FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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# EXPLAINING HEALTH REFORM: Medicare and the New Independent Payment Advisory Board

**The recently enacted health reform law (P.L. 111-148; P.L. 111-152) establishes a new Independent Payment Advisory Board with authority to recommend proposals to limit Medicare spending growth.** If projected per capita Medicare spending exceeds target growth rates, the Board is required to recommend proposals to reduce Medicare spending by specified amounts, with the first set of recommendations due in 2014 for implementation in 2015 (see "Key Implementation Dates" below). If the Board fails to submit a proposal, the Secretary of the Department of Health and Human Services is required to develop a detailed proposal to achieve the required level of Medicare savings. The Secretary is further required to implement the Board's (or Secretary's) proposals to achieve savings, unless Congress adopts alternative proposals resulting in an equivalent level of savings or if the President vetoes the Congressional package and the veto is not overridden. Implementation of the Board's recommendations by the Secretary is not subject to administrative or judicial review. The establishment of the Board represents the first time that the Medicare program will be subject to spending limits, with statutory requirements to achieve savings targets.

Congress is currently responsible for establishing policies affecting all aspects of the Medicare program, including eligibility, premiums, benefits, and Medicare payments to health care providers, facilities, and plans. The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) implements policy changes through regulations and manages day-to-day program operations. The Medicare Payment Advisory Commission (MedPAC) submits annual recommendations to Congress on a broad range of Medicare issues, but is not required to achieve budgetary targets and has no independent decision-making authority, and Congress is not obliged to follow its recommendations.

The health reform law creates the new Board, along with new processes for implementing its recommendations, while maintaining MedPAC as an advisory body for Congress. The Board will consist of 15 full-time members appointed by the President and confirmed by the Senate for six-year terms. A 10-member consumer advisory council will be established to advise the Board.

The Board is prohibited from submitting proposals that would ration care, increase taxes, change Medicare benefits or eligibility, increase beneficiary premiums and cost-sharing requirements, or reduce low-income subsidies under Part D. Prior to 2019, the Board is also prohibited from recommending changes in payments to providers and suppliers that are scheduled to receive a reduction in their payment updates in excess of a reduction due to productivity adjustments, as specified in the health reform law.[1] The law establishes specific rules and deadlines for Congressional consideration of the Board's recommendations, and specific timelines and procedures for Congressional action on alternative proposals to achieve equivalent savings.

## New Target Growth Rates for Medicare Spending and Required Savings

The Board is required to submit a proposal to Congress to reduce Medicare spending by a specified amount if the projected five-year average growth rate in Medicare per beneficiary spending is projected to exceed the target growth rate, according to the CMS Office of the Actuary (OACT).[2]

- Prior to 2018, the target growth rate is the projected five-year average rate of change in the Consumer Price Index for All Urban Consumers (CPI-U) and the CPI for Medical Care (CPI-M) averaged together.
- In 2018 and beyond, the target growth rate is the projected five-year average percentage increase in the nominal per capita gross domestic product (GDP) plus 1.0 percentage point.

If the five-year average Medicare spending growth rate exceeds the target growth rate, the Board is required to submit a savings proposal that achieves the lesser of either: (1) the amount by which projected Medicare per beneficiary spending exceeds the target, or (2) total projected Medicare spending for the year multiplied by 0.5 percent in 2015, 1.0 percent in 2016, 1.25 percent in 2017, and 1.5 percent in 2018 and future years.

Beginning in 2019, the Secretary is prohibited from implementing the recommendations contained in a Board proposal if two conditions are met: (1) the Board was required to submit a proposal to Congress the previous year, and (2) OACT determines that the five-year growth rate in average per capita national health expenditures exceeds the five-year growth rate in average per capita Medicare spending.

## Other Reports

Beginning January 15, 2015, and every other year thereafter, the law requires the Board to submit advisory recommendations to the Congress and the President to slow the growth in national health expenditures (excluding expenditures for Medicare and other Federal health care programs), while preserving or enhancing quality of care. In addition, beginning July 1, 2014, the Board is required to produce an annual public report with standardized information on system-wide health care costs, access to care, utilization of services, quality of care, including comparisons by region, types of services, and types of providers for both Medicare and private payers.

## Medicare Savings Estimates

The Congressional Budget Office (CBO) estimates the Board will achieve $15.5 billion in Medicare savings between 2010 and 2019, with all savings realized between 2015 and 2019, the years in which the Board's recommendations are scheduled to be implemented within this 10-year budget window. This estimate suggests that CBO assumes a level of growth in Medicare spending above the target levels that will require the Board to generate recommendations to reduce Medicare spending growth. Beyond 2019, CBO assumes that the Board would continue to be effective in reducing costs beyond the spending reductions that are expected from other Medicare-related provisions in the health care reform law.[3]

OACT estimates the Board's recommendations, in conjunction with strict limits on the growth in Medicare per capita spending, would achieve $24 billion in Medicare in the period between 2015 and 2019. According to OACT, meeting the target growth rates specified in the law will require Medicare growth rates to be reduced by an additional 0.3 percent per year, on average, even after taking into account all other savings that can be expected to arise from the health reform law. OACT has also noted that Medicare cost growth per beneficiary was below the target level of the average of CPI-U and CPI-M in only four of the past 25 years.[4] Future changes in Medicare policy that result in higher Medicare spending would require the Board to propose larger spending reductions.

## Policy Implications

Amid concern over rising health care costs and the growing federal budget deficit, the idea of establishing an independent board to impose strict limits on Medicare spending, along with a process for ensuring automatic implementation of spending reductions, held substantial appeal for many policymakers during the discussion over health care reform legislation. The Independent Payment Advisory Board was established, at least in part, to mitigate the influence of politics and stakeholders on Medicare payment decisions and give authority to a group of outside experts to recommend savings proposals, rather than Members of Congress. In creating the new Independent Payment Advisory Board, the Congress has established strict target growth rates for Medicare spending while ceding some of its authority over certain aspects of the Medicare program to an outside entity for the first time since the program was enacted in 1965.

Proponents claim that the structure and operations of the Board, as established by the health reform law, will effectively curb the growth in Medicare spending, while maintaining protections for beneficiaries by prohibiting the Board from rationing care or reducing benefits. Critics claim that explicit limits on Medicare spending growth are unrealistic given the overall growth in health costs generally, and that over time the limits could jeopardize beneficiaries' access to care, exacerbate the payment differential between Medicare and private payers, and make it harder for future Congresses to find savings within Medicare to offset the costs of program improvements. As the operations of the Board get underway, it will be important to monitor both the level and type of Medicare spending reductions that may be proposed in order to assess their potential impact on beneficiaries and ensure that quality and access to care are not diminished.

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[1] Section 3403(c)(2)(A)(iii).

[2] Medicare spending projections are to assume a zero update in physician payments if there is a negative payment update for physician services for that year.

[3] Congressional Budget Office, Cost Estimate for the Amendment in the Nature of a Substitute for H.R. 4872, Incorporating a Proposed Manager's Amendment Made Public on March 20, 2010; March 20, 2010.

[4] Centers for Medicare & Medicaid Services, Office of the Actuary, Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended; April 22, 2010.

## Key Implementation Dates for the Independent Payment Advisory Board

The health reform law specifies key dates for the operations of the Board and related activities of the Congress and the Administration. The dates specified below apply annually, unless otherwise noted.

| 2012 |
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| $15 million appropriated for the operations of the Board, indexed annually by CPI. The Board will have 15 members appointed by the President and confirmed by the Senate. Members will serve full time. A consumer advisory council will be established to advise the Board. |
| **2013** |
| **April 30:** The Chief Actuary of CMS reports on whether Medicare per capita growth rates exceed target growth rates, with projections for 2015.<br>**September 1:** The Board submits initial draft proposals to MedPAC and the Secretary. |
| **2014** |
| **January 15:** The Board submits a proposal to the President to reduce Medicare spending by specified amounts, unless the CMS Office of the Actuary determines that the growth rate for Medicare will not exceed the target growth rate, or the projected increase in CPI-M is less than CPI-U.<br>**January 17:** The President transmits the Board's proposal to Congress.<br>**January 25:** The Secretary of HHS submits to Congress a proposal to achieve the required level of savings, if the Board fails to submit a proposal.<br>**April 1:** Deadline for Congressional Committees of jurisdiction to report out a legislative package that would achieve the target level of Medicare savings, as recommended by the Board.<br>**July 1:** The Board is required to produce an annual public report with standardized information on system-wide health care costs, access to care, utilization of services, and quality of care, including comparisons by region, types of services, and types of providers for both Medicare and private payers.<br>**August 15:** The Secretary is required to implement the Board's proposal, unless Congress enacts an alternative package that achieves the required level of Medicare savings. If Congress does not enact a legislative package that achieves the required level of Medicare savings, or if the President vetoes the Congressional package and the veto is not overridden, the Secretary is required to implement the Board's (or Secretary's) original proposal. |
| **2015** |
| **January 15:** The Board is required to submit recommendations biannually to Congress and the President to slow the growth in national health expenditures (excluding Medicare and Federal health programs) while preserving or enhancing quality of care. These recommendations are non-binding. |
| **2017** |
| **February-August:** Provides for consideration of a joint resolution by Congress (requiring a 60 percent majority vote for approval in both the House and the Senate) to dissolve the Board and discontinue its operations. |
| **2018** |
| **In 2018 and beyond,** the target growth rate for per capita Medicare spending growth is the projected five-year average percentage increase in the nominal per capita gross domestic product (GDP) plus 1.0 percentage point. |
| **2019** |
| **Beginning in 2019,** the Secretary is prohibited from implementing the recommendations contained in a Board proposal if two conditions are met: (1) the Board was required to submit a proposal to Congress the previous year, and (2) the Office of the Actuary determines that the five-year growth rate in average per capita national health expenditures exceeds the five-year growth rate in average per capita Medicare spending. |

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