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Providing high quality healthcare in the United States in the future depends critically upon slowing the rate of growth in the costs of that care. Such concern is relevant for all Americans, but gets particular attention in the programs funded publically. The costs of Medicare are part of the debate over the budget and the deficit as well as the future of the program itself. Contrast this with the more hidden costs of employer-provided insurance where many recipients of that coverage have little idea how much is paid on their behalf. Thus, it is not surprising that so much attention is focused on Medicare and its "sustainability" over time. It is in this context that the Independent Payment Advisory Board (IPAB) was enacted as part of the Patient Protection and Affordable Care Act (hereafter referred to as the Affordable Care Act or the ACA).

In this testimony, I address both the context and rationale for the IPAB and some practical issues and concerns that need to be addressed. While the IPAB raises a number of legitimate concerns, it can be a reasonable tool if appropriately applied.

The Context for the Independent Payment Advisory Board

In the Affordable Care Act, Medicare was singled out for a number of efforts aimed at slowing spending growth; the nature of the legislation was such that the federal government could not exercise similar controls over the private sector that will cover most Americans under the age of 65. Instead, Medicare was to be the model for instituting change in the delivery of care in the U.S.

In addition to the Independent Payment Advisory Board (IPAB) which is the subject of this testimony, substantial resources have been given to the Centers for Medicare and Medicaid Services (CMS) to identify, evaluate and introduce innovations to the delivery and payment of care. This large infusion of funds to find ways to improve delivery and quality while holding down costs is at the heart of efforts to slow growth over time. It is only by identifying and implementing such change that we can expect to see improvements over time.

For the first time, substantial funding was established under the ACA which will allow for systematic investment in such change. Until we understand better how to use our resources more effectively and what organizations and treatments work well, it will be impossible to move forward to slow spending growth. It is fully appropriate for this to be

done at the federal level—which will ensure both a very broad look at innovations and make the information available to all providers of care. Research conducted by private insurers or providers is likely to remain proprietary and to not be of the needed scope to achieve the tasks that loom before us. With these other activities, the IPAB makes considerably more sense than if it had been enacted as a standalone gatekeeper of spending.

In conjunction with efforts to better understand various options for change, the IPAB establishes a process to enforce cost containment in Medicare if per capita spending growth exceeds certain target rates. It attempts to employ experts and reduce the influence of special interests to minimize political gamesmanship.

Research has indicated that the rapid infusion of new technology is the a major driver of the rising costs of care; it only makes sense then that this is also the area to which we should look to find ways of mitigating growth. And once such knowledge is accumulated, how should it be applied? Medicare, as an enormous share of our health care system, is a logical place to start. Changes can be imposed, but there need to be appropriate safeguards and protections for beneficiaries. Decisions need to be applied consistently and fairly—something that cannot be assured with less direct controls. This is an enormous task and one in which the federal government, providers of care, private insurers and beneficiaries all have a stake. Efforts to reduce the ability of the federal government to bring about change in care will weaken the tools available to tackle what is likely to be a long and challenging process.

By contrast, those who advocate decentralizing our Medicare program and turning decision-making over to beneficiaries place an enormous burden and risk on those beneficiaries. This is the hallmark of options that would require Medicare beneficiaries to buy insurance with a limited guarantee of subsidy from the federal government—referred to as vouchers or premium support—that are currently being discussed.

Supporters of such an approach often talk about having beneficiaries putting more "skin in the game" as a way of improving healthcare decision-making. Despite claims that this would create better consumers of care, they are asking the most vulnerable members of our society to make decisions for which they are likely to be poorly equipped. For example, proponents often cite the famous RAND experiment on this topic, but they ignore two key findings: first, that while making people more financially liable will result in lower spending, such lower spending will come both from discretionary expenditures and from expenditures that are critical to the health of the individual. Second, changes in behavior come more from those with limited resources: it is not the change in price that drives people to consume less, it is the inability to afford such care at all when deductibles or coinsurance rise.

Further, this approach shifts the risk of continuing cost growth onto beneficiaries. It lets the federal government off the hook, but expects individuals to face the tough choices between poor coverage or very expensive coverage if costs are not brought under control. There is no strong evidence that markets work to discipline the costs of healthcare, so we

have no reason to be optimistic that they will indeed be able to hold down cost growth over time. Private plans will be able to alter the benefit package and cause patients to face a range of hard choices that may substantially reduce the protections that Medicare now assures. Healthcare is complicated, and decisions are often made outside the control of beneficiaries when they are very ill and unable to participate in informed decision-making. We should not put the burden of improving the healthcare system on the shoulders of individual Medicare beneficiaries.

One positive aspect of IPAB that is often ignored, particularly when the idea is broadly challenged, is that it was explicitly set up to avoid cuts in benefits to beneficiaries and reductions in their coverage. (It also has an explicit prohibition on "rationing" although that is not clearly defined.) These protections strongly affirm the goal of insulating beneficiaries and stands in stark contrast with a voucher or premium support approach to Medicare. The IPAB statute implicitly recognizes that individuals cannot change the healthcare system, but rather that the focus needs to be on improving the delivery of care—an activity that requires research and determination to help the system change.

The role of the IPAB is to be a backstop to ensure that tough decisions do get made if costs remain out of control, and that they would be applied to everyone. Fortunately, projections of Medicare cost growth indicate that the IPAB will not need to make recommendations until at least 2021: Medicare spending is projected to remain well below the triggers for some time to come largely as a result of various parts of the ACA. The ACA made changes in provider payments and other aspects of Medicare that have substantially slowed its growth. What the Board could do in the interim is develop mechanisms for implementing change and work with the Innovations Center of CMS to identify where the most promising areas of change reside and be prepared to help that come about if there is resistance to such changes in moving forward. Viewed in this way, the IPAB could become a positive tool rather than merely a threatened approach to change.

Issues Facing the IPAB

Despite the arguments I have made above about the reasonableness of the goals of the IPAB, there are some serious challenges that ought to be addressed to improve its functioning.

First, setting goals on limited time horizons and then having short periods to implement change will put enormous pressure on a system that needs to change in many ways but is not yet set up to readily adopt reforms. Improved coordination of care, for example, is a key part of reforms but will require that individual providers and institutions make a broad range of changes in attitudes, policies, and financial arrangements. Instant savings should not be expected nor used to measure success. This may create a bias in favor of less complicated changes such as payment limits. A Board tasked with annual growth targets will find it very challenging to pursue a nuanced approach that encourages delivery system reforms. The longer time horizon of six year terms for members of the Board may help but probably is not sufficient to address this issue. The short time that

the Congress has to act if it were to seek other approaches is also problematic. Overall, changes to IPAB should be made that will improve its ability to foster delivery system reform.

Second, the tight conflict of interest requirements and the fulltime paid status of Board members may make it difficult to truly attract the types of high quality members that would be desired. The salaries will not compete with what many could make on the outside and requiring Board members to give up all their other connections and affiliations may discourage many who would like to participate. It is also not clear what the activities of the members of Board would be that would require fulltime participation. Modification of these rules, while continuing the goal of attracting members not beholden to special interests, is desirable.

Third, the lack of clarity about what constitutes rationing of care is an issue. It might be viewed either too narrowly or too broadly. Nonetheless, it is important to note that the spirit of not harming beneficiaries is the stated goal in the ACA—and certainly puts the IPAB in a stronger position to protect beneficiaries than does a premium support approach to care, for example.

Fourth, the exemption of some providers of care in the early years could generate equity problems if the choices facing the Board are unduly constrained.

Fifth, if Medicare is singled out for more controls while the rest of the healthcare system grows rapidly, access and quality problems could arise. The intent is to have Medicare be a model for others to follow, but it would be appropriate to add further considerations for the Board for how Medicare is functioning relative to the rest of the healthcare system in making recommendations.

Finally, what is the cumulative effect of very stringent controls over a long period of time? Tightening up on payments, requiring coordination of care, and improving the overall delivery of care are all desirable activities. But what happens if, over a period of time, these have happened and as a society we want to see spending on healthcare increase—perhaps because of crucial but expensive advances that truly improve peoples' lives? Establishing a system that assumes that we must follow a particular trajectory indefinitely may ultimately prove not to be good policy, and we may decide it is appropriate to actually increase the revenue we need to support a worthy program. The IPAB implicitly rejects that type of recommendation.

Conclusions

The IPAB is not an ideal mechanism; it needs improvements and even then it will still reflect the fact that policymakers have decided that some decisions are just very hard to make on their own. But it should be viewed in the broader context of what it is trying to achieve and whether it is a reasonable tool among many that the ACA has created. It should not be viewed in isolation.

Moreover, the IPAB needs to be compared to alternative approaches. As compared to a privatized Medicare system, it offers many positives. It does not penalize beneficiaries first and foremost. Its intent is to explicitly avoid rationing—an advantage over a system that limits the growth in the value of the subsidy to be paid for purchase of private insurance. It uses the considerable and valuable power of the federal government to consider changes that need to be applied equitably across the U.S. And the ACA is trying to target the source of healthcare spending: what we pay for what types of services.

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