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CONGRESS HAS ALLOWED MOST PREVIOUS MEDICARE CUTS TO TAKE EFFECT, NEW STUDY SHOWS

Contradicts Claim That Health Reform Bills Will Increase Deficit

Despite claims that the pending health reform bills aren't really paid for because Congress never lets Medicare savings take effect, Congress has allowed the vast majority of Medicare cuts that it enacted in the past two decades to take effect and produce significant savings, a new study shows.

The analysis, by James Horney and Paul Van de Water, former senior CBO officials now at the Center, examines the history of every significant Medicare cut that Congress has enacted in the past 20 years – specifically, cuts included in deficit reduction legislation enacted in 1990, 1993, 1997, and 2005.

The authors found that virtually 100 percent of the 1990 savings survived; virtually 100 percent of the 1993 savings survived; virtually 100 percent of the 2005 savings survived; and nearly 80 percent of the 1997 savings survived.

“Today’s conventional wisdom is wrong,” said Horney. “Medicare savings have been a big part of all major deficit-reduction packages that Congress has enacted since 1990, and lawmakers have allowed the vast majority of those cuts to take effect. Given that history, there is every reason to believe that Congress will allow the Medicare savings in the pending bills to take effect as well.”

Main “Example” of Failure to Implement Cuts Rests on Misunderstanding

In arguing that large Medicare cuts never “stick,” many critics focus on Congress’ repeated refusal to let the reductions in doctor reimbursement rates under Medicare’s “Sustainable Growth Rate” (SGR) mechanism to take full effect.

But, as the report explains, Congress didn’t intend the SGR to produce large savings. In fact, the SGR represented only 3 percent of the total ten-year Medicare savings in the 1997 deficit-reduction bill – only \$12 billion of the \$394 billion in total Medicare savings over ten years, as CBO estimated at the time.

Because it was badly designed, however, the SGR would actually have cut payments to physicians much more than had been anticipated and well below the level needed to keep pace with doctors’ costs. Congress’ decision to forestall these unintended cuts was therefore justified on policy grounds.

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But, Congress did not simply cancel the SGR and let physician reimbursement rates grow willy-nilly. In fact, although Congress has since 2002 prevented the full SGR cuts from going into effect, it has cut physician reimbursement rates substantially below what was needed simply to keep pace with inflation. Even if Congress blocks the next scheduled SGR cut and freezes the rate at current levels, the rate next year will be *17 percent below* the rate in effect in 2001, adjusted for medical inflation.

The Medicare savings provisions in the House and Senate health bills are very different from the poorly designed SGR cut. Instead, they are similar in both size and design to the past Medicare cuts that Congress has allowed to take effect.

Bills Contain Wide Range of Cost-Containment Measures

Claims that the House and Senate health reform bills lack serious cost-containment provisions also do not withstand close scrutiny, the report explains.

“These bills contain just about every reform that health policy experts have proposed to slow health care costs over time,” notes Van de Water. “While we will ultimately have to do much more, the bills take most of the steps that we know enough about to pursue now in the areas that experts view as promising.”

In Medicare, the bills would scale back overpayments to private insurers, reduce annual payment updates for hospitals and other providers, and, in the House bill, lower prescription drug costs. To reduce costs across the entire health care system, the bills would promote competition among insurers by creating an insurance exchange, cut insurers’ administrative costs, invest in preventive care, penalize hospitals with high readmission rates, and establish pilot projects in various areas to help determine the best approaches to controlling health care costs (while giving federal health officials some new authority to implement some changes in Medicare based on the knowledge gained without having to enact new legislation). In addition, the Senate bill would impose an excise tax on high-cost insurance plans to discourage overuse of health care and would create an independent board with the power to implement cost savings in Medicare.

“Lawmakers can strengthen the final bill by combining the strongest cost-control elements of the House and Senate bills,” Van de Water said.

Bills Are Fully Paid For and Would Begin to Rein in Long-Term Health Costs

A third major claim by critics — that, in the near term, the House and Senate bills would raise the nation’s total health care expenditures — is correct but not a meaningful argument against health reform, the report explains. Covering tens of millions of uninsured Americans will necessarily raise total health care spending in the short term.

“There are two fundamental tests for any health reform bill: does it expand coverage without increasing the deficit, and does it begin to slow health cost growth so total health spending will be lower over the long term than it otherwise would be? The House and Senate bills meet the first test and hold real promise for the second,” Horney said.

The Congressional Budget Office estimates that both bills would reduce deficits over the first ten years (the House bill by \$138 billion, the Senate bill by \$130 billion) and for at least a decade after that. Moreover, under the Senate bill, the total federal cost for all health care spending and tax subsidies in the decade after 2019 would be no higher than if we continued current law, according to CBO. This is a major accomplishment for a bill that extends coverage to more than 30 million of the uninsured, the report notes.

Finally, some critics complain that the CBO cost estimates showing that the bills would reduce the deficit are misleading and rest upon a gimmick — specifically, that neither the House nor the Senate bill includes a measure to permanently eliminate the SGR mechanism. Since Congress likely will continue to prevent the SGR from taking effect, critics say, Congress and CBO should consider the cost of such action as part of the cost of the health reform bills. Once that cost is added, they argue, the contention that the bills do not increase the deficit is false.

Indeed, Congress likely will never let the full SGR cuts take effect, and it probably won't offset the cost of scrapping them. But that cost is neither part of, nor in any way a result of, health care reform — the federal government will incur this cost regardless of health care reform, not because of it. This fact is undeniable: if health reform legislation were to die tomorrow, the full SGR cost would remain. To be sure, it would be better if Congress offset the cost of cancelling the SGR cuts. But that issue is separate from the question of whether the health care reform bills themselves add to the deficit or not.

The full report is available at <http://www.cbpp.org/cms/index.cfm?fa=view&id=3021>.

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