

The Independent Payment Advisory Board And Access to Health Care

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Introduction

A controversial feature of the Patient Protection and Affordable Care Act (ACA) is the new Independent Payment Advisory Board (IPAB). This appointed panel will be tasked with cutting Medicare spending, but some of its features appear to be problematic.

First, given its mission, IPAB's mandate is too narrow. The board is prohibited from recommending changes that would reduce payments to certain providers before 2020, especially hospitals. Because of directives and restrictions written into the law, reductions achieved by IPAB between 2013 and 2020 are likely to be limited primarily to Medicare Advantage (23 percent of total Medicare expenditures), to the Part D prescription drug program (11 percent), and to skilled nursing facility services (5 percent). That means that reductions will have to come from segments that together represent less than half of overall Medicare spending.

Second, the IPAB is effectively unaccountable. In practice, the law makes it almost impossible for Congress to reject or modify IPAB's decisions, even if those decisions override existing laws and protections that Congress passed. As a result, it is not in fact an advisory body, despite its name. The system is set up so that IPAB, rather than Congress and the Department of Health and Human Services (HHS) acting under Congress' authority, makes policy choices about Medicare.

Finally, IPAB's time horizon is too short. IPAB's cuts have to be achieved in one-year periods. That effectively rules out long-run quality improvements or preventive programs. Instead, IPAB will be forced to focus on reducing reimbursements to providers due to their short-term nature.

IPAB Reimbursement Policy and Access to Care

IPAB will be an agent for reimbursement cuts in Medicare.¹ This has two potentially damaging effects on Medicare and health care in the United States.

First, IPAB's actions may stifle U.S. led medical innovation in the medical device, pharmaceutical, biotechnology, and mobile health industries. As noted above, by statute, IPAB cannot directly alter Medicare benefits. Instead, the more likely threat to patients is that IPAB will be forced to limit or deny payments for medical services. In the process, it will effectively determine that patients should have coverage for one particular treatment option but not another, or must pay much more out of pocket for one of the treatment options.

This is especially troubling because it may choose to disproportionately make cuts to expensive new treatments. New medicines for conditions like Alzheimer's or Parkinson's will likely have rapid cost growth,

*I thank Joe Antos, Emily Egan, Cameron Smith and Grace-Marie Turner for valuable assistance. All errors are my own. This paper draws on my testimony before the House Budget Committee, July 2011.

¹ A less generous characterization is that IPAB stands for Independent Price-controls Advisory Board.

especially early after their introduction on the market. That will make them targets as IPAB is directed to focus on areas of “excess cost growth.” Worse, because about one-half of spending is off limits until after 2020, there will be a disproportionate and uneven application of IPAB’s scrutiny and payment initiatives.

U.S. medical innovation leadership is dependent on whether the regulatory environment nurtures growth or suppresses advancement. The ACA substantially increases the cost of innovation via industry taxes and, in addition, IPAB creates a level of uncertainty that will have a detrimental impact on venture capital investment in start-up firms and research and development investments from established firms.

The social cost of this effect is unknowable. Forgone innovation cannot be quantified as it results in undiscovered therapies for future Americans. However, regardless of the magnitude, this loss is avoidable.

The second impact is reduced access to care. If Medicare’s provider reimbursements are drastically reduced the market will react in accord with the basic laws of economics. Providers will have three options: to close up shop, to refuse to treat Medicare patients, or to shift the costs onto the other patients. None of these options help our healthcare system operate more effectively or more efficiently.

Today, Medicare coverage no longer guarantees access to care. Increasingly seniors enrolled in the Medicare program face barriers to accessing primary care physicians as well as medical and surgical specialists. The New York Times, Bloomberg News, and Houston Chronicle are among many newspapers reporting that doctors are opting out of Medicare at an alarming rate. For example, the Mayo Clinic, praised by the IPAB’s architects, will stop accepting Medicare patients at its primary-care clinics in Arizona.²

The physician access problem stems from Medicare’s below-cost reimbursement rates and the annual uncertainty regarding cuts in physician payments from the Medicare sustainable growth rate (SGR) formula. IPAB introduces further uncertainty into physician reimbursement and is likely to force more physicians to begin making difficult Medicare practice decisions.

Recognizing the increased payment uncertainty, physician practices have started to reshape their practice patterns. Moving forward, 67.2 percent of physician practices are considering limiting the number of new Medicare patients, 49.5 percent are considering the option of refusing new Medicare patients, 56.3 are contemplating whether to reduce the number of appointments for current Medicare patients, and 27.5 percent are debating whether to cease treating all Medicare patients.³

The upshot is clear. While IPAB appears to be barred from recommending rationing health care, raising revenue or premiums, increasing cost sharing, or restricting benefits and eligibility, its mission will inevitably endanger access to existing care and innovation in new therapies.

Although rationing is an unpopular and ungracious term IPAB may bring Medicare dangerously close to a rationed system. It will become more difficult to make appointments with providers of all sorts, thereby restricting care. On top of which, a provider will not offer a poorly-reimbursed, but effective, treatment unless there does not appear to be a therapeutic alternative. “Rationing” will occur in complex and often subtle ways, and patients may never know that they could have received a more effective treatment.

² <http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aHoYSI84VdL0>

³ Medical Group Management Association. 2010. Sustainable Growth Rate Study. <http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=39774>

This experience has been foreshadowed elsewhere. Britain's National Health Service does not ban coverage outright, but makes it more difficult to get newer treatments—or even older treatments that improve comfort and functioning but are not life-saving such as joint replacements.⁴

In Scotland, the same desire to save money in the face of a £55 million deficit sparked fears about a “lottery for patients. The removal of tonsils, varicose veins and ‘minor’ lumps are among the procedures it wants to scale back to save money.”⁵

But the largest recent controversies have been in regard to cancer drugs used for patients with only weeks to live. For example, Vemurafenib treats melanoma that has spread. It is new and innovative, but also very expensive – precisely the kind of target that will attract IPAB's attention. In Britain, it means that a patient must ask for it but might be dead before hearing a decision.⁶

Also in Britain, “A mother has flown her seven-year-old son to Germany for life-saving cancer treatment after two NHS hospitals delayed surgery because of a lack of beds. Sam Knighton has spent £10,000 on taking her son Zac abroad for treatment for neuroblastoma, a form of cancer of the nerve tissue found in young children.”⁷

Conclusion

The ACA is an enormous reform, of which IPAB is only one part. However, its structural defects make it a potentially damaging policy toward the future of health care in the United States. Inevitably, IPAB will be driven to implement reimbursement cuts, and consistent with the history of price controls, the result will be reduced access to care and diminished investment in medical innovation.

⁴ See <http://www.independent.co.uk/life-style/health-and-families/health-news/cataracts-hips-knees-and-tonsils-nhs-begins-rationing-operations-2327268.html>.

⁵ <http://www.heraldscotland.com/news/home-news/hundreds-of-operations-face-axe-to-save-pound55m-concern-as-operations-face-axe.14003519>.

⁶ <http://www.telegraph.co.uk/health/healthnews/9331485/Melanoma-drug-too-expensive-for-NHS.html>.

⁷ <http://www.telegraph.co.uk/health/healthnews/9004080/Boy-7-has-cancer-operation-in-Germany-because-of-NHS-bed-shortage.html>.