HealthAffairs | Robert Wood Johnson Foundation

Health Policy Brief

UPDATED: APRIL 5, 2012

The Independent Payment Advisory Board. Starting in 2013, a new entity will have authority to curb Medicare spending if growth exceeds targets. Should it?

WHAT'S THE ISSUE?

The Independent Payment Advisory Board (IPAB), a new executive-branch entity created by the Affordable Care Act of 2010, will have significant authority to curb rising Medicare spending if per beneficiary growth in that spending exceeds target growth rates.

In a process that begins in 2013, recommendations made by the 15-member board will go to Congress for rapid consideration; Congress must adopt these or enact savings of similar size in Medicare. If Congress doesn't act within a specified timetable, the secretary of the Department of Health and Human Services (HHS) must implement the board's recommendations. The board is not allowed by law to recommend changes in premiums, benefits, eligibility, or taxes, or other changes that would result in "rationing" of care to Medicare beneficiaries.

Proponents of IPAB say that the board is a vital mechanism for controlling Medicare spending, since Congress and the executive branch have historically been unwilling or unable to make many tough decisions about controlling rising Medicare outlays. Opponents, including an array of health-sector stakeholders, argue that the law cedes too much authority to an appointed panel and that its cuts could lead to dramatic reductions in the quantity or quality of health care services. On March 22, 2012, the House of Representatives passed a bill to repeal IPAB. The Senate is not expected to take up comparable legislation at present. This policy brief reviews why IPAB was created and the arguments pro and con.

WHAT'S THE BACKGROUND?

Medicare is the federal health program that provides insurance coverage for the aged and the disabled. In 2012 Medicare will cover more than 48 million Americans at a projected cost of nearly $566 billion, according to the Congressional Budget Office. The Affordable Care Act authorized major reductions in the growth of Medicare spending. Even so, Medicare spending is expected to rise to nearly $916 billion by 2020. Without additional changes, Medicare spending is projected to increase from 3.6 percent of the nation's gross domestic product in 2010 to 5.2 percent by 2030 (Exhibit 1).

NO AGREEMENT ON REDUCTIONS: Historically, Congress has found it extremely challenging to enact policies to curtail the growth of Medicare spending. Reasons include a lack of consensus over how to reduce Medicare spending and strong political pressure from those who would be affected by cuts—beneficiaries as well as hospitals, physicians, other types of health care providers, and suppliers.

Frustrated by this gridlock, some policy makers over the years have explored other approaches that might lead to reductions in the

10.1377/hpb2012.8

$566 billion

Cost of Medicare
In 2012 Medicare will cover more than 48 million Americans at a projected cost of nearly $566 billion, according to the Congressional Budget Office.

rate of growth of Medicare spending. In the debate leading up to passage of the Affordable Care Act, much concern was expressed that expanding coverage to millions of Americans would drive up health spending in the absence of offsetting measures to rein in that spending. A number of ideas were discussed, including creation of a Federal Health Board that would have broad powers to hold spending in check within both public and private health care programs. That proposal was ultimately rejected as too extensive, however.

The proposal that did emerge from the debate, and that was enacted into law, called for creation of the Independent Payment Advisory Board. IPAB was designed to be a souped-up version of the Medicare Payment Advisory Commission (MedPAC), an advisory body that makes recommendations to Congress about Medicare payment policies and related issues. But because MedPAC's recommendations have often been ignored, IPAB was given greater stature and more far-reaching authority, as discussed below.

WHAT'S IN THE LAW?

The Affordable Care Act specifies that IPAB will comprise 15 members appointed by the president and subject to confirmation by the Senate. For 12 of the members, the president will consult with the majority and minority leaders of the House and Senate; those four individuals will thus have a role in choosing three members each. The president will then appoint three additional members and also appoint the chair. The HHS secretary and the administrators of the federal Centers for Medicare and Medicaid Services (CMS) and Health Resources and Services Administration will serve ex officio as nonvoting members of the board.

The 15 panel members with voting authority will be considered executive-branch officers, and the panel will be housed in the executive branch, not Congress. Members will serve up to two six-year terms and receive an annual salary at level two of the executive schedule ($165,300 in 2011).

Panel members are expected to have diverse backgrounds as physicians and other health professionals, employers, third-party payers, and representatives of consumers and the elderly. They are also expected to have recognized expertise in areas such as health finance, economics, and biomedical health services. However, panel members are prohibited from any other business or employment during the time of their service on the board. A majority of panel members cannot have been directly involved in providing or managing Medicare-related services prior to their appointment to the board.

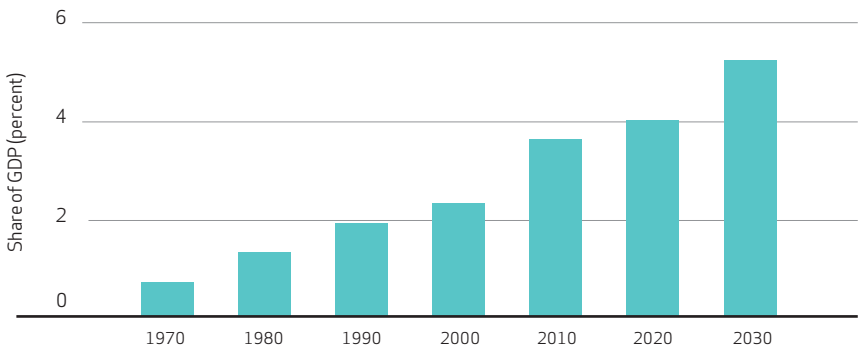
HOW IPAB WILL WORK: The main driver of IPAB's work will be projections of future Medicare spending. Here's how the new system will work.

By April 30 of every year, beginning in 2013, the chief actuary of CMS will be required to provide a calculation known as the projected Medicare growth rate. This measure is defined as the average federal spending for Medicare Parts A, B, and D, after subtracting the premiums that are projected to be collected for those years, divided by the number of Medicare enrollees. (This per enrollee calculation will in effect assume that Medicare spending will grow as more people become eligible for the program and will focus only on how fast Medicare spending is growing for reasons other than enrollment growth.)

Next, the CMS chief actuary will calculate the target growth rate of Medicare for the same future period. For the years 2015 through 2019 the target growth rate will be the midpoint of two projected rates of inflation: first, the Consumer Price Index for All Urban Consumers, known as the CPI-U, and second, the medical care expenditures category of the CPI-U, which includes changes in the prices of professional and hospital services and medical supplies. This target growth rate will be the midpoint of the projected average growth rates in these prices over five years.

EXHIBIT 1

Medicare Spending as a Share of the Gross Domestic Product (GDP), Selected Years 1970–2030



SOURCE 2011 annual report of the Boards of Trustees of the Medicare Trust Funds. **NOTE** Projections are based on the trustees' intermediate set of assumptions.

15

Panel members
IPAB will comprise 15 voting members appointed by the president and subject to Senate confirmation.

For 2020 and later years, the target for Medicare spending per enrollee will be linked not to growth in prices but rather to the rate of growth of the overall economy. Specifically, the target will be the increase in the national gross domestic product plus one percentage point. In effect, then, Medicare per enrollee spending growth will be measured against a projected growth rate that is somewhat faster than overall economic growth.

If the chief actuary finds that the projected Medicare growth rate will not exceed the projected annual target, IPAB will not have to issue any recommendations for savings. However, if the chief actuary finds that the growth rate will exceed the target, the actuary must determine how much Medicare spending growth should be reduced. IPAB will then have to recommend specific steps that will curb the rate of growth in Medicare spending.

The panel must submit a draft proposal to MedPAC and HHS for consultation by September 1 of the same year. A final proposal must go to Congress and the president by January 15 of the following year.

LIMITED OPTIONS: The total amount of the Medicare savings IPAB can propose, and the type of savings, are both limited by law. The total amount of these savings cannot exceed 0.5 percent of total Medicare outlays in 2015, 1 percent of outlays in 2016, 1.25 percent in 2017, and 1.5 percent in 2018 and thereafter.

IPAB cannot propose any recommendation to "ration" care, raise revenues, increase beneficiary premiums or cost sharing, restrict benefits, or alter rules for Medicare eligibility. The law directs the panel to give priority to measures that extend the solvency of the program, improve beneficiaries' access to care, and improve the health delivery system and health outcomes, among others.

IPAB can propose savings in any part of Medicare, except hospital payments in the short run. Because hospitals had already agreed to restraints on growth in their payments as part of the financing of the Affordable Care Act, they lobbied for and obtained protection from any additional hospital payment cuts proposed by IPAB until 2018.

IPAB's savings recommendations will be in the form of proposed legislation. The law sets firm deadlines for committee and Senate floor consideration of the proposal, as well as limits on the amendment process. Congress has the option of passing alternative legislation, but it must achieve the same results in terms of the magnitude of savings. If Congress does not act, the secretary of HHS is required to implement IPAB's proposals by August 15. By law, the secretary's actions cannot be reviewed or reversed by anyone else in the executive branch, or by the courts.

WHAT'S THE DEBATE?

Arguments for and against IPAB hinge on several key issues—including the degree to which decisions about saving money in Medicare are so political that they should be made outside the context of the day-to-day operations of Congress. The arguments don't necessarily correspond with divisions between the political parties, because Democrats are divided on their support for IPAB.

ARGUMENTS FOR IPAB: Proponents of IPAB say the board is needed because Congress has a record of ignoring or voting down many proposals to save money in Medicare, such as those suggested by MedPAC. Often, this is because lawmakers are lobbied hard by health-sector stakeholders resistant to any cuts. Therefore, it's appropriate to transfer authority to propose savings in Medicare to a panel outside of Congress, where decisions will be more insulated from stakeholder politics. In fact, IPAB proponents contend, the existence of IPAB may prompt members of Congress to undertake needed steps to save money on Medicare.

What's more, in the context of the Affordable Care Act, having a backstop such as IPAB is sorely needed, proponents say. The law calls for sharp slowdowns in the rate of growth of payment to hospitals and other providers, but it contains relatively few other measures that will reliably slow the growth of spending. IPAB will thus constitute an important mechanism for slowing Medicare growth if these other measures fail.

Proponents also point to appropriate limits that have been set on IPAB's powers. As noted, IPAB can't propose rationing care or making major Medicare changes that directly affect beneficiaries. Finally, proponents note that, at present, the existence of IPAB is not likely to make much difference. The Congressional Budget Office currently projects that growth in per beneficiary Medicare spending will be below target rates of growth for fiscal years 2015–21. Therefore, for that period, IPAB is not likely to have to propose additional sav-

"Historically, Congress has found it extremely challenging to enact policies to curtail the growth of Medicare spending."

0.5%

Limit to savings
The total savings IPAB can propose cannot exceed 0.5 percent of total Medicare outlays in 2015.

About Health Policy Briefs

Written by
Jennifer Haberkorn
(Haberkorn is a staff writer for *Politico* specializing in health care reform issues.)

Editorial review by
Joseph Antos
Resident Scholar
American Enterprise Institute

Robert D. Reischauer
President
Urban Institute

Ted Agres
Senior Editor for Special Content
Health Affairs

Anne Schwartz
Deputy Editor
Health Affairs

Susan Dentzer
Editor-in-Chief
Health Affairs

Health Policy Briefs are produced under a partnership of *Health Affairs* and the Robert Wood Johnson Foundation.

Cite as:
"Health Policy Brief: The Independent Payment Advisory Board," *Health Affairs*, Updated April 5, 2012.

Sign up for free policy briefs at:
www.healthaffairs.org/healthpolicybriefs

ings in Medicare above and beyond those already in law.

ARGUMENTS AGAINST IPAB: Opponents of IPAB include many segments of the health care industry. In June 2011, for example, 270 health care and business organizations sent a letter to congressional leadership asking that the board be abolished. Clearly, many worry that any Medicare savings effectively mandated by IPAB will affect their own financial well-being.

Other objections fall along two basic lines. First, opponents argue that the existence of the board will place too much control in the hands of unelected individuals, whose recommendations will lead to actions that cannot even be reviewed by the courts.

Second, opponents say that the consequences of exacting savings from Medicare will effectively limit beneficiaries' access to care. If IPAB is forced to find savings in Medicare, they say, it will have little choice but to cut or sharply restrain the growth of payments to providers. Physicians already facing Medicare reimbursement cuts for other reasons would then encounter additional reductions. The fear is that many doctors would stop treating Medicare patients, at the very time that larger numbers of baby boomers became eligible for Medicare.

Even groups or individuals not necessarily opposed to IPAB have raised concerns about some constraints imposed by the legislation. Under the law, IPAB has to make recommendations that would achieve savings in a single year, rather than over a longer period of time. The result will be that IPAB has less leeway to propose major health care delivery system reforms that could take years to play out, because such reforms would be unlikely to produce "scoreable" one-year savings.

WHAT'S NEXT?

As mentioned, on March 22, 2012, the House of Representatives approved a bill that abolishes IPAB. The vote was largely along party lines. A similar measure introduced in the Senate by Sen. John Cornyn (R-TX) has gained only Republican backing and is not likely to advance in that chamber. President Barack Obama is committed to retaining IPAB and has proposed several measures to broaden its scope. In September 2011 he proposed tightening the target for Medicare spending from 2020 onward. Instead of a target growth rate equal to the rate of gross domestic product growth plus 1 percent, the target would fall to gross domestic product growth plus 0.5 percent.

The president also proposed giving IPAB the authority to consider other approaches for saving money in Medicare, such as "value-based" benefit designs, which could reduce beneficiaries' cost sharing for services deemed most effective and could raise cost sharing for other services. An additional proposal would create some enforcement mechanism, such as an automatic sequester, that could dictate Medicare savings and serve as a backstop to IPAB.

Any such changes would require congressional approval, however, and given the extent of opposition in Congress, are not likely to be enacted. It is not known if President Obama will recommend appointments to IPAB before the November 2012 elections. If he does, it is likely that opponents in the Senate will attempt to block their confirmation. And given that the Supreme Court has agreed to rule on the constitutionality of the Affordable Care Act, IPAB's fate may well be bound up with that larger decision.

The bottom line is that, as with much that surrounds the Affordable Care Act, IPAB's fate is unclear for now. It may rise or fall with the Supreme Court decision or with the outcome of the November 2012 elections.■

RESOURCES

Ebeler, Jack, Tricia Neuman, and Juliette Cubanski, "The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending," Kaiser Family Foundation, April 2011.

Kaiser Family Foundation, "CBO Scoring of Proposed Changes to the Independent Payment Advisory Board," May 2011.

Newman, David and Christopher M. Davis, "The Independent Payment Advisory Board," Congressional Research Service, November 30, 2010.

Pear, Robert, "Obama Panel to Curb Medicare Finds Foes in Both Parties," *New York Times*, April 19, 2011.