Where will health care reform take GI practice?

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The great enemy of truth is very often not the lie—deliberate, contrived and dishonest—but the myth—persistent, persuasive, and unrealistic. Too often. . .we enjoy the comfort of opinion without the discomfort of thought.

— President John F. Kennedy, 1962[1]

This perspective examines a variety of myths and opinions. It reflects much discomfort of thought. After a gruesome political scrum, the Patient Protection and Affordable Care Act is now law. It is clear that "the center cannot hold," and major changes in the U.S. health care provision are at hand (Summary available online at www.giejournal.org).[2-6] Health care costs consume 17% of the gross domestic product and increases steadily 2% faster per annum than economic productivity,[3] and with unrelenting cost increases combined with pervasive quality/efficiency concerns, gastroenterology practices will be subject to major ongoing stress in the coming decade.

"There are more than enough fingers to go around" assigning blame for the current dilemma.*[,7] But a dollar in cost savings is a dollar less income for someone, and tinkering with the massive engine of health care, which redistributes dollars from employers, taxpayers, and households to health care providers, is tinkering at our peril.[8]

This perspective first notes some demographics of the gastroenterologist today. Second, it notes the chief initiatives—legislative, regulatory, and "thought leader" ideas in the public policy arena—with implications for GI practice. Finally, it provides some perspective and speculation about these changes.

WHO WE ARE, WHAT WE DO

Regarding the approximately 11,000 gastroenterologists in clinical practice in the United States, last year's American Society for Gastrointestinal Endoscopy membership survey reflects the following[9]:

- 20.7% have full-time academic status.
- 21.6% are in solo practice; 39% are in GI groups as partners; 6% are in GI groups as employees, 5% are in multispecialty groups as employees, and 0.6% are in staff model health maintenance organizations.
- GI groups are predominantly small; 54.6% have fewer than 6 providers, 22% have 6 to 10, and 15.5% have 11 to 50.
- 47.2% have a financial interest in an ambulatory center.
- A plurality has at least 1 full-time nurse practitioner or physician assistant.
- Medical Group Management Association data[10] show median compensation barely outpacing inflation over 5 years, whereas gross collections lag inflation adjustments.
- Medical Group Management Association productivity data suggest little regional variation or variation across single specialty versus multispecialty groups or across hospital-owned versus nonhospital-owned groups, yet substantially different, 22% lower, in the practices in which compensation is *not* based on productivity. Thus, "performance for pay" still motivates.
- Hard data are scant, but informal estimates suggest approximately 50% of time is spent on E&M activities, whereas 65% of revenues are procedural. Based on the American Society for Gastrointestinal Endoscopy 2009 Endoscopy Operations Survey data,[11] the average ambulatory surgery center procedure volume per physician was 1005 (hospital-based procedures not included). From available 2008 Medicare data,[12] colonoscopy makes up 53% of physician procedure volume and 61% of GI endoscopy work revenue value units, with upper GI/EUS/ERCP procedures composing 47% of volume and 39% of work revenue value units.

Thus, any future trends that put undue pressure on small practices or affect procedure numbers or reimbursement disproportionately to E&M services, may substan-

Abbreviations: ACO, CMS, EHR, electronic health record; HIT, Health Information Technology.

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*A good perspective on causes and trends for health care costs is summarized in an ACP position paper. Available at www:acponline.org/advocacy/where_we_stand?policy/controlling_healthcare_costs.pdf.

tially alter the practice environment or financial stability of GI practitioners.

It appears that only a small percentage of practices, chiefly large groups, have ancillary income (eg, in-house pathology, laboratory, infusion services) contributing substantially to the bottom line. Constant change in the regulatory environment leaves these ventures at hazard, with local market factors being key determinants of feasibility and effectiveness. Physician practice efficiency is assumed by the Center for Medicare and Medicaid Services (CMS) to increase by small yearly increments, yet this is not supported by data such as intraservice times from physician work value revenue unit surveys or data on physician visit length of time.[13] More patient volume is clearly accommodated by the widespread adoption of direct-referral endoscopy and template-questionnaire collection of patient history data, but it is likely that most practices have maximized these efficiencies.

GI manpower requirements are a growing concern. Wait times for nonemergency outpatient evaluations often exceed 4 weeks and wait times for routine colonoscopy exceed 2 to 3 months in many parts of the country. Open-access, same-day visit availability in the GI practice must be a rarity.*[,14,15]

Future capacity for colonoscopy and other GI service demand, which will reflect the maturation of the baby-boomer generation and a major expansion of the over-75 population, will clearly remain highly pressured.

The difference in perspective since 1996 is sobering. The Gastroenterology Work Force Study published in 1996 suggested that GI manpower was twice the manpower needed by the country. The "failure" of the country to accept a "Kaiser model" of gastroenterology services, combined with an explosion of screening colonoscopy, chronic hepatitis, and GERD, among other conditions, completely altered the landscape.[16] A Lewin group report now projects a shortfall of 1050 to 1500 gastroenterologists likely by 2020.[17] This need could be met if there is a 33% increase (approximately 130) in training slots, which would increase the physician supply to 1550 by 2020. Aging of existing GI practitioners and the increasing proportion of female practitioners (29% of current trainees) need to be factored in. Implications for future training needs are the subjects of a recent multisociety consensus report.[18]

*By comparison, in Canada, where uniform data of such parameters have become available, the performance is sobering. Per capita, gastroenterologists/100,000 population are constrained to 1.83 in Canada compared with 3.9 in the United States (although a geographically very wide range in the United States, unlike Canada). Total wait times for 7 indications exceeded the consensus targets; 51% to 88% of patients were not seen within the target wait time, ranging from probable cancer (median 26 days), probable inflammatory bowel disease (101 days), documented iron deficiency anemia or positive fecal occult blood test (71 to 73 days), dyspepsia with alarm symptoms (60 days), refractory dyspepsia without alarm symptoms (126 days), and chronic constipation and diarrhea (141 days). Overall numbers of days for all indications from referral to evaluation procedure date were 91/203 days (median/75th percentile).

FOUR TIDES, FOUR CURRENTS

Four major tides of "reform" converge into the coming decade's practice tsunami:

1. Current health reform legislation and how it will be implemented[2]
2. CMS initiatives
3. Health Information Technology (HIT) initiatives and coding changes anticipated
4. Common themes of health care reform proposals, including perspectives from MedPAC (which advises Congress on the Medicare program)[19]; Institute of Medicine; numerous quality agencies (eg, National Committee for Quality Assurance, National Quality Forum); many coalitions of payers, employers, and providers; and numerous entities to which legislators listen (eg, RAND, Commonwealth Fund, Kaiser Family Foundation, Dartmouth Atlas Project, Center for Studying Health System Change).

What currents are common in these tides?

1. Hostility to fee-for-service as a payment method and the conviction that new methods will be an incentive for the right service at the right time with the best quality and with accountability and transparency needed to ensure that there is appropriate value (outcomes/cost).[20]
2. The promise seen in HIT to support clinical integration, accountability through mandated reporting of performance measures, ability to abstract clinical outcomes to support (cost) effectiveness research,[21] and the availability of interexchangeable medical records.[22]
3. The pressure on solo and small group practices to integrate into systems (accountable care organizations [ACO]) competing to take clinical and financial responsibility for patient groups under more predictable budgets to generate savings that can be shared. At the microlevel, the primary care darling of the "medical home" is envisioned to transform provider teams empowered by HIT into parsimonious "patient-focused" bastions of coordinated care delivery, linked in turn to the larger ACOs (the "medical neighborhood").[23]
4. The ability to do all of the above while expanding health insurance coverage to most, if not all, Americans, and doing so without increasing the projected budget deficits of the next 10 years, thereby rescuing the Medicare trust fund and saving American industry from becoming noncompetitive.

PERSPECTIVES

These tides and currents seem undeniable, with substantial impacts. A perspective on these impacts reflects

both learned opinion (see opening quotes) about good intentions and my own speculative opinion about unintended consequences. Five general types of impacts are examined, for good, bad, and ugly.

Impact of coverage changes and insurance rules

The potential of enfranchising 32+ million Americans with health insurance should please us. Having health plans prohibited from underwriting and unfair rescissions and limiting profit margins by statute should delight us. Although substantial subsidies are entailed and the market requires new mechanisms to procure coverage (eg, exchanges), many individuals with chronic conditions like inflammatory bowel disease who were insurance pariahs will now be covered soon. So far so good.

The majority of newly covered individuals will *not* need GI specialty services or at most a screening colonoscopy from age 50 and up; a majority of those needing GI attention will likely be in Medicaid programs or in primary care arrangements in the public health sector; thus, we will not see much influx of new patients. With sudden newly available coverage, a brief backlog of pent-up demand does occur and will stress access; emergency departments and primary care will bear the brunt.

If coverage changes and insurance rules are implemented unwisely, adverse effects include hospitals losing safety-net subsidy support, plans with excessively bare-bones benefits, loss of consumer and provider protections that are now state based, more "high deductible" plans with attendant collection problems, tighter limits on formulary access, tighter utilization review by new unfamiliar entities with opaque rules, and so on. The backlash could become ugly.

Impact of payment reform proposals

Can fee-for-service be vanquished? Even if the "wicked witch" of fee-for-service died, would the munchkins be singing happier tunes?* Consider that within many systems that accept global capitation at risk, payments become productivity-based at *some* level, as individuals are held accountable for the volume of their work product, and we do not see *any* providers vying to NOT sell their products. Fee-for-service medicine is but a microcosm of the capitalist economy. Its demise is a Michael Moore pipedream. Atul Gawande's June 2009 *New Yorker* article "The Cost Conundrum. . ."[24] aptly captures our dysfunctional medical culture and offers glimpses of promising alternatives.

Given how few practices are now integrated, the arduous requirements of sound cultural norms to develop inside new systems, and the U.S. public "more is better" mentality (reinforced by pervasive advertising), replacement of the reimbursement systems will not happen soon. We should have time to make bundled payments, ACOs, episodic care–based payments, and medical home and medical neighborhood concepts evolve and function.[20,25-30] Unless we stampede, we cannot be readily herded.

More potentially serious are unexpected imposed initiatives like 2010's nonrecognition of consultation services or a new 5-year review of the value of colonoscopy, should its detractors prevail in stripping it further of work revenue value units.† If Ambulatory Surgery Center/Ambulatory Endoscopy Center (ASC/AEC) payment methodologies further erode facility payment for GI endoscopy, the future of many of our centers will be compromised. CMS could accelerate tilted fee schedules to favor integration and penalize the nonpar practice.

Our greatest risk is that the public gets so desperate and disgusted that hard core price controls and global budgets are imposed, and the public accepts explicit rationing, queues, and the imposition of strict utilization management at the microlevel, while cost-effectiveness calculus determines coverage (not so "nice"‡,[31]).

Impact of HIT initiatives

Thus far, the carrots of financial incentives do not adequately negate the sticks that attend electronic health record (EHR) adoption for most of us. The business case for the average practice is not compelling,[32] with a disconnection between those who pay and those who benefit. There is little progress on the interoperability that physicians need to share records across practices or the tools that we need to slash administrative kudzu, and yet incentives grow to implement EHR before its time. The requirements for "meaningful use"[33] suggest those well along with implementation will not be able to eat the financial carrots—even the federal government projects much smaller expenditures under incentives than advertised initially. Can we afford the inevitable loss of productivity during the EHR ramp-up? Adding the ICD-10 implementation to the agenda for 2013 will further burden us. The time and skills to assess, procure, and implement EHR are substantial, and many practices lack these resources and will not find them readily. Promised efforts to supply this expertise are thus far weak; so the greater the desperation

*I paraphrase historian Francis Fukuyama in an unrelated context, but it seems applicable. See The Neoconservative Legacy February 19, 2006, The New York Times ("The way the cold war shaped the thinking . . . younger neoconservatives like William Kristol and Robert Kagan, in two ways. First, it seems to have created an expectation that all totalitarian regimes were hollow at the core . . . once the wicked witch was dead, the munchkins would rise up and start singing joyously about their liberation"). We should not forget the power of myth and groupthink, which ideology motivates, no matter the context.

†For colonoscopy, for example, there has already been a 65% decrease in per-case reimbursement for Medicare, over 20 years, with inflation considered.

‡The English National Institute for Health and Clinical Excellence (NICE) uses a "quality-adjusted life-year" (QLY) methodology to tell the National Health Service whether new drugs and new technologies are worth paying for and publishes guidelines on what constitutes effective and appropriate health care.

to adopt the new technology, the greater the pressure on smaller practices will be to integrate with larger entities. Because HIT is just one of many paths toward higher quality practice, as a driving force, to integrate it seems inappropriate. Peasants should not always head for the castle when the skies darken.

The bottom line—automating a bad system does not per se make it better. GIGO (garbage in, garbage out)!

If some of the HIT hurdles *were* met, we could adopt "virtual group" structures in which smaller practices that now provide personalized service with efficient deployment of internal resources still gain the benefits of integration. The evolution of the practice networks may yet save us from the fate of independent neighborhood booksellers, but such challenges to overcome so quickly! Substantial overhaul of Stark regulations, antikickback laws, and probable loosening of antitrust regulations—an ambitious agenda!—will be necessary to allow virtual or real integration.

Impact of quality initiatives, comparative effectiveness research, and coding changes

The mantra is "accountability" with a growing array of performance measures, with comparative measures of cost per episode of care coming soon. Uses of such "efficiency" measures could include expanded tiering, differential contract rates and copay structures for beneficiaries, listing on public databases as "preferred" versus "also-ran" providers, which CMS might well itself use to provide bonuses or keep-backs from individual physicians.[26,30] These approaches have thus far been subject to bitter objections, internal controversy, and legal action, with clear indications that statistical significance of such efforts are lacking or premature.[34,35]

The time consumed to perform and then document these measures cannot help but distract from whatever else should make up the patient encounter. The British system, with substantial rewards for adherence to measures reporting,[36] has already demonstrated that physicians follow the bait at the cost of attention to other worthy activities. To capture so much data inevitably forces adoption of EHR. The imposition of ICD-10 in late 2013 will vastly expand specificity of diagnosis choices with alien nomenclature. Estimates of the implementation cost run as high as $80,000 per small physician group![*,37] Traditional hard copy systems and "cheat sheets" will cease being adequate.

There is scant evidence that all this activity improves the aspects of care delivery that are most important, nor is there good evidence that larger systems provide better quality care than smaller practices. We likely stand to gain more from focus on our own internal processes to improve access, patient adherence to beneficial treatments, patient satisfaction, and clinically pertinent care factors unique to the conditions that we see the most. Likewise, showing that we pursue effective continuing medical education and use evidence-based decision support in everyday practice should be counted as alternatives to participating in Physician Quality Reporting Initiative to get credit toward financial incentives or preferred tiering.

Impact of further inertia

Patient Protection and Affordable Care Act will lead to a significant reform of the insurance industry but does little to contain costs or reform the payment system. At the time of this writing, Congress has again missed a self-imposed deadline for preventing scheduled cuts in Medicare physician payments. Further pay-go short-term fixes are anticipated. Between growing budget deficit preoccupation and pay-go rules in the budgeting process, cutting of provider fees[8] is even more inevitable, with CMS leading the way. Further pressures on practice revenue will stem from further attrition of employer-provided plans, further proliferation of high-deductible plans, and much slower progress in administrative simplification. Much tighter utilization review, re-expansion of gatekeeper systems, and revisiting various versions of capitation may all ensue. Pay for performance will swing more quickly to penalty for nonreporting. CMS, employer-payer coalitions, and well-organized multispecialty groups (or hospitals with large captive physician populations) may keep pushing for ACO-based reforms, so pressure for integration will not slow down, but the financial base of such new entities may be more tenuous.

SUMMARY AND SPECULATION

I do not know which to prefer,
The beauty of inflections
Or the beauty of innuendoes

—Wallace Stevens, *13 Ways of Looking at a Blackbird*, 1917[†]

Current health care reform legislation offers grand compromises: health plans get 32 million customers forced to buy their products, but they will have to provide those products with stricter rules; pharma may end up with additional revenue and escapes tough cost controls, while promising modest cost reductions. Physicians are still stuck with the sustainable growth rate formula and the

*According to a study initiated by AMA, ACP, MGMA, and others and conducted by Nachimson Advisors, the cost for a 10-physician practice to implement ICD-10 is estimated at more than $285,000. This includes the cost of training expenditures, new claim forms software, business process analysis, practice management and billing software upgrades, increases in claim inquiries and reduction in cash flow, and increased documentation costs. For a small, 3-physician practice, the total cost to implement ICD-10 is estimated to be $83,290. For a large, 100-physician practice, the estimated cost of implementation is more than $2.7 million. The report itself is available at http://nachimsonadvisors.com/Documents/ICD-10%20Impacts%20on%20Providers.pdf.

†From Wallace Stevens' first book of poetry, Harmonium, published in 1917. Stevens, justly viewed as one of America's foremost poets, was an insurance executive in his day job.

threat of 40% Medicare fee cuts and remain dependent on short-term fixes for the time being. Notably, the American Association for Retired Persons and other senior lobbies supported the recent legislative package despite the projected $400 billion cut to Medicare expenditures over the next decade. No one loves a compromise. It comes down to us recognizing when something is the best that we will get, but also the recognition that if too many oxen are gored, the mess is too gory to deal with.

Will GI practice adapt to these forces by change because it is good for patient care or good for gastroenterologists' professional satisfaction or because financial, legal, and regulatory incentives force such change?

How we are organized and what we do all day have been chiefly shaped the past 2 decades by disease prevalence changes, development of preventive service strategies (eg, screening colonoscopy), and other new technology that matured (eg, pancreaticobiliary intervention, EUS) or failed to mature (eg, CT colonography). Arguably, regulatory and financial forces, regardless of their importance to practice administrators' agendas and workflows, have shaped the practice less than have these other forces.

Likewise, change to come will probably be determined less by the forces reviewed here than by such intangibles as the work ethic of Generation X (GI is my day job, not who I am); from as-yet unforeseen technology changes (eg, the new stool test that replaces most colonoscopy procedures, the simple safe drugs that allow primary care nonphysicians to effectively treat hepatitis B and C, forms of inflammatory bowel disease, or [*inshala*] irritable bowel syndrome), or by some future HealthGoogles that offer irresistible incentives to changes how we work. Can my job be outsourced to India?

The fact is that change is ever constant and the shape of change is ever mutating. Our challenge remains to adapt continuously while keeping our professional priorities uppermost in mind.

(You can't always get what you want)
But if you try sometimes, well you just might find
You get what you need

— Mick Jagger from *Let It Bleed,* 1969

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PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) PUBLIC LAW 111-148

Provisions and potential impact on GI Practice Management

Many of the law's general provisions and timetables for reforms are clear, but much of the details are yet to be worked out through implementing regulation and quite likely through a series of technical correction bills. Some anticipated changes and looming questions follow.

PATIENT CARE PROVISIONS

Increased Access to Colorectal Cancer Screenings.

Beginning immediately, private sector health-care plans will be required to provide a minimum benefits package and cover colorectal cancer (CRC) and other preventive screenings with no cost-sharing for the patient, essentially following guidelines of the US Preventive Services Task Force.

In 2011, Medicare and Medicaid will no longer charge copayments for proven preventive screenings such as CRC screenings. Medicare will also waive the deductible for CRC screenings regardless if a polyp or lesion is found. This does NOT affect the non-coverage of an office visit prior to the scheduling of a colonoscopy if the individual has no referable symptoms or illness.

Improved Access to Insurance Coverage.

During 2010, access to high-risk pools must be provided for people who have no insurance because of pre-existing conditions, with states having the option to set up or expand such programs, or cede responsibility to the federal government.

Beginning during 2010, insurers are barred from denying people coverage when they get sick ("recissions") and bans lifetime caps on coverage. Isurers can't deny coverage to children with pre-existing conditions, and requires insurers to allow children coverage under parents' health insurance until they are age 26, with some restrictions if other options exist for these individuals.

In 2014, no insurer would be allowed to deny coverage to a patient with a pre-existing condition.

PHYSICIAN REIMBURSEMENT PROVISIONS

Imaging Services.

Effective immediately, the law would change the equipment utilization rate assumption to 75 percent for advanced imaging equipment (CT, PET and MRI), resulting in lower technical component fees for imaging.

Physician Workforce.

Effective immediately, a National Health Care Workforce Commission will be established to provide comprehensive information and recommendations to Congress on the nation's workforce priorities. Beginning in 2011, unused graduate medical education (GME) slots would be re-distributed to primary care physician training. A number of provisions increase nursing education and facilitate advanced practice nurses serving primary care functions.

The PPAC (Practicing Physicians Advisory Committee) to CMS is abolished in favor of using other existing methods of physician feedback.

Misvalued Codes.

Effectively immediately, the law gives the secretary of HHS the authority to adjust codes that are deemed misvalued or overvalued, and specifically mentions codes that have experienced high volume and have not been subject to review since the implementation of the Resource Based Relative Value System, the so-called "Harvard codes," which contain many endoscopy codes. This is not truly a new authority but may result in CMS taking actions other than through the usual existing (e.g. AMA RUC, 5 year review etc) processes. .

Comparative Effectiveness Research.

A Patient Center Outcomes Research Institute, an independent institute governed by patients, providers, government officials and other stakeholders, is established, which will focus on clinical effectiveness research (CER) not on cost-effectives and ensures that CMS will not use the results to "ration care," *i.e.* use results in ways to overlook differences in patient needs or discriminate against the elderly or people with disabilities. The act also clarifies that findings published by the institute do not include practice guidelines, coverage, payment or policy recommendations. The institute will have a Board of Governors to oversee the research findings, including 4 of 7 positions representing physicians.

Physician Compare Web Site.

Beginning in 2011, HHS would develop a Web site on which to host information on Medicare providers and those physicians who participate in the PQRI program. The Web site will be designed to provide the public with information on quality, patient experience and assessment of patient outcomes. Comparable physician quality information will be incorporated on the Web site by 2013.

Ambulatory Surgery Centers.

The HHS Secretary would be required to submit a plan by Jan. 1, 2011 for value-based purchasing for ambulatory surgery centers (ASC), under which their payment would be based on quality and efficiency measures. Impact of this provision will be clearer only when implementing regulations are published; we expect these to be subject to feedback through the notice & comment process.

Effective 2011, an ASC productivity adjustment would be applied to reimbursement similar to the productivity

adjustment that is used in the calculation in the Medicare physician fee schedule where productivity is measured compared to the private sector; this means that a small negative update is applied with the presumption that productivity increases steadily.

Medical Liability Provisions

No substantial reform included, but $50 million over five years is provided as grants to states to conduct demonstration projects on alternative medical liability reform programs. The HHS Secretary would be required to submit reports to Congress on these pilots and MedPAC would conduct independent reviews of these pilot programs.

Physician Quality Reporting Initiative (PQRI)

Incentive payments for successful reporting are extended as a 1 percent bonus in 2011 and .5 percent in 2012-2014. Beginning in 2015, however, physicians who do not report on quality measures to the PQRI will receive a 1.5 percent cut in Medicare reimbursement and a 2 percent cut in payments in 2016 and thereafter. This is presumably in addition to payment cuts for NOT implementing e prescribing and NOT implementing EHRs under meaningful use criteria.

The Act requires CMS to create an appeals process for physicians and to provide timely feedback for participating physicians.

Physician Feedback Program.

Beginning in 2012, physicians would receive individual reports on their resource use compared with their peers who see a similar patient base. A pilot program was already underway. It is likely this will get linked to payment differentials, at some point, reflecting "efficiency," but this is not specifically a provision in the bill.

Accountable Care Organizations.

Beginning in 2012, physicians would be encouraged to join accountable care organizations through which they would be eligible for enhanced payment incentives based on quality and efficiency improvement. All physicians are eligible to participate. Already aggressive expansions by hospitals are underway to acquire or take control of physician groups through a variety of direct employment or indirect eg "foundation" mechanisms.

Bundling.

Effective 2013, the Secretary would be required to establish a pilot program on payment bundling to encourage providers to improve care coordination to achieve savings for the Medicare program. No specifics are spelled out in the bill.

Value-Based Payment Modifier.

Implements a new budget-neutral value-based modifier through which physicians would be reimbursed based on the cost and quality of care that they deliver. Beginning in 2013, and likely to be part of the 2013 Medicare physician fee schedule, the HHS Secretary would solicit input for quality outcomes measures on which to base the quality modifier; the new payment system would be implemented in 2015. Again, we need implementing regulation proposals to make clear how these concepts would be applied.

Physician Sunshine Provisions.

Effective March 31, 2013, drug, device, biological and medical supply manufacturers would be required to report any transfers of value to any physician, group practice or teaching hospital and disclose any ownership or investment that the physician may have with the manufacturer. These provisions do not appear to apply to CME programs.

Independent Payment Advisory Board.

The law creates an Independent Payment Advisory Board (IPAB), which would be comprised of 15 members appointed by the President, approved by the Senate, with 6 year terms; tasked with making recommendations to Congress on lowering costs to the Medicare program. The recommendations would take effect unless Congress rejects the proposal and offers a recommendation that achieves the same savings. The board would be prohibited from making decisions that ration care, increase beneficiary premiums or eliminate benefits, thus leaving physicians more vulnerable to potential cuts. Effective 2015, IPAB would submit a recommendation to Congress. The targets to be met grow steadily closer to that of overall Consumer Price Index and per capita gross domestic product growth, meaning that severe spending reductions in healthcare potentially will be imposed through this mechanism.

Sources: AMA, AGA, California Medical Association; and Kaiser Family Foundation, specifically

http://www.kff.org/healthreform/8060.cfm Health reform implementation timetable

http://www.kff.org/healthreform/upload/8061.pdf Health reform provisions summary

http://www.kff.org/healthreform/upload/7961-02.pdf Medicare & new independent payment advisory board

Accessed 6/6/2010

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