



# The Independent Payment Advisory Board

## Protecting Medicare Beneficiaries and Taxpayers from Special Interests

*Board Makes Premium Support Plans that Shift Costs to Beneficiaries Unnecessary*

By Topher Spiro March 5, 2012

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### Introduction

The U.S. House of Representatives has started the process of repealing one of the Affordable Care Act's central cost-cutting reforms: the Independent Payment Advisory Board. The purpose of the board as originally conceived, however, was to protect the Medicare program from special interests. For too long these special interests have wielded their money and used their lobbyists to block or delay commonsense reforms that would strengthen Medicare and put the program on a sustainable path. This issue brief details several case studies of this undue influence.

With the Independent Payment Advisory Board, policy recommendations will be driven by science, data, evidence, the expert advice of physicians, and the input of stakeholders—not by the lobbying clout of special interests. The final say will still rest with Congress, but doing nothing will no longer be an option.

The Independent Payment Advisory Board is essential to reducing health care costs while improving the quality of care. The board will save taxpayers money, limit the growth in Medicare spending, and reduce federal budget deficits and the federal debt. It will do so by changing the way health care is paid for and delivered—not by rationing care or cutting benefits. If the Independent Payment Advisory Board is repealed or hamstrung, the only alternative would be to ration care by privatizing Medicare, shifting costs to beneficiaries, and restricting eligibility.

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### How the Independent Payment Advisory Board works

The Affordable Care Act established the Independent Payment Advisory Board to limit the growth in Medicare costs. If growth exceeds a target rate—growth in the economy

plus 1 percentage point after 2017—then the board must propose savings that either reduce growth to the target rate or reduce spending by 1.5 percent after 2017—whichever is less. In this way the Independent Payment Advisory Board guarantees that Medicare will not grow too fast.

Congress retains the authority to accept or reject the board’s recommendations. Congress always has the option to enact different policies that achieve the same level of savings. But Congress no longer has the option of doing nothing while special interests put their own profits ahead of Medicare’s finances. In many ways this model is similar to the Defense Base Closure and Realignment Commission, which provides recommendations to close military bases that Congress must accept or reject.<sup>1</sup>

Board members must be confirmed by the Senate. The members will be national experts in health care, including physicians and other health professionals, employers, consumers, and seniors.<sup>2</sup> In other words, the Independent Payment Advisory Board will not be a board of government bureaucrats.

The board will improve the efficiency of the health care system by reforming the payment and delivery system. In fact, the board is specifically charged with making recommendations that “improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement.”<sup>3</sup>

But the Independent Payment Advisory Board will not ration care. The board is specifically prohibited by law from:<sup>4</sup>

- Rationing care
- Raising taxes or premiums
- Increasing cost-sharing
- Restricting benefits or modifying eligibility

Nor will the board recommend cuts to health care providers that threaten beneficiaries’ access to care. By law the board is required to consider the effects of cuts on beneficiaries.<sup>5</sup> In addition, the law established a Consumer Advisory Council to advise the board on the impact of payment policies on consumers.<sup>6</sup>

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## The Independent Payment Advisory Board’s effects on health care costs

The Independent Payment Advisory Board is essential to containing health care costs over the long term. That is the judgment of many independent experts—Democrats and Republicans alike.

In a letter to President Barack Obama, 23 prominent economists—including Nobel laureates and members of both Democratic and Republican administrations—identified the board as one of four key measures that will lower costs and reduce long-term deficits: “Creating such a commission will make sure that reforming the health care system does not end with this legislation, but continues in future decades, with new efforts to improve quality and contain costs.”<sup>7</sup> Similarly, former Bush administration Medicare chief Mark McClellan called for “[strengthening] and [clarifying] the authority and capacity of the Independent Payment Advisory Board.”

In fact, Rep. Paul Ryan (R-WI) asked the nonpartisan Congressional Budget Office, or CBO, what would happen if certain provisions of the Affordable Care Act were never implemented—including the Independent Payment Advisory Board. CBO responded that “federal budget deficits during the decade beyond 2019 would increase relative to those projected under current law.”<sup>8</sup>

In short, the Independent Payment Advisory Board was a major reason why CBO concluded that the Affordable Care Act will continue to reduce deficits over subsequent decades indefinitely.

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## The status quo: Special interests above Medicare beneficiaries

For too long special interests have influenced Medicare policy to serve their own interests—not the interests of beneficiaries and taxpayers. Here are just a few case studies.

### Competitive bidding program

From 2000 to 2002, Medicare conducted a demonstration of competitive bidding for durable medical equipment such as hospital beds and wheelchairs. Under this program prices are market-based: Medicare holds an auction and lower bids win the contract.

The demonstration found that competitive bidding lowered prices by 20 percent on average, saving Medicare about \$8.5 million—without affecting quality or access.<sup>9</sup> Given these “compelling” results, the independent Medicare Payment Advisory Commission—which advises Congress on Medicare—recommended expanding competitive bidding in 2003.<sup>10</sup>

Congress phased in an expansion of the program.<sup>11</sup> But only two weeks after the program was first implemented in 2008, Congress terminated the contracts that already existed and delayed the program.<sup>12</sup>

In 2011 the first round of the expansion finally went into effect. Not surprisingly, the benefits to seniors and taxpayers were substantial: The average price savings was 35 percent.<sup>13</sup> The program is now projected to save \$17 billion for taxpayers and \$11 billion for beneficiaries through lower coinsurance and monthly premiums over 10 years.<sup>14</sup>

Ultimately, the Affordable Care Act will expand competitive bidding nationwide by 2016,<sup>15</sup> but not without substantial delays and setbacks to a program that has been proven to work and to yield substantial savings.

### Excessive payments to health insurance companies

Through Medicare Advantage, Medicare beneficiaries have a choice of private insurance plans as an alternative to traditional Medicare. But these private plans do not compete with traditional Medicare on a level playing field—payments to private plans have on average been more than 10 percent higher than payments under traditional Medicare.<sup>16</sup>

These excessive payments amount to more than \$150 billion in wasteful spending over 10 years.<sup>17</sup> Since premiums for physician services are linked to program costs, these payments increase premiums for beneficiaries. But there is no evidence that private plans provide better quality care than traditional Medicare, and the quality of private plans is highly uneven.<sup>18</sup>

For all of these reasons, the independent Medicare Payment Advisory Commission has recommended payment equality between Medicare Advantage and traditional Medicare for more than 10 years.<sup>19</sup> But due to the lobbying clout of the health insurance industry, Congress never acted on this recommendation—until the Affordable Care Act was signed into law.

In 2011 the Affordable Care Act began to reduce overpayments to private plans, freezing the maximum payment amount at 2010 levels. But dire predictions have not come to pass. Since last year, Medicare Advantage premiums have declined by 7 percent on average, and enrollment has increased by about 10 percent.<sup>20</sup> Moreover, virtually all—more than 99 percent—of beneficiaries have access to a Medicare Advantage plan.<sup>21</sup>

### Drug rebates under Medicare

Drug manufacturers pay rebates for drugs provided to Medicaid beneficiaries, resulting in significant price discounts. Before the prescription drug program was created under Medicare Part D, drug manufacturers paid rebates for drugs provided to beneficiaries who are eligible for both Medicaid and Medicare—known as dual eligibles. While Medicare prescription drug plans negotiate rebates with manufacturers, these rebates are substan-

tially lower than Medicaid rebates. As a result, shifting drug coverage of dual eligibles from Medicaid to Medicare has produced an enormous windfall to drug manufacturers.

The National Commission on Fiscal Responsibility and Reform—led by former Republican Sen. Alan Simpson (WY) and former Clinton administration Chief of Staff Erskine Bowles—recommended extending the Medicaid rebate to dual eligibles covered by Medicare Part D—estimating that this policy would save \$57 billion over 10 years.<sup>22</sup> According to the Congressional Budget Office, applying the Medicaid rebate more broadly to brand-name drugs purchased by all Medicare beneficiaries would save \$110 billion over 10 years.<sup>23</sup> But despite these substantial savings to seniors and taxpayers, drug manufacturers have fiercely opposed any such policy.

### Physician-owned hospitals

When physicians self-refer patients to physician-owned hospitals in which they have a financial interest, there is a clear conflict of interest. Physicians have a financial incentive to invest in these hospitals and then to refer patients to them, increasing the number of surgeries and driving up health care costs. The independent Medicare Payment Advisory Commission, or MedPAC, found that physician-owned hospitals tend to be more costly, treat healthier and more profitable patients, increase the number of surgeries, and treat fewer Medicaid patients than community hospitals.<sup>24</sup>

Accordingly, MedPAC has recommended a moratorium on physician-owned hospitals since 2005. The Affordable Care Act finally prohibited physician referrals to new physician-owned hospitals, saving an estimated \$500 million over 10 years.<sup>25</sup> But the lobby for specialty hospitals is seeking to undo this reform—and the House version of the payroll tax cut extension would have relaxed this restriction at a cost of \$300 million.<sup>26</sup>

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### The Independent Payment Advisory Board versus Medicare premium support

Because the Independent Payment Advisory Board can thwart special interests, it can put Medicare on a sustainable path without making major structural changes to the program. But some would rather convert Medicare from a guaranteed benefit into a “defined contribution” model. Known as premium support, this model would provide vouchers to beneficiaries to purchase an insurance plan.

Premium support typically caps growth in the amount of the voucher at a rate that is slower than projected growth in health care costs. But because the Independent Payment Advisory Board already controls growth in Medicare costs, premium support would achieve little or no savings—and would therefore be unnecessary.

What’s more, premium support would have serious consequences for Medicare beneficiaries. As the Congressional Budget Office concluded in one analysis, premium support achieves savings from “increases in the premiums paid by beneficiaries, not from increases in the efficiency of health care delivery”<sup>27</sup>—in stark contrast to the way the Independent Payment Advisory Board achieves savings. While the board is specifically prohibited by law from increasing premiums or cost-sharing, premium support would shift these costs to beneficiaries.

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## Conclusion

The Independent Payment Advisory Board will reduce health care costs while improving the quality of care—increasing the efficiency of the health care system without rationing care. Medicare policy will serve beneficiaries and taxpayers, not narrow special interests. Repealing the board would increase federal budget deficits and the federal debt, and put the Medicare program at risk. By contrast, alternatives to the Independent Payment Advisory Board such as premium support would ration care by shifting costs to beneficiaries, making the care that they need less affordable.

*Topher Spiro is Managing Director for Health Policy at the Center for American Progress.*

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## Endnotes

- 1 For more information, see: "Defense Base Closure and Re-alignment System," available at [www.brac.gov](http://www.brac.gov) (last accessed March 2, 2012).
- 2 The Patient Protection and Affordable Care Act, Public Law 148, 111th Congress (March 23, 2010), 3403(g)(1)(B).
- 3 The Patient Protection and Affordable Care Act, Public Law 148, 111th Congress (March 23, 2010), 3403(c)(2)(B)(ii).
- 4 The Patient Protection and Affordable Care Act, Public Law 148, 111th Congress (March 23, 2010), 3403(c)(2)(A)(ii).
- 5 The Patient Protection and Affordable Care Act, Public Law 148, 111th Congress (March 23, 2010), 3403(c)(2)(B)(iv).
- 6 The Patient Protection and Affordable Care Act, Public Law 148, 111th Congress (March 23, 2010), 3403(k).
- 7 Letter from Alan M. Garber to President Barack Obama, November 17, 2009.
- 8 Letter from the Congressional Budget Office to the Honorable Paul Ryan, March 19, 2010.
- 9 Medicare Payment Advisory Commission, "Durable Medical Equipment Payment System" (2011), p. 2; Medicare Payment Advisory Commission, "Report to the Congress: Variation and Innovation in Medicare" (2003), p. 135.
- 10 Medicare Payment Advisory Commission, "Report to the Congress: Variation and Innovation in Medicare."
- 11 The Medicare Prescription Drug, Improvement, and Modernization Act, Public Law 173, 108th Congress (December 8, 2003).
- 12 The Medicare Improvements for Patients and Providers Act, Public Law 275, 110th Congress (July 15, 2008).
- 13 Centers for Medicare and Medicaid Services, Next Steps for Expansion of the Medicare Durable Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program (Department of Health and Human Services, 2011).
- 14 Ibid.
- 15 The Patient Protection and Affordable Care Act, Public Law 148, 111th Congress (March 23, 2010), 6410.
- 16 Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy" (2011), p. 286.
- 17 Congressional Budget Office, "Budget Options, Volume I: Health Care" (2008), p. 119.
- 18 Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy" (2011), pp. 294-307.
- 19 Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy" (2011), p. 113.
- 20 U.S. Department of Health and Human Services, "Medicare Advantage premiums down 7 percent on average, enrollment up 10 percent," Press release, February 1, 2012, available at <http://www.hhs.gov/news/press/2012pres/02/20120201a.html>.
- 21 Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy" (2011), p. 286.
- 22 Committee for a Responsible Federal Budget, "Updated Estimates of the Fiscal Commission Proposal" (2011), p. 9.
- 23 Congressional Budget Office, "Budget Options, Volume I: Health Care" (2008), p. 124.
- 24 Medicare Payment Advisory Commission, "Report to the Congress: Physician-Owned Specialty Hospitals Revisited" (2006).
- 25 The Patient Protection and Affordable Care Act, Public Law 148, 111th Congress (March 23, 2010), 6001; Letter from the Congressional Budget Office to the Honorable Nancy Pelosi, March 20, 2010.
- 26 The Middle Class Tax Relief and Job Creation Act, H.R. 3630 (2011).
- 27 Congressional Budget Office, "Budget Options, Volume I: Health Care" (2008), p. 121.