

THE CONCORD COALITION



Issue brief

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Rockefeller Amendment Would Strengthen Cost Control in Senate Health Care Legislation

Health care legislation currently being debated in the Senate creates a new Independent Medicare Advisory Board (IMAB). The board, not included in the House bill, would be tasked with making recommendations on slowing Medicare cost growth. The Secretary of Health and Human Services (HHS) would implement these recommendations unless Congress intervened with legislation to prevent the changes from taking effect. Unfortunately, the current version of this proposal places such severe restrictions on the IMAB that its effectiveness as a cost-control mechanism would be minimal. An amendment offered by Senators Rockefeller (D-WV), Lieberman (I-CT), Whitehouse (D-RI) and Bingaman (D-NM) would remove many of these restrictions and greatly improve the ability of IMAB to fulfill its potential.

In The Concord Coalition's view, establishing an independent Medicare review panel such as IMAB is a crucial element for cost control. As we stated in an October 9, 2009 letter to Senate Majority Leader Harry Reid (D-NV):

“Reducing health care cost inflation over the long-term is an enormous task that is crucial for our future fiscal sustainability. However, the only thing certain about the effort is that we are not certain which mix of policy tools will ultimately be successful in accomplishing the task. Savings from many cost control strategies included in the Senate bills -- such as payment reform, comparative effectiveness research, prevention programs and greater use of health care information technology -- are quite uncertain, involve substantial upfront costs, and at best would take many years to fully materialize. Under these circumstances, it is critical for any health care reform legislation to include a permanent review mechanism with the authority to make recommendations that must be considered by Congress. Enacting such a mechanism would help to ensure that assumed savings are realized, guard against unintended consequences, and provide a means to implement future ‘curve bending’ reforms.”

Health care analysts generally agree that for Medicare cost growth to slow, we will need 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 commission would be an important tool in this effort because it would help to isolate crucial decisions necessary to reorganize delivery and payment systems from interest group pressure and political temptations to micro-manage the entire Medicare program. This firewall is of even greater necessity under the very tight reimbursement levels assumed in the Senate legislation, which would require, at the very least, major efficiency improvements on the part of Medicare providers. These reduced reimbursement levels are likely to be politically difficult to maintain over time. Yet sticking to them will be necessary to meet the legislation's deficit reduction estimates provided by the Congressional Budget Office. Having a back-up mechanism in place to monitor the results and recommend new strategies as needed will be crucial. The IMAB would fill this role. Consisting of experts empowered to review the plethora of delivery system experiments, trials and pilot projects contained in the legislation, it would be able to implement those with the most promise system-wide. Congress would retain the ultimate authority to overturn these decisions, but it could not simply ignore them.

The current version of IMAB, which differs from the version contained in the Senate Finance Committee bill, effectively neuters the Board's powers. Even the original Finance Committee version had troubling restrictions. It stated, for example, that the IMAB could not “restrict” Medicare benefits, “modify” program eligibility, raise taxes or “ration” health care. While Medicare sustainability will likely require some combination of these things, such limitations would not necessarily be a fatal flaw, given that IMAB could still be effective in reorganizing Medicare payment and delivery systems -- also a necessary condition for slowing program cost growth.

Now, however, the commission has had additional limitations placed on it. While the Finance Committee version had already prohibited IMAB from altering reimbursements for doctors and hospitals for the first four years of its existence (2015-2018), the current version likely prohibits the board from even submitting recommendations for anything beyond 2019. That is because recommendations that must be considered by Congress will only be allowed if the five-year average of national health care expenditures grows more rapidly than five-year average Medicare expenditures. This limitation would likely be a de facto prohibition, because of the strict reimbursement schedule for Medicare included in the bill, and the fact that 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 is 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 this restriction, IMAB’s ability to change Medicare will instead be stuck waiting for the private sector to somehow restrain costs first. If private sectors costs continue to rise at unsustainable rates, Medicare can too. This turns the rationale of Medicare “leading the way” on its head and makes no sense.

The amendment being proposed by Senator Rockefeller would fix many of these restrictions and lift the board back to a position where it would be poised to encourage rapid innovation in Medicare, suggest similar innovations in the private sector, and serve as a crucial backstop against politically motivated attempts to increase reimbursement levels above that which is fiscally responsible.

The Board would be charged with making proposals annually, meaning even when cost-control targets were met, it could still propose delivery system changes covering the full range of Medicare providers. The commission would also be able to promote similar 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.

This amendment, along with another sponsored by Senator Mark Warner (D-VA) that strengthens some of the smaller cost-control ideas contained within the Senate’s bill, would be promising additions to the current legislation. As now written, the legislation barely achieves deficit neutrality over the long term, has a large amount of downside fiscal risk because of the large and certain new insurance subsidies and much less certain offsets to pay for them, and offers uncertain prospects for attacking the fundamental problem of health care inflation and its deleterious role in the country’s long-term fiscal outlook.