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## INDEPENDENT PAYMENT ADVISORY BOARD WILL HELP REDUCE HEALTH COSTS Repealing IPAB Would be Unwise

By Paul N. Van de Water

The health reform legislation enacted in 2010 (the Affordable Care Act, or ACA) establishes the Independent Payment Advisory Board, or IPAB — a presidentially appointed commission that will help slow the growth of Medicare costs if those costs are projected to exceed a specified target level.<sup>1</sup> Other cost-control measures included in the ACA will likely produce most or all of the savings needed to meet the spending target, but IPAB serves as an important backstop to contain costs if these measures prove inadequate.

Contrary to critics' claims, IPAB will not usurp the role of Congress in setting Medicare policy, nor will it limit Medicare beneficiaries' access to care. Efforts to repeal IPAB are misguided. If successful, such efforts could lead to more draconian steps, such as replacing guaranteed Medicare benefits with a premium support system, or voucher, whose value would fall farther behind the cost of health care each year.

### How IPAB Will Operate

The Independent Payment Advisory Board is an expert body charged with developing and submitting proposals to slow the growth of Medicare and private health care spending and improve the quality of care. The President nominates the board's 15 members, who require Senate confirmation, for staggered six-year terms. The board must include physicians and other health professionals, experts in health finance, health services researchers, employers, and representatives of consumers and the elderly. To prevent control by special interests, health care providers may not constitute a majority of the board's membership.

If the projected growth in Medicare costs per beneficiary for 2015 and thereafter exceeds a specified target level (computed as a five-year moving average), the board must produce a proposal to reduce or eliminate the difference. If the board fails to submit the required proposal, the Secretary of Health and Human Services (HHS) must submit one instead. For 2015 through 2019,

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<sup>1</sup> *Patient Protection and Affordable Care Act*, Public Law 111-148, section 3403, as amended by section 10320.

the target growth rate is the average of overall inflation and medical inflation. For 2020 and thereafter, the target is the rate of increase in gross domestic product (GDP) per capita plus one percentage point. The required reductions, however, may not exceed 0.5 percent of Medicare spending in 2015, 1.0 percent in 2016, 1.25 percent in 2017, and 1.5 percent in 2018 and thereafter.<sup>2</sup> Thus, the target growth rate does not necessarily represent a binding cap on Medicare spending.

The board's proposal (or that of the Secretary) may not include any recommendation to ration health care, increase Medicare premiums or cost-sharing, cut Medicare benefits, or restrict eligibility. It must focus exclusively on proposals for achieving savings in the payment and delivery of health care services — not shifting costs to beneficiaries.

The board's recommendations will go into effect automatically unless Congress passes, and the President signs, legislation to modify or overturn them. Congress may consider, on a fast-track basis, an alternative proposal that achieves the same amount of savings; if the alternative proposal achieves a smaller amount of savings, approval requires a three-fifths vote of the Senate. If the board recommends changes that the President supports, the President can veto legislation to block them, and as is always the case, a two-thirds vote of the House and Senate would be required to override a veto.

Starting in 2015, the board is also required to make *advisory* recommendations at least every other year for slowing the growth of non-federal health care spending while preserving or enhancing the quality of care. These recommendations do not go into effect automatically and can be implemented only through discretionary actions by the federal government, state or local governments, or private-sector entities.

## **IPAB Will Backstop Other Cost-Control Measures**

The Independent Payment Advisory Board provides an important backstop to the other cost-containment measures in the Affordable Care Act. The ACA puts in place several complementary approaches to slow the growth of Medicare costs.

First, the ACA trims payments to health care providers under Medicare's current payment mechanisms. Medicare payment rates for covered services are updated annually based on increases in the prices of the goods and services purchased by providers. The ACA reduces the annual payment updates to account for improvements in economy-wide productivity in those cases where the updates did not already incorporate such adjustments. The productivity adjustments will have a big effect over the long run, reducing the growth of payments to providers by about one percentage point per year.<sup>3</sup> The ACA also makes further reductions in the payment updates for hospitals through 2019 (in addition to the productivity adjustments), reduces overpayments to Medicare

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<sup>2</sup> For details of how the process will work, see Jack Ebeler, *The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending*, Kaiser Family Foundation, April 2011, <http://www.kff.org/medicare/upload/8150.pdf>.

<sup>3</sup> Office of the Actuary, Centers for Medicare & Medicaid Services, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*, May 13, 2011, <https://www.cms.gov/ReportsTrustFunds/Downloads/2011TRAlternativeScenario.pdf>.

Advantage plans (the private insurance plans that participate in Medicare), and revises payments for home health care.

Second, the ACA begins to restructure the health care payment and delivery system to stop paying providers for more visits or procedures and begin rewarding effective, high-value health care. Among other steps, it reduces Medicare payments to hospitals with high readmission rates, creates new payment models to reward accountable care organizations (physician-led organizations that take responsibility for the cost and quality of care), and initiates pilot programs for bundling Medicare payments to hospitals and other medical facilities for services they provide during a single episode of care. The ACA also establishes a Center for Medicare and Medicaid Innovation to identify and foster new ways to increase the value of care and better coordinate care for low-income Medicare beneficiaries who also are enrolled in Medicaid, and gives the HHS Secretary authority to implement approaches that prove successful in reducing costs and maintaining health-care quality without new legislation. The Congressional Budget Office (CBO) has not estimated savings from these provisions in the next ten years because their effects are not yet proven, but they hold promise to slow the growth of Medicare spending over the long run.

The third element of cost-control is the Independent Payment Advisory Board, which serves as a backstop or fail-safe mechanism. Only if the first two approaches do not hold the growth of Medicare spending to the targets will the IPAB process be triggered.

### **Payment Changes Will Produce Most of the Needed Savings**

Both CBO and the Administration project that the ACA's explicit reductions in Medicare payment rates will produce most or all of the savings needed to meet the law's spending targets and that IPAB recommendations will not be needed in the next few years.

According to the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS), Medicare spending per beneficiary is projected to grow by about 3 percent a year over the next ten years, well below its average of 7 percent a year during the previous decade and also below the projected rate of growth of private health care costs.<sup>4</sup> Both the 2011 Medicare trustees' report and the President's fiscal year 2013 budget project that IPAB will be called upon to reduce Medicare spending for 2018 and 2019 — but not in any other year.

CBO reaches much the same conclusion. It projects that Medicare expenditures per beneficiary will grow by an average of just under 3 percent per year from 2015 through 2022 and that IPAB will not be needed to achieve additional Medicare savings to hit the Medicare spending target in any of those years. Recognizing that any projections are uncertain, however, CBO acknowledges that there is some chance the IPAB mechanism will be triggered and therefore attaches a cost to repealing IPAB — about \$3 billion over the next ten years.<sup>5</sup>

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<sup>4</sup> Centers for Medicare & Medicaid Services, *National Health Expenditure Projections 2010-2020: Forecast Summary and Selected Tables*, July 2011, table 17, <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>.

<sup>5</sup> Congressional Budget Office, *Cost Estimate, H.R. 452, Medicare Decisions Accountability Act of 2011*, March 7, 2012, [http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr452\\_2012.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr452_2012.pdf).

Some observers have expressed concern that IPAB is prohibited from proposing cuts in hospital payments through 2019. Congress included this limitation in the ACA because hospitals agreed, as part of the ACA, to other reductions in their payment rates to help pay for health reform and to strengthen Medicare's finances. The measure restricting IPAB from proposing reductions in hospital payments through 2019 will have little practical significance anyway if IPAB is not required to recommend significant savings during these years.

The chief actuary of CMS and other analysts have raised questions about whether the health-care sector can consistently achieve the same improvements in productivity as the rest of the economy, and therefore whether the productivity-based adjustments to Medicare's payment rates can be sustained indefinitely. The actuary's office has therefore prepared an illustrative alternative projection in which the productivity adjustments are gradually phased down after 2020.<sup>6</sup> If the productivity adjustments in the Affordable Care Act were only partially implemented, as the actuary speculates, then IPAB would have an important role to play as a backstop method of cost containment. (Here, too, IPAB recommendations likely would not be needed before 2018.)

### **IPAB Will Not Usurp the Role of Congress**

One criticism of IPAB is that it will usurp the role of Congress and place too much power in the hands of unelected government officials.<sup>7</sup> This charge, however, is highly exaggerated.

To some extent, limiting congressional micromanagement of Medicare payment policy is desirable. Many times in the past, efforts to reform Medicare payments have been slowed or stopped by health-care interests that have successfully lobbied Congress to protect their income stream at Medicare's expense. Examples include attempts to institute such basic, common-sense reforms as use of competitive bidding for durable medical equipment and measures to reduce overpayments to private insurance plans, secure better prices for prescription drugs, and place limits on physician-owned hospitals (which typically focus on highly profitable services and healthier patients).<sup>8</sup> IPAB can give Congress political cover for making necessary but controversial decisions such as these that are opposed by special interests that can finance high-powered lobbying campaigns and make substantial campaign contributions.

Moreover, if Congress wishes to, it can structure the Medicare program so that it meets the spending targets without having to call upon IPAB. According to current projections, actions that Congress has already taken in enacting the ACA will do precisely that for much of the coming decade. But even if the IPAB process is triggered, Congress can always substitute its own proposals for those that IPAB recommends. Furthermore, as previously noted, the law places tight restrictions on what IPAB may propose; the board may not make recommendations to ration health care, cut benefits, increase premiums and cost sharing, or restrict eligibility for the program.

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<sup>6</sup> Office of the Actuary, Centers for Medicare & Medicaid Services, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*.

<sup>7</sup> Jennifer Haberkorn, "Health Policy Brief: The Independent Payment Advisory Board," *Health Affairs*, December 15, 2011, [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_59.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_59.pdf).

<sup>8</sup> Topher Spiro, *The Independent Payment Advisory Board: Protecting Medicare Beneficiaries and Taxpayers from Special Interests*, Center for American Progress, March 5, 2012, [http://www.americanprogress.org/issues/2012/03/pdf/spiro\\_ipab.pdf](http://www.americanprogress.org/issues/2012/03/pdf/spiro_ipab.pdf).

“Giving a body of experts the capacity to propose ways to slow spending growth will not diminish the power of elected officials,” a group of over 100 health policy experts has written, “because Congress may approve, disapprove, or replace the IPAB’s proposals with alternatives that achieve the same objectives.”<sup>9</sup> As Rep. Henry Waxman (D-CA) has put it, “Congress has the final say over Medicare policy. And Congress has the final say over all IPAB recommendations.”<sup>10</sup> Or as Rep. George Miller (D-CA) has observed, “Congress retains its role in health care — but in an improved, more efficient fashion.”<sup>11</sup>

## **Alternatives to IPAB Would Be Far Worse**

The other major criticism of IPAB is that it will limit beneficiaries’ access to care. This accusation is the opposite of the truth. In fact, if IPAB is repealed, the alternatives are likely to be much worse for Medicare beneficiaries.

IPAB has an important role to play in the effort to improve the efficiency of the health care payment and delivery system. Drawing on the studies, demonstrations, and pilot projects initiated by the ACA, the board will be in a position to develop thoughtful, cost-effective ways of slowing the growth of Medicare and other health spending instead of imposing across-the-board, poorly targeted cuts in payments to providers or increases in beneficiaries’ premiums or cost sharing.

For example, the law authorizes IPAB to recommend changes in relative payment amounts for different forms of care. IPAB could propose *higher* payments for treatments and prevention activities that are found to be more cost-effective. Such changes would not restrict the choices of either physicians or beneficiaries, but they could prompt both providers and patients to pay more careful attention to the latest research findings.<sup>12</sup> IPAB could also recommend payment methods that would reward providers for quality and efficiency and offer incentives for consumers to choose more efficient providers or procedures.<sup>13</sup>

IPAB is an important piece of the ACA’s strategy to slow the growth of health care costs through delivery system reforms, such as accountable care organizations, bundled payments, and comparative effectiveness research. If the law’s cost-growth target is missed, IPAB is charged with developing proposals to produce the requisite savings while shielding Medicare beneficiaries from increases in premiums or cost sharing or reductions in benefits. If IPAB is repealed, however, Congress is more likely to consider blunt proposals that would significantly shift costs to

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<sup>9</sup> Henry Aaron and others, Letter to the Honorable John Boehner, Nancy Pelosi, Harry Reid, and Mitch McConnell, May 20, 2011, <http://nchc.org/sites/default/files/resources/Document.pdf>.

<sup>10</sup> Henry A. Waxman, *Opening Statement, House Energy and Commerce Committee, Subcommittee on Health*, July 13, 2011.

<sup>11</sup> George Miller, *Testimony before the House Energy and Commerce Committee, Health Subcommittee, Hearing on the Independent Payment Advisory Board*, July 13, 2011.

<sup>12</sup> Henry Aaron, “IPAB Repeal Not Warranted,” *Politico*, July 14, 2011.

<sup>13</sup> Timothy Stoltzfus Jost, “The Independent Payment Advisory Board,” *New England Journal of Medicine*, May 26, 2010.

beneficiaries, such as sharply increasing Medicare premiums, deductibles, and co-insurance and raising the Medicare eligibility age.<sup>14</sup>

Most important, repealing IPAB would fuel pressure to replace the current Medicare guarantee with a system of vouchers or premium support, under which beneficiaries would bear the brunt of efforts to control costs. Premium support would replace Medicare's guarantee of health coverage with a fixed payment, or voucher, that beneficiaries would use to help them purchase either private health insurance or traditional Medicare.<sup>15</sup> It would achieve budgetary savings by limiting the growth of the voucher to less than the rate of growth of health care costs. As a result, Medicare beneficiaries would have to pay more in premiums or receive less in benefits with each passing year — precisely the outcome that IPAB is directed to avoid.

As well as shifting costs to beneficiaries, premium support would deny Medicare much of its ability to serve as a leader in controlling health-care costs by depriving it of the considerable market power it enjoys based on its large enrollment. Thanks to Medicare's role as the largest purchaser of health care, adoption by Medicare of IPAB recommendations is likely to lead in many cases to their adoption by private insurers as well, which have proven much less effective in driving cost control on their own, and who have often looked to Medicare to institute cost-containment measures first and then followed suit. In contrast, even if traditional Medicare were retained as an option, premium support would substantially reduce enrollment in traditional Medicare, dilute its buying power, and likely result in increases rather than decreases in overall health care costs.

## **Possible Improvements in IPAB**

Critics of IPAB have also raised other objections to the board — some simply false, others inconsistent with each other. For example, opponents have erroneously claimed that IPAB members could accept gifts of money or property from lobbyists.<sup>16</sup> In fact, the law makes clear that IPAB members are subject to the same ethical standards as officers of the executive branch — including a prohibition on receipt of gifts.<sup>17</sup> Some critics have described the salaries of IPAB's members as “generous,” while others have argued that the board won't pay enough to attract a sufficient number of well qualified members. (IPAB membership will be a full-time position, and members will be compensated at the rate for level III of the Executive Schedule, currently \$165,300 a year.)

None of this is to suggest that IPAB leaves no room for improvement. In particular, changes could be made that would allow IPAB to focus less on short-term savings and more on proposals to slow the growth of costs in the long run. In addition, since health care cost growth fundamentally is

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<sup>14</sup> See, for example, Paul N. Van de Water, *Raising Medicare's Eligibility Age Would Increase Overall Health Spending and Shift Costs to Seniors, States and Employers*, Center on Budget and Policy Priorities, August 23, 2011, and Juliette Cubanski *et al.*, *Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending*, Kaiser Family Foundation, November 2011.

<sup>15</sup> Paul N. Van de Water, *Converting Medicare to Premium Support Would Likely Lead to Two-Tier Health Care System*, Center on Budget and Policy Priorities, September 26, 2011.

<sup>16</sup> U.S. House of Representatives, Committee on Ways and Means, *Troubling Things You May Not Know About IPAB*, March 5, 2012.

<sup>17</sup> Section 1899A(g)(1)(C) of the Social Security Act, as added by section 3403 of the ACA.

a system-wide problem rather than a Medicare-specific problem, Congress could allow IPAB to make binding recommendations to reform payments and slow cost growth in the private sector as well as in Medicare. While Medicare has frequently been the key leader in developing innovative ways to reduce costs, such as developing the prospective payment system for hospital care that was later adopted by private insurers, IPAB could be improved to help accelerate that trend. In these ways, IPAB could play an expanded role in promoting payment and delivery reform throughout the health care system.<sup>18</sup>

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<sup>18</sup> Judith Feder, *Testimony Before the House Committee on Energy and Commerce, Health Subcommittee*, July 13, 2011.