HEALTHCARE LEADERSHIP COUNCIL

Testimony of

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Healthcare Leadership Council

Before the
House Energy and Commerce Committee
Subcommittee on Health:

Examining Bipartisan Legislation to Improve the Medicare Program

July 20, 2017

Chairman Burgess, Ranking Member Green, members of the committee. Thank you for the opportunity to testify this morning.

I'm speaking today on behalf of the members of the Healthcare Leadership Council, comprised of chief executives of innovative companies from every sector of American healthcare. One of HLC's foremost priorities is the attainment of a strong, sustainable, and patient-centered Medicare, and so we applaud this committee for your focus on bipartisan solutions to improve the program.

We believe an initial, and critical, step in making Medicare stronger is to remove an entity that threatens to weaken it. The Independent Payment Advisory Board, or IPAB, was created with the ostensible purpose of controlling Medicare spending, but it does so in a way that does not improve the health of beneficiaries, does not add value to the Medicare program, and does not respect the prerogative of the elected members of the legislative branch to set Medicare policy.

The Medicare Trustees report released last week, as we all know, did not project spending levels that triggered IPAB into action this year. We're fortunate that has not yet occurred. Even though neither President Obama nor President Trump has named members to the board, the Secretary of Health and Human Services still has the legal responsibility to initiate the process that would almost certainly lead to arbitrary cuts in what Medicare pays for healthcare services.

When that process does inevitably occur, it is projected that the gap between what private insurance pays physicians to treat patients and what Medicare pays will continue to widen, leading to a future in which an expanding beneficiary population will have greater difficulty finding a physician. Even today, two of my personal physicians have posted notices in their waiting rooms saying they are no longer taking new Medicare patients. IPAB, if implemented, will worsen this access problem.

This is actually made quite clear by the statute creating IPAB. Any notion that IPAB could be a catalyst in promoting productive healthcare reforms is undermined by the provisions in the law stating that IPAB must achieve scoreable savings – sufficient to reach statutory budget targets – within a one-year timeframe. Given this restriction, IPAB is most likely to focus on short-term savings in the form of payment cuts to

healthcare providers. The Congressional Budget Office, in fact, reached that very conclusion and projected that IPAB will reach savings through changes in payment rates or methodologies affecting non-exempt providers.

Nearly 800 organizations representing patients, healthcare providers, seniors, employers, veterans, Americans with disabilities and others are asking Congress to do away with the Independent Payment Advisory Board before harm is done to Medicare beneficiaries. Besides my own Healthcare Leadership Council, two of the organizations here at the witness table – the American Academy of Neurology and the American Physical Therapy Association – are among this group and I want to thank Dr. Kissela and Dr. Moore for their leadership on this issue. Fortunately, there is bipartisan legislation pending before Congress to do exactly what these hundreds of organizations are requesting.

H.R. 849, the Protecting Seniors Access to Medicare Act, sponsored by Representatives Phil Roe and Raul Ruiz, is being cosponsored by a majority of the House. It should also be noted that similar legislation has been introduced in the Senate, and a majority of that body has cosponsored one or more of the repeal bills and resolutions under consideration.

But I want to call your attention to the joint resolution, H.J. Res 51, which Congressmen Roe and Ruiz have also introduced. There is an unusual element in the IPAB authorizing legislation that allows both houses of Congress to enact a joint resolution by August 15, 2017 which will eliminate the IPAB threat once and for all. This joint resolution would be fast-tracked with no amendments and no filibuster in the Senate. We strongly urge lawmakers to take advantage of this one-time opportunity that was written into the law.

Steps do, of course, need to be taken to make Medicare a more value-focused program, to be a more effective combatant against rising rates of chronic disease, to save money in the long run by helping beneficiaries become healthier and lessen their need for hospitalizations and emergency room visits. You are considering bipartisan legislative measures today that will do that. IPAB, with its indiscriminate approach to healthcare spending cuts, will not.

We also believe very strongly that Medicare decisionmaking should be in the hands of the public's elected representatives. It does not matter if a future Independent Payment Advisory Board is filled with eminently-qualified appointees. It does not matter, in lieu of a board, if that power rests with a Democratic or Republican HHS Secretary. What does matter, and what should be opposed, is the idea of moving Medicare policymaking farther away from the millions of Americans who will feel the impact of these changes. Congress has shown repeatedly – most recently through the MACRA legislation – that it will act in a bipartisan fashion to improve healthcare for Medicare beneficiaries and it is with Congress that this authority should remain.

With this testimony, I am also providing a copy of the letter from nearly 800 organizations to Congress urging IPAB repeal, a comprehensive fact sheet on the issue, a paper discussing "myths and facts" regarding IPAB, and a number of recent news stories on the subject. I thank you again for this opportunity to testify and look forward to responding to your questions.

July 5, 2017

Dear Member of Congress:

The undersigned organizations – representing Medicare beneficiaries and patients, all sectors of the healthcare industry as well as employers and other purchasers of health care – believe strongly that the Medicare program must protect patient access to quality healthcare. The Independent Payment Advisory Board (IPAB), a provision of the Patient Protection and Affordable Care Act (PPACA), not only poses a threat to that access but also, once activated, will shift healthcare costs to consumers in the private sector and infringe upon the decisionmaking responsibilities and prerogatives of the Congress. We request your support to repeal IPAB.

IPAB, as constructed under PPACA, is a board comprised of Presidential appointees who will be charged with making recommendations to cut Medicare expenditures if spending growth reaches an arbitrary level. Once the Secretary of Health and Human Services (HHS) implements an IPAB recommendation, that action is not subject to administrative or judicial review. As constructed, IPAB is granted unprecedented powers – even the ability to change laws previously enacted by Congress – with virtually no oversight.

The potential impact of this board causes deep concern among our organizations and the millions of Americans we represent. IPAB proponents suggest that the board will be an asset in developing needed healthcare delivery reforms. That goal, however, is not realistically achievable. The law requires IPAB to achieve scoreable savings within a one-year time period. Thus, instead of pursuing long-term reforms that may not achieve immediate savings, IPAB is more likely to consider short-term savings in the form of payment cuts for healthcare providers. This was, in fact, the conclusion of the Congressional Budget Office, which stated that IPAB is most likely to focus on payment rates or methodologies for services provided by non-exempt providers.

This would be devastating for patients, affecting access to care and innovative therapies. Already, the number of physicians unable to accept new Medicare patients due to low reimbursement rates has been increasing over the past several years. IPAB-generated payment reductions would only increase the access difficulties faced by too many Medicare beneficiaries. Furthermore, payment reductions to Medicare providers will almost certainly result in a shifting of health costs to employers and consumers in the private sector.

Under IPAB's provisions, the responsibility for enacting healthcare system changes of this magnitude would be transferred from the legislative branch to the executive. More specifically, an unelected board without adequate oversight or accountability would be taking actions historically reserved for the public's elected representatives in the U.S. House and Senate. This is an unacceptable decisionmaking process for a program that millions of our nation's seniors and individuals with disabilities rely upon.

Moreover, if IPAB does not act within the law's required timeframe or if IPAB members are not appointed by the President or confirmed by the Senate, the law transfers IPAB's responsibilities solely to the HHS Secretary. This places an enormous degree of power in the hands of one unelected individual.

We strongly support bringing greater cost-efficiency to the Medicare program. We also advocate continuing efforts to improve the quality of care delivered to Medicare beneficiaries. The Independent Payment Advisory Board will achieve neither of these objectives and will only

weaken, not strengthen, a program critical to the health and well-being of current and future beneficiaries. We urge Congress to eliminate the IPAB provision.

Sincerely,

1 in 9: The Long Island Breast Cancer Action Coalition
60 Plus Alabama
60 Plus Association
AARP North Carolina
A Partnership of Diabetics
Abbott
Actelion Pharmaceuticals
Action CF
ADAP Advocacy Association (aaa+)
AdvaMed - the Advanced Medical Technology Association
Advocacy Council of ACAAI
Advocates for Responsible Care (ARxC)
AIDS Alliance for Women, Infants, Children, Youth & Families
AIDS Community Research Initiative of America
AIDS CT
AIDS Foundation of Chicago
AIDS Outreach Montana
AIDS Resource Center Ohio
AIDS Response Seacoast
AIDS Services for the Monadnock Region
Alabama ACEP
Alabama Association of Ambulatory Surgery Centers
Alabama Council of Community Mental Health Boards
Alabama Hospital Association
Alabama Lifespan Respite Resource Network
Alabama Podiatric Medical Association
Alabama Society for Clinical Social Work
Alabama Society for the Rheumatic Diseases
Alaska Behavioral Health Association
Alaska ACEP
Alaska Rheumatology Alliance
Alaska State Medical Association
Alliance for Patient Access
Alliance of Specialty Medicine
Alzheimer's & Dementia Alliance of Wisconsin
Alzheimer's Arkansas
Alzheimer's Association - Capital of Texas Chapter
Alzheimer's Texas
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Physical Medicine & Rehabilitation
American Association for Hand Surgery
American Association for Pediatric Ophthalmology and Strabismus
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Hip and Knee Surgeons

American Association of Neurological Surgeons
American Association of Oral and Maxillofacial Surgeons
American Association of Orthopaedic Surgeons
American Autoimmune Related Diseases Association
American Behcet's Disease Association
American College of Allergy, Asthma & Immunology
American College of Cardiology
American College of Emergency Physicians (ACEP)
American College of Mohs Surgery
American College of Osteopathic Family Physicians
American College of Osteopathic Surgeons
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Congress of Obstetricians & Gynecologists
American Congress of Obstetricians & Gynecologists, Oklahoma Chapter
American Gastroenterological Association
American Glaucoma Society
American Kidney Fund
American Liver Foundation
American Liver Foundation Pacific Coast Division
American Medical Association
American Military Society
American Orthopaedic Foot and Ankle Society
American Orthopaedic Society for Sports Medicine
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Osteopathic College of Rheumatology
American Physical Therapy Association
American Podiatric Medical Association
American Shoulder and Elbow Surgeons
American Society for Dermatologic Surgery Association
American Society for Mohs Surgery
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Ophthalmic Administrators
American Society of Ophthalmic Plastic and Reconstructive Surgery
American Society of Plastic Surgeons
American Spinal Injury Association
American Urological Association
American Uveitis Society
AmerisourceBergen
Amgen
AMN Healthcare
Arizona Bioindustry Association (AZBio)
Arizona College of Emergency Physicians
Arizona Radiological Society
Arizona United Rheumatology Alliance
Arizona Urological Society
Arkansas Chapter ACEP
Arkansas Medical Society
Arkansas Ophthalmological Society
Arkansas Orthopaedic Society
Arkansas Podiatric Medical Association

Arkansas Rheumatology Association
Arthritis Foundation
Arthritis Foundation South Central Region
Arthroscopy Association of North America
Ascension
Association of University Professors in Ophthalmology
Asthma and Allergy Foundation of America
Asthma and Allergy Foundation of America, New England Chapter
Atrius Health
Austin Radiological Association
BEACON - Biomedical Engineering Alliance & Consortium
Better Medicare Alliance
Bingham County Senior Center
Bio Nebraska Life Sciences Association
BioBuzz Workforce Foundation
Biocom
BioFlorida
BIOForward
BioHouston
BioKansas
BioNJ
BioNorthTX
BioOhio
Bioscience Association of West Virginia
Biotechnology Industry Organization (BIO)
BioUtah
Birmingham Neurosurgery and Spine Group, PC
Brain Injury Alliance of Oregon
Brain Injury Association of Nebraska
California Academy of Eye Physicians and Surgeons
California ACEP
California Asian Pacific Chamber of Commerce
California Association of Health Facilities
California Association of Neurological Surgeons, Inc
California Chronic Care Coalition
California Health Collaborative
California Hepatitis C Task Force
California Life Sciences Association - CLSA
California Medical Association
California Orthopaedic Association
California Podiatric Medical Association
California Rheumatology Alliance
California Senior Advocates League
California Society for Cardiac Rehabilitation
California Urological Association
Cambridge Chamber of Commerce
Campbell Clinic
Caregiver Action Network
Center for Health Care Services
Center for Healthcare Innovation
Center of Health Engagement
Central Coast Medical Society
Central Florida Behavioral Health Network
Centro de mi Salud
Cervical Spine Research Society
Charleston Parkinson's Support Group

Chattanooga-Hamilton County Medical Society
Chemed Corporation
Citrus Council NKFF
City of New Orleans
Cleveland Clinic
CNY HIV Care Network
COAAA
Coalition of Asian-American IPA
Coalition of State Rheumatology Organizations (CSRO)
Colon Cancer Alliance
Colorado BioScience Association
Colorado Cross-Disability Coalition
Colorado Gerontological Society
Colorado Medical Society
Colorado Podiatric Medical Association
Colorado Radiological Society
Colorado Rheumatology Association
Colorado Society of Eye Physicans & Surgeons
Colorado's Insurance Consultant, LLC
Communicating for America, Inc.
Community Access National Network (CANN)
Community Health Action Network
Community Health Charities of Nebraska
Community Liver Alliance
Community Oncology Alliance
Congress of Neurological Surgeons
Connecticut Orthopaedic Society
Connecticut Podiatric Medical Association
Council for Affordable Health Coverage
Council of State Neurosurgical Societies
CPEM, Inc
Crohn's & Colitis Foundation of America, Georgia Chapter
CSRA Area Agency on Aging
Delaware Academy of Ophthalmology
Delaware Ecumenical Council on Children and Families
Delaware HIV Consortium
Dia de la Mujer Latina
Easter Seals
Easter Seals Central and Southeast Ohio Inc.
Easter Seals Central Texas
Easter Seals Iowa
Easter Seals Massachusetts
Easter Seals Nebraska
Easter Seals North Georgia
Easter Seals of Southeastern PA
Eastern Orthopaedic Association
EDSers United Foundation
Eisai Inc.
Eli Lilly and Company
ELLAS
Emergency Department Practice Management Association
Enchantment Healthcare
Endometriosis Association
Enterprise Family Healthcare
Epilepsy Association of the Big Bend
Epilepsy Foundation of Greater Chicago

Epilepsy Foundation of Greater Southern Illinois
Epilepsy Foundation of Hawaii
Epilepsy Foundation of San Diego County
Epilepsy Foundation of Western Wisconsin
Familia Unida Living with MS
FCEP Florida College of Emergency Physicians
Federation of American Hospitals
Federation of Families for Children's Mental Health ~ CO Chapter
First Step House
Fleet Reserve Association
Florida Allergy, Asthma & Immunology Society
Florida Neurosurgical Society
Florida Orthopaedic Society
Florida Osteopathic Medical Association
Florida Partners in Crisis
Florida Podiatric Medical Association
Florida Society of Dermatology and Dermatologic Surgery
Florida Society of Rheumatology
Florida State Hispanic Chamber of Commerce
Friends of Our Lady of Good Counsel
Geaux Group
Georgia Bio
Georgia College of Emergency Physicians
Georgia Commission on Women
Georgia Neurosurgical Society
Georgia Orthopaedic Society
Georgia Osteoporosis Initiative
Georgia Podiatric Medical Association
Georgia Society of Clinical Oncology
Georgia Society of Dermatology and Dermatological Surgery
Georgia Society of Ophthalmology
Georgia Society of Rheumatology
Georgia Women's Institute
Global Genes
Global Healthy Living Foundation
Global Liver Institute
Granite State Taxpayers
Greater North Dakota Chamber
Greater Providence Chamber of Commerce
H.E.A.L.S of the South (Hepatitis Education, Awareness and Liver Support)
Hawaii ACEP
Hawaii Independent Physicians Association
Hawaii Medical Association
Hawaii Podiatric Medical Association
Health Agents for America, Inc. (HAFA)
Healthcare Innovation Exchange
HealthCare Institute of New Jersey (HINJ)
Healthcare Leadership Council
HealthHIV
Healthy African American Families
Hispanic CREO
Home Care Association of Washington
Hopkins County Memorial Hospital
ICAN, International Cancer Advocacy Network
Idaho Association of Nurse Anesthetists
Idaho Medical Association

Idaho Orthopaedic Association
Idaho Orthopaedic Society
Idaho Osteopathic Physicians Association
Idaho Podiatric Medical Association
Idaho State Dental Association
Illinois Biotechnology Innovation Organization
Illinois College of Emergency Physicians
Illinois Manufacturers' Association
Illinois Neurological Institute
Illinois Podiatric Medical Association
Illinois Society of Eye Physicians & Surgeons
Illinois State Ambulance Association
Illinois State Medical Society
INACEP
Independent Medical Providers Action Council
Indiana Academy of Ophthalmology
Indiana Health Industry Forum
Indiana Medical Device Manufacturers Council
Indiana Neurosurgical State Society
Indiana Podiatric Medical Association
Indiana State Medical Association
Indiana University Health, Inc.
Infectious Diseases Society of America
Insight Human Services
Integral Rheumatology and Immunology Specialists (IRIS)
International Foundation for Autoimmune Arthritis
International Institute of Human Empowerment
International Society for the Advancement of Spine Surgery
ION Solutions
Iowa Academy of Ophthalmology
Iowa ACEP
Iowa Biotechnology Association
Iowa Orthopaedic Society
Iowa Osteopathic Medical Association
Iowa Podiatric Medical Society
Iowa State Grange
J. Robert Gladden Orthopaedic Society
JobKeeper Alliance
Johnson & Johnson
Julian CNA Training School
Kansas Association of Osteopathic Medicine
Kansas Orthopaedic Society
Kansas Podiatric Medical Association
Kansas Rheumatology Alliance
Kansas Society of Eye Physicians & Surgeons
Kansas Urological Association
Kendall Square Association
Kentuckiana Rheumatology Alliance
Kentucky Academy of Eye Physicians and Surgeons
Kentucky ACEP
Kentucky Chamber of Commerce
Kentucky Life Sciences Council
Kentucky Medical Association
Kentucky Psychiatric Medical Association
Kidney Cancer Association
Kidney Care Partners

Latin American Chamber of Commerce
Latino Commission on AIDS
Latino Diabetes Association
Licensed Professional Counselors Association
Life Science Tennessee
Life Sciences Greenhouse of Central PA
Life Sciences Pennsylvania
Limb Lengthening and Reconstruction Society
Louisiana Alumni, Sigma Kappa GNO
Louisiana Association of Neurological Surgeons
Louisiana Liberty 64
Louisiana Lifespan Respite Coalition
Louisiana Orthopaedic Association
Louisiana Podiatric Medical Association
Louisiana Womens' Network
Lower New York Chapter, The American Association of Clinical Endocrinologists
Lupus Alliance of Long Island/Queens
Lupus Alliance of Upstate New York
Lupus and Allied Diseases Association
Lupus Foundation New England
Lupus Foundation of America
Lupus Foundation of America, DC/MD/VA Chapter
Lupus Foundation of Arkansas, Inc.
Lupus Foundation of Colorado
Lupus Foundation of Florida, Inc.
Lupus Foundation of Northern California
Lupus Foundation of PA
Lupus Foundation of Southern California
Lupus LA
Lupus Society of Illinois
MA Health Council
MACEP - Massachusetts College of Emergency Physicians
Maine ACEP
Malecare Cancer Support
Mallinckrodt Pharmaceuticals
Manufacture Alabama
Maryland Chapter American College of Emergency Physicians
Maryland Orthopaedic Association
Maryland Society of Eye Physicians and Surgeons
Massachusetts Association for Mental Health, Inc.
Massachusetts, Maine, and New Hampshire Rheumatology Association
Massachusetts Medical Device Industry Council (MassMEDIC)
Massachusetts Medical Society
Massachusetts Orthopaedic Association
Massachusetts Society of Eye Physicians and Surgeons
MassBio
Maxim Healthcare Services
Maxima Home Health LLC
Meals on Wheels North Carolina
MedChi, The Maryland State Medical Society
Medical Alley
Medical Association of Georgia
Medical Association of the State of Alabama
Medical Device Manufacturers Association (MDMA)
Medical News
Medical Oncology Association of Southern California

Medical Society of New Jersey
Medical Society of the State of New York
Medical University of South Carolina (MUSC)
MedTech Association
MemorialCare Health System
Mended Hearts
Men's Health Network
Mental Health America of Montana
Mental Health Systems
Merck
Metropolitan Milwaukee Association of Commerce
Michigan Association of Neurological Surgeons
Michigan Association of Osteopathic Family Physicians
Michigan Biosciences Industry Association - MichBio
Michigan Chamber of Commerce
Michigan College of Emergency Physicians
Michigan Lupus Foundation
Michigan Orthopaedic Society
Michigan Osteopathic Association
Michigan Rheumatism Society
Michigan Society of Eye Physicians and Surgeons
Minnesota Academy of Ophthalmology
Minnesota Chapter ACEP
Minnesota Medical Association
Minnesota Neurosurgical Society
Minnesota Orthopaedic Society
Minnesota State Grange
Mississippi Academy of Eye Physicians and Surgeons
Mississippi Osteopathic Medical Association
Mississippi Society of Eye Physicians and Surgeons
Mississippi State Medical Association
Missouri Ambulance Association
Missouri Association of Rural Health Clinics
Missouri Biotechnology Association
Missouri Chamber of Commerce and Industry
Missouri Hospital Association
Missouri State Medical Association
Missouri Urological Society
MoCEP - Missouri College of Emergency Physicians
Montana ACEP
Montana BioScience Alliance
Montana Chamber of Commerce
Montana Medical Association
Montana Orthopedic Society
Multiple Sclerosis Resources of Central New York, Inc.
Musculoskeletal Tumor Society
NAMI - Sheridan
NAMI Alabama
NAMI Anchorage
NAMI Buffalo & Erie County
NAMI Clackamas
NAMI Florida
NAMI Greater Des Moines
NAMI Hernando
NAMI Illinois
NAMI Indiana

NAMI Iowa
NAMI Kansas
NAMI Knox Licking County Ohio
NAMI Lewis County
NAMI Maine
NAMI Maryland
NAMI Mass
NAMI Minnesota
NAMI Montana
NAMI Nebraska
NAMI Nevada
NAMI New Mexico
NAMI North Carolina
NAMI North Dakota
NAMI Northern Nevada
NAMI Ohio
NAMI Rochester
NAMI Sioux Falls
NAMI Skagit
NAMI Stark County
NAMI Upper Valley Idaho
NAMI Virginia
NAMI Washington
NAMI York County
NASW Texas Chapter
National Alliance on Mental Illness
National Alliance on Mental Illness of Central Suffolk
National Alliance on Mental Illness of Park County, WY
National Association for Home Care & Hospice
National Association for Uniformed Services
National Association of Hepatitis Task Forces
National Association of Manufacturers
National Association of Nutrition and Aging Services Programs (NANASP)
National Association of Social Workers - NC Chapter
National Association of Social Workers - Virginia Chapter
National Association of Spine Specialists
National Center for Policy Analysis
National Coalition for LGBT Health
National Council for Behavioral Health
National Council of Asian Pacific Islander Physicians
National Fibromyalgia & Chronic Pain Association
National Grange
National Hispanic Medical Association
National Minority Quality Forum
National Psoriasis Foundation
National Retail Federation
National Rural Health Association
National Spasmodic Torticollis Association
NCCEP North Carolina College of Emergency Physicians
NC State Grange
Nebraska Medical Association
Nebraska Rural Health Association
Nebraska State Grange
Nebraska Taxpayers for Freedom
Neuro Network Partners
Neurofibromatosis, Inc. Mid-Atlantic

Neurosurgical Society of Kentucky
Nevada Academy of Ophthalmology
Nevada Chapter ACEP
Nevada Health Care Association
Nevada Orthopaedic Society
New England Biotech Association
New Jersey Academy of Ophthalmology
New Jersey Association of Mental Health and Addiction Agencies, Inc.
New Jersey Chapter ACEP
New Jersey Mayors Committee on Life Science
New Jersey Orthopaedic Society
New Jersey Rheumatology Association
New Mexico Biotechnology & Biomedical Association (NMBio)
New Mexico Association of Nurse Anesthetists
New Mexico Chapter ACEP
New Mexico Health Care Association
New Mexico Podiatric Medical Association
New York ACEP
New York Regional Society of Plastic Surgeons
New York State Neurological Society
New York State Ophthalmological Society
New York State Rheumatology Society
New York State Society of Orthopaedic Surgeons, Inc.
New York State Society of Plastic Surgeons, Inc
New York State Urological Society
NHACEP
North American Neuro-Ophthalmology Society
North Carolina Alliance for Retired Americans
North Carolina Biosciences Organization
North Carolina Chamber
North Carolina Foot & Ankle Society
North Carolina Psychological Association
North Carolina Rheumatology Association
North Carolina Society of Eye Physicians and Surgeons
North Dakota Chapter ACEP
North Dakota Medical Association
North Dakota Podiatric Medical Association
North Dakota Society of Eye Physicians and Surgeons
North Macon Family Healthcare Associates
Northeast Kidney Foundation
Northern Utah Coalition, Inc.
Novartis Pharmaceuticals Corporation
Occasional Riot
Ogden Branch of the NAACP
Ohio ACEP
Ohio Association of County Behavioral Health Authorities
Ohio Association of Medical Equipment Services
Ohio Association of Rheumatology
Ohio Chamber of Commerce
Ohio Council for Home Care and Hospice
Ohio Foot and Ankle Medical Association
Ohio Jewish Communities
Ohio Orthopaedic Society
Ohio Osteopathic Association
Ohio State Grange
Ohio Veterans United

OKBio
Oklahoma Academy of Ophthalmology
Oklahoma ACEP
Oklahoma Association of Nurse Anesthetists
Oklahoma Osteopathic Association
Oklahoma Podiatric Medical Association, Inc.
Oklahoma Society of Anesthesiologists
Oklahoma Society of Oral and Maxillofacial Surgeons
Oklahoma State Medical Association
ONEgeneration
Oregon Academy of Opthalmology
Oregon Chapter of American College of Emergency Physicians
Oregon Medical Association
Oregon Neurosurgical Society
Oregon Podiatric Medical Association
Oregon Rheumatology Alliance
Oregon Urological Society
Orthopaedic Research Society
Orthopaedic Society of Oklahoma
Orthopaedic Trauma Association
Osteopathic Physicians & Surgeons of California
Pacific Northwest Chapter of TRIO
PA Prostate Cancer Coalition
Partnership to Fight Chronic Disease
PCa Blue Inc.
Pediatric Orthopaedic Society of North America
Pennsylvania Chamber of Business and Industry
Pennsylvania College of Emergency Physicians
Pennsylvania Neurosurgical Society
Pennsylvania State Grange
Perennial Services Network
Pfizer
Pharmaceutical Care Management Association
Philadelphia Rheumatism Society
PhRMA
Plaza Community Services
Premier healthcare alliance
Prescription Assistance Network of Stark County, Inc.
Prevent Blindness Iowa
Prevent Blindness, Ohio Affiliate
Progressive Democrats of Central New Mexico
Progressive Leaders of Louisiana
Prostate Health Education Network
Radiology Associates of Macon
Rainy Day Patriots
Respiratory Health Association
RetireSafe
Rheumatism Society of the District of Columbia
Rheumatology Alliance of Louisiana
Rheumatology Association of Iowa
Rheumatology Association of Minnesota and the Dakotas
Rheumatology Association of Nevada
Rheumatology Society of North Texas
Rhode Island Chapter ACEP
Rhode Island Medical Society
Rhode Island Society of Eye Physicians and Surgeons

Rhode Island Tech Collective
Rio Grande Valley Diabetes Association
RIPMA
Rocky Mountain Stroke Center
RTI Surgical Inc.
Rush To Live
SAGE Utah
Saint Agnes Healthcare
Salud U.S.A.
Sandhills Adult Day Health Center, Inc.
San Diego County Podiatric Medical Association
Sanofi US
SC Podiatric Medical Association (SCPMA)
Scoliosis Research Society
Sea Island Pediatrics
Senior Connections, The Capital Area Agency on Aging
Seniors Golden Hammer
Seniors Hospitality Center / Bonners Ferry Senior Center
Sickle Cell Disease Association of Florida
Sjögren's and Lupus Foundation of Hawaii
Sjogren's Syndrome Foundation
Small Business & Entrepreneurship Council
Smile Community Action Partnership
Society of Academic Urologists
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Military Orthopaedic Surgeons
Society of Urologic Oncology
Solidarity Project Advocacy Center
South Carolina BIO
South Carolina Hospital Association
South Carolina Medical Association
South Carolina Medical Group Management Association (SCMGMA)
South Carolina Nurses Association
South Carolina Orthopaedic Association
South Carolina Rheumatism Society
South Carolina Society of Ophthalmology
South Carolina Urological Association
South Dakota Biotech
South Dakota State Medical Association
South Dakota State Orthopaedic Society
South Florida Cancer Association
Southern Orthopaedic Association
State Chamber of Oklahoma
State of Texas Association of Rheumatologists
State of Texas Kidney Foundation
Statewide Independent Living Council of Hawaii
StopAfib.org
Suicide Awareness Voices of Education
Sunovion Pharmaceuticals Inc.
Survivors Cancer Action Network
Takeda Pharmaceuticals, USA Inc.
TCEP Texas College of Emergency Physicians
Tech Council of Maryland
Tennessee Association of Long Term Care Physicians
Tennessee Geriatrics Society

Tennessee Hemophilia and Bleeding Disorders Foundation
Tennessee Medical Association
Tennessee Orthopaedic Society
Tennessee Rheumatology Society
Texas Association for Home Care and Hospice
Texas Association of Business
Texas Association of Neurological Surgeons
Texas BioAlliance
Texas Health Resources
Texas Healthcare and Bioscience Institute
Texas Life-Sciences Collaboration Center
Texas Medical Association
Texas Neurological Society
Texas Nurse Practitioners
Texas Orthopaedic Association
Texas Osteopathic Medical Association
Texas Pain Society
Texas Radiological Society
Texas State Grange
The AIDS Institute
The Arc in Hawaii
The Arc of Anchorage
The Benefits Consultancy
The Jewish Federations of North America
The Macula Society
The Marilyn Fagan Ovarian Cancer Patient Advocacy Program (ICAN-Hawaii)
The Meeting Group, Inc.
The Michael J. Fox Foundation for Parkinson's Research
The National Association of Catholic Nurses - U.S.A.
The National Catholic Bioethics Center
The New England Council
The New Mexico Association for Home and Hospice Care
The Retina Society
The Surgery Center of Huntsville
The US Oncology Network
The Vision Care Center
The Wall Las Memorias Project
Twin Falls Senior Center
U.S. Chamber of Commerce
U.S. Pain Foundation
Union Pacific Railroad Employees Health Systems
Urban Pain Institute
Utah Advocates
Utah Medical Association
Utah Podiatric Medical Association
Utah Pride Center
Utah State Orthopedic Society
Utah Support Advocates for Recovery Awareness
Vermont Medical Society
Vermont State Association of Osteopathic Physicians & Surgeons, Inc.
Veterans Health Council
Vietnam Veterans of America
Vietnamese Social Services of Minnesota
Virginia Bio
Virginia Chamber of Commerce
Virginia Hispanic Chamber of Commerce

Virginia Podiatric Medical Association
Virginia Society of Eye Physicians and surgeons
Visiting Nurse Association
Visiting Nurse Association of Ohio
VITAS Healthcare
Vizient, Inc.
Washington ACEP
Washington Biotechnology & Biomedical Association
Washington Rheumatology Alliance
Washington Rural Health Association
Washington State Medical Association
Washington State Orthopaedic Association
Washington State Podiatric Medical Association
Washington State Prostate Cancer Coalition
Washington State Urology Society
Wellness and Education Community Action Health Network
Wellness Station
West Virginia Academy of Eye Physicians & Surgeons
West Virginia Academy of Otolaryngology - Head and Neck Surgery, Inc.
West Virginia Orthopaedic Society
West Virginia State Rheumatology Society
Western Orthopaedic Association
Western Section of the American Urological Association
Wisconsin Academy of Nutrition and Dietetics
Wisconsin Academy of Ophthalmology
Wisconsin Association of Osteopathic Physicians & Surgeons (WAOPS)
Wisconsin Hospital Association
Wisconsin Manufacturers & Commerce
Wisconsin Medical Society
Wisconsin Rheumatology Association
Wisconsin State Grange
Wound Care Clinic - ESU
WPMA - Wisconsin Podiatric Medical Association
Wyoming Chapter American College Emergency Physicians
Wyoming Epilepsy Association
Wyoming Medical Society
Wyoming Ophthalmological Society
ZERO - The End of Prostate Cancer

INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

To rein in excessive growth in Medicare spending, the Independent Payment Advisory Board (IPAB) was established and given unprecedented executive power. Specifically, if the CMS Actuary projects that Medicare spending will exceed an arbitrary, formula-based target, then the IPAB is charged with proposing policies to achieve a certain amount of savings in Medicare. IPAB's proposals will take effect unless Congress acts to achieve at least the same amount of cuts to Medicare spending as is required by the savings target. Only a simple majority of its 15 members - who are appointed by the President and subject to Senate confirmation - are needed to approve a proposal before it is submitted to the Secretary of HHS and Congress. In addition, if the IPAB fails to submit a proposal to Congress (or if IPAB members have not been appointed or confirmed, as is currently the case), then the HHS Secretary must submit a proposal for meeting the savings target in lieu of IPAB. In other words, the support of just eight IPAB members or one HHS Secretary is sufficient to make cuts to Medicare unless Congress, including a supermajority in the Senate, can agree on an alternative. Proposals under IPAB, whether submitted by the board itself or by the Secretary, may not be challenged in court or by administrative review. Medicare's trustees project that IPAB's responsibilities will be triggered for the first time in 2017.

Despite legislative intent to protect the interests of patients, IPAB's structure and functions will ultimately have adverse effects on healthcare quality and accessibility. The Healthcare Leadership Council joins other advocates for patient-centered healthcare in believing IPAB is at odds with the ultimate goal of achieving a Medicare program that is cost-effective and that offers high value, high quality care to all beneficiaries. We are joined by a broad cross-section of health care stakeholders including patient advocates like the Easter Seals and the National Alliance on Mental Illness and providers like the American Medical Association and the American College of Emergency Physicians. Please see the attached letter to Congress of November 29, 2016 for the complete list of over 660 employers, trade associations, and national, state, and local organizations supporting the repeal of IPAB.

PROTECTING QUALITY OF CARE FOR MEDICARE BENEFICIARIES

ACA calls upon IPAB to implement changes that will improve quality of care, to the extent feasible. In practical terms, though, quality care improvements are highly unlikely. IPAB cuts must be achieved in a single year in order to meet the arbitrary savings target. Few quality improvements are scored by the Congressional Budget Office or the Office of Management and Budget as saving money in such a short timeframe. In its structure, IPAB realistically has a narrow focus on cutting spending. It is not designed as an instrument to encourage the kind of delivery reform that is now recognized as the way to slow the growth Medicare spending.

TRANSPARENCY AND ACCOUNTABILITY

IPAB divests Congress of its authority for Medicare payment policy and places it in the hands of an unelected executive branch entity. In essence, IPAB takes away Congress's ability to shape Medicare to provide the most effective programs and policies for the beneficiaries they represent. Placing this authority in the executive branch eliminates state and community input

into Medicare decisionmaking, diminishing the ability to develop policies that best meet the needs of diverse patient populations.

Because IPAB members are not directly answerable to voters and the Board's recommendations cannot be challenged in court, this concept is highly unusual in its lack of checks and balances. Without congressional oversight or judicial review, IPAB replaces the transparency of the legislative process with opaque decisionmaking. Without an open and transparent legislative process, Medicare beneficiaries and the providers who deliver their care will be limited in their ability to advocate new approaches to improve the quality and cost-effectiveness of healthcare.

Further, according to a March 2011 report by the Congressional Research Service, the President can use the recess appointment process to place members on IPAB board, bypassing the Senate confirmation process. If this occurs, it would further isolate IPAB from any sort of public input.

LIMITED SCOPE AND COST SHIFTING

IPAB is barred from examining changes to Medicare that would result in fundamentally changing the current system for beneficiaries. That places matters like premiums, cost-sharing and benefit design off limits. Because of these restrictions, IPAB's efforts to control spending will inevitably focus on reducing payments to providers, thus limiting patient access to quality healthcare and innovative therapies. Also, IPAB cuts to provider payments under Medicare will likely result in additional cost shifting onto private payers, increasing healthcare costs for millions of working Americans and exacerbating a problem that already exists.

PROJECTED IPAB IMPLEMENTATION

Since its enactment as part of ACA, IPAB has not been triggered into action because Medicare's per-beneficiary spending fell below the target rates of growth that would have activated the Board's authority. In its 2015 and 2016 report, Medicare's trustees projected that they expected IPAB to be triggered in 2017. This volatility underscores that IPAB, regardless of predictions, could be triggered at anytime, requiring significant cuts to be made.

COST CONTAINMENT PROVISIONS IN THE AFFORDABLE CARE ACT

The ACA includes a number of provisions intended to contain increases in healthcare costs, while also improving quality of care. The Healthcare Leadership Council (HLC) is committed to ensuring access to high quality, affordable healthcare and is encouraged by ACA provisions that will enable patients and communities to benefit from promising new healthcare delivery models. HLC urges members of Congress and the Administration to allow these provisions to take effect and study the results before resorting to an approach such as the IPAB that would make arbitrary cuts in Medicare spending and, in so doing, reduce healthcare access and undermine medical innovation. These promising ACA provisions include: Patient Centered Medical Homes, Accountable Care Organizations, Value-Based Purchasing, and Payment Bundling.

PROTECT MY DOCTOR & ME

Separating the Myths from the Facts About the Independent Payment Advisory Board

Medicare's Independent Payment Advisory Board (IPAB/Board) was designed to have extraordinary powers and override Congress's role in setting Medicare policy. Because IPAB's powers and structure are unprecedented, many myths have crept into discussions about it. The facts underscore the need to act now to repeal IPAB.

MYTH	FACT
Because no one has been appointed to IPAB, there will be no IPAB cuts to Medicare.	The law requires the HHS Secretary to make cuts if no Board members are appointed and IPAB is triggered.
Beneficiaries don't need to worry about IPAB because it can't ration care.	While the law doesn't define rationing, IPAB can decide on its own what "rationing" is and the law makes it very difficult to challenge IPAB in court.
IPAB protects beneficiaries because it is prohibited from increasing their Medicare premiums and cost sharing.	IPAB can't raise Medicare Parts A or B premiums. But millions of beneficiaries in Medicare Advantage (MA) plans are not protected against premium increases that could result from payment cuts to MA plans because of IPAB.
Congress can easily override IPAB proposals.	IPAB was designed to allow the unelected Board to literally rewrite federal law and make it difficult for Congress to override IPAB cuts.
IPAB's trigger overage will be small in early years, so the impact to Medicare will be minimal.	The law doesn't limit IPAB to just cutting the identified overage; in fact, there is no limit on the cuts that IPAB can make. The overage is the minimum target reduction, allowing IPAB to cut more than the required amount without restriction. Additionally: • IPAB must cut the amount set by the formula in one year, not the 10 year scoring window Congress usually considers when making policy changes. • There's no guarantee that the IPAB cuts will stay small or in line with the target overage amount; over time IPAB policies could grow and have a large impact on the Medicare program.
Hospitals are exempt from IPAB cuts.	While it is true that IPAB could not "reduce payment rates for items and services" furnished by hospitals until 2020, that exemption is now over because recommended cuts to IPAB made in 2018 would take effect in 2020, when the hospital exemption no longer applies.
IPAB will focus on achieving savings by improving quality of care in Medicare.	Quality of care initiatives take time to be designed, implemented, and save money. IPAB's charged with finding savings in one year, and thus is likely to make blunts cuts to Medicare instead of any long-term programmatic or quality improvements.
IPAB is the only way to control Medicare spending.	Congress frequently makes adjustments, including cuts, to Medicare through changes to law. Moreover, from 2010-2016 Medicare spending per enrollee grew by less than 2% per year. Outsourcing decisions about Medicare to an unaccountable Board is fundamentally at odds with preserving the sustainability of Medicare for future generations.
IPAB can be changed in ACA repeal/replace legislation.	If the Senate uses reconciliation to pass the AHCA, IPAB is unlikely to be eligible for repeal due to prohibitions in Senate rules on making changes to a program with expedited procedures (IPAB) in an expedited manner (via reconciliation).
IPAB's funding was rescinded in FY 2017, therefore, it has no power and is essentially "repealed."	IPAB has a permanent annual appropriation to support the Board's operational expenditures. While Congress has rescinded funding for IPAB in the past, IPAB is automatically allocated new resources each fiscal year. If no Board is seated or IPAB fails to act, the responsibilities and power IPAB transfers to the Secretary of HHS irrespective of the appropriations to finance the Board's operations.

Congress, cut loose ObamaCare's notorious Medicare board

BY MIA PALMIERI HECK, OPINION CONTRIBUTOR - 07/16/17 10:00 AM EDT

The debate over repealing and replacing ObamaCare has caused a political divide on policies affecting how every American will receive and access healthcare. However, “repeal and replace” isn’t the only legislative option available that will contribute to dismantling the Affordable Care Act. This year, repealing the Independent Payment Advisory Board (IPAB) has received a surprising amount of bipartisan support in Congress, and the deadline for off-ramping this powerful but not-yet-established body is quickly approaching.

Section 3403 of the Affordable Care Act provides the IPAB shall be established if the chief actuary for the Centers for Medicare & Medicaid Services (CMS) determines the five-year average per-capita growth rate for Medicare spending exceeds its annual target. Once exceeded, the president of the United States, with the consent of the Senate, shall appoint a 15-member federal board which will have the authority to propose ways to reduce Medicare spending.

While the board is prohibited from rationing care, they are required to make “hard decisions” that will amount to a reduction in access to healthcare for older Americans, with very little accountability.

Once the IPAB has determined how Medicare spending should be reduced, the decisions of the IPAB cannot be challenged in court, and are free from the normal federal administrative rules processes such as requirements of public notice, public comment, or review.

IPAB recommendations carry the full force of the law and will be difficult for Congress to override, as an override requires a supermajority vote of 2/3 passage in both the House and Senate, the same number of votes required for extraordinary actions such as impeaching the president of the United States or amending the Constitution. Unilateral federal action rarely results in implementing policies that encourage greater competition, choice and free-market principles. This, combined with the lack of oversight and accountability of the IPAB, has set off alarm bells and great opposition to the appointment of this board.

A provision included in Section 1899A of the Social Security Act provides if Congress passes legislation to discontinue the process for automatic implementation no later than August 15, 2017, the IPAB will be wiped from the statute. Pulling the trigger on an escape hatch for repealing automatic implementation of the IPAB is timely and necessary to relieve Americans of harmful provisions of the Affordable Care Act.

Congressional action has already been put in motion. House Joint Resolution 51 was introduced by Representative Phil Roe, M.D. (R-Tenn.) and Senate Joint Resolution 17 was introduced by Senator John Cornyn (R-Texas) and serves to dissolve the potential for the IPAB. The resolutions have attracted robust bipartisan support in Congress, and been referred to the committees required to move forward in the legislative process. When comparing the lack of partisan agreement on the 'repeal and replace' legislation being considered in Congress, this level of cooperation is remarkable.

Once a board, entitlement or governing body is statutorily in place, it is very difficult to justify removing it as we are seeing play out in the debate on repealing Medicaid Expansion and ObamaCare subsidies. Congress needs to capitalize on this moment and pass House Joint Resolution 51and Senate Joint Resolution 17 to discontinue the process for IPAB implementation before the August 15 deadline. Failing to do so will be a missed opportunity of monumental proportions.

Few argue the level of spending growth in healthcare is sustainable over the long term, and policymakers need to act on striking harmful regulatory constraints on private industry wherever and whenever they can. Solutions sought to bring down the cost of care should be rooted in reducing regulation while incentivizing competition and choice in the market, not governing boards of unelected bureaucrats who are accountable to no one.

Mia Palmieri Heck is the director of Health and Human Services at theAmerican Legislative Exchange Council.

MEDPAGE TODAY

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Medicare's Hospital Payment Fund Solvent Until 2029

Independent Payment Advisory Board not triggered this time, trustees say

by Joyce Frieden, News Editor, MedPage Today
July 13, 2017

WASHINGTON -- The hospital portion of the Medicare program will be solvent until 2029, a year longer than projected last year, and spending on Medicare was not high enough to trigger the use of the Independent Payment Advisory Board (IPAB) to advise on how to cut costs, the Medicare trustees said Thursday.

Despite that good news, "the Hospital Insurance Trust Fund is not in actuarial balance," said Health and Human Services Secretary Tom Price, MD, one of the trustees, during a press conference at the Treasury Department. "Congress must act to ensure the long-term survival of Medicare." Medicare parts B and D, which cover doctor visits and prescription drugs, respectively, "[remain] adequately financed into the future due to financing being derived from general revenues and beneficiary premiums," the Treasury Department said in a press release.

Last year, the trustees reported that the hospital care portion of the Medicare program will be solvent until 2028, which is two years less than was estimated the previous year but 11 years longer than was projected before the Affordable Care Act was passed. The trustees also project that Medicare costs will grow from approximately 3.6% of gross domestic product (GDP) in 2016 to 5.6% by 2041, and then increase gradually to about 5.9% by 2091.

Those numbers "sound like not much news," said Douglas Holtz-Eakin, president of the American Action Forum, a right-leaning lobbying group here. "It sounds like the program was in terrible shape last year and it remains that way this year. It reminds us that we will have to undertake Medicare reform."

Grace-Marie Turner, founder of the Galen Institute, a right-leaning think tank, agreed. "We see in the Medicare Part D prescription drug program a model for changes to the overall Medicare program -- engaging genuine competition and consumer choice to get costs under control using market forces," she wrote in an email to *MedPage Today*. "The longer Congress waits to modernize the program to make it sustainable over the long term, the more likely it will be that we face the prospect of triggering IPAB."

The IPAB was designed to be a 15-member independent body that would make recommendations on cuts to the Medicare budget. If the IPAB isn't established in time -- and as of yet no one has been named to it -- or if it meets but fails to devise an acceptable plan, the responsibility of making the cuts would fall to the current Health and Human Services Secretary, Tom Price, MD.

The idea of the board -- whose recommendations are binding unless both houses of Congress override or change them -- has raised controversy, with many Republican members of Congress opposed to the idea of its existence. Currently, a large group of healthcare organizations is pushing for Congress to repeal the law establishing the board before Aug. 15, warning that it will get a lot harder after that date.

That's because, although IPAB could be repealed at any time through the regular law-making process, there is a special provision in the ACA that would allow it to be repealed through a joint resolution -- a "cleaner" process that allows no amendments to the measure -- as long as it is done by Aug. 15. Hence the rush to get the repeal done. "We miss that [deadline] and then it would go to a normal legislative process," which would be much more complicated, said Mary Grealy, president of the Healthcare Leadership Council, a coalition of drug, medical device, health insurance, and other healthcare organizations that is spearheading the repeal push.

Congressional supporters of IPAB repeal held a news conference outside the Capitol in the 90-plus degree heat to continue their campaign. The fact that IPAB was not triggered this time around "is immaterial," said Rep. Phil Roe, MD (R-Tenn.), a sponsor of both a bill and a joint resolution in the House to repeal IPAB. "It's going to kick in -- it's not a question of if, but when." A companion measure in the Senate is being championed by senators Ron Wyden (D-Ore.) and John Cornyn (R-Texas). According to the trustees' report, "The first determination that the Medicare per capita growth rate exceeds the per capita target growth rate is projected to be made in 2021."

"We stand united that IPAB is not the way to go," said Rep. Ami Bera, MD (D-Calif.). Decisions about how to cut Medicare "shouldn't be done by an independent group that's not elected [by the people]. We will continue working on this."

So far, the bill to repeal IPAB has collected more than 240 co-sponsors in the House, and the joint resolution has 180 co-sponsors, Roe said. The Senate bill has the support of 12 Democrats and all 52 Republicans, "and I think more Democrats will vote for it" as they learn more about it, he added. But with the battle over the bill to repeal and replace the Affordable Care Act, as well as other items on the Senate's agenda, it might be tough to get a joint resolution passed by Aug. 15 "unless the Senate uses unanimous consent, which I urge them to do."

Paul Ginsburg, PhD, president of the USC-Brookings Schaeffer Initiative for Health Policy, said he was surprised that IPAB wasn't triggered this time around. "The projections from the actuary a year ago indicated that IPAB would be triggered ... and now the [spending] forecast is notably lower than it was before."

Medicare spending has been lower than expected for many years, said Ginsburg, who is a member of the Medicare Payment Advisory Commission (MedPAC) but was speaking for himself. "We know the Affordable Care Act (ACA) is responsible for part of it because it cut Medicare hospital rates and cut Medicare Advantage payment rates," but there may be other factors as well, including the recession and changes that private employers have made in their health plans, which affected overall healthcare costs.

Trustees' Report Shows Improving Medicare Finances

By **Kerry Young**, CQ Roll Call
July 13

A new report shows that Medicare funding is in somewhat better shape than projected last year.

The Medicare trustees estimated that because the giant health program's finances have improved, the date of when the depletion of a hospital trust fund would occur is later than previously predicted. The hospital trust fund will have enough money to cover Medicare inpatient expenses through 2029, while last year’s report estimated it would be tapped in 2028, the trustees for the program said.

In the annual report released Thursday, the Medicare trustees also said the dedicated revenue of the fund could cover 88 percent of hospital-related expenses in 2029, 81 percent in 2041 and then rebound to cover 88 percent by 2091.

And the trustees presented a rosier picture for another measure of Medicare's finances. They said a trigger for spending cuts under a fast-track process would not go into effect for the first time until 2023, with a target of trimming Medicare growth by just 0.002

percent that year. The cuts would occur through a controversial panel called the Independent Payment Advisory Board, which critics derided as a "death panel" when it was proposed in the 2010 health care law. Last year, the trustees predicted an initial round of IPAB cuts happening in 2019.

Killing the 'Death Panel' Board

Congress actually may never take action on those cuts, even though they are supposed to happen under the 2010 law (PL 111-148, PL 111-152). For starters, neither the Obama or Trump administration has nominated people to serve on IPAB and organize it.

Federal lawmakers also have proven willing to walk back their scheduled Medicare cuts in the past. Congress, for example, acted 17 times to block slated cuts in Medicare payments for doctors before entirely scrapping that system through a 2015 law (PL 114-10). There are strong bipartisan efforts underway already in Congress to get rid of the IPAB.

“We’re less concerned about when IPAB will be triggered into action and more concerned that this destructive approach to Medicare policymaking exists at all and will inevitably affect beneficiaries,” Mary Grealy, president of the Healthcare Leadership Council, told CQ Roll Call, noting there is an Aug. 15 deadline for Congress to use a fast-track process for killing IPAB.

The shortcut method for effectively ending IPAB, which was in the health law, requires passing a joint resolution by Aug. 15. But lawmakers in both chambers could act to take IPAB off the books at any time after that. Health and Human Services Secretary Tom Price supported a repeal of IPAB when the Georgia Republican served in the House. When asked at a Thursday press conference what he would do if IPAB were triggered, he was noncommittal.

"We'll cross that bridge when we come to it," Price said.

Still, the Trump administration supports eliminating IPAB. The White House’s fiscal 2018 budget estimated a $7.6 billion cost over a decade for abolishing it. That price tag could be a hurdle. Yet, when there’s broad bipartisan support for measures, lawmakers usually find ways to offset or ignore their costs.

“We are certain the bipartisan support exists to do away with IPAB and a joint resolution, if brought to the Senate and House floors, would pass easily," Grealy said. Reps. Phil Roe, R-Tenn., and Raul Ruiz, D-Calif., both doctors, planned a Thursday afternoon press conference on bipartisan legislation (HR 849) to wipe out IPAB. The 2010 health law (PL 111-148, PL 111-152) envisioned IPAB as a panel of doctors and policy experts with a mandate to cut costs and improve the quality of health care for people enrolled in Medicare. The giant federal program serves about 55 million people who are age 65 and older or have disabilities. IPAB’s charge would be to reduce Medicare expenses such as prescription drug purchases and payments to insurer-run Advantage plans. The law specifically said IPAB couldn’t ration health care.

Under the 2010 law, IPAB would put forward cost-cutting proposals if Medicare spending exceeded set targets. These proposals would immediately go on a legislative

fast track, forcing members of Congress to accept IPAB's work or design alternative cuts.

Roe had 192 GOP and 41 Democratic cosponsors for his bill (HR 849) to eliminate IPAB as of Thursday morning. He also has a resolution (H J Res 51) to end IPAB, with 157 Republican and 10 Democratic cosponsors.

In the Senate, Majority Whip John Cornyn, R-Texas, has 36 GOP cosponsors but no Democrats for his bill (S 260) to strike the provisions that created IPAB. He also has 20 Republican co-sponsors for his resolution (S J Res 17) for the same purpose. "Obamacare created a board of unelected and unaccountable bureaucrats to make health care decisions on behalf of American families," Cornyn said in a statement earlier this year.

With the election of President Donald Trump, Democrats have a new reason to back IPAB repeals. The 2010 law gives the Health and Human Services secretary the power to put forward a fast-track proposal for Medicare savings if the IPAB trigger were hit and an IPAB panel doesn't act. Sen. Ron Wyden, D-Ore., has introduced a resolution (S J Res 16) and a bill (S 251) seeking to end IPAB. Each has 12 Democratic co-sponsors. "Given the Trump administration's short but disturbing record of irresponsible and cruel executive actions, it would be a huge mistake to leave in place the authority to push through harmful cuts to Medicare with minimal input from Congress," Wyden said in January.

FierceHealthcare

Trustees say Medicare trust fund will run out in 2029, meaning no IPAB trigger

By Leslie Small
Jul 13, 2017 5:10pm

Medicare's hospital insurance trust fund is now projected to run out in 2029, one year later than last year's projection, according to the Medicare and Social Security trustees' annual report.

That means the controversial Independent Payment Advisory Board (IPAB) won't be triggered; the report now predicts that won't occur until 2021.

The Affordable Care Act designed the IPAB—which was meant to be a group of appointed members who would decide on Medicare cuts—to go into effect if Medicare spending exceeds a set limit. But since no members were ever named to the board, the Health and Human Services secretary would automatically assume control if the IPAB were triggered, raising concerns that important policy decisions would be taken out of lawmakers' hands.

Fearing that the unpopular IPAB could be triggered by the annual trustees' report (PDF), some healthcare trade groups recently increased pressure on Congress to repeal the provision before it adjourns for its August recess. In a statement Thursday,

Mary R. Grealy, president of the Healthcare Leadership Council, emphasized that a repeal of IPAB was still crucial even though it won't yet go into effect.

"The announcement today that IPAB will not be triggered into action this year may change the timing of the threat, but not its inevitability or impact," she said.

Added Elizabeth Carpenter, senior vice president of consulting firm Avalere Health: "The program is designed to be difficult for Congress to overrule and may provide the Trump administration with a significant opportunity to reform the Medicare program in future years."

Here are some additional highlights from the trustees' annual report:

- While the report projects the hospital insurance trust fund will run out in 2029, it says that the supplementary medical insurance trust fund, which consists of Medicare Part B and Part D, "will remain adequately financed into the indefinite future." That's because current law provides financing from general revenues and beneficiary premiums each year to meet the next year's expected costs.
- The hospital insurance trust fund's projected 75-year actuarial deficit is 0.64% of taxable payroll, down from 0.73% of taxable payroll projected in last year's report.
- In 2017, the combined cost of the Social Security and Medicare programs is estimated to equal 8.5% of GDP. The trustees project that will increase to 11.5% of GDP by 2035 and to 12% by 2091, with most of these increases attributable to Medicare.
- In fiscal year 2016, Medicare and Social Security accounted for 42% of all federal program expenditures.
- Social Security and Medicare "face long-term financing shortfalls under currently scheduled benefits and financing," the trustees state. They recommend lawmakers take action sooner rather than later to reduce those shortfalls in order to minimize negative impacts on vulnerable populations.

STAT

Trump administration may have to convene board that inspired 'death panel' fears

By Erin Mershon @eemershon
July 12, 2017

Remember "death panels"? They may be back.

As soon as Thursday, Trump administration officials may have to launch the process that inspired that phrase — and that is aimed at making cuts to Medicare.

Under Obamacare, a provision calls for the establishment of a wonky board of experts to reduce how much Medicare pays doctors or other health professionals — or even how much the program pays for prescription drugs — if Medicare spending surpasses a certain rate of growth.

The panel, known as the Independent Payment Advisory Board, or IPAB, has never had to meet or make a decision about spending.

But Medicare experts have warned that this year's data, which is widely expected to be released as soon as Thursday, might trigger the panel — setting off a new political firestorm in the midst of congressional Republicans' efforts to overhaul the rest of the health care system. If it is triggered, the panel is tasked with finding a way to cut enough money from the Medicare program to slow the growth rate. Last year's data suggested the panel would only need to cut a very small amount, around 0.2 percentage points.

"We won't know until we know," Tricia Neuman, a senior vice president for the Kaiser Family Foundation, told STAT Wednesday. "But if the actuary tomorrow says yes, then the law says that the IPAB would issue recommendations to the president and Congress for congressional action by January of 2018."

That timeline might be tough — because, right now, there is no IPAB.

Under the law, 15 presidentially appointed members would suggest cuts and submit those recommendations to Congress to pass into law. Congress, within only a few months, must either approve the cuts or find its own solution for savings, or the cuts would automatically take effect. The idea was to insulate tough decisions about spending cuts from lobbying efforts and political considerations, especially as Medicare approaches insolvency.

But because the panel is wildly unpopular politically, former President Barack Obama never appointed anyone to sit on it, and neither has President Trump. And without a panel, Health and Human Services Secretary Tom Price has wide latitude to suggest the cuts himself.

There is an escalating effort, however, to repeal the entire panel and revoke the authority before Trump can appoint anyone or Price can issue his own recommendations.

That effort can't simply be tucked into the Republican package to repeal and replace other parts of Obamacare. The IPAB can't be touched using the fast-track procedure Republicans are using to bypass the Senate's 60-vote threshold and advance that measure. Neither the House nor Senate repeal measures include it.

IPAB, however — or rather, the repeal of the panel — is one of the rare health care policy efforts with bipartisan backing. Dozens of Democratic lawmakers have co-sponsored bills that would repeal the panel, and 11 House Democrats joined Republicans in a 2015 vote to repeal it even though the measure included other provisions party leadership didn't support. The Trump administration also included the repeal of IPAB in its fiscal year 2017 budget proposal earlier this year.

The panel is also widely despised across the broad health care industry. Doctors, pharmaceutical companies, and hospitals, in particular, have panned the idea of an unelected panel making decisions about their reimbursements. Some 760 provider groups signed on to a letter earlier this summer that called for repealing the panel, an effort led by the **Healthcare Leadership Council**.

“I can’t imagine they couldn’t get rid of IPAB if they want to,” said Tim Jost, an emeritus professor at the Washington and Lee School of Law. “Frankly they could probably get a supermajority to do so if they wanted. Nobody’s ever liked it other than economists.”

Repeal will indeed require a supermajority, according to the original text of the Obamacare statute. The language includes an uncannily specific provision that says Congress can repeal the panel if it passes a joint resolution before Aug. 15, 2017. The law requires a three-fifths vote in both chambers — a 261-vote threshold in the House and a 60-vote threshold in the Senate.

“It’s such an unusual aspect of the legislation that created IPAB, but Congress put in this one-time-only off-ramp that they could just stop the IPAB process from moving forward,” said Mike Freeman, executive vice president of the **Healthcare Leadership Council**. “There’s bipartisan agreement that IPAB is a bad idea. … The most efficient and easy way to get rid of it is to just enact this resolution before that Aug. 15 deadline hits.”

The resolutions have already been introduced. A bipartisan House measure, led by Reps. Phil Roe (R-Tenn.) and Raul Ruiz (D-Calif.) tracks closely with separate measures from Sens. John Cornyn (R-Texas) and Ron Wyden (D-Ore.). If it’s not repealed before the deadline, overruling any proposed cuts recommended under IPAB authority would likely also require a supermajority vote.

NationalJournal

Another Health Care Headache on the Horizon: Automatic Medicare Cuts

Lawmakers have a chance to speedily repeal Obamacare’s controversial Medicare spending board, but they would need to act soon.

July 11, 2017, 8 p.m.

As the Senate GOP grapples with repealing the Affordable Care Act, a key part of President Obama’s signature health care law is poised to present Capitol Hill Republicans and the Trump administration with a politically thorny decision on Medicare spending.

Unless Congress acts, a series of cuts to Medicare are set to take place as soon as 2019. The spending reductions would stem from the ACA’s creation of the Independent Payment Advisory Board, a controversial body tasked with making cost-cutting recommendations when Medicare spending growth exceeds statutory targets.

The Medicare Trustees Report last year projected the IPAB to be triggered in 2017, and those cuts take effect automatically unless Congress votes to save money a different way. This year’s report has yet to be released.

The exact nature of the cuts isn’t yet clear. A 2016 Brookings Institution report asserted that IPAB’s role would be limited, recommending relatively small provider or plan payment reductions. But critics of the board say the cuts would affect Medicare physi-

cian reimbursements, which could lead doctors to limit the amount of Medicare patients they treat.

Unlike some other aspects of health care, there seems to be bipartisan support to nix this power, but lawmakers have a limited amount of time to do so in a fast-tracked manner. Making the situation even more complicated is the fact that members have never been appointed to the board, so that power would go to Health and Human Services Secretary Tom Price, who in the past has favored overhauling Medicare and privatizing the program.

Now some former House members and the Healthcare Leadership Council, a coalition of health care chief executives, are pressing to get the board repealed before the middle of August.

IPAB "is a blunt instrument that would take resources out of Medicare without bringing greater value to the program," said Healthcare Leadership Council President Mary Grealy in a press statement.

Congress could pass a resolution that would permanently get rid of IPAB, but the ACA mandates that it must be adopted by Aug. 15. And not everyone agrees that is the best path.

Matthew Fiedler, a former chief economist for President Obama's Council of Economic Advisers, thinks repealing the board would be a poor way to respond to a rise in Medicare spending.

"I think there are sensible opportunities to save amounts of money in Medicare without hurting the program or beneficiaries," said Fiedler, now a fellow with the Brookings Institution's Center for Health Policy. He added there is some value to having mechanisms that encourage making health spending more efficient in "bite-size pieces."

But HLC and some other critics complain that one of IPAB's main flaw is that it removes power from lawmakers.

Former Democratic Rep. Vic Fazio and former Wisconsin Republican Gov. Tommy Thompson wrote in an op-ed for *The Hill* that the likely outcome of the IPAB process is reduced reimbursements for physicians who treat Medicare patients, and they argued that, constitutionally, this power belongs to the legislative branch.

"There is a significant problem with transferring this authority to an unelected board whose decisions would not be subject, by law, to administrative or judicial review," they wrote.

Fiedler conceded that IPAB vests a decent amount of authority in the executive branch, but noted that Congress does have the opportunity to put forward its own proposals. HLC's Grealy, though, said the IPAB process does not give Congress enough time to act creatively. "It's sort of a meat-ax approach," she said.

IPAB was designed as a backup for other cost-curbing measures that were included in the Affordable Care Act.

Grealy argues that the ACA's move away from payments based on volume of services to payments more closely linked to outcomes has worked to curb costs in the program, and that this "off ramp" is not necessary. Reducing payments to Medicare could indirectly affect some of the value-based initiatives. "If there is less money … then that does create less resources in the system to invest in new value-based models," said Jeff Micklos, executive director of the Health Care Transformation Task Force.

A joint resolution introduced by Rep. Phil Roe to eliminate IPAB had 157 cosponsors as of Tuesday—148 Republicans and nine Democrats. Republican John Cornyn and Democrat Ron Wyden have introduced companion joint resolutions in the Senate.

Former Republican Rep. Charles Boustany noted that, given the time frame, this could provide both sides of the aisle a victory. A health care victory—even a narrow one—is something Republicans may need as the path forward on their larger Obamacare overhaul has become less certain. Repeal of IPAB could not be included in their Obamacare-repeal legislation due to restrictions in the reconciliation process.

Grealy said this is an opportunity for bipartisanship. "Their taking action will make sure these arbitrary cuts don't go into effect and make sure that your congressman is involved, not this arbitrary board or the HHS secretary," she said.

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Drama around healthcare law 'sucking all the life' from IPAB repeal

By Emily Mongan, Staff Writer
July 11, 2017

Mounting pressure on Republican lawmakers to pass their Affordable Care Act replacement may sweep other healthcare-related legislation under the rug, some observers say.

Bills that have been left in limbo while lawmakers work on tweaking and drumming up support for their healthcare reform proposal include user fee legislation for drug and medical device makers, as well as talks to eliminate the Public Health and Prevention Fund, Bloomberg BNA reported on Monday.

A former House staffer told Bloomberg that the focus on the healthcare overhaul is "really sucking all the life out of other initiatives, including appropriations."

Also among the issues left out of the spotlight amid the ACA overhaul saga is an upcoming deadline to repeal the Independent Payment Advisory Board, which was created under the Affordable Care Act to control Medicare costs. The board, which currently has no members, would have the ability to cut Medicare spending without Congressional approval.

While lawmakers from both sides of the aisle, as well as healthcare groups, have backed repealing the board, some fear that legislators will miss the Aug. 15 deadline to drop it. A repeal would require a simple majority vote ahead of Congress' August recess, which begins in five weeks.

“This is a one-time no-filibuster opportunity to repeal this,” Mary Grealy, president of the **Healthcare Leadership Council**, told Bloomberg.

IPAB previously expected to be spurred into action in 2017 by a rise in Medicare spending, but a federal spending report that was slated to trigger the board has yet to be released. Grealy noted that while some lawmakers think Medicare won't take any cuts from the board due to its lack of members, the task of implementing spending cuts would fall to Department of Health and Human Services Secretary Tom Price, M.D., in the event that the board doesn't convene.

“A lot of people don't know the Secretary would have the authority to make those cuts,” Grealy said. “Really, he'd be required to make those cuts under law.”

Bloomberg BNA

HEALTH-CARE DEBATE ‘SUCKING THE LIFE’ OUT OF OTHER INITIATIVES

Jul 10, 2017 / by Alex Ruoff & Jeannie Baumann

If Republicans can’t come to agreement on overhauling Obamacare in coming weeks, they’ll be forced to deal with several must-pass health bills while their signature health legislation waits in limbo.

Bills allowing the FDA to collect user fees, fund medical research, and ward off cuts to Medicare are being delayed by the health-care reform debate, lobbyists and former Hill staffers warn. Some worry lawmakers may miss crucial deadlines to pass some of this legislation if the debate lingers to the end of July, when Congress leaves for the monthlong August recess.

All the attention on Affordable Care Act reform is “really sucking all the life out of other initiatives, including appropriations,” a former House appropriations staffer who asked not to be identified told Bloomberg me recently.

Congress broke for the July 4 recess with Senate Republicans divided over a proposed repeal bill (H.R. 1628). According to Senate aides, with Congress back July 10, Republican leaders hope adding new money for opioid programs to the legislation and making tax credits for insurance more generous for some will win over some reluctant lawmakers.

The scramble by Republicans to pass a replacement health-care bill comes with just a little more than a dozen working days left before the August recess. Meanwhile, another

important health-care bill, the user fee legislation (S. 934), must pass Congress before the current agreement expires Sept. 30. If there's no action by the end of July, the Food and Drug Administration will have to begin the process of furloughing roughly 5,000 employees.

User fees are negotiated rates that makers of drug, device, and biologic products agree to pay to help fund the FDA's operations.

Another looming congressional deadline involves the repeal of IPAB, an independent board meant to address rising Medicare costs.

Health-care provider groups that represent doctors and hospitals are growing increasingly concerned Congress will miss the Aug. 15 deadline to repeal the Independent Payment Advisory Board (IPAB) without fear of a filibuster, Mary Grealy, president of the **Healthcare Leadership Council**, a coalition of health executives, told me recently. Grealy has spearheaded a lobbying effort to repeal the IPAB in coming weeks.

The ACA allows Congress to repeal the IPAB with a simple majority vote before Aug. 15, Grealy said. That means lawmakers have to act before the August recess, at the same time Republicans want to pass their ACA overhaul, she said.

“This is a one-time no-filibuster opportunity to repeal this,” Grealy said.
A lack of clarity on the ACA front is also impacting the debate on domestic discretionary funding and funding for the public health insurance program for poor children, the Children's Health Insurance Program (CHIP), which expires in the fall.

FierceHealthcare

Finance

Quest to get Congress to repeal the Independent Payment Advisory Board heats up

by *Ilene MacDonald*
Jun 30, 2017 1:11pm

A coalition of 700 healthcare groups is on a mission to get Congress to get rid of the Independent Payment Advisory Board before it’s too late.

The Independent Payment Advisory Board (IPAB) has been unpopular almost from the moment it was included in the Affordable Care Act. But now, a coalition of 700 healthcare groups is on a mission to get Congress to get rid of the program before it’s too late.

IPAB was designed as a **mechanism** that would be triggered if Medicare spending exceeds a particular limit. A 15-member board would then make recommendation for cuts to reduce the spending growth curb. But since no members have been named to

IPAB, its authority is automatically transferred to the secretary of Health and Human Services.

Trade groups, such as the **American Hospital Association** and the American Medical Association, have long opposed the IPAB and submitted letters to Congress supporting a repeal primarily because the board takes decision-making away from lawmakers regarding Medicare policy.

But there is no more time to waste, Mary R. Grealy, president of the Healthcare Leadership Council, told FierceHealthcare during an interview Thursday. Congress must act on IPAB before it adjourns for its August recess on July 28. That's because there is a provision in the law that allows Congress a one-time opportunity to pass a resolution that would permanently end the IPAB process. That resolution, which Grealy says could be fast-tracked through the legislative process without being subject to filibuster or amendment, must be adopted by August 15.

In a **letter** (PDF) to Congress, coalition members say they are worried because they suspect IPAB will be triggered this year when the Medicare actuaries announce their annual spending projections. The result: significant cuts to program spending in 2019. And those cuts would likely include a reduction in Medicare physician reimbursements, which Grealy said will undermine access to care for seniors and beneficiaries with disabilities as more doctors restrict the number of Medicare patients they treat.

But she said the good news is that the ACA includes an "off ramp" so to speak for eliminating IPAB with a joint resolution of Congress. "What is nice about this mechanism is it's a clean legislative process and there is bipartisan support for it," she said.

Indeed, the bipartisan legislation to repeal the IPAB, which is sponsored by congressmen Phil Roe, R-Tenn., and Raul Ruiz, D-Calif., now has 219 cosponsors, a majority of the U.S. House, according to Greely. Now, as the deadline nears, she urges hospital leaders to call their representatives and let them know they support a repeal.

As part of the campaign to overthrow the IPAB, her organization has **sponsored** a $2 million television, print and digital advertising campaign to raise awareness about the dangers the IPAB poses to Medicare beneficiaries.

Former Republican congressman Charles Boustany (La.), a former heart surgeon, told FierceHealthcare that his former colleagues in Congress do believe that the IPAB is a blunt instrument that is more a budgetary tool than a mechanism that would contain costs while maintaining or enhancing quality of healthcare. It's vital that lawmakers address quality and efficiency in delivery of care while bringing costs down to their lowest level, he said, in order to improve patient care.

Vic Fazio, a former Democratic congressman from California, said he believes the fast-track method to eliminate IPAB has the **support** it needs if it gets on the schedule before the summer recess.

Although House Democrats opposed the provision of IPAB when it was enacted as part of the ACA, he thinks many lawmakers forgot about it because no appointments were made to the board and it was never triggered.

But the danger now is that because there is no board, if the mechanism is triggered, HHS Secretary Tom Price will have unilateral authority to make required cuts and there will be no recourse if lawmakers oppose those cuts. That authority, he said, should return to Congress, an authority member should never have given away, he said.

Below, is one of the television spots the Healthcare Leadership Council is running to raise awareness about the IPAB deadline.

The little known threat that could change Medicare this August

BY TOMMY THOMPSON AND VIC FAZIO, OPINION CONTRIBUTOR - 06/29/17 04:20 PM ED

The Medicare program and seniors' health benefits face an imminent looming threat unless Republicans and Democrats in Congress can work together to address it — because time is running out.

The threat comes in the form of the Independent Payment Advisory Board (IPAB). The panel of presidential appointees, created under the Affordable Care Act, is charged with making cuts to Medicare if the program's spending hits a certain arbitrary level.
Up until now, most people haven't paid much thought to IPAB — in part, because per capita Medicare spending has remained relatively low, and also because President Obama didn't name anyone to the board.

Experts now predict, however, that spending could meet that threshold in a matter of weeks, triggering IPAB into action and launching a process that will affect care for 55 million seniors and Americans with disabilities. And the fact that there are no actual IPAB appointees should not be seen as salvation for Medicare beneficiaries. In this eventuality, IPAB's authority transfers to the Health and Human Service Secretary Tom Price.

The issue here is not whether Medicare needs to be improved and made more cost-efficient. Of course, it does. Efforts are already underway to transition the program from its traditional fee-for-service orientation to a structure that emphasizes paying for value. Gradually, steps are also being taken — although more needs to be done — to focus on wellness and disease prevention so we're spending less to treat the symptoms of seniors with multiple chronic illnesses.

The IPAB concept, though, doesn't have anything to do with value or keeping beneficiaries healthy. It's a blunt weapon that demands significant Medicare cuts to be applied over a one-year period in order to bring spending levels back down to legislatively-selected targets. The likely outcome of this process is reduced reimbursements for physicians who treat Medicare patients. That is a significant problem given that Medicare already pays significantly less than private insurance — limiting access to effective, innovative treatments and therapies.

There is also the issue of who should make decisions over Medicare policy. Constitutionally, this belongs in the hands of the legislative branch and, by extension,

the American people who vote members of Congress into office. There is a significant problem with transferring this authority to an unelected board whose decisions would not be subject, by law, to administrative or judicial review.

The good news is that there is a way out of this potentially damaging situation. Democrats and Republicans in both houses of Congress have introduced legislation to eliminate IPAB. There is a provision in the law creating the board that allows Congress to pass a resolution that will shut IPAB down for good. The catch is that this resolution must be passed by August 15 or the opportunity is gone forever. The bipartisan agreement on this issue needs to be quickly translated into essential action.

An Independent Payment Advisory Board is simply out of step with the times in which we're fortunate to live. Right now, medical science is developing new therapies that can more effectively address chronic conditions like diabetes and heart disease. Evidence-based medicine combined with greater access to health data is empowering doctors to keep their patients well instead of simply treating their sickness.

IPAB, with its indiscriminate approach to budget-cutting, would shrink seniors' access to these healthcare improvements, make it more difficult for them to see the doctors of their choosing and, in so doing, increase their use of expensive emergency rooms and acute care facilities. By taking a bad approach to cutting costs, IPAB would actually increase them in the long run.

Congress must do what's right for tens of millions of Medicare beneficiaries and the sustainability of the program. Bring an end to this bad idea before it can do real harm.

Tommy Thompson is the former Republican Governor of Wisconsin and served as the Secretary of the Department of Health and Human Services under President George W. Bush. Vic Fazio is a former Democratic Congressman from California. He is currently a Senior Advisor at the Washington offices of Akin Gump Strauss Hauer & Feld.

POLITICO PRO

Obamacare repeal bid leaves IPAB untouched
By Adam Cancryn | 06/05/2017 05:45 PM EDT

The GOP's crusade to tear down Obamacare has so far spared one of its most likely targets: a much-maligned Medicare cost-cutting board that Republican critics panned as a "death panel."

The unusually powerful board — which in seven years hasn't yet been named — endured searing criticism from Republicans who claimed it would ration seniors' health care. But now that Republicans finally have the power to eliminate the panel, known as the Independent Payment Advisory Board, lawmakers are dragging their feet.

Republicans believe their sweeping repeal legislation can't knock out IPAB, due to restrictions on what they are allowed to do through the fast-track budget procedure they're using to dismantle Obamacare. But so far, none of their so-called "phase three"

bills — separate legislation aimed at remaking the health care system — would target IPAB either, even as there's growing Democratic support for scrapping the board.

"I don't know what the timeline is," said Rep. Phil Roe (R-Tenn.), who for years has spearheaded legislation repealing IPAB. "But it's just a matter of getting it on the floor." For all the GOP warnings raised over IPAB, the issue has flown under the radar in recent years as Medicare costs grew more slowly than expected. The board, which would have powers to force potentially deep Medicare cuts to the health care industry if program spending spikes too high, has remained dormant since Obamacare's enactment in 2010. That's let IPAB repeal slip down the GOP to-do list, as Republicans grapple with more pressing concerns in their Obamacare replacement effort.

Republicans could be pressed into action soon, though. A looming report from Medicare's trustees is expected to show that Medicare costs are rising quickly enough to activate IPAB. That prospect has put the industry on edge, and it's prompting a swell of support for repeal among Democrats who have one key reason to fear the board: Tom Price.

Obamacare gave sole responsibility for making Medicare payment cuts to the HHS secretary if the full 15-member board weren't seated. Because no one has been nominated to IPAB, Price could be handed unilateral power to determine which provider and pharmaceutical groups will be forced to swallow a pay cut — a prospect that's making Democrats plenty nervous.

"Given the Trump administration's short but disturbing record of irresponsible and cruel executive actions, it would be a huge mistake to leave in place the authority to push through harmful cuts to Medicare with minimal input from Congress," said Sen. Ron Wyden (D-Ore.) when he introduced his own bill to repeal IPAB in February.

The board can't touch Medicare's benefits or add costs for consumers, and it can't target certain providers like hospitals until 2020. That would leave pharmaceutical companies and physicians as the groups most likely to receive a pay cut.

Since February, 10 Democratic senators have joined Wyden's bill as co-sponsors. In the House, another 30 Democrats are co-sponsoring Roe's bill — already 10 more than backed his repeal effort last year.
"It is too much authority and decision-making power on what one individual will decide," said Rep. Raul Ruiz (D-Calif.), the legislation's original Democratic co-sponsor.

Plenty of Democratic lawmakers have long raised concerns about ceding spending power to IPAB. And Republicans still bristle at the panel's broad authority even with the Trump administration in charge, arguing it saps power from elected officials.

But there's little consensus on when and how IPAB may be repealed, even as Congress faces a bigger crunch than ever before.

Medicare's trustees within the next two months are expected to publish their annual report, which analysts expect will project spending growth that exceeds the program's targets. That would trigger IPAB, forcing the board — or Price, if the board remains unseated — to recommend spending reductions.

The cuts wouldn't be immediate — they could take as long as a year and a half to take effect. Congress must accept IPAB's recommendations, or develop its own plan that can match the reductions.

There's also budgetary incentive to repeal the board sooner rather than later. The longer IPAB remains in law, the more expensive it could become to kill. When Republicans tried to advance an IPAB repeal in bill in 2012, it cost $3.1 billion. The repeal price tag could be as much as $5 billion now, industry groups estimate, based on how well congressional budget crunchers think IPAB could rein in Medicare's future expenses. Once IPAB triggers and starts actively cutting spending, that figure could grow even higher.

"There's a lot of angst," said Katie Orrico, the Washington office director for the American Association of Neurological Surgeons. "The estimates are not going to get better in terms of the costs."

Those agitating most for IPAB repeal are hoping that Republicans might be convinced to waive the costs of repealing the board. Lawmakers are pitching IPAB's elimination as a way to show that Washington can still work together.

"This is one of those rare opportunities to demonstrate that bipartisan, pragmatic solutions can actually pass the House and the Senate," Ruiz said. "As a stand-alone, this bill has a very, very good chance."

But industry lobbyists concede that Congress likely won't spring into action until IPAB is triggered, and even then it could be tough to fit it into an increasingly crowded legislative agenda. Republicans have signaled that after the broader Obamacare repeal fight, they'd like to tackle other divisive health care issues like medical malpractice reform and interstate health insurance sales.

It's also possible IPAB repeal could be attached to must-pass bills reauthorizing either the Children's Health Insurance Program or a batch of bills extending Medicare payment policies benefiting rural hospitals. That's a risky play — top Republicans have said they'd prefer a clean CHIP reauthorization, potentially leaving the Medicare extenders bill as a last-ditch chance to pile on smaller health care bills.

Still, after seven years spent trying and failing to prevent IPAB from stirring to life, industry representatives are willing to seize any opportunities they can get.

"We'd take a chance at passage whatever the mechanism," said Manuel Bonilla, the chief advocacy officer for the American Society of Anesthesiologists. "For as long as this has been around, we're not going to be choosy."

Bloomberg BNA

June 1, 2017

Obamacare Repeal Complicates Effort to Undo Medicare Cost Panel

From Health Care on Bloomberg Law

Stay ahead of developments in federal and state health care law, regulation and transactions with timely, expert news and analysis.

By Alex Ruoff

The growing partisan divide over the future of Obamacare may prevent repeal of a controversial Medicare cost-cutting provision that both Democrats and Republicans agree should be overturned, health lobbyists and researchers told Bloomberg BNA recently.

The Independent Payment Advisory Board, or IPAB, was created by the Affordable Care Act, and it may take on added importance this summer, when federal officials release the latest Medicare spending projections. The board can cut Medicare spending without approval by Congress, which prompted Republicans to label it a "death panel" and sparked worries among physicians' groups about where the cuts would fall.

Republicans like Senate Majority Whip John Cornyn (R-Texas) and Rep. Phil Roe (R-Tenn.) have led the charge to repeal IPAB. However, to pass a repeal lawmakers may need to find as much as $7 billion in cuts to Medicare spending and find support from some Senate Democrats, who have bristled at being left out of Obamacare repeal talks. "It's a prime example of how the legislative process can be overtaken by demons of its own creation," Pete Sepp, president of the National Taxpayers Union, told Bloomberg BNA May 31.

IPAB was created to lower Medicare spending if the per-person expense for medical services ever reached a certain threshold. The Centers for Medicare & Medicaid Services noted in 2016 that the panel would likely be triggered in 2017 by an expected rise in Medicare spending.

The 15-member IPAB panel has never been convened and has no members. Neither President Barack Obama nor President Donald Trump has nominated any IPAB members.

Determination Coming

The CMS's chief actuary is expected in coming weeks to determine if Medicare spending has reached the point where IPAB would be triggered, Kip Piper, a consultant who specializes in Medicare and Medicaid policy, told Bloomberg BNA May 31.

This determination will outline how much money the IPAB panel will need to cut from Medicare, he said. If the IPAB panel isn't formed, which is likely, then the head of the Department of Health and Human Services, Tom Price, will be tasked with finding spending cuts and implementing them.

This would put Price into a difficult bind: He would be required under law to cut Medicare spending, which Trump has repeatedly vowed not to do.

Just the threat of Medicare cuts is likely to set off alarm bells among physicians and the drug and medical device industries, which received much of the $646 billion in Medicare beneficiary payments in 2015.

“It’s a very large program, so there’s places where you could save a few billion dollars,” Piper said. “It’s just that no one wants it to come from them.”

A major concern is that IPAB or the HHS secretary would have to find the cuts through changes like reducing Medicare payments for physician services and prescription drugs, instead of making changes in Medicare policy that could save the program money, Sepp said. The ACA specifically requires the cuts to come at least in part from Medicare Advantage or Medicare Part D, the prescription drug benefit program.

“IPAB is not a vehicle for long-term reforms that will get the program on a sustainable footing,” Sepp said.

The triggering of IPAB will bring the issue to a head, likely focusing lawmakers to act quickly to stop the process, congressional staffers and health lobbyists told Bloomberg BNA.

Repeal Bills Filed

Both Roe and Cornyn filed legislation to repeal IPAB earlier this year, but no committees have acted on the bills. Sen. Ron Wyden (D-Ore.), the ranking Democrat on the Senate Finance Committee, has also filed a bill to repeal IPAB.

In the Senate, lawmakers appear divided along party lines. Wyden’s bill(S.251) has only Democrats as co-sponsors and Cornyn’s bill (S. 260) has only Republican co-sponsors. While both want to repeal the IPAB provision, they have vastly different reasons for doing so.

Wyden wants to head off any attempts by the Trump administration to cut Medicare spending without input from Congress, a Democratic staff member from the Senate Finance Committee told Bloomberg BNA May 30.

Cornyn, when he introduced his legislation in February, blamed the ACA for trying to give too much power to “unaccountable bureaucrats.”

Roe and Wyden’s bills are fast-track legislation permitted under the ACA to pass with only a simple majority. However, it’s unclear whether lawmakers will want to offset the cost of repealing IPAB, estimated between $7 billion and $15.9 billion.
Roe’s staff believes IPAB can be repealed without offsets. However, two Republican staffers told Bloomberg BNA that House leadership hasn’t decided if it will support legislation that doesn’t include an offset. If Republican leaders want a budget-neutral bill, they will need to find changes to Medicare policy or spending.

Estimates of the size of these cuts differ: The Congressional Budget Office originally projected IPAB would reduce Medicare spending by $15.9 billion, while the Trump

administration's estimate from May was $7.1 billion. If Medicare spending increases just above the threshold to trigger IPAB, the cuts could be just a few billion dollars.

In previously years, Republicans have looked to attach IPAB repeal to other health bills, such as medical malpractice reform, to combine estimated savings for Medicare and estimated increases in Medicare spending caused by the absence of the panel, Chris Sherin, director of congressional affairs for the American College of Radiology, a group that supports repeal of IPAB, told Bloomberg BNA June 1.

However, this is unlikely to occur this year because it would require support from at least eight Democrats in the Senate, he said.

OPINION

Remember IPAB? It's time for a full repeal

by Tyler Q. Houlton | May 22, 2017, 12:03 AM

The Independent Payment Advisory Board aroused considerable furor when it was included in the 2010 healthcare overhaul, then all but vanished from the public consciousness. It's about to come roaring back, and Congress should kill it before it can.

The idea behind the IPAB is to restrain the growth in spending by having 15 bureaucrats decide what should and should not be covered by Medicare – in effect, those unelected "experts" will be rationing healthcare for some of our most vulnerable citizens.

IPAB is supposed to come into being when Medicare spending growth begins to exceed target levels. We're not there yet.

The report from the Centers for Medicare and Medicaid Services' chief actuary, who determines whether growth is exceeding projections, is past due for 2017. But projections indicate there is a good chance growth will exceed the target this year or next. That gives Congress a narrow window to kill the beast before it emerges fully from its lair.

The decisions made by IPAB carry the force of law unless Congress specifically rejects them under Obamacare rules that make such a rejection extremely difficult. That gives this cabal of Washington power brokers almost unilateral authority to dictate healthcare policy, putting those bureaucrats between you and your doctor.

Congress has for the second year in a row refused to fund the IPAB as it awaits its summons from the actuary. But starving the beast isn't good enough. Lawmakers need to drive a stake through its heart.

Even if IPAB is not funded and no board members are appointed, the Affordable Care Act empowers the secretary of Health and Human Services to unilaterally implement program changes — such as altering what drugs or devices are covered, for example — to bring actual costs back into line with projections. This may not sound bad under Secretary Tom Price, but could raise problems under future administrations.

Congress abdicated its responsibility when it handed over that much authority. It can live up to its responsibility and reclaim its authority to write laws by getting rid of the IPAB.
There is bipartisan consensus to do just that.

Sens. John Cornyn, R-Texas, and Ron Wyden, D-Ore., have authored legislation to fully repeal the IPAB. In the House, Reps. Raul Ruiz, D-Calif., and Phil Roe, R-Tenn., are lead sponsors on a repeal measure, which has 124 cosponsors.

Short of an outright repeal, these same lawmakers have
also introduced joint resolutionsthat would discontinue the process for automatic implementation of IPAB recommendations.

In hyper-partisan Washington, this type of bipartisan support is rare. Members of Congress should seize the opportunity to show the American people that they can still work together for the public good and put an end to this disastrous and unaccountable panel.

Repealing Obamacare may be months away, at best, and will be a highly partisan and divisive fight.

But Congress can act right now, in a bipartisan fashion, to get rid of one of the law's worst aspects. Republicans and Democrats should act together to protect seniors and slay the Independent Payment Advisory Board.

HealthPayerIntelligence

650 Medical Groups Sign On to Abolish Medicare Budget Panel

Over 650 medical groups have signaled their agreement with bipartisan legislation that would eliminate the Medicare budget panel, IPAB.

May 18, 2017 - Over 650 medical organizations have signed a **letter** to Congress from the Healthcare Leadership Council (HLC) supporting the elimination of the Independent Payment Advisory Board (IPAB). The HLC joins a chorus of support for two bipartisan **bills** currently in Congress which would permanently eliminate the Medicare budget panel.

The 15 member IPAB board was created as part of the Patient Protection and Affordable Care Act (ACA). As part of the ACA, the board was the inspiration behind the infamous “death panels” used to scare seniors in several election cycles.

“As constructed, IPAB is granted unprecedented powers – even the ability to change laws previously enacted by Congress – with virtually no oversight. The potential impact of this board causes deep concern among our organizations and the millions of Americans we represent,” the HLC stated in the letter.

The IPAB panel is tasked with making immediate cuts to Medicare outlays if they exceeded a certain threshold.

As the law currently stands, if Medicare funding exceeds set limits, the IPAB must pass immediate reforms, which would be scored in a one-year window. The HLC maintains this would take the focus off long-term planning in exchange for mandated short-term cuts.
The group also voiced concern that Medicare reimbursement cuts would further reduce access for patients and diminish revenues for providers. This cost, they assert, would be passed on to employers and consumers.

“An unelected board without adequate oversight or accountability would be taking actions historically reserved for the public’s elected representatives in the U.S. House and Senate. This is an unacceptable decision making process for a program that millions of our nation’s seniors and individuals with disabilities rely upon,” said the HLC letter.

Opposition to the IPAB stems from the board’s singular ability to “fast track” legislative procedures to cut Medicare payments.

Any recommendations by IPAB automatically become law unless a three-fifths Senate majority blocks it. Furthermore, the IPAB mandate prohibits legislators from modifying its decisions, eliminating any executive or judicial oversight powers.

IPAB has remained vacant, with no confirmed members from either the Obama or Trump administration. This vacancy does not erase the board’s original charge. If Medicare spending levels trigger IPAB action, and no members exist, the HHS secretary would be required to submit ‘fast-track’ recommendations.

Since 2010 when the PPACA went into law, Medicare spending has not hit the levels which would mandate an automatic cut by the IPAB panel

“Economists, however, expect this string of good luck to end this year meaning that either IPAB or the HHS secretary will be required to initiate the process of developing and submitting spending reduction proposals for fast-track consideration by Congress,” **stated** a recent American College of Radiology (ACR) report.

Signatories of the HLC letter include organizations which represent Medicare beneficiaries and patients, all sectors of the healthcare industry, as well as employers and other purchasers of health care.

“We strongly support bringing greater cost-efficiency to the Medicare program. We also advocate continuing efforts to improve the quality of care delivered to Medicare beneficiaries,” the HLC letter concludes.

“The Independent Payment Advisory Board will achieve neither of these objectives and will only weaken, not strengthen, a program critical to the health and well-being of current and future beneficiaries. We urge Congress to eliminate the IPAB provision.” Despite both House and Senate bipartisan bills, it remains unclear at this time what action may be taken, or if either bill is voted on at all.

OP-ED CONTRIBUTOR

Repealing IPAB Key to Preserving Patient Access to Health Care

THOMAS E. ROHRER | APRIL 11, 2017 | 05:00 AM

As a dermatologic surgeon and president of the American Society for Dermatologic Surgery Association, I value our elderly citizens and proudly treat Medicare patients in my own practice. But the Medicare program and seniors’ access to quality health care faces an imminent threat unless Congress acts rapidly to address it.

That threat is the government-created Independent Payment Advisory Board, a never-tested entity charged with making significant cuts to the Medicare program. The panel is triggered when spending reaches an arbitrary level and it is expected that IPAB could be called into action soon, compelling it to make cuts that threaten access and care to seniors who make up the Medicare patient population. Fewer than half of IPAB appointees are health care providers and, oddly, none are permitted to be practicing physicians. Control over the health care of millions of seniors and disabled Americans will lack the input of those who know and understand how to treat patients best.

ASDSA has been steadfast in alerting Congress of these possibly dire implications due to the potential actions of this unelected, unaccountable panel. Access to quality skin cancer treatments is at risk, along with other pressing health care needs. Luckily, there is bipartisan agreement in Congress that IPAB is an ill-conceived idea that needs to be stopped. The Medicare program already shortchanges seniors by reimbursing physicians, including dermatologic surgeons, less than what private insurers feel is fair for quality patient care. IPAB-generated cuts would widen this gap and force more physicians to deny affordable care to Medicare patients, and create access issues that limit their ability to be treated with new, effective treatments. This includes therapies to treat the epidemic of skin cancer and other serious skin diseases. These barriers to care are not acceptable for our elderly patients, or anyone.

Meaningful IPAB repeal legislation has been introduced in Congress, but Republicans and Democrats must work together to pass these measures before the wheels of IPAB are set into motion and Medicare patients lose out on quality care.

Preserving a strong, accessible Medicare program is echoed by over 650 organizations across the country that represent patients, doctors, hospitals, employers, veterans and others who realize the urgency of this issue. There is widespread agreement that Medicare can and should be improved. Linking Medicare patients who fight chronic and deadly diseases daily (like skin cancer) to evidence-based treatments is key in transitioning Medicare away from the outdated fee-for-service model to value-based care that emphasizes preventive health, improved outcomes and greater cost-efficiency. These efforts should be allowed to continue without IPAB thwarting progress and hurting our most vulnerable patients.

Acting quickly is imperative. Health care experts, including Medicare's own trustees, predict IPAB will be triggered into action soon. There is no compelling justification to maintain a mechanism that will simply cut resources from a health care program serving over 55 million Americans and, in doing so, undermine quality, access, value and sustainability. Let Congress know they must act decisively and immediately to keep America's Medicare promise to the senior citizens of our great country.

Thomas E. Rohrer is president of the American Society for Dermatologic Surgery Association.

Let's be smart about how we rein in Medicare spending

BY JOEL WHITE, OPINION CONTRIBUTOR - 04/05/17 02:00 PM EDT

Developing sound healthcare policy is far from easy. Creating incentives to expand quality, accessible care to millions of Americans while protecting affordability and achieving long-term sustainability is complex and challenging. It can be done, though. Lawmakers proved that during my tenure as a congressional staffer when we developed a Medicare prescription drug program. Medicare Part D has improved the health of millions while costing less than half of what the Congressional Budget Office projected.

We're about to go in the opposite direction, though, when it comes to Medicare. The Affordable Care Act created the Independent Payment Advisory Board (IPAB), a panel of presidential appointees given the authority to make Medicare budget cuts if program spending exceeds an arbitrary statutory threshold.

Medicare's own actuaries project the threshold will be reached in a few weeks, triggering automatic cuts to a program President Trump promised to leave untouched. This will make Medicare less quality-driven, less cost-efficient, and less sustainable while doing harm to millions of beneficiaries.

It doesn't matter that President Obama and, now, President Trump haven't appointed any members to the board. The law transfers this budget-cutting authority to the Secretary of Health and Human Services if the IPAB table sits empty. Constitutionally dubious, this transfer of power from Congress to the Trump Administration will result in less innovation at the very time we need more efficiencies.

Someone might be able to make a good argument for IPAB, if it were used as a mechanism to make Medicare a better program for seniors and taxpayers. That's not the way it is structured, however. Once IPAB is triggered, cuts must take place within a one-year timeframe in order to meet the law's budget targets. That largely precludes any thoughtful policymaking to enhance Medicare's value.

Rather, IPAB will inevitably lead to cuts in physician reimbursement. Such a meat axe approach to payment policy is as ugly as it is inelegant. Just two years ago, Congress passed the most fundamental reform of physician payment policy in 20 years. Known as MACRA, the law incentivizes physicians to try new care structures, such as risk-based models, medical homes and capitated arrangements.

For example, risk-based models may pay a fixed amount per patient and require doctors to manage care within that allocation. Many physicians have responded to these incentives by aggressively managing chronic illness to keep people healthy and out of expensive emergency rooms. The model itself creates a win for doctors, one for patients and another for taxpayers as costs go down and health improves. IPAB would disrupt these incentives at the same time they are getting off the ground.

Layering IPAB cuts on top of these models will make it harder for doctors to run and manage these programs in their offices. As a result, there will inevitably be an increase in expensive emergency room visits and an escalation in those who see their illnesses progress. Two-thirds of Medicare beneficiaries have multiple chronic conditions and are more likely to visit the emergency room and be hospitalized than their peers with just one condition.

Almost all hospital readmissions — a significant driver of Medicare program costs — are for beneficiaries with multiple chronic illnesses. Limiting their access to care and new models that can help manage them away from these expensive settings will only send Medicare costs spiraling skyward.

There is a growing recognition in Congress that IPAB is a bad idea. Bipartisan legislation has been introduced in both the House and Senate to repeal IPAB. These bills have the support of more than 650 organizations representing patients, healthcare providers, employers, veterans and people with disabilities, who are urging Congress to repeal IPAB before significant damage is done.

There is no question that, for all of the improvements made to Medicare in recent years, more should be done. Medicare's trustees project program insolvency in 2028. To address this funding crisis, however, we need thoughtful, patient-centered reforms that ensure the program serves both today's beneficiaries and future generations. IPAB doesn't remotely fit that description. Congress can, and must, do better.

Joel White is the President of the Council for Affordable Health Coverage, which promotes lower healthcare costs through increased competition and consumer engagement.

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Opinion: Next up–Medicare cuts threatening seniors' care

By SARA RADCLIFFE
April 2, 2017 at 8:30 am

When the Affordable Care Act passed in 2010, few provisions were more controversial on both sides of the aisle than the Independent Payment Advisory Board. This board was created to cap Medicare spending growth, proposing cuts that automatically take effect unless Congress passes similar reductions. Congress can adjust the types of cuts, but it cannot change the dollar amount.

Since ACA's adoption, the advisory board has not received much attention because Medicare spending has not increased enough to spur it to action. But that is about to change. Medicare is poised to hit new spending levels that will trigger cuts, possibly within the next few weeks.
We don't know what types of cuts IPAB would propose, but we can virtually guarantee they will be bad for both seniors and the clinicians who provide their care. Medicare already reimburses physicians less than private insurance, and IPAB-generated cuts would likely widen that gap, forcing more doctors to limit the number of Medicare patients they see.

IPAB's cost containment approach may also harm biomedical innovation by reducing incentives for investment in new research and product development. This would ultimately limit patient access to lifesaving treatments. We are making tremendous headway against cancer, neurodegenerative disorders, rare diseases and other conditions. It is critical that we continue to encourage, not hamper, investment in groundbreaking therapies that preserve life and improve quality of life.

With more than 3,000 companies, employing nearly 300,000 people across the state, California's life sciences innovators have opposed IPAB from the start. Fortunately, because the spending trigger has not been activated and the board has not yet been formed, IPAB has not yet done any damage. Still, we are deeply concerned that the quality of care for our nation's seniors, those with disabilities and patients with chronic or rare diseases will suffer if IPAB takes effect.

On behalf of California's life sciences sector, California Life Sciences Association is particularly troubled by IPAB's lack of transparency and limited congressional oversight. Unfortunately, IPAB upends Congress's ability to manage Medicare spending.

An isolated board is not the appropriate way to make these difficult funding decisions. Rather, we must encourage robust debate by a wide-range of stakeholders, including members of Congress, physicians and the patient community to formulate sound policies for Medicare and its beneficiaries.

Considerable efforts are already underway to transform Medicare from an outdated fee-for-service approach into a value-based model that emphasizes preventive health, improved outcomes and greater cost-efficiency. These efforts must be encouraged without the blunt ax of IPAB.

Our call to preserve a strong, accessible Medicare program is echoed by more than 650 organizations across the country, representing patients, doctors, hospitals, employers, veterans and many others.

We all agree that Medicare can and should be improved. For example, much more can be done to link beneficiaries with chronic disease to innovative, evidence-based therapies. Unfortunately, IPAB will damage both Medicare and public trust.

Bipartisan legislation to repeal IPAB has been introduced in both the Senate and House of Representatives, and we urge policymakers from both parties to work together to pass it.
The clock is ticking. According to healthcare experts, including Medicare's own board of trustees, IPAB will soon be triggered.

There is no compelling justification for a mechanism that wantonly cuts resources from a healthcare program serving more than 55 million Americans. We call on Congress to act decisively and immediately to keep America's Medicare promise.

Sara Radcliffe is President & CEO of the California Life Sciences Association, a California-based non-profit public policy and business solutions organization. She wrote this for The Mercury News.

IPAB's Medicare cuts will threaten seniors' access to care

BY DR. ALEX B. VALADKA, OPINION CONTRIBUTOR - 02/22/17 12:20 PM EST

As Congress begins to debate the future of the Affordable Care Act (ACA), there is no doubt that the American people will hear a lot of rhetoric regarding changes in the ACA affecting Medicare.

However, there is one fact that cannot be overlooked even before the first repair or replacement bills are rolled out: significant Medicare cuts loom just around the corner, threatening seniors' timely access to vital healthcare services.

Why? Because for the first time since its inception in 2010, experts anticipate that growth in Medicare spending will exceed annual spending targets, thus triggering mandatory spending cuts by the Independent Payment Advisory Board or IPAB.

As a neurosurgeon who treats Medicare patients, I consider the IPAB to be one of the most insidious elements of the Affordable Care Act (ACA), and it needs to go.

Since Medicare's inception, Congress has led the way in shaping policies to ensure our seniors' healthcare needs will be taken care of.

We saw this in the last Congress with a major overhaul of Medicare's payment system — now known as MACRA — pass with strong bipartisan majorities and then get signed into law by President Obama.

This is how Medicare policy is supposed to work. Now however, with the advent of IPAB, the people's elected representatives will no longer have power over Medicare payment policy. Instead, these major health policy decisions will rest in the hands of 15 unelected and largely unaccountable bureaucrats, with little or no clinical expertise or the oversight required to protect access to care for our country's seniors.

And they will only have one job: to cut billions of dollars from Medicare. Even worse, if no board is appointed, which is the situation right now, the Secretary of Health and Human Services has the sole authority to make these decisions.
Specialty physicians recognize that we need to control the growth of healthcare spending, but the IPAB is simply the wrong solution for addressing these budgetary challenges.

Operating now under MACRA, physicians have plunged into the nascent value-based payment world, which, if implemented correctly, will not only improve healthcare quality but will also drive down Medicare costs.

Rather than this thoughtful approach to cost containment and quality improvement to enhance the value of the Medicare program, the IPAB is a merely blunt instrument to reduce what Medicare pays for medical treatments and will bring progress on value-based care to a screeching halt.

Having lived through a similarly flawed Medicare payment system — the sustainable growth rate or SGR formula — for more than a decade, the last thing we need is another rigid system that relies solely on payment cuts to control Medicare spending.

So, in the end analysis, arbitrarily ratcheting down provider reimbursement, without sufficient oversight and without care taken to ensure that Medicare beneficiaries receive the quality healthcare that they need and deserve, is this the wrong medicine for fixing our ailing healthcare system.

And Americans agree. According to a recent Morning Consult poll, voters oppose changes that would limit access to care, with the vast majority of adults putting their trust in doctors (84 percent), rather than government officials (4 percent) or members of Congress (three percent), when it comes to medical treatment decisions. Furthermore, more than half of our seniors (56 percent) say allowing IPAB to make changes to Medicare will hurt the quality of Medicare services.

Fortunately, it looks as if Congress is paying attention. In rare bipartisan fashion, legislation to repeal IPAB has been introduced by Sens. John Cornyn (R-Texas) and Ron Wyden (D-Ore.) in the Senate, and by Reps. Phil Roe (R-Tenn.) and Raul Ruiz (D-Calif.) in the House of Representatives.
The Alliance of Specialty Medicine — representing more than 100,000 medical specialists and their patients — is urging lawmakers to expedite action on this issue.

As a nation, we have promised our seniors a Medicare system that offers the best care in the world. Bringing an end to the IPAB once and for all is a vital step to fulfilling that promise.

Alex B. Valadka, MD, is a neurosurgeon at Virginia Commonwealth University and a spokesperson for the Alliance of Specialty Medicine.