

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

**STATEMENT OF THE
AMERICAN UROLOGICAL ASSOCIATION**

PRESENTED BY

DAVID F. PENSON, MD

BEFORE THE

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

TUESDAY, MARCH 6, 2012

“Impact of New Advisory Board on Medicare”

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

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

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

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

Critical Issues with the IPAB

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

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

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

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

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

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

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

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

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

The similarities between the USPSTF and the IPAB are uncanny.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

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

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

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

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