Failure to Launch: The Institutional Defects of the Independent Payment Advisory Board

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ABSTRACT

Created as part of the Affordable Care Act, the Independent Payment Advisory Board (IPAB) is charged with saving money for the Medicare system. To that end, IPAB was set apart from the political process, which has for decades proved itself unable to control Medicare costs. Yet no members have been appointed to IPAB as of fall 2017, and a broad coalition in Congress supports its elimination. This paper develops a theoretical framework to explain this phenomenon. At first glance, IPAB appears to employ a typical congressional strategy of delegation to solve the kind of collective action problem that frequently stymies legislative action. However, IPAB does not in fact solve that problem, because the same incentives that keep members of Congress from reforming Medicare also incentivize them not to appoint members to IPAB. Moreover, IPAB privileges liberal cost-control measures over conservative approaches, thus creating another incentive for Republicans to oppose it.

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In 2009, as the Obama administration and the Democrat-controlled Congress began the serious work of healthcare reform, one thing was clear: controlling the costs of healthcare was a top priority for many Americans seeking change. As President Obama noted in his speech to the American Medical Association on June 15, 2009,

> Make no mistake: the cost of our health care is a threat to our economy. It is an escalating burden on our families and businesses. It is a ticking time-bomb for the federal budget. And it is unsustainable for the United States of America.[1]

Of course, what controlling the costs meant often differed depending on which stakeholder you referenced. Consumers who experienced increased cost-sharing and premiums worried that the trend would eventually place health insurance out of reach (if it hadn't already).[2] Employers were frustrated that healthcare played an increasing role in employment costs, and efforts to control this trend often drove a wedge between employers and their employees.[3] Insurers worried that continued increases in provider costs would drive the price of their products up and lead to a riskier client mix as healthier individuals dropped coverage.[4] Policymakers considered the increasing size of healthcare relative to other priorities and feared that healthcare costs were crowding out other desired

1. "Text: Obama's Speech on Health Care Reform," *New York Times*, June 15, 2009, http://www.nytimes.com/2009/06/15/health/policy/15obama.text.html.
2. See Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven, CT: Yale University Press, 2011); Mollyann Brodie et al., "Liking the Pieces, Not the Package: Contradictions in Public Opinion during Health Reform," *Health Affairs* 29, no. 6 (2010): 1125–30.
3. Kaiser Family Foundation, "Employer Health Benefits Annual Survey Archives," September 14, 2016.
4. See examples at CNN.com: "Rates to Rise under Senate Health Plan, Industry Group Says," October 12, 2009; Ed Hornick, "Pushback Grows against Insurance Industry Report," October 13, 2009.

"The purpose of the Independent Payment Advisory Board . . . would be to reduce the per capita rate of growth in Medicare spending. But the story of IPAB has been far different from what its authors originally intended."

policies.[5] And, finally, healthcare providers feared that continued cost increases would trigger greater rationing and control.[6] Thus, "cost," while a general concern of reformers, suggested no single strategy for response. Of course, costs weren't the only concern of reformers. For example, Democrats pressed for the universal coverage that the Left had been championing unsuccessfully since at least the New Deal. However, most recognized that expansion was *politically* possible only if the proposed reform could simultaneously constrain the escalating costs that characterized the US healthcare market. Most citizens already had access to health insurance, but high costs threatened virtually everyone. Solving the cost problem could cement the broader coalition needed to pass reform.

A central feature of the Democratic strategy to simultaneously contain costs and expand coverage was to squeeze projected Medicare spending for savings that could be redirected to cover insurance for low-income, younger Americans. Policymakers had long worried about the pace of Medicare spending, but efforts to implement virtually any solution posed political challenges. By wrapping such cuts into the Affordable Care Act (ACA), advocates argued that Medicare savings could be directed to offset part of the expected new costs of the healthcare expansion.[7]

Thus, the purpose of the Independent Payment Advisory Board (IPAB), an entity intended to be removed from the ebb and flow of congressional politics, would be to reduce the per capita rate of growth in Medicare spending. But the story of IPAB has been far different from what its authors originally intended. It is, to date, an inert entity. President Obama nominated no members to the board,

5. See, for example, Social Security Advisory Board, "The Unsustainable Cost of Health Care," September 2009.
6. J. C. Tilburt et al., "Views of US Physicians about Controlling Health Care Costs," *JAMA* 310, no. 4 (2013): 380–89.
7. For an excellent review of the wide range of fiscal assumptions incorporated in the ACA, see Charles Blahous, "The Fiscal Consequences of the Affordable Care Act" (Mercatus Center at George Mason University, Arlington, VA, 2012).

congressional Republicans slashed its funding, and a bipartisan coalition in the House has sponsored legislation to abolish it.

This paper will explain why IPAB has been an institutional failure, offering three key reasons:

1. IPAB does nothing to change the collective action problem in Congress that structurally led to Medicare overspending in the first place. Thus, if it is effective, it will constantly be used to override the short-term political interests of members.
2. Although IPAB is supposed to leverage expert knowledge to generate efficiencies within the Medicare program, it is likely that its determinations will create winners and losers in the medical services industry—the same industry whose lobbying pressure has been used to thwart previous efforts to control costs. The neutral expertise assumed by proponents of IPAB does not exist, nor does anything in the structure suggest it can be created.
3. Although IPAB is nominally an independent body, the rules of the board—specifically what it may and may not consider—are systematically biased toward the progressive vision of Medicare and against the conservative one, disincentivizing Republicans in the Senate to confirm board appointees.

In sum, the political coalition that opposes IPAB is sufficiently broad-based to keep the board in its current idle state.

THE PROBLEM OF CONTROLLING MEDICARE COSTS: A COLLECTIVE DILEMMA

Since enacting Medicare in 1965, the federal government has struggled mightily—and often unsuccessfully—to contain the program's costs. Perhaps the key fault lies in the enacting legislation itself, the 1965 amendments to the Social Security Act. Interested in providing medical care to seniors but lacking the capacity to do so directly, the government depended on the voluntary participation of the medical services industry, which for years had balked at such initiatives. In response, the Lyndon Johnson administration, working in conjunction with House Ways and Means chairman Wilbur Mills, offered the industry a deal that was too good to pass up—virtually unlimited demand for services made by an aging population. In effect, doctors and hospitals were allowed to charge the government the usual and customary fees for whatever services the provider deemed necessary. Moreover, seniors, under the veil of third-party payment, rationally demanded ever more services. Since seniors are also those most likely

to require health services as their bodies age, the recipe for swift expansion was set.[8] Little wonder, then, that by 1969, Medicare was already a "runaway program," in the words of Louisiana senator Russell Long.[9]

The problem of cost control in Medicare endures to the present day, and indeed it is taking on a new shape more pernicious than ever before. The nation's aging demographics, improvements in technology, and life-saving methodologies will soon combine to pose serious future shortfalls in the Hospital Insurance Fund of Medicare Part A and a massive deficit of the general revenues because of increased outlays for Medicare Part B, unless expenditures or revenues change significantly.

Policymakers in Congress are well aware of this problem, but they have been hindered in formulating a response by two major factors. The first is ideological. Although conservatives and progressives are in general agreement that the federal government has an obligation to care for seniors—itself a major policy victory for the postwar liberals who fashioned the program—they hotly disagree over how to meet that obligation. On one hand, progressive Democrats want to expand the Medicare program to cover all Americans under a single-payer system, which would give the government total control over how much medical services may cost.[10] Conservative Republicans, on the other hand, wish to shift Medicare toward a "defined benefit" program, whereby the government provides seniors with a specific monetary contribution to assist them in purchasing their own insurance.[11] Given the competitive partisan divisions within Congress that have persisted since the 1980s, it is difficult to forge a sufficiently large majority to reform Medicare in either direction—and thus difficult to contain costs.

The other factor in the difficulty of controlling costs is the collective action problem of diffuse benefits and concentrated costs found at the heart of Medicare. The political contest over Medicare expenditures is highly disjointed: a highly organized minority who stand to lose if spending is reduced face off against a diffuse and largely uninterested majority of people who would benefit

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8. H. E. Frech, *Competition and Monopoly in Health Care*, (Lanham, MD: AEI Press, 1996); Victor Fuchs, *The Future of Health Policy* (Cambridge, MA: Harvard University Press, 1998); Casey Mulligan, *Side Effects and Complications: The Economic Consequences of Health Reform* (Chicago: University of Chicago Press, 2015); Jay Cost, *A Republic No More: Big Government and the Rise of American Political Corruption* (New York: Encounter Books, 2013), 236–39.
9. Quoted in James Morone, Theodor J. Litman, and Leonard S. Robins, *Health Politics and Policy*, 4th ed. (Clifton Park, NY: Delmar Cengage, 2008), 315.
10. See, for instance, Bernie Sanders, "Issues: Medicare for All," BernieSanders.com, accessed April 23, 2017.
11. See, for instance, Office of the Speaker, "A Better Way: Our Vision for a Confident America," June 22, 2016.

from long-term cost control. Although the national interest at large will benefit from containing Medicare costs, the burdens will fall narrowly upon several key groups—particularly medical service providers and senior citizens. These policy losers have a strong incentive to oppose any reforms that would cut against their interests, and they have proved themselves to be very vigorous in lobbying on behalf of their interests. In 2016 the health services industry spent $100 million on congressional elections and $500 million more on lobbying the government, while the American Association of Retired Persons (AARP) is consistently one of the most potent interest groups in the nation's capital.[12] Meanwhile, the benefits of long-term solvency are heavily discounted by average voters. In fact, most voters are only vaguely aware of the impending crisis. A 2011 Gallup poll found that although most Americans agree that the Medicare program will "create a crisis for the federal government," they still basically like the status quo. Just 31 percent of adults responded that the government should "completely overhaul" or "make major changes" to the program.[13] Members of Congress may feel a public-spirited duty to attend to the long-term solvency of Medicare, but their immediate political calculations—mobilized interests strongly opposed and the voting public generally indifferent—make it very difficult to straighten Medicare out. It is little wonder, then, that the many attempts to rein in Medicare spending have fallen short.[14]

The most recent example of Congress failing to accept the reality of Medicare cost savings can be seen in the reaction to the implementation of the Sustainable Growth Rate (SGR) provision for physician services in Medicare Part B, enacted as part of the Balanced Budget Act of 1997. The SGR formula used an automatic mechanism to tie the rate of growth for Medicare provider reimbursements to rates of GDP growth and to create greater predictability and budget control year to year. When Medicare spending growth fell below SGR predetermined levels, reimbursement rates to providers would increase, but if overall spending exceeded the target, which was usually the case, across-the-board reimbursement rate cuts would be imposed to bring spending in line with overall economic growth.

Since spending in Medicare is a function of both the rates providers charge and the volume of services provided, this budgetary limit quickly created a classic common pool dilemma for providers. Any single provider can control only

12. See Center for Responsive Politics, "Health: Money to Congress," OpenSecrets.org, accessed April 23, 2017.
13. "Medicare," In Depth: Topics A to Z, Gallup News, accessed April 23, 2017.
14. Joseph Antos, "Medicare Reform and Fiscal Reality," *Journal of Policy Analysis and Management* 30, no. 4 (2011): 934–42.

the services he or she orders because reimbursement rates are set by Medicare. But providers who restricted the number of services they ordered to ensure that higher reimbursement rates would be maintained could face even greater cuts to their income from those more limited services if the other million-plus providers did not similarly restrict their own services. Just as the individual farmer decides whether to add a cow to the common pasture, each provider could decide only how much to contribute to overall Medicare spending (by reducing the number of services ordered); providers had no individual incentive to cut their own income unilaterally unless they were assured that others would do likewise. They would decide that it's better to provide extra or costlier services, even at lower reimbursement rates, than to risk a decline in total salary.

By 2002, the reality of this SGR dilemma became clear as the Medicare base payment was cut by 4.8 percent. Of course, as a result, members of Congress faced political pressure both from physicians and from Medicare recipients who feared losing their doctors. The response of Congress was to "temporarily" restore the cuts imposed by the SGR in separate legislation (in essence, to replenish the common pool for further overuse). Even so, the SGR remained technically on the books, and the aggregate cuts mandated by the SGR continued to grow in theory, if not in practice. By the time the ACA passed, Medicare providers were staring at more than 20 percent reductions in reimbursements without an SGR "patch." Fearing that providers would flee the Medicare market if the ACA-mandated cuts went into effect, Congress ended the SGR and permanently restored all cuts in 2015 through the Medicare Access and CHIP Reauthorization Act (MACRA), which promised new cost controls for future budgets.[15]

The failure of Congress to accept the difficult cuts that would have resulted from the SGR illustrates quite well the collective action problem that Congress faces. Almost all members of Congress want to see the necessary changes made in the program to ensure that Medicare is sustained for constituents in the future, but no member wants to stand up independently to suggest specific cuts to the popular program. When all members face a similar dilemma, the legislature will struggle to behave in a collectively rational fashion.

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15. Collective action and common pool problems are well understood in public choice literature. In particular, see Mancur Olson, *The Logic of Collective Action* (Cambridge, MA: Harvard University Press, 1965); Elinor Ostrom, *Governing the Commons: The Evolution of Institutions for Collective Action* (Cambridge: Cambridge University Press, 1990). For more on the SGR, see Billy Wynne, "May the Era of Medicare's Doc Fix (1997–2015) Rest in Peace. Now What?," *Health Affairs*, April 14, 2015; Billy Wynne, Katie Pahner, and Devin Zatorski, "Breaking Down the MACRA Proposed Rule," *Health Affairs*, April 29, 2016.

THE IPAB ALTERNATIVE

With continued evidence that members of Congress were unwilling to accept the hard choices imposed by the SGR, reformers looked to other methods to keep Medicare costs under control. The ACA outsourced the authority to rein in Medicare spending to the executive branch, through demonstration projects, cuts to Medicare Advantage, and, if other methods proved inadequate, to IPAB, an independent entity staffed with experts whose proposals would be granted preferential treatment under the congressional rules. The effectiveness of these demonstrations has yet to materialize, and the Medicare Advantage cuts have been challenged as well, but this section focuses only on the potential of the IPAB approach.

The IPAB process happens across multiple stages. To begin, if the chief actuary for the Centers for Medicare and Medicaid Services (CMS) forecasts that the per capita growth rate of Medicare for an implementation year will exceed the statutory target, IPAB is tasked with developing a detailed proposal that will achieve the applicable savings target (calculated as the difference between the target rate and the projected rate). In that endeavor, IPAB is limited in what it may propose. It can make adjustments to Medicare reimbursement rates, but only for providers who are not otherwise facing reductions under other sections of the ACA. It cannot "ration health care, raise revenues or Medicare beneficiary premiums, . . . increase Medicare beneficiary cost sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria."[16]

IPAB proposals are fast-tracked through Congress under restrictive rules. Congress may reject IPAB's suggested cuts but must supply its own cuts to meet the CMS guidelines, unless three-fifths of the Senate waives the requirement. Debate in the Senate is statutorily limited, and

"Almost all members of Congress want to see the necessary changes made in the program to ensure that Medicare is sustained for constituents in the future, but no member wants to stand up independently to suggest specific cuts to the popular program."

16. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat 129, § 3403 (2010).

a failure by Congress to override IPAB will result in the enactment of the board's recommendations.

Membership in IPAB is designed to be bipartisan, representative of the stakeholders in Medicare, and free of special-interest influence. Of course, as public choice theory has demonstrated, one cannot have stakeholders represented without introducing special interests into the debate.[17] The issue then becomes, whose interests are represented by the experts? The 15-member board is appointed by the president, in conjunction with members from both chambers of Congress, and confirmed by the Senate. Board members are to possess expertise in relevant fields, including health finance and actuarial science, and they should be drawn from specified backgrounds, including physicians, pharmaceutical experts, and third-party payers. Board members are prohibited from engaging in any other vocation during their six-year term of office.

A key operating premise of IPAB is the idea that an expert panel such as this, sufficiently removed from the political process, could generate savings *without* the painful tradeoffs associated with benefit changes. According to Peter Orszag, chairman of Obama's Office of Management and Budget and a key proponent of IPAB, such an organization could reach spending targets simply by reducing the wasteful spending on inefficient services common in Medicare.[18] The collective action problems inherent in Medicare, in other words, would turn out to be mostly ephemeral. With knowledge of current best practices, and sufficiently insulated from political pressures, the experts could cut all the fat without cutting any of the meat or bone. In this way, IPAB is consistent with a long-held progressive conceit first expressed prominently by Woodrow Wilson—that depoliticizing the policymaking process by delegating authority to experts is integral to achieving better outcomes. In "The Study of Administration," published in 1887, Wilson argues for the need "to straighten the paths of government, to make its business less unbusinesslike, to strengthen and purify its organization, and to crown its duties with dutifulness."[19] The conceit of IPAB is similar.

Delegation to executive or independent agencies has long been used by Congress as a political strategy to solve difficult policy problems. Although the Constitution invests in Congress all legislative authority, the Supreme Court has

17. See Gordon Tullock, "The Welfare Costs of Tariffs, Monopolies, and Theft," *Western Economic Journal* 5, no. 3 (1967): 224–32; Gordon Tullock, "The Origin Rent-Seeking Concept," *International Journal of Business and Economics* 2, no. 1 (2003): 1–8.
18. See, for example, Peter Orszag, "A View from the Institute of Medicine," White House Office of Management and Budget, October 5, 2009.
19. Woodrow Wilson, "The Study of Administration," *Political Science Quarterly* 2, no. 2 (1887): 201.

validated congressional efforts to delegate its power, so long as there is some "intelligible principle" to guide the other branch.[20] Delegation is a useful tool for lowering the transaction costs of public policy.[21] In this way, it is similar to the committee system and to legislative parties—all three institutions help the legislature transcend the individual interests of members and act on behalf of the institution's collective goals.[22]

The most successful instance of delegation in the modern era, at least from a bipartisan political perspective, is the Base Realignment and Closure (BRAC) Commission. Facing politically unpopular budgetary shortfalls in the 1980s, Congress was intent on closing unnecessary military installations. However, because the harms from such closures would be concentrated in a handful of districts and the benefits would be distributed diffusely, members of Congress had strong incentives to bargain to save their bases, thus undermining the collective benefit. Simultaneously, congressional Democrats were worried that, in the face of inaction, the Republican administration of Ronald Reagan would close bases predominantly in Democratic districts. In 1988, Congress resolved this tension by passing the Defense Authorization Amendments and Base Closure and Realignment Act, which outsourced the decision-making to the BRAC Commission, an independent entity. Congress would vote to approve or disapprove the BRAC proposals on a fast-track basis, with no prospect for amendment—making it very difficult for a handful of legislators to undermine or halt the process. BRAC was considered such a success that it was reauthorized in 1990 for three successive rounds of closures in 1991, 1993, and 1995—with members appointed by the president, with advice and consent from the Senate.[23]

At first blush, IPAB appears similar to BRAC in its design as well as its motives. In both instances, Congress effectively voted to bind its own hands, voluntarily reducing its role in managing Medicare and base closures, empowering

20. J. W. Hampton, Jr. & Co. v. United States, 276 U.S. 394 (1928).
21. David Epstein and Sharyn O'Halloran, *Delegating Powers: A Transaction Cost Politics Approach to Policy Making under Separate Powers* (Cambridge: Cambridge University Press, 1999).
22. See, for instance, Barry R. Weingast and William J. Marshall, "The Industrial Organization of Congress: Or, Why Legislatures, Like Firms, Are Not Organized as Markets," *Journal of Political Economy* 96, no. 1 (1988): 132–63; Gary W. Cox and Mathew D. McCubbins, *Legislative Leviathan: Party Government in the House* (Cambridge: Cambridge University Press, 2007).
23. David E. Lockwood and George Siehl, "Military Base Closures: A Historical Review from 1988 to 1995" (CRS Report No. 97-305 F, Congressional Research Service, Washington, DC, 2004).

experts to make the tough choices, and retreating to a supervisory role.[24] As Henry Aaron puts it, legislators voted "to save themselves from themselves."[25]

But have they? Although the CMS actuary has so far determined that projected per capita Medicare spending remains below the target rate, IPAB is supposed to be filing annual public reports and biennial recommendations on how to slow the growth of national health expenditures.[26] However, it has not filed any reports because it has no members. The Obama administration never appointed a single member to the panel, and Senate Republicans have indicated their intention to block appointments anyway. In fact, the administration agreed to cut IPAB's funding by two-thirds as part of the 2014 omnibus deal to fund the government.[27]

Moreover, a large array of politically influential groups has come out against IPAB. A February 2017 letter from more than 500 organizations—including the American Medical Association—warned that IPAB cuts would "be devastating for patients" and called on Congress to "eliminate the IPAB provision."[28] Although the influential American Hospital Association was not a signatory to the letter, it has also called for a repeal of IPAB.[29] Meanwhile, AARP, one of the most powerful interest groups in the country, has not called for its repeal but has stopped far short of defending it. In a December 2016 letter to Congress, AARP stated that "while we did not support enactment of the Independent Payment Advisory Board, we do strongly support its requirement that Medicare savings not come on the backs of seniors through higher cost-sharing or cuts in benefits."[30] Little wonder that a bill introduced in the 114th Congress by

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24. See Jack Ebeler, Tricia Neumann, and Juliette Cubanski, "The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending" (Issue Brief, Kaiser Family Foundation, 2011); David Newman and Christopher M. Davis, "The Independent Payment Advisory Board" (CRS Report No. R41511, Congressional Research Service, Washington, DC, 2010); Jim Hahn, Christopher M. Davis, and Edward C. Liu, "The Independent Payment Advisory Board (IPAB): Frequently Asked Questions" (CRS Report No. R44075, Congressional Research Service, Washington, DC, 2017).
25. Henry Aaron, "The Independent Payment Advisory Board—Congress's 'Good Deed,'" *New England Journal of Medicine* 364 (2011): 2377–79.
26. Letter from Paul Spitalnic, Chief Actuary of the Centers for Medicare and Medicaid Services, to Administrator Slavitt, June 22, 2015, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/IPAB-2016-06-22.pdf.
27. Carolyn Long Engelhard, "The Phantom Death Panel That Won't Die," *The Hill*, May 14, 2015.
28. Letter from the AMA (American Medical Association) to Congress, May 6, 2015, http://www.aahks.org/wp-content/uploads/2015/05/letter-ipab-repeal-05062015.pdf.
29. American Hospital Association (AHA), "AHA Voices Support for IPAB Repeal Bill," *AHA News*, March 6, 2015.
30. Letter from Jo Ann C. Jenkins, CEO of AARP, to Congress, December 28, 2016, http://www.aarp.org/content/dam/aarp/politics/advocacy/2016/12/health-care-letter-final-letterhead-house-december-2016-aarp.pdf.

David Roe of Tennessee to repeal IPAB had 235 cosponsors from both sides of the aisle.[31] As it stands today, IPAB is a nugatory body, and in all likelihood it will remain that way for the foreseeable future.

Put another way, Congress and the former president have exercised a veto over IPAB that was embedded in the enacting legislation. Once empaneled, IPAB would gain wide discretion to alter the Medicare program, but the political branches possess the authority to empanel it in the first place. To date, they have decided not to, and there is no indication that they intend to revisit that judgment. The question is, why?

WINNERS AND LOSERS

Writing in the New Republic in 2011, Peter Orszag, former director of the Office of Management and Budget under the Obama administration and a key advocate for IPAB, bemoaned the excesses of democracy. "To solve the serious problems facing our country," Orszag wrote, "we need to minimize the harm from legislative inertia by relying more on automatic policies and depoliticized commissions for certain policy decisions. In other words, radical as it sounds, we need to counter the gridlock of our political institutions by making them a bit less democratic."[32]

Orszag's skepticism of democracy is hardly new. Speaking to the Constitutional Convention some 224 years earlier, Alexander Hamilton praised the "proper adjustment" the British Constitution offered to the republican principle of majority rule. The House of Commons was balanced by the House of Lords and a hereditary monarch, whose interests were "so interwoven with that of the nation" that he could "answer the purpose of the institution."[33] A century later, Wilson bemoaned the absence of a central authority in America's democratic institutions that could promote "the common consciousness, the common interests, the common standards of conduct, [and] the habit of concerted action."[34]

Orszag's criticism of democracy is of a piece with these considerations, and IPAB reflects this orientation. As noted previously, one of the main conceits of IPAB is that experts have the capacity to identify inefficiencies in the Medicare

31. See Protecting Seniors' Access to Medicare Act of 2015, H. R. 1190, 114th Cong. (2015).
32. Peter Orszag, "Too Much of a Good Thing," *New Republic*, September 14, 2011.
33. Alexander Hamilton, "James Madison's Version of Speech of 18 June 1787," in *The Papers of Alexander Hamilton*, ed. Harold C. Syrett, vol. 4, *January 1787–May 1788* (New York: Columbia University Press, 1962).
34. Woodrow Wilson, *Constitutional Government in the United States* (New York: Columbia University Press, 1908), 46.

system, thus reining in costs without diminishing the quality or availability of care. The idea is that, as IPAB identifies wasteful spending in the system, it alters reimbursement rates to incentivize providers to adhere to best practices. Put simply, IPAB takes the politics out of the equation, tasks the experts with finding solutions, and privileges their final assessments.

Of course, the other delegates to the Constitutional Convention were quite dubious of Hamilton's faith in the elites. They listened politely to his presentation, then set most of his ideas aside. By the same token, Orszag places too much faith in the capacity of experts to leverage their knowledge to reform policy problems. The assumption that "the correct" mix of healthcare utilization can be calculated by a panel of experts is highly dubious. As F. A. Hayek argued in his 1974 Nobel lecture, the experts simply do not know *enough* to accomplish such a heady task:

> To act on the belief that we possess the knowledge and the power which enable us to shape the processes of society entirely to our liking, knowledge which in fact we do *not* possess, is likely to make us do much harm. . . . [I]n the social field the erroneous belief that the exercise of some power would have beneficial consequences is likely to lead to a new power to coerce other men being conferred on some authority. Even if such power is not in itself bad, its exercise is likely to impede the functioning of those spontaneous ordering forces by which, without understanding them, man is in fact so largely assisted in the pursuit of his aims.[35]

Although the expertise of doctors, hospitals, insurers, senior advocacy groups, and so on is no doubt necessary to

"The assumption that 'the correct' mix of healthcare utilization can be calculated by a panel of experts is highly dubious. As F. A. Hayek argued in his 1974 Nobel lecture, the experts simply do not know *enough* to accomplish such a heady task."

35. Friedrich Von Hayek, "The Pretense of Knowledge" (lecture to the memory of Alfred Nobel, Stockholm, December 11, 1974).

formulating an efficient and effective Medicare system, it is hardly sufficient. The science of human interactions rarely provides the uncontestable certainty that the ACA implicitly assumes that IPAB will offer.

To appreciate this point, consider the controversy that resulted when the Preventive Services Task Force released new guidance on mammograms in the fall of 2009. The updated recommendations advised against routine screening before the age of 50 and advised that such regular screens end at the age of 74. In response to widespread pushback against the changes, Health and Human Services Secretary Kathleen Sebelius assured the public, "The U.S. Preventive Services Task Force is an outside independent panel of doctors and scientists who make recommendations. They do not set federal policy and they don't determine what services are covered by the federal government."[36]

The Preventive Services Task Force is not IPAB, but the logic behind IPAB's decisions on inefficiency and ineffective treatments, once released, may be perceived similarly to the recommendations of the task force. Without full consensus, decisions are likely to be second-guessed by providers or by other interests who lose out. Could the 15 individuals of an empaneled IPAB fully represent the broad range of interests such decisions will affect, and could they generate a consensus around strategies that will yield the necessary savings? That is doubtful, at best. And yet IPAB's decisions will go forward automatically unless Congress can propose an equal set of savings within the short time frame. In other words, IPAB is likely to create a set of winners and losers with its policy determinations.

From this perspective, IPAB looks quite different from BRAC. The purpose of BRAC was to realize the collective interest of Congress to streamline the use of military bases, over and above the interests of a minority of legislators whose particular districts would lose out. If IPAB cannot generate a true consensus on best practices, and is thus creating losers throughout the medical services industry, those losers will be geographically diffused across the country. Therefore, all members of Congress will feel an incentive to oppose IPAB—the very same incentive that has, so far, stymied the efforts of the political branches to get Medicare spending under control: the benefits of cost containment are years away and diffused, whereas the burdens are up front and discrete.

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36. Quoted in Kate Phillips, "Sebelius on Mammograms: Don't Change What You're Doing," Prescriptions, *New York Times*, November 18, 2009. In fact, as a result of the debate surrounding the ACA, additional restrictions on such limitations were included in the legislation. This controversy is an example of how "expertise" may be questioned in the public sphere when policies are made to serve all preferences simultaneously.

Although delegation has often been a useful strategy for Congress, it is not a panacea. It works by reducing the transaction costs of governance, rearranging the nature of legislative interactions to maximize benefits across all members of the legislature.[37] It cannot reorganize legislative preferences that existed before the interactions, which is a major reason why IPAB has been unsuccessful to date.

THE IDEOLOGICAL BIAS OF IPAB

Of course, some legislators may be animated principally by concern for the public good, or at least they may not be so sensitive to political concerns. As James Madison argues in Federalist No. 55, "As there is a degree of depravity in mankind which requires a certain degree of circumspection and distrust, so there are other qualities in human nature which justify a certain portion of esteem and confidence. Republican government presupposes the existence of these qualities in a higher degree than any other form."[38] There are some reasons for optimism in the case of Medicare. After all, most members come from safe congressional districts, where they need not fear a stiff challenge from the other party. Most members also have children and grandchildren and can appreciate the looming danger even if their forebears do not yet. Perhaps they may be inclined to act on behalf of the national interest, rightly understood, by supporting IPAB. But so far that has not been the case. And that brings us to our last argument: that the politics of IPAB do not lend themselves to the more universal political support needed to carry out its goals.

It is not simply that IPAB faces a collective action problem. It is rather that IPAB embodies a particular conception of the public good, and a highly partisan one at that. The task of IPAB is to alter reimbursement rates to limit per capita spending growth in Medicare in a target year. If successful, this would have the effect of propping up the traditional fee-for-service model of Medicare—which is a Democratic policy goal but not a Republican one. Insofar as congressional Republicans have expressed interest in reforming Medicare, it is usually in the more fundamental way advocated by House Speaker Paul Ryan, which would transform the program from the provision of guaranteed benefits into a defined contribution from the government.[39] Not only is IPAB expressly prohibited from

37. Epstein and O'Halloran, *Delegating Powers*.
38. James Madison, *Federalist* No. 55, in *The Papers of James Madison*, vol. 10, ed. Robert A. Rutland et al., *27 May 1787–3 March 1788* (Chicago: University of Chicago Press, 1977), 504–8.
39. Office of the Speaker, "A Better Way."

considering such reforms, its mandate is to make yearly tweaks to reimbursement rates such that structural reforms would be redundant, at least from a budgetary standpoint.

Thus, while IPAB is nominally supposed to be above politics—consisting as it does of a board of disinterested experts chosen in consultation between the parties—it is in fact deeply political. By its very design, it seeks to circumvent the debate between the two parties over the future of the Medicare program. This quality is reminiscent of the critique of the pluralist model of democracy proffered by E. E. Schattschneider in *The Semisovereign People*:

> Political conflict is not like an intercollegiate debate in which the opponents agree in advance on a definition of the issues. As a matter of fact, *the definition of the alternatives is the supreme instrument of power*; the antagonists can rarely agree on what the issues are because power is involved in the definition. He who determines what politics is about runs the country, because the definition of alternatives is the choice of conflicts, and the choice of conflicts allocates power.[40]

So it goes with IPAB. By its very rules, IPAB favors the Democratic vision for the future of Medicare and disfavors the Republican vision. Thus, Republican legislators who are genuinely interested in shoring up Medicare for future generations—despite the lack of immediate political benefits from such an endeavor—will disdain IPAB.

All told, this impasse leaves IPAB with a very small band of advocates in the halls of power. Members of both parties who are anxious about their reelection (or, relatedly, desire a path to future, better offices) will be wary of IPAB, as it harms a powerful political constituency without rewarding a similarly situated group. And Republicans who genuinely want to address the nation's fiscal problems will be disinclined to support IPAB because its design empowers an ideology contrary to their own. That leaves public-spirited Democrats as the only group in Congress who might support IPAB. This group held enough sway to design the board through the ACA in 2010, but it has proved itself to be inadequate to breathe life into IPAB ever since.

Given the power that IPAB will possess once it has been empaneled, the main opportunity that legislators opposed to IPAB have to stop it is by refusing to staff it, which is exactly what has happened. Neither President Obama nor

40. E. E. Schattschneider, *The Semisovereign People: A Realist's View of Democracy in America* (Hinsdale, IL: Dryden Press, 1975), 66.

President Trump has nominated members to it; Senate Republicans have vowed to stop any such nominees anyway; and a bipartisan coalition in the House has sponsored legislation to dismantle it. IPAB has failed, and in all likelihood will continue to fail, because it is a flawed institutional solution to the problems surrounding Medicare.

CONCLUSION

Although there is little doubt that Congress has struggled to secure the long-term solvency of Medicare in the face of interest group pressure, IPAB is a deeply flawed solution to the problem for two reasons. First, it is unlikely that the expert members of IPAB will be able to produce consensus-based decisions regarding cutting Medicare costs, a scenario that will create diffuse winners and losers, thus reinforcing the original collective action dilemma that prompted the creation of IPAB in the first place. Second, the ideological biases inherent in IPAB undermine its ability to act as a neutral arbiter on Medicare, presenting incentives for conservative Republicans in Congress to thwart the board when and as they can.

To date, policymakers have not had to face these conflicts, as no members have been appointed to the board, nor have IPAB limits been triggered. It would seem that now is the perfect time to correct this aspect of the ACA. So it is surprising that the Republicans who opposed IPAB from the beginning have not taken the opportunity provided by their unified government control to permanently eliminate this controversial budget-control mechanism. Republicans did not include IPAB repeal in the failed American Health Care Act.

Perhaps they no longer worry about the largely neutered board. In 2013 and 2015, House Republican leadership successfully passed House rules to substitute for the rules of debate outlined in the ACA IPAB language. The House parliamentarian ruled that the provisions of IPAB had no special standing over other procedural rules. Thus, as with any other House procedural rule, IPAB restrictions were open to be overridden by simple majority vote in any given Congress. If IPAB limits were triggered, the rule would allow House members to consider spending levels above those set out in IPAB. That parliamentarian decision may well shape the case for action within Congress, but such decisions do not extend to the IPAB, Health and Human Services (HHS), or the Medicare actuaries who are charged with putting forward Medicare estimates and recommended savings. With the antagonism expressed by Republicans toward IPAB, it is unlikely that President Trump will appoint members to IPAB or that any

appointments would be confirmed by the Senate. In this case, the authority of IPAB falls to the secretary of HHS, a position presently filled by Acting Secretary Don White.[41] Former Secretary Price was a strong opponent of the expert bureaucratic approach central to IPAB design:

> Patients, families, and doctors should make medical decisions, not Washington, DC. The Independent Payment Advisory Board is a direct threat to quality, innovative and responsive health care for America's seniors. This board of unelected, unaccountable bureaucrats has the power to deny care to seniors by deciding unilaterally what care will be paid for. Repealing IPAB will help protect the patient-doctor relationship for Medicare beneficiaries. It is part of what must be a broader effort to focus attention on solutions that put patients first. When bureaucrats choose, patients lose.[42]

While too early to know, it is possible that Acting Secretary White, a bureaucrat for the past 14 years (10 at HHS), is more supportive of bureaucratic approaches such as IPAB than Price. Regardless, it is likely he will be tested soon.

The demographic trend in Medicare, coupled with the changing limits built into the ACA after 2017, suggests that IPAB triggers will soon require action from either an empaneled IPAB or the secretary. When savings decisions move forward from IPAB or the HHS secretary, it will be interesting to see whether the House majority's interpretation of the rules stands up. Assuming the interpretation remains, the courts will likely be called on to rule whether the resulting power shift is even constitutional.[43] Until then, IPAB remaining on the books stands as one more step in the long erosion of congressional authority and accountability.

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41. President Trump appointed Don White to fill the role on September 29, when Thomas Price was forced to resign in the wake of a scandal involving excessive travel spending.

42. Quoted in Steven Ertelt, "Senate Confirms Pro-life Rep. Tom Price as HHS Secretary Despite Planned Parenthood's Objections," *LifeNews*, February 10, 2017.

43. On March 30, 2015, the Supreme Court refused to hear an appeal of the lower court dismissal of *Coons v. Lew*, a lawsuit challenging the constitutionality of IPAB and the ACA more generally. The lower courts had ruled that the decision was not ripe for challenge because IPAB had not made any decisions yet. See Timothy Jost, "Implementing Health Reform: Medicaid & CHIP Enrollment; Tax Forms; and SEP (March 30 Update, IPAB Challenge Dismissal)," *Health Affairs*, March 22, 2015.

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