The Independent Payment Advisory Board


*AJNR Am J Neuroradiol* 2014, 35 (6) 1066-1069
doi: https://doi.org/10.3174/ajnr.A3736
http://www.ajnr.org/content/35/6/1066

This information is current as of September 16, 2023.
The Independent Payment Advisory Board (IPAB) is considered the most potent cost-cutting measure of the Patient Protection and Affordable Care Act (ACA), which was signed into law in March 2010. Together with the Patient Centered Outcomes Research Institute (PCORI), it is 1 of 2 independent boards established as part of the sweeping health care reform bill and is one of the bill’s most controversial measures.

The IPAB, when complete, will be composed of 15 members charged with holding Medicare spending growth within specified limits. Whenever projected Medicare spending exceeds determined target levels, the IPAB is required to present recommendations to control costs, and the Health and Human Services Secretary is required to implement those changes unless Congress specifically takes action to override the recommendations and replace them with alternatives that achieve similar savings.

Neuroradiologists should be informed about the existence and purpose of the IPAB because their reimbursement may be significantly affected by its actions in the foreseeable future.

The Affordable Care Act represents a generational change in the provision of health care in the United States.1-3 It includes a monumental expansion of Medicaid as well as the development of a system of State-Based Health Insurance Exchanges for those citizens who do not qualify for the expanded Medicaid system. There are mandates for people to purchase insurance and for businesses to provide insurance to avoid penalties. To help fund this expansion, there are reductions in funding for programs such as Medicare Advantage; and there are new tax programs, such as the Medicare Tax Rate Increase, the Net Investment Income Tax, and the Cadillac Insurance Tax.2-4

The ACA is divided into 10 titles with elements that went into effect as early as June 21, 2010.1-3,5 There have been multiple attempts by House Republicans to revoke this law.6 Although small portions of the law have been enforced since the passage of the ACA, 2014 and 2015 will mark the implementation of some of its principal components.4,5,7,8

Two independent boards have been established as part of the law. The first is the Patient Centered Outcomes Research Institute. PCORI moves the agenda of comparative effectiveness research forward; given the limited work that has been done in this area, PCORI provides an opportunity for neuroradiologists to obtain funding to investigate practices that will improve patient care.8 Its formation has enjoyed the support of the American College of Radiology, as well as much of organized medicine, though there are notable exceptions.8,9 As part of the legislation, PCORI cannot be used for denial of coverage nor may it consider the cost of providing care.2,8,9,10

The second of the 2 boards is the Independent Payment Advisory Board. As opposed to PCORI, IPAB has drawn criticism from much of organized medicine, including the American College of Radiology and the American Society of Neuroradiology. The raison d’être for the IPAB is to facilitate statutory Medicare budget limits.7 This vignette will focus on the IPAB.

HISTORY

During the administration of President Lyndon B. Johnson, Congress created Medicare as part of a series of social reforms known as the “Great Society.” This landmark legislation occurred in 1965 as part of Title XVIII of the Social Security Act. Its purpose was to provide health insurance to people age 65 years and older, regardless of income or medical history.

The growth in cost during the past 45 years of the US health care endeavor, including Medicare, has been striking.5,10 In 2011, total US health care spending was $2.7 trillion; this represented 17.9% of gross domestic product, the highest percentage of any
Medicare and more rapidly deplete the Medicare trust fund. Most agree that this trend is unsustainable. Recent publications have documented a slowing of growth in US health care spending. In 2011, US health care spending grew 3.9%, marking the third consecutive year of relatively slow growth. Growth in national health spending closely tracked growth in nominal gross domestic product in 2010 and 2012, and health spending as a share of gross domestic product remained stable from 2009 through 2011. However, although growth in spending at the national level has remained stable, personal health care spending growth accelerated in 2011 from 3.7%–4.1%, in part because of faster growth in spending for prescription drugs and physician and clinical services. A recent Medicare trustees report postulated with cautious optimism that the slowdown in health spending that has extended the trust fund’s life is here to stay, and not a reflection of the slow economy of the past few years. However, in this estimation, it was assumed that the Sustainable Growth Rate cuts would be implemented. If the Sustainable Growth Rate were replaced, this would likely increase costs of Medicare and more rapidly deplete the Medicare trust fund.

During the years there have been a variety of proposals to create an independent entity, analogous to the United Kingdom’s National Institute for Health and Clinical Excellence of the National Health Service, that would be charged with curbing growth in federal health care spending. Theoretically, this independent status would insulate these policy makers from special-interest groups and lobbyists. Among those lines, the IPAB is an independent board within the executive branch. This is in direct contrast to the Medicare Payment Advisory Commission (MedPAC), an existing panel that reports to the legislative branch. MedPAC was enacted as part of the Balanced Budget Act of 1997 by merger of the Prospective Payment Assessment Commission and the Physician Payment Review Commission. Composed of 17 appointed members, it generates 2 formal reports per year to Congress on policy and payment issues affecting Medicare.

However, MedPAC’s role is purely advisory; Congress has frequently declined to follow its recommendations. The IPAB is composed of 15 full-time members to be appointed by the President, and approved by the Senate. As most of the members are required to be nonproviders, as mandated by the legislation, Board membership is a full-time job so as to limit any possibility of conflict of interest. The IPAB would have the authority to make both mandatory and advisory recommendations.

**IPAB RECOMMENDATIONS**

The IPAB is mandated to submit recommendations whenever Medicare per capita spending growth is projected to exceed statutory targets. The timelines are defined in the legislation. The recommendation requires an explanation and rationale, as well as an estimate of the necessary administrative funding. The Center for Medicare & Medicaid Services Actuary must certify that the recommendations will result in the legislatively mandated savings and will not result in any increase in Medicare spending during the subsequent 10-year period starting with the implementation year.

In addition to the mandatory recommendations above, the IPAB can make advisory recommendations on far-ranging health care policy issues, including recommendations to slow the growth of private health care expenditures—much like MedPAC.

As part of a common theme of the ACA (ie, more care at less cost), the mandatory recommendations are required to maintain or enhance beneficiary access to quality care. Moreover, the law prohibits certain recommendations that could negatively affect beneficiaries or certain providers. The IPAB may not recommend anything that could be construed as rationing health care, increase Medicare beneficiary costs, or otherwise restrict benefits.

**FAST-TRACK PROCEDURES**

The extraordinary powers of the IPAB, in part, derive from unique congressional fast-track procedures for its mandatory recommendations. The board’s proposals must be introduced to both the House and the Senate on the same day. Once introduced, these mandatory recommendations must be sent to the committees with relevant jurisdiction. The committees must report those recommendations, with any changes, within 3 months, or the proposals are formally discharged from the committees. Of note, the committees and the full House and Senate cannot consider any amendment that would change or repeal the IPAB’s recommendations unless those changes meet the same fiscal criteria under which the board operates. A supermajority in the Senate is required to waive this restriction.

**LIMITATIONS ON JUDICIAL OR ADMINISTRATIVE REVIEW**

In addition to the severe constraints placed on Congress, the ACA explicitly disallows review by either the administration or the judiciary. Although this move sounds aggressive, it is in keeping with the policy goal of moving forward with the mandatory recommendations of the IPAB. Specifically, the Secretary of Health and Human Services is required to implement the IPAB recommendations, or an alternative of a similar revenue-saving effect.

**DISCUSSION**

The ACA represents a paradigm shift in how health care will be delivered for millions of Americans. Its key programs of mandated insurance, elimination of pre-existing conditions, and children’s coverage until age 26 years have been widely reviewed. Less known to the broad audience who has interest in the ACA are the particulars of the IPAB. The IPAB has remarkable power to affect the reimbursement of physicians in general and neuroradiologists in particular. This is particularly true in early implementation of the ACA, as hospitals and nursing homes are insulated from IPAB authority until 2020, leaving the physician providers in the crosshairs.

There have been a multitude of arguments for and against IPAB, including arguments for expansion on the one hand, and repeal on the other. Aaron considered the IPAB akin to Congress good deed for the country. He pursued a fascinating line of...
CONCLUSIONS

The IPAB is a critical and controversial element of the ACA. Congress has ceded much of its own authority over Center for Medicare & Medicaid Services spending to this independent board. Further, it has limited its own ability to affect the actions of the board through the fast-track process. The IPAB has the potential to significantly affect neuroradiologists’ reimbursement.
ACKNOWLEDGMENTS

We would like to thank Mike Morrow, American Society of Neuroradiology staff, for his review of this manuscript. We would also like to thank Cynthia Hynes for her assistance with the manuscript.


REFERENCES

21. Testimony by Judith Feder, PhD, Professor and former Dean, Georgetown University Public Policy Institute, and Urban Fellow Institute before the United States House of Representatives, Committee on the Budget RE: Medicare’s future: An examination of the Independent Payment Advisory Board. July 12, 2011