

The Independent Medicare Advisory Board

Timothy Stoltzfus Jost

It is a common realization that neither unconstrained markets nor our current political institutions are capable of governing our health care system. The cost of health care is spinning dangerously out of control, yet market forces alone cannot manage these costs because of a host of relatively well-understood market failures.¹ Moreover, our traditional political institutions—Congress and the executive administrative agencies—have also failed us in this respect. These institutions are too driven by special interest politics and too limited in their expertise and vision to control costs.² Both Medicare payment formulas and coverage determinations often seem to be driven by political, rather than scientific or economic, considerations.

Enter the Platonic Guardians. The governance of the health care system should, it is argued, be turned over to an impartial, independent “Federal Health Board” of experts who could make coverage and payment determinations based purely on evaluations of effectiveness and perhaps efficiency. The Federal Health Board became a central theme in the 2009 debate primarily through Tom Daschle’s book *Critical*,³ but the idea of an impartial and independent board to govern the Medicare program goes back further to the 1999 report of the National Bipartisan Commission on the Future of Medicare.⁴ Other experts, including Victor Fuchs and Ezekiel Emanuel along with Len Nichols have also proposed some form of national health care governing board.⁵ The models of the Federal Reserve Board or the Base Closing Commission are often invoked as agencies that make difficult decisions largely insulated from political

1. These include information and agency failures, moral hazard, misaligned incentives, and externalities. See BARRY FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 565-74 (6th ed. 2008).

2. See Timothy Stoltzfus Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39 (1999).

3. Tom Daschle, Scott S. Greenberger & Jeanne M. Lambrew, *Critical: What We Can Do About the Health-Care Crisis* 169-80 (2008).

4. Nat’l Bipartisan Comm’n on the Future of Medicare, *The Medicare Board*, <http://thomas.loc.gov/medicare/3fmedbrd.htm> (last visited Nov. 3, 2010).

5. EZEKIEL J. EMANUEL & VICTOR R. FUCHS, THE BROOKINGS INST., *A COMPREHENSIVE CURE: UNIVERSAL HEALTH CARE VOUCHERS* 2 (2007), available at http://www.brookings.edu/~media/Files/rc/papers/2007/07useconomics_emanuel/200707emanuel_fuchs.pdf; Len M. Nichols, New Am. Found., *A Sustainable Health System for All Americans* 8 (2007), available at <http://www.policyarchive.org/handle/10207/bitstreams/8826.pdf>.

considerations and special interest pressure.⁶ The Federal Health Board would be composed of experts in health policy, health economics, and health care delivery who would be appointed for long terms of office through an apolitical process, such as appointment by the Comptroller General. Its members would be subject to rigorous conflict of interest strictures and would make decisions based on the evidence rather than on politics.

The role of the Federal Health Board has varied from proposal to proposal. One function it could serve would be to establish a standard set of benefits and determine coverage for items and services through evidence-based evaluation of quality, performance, and effectiveness. Another function would be to set payment rates for providers, practitioners, and suppliers to maximize incentives to provide high-quality, coordinated, and effective care. Yet another would be to set the rules for promoting competition among insurers through health insurance exchanges. The jurisdiction of the Federal Health Board could encompass only the Medicare program, all federal programs, or the entire health care system.

As the health reform legislation moved through Congress during 2009 and the winter of 2010, the concept of an independent board with power to set Medicare payment policy took shape. President Obama mentioned the idea of giving additional authority to the Medicare Payment Advisory Commission (MedPAC) in a June 2, 2009 letter to Senators Kennedy and Baucus.⁷ Peter Orszag, the Director of the Office of Management and Budget, followed up with a July 17 letter to Speaker Pelosi endorsing the creation of an Independent Medicare Advisory Council.⁸ MedPAC is a legislative branch agency that currently advises Congress on the operation of the Medicare program. The Independent Medicare Advisory Board (IMAB) appeared in the Senate Finance bill⁹ and in the combined Senate bill, HR 3590, introduced by Senator Reid in November.

The IMAB concept was generally supported by health economists, two dozen of whom sent a letter to Reid on December 7, 2009.¹⁰ Indeed, the

6. See PAUL N. VAN DE WATER, NAT'L ACAD. OF SOC. INS., *DESIGNING ADMINISTRATIVE ORGANIZATIONS FOR HEALTH REFORM* (2009), available at <http://www.rwjf.org/files/research/vandewater.pdf>; Joe White, *Getting the "IMAB" Proposal Right: Some Health Care Homework for the Recess*, ROLL CALL, Aug. 4, 2009, <http://www.rollcall.com/news/37522-1.html>.

7. Letter from President Barack Obama, to Senators Edward M. Kennedy & Max Baucus, U.S. Senate (June 2, 2009), available at http://www.whitehouse.gov/the_press_office/letter-from-president-obama-to-chairmen-edward-m-kennedy-and-max-baucus.

8. Letter from Peter R. Orszag, Dir., Office of Mgmt & Budget, to Representative Nancy Pelosi, Speaker, U.S. House of Representatives (July 17, 2009) (on file with author).

9. America's Healthy Future Act of 2009, S. 1796, 111th Cong. § 3403 (2009).

10. Posting of David Leonhardt to Economix, <http://economix.blogs.nytimes.com/2009/12/08/rockefeller-the-economists-man-in-the-senate> (Dec. 8, 2009, 23:56 EST).

economists argued that the IMAB should be given greater power to recommend changes in Medicare payments for physicians and hospitals and even for Medicaid, and that its recommendations should be considered for “fast track” action in Congress. Commentators with an interest in health economics, including David Leonhardt and Ezra Klein, added their voices.¹¹ Klein argued that Congress was “too captured by special interests and too baffled by technical arguments and too paralyzed by partisanship” to do health care reform, and that what was needed instead was “an expert body able to continuously evaluate the data and make changes to Medicare that will increase the program’s effectiveness and decrease its costs.”

The concept, on the other hand, was vigorously opposed by provider groups, a coalition of whom sent a letter to Senator Reid and Speaker Pelosi attacking the idea on January 11, 2010.¹² They argued that the cuts imposed by agency could “jeopardize both access for Medicare beneficiaries and even infrastructure for the entire health care system” and that the body accountable to no one but the President would “greatly limit the ability of Medicare beneficiaries, advocates and providers to work with Congress to improve the [Medicare] program.” A few independent health policy experts, including Joe White, also questioned the Commission concept: White published an opinion piece in *Roll Call* in August asking whether the proposal would give too much power to the President to shape Medicare policy, whether its authority should be limited to Medicare, and whether it would be dominated by provider interests.¹³ From the outset the provision included language prohibiting rationing or cutting of benefits to elide claims that had emerged over the summer that the reform law generally would cut Medicare benefits and impose rationing.¹⁴

The Senate extensively modified the IMAB provisions in the Senate bill through a manager’s amendment with language proposed by Senators Rockefeller, Lieberman, and Whitehouse. They were part of the final Senate bill enacted on December 23, 2009 and the House on March 21, 2010.¹⁵ Among the

11. See David Leonhardt, *Budget Hawks Have a Buffet of Options with Health Bill*, N.Y. TIMES, Nov. 25, 2009, at B1, available at <http://www.nytimes.com/2009/11/25/health/policy/25leonhardt.html>; Ezra Klein: Economic and Domestic Policy, and Lots of It, http://voices.washingtonpost.com/ezra-klein/2009/07/the_dull_reality_of_change.html (July 17, 2009, 17:10 EST).

12. Letter from AIDS Action Baltimore et al., to Senator Harry Reid, Majority Leader, U.S. Senate, & Representative Nancy Pelosi, Speaker, U.S. House of Representatives (Jan. 11, 2010), available at <http://www.aamc.org/advocacy/library/gme/corres/2010/011010.pdf>.

13. White, *supra* note 6.

14. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3403(a)(1), 124 Stat. 119, 489-506, modified by § 10320 (2010) (to be codified at 42 U.S.C. § 1395kkk) [hereinafter PPACA].

15. *Id.*

modifications included in the manager's amendment was the renaming of the IMAB to the Independent Payment Advisory Board (the IPAB or "the Board") with added authority to make recommendations to Congress affecting private insurance as well as Medicare. The budget reconciliation bill adopted by the House and Senate in late March did not modify the IPAB provisions of the Senate bill.

The IPAB is one of a number of boards, commissions, councils, and centers created by the Patient Protection and Affordable Care Act (PPACA).¹⁶ Most directly relevant to the scope of earlier health board proposals, the Center for Medicare and Medicaid Innovation is responsible for designing, evaluating, and implementing innovative Medicare payment and service delivery models.¹⁷ The Center also shares with the IPAB the responsibility for cutting Medicare costs and improving the quality of care through payment reform.¹⁸ The IPAB is composed of fifteen members appointed by the President with the advice and consent of the Senate, supplemented by the Secretary of Health and Human Services (HHS) and the Administrators of the Center for Medicare and Medicaid Services and of the Health Resources and Services Administration.¹⁹ The members are appointed to staggered six-year, one-time-renewable terms of office.²⁰

The members are to be nationally recognized experts in health finance, payment, economics, actuarial science, health facility management, and health plan and integrated delivery systems.²¹ The IPAB will also include: physicians or other health care providers;²² experts in medicine, pharmacoeconomics, and drug benefit programs; representatives of employers, third-party payors, consumers, and the elderly; and persons skilled in the conduct and interpretation of biomedical, health services, health economics, technology assessment, and outcomes and effectiveness research.²³ According to section 3403, the Board should be composed of a mix of different professionals, broad geographic representation, and a balanced urban and rural mix.²⁴ In addition, the majority of the Board must not be persons directly involved in the provision or management

16. *Id.*

17. § 3021(a), 124 Stat. at 389--94, *modified by* § 10306 (to be codified at 42 U.S.C. § 1315a).

18. *Id.*

19. § 3403(a)(1), 124 Stat. at 502, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

20. § 3403(a)(1), 124 Stat. at 503, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

21. § 3403(a)(1), 124 Stat. at 502, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

22. *Id.*

23. *Id.*

24. *Id.*

of health care items and services.²⁵ A separate ten-member consumer advisory board is supposed to be appointed by the Comptroller General of the United States.²⁶

Service on the IPAB, unlike service on Medicare Payment Advisory Commission (MedPAC) or on other boards and commissions created by the PPACA, is a full-time job. The IPAB members, like members of federal regulatory boards such as the NLRB, FTC, or SEC, are forbidden from engaging in “any other business, vocation, or employment.”²⁷ Members will be compensated at a rate equal to the annual rate prescribed for Level III of the Executive Schedule (currently, \$165,300), while the Chairperson is compensated at the Level II rate (\$179,700), and the executive director at the Level V (\$145,700) rate.²⁸

The basic task of the Board is to develop and implement specific detailed proposals to reduce Medicare spending in years when Medicare per capita spending is expected to exceed target levels.²⁹ These proposals must be implemented unless Congress acts following expedited procedures to implement alternative cost-cutting measures.³⁰ The Board is also charged with developing and submitting to Congress “advisory reports on matters related to the Medicare program.”³¹ Finally, at least once every two years beginning in January of 2015, the IPAB is responsible for submitting to Congress and the President publicly available recommendations as to how to slow the growth in national health care expenditures (other than through federal programs) while preserving or enhancing the quality of care.³² These recommendations are supposed to include proposals that could be addressed by federal legislation, as well as recommendations that could be implemented administratively or by state legislation or private action.

At the heart of the tasks of the IPAB is its responsibility for taking action to cut Medicare spending. Each year beginning with April 30, 2013, the Centers for

25. *Id.*

26. § 3403(a)(1), 124 Stat. at 505, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

27. § 3403(a)(1), 124 Stat. at 503, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

28. *See* U.S. Office of Personnel Mgmt, Salary Table No. 2010-EX: Rates of Basic Pay for the Executive Schedule (Jan. 2010), <http://www.opm.gov/oca/10tables/pdf/ex.pdf> (listing 2010 executive schedule rates of pay).

29. *See infra* notes 33-34.

30. *See infra* notes 47-50.

31. § 3403(a)(1), 124 Stat. at 489, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

32. § 10320(a)(5), 124 Stat. at 952 (to be codified at 42 U.S.C. § 1395kkk).

Medicare and Medicaid Services (CMS) Chief Actuary will make a determination whether the projected per capita growth rate for the implementation year (the second year following the determination year, initially 2015) will exceed the per capita target growth rate for that year.³³ If the Actuary determines that for any given year the projected Medicare growth rate will exceed the target rate, the Board shall make proposals that will reduce Medicare spending overall by an amount established by the statute.³⁴

The proposal, however, must fit within stringent constraints. First, the proposal may not “ration health care, raise revenues or Medicare beneficiary premiums,” increase the Part D based beneficiary premium percentage or full premium subsidies, “increase beneficiary cost-sharing . . . , or otherwise restrict benefits or modify eligibility criteria.”³⁵ Second, proposals submitted before 2019 for years before 2020 may not target particular providers and suppliers already singled out under section 3401 of the PPACA for cuts above those attributable to reductions based on constrained productivity increases.³⁶ This means that the Board cannot cut payments for inpatient or outpatient acute hospitals, long-term care hospitals, inpatient rehabilitation hospitals, psychiatric hospitals, and possibly hospice care prior to 2020 or clinical laboratories prior to 2016.³⁷ Third, proposals must take into account administrative expenditures that HHS will incur in carrying them out.³⁸ Finally, proposals may “only include recommendations related to the Medicare program.”³⁹ The Board is explicitly

33. § 3403(a)(1), 124 Stat. at 493, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk). The Medicare per capita growth rate for the implementation year will be calculated as the projected five-year average rate of growth in per capita spending under Medicare ending in the implementation year (not considering negative updates in the physician sustainable growth rate and taking into account payment reforms enacted but not yet implemented). *Id.* The target growth rate is the projected five-year average ending in the implementation year of, prior to 2018, the average of the Urban Consumer Price Index (U.S. city average), and the medical care category of the Urban Consumer CPI (U.S. city average). § 3403(a)(1), 124 Stat. at 494, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk). After 2017, it will be set at nominal gross domestic product per capita growth plus one percentage point. *Id.*

34. The established amount is 0.5% in 2015, 1% in 2016, 1.25% in 2017, and 1.5% in 2018 and thereafter, or, if less, the projected excess of the growth rate over the target rate. § 3403(a)(1), 124 Stat. at 494, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

35. § 3403(a)(1), 124 Stat. at 490, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

36. *Id.*

37. § 3401, 124 Stat. at 480–88, *modified by* § 10319 (to be codified as amended in scattered sections of 42 U.S.C.).

38. § 3403(a)(1), 124 Stat. at 491, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

39. *Id.*

allowed to reduce payments to Part C Medicare Advantage plans and Part D prescription drug plans.⁴⁰ It is not precluded from cutting payments for physicians, but it is likely that its powers will be limited under a permanent, sustainable growth rate fix.

In addition to these requirements, the Board’s proposals should: extend the solvency of the Trust fund; better coordinate care and improve quality, access, prevention, wellness, and efficiency; target reductions at areas of excessive cost growth; consider the effects of reductions in provider payment on beneficiaries; consider the effects on providers and suppliers with negative cost margins, and consider the unique needs of dual eligibles.⁴¹ Proposals also may not increase the total amount of Medicare program spending over the ten-year period starting with the implementation year—costs may not simply be shifted to future years.⁴² In other words, the Board should aim for everything that is good, true, and right.

By September 1 in a year in which the Board receives notice from the Actuary, it must submit a draft proposal to the HHS Secretary and to MedPAC.⁴³ By January, the proposal must be submitted to the President and then the Congress.⁴⁴ If the Board fails to submit a proposal by deadline, HHS must itself submit a proposal meeting statutory requirements.⁴⁵ The President will then forward the proposal to Congress.⁴⁶ The statute contains lengthy provisions for congressional consideration of a proposal from the Board or Secretary including consideration under an expedited procedure with limited debate.⁴⁷ Congress cannot consider any amendment to the proposal that does not achieve the cost-reduction requirements that the Board is required to meet unless both vote to waive this provision, the Senate by a three-fifths vote.⁴⁸ Congress may also adopt a Joint Resolution to abolish the Board, but must do so by a three-fifths vote not later than August 15, 2017.⁴⁹ The statute recognizes, however, that Congress has

40. *Id.*

41. *Id.*

42. *Id.*

43. § 3403(a)(1), 124 Stat. at 491–92, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

44. § 3403(a)(1), 124 Stat. at 500, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

45. § 3403(a)(1), 124 Stat. at 493, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

46. *Id.*

47. § 3403(a)(1), 124 Stat. at 495–99, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

48. § 3403(a)(1), 124 Stat. at 496, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

49. § 3403(a)(1), 124 Stat. at 500–02, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

the constitutional power to change its rules to remove the three-fifths majority requirement.⁵⁰ If Congress fails to adopt a substitute provision to reduce Medicare spending complying with the statute by August 15, HHS must implement the Board's proposal.⁵¹

No judicial review is permitted of an HHS decision to implement the Board's recommendations.⁵² Although provisions in Medicare laws limiting judicial review of specific legislative-type decisions, such as the setting of a conversion factor for a prospective payment scheme, are not uncommon, an across-the-board ban on judicial review of the implementation of a program is. It is unclear how any of the limitations on the power of the IPAB would be enforced absent judicial review. If, for example, the IPAB were to recommend a cut in benefits contrary to the law, would the decision be unreviewable? The courts have historically been reluctant to overturn executive policy decisions in the Medicare program,⁵³ but the complete removal of their oversight of the implementation of the IPAB proposals is problematic. On the other hand, Congress does have the power to limit the jurisdiction of the federal courts, and limitations on judicial review have been routinely upheld.⁵⁴ The PPACA appropriates \$15 million for the IPAB for 2012.⁵⁵ For each subsequent year this amount is increased by the percentage increase in the CPI. This is a standing appropriation and should further free the IPAB from political pressure.

The Congressional Budget Office (CBO) discussed the IPAB at some length in its December 19, 2009 report on the PPACA Manager's Amendment. The CBO concluded that the IPAB would reduce Medicare spending by \$28 billion over the 2010 to 2019 period, with most of the savings coming at the end of the period, and with significant savings continuing beyond 2019.⁵⁶ On December 20,

50. § 3403(a)(1), 124 Stat. at 499, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

51. § 3403(a)(1), 124 Stat. at 499-500, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

52. § 3403(a)(1), 124 Stat. at 500, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

53. Jost, *supra* note 2, at 54.

54. *See* United States v. Fausto, 484 U.S. 439 (1988); *CardioSom v. United States*, 91 Fed. Cl. 659 (2010). Courts are reluctant, however, to construe review preclusion statutes to deny the courts jurisdiction to decide constitutional questions, which would seem to be necessary to protect the ultimate responsibility of the judiciary to interpret the Constitution. *See also* *Bowen v. Mich. Acad. of Family Physicians*, 476 U.S. 667 (1986); *Bartlett v. Bowen*, 816 F.2d 695 (D.C. Cir. 1987). If, therefore, a challenge were brought to the constitutionality of the IPAB litigation, the courts may permit review.

55. § 3403(a)(1), 124 Stat. at 506, *modified by* § 10320 (to be codified at 42 U.S.C. § 1395kkk).

56. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Senator Harry Reid,

the CBO issued a correction noting that it had misunderstood the formula that the IPAB would apply after 2019, and that the IPAB could in fact be expected to decrease Medicare spending by between one-quarter and one-half of one percent of GDP going forward, instead of the one-half percent it had projected earlier. Still, it noted, this would reduce the annual growth rate of Medicare to six percent per year, as compared to average increases of eight percent over the past two decades.⁵⁷ In his report, however, the CMS Actuary questioned whether this goal was achievable, noting that, hypothetically, the IPAB target growth rates would have been met in only four of the past twenty-five years, and would have approximated the target growth rate in the Sustainable Growth Rate (SGR) formula, which Congress has routinely overridden.⁵⁸ The Chief Actuary expressed concern that health care providers would have difficulty remaining profitable and might leave the Medicare program when faced with these constraints. The Actuary concluded, however, that after 2019, further proposals from the IPAB would not be required as the other savings provisions in the bill, if permitted to continue, would achieve the spending goals set by the legislation.

Many questions remain about how and whether the IPAB will work. Staffing the IPAB with fifteen leading experts, who are willing to face a congressional confirmation as well as give up research, practice, and teaching for six years for a relatively modest salary, will be a challenge. The relationship between the IPAB and other boards and commissions, most notably the Center for Medicare and Medicaid Innovation and MedPAC along with the enhanced Medicaid and CHIP Payment and Access Commission (MACPAC), will need to be worked out. The legislation does not anticipate that MedPAC's role will be diminished, but instead strengthened. But necessarily MedPAC will lack the authority given to the IPAB to implement recommendations without direct congressional authorization. The Center for Medicare and Medicaid Innovation would seem to have even greater power than the IPAB for implementing innovative approaches to Medicare payment. Although multiple entities pursuing the same tasks could stumble over each other, there are also real opportunities for synergy. In particular, shared staffing between the IPAB and the innovation center and regular communications between the IPAB and the MedPAC and MACPAC

Majority Leader, U.S. Senate (Dec. 19, 2009), *available at* http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf.

57. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Senator Harry Reid, Majority Leader, U.S. Senate (Dec. 20, 2009), *available at* http://www.cbo.gov/ftpdocs/108xx/doc10870/12-20-Reid_Letter_Managers_Correction1.pdf.

58. Memorandum from Richard C. Foster, Chief Actuary, Ctrs. for Medicare & Medicaid Servs. (Apr. 22, 2010), *available at* http://www.politico.com/static/PPM130_oact_memorandum_on_financial_impact_of_ppaca_as_enacted.html.

could strengthen all three.

The legislative requirement that the IPAB submit annual proposals will encourage recommendations for short-term payment fixes rather than long-term changes that might in fact “bend the cost curve.” If the IPAB is to be truly effective, it must consider not just cuts in provider payments but also changes in how providers are paid. It might even find a way to alter consumer incentives, although the law would seem to block most paths to achieving this. Although the statute prohibits reduction in “payment rates” for hospitals before 2020, it does not prohibit the IPAB from recommending changes in payment methods, which might have longer-term effects on cost. The statute does not seem to prohibit, for example, the IPAB from making proposals for bundled payment or shared-savings arrangements, which could change the wasteful incentives built into fee-for-service payment. These kinds of incentive changes will be the focus of the innovation Center, and this is another argument for close coordination between the IPAB and the Center. But the necessity of making year-to-year cuts is likely to focus the IPAB’s attention on short-term payment cuts rather than on changes in program incentives. In particular, it is likely to focus on further cuts in Medicare Advantage plans, which are already slated for deep cuts under the PPACA, or on finding ways to save money in the Part D outpatient prescription drug program. The IPAB’s success will also depend on Congress’s reactions to its recommendations. A three-fifths vote will be needed to override payment cuts, but Congress could increase Medicare funding through independent legislation, effectively negating the IPAB cuts. Critics have cited the fact that Congress has regularly evaded the Medicare physician SGR formula as proof that Congress cannot cut Medicare costs.⁵⁹ On the other hand, Congress left in place the vast majority of the Medicare-savings provisions in the 1990, 1993, 1997, and 2005 Budget Reconciliation Acts.⁶⁰ And our current fiscal crisis may sharpen lawmakers’ resolve to cut spending. It is quite possible that a Congress focused on deficit reduction will see the IPAB’s proposed cuts as offering relief rather than a challenge.

The delegation of authority by Congress to the IPAB may be challenged as violating separation of power principles. The IPAB is effectively granted the power to amend the Medicare statute subject only to congressional veto. Although there are in theory constitutional limits to the power of Congress to delegate its authority, the Supreme Court has rarely found that Congress has

59. See Ezra Klein: Economic and Domestic Policy, and Lots of It, http://voices.washingtonpost.com/ezra-klein/2009/11/can_congress_control_costs.html (Nov. 6, 2009, 17:17 EST) (discussing this argument).

60. James R. Horney & Paul N. Van de Water, Ctr. on Budget & Policy Priorities, House-Passed and Senate Health Bills Reduce Deficit, Slow Health Care Costs, and Include Realistic Medicare Savings 10-11 (2009), available at <http://www.cbpp.org/files/12-4-09health.pdf>.

crossed these limits.⁶¹ As long as Congress lays down an “intelligible principle” to guide the discretion of an administrative agency to which authority has been delegated, the nondelegation doctrine has not been violated. A court would probably hold the guidelines contained in the IPAB provisions⁶² to give sufficient direction to survive a delegation challenge, if such a challenge were to survive the bar to judicial review. Nevertheless, the conscious abdication of congressional responsibility to the IPAB is striking. Moreover, the bar to judicial review calls into question the extent to which the intelligible principles found in the statute actually limit the IPAB’s discretion.

Another major question is whether it is possible to cut Medicare’s provider payments as long as private payers’ rates remain unconstrained. If the gap between private and Medicare rates continues to grow, health care providers may well abandon Medicare. Although the IPAB can make recommendations to Congress regarding private payments, these are nonbinding. In the long run, Congress may not be able to cap Medicare expenditures without addressing private expenditures as well. There is no reason to believe that Congress is ready to adopt price controls in the private sector, and thus the gap between Medicare and private payment is likely to continue to be an issue. At some point, however, the gap may become unacceptable, which may require Congress to take the private sector recommendations of the IPAB more seriously. If this leads to all-payer rate setting, this may be the most revolutionary contribution of the IPAB concept. If the IPAB plays a role in all-payer rate setting, it will truly have become the Platonic Guardian of our health care system.

In creating the IPAB, Congress is attempting to lash itself to the mast to keep the siren song of special interest lobbyists from distracting it from its task of controlling Medicare cost growth. For good measure, it has bound the courts to the mast as well. This attempt raises a host of questions involving law and policy. Has Congress violated separation of power principles by abdicating legislative responsibility and barring judicial oversight? Can any group of experts repeatedly create effective short-term cost control solutions year after year that do not cut benefits or ration care, and that focus on only a subset of Medicare providers? Can Medicare costs be cut while private sector costs grow unabated? Or will the IPAB simply become the conscience of Congress, forcing Congress itself to confront again and again each year the hard work of cost control, perhaps in the private sector as well as in Medicare? Only time will tell.

61. See *Whitman v. Am. Trucking Ass’ns*, 531 U.S. 457, 472-76 (2001); *Mistretta v. United States*, 488 U.S. 361, 371-79 (1989).

62. See *supra* notes 35-42.

