

HEALTH & MEDICINE

IS IPAB A PAPER TIGER?

Rather than rationing health care, PPACA likely will lead to increased spending on low-value care.

♦ BY THOMAS A. FIREY

From the earliest days of the Patient Protection and Affordable Care Act (PPACA, also known as “Obamacare”), its creation of an Independent Payment Advisory Board (IPAB) has come under sharp criticism. Sarah Palin infamously condemned IPAB as a “death panel” that will deprive the severely ill of vital medical care. More thoughtful commentators—including Christina Sandefur and Timothy Sandefur (“PPACA’s Corrupting Lawlessness,” p. 42)—criticize the board for covertly rationing care and being practically free of any oversight of its decisions and operations.

By the letter of the law, those latter criticisms seem appropriate. However, recent political history and public choice theory suggest that IPAB will have the exact opposite effect: it likely will be a paper tiger that will lead to *increased* spending on low-value medical care.

IPAB’s purpose / According to Obama administration health care czar Nancy-Ann DeParle, IPAB is to “recommend policies to Congress to help Medicare provide better care at lower costs.” Despite that innocuous description, PPACA gives the presidentially appointed 15-member board (or, if no members are appointed, the secretary of health and human services acting in the board’s stead) considerable power. It is to review various medical treatments and judge whether they are worthwhile, and then “recommend” that Medicare not fund treatments that IPAB judges not to measure up. These would be powerful recommendations: they automatically become federal policy unless Congress musters a supermajority vote to override them. In addition, IPAB’s decisions are expected to heavily influence what treatments private insurers cover and medical providers offer.

PPACA supporters say IPAB will eliminate costly treatments that yield little benefit. That would be a wonderful result; many health care analysts believe that a large portion—perhaps as much as one-third or more—of medical expenditures have little or no medical benefit. But critics question whether IPAB can do a better job than insurance companies in correctly identifying those procedures and, beyond that, whether a bureaucratic board is the proper judge of what is “worthwhile” vis-à-vis a sick patient or an insurance purchaser. Those criticisms have merit.

But I predict a very different problem for IPAB: Despite the ostensible legal protections intended to make it independent, I believe the White House and Congress will routinely influence or outright overrule the board until it becomes subservient to their political concerns. As a result, IPAB will not only fail to reduce inefficient treatments, but will contribute to the mandatory funding of inefficient ones. After all, this has happened before.

The USPSTF experience / A predecessor to IPAB is the U.S. Preventive Services Task Force (USPSTF). Created in 1984, the specific duties of this 16-member body have changed over the years, but its general purpose has always been to review empirical research on preventive practices and recommend those practices that the research suggests are worthwhile. Currently, according to the task force’s website, it “conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems.”

Unlike IPAB, the USPSTF recommendations truly are just recommendations. Yet that has not kept the task force from drawing the ire of Congress and the White House, resulting in some remarkable policy responses.

In 2009, the USPSTF released a much anticipated report on the use of mammography screening for breast cancer in asymp-

tomatic women. Previously, the task force had recommended that women over age 40 be screened every two years. However, the 2009 report backtracked on that advice somewhat, stating that it did not recommend screening for the typical woman under age 50, but that it did suggest health care providers inform women ages 40–49 of both the potential benefits and harms from such tests in light of each woman's individual circumstances.

What harms could come from screening? Besides the test's use of a (very low) dose of radiation, it is physically unpleasant and waiting for results can be emotionally taxing. False positives do occur and result in emotional distress and even painful and

actually recommended *against* the test for men of *all* ages.

Several facts supported that decision. For one, there is little evidence that early detection of prostate cancer from a PSA test increases the patient's likelihood of surviving the cancer. For another, most of the instances of prostate cancer identified by PSA tests prove to be insignificant to the patient's health—yet many patients undergo treatment anyway. Prostate cancer treatment is not only costly and unpleasant, it is risky. About half of men who undergo prostate-removal surgery experience sexual dysfunction; a third have urination problems; and between one and two in a thousand die as a result of iatrogenesis from the surgery and aftercare. Men who undergo radiation treatment also risk impotency and urinary problems (at lower rates than surgery), and 15 percent suffer radiation damage to the rectum, resulting in “moderate or big problems.”

Again, the USPSTF decision was met with sharp criticism from health care providers, the public, and politicians. Even before the report was released, Congress and the Obama administration adopted a law mandating that Medicare ignore the USPSTF findings and cover PSA screening. That law remains in effect today, mandating health care spending that a federally established panel of experts has judged

to be harmful to men's health. Fortunately, PPACA regulations do not mandate that private insurers cover routine PSA screening—yet.

The takeaway from the USPSTF experience is that when a predecessor panel of experts provided the sorts of recommendations that IPAB is now supposed to provide, and those recommendations were met with outcry from health care providers and the public, laws and regulations were quickly adopted to mandate *the exact opposite* of what the board recommended. (It should be noted that those laws and regulations were proffered by the same president and many of the same congressmen who are the architects of PPACA.) So why expect IPAB's experience will be different?

IPAB independence: are you serious? / Some people might respond that, unlike the USPSTF, IPAB is carefully sheltered from political intervention by provisions in PPACA. Like the Base Realignment and Closure (BRAC) process that has been used periodically since the late 1980s to select for closure military installations that have been made unnecessary by the end of the cold war, IPAB is



costly overtreatment. After weighing those concerns (the task force did not consider the cost of the test itself) against the early detection benefits of the screens, the USPSTF withdrew its general recommendation of mammography screening for women under 50, though it continues to recommend screening for older women.

That decision was met with sharp criticism from health care providers, the public, and politicians. Ultimately, Congress and the Obama administration mandated that government health care programs provide screening for women in their 40s and the Obama administration subsequently issued a PPACA regulation *requiring* private insurers to cover mammograms for women in their 40s, *with no deductible*. Put bluntly, the regulation mandates health care spending (with no cost-sharing) that a federally established panel of experts has judged not to be beneficial to women's health.

Matters grew worse for the USPSTF with its next controversy. In 2011, the task force released another much-anticipated report on prostate-specific antigen (PSA) screening, a common test for prostate cancer in asymptomatic men. This time, the USPSTF

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supposed to protect Medicare coverage decisions from political influence (or, more cynically, to protect federal lawmakers from the political fallout of Medicare coverage decisions). Sandefur and Sandefur describe the provisions intended to secure IPAB's independence in their article and assume (like many commentators on PPACA) those provisions will be effective. Yet, I believe that assumption will prove false.

Unpopular IPAB decisions will put political pressures on the White House and Capitol Hill that will be far broader and more powerful than BRAC decisions. Given the ease with which federal policymakers are already ignoring and altering PPACA provisions (as Sandefur and Sandefur summarize in their article), it should not be hard for a president and federal lawmakers to reverse IPAB decisions, remove its protections, and bring the board to political heel.

Consider that a mere late-night blog post, written by an assistant treasury secretary, overrode PPACA law and delayed the mandate that many employers provide insurance coverage for their workers. Just one Internal Revenue Service announcement extended PPACA fines and subsidies to states that were not covered by the law. Just one creative interpretation proffered by the Supreme Court chief justice transformed PPACA's unconstitutional fines into constitutional taxes. So imagine how quickly and dramatically the IPAB provisions will be altered when the news media begin reporting on how some telegenic children or senior

citizens will be deprived of vital medical treatment because of the pencil-pushing decision of some isolated group of bureaucratic eggheads. The term "death panel" will seem kind. Once those media firestorms hit, I submit that no legislative language or one-time "repeal window" will prove an impediment to presidential directives and congressional action to countermand IPAB recommendations or terminate the board altogether.

Conclusion / Until now, the fear has been that IPAB will ration health care. I believe the more likely outcome is that the board will do no such thing, except perhaps to increase government-mandated spending on care that is of little value except to politicians. That will be a painful blow to PPACA legislation that otherwise does practically nothing to contain the rising cost of health care.

The IPAB rationing monster sounds like a beast and it may flash some teeth, initially—but it will likely prove to be a paper tiger. R

READINGS

■ *Overdiagnosed: Making People Sick in the Pursuit of Health*, by H. Gilbert Welch, Lisa M. Schwartz, and Steven Woloshin. Beacon Press, 2011.

■ "The Facts about the Independent Payment Advisory Board," by Nancy-Ann DeParle. *White House Blog*, April

20, 2011.

■ "The Independent Payment Advisory Board: PPACA's Anti-Constitutional and Authoritarian Super-Legislature," by Diane Cohen and Michael F. Cannon. *Policy Analysis* #700, Cato Institute, June 14, 2012.

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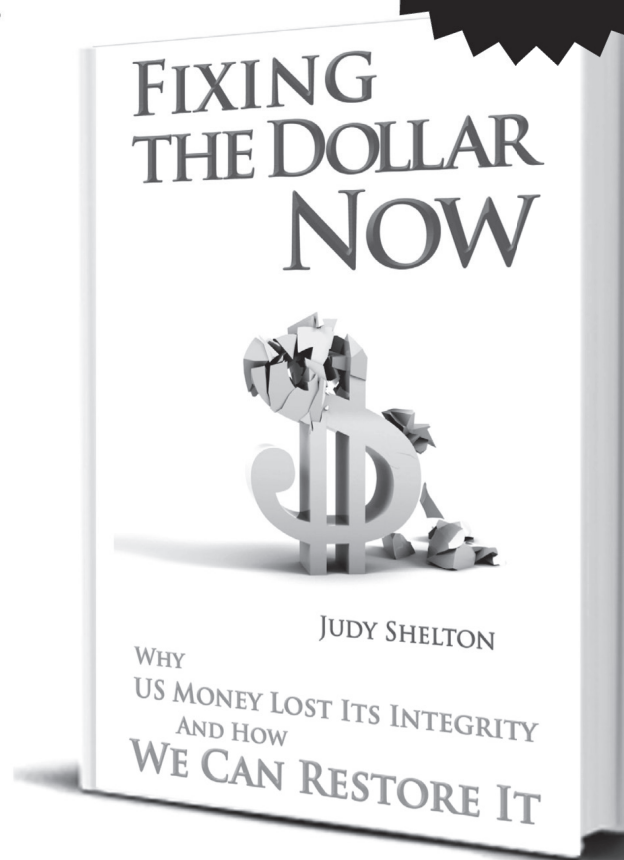
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