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Repealing and Replacing IPAB with Better Solutions

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The Independent Payment Advisory Board (IPAB) was created by Congress as part of the Patient Protection and Affordable Care Act (PPACA) as a means of containing Medicare spending. The IPAB was designed to take difficult decisions about Medicare payment reductions out of the legislative process and delegate them to a panel of independent experts. These 15 experts, to be appointed by the president and confirmed by the Senate, will have the authority to make binding recommendations to make cuts in Medicare payments if per capita spending exceeds defined targeted rates.¹ The board's recommendations will be sent to Congress at the beginning of each year for fast-track consideration.

PPACA gives the Congress a route to override the IPAB's recommendations, but it raises the bar on the legislative processes in a way that will make it difficult for Congress to intercede. Congress can override or amend the board's recommendations only with a supermajority vote in both houses, and it has a limited time period to pass legislation with alternative cuts that would meet the spending targets. If Congress does not act in the required timeframe, the secretary of Health and Human Services is required to implement cuts to reach the targets.

Clearly, the IPAB is unprecedented in the power given to unelected officials to direct hundreds of billions of dollars in federal spending. The IPAB will give unelected, unaccountable government appointees the

power to make decisions about payment policy in Medicare that will ultimately determine whether millions of seniors have access to the care they need.

A powerful board whose hands are tied

While the IPAB has unprecedented power, allocation of the tools available to the board reveals a fundamental conflict in American health policy: It simultaneously is given broad authority over Medicare payment policy, but its hands are tied in what it can do to reach the mandatory budgetary targets.

The board cannot make recommendations to improve how Medicare operates. The only thing it can do is cut Medicare payment rates for those providing services to beneficiaries. Basically the board will be limited to using as its basis Medicare's existing system of price controls and making further cuts in order to reach its targets.

The government approach to holding down Medicare spending traditionally defaults to making deeper and deeper reductions in payment rates to providers for medical goods and services rather than implementing reforms which reward innovation and which could lead to more efficient, more effective, and better-coordinated care delivery. The legislation is true to form.

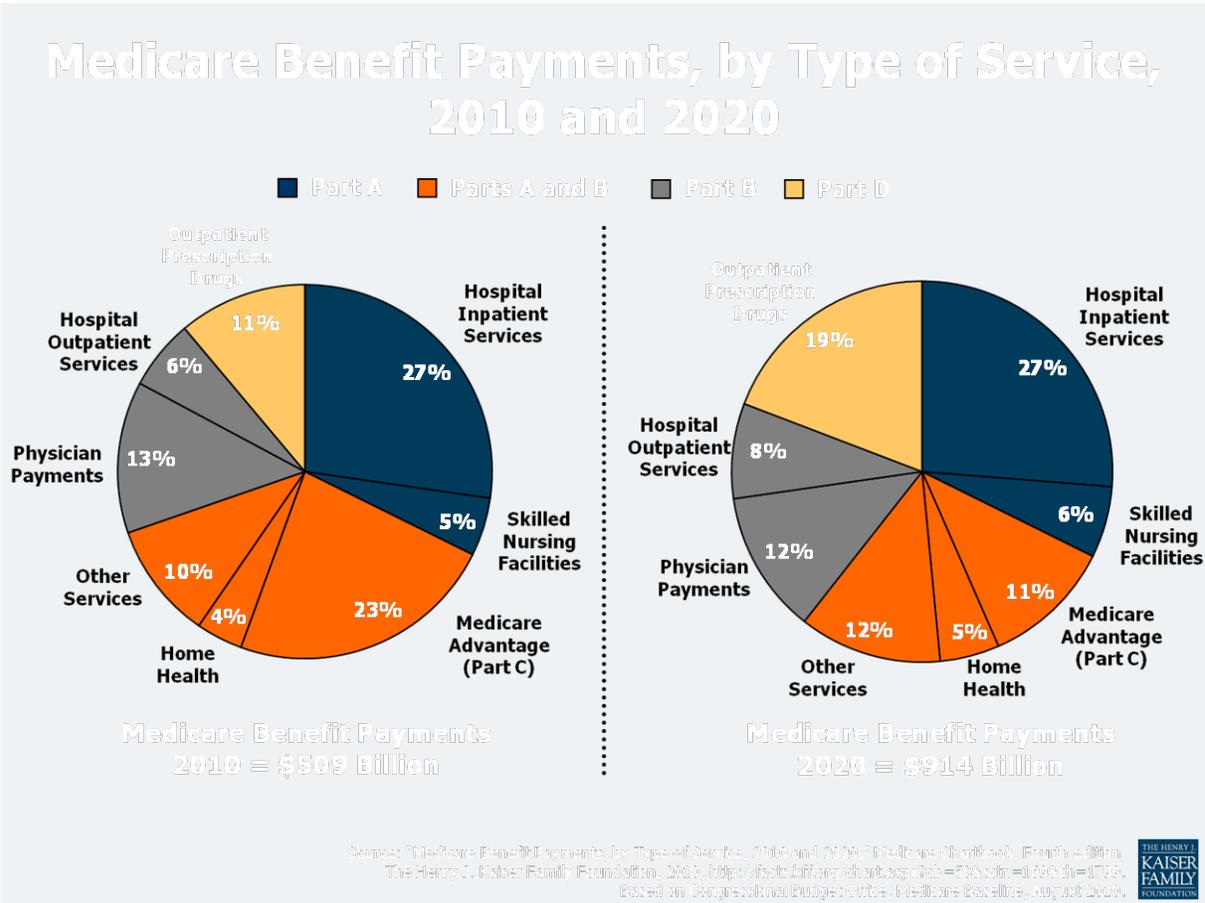
The IPAB is barred from making changes that would alter beneficiary premiums or cost-sharing for covered services, restrict benefits, or otherwise modernize the

program’s outdated fee-for-service structure. It cannot alter eligibility, increase taxes, or make any changes that would result in rationing, according to the statute. (The board’s payment decisions, however, will inevitably result in *de facto* rationing by cutting payments and therefore access to certain benefits.)

The board also is prohibited from recommending changes that would reduce payments to certain providers before 2020, especially hospitals (which are subject to a different set of constraints). Because of limitations written into the law, reductions achieved by the IPAB between 2013 and 2020 are likely to be limited primarily to Medicare Advantage (MA), the Part D prescription drug program, and skilled nursing facility services. That means that reductions in overall Medicare spending will have to come from segments that together represent a fraction of overall

Medicare spending. Skilled nursing care represents 5% of Medicare expenditures; prescription drugs, 11%; and Medicare Advantage, 23% — a share that shrinks to 11% by the year 2020, according to CBO data.²

Limits in payments under Medicare Advantage and Part D are explicitly within the scope of the IPAB’s authority. According to a Kaiser Family Foundation analysis, it would appear that the board could set Medicare Advantage payments at or below spending in the traditional Medicare fee for service (FFS) program, and build on provisions in PPACA that set MA payments below FFS payments in some communities. With respect to prescription drugs, it would appear that the IPAB could recommend that Part D plans receive rebates from prescription drug manufacturers in the same manner as state Medicaid programs. It is not clear whether the board could go



further — for example, whether the IPAB could recommend lower payment amounts for prescription drugs covered under Medicare Part B, or whether the board could establish a new Medicare-operated Part D plan to compete with private drug plans.³

One thing is clear: If the board is forced to reduce overall Medicare spending by focusing only on these relatively small segments of Medicare spending, the cuts would have to be very deep to achieve overall per capita spending reductions.

Medicare actuaries' warning

Even before the IPAB's cuts begin, steep Medicare payment reductions already are on track for providers because of 1997 legislation that reduces payments under "sustainable growth rate" (SGR) formulas and additional payment reductions called for in PPACA. The Medicare actuary's office recently released its updated alternative scenario⁴, reiterating its projection from last year that the "productivity adjustments" could cause approximately 40 percent of providers to become unprofitable by 2050. The actuaries also find that "the large reductions in Medicare payments rates to physicians would likely have serious implications for beneficiary access to care."

Seniors in many regions already are having difficulty finding physicians to see them. If the spending reductions in the law today were to take place, most seniors would face long waits for appointments and treatments, and many would be forced to wait in line in over-crowded emergency rooms to get care, just as Medicaid patients do throughout the country today.

Are seniors prepared for this?

Opposition grows

Opposition to IPAB is taking a rare bipartisan tone in the otherwise politically polarized health reform debate.

U.S. Rep. Allyson Schwartz (D-PA) and six other Democrats in Congress are supporting legislation that would repeal the board, and other members have suggested privately that they would support the bill if it comes to the House floor.

In a letter to her colleagues, Rep. Schwartz expressed concerns about turning so much power over to a board that will have little or no accountability to seniors impacted by its decisions. "[C]ongress is a representative body and must assume responsibility for legislating sound health care policy for Medicare beneficiaries," she wrote. "Abdicating this responsibility would undermine our ability to represent the needs of the seniors and disabled in our communities."

Representative Phil Roe introduced H.R. 452 in the 112th Congress, the Medicare Decisions Accountability Act of 2011, and Senator John Cornyn (R-TX) introduced S. 668, the Health Care Bureaucrats Elimination Act, both of which would repeal the board. The House Republican budget resolution for Fiscal Year 2012 proposed by Congressman Paul Ryan (R-WI), chair of the House Committee on the Budget, would also eliminate the IPAB. Several groups, including the pharmaceutical industry, the hospital industry, physician groups, and others, have indicated their opposition to the IPAB.

But not all are opposed.

Maya McGuinness, head of the Committee for a Responsible Federal Budget, says: "Outsourcing some of the harder policy decisions is the best chance we have" to contain the growth of Medicare spending.

Henry J. Aaron, Ph.D., of The Brookings Institution, wrote in *The New England Journal of Medicine*⁵ that: "Among the most important attributes of legislative statesmanship is self-abnegation — the willingness of legislators to abstain from

meddling in matters they are poorly equipped to manage,” he writes. “In establishing the Independent Payment Advisory Board (IPAB) in section 3403 of the Affordable Care Act (ACA), Congress may once again have shown such statesmanship.”

He acknowledges that the board is limited in the tools it has to reduce spending and even in the sectors of the health industry where it can cut. Aaron and others conclude that means that for this decade, all of the spending cuts will have to come from “private Medicare Advantage plans, Medicare’s Part D prescription-drug program, or spending on skilled-nursing facilities, home-based health care, dialysis, durable medical equipment, ambulance services, and services of ambulatory surgical centers.”

Rep. Pete Stark (D-CA), a strong supporter of PPACA, is a strong opponent of the IPAB and called the board “an unprecedented abrogation of congressional authority to an unelected, unaccountable body.”

The Arizona-based Goldwater Institute has filed suit to challenge the IPAB.

“No possible reading of the Constitution supports the idea of an unelected, standalone federal board that’s untouchable by both Congress and the courts,” Clint Bolick, the institute’s litigation director, said.⁶

Former Sens. John Breaux and Bill Frist wrote just before PPACA was enacted: “[IPAB’s] structure ... raises serious constitutional and process questions ... For all intents and purposes, the board would have the power to influence and rewrite nearly all aspects of Medicare.”⁷

Former White House Budget Director Peter Orszag said that if the IPAB realizes its potential to push Medicare toward paying

for better quality care, as opposed to paying for more care, “it could well turn out to be perhaps the most important component of the new legislation.”⁸

Doubling down on IPAB

The president wants to double-down on IPAB’s powers, giving the board authority to cut payments to doctors even more deeply than called for in the PPACA and giving it the power to “sequester” congressional appropriations. It is far from clear where the constitutional authority is for a board of appointees housed in the Executive Branch to usurp the power of Congress. There would surely be additional legal challenges should the president’s latest recommendation make it into law.

In his deficit-reduction speech in April of 2011, President Obama said he wants to give new powers to IPAB appointees, proposing they be directed to limit Medicare cost growth per beneficiary to GDP growth per capita plus 0.5 percent beginning in 2018. The IPAB’s targeted cuts are one percent above GDP growth under PPACA. The president also proposed giving the board new powers to *sequester* congressionally authorized funds if Congress were to overrule the board’s decisions.

The White House says that the president’s new plan will mean Medicare payments will be lowered by \$340 billion over ten years and \$480 billion by 2023. According to a House Budget Committee staffer, the president’s latest IPAB goals would lead to benefit cuts of \$9,600 for seniors over the coming decade.

White House Deputy Chief of Staff Nancy-Ann DeParle tried to take the offense in a blog, saying, “The President’s framework instead builds on the improvements made by the Affordable Care Act.”⁹

Among those “improvements” include taking \$575 billion¹⁰ out of Medicare to create two new entitlement programs and creating the IPAB to cut payments to Medicare providers — changes that surely will affect today’s seniors in the near future.

Meanwhile, the president is criticizing the Republican plan that would put Medicare on a sustainable path and give tomorrow’s seniors a choice of private competing plans that would provide them with access to care.

Repeal is the best solution

As documented above, there is growing bi-partisan support for putting responsibility for Medicare payments back in the hands of Congress where it belongs.

While there is widespread agreement that we must reduce the growth rate of Medicare spending, opposition to the IPAB as a vehicle to accomplish this crosses party lines. The strongest concerns involve the power given to the board’s unelected officials and the detrimental effect that ratcheting down payments could have on innovation and in limiting access to physicians, medicines, and other treatments.¹¹

It is possible that the House will pass a bill to repeal IPAB, even as it already has voted to repeal all of the PPACA. It is less likely that the Senate would take up the measure, but it is possible there, as well, that a repeal vote could gain bi-partisan support for passage. There is less likelihood that President Obama would sign any legislation repealing IPAB, especially since he has doubled-down on the board’s powers to finance PPACA and reduce the overall deficit. Even then, there is some discussion of attaching IPAB repeal to a must-sign bill, such as legislation increasing the federal debt ceiling.

What is needed is a plan that will achieve the goal of moderating Medicare spending

but does it in a way that is not destructive to patient access to care and to quality and innovation. In any discussion, it will be important to keep in mind that the Congressional Budget Office has estimated the IPAB would save \$15.5 billion between 2015 and 2019.

A number of alternate solutions are being discussed in the policy community to limit the IPAB’s authority or otherwise redirect its responsibilities. A few examples:

Widen the baseline

The legislation instructs the IPAB to focus primarily on a narrow range of Medicare spending involving Parts C and D — prescription drugs and Medicare Advantage plans, as discussed earlier. It will be extremely difficult to reach per capita spending growth targets by cutting payments only in these narrow categories.

IPAB could be given authority to consider overall Medicare spending, not just restrictions on pharmaceutical reimbursement and Medicare Advantage, in achieving its spending targets. That would mean including the full range of Medicare spending in the baseline calculations.

Break down the silos

The board could be required to evaluate the impact of its directives on overall spending, on access to care, and on innovation. It also should consider the impact of its decisions on the rate of hospitalizations, life expectancy, quality of care, and access to innovative treatments.

Demonstration projects

The IPAB could be given the authority to conduct demonstration projects to move away from Medicare’s outdated fee-for-service system and show the value of an integrated, coordinated care model. The Florida Healthy States

program, involving case management of high-risk Medicaid patients, could be replicated for Medicare patients. Programs that facilitate adherence to treatment recommendations, including medications, have been shown to reduce hospitalizations and decrease overall health care costs, with the largest savings gained from the newest medicines. It is essential to consider overall health spending in showing the value of investments in innovative treatments and care management.

Medical liability reform

Congress could tie IPAB to a serious effort to reform the medical liability system. There is considerable concern throughout the policy community about the huge amount of money spent on defensive medicine. One colleague suggested we first need a good baseline study so we know how much defensive medicine is costing the country — and Medicare in particular. If the medical liability system were reformed to reduce these expenditures, these savings could be applied to the savings that were projected from IPAB. This could lead to giving the IPAB a new mission: to monitor the cost of defensive medicine and to recommend ways to reduce unnecessary spending in Medicare.

Limit IPAB's powers

As reported, Congress is very concerned about the powers given to IPAB and the restrictions in PPACA on Congress' own authority to alter the board's decisions. Legislation is needed that will give Congress more power over IPAB's recommendations, particularly in assuring that the board does not focus on cost reductions at the expense of patient care.

Local quality control projects

Health policy analyst David Kendall of the Third Way wrote in a recent article¹² for *DemocracyJournal.org* that “A

better way to approach cost control is local action to improve quality.” He strongly supports broader use of best practices employed by the Mayo Clinic and Intermountain Health. But he acknowledges, “It is not yet clear how to bring such quality improvement to scale given a diverse population and a fragmented delivery system. But edicts from Washington to improve quality won't work. It has to come from local physician leadership with the support of the patients, insurers, employers, and taxpayers.” He suggested one place to start would be for the Center for Medicare and Medicaid Innovation to “organize regional collaborations among public and private payers to pay for the quality of care instead of the quantity of care.”

Long term modernization

There is agreement among policy experts on the right and the left that a premium support model for Medicare is the best way to modernize the program and achieve cost savings in the future. This is clearly a longer-term solution and one that will continue to be part of any conversation to modernize Medicare.

In any case, a serious conversation would need to begin by laying down some predicates for cost control. What can we do now and what do we need to start planning for the future? The goal needs to be to focus on payment and delivery system reforms rather than payment cuts that will lead to restricted access — the tools that current laws give to the IPAB.

Part D and the future

There is a better way. We have a working model in the popular Medicare Part D program, in which private companies compete to offer prescription drug benefits to seniors.

Created in 2003, Part D provides a range of choices and a subsidy to allow seniors to select the drug plan that best suits their needs. The plans compete on benefit design and price.

The 2011 CBO Medicare Part D baseline forecasts and actual recorded spending show costs for Part D benefit payments have declined by 46% for the 2004 to 2013 period compared with initial estimates of the 10-year cost projections for those years.¹³

And Part D's competitive model is saving seniors money as well. The average monthly beneficiary premium for Part D coverage will be \$30 in 2011, far below the \$53 forecast originally, and an increase of only \$1 over the 2010 average premium of \$29.¹⁴

Recently released polls show that Medicare Part D enrollees are overwhelmingly satisfied with their Part D coverage. Eighty-four percent of Part D enrollees are satisfied with their coverage, and 95 percent say their coverage works well. Additionally, vulnerable beneficiaries who are dually eligible for both Medicaid and Medicare exhibited the highest satisfaction.¹⁵

Looking beyond IPAB

House Budget Chairman Ryan has provided a comprehensive plan that builds on the Part D model for Medicare. The key to Ryan's plan is premium support, which provides seniors with an annual subsidy to purchase a Medicare-approved health plan. The Ryan plan, when it begins in the year 2022, would provide an age-adjusted payment so that seniors can pick the health plan to meet their needs. The older they are, the bigger the payment they would get. Premium support allows for flexible subsidies that can be adjusted and targeted to seniors based on their age, financial well-being, health status, and similar considerations.

Spending on Medicare and other entitlement programs must be contained. To survive,

Medicare must be changed, and the question is whether it will be under IPAB and the rationing built into the president's health care law, or through Rep. Ryan's plan that enables enrollees to apply the government's contribution to guaranteed health coverage while bringing the power of market competition to reduce health costs.

Ryan's plan takes a bottom-up approach, cultivating individual choice, forcing providers to compete to offer seniors the best value in health care, and providing a path to sustainability for Medicare. The president takes a top-down approach that puts a small number of independent experts in charge of decisions that will impact tens of millions of seniors and progressively limit their access to care. It is a clear choice.

Shifting the focus

The Constitution gives the power of the purse to Congress so that elected representatives can be accountable to the voters for their decisions. The IPAB would turn this principle upside down. The IPAB is at the center of the conflict between two world views. Do we entrust individuals with the decisions for their own care? Or do we entrust those decisions to a government-appointed panel of experts in Washington who will have authority over hundreds of billions of dollars in Medicare spending?

Congress could instead focus its attentions on providing better, more efficient care to the nearly nine million people, representing one in five Medicare beneficiaries, who are eligible for services through both Medicare and Medicaid — often called “dual eligibles.”¹⁶ They are the poorest and often the sickest beneficiaries, many of whom have multiple acute illnesses and long-term care needs.

They consume about 25 percent of Medicare's spending and nearly half of Medicaid's — more than \$250 billion in 2008. Yet 95 percent of them are stuck in an

antiquated 1960's fee-for-service payment model and are bounced back and forth between the two programs. Many patients get lost in a crevice between Medicare and Medicaid where no one is overseeing their total care, leading to gaps, duplication, and poor outcomes.

The focus should be on providing tools and solutions for these patients to receive better-coordinated care by contracting with care management plans, a strategy to save money and make these programs work better for vulnerable seniors. Providing them with truly integrated care could significantly improve their lives and also help reduce health costs by providing timely, appropriate, managed treatment.

There are better solutions than relying on the Independent Payment Advisory Board.

Conclusion

The more people learn about the IPAB, the more they will insist that it be repealed and replaced with better solutions.

Health economist Alain Enthoven summed it up in a recent *Wall Street Journal* commentary:¹⁷

The 2010 health-care reform's Independent Payment Advisory Board is unlikely to be effective. Appointed by the president, 15 experts with no financial ties to the health-care industry are supposed to dream up cost-cutting ideas that would go into effect unless overridden by a supermajority in Congress. But the reality is that most waste identification and cutting is local. These 15 central planners are unlikely to do as good a job as hundreds of doctors and managers in local delivery systems working with incentives to improve value for money for their enrolled members.

Prof. Enthoven is correct. The IPAB will fail, and we must begin now with solutions that will work to make Medicare sustainable for the future.

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