incorporate quality and value metrics into the Medicare reimbursement system.

From yet another quarter have come complaints that current payment methods penalize efficient providers for offering high-value care and that more pilots and demonstrations, administered by the new CMS innovation center, represent unaffordable temporizing. In particular, some of the multispecialty group practices that have been held up as prototypes of the organizations that new payment models should encourage, including Mayo Clinic and Cleveland Clinic, have expressed frustration with the current volume-based payment approaches for hospitals and physicians. Although some consider the volume-generating incentives of current payment systems so perverse that they would not spend much time correcting existing mispriced values, these payment systems will probably be with us for some time. Moreover, some of the new payment approaches being promoted — for example, bundled payment for an episode of care — will probably build on the current prices. And it is unlikely that highly compensated physician specialties that are thriving under the fee-for-service system will voluntarily participate in the envisioned accountable care organizations that require multispecialty cooperation. Paradoxically, it will be necessary to correct mispricing and other flaws in existing fee-for-service payment systems in order to ultimately dismantle them.

Finally, there was hope that Congress would end the saga of the sustainable growth rate (SGR), the formula used to calculate Medicare's physician-fee updates, which has been consistently overridden and should now produce immediate 21% fee cuts to physicians, another 6% next January, and a few percent more after that. The House initially attempted to settle the SGR problem by taking all the past fictional savings off the budget books, but since a real fix would have added more than $200 billion to the cost of reform, the provision disappeared when President Obama limited the legislation's cost to $1 trillion. The SGR can continues to be kicked down the road. It seems that the more things change, the more they stay the same.

Dr. Berenson is vice-chair of the Medicare Payment Advisory Commission (MedPAC); the views expressed in this article represent his personal views and not necessarily those of MedPAC.

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The Independent Payment Advisory Board

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A common theme in the health care reform debate in recent years has been the need for a board of impartial experts to oversee the health care system. Market forces alone, it is argued, cannot control health care costs, and Congress is too driven by special-interest politics and too limited in expertise and vision to control costs.

Provisions of the Patient Protection and Affordable Care Act (now being referred to as the Affordable Care Act, or ACA) create an Independent Payment Advisory Board (IPAB) to meet the need to oversee health care system costs.[1] The legislation establishes specific target growth rates for Medicare and charges the IPAB with ensuring that Medicare expenditures stay within these limits. The IPAB must also make recommendations to Congress as to how to control health care costs more generally.

The IPAB will have 15 members appointed by the President for 6-year terms, supplemented by 3 officials representing the Department of Health and Human Services (DHHS). IPAB members are supposed to be nationally recognized experts in health finance, payment, economics, actuarial science, or health facility and health plan management and to represent providers, consumers, and payers. Service on the IPAB is a full-time job. Members will be compensated at a rate equal to the annual rate prescribed for level III of the executive schedule (for highly ranked appointed positions in the government's executive branch), which is currently $165,300.[2]

The board is charged with developing specific detailed proposals to reduce per capita Medicare spending in years when spending is expected to exceed target levels, beginning with 2015. The DHHS must implement these proposals unless Congress adopts equally effective alternatives. The board is also charged with submitting to Congress annual detailed reports on health care costs, access, quality, and utilization. Finally, the IPAB must submit to Congress recommendations regarding ways of slowing the growth in private national health care expenditures.

Each year, beginning April 30, 2013, the chief actuary of the Centers for Medicare and Medicaid Services (CMS) will make a determination as to whether the projected average Medicare growth rate for the 5-year period ending 2 years later will exceed the target growth rate for the year ending that period. For years before 2018, the target growth rate is the projected 5-year average of the mean of the Consumer Price Index (CPI) and the medical care CPI; for 2018 and later years, the target is the nominal per capita growth rate of the gross domestic product plus 1 percentage point. If the CMS actuary determines for any given year that the projected Medicare growth rate will exceed the target rate, the board must make proposals that would reduce Medicare spending overall by either a percentage set in the statute (1.5% after 2017) or the projected excess, whichever is less.

The effects of the IPAB's proposals, however, may not be to "ration health care," raise costs to beneficiaries, restrict benefits, or modify eligibility criteria. Proposals may not, before 2020, target the rates of particular providers — primarily hospitals and hospices — that are already singled out by the ACA for extraordinary cuts. The board is not prohibited from cutting payments for physicians, but its powers may be limited if a permanent fix for the sustainable growth rate — the formula that determines increases or decreases in Medicare's physician payments — is passed.

Each September 1, the IPAB must submit a draft proposal to the secretary of health and human services. On January 15 of the following year (beginning with 2014), the board must submit a proposal to Congress. If the board fails to submit a proposal on deadline, the DHHS must itself submit a proposal. Congress must consider the proposal under an expedited procedure. Congress cannot consider any amendment to the proposal that does not meet the same cost-reduction goals, unless both houses of Congress (and three fifths of the Senate) vote to waive this requirement. If Congress fails to adopt a substitute provision complying with the statute by August 15, the DHHS must implement the board's proposal.

The ACA appropriates $15 million for the IPAB for 2012 and increases its funding at the rate of inflation for subsequent years. This standing appropriation may relieve some of the political pressure on the IPAB, but it may well prove too little to fund the complex research and data analysis that the board must conduct to design implementation-ready proposals.

The Congressional Budget Office concluded in its analysis of the ACA that the IPAB would reduce Medicare spending by $28 billion over the period from 2010 to 2019, with significant savings continuing beyond 2019.[3] In his report, however, the CMS actuary questioned whether this goal was achievable, noting that IPAB target growth rates would have been met in only 4 of the past 25 years and would have approximated the sustainable growth rate, the formula for updating Medicare's physician fees, which Congress has routinely overridden.[4] 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.

Many questions remain about how, and indeed whether, the IPAB will work. Staffing the board with 15 leading experts who are willing to give up research, practice, and teaching for 6 years for a relatively modest salary will be a challenge. The relationships between the IPAB and other boards and commissions, such as the

Medicare Payment Advisory Commission and the Center for Medicare and Medicaid Innovation created by the ACA, will need to be negotiated. 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 could strengthen both.

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, or perhaps even in consumer incentives. 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. But the necessity of making year-to-year cuts will probably focus the IPAB's attention on short-term cuts in Medicare Advantage plans, which are already slated for deep cuts under the ACA, or on prescription drug prices.

The IPAB's success will also depend on Congress's reactions to its recommendations. A three-fifths Senate vote will be needed to override payment cuts, but Congress could increase Medicare funding through independent legislation. The fact that legislators regularly evade the sustainable growth rate has been cited as proof that Congress cannot cut Medicare costs. 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.[5] And our current fiscal crisis may sharpen lawmakers' resolve to cut spending.

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. And the IPAB can make only nonbinding recommendations to Congress regarding private payments. In the long run, Congress may not be able to cap Medicare expenditures without addressing private expenditures as well. If the IPAB opens the door to rate setting for all payers, it may well be the most revolutionary innovation of the ACA.

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Identifying and Eliminating the Roadblocks to Comparative-Effectiveness Research

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Patient-advocacy and health policy groups have hailed comparative-effectiveness research (CER) as a means of reducing health care costs without compromising the quality of care. The federal commitment of $1.1 billion under the American Recovery and Reinvestment Act (ARRA) ensures that the scientific community will undertake considerable amounts of such research. Yet major federal policy changes and innovative measures were required before one CER study, "Comparison of Age-Related Macular Degeneration [AMD] Treatments Trials (CATT)," could even be launched. Our experience with CATT highlights important roadblocks and dramatic changes needed in federal infrastructure for CER to be conducted efficiently.

In July 2005, clinical trial results established the efficacy of ranibizumab (Lucentis) for the