REFORMING MEDICARE

Option: Strengthen the Independent Payment Advisory Board (IPAB)

The IPAB is a group of 15 health experts (generally appointed by the president and approved by the Senate) who are required to recommend ways to hold down Medicare spending growth if that growth exceeds a certain limit. The IPAB has the authority to reduce payments to some Medicare providers (e.g., hospitals, doctors), but it cannot raise beneficiary premiums or reduce their benefits. Some proposals would change the law to give the IPAB more authority so it could also reduce benefits, while other proposals would further limit the amount of Medicare spending growth, which could require the IPAB to further reduce spending on doctors, hospitals and other health care providers. Some would eliminate the IPAB altogether.

Argument for:

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Argument against:

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A key provision of the recently enacted health reform legislation authorizes the establishment of the Independent Payment Advisory Board, or IPAB. Because excessively rapid growth of health care spending threatens the U.S. government budget, the IPAB should be retained and strengthened.

The health reform legislation contains many provisions—pilots, experiments, and other reforms—designed to improve quality of care and hold down the growth of spending. It encourages doctors and other providers to band together to deliver care cooperatively. If they can maintain or improve quality and slow spending growth, they can share in the savings. It funds research so that doctors and patients alike will have improved information on what interventions work best. If these provisions work as planned and growth of health care spending is contained, the IPAB will have nothing to do. But if they do not, and Medicare spending grows larger than a set limit, the IPAB will step in and propose ways to hold down growth of health care spending.

There are some things the IPAB can do, some things it may do, and some things it is prohibited from doing. It can propose changes in how some providers are paid or how care is organized. Congress may substitute other ways of reaching the spending targets, but if it does not, the IPAB recommendations take effect. The IPAB may suggest ways to change the health care system outside Medicare. But these recommendations have no binding legal force. The IPAB is prohibited from making any recommendations that
would result in health care rationing or that would change Medicare benefits, premiums, deductibles, or cost-sharing.

If the targets for Medicare spending growth are met, the long-term financing problems of Medicare will be largely solved. The number of enrollees will grow as baby boomers reach age 65, but costs per person will be well controlled. The success of the IPAB is therefore of critical importance.

Some members of Congress want to kill the IPAB even before it goes to work because of a mistaken belief that it usurps congressional authority. It does not. Congress remains free to reverse any recommendations that the IPAB makes. It could even kill the IPAB with new legislation. But the creation of the IPAB expresses a congressional commitment to an important goal—slowing the growth of health care spending.

Expanding what the IPAB is allowed to do could improve its effectiveness. It should be able to recommend changes in payments to all providers. It should be authorized to invest money in ways that will eventually save money, such as simplified billing systems or collection of data on treatment outcomes. It should be provided a larger staff than the legislation now authorizes. But the IPAB must be preserved as a key element, along with other cost-reducing, quality-improving provisions, to promote an increasingly cost-effective Medicare system.

**Stuart Butler**

The IPAB was created in the new health law to cap total Medicare spending so that it grows only a little more each year than the economy grows. To accomplish this, the 15 unelected board members will be able to cut payments each year to your physicians, hospitals, or Medicare plan provider by however much it takes to stay under the spending cap. If Congress cannot agree on its own package of cuts, then the IPAB’s cuts will go into place automatically, and nobody—not the courts or even Congress itself—can stop them. This IPAB should not be strengthened. It should be dismantled.

True, Congress can come up with different cuts to hit the same target, and that will overturn the IPAB’s plan. But if Congress can’t agree on its own package of cuts then the IPAB’s cuts will go into place automatically and nobody—not the courts or even Congress itself—can stop them.

This is a bad way to control Medicare spending. Physicians are already dropping out of Medicare in droves because the program shortchanges them compared with the payments they get for treating most other patients.

Yet some are now arguing that the IPAB should be able to make even deeper cuts in payments to doctors and hospitals. But lower payments will make it even less likely that your doctor will keep you as a patient, and less likely that hospitals will give you the tests or treatment you need. If you have enrolled in a private Medicare plan, expect fewer services and brand-name drugs.

Some also say to strengthen the IPAB’s cost-cutting powers by letting it change the actual Medicare benefits you can receive, rather than only cutting doctor and hospital payments. But that means allowing an unelected and uncontrollable board to change your basic Medicare benefits.
Others who support allowing the IPAB to change benefits say it should do so using research from a new government-created institute that is supposed to figure out which treatments are most effective. Right now the law says the IPAB mustn’t use such data. Why? Because lawmakers fear that giving the IPAB this option would lead to thinly disguised rationing. The British health system has a controversial board with exactly that kind of power. We all want effective care rather than ineffective care, of course. But older people would be unwise to allow a strong, unelected board to take the place of their doctor in deciding what the best treatment is.

Medicare will need to stick to a real budget, as federal education or transportation programs must do, if we are to avoid our children and grandchildren becoming overwhelmed by the future costs of the program. The question is who gets to decide how a reined-in Medicare budget will be spent. Using a Medicare board is a top-down vision of how to do that. It means the government decides what your doctor will be paid and, ultimately, what health care you will get. The alternative vision has no board because each older person would have the right to decide either which health plan, or which doctor and hospital, will get that person’s portion of the Medicare budget.

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