



## **CONTACT INFORMATION**

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



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

to the  
House Ways and Means  
Health Subcommittee

Independent Payment Advisory Board (IPAB) Hearing

March 6, 2012

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

A handwritten signature in black ink, reading "Mary R. Grealy". The signature is written in a cursive style with a large, prominent initial "M".

Mary R. Grealy  
President  
Healthcare Leadership Council

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