NATIONAL CENTER FOR POLICY ANALYSIS

Medicare's New Price Control Board

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Medicare spending has been growing faster than the economy for four decades. In 2010, Medicare required nearly $280 billion in general revenue transfers to meet its obligations. By 2020 the cash-flow deficit will reach $600 billion, absent policy changes.

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Supporters of the Patient Protection and Affordable Care Act (ACA) claim that the health reform law passed in 2010 will "bend the cost curve," reducing the growth in Medicare spending to a sustainable rate — without denying necessary or effective care to any senior. Over the first 10 years, the ACA will reduce spending on Medicare by an estimated $716 billion.

The ACA assigns the task of figuring out how to slow Medicare's growth to a newly created, 15-member body called the Independent Payment Advisory Board (IPAB). The Obama administration claims the cuts in Medicare spending called for under the ACA can be accomplished by finding more efficient ways to deliver care, allowing substantial spending cuts without impairing access to care. In the long run, IPAB recommendations will be based on the results of demonstration projects and pilot programs that will focus on disease management and care coordination as well as value-based payments to health care providers.

Over the past two decades, Medicare has conducted several demonstrations aimed at enhancing quality in these categories of health care at low cost. However, three separate Congressional Budget Office (CBO) reports found that most of these pilot programs and demonstration projects did not reduce Medicare spending. In nearly every case, spending was either unchanged or increased relative to the spending that would have occurred in the absence of the program. The problem with pilot programs in general is that even the most successful programs cannot be replicated successfully on a large scale. Thus, in the future IPAB will be expected to contain Medicare's growth based on efforts that yielded lackluster results.

What Is IPAB? Each of the 15 full-time members of the board will be appointed by the president, but only 12 require Senate confirmation. They will serve up to two six-year terms beginning in 2014. The appointees will be experts in health finance, payment, economics, actuarial science, and health facility and health plan management, though they are tasked with representing both providers and consumers in determining Medicare's reimbursements for services. The secretary of the Department of Health and Human Services and the administrators of the Centers for Medicare and Medicaid Services and the Health Resources and Services Administration will be *ex officio* nonvoting members.

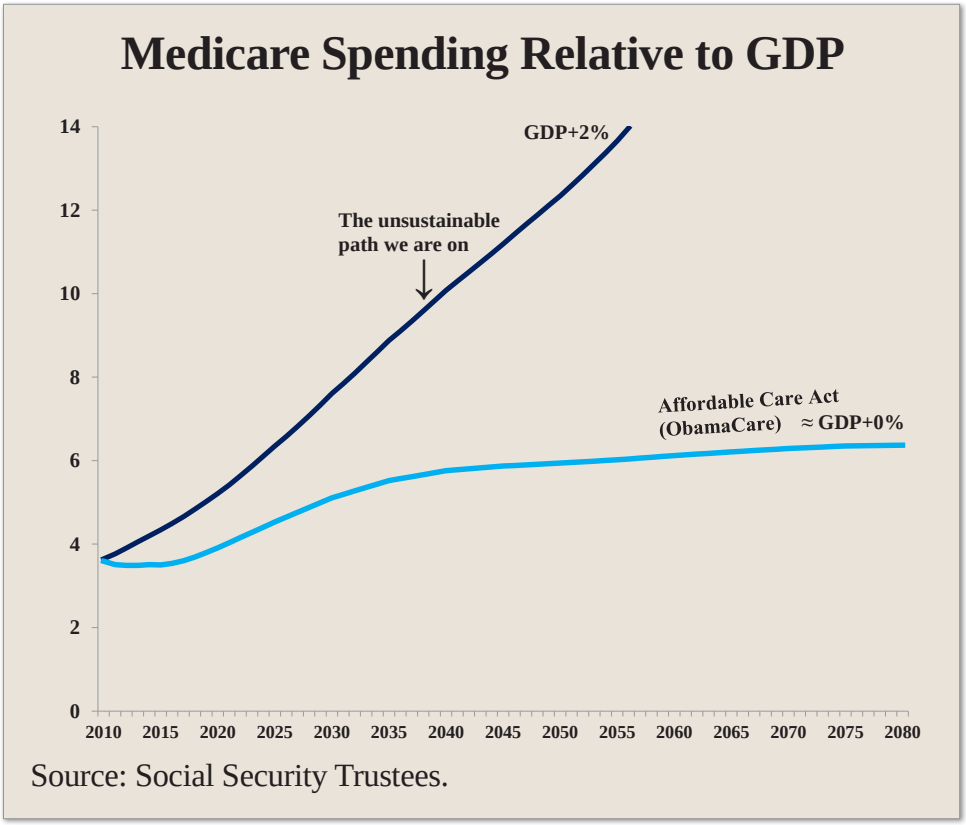
If Medicare spending exceeds target growth rates, as calculated by Medicare's chief actuary, the board must issue "legislative proposals" to limit future spending. If Congress fails to change IPAB's recommendations they will automatically go into effect.

According to the 2010 Report of the Medicare Trustees, assuming the ACA is fully implemented, the long-term growth of Medicare will be reduced to the same growth rate as gross domestic product (GDP). [See the figure.] Without reform, Medicare spending has been projected to continue growing an average of 2 percentage-points faster than GDP.

By law, however, the board cannot recommend raising revenues or beneficiary premiums or reducing payments to hospitals before 2020. IPAB is also prohibited from directly altering Medicare benefits or eligibility. Required to focus on areas of "excessive cost growth," IPAB will have no choice but to reduce reimbursements to physicians. As a result, many physicians will make difficult decisions about treating Medicare patients that will ultimately limit beneficiaries' access to care.

How Will the Board's Recommendations Be Implemented? IPAB's recommended savings will be proposed as a bill to Congress at the beginning of every year. Congress can propose an alternate plan, but it must achieve cuts of the same size. If Congress does not alter the board's savings recommendations through legislative action by August 15 each year, the secretary of Health and Human Services is required to implement the board's recommendations.

Though the ACA expressly forbids the board from raising taxes or rationing care, this provision is meaningless because the law allows IPAB to define "rationing" and protects that definition, along with the secretary's implementation of IPAB's recommendations, from administrative or judicial review. Exemption from judicial review is unusual, and prevents the judicial branch from providing an institutional check on executive power. Thus, 15 people will determine access to care for more than 50 million people with almost no scrutiny or accountability.



Source: Social Security Trustees.

What Is The Likely Impact of IPAB? As discussed above, IPAB's design makes it likely that cuts will come from physician reimbursements. IPAB will also stifle innovation. President Obama claims that demonstration projects and pilot programs will lead to greater quality of care at lower costs. However, IPAB will create uncertainty regarding new medicines and treatments. For example, the cost of a new medicine to treat Alzheimer's disease is high at first, but in order to meet yearly targets IPAB might forgo covering costs for a potentially life-saving drug. This scenario has already occurred under the United Kingdom's National Institute for Health and Clinical Excellence (NICE) (the model for IPAB) when it denied use of new drugs to National Health Service patients with chronic leukemia. NICE's reason: "When we recommend the use of very expensive treatments, we need to be confident that they bring sufficient benefit to justify their cost." Not only will IPAB have the authority to make similar medical decisions, the incentives and restrictions of the law make it likely.

Conclusion. IPAB is a mechanism that will create a series of short-term solutions that do not deal with Medicare's larger, systemic problems. The board will make recommendations to cut costs on a yearly basis; this is reactionary and shortsighted, not structural long-term reform. The method of cost cutting ignores the problem of the growth in health care costs in general.

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