Affordable care 2014: a tale of two boards

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ABSTRACT
The Patient Protection and Affordable Care Act (ACA) became law on 23 March 2010. As part of the law, two independent boards were established. The Patient-Centered Outcomes Research Institute embodies national aspirations for employing comparative effectiveness research in healthcare decision-making, and the Independent Payment Advisory Board is focused on the need for a group of impartial experts to establish anticipatable growth rates for Medicare. Approximately 4 years after the bill was passed into law, these independent boards are at very different points in their life cycles. This article provides a status update.

INTRODUCTION
The sweeping legislation that is the Patient Protection and Affordable Care Act (ACA) is, without question, the single most important shaper of the US healthcare system since President Lyndon B Johnson introduced Medicare in 1965. The ACA itself is divided into 10 titles with several provisions that went into effect as early as 21 June 2010.1,2 Bearing that in mind, 2014 was always expected to be a pivotal year in the implementation of the ACA. We will briefly review the general aspects of the ACA and then analyze the independent boards created by it. This paper expands upon our prior explorations of the ACA and each of the independent boards previously discussed in this journal.3,4 Readers of JNIS might be surprised to find out the remarkably divergent situations that confront the boards.

THE ACA
The ACA attempts to address the large number of uninsured Americans by establishing a system that subsidizes the purchase of health insurance based on formulaic relationships to the poverty level. Medicaid expansion is a critical part of this subsidy. In addition, cost sharing relationships are established through Health Insurance Exchanges which are designed for people who do not have access to employer-provided health insurance. Financial penalties will be assessed on those who fail to purchase health insurance (the individual mandate) or employers above a threshold number of employees who fail to provide health insurance (the employer mandate).1 The ACA regulates many aspects of the healthcare insurance industry, such that patient protection is part of its broader name. For example, insurance companies cannot practice adverse selection in the fashion that previously existed. The ACA requires the issuance of policies to anybody qualified who applies, irrespective of pre-existing conditions. Insurance companies are required to spend a minimum of 85% of premiums on medical care.1

INDEPENDENT BOARDS
Two very powerful boards were established as part of the legislation. The boards have different functions but share the common attribute of being financially independent, a key component inherent in their design. We will review how they were conceived and follow that with a statement on their function in 2014.

The Patient-Centered Outcomes Research Institute (PCORI)
The Patient-Centered Outcomes Research Institute (PCORI) is described in the founding legislation as a private, non-profit, tax-exempt corporation designed to ‘assist patients, clinicians, purchasers and policy makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored and managed through research and evidence synthesis’. The ACA’s directive is that the institute ‘shall enter into contracts for the management of funding and conduct of research with government agencies and academic or private sector research entities and that it shall give preference to the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH).’ Having been elected in a time of financial crisis, in 2009 President Obama promoted the American Recovery and Reinvestment Act (ARRA), the so-called ‘stimulus’. As part of that Act, $1.1 billion was used to fund Comparative Effectiveness Research (CER).7 Important and germane to this discussion is that the ARRA established the Federal Coordinating Council of CER.

The Federal Coordinating Council was designed to do exactly what its name suggested—that is, to optimize coordination of the CER efforts of the Federal Government. The Council consisted of 15 members, although only 50% were required to have clinical experience. An example of the enthusiasm of this Coordinating Council was that, as early as June 2009 (the year of the ARRA), the Council had already made its recommendations for CER funding priorities. Importantly, the Council had also developed a strategic framework for categorizing CER-related activities.

It is within this framework of the primacy of CER that the ACA became law. Much of the prior work dedicated to the creation of the Federal...
Coordinating Council was used in the establishment of the PCORI. The PCORI is governed by a 21-member Board of Governors and a 17-member Methodology Committee, both of whom are appointed by the Government Accountability Office. Our previous paper on the PCORI looked at important issues of governance in detail and contrasted the PCORI with prior efforts at CER. These contrasts include stakeholder involvement, public participation, transparency and open decision-making.

Funding for the PCORI is substantial and considered a critical element in its independence. The ACA created the Patient-Centered Outcomes Research Trust Fund (PCORTF), which receives funding from two separate mechanisms. Start-up funds came from the Treasury, and the second source of funding for the PCORTF comes from fees assessed on health insurance plans including Medicare. In total, the estimate is that $3.5 billion will be provided by these different funding sources prior to 30 September 2019.

The PCORI has proceeded with its work, including defining patient-centered outcomes research and affirming the role of the PCORI in developing methodological standards. The PCORI has a robust website and has moved forward in regular order. The five PCORI research priorities are: (1) assessment of prevention, diagnosis, and treatment options; (2) improving healthcare systems; (3) communication and dissemination of research; (4) addressing disparities; and (5) accelerating patient-centered outcomes research and methodological research.

As part of the legislation, the PCORI cannot be used for denial of coverage nor can it consider the cost of providing care. The PCORI has established several methods to provide funding for proposals. The first is an investigator-initiated approach that was launched in May 2012, while the second relies on patients and other stakeholders to initiate. These include the PCORI Funding Announcements, which seek projects based upon the research priorities above, and targeted Requests for Proposals for specific high-priority topics.

The Independent Payment Advisory Board (IPAB)
The ACA aims to stem the rising cost of providing healthcare to the US citizenry. In the years prior to the ACA there were a variety of ideas that centered around the core concept of creating an independent policy-making entity that would be charged with limiting the further growth in Medicare expenditures.

For intuitive reasons, the foreseen ‘agency’ should be financially independent such that special interest groups (including physicians) would have a limited ability to influence policy. To that end, financial independence was indeed proposed.

The Independent Payment Advisory Board (IPAB) was established as part of the ACA to reduce the per capita rate of growth in Medicare spending. The IPAB is established in the ACA as part of the Executive Branch. Fifteen full-time members are to be appointed by the President and confirmed by the Senate. A majority of members must be non-providers and all members are full-time federal employees.

The budget for the IPAB for fiscal year 2012 was $15 million, with annual adjustments based on increases in the consumer price index (CPI).

The statute itself sets the target growth rates for Medicare spending. The target is not a cap per se on Medicare spending growth but, if spending exceeds these targets, the IPAB is required to submit recommendations to reduce Medicare spending by a specified per annum percentage, with maximum savings reaching their ceiling at 1.5%.

These recommendations are mandatory and require particular language and style which solidify the IPAB’s power. The IPAB also has the ability to make advisory recommendations on a much broader range of Medicare and health policy issues and, in some cases, is required to provide such advice. Interestingly, the IPAB is limited in that its recommendations cannot ration healthcare, raise revenues, increase Medicare beneficiary premiums or cost sharing, or otherwise restrict benefits.

While legislative procedural minutiae would not typically belong in a peer-reviewed subspecialty medical journal, understanding the special ‘fast-track’ procedures set out in the statute for the IPAB can be instructive. The board’s legislative proposals must be introduced to both Houses of Congress on the day the IPAB report is made and subsequently referred to the relevant committees. These committees must report those recommendations, with any changes, within 3 months. The committees and the full House and Senate cannot consider any amendment that would change or repeal the IPAB’s recommendations unless those changes meet the same fiscal criteria under which the board operates.

Provision is made for a one-time fast-track consideration of a joint resolution to dissolve the IPAB. Such a resolution must be introduced in 2017, no later than 1 February of that year. Given the circumstances that will be discussed later in this article, one can wonder whether the need for this resolution is becoming a historical curiosity.

While the authors believe the fast-track consideration of mandatory recommendations is central to the IPAB’s power, another key element is that the ACA does not allow for administrative or judicial review of the Secretary of Health and Human Services implementing recommendations contained in the IPAB proposal.

The PCORI 2014
The PCORI enjoyed early support from many professional medical organizations including the American College of Radiology and American Society for Neuroradiology, although this was by no means universal. The Society of NeuroInterventional Surgery did not have an official position on the PCORI.

The US Government Accountability Office has indeed appointed the PCORI Board of Governors and Methodology Committee and in 2014 both are functioning. Funding of the PCORI and thus CER has moved forward as expected and is massive. From the passage of the ACA through 2012, the PCORTF received $210 million from the Federal Treasury. In 2013 the PCORTF started receiving funds from fees applied to healthcare plans in addition to the Treasury support described above. The cumulative amount was $320 million in 2013. From 2014 to 2019 the fees charged to healthcare plans increase the US Treasury continues to provide the same amount for a total of $650 million per year.

In 2012 the Board of Governors approved a definition of patient-centered outcomes research and developed a draft plan for research priorities. As part of this roll-out, the PCORI allowed for an open comment period for the public. This was well subscribed with 474 comments. Indeed, by 2014, funding has gone out from the PCORI, in keeping with its intended mission.

The IPAB 2014
Prior to and following the passage of the ACA, there has been heated debate about the IPAB. Indeed, a number of medical professional organizations have come out strongly against it. Some
Policy experts have been divided on the best approach to the IPAB. Some argue it has not gone far enough. Indeed, there are those who believe that the IPAB should be extended outside of its originally legislated scope of Medicare. These experts advocate that the IPAB should include all types of payers including Medicaid and the newly formed health insurance exchanges. In testimony before the House Budget Committee in 2011, Judith Feder argued that the expertise and authority of the IPAB should be applied to all payers—including private payers—with a system-wide spending target. In contrast, Douglas Holtz-Eakin described the IPAB as a dramatic policy error that should be corrected. He believes that it could exacerbate existing reimbursement problems that already limit access to care for Medicare beneficiaries and stifle US-led medical innovation.

Jonathan Oberlander and Marisa Morrison published an excellent update in the New England Journal of Medicine that included a description of the current state of IPAB affairs. One of the most telling points in their article is their observation that the first major milestone in the IPAB’s operation passed with little fanfare. We think it is critical to underscore this point; after so much antagonism towards the IPAB, most readers are likely to have heard nothing about this recent and critical milestone. The April 2013 report of the Chief Actuary of the Center for Medicare and Medicaid Services (CMS) projected that Medicare spending per person will grow at an average rate of 1.15% during 2011–2013, far below the target growth rate set by the ACA—the average of the CPI and the medical CPI. Consequently, this level of spending growth will not necessitate the IPAB to propose reductions in Medicare reimbursement. If this level of Medicare spending growth becomes the norm, then the most controversial feature of the IPAB—congressional consideration of IPAB proposals under fast-track procedures—will not become active. However, since the target growth rate set by the ACA is a rolling calculation performed annually, the IPAB retains the potential to impact providers in the future.

2014 was meant to be a year of action by the IPAB; recommendations were to be made for the 2015 Medicare budget. Critically, in 2014—fully 3 years after the ACA’s enactment—President Obama has yet to nominate a single member for the board. It remains unknown whether the President will in fact be able to fill these positions on the IPAB. They will require Senate approval—until recently a meaningful challenge in the current partisan political climate. On 21 November 2013, Senate Democrats and Majority Leader Harry Reid (D-NV) used a rare parliamentary move dubbed the ‘nuclear option’ that changed the rules of governance such that federal judicial nominees (and critical for the IPAB) executive office appointments can be confirmed by a simple majority rather than the 60-vote supermajority that had been in place for almost four decades. This move could pave the way for President Obama to have board members confirmed.

An interesting juxtaposition to the President’s seemingly greater ability to appoint members to the IPAB came out during the confirmation hearing for Sylvia Mathews Burwell to become Secretary of Health and Human Services. In response to a question by Senator Pat Roberts (R-KS) on whether Burwell would repeal the IPAB, Burwell opined that the “IPAB as it is currently written would not affect beneficiaries”, and that there are barriers in place to halt triggering of the board. Thus, the 2014 update of the IPAB is that the IPAB is not functioning and it is not clear how it will function going forward. For all the angst by providers and their representative professional organizations, the IPAB has been rendered dormant by the current stagnation in healthcare spending growth.

**SUMMARY**

The Patient Protection and ACA of 2010 changes the way healthcare is delivered in the USA. Elements of the ACA are discussed regularly in legislative efforts and newspaper accounts. 2014 was always supposed to be a critical year for implementation. As part of the ACA, two powerful independent boards were established: the PCORI and the IPAB. Four years later these boards are on two very different trajectories with the PCORI being highly functional while the IPAB remains member-less. Indeed, a tale of two boards.

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