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THE INDEPENDENT PAYMENT ADVISORY BOARD: A NEW APPROACH TO CONTROLLING MEDICARE SPENDING

Prepared by:

Jack Ebeler
Health Policy Alternatives, Inc.

and

Tricia Neuman and Juliette Cubanski
The Henry J. Kaiser Family Foundation

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INTRODUCTION

The 2010 health reform law (the Patient Protection and Affordable Care Act[1], also referred to as the ACA) establishes a new Independent Payment Advisory Board (IPAB) with authority to issue recommendations to reduce the growth in Medicare spending, and provides for the Board's recommendations to be considered by Congress and implemented by the Administration on a fast-track basis. IPAB has been heralded by some as a cornerstone of efforts to slow the growth in health care spending, beginning with enforceable savings targets for Medicare to help limit the growth in program spending. Some, including the President's National Commission on Fiscal Responsibility and Reform, have advocated strengthening the role of IPAB. Yet others, including some in Congress, representatives of some aging organizations, and various health industry stakeholders, are opposed to IPAB and are pressing to block its implementation.[2]

As authorized by the health reform law, IPAB is an independent board housed in the executive branch and composed of 15 full-time members appointed by the President and confirmed by the Senate. IPAB is directed to recommend savings for Medicare if the per capita growth in Medicare spending exceeds defined target growth rates. Prior to 2020, the growth target is based on a measure of inflation, and in subsequent years, it is based on the per capita growth in the economy (gross domestic product (GDP) plus one percentage point). The recommendations made by IPAB move to the Congress for fast-track consideration. If Congress does not act in the required timeframe, the Secretary is required to implement the Board's recommendations, also on a fast-track basis. The Board is prohibited from recommending changes that would reduce payments to certain providers before 2020, and is also prohibited from recommending changes in premiums, benefits, eligibility and taxes, or other changes that would result in rationing.

This paper explains the genesis of IPAB, describes its structure, scope of authority, operational procedures, and the processes and timelines for considering, modifying, and implementing the Board's recommendations. The paper also identifies issues that may be the subject of future policy discussions, along with policy options for consideration, including:

- ***Spending targets for Medicare:*** What specific target growth rates were established under the ACA for Medicare, and what are the implications? What are the implications of imposing spending targets for Medicare alone, and should they be applied to total public and private health care spending, rather than limited solely to Medicare?
- ***Magnitude and timeline for achieving Medicare savings:*** What level of savings is IPAB required to achieve in a year in which Medicare spending exceeds the targets? What are the implications of requiring IPAB to achieve savings in a single year, rather than over a longer period of time?
- ***Limits on the authority of IPAB:*** What constraints are imposed on the Board's ability to make recommendations? Which providers are exempt from IPAB's reach and for how long? Can IPAB make changes that could directly or indirectly affect beneficiaries' out-of-pocket costs or access to care? What are the implications of exempting IPAB recommendations from judicial review?

- ***Role of Congress and the Administration:*** How does IPAB affect the balance of power between Congress and the Administration with respect to Medicare policy? Which entity is ultimately accountable for setting Medicare policy, and which entity in the executive branch, IPAB or the Centers for Medicare & Medicaid Services, is accountable for implementing policy?
- ***Implementation and Timing:*** When will the appointment process for Board members begin? When will regulations for IPAB be promulgated?

With ongoing attention to rising health care costs and the role of Medicare and health spending in the context of federal budget and deficit discussions, the role of IPAB is likely to remain a key issue in future policy discussions.

RATIONALE AND HISTORY OF IPAB

The Rationale for the Creation of IPAB

The Independent Payment Advisory Board was enacted to address a number of Medicare fiscal, governance, and policy issues. Driven by concern about rising Medicare program spending, some have questioned the ability of the Congress to make needed decisions to slow the growth in Medicare spending, particularly in light of the political influence of stakeholders. Based on similar concerns, some also questioned whether the Centers for Medicare & Medicaid Services (CMS) would be able to adopt and implement needed programmatic changes. As Senator Jay Rockefeller (D-WV), a principal architect of the IPAB model, noted in June 2009, "It is long past time that Medicare payment policy is determined by experts, using evidence, instead of by the undue influence of special interests."[3]

In addition to concerns about the influence of stakeholders, policymakers involved in negotiations over the health reform law were concerned about the federal deficit and rising health care costs overall. Even with the more than $400 billion in 10-year Medicare savings included in the health reform law, Medicare is projected to increase from 3.6 percent of the GDP in 2010 to 5.9 percent in 2035, assuming steep cuts in Medicare physician payments go into effect and that the restraints on provider payments included in the ACA stay in place.[4] However, if Congress acts to prevent future cuts in physician fees, Medicare spending is projected to rise to seven percent of the GDP in 2035.[5] Policymakers in Congress and the Administration created IPAB to help constrain the growth in Medicare spending.

There were governance motivations as well as fiscal ones. Policy and political opinion leaders throughout the last 20 years have expressed concerns about the governance process for Medicare, and in particular the ability of Congress to deal with the difficult and exceptionally detailed technical programmatic and budgetary issues in an intensely political environment. Over the years, Congress has relied on its own independent advisory body—the Medicare Payment Advisory Commission, or MedPAC—to provide guidance on Medicare payment policy and other Medicare policy issues. MedPAC has maintained a great deal of credibility with the Congress and the broader stakeholder community involved with Medicare.[6] But MedPAC is an advisory body and does not have authority to set Medicare payment policy.

Several Medicare policy experts and researchers have laid out alternative governance and policy approaches for Medicare, such as a model based on the Federal Employees Health Benefits Program (FEHB)[7], a Securities and Exchange Commission (SEC) model for regulating all of health care[8], along with additional options for a new decision-making structure that might be more insulated from stakeholder influence.[9] The Bipartisan Commission on Medicare in the late 1990s, chaired by then-Senator John Breaux (D-LA) and then-Ways and Means Committee Chair Bill Thomas (R-CA) attempted

to address the issue[10], and study panels of the National Academy of Social Insurance explored governance issues and options for Medicare in 2002[11] and again in 2009 (with the National Academy of Public Administration) presented administrative options for Medicare along with other aspects of health reform.[12]

Legislative History of IPAB

As debate over health reform legislation got underway in 2009, the idea of creating an independent entity tasked with monitoring and, if necessary, reducing Medicare's spending growth rate, coupled with caps on Medicare spending, gained traction as a means to lower Medicare spending growth and provide some insulation from political pressures in Congress. Senator Rockefeller introduced legislation in June 2009 (S.1370) that would have converted MedPAC into an executive branch commission with specific savings targets and more formal authority of the type ultimately included for IPAB. In the Administration, then-Office of Management and Budget (OMB) Director Peter Orszag advocated a series of Medicare changes to constrain spending growth, and in July 2009 proposed an Independent Medicare Advisory Commission (IMAC). The Administration's IMAC proposal was scored by the Congressional Budget Office (CBO) in July 2009 as achieving Medicare savings of $2 billion over 10 years when incorporated into the initial House health care reform bill (H.R.3200) – far less than what some hoped for or expected. The savings were limited in part because of deep Medicare spending reductions already included in the bill, and because the Administration's IMAC proposal did not include explicit targets for Medicare spending or enforceable savings mechanisms.[13]

The Senate Finance Committee included a variant of the Rockefeller proposal, with defined targets for spending growth and more enforceable savings targets and procedures, in the health reform bill it reported in October 2009 (S.1796), and the Senate ultimately adopted the IPAB provision into the Patient Protection and Affordable Care Act that it passed on December 24, 2009. That legislation was subsequently passed by the House on March 20, 2010 and signed by the President on March 23, 2010, with CBO attributing to IPAB savings of $15.5 billion between 2015 and 2019.[14] This amount constitutes less than four percent of the net 10-year Medicare savings in the health reform law.

THE STRUCTURE OF IPAB

Board Membership

IPAB is established as an independent board in the executive branch, composed of 15 full-time members appointed by the President and confirmed by the Senate. The statute sets out an array of qualifications for Board members: expertise in health care, economics, research and technology assessment, experience with employers and third-party payers, and consumers. It requires a balance between urban and rural representation. A majority of members must be non-providers. Unlike the MedPAC commissioners, the Board members, as full-time federal employees, cannot engage in any other "business, vocation or employment." Thus, it would appear that medical professionals, patient advocates, or policy experts who are otherwise employed on a full–time basis would not be permitted to serve on IPAB.

The President is required to consult with Congressional leadership in making 12 of the 15 appointments. He is to consult, concerning three appointments each, with the Majority Leader and Minority Leader of the Senate, and the Speaker and Minority Leader of the House. The IPAB Chair is appointed by the President, with advice and consent of the Senate; the Board elects its Vice Chair annually. Terms are for six years, and members may serve no more than two consecutive terms. Terms for initial appointments

are staggered—five are to be appointed for one year, five for three years, and five for six years. IPAB members are paid at a rate prescribed for level III of the Executive Schedule, which is $165,300 in 2011.[15]

In addition, there are three ex officio, non-voting members: the Secretary of Health and Human Services (HHS), the Administrator of the CMS, and the Administrator of the Health Resources and Services Administration (HRSA). The Chief Actuary of CMS is responsible for providing to IPAB all estimates called for under the statute.

The law does not specify the timing for the appointment and confirmation of IPAB members.

Consumer Advisory Council

A Consumer Advisory Council, composed of 10 members appointed by the Comptroller General, one from each of the 10 HHS regions, will advise IPAB on the impact of payment policies on consumers. The Council is required to meet at least twice a year, and its meetings must be open to the public.

Funding

The ACA establishes a permanent mechanism for funding IPAB, and appropriates (and transfers from the Medicare Trust Funds) $15 million for FY 2012, with automatic subsequent appropriations to be indexed annually to the consumer price index (CPI).

MEDICARE SPENDING AND SAVINGS TARGETS

Targets on Medicare Spending Growth Rate

The statute sets target growth rates for Medicare spending. The target is not a "hard cap" on Medicare spending growth, but if spending exceeds these targets, IPAB is required to submit recommendations to reduce Medicare spending by a specified percentage (discussed below). For 2015 through 2019, the target for Medicare spending per capita is the average of general and medical inflation: specifically, the average of the projected percentage increase in the consumer price index for all Urban Consumers (CPI-U) and the medical care expenditure category of the CPI-U. For 2020 and later years, the target for Medicare spending per capita is the increase in the gross domestic product (GDP) plus one percentage point, which historically has increased at a higher rate than the CPI-based measures.

Each year, starting in 2013, no later than April 30, the CMS Actuary determines if the Medicare growth per capita in the "implementation year" (the second succeeding year, or 2015 for the determination made in 2013) exceeds the target growth rate for that year. In addition, the Actuary must determine if the projected increase in the medical care expenditure component of the CPI-U for the implementation year exceeds the CPI-U.

If projected growth for the implementation year exceeds the target, and the medical care component of the CPI-U exceeds the CPI-U, then IPAB is required to develop and submit a proposal to bring Medicare per capita growth within the target in the implementation year, subject to the applicable limits (maximum savings) on reductions described below. If overall medical inflation, as measured by the medical care component of the CPI-U, does not exceed general inflation as measured by the CPI-U, then IPAB does not make binding proposals even if Medicare spending exceeds the growth targets.

The calculation of both the Medicare growth rate and the target growth rate is based on the five-year average ending with that implementation year (for example, the calculation of the target and of Medicare growth for 2015 is based on the 2010-2015 period). The five-year period is likely to include three years of actual data for Medicare spending, and two years of projections. Using a five-year period is designed to smooth the impact of annual fluctuations in computing the average growth rate, but necessarily relies on projections for the implementation year that may or may not prove to be accurate.

Requirements for Medicare Spending Reductions

While IPAB is generally required to make recommendations to lower growth in Medicare spending if the growth in per capita spending exceeds the target growth rates, the law imposes a limit on how much savings it can achieve, expressed as a percentage of total program payments, known as the "applicable percent." The applicable percents, or maximum savings, for 2015 and subsequent years, are as follows:

Implementation Year	Applicable Percent (Maximum Savings)
2015	0.5%
2016	1.0%
2017	1.25%
2018 and later	1.5%

This means the ACA does not require IPAB to recommend proposals to keep Medicare spending below target growth rates; instead, it requires IPAB to reduce Medicare spending by the amount of the excess over the target but only up to the specified "applicable" percentage for a particular year.

TIMELINE FOR RECOMMENDATIONS

Beginning in 2013, the Board is required to begin its work organized around a standard and repeating three-year cycle of activity, starting in a "determination year," then proceeding through a "proposal year" and ending with the "implementation year," as summarized below and in the table that follows.

Determination Year (Year 1)

Each year, no later than **April 30**, the CMS Actuary makes a determination of whether Medicare spending growth per capita in the implementation year (the second succeeding year, or 2015 for the determination made in 2013) exceeds the target growth rate. If the Actuary projects that growth exceeds the target, IPAB must develop and submit a proposal to bring Medicare per capita growth within the target in the implementation year, subject to the applicable limits on reductions. IPAB must submit draft copies of its proposals to the Secretary and to MedPAC within four months (by **September 1**).

Proposal Year (Year 2)

IPAB is required to submit its final recommendations to the President and the Congress no later than **January 15** of the proposal year, along with an opinion by the Chief Actuary that it meets the statutory savings requirements. The President must formally submit the recommendations to the Congress within

two days of receipt. In the event that IPAB fails to submit a required proposal by **January 15**, the Secretary is required to submit a proposal meeting the requirements by **January 25**.

The Secretary is required to submit a report to Congress reviewing the IPAB recommendations by **March 1**, and MedPAC is required to comment on the IPAB proposal, with recommendations as appropriate, by **March 1**. The Congressional process, described below, then takes place during the proposal year. The Congressional Committees are required to act by **April 1.**

The Secretary is required to implement, by **August 15** of the proposal year, changes in payment rates effective with the beginning of the upcoming implementation year. Those changes are applicable for the fiscal year (starting **October 1** of the proposal year) or calendar year (starting **January 1** of the implementation year), depending on the payment cycle for the relevant providers.

Implementation Year (Year 3)

The changes in payments implemented by the Secretary are effective during the implementation year.

The schedule and deadlines for the entire three-year cycle are set out in the table below. A new three-year cycle begins each year.

IPAB Schedule and Deadlines Based on Three-Year Cycle: Determination Year, Proposal Year; Implementation Year

	1st "Determination Year" CY 2013 - *Quarters:*				1st "Proposal Year" CY 2014 - *Quarters:*				1st "Implementation Year" CY 2015 - *Quarters:*			
	1	2	3	4	1	2	3	4	1	2	3	4
CMS Actuary projection, determination		4/30										
IPAB draft to MedPAC and HHS Secretary			9/1									
IPAB proposal to President and Congress					1/15							
Default - HHS Secretary proposal if IPAB doesn't act					1/25							
HHS Secretary and MedPAC reports on IPAB proposal					3/1							
Deadline for Congressional Committees						4/1						
Secretary Implements Recommendations							8/15					
Recommendations for CY Payment rates effective								10/1----------9/31				
Recommendations for FY Payment rates effective									1/1 ----------12/31			

In addition, each year starting with determination year 2018, the Actuary must also determine the projected growth in total national health expenditures per capita for implementation years starting with 2020, which the Secretary is required to take into account as noted below.

PROCESS FOR MAKING RECOMMENDATIONS

Mandatory and Advisory Recommendations and Reporting Requirements

The statute sets out two distinct types of recommendation for IPAB.

Mandatory Recommendations

Most attention is devoted to those situations in which IPAB is *mandated* to submit recommendations because Medicare per capita spending growth exceeds statutory targets.

If the CMS Actuary makes a determination that IPAB must submit a set of recommendations, then the Board must proceed according to the deadlines set in law. It must develop proposals that include:

- Recommendations related only to Medicare, along with an explanation and rationale for the recommendations;
- Recommendations regarding any administrative funding required to implement its proposals;
- Certification by the CMS Actuary that, in his opinion, the recommendations will result in savings that are at least equal to the applicable savings target (constrained by the "applicable limit") and are not expected to result in any increase in Medicare spending over the 10-year period starting with the implementation year (IPAB can recommend proposals that would increase spending in individual years but the 10-year total cannot increase); and
- Legislative language that implements the recommendations.

IPAB recommendations are also required to maintain or enhance beneficiary access to quality care. These mandatory recommendations are subject to special fast-track Congressional procedures and default implementation by the Secretary if the Congress does not act. When IPAB is required to submit mandatory recommendations, there are statutory standards and prohibitions on the scope of the recommendations, as well as several areas of guidance that must be taken into account.

Advisory Recommendations

IPAB also has the ability to make *advisory* recommendations on a much broader range of Medicare and health care policy issues, and in some cases is required to provide such advice. It may issue advisory recommendations in a year in which savings recommendations are not required because spending was within targets. It may also issue advisory recommendations in conjunction with mandatory recommendations. But those recommendations, like those of other advisory boards such as MedPAC, or typical recommendations of executive branch agencies, are not automatically given the special Congressional fast-track consideration. Starting January 15, 2015 and at least every two years thereafter, IPAB is required to make advisory recommendations for slowing national health spending growth along with recommendations applicable to non-federal health programs. There are no constraints on the scope of what IPAB can include in its advisory recommendations.

In addition to these different types of recommendations, starting in 2014, IPAB is required to issue an annual public report on total national health care costs, access, use, and quality that provides regional comparisons as well as comparisons between Medicare and private payers.

Voting Requirements

The statute sets out quorum requirements for the deliberations of IPAB. A quorum is a majority of the appointed members. Any proposal must be approved by a majority of the appointed members who are present for the vote. For example, in a situation in which all 15 members are appointed and confirmed, a quorum is eight members and a proposal would require five of those eight votes. If there are fewer total Board members present, or if the Senate has confirmed fewer than 15 members, the quorum and number of required majority votes decline accordingly. It is not clear what happens if the Senate fails to confirm any nominees on a timely basis, or confirms just a very small number. The President always has the authority to make recess appointments, and it appears that IPAB could function with fewer appointees if not all 15 members are appointed and confirmed.

Limits on IPAB's Authority

The law includes language that limits IPAB's scope of authority, prohibiting certain recommendations that could negatively affect beneficiaries and prohibiting recommendations that could affect certain providers.

IPAB is prohibited from including any recommendation that would: (1) ration health care; (2) raise revenues or increase Medicare beneficiary premiums or cost sharing; or (3) otherwise restrict benefits or modify eligibility criteria. In addition, for implementation years through 2019, mandatory proposals cannot include recommendations that would reduce payment rates for providers and suppliers of services scheduled to receive reductions under the ACA below the level of the automatic annual productivity adjustment called for under the Act.[16] As a result, payments for inpatient and outpatient hospital services, inpatient rehabilitation and psychiatric facilities, long-term care hospitals, and hospices are exempt from IPAB-proposed reductions in payment rates until 2020; clinical laboratories are exempt until 2016. These exclusions leave Medicare Advantage, the Part D prescription drug program, skilled nursing facility, home health, dialysis, ambulance and ambulatory surgical center services, and durable medical equipment (DME) as the focus of attention.[17]

The statute sets out several areas of policy guidance which are not mandatory. Specifically, the Board can include recommendations "as appropriate" to reduce Medicare payments under Part C (Medicare Advantage) and Part D (prescription drug program). Those recommendations can include reductions in direct subsidy payments related to administrative expenses and profits, denying high bids or excluding them from the average bid amount used for calculating the Part D payment. Drug rebates, such as those required from pharmaceutical manufacturers under the Medicaid program, would presumably fall within the scope of IPAB's authority as well.

The statute directs that the Board "to the extent feasible" take into account additional considerations, such as Medicare solvency, improvements in delivery, access to care (especially in rural and frontier areas), effects on beneficiaries and certain providers, and the unique needs of dual Medicare and Medicaid eligibles.

Implementation of Recommendations and Judicial Review

The Secretary must implement IPAB recommendations, or an alternative that has been enacted, by August 15 of the proposal year. If there is no formal Congressional action (as described further below), the Secretary must implement IPAB's proposal. The ACA precludes administrative or judicial review of the implementation by the Secretary of recommendations contained in an IPAB proposal.

CONGRESSIONAL CONSIDERATION OF IPAB PROPOSALS

"Fast-Track" Procedures

The Congress considers IPAB's required recommendations under special "fast-track" procedures set out in the statute.[18] The Board's legislative proposal must be introduced by the majority leaders of the House and Senate on the day it is submitted to Congress, and is referred to the appropriate committees. The committees must report those recommendations, with any changes, in just two and one-half months, no later than April 1 of the proposal year, or the proposals are formally discharged from the committees.

The committees, and the full House and Senate, cannot consider any amendment that would change or repeal the Board's recommendations unless those changes meet the same fiscal criteria under which the Board operates. A vote of three-fifths of Members in the Senate ("duly chosen and sworn") is required to waive this restriction.

There are no special provisions for House consideration, as the House Rules Committee would presumably set the rules for debate. In the Senate, a motion to proceed to the legislation is not debatable, a departure from standing Senate rules under which a three-fifths vote may be required to invoke cloture and proceed to debate. Amendments offered on the floor must be germane and must not reduce the savings below the established targets. The time for Senate consideration may not exceed 30 hours, followed by a final vote. If the House and Senate adopt different versions and Conference is required, debate on any Conference report or amendment is limited to no more than 10 hours.

Amending and Discontinuing IPAB

The ACA sets up special procedures for discontinuing IPAB and its fast-track procedures. In general, it is not in order to "consider any bill, resolution, amendment, or conference report that would repeal or otherwise change..." the processes for Congressional consideration of IPAB. That provision can be waived in the Senate only with a vote of three-fifths of the Members.

Provision is made for a one-time fast-track consideration of a joint resolution to dissolve IPAB. Such a resolution must be introduced in 2017, no later than February 1 of that year. Fast-track procedures call for committee action, with procedures for a discharge petition in the Senate if the committees have not acted within 20 days. A motion to proceed is not debatable, and debate is limited to no more than 10 hours. Action requires approval, before August 15, 2017, of three-fifths of members in the House and Senate.

RELATIONSHIPS BETWEEN IPAB AND OTHER ENTITIES

IPAB is structured to have a strong relationship with HHS and CMS, through ex-officio Board membership, the dominant technical role of the CMS Actuary, and the Secretary's responsibility to present, comment on, and implement IPAB's recommendations. Further, IPAB must submit its draft recommendations to MedPAC, as well as to the Secretary, and MedPAC will comment on those recommendations and continue to advise the Congress more generally on Medicare policy.

Role of the CMS Actuary

The CMS Actuary assumes a great deal of technical authority. The Actuary's projections, without regard to either OMB estimates or the CBO estimates that normally guide Congressional consideration, are the sole trigger for three critical decisions for IPAB and therefore for Medicare: (1) whether IPAB must make recommendations to reduce spending in the implementation year; (2) how deep a reduction is required; and (3) whether the recommendations by IPAB meet those standards for submission to the Congress.

Once the Congressional process is triggered, CBO estimates are determinative. So, for example, IPAB could submit in January a proposal to meet a required savings target of $1 billion. CBO would build that proposal into its Medicare baseline issued in February. The Congress could develop an alternative that CBO scores as staying within that revised baseline (saving $1 billion), which would presumably comply with the rules, even if the CMS Actuary scored that same proposal at $1.1 billion (and thus possibly in excess of the "applicable percentage") or $900 million (and thus below the required savings). It would not be until the CMS Actuary delivers his estimate in April of the next determination year, when the Actuary again assesses Medicare spending under the new policy against the targets, that the Actuary's calculation would come into play.

Role of the HHS Secretary

The HHS Secretary is an ex officio member of IPAB, and the superior official over the other two ex officio members (the Administrators of CMS and HRSA). HHS staff also could be among those detailed to support IPAB. And the Secretary and CMS Administrator are the implementing officials for IPAB recommendations and any revised Congressional proposals.

Additionally, in the case where IPAB is required to make recommendations but for whatever reason fails to act, the HHS Secretary is solely responsible for submitting a proposal to Congress to meet the savings requirements. In that case, the Secretary's recommendations would have the same standing, and fast-track consideration, as the Board's would have had. It would appear that the Secretary's obligation to submit a proposal may technically include a situation in which the Actuary makes a determination that mandatory recommendations are required, but there is a failure of IPAB to act because there are no confirmed or appointed members of IPAB.

MedPAC, CMS, and HHS

Based on the statutorily-defined relationships between IPAB and other entities, the potential exists for collaborative policy development and program improvement. MedPAC has framed policy recommendations for the Congress for years, and would be a valuable resource for IPAB. IPAB, MedPAC, and the new Center for Medicare and Medicaid Innovation (CMMI) within CMS could identify potential models that the CMMI would test, with IPAB in turn building on those tested models in developing its legislative proposals for the Congress. Further, IPAB could be well-served by a strong relationship with CMS to take advantage of its technical expertise and, in particular, its experience in the practicalities of implementation.

Alternatively, the relationships between IPAB and other entities could be more competitive than collaborative. IPAB is designed to be an independent entity, and an IPAB chair and membership appointed by one President and confirmed by the Senate, and working with one set of administration officials, would then need to work equally closely with a new Secretary and CMS Administrator,

representing a newly-elected President, with a policy agenda that may be substantially different. IPAB may then make recommendations that the Secretary and President oppose. IPAB and MedPAC could also develop very different policy agendas, leading to dissonance in the recommendations presented to the Congress. Further, over time, tensions among the various entities could develop. A potential risk is a disconnect between the policy recommendations of IPAB and the administrative imperatives and constraints confronting CMS, which could result in diffused accountability for implementation of Medicare policy. The evolution of these relationships requires careful attention by the leadership of IPAB, HHS, and the Congress.

ISSUES AND QUESTIONS RELATED TO IPAB

Issues Related to Targets and Consideration of Medicare Versus Total Health Care Spending

IPAB's targets, and required recommendations that receive fast-track consideration, relate only to Medicare.[19] However, there are two provisions in the law that affect requirements for IPAB and the Secretary that are related to total health care spending.

- First, IPAB is required to submit mandatory recommendations only if Medicare spending is in excess of its statutory target *and* the medical care component of the CPI-U exceeds the CPI-U. Thus, if medical inflation is lower than general inflation, IPAB does not submit mandatory recommendations even if Medicare spending is in excess of its target. The Congressional Research Service indicates medical inflation has been below general inflation once in 25 years (in 1998).[20]

- Second, starting with determination year 2018, the CMS Actuary must also project growth in national health spending per capita (for implementation years starting with 2020). If Medicare spending growth is lower than the projected growth in national health spending, IPAB is still required to make its mandatory recommendations, but the Secretary must not implement them automatically. This prohibition cannot apply two years in a row, meaning that even if Medicare spending growth remains below that of private health spending, any reductions in Medicare that would occur because Medicare spending growth exceeds the Medicare targets would be implemented in that second year.

As noted earlier, the law also includes provisions requiring advisory reports and recommendations issued by IPAB related to national health spending growth. However, these reports and recommendations do not lead directly to action by Congress or the Secretary.

Some have argued for more attention to total health care costs, for several reasons:

- Growth in underlying health care costs drives all health care spending, including Medicare spending, and is of great concern to the public and employers.
- The federal government has an increasing stake in the issue, as growth in health care costs will drive the new federal spending under the ACA for premium tax credits and cost-sharing subsidies for the uninsured with lower incomes, as well as federal and state costs under Medicaid.
- Attention solely to Medicare spending could have negative implications for beneficiaries if Medicare provider payments fall too far behind private-sector rates. At the same time, employers and private insurers believe that cuts in Medicare payment result in cost shifting to private payers.

Issues Related to Medicare Spending Targets

The new statutory targets on per capita growth in Medicare that trigger IPAB's savings recommendations have been subject to relatively little discussion, but are a central feature of IPAB's role and authority, and the savings attributed to it. Several questions have been raised about these growth targets.

The first and fundamental issue relates to the establishment of enforceable target growth rates for Medicare spending per capita. From a budgetary perspective, setting a target growth rate for Medicare spending–albeit not a "hard cap" but rather a target that compels IPAB to make recommendations, Congress to consider them, and the Secretary to proceed with implementation—is considered by some to be necessary for reining in total federal spending and reducing the deficit. However, any statutory target on Medicare growth, whether imposed by IPAB or other means, could have negative consequences. If, for example, the growth limits do not keep pace with the growth in underlying health care costs, there is concern about the long-term effects on coverage provided to beneficiaries, the adequacy of provider payments, provider participation, and beneficiaries' access to needed services.

The experience with the Sustainable Growth Rate (SGR) formula under Medicare for physician payment illustrates how the application of formulas can have unintended and negative consequences that were not anticipated when Congress created the formula to limit the volume of physician services. This formula, set in budgetary legislation in 1997, caps the statutory growth in aggregate physician payments, limiting increases in physician fees if total spending exceeds specified targets due to volume growth. The result has been an annual series of projected cuts in physician fees throughout the last decade. With one exception, the Congress has blocked the impending cuts from occurring, generally for months or a year at a time, which under the formula results in an increased need for deeper cuts in the future. Most recently, Congress enacted an "extender" law which averted a 25 percent fee cut from taking effect in January 2011. Because formula-driven cuts are built into baseline spending projections, a complete "fix" of the physician payment formula now carries a 10-year price tag of about $300 billion. There is some concern that similar problems could emerge in the future if Medicare spending is constrained by a formula set forth in the law that IPAB is required to recommend and the Secretary to implement.

On the one hand, the SGR has imposed some constraints on Medicare spending growth and on the Congress. On the other hand, it has made Medicare an unreliable partner with physicians, whose participation is essential to carrying out the program's mission of assuring access to care for beneficiaries. While national surveys of access have thus far not flagged beneficiary access issues[21] the concerns about the long-term impact on access remain.

Importantly for IPAB purposes, the SGR yields a budget "baseline" for physician payments in Medicare that is artificially low, because the Congress is highly likely to continue to prevent such deep cuts. The CMS Office of the Actuary, in an August 5, 2010 memo setting out alternative growth assumptions in Medicare, recounts the history of the SGR and states that "Multiple consecutive years of large negative updates are extremely unlikely to occur."[22] To account for that baseline problem with the SGR, the law sets an assumption that in computing the Medicare projection on which IPAB action would be based, the Actuary is to assume a zero percent increase in physician payment rates rather than the cuts called for in the statute. This complicates whether and how IPAB is to deal with physician payments. The actual baseline is whatever is in law, including the negative updates, but the IPAB baseline assumes a freeze. As a technical matter, it is unclear what would happen if IPAB makes a statutory recommendation to enact a freeze for several years. From the Board's baseline perspective, this has no cost, but it clearly has a CBO scoreable cost.

Another concern that has been raised relates to problems that could result from having a trigger based in part on projections rather than actual data. The Actuary is required to use a five-year average calculation of Medicare spending in which the key assumption is the projection for the implementation year, from which the five-year average is calculated. Theoretically, if estimates for that implementation year are higher than actual Medicare spending, IPAB could be compelled to recommend savings that may not have been required based on what actually happens, and the converse is true if the Actuary projects spending lower than that which actually occurs.

The second issue relates to the specific targets themselves, how they compare with underlying growth rates, and the likelihood and depth of potential action required by IPAB. The law establishes targets for Medicare per capita spending—one based on a measure of inflation (2015-2019) and the other based on GDP plus one percentage point (beginning in 2020)—that have historically grown at slower rates than Medicare per capita spending over the last 25 years. From 1985-2009, Medicare spending growth per capita exceeded by 2.7 percent the initial target based on the average of the CPI and the Medical Care Component of the CPI. During this same period, Medicare spending growth per capita exceeded by 1.6 percentage points the longer term target of growth in GDP per capita plus one percentage point.

Average Annual Growth in Medicare Spending and Economic Benchmarks, 1985 - 2009[23]	
Medicare spending per enrollee	**6.7%**
Average of CPI and CPI-Medical Care	**4.0%**
GDP per capita plus 1 percentage point	**5.1%**

Given any target, whether through IPAB or other means, it is never clear what the "right" number should be, but the decision is expected to have significant implications for Medicare. There are both technical and political questions about the proper growth trajectory over time, and that becomes especially difficult when looking at individual years. The target, whether relatively tight or relatively loose, is the key determinant for coming to a decision that Medicare spending has grown more rapidly than a benchmark, and for setting in motion a process that will result in Medicare savings.

Projections for Medicare spending typically change to reflect inflation forecasts and Medicare-specific issues, Those changes can have a substantial impact on whether and how much savings IPAB must achieve. When the health reform law was enacted in March 2010, CBO estimated that IPAB would achieve savings of $15.5 billion in FY 2015-2019. CBO's most recent Medicare baseline states that "CBO's projections of the rates of growth in spending per beneficiary in the March 2011 baseline are below the target rates of growth for fiscal years 2015 through 2021. As a result, CBO projects that under current law, the IPAB mechanism will not affect Medicare spending during the 2011-2021 period."[24]

Issues Related to Achieving Savings in a Single Implementation Year

The test for whether IPAB's recommendation meets the target is whether it brings spending in that one year down to the target, subject to the constraints of the "applicable limits." The only longer-term consideration is that total spending over the 10-year period cannot increase above the Medicare baseline. While the requirement to achieve Medicare savings for the implementation year provides a clear direction and target for the Board, it may discourage the type of longer-term policy change that could be most important for Medicare and the underlying growth in health care costs, including delivery reforms that MedPAC and others have recommended which are included in the ACA—and which generally require several years to achieve savings. If these delivery system reforms are not "scoreable" for the first year of implementation, IPAB may be more likely to consider more predictable, short-term scoreable savings, such as reductions in payment updates for certain providers.

Issues Related to IPAB's Scope of Authority

The scope of IPAB's recommendations raises issues from differing perspectives. On the one hand, the statutory limits on IPAB were designed to preserve Congressional prerogatives over key elements of program design, and provide some substantive and political protection for beneficiaries and selected providers. On the other hand, statutory constraints on scope require the Board to limit its payment policy changes to the other providers, and prevent it from recommending more substantive policy changes that would apply across the entire program.

There are a number of open questions about IPAB's scope of authority that affect providers, plans and others health industry stakeholders. In addition, even with constraints imposed in the law, questions remain as to the reach of IPAB with respect to beneficiaries.

Plans and Providers

The law prohibits IPAB from making recommendations affecting certain providers, including those receiving updates under the ACA that are below market basket increases by more than the productivity adjustment. IPAB would appear to have the authority to make recommendations that affect providers and others that are not explicitly exempted. Together, with the limitations that appear to be imposed on recommendations that would more directly affect beneficiaries, these constraints mean that reductions achieved by IPAB by 2020 are likely to affect payments related to Medicare Advantage (MA), the Part D prescription drug program, and skilled nursing facility services.

These constraints also narrow IPAB's scope even within the payment policy arena. There is uncertainty unclear whether IPAB may, within its scope, address other aspects of payments beyond "payment rates" before 2021 for otherwise protected entities such as hospitals. For example, could IPAB make recommendations to alter payment for "never events," or propose changes in medical education payment policy, with the rationale being that those are not reductions in payment rates but alternative approaches to payment policy?

The Medicare physician payment policy issue under the SGR formula noted previously also complicates the scope of IPAB's review of provider payments. Given the artificially low current law baseline for physician services, and the pattern of annual extensions of the SGR policy for physician payment, it would appear to be very difficult for IPAB to make mandatory recommendations in this critical area of Medicare payment policy.

Limits in payments under Medicare Advantage and Part D are explicitly within the scope of IPAB's authority. For example, 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 the ACA provisions that set MA payments below FFS payments in some communities.

With respect to prescription drugs, it would appear that 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 IPAB 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.

Provisions Affecting Beneficiaries

Despite efforts to limit the reach of IPAB with respect to beneficiaries, there is some ambiguity in the ACA that could leave room for proposals that could directly or indirectly affect beneficiaries. The statute explicitly takes benefits, premiums, cost sharing, and "rationing" out of the scope of IPAB's general authority, which appears to remove beneficiary issues from consideration. Yet, it is not entirely clear which proposals would be outside the scope of IPAB's authority.

For example, it is not clear whether IPAB could adopt a recommendation that would prohibit Medigap policies from offering first-dollar coverage, as has been suggested by some in the context of current deficit reduction discussions. Medigap products are the private insurance policies purchased by some beneficiaries to supplement Medicare, often by covering Medicare deductibles and cost sharing. According to CBO, MedPAC, and others, Medigap coverage increases Medicare costs because it lessens the disincentives to utilization that the underlying Medicare cost sharing imposes. CBO has estimated that limiting the ability of Medigap policies to cover Medicare cost sharing could save more than $40 billion over 10 years.[25] This proposal would not directly reduce benefits or raise Medicare cost sharing per se. Thus it is not clear whether IPAB has the authority to include such a policy in its mandatory recommendations.

It is also not clear whether IPAB could make recommendations that would affect low-income beneficiaries who are either dually eligible for both Medicare and Medicaid, or those who qualify for special subsidies of premiums and/or cost sharing under the Medicare Savings Programs or the Part D Low Income Subsidy program. The statute prohibits IPAB from making mandatory recommendations relating to any program other than Medicare, but it is unclear whether IPAB could, for example, require dual eligibles to enroll in low-cost managed care plans in a given area.

Benefit redesign is another area of reform that has received considerable attention of late, but appears to be beyond the scope of IPAB, unless on an advisory basis. By lowering the growth rate in Medicare spending per capita, IPAB is intended to preserve a financially viable Medicare program for future as well as current beneficiaries. And for the long-term viability of Medicare, whether to improve the program or to achieve savings, policy proposals for benefit redesign may be needed, whereas IPAB can make only advisory recommendations. For example, the idea of modifying Medicare premiums and cost sharing has emerged in several deficit reduction proposals. The National Commission on Fiscal Responsibility and Reform recommended a single deductible along with a relatively high limit on out-of pocket spending (although they did not have sufficient votes to report out a formal recommendation). The Rivlin-Domenici Task Force also endorsed this idea, as have others. This idea was described by CBO in its December 2008 report *Budget Options*,[26] and MedPAC in its most recent report identified options for both short- and long-term changes in Medicare's benefit design.[27] Yet, it would appear these reforms may be beyond the reach of IPAB, based on the constraints established by the law.

More broadly, to the extent changes in payments to providers affect beneficiaries' access to care, such policies have an impact on beneficiaries. This issue is raised by the current physician payment limits and in evidence in Medicaid, where the state provider payment constraints are often severe, and is a potential consequence of any enforced target for Medicare growth, whether through IPAB or other means. If IPAB recommends policies that squeeze Medicare payment rates without equal pressure being placed on private payment rates, there is some concern that Medicare beneficiaries would be at greater risk of having access problems, as providers become more inclined to serve other patients. While the ACA requires that proposals achieve the savings target "...while maintaining or enhancing beneficiary access to quality care...", there is no further clarification of how this is to be determined. The law calls for a GAO report no later than January 1, 2015, that includes a study of effects on access, affordability, and quality, but since 2015 is the first implementation year, that would appear to be too early for any clear assessment,

and there is no required follow-up to that report by GAO, IPAB, HHS, or any other entity. IPAB would be required to continue to make annual recommendations to further constrain payments if the CMS Actuary determined that Medicare spending exceeded the target, even if evidence of access or quality concerns surfaced.

Even more broadly, it is unclear whether IPAB could limit FFS payments to the level of the lowest price Medicare Advantage plan in the community, or offer beneficiaries the equivalent of a voucher priced at that level, along the lines that some have proposed in the context of deficit reduction proposals.

Issues Related to Prohibition on Judicial Review

It is not clear how the broad prohibition on administrative or judicial review of the Secretary's implementation of IPAB proposals will be interpreted. Congress has on occasion waived judicial review under the Medicare statute for the Secretary's implementation of various components of, for example, a new or revised payment methodology. The waivers tend to apply to specific technical components of that methodology. One question about IPAB language is how to interpret IPAB's processes and scope of authority. What is the situation if IPAB makes a recommendation that the Congress fails to amend on the required timetable but that the Secretary questions as to whether it is within the scope of IPAB's authority—a provision, for example, applying to one of the protected providers, or affecting beneficiary cost sharing in some manner?

POLICY OPTIONS

In light of issues that have been raised, a variety of policy options could be considered for revising or refining various features of IPAB. On the one hand, some propose to repeal IPAB altogether. 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.[28] On the other hand, some individuals and groups, such as the Bowles-Simpson National Commission on Fiscal Responsibility and Reform, have recently proposed to strengthen the role and authority of IPAB to give it greater flexibility to reduce the growth in Medicare spending. And others have proposed a range of options that could be considered to modify the structure of IPAB as currently outlined in the ACA.

In the following section, we catalogue a range of options that could be considered. The menu of options presented below is not exhaustive. Several of the options relate to clarifications in cases where the statutory language raises issues and questions that appear to require greater clarity. Other options described below could either strengthen or weaken the role of IPAB, depending on policy desires. One set of options would generally build on and enhance IPAB's authority so that it can deal with Medicare more comprehensively, and possibly even all of health care spending, with fewer constraints on recommendations. Another set of options would pull back somewhat from IPAB's current statutory requirements and authority, such as modifying the spending targets or imposing fewer constraints and timelines on Congressional deliberations.

Options to Modify Medicare Spending Targets

- **Drop the targets:** IPAB could continue to make recommendations, and could opt to hit whatever target it thought appropriate, but without the constraint of the statutory target and trigger for IPAB action. This approach would retain IPAB as an expert advisory body, whose proposals would merit fast-track consideration in Congress, but without the target. This would likely be scored by the Congressional Budget Office as increasing spending because of the loss of guaranteed target that yielded previously scored savings attributed to IPAB.

- **Retain and revise the targets:** In general, such options would be designed to move IPAB targets in one of two directions. Targets could be tightened so that IPAB is even more effective as a budget and deficit control device. Alternatively, the targets could be weakened. For example, greater weight could be given to medical care prices than general price increases. Or the target could be based on a comparison of Medicare and private per capita spending for similar services, requiring IPAB to make formal recommendations with fast-track follow-up only when program spending is *substantially* above projected growth patterns. Over the 1970-2009 period, Medicare has actually grown more slowly than private health insurance (8.3 percent per year compared with 9.3 percent[29]), although the pattern varies in different time periods. CBO originally estimated savings from IPAB and now projects that Medicare spending will be within the targets through 2021, and such annual changes in projections, and impact on whether IPAB is required to issue mandatory savings recommendations, can be expected to continue.

- **Modify the five-year timeframe used to calculate the target:** Careful analysis would be needed to assess the impact, but the implications of alternative timeframes for the target calculations could be considered.

- **Allow savings to accrue over a longer period of time, rather than in a single "implementation" year:** The requirement to achieve Medicare savings for the implementation year may discourage the type of longer-term policy change that could be most important for Medicare and the underlying growth in health care costs, including delivery reforms which generally require several years to achieve savings.

Options to Modify the "Applicable Limits" for Medicare Savings Targets

- **Raise or eliminate the applicable limits:** This would allow IPAB to keep Medicare spending below the targets, without the current law constraints. This could turn the current-law IPAB targets into a true cap on spending growth. If a two percent cut in spending is called for, then IPAB would be called on to reduce spending by the full amount required to reach that target.

- **Reduce the applicable limits, or allow the limits to phase in more slowly:** This would reduce the magnitude of savings that IPAB would be charged to recommend. The applicable limits could be phased in more slowly, for example staying at 0.5 percent of Medicare spending or phasing up to 1 percent of Medicare spending rather than 1.5 percent by 2018.

Options to Revise the Process for IPAB and Congressional Consideration of Proposals

- **Give IPAB its own actuary:** IPAB could be given more independence from HHS by assigning it its own actuary for purposes of making determinations under the statute, rather than assigning this authority to the CMS Actuary, and/or by limiting HHS ex officio representation to the CMS Administrator rather than the three officials now named.

- **Modify the Secretary's authority to implement IPAB proposals:** The requirement that the Secretary advance a proposal in the event that IPAB fails to act, with that proposal then benefiting from the same fast-track treatment available to IPAB, could be revised. For example, in the event that IPAB fails to act, the statute could recognize that there were no recommendations that year, allowing the Congress to deliberate and set policy under standard procedures. Alternatively, to maintain adherence to the statutory targets, if retained, the statute could call for a simple sequestration proposal to be presented to the Congress in that situation, to be implemented by the Secretary if the Congress fails to develop an alternative.

- **Revise IPAB's quorum rules:** IPAB's quorum rules could be revised given the importance of the recommendations it ultimately makes. For example, a super majority could be required to constitute a quorum and to vote out IPAB proposals. The rules could also be revised to require a minimum number of members to be present for a vote to avoid giving a few members excessive authority if the Senate does not confirm all 15 members.

- **Revise the Congressional super-majority requirements:** The super-majority requirements for Congressional amendments to the recommendations that may differ from the underlying targets could be revised, allowing the standard working majorities to make decisions, as is the case for other statutory decisions.

- **Remove the prohibitions on administrative and judicial review:** Administrative and judicial review provisions could be clarified to deal with situations in which it is questionable whether IPAB is acting within the bounds of its authority. The statute could clarify that the Secretary is not to act on particular provisions if it is determined that it is questionable whether that IPAB provision was within the Board's authority.

- **Eliminate the fast-track provisions for adoption of IPAB proposals:** The ultimate change would be to drop the Congressional fast-track provisions altogether, which would turn IPAB into a more traditional advisory body.

Options to Revise the Scope of Recommendations Affecting Benefits

- **Clarify IPAB's authority with regard to benefits:** Clarity could be provided about the definitions and constraints envisioned in the current language of the ACA. Such clarity would yield a greater understanding of what the Board can and cannot recommend, and could be designed to tighten or loosen IPAB's authority depending on policy objectives.

- **Remove the prohibition on IPAB consideration of benefit changes:** The statutory prohibition on IPAB making recommendations related to benefits or cost sharing could be changed. It could be modified to allow IPAB to recommend selected cost sharing and benefit adjustments. For example, it could propose tradeoffs between improved catastrophic coverage coupled with higher cost sharing for

other services in the program. Alternatively, the constraint could be eliminated, presumably as part of a more general broadening of IPAB's authority. This would give the Board the ability to deal with a broader range of Medicare issues, though it could also raise concerns about such a wide scope of authority over core Medicare issues such as benefits.

- **Strengthen the requirements related to beneficiary access and quality:** IPAB could be directed to balance its requirements to hit specified spending targets with stronger requirements related to beneficiary access and quality. The statutory requirement about maintaining or enhancing beneficiary access to quality care could be strengthened. For example, given the overall direction of the ACA to pursue quality improvement while constraining costs, the requirement could be restated to call for improving quality and access, not just maintaining it. Further, the provision could be strengthened by requiring certification and a report by HHS that the proposals will improve quality and/or access, and put in place a tracking and reporting requirement on these critical indicators, including extending the GAO reporting requirement beyond the January 2015 reporting date, with default provisions limiting further action by IPAB if it appears that either access or quality have been compromised.

Options to Revise the Scope of Recommendations Affecting Providers

- **Clarify the extent of IPAB's authority as it relates to providers:** One option would be to clarify the extent of IPAB's authority, and the constraints on that authority, in particular as it relates to the providers protected from payment rate reductions prior to 2020, as well as physicians. Such clarity is needed to address such questions as whether IPAB can make mandatory recommendations other than payment rate reductions, such as proposals to change medical education financing, and to specify exactly what is IPAB's scope of authority for physician payments.

- **Eliminate some or all of the statutory prohibitions on the scope of IPAB's required recommendations:** For example, the statutory protections for selected providers until 2020 could be repealed, or the time period for the protections shortened (to 2017, for example). While it may still be difficult for IPAB to recommend further cuts given the current law payment reductions, removing the statutory constraint on IPAB would give it the flexibility to review the data in future years and make policy judgments.

- **Place additional constraints on the scope of IPAB's authority related to providers:** IPAB could be further constrained, for example, by including physicians within the providers that cannot be addressed until the SGR problem is permanently fixed in some manner by the Congress.

Options to Revise the Scope of Recommendations Affecting Non-Medicare Spending

- **Require IPAB to submit recommendations related to private health spending:** The Secretary could then apply these recommendations to the qualified health plans providing health benefits in the new health insurance Exchanges, beginning in 2014, where federal premium and cost-sharing subsidies are provided.

- **Require IPAB to more directly address private sector spending as well as Medicare spending:** To do that, it would likely be necessary to establish a formal process for first recommending the appropriate targets for Congressional review. Then, IPAB would be called on to make recommendations when spending exceeds those targets. For example, it might be called on to make

recommendations that would allow (or require) private health plans or third party administrators serving self-insured employers, to link their private sector payment rates for providers to Medicare payment rates (either at the Medicare rate or some percentage above them).

CONCLUSION

One of the rationales for establishing IPAB was to separate Medicare policymaking from Congressional politics. It is an independent body that can make expert recommendations about Medicare, within spending constraints established by Congress in the enabling legislation. It is presumed to make these recommendations without the political pressures that often confront elected officials, and with a fast-track Congressional review process and default implementation in the absence of Congressional action. The Congress, in enacting IPAB, subjected itself to future constraints in the form of the fast-track process, and shifted policy authority to IPAB and other executive branch officials, through both the new authority provided to IPAB and the explicit constraints and timetable the ACA placed on the Congress.

IPAB evolved from a long history of concern about Medicare spending and Medicare governance, and like any major change in a public program, it raises issues to deal with in the future. IPAB continues to be the source of some controversy. Some groups are pushing to repeal IPAB even though they support other provisions of the ACA, and are pressing for implementation. Others see great promise in IPAB, particularly given concerns about the future growth in health care spending.

Looking to the future, a number of questions are on the table. Will IPAB's role be strengthened so it can play a greater role in efforts to reduce the federal deficit and slow the growth of Medicare and other federal health care spending? Will IPAB be operational by 2013, and if so, will Congress make any changes to modify its structure and authority between now and then? Will IPAB be repealed despite strong support among key policymakers?

Given the important role this new independent board is authorized to play in Medicare policy and budget discussions, and the potentially significant implications for beneficiaries, health plans, and providers, IPAB is likely to be the subject of considerable interest in the months and years to come.

ENDNOTES

[1] P.L. 111-148; P.L. 111-152.
[2] A recent example from the 112th Congress of legislation to repeal the IPAB provision is H.R. 452, the "Medicare Decisions Accountability Act of 2011" sponsored by Rep. Phil Roe (R-TN).
[3] Senator Jay Rockefeller, Press Statement, June 2009.
[4] Congressional Budget Office. *The Long Term Budget Outlook*. June 2010.
[5] Kaiser Family Foundation. *A Primer on Medicare Spending and Financing*. February 2011.
[6] Previously, the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC) served Congress in this advisory capacity before the two Commissions were merged into one, as MedPAC.
[7] Stuart M. Butler and Robert E. Moffit. *The FEHBP as a Model for a new Medicare Program*. Health Affairs, Winter, 1995.
[8] Lynn Etheredge. *Promarket Regulation: An SEC-FASB Model.* Health Affairs, November/December, 1997.
[9] Hoangmai H. Pham, Paul B. Ginsburg, and James M. Verdier. *Medicare Governance and Provider Payment Policy*. Health Affairs, September/October 2009.
[10]Congressional Research Service. *Memorandum from Rogelio Garcia to the Bipartisan Commission on Medicare. Subject: Organizational Factors Affecting Independence of Proposed Federal Medicare Board.* February 23, 1999.
[11] National Academy of Social Insurance. *Improving Medicare's Governance and Management.* July 2002.
[12] Paul N. Van de Water. National Academy of Social Insurance and National Academy of Public Administration. *Designing Administrative Organizations for Health Reform*. January 2009.
[13] Congressional Budget Office. Letter to Steny H. Hoyer, Majority Leader, U.S. House of Representatives, July 25, 2009.
[14] Congressional Budget Office. Letter to House Speaker Nancy Pelosi, March 20, 2010.
[15] Opm.gov/oca/11tables. January 2011.
[16] Sec. 3401 of PPACA calls for reducing market basket updates for providers by a productivity adjustment, computed as the 10-year moving average of annual changes in economy wide nonfarm multi-factor productivity. In addition, certain providers have further payment reductions below those productivity adjustments.
[17] Congressional Research. *The Independent Payment Advisory Board,* November 30, 2010: see Appendix Table C-1, page 32 for detailed review of the applicable exemptions.
[18]Congressional Research Service. *The Independent Payment Advisory Board*, November 30, 2010, provides an excellent background on these procedures as well as on other IPAB provisions..
[19] Senators Rockefeller, Lieberman and Whitehouse developed an amendment to strengthen IPAB for consideration on the floor of the Senate. It would have required, in years when there are no Medicare spending targets to achieve, that IPAB make recommendations to the private sector. The Secretary of HHS would have been required to review those proposals, and the amendment would have provided her with the authority to apply the proposals as she sets the requirements for certification of qualified health benefit plans operating in the new Exchanges established under the ACA. The amendment was not included in the final legislation.
[20] CRS, IPAB, November 30, 2010.
[21] Medicare Payment Advisory Commission. *Report to the Congress, Medicare Payment Policy*, March 2010. (See Table 2.B.1.)
[22] John D. Shatto and M. Kent Clemens (CMS Actuaries). *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment updates to Medicare Providers.* August 5, 2010.
[23] Kaiser Family Foundation. *A Primer on Medicare Spending and Financing*. February 2011.
[24] Congressional Budget Office. March 2011 Medicare Baseline, March 18, 2011.
[25] Congressional Budget Office. *Budget Options, Volume 1. Health Care*. December 2008
[26] Congressional Budget Office. *Budget Options, Volume 1. Health Care*. December 2008.
[27] Medicare Payment Advisory Commission. *Report to the Congress: Aligning Incentives in Medicare*. June 2010.
[28] Wilson, Duff. "Industry Aims at Medicare Board." *New York Times.* November 4, 2010
[29] Centers for Medicare & Medicaid Services. Office of the Actuary, National Health Statistics Group, 2011.

THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

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