



## **The Importance of a Cost Control Enforcement Entity in Health Care Reform Legislation**

### **I. Health care savings: trust but verify**

Despite the contentious nature of the debate over health care reform, all sides accept one central premise: the projected growth rate of health care costs is unsustainable. Cost control is thus fundamental to the nation's fiscal sustainability and economic well-being. Because of that, it is the key to successful health care reform. Unfortunately, the preliminary legislative proposals in the House and Senate do not go far enough in restructuring the health care system in ways that might "bend the curve" of per-capita cost growth. While they do promote limited delivery system and payment reforms, The Concord Coalition agrees with Congressional Budget Office (CBO) Director Douglas Elmendorf<sup>1</sup> that current proposals lack the fundamental changes that are needed. Even more troubling is CBO's conclusion that at least one of the main proposals (H.R. 3200) "would probably generate substantial increases in federal deficits during the decade beyond the current 10-year budget window."<sup>2</sup>

It is possible that the final product to emerge from the legislative process will respond to these concerns with more aggressive and specific cost reduction measures. It is also possible that the drive to produce "something" will result in a bill with budgetary gimmicks and little prospect of meaningful cost control. In either case, there will be a need to continually monitor projected savings, evaluate cost growth rates, and recommend further changes as needed. This is made all the more important by the fact that savings from many cost control strategies -- 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.

### **II. The administration's proposal**

The Obama administration has proposed the creation a new panel of experts called the Independent Medicare Advisory Council (IMAC). The idea for such a council is not new to the reform debate, and is often referred to as a "Super MedPAC," named after the Medicare Payments and Advisory Commission. This commission, established in 1997 with bipartisan support, makes thoughtful recommendations to Congress with an eye towards reducing

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<sup>1</sup> Testimony before the Senate Budget Committee on July 16, 2009 regarding "The Long-Term Budget Outlook."

<sup>2</sup> Letter to Representative David Camp from CBO Director Douglas Elmendorf, July 26, 2009, p.13.

unnecessary and inefficient Medicare spending. Yet, their suggestions are just advisory, and Congress routinely ignores them. To its credit, the administration has proposed a number of Medicare reforms taken from past MedPAC recommendations to help pay for health care reform, and it is likely that many of these will be used as offsets in the final health care bill. However, without enhanced authority for MedPAC or a new entity with enforcement powers, it seems likely that future recommendations for change will fall victim to the same political and interest group pressures that have prevailed in the past.

The administration's IMAC proposal is a very valuable contribution to the health care reform debate. It would set up an ongoing process, beginning in 2015, whereby the panel of health care experts, not politicians, would make annual recommendations to the President on Medicare payment rates, which are now set by Congress. The President would have to accept or reject the recommendations as a whole. If the recommendations were accepted, they would become law unless Congress adopted a joint resolution disapproving them within 30 days. Structuring the system in this way would ensure the default action would be beneficial to the budget outlook.

Moreover, the IMAC would have authority to make broader Medicare reform recommendations subject to certain limits. It could not, for example, abolish the Medicare trust funds or interfere with the practice of Medicine. Those limitations still allow for plenty of room to recommend substantial reforms in payment and delivery mechanisms where much of the Medicare cost drivers exist. And, while IMAC would not have jurisdiction over the broader health care system, it is quite likely that reforms in Medicare -- the largest payer of the nation's health care bills -- would influence the rest of the system.

The IMAC would serve as a permanent cost and quality sentinel for Medicare. Its recommendations would be prohibited from causing an aggregate increase in Medicare expenditures over a 10-year period relative to what they would otherwise be, and any proposed reforms would have to either "improve the quality of medical care received by beneficiaries" or "improve the efficiency of the Medicare program's operations." These combined criteria would provide continuous opportunities to improve value in health care.

Establishing such a panel would allow experts to evaluate the year-to-year and procedure-by-procedure operations of Medicare based on their professional expertise. Since Members of Congress are not all authorities on the particulars of health care finance and up-to-date on specific procedures and devices, leaving these decisions to them sometimes allows for parochial decision-making which reflects neither fiscal responsibility nor quality health care. Under the proposal, Congress would retain its appropriate authority to override the panel's recommendations, but unlike the current situation with MedPac, Congress could not prevent the recommendations from taking effect by simply ignoring them.

### **III. The need to think long term**

In response to a request from Majority Leader Steny Hoyer (D-MD), the Congressional Budget Office (CBO) provided an evaluation of the IMAC proposal including potential cost savings.<sup>3</sup> It is important to look carefully at what CBO said in this regard because much of the reaction from members of Congress and the media focused undue attention on the rather trivial point that

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<sup>3</sup> ["Approaches for Giving the President Broad Authority to Change Medicare,"](#) (July 25, 2009).

IMAC would only save about \$2 billion over the next 10 years. This would be significant *only* if the purpose of IMAC was to save money in the short-term. However, that is decidedly *not* the purpose of IMAC. Its fundamental purpose, as described by the President’s budget director Peter Orszag, is to “provide a mechanism for improving quality of care for beneficiaries and reducing costs over the long-term.”<sup>4</sup> This valuable function is unrelated to whatever short-term savings may result. Moreover, as noted by CBO, the first recommendations of IMAC would not take effect until 2016, meaning that it would be operational in only four of the coming 10 years. During that period, CBO also notes that under the House bill (H.R.3200) “payment rates for nearly all Medicare services would grow more slowly than anticipated inflation. Thus, ... it is unlikely that IMAC would recommend substantial additional savings (relative to savings already expected under H.R. 3200) through *further* reductions in Medicare payment rates.” (emphasis in original).<sup>5</sup>

This is a good example of why it is crucial to distinguish between two fundamental objectives of health care reform: deficit neutrality over 10 years and long-term pressure to reduce projected costs. Both are important, but not all proposals will contribute to both objectives. All proposals should be evaluated for what they are designed to do. The true value of IMAC is not in its potential to achieve 10-year deficit neutrality. It is in its potential to be a long-term “watchdog,” continually working towards cutting costs and reacting to the health care system’s evolution. By its nature, any such entity should be formed and assessed with an eye towards the longer-term budget picture. Even with the long-term, however, “scoreable” savings are not the key to evaluating a proposal such as IMAC. Savings projections from process reform are always more uncertain than those from specific policy changes. It is impossible to know what a future entity might recommend, how a future President might react, and whether a future Congress would assent. What is most important is establishing a credible and effective process.

In that regard, CBO concluded in its letter to Rep. Hoyer:

[I]f legislation were to provide an independent advisory council with broad authority, establish ambitious but feasible savings targets, and create a clear fall-back mechanism for instituting across-the-board reductions in net Medicare outlays, CBO believes such a council would identify steps that could eventually achieve annual savings equivalent to several percent of total spending on Medicare. Achieving such savings, in addition to those estimated to result from the provisions in H.R. 3200 that govern Medicare’s payment rates, would probably require significant changes in the program’s coverage, benefit design, and payment and delivery systems -- and a council with the clear mandate, independence, and resources to propose such changes.<sup>6</sup>

These suggestions imply that IMAC, or a similar mechanism, has the potential for producing substantial savings. As proposed, IMAC does not have savings targets or a "fall-back" mechanism. Both would be good additions. CBO’s conclusion is also a reminder that process changes alone will not be enough.

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<sup>4</sup> OMB, Director’s Blog “CBO and IMAC,” July 25, 2009.

<sup>5</sup> CBO letter to Hoyer, p.3.

<sup>6</sup> CBO letter to Hoyer, p.2.

The Administration's proposal is not the only useful model. Representative Jim Cooper (D-TN) and Senator Jay Rockefeller (D-WV) have proposed the “MedPAC Reform Act of 2009” (H.R. 2718, S. 1110), which would rename the current agency as the “Medicare Payment and Access Commission” and establish it as an independent executive agency. The Commission would be provided with broad authority capable of setting Medicare payment rates and advising the Secretary of Health and Human Services on funding health research.

Another alternative, sponsored by Senator Rockefeller, would seek to further enhance cost containment enforcement by establishing a 1.5 percent annual target for expenditure reductions. The Government Accountability Office would audit such changes to ensure the target is achieved. If the target were not met, the Secretary would implement an automatic cut to reimbursement rates for providers of services and suppliers under Medicare Parts A and B. Both of these bills in Congress would require a supermajority to overrule the Commission’s changes.

Other similar mechanisms may yet emerge from the Senate Finance Committee or from members seeking to improve the overall health care legislation. The precise design is less important than having a *permanent* structure with broad authority and enforcement powers to ensure continual review and guaranteed action.

#### **IV. Conclusion**

Policymakers must recognize that rising health care costs are too large of a problem to solve in a one-shot reform. Short-term savings might only have a negligible contribution to long-term sustainability and even those reforms intended to produce long-term savings may need a mid-course correction. Thus, any legislative package looking to rein in rising costs should include a cost control enforcement entity. And that entity must be given the tools to do the job.