



Bad medicine: IPAB, Medicare costs

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During the original debate over the Affordable Care Act, [I wrote](#) that the proposed law failed to address out-of-control Medicare spending. Two years later, this urgent problem remains.

Medicare is awash in a sea of red ink — \$280 billion in cash flow deficits already and getting worse — that is driving the U.S. credit rating south and threatening the very foundations of the U.S. economy. It makes no sense to sit idly by while the social safety net unravels and the promise of our future dims.

Advocates argue the health care law solves this problem. Specifically, it creates the Independent Payment and Advisory Board, which will be formed in 2014 and could make its first recommendations in 2015. This advisory board will consist of 15 officials appointed by the president. Board members will be required to make recommendations to cut Medicare funding in years when spending growth exceeds targeted rates. For Congress to block these recommendations, it must veto the board's proposal with a 60 percent majority and pass alternative cuts of the same size.

In other words, this board puts Medicare on a budgetary diet. What's wrong with that?

First, the system is clearly set up so that the advisory board, rather than Congress, makes the policy choices about Medicare. This means that the IPAB is not just an advisory body — despite its name. And policy choices, which should be made by elected representatives, are not.

Second, the advisory board threatens the quality of patient care. It can, in essence, ration the health care available to seniors. While technically prohibited from directly altering Medicare benefits, the IPAB will have no choice but to attempt to ratchet back spending by slashing providers' reimbursement rates.

We've seen this movie before when physicians' Medicare payment rates have faced cuts. Many physicians have no choice but to limit the number of Medicare patients they see. Others have stopped serving these patients entirely.

Doctors are cutting down on services for Medicare recipients at an alarming rate, according to a recent GMA sustainable growth rate study, because of threats of cuts under the system.

The study shows that 67.2 percent of physician practices are considering limiting the number of new Medicare patients; 49.5 percent are considering the option of refusing new Medicare patients; 56.3 are contemplating whether to reduce the number of appointments for current Medicare patients; and 27.5 percent are debating whether to discontinue service for all Medicare patients.

Keep in mind — this advisory board hasn't even been formed yet. Once it is formed, expect these numbers to worsen.

A more blatant form of health care rationing could also cut costs. In Britain, the National Institute for Health and Clinical Excellence recommends to the National Institutes of Health which medical treatments the government should cover. Advocates of this approach see the new Patient-Centered Outcomes Research Institute — which is meant to set comparative effectiveness research priorities for the government — as an opportunity to create the U.S. equivalent of NICE.

Defenders of the health care law now argue that the new research institute will just compare similar medical treatments and find those that are most effective — since the statute prohibits the government from using research data as an excuse to dictate coverage decisions. Many fear, however, that the research will eventually be used to cut costs anyway — a fear that could be alleviated by the PCORI itself.

But unfortunately, at a recent research institute forum, when the board discussed its draft of priorities for spending the \$1.1 billion in taxpayer money for comparative effectiveness research in the “stimulus” bill (imagine that!), the vague guidelines failed to allay concerns that research data could be used to refuse treatments for patients. That’s the wrong way to cut costs.

Finally, the heart of American health care success has been vigorous medical science and innovation. The new advisory board is a threat to the very innovation that has fostered breakthrough treatments for heart disease, joint failure and many other maladies faced by Medicare beneficiaries.

When faced with the need to cut something — anything — to hit its target, what will IPAB choose? Most likely, it will be looking to the expensive new therapies, drugs and devices that represent the cutting edge of medical advance.

Innovators will not continue to sink billions into research-and-development efforts if the financial rug is regularly pulled from under them.

Medicare does need to be put on a budget. But it should not be done in a way that endangers the very beneficiaries for which it was created — and for whom it should be reformed and preserved.

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