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Obamacare and the Independent Payment Advisory Board: Falling Short of Real Medicare Reform

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Under Section 3403 of the Patient Protection and Affordable Care Act,[1] Congress established the Independent Payment Advisory Board, a body composed of 15 members appointed by the President and confirmed by the Senate.[2] The board's stated responsibility is to develop proposals to reduce the growth of Medicare spending. The Secretary of the Department of Health and Human Services (HHS) is to implement the board's recommendations unless Congress enacts an alternative set of proposals that would achieve the same level of Medicare savings. This is the first time Congress has created a special mechanism to impose a hard cap on future Medicare spending.

The problem is that the board is prohibited by law from proposing real structural reforms. The only cuts it is allowed to make would be cutting providers' reimbursements—including administrative costs and profit margins of Medicare Advantage plans, which are already slated for a payment freeze and future cuts under the new law.[3]

Summary. Beginning on January 15, 2014, the board is authorized to make its first recommendations to reduce the per capita growth rate in Medicare spending in accordance with spending targets set in the statute.[4] The board is also to give priority to recommendations that extend the solvency of the program.[5]

The initial target for growth in Medicare per capita spending for the period 2013 through 2018 is inflation. For the first five years, the target is based on an average of the Consumer Price Index (CPI) and the Medical CPI. Beginning in 2018, however, the target for Medicare growth is changed to the percentage increase in the general economy as measured by GDP, plus 1 percent.[6] If, in any given year, the growth in Medicare per capita spending exceeds inflation (or after 2017, the GDP growth target), the board is required to make "detailed and specific" recommendations to secure necessary reductions. These reductions are to be the *lesser* of (a) the amount by which the growth rate exceeds the target, or (b) a more modest percentage growth in Medicare spending, initially ranging from 0.5 percent to 1.5 percent over the period 2015–2018. The board is required to submit these recommendations to both the President and Congress for expeditious action.

It is difficult to predict future health spending,[7] but health care costs have historically grown at roughly twice the rate of general inflation and outpaced growth in the general economy.

The board, as noted, is authorized to make its first set of recommendations on January 15, 2014. These are to be transmitted to the President, who must submit them to Congress within two days of receiving them. The congressional committees of

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jurisdiction are to report out a legislative package that will achieve the Medicare savings as recommended by the board no later than April 1. Congress could enact an alternative package, but, as noted, it must achieve the same level of Medicare savings. If Congress does not act, the HHS Secretary is required to implement the board's recommendations to achieve the Medicare savings, and the Secretary's actions are subject neither to administrative or judicial review.

The law largely confines the board's recommendations to reductions in Medicare reimbursements for providers. This includes reductions in Medicare Parts C and D payments related to their administrative costs (including profits).

The statutory language carefully states what the board may *not* do to achieve the desired level of Medicare savings. The board is prohibited from making any recommendation that would ration care, increase taxes, change beneficiaries' benefits or eligibility for coverage, increase beneficiary premiums, increase beneficiary cost-sharing, reduce drug subsidies for low-income beneficiaries enrolled in Medicare Part D, or reduce payments to Medicare providers who are already subject to Medicare payment update reductions that are required by the law until 2019.[8] The board can make no recommendations that affect hospitals or hospice care until 2020.

Impact:

The Language of the Law Is Inflexible. Physicians' services under Medicare Part B could be subject to more payment reductions, even though Medicare physicians are already struggling under a flawed and volatile payment update system that routinely threatens them with draconian reductions. Hospital payments under Medicare Part A are exempt, even though they are the largest single category of Medicare spending. Though hospital payment updates would be reduced under other provisions of PPACA, their exclusion from the board's range of action over the next 10 years is still a serious limitation on the board's ability to control Medicare spending. Medicare providers that are exempt from the range of the board's recommendations accounted for 37 percent of all Medicare benefit payments in 2009.[9]

By tying future Medicare spending growth to trends in the general economy, the stated objective is to keep future Medicare spending from growing faster than GDP plus 1 percent. In the case of Medi-

1. Congress cannot build sound market-based health care reform on the foundation of a flawed health care law. Therefore, the health care law must be repealed in its entirety.

   The House of Representatives has taken a major step towards full repeal of the Patient Protection and Affordable Care Act (PPACA—otherwise known as "Obamacare"). Until full repeal occurs, Congress must continue to focus on the core failures and consequences of PPACA and block its implementation to allow time to achieve repeal and lay the groundwork for a new market-based direction for health care reform.
2. In creating the board, Congress amends Title XVIII of the Social Security Act and creates a new Section 1899A.
3. Patient Protection and Affordable Care Act of 2010, Public Law 111–148, and Health Care and Education Reconciliation Act of 2010, Public Law 111–152.
4. Beginning on August 15, 2014, if the board does not or cannot make the recommendations and Congress does not enact an alternative, the Secretary of HHS is authorized to make recommendations and implement them unilaterally.
5. The Congressional Budget Office's 10-year estimate of the savings of this provision (Section 3403) is modest: $15.5 billion. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to Nancy Pelosi, Speaker, U.S. House of Representatives, March 20, 2010, Table 5. l.
6. The politically unpalatable Sustainable Growth Rate formula for updating physician Medicare payment is likewise tied to general economic performance, not the conditions of supply and demand for medical services.
7. In 2009, health care spending grew at a rate of 4 percent, which still outpaced the growth of the recession-ravaged general economy.
8. In January 15, 2015, the board "shall" submit non-binding recommendations to the President and Congress to "slow the growth" in national health expenditures, including those incurred by "private sector entities."
9. David Newman and Christopher M. Davis, "The Independent Payment Advisory Board," Congressional Research Service *Report for Congress*, November 30, 2010, p. 33.

care physician payment updates, this general approach has failed. Under current law, if physician spending exceeds the GDP growth target, it would automatically be reduced—in theory. Since 2003, Congress has routinely blocked these automatic cuts. Congress has changed neither its formula nor its own response to that formula. With the more far reaching recommendations, it is difficult to imagine why a future Congress would behave differently.

It Positions Medicare Advantage for Even Deeper Cuts. The board is authorized to target the administrative costs of Medicare Advantage plans under Medicare Part C. But these reductions would come in addition to significant Medicare Advantage payment reductions already fixed in the new law. Meanwhile, by law, the board is forbidden to make recommendations for any structural changes in Medicare, such as introducing a premium support system of financing or changes in eligibility or Medicare cost-sharing. Large areas of potential savings, in other words, are simply off limits.

It Accelerates Cost Shifting to the Private Sector. If the board merely reduces Medicare spending to the statutorily prescribed levels, it will likely increase the gap between Medicare payment and private payment for services, thus fueling even more Medicare cost-shifting to individuals and families in the private sector. Additional cuts could also accelerate physician exodus from the Medicare program, mirroring the decline in physician participation in Medicaid and creating potentially disastrous problems of access to care for seniors and worsening today's emergency room overcrowding.

It Continues the Special Interest Politics of the Existing System. Instead of allowing market forces to control costs, Congress is perpetuating the special interest politics that drive multiple Medicare provider payments today. The law specifies that persons with certain professional backgrounds in the health care industry—such as physicians and experts in prescription drug benefits and third-party payment—be appointed to the board. As analysts for the Congressional Research Service observe, "In moving beyond expertise, skills and experience and naming specific groups that should be included on the Board, the legislation designates some interests as worthy of being represented and others, by omission, as not being worthy."[10]

Real reform would transcend the decision-making of this board. Meanwhile, the law includes extraordinary obstacles to the board's abolition, which will attempt to bind a future Congress. Under the statute, Congress must pass a joint resolution to discontinue the board and its functions, and such a resolution must secure an affirmative vote of three-fifths of the Members of the House and Senate. Furthermore, such a resolution cannot be introduced until 2017.

A New Direction. To control Medicare spending, policymakers do not have many options. Unless they limit eligibility, they cannot control consumer demand. They can, of course, control provider supply. In controlling supply, they can play variations on two old themes: cut patient benefits or cut provider reimbursement. Despite official claims to the contrary, this is PPACA's basic prescription.

Real Medicare reform would require precisely the kind of structural change the board is legally prohibited from considering.

Congress should pursue serious Medicare reform based on a flexible and market-driven premium support model.[11] Such a system would be based on a defined government contribution to a beneficiary's chosen plan, and it would be characterized by predictable and stable financing (similar to today's financing of federal employee and retiree health coverage under the Federal Employees Health Benefits Program). It would have several attractive features: a broad choice of health plans and options, including the right of persons to take their pre-retirement health coverage into retirement, if they wish, and secure a government contribution to off-

10. *Ibid.*, p. 25. The analysts also note, however, that a majority of board members cannot be "directly involved" in the provision of Medicare benefits or services.

11. For a basic overview of this approach, see Robert E. Moffit and James C. Capretta, "How to Fix Medicare: A New Vision for a Better Program," Heritage Foundation *Backgrounder* No. 2500, December 13, 2010, at *http://www.heritage.org/Research/Reports/2010/12/How-to-Fix-Medicare-A-New-Vision-for-a-Better-Program.*

set its cost; consumer protection standards that meet or exceed those governing health plans that cover Members of Congress and federal workers and retirees; a minimum of bureaucracy and red tape; and a high degree of flexibility in its administration. Congress can do much better than reinforcing the worst features of the status quo.

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