

THE CONCORD COALITION



Issue brief

December 23, 2009

Health Care Reform: End Game Fiscal Considerations

I. Introduction

With the House having passed its version of health care reform (H.R. 3962) and the Senate on the verge of passing its version (H.R. 3590), the outline of a final bill is beginning to take shape. It is thus appropriate to look ahead at the fiscal considerations that will likely be the subject of conference committee discussions and “end game” negotiations. These include the cost of expanding coverage, the methods used to prevent that cost from adding to the deficit, and the prospects for systemic reforms to reduce cost growth over time.

While differing in key details, the House and Senate bills share a basic fiscal premise: extending health insurance coverage to nearly all Americans should not add to the deficit over the 10-year budget window or beyond. To accomplish this, both bills would pay for the cost of expanding coverage with a mix of spending cuts, penalties and taxes.

This issue brief gives The Concord Coalition’s perspective on how the bills measure up, what the risks are and how these risks could be lessened. We conclude that:

- Both bills establish an important benchmark by achieving deficit reduction according to official cost estimates by the Congressional Budget Office (CBO). However, the fiscal outlook would remain on an unsustainable track even with the modest deficit reduction achieved under either plan.
- There are clear risks that some of the methods used to achieve deficit reduction in the official scores may not hold up over the long-term.
- The revenue package in the Senate bill holds more promise to reduce the deficit than the House version because the Senate bill’s largest component -- the excise tax on high-cost insurance plans -- will better keep pace with the growth rate of health care spending, and will also work to lower health care costs.
- Both bills contain many promising reform strategies to achieve long-term cost control. However, these strategies remain unproven and cannot be counted on to produce timely, reliable savings without a strong cost control mechanism such as the Senate’s proposed Independent Payment Advisory Board (IPAB).

II. The official path of deficit reduction

Expanding coverage

The most obvious benefit of either bill is that they would expand health insurance coverage to almost all Americans. According to CBO estimates, the House bill would expand coverage from 83 percent of the legal nonelderly population in 2010 to 96 percent by 2015. The Senate version would expand such coverage to 94 percent by 2016.

This would be achieved by expanding Medicaid, requiring most individuals to obtain coverage or pay a penalty, requiring most employers to provide coverage or pay a penalty, and assisting many individuals and employers with subsidies or tax credits to help defray the costs.

Expanding coverage is a desirable social goal but it raises the bar for fiscal sustainability. According to CBO, both bills would increase federal health care costs relative to the baseline. This means that reforms must not only bring existing commitments down to a sustainable level but also find a way to accommodate the new costs.¹

Gross cost of coverage expansion (2010-2019):

House bill:

Medicaid expansion:	\$425 billion
Premium subsidies:	\$602 billion
Employer tax credits:	<u>\$25 billion</u>
Total:	\$1.052 trillion

Senate bill:

Medicaid expansion:	\$395 billion
Premium subsidies:	\$436 billion
Employer tax credits:	<u>\$40 billion</u>
Total:	\$871 billion

It may appear from the gross cost that the House bill is much more “expensive” than the Senate bill. However, the apparent difference is largely a matter of timing. In the House bill, expanded coverage takes effect in 2013 but in the Senate bill it does not take effect until 2014. Once the two plans are fully operational, the cost difference is slight. This can be seen by comparing the gross costs of the respective bills in the tenth year.

¹ In addition to the gross cost, CBO has also estimated the “federal budgetary commitment to health care,” which includes both outlays and tax preferences for health care such as the exclusion of employer-provided insurance from taxable income. According to CBO, the net increase of this commitment in the House bill is about \$600 billion over 10 years and about \$200 billion in the Senate bill.

Gross cost of coverage expansion in 2019:

House bill: \$207 billion

Senate bill: \$199 billion

CBO estimates that the gross cost of both bills would continue to expand at about eight percent annually beyond the initial 10-year period. Given the goal of deficit neutrality, the gross cost of coverage expansion must be adequately financed. Both bills employ a combination of spending cuts, tax increases and penalties to accomplish this.

Spending cuts

Both bills include substantial spending reductions from the current 10-year baseline. The largest spending reductions come from changes in Medicare. Both bills would permanently reduce Medicare's annual payment updates for provider services other than physicians. They would also reduce payments to Medicare Advantage plans (Part C) -- private plans that are currently reimbursed at a higher per-capita rate on average than the traditional fee-for-service Medicare program in return for additional benefits, lower premiums or both. These two provisions total \$398 billion of savings in the House bill and \$304 billion in the Senate bill. Other changes in Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP) account for the remaining spending cuts.

Included as "reduced spending" in the scoring of the bills are premiums collected for a new entitlement program called the Community Living Assistance Services Support program (CLASS). Premiums in excess of benefits for this program offset other spending by \$102 billion over 10 years in the House bill and by \$72 billion in the Senate bill. As discussed more fully below, these premiums do not constitute genuine "savings" because they will be needed to pay future benefits of the new program. By scoring conventions, however, they are viewed as offsetting receipts or "negative outlays."

Penalties and tax increases

Both plans would partially offset the cost of coverage by imposing penalties on individuals who fail to obtain coverage and employers who fail to offer coverage to their employees. These penalties vary between the two bills but do not constitute a significant source of funding. Their main purpose is to provide an incentive for individuals to obtain coverage and for employers to offer coverage to their workers.

Both bills also include tax increases. The main revenue raiser in the House bill is a surtax of 5.4 percent on individuals with incomes in excess of \$500,000 and couples with incomes in excess of \$1 million. This would raise revenues by \$460 billion over 10 years.

The Senate's approach is more diverse, imposing a 40 percent excise tax on high-cost insurance plans (defined as those with annual premiums of \$8,500 for individuals and \$23,000 for families), an increase of 0.9 percent in the Medicare payroll tax for upper

income earners (\$200,000 for individuals; \$250,000 for families) and various taxes on providers.

The bottom line

The Congressional Budget Office (CBO) has determined that either bill, if enacted and maintained as written, would slightly decrease the deficit in the 10-year window:

House bill 10-year deficit reduction:	\$138 billion
Senate bill 10-year deficit reduction:	\$132 billion

In the second decade following enactment -- a key measure of fiscal sustainability -- CBO projects that the House bill would reduce projected deficits by zero to one-quarter percent of GDP and that the Senate bill would reduce deficits by about one-quarter to one-half percent of GDP. As CBO notes, however, "The expected reduction in deficits would represent a small share of the total deficits that would be likely to arise in that decade under current policies."²

This means that both bills pass the threshold test for fiscal responsibility -- they have received official estimates that they would reduce projected deficits. It does not mean, however, that the inquiry should stop there. For one thing, it is quite possible to produce a bill that is "paid for" over 10 years by using various scoring gimmicks that would not ensure deficit-neutrality over a longer period. Moreover, the assumptions used to achieve long-term savings must be credible. In its analysis, the CBO must accept the timing mechanisms and policy assumptions contained in legislation.

It must also be noted that both bills ignore the expense of permanently adjusting the Sustainable Growth Rate (SGR) in Medicare for physician payments. The continual piecemeal "fixes" that have been enacted over the years have cost in the tens of billions, and enacting a permanent fix, such as the one passed by the House in October, would cost \$210 billion over the next ten years. This represents an additional health care expense regardless of the legislative vehicle that it comes in.

III. What are the fiscal risks?

Doing nothing

To begin with, there is the risk of doing nothing. Virtually all analysts and policymakers, regardless of ideology or partisan affiliation, agree that national health care costs are on an unsustainable track. National health expenditures are projected to rise from 17 percent of GDP in 2009 to over 20 percent by 2019. At the federal level, Medicare is projected to double as a share of GDP by 2035 and Medicaid is projected to increase from 1.8 percent of GDP to 3.4 percent over the same time frame. Thus in combination, these two programs alone will add expenditures equaling close to 5 percent of GDP to the budget

² CBO, Letter to Honorable Harry Reid, December 19, 2009, p.16.

by 2040. This is roughly the equivalent of adding an entire new defense department to the federal budget.³

Reducing health care cost growth -- not just over the 10-year budget window, but long into the future -- is thus a key consideration in piecing together a final bill. In that regard, doing nothing is not a responsible option. It does not follow, however, that doing *anything* would improve the situation. Bringing more than 30 million people into an unreformed, unsustainable system would, in fact, make the situation worse. The current bills contain many fiscal risks that must be considered in final negotiations.

Spending offsets that are not maintained over time

The Concord Coalition has often supported reductions in future Medicare costs. Because the current Medicare system is widely viewed as unsustainable, including by its trustees, any credible reform effort must include spending reductions. Unfortunately, any such reductions can be subject to the false, but politically toxic, charge of “slashing Medicare.”

Such politicking is unfortunate because it stirs opposition to hard policy options that must eventually be confronted and because ample evidence exists of wide variation in Medicare spending nationwide that has no apparent positive effect on health care outcomes. This suggests that it is possible to reduce Medicare spending without harming the health of beneficiaries.

However, there are legitimate concerns about the spending reductions being proposed. The first is that the cuts in the bills are all used to fund new health care spending and do not reduce overall federal health care costs. Instead, they simply shift priorities.

The second point of concern is that the magnitude of the spending cuts might prove difficult to maintain over time, either politically or in terms of maintaining beneficiary access to providers. Politically, the congressional experience with the SGR fixes shows that members of Congress can be persuaded to step in and prevent automatic cuts if they might harm the profitability of providers in their states and districts.

Furthermore, cuts that get too deep could lead providers to decline treatment for Medicare patients. This point is significant enough that both CBO and the Center for Medicare and Medicaid Services (CMS) noted it in their respective evaluations of the health care bills. As CBO has observed, “Adjusting for inflation, Medicare spending per beneficiary under the [Senate] legislation would increase at an average annual rate of less than 2 percent during the next two decades -- about half of the roughly 4 percent annual growth rate of the past two decades. It is unclear whether such a reduction in the growth rate could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or would reduce access to care or diminish the quality of care.”⁴

³ Defense spending in 2010 is projected to equal 4.8 percent of GDP.

⁴ CBO, Letter to Honorable Harry Reid, December, 19, 2009, p. 19.

An evaluation by the Chief Actuary of CMS stated that the estimated savings from Medicare “may be unrealistic.” In particular, the Chief Actuary noted that, “Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the providers’ costs of furnishing services to beneficiaries.”⁵

As a result, the Chief Actuary suggested that by 2019, roughly 20 percent of Medicare Part A providers would become unprofitable. Such an outcome would either lead to declining patient access or increased reimbursement by a Congress afraid its constituents might lose access.

The hope is that such prospective cuts will spur innovation and efficiencies among providers to avoid unprofitability. The Medicare Payment Advisory Commission (MedPAC) suggests in a recent report that hospitals with lower reimbursement rates have done just that.⁶ The risk is that it will be far easier just to lobby Congress to ease up on cuts.

This highlights the greater risk of counting on these provider cuts to offset new spending. If the cuts prove to be unattainable, yet the new spending grows as anticipated, the deficit will worsen. So while the numbers work out on paper, it is appropriate to point out the difficulties involved in making them work in practice.

“Curve benders” that don’t pan out or are not adopted more broadly

In some form or other, the two health care bills contain all of the usual strategies advocated by reformers to “bend the curve” of health care costs -- lowering health care inflation over the long term. These include experiments and pilot projects encouraging the creation of accountable care organizations, payment bundling, primary care incentives, coordinated care, wellness programs and prevention. If at least some of these prove successful and are extended more broadly they could both improve quality and achieve savings down the road. Yet, a risk of the House and Senate bills is that the long-term cost control strategies will not pan out, or that successful programs will not be expanded when appropriate to ensure long-term fiscal benefit.

Furthermore, current legislation falls short in linking the substantial investment in comparative effectiveness research made in the 2009 stimulus bill, and continued in these bills, with any concrete steps or processes designed to put that information to use. Ultimately, if we are going to reward doctors, hospitals and patients for making the choices that lead to the best health outcomes in the most efficient manner, they are going to need better information. While doing that research, we also need to start building the rules and infrastructure to disseminate that information and reward those who put it to good use. While suggesting the need to consider cost effectiveness when deciding

⁵ CMS Office of the Actuary, *Estimated Financial Effects of the “Patient Protection and Affordable Care Act of 2009,”* December 10, 2009 p. 8-9.

⁶ MedPAC is the board that now exists to advise Congress on Medicare payments. Its reports are non-binding and its recommendations are often ignored. Annual Report to Congress, March 2009.

treatments has often been demagogued as “rationing,” achieving health care cost sustainability will require some limits on what we pay for ineffective or unnecessary interventions.

There is another cost control strategy absent from both bills -- a substantive attempt at medical malpractice reform. The CBO has found that comprehensive reform would save the government over \$50 billion in its first 10 years both by reducing health care services utilization and by reducing medical malpractice costs (which increases government revenues from increased physician income tax collection). When looking for ways to incentivize changes in physician behavior, as well as looking for offsets to expanded coverage, this is an avenue that should be included.

Both bills makes small steps toward encouraging broad implementation of pilot projects that have proven effective. The Secretary of Health and Human Services is given some authority to expand programs that are shown to be cost effective and which improve or do not change quality of care. The Senate bill also includes an independent board (more about that below) given the power to suggest delivery system changes in Medicare that would be implemented unless blocked by Congress.

Some of these possible avenues for cost control were improved through last-minute changes in the Senate bill. If they get weakened in conference negotiations, the implementation of successful strategies will be left to whims of Congress. History has shown that Congress is often unwilling to enact cost-saving reforms when the federal savings come out of the pockets of key interest groups or constituencies. Thus, much of the hoped for long-term cost control in the bills depends on the willingness of future Congresses to make or allow the kinds of fundamental changes that the current Congress seems unwilling or unable to make. The changes this Congress is prepared to accept will only be enough to pay for the new spending commitments. While this is no small feat, it would not bend the curve. At best, it would provide future policymakers with more information and a framework for going forward.

Failure to include an effective cost control mechanism

One protection designed to ensure that long-term savings targets will actually be met and that successful cost control experiments will be implemented is the Independent Payment Advisory Board (IPAB) created in the Senate bill. This new board, not included in the House bill, would be comprised of health care experts. It would be tasked with making recommendations on slowing future Medicare cost growth. The Secretary of Health and Human Services (HHS) would be required to implement these recommendations unless Congress intervenes. The board would also be given authority to make non-binding recommendations on the broader health care system.

Establishing an independent board such as IPAB is one of the most important elements for cost control to include in the current legislation. In order for tight reimbursement levels to have a chance to stick, Medicare will have to reorient the delivery of health care away from fee-for-service payment, which rewards quantity, to paying for value and

quality of care. The board would be an important tool in this effort because it would help to insulate crucial decisions from interest group pressure and political temptations to micro-manage the entire Medicare program.

During the legislative process, the IPAB has survived numerous attempts to limit its power and many restrictions still exist. The original Finance Committee version stated, for example, that the board could not “restrict” Medicare benefits, “modify” program eligibility, raise taxes or “ration” health care. Unfortunately these still apply. However, while Medicare sustainability will likely require some combination of these things, such limitations would not necessarily be a fatal flaw, given that IPAB could still be effective in reorganizing Medicare payment and delivery systems -- also a necessary condition for slowing program cost growth.

The Finance Committee version also prohibited IPAB from altering reimbursements for doctors and hospitals for the first four years of its existence (2015-2018). Then, the initial bill debated in the full Senate went further and prohibited the board from submitting recommendations for anything beyond 2019 if the national health care expenditures grew more rapidly than Medicare expenditures. This limitation would have likely prevented any recommendations because Medicare expenditures historically tend to rise at lower rates than overall health care expenditures. (From 1970-2007 annual per capita Medicare inflation averaged 9.2 percent while the private health care average was 10.4 percent.)

An irony of this formula-based prohibition was that almost the entire cost-control structure of current health care legislation is predicated on the idea that reforms in Medicare can lead the way towards a broader reform of the private health care system. That is because Medicare’s market share and the government’s ability to experiment and alter Medicare makes it an easier vehicle for reform than trying to dictate systemic transformation in the private sector. Yet, with that restriction, IPAB’s ability to change Medicare would have been stuck waiting for the private sector to somehow restrain costs first. This turned the rationale of Medicare “leading the way” on its head and made no sense.

In the manager’s amendment added to the Senate bill immediately prior to the bill’s final consideration, the most onerous post-2019 restriction was eliminated. The IPAB will now be able to issue fast-tracked recommendations at least every other year beyond 2019, and advisory opinions in the intervening years. The board’s mission was also expanded to promote delivery system changes in the private health insurance plans within the newly created insurance exchanges. This additional power might lead to health care cost control throughout the entire economy, not just the federal sector. It is important for the future of health care cost control that the most recent changes -- which lifted restrictions and restored board power -- remain in the final conference report.

Lagging revenue increases

Raising revenue to pay for part of the cost of health care reform is a responsible offset. No one should be under any illusions that expanding coverage is cost-free. The main

challenge regarding the revenue offsets in any health reform package is in finding a revenue source capable of keeping pace with health care expenses, which will still rise rapidly, especially under reform that simultaneously expands coverage.

In order to sufficiently offset the costs of expanded coverage without creating substantial drag on economic activity, the tax policies contained in any health reform package should strive to achieve these goals:

- (1) ***A tax base that includes health spending.*** Taxes on this base allow revenues to grow at approximately the same rate as expenses. Taxing employer-provided health benefits (which are now exempt from the federal income tax) is one example of a revenue source that will keep pace with the costs of health care. As an added benefit, such taxes further the reform goal of letting consumers see a truer price of health care -- thus working to hold down spending.
- (2) ***Taxes not limited to a very narrow segment of the population.*** Limiting tax increases to only the very richest households means that marginal tax rates on such households would likely rise substantially compared with a tax increase levied on the broader population. Not only does this increase any adverse effects of the tax on economic incentives, but it raises a potential political challenge as one small segment of the population is asked to pay for the benefits that go largely to others. Broadly based tax increases, even if they remain progressive, spread the notion that all must contribute something for government benefits -- imposing an important breaker against “free lunch” spending giveaways.
- (3) ***A desired distribution of tax burdens that is as transparent as possible and easily tailored to adjust for fairness concerns.*** People bear the ultimate burden of any tax, whether it is levied directly on households or indirectly on businesses which hire real people, have real people who invest in them, and sell goods and services to real people. The advantage of transparently levying the tax at the household level (as opposed to the business level) is that the tax is more easily understood by those who bear its burden, and policymakers can more easily and precisely tailor that burden to account for different abilities to pay.
- (4) ***A tax specification that does not rely on a lack of indexing to general inflation to deepen the reach of the tax over time.*** Any rising path of revenues is likely to be undone over time (to keep revenues more constant), but this is especially true for a rising path that is due to inflation eroding the real value of what is exempt from the tax. This is the major problem with the Alternative Minimum Tax (AMT), which grows with inflation because its taxable income floor is unindexed.
- (5) ***A broad and robust version of the desirable aspects of the tax policy.*** Watered down, “mini” versions of targeted taxes often have little of their policy-intended effects on incentives or behavior and raise little revenue.

The problematic aspects of tax policy contained in the House health reform bill are the following: it provides no tax on health benefits (violates #1), and it heavily relies on a “millionaire” surtax (violates #2) which is unindexed (violates #4).

The bulk of the revenue raised in the House health reform bill (\$460 billion over 10 years) comes from a “millionaire surtax,” levied on individuals with annual incomes in excess of \$500,000 and couples in excess of \$1 million. In 2011, these thresholds would limit the surtax to only the top 0.2 percent of households,⁷ when the tax is estimated to raise \$31 billion in revenue. But because the income thresholds are not indexed for inflation, by 2019 the surtax would be paid by the top 0.5 percent of households, and the revenue raised would similarly more than double, to \$68 billion. This revenue offset thus relies on a tax levied on a very small segment of the population, and it grows over time because of the lack of indexing.

For those reasons, this is not likely to be a reliable revenue source to fund health care reform. Even if future Congresses allow the tax to reach further down into the income distribution (which they have not been willing to do with the AMT), the high-income surtax does not broaden the definition of taxable income to include any health benefits and so will not keep pace with the growth of the costs in the health reform bill. To be clear, we do not mean to suggest we are generally opposed to higher taxes on the wealthy. However, any such initiative would be better used for purposes not directly offsetting health care spending, such as the inevitable need to reduce the deficit once the economy is on a sounder footing.

The problematic aspects of tax policy in the Senate health reform bill are the following: it also relies on a high-income surtax, via an increase in the Medicare payroll tax, and adds an excise tax on only the most expensive insurance plans rather than health insurance more broadly (violates #2); furthermore, that tax on insurance plans is levied on insurers at the business level rather than on insured households (violates #3); and the threshold for the insurance excise tax is so high that any desirable effects on economic incentives are diluted (violates #5).

Compared with the House bill, the Senate’s health reform bill relies less on revenue increases to achieve deficit neutrality, but the bulk of its revenue comes from an excise tax on high-premium health insurance plans levied at the insurer level (\$149 billion over 10 years) and an increase in the Medicare payroll tax for high-income households (\$87 billion over 10 years). The Medicare tax increase amounts to another version of a high-income surtax, in this case applying to labor income only but also unindexed; it would affect individuals with earnings over \$200,000 (and joint earnings over \$250,000) and adds 0.9 percentage points to the current 2.9 percent tax. Note, however, that the fact that this tax increase is an increase in a “Medicare tax” does not mean it does anything to either improve Medicare’s financial position or even provide a revenue source that would keep up with the costs of the new federal health benefits it is intended to cover.

⁷ According to the Tax Policy Center (www.taxpolicycenter.org).

As estimated by the CBO and JCT, revenue from the excise tax has the potential to keep up with increasing health care costs -- a crucial element in the effort to prevent health care reform from increasing the deficit beyond the 10-year budget window. By indexing the exemption level to the rate of general inflation plus one percent, the excise tax would actually more than keep up with the growth in health costs to the extent that health inflation continues to exceed that index. While it seems that this indexing might violate goal #4, such growth in the excise tax over time (from just \$7 billion and \$13 billion in fiscal years 2013 and 2014 to \$35 billion in 2019) is an intended part of the policy package, as opposed to a stealth tax increase. That is because the tax is not just a revenue offset but also works synergistically with health reform goals. It does this by partially counteracting the large and distortionary subsidy to employer-provided health care operating through the federal income tax.

Current tax preferences for health insurance create perverse incentives that encourage higher demand for health care services and push up total health costs and expenditures. They are also regressive and unfair to those attempting to purchase their own health insurance. With substantial cuts in Medicare benefits off the table and delivery system reforms needing time and research to prove themselves, eliminating or substantially reducing the tax subsidy for employer-provided health care is very likely the single most reliable way to immediately begin to lower long-term health care costs. The tax will act as a type of budget cap, where insurers, businesses and individuals will have to increasingly become cost sensitive and prioritize resources for health care. Furthermore, the economic incidence of the excise tax will ultimately work in a manner similar to a reduction in the income tax exclusion: both tax increases result in a broader, more comprehensive (and more efficient) tax treatment of income where taxable wages rise. In fact, the JCT's tax estimate assumes a larger revenue take associated with increases in taxable income than from the levied excise tax itself.

The biggest problem with the Senate's proposed excise tax is probably that it is not large enough or comprehensive enough. In addition, the excise tax is an indirect tax levied on insurance companies but which will ultimately burden individuals (real people). The Senate opted for this tax instead of a reduction in the individual income tax exclusion, probably because the distribution of the burden of this tax would be less obviously tied to households. But a tax levied more directly on households would be more transparent and also more easily targeted to households at certain income levels or with certain characteristics.

General revenue bailout of the CLASS provision

One of the "offsets" used to achieve deficit reduction in both the House and Senate bills is actually a new entitlement program — the Community Living Assistance Services and Supports (CLASS) Act. It constitutes a glaring accounting gimmick and an obvious fiscal risk in the legislation.⁸

⁸ For more details on the CLASS Act and its flawed design, see "[The Other New Health Entitlement](#)," a Facing Facts Quarterly Report by The Concord Coalition, December, 2009.

The accounting gimmick is produced by the fact that the program would collect premiums for the first five years before paying out benefits. On paper, this sum counts as an offset against other provisions of health care reform. However, as noted above, this money is not a savings. It represents premiums that would be needed to pay benefits once the five-year vesting period ends. The fiscal risk comes because the program itself is not well designed. While the legislation states that the program needs to be “actuarially sound” -- with premiums high enough to support benefits -- such a claim relies both on trust fund accounting and optimistic assumptions about premium levels.

The bill establishes a voluntary public long-term care insurance program open to any active worker (in the Senate bill) or any active worker and nonworking spouse (in the House bill). Cash benefits would be payable after a five-year waiting period. It would also guarantee coverage without exclusion for pre-existing conditions and allow enrollees to opt in and out of the program.

Given these conditions, the program will inevitably attract disproportionate numbers of sicker and more costly participants. This leads to the clear danger of an adverse selection ‘death spiral’ because necessary premium increases would make the program even less attractive for younger, healthier workers. As more people drop out, premiums would have to go even higher. In the end, there will likely be strong pressure for Congress to bail out the program with general revenues, regardless of any current intent for the system to be actuarially sound. Furthermore, because the program pays for a panoply of desirable home-care benefits, but fails to provide for adequate oversight, it also invites moral hazard. Even as adverse selection drives up costs and premiums, so will induced demand.

The dramatic increase in projected premiums for the program over the past several months indicates great uncertainty as to the program’s stability and sustainability. The Senate bill introduced in March 2009 set the first year monthly premium at \$30. A later version more than doubled the premium to \$65. The current version does not set a specific premium, however, the CBO assumes that an actuarially appropriate premium for the CLASS Act would range from \$123 per month in the Senate bill to \$146 per month in the House version. The CMS has suggested it might be even higher, at \$240 per month.

The vulnerability of American families to rising long-term care costs is a legitimate policy concern. But the CLASS Act, with its budget gimmickry and flawed design, is not the answer. To be sure, proponents insist that the CLASS Act will not cost taxpayers a dime. But in fact, it poses a serious risk of becoming a large and growing burden on the budget.

Inadequate premium subsidies, weak penalties and a poorly designed exchange

If reform contains a mandate for individuals to purchase health insurance, as seems a likely precondition to enacting broad insurance reform, it is responsible and necessary to have subsidies generous enough for the currently uninsured to be able to afford insurance. Lowering subsidies for the sole purpose of making reform less costly does not make

sense in the long run if it creates an incentive for families to forgo purchasing insurance. A better approach would be to figure out what the right subsidy policy should be, and then pay for it honestly and responsibly.

The same considerations exist for the penalties for the individual and employer mandates. If the penalties are too low, individuals or employers will pay the penalties instead of purchasing or providing insurance -- raising costs for everyone else. Or, on the employer side, improperly designed mandates or penalties could distort hiring decisions to favor some over others, depending on applicants' health insurance needs or income.

Additionally, a poorly designed and haphazardly regulated insurance purchasing exchange will either raise costs for everyone (including the government) or lead to the provision of inadequate coverage -- negating the point of creating the new insurance entitlement in the first place. On subsidies, penalties, and exchange design, the House bill does a better job of setting in place an adequate framework for coverage expansion.

The danger in simply trying to cut costs on these provisions without consideration of the best policy design is that in the long-run you could wind up in a less fiscally responsible place. As mentioned already, insurance premiums will be lower the more people and businesses participate. Furthermore, if the middle class ultimately can't afford insurance and begin to punish their elected representatives, the temptation for those representatives will be to throw more money at the problem. Doing it correctly now -- in the context of a bill that is paid for -- is far preferable to future action taken while under political duress, where the extra spending is much less likely to be paid for. The constant need to revise the SGR is an example of the reality of this risk.

IV. Concluding suggestions for improving the bills

In Concord's view, the best approach to reform would be to enact several cost control strategies, such as those contained in the pending legislation, and see if they work before expanding coverage. Expanding coverage first means adding more than 30 million people to a system that is not assured of improving value or outcomes and is fiscally unsustainable already.

As CBO Director Douglas Elmendorf warned several months ago, "Without meaningful reforms, the substantial costs of many current proposals to expand federal subsidies for health insurance would be much more likely to worsen the long-term budget outlook than to improve it."⁹ While CBO has since concluded that the House and Senate bills would not worsen the budget outlook, it is far from clear that the necessary meaningful reforms will be enacted to improve it.

Moreover, to the extent that higher taxes on the wealthy and substantial reductions in Medicare cost growth are used to pay for new commitments, they will not be available to close the preexisting budget gap. This would leave future policymakers with fewer and more politically difficult options. Any "low hanging fruit" will have already been picked.

⁹ CBO, Letter to Honorable Kent Conrad, June 16, 2009, p. 1.

However, the congressional leadership and the Obama Administration have chosen to lead with coverage expansion. Given that choice, we must evaluate the legislation at hand.

If we are going to expand coverage first, every effort must be made to ensure that the final bill contains the strongest possible mechanisms for producing reliable savings over time -- not just by paying for new commitments but actually reducing costs to a more sustainable level. For those who are genuinely concerned with expanding coverage in a fiscally responsible manner, the place to fight for cost control is in the conference committee that will convene when Congress returns in January.

In our view, the two most important items for controlling long-term costs that must be retained and preferably strengthened in the conference committee are the excise tax on high-cost insurance plans and the Independent Payment Advisory Board. In addition, we view the new long-term care entitlement (CLASS) as a poorly designed and fiscally unsound program that should be deferred for future consideration and revision. Finally, we would include the full cost of a permanent adjustment to the Medicare sustainable growth rate for physician payments in the total cost of reform.

Tax on high-cost insurance plans

It will be crucial for this tax to be included in the final bill, and not limited any more than it already has been. Health care economists on either side of the partisan divide have often argued that the tax-free nature of employer-provided health insurance drains federal revenues and encourages higher spending on health care. As CBO has suggested, “Changes in the tax exclusion for employer-sponsored health insurance can affect the efficiency of health care financed by the private sector, by giving workers stronger incentives to seek lower-cost health insurance plans. Those steps could well have spillover effects on Medicare.”¹⁰

While the tax, as designed, would not be as effective in reining in costs nor raise as much revenue as lifting the exclusion, it would promote the same general purpose. Relying on traditional tax increases that are not tied to the health care system would not provide any downward pressure on costs and would eventually fall behind the growth rate of health care spending.

Independent Payment Advisory Board

The bills contain many promising reforms that could, if successful and broadly implemented, begin to control costs. There will be strong political headwinds, however, against any reform that bucks the status quo by asking any particular stakeholder to give up any advantage it now enjoys. That is why a permanent non-political panel of experts with constant focus on the need for improvements is so crucial. It is the only real

¹⁰ Ibid.

mechanism in either bill to provide a path from experimentation to practice. It has the potential to be, in White House budget director Peter Orszag's words, a "game changer."

The IPAB must be empowered to make recommendations over the long-term that can transform all aspects of the Medicare delivery and payment systems without exclusions. Health care reform is not a one-time initiative. It will take many years of work and tinkering to put the system on a sustainable path. Moreover, a limited scope means limited effectiveness and complaints that the process is not fair. Efforts to exclude the IPAB from the final legislation, or to weaken it further than it has been, would only serve to signal that lawmakers are not yet prepared to accept the kind of changes that will truly transform our health care system.

CLASS

Further improving the bill would be the elimination of the CLASS Act. As it stands, CLASS embodies the worst sort of budgetary and actuarial chicanery. It pretends that premiums can be double-counted both as a near-term budget offset and as long-term savings. And it violates the most basic principles of sound insurance design by failing to provide for either underwriting or a mandate and by underfunding the oversight needed to detect fraud. The losers will be today's younger taxpayers, who will have to bear the ultimate cost.