[Congressional Record: March 24, 2010 (Extensions)]
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[DOCID:cr24mr10-9]

# RECONCILIATION ACT OF 2010

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speech of

HON. FORTNEY PETE STARK

of california

in the house of representatives

Sunday, March 21, 2010

Mr. STARK. Mr. Speaker, I, on behalf of myself and Ms. Slaughter, rise to speak about the Independent Payment Advisory Board, IPAB, which is a new executive branch body created in the Senate-passed health reform bill and charged with constraining Medicare spending. The IPAB is given unprecedented power to make sweeping changes to the Medicare program without going to Congress for approval. I and many of my colleagues in the House are concerned about some of the specific provisions and procedural changes included in section 3403 of H.R. 3590.

Since its inception in 1965, Medicare has guaranteed access to health care for 115 million Americans who would otherwise find it nearly impossible to obtain affordable health insurance in the private market: senior citizens, people with disabilities, and those with end-stage renal disease. Medicare is a critical part of this nation's social compact, and it is our obligation as elected representatives of our constituents to protect and preserve the program now and in the future. The health care reform legislation fulfills this responsibility by making a number of substantial improvements to Medicare, including provisions that improve benefits, extend solvency by at least 9 years and winnow out waste, fraud and abuse.

As part of the effort to make improvements to the Senate-passed bill, key chairmen and Members of the House and Senate, along with the administration, were also working on a number of important and necessary changes to the IPAB policy. Unfortunately, the Senate Parliamentarian indicated that any attempt to improve IPAB in the reconciliation bill would be ruled out of order, and could jeopardize the status of the entire reconciliation bill.

Since we were unable to make any changes to the IPAB as part of the reconciliation bill, I would like to identify critical improvements that need to be made in subsequent legislation. Many of these changes had been agreed to by our colleagues in the Senate, as well as the administration, and I look forward to working with them to ensure they are enacted in the near future.

While IPAB is designed to help control growing costs in Medicare through swift implementation of payment and delivery reforms, the actions of the board will be driven by the need to meet targets for

Medicare cost growth. As we have seen with prior attempts to control health care spending, limiting spending to arbitrary and unrealistically low growth caps is a recipe for failure. In order for IPAB to have any real hope of controlling Medicare cost growth without threatening access to care, as is required, the growth targets must be rational and realistic. The current spending targets mandated by IPAB are neither. They fail to fully take into account the three variables that drive health spending growth: price, volume of services, and intensity of services. The target only accounts for price growth, and does so at an unrealistically low rate. Controlling costs in the health care system is important, and I am committed to doing so. In fact, Medicare growth has typically been below private sector health care cost growth. However, the growth targets established by IPAB need to be revised and increased to reflect a more realistic expectation about how much growth can be slowed in order to ensure continued access to care and a strong program infrastructure in the future.

The IPAB policy as written by the Senate also tips the balance of power too far in favor of the executive branch. In the event that IPAB cannot agree on Medicare recommendations required by the targets, the Senate bill requires the Health and Human Services Secretary to make recommendations instead. Like IPAB's proposal, the Secretary's proposal would become law unless Congress passes an alternative. It is one thing to give an independent board of health care experts such sweeping power to change the Medicare program, but it is quite another to give that power to a partisan political figure who reports directly to the President. I say this not as a negative comment directed toward our current Secretary or President, but a general concern about whether we should empower one person with the ability to make such potentially sweeping changes to the Nation's signature health program.

Furthermore, by placing unprecedented procedural barriers to congressional consideration of alternatives to the IPAB or secretarial proposals, the bill attempts to virtually lock Congress out of the process of making changes to Medicare. In the event IPAB or the Secretary mandates implementation of draconian cuts to Medicare, Congress will encounter procedural barriers to changing those recommendations in a meaningful way.

Thus, in order to maintain a proper balance between Congress and the executive branch, all parties had agreed to use a sequestration process to meet the mandated savings targets should IPAB fail to make recommendations on how to meet those targets. Instead of the decisions going to the executive branch, the onus would fall on Congress to arrive at thoughtful ways of reducing spending. If Congress failed to agree on ways to reduce spending, sequestration would go into effect. But it would be my hope and expectation that this would not happen, and that Congress would instead be spurred to action by the threat of sequestration.

Another important flaw with IPAB that needs to be addressed is the fact that it ignores the broken system used to update Medicare physician payment rates. Under current law, the sustainable growth rate formula will require physician payment rates to be reduced by more than 30 percent over the next decade. Yet, the IPAB could decide to make additional cuts on top of those already set to take place. The House has passed legislation that would make comprehensive permanent reforms to the physician payment formula, but that bill has not been taken up by the Senate. As such, all parties agreed that physician payment rates should be off limits to IPAB until the sustainable growth rate is replaced with a permanent, stable way of updating payments to physicians.

I also want to clarify legislative intent with regard to one issue in IPAB. Section 1899A(c)(2)(A)(iii) of the Social Security Act, as added by Section 3403 of PPACA, states that in the case of IPAB proposals submitted prior to December 31, 2018, IPAB shall not include any recommendations that would reduce

payment rates for providers that receive an additional market basket cut on top of the productivity adjustment. The rationale for this provision is that these providers are already facing extra downward adjustments in their payments and thus should not be subject to ``double jeopardy'' by also being subject to IPAB recommendations which will further reduce spending. In creating this exclusion, it is the intent of Congress to exclude all payment reductions applicable to providers captured by this language in all the relevant years. Therefore, in the case of inpatient hospitals, the provision excludes from IPAB recommendations payment reductions applicable to hospitals including payment reductions for indirect medical education under 1886(d)(5)(B), graduate medical education under 1886(h), disproportionate share hospital payments under

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1886(d)(5)(F), and capital payments, as well as incentives for adoption and maintenance of meaningful use of certified electronic health record technology under 1886(n). In addition, further clarifications are needed to ensure that IPAB is empowered to seek savings or payment improvements for all items and services provided to Medicare beneficiaries.

There are smaller, but no less important additional improvements that I believe need to be made. Changes made to the Medicare program by IPAB are granted broad exemption from judicial review. We should remove this exemption to ensure that IPAB is not above the law and its actions can be reviewed in a court of law.

The legislation also prevents IPAB from making changes that would increase premiums or ration care, but it is important to include the specific protections that are scattered through the Social Security Act. Medicare law contains an array of beneficiary protections that are designed to ensure that seniors and people with disabilities have access to affordable care. The IPAB should not be permitted to make changes to these key beneficiary protections.

Finally, as the legislation is written, IPAB would be required to reduce spending above the growth targets resulting from unforeseen and unavoidable health events, such as a flu pandemic, hurricane, or act of terrorism. Increases in spending from these kinds of catastrophic events should be excluded from the overall spending targets.

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