

The Independent Payment Advisory Board

Timothy Stoltzfus Jost

A common theme in the health care reform debate in recent years has been the need for a board of “Platonic Guardians” to govern the health care system or some aspects of it. The cost of health care is spinning dangerously out of control. Market forces alone cannot control these costs because of a host of well understood market failures, but our traditional political institutions—Congress and the executive administrative agencies—are too driven by special interest politics and too limited in their expertise and vision to control costs

Enter the Platonic guardians. The governance of the health care system should, it is argued, be turned over to an impartial, independent board of experts who could make evidence-based policy determinations based purely on the basis of effectiveness and perhaps efficiency. The models of the Federal Reserve Board or the Base Closing Commission are often invoked as models

The Patient Protection and Affordable Care Act (PPACA) creates an Independent Payment Advisory Board (IPAB) to fulfill this function, at least for Medicare.¹ The health reform legislation establishes specific target growth rates for Medicare and assigns to the IPAB the primary responsibility for making sure that Medicare expenditure increases stay within these limits. The IPAB is also responsible for making recommendations to Congress as to how to control health care costs more generally.

The IPAB is one of a number of boards, commissions, councils, and centers created by the Patient Protection and Affordable Care Act (PPACA). Most directly relevant to its mission is the Center for Medicare and Medicaid Innovation, which is responsible for designing, evaluating, and implementing innovative Medicare payment and service delivery models.² The PPACA also continues and expands the remit of the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment Advisory Commission (MACPAC), the legislative branch counterparts of the IPAB.

The IPAB will have 15 members appointed by the President with the advice and consent of the Senate, supplemented by the Secretary of HHS and the Administrators of the Center for Medicare and Medicaid Services and of the Health Resources and Services Administration. The members will be appointed to six year terms of office.

IPAB members are supposed to be nationally recognized experts in health finance, payment, economics, actuarial science, health facility management, and health plan and integrated delivery systems. The IPAB must include physicians or other health care providers. The Board is also supposed to include experts in medicine, pharmaco-economics, and drug benefit programs; representatives of employers, third-party payors,

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consumers, and the elderly; and persons skilled in the conduct and interpretation of biomedical, health services, health economics, technology assessment, and outcomes and effectiveness research. The Board should be composed of a mix of different professionals, broad geographic representation, and a balanced urban and rural mix. A majority of the members of the Board must not be persons directly involved in the provision or management of health care items and services. The IPAB will also have a ten-member consumer advisory board.

Service on the IPAB, unlike service on MedPAC or on other boards and commissions created by the PPAC, is a full-time job. Members will be compensated at a rate equal to the annual rate prescribed for Level III of the Executive Schedule (currently, \$165,300) (5 USC 5315), while the Chairperson is compensated at the Level II rate (\$179,500), and the executive director at the Level V (\$145,700) rate.³

The basic task of the Board is to develop specific detailed proposals to reduce Medicare spending in years, beginning in 2015, when Medicare per capita spending is expected to exceed target levels. These proposals must be implemented unless Congress acts following expedited procedures to adopt alternative cost-cutting measures. The Board is also charged with developing and submitting to Congress advisory reports in years in which it is not required to make cost-cutting proposals, as well as detailed annual reports on health care costs, access, quality, and utilization. Finally, the IPAB is responsible for submitting to Congress and the President at least once every two years beginning with 2015, recommendations as to how to slow the growth in private national health care expenditures. These recommendations must include proposals that could be addressed by federal legislation, as well as recommendations that could be implemented administratively or by state legislation or private action.

Each year beginning with April 30, 2013, the CMS Chief Actuary will make a determination whether the projected 5-year average per capita growth rate ending in the implementation year (the second year following the determination year, initially 2015) will exceed the target growth rate for that year. The target growth rate is the projected 5 year average ending in the implementation year of the average of the CPI and the medical care category of the CPI prior to 2018, and the nominal gross domestic product per capita growth plus 1 percentage point after 2017.

If the Actuary determines that for any given year the projected Medicare growth rate will exceed the target rate, the Board must make proposals that would reduce Medicare spending overall by an amount equal to the lesser of: a) .5 percent in 2015, 1 percent in 2016, 1.25 percent in 2017, and 1.5 percent in 2018 and thereafter, or, b) the projected excess of the growth rate over the target rate. In years when the projected Medicare growth rate falls below the target growth rate or the medical care category of the CPI falls below the CPI, no proposal may be made.

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The proposal, however, must fit within stringent constraints. First, the proposal may not “ration health care,” raise revenues or beneficiary premiums, increase the Part D-based beneficiary premium percentage or full premium subsidies, increase beneficiary cost sharing, or in any way restrict benefits or modify eligibility criteria. Second, proposals for years before 2020 may not target the payment rates of particular providers and suppliers already singled out under section 3401 of the PPACA for cuts above those attributable to constrained productivity increases. This means that the Board cannot cut payments for hospitals and possibly hospice care prior to 2020 and for clinical laboratories for 2015. Third, proposals must take into account administrative expenditures HHS will incur to carrying them out. Fourth, proposals may only include recommendations related to the Medicare program. Finally, proposals must maintain or enhance beneficiary access to quality care. The Board is not precluded from cutting payments for physicians, but it is possible that its powers will be limited under a permanent sustainable growth rate fix.

In addition to these requirements, the Board’s proposals should also strive to 1) extend the solvency of the Trust fund, 2) better coordinate and integrate care and improve quality, access, prevention, wellness, and efficiency, 3) target reductions at areas of excessive cost growth, 4) consider the effects of reductions in provider payment on beneficiaries, and 5) consider the unique needs of dual eligibles. Proposals also may not increase the total amount of Medicare program spending over the ten year period starting with the implementation year—costs may not simply be shifted to future years. In other words, the Board should aim for everything that is good, true, and right.

By September 1 in years that the Actuary gives notice, the IPAB must submit a draft proposal to HHS Secretary and to MedPAC. On January 15 of the following year (beginning with 2014), the Board must submit a proposal to Congress and the President. If the Board fails to submit a proposal on deadline, HHS must itself submit a proposal meeting the statutory requirements. The President shall then forward the proposal to Congress. Beginning in 2019, HHS may not implement a Board proposal in a year in which the five-year average in national health expenditures generally will exceed the growth rate in Medicare (as it often does) and in which the Board submitted a proposal to Congress the year before.

Congress must consider the proposal under an expedited procedure with limited debate, with committee reports due by April 1 of years in which a proposal is made. Congress cannot consider any amendment to the proposal that does not achieve the cost-reduction requirements unless both houses vote to waive this provision, with the Senate voting by a three-fifths majority. Congress may also adopt a joint resolution to abolish the Board, but must do so by a three-fifths vote of the Senate and not later than August 15, 2017. The statute recognizes, however, that Congress has the constitutional power to change its rules to remove the three-fifths majority requirement. If Congress fails to adopt a substitute provision complying with the statute by August 15, HHS must implement the Board’s proposal. No judicial review is permitted of an HHS decision to implement the

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Board's recommendations, which raises the question as to how the IPAB's compliance with the statutory requirements will be ensured.

The PPACA appropriates \$15 million for the IPAB for 2012, increased by inflation for subsequent years. Funding will come from the Part A and B Trust Funds. This standing appropriation may relieve some of the political pressure on the IPAB, but it may well prove too little to fund the complex research and data analysis that IPAB must do. IPAB must design implementation-ready proposals, a formidable task for even a generously-staffed agency.

The Congressional Budget Office discussed the IPAB at some length in its December 19, 2009 report on the PPACA Manager's Amendment. The CBO concluded that the IPAB would reduce Medicare spending by \$28 billion over the 2010 to 2019 period, with most of the savings coming at the end of the period, and with significant savings continuing beyond 2019.⁴ On December 20, the CBO issued a correction noting that it had misunderstood the formula that the IPAB would apply after 2019, and that savings after 2019 would be lower. Still, it noted, this would reduce the annual growth rate of Medicare to 6 percent per year as compared to average increases of 8 percent over the past two decades.⁵

In his report of April 22, 2010, the CMS Actuary noted that the IPAB target growth rates would only have been met in 4 of the last 25 years, and approximated the target growth rate in the SGR formula, which Congress routinely overrides.⁶ On the other hand, the Chief Actuary estimated that after 2019 further IPAB cuts would not be required if the other cuts in the bill were left in place. The Chief Actuary expressed concern, however, that if the cuts remained in place, Part A providers would have a difficult time remaining profitable and might leave the program.

Many questions remain going forward as to how, and indeed whether, the IPAB will work. Staffing the IPAB with 15 leading experts who are willing to give up research, practice, and teaching for six years for a relatively modest salary will be a challenge. On the other hand, the opportunity to really make a difference in the health care system may well attract talented individuals to these positions. The relationship between the IPAB and other boards and commissions, such as the Innovation Center, will need to be worked out. Although multiple entities pursuing the same tasks could stumble over each other, there are also real opportunities for synergy. In particular, the IPAD and the Innovation Center could perhaps coordinate research and use of staff resources.

The three biggest questions raised by the legislation are what kind of cuts the IPAB will recommend; whether Congress will in fact let the IPAB proposals go into effect; and how, if it does, cutting provider payments will affect Medicare if private payments continue to grow unabated.

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The legislative requirement that IPAB submit annual proposals would seem to encourage recommendations for short-term payment fixes rather than long term changes that might in fact “bend the curve.” If the IPAB is to be truly effective, it must consider not just changes in provider payments, but also changes in how providers are paid, or perhaps even in consumer incentives. It must come up with recommendations that actually increase efficiency and productivity, most likely by moving away from fee-for-service payments and toward increased bundling of payments involving multiple providers and services. The IPAB must pursue a long-term strategy for cost reduction as well as proposing year to year cuts.

IPAB’s success will also depend on how Congress reacts to its recommendations. The sustainable growth rate physician payment update formula, which Congress evades every year through special legislation, is frequently raised as proof that Congress cannot cut Medicare costs. On the other hand, the SGR story is not necessarily representative. Paul van de Water and Jim Horney note that the vast majority of the Medicare savings provisions in the 1990, 1993, 1997, and 2005 budget reconciliation acts were left in place.⁷

How Congress will react to the IPAB recommendations is difficult to predict. IPAB may make cuts targeted at particular regions or providers that Congress would have been lobbied heavily to protect. Given the tight timeframe under which Congress must react to IPAB recommendations, it may be difficult for Congress to come up with substitute legislation. Congress might attempt to increase Medicare expenditures through unrelated legislation. This would simply increase the Medicare growth rate for succeeding years. On the other hand, rising pressure from the deficit may drive Congress to simply let IPAB proposals go into effect.

The other major issue confronting the IPAB is whether it is possible to cut Medicare provider payments as long as private payer rates remain unconstrained. There is already a sizeable gap between Medicare and private payer payments in most markets. If this gap continues to grow, providers who are may well abandon Medicare participation. This will in turn result in access and perhaps quality problems for beneficiaries. The IPAB has, of course, authority to make recommendations to Congress regarding private sector payments. Increased provider concentration has made it very difficult for private payers to control costs in many markets. In the long run Congress may have to consider all-payer rate setting to preserve provider participation in Medicare.

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¹ Pub. L. 111-148, § 3403

² Pub. L. 111-148, § 3021

³ See Office of Personnel Management, Salary Table No. 2010-Ex, available at <http://www.opm.gov/oca/10tables/pdf/ex.pdf>

⁴ CBO, Letter to Harry Reid (Dec. 19, 2009).

⁵ CBO, Letter to Harry Reid (Dec. 20, 2009), available at .

http://www.cbo.gov/ftpdocs/108xx/doc10870/12-20-Reid_Letter_Managers_Correction1.pdf

⁶ Report of Richard S.Foster, CMS Chief Actuary, Financial Effects of the “Patient Protection and Affordable Care Act as Amended (April 22, 2010).

⁷ James R. Horney and Paul N. Van de Water, House-Passed and Senate Bills Reduce Deficit, Slow Health Care Costs, and Include Realistic Medicare Savings (Dec. 4, 2009), available at <http://www.cbpp.org/files/12-4-09health.pdf>