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The Independent Payment Advisory Board (IPAB): Frequently Asked Questions

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Summary

This report responds to frequently asked questions about the Independent Payment Advisory Board (IPAB), including the board's background, current status, controversial issues including legal challenges, and recent legislative efforts to repeal the IPAB.

For additional information, see CRS Report R41511, *The Independent Payment Advisory Board*, by Jim Hahn and Christopher M. Davis.

Contents

Frequently Asked Questions 1
What Is the Independent Payment Advisory Board? 1
Why Was the IPAB Created? 1
Why Is the IPAB Controversial? 2
What Triggers IPAB Action? 2
Who Are the Members of the IPAB, and How Are They Appointed? 3
Why Hasn't the IPAB Been Constituted? Why Haven't Any Members Been Appointed? 3
The 2015 and 2016 CMS Actuary Determinations Projected That IPAB Activity Would Be Triggered First in 2017, but the 2017 Determination Indicates That 2021 Will Be the First Year. What Changed? 4
What Are the Fast-Track Procedures That IPAB Legislation Would Receive in Congress? 6
What Are the Fast-Track Procedures for Legislation Discontinuing IPAB? 7
What Internal Congressional Rules Have Been Adopted Addressing the IPAB? 8
Are the House and Senate Required to Follow the Fast-Track Procedures in the Act? 9
What Restrictions Did the ACA Place on Congressional Consideration of IPAB Legislation? 9
What If the IPAB Fails to Submit a Required Proposal? 9
What Legal Challenges Have Been Raised Regarding the IPAB, and What Is the Status of the Lawsuits? 10
What Legislative Activity Related to the IPAB Has There Been? 10
How Has CBO Scored IPAB-Related Bills? 13

Figures

Figure 1. Rates of Growth for IPAB Determination 5

Tables

Table 1. Calculating the Medicare Per Capita and IPAB Target Growth Rates 6
Table 2. Summary of IPAB-Related Bills 11

Contacts

Author Information 14
Acknowledgments 14

Frequently Asked Questions

What Is the Independent Payment Advisory Board?

Established as part of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), the Independent Payment Advisory Board (IPAB) is charged with developing proposals to "reduce the per capita rate of growth in Medicare spending."[1] The board's proposals are to be implemented by the Secretary of Health and Human Services (the Secretary) unless Congress acts either by formulating its own proposal to achieve the same savings or by discontinuing the automatic implementation process defined in the statute.

Why Was the IPAB Created?

Historic patterns of growth in overall health care spending, and in the Medicare program in particular, are viewed as not being sustainable. As the 2017 Medicare Trustees report recently noted, Medicare faces "a substantial financial shortfall that will need to be addressed with further legislation. Such legislation should be enacted sooner rather than later to minimize the impact on beneficiaries, providers, and taxpayers."[2] Several proposals have been advanced over the years to create an independent policymaking entity that would (1) be charged with limiting the future growth in Medicare expenditures; (2) be insulated from special interests and lobbyists because its members would be appointed, rather than elected; and (3) be comprised of officials who would serve for extended terms. Such officials were envisioned to be able to make "hard decisions" to control rising costs. Moreover, it has been assumed that these officials would possess the specialized expertise needed to make operational decisions regarding payments and focus initiatives on beneficiary interests and the longer-term financial viability of the program. Prior proposals for similar entities include the following:

- In 2000 and 2001, Senators Breaux and Frist introduced reform proposals to increase the budget of the Centers for Medicare and Medicaid Services (CMS), create separate agencies to administer parts of the Medicare program, and establish a Medicare board to manage competition among private plans and traditional Medicare (referred to as "Breaux-Frist I," S. 1895, and "Breaux-Frist II," S. 358).
- In 2008, Senator Daschle proposed the Federal Health Board, modeled after the Federal Reserve Board, with broad authority over both private and public health care programs, including benefit and coverage recommendations, regulation of private insurance markets, and improvements in quality of care.[3]
- In July 2009, then-President Obama submitted a draft proposal to Congress titled the Independent Medicare Advisory Council Act of 2009 (referred to as the IMAC proposal), that would have established a five-member council to advise the President on Medicare payment rates for certain providers. While the council

[1] Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), §3403(b).

[2] *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf, pp. 3-4. (Hereinafter the 2017 Medicare Trustees' Report.)

[3] Tom Daschle, Scott S. Greenberger, and Jeanne M. Lambrew, *Critical: What Can We Do About the Health-care Crisis* (St. Martin's Press, 2008).

would have had authority to recommend broader policy reforms, its authority outside of Medicare payment policy would have been limited.

The stated goal of the IPAB, as specified in the enabling statute, is to reduce the per capita growth in Medicare expenditures. The IPAB would achieve this goal by developing proposals for the Secretary to implement that reduce the growth in Medicare expenditures.

By statute, the IPAB's proposals must (1) relate only to the Medicare program; (2) result in a net reduction in total Medicare program expenditures at least equal to the savings target established by the Chief Actuary of CMS [to reduce the expenditure per capita growth rate]; (3) not include any recommendation to ration care, raise revenues or Medicare beneficiary premiums, increase cost sharing, restrict benefits, or alter eligibility; (4) not reduce payments to providers or suppliers scheduled to receive a reduction in payment as the result of certain productivity adjustments under ACA Section 3401;[4] (5) include recommendations to reduce Medicare payments under Parts C and/or D; and (6) include recommendations with respect to administrative funding for the Secretary to carry out the board's recommendations. The IPAB's proposals would receive special status, as described below, including "fast-track" procedures for congressional consideration.

The Congressional Budget Office (CBO), in its cost estimate of the ACA prior to passage, projected that the cumulative impact of the board's recommendations from 2015 through 2019 would reduce total spending by $15.5 billion; during the same period, total Medicare expenditures were projected to be $3.9 trillion with average spending per beneficiary increasing from $13,374 in 2015 to $15,749 in 2019. These savings represent a reduction of about $60.00 per year per Medicare beneficiary over the 2015 through 2019 period.

Why Is the IPAB Controversial?

Since the ACA was enacted (and the IPAB authorized), there have been several challenges to the mission, authority, and constitutionality of the IPAB. In particular, critics have noted the special procedures that IPAB bills would receive and the board's ability and powers to affect federal health care programs specifically and the health care sector more broadly. Each of these concerns is addressed in the questions below.

What Triggers IPAB Action?

Section 1899A of the Social Security Act (SSA) requires the Chief Actuary of CMS to determine by April 30, 2013, and annually thereafter, whether the projected five-year average growth in per capita Medicare program spending exceeds a specified target. Such a determination would trigger a series of actions. For determination years through 2017, the target is equal to the average of the projected five-year average growth in the Consumer Price Index for All Urban Consumers (all categories; United States city average, or CPI-U) and the medical care expenditure category of the CPI-U. Beginning in 2018 and in subsequent years, the target growth rate will be the projected five-year average percentage increase in the nominal gross domestic product per capita plus one percentage point (GDP+1%). The five years to be used for a given determination year consist of the two prior years, the current year, and the two following years; thus, the growth rates used in the determination will include both actual and projected rates.

[4] See Appendix C in CRS Report R41511, *The Independent Payment Advisory Board*, by Jim Hahn and Christopher M. Davis.

If the Chief Actuary finds that the growth rate does not exceed the targeted growth rate, the process for the year ends. If the Chief Actuary determines that the growth rate exceeds the target growth rate for any determination year, the Chief Actuary is required to establish an applicable savings target for the implementation year, two years following the determination year.[5]

Who Are the Members of the IPAB, and How Are They Appointed?

The board is to be composed of 15 members appointed by the President with the advice and consent of the Senate for up to two consecutive six-year terms.[6] As such, the members would be officers of the United States under the appointments clause of the U.S. Constitution.[7] The Secretary, the Administrator of CMS, and the Administrator of the Health Resources and Services Administration (HRSA) would be ex-officio nonvoting members. In selecting individuals for nomination, the President is to consult with the majority and minority leadership of the Senate and House of Representatives—each respectively, regarding the appointment of three members. The chairperson is to be appointed by the President, with the advice and consent of the Senate, from among the members of the board.

The appointed members of the board are to represent varied professional and geographic backgrounds and possess recognized expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, and reimbursement of health facilities. The members are to be drawn from a wide range of backgrounds, including but not limited to

- physicians (allopathic and osteopathic) and other health professionals, providers of health services, and related fields;
- experts in the area of pharmaco-economics or prescription drug benefit programs;
- employers;
- third-party payers; and
- individuals skilled in the conduct and interpretation of biomedical health services and health economics research who have expertise in outcomes and effectiveness research and technology assessment.

Board members are to include representatives of consumers and the elderly. A majority of the appointed members cannot be individuals directly involved in the provision or management of the delivery of Medicare items and services. The appointments would be for full-time service and members would be compensated at Executive Schedule rates.

Why Hasn't the IPAB Been Constituted? Why Haven't Any Members Been Appointed?

In brief, the IPAB has yet to be constituted and no members have been nominated (let alone confirmed) because the conditions that would trigger IPAB activity have yet to be met. The CMS

[5] For details, see CRS Report R41511, *The Independent Payment Advisory Board*, by Jim Hahn and Christopher M. Davis.

[6] See ACA §3403(g)(1).

[7] See Department of Justice Memorandum entitled "Officers Of The United States Within The Meaning Of The Appointments Clause" for a discussion of why board members can exercise the authority delegated to them under the statute, at http://www.justice.gov/olc/2007/appointmentsclausev10.pdf.

Chief Actuary's IPAB determination website details the calculations that compare the projected five-year average growth in per capita Medicare program spending to the IPAB target.[8] The CMS Chief Actuary's 2017 IPAB determination states that "[b]ecause the projected 5-year Medicare per capita growth rate does not exceed the Medicare per capita target growth rate, there is no applicable savings target for implementation year 2019 (determination year 2017)."[9] This result is a change from the 2016 and 2015 Medicare Trustees reports, which each projected that the Medicare spending per capita growth rate would exceed the per capita target growth rate in 2017.[10]

The 2015 and 2016 CMS Actuary Determinations Projected That IPAB Activity Would Be Triggered First in 2017, but the 2017 Determination Indicates That 2021 Will Be the First Year. What Changed?

The underlying data used in the 2017 IPAB determination show that the five-year average growth rate in Medicare per capita expenditures was lower than in the 2016 IPAB determination, whereas the target growth rate (based on the CPI-U) was higher than in the 2016 determination. This caused a divergence of the two trends (see **Figure 1**). The first year of the IPAB activation is no longer 2017 but is now 2021, according to the latest IPAB determination.[11]

[8] Centers for Medicare & Medicaid Services (CMS), "IPAB Determination," at http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/IPAB-Determination.html.

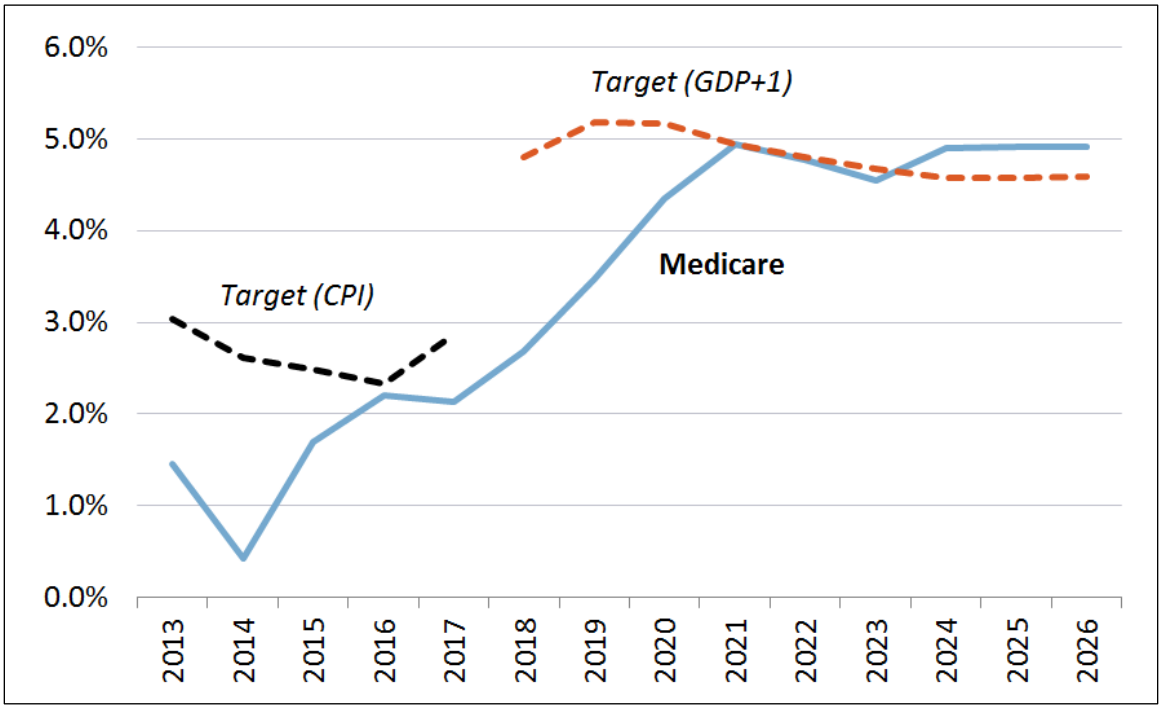
[9] CMS, "IPAB Determination," at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/IPAB-2017-07-13.pdf.

[10] The 2015 Medicare Trustees' Report made the initial determination, and the 2016 report contained the same projection. For details, see Table V.B2 on p. 182 of the 2016 Medicare Trustees' Report at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf.

[11] The 2015 and 2016 Medicare Trustees' Reports both included the CMS Chief Actuary's determination that the projected Medicare spending per capita growth rate would exceed the per capita target growth rate in 2017, but would flip in the subsequent four years, with the projected Medicare per capita growth rate being lower than the target growth rate from 2019-2021. The projections were that the trigger would then be reactivated in 2022 but not in 2023, to be followed by another reversal in 2024 and 2025 (the last year of the projections included in the report), when the Medicare growth rate would again exceed the target.

Figure 1. Rates of Growth for IPAB Determination

(comparison of target rates using separate methodologies to project growth in Medicare per capita spending)



Source: CRS figure based on data from Table V.B2, CMS, *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 13, 2017.

Notes: By law, the methodology for calculating the Medicare per capita target growth rate changes from the average of the projected five-year average growth rates in the Consumer Price Index for All Urban Consumers (CPI-U) and the medical care expenditure category of the CPI-U for determination years through 2017 to the projected five-year average percentage increase in the nominal per capita gross domestic product plus 1% (GDP+1%) in 2018 and in subsequent determination years.

As seen in **Table 1**, the actual 2016 Medicare per capita growth rate (1.11%) was less than two-thirds the value of the 2016 determination projected rate (1.79%), whereas the 2017 determination projections for the 2017 (0.44%) and 2018 (1.51%) values are each lower than the 2016 determination projections (1.10% for 2017 and 4.32% for 2018). For the CPI-U and medical CPI-U growth figures, three out of the four overlapping years (out of the five-year moving averages) show higher values in the 2017 determination compared with the 2016 determination. These differences combined to lower the five-year average Medicare per capita growth rate while raising the CPI-U-based IPAB target growth rate, switching the comparison for 2017 from positive in the 2016 determination (Medicare per capita growth rate greater than IPAB target growth rate) to negative in the 2017 determination.

Table 1. Calculating the Medicare Per Capita and IPAB Target Growth Rates

(comparison of 2016 and 2017 actual and projected values)

	Medicare per Capita Growth (percentage)		CPI-U Growth (percentage)		Medical CPI-U Growth (percentage)	
Year	2016 Determination	2017 Determination	2016 Determination	2017 Determination	2016 Determination	2017 Determination
2014	1.84		1.62		2.39	
2015	2.04	2.03	0.04	0.12	2.21	2.63
2016	1.79	1.11	0.86	1.24	2.04	3.94
2017	1.10	0.44	2.79	2.20	4.43	4.11
2018	4.32	1.51	2.68	3.01	4.34	4.62
2019		5.72		2.65		4.26

Source: CMS Chief Actuary IPAB Determination, June 22, 2016, and July 13, 2017, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/IPAB-Determination.html.

Note: The Medicare per capita and IPAB target growth rates are computed as five-year moving averages.

The projected future IPAB determinations can be seen in **Figure 1**. Although the projected Medicare spending per capita growth rate continues to increase from 2017 to 2021, the delay in the first year in which IPAB activity would be required until 2021 is largely a result of changes in the methodology for determining the conditions that trigger IPAB activity, as specified in statute.[12] By law, the methodology for calculating the Medicare per capita target growth rate changes from the five-year moving average of the CPI-U and the medical care expenditure category of the CPI-U for determination years through 2017 to the five-year moving average per capita gross domestic product plus 1% (GDP+1%) in 2018 and in subsequent determination years. (See "What Triggers IPAB Action?" for more information.) **Figure 1** shows that the two target trend lines follow different trajectories.

What Are the Fast-Track Procedures That IPAB Legislation Would Receive in Congress?

The ACA establishes two sets of parliamentary procedures.[13] The first set of procedures governs congressional consideration of IPAB implementing legislation. The act establishes a second set of fast-track procedures (discussed in detail in "What Are the Fast-Track Procedures for Legislation Discontinuing IPAB?," below) governing the consideration in 2017 of a joint resolution discontinuing the automatic IPAB implementation process.

The ACA requires the board (and, in cases in which the board does not act, the Secretary) to submit its proposal to both Congress and the President. The proposal is to be accompanied by, among other things, implementing legislation. The Secretary is required to automatically implement the proposals contained in the IPAB legislation on August 15 of the year such a proposal is submitted, unless

[12] SSA §1899A(c)(6)(C).

[13] Some of the procedures refer to specific dates as to when certain actions may be initiated. These dates do not change.

- prior to that date, legislation is enacted that includes the statement, "This Act supersedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act,"[14] or
- in 2017, a joint resolution discontinuing the automatic IPAB implementation process has been enacted.[15]

The act establishes special fast-track parliamentary procedures governing House and Senate committee consideration, and Senate floor consideration, of legislation implementing the board's or Secretary's proposal. These procedures differ from the parliamentary mechanisms the chambers usually use to consider most legislation, and they are designed to ensure that Congress can act promptly on the implementing legislation should it choose to do so. The ACA-established procedures accomplish this goal by mandating the immediate introduction of the legislation in Congress and by establishing strict deadlines for committee and Senate floor consideration, as well as by placing certain limits on the amending process. The procedures established by the act permit Congress to amend the IPAB-implementing legislation, but only in a manner that achieves at least the same level of targeted reductions in Medicare spending growth as is contained in the IPAB plan. The act bars Congress from changing the IPAB fiscal targets in any other legislation it considers as well, and it establishes procedures whereby a supermajority vote is required in the Senate to waive this requirement. In addition, the act's procedures include expedited mechanisms that are intended to facilitate the exchange of implementing legislation between the House and Senate. Finally, the procedures also expedite Senate consideration of a veto message on IPAB implementing legislation, which otherwise would be subject to extended debate.

What Are the Fast-Track Procedures for Legislation Discontinuing IPAB?

As noted above, the ACA established a second fast-track parliamentary mechanism for consideration of legislation discontinuing the automatic implementation process for the recommendations of the IPAB.

Under the terms of the act, to qualify for consideration under fast-track procedures, a joint resolution discontinuing the process must meet several conditions. The resolution must

- be introduced in the year 2017 by February 1, 2017.[16]
- not have a preamble.[17]
- have the title, "Joint resolution approving the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act."[18]

[14] ACA §1899(e)(3)(A)(i).

[15] Such a joint resolution and the procedures for its consideration are described in this report in "What Are the Fast-Track Procedures for Legislation Discontinuing IPAB?"

[16] See "What Legislative Activity Related to the IPAB Has There Been?"

[17] A preamble is a series of "whereas" clauses at the beginning of a measure describing the reasons for and intent of the legislation.

[18] ACA §1899(f)(1)(C).

- have the sole text, "That Congress approves the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act."[19]

Such a joint resolution may be introduced by any Member in either chamber. When introduced, the joint resolution is referred to the Committees on Ways and Means and on Energy and Commerce in the House, and to the Committee on Finance in the Senate.

In the Senate, if the Committee on Finance has not reported this joint resolution (or an identical joint resolution) by the end of 20 days of continuous session after its introduction, the committee may be discharged from its further consideration of the measure upon a petition signed by 30 Senators. A non-debatable motion to proceed is in order in the Senate and, if adopted, debate on the joint resolution is limited to 10 hours. The act does not establish any special procedures for House floor consideration of such a joint resolution.

As with the special procedures established for considering IPAB-implementing bills described above, the act also establishes "hookup" procedures to facilitate the consideration in one chamber of a joint resolution passed by the other. Such provisions are designed to ensure that the House and Senate act on the same legislation.

What Internal Congressional Rules Have Been Adopted Addressing the IPAB?

On the opening days of the 113th (January 3, 2013), 114th (January 6, 2015), and 115th (January 3, 2017) Congresses, the House of Representatives agreed to H.Res. 5, adopting the standing rules of the House for the 113th Congress (2013-2014), 114th Congress (2015-2016), and 115th Congress (2017-2018), respectively. Section 3 of H.Res. 5 included the following identical language in each Congress: "Independent Payment Advisory Board–Section 1899A(d) of the Social Security Act shall not apply in the One Hundred [Thirteenth/Fourteenth/Fifteenth] Congress."[20]

A section-by-section analysis of H.Res. 5 created by the House Committee on Rules and inserted in the *Congressional Record* in each case stated that the intent of the language contained in H.Res. 5 was to eliminate "provisions contained in the [Patient Protection and] Affordable Care Act that limit the ability of the House to determine the method of consideration for a recommendation from the Independent Payment Advisory Board or to repeal the provision in its entirety."[21]

As a result, the fast-track parliamentary procedures governing consideration of an IPAB proposal were not in force in the House of Representatives in the 113th or 114th Congresses, nor are they in force in the 115th Congress. The procedural rules still apply, however, in the Senate.

[19] ACA §1899(f)(1)(D). Those interested in submitting a disapproval resolution should consult with the House or Senate Parliamentarian to ensure that the joint resolution is drafted to comply with the terms of the statute and is privileged.

[20] Rules of the House, *Congressional Record*, daily edition, vol. 159, no. 1 (January 3, 2013), p. H7.

[21] Rules of the House, *Congressional Record*, daily edition, vol. 161, no. 1 (January 6, 2015), p. H13, and vol. 163, no. 1 (January 3, 2017), p. H9.

Are the House and Senate Required to Follow the Fast-Track Procedures in the Act?

The fast-track parliamentary procedures established by the ACA for the consideration of both types of IPAB legislation (an implementing bill and a joint resolution discontinuing the IPAB process) are considered to be rules of the respective houses of Congress even though they are in statute. As such, Congress traditionally has viewed them as subject to change in the same manner and to the same extent that any House or Senate rule can be altered by the Members of that chamber. In other words, Congress is not required to amend or repeal the ACA to change the internal congressional procedures these procedures contain. The House or Senate can change the procedures by unanimous consent, by suspension of the rules, or by special rule reported by the House Committee on Rules and adopted by the House. As noted above, the House has done precisely this in the current and prior two Congresses, adopting a resolution on the opening day of each of the Congresses taking the fast-track procedures out of force in the House.

What Restrictions Did the ACA Place on Congressional Consideration of IPAB Legislation?

As noted above, the special parliamentary procedures established by the ACA attempt to bar the House or Senate from considering any bill, resolution, amendment, or conference report pursuant to the special fast-track procedures contained in the act or by any other legislative mechanism that would repeal or change the recommendations of the IPAB if that change would fail to achieve the same targeted reductions in Medicare spending growth achieved by the IPAB proposal. In other words, the procedures propose to bar Congress from considering, in any legislation (not just the IPAB implementing bill), changes to the board's recommendations that fail to meet at least the same fiscal targets as those advanced by IPAB. Because the act establishes procedural rules related not just to congressional consideration of the IPAB implementing bill but also governing the consideration of other legislation as well, it differs from most expedited procedure statutes now in force.

The act attempts to entrench this limitation on congressional action by stating that the provision can be waived in the Senate only by an affirmative vote of three-fifths of Senators chosen and sworn (60 votes if there is no more than one vacancy), the same threshold required to invoke cloture on most measures and matters. An appeal of a ruling on a point of order under this provision carries the same supermajority vote threshold to overturn the ruling of the Senate's presiding officer.

Significant questions exist about the ability of these provisions to restrict House and Senate legislative action.[22]

What If the IPAB Fails to Submit a Required Proposal?

Following the activation of the trigger for an IPAB proposal as described above and if, for whatever reason, the IPAB were to fail to submit a proposal as required (e.g., if members are not appointed and confirmed in a timely manner), under current law the Secretary is directed to develop and implement proposals automatically unless Congress affirmatively acts to alter the proposals or to discontinue the automatic implementation of such proposals.

[22] For a more extensive discussion of these questions, see CRS Report R41511, *The Independent Payment Advisory Board*, by Jim Hahn and Christopher M. Davis.

What Legal Challenges Have Been Raised Regarding the IPAB, and What Is the Status of the Lawsuits?

The constitutionality of the IPAB has been the subject of litigation. However, the Supreme Court refused to review the dismissal of such a suit by the Ninth Circuit in March 2015, effectively ending that litigation for the time being.

The challenge to the IPAB, in a case entitled *Coons v. Lew*, was brought by a physician who feared that he would be injured by the IPAB, because it had authority to recommend the reduction of Medicare payment rates that would be implemented unless Congress acted to alter the recommended reductions.[23] The plaintiff further argued that the IPAB itself was unconstitutional because it was an impermissible delegation of legislative authority by Congress.

The non-delegation doctrine limits Congress's authority to delegate legislative authority to federal agencies. In its modern form, the doctrine generally requires that a statutory delegation include an "intelligible principle" to guide the agency's use of the delegated authority.[24] In challenging the IPAB as a violation of the non-delegation doctrine, the plaintiffs argued that the provisions in Section 1899A of the SSA do not provide a sufficiently "intelligible principle" that the IPAB could use to guide its recommendations.

Without reaching the merits of the non-delegation claim, the Ninth Circuit dismissed the suit for lack of jurisdiction. Specifically, the court determined that the suit was unripe because the plaintiffs' claimed harm from a future reduction in Medicare payment rates was "wholly contingent upon the occurrence of unforeseeable events."[25] Ripeness is a constitutional doctrine that concerns whether it is appropriate for a court to resolve a particular dispute at the current time. If a suit is unripe, federal court jurisdiction must be withheld until such time as "the plaintiffs face a realistic danger of sustaining direct injury as a result of the statute's operation or enforcement."[26] Although the Ninth Circuit concluded that the plaintiffs had not met this standard, these plaintiffs or others may be able to challenge the constitutionality of the IPAB in the future, should conditions trigger the need for IPAB proposals that modify provider payments.

What Legislative Activity Related to the IPAB Has There Been?

In addition to the opening day rules in the House of Representatives (see "What Internal Congressional Rules Have Been Adopted Addressing the IPAB?"), two bills to repeal the IPAB were introduced in the House and three bills were introduced in the Senate during the 113th Congress. In the 114th Congress, two bills to repeal the IPAB were introduced in the House and one was introduced in the Senate. (See **Table 2**.) On October 16, 2015, the House Budget Committee reported an original measure, the Restoring American's Healthcare Freedom Reconciliation Act of 2015 (H.Rept. 114-293). Title III, Subtitle B, as reported by the Committee on Ways and Means on September 29, 2015, would have repealed the IPAB. However, this provision was not included in the version of the reconciliation bill (H.R. 3762) passed by the House on October 23, 2015, or in the subsequent, vetoed version.

[23] Coons v. Lew, 2014 U.S. App. LEXIS 17360 (9th Cir. Sept. 2, 2014) cert. denied, 135 S. Ct. 1699 (Mar. 30, 2015).

[24] Panama Refining Co. v. Ryan, 293 U.S. 388 (1935); A.L.A. Schechter Poultry Corp. v. United States, 295 U.S. 495 (1935).

[25] Coons v. Lew, 2014 U.S. App. LEXIS 17360.

[26] Coons v. Lew, 2014 U.S. App. LEXIS 17360 (quoting Thomas v. Anchorage Equal Rights Comm'n, 220 F.3d 1134, 1138-9 (9th Cir. 2000)).

Table 2. Summary of IPAB-Related Bills

(113th, 114th, and 115th Congresses)

Bill	Title	Summary	Lead Sponsor
		113th Congress	
H.R. 37	Business and Government Operations Improvement Act	"Amends the Internal Revenue Code and the Patient Protection and Affordable Care Act to repeal the employer and individual health insurance mandates and the Independent Payment Advisory Board."	Rep. Barrow, John
H.R. 351	Protecting Seniors' Access to Medicare Act of 2013	"Repeals sections of the Patient Protection and Affordable Care (PPACA) (and restores provisions of law amended by such sections) related to the establishment of an Independent Payment Advisory Board to develop and submit detailed proposals to reduce the per capita rate of growth in Medicare spending to the President for Congress to consider."	Rep. Roe, David P.
S. 351	Protecting Seniors' Access to Medicare Act of 2013	"Repeals sections of the Patient Protection and Affordable Care (PPACA) (and restores provisions of law amended by such sections) related to the establishment of an Independent Payment Advisory Board to develop and submit detailed proposals to reduce the per capita rate of growth in Medicare spending to the President for Congress to consider."	Sen. Cornyn, John
S. 1316	Protecting Seniors' Access to Medicare Act of 2013	"Repeals sections of the Patient Protection and Affordable Care (PPACA) (and restores provisions of law amended by such sections) related to the establishment of an Independent Payment Advisory Board to develop and submit detailed proposals to reduce the per capita rate of growth in Medicare spending to the President for Congress to consider."	Sen. Cornyn, John
S. 2064	Four Rationers Repeal Act of 2014	"Repeals sections of the Patient Protection and Affordable Care (PPACA) (and restores provisions of law amended by such sections) related to the establishment of an Independent Payment Advisory Board to develop and submit detailed proposals to reduce the per capita rate of growth in Medicare spending to the President for Congress to consider."	Sen. Roberts, Pat
		114th Congress	
H.R. 1190	Protecting Seniors' Access to Medicare Act of 2015	"Repeals sections of the Patient Protection and Affordable Care Act (and restores provisions of law amended by those sections) related to the establishment of an Independent Payment Advisory Board to develop proposals to reduce the per capita rate of growth in spending under title XVIII (Medicare) of the Social Security Act."	Rep. Roe, David P.

Bill	Title	Summary	Lead Sponsor
S. 141	Protecting Seniors' Access to Medicare Act of 2015	"Repeals sections of the Patient Protection and Affordable Care Act (and restores provisions of law amended by those sections) related to the establishment of an Independent Payment Advisory Board to develop proposals to reduce the per capita rate of growth in spending under title XVIII (Medicare) of the Social Security Act."	Sen. Cornyn, John
H.Rept. 114-293 to accompany H.R. 3762	Restoring Americans' Healthcare Freedom Reconciliation Act of 2015	"A bill to provide for reconciliation pursuant to Section 2002 of the concurrent resolution on the budget for fiscal year 2016."	Rep. Price, Tom
		115th Congress	
H.J.Res. 51		"Approving the discontinuation of the process for considering and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act."	Rep. Roe, David P.
S.J.Res. 16		"Approving the discontinuation of the process for considering and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act."	Sen. Wyden, Ron
S.J.Res. 17		"Approving the discontinuation of the process for considering and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act."	Sen. Cornyn, John
S. 251	Protecting Medicare from Executive Action Act of 2017	"To repeal the Independent Payment Advisory Board in order to ensure that it cannot be used to undermine the Medicare entitlement for beneficiaries."	Sen. Wyden, Ron
H.R. 849	Protecting Seniors' Access to Medicare Act of 2017	"To repeal the provisions of the Patient Protection and Affordable Care Act providing for the Independent Payment Advisory Board."	Rep. Roe, David P.
S. 260	Protecting Seniors' Access to Medicare Act of 2017	"To repeal the provisions of the Patient Protection and Affordable Care Act providing for the Independent Payment Advisory Board."	Sen. Cornyn, John

Source: Congressional Research Service.

Notes: In the 113th Congress, H.R. 351 and S. 351 were identical bills, whereas H.R. 1190 and S. 141 were identical bills in the 114th Congress. In the 115th Congress, H.R. 849 and S. 260 are identical, whereas H.J.Res. 51, S.J.Res. 16, and S.J.Res. 17 each contain exactly the IPAB repeal language specified in statute. Each summary is taken from the bill itself.

Six bills addressing the IPAB have been introduced in the 115th Congress. Three of the bills (H.J.Res. 51, S.J.Res. 16, and S.J.Res. 17) are identical in content and consist solely of the repeal language as specified in statute.[27] H.R. 849 and S. 260 would repeal the enabling provisions, Sections 3403 ("Independent Medicare Advisory Board") and 10320 ("Expansion of the Scope

[27] SSA §1899A(f)(1).

of, and Additional Improvements to, the Independent Medicare Advisory Board") of the ACA. S. 251 would not only repeals Section 1899A of the SSA but also includes conforming amendments that would repeal certain IPAB-related provisions from the ACA, such as the Government Accountability Office study and report to Congress and the requirement that the Medicare Payment Advisory Commission (MedPAC) review and comment on IPAB proposals.

On November 2, 2017, the House passed H.R. 849 by a vote of 307-111.[28]

How Has CBO Scored IPAB-Related Bills?

To date, CBO has provided a cost estimate for three of the bills from **Table 2**. On June 11, 2015, CBO released a score for H.R. 1190[29] as reported on June 2, 2015, by the House Ways and Means Committee. CBO indicates that repealing the IPAB would increase direct spending in the future; however, the estimate is subject to a high degree of uncertainty because of the unknown likelihood that the IPAB authority would be triggered. Specifically, the cost estimate includes the following summary:

> CBO estimates that enacting H.R. 1190 would not have any budgetary impact between 2015 and 2021, but would increase direct spending by $7.1 billion over the 2022-2025 period. That estimate is extremely uncertain because it is not clear whether the mechanism for spending reductions under the IPAB authority will be triggered under current law for most of the next ten years; under CBO's current baseline projections such authority is projected to be triggered in 2025. However, given the uncertainty that surrounds those projections, it is possible that such authority would be triggered in more than one of those years; taking into account that possibility, CBO estimates that repealing the IPAB provision of the ACA would probably result in higher spending for the Medicare program in the years 2022 through 2025 than would occur under current law. CBO's estimate represents the expected value of a broad range of possible effects of repealing the provision over that period.

Although the CMS Chief Actuary makes the official determination regarding the IPAB, CBO makes independent projections of IPAB activity when producing cost estimates, and their conclusions have differed. For example, CBO previously estimated "an IPAB spending measure that is at or below the economic measure in each target year through 2024 (that is, in the last year of each five-year period), but not in 2025,"[30] whereas the corresponding CMS Chief Actuary estimate had been that 2017 was going to be the first year in which IPAB activity would be triggered. Differences between the CBO and CMS Chief Actuary estimates reflect differences in methodology regarding how potential savings are treated over time.[31]

On October 2, 2015, CBO issued a cost estimate for the *Reconciliation Recommendations of the House Committee on Ways and Means*.[32] Subtitle B of the Ways and Means recommendations would repeal the IPAB and CBO estimates that this provision "would not have any budgetary

[28] http://clerk.house.gov/evs/2017/roll604.xml.

[29] Congressional Budget Office (CBO), *Cost Estimate:* H.R. 1190*: Protecting Seniors' Access to Medicare Act of 2015*, June 11, 2015, at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr11900.pdf.

[30] Ibid.

[31] Confirmed in an August 6, 2015, CRS conversation with CBO.

[32] CBO, Cost Estimate: Reconciliation Recommendations of the House Committee on Ways and Means as Approved by the House Committee on Ways and Means on September 29, 2015, October 2, 2015, at https://www.cbo.gov/publication/50869.

impact between 2015 and 2021, but would increase direct spending by $7.1 billion over the 2022-2025 period."

On October 27, 2017, CBO released a score for H.R. 849, which reiterates the high degree of uncertainty in their estimate and includes the following explication:

> The IPAB mechanism is essentially a one-sided bet: either modifications to achieve a savings target are required (resulting in savings) or they are not (resulting in no change). IPAB cannot be instructed to increase spending. So, variations in those measures might lead to additional savings but could not lead to added costs. Because of the one-sided nature of the budgetary impact of variations in the spending and economic measures that determine IPAB's savings target, CBO must consider the probabilities associated with such variations when assessing the budgetary effects of possible changes in law.[33]

CBO concludes that "repealing the IPAB mechanism would increase expected Medicare spending each year from 2022 through 2027, with the expected value of the net increase in Medicare spending for benefits totaling $17.5 billion over that period."[34]

CBO also has noted that the IPAB could interact with provisions in other bills for which they have provided cost estimates. For instance, the score for some bills that increase Medicare spending by raising payments to Medicare providers includes an interaction with the IPAB because of the increase in the likelihood that the trigger would be activated due to greater Medicare program expenditures.[35]

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[33] CBO cost estimate for H.R. 849, the Protecting Senior's Access to Medicare Act, at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr849.pdf.

[34] Ibid.

[35] CBO cost estimate for H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015, which became P.L. 114-10, at http://www.cbo.gov/publication/50053.

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