

# Technocratic Dreams, Political Realities: The Rise and Demise of Medicare's Independent Payment Advisory Board

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**Abstract** Enacted as part of the 2010 Patient Protection and Affordable Care Act, the Independent Payment Advisory Board (IPAB) was hailed by many analysts as a major innovation in US health policy making and cost control. The board promised to put a brake on Medicare spending through an extraordinary combination of budgetary discipline, expert advice, uncommon legislative procedures, and administrative delegation. IPAB embodied the aspirations of technocracy: the board would rise above partisanship and interest group pressures, formulating Medicare policy recommendations based on evidence and reason rather than politics. The special legislative rules and administrative powers associated with IPAB were to be an antidote to both congressional inaction and micromanagement. Those aspirations resonated with many politicians, policy makers, and health services researchers. Yet IPAB has fallen far short of the aspirations and enthusiasm that accompanied its establishment. It has remained in political purgatory, paralyzed by controversy and partisanship. We explore why IPAB has failed to live up to the hype and what the IPAB story tells us about the promise and limits of technocracy in US health care policy.

**Keywords** Medicare, Affordable Care Act, Independent Payment Advisory Board, cost control, health care costs

Enacted as part of the 2010 Patient Protection and Affordable Care Act (ACA), the Independent Payment Advisory Board (IPAB) was hailed by many analysts as a major innovation in US health policy making and cost control. The board promised to put a brake on Medicare spending through an extraordinary combination of budgetary discipline, expert advice, uncommon legislative procedures, and administrative delegation. If per-person Medicare spending growth exceeded specified targets, a nonelected board

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of experts, health care professionals, and consumer representatives would be empowered to make recommendations to Congress to curb Medicare spending. Congress would consider IPAB's recommendations under special rules designed to ensure speedy action. If it did not act to reduce program spending growth, then the secretary of health and human services would have authority to implement IPAB's recommendations (Oberlander and Morrison 2013).

IPAB embodied the aspirations of technocracy: the board would rise above partisanship and interest group pressures, formulating Medicare policy recommendations based on evidence and reason rather than politics. The special legislative rules and administrative powers associated with IPAB, which was to be located in the executive branch, were to be an antidote to both congressional inaction and micromanagement. The board's establishment arguably constituted the "single-biggest yielding of power to an independent entity since the creation of the Federal Reserve" (Bai 2010). IPAB thus reflected an effort not simply to moderate Medicare spending but to reconfigure the institutional structure of health policy making (Orszag 2011).

Those aspirations resonated with many politicians, policy makers, and health services researchers. Obama administration officials Peter Orszag and Ezekiel Emmanuel (2010: 603) declared that IPAB likely represented "the most important institutional change in the ACA." Former Senate majority leader Tom Daschle (Daschle and Nather 2010: 300) judged the board to be the ACA's "most promising device" to control costs, while Henry Aaron (2011) praised IPAB as Congress's "good deed." Anne Marie Marcialle and J. Bradley DeLong (2011: 78) argued that "the long-term viability of social insurance in America depends on whether IPAB is able to successfully manage Medicare pricing." A group of over one hundred health policy researchers signed a letter to Congress emphasizing the importance of keeping IPAB because it "will force debate on difficult choices that Congress has not thus far addressed . . . [and] make . . . professional expertise available to the Congress" (Aaron et al. 2011). As he prepared to leave office, President Barack Obama (2016) reiterated his long-standing support for the board as "a valuable backstop if rapid cost growth returns to Medicare."

Yet IPAB has fallen far short of the aspirations and enthusiasm that accompanied its establishment. From IPAB's inception, the board has been surrounded by controversy. Conservative critics denounce it as a "death panel" that would ration medical care for Medicare beneficiaries, and congressional Republicans fiercely oppose it. The board has never managed to

escape the politics and partisanship that advocates hoped it would supplant. IPAB became ensnared in the broader fight over Obamacare, a symbol of the hyperpartisanship and ideological polarization that has engulfed US health policy. Over seven years after its creation, not a single person had been named or even nominated to serve on it, and IPAB finds itself, both inside and outside of Congress, with “few defenders” (Jost 2017). Meanwhile, lower than anticipated Medicare spending growth has postponed IPAB’s triggers and obviated any potential role as a backstop against excessive spending. The board that advocates envisioned as an institutional bulwark against rising health care costs and critics demonized as an instrument of rationing has turned out to be neither. Instead, IPAB has had no impact at all on Medicare or health care costs. It has remained in political purgatory, paralyzed by controversy and partisanship that have prevented its launch.

This article explores what the IPAB story tells us about the promise and limits of technocracy in US health care policy. Why did Congress enact IPAB, and how do we understand its broad appeal to the health policy community? Is the case for IPAB as compelling as the conventional wisdom would suggest? Why has IPAB failed to live up to the hype? IPAB’s brief, troubled history offers a cautionary tale about the role of evidence, expertise, and independent panels in US health policy making.

## Origins

IPAB’s roots lie in prior Medicare institutions and payment policies. Since the 1980s, Congress had relied on an alphabet soup of commissions to advise it on Medicare payment policy: PPRC (Physician Payment Review Commission) and PROPAC (Prospective Payment Assessment Commission), and then the Medicare Payment Advisory Commission (MedPAC), which merged its two predecessors (Oliver 1993). Those commissions reflected a broader pattern of Congress equipping itself with resources and expertise, including the Congressional Budget Office (CBO) and Congressional Research Service, to help give legislators the capacity to make policy (Oberlander 2003). This distinctive form of congressional government exemplifies, relative to other nations that have more established bureaucracies, the unique influence that the American national legislature exerts over public policy. IPAB built on this precedent of expert advice in Medicare policy, though crucially the board was relocated from the legislative to executive branch.

IPAB also has roots in another alphabet soup of technical formulas adopted to help restrain Medicare spending: DRGs (Diagnosis-Related

Groups), RBRVS (Resource-Based Relative Value Scale), and the SGR (Sustainable Growth Rate). They promised to set prospective limits on Medicare spending (DRGs), base program payments on expert judgment of relative costs (RBRVS), and create spending growth targets tied to economic indexes that would generate automatic cuts if Medicare expenditures exceeded the targets (SGR). The 45 percent trigger, created by the 2003 Medicare Modernization Act, that required Medicare trustees to issue a funding warning if the share of general revenue funding for program spending exceeded the threshold, was another IPAB antecedent (Davis, Garvey, and Davis 2017).

Outside of health care, IPAB's spending targets and automatic enforcement mechanisms recall the budget caps that Congress has used since the 1990s (White 2016). Like such caps, IPAB's targets committed Congress (at least theoretically) to doing something to restrain future spending without specifying what exactly would be cut. The board also harkens back to early twentieth-century Progressive Era ideals of scientific government and expert administration. The Progressives' vision for rationalizing government called for establishing new commissions that were independent of "the corrosive politics of interest groups and the legislature" and comprising "experts impartially applying specialized knowledge in specialized fields" (Morone 1990: 117–18). The Federal Reserve, created in 1913, embodied such Progressive ideals and would become an important model for IPAB. Former senator Tom Daschle drew on the Federal Reserve in proposing a federal health board in 2008. According to Daschle and coauthors Scott Greenberger and Jeanne Lambrew (2008: 129–30, 134–35), "In Congress every decision is political . . . The Fed, in contrast, can make decisions based on data and a thorough analysis of what's best for the country."

Perhaps the most influential model for IPAB, though, was the Base Realignment and Closure Commission (BRAC). Congress established BRAC, which aimed to overcome years of legislative stalemate, in 1988 with the task of identifying military bases for closure. It proposed five rounds of cuts between 1988 and 2005, resulting in the closure of over one hundred military bases (Mayer 1995, 1999, 2007). BRAC combined the appeal of an independent commission, bipartisan policy making, and a mechanism to spare Congress from political blame for making controversial decisions that imposed concentrated costs on localities with fast-track legislative procedures that made it difficult for lawmakers to override its decisions and micromanage policy. BRAC reviewed a list of recommended base closures from the Department of Defense and made

its own recommendations to the president. The president could either approve or reject the entire list but could not alter it. If the president approved the list, then Congress, which also could not change it, had forty-five days to overturn the president's decision through a joint resolution (a two-thirds majority would be required to override a presidential veto of such a resolution) or the closures would be implemented (Mayer 1995, 1999, 2007). BRAC thus represented an "astonishing delegation of legislative power" (Mayer 1999: 32) and a model of Congress effectively recusing itself from policy making when lawmakers recognized they needed to act but could not do so (Teter 2011).

Health policy makers and analysts cited BRAC as an example of how an independent commission could work in health care. BRAC emerged as one model for former Senate majority leader Daschle's federal health board: "The BRAC process is as valiant an attempt as Congress has made to create a workable process of critical national decisions" (Daschle, Greenberger, and Lambrew 2008: 115–17). Prior to the ACA's enactment and IPAB's establishment, President Obama (2009) noted in a letter to Senate Democrats that he was open to giving special consideration to MedPAC recommendations regarding Medicare savings where such reductions would be adopted "unless opposed by a joint resolution of the Congress." "This is similar," Obama noted, "to a process that has been used effectively by a commission charged with closing military bases, and could be a valuable tool to help achieve health care reform in a fiscally responsible way." Former Obama administration official Ezekiel Emanuel (2014) argued that BRAC represented a successful model for how an independent panel could control government expenditures that IPAB would emulate. Congress, too, saw the similarities. Congressman Frank Pallone remarked that "IPAB is just another BRAC, only the healthcare version" (US House of Representatives 2011: 6). For the health policy community, BRAC provided evidence that Congress could successfully delegate critical, difficult decisions to an independent commission (Orszag 2011). However, some observers pointed out that, despite BRAC's initial successes, its later experiences underscored the "difficulty of keeping politics out of policy-making" (Daschle, Greenberger, and Lambrew 2008: 117). That caution would prove to be prescient.

### **The Legislative Path to IPAB**

As Tim Jost (2010: 103) observed, during the 2008–10 health reform debate "a common theme . . . [was] the need for a board of impartial experts to

oversee the health care system.” Following Daschle’s 2008 call for a federal health board, several proposals for an independent Medicare board emerged. In 2009, Robert Berenson, Len Nichols, and Tom Emswiler proposed establishing a board of Medicare guardians, echoing “Plato’s Guardians of the Republic,” that would serve as a board of directors of Medicare (Berenson, Nichols, and Emswiler 2009: 47). That same year Senator Jay Rockefeller (D-WV) introduced the MedPAC Reform Act (Stockdale 2010). Rockefeller proposed a substantial expansion of MedPAC’s authority. Instead of serving as an advisory commission to Congress, it would become an executive branch agency with “authority both to make payment and coverage decisions” (Hahn and Davis 2012: 3). The newly empowered MedPAC (“on steroids”) would be charged with making recommendations to reduce Medicare spending according to specified targets (Ebeler, Neuman, and Cubanski 2011; Hahn and Davis 2012; Stockdale 2010).

Shortly after Rockefeller introduced his legislation, the Obama administration, with the support of Office of Management and Budget (OMB) director Peter Orszag, proposed creating an Independent Medicare Advisory Council (IMAC) that would make recommendations to the president on “annual Medicare payment rates as well as other reforms” (Orszag 2009). IMAC emulated BRAC’s fast-track legislative processes. The president had to approve or reject IMAC’s recommendations “as a package,” and if the president approved them, Congress would have thirty days to act on those recommendations “before the Secretary of Health and Human Services is authorized to implement them” (Orszag 2009).

In addition to Orszag’s enthusiasm, an independent Medicare board also appealed to the Obama administration as, in the words of former Secretary of Health and Human Services Kathleen Sebelius, “a backstop, a failsafe” (Kane 2011). As a failsafe mechanism, IPAB would ensure that Medicare spending growth remained moderate, provide a safeguard if other cost containment measures did not work as expected, and potentially generate scorable savings from the CBO. IPAB additionally served an important political purpose: helping win over conservative, Blue Dog Democrats whose votes were crucial to passing ambitious health care reform legislation through Congress (White 2009). They requested the board’s inclusion as part of efforts to ensure that the bill was fiscally responsible and would control costs (Dennis 2009; Dixon 2009). In negotiations with House Energy and Commerce chair Henry Waxman, Blue Dogs like Arkansas Democrat Mike Ross emphasized the importance of creating an independent Medicare commission (Dennis and Newmyer

2009). Tennessee Democrat Jim Cooper, another Blue Dog, became a cosponsor of Rockefeller's MedPAC reform legislation (Murray 2009).

Nonetheless, both the Obama and Rockefeller proposals drew significant opposition in Congress (Pear and Zeleny 2009). However, that opposition was not strong enough to stop IPAB's ascent. The Senate Finance Committee included a version of Rockefeller's MedPAC proposal, renamed the Independent Payment Advisory Board, to reflect its broadened charge to also examine non-Medicare spending, in 2009 health reform legislation that would become law as the ACA in 2010 (Ebeler, Neuman, and Cubanski 2011; Hahn and Davis 2012). The ACA established IPAB and related spending targets to "reduce the per capita rate of growth in Medicare spending" (US House of Representatives 2010).

### **The Case for IPAB**

IPAB enjoyed strong support in the health policy community. Many analysts celebrated its establishment and subsequently warned Congress against dismantling the board (Aaron et al. 2011). The rationale for IPAB rests largely on a broad indictment of Congress's shortcomings—a critique shared by some lawmakers. "Congress," Senator Rockefeller bluntly observed, "doesn't know anything about health care" (Cohn 2009). Congress is said to lack the expertise necessary to properly understand and manage the complexities of Medicare policy. "Few members of Congress are well enough informed," Henry Aaron (2011) asserted, "to make such [Medicare] decisions wisely." Yet even with its acute limitations, Congress does not heed the advice of Medicare experts. MedPAC's recommendations are ignored, its reports regularly "collecting dust" (Orszag 2011) on Capitol Hill. Moreover, Congress interferes with Medicare policy in ways that harm both the program and the public interest. "Every Democratic and Republican policy expert knows," Harold Pollock (2011) argued, "that we must reduce congressional micromanagement of Medicare policy." Because Congress does not use evidence sufficiently, it produces irrational Medicare policy that "undermines the credibility of both the civil servant led-research bureaucracy and the very idea of objective scientific evidence itself" (Berenson, Nichols, and Emswiler 2009: 44).

Congress is also said to be too beholden to interest groups and the health care industry. That is a major reason, critics contend, that it ignores evidence and experts' recommendations. Health system stakeholders have a concentrated interest in protecting the profitable status quo, resisting cost controls that threaten favorable payment and coverage arrangements, and assuring that Medicare conforms to their economic interests. They have the

political resources, including campaign contributions, to press their agendas on Congress, which is unable to resist such influence (Aaron 2011). In 2008, for example, Congress delayed Medicare's competitive bidding initiative for durable medical equipment, despite initial promising results, when suppliers complained its deleterious financial impacts, demonstrating that "political factors often hinder data driven decisions in Medicare particularly when those decisions create economic losers among influential special interests" (Pham, Ginsburg, and Verdier 2009: 1383).

Medicare administrators, too, are vulnerable to pressure from the medical industry, with Congress frequently responding to stakeholders' pleas for relief from administrative actions that threaten their bottom lines. In other words, the health care industry, special interests, and lobbyists have captured Medicare. Too often, Senator Rockefeller charged, "money trumps substance" in Medicare policy (Cohn 2009). Furthermore, because of its institutional structure of state and district representation, when Congress makes Medicare policy it represents particular geographic interests rather than the national interest. The political economy of Medicare means that legislation commonly includes provisions that aim to help specific hospitals, medical device manufacturers, or other medical providers located in lawmakers' districts or states (Vladeck 1999).

For all of these reasons, critics contend, Congress cannot make hard choices about Medicare reform or adopt promising innovations that would put the program on a sustainable financial path. Inaction, in this account, is the defining feature of congressional policy making. Moreover, partisan polarization exacerbates such gridlock (Orszag 2011). Consequently, to govern and address crucial issues such as long-term fiscal stability, "we need," former OMB director and IPAB advocate Peter Orszag (2011) contended, "to minimize the harm from legislative inertia by relying more on automatic policies and depoliticized commissions for certain policy decisions. In other words . . . we need to counter the gridlock of our political institutions by making them a bit less democratic."

IPAB embodied an ambitious effort to address Congress' numerous failings. It provided legislators with political cover, a way to shift blame to unelected officials for controversial, unpopular decisions (Weaver 1986). As an independent, non-elected board, IPAB was designed to be politically insulated from interest groups. It was also constructed, reflecting the experiences of both MedPAC and the Center for Medicare and Medicaid Services (CMS), to counter any congressional instincts to micromanage, eliminate, or ignore the board. If Congress did not act on IPAB recommendations (which also went to the president), the secretary of health and human services would automatically implement those recommendations.



IPAB, in other words, would act even if Congress did not. IPAB additionally had the imprimatur of bipartisanship. Its fifteen members, who would serve six-year terms, were to be appointed by the president in consultation with majority and minority leaders in the House and Senate, each of whom could recommend three appointees (Hahn, Davis, and Liu 2017).

Congress had only a narrow window to discontinue IPAB by a certain year (2017) through a specified legislative process; otherwise, it could not repeal it. Nor could Congress change IPAB's savings targets absent a supermajority vote in the Senate. The goal was to entrench the board and its processes (Hahn, Davis, and Liu 2017). In another act of insulation, IPAB's implemented recommendations were immune from administrative and judicial review (Ebeler, Neuman, and Cubanski 2011). Moreover, along with IPAB, the ACA established per-capita Medicare spending targets, measured over five-year periods, linked to growth in the Consumer Price Index (CPI), the CPI's medical care component, and the gross domestic product. If program expenditures exceeded those targets, the IPAB process would be triggered, requiring specified reductions in Medicare expenditures. IPAB represented a commitment to budgetary discipline, a backstop against excessive Medicare spending.

It also held out the promise of advancing implementation of value-based purchasing and other reforms—what Joe White (2013) has termed the aspirational agenda—that many health policy analysts argued were the key to controlling Medicare spending. “IPAB,” Paul Van de Water (2012) explained, “is an important piece of the ACA's strategy to slow the growth of health care costs through delivery system reforms, such as accountable care organizations, bundled payments, and comparative effectiveness research.” Policy analysts saw IPAB as an instrument of health services research as well as of congressional self-control.

### **An Open-and-Shut Case?**

IPAB fused traditional distrust and loathing of Congress, cynicism about its political independence and policy-making capacities, and Progressive Era belief in scientific administration with contemporary concerns from budget hawks about unsustainable Medicare spending and health services researchers' faith in payment and delivery system reform. The rationale for IPAB seems compelling, but a closer examination of the assumptions underlying IPAB raises questions about the case for the board.

For starters, it is hardly surprising that health policy experts favored reforming Medicare governance in a way that privileged the role of expertise and evidence; health services researchers were essentially backing

proposals to empower themselves. The presumption that apolitical experts should exert strong influence over public programs is itself political. Politics, after all, is about the allocation of power. A scheme that gives experts a more and lawmakers less prominent role in policy making is redistributing power. In that sense, the rationalizing impulse behind IPAB obscures the extent to which in its design the board is inherently a political institution, regardless of the aspirations to an ideal of scientific, neutral policy making. Rationalizing Medicare policy may be sensible, but it is also political.

IPAB contained a number of political compromises and conventions that belied its supposedly apolitical character. The board was supposed to make hard decisions about Medicare policy, but by statute it could not recommend tax increases. That meant it could only look at a constricted choice set to respond to rising spending, one that had to focus on payment reform and reimbursement cuts. Medicare enrollees were to be shielded from the board. IPAB could not recommend increases in beneficiary cost sharing and premiums, modifications in eligibility, or restrictions on benefits (Congress explicitly prohibited the board from recommending any proposals to “ration health care”) (Ebeler, Neuman, and Cubanski 2011). Hospitals were initially excluded from any IPAB reductions until 2020, another concession that presumably reflected the significant hit they were to take under other ACA cost containment measures (hospice providers were also initially exempt). And the composition of the board was configured to achieve a balance between physicians and other medical providers, health policy experts, employers, other payers, consumers, and urban and rural representatives. IPAB was never, despite some advocates’ desires, going to be simply a board of impartial experts; it was always a political entity.

The case for IPAB also presumes that Congress is incapable of controlling Medicare spending itself. However, Congress has enacted major reforms to slow Medicare spending growth, including the 1983 Prospective Payment System for hospitals, the 1989 Medicare Fee Schedule for physicians, the 1997 Balanced Budget Act, and the 2010 Affordable Care Act. Those reforms have succeeded in restraining Medicare outlays; the rate of excess Medicare spending generally has fallen over the past three decades (White 2008). They contravene the stereotype that Congress is always doing the bidding of health system stakeholders. And they challenge the idea that Congress does not have the capacity to engage in technical health policy (Oberlander 2003). To be sure, Congress’s record in Medicare cost control is not consistently good—witness the annual cancellation of Medicare physician fee adjustments, rising expenditures for outpatient services, and problems in moderating the volume and complexity of services

delivered to Medicare beneficiaries. Nonetheless, Congress has occasionally demonstrated independence from health system stakeholders, often because of budget deficit or trust fund politics, and that independence has at times reduced Medicare spending growth (Oberlander 2003).

Finally, there is a wide gap between IPAB's purported significance and its actual fiscal impact. CBO projections of savings from IPAB have ranged from negligible to nothing. Low Medicare spending growth means, according to CBO, that the board's spending triggers will not often be exceeded in its early years. Moreover, when IPAB is triggered, CBO (2011) expects that its savings targets will produce only modest reductions in program expenditures. Initially, CBO forecasted that IPAB would save a total of \$15.5 billion during 2015–19 (CBO 2010; Hahn and Davis 2012). In 2015, the agency forecasted that repealing IPAB would have no budgetary impact during 2015–21 and would increase federal spending by a total of \$7 billion during 2021–25 (CBO 2015; Hahn, Davis, and Liu 2017). By comparison, during 2015–25 Medicare spending is projected to exceed \$6 trillion. Expected savings from IPAB never amounted to more than a tiny drop in a very large bucket.

Advocates' rhetoric suggests that IPAB has a crucial role to play in restraining Medicare spending. That claim, though, is based more on wishful thinking than on evidence. The reality is that under any reasonable scenario IPAB, even if fully constituted and operational, would not make much of a dent in Medicare spending. IPAB backers point to its long-range potential to promote payment and delivery reform that will slow down health care spending. Yet the presumption that such reforms are the key to cost control is itself problematic and not supported by international experience (Marmor, Oberlander, and White 2009). IPAB may be a potential engine of payment and delivery reform, but if those reforms do not generate large savings, then the board's ability to drive health care cost control is limited. Indeed, if such reforms did not generate the anticipated savings, then IPAB's spending triggers, which require short-term savings, would instead likely lead policy makers to seek savings through Medicare's traditional means: cutting provider payments (though such cuts would be relatively small).

## Opposition

Whatever the problems with the substantive case for IPAB, politics has been its most serious limitation. An impressive number of political interests have lined up against IPAB, which has proven to be one of the ACA's most contentious provisions (no small accomplishment, given all the controversies Obamacare has generated). The health care industry, which views

even modest cost controls as a danger, has fiercely opposed the board. Given that IPAB's aim is to slow Medicare spending growth, and thereby the flow of payments to medical providers, such hostility is hardly surprising. Any reform that seeks to impose spending targets on Medicare and transfer responsibility for controlling costs from a permeable Congress susceptible to stakeholder lobbying to an unelected board ostensibly more interested in evidence is certain to draw heavy fire from the industry. IPAB represents both a threat to health care providers' economic interests and their political methods of securing those interests through the legislative process.

Predictably, the very groups who are IPAB's intended targets have instead targeted the board. The goal has not been to capture IPAB but to eliminate it before it cuts their payments. Broad coalitions of health care providers and companies are united against IPAB. Since 2012, hundreds of state and national organizations—encompassing a staggering array of physician specialty societies, as well as the American Medical Association, hospitals, pharmaceutical companies, and disease advocacy groups—have signed onto a letter sponsored by the Healthcare Leadership Council (2017) urging Congress to repeal IPAB. The American Hospital Association also has lobbied Congress to abolish IPAB, as has the pharmaceutical industry. Notably, concerns regarding IPAB can affect health care stocks. The price of pharmaceutical companies' stocks surged in 2016 immediately after an announcement that IPAB would not be triggered until at least 2017 (Edney and Tracer 2016).

Improving stock value, increasing profits, and maintaining high payment rates are not exactly messages likely to command public sympathy. The health care industry consequently has framed its opposition to IPAB as reflecting concern for patients: "Strict budgetary targets and other limitations imposed on the IPAB will ultimately threaten the ability of our nation's seniors and disabled to obtain the health care they need when they need it" (Alliance of Specialty Medicine et al. 2017). IPAB's focus on payment cuts "would be devastating for patients, affecting access to care and innovative therapies" (Healthcare Leadership Council 2017). Physician groups also object to the requirement that "fewer than half of the IPAB members can be health care providers, and none are permitted to be practicing physicians" (Alliance of Specialty Medicine et al. 2017). They argue that because hospitals and hospice care providers are exempt from IPAB until 2020 that "cuts will fall disproportionately on physicians" (Alliance of Specialty Medicine et al. 2017). The health care industry has voiced additional concerns that IPAB is granted "unprecedented powers" and its actions are "not subject to administrative or judicial review" while

“infringe[ing] upon the decision-making responsibilities and prerogatives of the Congress” (Healthcare Leadership Council 2017).

The view that IPAB usurps legislative responsibilities is widely shared by conservatives who intensely oppose the board. Republican lawmakers believe that it gives “too much power to unelected bureaucrats” (Wicker 2017). They view IPAB as an example of executive overreach, stripping Congress of its constitutional responsibility to determine Medicare’s budget. Conservative commentator George Will (2011), capturing prevailing GOP sentiment, vilified IPAB as “a travesty of constitutional lawmaking” that “radiate[s] distrust of the public and its elected representatives.” Scott Gottlieb (2011: 2), then a fellow at the American Enterprise Institute and currently commissioner of the Food and Drug Administration, warned that IPAB’s appointment rules would mean “most of its outside members hail from the insular ranks of academia.”

In 2013, the Republican House majority passed a rule rejecting the fast-track procedures that IPAB had established (they did so again in 2015 and 2017) (Hahn, Davis, and Liu 2017). In a letter to President Obama, Speaker of the House John Boehner (R-MO) and Senate Minority Leader Mitch McConnell (R-KY) warned that “IPAB’s 15 unelected, unaccountable individuals” would make “decisions which impact America’s seniors . . . in the absence of democratic process, without the systems of checks and balances that would normally apply to important matters of public policy” (Boehner and McConnell 2013).

Republicans commonly argue that IPAB will lead to rationing (US House of Representatives 2016a). Those fears persist despite the ACA’s explicit prohibition on IPAB making any recommendation to ration health care. However, the law does not define what constitutes rationing, and critics allege that IPAB will cut benefits and reduce access to medical services for Medicare beneficiaries (Fox 2014; Haverly 2017; Hrozencik 2016). Wisconsin Republican Paul Ryan (2012), then chair of the House Budget Committee, asserted that “repealing the Independent Payment Advisory Board is critical to ensuring that seniors never have to face the waiting lists and rationed care that have affected other nations who have gone down the misguided path of bureaucratic medicine.” Outside of Congress, conservative commentators amplified fears of rationing into charges that IPAB is the real “death panel” (Catron 2011; Kurtz 2011; Limbaugh 2011). Since there has been scant polling on IPAB, it is impossible to say how such rhetoric has influenced public opinion, though some polls do indicate public discomfort with the idea of an independent expert panel making Medicare decisions (Harris Interactive 2012; KFF 2011).

What is clear is that there has been a broad campaign to discredit IPAB as an instrument of rationing.

Although Republicans have led the charge against IPAB, attacks on the board have not been exclusively partisan. Numerous Democrats have criticized IPAB and backed its repeal, sometimes echoing Republican criticisms of the board. Congresswoman Allyson Schwartz (D-PA) criticized IPAB's focus on reducing provider payments, writing that "simply cutting reimbursements is not the answer. IPAB brings unpredictability and uncertainty to providers and has the potential for stifling innovation and collaboration" (Schwartz 2011). Democrats and their staff who have been heavily involved in Medicare policy making have questioned whether the board is necessary. California congressman Pete Stark, a frequent critic, called the IMAC, IPAB's legislative predecessor, "stupid at best, unworkable, childish, idiotic" (quoted in *HomeCare* 2009: 3). Given the board's authority, he wondered, "Why have legislators?" (Pear 2011). In 2013, twenty-two Democrats cosponsored a bill to repeal IPAB, and another twenty backed a 2015 IPAB repeal bill (Sullivan and Marcos 2015; Viebeck 2013).

### **Efforts to Dismantle IPAB**

Opponents have pursued legislative, fiscal, and legal tactics to undermine IPAB. Since 2013, members of Congress have introduced eleven bills with the goal of repealing IPAB, nine of which were sponsored by Republicans (Hahn, Davis, and Liu 2017). None of these bills has been enacted into law, though a 2015 bill did pass the House before failing in the Senate. While in office, President Obama threatened to veto any legislation eliminating the board.

The appropriations process has provided another avenue for opponents to attack IPAB. Congressional Republicans have reduced IPAB funding by millions of dollars as part of yearly omnibus and continuing appropriations bills. Between fiscal years 2012 and 2015 these bills rescinded \$10 million a year from IPAB. The 2016 omnibus bill cut another \$15 million (Redhead and Cornell 2017). These reductions are significant in scope; the ACA appropriated only \$15 million a year for IPAB. However, since IPAB doesn't have any members and has never met, and its process has not yet been triggered, these cuts are largely symbolic.

IPAB opponents also have challenged its legality. In 2011, Nick Coons and Erick Novack, two physicians, sued the federal government, arguing irreparable harm from potential IPAB spending cuts. They additionally contended that IPAB violated Congress's legislative authority by illegally

delegating responsibilities to an executive agency (*Coons v. Lew*, 762 F.3d 891, 897 [9th Cir. 2014]; Sumski 2015). The Ninth Circuit dismissed the case as premature because the board had yet to be constituted or take any actions that could injure the plaintiffs (Adler 2014). Congressional Republicans asked the Supreme Court to hear the case, but it refused to review the decision (Bettelheim 2014; Redhead and Cornell 2017). Health law experts have also raised questions about procedures barring judicial review of IPAB proposals implemented by the US Department of Health and Human Services, though the courts have yet to rule against it on those grounds (Jost 2011).

In sum, despite fierce opposition from the health care industry, unified Republican and significant Democratic opposition, and the stigma of rationing and death panels, IPAB survived the Obama administration. The board, though, existed largely in name only, with the deep opposition to its operation preventing any movement toward IPAB realizing the aspirations held by its architects and advocates.

### **The Board That Did Not Roar**

While opponents did not succeed in eliminating IPAB during the Obama administration, they could at least take solace in the reality that when it came to Medicare policy and health care cost containment, the board was mired in absolute irrelevance. Initially, some policy makers and analysts sought to fortify IPAB. The National Commission on Fiscal Responsibility and Reform (2010), commonly known as Bowles-Simpson, recommended broadening IPAB's authority by eliminating the exemptions that hospitals and some other providers enjoyed from the board's purview. President Obama proposed expanding IPAB's powers in 2011 and 2013, including tightening Medicare spending growth targets and giving it the authority to examine "value-based benefit design" (Hahn and Davis 2012: 29). However, amidst the controversy surrounding the board, nothing came of those proposals (Pear 2011). It proved impossible to get IPAB off the ground, let alone strengthen it. IPAB has the dubious distinction of being a board with no members. Nearly eight years after its enactment, not a single person has been named or even nominated to IPAB. That is largely because congressional Republicans refused to cooperate in the board's implementation. Not only was IPAB allegedly an instrument of rationing, but it was also part of the ACA, thereby providing another front for Republicans to fight against Obamacare.

What was to be a bipartisan process to name experts, medical providers, and consumer representatives to the board instead became another

exercise in partisan politics. In response to a 2013 invitation from President Obama inviting them to submit the names of persons to serve on IPAB, Republican Speaker of the House John Boehner and Senate Minority leader Mitch McConnell declined to recommend any appointments (Boehner and McConnell 2013), instead calling for the board's repeal. Senate Republicans threatened to filibuster any nominees. The message—that Republicans would not cooperate in empaneling IPAB—was received. The Obama administration never did nominate anyone for the board or again ask congressional Republicans to do so. IPAB became a shell institution and a ghost board, uninhabited by the experts who were supposed to carry out its mission (dEngelhard 2015). Former Secretary of Health and Human Services Sylvia Burwell noted in 2015 that there was no need for the Obama administration to nominate anyone to IPAB for reasons discussed below. However, the reality is that it was politically impossible for the White House to appoint members to the board. Nor was it in the administration's interest to push for an unwinnable confirmation fight for a controversial board that promised to have limited impact (Ebeler, Neuman, and Cubanski 2011; US House of Representatives 2015a).

The other reason for IPAB's irrelevance was fiscal rather than political. In the years following the ACA's enactment, Medicare spending growth was far lower than had been anticipated. Consequently, the IPAB process did not trigger at any point during the Obama administration. The CMS actuary released annual reports during 2013–16, as mandated by the ACA. Each report confirmed that IPAB had yet to be triggered since projected Medicare growth did not exceed specified targets. For example, in the 2016 report CMS forecast that projected growth in Medicare's per person spending during 2014–18 would average 2.21 percent, below the target of 2.33 percent that reflected an average of the CPI and medical CPI (Spitalnic 2016).

Medicare's spending slowdown in recent years is striking. Medicare spent \$10,537 per beneficiary in 2009, yet only \$10,809 in 2014. In 2014, Medicare spending came in \$126 billion less, or \$1,000 less per person, than analysts forecasted in 2009 (White, Cubanski, and Neuman 2014). Most of that slowdown is attributable to changes made by the ACA, including reducing the rate of growth in payments to medical providers and reducing payments to Medicare Advantage plans (White, Cubanski, and Neuman 2014). There has been a slowdown in US health care spending growth more generally during the last decade, and it remains unclear what additional role other factors, such as the recession, changes in medical care payment and delivery arrangements, or spillover effects from private sector cost containment measures, may have played in Medicare's spending



slowdown (Kronick and Po 2013; Levine and Buntin 2013; McMorrow and Holahan 2015; White, Cubanski, and Neuman 2014).

The ACA created IPAB as a restraint against high Medicare spending growth. Yet the extraordinary success of other ACA measures in slowing down Medicare expenditures meant that IPAB was never triggered during the Obama administration—a fortuitous outcome given the controversy that beset the board. The question for IPAB is what its future looks like under a Trump administration.

### **IPAB under Trump**

IPAB now exists, at least as a shell, under a presidential administration opposed to its existence. Former Georgia congressman and orthopedic surgeon Tom Price, Donald Trump's first secretary of health and human services, had criticized IPAB as “a board of unelected, unaccountable bureaucrats” (US House of Representatives 2016b; CNN 2017). However, since nobody has been named to the board, if the IPAB process is triggered the board's powers would revert to the Trump administration's secretary of health and human services (Price resigned in September 2017). In fact, CMS predicted in 2016 that the IPAB process would be triggered in 2017, a forecast that set off alarm bells in the health care industry (Spitalnic 2016). However, it proved to be a false alarm. In 2017 the CMS actuary determined that projected Medicare spending growth during 2015–19 did not exceed the target and will not do so until 2021 (Spitalnic 2017).

Nonetheless, the specter of IPAB's powers in the hands of the Trump administration has persuaded some Democrats that it is time to eliminate the board. Oregon Senator Ron Wyden is sponsoring both a joint resolution and a bill to repeal IPAB that has eight Democratic cosponsors. Wyden explained that, “given the Trump administration's short but disturbing record of irresponsible and cruel executive actions, it would be a huge mistake to leave in place the authority to push through harmful cuts to Medicare with minimal input from Congress” (Committee on Finance 2017). It is evidently one thing to create a powerful, independent board and an expedited process to adopt Medicare spending cuts when that board is shaped and the process operated by your party; it is something else to have it being run by the other party.

While Democrats are discovering new reasons to dump IPAB, congressional Republicans continue their crusade to end it. In 2017, Representative David Roe and Senator John Cornyn reintroduced IPAB repeal bills. Conservatives would like to jettison IPAB when—and if—they pass legislation repealing and replacing major provisions of the ACA. However,

budget reconciliation rules have made it impossible for Republicans to include IPAB in their repeal bills (ACR 2015). The various Republican-sponsored repeal-and-replace bills that the House and Senate debated in 2017 did not contain provisions to rescind IPAB. Nor did lawmakers meet the August 15, 2017, deadline the ACA had set for Congress to eliminate the board through a joint resolution. Despite missing that opportunity, though, “Congress could presumably change its rules to allow it to abolish the IPAB whenever it chose to do so” (Jost 2017).

## Lessons

IPAB’s misadventures offer important lessons about the limits of expertise and evidence in US health policy making. IPAB’s establishment reflected good intentions: to restructure Medicare governance so that program policy making was driven more by evidence and less by interest group pressures; to compel policy makers to consider and ultimately make difficult choices in Medicare reform; to prevent Congress from micromanaging and mismanaging Medicare; to ensure that, if Congress did not act, steps were still taken to restrain Medicare spending; and to create safeguards against excessive spending. Yet the aspirations to rationalize Medicare through IPAB have floundered against political realities.

## Polarization

The idea that a nonpartisan, expert, and independent board charged with curbing Medicare spending and devising program reforms could exist, let alone thrive, in this extraordinary environment of partisan and ideological polarization was a fantasy. Polarization between Democrats and Republicans in Congress has reached historic levels (McCarty, Poole, and Rosenthal 2008). In such an atmosphere it would have been exceptionally difficult, and likely impossible, for Congress to reach consensus on a balance between Republican and Democratic appointed members to IPAB. Even if they could agree on nominees, if the IPAB process was triggered there was no guarantee that the two parties would agree on how to generate Medicare savings. The current hyperpartisan political environment in US politics, in which even relatively sacrosanct institutions like CBO are under attack, is too toxic for an independent board like IPAB whose charge is to make controversial recommendations about one of the nation’s largest and most popular social programs, recommendations that would inevitably touch on sensitive issues of medical care.

In this era of hyperpartisanship, IPAB was the wrong solution at the wrong time. That IPAB never got off the ground, its launch canceled by partisan politics, was entirely predictable. IPAB's architects and the health policy community were largely blind to its political weaknesses because they believed in the board's technocratic aspirations. IPAB reflected the politics of wishful thinking as much as the politics of technocracy.

### A Health Care BRAC?

Health policy makers and researchers alike saw IPAB as the health care BRAC and hoped that the new board could reprise the successful process that led to closing of numerous military bases during the 1980s and 1990s. However, that analogy was misguided. Health policy analysts neglected the political conditions that made BRAC work—conditions that help explain why BRAC operated successfully for over a decade while IPAB has been under attack since its inception. Kenneth Mayer (2007: 3) argued that there are three important prerequisites for independent commissions like the BRAC to be successful: “consensus on the goals, agreement about what precise policy steps were necessary, and the narrow range . . . of the policy making authority.”

The exceptional circumstances that propelled BRAC did not hold for Medicare. In the case of BRAC, consensus existed that a substantial number of military bases were obsolete and should be closed permanently. In contrast, there is not consensus in Congress on how to reform Medicare, how much (or whether) to slow its spending, or how to achieve program savings. As Mayer (2007: 14) noted, “BRAC-like commissions cannot . . . create consensus where none exists” and cannot work “where there is still controversy about that the [policy] instrument should be.” Moreover, IPAB was born into a contested environment where one party challenged its legitimacy. While closing military bases is a collective action problem that requires overcoming regional politics, such closures impact a relatively modest portion of the public, and concentrated losses are limited to specific geographic areas, reducing the ability of opponents to shape national policy (Goren and Lackenbauer 2003).

Medicare is a program that almost all American families come to rely on. Its benefits are held by tens of millions of persons, the consequences of spending and benefit cuts are widely distributed nationally rather than concentrated in specific areas, and cutting Medicare spending invites the perennial controversies that arise in American politics over rationing medical care. The political and fiscal magnitude of decisions to control Medicare spending is vastly larger than those over base closings. Moreover,

strong public support existed for closing military bases (Mayer 1995), but that was not the case for cutting Medicare spending. Opponents can frame reductions in Medicare spending growth as threats to older Americans' access to medical care. BRAC, then, was a more focused body charged with a politically more manageable, less explosive, narrower, and more popular task than IPAB.

While Congress may be willing to cede its authority to an independent board when spending cuts are relatively minor, it is much more reluctant to do so when the stakes are so high (Mayer 1995). All members of Congress have a hospital, physician, or other medical care provider in their district, as well as Medicare beneficiaries. Allowing an independent board to make decisions that could negatively affect these constituents, with limited ability to overturn the cuts, is a hard pill to swallow for lawmakers. IPAB did not have much of a natural constituency, other than health services researchers, and it offered only the potential of modest, diffuse benefits, whereas the constituencies aligned against it had a strong interest to avoid possible concentrated losses. That is not often a recipe for political success. Congress may be interested in shifting blame for controversial decisions to other institutions and actors (Weaver 1986). However, Congress is not interested in being blamed for decisions beyond its control that could potentially ignite major controversies and jeopardize legislators' electoral futures.

Finally, health policy makers and analysts did not appreciate the fact that BRAC, the model for IPAB, ran into significant political difficulties over time. While BRAC proved successful and popular with Congress at first, it became more controversial once the easiest decisions had been made (Mayer 1999). After closing the most remote, least populated bases, BRAC confronted tougher choices that could impact tens of thousands of jobs. As the stakes increased, it faced growing pressures from outside lobbyists and politicians increasingly sought to intervene in its decisions (Mayer 2007). In 1995, the Clinton administration intervened in the process to stop job losses from military base closings in California and Texas. By 1999, as "political pressure seeped in," analysts were declaring "the demise of BRAC" (Mayer 1999: 33). Even with much more favorable conditions than IPAB enjoyed, BRAC's immunity from politics did not last.

In the end, BRAC was a deceptive model for Medicare. While analogies can have a powerful influence on policy making, they often are drawn in misleading ways (Khong 1992), and so it was that the health policy community inadequately understood the lessons and limits of BRAC and its implications for IPAB.

## The Technocratic Myth

The erosion of political insulation designed to protect controversial policy processes or automatic spending triggers from congressional interference is a familiar phenomenon in health care policy. After all, Congress intervened repeatedly to stop cuts generated by Medicare's SGR physician payment formula, another device designed to control program spending via formula and spending targets linked to measures of inflation (Laugesen 2009; Oberlander and Laugesen 2015). If Congress could not resist the "siren song" (Laugesen 2009) of physicians who sought to avoid fee cuts, why would we think that Congress would abide by the IPAB process? Arguably, the strongest case for IPAB rested on the establishment of spending targets for Medicare as a failsafe. But such targets are ultimately only as strong as Congress's willingness to enforce them. American political institutions are too fragmented, with Congress playing too central a role in policy making, to sideline it from Medicare policy. No matter how independent a board or supposedly immune a policy-making process is from interest group and congressional machinations, if lawmakers don't like the outcomes (and if they feel intense pressure from interest groups or constituents) they can find ways to circumvent the process. The political immunity of the IPAB process and independence of its board was inevitably greater in design than in reality.

The idea that politics can be removed from health care policy making, which was one impetus for IPAB's creation, is more than a technocratic aspiration (Belkin 1997)—it is a myth. Health care is too visible, too consequential, too fiscally important, too economically large, too full of powerful stakeholders, too partisan, and too emotional an issue to isolate it from politics. There is no such thing as apolitical Medicare policy. Peter Orszag's (2011) notion that "we might be a healthier democracy if we were a slightly less democratic one" and rely more on "automatic policies and depoliticized commissions" rests on a disquieting impatience with democratic institutions, a naïve faith in the power of expertise, and the illusion that policies and commissions can be depoliticized.

IPAB's quest to rationalize Medicare policy making and suppress politics, especially in this era of polarization, was destined to fail. The conditions necessary for IPAB to succeed did not exist in either Medicare or American politics. Politics vanquished IPAB rather than IPAB vanquishing politics. That is a depressing outcome for health policy analysts who invested the board with symbolic importance as an expert bulwark against rising medical care spending. The triumph of politics over expertise in the case of IPAB, though, does not mean we should despair that health care cost

containment is impossible in the United States or that Medicare spending is beyond control. IPAB represented an answer to an ostensible problem—congressional inaction on Medicare spending—that was incorrectly diagnosed. The success of ACA policies enacted at the same time as IPAB, which have produced substantial Medicare savings, has demonstrated that Congress is capable of taking decisive action and implementing effective reforms to slow federal spending on health care. The Medicare spending challenge is hardly over, yet IPAB’s potential contribution to health care cost control was always exaggerated. Despite all the hype surrounding IPAB, the board’s elimination would not make much of a difference to containing medical care costs.

The IPAB story is not over. Its spending triggers could be pulled in coming years, and the Trump administration could then decide to put aside conservative objections and leverage its powers through the secretary of Health and Human Services to reshape Medicare. Alternatively, Congress could finally repeal the board. IPAB has, in its short and controversial existence, oscillated between political purgatory and hibernation. Is oblivion its final destination?

### Postscript

As it turns out, IPAB survived only one year of the Trump Administration. As this issue of *JHPPL* went to press, Congress repealed the board as part of the Bipartisan Budget Act of 2018. IPAB had few defenders remaining, and there was no resistance to its demise. In the end, IPAB succumbed to the political forces it was created to supplant, leaving behind a legacy of controversy, disappointment, and failure.

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