

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM
January 19, 2015

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on “A Permanent Solution to the SGR: The Time Is Now”

On Wednesday, January 21, 2015 at 10:15 am in 2322 Rayburn House Office Building, the Subcommittee on Health of the Committee on Energy and Commerce will hold a hearing entitled “A Permanent Solution to the SGR: The Time Is Now.” The hearing will recess following the conclusion of testimony and questions of the first panel, and will continue on Thursday January 22, 2015 at 10:15 am in 2322 Rayburn House Office Building for the second panel.

This memo describes the updated landscape for permanently repealing the Medicare Sustainable Growth Rate (SGR). A section-by-section summary of H.R. 4015, which was a bipartisan, bicameral bill introduced in the 113th Congress to replace the SGR, is attached as a supplement.

I. BACKGROUND

Since 2003, Congress has enacted 17 patches to address cuts to Medicare physician payments derived from the sustainable growth rate (SGR) formula. Cumulatively, Congress has spent a total of \$169.5 billion patching the SGR, which exceeds the current cost of the bipartisan repeal/replace legislation. The current Congressional Budget Office (CBO) estimate of the cost of H.R. 4015, is \$144 billion over ten years.¹

In early 2014, a historic agreement was reached between the Chairmen and Ranking Members of the House and Senate Committees of jurisdiction. Together, they introduced a

¹ Congressional Budget Office, *Medicare’s Payment to Physicians: the Budgetary Effects of Alternative Policies Relative to CBO’s April 2014 Baseline updates for the Final Physician Fee Schedule Rule* (Nov. 14, 2014).

bipartisan bill to permanently repeal the SGR and replace it with a system that rewards value and quality (H.R. 4015, 113th Congress).

Seeing that it was unable to agree on whether and how to offset the SGR repeal bill (before the last patch expired), Congress postponed further consideration of the bill. Rather, Congress went on to enact another year-long patch, which maintained physician payment rates through March 31, 2015, at a cost of \$15.8 billion.²

II. SGR OFFSET ISSUES

Some have advocated that the permanent SGR repeal bill would not need to be offset because the SGR formula's attendant costs result from budget gimmicks.³ In addition, both the CBO and the Medicare Chief Actuary have acknowledged that the current baseline fails to reflect secondary effects of major physician cuts, such as the costs for emergency room use, hospital visits, and Medicare Advantage enrollment. In addition to not accounting for these effects, the current baseline does not factor in political climate constraints, including the high likelihood that Congress would never allow Medicare physician payment cuts to reach 20 percent or more.

Despite this gimmickry and a forming legislative consensus to repeal SGR, the House Majority has strictly applied offset requirements where it relates to the SGR fix. In other comparable instances however (such as permanent AMT relief), the Majority has not been as strict in insisting on offsets to billions in government spending.^{4,5} Without demands for offsetting expenditures or receipts, the corresponding bills proceeded, uninterrupted and on-course through normal legislative order.

III. MEDICARE SPENDING

The Medicare program is stronger than ever. The most recent (2014) Medicare Trustees Report estimates that the Medicare Part A Trust fund will now be solvent until 2030, a four-year increase as compared to the 2013 Trustees Report, in part because of the Affordable Care Act and lower than expected spending on hospital stays.⁶

² Protecting Access to Medicare Act, PL 113-93.

³ American Medical Association, *Continuing to patch the SGR is fiscally irresponsible. Repeal is fiscally responsible*, White Paper (2014).

⁵ For example, House Republicans voted in 2012 for an ACA repeal bill that CBO scored as increasing the deficit by \$109 billion over ten years. Based on CBO's latest estimates, simply maintaining current physician payment rates and preventing SGR cuts for ten years would cost a similar amount: \$119 billion. To lend perspective, these amounts are roughly equivalent to the cost of a ten-year SGR fix for health-related bills they support.

⁶ Amy Goldstein, *Medicare Finances Improve Partly Due To ACA, Hospital Expenses, Trustee Report Says*, Washington Post (July 28, 2014).

Projected federal spending for Medicare and Medicaid have fallen by \$979 billion since 2010.⁷ Comparing CBO's [August 2010](#) and [August 2014](#) baselines, Medicare spending in 2015, will be about \$1,200 lower⁴ per person than was expected in 2010.⁸

IV. IMPACTS OF SGR OFFSETS ON BENEFICIARIES

Beneficiaries are already bearing increased costs as a result of a SGR fix. Increasing physician salaries raises beneficiary costs in two ways. First, beneficiary Part B premiums are set at 25 percent of Part B program costs. Fixing the SGR would increase overall Part B spending, thereby raising Part B premiums for beneficiaries. Second, beneficiary co-insurance is set as a percentage of service cost (i.e., 20 percent). To the extent that fixing the SGR increases the amount Medicare pays for individual physician services, the dollar amount of beneficiaries' out-of-pocket costs for individual services will increase.

Seniors are also bearing substantial cost burdens out-of-pocket for their Medicare coverage. On average, health expenses accounted for 14 percent of Medicare household budgets in 2012. This is nearly three times (3x) the share of health spending among non-Medicare households (5 percent).⁹ As it stands, most seniors live on very modest incomes. In 2013, half of all senior beneficiaries lived on less than \$23,500 per year. And, median incomes were substantially lower for black beneficiaries (\$16,350) or Hispanic beneficiaries (\$13,300), as well as those over 85 (more than half living on less than \$18,000 a year).¹⁰

V. MEDICARE STRUCTURAL REFORM PROPOSALS

In recent years, there have been a number of proposals to make structural reforms to the Medicare program, including proposals to alter the benefit, cost sharing, and eligibility structure. The President put forward proposals in previous budgets that included additional income-relating of premiums for higher income beneficiaries, increasing the Medicare deductible, and making changes to the sale of supplemental insurance policies (e.g., Medigap). Prior Administration budgets have also included proposals to ensure that Medicare obtains fairer prices for drugs (Part D rebate) and changes in provider payments to promote efficiency and accuracy.¹¹

⁷ Paul N. Van de Water, Center on Budget and Policy Priorities, *Projected Spending for Medicare and Medicaid Has Fallen by \$979 billion since 2010* (May 20, 2013) (online at <http://www.offthechartsblog.org/projected-medicare-and-medicaid-spending-has-fallen-by-900-billion/>).

⁸ Tricia Neuman et al., Kaiser Family Foundation, *The Mystery of the Missing \$1,00 Per Person: Can Medicare's Spending Slowdown Continue?* (Sept. 29, 2014).

⁹ Juliette Cubanski, et al., Kaiser Family Foundation, *Health Care on A Budget: The Financial Burden of Health Spending by Medicare Households* (Jan. 9, 2014).

¹⁰ Tricia Neuman et al., Kaiser Family Foundation, *Income and Assets of Medicare Beneficiaries, 2013 – 2020* (Jan. 9, 2014).

¹¹ Office of Management and Budget, *Living Within Our Means and Investing in the Future, The President's Plan for Economic Growth and Deficit Reduction* (Sept. 2011). Many of these proposals were also offered by the White House in the context of the Joint Select Committee on Deficit Reduction.

It is important to note that these proposals have all been offered in the context of a broader deficit reduction effort or budget blueprint, which included tax policies and other measures, and should not be considered in isolation. Many of these proposals are concerning in that they would shift additional costs to beneficiaries.

Former Senator Lieberman¹² and former CBO Director Alice Rivlin¹³ have also proposed deficit reduction proposals that used savings from cuts to and restructuring of Medicare as one component of a broader deficit package. Both Lieberman and Rivlin have previously expressed interest in moving Medicare to a premium support system. This concept would save money for the government by shifting significant costs to Medicare beneficiaries, particularly those who needed to remain in traditional Medicare (as opposed to a private plan).¹⁴ However, it would actually *increase* national health expenditures due to its reliance on private health insurance plans, which are more costly and less efficient than Medicare.

VI. WITNESSES

The following witnesses have been invited to testify:

Panel I - Wednesday

Joseph I. Lieberman

Former United States Senator

Alice Rivlin

Co-Chair, Delivery System Reform Initiative
Bipartisan Policy Center; and
Director, Engelberg Center for Health Reform
The Brookings Institution

Marilyn Moon

Institute Fellow
American Institutes for Research

Panel II - Thursday

Richard Umbdenstock

President and Chief Executive Officer
American Hospital Association

¹² A Bipartisan Plan To Save Medicare & Reduce the Debt, The Lieberman/Coburn Proposal (June 2011).

¹³ Domenici-Rivlin, *Debt Reduction Task Force Plan 2.0*, Bipartisan Policy Center (2013).

¹⁴ Paul Van de Water, Center on Budget and Policy Priorities, *Medicare in Ryan's 2015 Budget* (Apr. 8, 2014).

Alan Speir, M.D.

Medical Director
Cardiac Surgical Services for Inova Health System; and
Chair, Workforce on Health Policy, Reform, and Advocacy
The Society of Thoracic Surgeons

Eric Schneidewind

President-Elect
AARP

Geraldine O'Shea, D.O.

First Vice President
American Osteopathic Association Board of Trustees; and
Medical Director Foothills Women's Medical Center in California

Barbara McAneny, M.D.

Chair
American Medical Association Board of Trustees; and
CEO
New Mexico Oncology Hematology Consultants, Ltd

Ken P. Miller, PhD, R.N.

Board President
American Association of Nurse Practitioners