THE COMMITTEE ON ENERGY AND COMMERCE

MEMORANDUM

January 19, 2015

To: Health Subcommittee Members

From: Majority Committee Staff

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

On Wednesday, January 21, 2015 at 10:15 a.m. and Thursday, January 22, 2015, in 2322 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled "A Permanent Solution to the SGR: The Time Is Now." The Subcommittee will hear testimony from key thought leaders and representatives of the health care community about the need to advance a permanent legislative solution to the broken Medicare physician reimbursement formula known as the Sustainable Growth Rate (SGR).

Witnesses will discuss steps to advance bipartisan, bicameral SGR legislation, including a discussion of offsets. The following contains additional background on the witnesses and issues for consideration.

I. Witnesses

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; and,
- Marilyn Moon, Institute Fellow, American Institutes for Research.

Thursday

- Richard Umbdenstock, President and Chief Executive Officer, American Hospital Association;
- Alan Speir, M.D., Medical Director of Cardiac Surgical Services for Inova Health System, and Chair, Workforce on Health Policy, Reform, and Advocacy, The Society of Thoracic Surgeons;
- Eric Schneidewind, AARP, President-Elect;
- Geraldine O'Shea, D.O., First Vice President, AOA Board Of Trustees, and Medical Director, Foothills Women's Medical Center in California;
- Barbara McAneny, M.D., Chair, AMA Board of Trustees, and CEO, New Mexico Oncology Hematology Consultants, Ltd; and,
- Ken P. Miller, PhD, R.N., Board President, American Association of Nurse Practitioners.

II. Bipartisan, Bicameral SGR Legislation

In the 113th Congress, the Committee on Energy and Commerce Committee, the Committee on Ways and Means, and the Senate Committee on Finance agreed on a bipartisan bill to repeal the SGR. The product of this agreement, H.R. 4015, SGR Repeal and Medicare Provider Payment Modernization Act, was introduced by Michael C. Burgess, M.D. (R-TX) on February 6, 2014.[1] In the Senate, a similar SGR repeal bill, S. 2000, Medicare Provider Payment Modernization Act of 2014, was introduced.

H.R. 4015 would replace the SGR with new payment systems over the next several years. The major provisions of the new payment systems specified in H.R. 4015 are as follows (as summarized by the Congressional Budget Office):

- The bill would maintain payment rates at the current level for services on the physician fee schedule for the rest of calendar year 2014 and increase Medicare's payment rates for services on the physician fee schedule by 0.5 percent a year for services furnished during calendar years 2015 through 2018.

- Payment rates for services on the physician fee schedule would remain at the 2018 level through 2023, but the amounts paid to individual providers would be subject to adjustment through one of two mechanisms, depending on whether the physician chose to participate in a Merit-Based Incentive Payment System (MIPS) or an Alternative Payment Model (APM) program.

- For 2024 and subsequent years, there would be two payment rates for services on the physician fee schedule. For providers paid through the MIPS program, payment rates would be increased each year by 0.5 percent. For providers paid through an APM, payment rates would be increased each year by 1 percent.

- Payments to providers who participate in the MIPS program would be subject to positive or negative performance adjustments. Those adjustments would be designed to be offsetting in aggregate, so that they would have no net effect on overall payments. The performance adjustment for an individual provider would depend on that provider's performance compared to a performance threshold. In addition, H.R. 4015 would provide $500 million each year from 2018 to 2023 for an additional performance adjustment for providers achieving exceptional performance.

- Payments to providers who participate in an APM program (in particular, those who receive a substantial portion of their revenue from alternative payment models) would receive, from 2018 through 2023, a lump-sum payment equal to 5 percent of their Medicare payments in the prior year for services paid according to the physician fee schedule. Providers with revenue close to the APM revenue threshold would receive either no adjustment to their

[1] http://energycommerce.house.gov/press-release/committee-leaders-applaud-bipartisan-bicameral-agreement-repeal-and-replace-sgr.

Medicare payments or the MIPS performance adjustment if they reported measures and activities in that program. Providers would not be eligible for a lump-sum payment in 2024.

- In addition, H.R. 4015 would eliminate current-law penalties for providers who do not achieve meaningful use of electronic health records (EHR) or satisfactorily report data on quality. However, physicians would have to meet standards for use of EHR and quality as part of the MIPS program. Also, the bill would modify payment rates in certain California counties, adjust relative value units for certain physicians' services, and require the development of payment codes that would encourage care coordination and the use of medical homes. [2]

In a House vote on March 14, 2014, H.R. 4015 was approved by a vote of 238 to 181.[3]

III. Considerations for Congress

There is strong, broad support from Members of Congress and the patient and provider communities to adopt the bipartisan, bicameral SGR legislation. However, as a practical matter, the legislation must be offset or it will add approximately $140 billion to our nation's debt.

Despite this, some suggest that Congress not pay for the cost of the SGR legislation. This ignores the precedent set by Congress of paying for temporary fixes for more than a decade. According to the Center for a Responsible Federal Budget, Congress has paid for 98 percent of the temporary patches to the program since 2004 with equivalent savings—usually from health care programs.[4]

Therefore, it is imperative Congress work together to help offset the costs of permanently disposing of the SGR. The President's National Commission on Fiscal Responsibility and Reform (Fiscal Commission) recommended reforming the SGR and requiring the fix to be "fully offset."[5]

There are several common-sense, bipartisan health policies that can help reduce costs without cutting care. Some combination of these proposals could be used to help pay for the cost of SGR reform.

For example, the Fiscal Commission recommended modernizing Medicare's benefit structure, explaining:

> Medicare beneficiaries must navigate a hodge-podge of premiums, deductibles, and copays that offer neither spending predictability nor protection from catastrophic financial risk. Because cost-sharing for most medical services is low, the benefit structure encourages over-utilization of health care. In place of the current structure, the

[2] http://www.cbo.gov/sites/default/files/hr4015.pdf
[3] http://energycommerce.house.gov/press-release/house-passes-bill-keepthepromise-protect-seniors%E2%80%99-access-medicare-physicians
[4] http://crfb.org/blogs/sgr-continues-slow-health-care-cost-growth
[5] http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf

> Commission recommends establishing a single combined annual deductible . . . along with . . . uniform coinsurance on health spending above the deductible.[6]

Alice Rivlin authored a *Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment* with former Senators Bill Frist, Pete Domenici, and Tom Daschle.[7] This proposal endorses more competitive networks in Medicare, along with reforms to improve the Medicare benefit by providing long-overdue catastrophic protections and modernizing the cost-sharing design. This proposal would ensure that beneficiaries could visit their doctors without facing high out-of-pocket costs, but also would prohibit first-dollar supplemental coverage because it can lead to greater use of services without producing better outcomes. The proposal also reduces Federal subsidies for higher-income individuals.

Former U.S. Senator Joseph I. Lieberman authored a Medicare reform plan with former U.S. Senator Tom Coburn, which included similar benefit modernization proposals and included additional reforms.[8] The Office of the Actuary at Medicare estimated that the Lieberman-Coburn Medicare plan could save the program more than $530 and make Medicare solvent for the foreseeable future.[9]

The President also has embraced Medicare reforms that could save billions of dollars and be used to help offset the cost of the SGR legislation. For example, the President's fiscal year 2015 budget included one proposal to save nearly $50 billion by charging wealthier seniors more for their Medicare physician services and drug coverage.[10]

In summary, there are a number of common-sense, bipartisan policies that can help offset the cost of the SGR bill while improving and strengthening Medicare.

IV. Conclusion

Should you have any questions regarding the hearing, please contact Robert Horne or Josh Trent at 202-225-2927.

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[6] http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf
[7] http://bipartisanpolicy.org/library/health-care-cost-containment/.
[8] http://crfb.org/blogs/senators-lieberman-and-coburn-release-medicare-proposal.
[9] http://crfb.org/sites/default/files/lieberman-coburn_actuaries.pdf.
[10] https://www.cbo.gov/sites/default/files/45250-Health_Programs_Proposals.pdf .