Op-Ed

In Defense of the Independent Payment Advisory Board

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ONE OF THE MOST CHALLENGING ASPECTS OF CONTROLLING health care costs is the unpopularity of most health care cost controls. We seem not to like what we want when we see the details. As exhibit A, I offer the IPAB, or Independent Payment Advisory Board, among the most reviled sections of the Affordable Care Act (ACA), sometimes referred to as the law's "death panel."¹ Though high on the hit list of many congressional Republicans and Democrats, as well as a jumbo jet load of health care interest groups, it's a smart provision that just might provide a way to circumvent Congress's inability to confront exploding prescription drug costs.

Here is how IPAB is supposed to work. When Medicare per enrollee spending in any year rises above the ACA's target growth rate—as determined by the chief actuary of the US Centers for Medicare and Medicaid Services—IPAB is required by law to develop and submit formal recommendations to reduce Medicare's per capita growth rate down to the target level.

Since the ACA's signing in 2010, Medicare spending has not risen to the target level; 2017 or 2018 may be the first year, though not by a huge amount. At a Brookings Institution event last year, Medicare Chief Actuary Paul Spitalnic said: "Based on the current Medicare trustees report projections, it will be expected . . . that there would be a determination for the IPAB in 2017. . . . That means that I would have to issue that the Medicare growth rates exceeds the targets and that savings will need to be generated to effectively account for this .2 percent of difference."² As of early-July, the chief actuary's projections had yet to be released.

Though the increase may be small, it will be a moment of truth to see how serious the Trump administration and Congress are in terms of confronting rising costs in this new era. Or, they might just try to repeal the IPAB (ACA's section 3403) instead. Originally called the

Independent Medicare Advisory Board, IPAB was added to the final ACA to address business sector complaints that the legislation fell short in tackling rising health care costs. The prime mover was former Senator Jay Rockefeller (D-WV).

IPAB was designed to have 15 expert members, nominated by the president and confirmed by the Senate. The ACA envisioned that the board would be fully operational by 2014. That didn't happen. President Barack Obama never nominated anyone to the board, aware that Senate Republicans would joyfully block any nominee to the "death panel," and cognizant that Medicare's per enrollee growth rate had dropped to historically low levels between 2009 and 2015. It was a logical choice of picking one's battles.

Importantly, the ACA directs that if IPAB fails to file recommendations, the secretary of the Department of Health and Human Services (HHS) "shall develop a detailed and specific proposal" in its place for consideration by the Senate and House. If the House and Senate can agree on and pass an alternative cost reduction plan, then their plan would substitute for the board or secretary's plan. If they can't agree, then IPAB's or the secretary's plan goes into effect as though it had been enacted into law. It is a form of cost control on steroids—even including detailed procedures for expedited House and Senate consideration.

When making recommendations to lower Medicare's growth rate, ACA section 3403 prohibits the board or secretary from recommending changes that would "ration health care, raise revenues on Medicare beneficiary premiums . . . increase Medicare beneficiary cost sharing . . . or otherwise restrict benefits or modify eligibility criteria." With those restrictions, what's left are measures to improve health care delivery and outcomes or, more likely, reductions in Medicare payments to medical care providers.

This explains why IPAB is a major target for repeal by nearly every major medical provider and manufacturing organization in America, including hospitals, physicians, pharmaceutical, biotechnology, medical device, and insurance companies, home health agencies, and many more. The Healthcare Leadership Council organized more than 530 health care organizations to cosign a 2015 letter to Congress urging IPAB repeal.³ They now have more than 600 cosigners. You can thank former Alaska governor and 2008 vice presidential candidate Sarah Palin for starting public references to IPAB as a "death panel." Sadly, it is a durable meme.⁴

The ACA makes clear that, prior to 2018, any IPAB recommendations cannot impose reduced payments to medical providers who took significant cuts in the ACA (section 3401), including most hospitals, home health agencies, ambulance and lab services, and others. Specifically identified as potential IPAB targets before 2018 are Medicare Part C (Medicare Advantage insurance plans) and Part D for outpatient drugs (pharmaceutical companies).

Despite repeated IPAB condemnations since the ACA's 2010 signing, Republicans included no reference to IPAB in their American Health Care Act, the Republican repeal-and-replace legislation that was engrossed in the House of Representatives on May 4, perhaps because forfeiting long-term savings from IPAB might jeopardize the bill's satisfaction of budget reconciliation standards. Curiously, President Trump's 2018 federal budget proposal, submitted in late May, assumes that Congress will repeal IPAB, foregoing \$7 billion to \$8 billion in expected savings.

Repeal sentiment in Congress is bipartisan. Earlier this year, Senator Ron Wyden (D-OR), Senate Finance Committee ranking member, filed S. 251, The Protecting Medicare from Executive Action of 2017 Act, and joint resolution S.J.Res. 16, to authorize IPAB's permanent repeal. Also, Majority Whip Senator John Cornyn (R-TX) introduced S. 260 to rescind IPAB's authorization. In the House, Representative Raul Ruiz (D-CA) introduced a companion joint resolution (H.J.Res. 51), and Representative Phil Roe MD (R-TX), has filed a House companion bill to S. 260.

Meanwhile, the costs of catastrophic prescription drug coverage under Medicare Part D are rising at faster and faster rates. The HHS inspector general reported in January that federal costs for Part D catastrophic drugs more than tripled between 2010 and 2015, from \$10.8 billion to \$33.2 billion.⁵ If Medicare exceeds the ACA's IPAB spending target, Part D costs may be the likely primary culprit.

During his campaign and into his presidency's early months, Donald Trump made pointed attacks against rising drug costs, promising tough action. His words have not yet been accompanied by action. Perhaps—despite rhetoric—the wall of congressional opposition to taking on the pharmaceutical lobby is his reason. Any Trump proposal to Congress to rein in drug prices would be ignored by nearly all Republicans and by many Democrats.

If Trump wants to address rising drug costs, he may have no tool at his disposal more potent than IPAB, to be exercised by HHS Secretary Tom Price.

References

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