



STATEMENT OF THE
ALLIANCE OF SPECIALTY MEDICINE

PRESENTED BY

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BEFORE THE

**SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES**

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“IPAB: The Controversial Consequences for Medicare and Seniors”

Alliance of Specialty Members Include:

American Academy of Facial Plastic and Reconstructive Surgery • American Association of Neurological Surgeons • American Gastroenterological Association • American Society of Cataract & Refractive Surgery • American Society of Plastic Surgeons • American Urological Association • Coalition of State Rheumatology Organizations • Congress of Neurological Surgeons • Heart Rhythm Society • National Association of Spine Specialists • Society for Cardiovascular Angiography and Interventions

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EXECUTIVE SUMMARY

The Alliance of Specialty Medicine is deeply concerned about the potential, unintended consequences that will likely result from the establishment of the Independent Payment Advisory Board (IPAB). We opposed its creation and we are now urging Congress to immediately act and repeal the IPAB.

The Alliance believes that under the IPAB access to specialty care will be severely limited due, in part, to the additional payment cuts it will impose on physicians. Medicare physician payments are already well below market rates and continue to be subject to deep cuts as a result of the flawed sustainable growth rate (SGR) formula. Cuts to physician reimbursement under the IPAB will only exacerbate those already imposed on physicians as a result of the SGR cuts as well as other changes that occur each year as part of the Medicare physician fee schedule. Physician survey data demonstrates that these cuts, including those imposed by IPAB, may ultimately force specialists out of the Medicare program, severely threatening Medicare beneficiary access to innovative therapies and specialty care.

The Alliance has numerous concerns with both the concept of the IPAB as well as its structure. Our primary criticisms include the following:

- The IPAB lacks accountability and sets a dangerous precedent for overriding the normal legislative process. As drafted, the IPAB has little, if any, accountability to the Medicare beneficiaries whose healthcare will be affected by such decisions. Yet, its recommendations have the force of law if Congress fails, or chooses not, to act. The Alliance maintains that Congress should be the entity to legislate healthcare policy, not the IPAB.
- The limited transparency of IPAB proceedings severely limits Congressional oversight of the Medicare program and replaces the transparency of Congressional hearings and debate with a less transparent process overseen by the executive branch, with at best, minimal accountability for the healthcare decisions it makes.
- The statute provides “fast-track” procedures for IPAB proposals, which automatically become law if Congress is unable to quickly amend the proposal. These expedited procedures vary significantly from the procedures the House and Senate usually follow to consider most legislation.
- The breadth of IPAB’s authority is unfairly limited and does not treat all providers equally since the statute specifically exempts some providers, such as hospitals and nursing homes, from IPAB cuts for several years. We contend, as does the Congressional Budget Office (CBO), that this will place greater pressures to achieve savings from physicians.
- The process for making appointments to the IPAB is imbalanced as appointments are made solely by the President. Furthermore, the structure ensures that the board will have inadequate expertise since it fails to include practicing clinicians who can draw from firsthand experience when considering how proposed recommendations could impact the delivery of healthcare from both the provider and patient perspective.

Thank you Chairman Pitts, Ranking Member Pallone and other distinguished members of the Subcommittee, for allowing me to testify on the Independent Payment Advisory Board. My name is Alex Valadka, and I am a practicing neurosurgeon from Austin, Texas. I serve as the chair of the American Association of Neurological Surgeons' and the Congress of Neurological Surgeons' Washington Committee, as well as the spokesperson for the Alliance of Specialty Medicine, which I am here representing today.

The Alliance of Specialty Medicine was founded in 2001, with a mission to develop sound federal healthcare policy that fosters patient access to the highest quality specialty care and improves timely access to high quality medical care for all Americans.

As patient and physician advocates, the Alliance welcomes the opportunity to contribute to the ongoing debate regarding the Independent Payment Advisory Board (IPAB). For the reasons I will discuss today, we opposed the creation of the IPAB and support its full repeal.

ONGOING OPPOSITION TO THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

As discussions ensued during healthcare reform over the development of an executive branch board that would divest Congress of its authority for Medicare payment policy – specifically, proposals that would have expanded the Medicare Payment Advisory Commission's (MedPAC) authority or established the Independent Medicare Advisory Council (IMAC) – the Alliance of Specialty Medicine voiced serious concerns over potential, unintended consequences that would likely result from its establishment. Despite numerous communications to Congressional leadership voicing concern about such a board, the Senate included the Independent Payment Advisory Board, referred to as the "IPAB," as part of the now-enacted Patient Protection and Affordable Care Act (PPACA).

Starting in 2014, the IPAB will require a 15-member board of non-elected officials to recommend Medicare spending reductions to reduce the per capita rate of growth in Medicare in years when spending exceeds a targeted growth rate, without causing a reduction in patient benefits or an increase in revenues, beneficiary premiums or cost-sharing. In addition, if targeted growth rates are not surpassed, the IPAB could still submit an advisory report recommending additional cuts or alterations to payment policies. The Alliance believes these cuts will further pressure more and more specialty physicians to stop seeing Medicare patients and jeopardize an already vulnerable Medicare program.

Growing concerns over the rising costs of healthcare are shared by physicians, but we are confident that the IPAB is the wrong solution. The IPAB, as it has been described in statute, will simply ratchet down costs in the absence of adequate clinical expertise or the research capacity to examine the national and regional effects of proposed recommendations to ensure patients are not unduly impacted.

Without regard for the physician community's concerns – concerns raised by those who understand our healthcare delivery system best – the President has proposed to "strengthen" IPAB through various tools and mechanisms including reducing Medicare's target growth by GDP per capita plus 0.5 percent, as well as giving IPAB the ability to automatically sequester Medicare spending.

To be blunt, Alliance member organizations and the specialists they represent -- me included -- are just as concerned about the negative impact of the IPAB as we are about the flawed Medicare physician payment system -- which we have asked you to correct for more than 10 years. This should tell you something -- the IPAB is dangerous and must be eliminated.

As you know, funding for the IPAB will be appropriated beginning with fiscal year 2012 -- less than 3 months from today. This committee should make every effort to repeal the IPAB before it even gets off the ground.

I will now highlight some of the most troubling aspects of the IPAB for Medicare and America's seniors.

RESTRICTED ACCESS TO SPECIALTY CARE

As this subcommittee is fully aware, Medicare physician payments are already well below market rates and continue to be subject to substantial, unprecedented cuts as a result of the flawed sustainable growth rate (SGR) formula. Congress has typically stepped in to delay the SGR cuts, but the threat of reimbursement reductions remains very real. Indeed, the SGR requires physician payment rates to be reduced by nearly 30 percent on January 1, 2012 and by more than 40 percent over the next decade.

In addition, each year as part of the annual Medicare physician fee schedule (MPFS), physicians are subject to further reductions as a result of changes in payment policies for the services they provide. For example, in the 2012 MPFS that was released less than two weeks ago, CMS proposes deep cuts to certain imaging services paid under the physician fee schedule by applying a multiple procedure payment reduction (MPPR). CMS also proposes a number of changes to the relative value units, or RVUs, for several procedures, as well as continuing to implement changes to the practice expense values.

Moreover, the IPAB has unfettered authority to achieve targeted spending reductions as it sees fit, which could include targeting more spending cuts from certain healthcare providers rather than others. The statute explicitly states that the IPAB should give priority to recommendations that prioritize primary care. Effectively, this means that the IPAB could hold certain medical specialties, such as primary care, harmless, while significantly cutting specialists.

Thus, under the IPAB, the cuts resulting from the SGR and changes to Medicare's payment policies will be exacerbated -- subjecting physicians to potential double jeopardy. As hospitals and other Part A providers have been exempted from the IPAB's reach until 2020, this effectively means IPAB will place a disproportionate focus on reductions to physician reimbursements. Even the Congressional Budget Office (CBO) has stated that the IPAB is likely to focus its recommendations on changes to payment rates or methodologies for services in the fee-for-service sector by non-exempt providers -- that is, physicians.

Beneficiary access to care has already been hindered as a result of the instability and inequities in Medicare physician payments. The number of physicians who no longer accept new Medicare patients because of low reimbursement rates has more than doubled, and we believe this number will continue to grow. In fact, a recent survey of specialists represented by the Alliance shows more than one-third plan to change their participation status to non-participating if Medicare reimbursement to physicians is significantly cut, while another third will opt out of Medicare for two years and privately contract with Medicare patients. Over the next twelve months, two-thirds said they would limit the number of Medicare patient appointments, while close to half said they would reduce time spent with Medicare patients, stop providing certain services, and reduce staff.

In addition, an American Medical Association survey shows that current reimbursement rates have already led close to one-fifth of all doctors, including a third of primary care physicians, to restrict the number of Medicare patients in their practices. Beneficiaries are at risk of losing the doctor of their choice as more physicians are forced to limit the number of Medicare patients they see.

The threat of the IPAB, particularly if it is coupled with the flawed SGR formula, may ultimately force specialists out of the Medicare program, which will severely threaten Medicare beneficiary access to innovative therapies and specialty care.

LACK OF ACCOUNTABILITY

As drafted, the IPAB has little, if any, accountability to the more than 45 million Medicare beneficiaries whose healthcare will be affected by such decisions. Yet, its recommendations have the force of law if Congress fails, or chooses not, to act.

Over the past several years, Congress has long looked to MedPAC and its predecessor, the Physician Payment Review Commission (PPRC), for recommendations and expertise in Medicare policy changes. Congress admittedly struggles to make the “hard decisions” to control rising costs in Medicare expenditures.

To deal with the challenge, Congress has put forward several proposals to create an independent policy-making entity that would be able to control the growth in Medicare expenditures, and be insulated from special interests and lobbyists. Ironically, the IPAB fails to remove politics from Medicare payment policy; rather, by failing to provide balance in the appointment process, it creates a potential vehicle for one political party – and the President’s own “special interests” – to maintain complete control of the healthcare delivery reform process.

Recently, Secretary Sebelius published an article on Politico’s website, describing IPAB as an “advisory board” whose “work will be transparent, independent and accountable to Congress and the President.” It is unclear how this advisory board can be both independent and accountable. Indeed, it is independent and it is certainly not merely advisory, as the IPAB enjoys totally unreviewable and unaccountable power to change the law. If it has any accountability, it is only to the President who appointed its members, not to the Congress, and certainly not to the American people.

Furthermore, the law precludes administrative or judicial review of the implementation of IPAB recommendations and Congress, which under certain conditions may amend IPAB recommendations, is given very little time to do so. Specifically, under the “fast-track” process, if Congress fails to find off-sets to meet or exceed the Medicare cost cutting targets for that year, the Secretary must implement the IPAB recommendations. In the event that the IPAB is not constituted or if it fails to make recommendations for reducing spending in Medicare, the Secretary of Health and Human Services is required to come up with a detailed and specific proposal of her own.

The Alliance is extremely concerned that the timeframe for Congress to act under the fast-track procedure is frightfully short. As described in statute, the IPAB must submit a proposal to Congress and the President for achieving Medicare savings targets in the following year, by January 15 of each year beginning in 2014. In the event this deadline is missed, the Secretary must submit a proposal, meeting the same targets, to the President and MedPAC 10 days later. Then, the proposal must be delivered to Congress within 48 hours, whereby it must be immediately introduced and referred to the appropriate committees of jurisdiction for consideration, which must complete their action by April 1. Congress is prohibited from considering any bill or amendment that would not meet or exceed the IPAB targets. If Congress does not pass an alternative proposal to that of the IPAB before August 15, or if the President vetoes the proposal as passed by Congress, the original IPAB recommendations would be implemented by the HHS Secretary on January 1 of the following year.

These expedited procedures vary significantly from the parliamentary mechanism the House and Senate usually follow to consider most legislation and we believe was intentionally designed to ensure that Congress will have insufficient time to alter or override IPAB recommendations.

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

We agree that growth in Medicare spending is unsustainable and the issues that Congress faces in addressing Medicare payment policy are difficult; however, we contend that it is the duty and responsibility of our nation’s elected officials to address these issues rather than ceding this important work to a handful of government appointees.

LIMITED TRANSPARENCY IN IPAB PROCEEDINGS

In its current role, MedPAC serves an important function as an advisory committee to elected decision makers in Congress. Using MedPAC’s recommendations, Congressional leaders are currently able to consider the realities facing Medicare beneficiaries and providers through an open legislative process. The Alliance appreciates the continued role MedPAC will play regarding review of recommendations made by the IPAB. However, the IPAB severely limits Congressional oversight of the Medicare program and replaces the transparency of Congressional hearings and debate with a

less transparent process overseen by the executive branch with at best minimal accountability for the healthcare decisions it makes. Additionally, there is no notice and comment process to solicit public input prior to the IPAB sending its recommendations to the President and Congress. Notice and comment is a fundamental aspect of the federal rulemaking process to ensure transparency and accountability. The failure to include a mechanism for the public to have a meaningful opportunity to be heard further isolates the IPAB.

FAILURE TO MAINTAIN EQUALITY

The breadth of IPAB's authority is unfairly limited and does not treat all providers equally.

For its first 5 years, IPAB's potential cuts are primarily limited to Medicare Parts B, C, and D. Most Medicare Part A providers, including hospitals, long term care facilities, and clinical laboratory services, are exempt, despite the fact that these providers comprise over a third of all Medicare spending. Shielding Part A providers from the IPAB's cost reductions until 2020 effectively means IPAB's focus will be on reductions to physician reimbursements while ignoring that physicians already are subject to cost and volume controls under Medicare.

Exempting some groups places greater pressure to achieve savings from a more limited pool of providers. If these carve outs are left unaddressed, and the entities responsible for the bulk of Medicare spending remain exempt from payment cuts until 2020, the end result of this will mean a further reduction in the already below market reimbursement rates for physicians who treat Medicare patients. The Congressional Budget Office (CBO) has verified that the IPAB is likely to focus its recommendations on changes to payment rates or methodologies for services in the fee-for-service sector by non-exempt providers; that is, physicians.

IMBALANCE IN APPOINTMENTS

The Alliance is concerned about the manner in which appointments to the IPAB will be made.

As enacted, the IPAB will be composed of 15 members appointed by the President with the advice and consent of the Senate. In addition, the PPACA requires the President to consult with the Speaker of the House, the House minority leader, and the Senate majority and minority leaders, each on the appointment of three IPAB members. Presumably, the remaining three IPAB appointments will be the selections of the President alone, without any advice or counsel. The Chairman of the IPAB is appointed by the President from among the 15 members of the Board and is also subject to Senate confirmation.

Most concerning is that, should the Senate be in recess, the President is empowered to unilaterally make appointments to the board if a position is vacant. The Alliance maintains that this level of executive control over the so-called independent policy-making entity is inappropriate.

Were the President to make recess appointments to the IPAB, he could fill whichever positions on the board he chose to without ensuring that his appointments result in a politically balanced board. In

fact, the President could make recess appointments to those membership slots that are likely to be filled by members of his own party: the three filled in consultation with the Senate majority leader, the three filled in consultation with the House minority leader, and the three filled without consultation. Indeed, 9 of the 15 member positions could feasibly be filled by the President allowing him to “stack the deck” in favor of his own political agenda. And, as we understand, this number would be sufficient to provide a quorum for the board to conduct business, thereby submitting proposals and making recommendations of a partisan nature.

Furthermore, the President could use his recess appointment power to appoint one of his nine “hand-picked” members as chair.

Regardless of the President’s statutory mandate to consult with House and Senate leadership on his recommendation, it is still the President who is solely and explicitly authorized to make IPAB appointments. The imbalance appears to have been purposefully built into the IPAB and is concerning.

INADEQUATE EXPERTISE OF IPAB OFFICIALS

The qualifications to serve as a member of the IPAB as they are written are of great concern to the Alliance. According to the law, appointed members of the Board are to provide varied professional and geographic representation and possess recognized expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, and reimbursement of health facilities.

IPAB Commissioners should have current clinical expertise; that is, they should be practicing physicians and other healthcare providers with the ability to draw from firsthand experience when considering how proposed recommendations could impact the delivery of healthcare from both the provider and patient perspective.

While the law states that the board members are to be drawn from a wide range of backgrounds, including physicians and other health professionals, the law further states that appointed members cannot be individuals directly involved in the provision or management of the delivery of Medicare items and services. The statute also specifies that the majority of IPAB members cannot constitute healthcare providers. Further, the law states that no individual may serve as an appointed member if they engage in any other business, vocation or employment. This explicit exclusion of providers who treat the very patients this board will impact is inappropriate. Only practicing physicians who see Medicare beneficiaries have the current and necessary, in-depth perspectives of the patients whose care will be impacted by the IPAB’s proposals.

CONCLUSION

While we all recognize the need for more sustainable healthcare costs, we do not believe that IPAB is the way to, or will, accomplish this goal. The IPAB, particularly if it is coupled with the SGR crisis, will severely threaten Medicare beneficiary access to innovative therapies and specialty care.

Furthermore, IPAB-related cuts have the potential to drive many physicians out of business, putting thousands of jobs at risk -- from the staff that they employ, to those employed by support and referral entities, such as medical billing companies and clinical ancillary services.

No one can argue that Medicare payment policy requires a broad and thorough analysis; thus leaving these decisions in the hands of an unelected, unaccountable governmental body with minimal Congressional input will most certainly have a negative impact the availability of quality, efficient healthcare to Americans. We cannot afford to disregard Congressional oversight when making decisions that impact millions of beneficiaries' ability, and indeed the ability of all Americans, to receive quality care. Democrat and Republican Members of Congress; organizations representing seniors, the disabled and other patient groups; physicians and other healthcare providers; and health policy experts all agree. To date, approximately 150 Members of the House of Representatives have signed on to support the bipartisan bill, H.R. 452, the Medicare Decisions Accountability Act, and growing number (at least 300 at present) of physician and patient organizations are also rallying for IPAB repeal.

You have chosen to become elected officials, as I have chosen to be a neurosurgeon. We both have a duty and responsibility – I to my patients, and you to your constituents and all Americans. I am committed to serving my patients and providing the highest quality care possible. I ask that you make the same commitment, and work with the medical community to meet the challenges facing our healthcare system.

In June 2009, President Obama gave a speech at the American Medical Association's House of Delegates meeting to an audience of physicians who are dedicated to seeing through positive reforms for the American healthcare delivery system. The President said, "I need your help. Doctors, to most Americans, you are the healthcare system... That's why I will listen to you and work with you to pursue reform that works for you."

Today, the more than 100,000 doctors represented by the Alliance are reiterating our pledge to work with Congress to make the necessary improvements in our healthcare system that will ensure that patients receive the right care at the right time. A significant step in that direction will be to repeal the IPAB so millions of Medicare beneficiaries' access to care will not be at risk.

Mr. Chairman, thank you again for including the Alliance of Specialty Medicine as a witness. I am happy to answer any questions.