CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

March 8, 2012

H.R. 452
Medicare Decisions Accountability Act of 2011

As ordered reported by the House Committee on Ways and Means
on March 8, 2012

SUMMARY

H.R. 452 would repeal the provisions of the Affordable Care Act (ACA) that established the Independent Payment Advisory Board (IPAB) and created a process by which that Board (or the Secretary of the Department of Health and Human Services) would be required under certain circumstances to modify the Medicare program to achieve certain specified savings.

CBO estimates that enacting H.R. 452 would not have any budgetary impact in 2012 but would increase direct spending by $3.1 billion over the 2013-2022 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 over the next 10 years. However, it is possible that such authority would be triggered in one or more of those years; thus, repealing the IPAB provision of the ACA could result in higher spending for the Medicare program 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.

Pay-as-you-go procedures apply because enacting the legislation would affect direct spending. Enacting the bill would not affect revenues.

H.R. 452 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 452 is shown in the following table. The costs of this legislation fall within budget function 570 (Medicare).

	By Fiscal Year, in Millions of Dollars												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012-2017	2012-2022
CHANGES IN DIRECT SPENDING													
Estimated Budget Authority	0	-14	-14	-14	-14	-15	475	1,095	384	414	824	-71	3,121
Estimated Outlays	0	-6	-10	-14	-14	-15	475	1,095	384	414	824	-59	3,133

BASIS OF ESTIMATE

H.R. 452 would repeal the provisions of the ACA that created the Independent Payment Advisory Board. Assuming enactment near the beginning of fiscal year 2013, CBO estimates that the bill would reduce direct spending by $59 million over the 2013-2017 period, but would increase direct spending, on an expected-value basis, after 2017. On balance, CBO estimates that enacting H.R. 452 would lead to a net increase in direct spending of $3,133 million over the 2013-2022 period.

Administrative Costs

The Congress appropriated $15 million for the IPAB in the ACA for fiscal year 2012, along with a formula for increasing that amount in subsequent years by the percentage increase in the consumer price index for all urban consumers (CPI-U). (However, $10 million of the $15 million provided for 2012 was subsequently rescinded.) Funds appropriated in authorizing legislation are considered direct spending, because the availability of those funds is not contingent on future appropriation acts.

CBO estimates that net funding for IPAB administrative costs will total $149 million over the 2013-2022 period, and that outlays will total $137 million through 2022. Those amounts take into account that about 10 percent of the funds provided for the IPAB will be offset by changes in receipts from Medicare Part B premiums. For example, the estimated gross funding for 2013 under current law is $15 million, and about $1 million in additional Part B premiums will be collected, resulting in an estimated net change in budget authority of $14 million for next year.

In total, CBO estimates that enacting H.R. 452 would reduce net direct spending for administrative costs by $137 million over the 2013-2022 period.

Net Spending for Medicare Benefits

Under current law, the Independent Payment Advisory Board has the obligation to reduce Medicare spending—beginning in 2015—relative to what otherwise would occur if the rate of growth in spending per beneficiary is projected to exceed a target rate that is based on inflation (for 2015 to 2019) or growth in the economy (for 2020 and subsequent years). Each year, beginning in the spring of 2013, the law requires the Chief Actuary of the Centers for Medicare and Medicaid Services (CMS) to project two numbers, each of which is a five-year moving average for the period ending two years in the future:

- The rate of change in net Medicare spending per beneficiary (that is, gross Medicare spending less enrollees' payments for premiums), and

- The rate of change in an economic measure—which is the average of the CPI-U and CPI-M[1] for five-year periods ending in 2015 through 2019, and GDP per capita plus 1 percentage point for five-year periods ending in 2020 and subsequent years.

The Chief Actuary of CMS will compare those two values, and if the spending measure is larger than the economic measure, the difference will be used to determine the IPAB's savings target for the last year of the five-year period.

CBO's current estimates of Medicare spending and its current economic projections result in an IPAB spending measure that is below the economic measure in each target year through 2022 (that is, in the last year of each five-year period):

	2015	2016	2017	2018	2019	2020	2021	2022
Spending Measure	1.7%	1.7%	1.5%	2.7%	3.1%	3.6%	3.9%	4.2%
Economic Measure	2.8%	2.8%	2.9%	3.0%	3.2%	5.2%	4.9%	4.7%
Difference	-1.1%	-1.1%	-1.4%	-0.3%	-0.1%	-1.6%	-1.0%	-0.5%

The point estimates in CBO's baseline projections, therefore, result in a projected savings target of zero in every year through 2022.

The IPAB mechanism, however, is essentially a one-sided bet: The resulting target can be only zero or savings; the IPAB cannot be instructed to increase spending. So, variations in those measures might lead to additional savings but could not lead to added costs.[2]

[1] The CPI-U is the consumer price index for all urban consumers and the CPI-M is the medical care category of the CPI-U. The medical care category is one of eight major expenditure groups that make up the CPI-U (see *http://www.bls.gov/cpi/cpifact4.htm*).

[2] For a discussion of CBO's longstanding approach to estimating one-sided bets, see http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/15xx/doc1589/onesided.pdf

In fact, the difference between the spending measure and the economic measure in each year that the Chief Actuary makes an IPAB determination will probably not be equal to the difference that CBO currently projects. If the Chief Actuary ends up projecting some combination of a higher spending measure or a lower economic measure than CBO currently projects, the savings target for the IPAB mechanism could exceed zero.

Because of the one-sided nature of the budgetary impact of variations in the spending and economic measures that determine IPAB's savings target, it is important to consider the probabilities associated with such variations when assessing the effects of possible changes in law. To assess the probability of the IPAB mechanism being triggered, CBO analyzed the technical component of changes in its recent baseline projections of Medicare spending.[3] We concluded that there is a roughly two-thirds chance that the amount of spending in five years will differ from the agency's current projection by less than 2 percent as a result of technical factors.[4] (Thus, there is a one-third chance that the amount of spending in five years would differ by more than 2 percent as a result of such factors.) The uncertainty regarding the five-year moving average of the rate of growth in net Medicare spending per beneficiary is approximately one-fifth of the uncertainty concerning the amount of Medicare spending in the fifth year.

To produce estimates for proposed legislative changes to the IPAB mechanism that take into account the probabilities of variations in the relevant measures, CBO applies that probability distribution to its point estimates of the five-year moving average of net Medicare spending per beneficiary to calculate an expected value for the IPAB's savings target under both current law and with the proposed change in law. CBO applies a *de minimis* rule that the target will be zero if the expected value of the savings target is less than 0.05 percent.

The use of probability-based estimates for changes to the IPAB mechanism does not affect the presentation of the effects of that mechanism in CBO's baseline. The baseline reflects the agency's current best judgment of the likely level of spending under current law; if the IPAB mechanism is triggered, that outcome probably will result from spending that exceeds CBO's current projections.

[3] CBO characterizes the components of changes in baseline projections as technical, economic, and legislative. This analysis of variability in projections focuses on the technical component—which largely represents unanticipated changes in the utilization of health care services—because the economic component is expected to have similar, and largely offsetting, effects on the spending and economic measures whose difference determines the IPAB's savings targets. The analysis excludes the legislative component of changes in CBO's baseline projections because the baseline reflects current law and does not anticipate future legislative changes.

[4] The total uncertainty around CBO's projections of Medicare spending—taking into account the economic and legislative components of changes in those projections—would be considerably larger.

Following the above logic, repeal of the IPAB mechanism would have a budgetary cost. After application of the *de minimis* rule (for estimated effects that round to 0.0 percent), the expected value of the IPAB's savings target would be zero in 2015, 2016, 2017, 2020, and 2021(but not in 2018, 2019, and 2022, when the expected value of the savings target would be between 0.1 percent and 0.2 percent of projected net Medicare spending). In addition, CBO anticipates that, if the IPAB mechanism was triggered, some of the savings in the target year would compound and produce savings in subsequent years. As a result, CBO estimates that repealing the IPAB mechanism would increase expected Medicare spending each year from 2018 through 2022, with the expected value of the net increase in Medicare spending for benefits totaling about $3.3 billion over that five-year period.

PAY-AS-YOU-GO CONSIDERATIONS

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table. (Enacting H.R. 452 would not affect revenues.)

CBO Estimate of Pay-As-You-Go Effects for H.R. 452, as ordered reported by the House Committee on Energy and Commerce on March 6, 2012

	By Fiscal Year, in Millions of Dollars												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012-2017	2012-2022
NET INCREASE OR DECREASE (-) IN THE DEFICIT													
Statutory Pay-As-You-Go Impact	0	-6	-10	-14	-14	-15	475	1,095	384	414	824	-59	3,133

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 452 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

PREVIOUS ESTIMATE

On March 7, 2012, CBO transmitted a cost estimate for H.R. 452 as ordered reported by the House Committee on Energy and Commerce on March 6, 2012. The two versions of the bill are identical, as are the two CBO cost estimates.

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