

Testimony

by

Judith Feder, Ph.D.

**Professor and former Dean, Georgetown Public Policy Institute, and
Urban Institute Fellow**

Before the

**COMMITTEE ON THE BUDGET
U.S. HOUSE OF REPRESENTATIVES**

July 12, 2011

Chairman Ryan, Ranking Member Van Hollen and members of the committee, I appreciate the opportunity to appear before you today as you consider the role of the Independent Payment Advisory Board established by the Affordable Care Act (ACA). Along with its extension of essential health insurance coverage to tens of millions of Americans, the ACA reduces the federal deficit—in large part because of measures the law takes to responsibly slow the growth in Medicare and overall health spending. Establishment of the Independent Payment Advisory Board (IPAB) is one such measure. The IPAB serves as a guarantor of the ACA's investment in cost-containment.

Having IPAB as a backstop to sustain Medicare's financing is not only critical to securing this vital program that makes health care affordable for older and many disabled Americans; but also to assure that Medicare leads the much-needed transformation of the nation's entire health care payment system—moving from reliance on mechanisms that reward the delivery of ever more, and ever more expensive services, regardless of their contribution to health, to mechanisms that reward high quality care, efficiently provided. In short, the IPAB is part of the Affordable Care Act's commitment to assuring all Americans quality care at lower cost.

As you consider the role of the IPAB, I urge you to consider that:

- Medicare is an enormously successful program—more successful than private insurance in pooling risk and controlling costs.
- Medicare's per capita cost growth has historically been slower than per capita growth in private insurance. But, as a result of measures taken in the Affordable Care Act, Medicare's relative advantage grows dramatically in the coming decade. Its projected 2.8 percent average annual growth rate in spending per beneficiary is projected to be a full percentage point below per capita growth in GDP and three percentage points below growth in national health expenditures per capita. ACA-initiated payment reforms, already under way, have the potential to improve quality and reduce spending growth even further. The IPAB provides a back-up to assure that these savings and efficiencies are actually achieved.
- Medicare is clearly doing its part to control health care cost growth. But spending growth is not, fundamentally, a Medicare problem; it's the problem of the entire health care system. Medicare can only go so far on its own in promoting efficiencies, without partnership with the private sector. Effective payment and delivery reform requires an all-payer partnership to assure that providers' actually change their behavior, rather than looking to favor some patients over others or pit one payer against another. .
- What's needed, therefore, is not to abandon IPAB—and certainly not to morph Medicare into less effective private insurance. Rather, we should extend the expertise and authority IPAB focuses on Medicare to apply to all payers—with a system-wide spending target

that triggers all-payer payment reform to assure Medicare beneficiaries and all Americans the high quality, efficiently delivered care we deserve.

The importance of securing Medicare cannot be overstated. From its inception, Medicare was designed to avoid the problems that plague the private health insurance market. Unlike private insurers, for whom administration, marketing and profits may absorb 15-20 percent of health care premiums, Medicare spends only 3 percent on program administration. While private insurers compete to enroll the healthy and avoid the sick, Medicare pools the overwhelming majority of beneficiaries in a single program—avoiding discrimination based on pre-existing conditions and denials of coverage when people are sick. And, when it comes to costs, Medicare’s ability to purchase care from hospitals, doctors and other providers on behalf of virtually all its beneficiaries—rather than having individual beneficiaries or even several insurers negotiate on their own—has historically kept its rate of cost growth per beneficiary below premium growth in private insurance.

The Affordable Care Act promotes cost containment for the future in multiple ways, beginning by setting future payment rates to hold hospitals and other institutional health care providers accountable for productivity gains on a par with those achieved by every other sector of our economy over the past several decades. The result is an average annual per beneficiary growth rate of 2.8 percent for 2010 to 2021—3 percentage points slower than per capita national health expenditures. At this growth rate (3.9 percent per year), national health spending will actually exceed average annual GDP growth per capita by close to 2 percentage points. By contrast, Medicare’s projected per beneficiary spending growth will be a full percentage point below growth in per capita GDP. With per capita cost growth slowed, for the first time in the program’s history, enrollment growth has become a major driver of overall Medicare spending.

A slower spending increase than the private sector’s, however, does not mean that Medicare uses its dollars as efficiently and effectively as it can—particularly as the aging of the baby boomers and expanded enrollment become a significant driver of its overall costs. Public and private insurers alike pay too much for too many services and fail to assure efficiently delivered, quality care. That’s why the Affordable Care Act goes beyond tightening fee-for-service payments to pursue a strategy of payment and delivery reform—and creates the IPAB to assure effective results. Payment reform involves a mix of strategies to support not just cheaper but better care:

- **No rewards for ‘bad’ behavior.** The ACA authorizes the Secretary of Health and Human Services to review and alter “misvalued” fees, such as paying more for services than they’re worth, and to reduce payments for clearly undesirable behavior, such as hospital-acquired infections or conditions, inappropriate hospital readmissions, and, even more egregious, outright fraud.
- **Bonuses for ‘good’ behavior.** Alongside what might be considered these “sticks” to change behavior, the ACA authorizes a set of “carrots,” or rewards to delivery of more

effective and efficient care. At the most basic level, these rewards are extra payments to providers for doing “good” things—say, meeting a set of efficiency standards while maintaining quality care. But more importantly, these rewards reside in alternative payment mechanisms to replace today’s fee-for-service payment system.

- **Payment reforms.** Among the new payment systems the new health law encourages are “accountable care organizations”, collaboratives of inpatient and outpatient providers who will be rewarded for delivering quality care to a defined set of patients at lower-than-projected costs; “patient-centered medical homes” to promote the financial and health benefits of primary care and chronic care management; and “bundling” separate fees surrounding a hospital episode into a single payment for services associated with a specific condition, such as a hip fracture, which today would include separate fees for diagnosis, surgery, and postoperative care.

These reforms have the potential to transform both Medicare and, by example and in partnership, the nation’s health care delivery system to provide better quality care at lower costs. But their achievement and implementation cannot be assumed. To assure that its savings objectives are actually achieved, the ACA’s cost containment strategy includes a back-up enforcement mechanism—the Independent Payment Advisory Board or IPAB. The board consists of 15 members, appointed by the President and confirmed by the Senate, to include experts in health economics and insurance, as well as consumer representatives.

The Board is empowered to undertake analysis on ways to promote efficiency in both Medicare and national care spending, and to make recommendations accordingly. But, with respect to Medicare, if spending is projected to exceed the annual Medicare per capita cost-growth target specified in the ACA, the IPAB is required to recommend ways to achieve specified reductions in Medicare spending by changing payments to health care providers, and Congress is required to fast-track consideration of those proposals in the legislative process. Unless Congress votes to reject the proposal (with 60 votes in the Senate) or passes an alternative proposal that achieves similar savings, the Secretary of Health and Human Services must implement the IPAB recommendations. In essence, IPAB serves to inform and assure congressional action to keep provider payment under control.

Some legislators have proposed to repeal the IPAB. But along with about a hundred health policy experts who recently wrote congressional leaders in support of IPAB, I see that effort as sorely misguided. As we wrote, the IPAB enables Congress to mobilize the expertise of professionals to assemble evidence on how payment incentives affect care delivery and to use that evidence to suggest sensible improvements. As an independent, expert, evidence-driven body, we argued, the IPAB will support, not diminish, the Congress’ capacity to assure that the Medicare program acts on the lessons of the payment and delivery innovations the Affordable Care Act seeks to promote.

Rather than support this strategy to strengthen Medicare and, indeed, the overall health care system by promoting better care at lower costs, opponents of the Affordable Care Act have proposed not only to repeal IPAB but also to eliminate Medicare for future beneficiaries—replacing it with vouchers for the purchase of private insurance. As analysis of that proposal by the Congressional Budget Office makes crystal clear that strategy would not slow health care cost growth. Instead, it would increase insurance costs and shift responsibility for paying most of them onto seniors. The cost of private insurance is, to start with higher than the cost of Medicare, and, as noted above is growing considerably faster. A voucher set equal to Medicare costs in 2022, when the proposed change would begin, would be insufficient to buy Medicare benefits in private insurance. With this voucher, a typical 65 year old’s out-of-pocket spending would be about twice what it’s projected to be under traditional Medicare—an additional \$6000 in out-of-pocket spending—in 2022. And as the gap between Medicare costs and private premiums continues to grow—extra out-of-pocket spending would rise to \$11,000 in 2030. Given Medicare’s track record relative to private insurance in delivering benefits and controlling costs, morphing Medicare into a private insurance market simply makes no sense.

Rather than replace the IPAB, let alone Medicare, what does make sense is to use the IPAB to align the private sector with the public sector’s commitment to health care payment reform and slower cost growth. Medicare payment changes have already brought its spending per capita well below both per capita growth in GDP and per capita private health care costs. And its emphasis on payment and delivery reform can achieve even more. But success in that effort depends on more than Medicare. Medicare can only go so far on its own to promote efficiencies, without partnership with the private sector. Effective payment and delivery reform requires an all-payer partnership to assure that providers actually change their behavior, rather than looking to favor some patients or others or pit one payer against another. Rather than moving to abandon IPAB, which supports Medicare’s continued and improved efficiency, Congress should therefore modify IPAB’s current spending target to apply not just to Medicare but to private insurance—all health care spending, and extend its authorities to trigger recommendations for all-payer payment reform if the target is breached.

Health care cost growth is not, fundamentally, a Medicare problem—though Medicare is doing its part to control it; it’s a health care system problem—and it’s the private sector that needs to become a full-fledged partner in Medicare’s efforts. As you address concerns about Medicare’s future and the fiscal future of the nation, I therefore urge you not simply to recognize IPAB’s value in helping slow Medicare cost growth, but also to take action to extend the expertise and authority IPAB provides to move all payers in partnership toward reforms that will deliver better quality care at lower costs. Only payment efficiencies that apply to all payers can assure Medicare and all Americans the affordable, quality care we deserve.