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The Independent Payment Advisory Board May Be Dead Before It's Born

by Tim Trysla, Michael Park, and Brian Lee

The Independent Payment Advisory Board (IPAB) was established under the Affordable Care Act (ACA) with the mission of reducing the growth rate of Medicare spending. The necessary conditions to trigger IPAB activity have not yet been met. Consequently, there has been no IPAB activity, and no members have been nominated to the board. In July 2016, the Centers for Medicare & Medicaid Services' (CMS) chief actuary stated in his letter to the CMS administrator that the growth in Medicare per capita spending was less than the target growth rate, and therefore the IPAB would not be triggered for 2016. However, the chief actuary and the Medicare trustees believe that the IPAB will be triggered in 2017, followed by several years of volatility when the IPAB may or may not be triggered. According to the chief actuary, the volatility is due to statutory methodology changes in assessing when IPAB activity is triggered.

It is important to note that although no members of the IPAB have been nominated by the President, the IPAB recommendation requirements could still force action by Congress since the IPAB statute requires the Secretary of Health & Human Services (HHS) to submit a contingent proposal if the IPAB fails to submit a proposal to Congress. This contingent proposal would be required to meet the same savings targets as an IPAB proposal and would operate under the same special congressional procedural processes as a proposal issued by the IPAB itself.

Given widespread opposition to the IPAB in Congress, we expect that a triggering of the IPAB recommendation requirements would result in renewed efforts to repeal the IPAB, with corresponding budgetary offsets. The President's Fiscal Year (FY) 2018 Budget proposal also calls for the repeal of the IPAB. In addition, a number of court challenges to the constitutionality of the IPAB have been dismissed due to lack of ripeness and lack of injury-in-fact for the plaintiffs. We expect that the actual triggering of the IPAB recommendation requirements could result in new court challenges that would have a better likelihood of overcoming a motion to dismiss.

Background

Section 3403 of the ACA added Section 1899A to the Social Security Act to establish the IPAB and create a procedural framework for congressional consideration of IPAB recommendations.

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Appointment of board members

Social Security Act § 1899A(g) requires that 15 voting members of the IPAB must be nominated by the President and confirmed by the Senate. To date, there have been no nominations to the IPAB.

Determination year, proposal year, and implementation year

The Social Security Act defines the "determination year" as the year in which the CMS chief actuary projects the five-year average per capita growth rate under Medicare for the second following year. That second following year is referred to as the "implementation year." The "proposal year" is the year between the determination and implementation years. For example, if 2017 was the determination year, then the CMS actuary would be projecting the five-year average per capita growth rate in Medicare spending for a period ending in 2019. The proposal year would be 2018, with 2019 being the implementation year.

Timing for determination year, proposal year, and implementation year

The Social Security Act requires that during each determination year, the CMS chief actuary must determine whether the five-year average Medicare per capita growth rate for the period ending in the implementation year is projected to exceed the five-year average target growth rate for the period ending in the implementation year. Although the chief actuary is required to make the determination by April 30 of each year, in practice, the CMS actuary has typically issued these determinations during the summer of the determination year, in conjunction with the release of the Medicare Trustees Report. If the CMS actuary projects that the five-year average Medicare per capita spending growth will exceed the target growth rate for the period ending in the implementation year, then the IPAB is required to submit recommendations for Medicare spending reductions during the proposal year. The IPAB must submit its recommendations to Congress and the President by January 15 of the proposal year. Congress must then report legislation by April 1 of the proposal year to implement the recommendations or implement its own proposal that meets the same fiscal requirements. Fiscal year payment rate recommendations take effect October 1 of the proposal year, while calendar year payment rate recommendations and recommendations related to Parts C and D take effect on January 1 of the implementation year.

Spending growth rates versus target growth rates

The IPAB is required to recommend policy proposals to Congress that would reduce Medicare per capita spending for any year in which the projected growth in the five-year average Medicare per capita spending under Medicare Parts A, B, and D is projected to exceed the per capita target growth rate. For Determination Year 2017, the target growth rate is the average of the projected five-year average percentage increase in the Consumer Price Index for All Urban Consumers (CPI-U) and the medical expenditure category of the CPI-U. For Determination Year 2018 and all subsequent years, the target growth rate is the projected five-year average of growth in gross domestic product (GDP) per capita plus 1 percent. In all instances, the projected five-year average consists of projected growth rates from the two years before the determination year, the determination year, and the two years following the determination year. For example, for Determination Year 2017, the five-year average consists of the years 2015, 2016, 2017, 2018, and 2019.

Proposal requirements

The Social Security Act requires the CMS actuary to establish a savings target for the implementation year. This savings target is the product of the projected Medicare spending for the proposal year and the "applicable percent" for the implementation year. The applicable percent is the lesser of the projected excess spending in the

form of a percentage or statutorily defined percentages.[1] The IPAB is required to make recommendations that would reduce overall Medicare spending by the applicable percent determined by the CMS actuary.

Generally, proposals made pursuant to the IPAB statutory authority are limited to Medicare policies that do not ration health care, raise revenues or Medicare beneficiary premiums, increase Medicare beneficiary cost-sharing, or otherwise restrict benefits or modify eligibility criteria. In addition, all proposals submitted before December 31, 2018, may not include recommendations that would reduce payment rates before December 31, 2019, for hospital inpatient or outpatient services, long-term care hospital services, inpatient rehabilitation facility services, inpatient psychiatric facility services, hospice services, or clinical laboratory services.

Process for scenarios where the IPAB fails to make required recommendations

Under Social Security Act Section 1899A(c)(3)(A), if the CMS actuary makes a determination that the five-year average Medicare per capita growth rate is projected to exceed the target growth rate for the period ending in the implementation year, then the IPAB must submit recommendations to Congress by January 15 of the proposal year. Importantly, if the IPAB fails to make its recommendations by January 15 as required, then the HHS Secretary is required to develop a detailed proposal in lieu of the IPAB proposal by January 25 of the proposal year. The Secretary's proposal must follow the same proposal requirements outlined in the IPAB statutory authority.

Process for congressional consideration of IPAB/HHS proposals

The Social Security Act establishes an accelerated approval process in the House and Senate for consideration of the proposals. Upon receipt of the IPAB recommendations (or the HHS proposal), the committees of jurisdiction have until April 1 of the proposal year to report legislation that approves the proposal or alternative legislation that modifies the proposal but achieves the same level of savings. The savings requirement for alternative legislation can only be waived in the Senate with an affirmative vote by at least a three-fifths' majority. Any separate legislation to repeal the savings requirement (or repeal any IPAB-recommended proposals) would also require a three-fifths' majority in the Senate.

On August 15 of the proposal year, the Secretary of HHS is required to implement the proposal (or as modified in alternative legislation). Recommendations under the proposal that are related to fiscal year payment rate changes would be implemented on October 1 of the proposal year, while recommendations relating to calendar year payment rate changes or changes to Medicare Advantage or Medicare Part D would be implemented on January 1 of the implementation year. Finally, for implementation years after 2019, the Social Security Act establishes a process by which Congress and the President could enact a joint resolution to discontinue the IPAB, although this joint resolution would also require a three-fifths' majority in the Senate. The joint resolution for discontinuation would need to be introduced in Congress before February 1, 2017,[2] and would need to be enacted by August 15, 2017. Despite the enactment date deadline, Congress has viewed IPAB procedures as rules of the respective chambers and subject to alteration as any other rule. Subsequently, the Senate or House could change the procedures, suspend the rules, or report a special rule to circumvent the statutory processes for considering proposals or discontinuing the IPAB process.

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1 Note: Under Social Security Act § 1899A(c)(7), the maximum amount of spending reductions required for IPAB recommendations in any given implementation year for 2018 or later is capped at 1.5 percent of Medicare spending.

2 Three joint resolutions were introduced on or before February 1, 2017, that contain the statutorily required language to repeal the IPAB: H.J.Res. 51 (Rep. David P. Roe, R-TN), S.J.Res. 16 (Sen. Ron Wyden, D-OR), and S.J.Res. 17 (Sen. John Cornyn, R-TX).

Projections for 2017 and Subsequent Years

The CMS actuary issued a determination for Determination Year 2016 on June 22, 2016. Although the actuary found that "the projected 5-year Medicare per capita growth rate does not exceed the Medicare per capita target growth rate" for 2016, the 2016 Medicare Trustees Report projected that the Medicare spending per capita growth rate will, in 2017, exceed the target growth rate. Further, according to the 2016 Medicare Trustees Report, after being triggered in 2017, the IPAB will not be triggered during 2018–2021, triggered in 2022, not triggered in 2023, and triggered again 2024–2025.

Table V.B2.—Key Rates of Growth for IPAB Determination

[In percent]

Calendar year	Medicare per capita[1]	CPI-U	CPI-medical care	GDP per capita	NHE per capita[2]	IPAB determination[3,4] Medicare	Target[5]
2011	2.4%	3.2%	3.0%	3.0%	3.1%	—	—
2012	0.3	2.1	3.7	3.4	3.0	—	—
2013	−1.1	1.5	2.5	2.4	2.1	1.46%	3.04%
2014	1.8	1.6	2.4	3.3	4.5	0.43	2.61
2015	2.0	0.0	2.2	2.6	4.4	1.70	2.48
2016	1.8	0.9	2.0	3.0	4.0	2.21	2.33
2017	1.1	2.8	4.4	4.5	4.5	2.82	2.62
2018	4.3	2.7	4.3	4.5	4.6	3.40	5.06
2019	4.7	2.6	4.2	4.3	5.2	3.98	5.26
2020	4.9	2.6	4.2	4.1	5.3	4.72	5.11
2021	4.9	2.6	4.2	4.0	5.3	4.83	4.92
2022	4.8	2.6	4.2	3.7	5.3	4.80	4.78
2023	4.9	2.6	4.2	3.5	5.2	4.57	4.67
2024	4.6	2.6	4.2	3.6	5.1	4.96	4.60
2025	3.8	2.6	4.2	3.6	4.9	4.94	4.59

[1]These amounts differ from those presented in section V.D because they are determined based on the methodology required for the IPAB determination. They are calculated as the sum of the average per capita spending under each of Parts A, B, and D. For Parts B and D, the spending is net of premiums. In addition, the amounts in section V.D include other miscellaneous items such as Medicare Advantage additional premiums.

[2]Source: For years 2011-2014, the national health expenditure (NHE) data were published in December 2015 (*Health Affairs*, vol. 35, no.1) and are available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. For years 2015-2024, the NHE data were published in July 2015 (*Health Affairs*, vol. 34, no.8) and are available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html. For 2025, NHE growth rates were determined based on the methods described in section IV.D.

[3]5-year average starting 2 years prior to the determination year and ending 2 years after the determination year. An implementation year is 2 years after a determination year in which Medicare per capita costs are projected to grow at a faster rate than the target, requiring a reduction in spending.

[4]The determination values for 2013-2015 reflect the actual determinations made in those years.

[5]For determinations made in 2013-2017, the target is equal to the average of the growth in the Consumer Price Index for All Urban Consumers (all items; United States city average) and the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average). For 2018 and later determinations, the target rate of growth is per capita GDP plus 1 percent.

Outlook

The 2017 Medicare Trustees Report and CMS actuary's determination are expected to be released this summer. Given findings from the Medicare trustees and actuary reflecting recent increases in Medicare spending growth, relative to the slow rate of growth in the 2010–2014 period, the potential for IPAB triggering is a situation that should be closely monitored.

Several legal challenges have been raised about the constitutionality of the IPAB. In March 2015, the U.S. Supreme Court chose not to take up *Coons v. Lew*, a Ninth Circuit dismissal of the plaintiffs' argument that the IPAB is an unconstitutional delegation of legislative authority by Congress and that the plaintiffs – physicians – would be injured

by the IPAB recommendations and reduced Medicare payment rates. The Ninth Circuit dismissed the case without addressing the constitutionality of the IPAB, stating that the suit was not ripe since the plaintiffs' claim of harm was contingent on future, unknowable events. Subsequently, any eventual triggering of the IPAB process would likely result in renewed legal activity and court challenges to the constitutionality of the IPAB.

In addition to legal challenges, there have been several bills introduced to repeal the IPAB. Most recently, H.J. Res. 51, S.J. Res. 16, S.J. Res. 17, S. 251, H.R. 849, and S. 260, all introduced in the 115th Congress, would repeal the IPAB. Further, the President's FY 2018 Budget proposal for HHS includes a repeal of the IPAB, resulting in $7.6 billion in costs over 10 years (the Congressional Budget Office has scored previous IPAB repeal legislation, noting that the repeal would result in an increase of direct spending by $7.1 billion during 2022–2025). The triggering of the IPAB may result in these legislative proposals receiving consideration in Congress.

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