June 2, 2011

The Honorable Richard Blumenthal
G55 Dirksen Senate Office Building
Washington, DC 20510

RE: The Independent Payment Advisory Board

Dear Senator Blumenthal:

This letter concerns the above referenced matter and several legislative efforts to repeal it - the Medicare Decisions Accountability Act (H.R. 452) sponsored by Representative Roe (R-TN) and the Health Care Bureaucrats Elimination Act (S. 668) sponsored by Senator John Cornyn (R-TX). Through the decision-making power it granted to the Independent Payment Advisory Board and the self-imposed limits and timetables on its ability to act, presently and in the future, Congress needlessly delegated its legislative authority to an executive branch agency. On behalf of The New England Council's Healthcare Committee, I urge you to support legislation to repeal the Independent Payment Advisory Board, or, in the alternative, amendments to reorganize the Board into a more traditional advisory body.

As you know, The New England Council is a non-partisan alliance of businesses, academic and health institutions, and public and private organizations throughout New England formed to promote economic growth and a high quality of life in the New England region. The members of our Healthcare Committee consist of health insurers and plan providers, community, rural and teaching hospitals, pharmaceutical companies, medical device manufacturers and suppliers, independent physician organizations, non-profit policy organizations, and trade groups and associations representing all of the above.

The Patient Protection and Affordable Care Act (the Affordable Care Act, or the Act) created the Independent Payment Advisory Board (IPAB, or the Board) to "reduce the per capita rate of growth in Medicare spending."[1] The Act sets annual goals - "target growth rates" - for Medicare spending below the average of the last 15 years. The Board's proposals will be implemented by the Secretary of Health and Human Services (the Secretary) unless Congress acts either by formulating its own proposal to achieve the same savings or by discontinuing the automatic implementation process defined in the statute.

Each year, beginning April 30, 2013, the chief actuary of the Centers for Medicare and Medicaid Services (CMS) will make a determination as to whether the projected average Medicare growth rate for the 5-year period ending 2 years later will exceed the target growth rate for the year ending that period. For years before 2018, the target growth rate is the projected 5-year average of the mean of the Consumer Price Index (CPI) and the medical care CPI; for 2018 and later years, the target is the nominal per capita growth rate of the gross domestic product plus 1 percentage point. If the CMS actuary determines for any given year that the projected Medicare growth rate will exceed the target rate, the board must make proposals that would reduce Medicare spending overall by either a percentage set in the statute (1.5 percent after 2017) or the projected excess, whichever is less.

The Board's proposals must be submitted to the Secretary by September 1 of each year and to the President and Congress by January 15 of the following year.[2] A proposal must include:

- the Board's recommendations;
- an explanation of each recommendation and the reasons for including such recommendation, and
- an actuarial opinion from the Chief Actuary certifying that the recommendations contained in the proposal will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target, and are not expected to result, over the ten-year period beginning with the implementation year, in any increase in the total amount of net Medicare program spending relative to what it would have been absent the proposal.

The IPAB proposals must be accompanied by implementing legislation, which is "fast-tracked" in Congress according to special parliamentary procedures established by the Act. But regardless of the legal necessity for authorizing language, the Secretary is required to automatically adopt

[1] Section 3403(b).

[2] If the Board fails to act, the Secretary is directed to prepare a proposal.

the proposals contained in the implementing legislation on August 15 of the year it is submitted, unless:

- prior to that date, legislation is enacted that includes the statement, "This Act supersedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act," or
- in 2017, a joint resolution discontinuing the automatic IPAB implementation process has been enacted.[3]

The procedures established by the Act allow Congress to amend the implementing legislation, but only if the amendments result in at least the same level of targeted reductions in Medicare spending growth that are contained in the IPAB plan. Remarkably, the Act prohibits Congress from changing the IPAB fiscal targets in any other legislation it considers, and establishes procedures requiring a super majority vote in the Senate to waive this prohibition. In other words, the procedures prohibit Congress from considering in any legislation, not just the IPAB implementing legislation, changes to the Board's recommendations that fail to meet at least the same targeted reductions in Medicare spending growth. Likewise, the procedures governing the joint resolution for discontinuing the automatic IPAB implementation process require the super majority vote of both chambers and the President's signature or a veto override before it takes effect. The Act also precludes the administrative and judicial review of the Secretary's implementation of an IPAB proposal.

Thus, Congress has assigned its traditional legislative authority to the executive branch through the statutory disapproval mechanisms contained in the Act. It also acted, contrary to its customary practice, to restrict the ability of future Congresses to enact certain Medicare related policy changes in legislation unrelated to the IPAB. That a congressional cession of power is voluntary does not make it harmless. The Constitution is a compact enduring for more than our time, and one Congress cannot yield up its own powers, much less those of other Congresses to follow. It is no answer to say that Congress surrendered its authority by its own hand; nor is it sufficient to point out that a new statute, signed by the President or enacted over his veto, could restore to Congress the power it has relinquished. The abdication of responsibility is not part of the constitutional design.

[3] Both this legislation and the joint resolution must, of course, be signed by the President or enacted over his veto to take effect. Overriding the President's veto requires an affirmative vote of two-thirds of the House and Senate members.

Although administrative agencies are said to constitute a fourth branch of government, it is important to remember that they are creatures of Congress. Congress has delegated to them the task of implementing the statutes that Congress has enacted. Congress has traditionally responded to the charge of lack of political accountability within administrative agencies by providing for more public participation in the deliberations and decision making processes of these agencies. As a practical matter, it can provide a democratic constraint on agency decisions, in addition to the role played by the courts under the Administrative Procedures Act. But the IPAB decision making process lacks any meaningful public role and fails to provide for judicial review.

Those who support the IPAB believe that removing short term political and public opinion, focusing on spending and using automatic mechanisms is required to reduce the growth in expenditures and rationalize healthcare decision making. And it seems undeniable that as it is currently constituted the IPAB will tend to restrain what many have qualified as persistent excessive spending. But despite the convenience associated with such measures, money is the instrument of policy and policy affects the lives of citizens. The citizenry loses rights in a real sense if that instrument is not subject to traditional political accountability. Medicare expenditures represented close to 13 percent of all federal spending in Fiscal Year 2010. Such a sizable proportion of federal outlays should not be beyond the scrutiny and review of elected officials or the public.

Any statutory target on Medicare growth, whether imposed by IPAB or other means, could have negative consequences. If, for example, the growth limits do not keep pace with the growth in underlying healthcare costs, there is concern about the long-term effects on coverage provided to beneficiaries, the adequacy of provider payments, provider participation, and beneficiaries' access to needed services. The experience with the Sustainable Growth Rate (SGR) formula under Medicare for physician payment illustrates how the application of formulas can have unintended and negative consequences that were not anticipated when Congress created the formula to limit the volume of physician services.

Enacted as part of the Balanced Budget Act of 1997, the sustainable growth rate formula determines how much Medicare pays for services that physicians provide. Under the SGR, cumulative Medicare spending on physicians' services is supposed to follow a target path that depends on the rates of growth in physicians' costs, Medicare enrollment, and real gross domestic product per person. If spending in a given year exceeds the SGR target for that year, then the amounts paid to physicians for each service they provide are supposed to be reduced in the following year to move total spending back towards the target path. The Congressional Budget Office (CBO) and Congress originally expected the SGR formula to lower physician payment rates only mod-

estly below the levels they would have attained under previous Medicare law. When Congress enacted the SGR in 1997, the volume and complexity of physicians' services were growing more slowly than they had been earlier, and many forecasters assumed that those lower rates of growth would continue. By 2002, however, the increase in the volume and complexity of physicians' services began to return to its long-term trend, and the SGR formula produced a 4.8-percent cut in payment rates – a larger cut than had been anticipated. Because the SGR's designers greatly underestimated the increase in the volume and complexity of doctors' services, the formula requires cuts in physician payments that become more severe with each passing year. Since 2003, Congress has regularly prevented the full cuts required by the SGR from going into effect[4], including earlier this year when Congress enacted an extender law which averted a 25 percent payment rate reduction from taking effect in January 2011.

The SGR formula has made Medicare an unreliable partner with physicians, whose participation is essential to carrying out the program's mission of assuring access to care for beneficiaries. While beneficiary access has not yet become an issue the concerns about the long-term impact on access remain. There are concerns that similar problems could emerge in the future if Medicare spending is constrained by a statutory formula that IPAB is required to recommend and the Secretary to implement.

And, while the fact that Congress has regularly suspended provider payment reductions under the SGR formula has been cited as proof that Congress cannot cut Medicare costs, the vast majority of the provisions enacted by Congress over the past 20 years to produce Medicare savings were successfully implemented. Virtually all of the Medicare savings in the 1990, 1993, and 2005 budget reconciliation bills took effect, as did nearly four-fifths of the savings in the 1997 Balanced Budget Act.[5] Most of the Medicare savings provisions in the Affordable Care Act are similar to the types of Medicare provisions that Congress has allowed to take effect.

Furthermore, the purpose of the IPAB is to reduce Medicare expenditures while maintaining quality and access and without raising out-of-pocket costs for Medicare beneficiaries. The Board cannot make recommendations to "ration health care," raise revenues or increase beneficiaries' premiums, deductibles or co-payments. This increases the likelihood that the Board will attempt to reduce expenditures through reductions in Medicare payments to healthcare providers and

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[4] Jim Hahn, *Medicare Physician Payment Update and the Sustainable Growth Rate (SGR) System*, Congressional Research Service, March 18, 2010.
[5] James R. Horney and Paul N. Van de Water, *House-Passed and Senate Health Bills Reduce Deficit, Slow Health Care Costs, and Include Realistic Medicare Savings*, Center on Budget and Policy Priorities, December 4, 2009.

suppliers. The impact of the Board's decisions could be magnified because private insurers often use Medicare rates as a guide or a benchmark in paying doctors, hospitals and other providers. The CMS actuary noted that IPAB target growth rates would have been met in only 4 of the past 25 years and would have approximated the sustainable growth rate, the formula for updating Medicare's physician fees, which Congress has routinely overridden.[6] The chief actuary expressed concern that healthcare providers would have difficulty remaining profitable and might leave the Medicare program when faced with these constraints. If the gap between private and Medicare rates continues to grow, healthcare providers may well abandon Medicare.

Moreover, since Medicare payments have historically been below physicians' average costs, they have been required to make up the difference by increasing the charges for providing care to privately insured patients. As the proportion of Medicare patients increase, privately insured patients will continue to be charged higher rates. This payment differential results in a cost shift from Medicare to private insurers. Overall, it represents 15 percent of the current amount spent by insurers on physicians. In other words, private insurers and their insured's are subsidizing the cost of Medicare by paying the amounts that Medicare should pay but does not.[7]

There are difficult decisions to be made concerning Medicare. Clearly, reducing expenditures must be considered, but with an aging population and costly but worthwhile advances in medical technology, we must balance these reductions with providing necessary treatment under our healthcare system. At times the best decision might be to maintain current levels of spending, or perhaps even to spend more as opposed to cutting costs. A board designed primarily to cut costs will not necessarily make the decisions that are in the beneficiary's best interests. The IPAB is structured to reduce spending at levels which very well might exceed that desired by most Americans and members of Congress. Independent groups should make recommendations but the final

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[6] Foster RS, *Estimated financial effects of the "Patient Protection and Affordable Care Act," as amended*. Washington D.C.: Centers for Medicare and Medicaid Services, April 22, 2010.

[7] Milliman, Inc., an independent consulting firm retained by several hospital and insurer associations, developed an estimate of this cost shift based on fiscal year 2006 survey data from 4,927 short-term, community hospitals throughout the United States. The Milliman study measured the disparities among current payment rates between Medicare and private payers to both hospitals and physicians and found that annual healthcare spending for an average family of four is $1,788 higher than it would be if Medicare paid hospitals and physicians private payor rates. Millman, Inc., *Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers*, (December, 2008) at: http://www.ahip.org/content/default.aspx?docid=25216

decision on such matters should be made by elective representatives who are responsible to the voters.

If you have any questions or if I can provide any additional information, please contact David O'Donnell in the Council's Boston Office at (617) 723-4009.

Sincerely,

Laurel Sweeney
Healthcare Committee Chair
The New England Council