ANNALS OF HEALTH LAW
Advance Directive

VOLUME 20 SPRING 2011 PAGES 124-133

The Independent Payment Advisory Board: Will it Effectively Curb the Medicare Growth Rate?

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I. INTRODUCTION

The Medicare program is growing at an explosive rate. Today, Medicare provides access to vital healthcare services for forty-seven million disabled and elderly Americans.[1] By 2030, due to an aging population and increasing life expectancies, this number is expected to reach eighty million.[2] Because of this dramatic increase in Medicare enrollees—together with new technologies and increased use, volume, and prices of healthcare services—total Medicare spending is expected to rise from its current rate of $519 billion annually to $929 billion annually by 2020.[3]

The Patient Protection and Affordable Care Act (PPACA) addresses the widespread concerns over these rising healthcare costs and the growing federal budget deficit[4] through its numerous measures designed to curb the growth rate of Medicare spending.[5] Some of these measures include a tax on "Cadillac" insurance plans, increased coordination of care through the establishment of medical homes and accountable care

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1. KAISER FAMILY FOUND., MEDICARE SPENDING AND FINANCING 1 (Aug. 2010), http://www.kff.org/medicare/ upload/7305-05.pdf [hereinafter MEDICARE SPENDING AND FINANCING].

2. *Id.* at 2.

3. *Id.* at 1–2. Notably, this increase reflects the savings in Medicare spending enacted by PPACA. *Id.* at 2.

4. KAISER FAMILY FOUND., EXPLAINING HEALTH REFORM: MEDICARE AND THE NEW INDEPENDENT PAYMENT ADVISORY BOARD 2 (May 2010), http://www.kff.org/healthreform/upload/7961-02.pdf [hereinafter EXPLAINING HEALTH REFORM]. A consideration of the national deficit is appropriate for a discussion about Medicare, because, in 2010, Medicare comprised twelve percent of the entire federal budget. MEDICARE SPENDING AND FINANCING, *supra* note 1, at 1.

5. Peter R. Orszag & Ezekiel J. Emanuel, *Health Care Reform and Cost Control*, 363 NEW ENG. J. MED. PERSP. 601, 601–02 (2010).

organizations (ACOs), and the creation of institutions such as the Patient-Centered Outcomes Research Institute (PCORI)[6] and the Innovation Center in the Centers for Medicare and Medicaid Services (Innovation Center).[7]

Perhaps the most important—and most controversial[8]—institutional creation for curbing Medicare cost growth, however, is the Independent Payment Advisory Board (IPAB),[9] established by Section 3403 of PPACA.[10] The IPAB will be a fifteen-member panel of medical experts, independent from Congress, charged with the difficult task of developing and proposing modifications to the payment system under Medicare in order to curb spending.[11] This Article discusses the multiple challenges that the IPAB faces in this task, which it must overcome in order to produce desired savings in the Medicare program. The Article begins with a discussion of the purpose, structure, and authority of the IPAB. Then, it analyzes varying opinions about whether the IPAB will be able to ultimately achieve its goal.

II. THE PURPOSE, STRUCTURE, AND AUTHORITY OF THE IPAB

The purpose of the IPAB, according to the PPACA statute, is to "reduce the per capita rate of growth in Medicare spending."[12] To do this, the legislation establishes strict target growth rates for Medicare spending and sets forth a process for the IPAB to keep rates within these limits[13]—the first mandated spending limits the Medicare program has ever seen.[14] In addition to submitting proposals to curb Medicare spending, the IPAB is also tasked with the more minor roles of submitting annual reports to Congress regarding

6. PCORI will assess new medical tests, drugs, and other treatments as they are developed, thereby providing continuously updated information for physicians and patients. *Id.* at 602–03.

7. *Id.* at 603.

8. AM. MED. ASS'N, INDEPENDENT PAYMENT ADVISORY BOARD 1, http://www.amaassn.org/ama1/pub/upload/mm/ 399/hsr-payment-advisory-board.pdf (last visited Feb. 19, 2011).

9. Orszag & Emanuel, *supra* note 5, at 603.

10. Patient Protection and Affordable Care Act (PPACA) § 3403, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 42 U.S.C.). The original name of the IPAB was the Independent *Medicare* Advisory Board, but this was later changed to the current name of the Independent *Payment* Advisory Board in the Health Care and Education Reconciliation Act of 2010 § 10320(b), Pub. L. No. 111-152, 124 Stat. 1029.

11. Orszag & Emanuel, *supra* note 5, at 603; James C. Capretta, *The Independent Payment Advisory Board and Health Care Price Controls*, KAISER HEALTH NEWS (May 6, 2010), http://www.kaiserhealthnews.org/Columns/ 2010/May/ 050610Capretta.aspx.

12. PPACA § 3403(b).

13. Timothy Stoltzfus Jost, *The Independent Payment Advisory Board*, 363 NEW ENG. J. MED. PERSP. 103, 103 (2010).

14. EXPLAINING HEALTH REFORM, *supra* note 4, at 1.

issues of cost, access, quality, and utilization of healthcare services for private payers and Medicare, as well as submitting non-binding recommendations to curb the growth of private national health care spending.[15]

The fifteen members of IPAB will be nationally recognized experts in the fields of health facility and health plan management, actuarial science, and health finance and payment. Three of the members will be officials from the Department of Health and Human Services (HHS).[16] Members will be appointed by the President and confirmed by the Senate for six-year terms, and will work for the IPAB full-time with an annual salary of approximately $165,000.00.[17] In addition to the fifteen-member board, PPACA also provides for a ten-member consumer advisory council.[18] The IPAB's independence from Congress is a key component of its structure.[19] As an independent panel of healthcare experts, the IPAB can make more knowledgeable determinations than Congress about the healthcare industry, and can ideally mitigate the influence of politics and special interests on Medicare payment decisions.[20]

Before the IPAB is required to submit a proposal to reduce Medicare spending, the Office of the Actuary (OACT) must first determine whether Medicare spending growth rates will exceed target levels in a given year.[21] Prior to 2018, these target levels will be based on a combination of general inflation and medical inflation.[22] In 2018 and thereafter, the target levels will be based on the rate of general inflation plus one percentage point.[23] If OACT projects that Medicare growth rates will exceed target levels in a given year, then the IPAB must submit proposals to reduce Medicare spending

15. *Id.* at 2; Jost, *supra* note 13, at 104.

16. Jost, *supra* note 13, at 104. For more information about the process for appointment and confirmation of IPAB members, as well as additional qualifications and requirements of members, see AM. MED. ASS'N, *supra* note 8, at 2–3.

17. EXPLAINING HEALTH REFORM, *supra* note 4, at 1; Jost, *supra* note 13, at 104.

18. EXPLAINING HEALTH REFORM, *supra* note 4, at 1.

19. *Id.* at 2. According to the Kaiser Family Foundation, this is the first time Congress has ceded authority of parts of the Medicare program since the program started in 1965. *Id.*

20. EXPLAINING HEALTH REFORM, *supra* note 4, at 2; Jost, *supra* note 13, at 103.

21. Jost, *supra* note 13, at 104; Orszag & Emanuel, *supra* note 5, at 603. To determine whether spending will exceed target levels, OACT will determine "whether the projected average Medicare growth rate for the 5-year period ending 2 years later will exceed the target growth rate for the year ending that period." Jost, *supra* note 13, at 104. OACT will first report on this determination on April 30, 2013. EXPLAINING HEALTH REFORM, *supra* note 4, at 4. For an excellent breakdown of this and every other key implementation date for the IPAB, see *id.*

22. Orszag & Emanuel, *supra* note 5, at 603. To be exact, these target levels will be "the projected 5-year average of the mean of the Consumer Price Index (CPI) and the medical care CPI . . . ." Jost, *supra* note 13, at 104.

by the lesser of the percentage set in the statute or the amount by which spending will exceed the target.[24]

On September 1 of each year, the IPAB must submit a draft of its proposal to the Secretary of HHS.[25] Then, on January 15 (beginning in 2014), the IPAB must submit its final proposal to Congress.[26] Once Congress receives the proposal, it must review it under an expedited procedure.[27] Congress cannot consider any amendments that do not achieve the same level of cost savings, unless this requirement is waived by a vote from both houses of Congress and three-fifths of the Senate.[28] Unless Congress adopts an alternative to the proposal that will produce equally effective cost savings, or the President vetoes the Congressional proposal and that veto is not overridden, the Secretary of HHS must implement the IPAB's proposals by August 15 of that year.[29] Significantly, the Secretary's implementation of the proposals is not subject to judicial or administrative review.[30]

Yet, the IPAB does have some significant limitations on the scope of its proposals. Namely, the IPAB cannot submit any proposals that would ration care, modify Medicare eligibility criteria, raise costs to beneficiaries, change cost-sharing for covered services, or restrict benefits in any way.[31] Prior to 2020, the IPAB's proposals cannot include recommendations for changes to rates for hospitals and hospices, which are already receiving a reduction in their payments in other provisions of PPACA.[32] There are no restrictions, however, on the IPAB's ability to cut Medicare payment rates for physicians.[33]

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23. Jost, *supra* note 13, at 104; Orszag & Emanuel, *supra* note 5, at 603; Capretta, *supra* note 11.

24. EXPLAINING HEALTH REFORM, *supra* note 4, at 2; Jost, *supra* note 13, at 104. A reduction by the percent set in the statute means the "total projected Medicare spending for the year multiplied by 0.5 percent in 2015, 1.0 percent in 2016, 1.25 percent in 2017, and 1.5 percent in 2018 and future years." EXPLAINING HEALTH REFORM, *supra* note 4, at 2.

25. Jost, *supra* note 13, at 104.

26. *Id.* at 104. If IPAB fails to submit a proposal to Congress on time, then the Secretary of HHS must submit a proposal that will achieve the same level of spending reductions. *Id.*; *see also* EXPLAINING HEALTH REFORM, *supra* note 4, at 1.

27. Jost, *supra* note 13, at 104.

28. *Id.*

29. EXPLAINING HEALTH REFORM, *supra* note 4, at 1; Jost, *supra* note 13, at 104; Orszag & Emanuel, *supra* note 5, at 603.

30. EXPLAINING HEALTH REFORM, *supra* note 4, at 1.

31. *Id.*; Jost, *supra* note 13, at 104; Capretta, *supra* note 11.

32. EXPLAINING HEALTH REFORM, *supra* note 4, at 1; Jost, *supra* note 13, at 104.

33. Jost, *supra* note 13, at 104. The IPAB's ability to make payment cuts for physicians may be limited, however, "if a permanent fix for the sustainable growth rate—the formula that determines increases or

The IPAB has several similarities to the Center for Medicare and Medicaid Services' Innovation Center and the Medicare Payment Advisory Commission (MedPAC), but both of these programs can be distinguished from IPAB.[34] First, the Innovation Center, which was established by PPACA, will be evaluating Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), and will test and expand various payment structures to reduce expenditures and increase quality in all of these programs.[35] The Innovation Center will not have the same independent authority of the IPAB, however. Second, MedPAC, which was in place before PPACA's enactment, prepares recommendations for Congress on many aspects of the Medicare program, and it will continue in this advisory role for Congress after the IPAB's establishment.[36] MedPAC differs from the IPAB in that it does not have budget targets or decision-making authority, and Congress is not bound by its recommendations.[37] As the IPAB and other PPACA programs are implemented, the relationships between these boards will need to be navigated carefully so that they can complement rather than duplicate each other's work.[38]

III. ANALYSIS: CAN THE IPAB CURB MEDICARE SPENDING?

With this overview of the purpose, structure, and authority of the IPAB in mind, this section turns to an analysis of the varying perspectives on whether the IPAB will be able to achieve its intended purpose. Proponents of the IPAB claim that it will be able to slow the growth rate of Medicare spending while protecting beneficiaries through the prohibition on reducing benefits and rationing care.[39] Peter Orszag, former Director of the White House Office of Management and Budget, claims that the IPAB (along with other PPACA reforms) will be able to stem the long-term growth in Medicare costs because its flexible structure is able to institute policies for cost savings in real time, rather than through a rigid bureaucratic structure.[40] It is possible that the IPAB could

decreases in Medicare's physician payments—is passed." *Id.*

34. *Id.* at 104–05.

35. KAISER FAMILY FOUND., SUMMARY OF NEW HEALTH REFORM LAW 8 (Mar. 2010), http://www.kff.org/healthreform/upload/8061.pdf; Orszag & Emanuel, *supra* note 5, at 603.

36. EXPLAINING HEALTH REFORM, *supra* note 4, at 1.

37. *Id.*; *see also* DAVID NEWMAN & CHRISTOPHER M. DAVIS, CONG. RESEARCH SERV., R41511, THE INDEPENDENT PAYMENT ADVISORY BOARD 30 (2010) (comparing and contrasting IPAB and MedPAC).

38. Jost, *supra* note 13, at 104–05. For instance, the IPAB and the Innovation Center could share some staff members. *Id.* at 105.

39. EXPLAINING HEALTH REFORM, *supra* note 4, at 3.

40. Orszag & Emanuel, *supra* note 5, at 601.

produce tremendous cost savings, assuming that Medicare spending growth rates exceed target levels each year, thereby triggering the IPAB proposal process.[41] The Congressional Budget Office (CBO) estimates that the IPAB could reduce Medicare spending by as much as $28 billion from 2015–2019[42] and would continue to produce savings thereafter.[43] OACT estimates that the IPAB could achieve up to $24 billion in Medicare savings from 2015–2019.[44]

It is questionable whether this level of savings is realistic, however.[45] Notably, the target growth rates delineated in PPACA were only met in four of the past twenty-five years.[46] In those years, the IPAB target growth rate would have been approximately the same as the Medicare sustainable growth rate, which legislators have frequently overridden in the past.[47] In the future, when changes to Medicare policy produce higher spending, the IPAB will need to make even larger spending reduction proposals to achieve target rates, which is certainly a formidable task.[48] Moreover, in order to achieve long-term spending solutions, the IPAB will need to do more than propose reductions in provider payments, but may also need to propose changes to Medicare payment methods.[49]

Additional challenges facing the IPAB may also prevent it from achieving optimal cost savings in the Medicare program. For instance, it will likely be difficult to staff the IPAB with fifteen nationally recognized experts who are willing to leave their current positions for six years in exchange for a fairly modest salary.[50] The success of the program will

41. EXPLAINING HEALTH REFORM, *supra* note 4, at 2.

42. Jost, *supra* note 13, at 104. *But see* EXPLAINING HEALTH REFORM, *supra* note 4, at 2 (citing a CBO report that estimated Medicare savings from the IPAB of only $15.5 billion between 2010 and 2019, with all savings realized between 2015 and 2019).

43. Jost, *supra* note 13, at 104. CBO estimates that the savings after 2019 from IPAB would be in addition to other savings realized in Medicare spending from other Medicare-related PPACA provisions. EXPLAINING HEALTH REFORM, *supra* note 4, at 2.

44. EXPLAINING HEALTH REFORM, *supra* note 4, at 2. "According to OACT, meeting the target growth rates specified in the law will require Medicare growth rates to be reduced by an additional 0.3 percent per year, on average, *even after taking into account all other savings* that can be expected to arise from [PPACA]." *Id.* (emphasis added).

45. *See, e.g.*, Capretta, *supra* note 11 (arguing that IPAB will not produce cost savings).

46. EXPLAINING HEALTH REFORM, *supra* note 4, at 2; Jost, *supra* note 13, at 104.

47. Jost, *supra* note 13, at 104. The Medicare sustainable growth rate is the formula by which Congress updates Medicare's physician fee schedule. *Id.*

48. EXPLAINING HEALTH REFORM, *supra* note 4, at 2.

49. Jost, *supra* note 13, at 105.

50. *Id.* at 104.

also be contingent on Congress' response to IPAB's proposals.[51] Although both houses of Congress and a three-fifths Senate vote are required to override payment cuts, Congress can propose independent legislation to increase Medicare funding, in the same way that Congress has evaded the Medicare sustainable growth rate in the past.[52]

Another major concern that the IPAB's critics express is that its imposed spending limits are not attainable due to the continual rise of overall healthcare costs in the United States.[53] Given these rising costs, if Medicare provider payment rates are cut but *private* payers' rates remain relatively unregulated, many healthcare providers may abandon the Medicare program because they are not able to remain profitable when serving Medicare beneficiaries[54] (much like many providers have abandoned the Medicaid program). This, in turn, would certainly jeopardize Medicare beneficiaries' ability to access healthcare services.[55] Although the IPAB is charged with making recommendations to Congress to curb the growth of private national health care spending, these recommendations are advisory only.[56] Thus, it is likely that "Congress may not be able to cap Medicare expenditures without addressing private expenditures as well."[57]

One would expect that a measure such as the IPAB, which is intended to cap spending on a federal entitlement program, would encounter support from Republicans and opposition from Democrats.[58] The reality, however, has been the opposite. Democrats included the IPAB legislation in PPACA out of a belief that stronger federal payment controls will cut healthcare costs, somewhat like "government-driven managed care."[59] Republicans, on the other hand, have vehemently opposed implementation of the IPAB. In fact, in July 2010, a group of Republican Senators introduced the "Health Care Bureaucrats Elimination Act," which has as its sole intention the repeal of the IPAB

51. *Id.* at 105.

52. *Id.* The fact that Congress regularly evades the Medicare sustainable growth rate has been cited as a reason why Congress cannot effectively cut costs in the Medicare program. *Id.*

53. EXPLAINING HEALTH REFORM, *supra* note 4, at 3.

54. *Id.*; Jost, *supra* note 13, at 104–05. It is not clear, however, that healthcare providers would abandon Medicare beneficiaries on a widespread basis when faced with reductions in Medicare payment rates, due to the fact that Medicare comprises a significant portion (twenty-three percent) of total national healthcare spending. MEDICARE SPENDING AND FINANCING, *supra* note 1, at 1.

55. EXPLAINING HEALTH REFORM, *supra* note 4, at 3.

56. *See id.*

57. Jost, *supra* note 13, at 105.

58. Capretta, *supra* note 11.

59. *Id.*

legislation.[60] Section two of this bill argues that the IPAB's repeal is necessary in order to remove "unelected, unaccountable bureaucrats from seniors' personal health decisions . . . ."[61] In a press release supporting the bill, Republican Senators criticized the IPAB for "punt[ing] tough decisions to a bunch of bureaucrats with no accountability to the American people" and even described it as "the definition of a government takeover."[62] The Republican claim that attracted the greatest media attention, however, was that the IPAB would result in rationing of health care, because it would have the power to decide whether certain treatments and tests were too expensive and could not be covered by Medicare.[63]

The IPAB provision in PPACA has also drawn nearly universal criticism from major players in the healthcare industry, including the American Medical Association (AMA), American Hospital Association (AHA), and Pharmaceutical Research and Manufacturers' Association (PhRMA).[64] The AMA calls the IPAB "one of the most controversial provisions of PPACA" and declared that modifying IPAB's framework and authority "is one of [its] highest legislative priorities."[65] The AHA went even further and wrote a letter to Senator John Cornyn, one of the sponsors of the Health Care Bureaucrats Elimination Act, expressing its support for the bill.[66] In this letter, the AHA explained that U.S. hospitals support repealing the IPAB because

its existence permanently removes Congress from the decision-making process, and threatens the long-time, open and important dialogue between hospitals and their elected officials about the needs of local hospitals and how to provide the highest quality care to their patients and communities.

Already, America's hospitals are paid less than the cost of treating Medicare patients,

60. S. 3653, 111th Congr. (2010); Ezra Klein, *A Prescription for Ruin*, NEWSWEEK.COM (Aug. 13, 2010), http://www.newsweek.com/2010/08/13/a_prescription_forruin.html. The Healthcare Bureaucrats Elimination Act was still pending at the time of this Article's writing.

61. S. 3653 § 2.

62. Press Release, Sen. Orrin Hatch, Hatch, Group of Sens. Introduce Health Care Bureaucrats Elimination Act (July 27, 2010), *available at* http://hatch.senate.gov/public/index.cfm?FuseAction=PressReleases.Print&PressRelease_id= 15babd06-1b78-be3e-e064-18242ae805bb&suppresslayouts=true.

63. *Id.*

64. Duff Wilson, *Industry Aims at Medicare Board*, N.Y. TIMES PRESCRIPTIONS (Nov. 4, 2010, 1:23 PM), http://prescriptions.blogs.nytimes.com/2010/11/04/industry-targets-medicare-board/.

65. AM. MED. ASS'N, *supra* note 8, at 1.

66. Letter from Rick Pollack, Exec. Vice President, Am. Hosp. Ass'n, to Senator John Cornyn (Oct. 26, 2010), *available at* http://www.aha.org/aha/main-story/2010/101026-ms-ipab.html (follow "letter" hyperlink).

and although hospitals will not be subject to IPAB decisions until 2020, we are deeply concerned that removing elected officials from the decision-making process could result in even deeper cuts to the Medicare program in the future.[67]

These concerns are even more pressing for physicians, because there are no temporary restrictions on the IPAB's ability to cut Medicare payment rates for physicians, as there are for hospitals.[68]

Although many of these concerns are legitimate, there are also many reasons to be optimistic about the IPAB's potential. First, while Republicans fear that the IPAB will lead to the rationing of health care, the legislation specifically prohibits the IPAB from submitting any proposals that would ration care, restrict benefits, modify eligibility criteria, raise costs to beneficiaries, or change cost-sharing for covered services.[69] Furthermore, the fear of a "government takeover" through the IPAB is not substantiated because Medicare itself is a federal government program, and the IPAB's recommendations are only binding on issues related to Medicare spending.[70]

While it is true that the IPAB shifts the balance of power from the legislative branch to the executive branch,[71] this is a necessary component of the IPAB. Congress has been unable to make major Medicare cost reform in the past due to special interests and the political unpopularity of making cuts to the Medicare program.[72] Moreover, there are numerous safeguards in place to keep the IPAB accountable to voters. The Senate must confirm all IPAB members, and a consumer council will be in place to advise the IPAB.[73] Once the IPAB submits a proposal, if Congress disagrees with the proposed cost-cutting measures, it can propose alternative measures that achieve the same level of cost savings, and can even waive the requirement to achieve equal cost savings by a vote from both houses of Congress and three-fifths of the Senate.[74] Even though this is a difficult hurdle,

67. *Id.*

68. *See supra* note 33 and accompanying text (explaining the fact that there are no restrictions in the legislation on the IPAB's ability to cut Medicare payment rates for physicians).

69. *See supra* note 31 and accompanying text (describing these restrictions on the IPAB's authority).

70. Klein, *supra* note 60.

71. *Republicans Take On Cost-Cutting Panel Backed by Budget Chief Orszag*, KAISER HEALTH NEWS (July 29, 2010), http://www.kaiserhealthnews.org/Daily-Reports/2010/July/29/IPAB.aspx.

72. Klein, *supra* note 60; *see also supra* notes 19–20 and accompanying text (discussing the influence of politics and special interests on Medicare cost reform).

73. *See supra* notes 17–18 and accompanying text (explaining these safeguards).

74. *See supra* text accompanying note 28 (describing the process set forth in the IPAB legislation by which Congress reviews the IPAB's proposals).

it is an important safeguard to keep the IPAB accountable to Congress, and subsequently to voters.

Perhaps the most legitimate concern expressed by the IPAB's critics is that many healthcare providers will abandon the Medicare program if the gap continues to widen between private payment rates and Medicare rates.[75] As AHA explained, Medicare payment rates to hospitals today are less than the cost of treating patients.[76] With the IPAB's additional downward pressure on Medicare payment rates in the years to come, hospitals and physicians will be faced with greater challenges in treating Medicare patients. As the IPAB proposes and HHS implements significant changes under PPACA, both entities will need to be mindful of financial pressures on providers to ensure that the millions of Americans on Medicare can continue to access vital healthcare services.

IV. CONCLUSION

Clearly, the explosive growth rate in Medicare spending must be curbed. Inevitably, reductions in Medicare payment levels and changes in payment methods are a politically contentious issue because of the growing ranks of constituents who will be impacted by such measures. Perhaps, the best solution to achieve needed reform in Medicare spending is to remove Medicare payment decisions from the realm of politics. It remains to be seen whether the IPAB, by doing just that, will be able to effectively rein in Medicare spending.

75. *See supra* notes 53–55 and accompanying text (discussing the challenges facing providers due to reductions in Medicare payment rates).

76. *See supra* notes 66–67 and accompanying text (explaining the contents of the AHA letter).