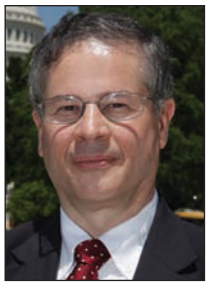
IMPLEMENTING HEALTH REFORM

The Independent Payment Advisory Board

Tucked within the Affordable Care Act is a provision that creates the Independent Payment Advisory Board (IPAB), a panel of 15 experts charged with slowing the growth of Medicare and private health care spending, and improving health care quality. By law, the board's recommendations will automatically take effect unless Congress enacts its own cost-cutting plan that achieves the same level of savings. The board isn't expected to submit its first recommendations to Congress until 2014, but already the medical community is crying foul.



Dr. J. Fred Ralston Jr., president of the American College of Physicians, explains some of the issues with the new board.

CLINICAL ENDOCRINOLOGY NEWS: Everyone agrees there is a need to control health care spending, so why is the IPAB so unpopular with physicians?

Dr. Ralston: The ACP supports the general concept of an entity such as the IPAB. We believe that making complex Medicare payment and budgetary decisions is very difficult within a political process with substantial lobbying pressures, and that a knowledgeable, independent board would have some protection from this undue influence.

Many physician and other provider groups are opposed to this provision because a significant amount of influence is removed from the accessible, elected congressional body by the legislation. The sense is that too much congressional authority is removed, resulting in a situation in which there will be inadequate opportunity for physicians and other providers to express their point of view and influence the actions taken.

CEN: How does the IPAB differ from other bodies such as the Medicare Payment Advisory Commission (MedPAC)?

Dr. Ralston: The IPAB, whose members must be appointed by the president and confirmed by the Senate, has the authority to have changes made by the Secretary [of Health and Human Services] to the Medicare system to reach a budgetary target. The IPAB-recommended changes will take effect unless Congress passes legislation that meets the same budgetary target. Even if Congress passes such legislation, that legislation can be vetoed by the president and the IPAB recommendation would still take effect.

MedPAC can only make recommendations, which Congress can choose to enact or not. It has no direct authority to implement change, which differs significantly from the IPAB.

CEN: The ACP and other medical societies have called for changes to the IPAB structure. What changes would the ACP like to see?

Dr. Ralston: The college would like to see the following changes:

► A requirement for inclusion of a primary care physician on the IPAB—the perspective of those physicians who provide first-contact, comprehensive, and continuous care must be a part of the process.

The ACP wants a primary care physician on the advisory board and an equal distribution of budgetary cuts.

DR. RALSTON

► Stronger protections to ensure that the recommendations to decrease expenditures do not result in decreased quality of care.

► The authority for Congress to reject the implementation of IPAB recommendations with a majority vote, which maintains a reasonable influence in the hands of the elected body.

► Equal distribution of risk for budgetary reductions among all health care providers. Hospitals and certain other provider groups, for example, hospices, are protected from budgetary reductions over the first several years of the legislation, placing physicians at increased risk of being required to take reductions.

CEN: What elements of the IPAB does the ACP favor?

Dr. Ralston: As stated above, the concept of providing a knowledgeable body with some protection from undue influence.

CEN: If Congress eliminated the IPAB, how could it achieve comparable health care savings?

Dr. Ralston: The college believes that the [Affordable Care Act] sets a foundation for many changes that can lead to increased savings. This includes the piloting of integrative payment models that reward efficiency and effectiveness, as opposed to the current system that rewards only volume. These models include accountable care organizations, increased bundled payments, and gainsharing arrangements.

Data from ongoing demonstrations of the patient-centered medical home care model, which fosters increased care coordination and improved treatment of chronic conditions, indicate a high potential to cut costs and improve quality.

Finally, the increased development and dissemination of comparative effectiveness information to help inform the decisions of patients in consultation with their physicians also has the potential to significantly reduce costs while improving, or at least maintaining, quality. ■

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POLICY & PRACTICE

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Abbott Warned on Quality Issues

The Food and Drug Administration concluded that Abbott Diabetes Care Inc. exercised inadequate quality control in manufacturing its FreeStyle and FreeStyle Navigator blood glucose monitoring systems, in a July warning letter based on the findings of a month-long inspection at Abbott's Alameda, Calif., plant. Abbott also failed to have properly trained personnel overseeing FreeStyle device manufacturing, the agency said. The director of quality systems at the plant, for example, should have a bachelor of science or an equivalent degree, but the person in that post holds a business administration degree. Abbott recalled 5,449 of its FreeStyle Navigator units earlier this year after an investigation indicated that the device's plastic housing could crack, causing inaccurate readings. The company told the FDA that it was addressing the quality issues.

Judge Okays Zimulti Case Revival

A federal judge has granted permission for investors to refile a lawsuit against Sanofi-Aventis over the drug manufacturer's antiobesity drug rimonabant (Zimulti). Sanofi had sought FDA approval to market the drug in the United States but withdrew its application after an FDA advisory panel said that the drug's effects on weight loss could not overcome potential psychological side effects. The investors sued Sanofi in November 2007, saying the French manufacturer failed to disclose data on the medication's link to suicidal behavior, which led to a major loss in Sanofi stock value once the FDA panel made its decision. U.S. District Judge George Daniels dismissed the lawsuit in 2009, saying Sanofi had not acted recklessly, as the plaintiffs contended. But last month, the judge agreed to let the plaintiffs refile their complaint, saying in his ruling that the new complaint "adequately pleads violations of the federal securities laws."

Generic Makers Claim Big Savings

Generic metabolism drugs accounted for 13% of a total $824 billion saved by use of all generic medications over brand name products in the past decade, according to a report from the Generic Pharmaceutical Association. Metabolism, cardiovascular, and central nervous system drugs accounted for nearly three-quarters of the total $139 billion saved by generics in 2009, the report said. The figures are growing each year as brand-name drugs lose patent protection and lower-cost generic alternatives hit the market, the report said. Two more diabetes medications will come off patent in the next 2 years: Takeda's Actos (pioglitazone) in 2011, and GlaxoSmithKline's Avandia (rosiglitazone) in 2012.

Preventive Training Supported

The Department of Health and Human Services has awarded 15 grants totaling $9 million to train 55 residents in preventive medicine. Some of the funds come from the American Recovery and Reinvestment Act of 2009. The support goes to accredited schools of public health and medicine and hospital-based residency programs, the agency said. Griffin Health Services Corp., the parent company of Griffin Hospital in Derby, Conn., was awarded the top grant of $1.4 million. The Johns Hopkins Bloomberg School of Public Health received $1.1 million, and the University of California, Davis, received $1 million.

State Backs Coordinated Care

Health care providers in five communities across New Hampshire have agreed with the state's major insurance companies to participate in a 5-year pilot program to encourage collaboration, prevention, and disease management instead of fee-for-service medicine, said Gov. John Lynch (D). Groups of providers in each community will become "accountable care organizations" and thus take responsibility for coordinating health care and preventive services to local residents. Each organization will determine how to spend its budget to achieve quality outcomes and efficiency in its area. "Our current health care system rewards providers for seeing as many patients as possible. We're going to change that. Under this pilot project, we are moving to a system where health care providers will profit from spending time with their patients and keeping them healthy," Gov. Lynch said in the statement.

J&J Discloses Physician Payments

Following in the footsteps of Pfizer, GlaxoSmithKline, and Medtronic, Johnson & Johnson is disclosing how much it pays physician speakers and consultants, at least for a number of its pharmaceutical subsidiaries. However, the data cover only J&J divisions that were subject to corporate integrity agreements with the federal government: PriCara, Ortho-McNeil Pharmaceutical, Ortho-McNeil Neurologics, Janssen, and McNeil Pediatrics. Payment disclosures are listed at those units' individual Web sites. Quarterly updates will give way to semiannual and then annual updates by 2012 for all the divisions. The company will start disclosing payments for medical devices and diagnostics by June 30, 2011, according to a spokesman for J&J.

—Jane Anderson