Medicare's Future:
An Examination of the Independent Payment Advisory Board

Testimony before the United States House of Representatives
Committee on the Budget

Douglas Holtz-Eakin
President, American Action Forum*

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Chairman Ryan, Ranking Member Van Hollen and members of the committee, thank you for the privilege of appearing today. In this written statement, I hope to make the following points:

- The Independent Payment Advisory Board (IPAB) is a dramatic policy error that will fail to deliver meaningful reform to the Medicare program.

- The IPAB is likely to exacerbate existing reimbursement problems that already limit access to care for Medicare beneficiaries.

- The IPAB will tend to stifle U.S. led medical innovation in the medical device, pharmaceutical, biotechnology, and mobile health industries.

- If left unaddressed, the Medicare *status quo* and the IPAB will pose a danger to the fiscal health of the federal government, the U.S. economy, and Medicare beneficiaries.

Let me discuss each in turn.

The Independent Payment Advisory Board (IPAB) is a dramatic policy error that will fail to deliver meaningful reform to the Medicare program.

The creation of the Independent Payment Advisory Board (IPAB) is possibly the most dangerous aspect of the Patient Protection and Affordable Care Act. It should be repealed immediately.

This appointed panel will be tasked with cutting Medicare spending, but its poor design will prove ineffective in bending the cost curve, and instead will lead to restricted patients' access and stifled innovation. Four design elements stand-out as especially troublesome.

First, the board is prohibited from recommending changes that would reduce payments to certain providers before 2020, especially hospitals. Because of directives written into the law, reductions achieved by the IPAB between 2013 and 2020 are likely to be limited primarily to Medicare Advantage (23 percent of total Medicare Expenditures), to the Part D prescription drug program (11 percent), and to skilled nursing facility services (5 percent).[1] That means that reductions will have to come from segments that together represent less than half of overall Medicare spending.

Second, IPAB's cuts have to be achieved in one-year periods there will be an enhanced focus on reducing reimbursements at the expense of longer-run quality

[1] "Medicare Benefit Payments, by Type of Service, 2010 and 2020," Medicare Chartbook, Fourth edition, The Henry J. Kaiser Family Foundation, 2010, http://facts.kff.org/chart.aspx?cb=58&sctn=169&ch=1799.

improvements or preventive programs. In this way IPAB could actually discourage rather than encourage a focus on quality improvement.

Third, IPAB is effectively unaccountable. In practice, the law makes it almost impossible for Congress to reject or modify IPAB's decisions, even if those decisions override existing laws and protections that Congress passed. It's not really an advisory body, despite its name. The system is set up so that IPAB, rather than Congress and HHS acting under Congress' authority, makes the policy choices about Medicare.

All of this suggests that IPAB is a potent mechanism for undesirable policy. The Independent Payment Advisory Board is at best a band-aid on out-of-control Medicare spending and at its worst a threat to physician autonomy and patient choice.

Saving Medicare from ruin requires nothing short of total and comprehensive reform. Adding in more cuts to a broken system does not make it any less broken. The IPAB proposals will be short-term fixes and cuts. We need long-term thinking and long-term solutions. We need to move the focus from merely containing costs to focus on how to get the most value for our health care dollars.

The IPAB is likely to exacerbate existing reimbursement problems that already limit access to care for Medicare beneficiaries

If Medicare's provider reimbursements are drastically reduced the market will react in accord with the basic laws of economics. Providers will have three options: to close up shop, to refuse Medicare patients, or to shift the costs onto the other patients. None of these options help our healthcare system operate more effectively or more efficiently.

Today, Medicare coverage no longer guarantees access to care. Increasingly seniors enrolled in the Medicare program face barriers to accessing primary care physicians as well as medical and surgical specialists. The New York Times, Bloomberg News, and Houston Chronicle are among many newspapers reporting that doctors are opting out of Medicare at an alarming rate. For example, the Mayo Clinic, praised by President Obama and the IPAB's architects, will stop accepting Medicare patients at its primary-care clinics in Arizona.

The physician access problem stems from Medicare's below-cost reimbursement rates and the uncertainty surrounding the Medicare sustainable growth rate (SGR) formula for physician payments. IPAB introduces further uncertainty into physician reimbursement and is likely to force more physicians to begin making difficult Medicare practice decisions.

Table 3 shows the impact on physician access for Medicare enrollees the last time a major payment reduction loomed. In response, 11.8 percent of physicians stopped accepting new Medicare patients, 29.5 percent reduced the number of appointments for new Medicare patients, 15.5 percent reduced the number of appointments for current Medicare patients, and 1.1 percent of physicians decided to stop treating Medicare patients altogether.[2]

Recognizing the increased payment uncertainty, physician practices have started to reshape their practice patterns. Moving forward 67.2 percent of physician practices are considering limiting the number of new Medicare patients, 49.5 percent are considering the option of refusing new Medicare patients, 56.3 are contemplating whether to reduce the number of appointments for current Medicare patients, and 27.5 percent are debating whether to cease treating all Medicare patients. [3]

Medicare's status quo is fraying the nation's social safety net. The IPAB will only make the net fray more quickly.

The IPAB will stifle U.S. led medical innovation in the medical device, pharmaceutical, biotechnology, and mobile health industries.

By statute, IPAB cannot directly alter Medicare benefits. Instead, the more likely threat to patients is that the IPAB will be forced to limit payments for medical services. In the process, it will effectively determine that patients should have coverage for one particular treatment option but not another, or must pay much more for one of the treatment options.

This is especially troubling because it may choose to disproportionately focus on expensive new treatments. New medicines for conditions like Alzheimer's or Parkinson's will likely have rapid cost growth, especially early after their introduction. That will make them targets because the IPAB is directed to focus on areas of "excess cost growth." Worse, because about one-half of spending is off limits until after 2020, there will be a disproportionate and uneven application of IPAB's scrutiny and payment initiatives.

U.S. medical innovation leadership is dependent on whether the regulatory environment nurtures growth or suppresses innovation. The Affordable Care Act substantially increases the cost of innovation and the IPAB creates a level of uncertainty that will likely drive away venture capital investment in start-up firms and research and development investments from established firms.

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[2] Medical Group Management Association. 2010. Sustainable Growth Rate Study. http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=39774

[3] Medical Group Management Association. 2010. Sustainable Growth Rate Study. http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=39774

If left unaddressed, the Medicare status quo and the IPAB will pose a danger to the fiscal health of the federal government, the U.S. economy, and Medicare beneficiaries.

Medicare as we know it is financially unsustainable. The reality is that the combination of payroll taxes and premiums do not come close to covering the outlays of the program. As shown in Table 1, in 2010 Medicare required nearly $280 billion in general revenue transfers to meet its cash outlays of $523 billion. As program costs escalate, the shortfalls will continue to grow and reach a projected cash-flow deficit of over $600 billion in 2020.

These shortfalls are at the heart of past deficit and projected future debt accumulation. As shown in Table 2, between 1996 and 2010, cumulative Medicare cash-flow deficits totaled just over $2 trillion, or 22 percent of the federal debt in the hands of the public. Including the interest cost on those Medicare deficits means that the program is responsible for 23 percent of the total debt accumulation to date.

Going forward, the situation is even worse. By 2020, the cumulative cash-flow deficits of 6.2 trillion will constitute 35 percent of the debt accumulation. Again, appropriately attributing the program its share of the interest costs raises this to 37 percent.

Viewed in isolation, Medicare is a fiscal nightmare that must change course. When combined with other budgetary stresses, it contributes to a dangerous fiscal future for the United States.

The federal government faces enormous budgetary difficulties, largely due to long-term pension, health, and other spending promises coupled with recent programmatic expansions. The core, long-term issue has been outlined in successive versions of the Congressional Budget Office's (CBO's) *Long-Term Budget Outlook*.[4] In broad terms, over the next 30 years, the inexorable dynamics of current law will raise federal outlays from an historic norm of about 20 percent of Gross Domestic Product (GDP) to anywhere from 30 to 40 percent of GDP.[5]

This depiction of the federal budgetary future and its diagnosis and prescription has all remained unchanged for at least a decade. Despite this, action (in the right direction) has yet to be seen.

In the past several years, the outlook has worsened significantly.

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[4] Congressional Budget Office. 2011. *The Long-Term Budget Outlook*. Pub. No. 4277. http://cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf

[5] Congressional Budget Office. 2011. *The Long-Term Budget Outlook*. Pub. No. 4277. http://cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf

Over the next ten years, according to the Congressional Budget Office's (CBO's) analysis of the President's Budgetary Proposals for Fiscal Year 2012, the deficit will never fall below $740 billion. [6] Ten years from now, in 2021, the deficit will be nearly 5 percent of GDP, roughly $1.15 trillion, of which over $900 billion will be devoted to servicing debt on previous borrowing.

As a result of the spending binge, in 2021 public debt will have more than doubled from its 2008 level to 90 percent of GDP and will continue its upward trajectory. [7]

A United States fiscal crisis is now a threatening reality. It wasn't always so, even though – as noted above – the Congressional Budget Office has long published a pessimistic *Long-Term Budget Outlook*. Despite these gloomy forecasts, nobody seemed to care. Bond markets were quiescent. Voters were indifferent. And politicians were positively in denial that the "spend now, worry later" era would ever end.

Those days have passed. Now Greece, Portugal, Spain, Ireland, and even Britain are under the scrutiny of skeptical financial markets. And there are signs that the U.S. is next, as each of the major rating agencies have publicized heightened scrutiny of the United States. What happened?

First, the U.S. frittered away its lead time. It was widely recognized that the crunch would only arrive when the baby boomers began to retire. Guess what? The very first official baby boomer already chose to retire early at age 62, and the number of retirees will rise as the years progress. Crunch time has arrived and nothing was done in the interim to solve the basic spending problem.

Second, the events of the financial crisis and recession used up the federal government's cushion. In 2008, debt outstanding was only 40 percent of GDP. Already it is over 60 percent and rising rapidly.

Third, active steps continue to make the problem worse. The Affordable Care Act "reform" adds two new entitlement programs for insurance subsidies and long-term care insurance without fixing the existing problems in Social Security, Medicare, and Medicaid.

Financial markets no longer can comfort themselves with the fact that the United States has time and flexibility to get its fiscal act together. Time passed, wiggle room vanished, and the only actions taken thus far have made matters worse.

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[6] Congressional Budget Office. 2011. *An Analysis of the President's Budgetary Proposals for Fiscal Year 2012.* Pub. No. 4258. http://www.cbo.gov/ftpdocs/121xx/doc12130/04-15-AnalysisPresidentsBudget.pdf

[7] Congressional Budget Office. 2011. *An Analysis of the President's Budgetary Proposals for Fiscal Year 2012.* Pub. No. 4258. http://www.cbo.gov/ftpdocs/121xx/doc12130/04-15-AnalysisPresidentsBudget.pdf

As noted above, in 2020 public debt will have more than doubled from its 2008 level to 90 percent of GDP and will continue its upward trajectory. Traditionally, a debt-to-GDP ratio of 90 percent or more is associated with the risk of a sovereign debt crisis.

Perhaps even more troubling, much of this borrowing comes from international lending sources, including sovereign lenders like China that do not share our core values.

For Main Street America, the "bad news" version of the fiscal crisis would occur when international lenders revolt over the outlook for debt and cut off U.S. access to international credit. In an eerie reprise of the recent financial crisis, the credit freeze would drag down business activity and household spending. The resulting deep recession would be exacerbated by the inability of the federal government's automatic stabilizers – unemployment insurance, lower taxes, etc. – to operate freely.

Worse, the crisis would arrive without the U.S. having fixed the fundamental problems. Getting spending under control in a crisis will be much more painful than a thoughtful, pro-active approach. In a crisis, there will be a greater pressure to resort to damaging tax increases. The upshot will be a threat to the ability of the United States to bequeath to future generations a standard of living greater than experienced at the present.

Future generations will find their freedoms diminished as well. The ability of the United States to project its values around the globe is fundamentally dependent upon its large, robust economy. Its diminished state will have security repercussions, as will the need to negotiate with less-than-friendly international lenders.

Some will argue that it is unrealistic to anticipate a cataclysmic financial market upheaval for the United States. Perhaps so. But an alternative future that simply skirts the major crisis would likely entail piecemeal revenue increases and spending cuts – just enough to keep an explosion from occurring. Under this "good news" version, the debt would continue to edge northward – perhaps at times slowed by modest and ineffectual "reforms" – and borrowing costs in the United States would remain elevated.

Profitable innovation and investment will flow elsewhere in the global economy. As U.S. productivity growth suffers, wage growth stagnates, and standards of living stall. With little economic advancement prior to tax, and a very large tax burden from the debt, the next generation will inherit a standard of living inferior to that bequeathed to this one.

Thank you and I look forward to answering your questions.

Table 1: Annual Medicare Cash Flows

Annual Medicare Cash Flows	1996	1997	1998	1999	2000
Projected Total Income	210.2	212.1	228.2	232.5	257.1
Total Payroll Taxes Collected	92.7	98.8	105.6	112.8	144
Total Premiums Collected	19	19.3	21	19	22
Annual Cash Revenues	111.70	118.10	126.60	131.80	166.00
Annual Expenditures	-200.3	-213.6	-213.4	-212.9	-221.8
Total Medicare Net Cash-Flow	**$ (88.60)**	**$ (95.50)**	**$ (86.80)**	**$ (81.10)**	**$ (55.80)**

Annual Medicare Cash Flows	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Projected Total Income	273.2	284.8	291.6	317.7	357.5	437	461.9	480.8	508.2	*486.1*
Total Payroll Taxes Collected	152	152.7	149.2	156.7	171.4	181.3	191.9	198.7	190.9	182.0
Total Premiums Collected	24.2	26.7	29.0	33.4	40.0	48.9	53.5	58.2	65.2	61.80
Annual Cash Revenues	176.20	179.40	178.20	190.10	211.40	230.20	245.40	256.90	256.10	243.80
Annual Expenditures	-240.9	-265.7	-280.7	-308.9	-336.4	-408.3	-431.5	-468.2	-509	-522.8
Total Medicare Net Cash-Flow	**$ (64.70)**	**$ (86.30)**	**$ (102.50)**	**$ (118.80)**	**$ (125.00)**	**$ (178.10)**	**$ (186.10)**	**$ (211.30)**	**$ (252.90)**	**$ (279.00)**

Annual Medicare Cash Flows	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Projected Total Income	*529.9*	*575.8*	*642*	*700.7*	*786.4*	*808.1*	*914*	*1000.6*	*1094.9*	*1205.5*
Total Payroll Taxes Collected	202.95	217.47	239.10	257.34	284.80	288.59	321.88	347.48	374.95	401.43
Total Premiums Collected	71.01	78.08	88.11	97.32	110.53	114.95	131.58	145.77	161.43	182.03
Annual Cash Revenues	273.96	295.55	327.21	354.66	395.33	403.54	453.45	493.25	536.37	583.46
Annual Expenditures	-568.30	-597.90	-648.40	-703.40	-757.90	-826.40	-902.30	-985.10	-1078.80	-1192.60
Total Medicare Net Cash-Flow	**$ (294.34)**	**$ (302.35)**	**$ (321.19)**	**$ (348.74)**	**$ (362.57)**	**$ (422.86)**	**$ (448.85)**	**$ (491.85)**	**$ (542.43)**	**$ (609.14)**

Source: 1997-2011 CMS Medicare Trustees Reports and Authors Calculations

Table 2: Medicare and the National Debt

CBO & Author's Calculations	1996	1997	1998	1999	2000
Cummulative Medicare Cash Flow	$ (88.60)	$ (184.10)	$ (270.90)	$ (352.00)	$ (407.80)
Interest Paid on Medicare Shortfall	$ (5.70)	$ (11.69)	$ (14.26)	$ (19.84)	$ (24.59)
Total Medicare Debt Burden	**$ (94.30)**	**$ (195.79)**	**$ (285.16)**	**$ (371.84)**	**$ (432.39)**
Total Debt Held by Public	**$ 3,734**	**$ 3,772**	**$ 3,721**	**$ 3,632**	**$ 3,410**
Total Medicare Cash Flow as % Debt	*2.4%*	*4.9%*	*7.3%*	*9.7%*	*12.0%*
Total Medicare Burden as % Debt	*2.5%*	*5.2%*	*7.7%*	*10.2%*	*12.7%*

CBO & Author's Calculations	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Cummulative Medicare Cash Flow	$ (472.50)	$ (558.80)	$ (661.30)	$ (780.10)	$ (905.10)	$ (1,083.20)	$ (1,269.30)	$ (1,480.60)	$ (1,733.50)	$ (2,012.50)
Interest Paid on Medicare Shortfall	$ (23.71)	$ (25.77)	$ (26.55)	$ (33.34)	$ (38.83)	$ (51.90)	$ (58.76)	$ (54.29)	$ (56.45)	$ (64.11)
Total Medicare Debt Burden	**$ (496.21)**	**$ (584.57)**	**$ (687.85)**	**$ (813.44)**	**$ (943.93)**	**$ (1,135.10)**	**$ (1,328.06)**	**$ (1,534.89)**	**$ (1,789.95)**	**$ (2,076.61)**
Total Debt Held by Public	**$ 3,320**	**$ 3,540**	**$ 3,913**	**$ 4,296**	**$ 4,592**	**$ 4,829**	**$ 5,035**	**$ 5,803**	**$ 7,545**	**$ 9,018**
Total Medicare Cash Flow as % Debt	*14.2%*	*15.8%*	*16.9%*	*18.2%*	*19.7%*	*22.4%*	*25.2%*	*25.5%*	*23.0%*	*22.3%*
Total Medicare Burden as % Debt	*14.9%*	*16.5%*	*17.6%*	*18.9%*	*20.6%*	*23.5%*	*26.4%*	*26.4%*	*23.7%*	*23.0%*

CBO & Author's Calculations	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Cummulative Medicare Cash Flow	$ (2,306.84)	$ (2,609.19)	$ (2,930.38)	$ (3,279.12)	$ (3,641.69)	$ (4,064.55)	$ (4,513.39)	$ (5,005.24)	$ (5,547.66)	$ (6,156.80)
Interest Paid on Medicare Shortfall	$ (77.28)	$ (97.84)	$ (121.61)	$ (149.20)	$ (180.26)	$ (216.44)	$ (243.72)	$ (270.28)	$ (299.57)	$ (332.47)
Total Medicare Debt Burden	**$ (2,384.12)**	**$ (2,707.03)**	**$ (3,051.99)**	**$ (3,428.32)**	**$ (3,821.95)**	**$ (4,280.98)**	**$ (4,757.11)**	**$ (5,275.52)**	**$ (5,847.24)**	**$ (6,489.27)**
Total Debt Held by Public	**$ 10,430**	**$ 11,598**	**$ 12,386**	**$ 12,996**	**$ 13,625**	**$ 14,358**	**$ 15,064**	**$ 15,767**	**$ 16,557**	**$ 17,392**
Total Medicare Cash Flow as % Debt	*22.1%*	*22.5%*	*23.7%*	*25.2%*	*26.7%*	*28.3%*	*30.0%*	*31.7%*	*33.5%*	*35.4%*
Total Medicare Burden as % Debt	*22.9%*	*23.3%*	*24.6%*	*26.4%*	*28.1%*	*29.8%*	*31.6%*	*33.5%*	*35.3%*	*37.3%*

Source: 1997-2011 CMS Medicare Trustees Reports; Congressional Budget Office March 2011 Baseline; and Authors Calculations

Table 3: Impact on Physician Access for Medicare Enrollees

As a result of the uncertainty created by the June 1, 2010 Medicare Part B payment reduction of 21.3 percent, later reversed by Congress, which decisions **DID** your practice implement in June?		Which business considerations are currently **under discussion** by your practice due to this reimbursement uncertainty?	
Stopped accepting new Medicare patients	**11.8%**	Limit the number of new Medicare patients	**67.2%**
Reduced the number of appointments for new Medicare patients	**29.5%**	Refuse to accept new Medicare patients	**49.5%**
Reduced the number of appointments for current Medicare patients	**15.5%**	Cease treating all Medicare patients	**27.5%**
Ceased treating all Medicare patients	**1.1%**	Reduce the number of appointments for current Medicare patients	**56.3%**

Source: September 2010 MGMA Sustainable Growth Rate Study

Table 4: Hospital Economic Impact on a Sample of 401 Non-Profit Stand-Alone Hospitals ($ Thousands)

	Moody's Non-Profit Stand Alone Hospital Credit Rating										
Financial Performance Metrics	**Aa2**	**Aa3**	**A1**	**A2**	**A3**	**Baa1**	**Baa2**	**Baa3**	**Ba**	**B**	**Below Baa**
Sample Size (# Hospitals)	*14*	*38*	*48*	*72*	*78*	*39*	*45*	*29*	*32*	*6*	*38*
PPPACA Adjusted Total Operating Revenue	$2,143,526	$1,312,240	$729,216	$457,142	$381,896	$354,088	$261,260	$180,942	$233,253	$197,267	$233,253
Total Operating Expenses	$2,050,665	$1,284,712	$709,304	$458,770	$364,209	$361,670	$265,825	$179,093	$236,374	$207,003	$236,374
Adjusted Operating Margin	$ 92,861	$ 27,528	$ 19,912	$ (1,628)	$ 17,687	$ (7,582)	$ (4,565)	$ 1,849	$ (3,121)	$ (9,736)	$ (3,121)
Potential Hospital Closures (# Hospitals):				72		39	45		32	6	38

Source: Moody's Investors Service Not-For-Profit Healthcare Medians for FY 2009

Table 5: Hospital Patient Access Impact on a Sample of 401 Non-Profit Stand-Alone Hospitals

Hospital Access Metrics	
Potential Hospital Closures:	232 Hospitals
Potential Decline in Hospital Beds:	69,061 Beds
Potential Loss of Emergency Room Capacity:	14,127,690 ER visits

Source: Moody's Investors Service Not-For-Profit Healthcare Medians for FY 2009