

Will Health Care Costs Come Down? Watch the IPAB



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The Affordable Care Act (ACA) offers many different attempts to reduce spending, but none is more hotly debated than the Independent Payment Advisory Board (IPAB). Let's take a look at some of the controversy surrounding the IPAB.

As demonstrated by the recent *Time* magazine article, "Bitter Pill,"¹ the economics of health care are complex and unlike any other business models. Well before this provocative feature story, economists have proven that health care does not respond to supply and demand like other industries.²

Frequently, costs continue to increase even when a particular procedure is shown to offer equal—if not poorer—outcomes than cheaper, alternative treatments.³ In fact, in our health care system any correlation between cost and quality is inconsistent and may be either a positive or negative association.⁴ What's more, politics and lobbying in Congress further complicate the discussion of federal health care expenditures, representing 21 percent of the federal budget in 2011.⁵

In an effort to lower the ever-increasing cost of health care, the ACA created the IPAB based upon an idea that was floated back in 1999 by the National Bipartisan Commission on the Future of Medicare.

The Congressional Budget Office (CBO) estimated in 2009 that the IPAB could reduce Medicare spending by \$15.5 billion between 2010 and 2019, with cost savings continuing into the future.⁶ This is in stark contrast to the history of Medicare spending, which—until now—has never been subject to spending caps.⁷ Former White House budget chief Peter Orzag has said that the IPAB is among the most important provisions in the ACA to sustain Medicare,

which is projected to go broke within a decade on its current trajectory.⁸ Many consider the IPAB the cornerstone of the ACA's goal to slow health care spending in the country.⁶

Structure of the IPAB

Section 3403 of the ACA created the "Independent Medicare Advisory Board," renamed the "Independent Payment Advisory Board" in the budget reconciliation bill necessary to make passage of the ACA a reality in March, 2010.⁹

The IPAB is designed as a board with 15 full-time members situated within the executive branch of the federal government [as opposed to Medicare Payment Advisory Commission (MedPAC), which is a non-binding, independent advisory body for Congress]. IPAB members are appointed by the president with congressional input on 12 of the 15: the Senate majority leader, Senate minority leader, speaker of the House, and House minority leader are each to be consulted for three members of the IPAB. All are subject to Senate confirmation.⁶

The members are to be recognized experts in medicine and the financial and policy realms of the health care system, and they cannot be employed outside of the IPAB during their six-year terms. An additional 10-member board, representing patients, will advise the IPAB.⁷

If the chief actuary of the Centers for Medicare and Medicaid Services (CMS) projects that per-capita growth of Medicare spending will exceed the "targeted growth rate," the IPAB must recommend ways to reduce costs. (The first potential year will be 2015.) The criteria for IPAB activity is subject to different factors beginning in 2020.⁶

IPAB recommendations are limited under the law. It may not raise costs to beneficiaries, restrict benefits or modify eligibility criteria. Imposition by the IPAB of physician fee reductions may be curtailed if alternative payment control is successful under the Sustained Growth Rate (SGR) formula, or if other avenues for lowering costs prove successful.⁹

Through 2019, the IPAB is also prohibited from implementing controls on providers already scheduled to sustain reductions under the ACA, such as inpatient and outpatient hospital services, inpatient rehabilitation and psychiatric facilities, long-term care hospitals, and hospices; clinical laboratories are protected from IPAB reductions until 2016.⁶

Because of these limitations, IPAB recommendations are likely to focus on Medicare Advantage Plans, Medicare Part D, skilled nursing facilities, home health, dialysis, ambulance services, ambulatory surgical centers and durable medical equipment. The law prohibits any recommendations that would create health care rationing.⁶

Congress may not amend or reject the IPAB's recommendations but may implement alternative, cost-cutting measures if their actions meet the same goal of expenditure reductions with cost savings equal to the rejected IPAB recommendations.⁶

If Congress wants to avoid the recommendations of the IPAB and avoid having to make similar reductions in spending through alternative means, both houses must vote to waive the rule— via a three-fifths vote in the Senate and simple majority vote in the House.⁹ As is true with any congressional action the implementation of alternatives to the IPAB recommendations passed by Congress could be subject to a presidential veto.

In the absence of congressional action upon the IPAB's recommendations, the ACA requires the secretary of the Department of Health and Human Services to implement the IPAB's cost-cutting measures. Administrative or judicial review of actions taken by the secretary in response to IPAB recommendations is restricted under the ACA.⁶

Goal of the IPAB

The inception of the IPAB is an attempt to reduce political forces on



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health care spending. This reflects the concern that the non-binding, cost-cutting recommendations made by MedPAC have been largely ignored by Congress since its creation in 1997.⁸

Advocates point to the Federal Reserve Board and the Base Realignment and Closing Commissions (BRAC) as other bodies that effectively make difficult, concrete decisions on spending beyond political influence. BRAC, for example, is set up so that an independent panel publishes a list of military bases that should be closed or combined, and the president and Congress must reject or accept the recommendations without any changes.¹⁰

In the absence of these commissions in the past, congressional representatives—facing the forces of frequent, local elections—became deadlocked over closing bases. Similarly—in creating the IPAB—

Timothy Stoltzfus Jost writes, "Congress is attempting to lash itself to the mast to keep the siren song of special interest lobbyists from distracting it from its task of controlling Medicare cost growth."⁹

The controversy

Repeal initiatives and concerns over the IPAB began immediately after its inception; at the time of this writing, it is arguably the most hotly debated component of the ACA. In early 2013, bills with bipartisan support were introduced in the House and Senate to repeal the IPAB.¹¹

Similarly, there are currently attempts in the House to change the procedural rules of the IPAB, such as eliminating the requirement that Congress enact alternative measures only if they achieve similar savings to the IPAB recommendations. Other proposed legislation would restrain

congressional Medicare-reduction activity and/or repeal the procedural rules creating a “fast track” status for IPAB recommendations (thereby limiting debate and voting time allowances).¹²

In a Feb. 25, 2013, letter to Senator John Cornyn (R-TX), the American Hospital Association expressed support for his bill to repeal the IPAB, “because its existence permanently removes Congress from the process of making decisions regarding Medicare payment, and [it] threatens the important dialogue between hospitals and their elected officials about how hospitals can continue to provide the highest quality care to their patients and communities.”¹³

The American Medical Association has condemned the IPAB as “a panel that would have little accountability and the power to make indiscriminate cuts that adversely affect access to healthcare [sic] for patients.”¹⁴

Physician reaction to the IPAB has been weighted toward specialty-practice associations. The Alliance of Specialty Medicine (whose members include neurosurgeons, plastic surgeons and cardiologists)¹⁵ the College of Neurological Surgeons, and the American Association of Neurological Surgeons have all voiced support for Congressional repeal attempts.¹⁶ To date, there have been few public announcements of support or opposition from primary care associations.

In an article published by AARP last June, the arguments for and against the IPAB are briefly reviewed by representatives from two widely known political think tanks. Stuart Butler, PhD, of the Heritage Foundation expressed concern about the ability for unelected people to set government spending, (similar to the provider groups mentioned above).

Recognizing that Congress can set alternatives to equal the savings of IPAB proposals, Butler notes that “if Congress can’t agree on its

own package, then the IPAB’s cuts will go into place automatically and nobody—not the courts or even Congress itself—can stop them.” He also fears that cuts in Medicare spending will result in fewer participating physicians, leaving Medicare beneficiaries without care. In the aftermath of the complete repeal of the IPAB “each older person would have the right to decide either which health plan, or which doctor and hospital, will get that person’s portion of the Medicare budget.”¹⁷

The opposing view in the AARP paper is voiced by Henry J. Aaron, Ph.D. of the Brookings Institution, who argues that if the ACA works as intended, costs will decrease sufficiently without the need for IPAB recommendations. Aaron argues that the IPAB does not “usurp Congressional authority” because Congress created it in the first place as an expression of an important goal: “slowing the growth of health care spending.”

He concludes that the IPAB should in fact be strengthened, allowing it to recommend changes in provider payments, invest in other cost-saving endeavors (such as billing efficiencies), and be given greater funding to support a larger staff.¹⁷

Other advocates have noted that current Medicare spending has slowed sufficiently to fall under the limit that would trigger IPAB recommendations. “If Medicare spending keeps going the way it has the past few years, the board will never hold a meeting.”¹⁸

Arguments against repeal also reflect the underlying concern that Congress is incapable of making politically difficult decisions regarding health care expenditures, so “removing Congress permanently from the process of making decisions regarding Medicare payment might be just the thing to get some control over the health care cost monster.”¹⁹

Perhaps the debate over the IPAB can best be summarized by

the conflicting cries of those who rally against the board and strive to remain true to a representative government where voters can petition their elected officials, and the proponents of the IPAB who argue that it is petitioning and the role of politics in health care spending that created the necessity for an independent board in the first place. The argument over the IPAB is as fundamental as any controversy over the role of government in society.

The final resolution over the IPAB controversy will be indicative of the future of health care reform in general and the ACA in particular. Although the IPAB is controversial, most people agree that health care costs are not indefinitely sustainable if they continue to increase unchecked.

Parties may differ on where cuts may be made, but they agree that the country can’t decrease health care costs without some sectors bearing those reductions. Herein lies the rub, for any cut, cost saving measure, or reduction in reimbursement will raise the ire and political forces associated with that demographic.

The final solution may not be the IPAB as conceived, however, in order to protect the system as a whole, there has to be some limitation of spending. If political forces successfully strip the ACA of all cost-saving measures, America will have created a paper giant. That may be the reader’s goal or the reader’s fear, but both should be watching the future of the IPAB as the political canary in the mine of health care reform.



References

1. Brill S. Bitter Pill: Why Medical Bills Are Killing Us. *Time*, 2013, 181(8).
2. Goldhill D. Focus on Health-Care Costs Causes More Spending. *Bloomberg*, 2013. <http://www.bloomberg.com/news/2013-01-01/focus-on-health-care-costs-causes-more-spending.html>.
3. Brownlee S, Colucci J, Walsh T. What "Health Care Costs" Really Means. *Atlantic*, 2012. <http://www.theatlantic.com/health/archive/2012/12/what-health-care-costs-really-means/266522/>
4. Hussey PS, Wertheimer S, Mehrotra A. The Association Between Health Care Quality and Cost: A Systematic Review. *Annals of Internal Medicine*, 2013, 158(1):27-34.
5. Leonard, D. Medicare and Medicaid Must Be Cut. Period. *Bloomberg Businessweek*, 2012. <http://www.businessweek.com/articles/2012-11-08/medicare-and-medicare-must-be-cut-dot-period>.
6. Ebeler J, Neuman T, Cubanski J. The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending. The Kaiser Family Foundation Program on Medicare Policy, 2011.
7. Explaining Health Reform: Medicare and the New Independent Payment Advisory Board. Kaiser Family Foundation Focus on Health Reform, 2010.
8. Lillis M. GOP Leaders Push to Repeal Medicare Cost-Cutting Panel, *The Hill*, 2010. <http://thehill.com/blogs/healthwatch/health-reform-implementation/111425-gop-leaders-push-to-repeal-medicare-cost-cutting-panel>.
9. Jost TS. The Independent Medicare Advisory Board. *Yale Journal of Health Policy, Law and Ethics*, 2013, 11(1).
10. Simeone N. DOD Official Discusses BRAC Issues with Congress. Department of Defense News, 2013. <http://www.defense.gov/news/newsarticle.aspx?id=119535>
11. Zigmond J. New Session of Congress Brings More Anti-Reform Legislation. *Modern Healthcare*, 2013. <http://www.modernhealthcare.com/article/20130123/NEWS/301239951/new-session-of-congress-brings-more-anti-reform-legislation>.
12. Ethridge E. New House Rules Would Amend Requirements on Medicare Board. *Roll Call*, 2013. http://www.rollcall.com/news/new_house_rules_would_amend_requirements_on_medicare_board-220428-1.html
13. Letter from Rick Pollack (Executive Vice President, American Hospital Association) to Senator John Cornyn, Feb. 25, 2013.
14. Lazarus JA. AMA Applauds Bipartisan House Bill to Repeal IPAB. American Medical Association, 2013. <http://www.ama-assn.org/ama/pub/news/news/2013-01-23-ama-applauds-bill-to-repeal-ipab.page>.
15. Baker S. Specialty Groups Back IPAB Repeal. *The Hill*, 2013. <http://thehill.com/blogs/healthwatch/health-reform-implementation/279825-specialty-groups-back-ipab-repeal>.
16. Desjardins D. Physician Groups Blast IPAB, Rally Behind Repeal Effort. *Health Leaders Media*, 2013.
17. Aaron HJ, Butler S. Medicare Reform Option: Strengthen the Independent Medicare Advisory Board (IPAB), AARP Public Policy Institute, 2013.
18. Zigmond, J. IPAB Not So Scary? *Modern Healthcare*, 2013, 37(2).
19. Betbeze P. IPAB Repeal Arguments Weak, For Now. *Health Leaders Media*, 2013. <http://www.healthleadersmedia.com/page-4/led-289947/IPAB-Repeal-Arguments-Weak-For-Now>.

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