

MERCATUS ON POLICY

The Independent Payment Advisory Board

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The Affordable Care Act (ACA) is known primarily for its provisions that subsidize and regulate health insurance for the working-age population and their families, but it also made many important changes to the Medicare program. Perhaps the most important of those changes is a new upper limit on Medicare spending, enforced by the Independent Payment Advisory Board, or IPAB.

It remains surprising, five years after the fact, that Congress, at the urging of the Obama administration, imposed a new cap on overall Medicare spending growth in the ACA. Placing an upper limit on annual Medicare expenditures is an idea that would normally be associated with policymakers more focused on restraining entitlement spending than with those who wrote and passed the ACA.

But not all “caps” are created equal. The key feature of a cap is how it is enforced. And using the IPAB to restrain Medicare growth is actually very much in line with an approach to healthcare policy that emphasizes cost control through government regulation rather than competition and consumer choice.

HOW THE CAP AND THE IPAB WORK

The ACA specifies targets for annual Medicare growth per beneficiary. From 2013 to 2017, the target growth rate is the average of the consumer price index for all products and services and the consumer price index for medical care. After 2017, the target growth rate is aggregate GDP growth plus 1 percentage point.¹

The IPAB is a 15-member board appointed by the president and charged with enforcing the Medicare

spending targets. The law specifies that the IPAB members cannot engage in any other “business, vocation, or employment,” which means they must rely entirely on their salary as IPAB members.² These IPAB members are also supposed to be nationally recognized experts in medical care, health insurance, or economics, and a majority of members on the board must not be physicians or professionally associated with other healthcare service providers, such as hospitals. These criteria are very restrictive and are likely to lead many of the nation’s true experts on Medicare and health costs to decline membership in the IPAB because it would effectively terminate their other relationships that are more rewarding, both financially and professionally.

If the chief actuary of the Medicare program determines that the program is going to exceed the target growth rate, then the IPAB is required to make recommendations to eliminate the excessive spending.

But the IPAB is severely constrained in what it can recommend to bring Medicare spending below the target. The law states that IPAB recommendations cannot increase beneficiary premiums or cost sharing, and it cannot reduce benefits in any way. The IPAB also cannot recommend tax increases. The only options available to the board are adjustments to what Medicare pays for various medical services.

Certification by the IPAB of recommendations to trim Medicare cost growth triggers an expedited process in Congress to enact legislation that would eliminate any projected breach of Medicare spending above the target growth rate for Medicare spending. In this process, the default assumption is that the House and Senate will consider the IPAB’s recommendations, but Congress can also choose to approve a different set of changes from the IPAB’s recommendations. If those alternate provisions were passed by Congress and signed into law by the president, then of course the IPAB’s recommendations would become moot.

However—and this is the most important point about the IPAB—if Congress fails to pass legislation that overrides what the IPAB recommends, *then the IPAB’s recommendations automatically go into effect.*

Although the IPAB was supposed to begin operations in 2013, the president has yet to nominate anyone to fill the 15 seats. That has not been a problem to date because Medicare spending has risen at rates that are low by historical standards, and thus there has not yet been a

finding by the actuaries that spending must be reduced to keep spending growth below the targeted rate. Thus, nothing yet has occurred which would trigger the IPAB to take action.

A FLAWED CONCEPT

There are two primary reasons why the IPAB, as constituted in the ACA, is a misguided way to control Medicare spending.

1. The IPAB Shifts Legislative Power from Congress to an Unaccountable Technocratic Body

As conceived in the ACA, the IPAB would have sweeping powers that have traditionally resided in Congress. In years when Medicare spending is expected to exceed the target, the IPAB would have the authority to rewrite any aspect of Medicare’s payment policies—including hospital payments, physician fees, and even the way Part D prescription drug plans pay for covered medications—to achieve additional savings. Although the law on paper allows Congress to substitute its own ideas for the IPAB’s reforms, in reality it is very unlikely that Congress would ever be able to override the decisions of the board. For one thing, the timeline is too constrained. The IPAB must submit its plan for reducing Medicare spending to Congress by January 15. Those recommendations automatically go into effect on August 15 unless Congress passes, and the president signs, an alternative plan before that date. Inevitably, the changes needed to reduce Medicare spending below the target will be controversial, making swift congressional consideration difficult, at best.

Moreover, even if Congress were to pass an alternative to the IPAB’s plan, that alternative would need to be approved by the president. It seems far more likely that the president will prefer the recommendations of the IPAB, a board to which he will likely have appointed at least some of the members. If that is the case, he will veto the congressional alternative and thus force Congress to attempt an override, which requires a two-thirds majority vote in both the House and Senate. Overrides of presidential vetoes are very rare occurrences.

The broad delegation of authority to the IPAB to rewrite much of how Medicare operates is a major encroachment on what should be a congressional function.

Congress has the constitutional power to write new legislation for a reason: voters can hold their elected representatives accountable for the kinds of laws they pass. Not so, at least not directly, with the IPAB. Board members are appointed for six-year terms and may be reappointed once. Removing them from their positions is extremely difficult. In short, once they are on the board, IPAB members will answer to no one for what they recommend and put into effect in the Medicare program. That lack of accountability is reason enough to oppose the entire concept of the IPAB.

2. Payment Regulation Instead of Real Reform

The restraints placed on what the IPAB can recommend—in effect, no changes in the relationship of the beneficiaries to the program—were not accidental. The authors of the ACA support restraining Medicare spending, but only with government-imposed payment restrictions, not consumer financial incentives. This means the IPAB can propose blunt payment cuts for physicians and hospitals as well as for the HMOs serving Medicare patients; but it cannot recommend structural changes, like introducing stronger price competition among competing insurance offerings or giving participants in the program more up-front responsibility for the cost of care. This is the case even though these changes would encourage the beneficiaries to use services more judiciously or to sign up for lower-cost options.

Using payment cuts exclusively as a means of controlling Medicare costs is a shortsighted approach. As can be seen in the Medicaid program today, if payments are reduced too much, the network of willing providers of medical services becomes very constrained, and the participants in the program begin to have trouble securing access to the care they need.

The IPAB was created to facilitate cost control through payment rate reductions, but this means it also pushes aside reforms that have the potential to do much more to improve value and efficiency in the Medicare program.

CONCLUSION

In 2010, as part of the Affordable Care Act, Congress put a cap on future Medicare spending growth and created a new, unaccountable board to enforce the growth

cap with payment regulations. Members of Congress from both parties have taken notice of the threat that the IPAB represents to their role in Medicare oversight. In June 2015, the House passed legislation to repeal the IPAB in its entirety.³

Cost discipline in Medicare is certainly needed. But the ACA's cap on Medicare spending, enforced by the IPAB, is the wrong way to go about addressing costs. The IPAB is a clear example of an unelected and unaccountable technocratic body given the power to make decisions that should be handled by the people's elected representatives. It would also further entrench an approach to cost control—payment rate regulation—that stifles innovation and reduces access to care, even as it also precludes more promising approaches to reform.

NOTES

1. John M. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Office of the Actuary, Centers for Medicare and Medicaid Services, July 22, 2015.
2. See Patient Protection and Affordable Care Act, § 1899A, 42 U.S.C. § 1395kkk (May 2010).
3. The Congressional Budget Office estimated that IPAB repeal would increase federal spending by \$7.1 billion through 2025, which is less than 0.1 percent of Medicare spending over that period. See Congressional Budget Office, "H.R. 1190: Protecting Seniors; Access to Medicare Act of 2015," June 11, 2015.

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