Care Act and other policy ideas as well. So I  
3323 would hope that IPAB wouldn't be an either-or proposition,  
3324 that you would either take IPAB or the Congress or some other  
3325 party but that it would be people working together to try to  
3326 find the best policies available to accomplish the goals that  
3327 IPAB was established for, which is to slow Medicare spending  
3328 and more broadly to slow healthcare spending.

3329 Mr. {Pitts.} The chair thanks the gentleman. My time  
3330 has expired. The chair recognizes Ms. Schakowsky for 5  
3331 minutes for questions.

3332 Ms. {Schakowsky.} I thank you, Mr. Chairman and Mr.  
3333 Pallone, for letting me go out of order.

3334 Mr. Roy, I have to say that I am deeply offended by your  
3335 open-bar analogy. It is like saying oh, honey, now that we  
3336 are 65, I can get breast cancer and you can have that heart

3337 attack. And we are now able to get--I can now get a PET scan  
3338 and an MRI and a CAT scan as if older Americans are making  
3339 those kinds of decisions or--as I think Dr. Guterman pointed  
3340 out--as if they are making those decisions differently from  
3341 people who have insurance who also, you know, go about their  
3342 business knowing that they are insured and get the  
3343 healthcare. I mean, really. And also that Medicare has  
3344 exploded. It has not, in fact, exploded more than healthcare  
3345 costs in the private sector. Is that true, Dr. Feder?

3346 Ms. {Feder.} That is true, Congresswoman, that Medicare  
3347 spending per capita grows more slowly than in the private  
3348 sector.

3349 Ms. {Schakowsky.} More slowly. The other thing is you  
3350 must not have seen the recent Medicaid study, a scientific  
3351 study done out of Oregon that absolutely showed--the first  
3352 actual scientific study that was able to take 10,000 people  
3353 who got Medicaid, 10,000 who did not and had profound  
3354 improvements in the healthcare of people--you ought to check  
3355 it out. It is a very important study.

3356 So I think it is insulting to older Americans to say  
3357 that now they are just spending their days just having a  
3358 great time at the doctor. You know, mostly I think people  
3359 are trying to figure out, you know, perhaps have a little  
3360 vacation or something or pay for their medications is more

3361 likely.

3362           So Dr. Feder, what you are saying in your testimony is  
3363 that because the problem is system-wide that this will--and  
3364 you mentioned how consumers should have choices and mentioned  
3365 Switzerland, you know, Switzerland says in the basic package,  
3366 insurance companies can't make any profit. Did you know  
3367 that?

3368           Mr. {Roy.} Yes, they are nonprofit companies.

3369           Ms. {Schakowsky.} They are nonprofit companies. That  
3370 makes a rather big difference between the U.S. system that  
3371 anyone has proposed and the Swiss system which I think was  
3372 sort of glossed over in your saying that, you know, we should  
3373 have more--I think it is--I would like that. That would be  
3374 just fine.

3375           But Dr. Feder, I want to get back to you and say so how  
3376 exactly would that work if we were to bring everyone under  
3377 this system?

3378           Ms. {Feder.} Ms. Schakowsky, as you know, the  
3379 Independent Payment Advisory Board is now authorized to make  
3380 recommendations for the private sector but they are not  
3381 binding. There is not an overall target. There is a target  
3382 on Medicare alone. And since, as you say and I agree, the  
3383 problem is system-wide. We could modify that is a target  
3384 that authorization to apply to all of healthcare spending

3385 because Medicare and private spending are driven by the same  
3386 factors and can be most effective if their payment mechanisms  
3387 are aligned. And a way to do that is as the IPAB examines  
3388 the evidence, as Dr. Guterman said, works with the Innovation  
3389 Center and looks for ways to improve payments in both the  
3390 public and private sector, adoption of those improved payment  
3391 mechanisms could be applied, recommended to the Congress for  
3392 application not only to Medicare but as conditions we could  
3393 say for favorable tax preferences under current law. So we  
3394 have the capacity to apply these mechanisms across the board.

3395 Ms. {Schakowsky.} And there could be some carrots you  
3396 put out, as well sticks.

3397 Ms. {Feder.} I beg your pardon? There could be?

3398 Ms. {Schakowsky.} The carrots as well as sticks.

3399 Ms. {Feder.} Absolutely. I think the goal is to  
3400 actually change the way in which we pay consistent with I  
3401 believe it was Mr. Murphy was asking the secretary about  
3402 coordinating care. The goal is to move away from rewarding  
3403 providers for delivering ever more and expensive service and  
3404 more expensive services toward delivering good care,  
3405 efficient higher-quality care, coordinated and efficiently  
3406 delivered and rewarding providers accordingly.

3407 Ms. {Schakowsky.} Okay. Would anybody want to comment  
3408 on the issue of access to care? Is it really a concern that

3409 we--and I will leave that to--that if Medicare reimbursements  
3410 are too low as a result of a decision by IPAB that doctors  
3411 simply won't take Medicare patients.

3412 Mr. {Roy.} That is already happening. So if you look  
3413 at consistent surveys, the rate of the difficulty for  
3414 Medicare beneficiaries gaining access to care is higher than  
3415 it is for people in private insurance.

3416 Ms. {Schakowsky.} Actually, I saw an opposite study.  
3417 Maybe you haven't seen a more recent study that has 93  
3418 percent of Medicare patients were able to access care as  
3419 opposed to 88 percent of people who had private insurance.

3420 Mr. {Roy.} The consistent consensus of all the data is  
3421 access to care for Medicare beneficiaries is worse, and I  
3422 recommend that you talk to the physicians in your district  
3423 and I think they will agree.

3424 Ms. {Feder.} Actually, I have to take issue with that.  
3425 It is not consistent. The MedPAC finds through the surveys  
3426 that they do that the access that Medicare beneficiaries have  
3427 access in the vast majority of communities around the  
3428 country. There are variations and that in many respects if  
3429 not most or if not all it is that the access is superior to  
3430 those for private insurers.

3431 Ms. {Schakowsky.} Thank you. My time has actually run  
3432 out. I don't know, Mr. Chairman, if Dr. Guterman--

3433 Mr. {Guterman.} If I can add one more comment. Any  
3434 issues there are with current or future access problems for  
3435 Medicare beneficiaries is probably attributable to the  
3436 sustainable growth rate mechanism, which is kind of a  
3437 separate issue from the IPAB. And I would also point out  
3438 that CBO's estimate of the impact of the whole Affordable  
3439 Care Act on Medicare spending was that the projected increase  
3440 pre the ACA of 94 percent over the next 10 years would be  
3441 reduced to an increase of 71 percent over the next 10 years  
3442 in Medicare spending. I think that could hardly be described  
3443 as rationing care or starving providers.

3444 Mr. {Pitts.} Okay.

3445 Ms. {Schakowsky.} Thank you.

3446 Mr. {Pitts.} The chair thanks the gentlelady and  
3447 recognizes Dr. Burgess for 5 minutes for questions.

3448 Dr. {Burgess.} Thank you, Mr. Chairman.

3449 Let me just say on the issue of access to care, Mr. Roy,  
3450 I have talked to the doctors in Ms. Schakowsky's district and  
3451 they tell me to a man and a woman that they are in deep  
3452 trouble because they cannot afford the cost of delivering  
3453 their care. Now, true enough MedPAC came to this panel, I  
3454 think it was the last Congress, testified to us that there  
3455 were not access issues that they had identified and then  
3456 Glenn Hackbarth has visited with me since then saying he is

3457 becoming concerned about people, particularly seniors who  
3458 move, and when does that happen? I want to be closer to the  
3459 grandkids, so they move to a new city or location and there  
3460 they find the door is closed. And if this Congress continues  
3461 to bury its head in the sand about that, we are going to find  
3462 that the world becomes very, very hostile.

3463 Now, Mr. Roy, let me just tell you I was not offended by  
3464 your open-bar analogy.

3465 Mr. {Roy.} Thank you.

3466 Dr. {Burgess.} I do not drink myself but I thought it  
3467 was apropos. And, you know, the President of the United  
3468 States, when he had the Republicans down 3 or 4 or 5 weeks  
3469 ago to the White House, big reception in the East Room, and  
3470 he wanted to drive a point home with us. And I think the  
3471 point he wanted to make was that drugs cost too much.

3472 But the point he made was that during the--and it is not  
3473 a HIPAA violation because he told us in an open forum--in the  
3474 election he developed a rash on his back and he was concerned  
3475 about it. So he went to a doctor who prescribed some goop to  
3476 put on it. And he put the goop--he didn't use the word goop;  
3477 I made that up--but he put this cream on it for the  
3478 prescribed time and it might have helped a little bit but not  
3479 so much so he had it refilled. He had a little prescription  
3480 card and it cost him 5 bucks to get it refilled. So he went

3481 down and had it refilled.

3482           And then he was on the campaign trail and he ran out.  
3483 So what to do? He went to a pharmacist, explained to the  
3484 pharmacist his dilemma, got the prescription transferred via  
3485 the miracle of electronic records and the pharmacist bagged  
3486 it up for him and said that will be \$400. And the President  
3487 looked at the pharmacist and said, you know, this rash is not  
3488 that bad. And at that point, the President became an  
3489 informed consumer and was spending his healthcare dollars  
3490 wisely. Now, people do argue that well, wait a minute. You  
3491 go into that sort of system and people will not get  
3492 healthcare when they need it.

3493           He also pointed out to us, and I did not know this, but  
3494 apparently one of his daughters was gravely ill when she was  
3495 very young and he went to the emergency room with her and the  
3496 doctor explained the diagnoses and what would have to be done  
3497 and what he proposed and the President--then not the  
3498 President--he said do whatever it takes. And of course he  
3499 did. He behaved in a rational fashion that you would expect  
3500 a father to do when their child is gravely ill. He did not  
3501 question cost.

3502           So I guess the point I am trying to make is the  
3503 President actually articulated a strategy for consumer-  
3504 directed healthcare that I thought was phenomenal for him to

3505 admit. Now, we had some hearings leading up to the  
3506 Affordable Care Act. We didn't have hearings that I thought  
3507 really would have gotten to the issue of the cost of  
3508 delivering care. If we were serious about that, we should  
3509 have invited Mitch Daniels in here and said how did you do it  
3510 with your Healthy Indiana plan? Now, Dr. Feder is saying  
3511 that the cost of Medicare grows more slowly than other areas.  
3512 I don't think that is accurate and I would like to hear Dr.  
3513 Gottlieb, perhaps Ms. Cohen weigh in on that, and you, too,  
3514 Mr. Roy, but we never heard from someone who is actually  
3515 making it happen on the ground. Healthy Indiana program  
3516 costs went down by 11 percent over 2 years. So even if we  
3517 accept the figures that I believe are wrong that Dr. Feder is  
3518 talking about, why wouldn't we do something that is even  
3519 better than that, which was look into consumer-directed  
3520 healthcare? Because as the President so correctly  
3521 articulated, something magic happens when people spend their  
3522 own money.

3523 Now, we are left with this Independent Payment Advisory  
3524 Board that is going to tell us how to magically spend less  
3525 money, and it just takes me back to a speech that Ronald  
3526 Reagan gave in 1964, and he talked then about some of the  
3527 issues that were ahead and whether or not this country still  
3528 believes in this capacity for self-government or whether we

3529 abandon the American Revolution and confess that it is a  
3530 little intellectual elite in a far-distant Capitol that can  
3531 plan our lives for us better than we can plan them ourselves.  
3532 Ronald Reagan was describing the Independent Payment Advisory  
3533 Board.

3534 I have gone on too long, but Dr. Gottlieb, do you have  
3535 an impression as to whether or not the cost of delivering  
3536 care is rising more slowly in Medicare than in other areas?

3537 Dr. {Gottlieb.} I would defer to Mr. Roy on an analysis  
3538 of numbers. I haven't seen any apples-to-apples comparisons  
3539 on senior care because everyone is in Medicare.

3540 Mr. {Roy.} That is correct so you can't really analyze  
3541 the numbers directly because seniors, of course, are almost  
3542 all on Medicare. Not all of them but--and they are also over  
3543 65 so they have higher medical expenditures.

3544 Dr. {Burgess.} Well, let me ask you a question.  
3545 Regardless of whether you are for-profit or not-for-profit  
3546 insurance company, you need to have access to capital, so the  
3547 cost of that capital is the cost of what the cost of the  
3548 capital is on the open market, but does Medicare have a cost  
3549 of capital that they have to put on their balance sheet?

3550 Mr. {Roy.} No, in fact there are a number--

3551 Dr. {Burgess.} Do they have a cost for advertising they  
3552 need to put on their balance sheet?

3553 Mr. {Roy.} There are a number of different aspects of  
3554 Medicare administrative costs that are off the HHS or  
3555 Medicare--

3556 Dr. {Burgess.} And on that general administrative side  
3557 to the balance sheet, what about all the administration that  
3558 goes on in the Department of Health and Human Services that  
3559 is appropriated through a discretionary appropriation, which  
3560 is the largest appropriation that occurs every year that the  
3561 Congress deigns to do appropriations bills?

3562 Dr. {Gottlieb.} I would just add, you know, the most  
3563 significant cost to Medicare is the cost of compliance with  
3564 the Medicare program, which is a cost that isn't estimated.  
3565 If you look at what goes on in medical practice, a good  
3566 percentage of the expenditures in any medical practice or in  
3567 the hospital is on trying to comply with the Medicare program  
3568 because of the threat of, you know, a Justice Department  
3569 audit or a Medicare audit. Hospitals, medical practices  
3570 overspend on that. That doesn't get calculated in the cost  
3571 of the overall program if you will. Private healthcare plans  
3572 have to actually hire staff to do that kind of work.  
3573 Medicare can just foist rules on the private sector and back  
3574 it up with the threat of litigation or criminal penalty, and  
3575 those costs don't get estimated in the cost of the program.

3576 Dr. {Burgess.} Very well. Thank you.

3577 Mr. {Roy.} Roughly speaking, the administrative costs  
3578 are double when you count all the off-budget expenditures of  
3579 Medicare, and that doesn't also include the cost of fraud,  
3580 which is very significant in the Medicare program relative to  
3581 that for private insurers. If you add all that up, the  
3582 administrative cost per beneficiary for Medicare between  
3583 fraud and the actual administrative costs is arguably double  
3584 to three times that of private insurers. If you leave fraud  
3585 out, it is about 20 percent higher.

3586 Dr. {Burgess.} Thank you. Thank you all for being on  
3587 the panel today.

3588 Mr. {Pitts.} The chair thanks the gentleman and  
3589 recognizes the gentleman, Mr. Pallone, for 5 minutes for  
3590 questions.

3591 Mr. {Pallone.} Thank you, Mr. Chairman. I am going to  
3592 try to divide my time between asking Dr. Guterman about the  
3593 Affordable Care Act and asking Mr. Davis about IPAB. So just  
3594 bear that in mind if I cut you off.

3595 You heard me in the beginning that I am against IPAB. I  
3596 think it is a usurpation of, you know, congressional  
3597 authority and, you know, I have never been in favor. I spent  
3598 a lot of time trying to make sure it wasn't in the House  
3599 bill, which it wasn't. But a lot of my concern is that it is  
3600 very much like the BRAC, which I think is a disaster. And

3601 the concern about the BRAC is that it is totally stacked  
3602 against Congress. I mean I don't like the idea to begin with  
3603 because it takes away congressional authority and gives it to  
3604 the executive or independent commission, but I also think it  
3605 is stacked. There is no way we are ever going to overturn a  
3606 BRAC decision. We have had three BRACs since I have been  
3607 here. Every time we try to overturn it we fail, and that is  
3608 it. There is no congressional input.

3609         What I wanted to ask Mr. Davis quickly is to what extent  
3610 is IPAB the same? In other words, we have been operating  
3611 with MedPAC, they make recommendations, we usually adopt  
3612 them. I think we have been very effective. I don't see any  
3613 need to change MedPAC. With BRAC, you know, it is one deal.  
3614 You either vote it up or down. You need a super majority,  
3615 which we never get. Is the process similar and stacked in a  
3616 way that it is going to be virtually impossible as it is with  
3617 the BRAC to overturn?

3618         Mr. {Davis.} Thank you, Mr. Pallone.

3619         Mr. {Pallone.} And I am asking him as opposed to the D  
3620 or R witnesses because I am trying to be--not that you are  
3621 biased but I am trying to get an unbiased opinion. Go ahead.

3622         Mr. {Davis.} Yes, Mr. Pallone. As you said in your  
3623 opening comments, there are very many similarities between  
3624 the IPAB model and the base-closure commission. Principally

3625 is, as you indicated, that this is a commission that makes  
3626 recommendations that go into force unless Congress stops  
3627 them. That is also, of course, the case with IPAB. And  
3628 whether under this procedure there are certain super  
3629 majorities that are required to overturn IPAB and some of  
3630 them, frankly, are de facto super majorities as they are with  
3631 BRAC, the idea that if Congress were to put forward something  
3632 different it would be vetoed and require a 2/3 override in  
3633 both chambers. So in that way it is similar to the base  
3634 closure process.

3635         There are two differences I would highlight, though.  
3636 The first is is that Congress, unlike under BRAC, can change  
3637 the procedures--or rather change the recommendations of IPAB  
3638 as long as they fit within the same fiscal targets. That, as  
3639 you know, is not the case with BRAC where it is simply an up-  
3640 or-down vote. Others have pointed out another difference,  
3641 frankly, with BRAC in simply that it is related only to  
3642 facilities while, of course, very important, can be thought  
3643 of as very different to a sweeping policy area such as  
3644 Medicare or healthcare reform. So I think in sum there is  
3645 similarities and differences.

3646         Mr. {Pallone.} All right. Thank you. I appreciate  
3647 that.

3648         Now, let me ask Dr. Guterman, I don't know if I was

3649 going to ask Judy Feder to jump in, too, but I don't know if  
3650 we have time. I believe very strongly--I am opposed to IPAB,  
3651 but one of the reasons I also was opposed to it was because I  
3652 thought that in the Affordable Care Act that we did a very  
3653 good job about keeping costs down and that we put together  
3654 under Medicare, under the Affordable Care Act a sustainable  
3655 trajectory if you will for the next generation with all the  
3656 things that we did and we don't need IPAB, not necessary.

3657         So what I wanted to ask you is if you could outline how  
3658 the Affordable Care Act's approach to reducing health costs  
3659 is affective. You know, don't get into IPAB. I mean to what  
3660 extent did we set up a sustainable Medicare program here and  
3661 get towards the cost without IPAB, with the other things. In  
3662 1 minute or so.

3663         Mr. {Davis.} The Affordable Care Act laid out a number  
3664 of tools that one could use to build a better healthcare  
3665 system, and that is really the answer. It is not a matter of  
3666 how much we pay so much as how we pay and what we pay for in  
3667 healthcare and how healthcare is organized and delivered that  
3668 needs to be addressed. And the Affordable Care Act, through  
3669 the Innovation Center, through the Medicare/Medicaid  
3670 Coordination Office. Those are two big steps because the  
3671 Innovation Center is supposed to develop in collaboration  
3672 with outside parties innovations that help improve the

3673 delivery of care and save money in Medicare and Medicaid and  
3674 across the healthcare sector.

3675           And they have already begun to initiate projects that  
3676 involve States in broader initiatives. They are working with  
3677 private payers. The ACO model that they are working on is  
3678 one that has been picked up by the private sector, and in  
3679 fact there are a number of private sector initiatives that  
3680 are ongoing to try to achieve the Accountable Care  
3681 Organization model that has been put forward in the ACA.

3682           And also having Medicare and Medicaid work together for  
3683 a change, there are 9 million beneficiaries who are eligible  
3684 for both programs, and right now the two programs just aren't  
3685 well aligned to serve those beneficiaries' needs or to make  
3686 sure that the money that is spent is well spent for those  
3687 beneficiaries.

3688           Mr. {Pallone.} Thank you. Thank you, Mr. Chairman.

3689           Mr. {Pitts.} The chair thanks the gentleman and  
3690 recognizes the gentleman from Georgia, Dr. Gingrey, for 5  
3691 minutes for questions.

3692           Dr. {Gingrey.} Mr. Chairman, thank you very much and I  
3693 thank the panel. I am sorry I had to step out to give a  
3694 little quick speech and I missed all of your testimony but I  
3695 certainly intend to read it all because what I heard was  
3696 extremely interesting, a little bit diverse, which is to be

3697 expected.

3698           Before I go into questions, I want to raise one very  
3699 important point today. In the press, Secretary Sebelius has  
3700 often chided opponents of IPAB for suggesting that it has the  
3701 power to restrict access to physicians' services or life-  
3702 saving drugs and treatments, otherwise known as rationing.  
3703 And yet under oath here today she has admitted that IPAB is  
3704 charged with reducing excessive growth areas of Medicare  
3705 spending when President Obama's own OMB director states that  
3706 excessive growth in Medicare spending is due to the  
3707 availability and adoption of new, high-cost drugs and  
3708 treatments.

3709           Finally, nowhere in ObamaCare are the words rationing or  
3710 excessive growth areas defined in statute, which means it is  
3711 up to the secretary and the IPAB board to ultimately decide  
3712 what is rationing and what cutting excessive growth areas  
3713 means. It is up to them. And if the American public  
3714 disagrees with how the secretary or IPAB define rationing,  
3715 they are, as I got from her testimony, prohibited from suing  
3716 in court to stop it.

3717           So my concern here is simple. What one person considers  
3718 rationing, another might refer to as reducing excessive  
3719 growth areas of Medicare, known here as new treatments or  
3720 drugs. And I believe the secretary of Health and Human

3721 Services owes this committee and owes the American people a  
3722 lot more clarity on this issue.

3723         Now, let me in the remaining time get to my questions  
3724 and I will go to Dr. Gottlieb, yes, and Mr. Roy. I am  
3725 interested in your thoughts on the lack of clarity in the law  
3726 with regards to, one, rationing and reductions in excessive  
3727 growth areas, along with the lack of judicial review, as I  
3728 mentioned, for patients who feel the board is in fact denying  
3729 them the benefits that they need to survive.

3730         Dr. {Gottlieb.} Well, I think the issue of rationing  
3731 versus squeezing payments is a distinction without a  
3732 difference because we have seen it already that when you  
3733 squeeze payments, it effectively closes off access to care,  
3734 and there is some debate about what is happening in the  
3735 Medicare program, and I would submit there has been some  
3736 recent studies, one out of Massachusetts that shows that  
3737 Medicare beneficiaries having a hard time getting access to  
3738 providers up there. There is certainly no debate around  
3739 Medicaid and whether or not patients under the Medicaid  
3740 program have a difficult time getting access to medical care  
3741 because of how low rates have been squeezed in that program.  
3742 So so long as IPAB is going to squeeze down payments, it is  
3743 going to ration care, and I think, you know, the distinction  
3744 is just semantics.

3745           What was the second question, Congressman? I am sorry.

3746           Dr. {Gingrey.} Well, let me do this, Dr. Gottlieb.

3747 Thank you. And I would like to get Mr. Roy's opinion on that  
3748 same thing if he can.

3749           Mr. {Roy.} I think that I would echo Dr. Gottlieb's  
3750 comments. I think that the importance of access to a  
3751 physician cannot be understated. It is the most important  
3752 thing. If you have a problem and you can't see a doctor for  
3753 that problem and that problem festers, you could have a much  
3754 more serious medical condition. Children die of toothaches  
3755 on Medicaid because they can't see a dentist and have their  
3756 abscesses removed. There are serious, serious medical  
3757 problems of healthcare that if you can't have access to a  
3758 physician, you can't do anything. So the fact that the IPAB  
3759 is explicitly restricted from changing the mix of benefits  
3760 really doesn't matter if somebody can't actually see a doctor  
3761 in the first place.

3762           Dr. {Gingrey.} Right. Right. Well, I thank you both  
3763 for that answer to that question. And I have got one more,  
3764 Mr. Chairman.

3765           Secretary Sebelius in her statements today said that the  
3766 administration has begun outreach efforts to fill these 15  
3767 seats on the Independent Payment Advisory Board. I would  
3768 just be curious to know among this distinguished panel

3769 whether or not any of you have been contacted, and I very  
3770 specifically ask Ms. Cohen. Has anyone from the  
3771 administration contacted you about serving on our IPAB?

3772 Ms. {Cohen.} No, probably because I am suing them.

3773 Dr. {Gingrey.} Ms. Feder, Judy Feder, has anyone from  
3774 the administration asked you--contacted you about this?

3775 Ms. {Feder.} I have actually had lots of discussions  
3776 about various aspects of the Affordable Care Act with the  
3777 administration and indicated that I would be proud to serve  
3778 on the Independent Payment Advisory Board.

3779 Dr. {Gingrey.} So the answer is yes? That sounds like  
3780 a yes to me.

3781 Ms. {Feder.} Asked would be grossly overstating.

3782 Dr. {Gingrey.} Yeah. I take that as a yes. Mr. Roy,  
3783 how about yourself? Have you been asked?

3784 Mr. {Roy.} I am afraid not. I like my current job, so  
3785 I am okay.

3786 Dr. {Gingrey.} Dr. Gottlieb?

3787 Dr. {Gottlieb.} I have been asked by some Senate staff  
3788 and I indicated that I would be interested in being nominated  
3789 but I wouldn't want to serve. My only reason for being  
3790 nominated is I want to write an op ed. outlining why the  
3791 President shouldn't pick me to serve on the board.

3792 Dr. {Gingrey.} So the response, Mr. Chairman, is that

3793 two of our panelists have been at least approached and one is  
3794 enthusiastic about the possibility of serving and the other  
3795 one is not. I thank you all very much for your response and  
3796 I yield back my time.

3797 Ms. {Feder.} If I might just clarify, the approach was  
3798 mine I just want to say.

3799 Dr. {Gingrey.} Mr. Chairman, would you yield me another  
3800 15 seconds?

3801 Mr. {Pitts.} Go ahead.

3802 Dr. {Gingrey.} Did I not ask Dr. Guterman?

3803 Mr. {Guterman.} No, you didn't.

3804 Dr. {Gingrey.} I apologize, Dr. Guterman. Have you  
3805 been approached?

3806 Mr. {Guterman.} You don't need 15 seconds. No, I have  
3807 not.

3808 Dr. {Gingrey.} You have not. Okay. Thank you. And I  
3809 yield back.

3810 Mr. {Pitts.} All right. The chair thanks the gentleman  
3811 and recognizes the gentl lady from California, Mrs. Capps,  
3812 for 5 minutes for questioning.

3813 Mrs. {Capps.} Thank you, Mr. Chairman.

3814 Well, welcome to all of you and thank you. This is a  
3815 big panel and thank you to each of you for your testimony. I  
3816 am in and out today but my computer and my television set are

3817 all locked in so I could watch and listen.

3818 Dr. Feder, the Republican plan for Medicare is to end it  
3819 in 2022 and replace it with a limited voucher, whatever it  
3820 needs to be called, with which to purchase a coverage on  
3821 their own. Each senior, then, would have this opportunity or  
3822 responsibility. It would solve the Federal Government's  
3823 healthcare cost problems by asking seniors and those with  
3824 disability to make sure that all the costs were covered and  
3825 using their voucher or subsidy or premium support to help  
3826 them do this. The Congressional Budget Office estimates that  
3827 the Republican budget would double annual costs. Despite  
3828 this cost-saving or cost-shifting in the Ryan budget plan,  
3829 the Republican budget would actually double the annual cost  
3830 for Medicare by 2022 and nearly triple them by 2030. But  
3831 this isn't just a problem for the future. Costs that large  
3832 cannot be covered by our future seniors overnight.

3833 The Center for Economic and Policy Research looked into  
3834 what these changes would mean for the retirement planning of  
3835 people who are 54 or under today, which will be the first  
3836 cohort of people who will live under--should the Ryan plan  
3837 become actualized. They found that this plan would require  
3838 that each senior would have to save about \$182,000 for  
3839 retirement over whatever they would be currently planning to  
3840 save. Does this lead you to question the claim that the

3841 Republican budget doesn't hurt people today, only in the  
3842 future?

3843         Ms. {Feder.} It does, indeed, Ms. Capps, and I  
3844 appreciate your drawing attention to the fact that it is not  
3845 just about the future. It is about the current period. And  
3846 I would add to it the concern that you have raised about  
3847 people becoming uncertain as to what they would have to pay  
3848 for insurance. And at the time when they are struggling to  
3849 put aside pensions for the future, as well as take care of  
3850 their kids, get them started and educated, that they would  
3851 have to be putting money away to deal with future insurance  
3852 costs seems to me an outrage.

3853         In addition to that, those who were talking about the  
3854 repeal of the IPAB are also talking about the repeal of the  
3855 Affordable Care Act. And so the protections that have been  
3856 added for prescription drug costs, for preventive benefits,  
3857 and other advantages that are available to current seniors,  
3858 current beneficiaries would also disappear.

3859         In addition, there would be an enormous--as this  
3860 proposal has set up--there would be a huge cliff that occurs  
3861 at that year when that goes into effect. And that seems an  
3862 enormous burden to put on people into the future.

3863         Mrs. {Capps.} I would like to shift to a topic of  
3864 Medicaid in just a minute, but I want you to respond briefly

3865 to many concerns that current seniors--today's Medicare  
3866 recipients are the ones who are voicing their concerns about  
3867 this change in plan, even though they have been reassured  
3868 that nothing will happen to them. There is a concern and I  
3869 haven't been able to address it--I wondered if you could--  
3870 about what is to stop, you know, the majority from pushing  
3871 forward this time. I mean if it is going to be that kind of  
3872 cost shift to start, you know, for those who are 54 now, what  
3873 is there sacred about this contract that the current seniors  
3874 now have with their government?

3875 Ms. {Feder.} The people that would be affected in 2022  
3876 are paying into Medicare for Medicare benefits as we speak  
3877 and they are expecting them. If the Congress changes that  
3878 contract, there is nothing to say that they couldn't change  
3879 the contract for those currently on Medicare.

3880 Mrs. {Capps.} Now, similarly, the Republican plan for  
3881 Medicaid would also slash payments to States starting in just  
3882 2 years. It would be sort of a block-grant approach to  
3883 Medicaid, the match that is now guaranteed. The federal  
3884 portion of it would no longer be in the same way. I am from  
3885 California, and boy, there is tremendous concern about this  
3886 because our State has terrific economic challenges. We have  
3887 lots of people receiving Medicaid benefits, and to have this  
3888 double whammy to the State of having to pick up more of the

3889 piece, which is apparently what is intended. Maybe you will  
3890 explain what the cuts to Medicaid would have any effect on  
3891 Medicare beneficiaries, some of them being dually eligible.

3892 Ms. {Feder.} The Republican budget calls for a cut in  
3893 federal funding to the States for Medicaid of about 3/4 of a  
3894 trillion dollars. It is a huge cut in the resources going to  
3895 States to support a population which, as we all know and are  
3896 discussing with respect to Medicare is aging and then  
3897 becoming increasingly in need of care. About a third of  
3898 Medicaid spending is for long-term care services, long-term  
3899 services and support, some in nursing homes, some outside  
3900 nursing homes. The elderly along with younger people with  
3901 disabilities but the elderly are primary beneficiaries. They  
3902 are also beneficiaries of Medicare.

3903 We have improved services in recent years to try to get  
3904 people who need long-term care services at home and in the  
3905 community where they want to stay and not go into nursing  
3906 homes, those as well as a host of other services who are dual  
3907 eligibles. Medicare beneficiaries who are also dependent on  
3908 Medicaid would be tremendously at risk as we know from what  
3909 States are already considering as cuts in benefits.

3910 Mrs. {Capps.} Thank you, Dr. Feder.

3911 Mr. {Pitts.} The chair thanks the gentlelady and  
3912 recognizes the gentleman from Kentucky, Mr. Guthrie, for 5

3913 minutes.

3914 Mr. {Guthrie.} Thank you, Mr. Chairman. Thank you for  
3915 coming.

3916 I talked with the secretary earlier today and here is my  
3917 concern. And people have paid into Medicare and it is not a  
3918 dollar in, you get a dollar out. I understand that. But we  
3919 have a study from the Urban Institute says people average  
3920 about 100,000 or a little more into Medicare and take out  
3921 about 300,000. And people might say that is not a correct  
3922 study or not. I know. And I have seen other studies about  
3923 three to one what you pay and what you receive. And I am  
3924 1964 into the baby boomer. Beginning of the baby boomer is  
3925 1946. We are all retiring starts now. It starts now. We  
3926 know in 2024 I think the President even said Medicare is  
3927 unsustainable. Now, they say during the Obama healthcare  
3928 plan, President Obama's healthcare plan they preserve  
3929 Medicare, but he even said yesterday that it is unsustainable  
3930 the path that it is on. And what we are trying to do is  
3931 offer a solution, a reform that preserves it for those who  
3932 have it and to have it for people that are--I am 47. I am  
3933 affected by it--to move forward. And to say that we paid  
3934 into Medicare and it is not going to be there. That is just  
3935 incorrect. That is absolutely incorrect because it is a  
3936 government-sponsored program that we are offering that uses

3937 Medicare dollars to move forward.

3938           So my question is--and Dr. Feder, with the vast of baby  
3939 boomers moving--taking out \$3 for every \$1 we put in, how do  
3940 you keep the system as it is for people in the future? You  
3941 can't just--you know, they talked about DME medical  
3942 equipment. If you stopped people from buying the scooters--  
3943 the free advertising, I will get you a scooter on television--  
3944 -you can't save enough money to make up for the demographic  
3945 move, the wave that is coming of baby boomers. And it starts  
3946 today. It has started today.

3947           Ms. {Feder.} Mr. Guthrie, I am an earlier baby boomer.  
3948 I will be 65 next year, so I am at the point of the pressure  
3949 here. And there is no question that it is growth in  
3950 population that is what is driving Medicare spending, total  
3951 spending much more than any other period in the history of  
3952 the program as the enrollment grows because the per capital  
3953 spending growth, remember, for Medicare is much slower than  
3954 private sector growth, but what is now come to drive along  
3955 with that spending growth, cost per beneficiary, is the  
3956 number of beneficiaries.

3957           Mr. {Guthrie.} Right.

3958           Ms. {Feder.} And it is true for all of us that we don't  
3959 want 1965 healthcare or in 1985 or in 2020. We want the  
3960 healthcare that is available today.

3961 Mr. {Guthrie.} Right. So how do you have the fee-for-  
3962 services as it exists today with the vast baby boomers  
3963 retiring and not--talk about cost-shifting. I have a 17-  
3964 year-old daughter who in 30 years will be 47 years old which  
3965 is my age. And in 40 years, according to the CBO, 100  
3966 percent--if you have 18 percent of revenue GDP--coming to the  
3967 Federal Government will be for Medicare, Medicaid, and Social  
3968 Security. So the greatest generation who provided the  
3969 interstate highways, fought World War II, did everything to  
3970 give my generation the opportunities, my generation, if we  
3971 don't address it--I know everybody is here criticizing  
3972 everything we are doing--but if we do not address it, my  
3973 child will go to work when she is my age for me to be  
3974 retired, solely for me to be retired.

3975 Ms. {Feder.} Well, I understand your concern and I  
3976 share it. I have 4-year-old twin granddaughters, and I am  
3977 doing my best to guarantee affordable healthcare for them  
3978 well into the future when they are my age and older. And  
3979 what we are all concerned about here is how to do that. And  
3980 the way to do that is to change the overall healthcare  
3981 system. The Affordable Care Act gave Medicare the lead in  
3982 changing the way we pay for healthcare and making the whole  
3983 system more efficient. And that is what we need to do  
3984 because an alternative is simply to deny care to those who

3985 don't have the resources to pay a cost that is going up.

3986 Mr. {Guthrie.} The Republican plan doesn't deny care.

3987 And just like Medicare Part D, it is 40 percent under

3988 estimate because health plans have to compete. Anybody can

3989 answer what I just--I am just not asking the one question--

3990 Ms. {Feder.} Well, if I may stay with you, I don't

3991 think Medicare Part D offers you the answer there, sir, and

3992 the cost of prescription drugs are rising as well. We need

3993 to make the system more efficient--

3994 Mr. {Guthrie.} Well, let me ask--Mr. Roy, I am about

3995 out of time. I am sorry to cut you off but I only have 40

3996 seconds left.

3997 Mr. {Roy.} No, I think that one of the things that we

3998 see with the CBO projections is the CBO consistently

3999 underestimates the importance of cost-shifting in medical

4000 expenditures, so Medicare Part D has a significant cost-

4001 sharing component, which is the so-called donut hole, which

4002 is now going away. But that donut hole is a big part of the

4003 reason, along with the choice and plans, that Medicare Part D

4004 is coming 40 percent under budget, whereas with the

4005 conventional, traditional parts of the program, expenditures

4006 have skyrocketed out of control because there has been

4007 minimal cost-sharing.

4008 Mr. {Guthrie.} And the administration wants people

4009 making \$250,000 or more to pay more taxes but they don't want  
4010 them to pay more for their healthcare. And what our plan  
4011 does is if you are at the lower end, you still get covered,  
4012 and at the higher end you would pay more. And so instead of  
4013 a \$250,000-a-year person at 65 years old paying more for  
4014 their healthcare, they are going to send the bill to my 17-  
4015 year-old daughter and my 16-year-old son and my 13-year-old  
4016 daughter.

4017       Mr. {Roy.} I would make a point about that which is  
4018 that because medical expenditures grow at faster than the  
4019 rate of GDP, you can never raise taxes fast enough to  
4020 compensate for the rise in healthcare spending. So it is  
4021 always much more efficient if you want a means test to means  
4022 test on a spending side rather than on the taxation side.

4023       Mr. {Pitts.} The chair thanks the gentleman and  
4024 recognizes the gentleman from Texas, Mr. Gonzalez, for 5  
4025 minutes.

4026       Mr. {Gonzalez.} Well, thank you very much, Mr.  
4027 Chairman. And I really appreciate the testimony of all the  
4028 witnesses. I may not agree with a few of you but I do think  
4029 that IPAB is actually one of the best approaches as trying to  
4030 get a handle on what are exploding healthcare costs. And I  
4031 think we all acknowledge that healthcare costs consumes too  
4032 much of our GDP, that employers are no longer providing it to

4033 the degree that they used to provide it to their employees,  
4034 that individuals in this country very likely cannot afford  
4035 healthcare. It is that simple. That 50 cents out of every  
4036 dollar spent on healthcare comes from some entity of  
4037 government.

4038         And I do--I share some of the real concerns of my  
4039 colleagues on the other side of the aisle about where we are  
4040 going to be and such. A generation that may have provided  
4041 great opportunity for us, the interstate highway system, but  
4042 I remind everybody that what Eisenhower and others did in the  
4043 '50s to give us that interstate highway system was to, in  
4044 essence, raise the gasoline tax what would be the equivalent  
4045 of 96 cents a gallon today. There is not one of my  
4046 colleagues--and I hate to say it--I don't think I would vote  
4047 on that myself today. So there is a difference that is going  
4048 on out there as to what people are willing to pay for in this  
4049 country and still expect to receive the benefit.

4050         I am concerned about something you said, Mr. Roy, and  
4051 because in the United States either the government is  
4052 subsidizing the payment for healthcare or the private sector  
4053 is. But the individual consumer--and there is no other  
4054 product or service that has that kind of status in this  
4055 country that I am aware of. But I am somewhat disturbed by  
4056 the fact that it must be all of the patient's fault.

4057           And I am concerned about some aspects of IPAB. I share  
4058 the concerns of my physicians in my district that are saying  
4059 where will our input--how are we guaranteed that we have  
4060 something to say as far as the information that is going to  
4061 be considered by the members of this board? I am really  
4062 worried about that. But where does the responsibility lie?  
4063 I will tell you right now if I go into my doctors--and I have  
4064 been going to them for a number of years--and if they tell me  
4065 I need a certain procedure or certain test, I really don't  
4066 question it.

4067           Now, let us just say I didn't have Blue Cross/Blue  
4068 Shield because it is employer-sponsored. I am a Member of  
4069 Congress. But I was going to pay that out of my own pocket.  
4070 I am still not real sure--your premise is that I am going to  
4071 shop around and I am going to go around and say well, I am  
4072 not sure that I really need that test. I think I will go and  
4073 see another doctor and get another opinion, which is going to  
4074 cost me money and such. So where does the responsibility  
4075 lie? Do you believe that maybe the physicians have a  
4076 responsibility only to provide that service which is  
4077 absolutely necessary? I am not going to get into the  
4078 argument of unnecessary testing and everything else because I  
4079 have got the gold standard in the State of Texas, and it has  
4080 not brought down the cost of healthcare in the State of

4081 Texas. It has brought down the cost of insurance policies  
4082 for certain specialties. So where is this shared  
4083 responsibility? How do we get a handle on this? And isn't  
4084 IPAB maybe a method of achieving that goal?

4085 Mr. {Roy.} If one looks at a number of studies around  
4086 the behavior of patients and physicians with high deductible  
4087 health plans and health savings accounts where there is more  
4088 consumerism, where there is more ability to shop for  
4089 procedures and tests and office visits, you see a lot more  
4090 intelligent consumption.

4091 I think in Washington we have an excessively pessimistic  
4092 view of the ability of individuals to make intelligent  
4093 decisions about their own care. Especially in the days of  
4094 the internet, people do a lot of research; people have a lot  
4095 of knowledge. If we had a system where consistently across  
4096 the system for everyone there were more and more people who  
4097 could shop for care, who bought insurance for themselves  
4098 instead of having it provided by someone else, you have more  
4099 of the ability to start thinking in the way that people need  
4100 to think about well, do I really need that test? And if a  
4101 doctor says, yes, I really do think you need that test even  
4102 though it costs \$2,000, the patient might say yes. But maybe  
4103 the doctor will say you know what? That test is \$2,000. I  
4104 think it might benefit you a little bit but maybe it is not

4105 worth paying for for you right now because it is \$2,000 and  
4106 you are very unlikely to benefit from it.

4107 Mr. {Gonzalez.} Don't you think the determining factor,  
4108 though, really in most tests--and I know this is going to be  
4109 controversial--is whether it is covered or not?

4110 Mr. {Roy.} Could you repeat the question?

4111 Mr. {Gonzalez.} What I am saying is whether you have  
4112 access to a number of tests or not is whether that test is  
4113 going to be paid for though some subsidy, either through  
4114 private insurance or government. Isn't that the truth?

4115 Mr. {Roy.} Not necessarily because, again, if you have  
4116 co-pays, deductibles, health savings accounts, and other  
4117 mechanisms by where the patient shares in the expenditure,  
4118 the patient has more of an incentive to monitor those  
4119 expenditures and make sure they are being executed  
4120 intelligently.

4121 Mr. {Gonzalez.} And Mr. Chairman, I am going to ask  
4122 your indulgence just to give Dr. Guterman a couple of minutes  
4123 to respond to some of the comments.

4124 Mr. {Pitts.} Dr. Guterman?

4125 Mr. {Guterman.} I promise this will be brief. I wanted  
4126 to point out that in my written testimony, I point out that  
4127 58 percent of total Medicare spending is accounting for by 10  
4128 percent of Medicare beneficiaries, who account for an average

4129 of \$48,000 in Medicare costs. These are people who are very  
4130 sick. It is not that they are incurring those costs because  
4131 they are bad shoppers. The other thing I would point out is  
4132 that there was a large-scale experiment on the impact of out-  
4133 of-pocket costs on the utilization of healthcare and what it  
4134 found was that, indeed, higher out-of-pocket costs reduced  
4135 the utilization of healthcare both desirable and undesirable  
4136 healthcare. So putting the onus on the back of Medicare  
4137 beneficiaries, especially ones who are sick who are the ones  
4138 who are spending the money is kind of a difficult way to make  
4139 sure that the system runs efficiently.

4140 Mr. {Pitts.} The chair thanks the gentleman. That  
4141 completes this round of questioning. We will have one  
4142 follow-up for each side. Dr. Burgess?

4143 Dr. {Burgess.} Thank you, Mr. Chairman.

4144 Dr. Guterma, I recognize one size fits all doesn't work  
4145 and that is one of the reasons I have got some concerns about  
4146 what we have done, what Congress has done with the Affordable  
4147 Care Act. But I am a big believer and letting people spend  
4148 their own money for healthcare, but I also recognize that  
4149 there are populations out there where this would not be the  
4150 wisest course of action.

4151 Now, when I practice medicine, I kind of considered  
4152 myself to be--well, what I have learned now--we call it a

4153 medical home--but I mean I was always the one that arranged  
4154 things for my patient. I always went the extra mile to do  
4155 things that were not necessarily reimbursed but were required  
4156 as part of giving good care. And I don't remember if you  
4157 were there at the Commonwealth meeting in January but it came  
4158 up during the course of that meeting that one of the Members  
4159 of Congress who was there said that healthcare is so  
4160 complicated I have to use a concierge doctor to sort of sort  
4161 things out for me. And this was not a Republican Member who  
4162 said it. So it was kind of a shock to hear this come from a  
4163 Member of Congress. And I asked Don Berwick. Dr. Berwick  
4164 was there and he was on that panel, and I said, so Don, you  
4165 just complained about 20 percent of your patients consuming  
4166 80 percent of your resources. Why don't you buy these folks  
4167 a concierge doctor? Or why don't you directly contract with  
4168 a physician to be responsible for a pool or panel of patients  
4169 in the dual eligible world. And we all know who those  
4170 patients are. They are readily identifiable. They don't  
4171 move around a lot. They stay in one place. So wouldn't that  
4172 be a population that would be amenable to a different type of  
4173 practice model? You talk about wanting to change the payment  
4174 structure for everyone and maybe that is not necessary.

4175           Maybe we could look at this defined population and say  
4176 we want to do a better job for these patients. And we know

4177 that they are not served by having to go from doctor to  
4178 doctor to doctor to doctor. Why don't we put one person in  
4179 charge? We used to have a saying when I was in practice too  
4180 many doctors means no doctor and that is exactly true. So if  
4181 you had one person who was directly accountable to that  
4182 arguably very complicated and very ill and multiple-medical-  
4183 conditions patient, if you have one doctor, don't you think  
4184 you would get a better return on investment for that money  
4185 that you spend?

4186 Mr. {Guterman.} Dr. Burgess, I agree with everything  
4187 you said, and I think that is the underlying philosophy of  
4188 the medical home model. I think it is the underlying  
4189 philosophy of the Accountable Care Organization. And I  
4190 think, you know, what this represents is that I think we all  
4191 agree that the healthcare system needs to work better to  
4192 provide care, especially for those with multiple chronic  
4193 illnesses and the people who are sickest. And I think  
4194 whatever approach you take, whether it is a--

4195 Dr. {Burgess.} But, sir, that is not new information.  
4196 You said you have been working on this for 30 years. Where  
4197 is the beef?

4198 Mr. {Guterman.} The medical home model has been one  
4199 that has been talked about and tried in limited, you know,  
4200 scale, but--

4201 Dr. {Burgess.} And yet, I am the kind of doctor who was  
4202 providing that type of care and you basically ran me out of  
4203 business--

4204 Mr. {Guterman.} Right.

4205 Dr. {Burgess.} --by not paying the freight, by not  
4206 paying for these activities.

4207 Mr. {Guterman.} The problem is that in our current fee-  
4208 for-service system, people get punished for doing the kind of  
4209 care that you would like to provide. And, you know, we hear  
4210 people from various systems around the country, you know,  
4211 that can enumerate the way they get punished for doing good  
4212 things for their patients, but under the current payment  
4213 system, those good things are rewarded with lower payment, so  
4214 in a sense they are punished for doing what they would like  
4215 to do for their patients. So I think we can agree--and maybe  
4216 this is a platform for kind of collaboration, you know,  
4217 across the aisle that we agree, I think, on the kind of care  
4218 we would like to see and we agree that getting to that kind  
4219 of care is what we really need to solve the problems that we  
4220 are all concerned with.

4221 Dr. {Burgess.} And I would just submit the obstacle so  
4222 far has been CMS. They haven't been a facilitator; they have  
4223 been an obstacle. But I welcome the opportunity to work with  
4224 you on this. Obviously, I have got some discussions going on

4225 with other people and I would welcome the Commonwealth Fund  
4226 being part of that discussion as well.

4227 Thank you, Mr. Chairman. I will yield back.

4228 Mr. {Pitts.} The chair thanks the gentleman. Mr.  
4229 Pallone for a follow-up?

4230 Mr. {Pallone.} Thank you, Mr. Chairman. I am going to  
4231 ask Dr. Guterman. You know, before I was asking you  
4232 questions about how the Affordable Care Act would save money  
4233 even without IPAB, and I believe very strongly that it saves  
4234 money, particularly for not only the government but also for  
4235 beneficiaries as opposed to the Republican budget, which I  
4236 think is going to cost, you know, Medicare beneficiaries a  
4237 lot more. So I just want to ask you to compare and contrast  
4238 the Affordable Care Act's approach to saving money and that  
4239 of the Republican budget, particularly as beneficiaries are  
4240 affected if you would.

4241 Mr. {Guterman.} Let me start by adding something I  
4242 omitted in my answer to your previous question and that is  
4243 the Patient-Centered Outcomes Research Institute, which is a  
4244 public-private organization that is charged with producing  
4245 evidence to help make better clinical decisions in the  
4246 healthcare sector, which I think can only help. It is not  
4247 like those decisions aren't being made every day millions of  
4248 times. It is just they are being made with too little

4249 information. But I guess rather than contrast the two  
4250 approaches, I would say that under both approaches the  
4251 problem is not solved unless we change the way healthcare is  
4252 delivered and paid for because in the end you need to control  
4253 the cost of healthcare and you need to control the way  
4254 healthcare is delivered and the way it is targeted at the  
4255 people who need it most and providing the services that  
4256 benefit people most.

4257         And if you provide people with premium support, if the  
4258 cost of healthcare isn't controlled, they are going to find  
4259 themselves more and more left out of the market for health  
4260 insurance. If you just rely on cutting payments alone, you  
4261 are going to make access more difficult for Medicare  
4262 beneficiaries. If you address broader issues either through  
4263 the IPAB or other mechanisms that are already in place with  
4264 the Affordable Care Act, then I think you achieve what you  
4265 want to achieve and then, you know, even perhaps make the  
4266 Independent Payment Advisory Board unnecessary because you  
4267 have controlled costs already and met their targets.

4268         Mr. {Pallone.} Thank you.

4269         Mr. {Pitts.} Dr. Cassidy, you came in and missed the  
4270 first round. Do you have questions?

4271         Dr. {Cassidy.} Yes.

4272         Mr. {Pitts.} You are recognized for 5 minutes.

4273 Dr. {Cassidy.} I apologize for having to leave.

4274 Dr. Guterman, I kind of had a schizophrenic approach to  
4275 your testimony. Part of it I liked and part of it I am  
4276 thinking what is the guy thinking? So the part that I liked  
4277 is where you mention that we have to take a global view.  
4278 History clearly shows that Medicare and Medicaid will do a  
4279 downward pressure upon their cost and shift that to the  
4280 private sector. I mean there is no mystery about that. I  
4281 could almost stipulate that. There is a good article by one  
4282 of the--maybe McKinsey, maybe somebody else about the  
4283 hydraulic effect. The more Medicare, the more Medicaid you  
4284 have in your book of business, the greater the upward impact  
4285 upon costs for small businesses and the private health  
4286 insurance market.

4287 So what gives you kind of encouragement that IPAB--which  
4288 is really just looking after the Medicare book of business--  
4289 will not succumb to that same temptation that Medicare always  
4290 has and Medicaid specifically really has to shift cost to the  
4291 private sector?

4292 Mr. {Guterman.} Let me first--the term cost-shifting is  
4293 often misunderstood partly because it assumes that the cost  
4294 of healthcare is somehow immutable and can't be reduced by  
4295 better examination of what is appropriate to--

4296 Dr. {Cassidy.} I will give you that we can do a better

4297 job with what we have, but if Medicaid pays 60 percent of  
4298 cost, then clearly there has to be a makeup someplace.

4299 Mr. {Guterman.} Well, but that depends on whether you  
4300 think costs are right. But beyond that, what I think is  
4301 important to think of IPAB in the context of is the broader  
4302 set of tools that are available to us, that I think there is  
4303 more really unprecedented push to use to address the problems  
4304 that we are facing now. And I think, you know, looking at  
4305 IPAB alone--IPAB alone is not going to solve the problem.  
4306 But IPAB is in the context of a broad array of policies that  
4307 are on the table that may in fact be able to solve the  
4308 problem. And it is also part of a process that I think the  
4309 Congress has to be involved in. You know, sometimes--

4310 Dr. {Cassidy.} Let me pause you there because I have  
4311 limited time.

4312 Mr. Roy, what would you--I think we know where Dr.  
4313 Guterman is going. What would be your thoughts?

4314 Mr. {Roy.} Yeah, so I think you actually, Dr. Cassidy,  
4315 bring up the most important point around this faulty idea  
4316 that somehow Medicare expenditures are growing more slowly  
4317 than private sector because what happened is Medicare shifts  
4318 costs to private insurers, so if I have two Chevys that I  
4319 paid \$10,000 each for and the government comes to me and says  
4320 I am buying that one Chevy from you for \$5,000 and I lose

4321 5,000 on that, maybe I charge the other guy 15,000 to make it  
4322 up. And that is effectively what cost sharing is. It is  
4323 more complicated than that in reality, but that is basically  
4324 what Medicare does. Medicare cheats by underpaying for care  
4325 and restricting access. And these are the problems that,  
4326 unfortunately, have a significant--what IPAB is all about.

4327 Dr. {Cassidy.} Dr. Gottlieb, your thoughts, please?

4328 Dr. {Gottlieb.} I think IPAB has no alternative but to  
4329 try to squeeze payments in the short term because anything it  
4330 could do to try to fundamentally reform payment systems or  
4331 the way care is delivered isn't going to score well at CBO.  
4332 They are going to have to achieve immediate savings.

4333 I think one of the larger problems here is that a lot of  
4334 the reforms in the Accountable Care Act and a lot of things  
4335 we are talking about here today are predicated on changing  
4336 the delivery model, getting better coordination of care.  
4337 Those require investments in innovation and how care is  
4338 delivered, and the only that providers, hospitals, doctors  
4339 are going to invest money to better coordinate care is if  
4340 they can earn an above-market rate of return for a  
4341 sustainable period of time on their invested capital. And  
4342 the problem is that the administration's legislation, the  
4343 regulations don't allow for that. And that is why is you are  
4344 seeing the adverse reaction to the regulations on the

4345 Accountable Care organizations.

4346 I could tell you I have seen a lot of business plans  
4347 floated with venture capitalists on creating new Accountable  
4348 Care organizations or services that would provide services to  
4349 the Accountable Care organizations. I haven't seen a single  
4350 one yet funded for that precise reason that the presumption  
4351 out there is that you are not going to be able to earn a  
4352 return on capital. If you do earn an above-market rate of  
4353 return on capital for any length of time, it is going to be  
4354 regulated. If you continue to earn an above-market rate of  
4355 return, it is going to be taxed. And if you continue to earn  
4356 it after it is taxed, you are going to be criminalized.

4357 Dr. {Cassidy.} But on the other hand, if you don't, you  
4358 will be subsidized.

4359 Dr. {Gottlieb.} And when it is gone, you subsidize it.

4360 Dr. {Cassidy.} And that is without saying that, again,  
4361 as I mentioned earlier, the New England Journal of Medicine  
4362 article that reflected upon the 10 Accountable Care  
4363 organization pilot studies, places specifically chosen so  
4364 that they would be more likely to succeed did not.

4365 Now, Dr. Guterman, you must have some thoughts about  
4366 that.

4367 Mr. {Guterman.} In fact, as I was saying when we  
4368 started up those demonstrations, and in fact I would describe

4369 that demonstration as a rousing success for several reasons.  
4370 One is that half of those 10 sites were able to achieve  
4371 measurable savings according to the rules of the  
4372 demonstration and received bonus payments for saving Medicare  
4373 millions of dollars compared to the targets that they were  
4374 working under.

4375 Dr. {Cassidy.} Now, in fairness, it was a 3-year  
4376 demonstration project and I think 3 did and it was not every  
4377 year and several did not.

4378 Mr. {Guterman.} But in the last 3 years there were 5 of  
4379 them. And all of the sites achieved noticeable increases in  
4380 the quality of care, which perhaps was even more important,  
4381 certainly without spending more money. And there were some--  
4382 as there will be--and I think something that the IPAB or any  
4383 other mechanism is going to have to deal with is compared to  
4384 what? And how you deal with getting either CBO scoring or  
4385 the Office of the Actuary in CMS to agree that a particular  
4386 project is going to save money. But that is going to have to  
4387 be dealt with. That is a methodological issue that I think  
4388 needs to be dealt with.

4389 Dr. {Cassidy.} I am out of time. I yield back. Thank  
4390 you all.

4391 Mr. {Pitts.} The chair thanks the gentleman. Did you--

4392 Dr. {Burgess.} But Mr. Chairman?

4393 Mr. {Pitts.} Go ahead.

4394 Dr. {Burgess.} Did you rule on my unanimous consent  
4395 request for Senator Cornyn's letters from Scott and White?

4396 Mr. {Pitts.} Without objection, so ordered.

4397 [The information follows:]

4398 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
4399 Dr. {Burgess.} Thank you.

4400 Mr. {Pitts.} Thank you and thank you to the panel.

4401 Very informative. I appreciate your patience.

4402 We will now change panels to a fourth panel, and I will  
4403 introduce the fourth panel as they come to the table.

4404 Joining us on our fourth panel are Dr. Alex Valadka, a  
4405 neurosurgeon. He is the chief executive officer at the Seton  
4406 Brain and Spine Institute, Austin, Texas. He represents the  
4407 Alliance for Specialty Medicine. Secondly, we have Mary  
4408 Grealy, who is the president of the Healthcare Leadership  
4409 Council in Washington, D.C. Then we have Dr. Jack Lewin,  
4410 Chief Executive Officer of the American College of  
4411 Cardiology. And fourthly, we have Teresa Morrow, who is the  
4412 cofounder and president of Women Against Prostate Cancer.

4413 Your written testimony will be entered into the record.

4414 We ask that you summarize your opening statements in 5

4415 minutes each.

4416 Dr. Valadka, you may begin your opening statement.

|  
4417 ^STATEMENTS OF DR. ALEX B. VALADKA, CHIEF EXECUTIVE OFFICER,  
4418 SETON BRAIN AND SPINE INSTITUTE, REPRESENTING THE ALLIANCE OF  
4419 SPECIALTY MEDICINE; MARY R. GREALY, PRESIDENT, HEALTHCARE  
4420 LEADERSHIP COUNCIL; DR. JACK LEWIN, CHIEF EXECUTIVE OFFICER,  
4421 AMERICAN COLLEGE OF CARDIOLOGY; AND TERESA MORROW, COFOUNDER  
4422 AND PRESIDENT, WOMEN AGAINST PROSTATE CANCER

|  
4423 ^STATEMENT OF DR. ALEX B. VALADKA

4424 } Dr. {Valadka.} Thank you, Chairman Pitts, Ranking  
4425 Member Pallone, members of the subcommittee, for allowing me  
4426 to testify about the Independent Payment Advisory Board. My  
4427 name is Alex Valadka. I am a practicing neurosurgeon from  
4428 Austin, Texas, and as far as I can tell, I am the only  
4429 practicing physician who has the privilege of testifying  
4430 before you here today.

4431 I am pleased to be here today on behalf of the Alliance  
4432 of Specialty Medicine which was founded in 2001 with the  
4433 mission to develop sound federal healthcare policy that  
4434 fosters patient access to the highest quality specialty care  
4435 and improves timely access to high-quality medical care for  
4436 all Americans. As advocates for patients and physicians, the  
4437 alliance and its members welcome the opportunity to

4438 contribute to the ongoing debate regarding IPAB, or as we  
4439 think about it, the Impacts Patients Adversely Board.

4440         We are deeply concerned about the unintended  
4441 consequences that will result from the establishment of IPAB.  
4442 We oppose its creation and we are now urging Congress to  
4443 immediately act to repeal IPAB. Now, I realize that by this  
4444 time in our IPAB-athon here today, you have had an earful and  
4445 I don't to be overly repetitive, but I do want to make you  
4446 aware that America's specialty physicians have numerous  
4447 concerns at both the concept of IPAB and its structure.

4448         First and foremost, the alliance believes that under the  
4449 IPAB, access to specialty care will be severely limited due  
4450 in part to the additional payment cuts that it will impose on  
4451 physicians. Medicare physician payments are already well  
4452 below market rates, as you heard earlier today, and they  
4453 continue to be subject to deep cuts as a result of the flawed  
4454 SGR formula. Cuts to physician reimbursement under IPAB will  
4455 only exacerbate those already imposed on physicians as a  
4456 result of SGR cuts and other cuts that are going to occur  
4457 each year as part of the Medicare physician fee schedule for  
4458 things like problems with the electronic health record, value  
4459 of base quality modifiers, meaningful use requirements, and  
4460 things of that type.

4461         Our physician survey data demonstrates that these cuts,

4462 including those imposed by IPAB, may ultimately force  
4463 specialists out of the Medicare program severely threatening  
4464 Medicare access to its beneficiaries to innovative therapies  
4465 and quality of care. And to echo something that was said  
4466 earlier today, participation in Medicare is not on or off.  
4467 Many physicians still continue to participate but they have  
4468 to limit the number of Medicare patients they can see in  
4469 their offices or otherwise provide access to.

4470         Our second concern is that IPAB lacks accountabilities,  
4471 sets a dangerous precedent for overriding the normal  
4472 legislative process. As drafted, the IPAB has little if any  
4473 accountability to the Medicare beneficiaries whose healthcare  
4474 will be affected by its decisions. And yet its  
4475 recommendations will have the force of law if Congress fails  
4476 or chooses not to act. The alliance maintains that Congress  
4477 should be the entity to legislate healthcare policy, not an  
4478 independent board.

4479         An additional concern is that the limited transparency  
4480 of IPAB proceedings severely limits congressional oversight  
4481 of the Medicare program and replaces the transparency of  
4482 hearings like this one with the less transparent process  
4483 overseen by the executive branch, not the legislative branch.  
4484 The IPAB statute also provides fast-track procedures for IPAB  
4485 proposals, which will automatically become law unless

4486 Congress can act very quickly to amend the proposal.  
4487 Congress already faces significant challenges in moving  
4488 legislation through the regular legislative process and we  
4489 seriously doubt its ability to jump through all the  
4490 procedural hoops within the required 7 months to override  
4491 IPAB recommendations.

4492         Although its proponents argue that the IPAB is critical  
4493 to holding down the growth in healthcare spending, providers  
4494 representing nearly 40 percent of Medicare expenditures,  
4495 including hospitals and nursing homes, are exempt from the  
4496 reach of IPAB for several years. We agree with the CBO that  
4497 this would place greater pressures to achieve saving on  
4498 physicians which, as I previously noted, will ultimately  
4499 curtail seniors' timely access to specialty care.

4500         Finally--and again as discussed earlier today--the  
4501 process for making appointments to the IPAB isn't balanced  
4502 because appointments are made solely by the President. This  
4503 structure also ensures that the board will have inadequate  
4504 expertise since it fails to include practicing clinicians  
4505 like me who can draw from firsthand experience when  
4506 considering how proposed recommendations could impact the  
4507 delivery of healthcare for both the patient and provider  
4508 perspective.

4509         Although the alliance recognizes the need to hold down

4510 the growth of Medicare costs, the IPAB is simply the wrong  
4511 way to go. But the more than 100,000 physicians represented  
4512 by the alliance reiterate our pledge to work with Congress to  
4513 identify more appropriate ways to achieve this goal. I ask  
4514 that you make the same commitment and work with the medical  
4515 community to meet the challenges facing our healthcare system  
4516 and not leave these very important decisions to a group of 15  
4517 unelected and largely unaccountable individuals.

4518 Mr. Chairman, thank you again for allowing the alliance  
4519 to testify, and I would be happy to answer any questions.

4520 [The prepared statement of Dr. Valadka follows:]

4521 \*\*\*\*\* INSERT 12 \*\*\*\*\*

|  
4522           Mr. {Pitts.} The chair thanks the gentleman and  
4523 recognizes Ms. Grealy for 5 minutes for an opening statement.

|  
4524 ^STATEMENT OF MARY R. GREALY

4525 } Ms. {Grealy.} Chairman Pitts, Ranking Member Pallone,  
4526 members of the subcommittee, on behalf of the members of the  
4527 Healthcare Leadership Council, I want to thank you for the  
4528 opportunity to testify on the ramifications of the  
4529 Independent Payment Advisory Board, or IPAB, for patients and  
4530 the U.S. healthcare system.

4531 Now, already today you have heard a number of  
4532 perspectives on IPAB. While I request to submit my full  
4533 testimony for the record, I would like to briefly share the  
4534 point of view of HLC members who are chief executives of the  
4535 Nation's leading healthcare companies and organizations. The  
4536 views I express today reflect the conclusions of hospitals,  
4537 academic health centers, insurers, pharmaceutical and medical  
4538 device innovators, distributors, pharmacies, and other  
4539 sectors within our healthcare system.

4540 Mr. Chairman, we fully agree that it is imperative to  
4541 make Medicare a more cost-efficient program, that its current  
4542 spending growth rates are unsustainable. The question is how  
4543 to address this challenge in a way that strengthens and does  
4544 not undermine the accessibility, the affordability, and  
4545 quality of healthcare for Medicare beneficiaries and for all

4546 Americans.

4547         Now, there are different approaches available to  
4548 Congress in pursuing this objective. On one hand, you have  
4549 the direction embodied in IPAB to simply slash expenditures  
4550 whenever spending exceeds a certain arbitrary level. Now, we  
4551 can talk all we want about the expertise of those who  
4552 conceivably would be serving on IPAB, but those credentials  
4553 are largely irrelevant. IPAB isn't designed to develop  
4554 meaningful long-term reforms to strengthen the value of the  
4555 Medicare program. Rather, its mandate is to achieve  
4556 immediate scorable savings.

4557         Now, according to analysis from the Congressional Budget  
4558 Office and the Kaiser Family Foundation, this imperative to  
4559 make immediate reductions means that IPAB's course of action  
4560 will likely focus on reducing payments to providers. The  
4561 impact of this action is easy to predict. Today, as we have  
4562 heard, an increasing number of physicians are restricting the  
4563 number of Medicare patients that they see in their practice  
4564 because of low payment rates. According to a survey of the  
4565 American Medical Association's members, that number includes  
4566 one of every three primary care physicians.

4567         Now, if IPAB is expected to cut the payment rates to  
4568 even lower levels, then we will almost certainly see more  
4569 physicians unable to treat Medicare beneficiaries and access

4570 will become a more critical issue. With those 80 million  
4571 baby boomers entering the Medicare program at an average of  
4572 9,000 per day and the projected physician shortages already  
4573 on the horizon, we could find ourselves on the verge of a  
4574 healthcare access perfect storm that will hit seniors the  
4575 hardest.

4576         These payment cuts also will likely result in greater  
4577 cost-shifting to private payers and their beneficiaries. It  
4578 should also be noted that IPAB will function much as that  
4579 deadly robot in the Terminator movies. It will have a  
4580 single-minded, relentless focus on achieving its cost-cutting  
4581 function. There is no statutory latitude to take into  
4582 consideration unforeseen public health concerns that may, in  
4583 the short term, necessitate more, not less, healthcare  
4584 spending. It does not take into consideration the potential  
4585 of new medicines and devices that may have high upfront cost  
4586 but that will reduce Medicare spending in the long run.

4587         Now, there is no question that Congress has more  
4588 flexibility than the IPAB in being responsive to healthcare's  
4589 circumstances, capabilities, and needs and will certainly be  
4590 more responsive to public concerns than an unelected board  
4591 ever will be. There are far more preferable approaches to  
4592 making Medicare more cost-efficient. There are multiple  
4593 provisions, for example, as we have heard today, within the

4594 Patient Protection and Affordable Care Act that are focused  
4595 on moving away from the fee-for-service model and aligning  
4596 incentives to reward providers for high-quality cost-  
4597 effective care. We should give these reforms an opportunity  
4598 to work before we think of turning to an approach as extreme  
4599 as the IPAB.

4600 Also, throughout the country, private-sector healthcare  
4601 providers are demonstrating innovative ways to generate  
4602 better health outcomes with less cost. We have documented  
4603 many of these successes in our HLC value compendium, which we  
4604 provided to CMS and I would like to submit for the record.

4605 Mr. Chairman, thank you again for this opportunity to  
4606 present our views.

4607 In summary, the members of the Healthcare Leadership  
4608 Council believe that the IPAB mandate and inherent  
4609 inflexibility will inevitably result in reduced healthcare  
4610 access for seniors. We need, instead, to turn to payment and  
4611 delivery reforms that will actually improve care while  
4612 reducing costs.

4613 Thank you, and I will be happy to answer any questions.

4614 [The prepared statement of Ms. Grealy follows:]

4615 \*\*\*\*\* INSERT 13 \*\*\*\*\*

|  
4616           Mr. {Pitts.} The chair thanks the gentlelady and  
4617 recognizes Dr. Lewin for 5 minutes.

|  
4618 ^STATEMENT OF DR. JACK LEWIN

4619 } Dr. {Lewin.} Thank you very much, Chairman Pitts,  
4620 Ranking Member Pallone, and Vice Chair Dr. Burgess. It is a  
4621 pleasure to be here today representing the American College  
4622 of Cardiology, all of America's cardiologists, and the many  
4623 cardiovascular nurses and researchers.

4624 Cardiovascular medicine represents 43 percent of  
4625 Medicare costs today, still, unfortunately the number one  
4626 killer in America, yet we have made some real progress. In  
4627 the last decade, morbidity and mortality for cardiovascular  
4628 disease has gone down by 30 percent in the United States, and  
4629 that is because of new imaging techniques, new procedures,  
4630 new therapeutics, new approaches to prevention, but also  
4631 because for the last decade we have been able to take  
4632 electronic tools, guidelines, performance measures,  
4633 appropriate-use criteria and apply them closer and closer to  
4634 the point of care to measure best evidence and get the best  
4635 results reducing unnecessary spending and activities.

4636 The Door-to-Balloon Campaign is one approach where we  
4637 have been able to speed the treatment of heart attacks in  
4638 hospitals through system improvement using the data we  
4639 collect in the registries we have in 2,500 U.S. hospitals.

4640 We have reduced the variation for heart attack treatment by a  
4641 factor of 3, the length of stay from 5 to 3 days, the costs  
4642 by 30 percent across the United States just in the last 3 to  
4643 4 years. Unbelievable.

4644 But here is the thing. We got no reward for that, no  
4645 incentives for that. It happened because we believe in it.  
4646 The IPAB, as proposed, is going to fail. Its price controls  
4647 won't work. It is a mechanism that represents the past, not  
4648 the future. And we are very concerned about that. In fact,  
4649 you know, we probably ought to get rid of the existing flawed  
4650 price-control mechanism, the SGR that you have on the books  
4651 right now. It hasn't worked very well, has it? We get rid  
4652 of that one before we launch the next one, please.

4653 We need an immediate and different approach or a very  
4654 different IPAB to bend the cost curve. In the last 40 years,  
4655 amazingly enough, the healthcare costs have gone up, you  
4656 know, multiples of the GDP 40 years in a row. This is really  
4657 amazing. If we got the GDP--if healthcare costs were GDP  
4658 plus 1 percent, the U.S. national deficit would go away in 20  
4659 years. So, you know, it is a patriotic kind of thing calling  
4660 for me at least for the profession of medicine, physicians,  
4661 hospitals, and others to get on this. We really have to bend  
4662 the cost curve. And can we do it? Yes, we can. If we get  
4663 the unnecessary spending out of the system, we can get this

4664 done.

4665           Now, I think to do that we have got to go back to using  
4666 those tools at the point of care, the guidelines, the  
4667 appropriate-use criteria. These measure not only quality but  
4668 for appropriate use, effectiveness in terms of efficiency and  
4669 spending, getting the right test the first time, getting the  
4670 right procedure the first time, et cetera. We can now  
4671 measure comparative outcomes. We couldn't do that 10 years  
4672 ago. We didn't have the electronic means to do that. We  
4673 couldn't tell doctors and hospitals how they are doing as to  
4674 whether they are spending the money efficiently, providing  
4675 patients with the best care. Now, we can.

4676           So let us provide the incentives for consistent best  
4677 evidence at the point of care, let us systematically reduce  
4678 variation, get rid of the unnecessary tests and procedures,  
4679 unnecessary admissions and costs. Let us use that kind of a  
4680 price-control approach. That is not the IPAB, folks. If we  
4681 want to IPAB to work, it is going to have to be so radically  
4682 modified to do the following: it has got to develop  
4683 incentives for doctors and hospitals to reward quality and  
4684 not volume. Setting price controls on volume is not going to  
4685 solve our problem. We already know that. It needs to apply  
4686 to healthcare sectors, not just the doctors, and wait a few  
4687 years and add the hospitals later. It needs to be flexible

4688 to attract people who really understand the healthcare system  
4689 and are in it and see it from various perspectives. And it  
4690 is currently designed so that it can't do that in terms of  
4691 the 15 members it is going to attract to be full-time parties  
4692 as it is designed now.

4693         So, you know, we are committed to the cause of the IPAB.  
4694 We think its purpose is absolutely right on. We believe in  
4695 that purpose. We see it as, in fact, a national kind of  
4696 patriotism. Let us compete in a global economy and get  
4697 healthcare costs down without destroying innovation in  
4698 healthcare and without destroying patient care itself.

4699         So let us rethink the IPAB or amend it so that it can  
4700 achieve the kinds of targets that will provide viable  
4701 Medicare--well, the targets for Medicare spending that will  
4702 keep the healthcare system viable but that won't stifle  
4703 innovation and won't harm patient care.

4704         Thank you very much.

4705         [The prepared statement of Dr. Lewin follows:]

4706 \*\*\*\*\* INSERT 14 \*\*\*\*\*

|  
4707           Mr. {Pitts.} The chair thanks the gentleman and  
4708 recognizes Ms. Morrow for 5 minutes.

|  
4709 ^STATEMENT OF TERESA MORROW

4710 } Ms. {Morrow.} Thank you. I would like to thank  
4711 Chairman Pitts and Ranking Member Pallone and the committee  
4712 for holding this important hearing today and I appreciate the  
4713 opportunity to submit my testimony on a topic that will  
4714 definitely have significant implications on the lives of  
4715 thousands of men, women, and families.

4716 My name is Teresa Morrow, and I am cofounder and  
4717 president of Women Against Prostate Cancer. Our mission is  
4718 to unite the voices and provide support for the millions of  
4719 women affected by prostate cancer. As healthcare leaders of  
4720 the household, the role that women play in all phases of  
4721 prostate cancer from preventative screenings to treatment and  
4722 follow-up care is critical.

4723 As you know, prostate cancer, as with any cancer,  
4724 impacts the entire family. Our own cofounder, Betty Gallo,  
4725 experienced the impact of this firsthand when her husband and  
4726 your former colleague, Representative Dean Gallo, was  
4727 diagnosed with prostate cancer in 1992 and subsequently died  
4728 from the disease in 1994. Since his passing, many  
4729 advancements in treatment and access to screenings and  
4730 quality healthcare have saved the lives of thousands of men

4731 diagnosed with prostate cancer and fewer families have to  
4732 suffer the loss of their loved ones as the Gallo family did.

4733         We are here today because we are concerned about the  
4734 effect that implementation of the Independent Payment  
4735 Advisory Board will have on Medicare patients and families,  
4736 including the large number of seniors that are diagnosed with  
4737 prostate cancer each year. We share your concerns for more  
4738 sustainable healthcare costs but do not believe that IPAB is  
4739 the best way to achieve this goal.

4740         We believe that IPAB will have a negative impact on  
4741 patient access to quality care. IPAB's power to dramatically  
4742 cut payments to healthcare providers and physicians who  
4743 provide services to beneficiaries will likely result in fewer  
4744 providers being willing to accept new Medicare patients and  
4745 limiting senior's access to quality providers. We are  
4746 concerned that IPAB could ultimately limit access to certain  
4747 treatments or medications. While IPAB may be specifically  
4748 prohibited from rationing care, reduced payments for certain  
4749 medical services and providers could lead to the unintended  
4750 consequence that beneficiaries should have access to certain  
4751 treatments and therapies but not to others.

4752         As a prostate cancer organization, we are particularly  
4753 concerned that patients may not have access to new and  
4754 innovative therapies to treat cancer that can ultimately

4755 improve and save lives. Treatment decisions should be made  
4756 between a healthcare provider and a patient and his or her  
4757 family and not be limited by an unelected board.

4758 I recently spoke with a prostate cancer patient named  
4759 Doug Magill from Northeast Ohio, and when he was diagnosed  
4760 with prostate cancer, he began his quest to determine which  
4761 treatment to pursue. He did all the things an informed  
4762 patient would do--got a second opinion, spoke with other  
4763 patients, family and friends, and he did a lot of research.  
4764 Ultimately, he chose to travel across the country to Loma  
4765 Linda University Medical Center to receive proton radiation  
4766 therapy. He chose proton therapy because of his fear of the  
4767 side effects such as impotence and incontinence that other  
4768 treatments may cause.

4769 Doug expressed his concern to me that an entity like  
4770 IPAB may have restricted his right to choose his treatment.  
4771 By limiting his access to certain providers, he may have been  
4772 forced to choose surgery instead of proton therapy and  
4773 possibly left incontinent and impotent for the rest of his  
4774 life.

4775 Like Doug, each prostate cancer patient is unique and  
4776 that should come into play when determining a treatment path.  
4777 Patients and providers should have the right to choose what  
4778 is best for them.

4779 Another negative impact to seniors will be IPAB's  
4780 requirement to achieve savings in 1-year periods. This means  
4781 that the focus will largely be on cutting payments and other  
4782 short-term savings rather than on long-term savings and  
4783 reforms that could save money or help patients avoid  
4784 unnecessary care in the future.

4785 More emphasis should be placed on prevention. Catching  
4786 health problems in their early stages while they are still  
4787 treatable and preventable is the best way to ensure that  
4788 seniors stay healthy and incur less expense to Medicare in  
4789 the long run. More emphasis should be placed on  
4790 participation in benefits like the Welcome to Medicare  
4791 physical. Currently, less than 10 percent of those eligible  
4792 to participate in this screening do so even though it can  
4793 serve to provide guidance for seniors' health maintenance as  
4794 they age.

4795 Finally, we are concerned about the lack of oversight of  
4796 IPAB. The board has the power to change laws previously  
4797 enacted by Congress without actually needing congressional  
4798 approval. Furthermore, the secretary's implementation of  
4799 IPAB's recommendations is exempt from judicial and  
4800 administrative review.

4801 We are also troubled that there is no patient  
4802 representation on the board and that IPAB is not required to

4803 hold public meetings where the voices of patients,  
4804 caregivers, and families can be heard. Important healthcare  
4805 decisions that can dramatically impact patients will be made  
4806 by an unelected board without accountability to the public.

4807 In conclusion, I would like to thank the committee and  
4808 just reiterate that while we agree that healthcare costs do  
4809 need to be reigned in, we do not believe that IPAB is the  
4810 right way to do so. Thank you.

4811 [The prepared statement of Ms. Morrow follows:]

4812 \*\*\*\*\* INSERT 15 \*\*\*\*\*

|  
4813           Mr. {Pitts.} The chair thanks the gentle lady and thanks  
4814 the panel for your testimony. We will now begin questioning  
4815 and I will recognize myself for 5 minutes for that purpose.

4816           Dr. Valadka, you state that the IPAB as it has been  
4817 described in statute will simply ratchet down costs in the  
4818 absence of adequate clinical expertise or the research  
4819 capacity to examine the national and regional effects of  
4820 proposed recommendations to ensure patients are not unduly  
4821 impacted. Are you concerned that the IPAB's mandate to cut  
4822 spending in the short-term will undermine longer-term  
4823 improvements to Medicare and the healthcare system in  
4824 general? Would you elaborate?

4825           Dr. {Valadka.} Yes, thank you for the question.

4826           One aspect of this which has not been addressed much  
4827 this morning is the fact that Medicare not only funds a lot  
4828 of practitioners in the private sector but also is a huge  
4829 contributor to medical schools and other places that do  
4830 research. And that margin is getting thinner and thinner.  
4831 As someone who spent over 12 years as a medical school  
4832 faculty member, I can attest to that firsthand.

4833           So if Medicare reimbursements to all the physicians  
4834 participating in medical schools are going down, that leaves  
4835 very little excess room for research to develop new

4836 treatments, as well as for education of medical students and  
4837 residents who are going to be the next generation of  
4838 practitioners. And those are the most fertile source for new  
4839 innovations, ideas coming forward for the several decades  
4840 following their training.

4841         And moving to people who are already in practice, there  
4842 is a lot of very clever people practicing out there who come  
4843 up with better ways to do a procedure or treat a patient or  
4844 to treat a disease. But again, if there is less excess  
4845 capital flowing into their practices, they are not going to  
4846 have the luxury of that time to develop new and better  
4847 treatments.

4848         Mr. {Pitts.} Thank you.

4849         Ms. Grealy, many if not most healthcare analysts think  
4850 that meaningful health reform will occur over a number of  
4851 years. Are the short-term scorable proposals that the board  
4852 is likely to have to make consistent with meaningful health  
4853 reform in your opinion?

4854         Ms. {Grealy.} Well, actually, I think it could be a  
4855 barrier to that long-term meaningful reform. I think as you  
4856 have heard among this panel that things that could save  
4857 Medicare money in the long run may require a capital  
4858 investment up front. We look at the current development of  
4859 Accountable Care organizations. It requires investment. As

4860 Dr. Lewin has pointed out, we need to have health information  
4861 technology as an important tool. Again, these are things  
4862 that in the short-term could increase spending, and this idea  
4863 of having a year-by-year, 1-year budget reduction requirement  
4864 I think really could impede some of those longer-term savings  
4865 that would improve quality as well as reduce the cost of  
4866 care.

4867 Mr. {Pitts.} Thank you.

4868 Dr. Lewin, in your testimony you state that ``until the  
4869 SGR is replaced, you cannot support implementation of the  
4870 IPAB.'' Does that mean that if the SGR is replaced, you  
4871 would then support the IPAB?

4872 Dr. {Lewin.} Thank you for the question, Mr. Chairman.

4873 No, I think the SGR needs to be replaced and that is  
4874 going to be exceedingly difficult as you well know because of  
4875 the accumulated debt that it has accrued.

4876 I think that we need something different from the IPAB  
4877 and the SGR, something that is not a price-control approach.  
4878 In fact, let us move away from the past and really innovate  
4879 in health system reform to a new future where we start  
4880 rewarding for better quality, more efficient care rather than  
4881 the volume of care. And so, you know, we need to get on this  
4882 now. We may not get the SGR fixed for years as far as I  
4883 know. So we need to develop a new mechanism.

4884           And sir, the IPAB, while the goal is right, the method  
4885 is wrong. And so we will work with you to develop something  
4886 that really will bend the cost curve, really will achieve  
4887 those spending targets but to do so in a fashion that could  
4888 actually work.

4889           Mr. {Pitts.} Thank you.

4890           Ms. Morrow, how could the IPAB affect the development of  
4891 newer treatment modalities for prostate cancer as they are  
4892 developed in the future? Does the IPAB have the potential to  
4893 limit care for future patients as well as current patients in  
4894 your opinion?

4895           Ms. {Morrow.} Yes, we do believe that, you know, IPAB  
4896 is charged to reduce excessive growth rates and Medicare  
4897 spending and, you know, that could be defined as reducing  
4898 payments for new, high-priced drugs and yeah, we are very  
4899 concerned about that taking prostate cancer.

4900           Mr. {Pitts.} Thank you. The chair yields to Mr.  
4901 Pallone for 5 minutes for questions.

4902           Mr. {Pallone.} Thank you, Mr. Chairman.

4903           I wanted to ask Dr. Lewin one of the many ideas put into  
4904 place by the Affordable Care Act was the Center for Medicare  
4905 and Medicaid Innovation. It is a new effort by CMS to  
4906 research and develop ideas to save money and improve quality  
4907 in Medicare and Medicaid more quickly than before. Last

4908 week, the Innovations Center announced projects to improve  
4909 the coordination of care for dual eligibles--for instance, in  
4910 cooperation with the States. Do you believe that the  
4911 Innovations Center is a good idea? Would you just comment on  
4912 it and why you might think that it is a good idea?

4913 Dr. {Lewin.} We heartily applaud the Innovation Center  
4914 idea. We think that this is exactly what we need, a part of  
4915 the CMS agency that really starts rewarding and funding  
4916 innovation and new idea. I mean, we want to continue to have  
4917 the best healthcare for all people in this country, including  
4918 those who don't have access right now, and we want to  
4919 continue innovating. But we are going to have to cut  
4920 spending. Fortunately, you know, we can do this because  
4921 there is so much waste in the current healthcare system.

4922 The Innovation Center moving toward the triple aim--  
4923 things that improve health, improve healthcare, and lower  
4924 costs at the same time are possible. The Door-to-Balloon,  
4925 the speeding up of heart attack treatment is an example. And  
4926 I could give you numerous more that we are working on in  
4927 cardiology. So if we could start funding models and show  
4928 people out there what best practices are and then diffuse  
4929 those across the healthcare system with a new kind of payment  
4930 incentive process, I think we can solve this problem, have  
4931 the best healthcare system in the world, and do it at GDP

4932 plus 1 percent.

4933 Mr. {Pallone.} Thank you.

4934 Did you want to comment, Ms. Grealy, on the Innovation  
4935 Center as well?

4936 Ms. {Grealy.} Yeah, I think this is a real opportunity  
4937 for a public-private partnership. I think Jack has given  
4938 some great models of what is being done in the private sector  
4939 now against the financial incentives in the current Medicare  
4940 program. They are doing the right thing despite not really  
4941 getting rewarded for it. The value compendium that we have  
4942 submitted will show you other examples of that. So I think  
4943 it is an opportunity for the Medicare and Medicaid programs  
4944 to learn from the private sector and to test pilot these  
4945 things as opposed to this board of 15 people coming up with a  
4946 number, making some recommendations that perhaps haven't even  
4947 been test piloted. And I think that is the real advantage of  
4948 having the Center for Innovation.

4949 Mr. {Pallone.} Thank you. I was going to ask you also,  
4950 Ms. Grealy, this is a quote from the CBO analysis of the  
4951 Republican plan for Medicare and Medicaid in their budget.  
4952 It says, ``Under the Republican budget proposal, the  
4953 gradually increasing number of Medicare beneficiaries  
4954 participating in the new premium-support program would bear a  
4955 much larger share of their healthcare costs than they would

4956 under the traditional program, and that greater burden would  
4957 require them to reduce their use of healthcare services,  
4958 spend less on other goods and services, or save more in  
4959 advance of retirement than they would under current law.'

4960 Now, in your testimony, you said that ``IPAB has the  
4961 potential to cause serious harm to Medicare beneficiaries''  
4962 but, you know, I would like to know what your views would be  
4963 of the Republican budget plan and its effect on  
4964 beneficiaries. Do you agree with the CBO's characterization  
4965 of the Republican plan?

4966 Ms. {Grealy.} The Healthcare Leadership Council for  
4967 over a decade has supported the concept of moving to a  
4968 premium-support model for the Medicare program to give  
4969 seniors more choice, to have those private plans competing,  
4970 much as they do in the Medicare Part D program. I think what  
4971 we need to do is to look at the premium-support model. There  
4972 are many components to it. We probably would recommend using  
4973 a different inflation factor. Much like Alice Rivlin, we  
4974 would probably recommend maintaining for a period of time the  
4975 traditional Medicare program. So I think there is a lot of  
4976 merit to the concept. I think there are some modifications  
4977 that we would make to the proposal that was put forward.

4978 Mr. {Pallone.} Thank you.

4979 Let me ask--I guess I have another 50 seconds here. I

4980 wanted to ask Ms. Morrow, you know, again you made your  
4981 concerns about IPAB clear but as you know, this was developed  
4982 as a backstop mechanism to address to growing costs of  
4983 healthcare. In the Republican approach in the budget is very  
4984 different. They would simply slash existing programs. They  
4985 would end Medicare as we know it, and they would slash  
4986 medical research. And I am concerned about the impact on  
4987 medical research of the Republican budget. The NIH budget  
4988 was actually cut under the continuing resolution for this  
4989 year, and for 2012 it doesn't look any better. If you would  
4990 just comment on it. I mean I am just concerned where are we  
4991 going with research with what happened with the CR and what  
4992 is in the Republican budget for the future?

4993 Ms. {Morrow.} Yeah, continuing research in cancer is  
4994 extremely important to us and we do advocate for increased  
4995 funding for research. And I am not familiar with everything  
4996 that is in the Republican plan but, I mean, we will continue  
4997 to support more increased funding for research.

4998 Mr. {Pallone.} Okay. Thank you very much. Thank you,  
4999 Mr. Chairman.

5000 Mr. {Pitts.} The chair thanks the gentleman and  
5001 recognizes the vice chairman of the subcommittee, Dr.  
5002 Burgess, for 5 minutes.

5003 Dr. {Burgess.} Well, thank you, Mr. Chairman. And I

5004 thank you all for being here. This has been an interesting--  
5005 although, Dr. Valadka, you are correct that this was--what  
5006 did you call it? The IPAB-alooza of--IPAB-ulous?

5007 Dr. {Valadka.} IPAB-athon, but IPAB-alooza applies as  
5008 well.

5009 Dr. {Burgess.} I do so welcome the comments of all of  
5010 you. I think they have been very helpful.

5011 Ms. Grealy, I hope that you will take some time and take  
5012 the secretary of Health and Human Services perhaps to lunch  
5013 and explain to her what premium support actually is. You  
5014 might even want to include Ranking Member Waxman in that  
5015 discussion because he seems to have some difficulty and even  
5016 the President of the United States required a little remedial  
5017 education of the difference between a voucher and a premium-  
5018 support system.

5019 Dr. Valadka, let me just ask you, we hear a lot about  
5020 the IPAB. We have heard a lot about it today, but I get the  
5021 general impression that doctors and patients and patient-  
5022 advocacy groups do not support the IPAB. Is that a fair  
5023 assessment, and if that is fair, why do you suppose that is?

5024 Dr. {Valadka.} To borrow a line from a high-ranking  
5025 member of this body, when the healthcare debate was going on  
5026 a couple of years ago, you have to pass the bill to find out  
5027 what is in it.

5028 Dr. {Burgess.} Now, we know.

5029 Dr. {Valadka.} I have had that same conversation with  
5030 many of my colleagues in the operating room and the ICU in  
5031 the hallways where they don't really quite know what IPAB is.  
5032 And the more you talk to them and educate them, I don't think  
5033 anyone thinks it is a good idea. And I think it has been  
5034 gratifying to see this started as a very obscure issue that  
5035 only policy wonks knew about, and now I understand they get  
5036 discussed in the New York Times, Wall Street Journal, CNN,  
5037 mainstream media outlets like that. So I do think that the  
5038 more people learn about it, the less they are going to  
5039 support it.

5040 Dr. {Burgess.} And I think that is in general true.

5041 Now, Dr. Lewin, you talked about repeal the SGR before  
5042 you do the IPAB. I got to believe that really you are the  
5043 membership of the American College of Cardiology would not  
5044 support either of those control mechanisms. Is that correct?  
5045 Now, the AMA did--you know, unlike Mr. Pallone, who voted for  
5046 that bill, I voted against it. I thought the AMA was wrong  
5047 to support it. What does your membership say?

5048 Dr. {Lewin.} Well, we certainly don't have any affinity  
5049 for the SGR. It clearly doesn't work and it is too bad we  
5050 didn't deal with it 10 years ago, right? We all wish we had.  
5051 But that said, I think the IPAB as it is currently designed

5052 we don't believe will be effective in any way, shape, or  
5053 form. It is going to be another price-control mechanism. So  
5054 we would like to get on with the challenge that we have as a  
5055 Nation of, you know, creating the healthcare system of the  
5056 future that provides access to everybody, that continues to  
5057 reward innovation and improve quality. And we think we need  
5058 a different approach than the IPAB.

5059 Dr. {Burgess.} Well, let me tell you the problem,  
5060 though, because you reference the SGR and your pessimism of  
5061 the SGR that anything meaningful will happen, and I actually-  
5062 -this here I am more optimistic that something can happen to  
5063 the SGR than any time previous in my 9 years here.

5064 But here is the deal. You are exactly right. What if  
5065 in 1998 someone had had the courage to say oh, this SGR thing  
5066 is going to be a disaster in 10 years' time and I want to fix  
5067 it. We have that opportunity with the IPAB now. Once the  
5068 IPAB begins that cumulative effect of, you know, this  
5069 specious thing of a dollar saved, then there is going to be a  
5070 CBO-directed cost associated with its repeal. And it won't  
5071 be too terribly long before that cost becomes a mountain too  
5072 tall to climb just as the SGR is today.

5073 So yeah, we got to kill one that is mature, which is the  
5074 SGR, but the other one, we do need to get a handle on it  
5075 before it ever gets out of the box. And I would say the time

5076 is now to repeal the Independent Payment Advisory Board, and  
5077 I would encourage Mr. Pallone to join with us on that because  
5078 once this thing gets away from you, it is Katy bar the door.  
5079 It would be impossible to undo it.

5080           And I think honestly that is what the administration is  
5081 banking on. They want to get this thing up and running and  
5082 it is another method--but let us be honest, this thing was  
5083 not about healthcare, never was. It is a tax bill, but  
5084 bottom line, it is about control. They want to control you.  
5085 They want to control Dr. Valadka. They want to control what  
5086 you do. They want you to do only what they tell you you can  
5087 do and they want to be able to tell you when to stop, don't  
5088 do anymore. That patient has had enough. That is where this  
5089 thing is going.

5090           Ms. Morrow, let me just thank you for being here. I  
5091 don't have a question for you as relates to the IPAB on  
5092 prostate cancer, but I do remember in the discussion of  
5093 healthcare reform as it was going through, I read somewhere  
5094 where some healthcare thinker said we will be able to tell if  
5095 Congress was serious about reforming healthcare as to what  
5096 they do with prostate cancer because the implication was we  
5097 over-treat prostate cancer in the United States of America.  
5098 However, recent studies comparing survival rates for prostate  
5099 cancer in the United States versus Europe, it is like 99

5100 versus 77 percent. I would rather be here with all our  
5101 faults than anywhere else in the world. Do you have any  
5102 comments on that?

5103 Ms. {Morrow.} I have seen those same statistics and,  
5104 you know, as far overtreatment, we strongly disagree with  
5105 that term. You know, it is up to the patient. The doctor  
5106 and the patient can have an informed discussion about the  
5107 person's prostate cancer and whether it is going to grow and  
5108 affect them in their lifetime, but the decision should be  
5109 between the patient and the provider.

5110 Dr. {Burgess.} And not the IPAB and the provider.

5111 Ms. {Morrow.} Exactly.

5112 Dr. {Burgess.} Thank you.

5113 Mr. {Pitts.} The chair thanks the gentleman and  
5114 recognizes Dr. Cassidy for 5 minutes.

5115 Dr. {Cassidy.} Dr. Valadka, a friend emailed me and  
5116 said how come you don't have a practicing physician on the  
5117 panels, one passionate about our practices? And so I will  
5118 have to email her back and say although I didn't pick it, we  
5119 have one.

5120 My question for you is that when you look at the CBO  
5121 score that Mr. Pallone referenced, it says the reason that  
5122 traditional Medicare scores less than a private insurance  
5123 plan is that traditional Medicare pays physicians less.

5124 Indeed, the way CBO scored it is although they don't assume  
5125 the SGR cuts go through, they also have no inflation  
5126 adjustment. Now, that has been the case since 2002, and  
5127 effectively, Medicare is paying physicians significantly less  
5128 now than they were in 2002, so much so that Richard Foster  
5129 says that within 9 years Medicare will pay less on average  
5130 than Medicaid. You are a practicing physician. Secretary  
5131 Sebelius avoided answering this question every which way.  
5132 But if Medicare is now paying less than Texas Medicaid, what  
5133 will that do for access to services for those who have  
5134 Medicare?

5135 Dr. {Valadka.} In one word, cost-shifting. As we  
5136 discussed here earlier today--

5137 Dr. {Cassidy.} Now, let me say this. You are saying  
5138 that as a specialist who sees people coming through the ER  
5139 and almost have no choice but to see the patient. So speak  
5140 first as a specialist and then imagine what it would do for  
5141 access to primary care.

5142 Dr. {Valadka.} Well, as you well know, when patients  
5143 come through the emergency room, we take care of them first  
5144 and oftentimes we don't even know their name. You know, they  
5145 are in the computer as unknown, number something, we operate  
5146 and take care of them and then later figure out who they are,  
5147 who the family is, you know, if they have any resources.

5148 That is a hospital administration issue. But that is time  
5149 that takes away from your practice. And as you know, time is  
5150 a very precious thing. So you are going to have to make up  
5151 the gap in other ways because you are going to have pay your  
5152 secretary, your nurses, your--

5153 Dr. {Cassidy.} You have a fixed overhead?

5154 Dr. {Valadka.} Absolutely.

5155 Dr. {Cassidy.} Now, I know you are not primary care,  
5156 but if you are primary care and you are spending 50 percent  
5157 of your receipts on fixed overhead and you got a choice of  
5158 which patients that you can afford to take--New York Times  
5159 documented this very well with an oncologist in Michigan  
5160 getting paid below cost by Michigan Medicaid at some point  
5161 could no longer afford to take more Michigan Medicaid  
5162 patients, would you accept that it is going to hurt access to  
5163 primary care?

5164 Dr. {Valadka.} Well, I think you used the word choice  
5165 as to what patients are going to have to take, and I would  
5166 quibble with you a little bit. You don't have a choice. You  
5167 have to take more patients with commercial insurance just to  
5168 subsidize all of the activity you are spending taking care of  
5169 the patients with no insurance or Medicaid.

5170 Dr. {Cassidy.} Or limit what you--now, in this case, if  
5171 Medicare is paying less than Medicaid, you would now put the

5172 Medicare patient in the same boat if you will as that  
5173 Michigan Medicaid cancer patient who could not find a  
5174 provider?

5175 Dr. {Valadka.} That is exactly right.

5176 Dr. {Cassidy.} Yeah. And again, in 9 years under the  
5177 provision that CBO describes is saving money for traditional  
5178 fee-for-service Medicare, we and Medicare as we know it  
5179 because seniors will not be able to access care, that is a  
5180 little--and you raised something, just kind of--I thought  
5181 about it but the way you phrase it kind of ticked my mind a  
5182 little bit. So IPAB can only cut among providers,  
5183 physicians.

5184 Dr. {Valadka.} Yeah.

5185 Dr. {Cassidy.} So really we could have a hole in the  
5186 bucket for hospitals. There could be a hole in the bucket  
5187 for hospitals with just an inordinate amount of cost going  
5188 there, but physicians would have to make up the difference,  
5189 correct?

5190 Dr. {Valadka.} As it is now, yeah, because hospitals  
5191 have I think until 2018 or 2019. Yeah. They are out of the  
5192 loop. They kind of negotiated themselves out. I just can't  
5193 stress it enough--it is like a broken record--we have to do  
5194 something different than this. We need to deal with the  
5195 rising costs of Medicare. We can but we need help from

5196 Congress to do that with a different approach than this  
5197 design. This isn't going to work and if this is health  
5198 reform, then let us start off and do something the right way  
5199 and reward incentives for quality and efficiency and improved  
5200 care. That we can do. We now have the tools to do that. We  
5201 couldn't have done that in the '90s when health reform was  
5202 proposed. We can do that now. And physicians want to do  
5203 this. We still want--clinical judgments are still going to  
5204 be important and we want to protect the patient-physician  
5205 relationship in this process.

5206 Dr. {Cassidy.} I like the way you emphasize the  
5207 practicing physician's role in controlling healthcare costs.  
5208 I note in IPAB I don't think you are allowed to continue to  
5209 practice and still serve on the board, which gives me kind of  
5210 pause. Wait a second. If the person who is in the mix, if  
5211 she is the one who knows best how to do it but she is the one  
5212 who, by statute, is not allowed to serve, it seems kind of  
5213 odd.

5214 Dr. {Valadka.} Certainly. And especially a full-time  
5215 occupation to be on the board. We are going to attract  
5216 people that are going to be retired people. So this is not  
5217 the design for a system that is really going to innovatively  
5218 improve Medicare.

5219 Dr. {Cassidy.} There is a system designed by staffers,

5220 not by people involved in healthcare.

5221 I am out of time. I yield back. I thank you all.

5222 Dr. {Valadka.} Thank you.

5223 Mr. {Pitts.} The chair thanks the gentleman. That  
5224 completes the first round. We will have one follow-up on  
5225 each side. Dr. Burgess?

5226 Dr. {Burgess.} Dr. Lewin, you referenced that setting  
5227 price controls on volume doesn't work, and I think we have  
5228 seen that with the SGR rather eloquently. You reduce the  
5229 amount you pay and you drive up volume because, as Dr.  
5230 Cassidy pointed out, overhead costs are fixed so you have got  
5231 to do more if you are going to keep those overhead costs met  
5232 and continue to earn a salary if you are at an individual or  
5233 a small-group practice, which I was.

5234 Now, fee-for-service medicine gets a bad rap in all of  
5235 this and we are told by all the great thinkers in healthcare  
5236 that the fee-for-service system is the culprit. But really  
5237 the culprit is the administrative pricing brought to us by  
5238 the Center for Medicare and Medicaid Services and your  
5239 specialty in particular. I mean, I have had deans of medical  
5240 schools who are cardiologists come to me and say the big  
5241 problem is the overutilization of our specialty, you know,  
5242 Door-to-Balloon time studies that you have done, that is  
5243 great and a great metric, but if these guys are accurate and

5244 more balloons are being done than are necessary, then it  
5245 doesn't matter that you do them quickly. It is still going  
5246 to be a cost driver. And yet because of administrative  
5247 pricing, we have favored that type of activity in the  
5248 Medicare system.

5249         You know, you would ask yourself the big problem that  
5250 everyone talks about is childhood obesity. You have got the  
5251 First Lady working on that is her main cause. You would  
5252 think that with childhood obesity under the raft of childhood  
5253 diabetes that will follow that we will be churning up  
5254 pediatric endocrinologists right, left, and center. And yet  
5255 we turn them out a handful a year. And cardiologists know we  
5256 turn out a lot. So as the leader of your professional  
5257 organization, how are you proposing to deal with this?  
5258 Forget SGR and IPAB for a moment. You guys have a  
5259 responsibility here.

5260         Dr. {Lewin.} Yeah, you know, just as a quick aside with  
5261 the tsunami of obesity and diabetes, you know, we won't have  
5262 enough cardiologists to deal with what is coming up in the  
5263 future. But, you know, we really have the tools now to make  
5264 sure that people who have chronic stable angina who are  
5265 approaching the system for care don't get a stent when it  
5266 really wasn't needed or don't get bypass surgery where a  
5267 stent would have been better or get to optimal medical

5268 therapy when the data shows the results will be better and  
5269 they will have no risk of complications in the meantime. We  
5270 have these tools, we have the science, but there are no  
5271 incentives to apply them in hospitals across the country.

5272 We have incentives to reduce the use of implantable  
5273 defibrillators for people for whom the science says shouldn't  
5274 have gotten them. We published it. We published our data.  
5275 We have 100 percent--thanks to--Medicare requires the use of  
5276 our registry. We have 100 percent of the implantable  
5277 defibrillator data in the United States. We pointed out 23  
5278 percent of them apparently were placed without the best  
5279 guideline evidence being present. And we want to go around  
5280 and educate everybody, but the incentives are not there to  
5281 say to the hospitals and the doctors we are going to reward  
5282 those who start to reduce that variation, not pay for the  
5283 volume.

5284 Dr. {Burgess.} Well, how will IPAB reduce that  
5285 variation?

5286 Dr. {Lewin.} It won't. It will not. IPAB just has no  
5287 way to do that. We need a different mechanism and that is  
5288 payment incentives for improved quality and outcomes and  
5289 efficiency. And you have to measure to manage. So you have  
5290 got to have systems out there to give doctors and hospitals  
5291 feedback, dashboards of feedback on how they are doing as

5292 compared to all their peers. When they have that  
5293 information, they will change.

5294 Dr. {Burgess.} And Dr. Valadka, let me just ask you to,  
5295 you know, you are the only practicing physician we have heard  
5296 from all day. What about how does medical liability reform  
5297 factor into what Dr. Lewin was just talking about?

5298 Dr. {Valadka.} I think liability reform is a huge way  
5299 to try to bring down costs in the healthcare system. Now,  
5300 that is not part of IPAB. Of course, we would beginning far  
5301 afield. But you are a Texan. You have heard about the Texas  
5302 miracle following tort reform there in 2003. It did  
5303 everything that its proponents said it would. It lowered the  
5304 cost of professional liability insurance. It brought more  
5305 PLI carriers into the State, and most importantly, it brought  
5306 a lot more physicians into the State. And those guys are  
5307 going to the rural and underserved areas just as much as  
5308 going to the major metropolitan centers. The only downside  
5309 has been the flood of applications to the Texas Medical Board  
5310 because--

5311 Dr. {Burgess.} Yeah, the Texas Medical Board is in  
5312 trouble. But Dr. Lewin referenced, you know, the fact that  
5313 sometimes a stent might do instead of a bypass or maybe  
5314 maximum medical therapy. But it could be tough if you are  
5315 the doctor on the frontline who is worried about the

5316 appearance of did I do everything possible if this patient  
5317 walks out of the office and crashes and burns in my parking  
5318 lot, did I do everything possible to prevent that from  
5319 happening? And that is a burden with which we live as  
5320 practicing physicians every day, is it not?

5321 Dr. {Valadka.} Well, that is absolutely true. And  
5322 again, to put that in perspective, that is going to happen a  
5323 certain percentage of the time even if you do everything  
5324 right. So now you are thinking, okay, did I do everything  
5325 right? Someone is going to be looking over my shoulder in 6  
5326 months or 12 months if there is a bad outcome. And again,  
5327 you know, Abraham Lincoln said even if you did everything  
5328 right and events prove you wrong, a thousand angels swearing  
5329 you were right won't make a difference. So that is a huge  
5330 concern for all practicing physicians.

5331 Dr. {Burgess.} Thank you for being here today, all of  
5332 you. Thank you.

5333 Mr. {Pitts.} The chair thanks the gentleman and  
5334 recognizes the gentleman from Michigan, the ranking member  
5335 emeritus, Mr. Dingell, for 5 minutes of questions.

5336 Mr. {Dingell.} Mr. Chairman, you are most courteous.  
5337 Thank you.

5338 Dr. Lewin, welcome to today's hearing. I would like to  
5339 begin to discuss your recommended improvements to IPAB. You

5340 mentioned in your testimony that flexibility should be  
5341 provided to help recruit high-quality board candidates. Do  
5342 you believe, then, that under the current statute the board  
5343 will be unable or will be able to recruit high candidates?

5344 Dr. {Lewin.} Congressman Dingell, thank you for the  
5345 question. I don't believe the way it is currently  
5346 constructed the IPAB will recruit the kind of people that we  
5347 want. First of all, the IPAB membership is a full-time, if  
5348 you will, occupation. It means that we can't bring in the  
5349 best and the brightest from throughout the health sector with  
5350 various perspectives to help guide this process. We are  
5351 almost destined with that approach to bring in retired  
5352 people.

5353 Mr. {Dingell.} My next question, you have gotten a bit  
5354 ahead, but one, what will be the barriers to recruiting  
5355 candidates; and two, what should we do to eliminate those  
5356 barriers to enable us to recruit the strongest candidates?

5357 Dr. {Lewin.} My guess is that the importance of this  
5358 process is that some excellent candidates may come to serve  
5359 just with their expenses covered, but I think this shouldn't  
5360 have to be a full-time commitment on the part of those  
5361 individuals. We need people who are the best and the  
5362 brightest in the healthcare sector who understand the  
5363 economics as well as the clinical realities of this and the

5364 patient perspective part of this to be sitting around this  
5365 table. So I think that the way that it is designed in terms  
5366 of the pay and the requirement that it be a full-time  
5367 occupation will make it very untenable.

5368 Mr. {Dingell.} Okay. Now, Doctor, IPAB establishes a  
5369 Consumer Advisory Council to advise the board on how payment  
5370 policies impact consumers. However, this is an advisory  
5371 capacity only and does not include patient representation.  
5372 Now, as a physician, how would you recommend addressing this  
5373 problem and encouraging patients' participation to help in  
5374 decision-making necessary for the board to issue the best  
5375 recommendations?

5376 Dr. {Lewin.} Well, I think the IPAB ought to have  
5377 patient representation sitting right there on the board  
5378 itself if it was to exist. Patient representation should  
5379 have been part of the process of the IPAB. But I would say,  
5380 Congressman Dingell, that I think we have to reconstruct what  
5381 we consider this IPAB model if we want it to actually achieve  
5382 cost containment over time by systematic improving quality of  
5383 care. I think the way it is designed isn't going to work so  
5384 I am not so concerned about how we get the members on it  
5385 right now. I would like to see a design of a system that  
5386 might actually reduce costs and improve quality.

5387 Mr. {Dingell.} I notice you, Dr. Valadka, were nodding

5388 yes?

5389 Dr. {Valadka.} Yes, I agree completely. It seems like  
5390 we have gotten a little bit ahead of the conversation when we  
5391 are talking about how to structure IPAB and how it should be  
5392 set up in advisory committees, but I think a more fundamental  
5393 question is really will it achieve the aims it sets out to do  
5394 without creating too many adverse events like limiting access  
5395 to care for our seniors.

5396 Mr. {Dingell.} Thank you.

5397 Now, again, coming back to our first witness here. Your  
5398 testimony suggests the use of data registries as one way to  
5399 ensure high-quality care while identifying areas to reduce  
5400 spending. In particular, Doctor, you mentioned the ACC's  
5401 Pinnacle outpatient registry. I happen to believe that the  
5402 technology advances like electronic health records and  
5403 registries can create savings but also know that there could  
5404 be a resistance to implementing such technologies. How many  
5405 providers participate in this registry currently, Dr. Lewin?

5406 Dr. {Lewin.} Thank you for that question, Congressman  
5407 Dingell. Nearly all the major hospitals in the United States  
5408 participate in the registries and they pay us for the data,  
5409 and that allows us to actually keep this very expensive  
5410 operation going. In the physician outpatient setting, it is  
5411 really hard to ask the doctors to pay us for collection of

5412 data at this time, but a thousand practices have signed up.  
5413 We have two million patient records already with this  
5414 relatively new system. And we can see measured improvement  
5415 in quality across the entire Pinnacle network. I might add  
5416 that 100 percent of the Pinnacle participants received the  
5417 full PQRS reward and the e-prescribing reward, and we were  
5418 able to file for them. So there is some small reward. But  
5419 if we were to use payment reform to provide real incentives  
5420 for improved outcomes and quality, this would go rapidly  
5421 across the entire environment. It needs to reach to internal  
5422 medicine and family practice and others who share in the care  
5423 of cardiology patients with us in the outpatient setting.

5424 Mr. {Dingell.} My time is up, Doctor, but with the  
5425 patience of the chair, I am going to ask you can you give me  
5426 an example of how a member of ACC has used the registry to  
5427 bring down the costs of their practice?

5428 Dr. {Lewin.} Absolutely. The one thing I can give you  
5429 is that they got an average of 8 to \$10,000 back from the  
5430 rather pitifully small reward program called PQRS that  
5431 Medicare uses today by just by participating in the registry.  
5432 They got the rewards from Bridges to Excellence and from  
5433 other employer-based private insurance approaches. And some  
5434 of them are now going to receive a bypass of having to go  
5435 through, you know, call a nurse to get permission for a

5436 procedure because they can demonstrate to the insurance  
5437 company that they are making the right decisions using the  
5438 clinical decision support tools embedded in the registry. So  
5439 it is a hassle factor improvement for the doctor, and time is  
5440 worth money. So even though the payment incentives aren't  
5441 really aligned yet to improve quality, even now, this  
5442 Pinnacle registry is offering some benefits to people in the  
5443 current environment.

5444 Mr. {Dingell.} Thank you, Doctor.

5445 Thank you, Mr. Chairman.

5446 Mr. {Pitts.} The chair thanks the gentleman. We are  
5447 voting on the Floor. We have 11 minutes to go. We have time  
5448 for follow-up from Mr. Pallone.

5449 Mr. {Pallone.} I will be quick. I know that both Dr.  
5450 Burgess and you, Dr. Lewin, brought up the SGR and I do think  
5451 that certainly when I hear from the doctors, you know, they  
5452 see the SGR and, again, the cliff we faced in January as the  
5453 biggest threat to Medicare, more so than IPAB. And you know,  
5454 I am opposed to IPAB but I just wanted you to comment on  
5455 that. I mean, isn't this SGR a major threat, more so than  
5456 IPAB and what are the doctors telling you about it?

5457 Dr. {Lewin.} We would have to think that it is a major  
5458 threat. It is certainly a threat to access. If more doctors  
5459 can't afford to accept Medicare patients, clearly it is going

5460 to pose a nightmare for our healthcare system, for emergency  
5461 rooms and for the entire system. So we are very, very  
5462 worried about it and particularly because it is a big, big  
5463 price tag to try to fix it.

5464 Mr. {Pallone.} The cut.

5465 Dr. {Lewin.} And I honestly don't know how it is going  
5466 to happen given the conversation on, you know, the debt  
5467 ceiling and the deficit. So, you know, I assume we might end  
5468 up kicking that can down the road again, and I am very, very  
5469 worried about that, much more worried than I am about the  
5470 IPAB.

5471 Mr. {Pallone.} Well, I just wanted to say I know that  
5472 Dr. Burgess mentioned that, you know, he hopes that we can  
5473 get to it and do a long-term fix this year. And I am very  
5474 much supportive of that. I always kid him because he was I  
5475 think the only Republican who voted for the Democrat long-  
5476 term fix that we passed a couple years ago. So I have to  
5477 commend him for that although maybe he doesn't like to be  
5478 commended for that.

5479 But I would just ask, Mr. Chairman, that I know that we  
5480 have already had a hearing on it, but I would urge that we do  
5481 try to address it and not wait until the last minute and kick  
5482 the can down the road.

5483 Thank you, Mr. Chairman.

5484           Mr. {Pitts.} The chair thanks the gentleman and for the  
5485 information of the panel. We are going to deal with the SGR  
5486 this year. We intend to do a long-term fix. We are in the  
5487 process. We have collected information from all the doctor  
5488 groups. We have had meetings, many meetings, and we are in  
5489 the process of developing a vehicle, but it will probably be  
5490 after the break in the fall before we get to it. But we  
5491 intend to deal with it on a permanent basis before the end of  
5492 the year.

5493           This has been an excellent panel. Thank you for the  
5494 information you have shared.

5495           That concludes today's hearing. I remind members that  
5496 they have 10 business days to submit questions for the  
5497 record, and I ask the witnesses to please agree to respond  
5498 promptly to these questions. With that, this subcommittee is  
5499 adjourned.

5500           [Whereupon, at 2:06 p.m., the subcommittee was  
5501 adjourned.]