

THE CONCORD COALITION



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October 9, 2009

The Honorable Harry Reid
Majority Leader
United States Senate
Washington DC

Dear Senator Reid,

We have followed the health care reform debate very carefully. We applaud you and the entire Congress for focusing on what we consider to be the most important and most difficult public policy issue. And, we applaud your concern for the potential fiscal impact of the final legislation. It is that concern which brings us to write this letter to you.

In the coming days, you have the unenviable task of combining the Senate Finance Committee's health care reform bill with the bill that emerged from the Health, Education, Labor and Pensions Committee. Aware of the difficulty and the competing pressures you face, we have identified in the attached memorandum key areas where we believe the potential of the legislation to produce fiscal gains can be strengthened. We hope our views will help guide your work -- consistent with fiscal responsibility and sustainability.

In making these suggestions, we are reminded of the words of the late Paul Tsongas, a former Senate colleague from Massachusetts who inspired the founding of The Concord Coalition. In 1992, Senator Tsongas warned:

America faces great economic peril as our standard of living is threatened by current economic policies. Once the world's greatest economic power, we are selling off our national patrimony as we sink ever deeper into national debt....This nation's will is not being called upon on the home front because of a fear that our people are not ready for an honest and forceful response to these threats. I strongly disagree....The purposeful avoidance of difficult issues caused serious erosion to our society. The icon of indulgence that we worshiped during the past decade has proven to be a false god.

Those same words could be spoken today. The only difference between then and now is that 17 years have elapsed and the circumstances we face are worse -- particularly with regard to health care costs.

In that spirit, we strongly urge you to submit a bill to the Senate that does not add to our long-term fiscal deficits. Senator Reid, you have tackled the most difficult and daunting domestic public issue our country faces. We recognize how challenging it can be to balance short-term demands for more benefits with long-term need for fiscal balance. We applaud you for your efforts to achieve that balance. We encourage you to stay the course and send to the floor a bill that accomplishes that objective and have attached a memo, which details our concerns and recommendations.



Bob Kerrey



Peter G. Peterson



Warren B. Rudman

Attachment

MEMORANDUM: HEALTH CARE REFORM

- A broad consensus exists that health care spending in the United States is already on an unsustainable path, not just for the federal government, but for families, businesses and local governments as well. Making this problem worse may avoid short-term political pain but it will not make life easier in the long run.
- It is a lot easier to come up with new ways to expand health care coverage than it is to find politically acceptable ways of paying for it.
- Paying for healthcare reform over the 10-year budget window -- the main focus of attention in Washington -- is an important and responsible goal, but it is not sufficient. 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, even a legitimately paid for 10-year bill could still leave health care on an unsustainable track absent reforms that produce long-term savings from current projections. Thus, reform legislation must not only pay for itself, but must actually *reduce* projected costs.
- Using tax increases to cover the cost of new commitments is a more responsible approach to reform than reliance on new borrowing but would not necessarily control costs and would not be available to achieve broader deficit reduction.
- Medicare is already facing a \$38 trillion unfunded obligation over the next 75 years. Using savings from this program, which we strongly support, to pay for new commitments would not leave overall health care spending on a more sustainable track
- Deficits really do matter to the public. While it is true that some opponents of reform may hide behind today’s high deficits for political motivations or as a means of protecting self-interest in maintaining the status quo, it is also true that the public has grown increasingly concerned with record deficits and spiraling debt -- and with good reason. The up-front costs of health care reform pose a major fiscal challenge that cannot be ignored or minimized.

All of the above must be kept in mind as you stitch together a mix of policies from the two Senate committee bills. We offer the following suggestions:

1. Tax incentives

We encourage you to keep the excise tax on high premium insurance plans. Current tax preferences for health insurance create perverse incentives that encourage higher health care spending. They are also regressive and unfair to those attempting to purchase their own health insurance.

Since health care reform should at a minimum be deficit neutral, raising revenue to pay for part of the cost is a responsible offset. No one should be under any illusions that expanding coverage

is cost-free. Not only would the excise tax proposed by the Finance Committee raise \$201 billion over 10 years, according to the Joint Committee on Taxation (JCT), but it would also serve as a constraint on plan premiums -- thereby encouraging insurers to exert downward pressure on provider costs. Furthermore, as estimated by the JCT, because the threshold for the excise tax is indexed to a rate below the rate of health care inflation, revenue from this provision is designed to grow faster than health care costs. That will increase its effectiveness at helping to control costs and make it a crucial element in the effort to prevent health care reform from increasing the deficit beyond the 10-year budget window. However, it is important to note that this approach will fail to produce the projected revenues if future lawmakers set aside its “bite.”

The excise tax contrasts with the approach taken in the House bill, which would impose a surtax on upper income households. While raising significant revenue, the House surtax lacks the potential to put downward pressure on health care cost growth and would lag behind the growth rate of new costs. It thus provides a less reliable source of funding. To be clear, we are not opposed to higher taxes on the wealthy. We believe, however, that any such initiative would be better used for other purposes, such as the inevitable need to reduce the deficit once the economy is on a sounder footing.

2. Payment reform

Fee-for-service payment -- reimbursing providers for each individual service -- contributes to rising costs in two ways. It maximizes costs by rewarding providers who do more, regardless of whether the increased volume contributes to better health. And, it encourages fragmented care rather than a coordinated approach in which providers are jointly accountable for a patient's health. When combined with third-party insurance coverage and open-ended budgets for public programs such as Medicare, this means no one has an incentive to minimize costs.

The Medicare Payment Advisory Council (MedPac) stated in its June 2008 report to Congress: “Fee-for-service (FFS) payment systems encourage service volume growth regardless of the quality or appropriateness of care....Because of this strong incentive for volume growth, a fundamental restructuring of Medicare payment systems toward quality and accountability is needed to improve the value of health care spending.”¹

In Massachusetts, where mandated universal coverage has not resulted in lower costs, a Special Commission recently reported that, “Most health care experts view fee-for-service payment as a primary reason for growing health care costs and fragmented, ineffective care. Fee-for-service payment gives providers financial incentives to favor high-cost procedures over low-cost procedures, increase the volume of tests and procedures, and deliver specialty care rather than primary care -- all with no necessary improvement in health outcomes.”²

Moving away from fee-for-service payments is a crucial element of reform. The Finance Committee bill includes payment reforms that have the promise of helping to control costs over the long-term. We support, for example, the demonstration projects for Accountable Care Organizations (ACO) to encourage coordinated care, and bundling of payments for episodes of

¹ MedPAC, *Report to the Congress, Reforming the Delivery System*, June 2008, p.7.

² Recommendations of the Special Commission on Health Care Payment System, July 16, 2009, p.24.

care. Ultimately, however, in our view neither bill does enough to change the perverse incentives in the current system.

3. Getting the incentives right on subsidies

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 Finance Committee bill's "free rider" provision designed to require employers to either provide insurance or pay for employee subsidies. While it attempts to lower the burden on small businesses, it creates high administrative costs and perverse incentives against hiring middle income workers or workers with families. A better approach would be to enact a traditional "pay or play" provision designed to prevent employers from dropping coverage and shifting costs to taxpayers.

Not creating proper incentives on insurance subsidies might wind up being less fiscally responsible in the long-run for two reasons. One, insurance premiums will be lower if everyone is able to participate in the system. And two, 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. It is very risky to count on the "fail safe" mechanism to keep subsidy costs in check. The constant need to revise Medicare's Sustainable Growth Rate (SGR) for physician payments serves as an example of what can happen (see below).

4. Fixing Medicare's sustainable growth rate

It has become quite obvious that Congress is not prepared to enforce the SGR formula for Medicare physician payments. Routine annual adjustments have been made to prevent scheduled cuts from taking effect but no permanent "fix" has been adopted. These incremental and temporary adjustments to physician payments have resulted in great uncertainty and a growing distortion of projected Medicare costs. When the Congressional Budget Office (CBO) or the Medicare Trustees forecast future expenditures they do so based on "current law," meaning that they assume the SGR targets will be enforced. This assumption produces phantom savings. As stated by the Trustees in their 2009 report on Medicare's finances, "It is important to note that projected...expenditures are substantially understated because future reductions in physician payment rate, required under current law, are unrealistic and very likely to be overridden by Congress."³

Unfortunately, the Finance Committee bill continues the practice of a one-year upward adjustment followed by an assumed cut of 25 percent. This is not a believable scenario and calls

³ 2009 Report of the Medicare Trustees, p. 79.

into question the claim of deficit neutrality. Indeed, in its preliminary scoring of the Finance Committee bill, CBO specifically notes, “These projections assume that the proposals are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation. For example, the sustainable growth rate (SGR) mechanism governing Medicare’s payments to physicians has frequently been modified...to avoid reductions in those payments.”

The House bill assumes a permanent fix to the SGR, but does not pay for it on a pay-as-you-go (PAYGO) basis. While we believe that the best approach would be to enact a permanent fix, and one that is paid for, we would rather see likely costs acknowledged than hidden behind an assumed cut that no one believes will actually happen.

5. Lower Medicare Part D subsidies

We urge you to include the Finance Committee’s proposal to reduce Medicare Part D subsidies for upper income beneficiaries. While this proposal does not generate huge savings, (\$11 billion) it sends an important signal that public dollars should not be used to provide generous subsidies to those who can afford to pay more on their own. We must begin to impose limits. Many people mistakenly assume that their Medicare premiums cover the cost of the program. They do not. In fact, the Part D premium is designed to cover just 25 percent of the benefits. That means all beneficiaries receive a general revenue subsidy of 75 percent. Lowering this subsidy would improve Medicare’s fiscal outlook, align the Part D structure with Part B’s reduced subsidy for the wealthy, and reduce a small portion of the price insensitivity that contributes to excess spending on health care. It is step in the right direction and we applaud the Finance Committee’s willingness to include it their bill.

6. Independent Commission

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. Given the experience with the SGR, it is easy to imagine that the provider payment restraints included in the Finance Committee bill would be overridden if the desired efficiencies in the delivery system do not materialize or providers are not willing to manage within the projected limits. Under these circumstances, it is critical for any health care reform legislation to include both realistic payment restraints and 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.

We encourage you to include a Medicare Commission like the one proposed by the Finance Committee in your legislation but are concerned that limitations on the commission and its jurisdiction could wind up impeding its effectiveness.

7. Avoid “Medicare for all”

Creation of a public plan might, or might not, help to control costs. If a public plan mandates coordinated care, insists on evidence-based practices and moves away from fee-for-service payments, it might help to control costs by encouraging the private sector to do the same. If, on the other hand, the public plan is “Medicare for all” with no payment or practice reform there is no reason to believe that it will help to slow the growth rate of healthcare spending, even if its price structure was somewhat lower than private sector plans.

8. Do not use the CLASS Act, a new entitlement program, as an offset for new spending

The Health, Education, Labor and Pensions Committee bill includes a new entitlement program, called the Community Living Assistance Services and Supports (CLASS) Act, which we believe is structurally and fiscally unsound. Moreover, the long-term cost of the program, which could be substantial, is hidden by the fact that it appears to produce a short-term windfall and actually scores as a budget “offset.” This is because the program would collect premiums for the first five years before paying out benefits. On paper, this sum would count as an offset against other provisions of health care reform. However, this money is not a savings. It represents premiums that would be needed to pay benefits once the five-year vesting period ends. Beyond the scoring issue, we are concerned that the program itself is not well designed. The American Academy of Actuaries and CBO have estimated that monthly premiums would need to be substantially higher than originally projected by proponents of the bill. There is a 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. We are concerned that in the end, there would 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.