

## Mission Impossible: Medicare's Independent Payment Advisory Board

By John R. Graham

Before Congress passed the law federalizing health care, President Obama used to say that the government would save money by implementing the principle that if the “red pill” works just as well as the “blue pill,” but costs half as much, patients should use the red pill.

This dangerously simplistic notion is incorporated in the Independent Payment Advisory Board (IPAB), a creation of the Patient Protection and Affordable Care Act (PPACA). IPAB, governed by a 15-person board of presidential appointees, targets certain Medicare spending, and attempts to take it away from congressional oversight. As stated by an advocate: “A common theme in the health care reform debate in recent years has been the need for a board of impartial experts to oversee the health care system. . . Congress is too driven by special-interest politics and too limited in expertise and vision to control costs.”<sup>1</sup> Much of the section of PPACA that institutes IPAB is given over to describing the byzantine rules and procedures that try to limit Congress’ ability to derail IPAB’s recommendations.<sup>2</sup>

IPAB’s authority is triggered when Medicare’s future spending is anticipated to increase faster than a target rate. The target growth rate through 2018 is the average of the change in the Consumer Price Index (CPI) and the medical-care component of the CPI. For 2018 and later, the target rate is nominal Gross Domestic Product (GDP) per capital plus 1 percentage point.

For every year the projected Medicare growth rate exceeds the target, the IPAB will put forward proposals to cut spending by a certain percentage that increases to 1.5 percent (after 2017) or the projected excess, whichever is less.<sup>3</sup> But IPAB may only attack *some* providers. Before 2020, it may not target providers for which rates are already cut by Obamacare – primarily hospitals.

### Key Points:

- The Independent Payment Advisory Board (IPAB) is a new bureaucracy established by Obamacare that will limit Medicare beneficiaries’ access to certain medical goods and services—especially new prescription drugs.
- IPAB puts Medicare beneficiaries’ access to prescription drugs and certain other medical goods and services under control of a board of 15 presidential appointees, while leaving decisions about other medical goods and services under control of Congress.
- IPAB will be called upon to cut much more Medicare spending than officially estimated, because physicians and hospitals are highly likely to succeed in restoring the cuts that Obamacare imposes upon them.
- IPAB could deny Medicare beneficiaries access to every innovative prescription drug introduced every year, but still have little effect on Medicare spending.
- As long as Congress exerts political control over Medicare beneficiaries’ access to medical care, all treatments and providers should be treated equally, which implies that IPAB should be abolished.

For the entire 25 years, 1984 through 2009, medical inflation has increased at a faster rate than CPI in every year except 1997, when both increased by a rate slightly over 2 percent.<sup>4</sup> From 1985 through 2009, Medicare spending per enrollee has increased by an average of 6.7 percent annually, whereas CPI has increased by 2.9 percent, its medical-care component by 5.1 percent, and GDP per capita by 4.1 percent.<sup>5</sup>

**IPAB targets certain Medicare spending, and attempts to take it away from congressional oversight.**

So, if history is a guide, the first spending target would be 4 percent (the average of 2.9 percent and 5.1 percent), and we should expect the increase in Medicare spending to be *fully two-thirds above target*, or 2.7 percentage points. The second spending target would be 5.1 percent (4.1 percent plus one percent). Even with this higher target, the actual increase in Medicare spending would be almost *one-third above target*. But official estimates of IPAB's consequences are implausibly small.

Table 1 shows how little effect IPAB is supposed to have in the years to come. Column A reports estimated Medicare spending over this decade. Column B reports the amount of money saved by IPAB's actions. The reason for this disconnect between the past and the future is the magical thinking incorporated into post-Obamacare estimates of Medicare spending.

**Table 1: Obamacare Spending, 2010-2019, Under Different Assumptions (\$ billions)**

	A	B	C	D	E	F	G	H
	Medicare Spending	Of Which: IBAP Savings	Of Which: Physicians' Fee Schedule Cut As Per SGR	Medicare Spending With Physicians' Fee Schedule Restored (A+C)	PPACA Section 3401 Provider Cuts	PPACA Section 3401 Cuts to Inpatient Prospective Payment System (subset of E)	Physicians' Fee Schedule Cut + Inpatient Prospective Payment System Cut (C+F)	Medicare Spending With Physicians' Fee Schedule and Inpatient Prospective Payment System Restored
2010	\$529	\$0	\$0	\$529	(\$0)	(\$0)	(\$0)	\$530
2011	\$555	\$0	\$0	\$555	(\$1)	(\$1)	(\$1)	\$556
2012	\$570	\$0	(\$12)	\$582	(\$5)	(\$3)	(\$15)	\$585
2013	\$609	\$0	(\$20)	\$629	(\$9)	(\$5)	(\$25)	\$634
2014	\$646	\$0	(\$23)	\$669	(\$14)	(\$8)	(\$31)	\$676
2015	\$678	(\$1)	(\$28)	\$706	(\$19)	(\$10)	(\$38)	\$716
2016	\$726	(\$2)	(\$30)	\$756	(\$26)	(\$14)	(\$44)	\$770
2017	\$766	(\$4)	(\$35)	\$801	(\$34)	(\$19)	(\$54)	\$820
2018	\$812	(\$7)	(\$40)	\$852	(\$43)	(\$24)	(\$64)	\$876
2019	\$880	(\$10)	(\$45)	\$925	(\$54)	(\$30)	(\$75)	\$955

Source: Authors' calculations based on Richard S. Foster, Estimated Financial Effects of the "Patient Protection and Affordable Care Act", as Amended (Baltimore, MD: Centers for Medicare & Medicaid Services, Office of the Actuary, April 22, 2010); National Health Expenditure Projections 2009-2019 (Baltimore, MD: Centers for Medicare & Medicaid Services, Office of the Actuary, September 2010); 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds (Washington, DC: The Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, August 5, 2010); The Budget and Economic Outlook: Fiscal Years 2011 to 2021 (Washington, DC: Congressional Budget Office, January 26, 2011); March 2011 Medicare Baseline (Washington, DC: Congressional Budget Office, March 2011).

First, Obamacare assumes dramatic cuts to physicians' fees, just like Congress assumed pre-Obamacare. The Sustainable Growth Rate (SGR), introduced in 1997, was meant to constrain Medicare's physicians' fee schedule by the growth in GDP. Because the Medicare Economic Index (MEI, which estimates the costs of inputs to physicians' practices) has been increasing faster than GDP for years, pre-Obamacare law mandated cuts to the fee schedule.

Beginning in 2003, however, Congress has "fixed" the SGR to prevent a cut 13 times – renewing the "fix," once every seven or eight months on average!<sup>6</sup> President Obama signed a fix of zero in December 2010, which runs through the end of 2011.<sup>7</sup>

Official estimates of Medicare spending assume that last December's fix was the last one. This is unrealistic. Last December's fix, H.R. 4994, passed the U.S. Senate unanimously and passed the House of Representatives 409-2. If the SGR is not "fixed" again, the fee schedule for physicians will drop 28 percent next January!<sup>8</sup> If IPAB begins recommending cuts to the physicians' fee schedule, it is not plausible that Congress will obey the rules attempting to constrain it, but will restore the 2010 fee schedule, *at least*. To reflect this more realistic scenario, Columns C and D of Table 1 display the fix through 2019 and a correspondingly higher estimate of total Medicare spending.

Obamacare also introduces some new magical thinking into Medicare estimates. Section 3401 of PPACA imposes various measurements of "value" and "productivity" on providers such as hospitals and other providers, which are supposed to save more than \$200 billion in this decade. Column E of Table 1 displays the estimated savings

from these measures. The most significant of these measures is cuts to the Inpatient Prospective Payment System (IPPS), a complex of calculations by which Medicare pays hospitals, shown in Column F.

**Obamacare has already subjected Medicare Advantage to \$145 billion in cuts this decade. That leaves prescription drugs as IPAB's central target.**

It is highly unlikely that all these cuts will take effect. To be sure, these are hard targets – but the SGR is also a hard target. Recall that IPAB cannot recommend serious cuts to hospitals or hospices in the intermediate term, removing an important impediment to hospitals' lobbying. Hospitals enjoy similar political advantages as physicians. Especially, they operate in every congressional district and can therefore mount a credible "all hands on deck" lobbying effort when their revenues are threatened. Because they also spend

a lot on supplies and services locally, they enjoy an even stronger natural coalition of allies in congressional districts than physicians do.

This analysis anticipates that hospitals will be able to override cuts to the IPPS, but that other Section 3401 cuts will take place as scheduled. The total of the fix to the physicians' fee schedule plus an IPPS override is shown in Column G, and the resulting total estimated Medicare spending in Column H.

Under this scenario, IPAB has to carry a lot more weight than officially anticipated. In 2019, Medicare spending will be \$75 billion higher than officially estimated – or 7.5 times greater than IPAB is called upon to save in the official estimate.

And IPAB's only real targets are Medicare Advantage plans, skilled nursing facilities, home health, dialysis, ambulance, ambulatory surgical centers, durable medical equipment (DME), and prescription drugs. Although Medicare Advantage is a big program, further significant cuts are not really possible, because Obamacare has already subjected Medicare Advantage to \$145 billion in cuts this decade. That leaves prescription drugs as IPAB's central target.

Prescription drugs only account for 12 percent of Medicare spending. According to official estimates, this will increase to 17 percent by 2019, or 15 percent according to my scenario. And prescription use is increasingly dominated by generic drugs, often available at chain pharmacies for less than 10 dollars or less for a month's supply. Generics now account for fewer than eight out of 10 retail prescriptions filled. It's not possible that IPAB can find much more savings there. Innovative drugs, that is, branded drugs made available within the last two years, only accounted for \$4 billion of U.S. prescription spending last year.<sup>9</sup> And that is for *all* prescriptions dispensed. Medicare might account for a third of this spending. IPAB could deny coverage of *every* innovative drug *every* year and not come close to achieving the savings anticipated by either the official estimate or the scenario described in this analysis.

It will, however, have a chilling effect on investors' willingness to invest their capital in pharmaceutical enterprise. IPAB takes a very narrow slice of Medicare spending, isolates it from the usual ebb and flow of Medicare politics, and gives it to an unaccountable board of presidential appointees.

In an ideal world, *all* medical spending would be free of politicians' control. But that is not how Medicare works today – nor is it likely to until reformers succeed in transforming it into some kind of voucher program. Until this occurs, all types of Medicare spending should be subject to the same political processes. This implies that the Independent Payment Advisory Board should be abolished.

# Endnotes

- 1 Timothy Stoltzfus Jost, “The Independent Payment Advisory Board,” *New England Journal of Medicine*, online perspective, May 26, 2010. Available at <http://healthpolicyandreform.nejm.org/?p=3478>.
- 2 There is one opportunity to fast-track a resolution to dissolve IPAB: A resolution introduced between January 1 and February 1, 2017. However, this is also constrained by strict procedural limits. Action requires approval by three-fifths of each chamber before August 15, 2017.
- 3 If Medicare spending growth is estimated to grow slower than national health spending, the government is not bound to implement IPAB’s cuts. However, if this occurs a second year in a row, the government must implement the cuts nevertheless. IPAB must report but the Secretary is not bound to implement, but this cannot happen two years in a row. In the second year, the Secretary must implement. See: Jack Ebeler, et al., *The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending*, report #8150 (Menlo Park, CA: The Henry J. Kaiser Family Foundation, April 2011), p. 13.
- 4 David Newman and Christopher M. Davis, *The Independent Payment Advisory Board* (Washington, DC: Congressional Research Service, November 30, 2010), pp. 1-2.
- 5 Lisa Potetz, et al., *Medicare Spending and Financing: A Primer*, report #7731-03 (Menlo Park, CA: The Henry J. Kaiser Family Foundation, February 2011), p. 2.
- 6 Jim Hahn, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System* (Washington, DC: Congressional Research Service, August 6, 2010), pp. 4-5 describes 12 instances up to and including the “fix” of June 2010. This was superseded in December 2010, making the total number of fixes 13.
- 7 Jim Hahn, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System* (Washington, DC: Congressional Research Service, August 6, 2010), p. 9.
- 8 *The Budget and Economic Outlook: Fiscal Years 2011 to 2021* (Washington, DC: Congressional Budget Office, January 2011), p. 69.
- 9 *The Use of Medicines in the United States: Review of 2010* (IMS Institute for Healthcare Informatics, April 19, 2011), pp. 4, 6, 18.

*John R. Graham*

*Director of Health Studies, Pacific Research Institute  
San Francisco, CA*

*E-mail:* [jgraham@pacificresearch.org](mailto:jgraham@pacificresearch.org)

*Twitter:* [johnrgraham](https://twitter.com/johnrgraham)

*Facebook:* [www.facebook.com/pages/JFreeAmericanHealthCare](http://www.facebook.com/pages/JFreeAmericanHealthCare)

*Blog:* <http://free-american-healthcare.blogspot.com>