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The Independent Payment Advisory Board And its Limited Impact on Medicare Spending

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1. Introduction

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) created the Independent Payment Advisory Board (IPAB or Board) to "reduce the per capita rate of growth in Medicare spending."[1] IPAB is good vice presidential fodder being both Sarah Palin's "death panel" and the basis for only a slightly more informed exchange in the 2012 debate between Representative Ryan and Vice President Biden.

The Board is charged with developing proposals to reduce the Medicare growth rate by an applicable savings target. The Board takes action once the Chief Actuary at the Centers for Medicare & Medicaid Services (CMS) makes a determination that the projected per capita Medicare expenditures will exceed certain target levels.

In 2010 and 2012, the Congressional Budget Office (CBO) estimated the cost savings from IPAB at $15.5 billion and $3.3 billion respectively (Elmendorf, 2010; CBO 2012). The range in estimates is due to changes in law and economic circumstances. Since the estimates are likely to continue to change, in this paper, we estimate the maximum potential savings of the Board's recommendations through 2021.The CMS Chief Actuary attributes savings of $24 billion due to IPAB through 2019 but warns that achieving growth rate targets may be a "difficult challenge" (Foster, 2010). In addition, the Chief Actuary points out that "after 2019, further Advisory Board recommendations for growth rate reductions would generally not be required if other savings provisions were permitted to continue."

Our estimates provide an outer bound for the savings from IPAB so that the range of potential

[1] Subsequent citations to statutory provisions have been omitted.

savings may be better understood. Regardless of changed circumstances or the set of reasonable assumptions one might make, IPAB is not likely to be the tool for significantly constraining growth in Medicare expenditures.

2. Key Calculations by the Chief Actuary

The Chief Actuary's projection of per capita Medicare expenditures, made in April of each year, sets in motion a three-year sequence of events (see Table 1). The year in which the Chief Actuary makes its determination that expenditures exceed targets is referred to as the determination year, followed by the proposal year and the implementation year.

Table 1: Three Year Sequence of Events

Determination Year	
By April 30	Chief Actuary of CMS makes projections and determination
If Process Continues	
By September 1	Draft proposal sent by IPAB to MedPAC for consultation Draft proposal sent by IPAB to Secretary for review and comment
Proposal Year	
By January 15	Proposal submitted by IPAB to Congress and the President
By January 25	Secretary submits own proposal to Congress and the President, with a copy to MedPAC (if IPAB was required to submit a proposal but failed to do so)
By March 1	Secretary submits report containing review and comments to Congress on IPAB proposal (unless the Secretary submitted own proposal because IPAB failed to do so)
By April 1	Deadline for specified Congressional Committees to consider the submitted proposal and report out legislative language implementing the recommendations. Congress has the authority to develop its own proposal provided it meets the same fiscal requirements as established for the Board and meets this deadline.
Beginning August 15	Secretary implements the proposal subject to exceptions
On October 1	Recommendations relating to fiscal year payment rate changes take effect
Implementation Year	
On January 1	Recommendations relating to Medicare Part C and D payments take effect Recommendations relating to calendar year payment rate changes take effect

Beginning in 2013, the Chief Actuary is required to calculate:

- the Medicare per capita growth rate (the "growth rate"), and
- the Medicare per capita target growth rate (the "target growth rate") (see Table 2 for calculations).

In the determination year the Chief Actuary will compare the *growth rate* and the *target growth rate* to determine whether Medicare spending needs to be reduced in the associated implementation year. The reduction in spending, the *applicable savings target*, equals the projected Medicare program expenditures in the proposal year times the *applicable percent* of the implementation year. The *applicable percent* is the lesser of either the projected excess for the implementation year (the amount by which Medicare spending is forecast to exceed the targeted growth in spending expressed as a percent of total Medicare expenditures) or the percent as specified in the statute (see Table 2).

In summary, if Medicare spending grows too fast the program's expenditures must be reduced by the amount determined by the Chief Actuary of CMS.

Table 2. Definition and Applicability of Key Terms over Time

DY = Determination Year; PY = Proposal Year; IY = Implementation Year

	DY 2013 PY 2014 IY 2015	DY 2014 PY 2015 IY 2016	DY 2015 PY 2016 IY 2017	DY 2016 PY 2017 IY 2018	DY 2017 PY 2018 IY 2019	DY 2018+ PY 2019+ IY 2020+
Applicable Percent (if growth rate exceeds target growth rate)	The lesser of 0.5 percent or the projected excess	The lesser of 1.0 percent or the projected excess	The lesser of 1.25 percent or the projected excess	The lesser of 1.5 percent or the projected excess	The lesser of 1.5 percent or the projected excess	The lesser of 1.5 percent or the projected excess
Medicare Per Capita Target Growth Rate	The midpoint between the projected five-year average (the implementation year and four prior years) percentage increase (if any) in the Consumer Price Index for All Urban Consumers (all items, U.S. city average) and the Consumer Price Index for All Urban Consumers (medical care, U.S. city average).					The projected five-year average percentage increase in nominal GDP per capita ending in the IY plus one percentage point, for each of 5 years
Medicare Per Capita Growth Rate	The projected five-year average (the implementation year and four prior years) of the growth in Medicare program spending per unduplicated enrollee for Parts A, B, and D net of premiums.					
Applicable Savings Target	The product of the total projected Medicare expenditures in the proposal year and the *applicable percent* for that implementation year.					

3. IPAB Proposals

If the Chief Actuary makes a determination by April 30 of the determination year that the *growth rate* for an implementation year will exceed the *target growth rate* for that year, the Board is to develop a detailed proposal to reduce the *growth rate* by the *applicable savings target*.

The ACA directs the Board that its proposal

- relate only to the Medicare program;
- result in a net reduction in total Medicare program expenditures in the implementation year that are at least equal to the *applicable savings target*;
- not include any recommendation to ration care, raise revenues, raise Medicare beneficiary premiums, increase cost-sharing, restrict benefits, or alter eligibility;
- not reduce payments to providers or suppliers scheduled to receive a reduction in payment as the result of productivity adjustments under § 3401;
- include, as appropriate, recommendations to reduce Medicare payments under parts C and D, such as reductions in direct subsidy payments[2], reductions in payments related to

[2] Direct subsidy payments are payments made by CMS on behalf of insureds, for cost-sharing elements of the benefit design with respect to low-income enrollees who are exempted by CMS from paying these elements themselves.

administrative expenses[3], and limiting the inclusion of high bids for prescription drug coverage from the calculation of the national average monthly bid amount[4]; and

- include recommendations with respect to administrative funding for the Secretary to carry out the Board's recommendations.

In developing its proposal, the Board is also directed, to the extent feasible, to:

- give priority to recommendations that extend Medicare solvency; and
- give recommendations that:
    - improve the health care delivery system and health outcomes by promoting integrated care, care coordination, prevention, and wellness, and quality and efficiency improvements;
    - protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas;
    - target reductions in Medicare program spending to sources of excess growth;
    - consider the effects on Medicare beneficiaries of changes in payments to providers of services and supplies;
    - consider the effects of recommendations on providers of services and suppliers with actual or projected negative cost margins or payment updates;
    - consider the unique needs of Medicare beneficiaries who are dual-eligible for Medicare and Medicaid; and
    - promote the delivery of efficient, high quality care to Medicare beneficiaries.

So again, in summary, the Board has to generate proposed savings without rationing care, raising revenues or increasing premiums, shifting costs, restricting benefits, altering eligibility or reducing benefits to providers that accepted negotiated cuts in their market basket adjustments under § 3401of the ACA such as most hospitals. The principal remaining targets for potential cuts are Medicare Advantage and prescription drug plans.

4. Estimated Savings over Time

[3] Medicare Part C and D plans may have been emphasized as a result of concerns regarding the higher costs of Medicare Advantage relative to Medicare fee-for-service, and unfavorable reports of some of their practices. "The average Medicare payment to Medicare Advantage plans is 113% of the cost of similar benefits in the original fee-for-service program." (The Henry J. Kaiser Family Foundation, 2008) However, the higher estimated spending under Part C relative to traditional Medicare may be reduced due to payment rate changes in the ACA.

[4] The national average monthly bid amount is the average of the standardized bid amounts for each part D prescription drug plan and it is used to calculate the base beneficiary premium. Denying or removing high bids would lower the national average monthly bid amount.

In Table 3, we estimate the maximum potential savings of the Board's recommendations between 2013 and 2021 using the projections of Medicare spending, premiums, and enrollment provided in the *2012 Trustees Report*. To obtain an estimate of IPAB savings we used projected spending that replaced the Sustainable Growth Rate (SGR) with an annual 1 percent increase in physician payments (Shatto, 2012). Maximum savings in each implementation year were calculated using the applicable percent and the associated proposal year spending net premiums.

Between 2015 and 2021 per capita Medicare expenditures net premiums are projected to increase by 29.5%, from $10,798 to $13,982. Total Medicare expenditures net premiums are projected to increase by 53.3%, driven by the rising per capita expenditures and enrollment growth. The high growth in Medicare expenditures would seem to suggest the potential for large savings; however, IPAB savings are restricted by the applicable percent.

Although the first recommendation will occur in 2013, savings will not begin to accrue until 2015 (October 1, 2014 for fiscal year recommendations) due to the determination year, proposal year, and implementation year structure. Assuming that the *growth rate* exceeds the *target growth rate* in every decision year from 2013 to 2019 and the savings occur only in the associated implementation year, IPAB generates a total savings of $62.3 billion between 2015 and 2021. This savings represents 1.2% of Medicare spending net premiums for that period.

It is possible that savings from one year will carry-over to the next at the same level or at either an increasing or decreasing level. Assuming that the savings occur in the associated implementation year and carry-over as a constant savings to all future years, IPAB will result in a total savings of $205.6 billion. While not a trivial dollar amount, this represents just 4.0% of Medicare spending net premiums between 2015 and 2021.

Our assumptions that the *growth rate* exceeds the *target growth rate* in every year and that the savings occur as a permanent decrease in spending describe an extreme scenario that would result in maximum savings from the Board's recommendations. Even in this extreme scenario, the savings constitute four percent of Medicare expenditures; however, some of these savings may disproportionately fall on certain provider groups and service categories.

Table 3: Maximum Savings Estimates

Year	Per Capita Expenditures ($)	Per Capita Premiums ($)	Per Capita Net Expenditures ($)	Total Net Expenditures ($ billions)	Applicable Percent	Maximum Savings Target ($ billions)	Maximum Savings Target with Carry-Over ($ billions
2013	11,906	1,538	10,368	539.8			
2014	12,267	1,597	10,670	573.3			
2015	12,542	1,744	10,798	597.4	0.5%	2.87	2.87
2016	12,982	1,739	11,243	639.9	1.0%	5.97	8.84
2017	13,514	1,898	11,616	679.8	1.25%	8.00	16.84
2018	14,119	2,012	12,107	728.7	1.5%	10.20	27.04
2019	14,768	2,137	12,631	782.0	1.5%	10.93	37.97
2020	15,517	2,297	13,220	842.0	1.5%	11.73	49.70
2021	16,277	2,295	13,982	915.8	1.5%	12.63	62.33
Total[5]				5,185.6		62.33	205.57

6. Discussion

The potential savings from the IPAB range from none (CBO 2012) to $205.6 billion. The most recent Congressional Budget Office (CBO) projection of $3.3 billion is likely to be the best current estimate of the impact of IPAB's effect with most years having no need for a Board proposal. These $3.3 billion are just 0.06% of program spending during the same time period. Even if spending grows dramatically, as this paper demonstrates, IPAB is not likely to be an effective mechanism to constrain growth given the relatively small statutory applicable percentages. Again, even if spending growth was rampant over this time period, the Board's efforts would have a small impact on total program spending.

[5] Totals are for years 2015-2021. No savings will occur in 2013 or 2014, but these years are used in the calculation of maximum savings in later years.

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