Testimony Before the House Committee on Energy and Commerce

Health Subcommittee Hearing

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

The Honorable Joseph I. Lieberman, Former United States Senator

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Good morning. Chairman Pitts, Ranking Member Pallone, and members of the Committee. Thank you for the opportunity to testify before this committee on the issue of Medicare's physician reimbursement formula known as the Sustainable Growth Rate, or "SGR."

The Committee is here today to start taking what we all hope will be the final steps in Congress repealing the broken payment formula, the SGR. The members of this committee deserve a lot credit for working last Congress with their colleagues on other committees here in the House, and in the Senate, to forge a bipartisan bill to finally scrap the SGR and lay a foundation for better payment formulas to replace it. As someone who was perennially plagued by the SGR when I was in the Senate, my hat is off to members on both sides of the aisle, on both sides of the Hill, who rolled up their sleeves and achieved consensus on the bill to repeal the SGR.

We know too well the problem with the SGR. Created back in 1997 by Congress, the aim of the payment formula may have been laudable: to curb federal spending by restraining the growth of Medicare's reimbursements to physicians. Unfortunately, the crude budget cap did little to incentivize efficient provider or

patient behaviors. So, since 2002, Congress has routinely intervened to prevent cuts scheduled under the law, passing so-called "doc-fix" legislation, so physicians who provide care for Medicare beneficiaries continue to receive adequate reimbursement. Without repeated Congressional intervention, Medicare reimbursements would be dramatically reduced, threatening the quality and breadth of millions of seniors' access to care.

Today marks a critical juncture in the work of this Committee to pass SGR reform legislation. There has been bipartisan, bicameral agreement on the SGR policy. Now Congress must decide how to address the issue of the approximately $140 billion price tag of the legislation.

As is usual, there are a range of opinions in Congress on this issue. Some in Congress do not believe the estimated $140 billion cost of the bill needs to be offset. The SGR cost is just "funny money," so the argument goes—bad math due to years of temporary patches.

However, I find it interesting to note that, according to an analysis by the Center for a Responsible Federal Budget (CRFB), since 2004, Congress has offset 120 out of the 123 months of doc fixes with equivalent savings—98 percent of the time. As CFRB says, "even ignoring the couple times small gimmicks were used,

policymakers still paid for these delays 95 percent of the time – with almost all of those savings coming from health care programs."[1]

More importantly, according to the Congressional Budget Office, if the SGR bill is not offset, it will increase the nation's deficit. And while there are a lot of issues Congress may disagree on, we should be able to agree that we cannot keep spending money we don't have while charging growing debts to our national credit card.

Today our national debt stands at $18 trillion. The Congressional Budget Office has warned that continued deficit spending could eventually lead to reduced economic output, reduced household incomes, reduced discretionary spending on other important priorities, and even increase the chance of another sudden fiscal crisis.[2]

So now members of this Committee need to finish their work by figuring out how to pay for the SGR bill. I know discussions over offsets can sometimes be tense. During my service in the U.S. Senate, I certainly disagreed –with members of both parties—on any number of "pay-fors" over time.

So, in the spirit of being constructive and supportive of Congress' work on the SGR, I am here today to offer my perspective on policies that could be adopted

[1] http://crfb.org/blogs/actually-sgr-has-slowed-health-care-cost-growth
[2] https://www.cbo.gov/sites/default/files/45471-Long-TermBudgetOutlook_7-29.pdf

as a possible path forward. These ideas are based on a Medicare proposal I introduced in the summer of 2011 with former U.S. Senator Tom Coburn.

As I have reviewed the bipartisan, bicameral agreement on SGR reform, I find that it adopts some new policies that are consistent some of our thinking behind the Lieberman-Coburn Medicare reform plan. While our proposal did not permanently scrap the SGR, it did allocate savings to provide a three-year "bridge" toward a new payment models. At the time we said three years was enough time for Congress to develop proposals to replace the SGR. Little did we realize how accurate that estimation would be at the time. So, while the policies Tom Coburn and I outlined could provide some of savings necessary to pay for the SGR reform, the SGR reform agreement could also serve as a platform from which to move naturally to larger Medicare reform that will strengthen the program for years to come.

There are a lot of issues that Tom Coburn and I disagreed on; but there are two bigger things we agreed on that brought us together. First, we both loved our country and saw that it was heading over a fiscal cliff unless people like us came together to get our government's books back in balance. Second, we both loved our children and grandchildren and didn't want to leave our country to them in such an economic mess that they would not have the same opportunities we had,

growing up in America. So Senator Coburn and I put forward a proposal which would have preserved Medicare for current and future seniors.

One reason we offered a package of Medicare reforms was that the biggest structural drivers of our national debt are entitlements, including Medicare. In FY 2015, gross spending on Medicare totaled $605.9 billion as Medicare provided coverage to 55 million individuals who are 65 or older, disabled, or have end-stage renal disease.[3] According to CBO, Medicare's spending will continue to climb over the coming decade—totaling well over $1 trillion just in 2024—while the number of Baby Boomers enrolled swells by a third.[4] At the same time, each Medicare beneficiary will, on the average, take almost three times more out in Medicare benefits than they put in to the system in payroll taxes and premiums.[5]

If we do nothing, Medicare's continued mandatory spending will consume more and more general revenue, as Parts B and D (doctor's services and prescription drugs) will continue to drain increasingly large and unacceptable amounts from our federal treasury, adding to our already-enormous debt. This will also crowd out federal spending on important discretionary programs. And at some point in the next decade, Medicare's Hospital Insurance Trust Fund will be insolvent. Each year, the actual date of anticipated of the HI Trust Fund's

[3] http://www.hhs.gov/budget/fy2015/fy-2015-budget-in-brief.pdf
[4] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf
[5] http://www.washingtonpost.com/wp-dyn/content/article/2011/01/02/AR2011010203213.html, http://www.urban.org/UploadedPDF/412945-Social-Security-and-Medicare-Taxes-and-Benefits-over-a-Lifetime.pdf

insolvency moves slightly closer or farther away, as the models used by CBO and the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) are very sensitive to small changes in the baseline or in base assumptions. But arguing about when Medicare's trust fund is going to be insolvent is a little like arguing over the speed of an oncoming tidal wave—speed is relevant, but it's the scope and direction of the problem that determines the outcome. That's why the status quo in Medicare cannot continue.

Therefore, Medicare reforms are not only important, they are necessary and lead to two tough but unavoidable conclusions. First, we can't balance our budget without dealing with mandatory spending programs like Medicare. Second, we can only save Medicare if we change it. The status quo is unsustainable.

So I offer some specific ideas from our proposal which can help pay for the costs of this needed change to Medicare – fixing the broken SGR formula. I should stress that, while Senator Coburn and I offered our proposal as a coherent whole, our blueprint includes a number of policies and reforms which Congress could chose to adopt and *modify* to help pay for the SGR bill. Our proposal asked just about everyone to give something to help preserve Medicare. But the effects were significant. According to the Office of the Actuary at CMS, the reforms we proposed could save Medicare more than $535 billion and extend the solvency of Medicare for the foreseeable future.

Benefit Modernization. The Medicare benefit structure has long been criticized for being too complex and for promoting overutilization, which wastes taxpayers' money. Within the current Medicare system, cost-sharing such as copays and deductibles vary significantly depending on the type of service provided. Building on a recommendation from the President's fiscal commission, our proposal would streamline Medicare into a single combined annual deductible of $550 for both Part A and B services. Streamlining the deductibles would make it easier for seniors to navigate Medicare while also directly reducing overutilization.

The proposal would also add an annual "out-of-pocket maximum" of $7,500 so that each Medicare recipient would have a cap on annual medical costs to protect them from financial hardship or bankruptcy in the event of a major illness. Medicare enrollees do not have this protection now. That means that, if our proposal were adopted, for the first time in history, seniors would be protected from paying more than $7,500 out of their pockets for health care in any one year because of a serious medical crisis or long term illness. This maximum out-of-pocket protection is the reason most Americans buy health insurance – so they are protected against the financial costs of a devastating illness or disease. Yet, it's a shame that basic Medicare does not offer seniors this peace of mind. There's no reason Congress shouldn't change that.

Medigap Reforms. Today, roughly one in five Medicare enrollees obtain supplemental coverage known as a "Medigap" policy to pay deductibles and copays. Most seniors buy these policies because of the lack of maximum out-of-pocket protection I mentioned previously. Because Medigap plans cover all of the "gaps" in an enrollee's Medicare coverage, policyholders use up to 25% more services than Medicare participants who have no supplemental coverage, even though numerous studies have indicated that this increase in utilization does not lead to better health care outcomes.[6] And because enrollees are only liable for a small portion of this increase in utilization, it is taxpayers – through Medicare costs – and not Medigap insurers who bear most of the costs that result from the increased utilization. Federal costs for Medicare could be reduced significantly if Medigap plans were restructured so that policyholders faced *minimal* cost-sharing for all Medicare services. So, similar to the recommendation from the President's fiscal commission, our proposal would bar Medigap policies from paying any of the first $550 of an enrollee's cost-sharing liabilities and would limit coverage to half of the remaining coinsurance up to the newly created $7,500 max out-of-pocket.[7]

Let me address some objections I have heard to this particular policy. Some worry that changing Medigap plan offerings removes a choice from beneficiaries.

[6] Sample literature: https://www.fas.org/sgp/crs/misc/R42745.pdf, http://www.gao.gov/products/GAO-13-811
[7] Citing original Lieberman-Coburn materials.

Actually, by modernizing the Medicare benefit, Congress would be giving seniors a better choice in traditional Medicare. Others worry about how such changes would impact lower-income beneficiaries. They say that changing first-dollar cost-sharing could harm low-income beneficiaries by allowing them to face greater cost-sharing. However, as mentioned, in addition to the low-income protections that eligible seniors would enjoy, all seniors in traditional Medicare would benefit from more predictable and transparent cost-sharing. Because they would have a maximum out-of-pocket protection, they would not need to buy an expensive Medigap policy to enjoy peace of mind and financial stability. In fact, a 2011 Kaiser Family Foundation analysis released after our proposal was introduced found that Medigap reforms similar to ours would have a profound effect on seniors' pocketbooks in a positive way.[8] Kaiser estimated that roughly four out of five seniors would save money with Medigap reforms, and some seniors would save more than $1,000 a year from this change. I'd challenge anyone to come up with a policy which saves the Medicare program and also reduces costs for 80% of seniors! Moreover, the study also found that even if insurers did not pass the full amount of savings directly to seniors, or if seniors didn't make notable behavioral changes, the policy would still substantially save seniors and the program money.

[8] http://kff.org/medicare/report/potential-effects-of-medigap-reforms

Increasing Income-Related Premiums. Our proposal required higher income Americans to pay more for their share of Medicare Parts A, B and D. For Medicare Parts B and D, we asked the wealthiest Americans to pay 100 percent of *premium* cost. I do not believe tax dollars should be used to pay premiums for those who can afford to pay on their own. For example, according to data the Social Security Administration shared with Dr. Coburn, there are more than 60,000 seniors enrolled in Medicare with annual income at or above $1 million. With Medicare facing a financial crisis, why should we subsidize their premiums? Our policy would allow the wealthiest seniors to remain in the program, but they would be responsible for the full share of their premiums.

Eligibility Age. The eligibility age for Medicare benefits is 65, although certain people qualify for coverage earlier because of disability. Since the creation of the Medicare program in 1965, life expectancy and the average length of time that people are covered by Medicare has risen dramatically. According to the Centers for Disease Control, when Medicare was passed in 1965, the average lifespan for Americans was 70.2. In 2006, the average lifespan for Americans was 77.7 – an increase of 10.6%.[9] This increase in the length of time an enrollee may be covered by Medicare has significantly raised the costs of the overall program. Our proposal would increase the eligibility age for Medicare over a 12 year period from 65 to 67

[9] Citing original Lieberman-Coburn materials.

to reflect gains in life expectancy, which has increased since 1965, from about 70 to just under 78 now. Under our plan, as the eligibility age increased two months each year, so too would the access to the exchanges created under the ACA. The eventual eligibility age of 77 has been viewed by some as a radical change to Medicare. But the greatest threat to Medicare is not reform; it's the status quo. I also find it interesting that some critics disparage moving the age to 77, even though that would mirror the eligibility age of Social Security. A survey from Gallup last year found that one in four seniors over age 65 are still employed.[10] A similar survey in 2013 found that fully three-quarters of workers anticipate working past the retirement age.[11] Importantly, adopting this particular reform would not change the benefit for a single senior – but it could help save the program for the millions of seniors to come.

Aligning Premiums With Value. Medicare Part B allows seniors to purchase insurance coverage for physicians' and other outpatient services for a set monthly premium. When the program began in 1966, the premium was intended to finance 50% of Part B costs per aged enrollee with the remainder funded by the federal government. President Lyndon Johnson noted this 50/50 cost share in his speech when he signed Medicare into law saying, "And under a separate plan, when you are 65 you may be covered for medical and surgical fees whether you are in or out

[10] http://www.gallup.com/poll/165470/end-recession-seniors-workforce.aspx
[11] http://www.gallup.com/poll/162758/three-four-workers-plan-work-past-retirement-age.aspx

of the hospital. You will pay $3 per month after you are 65 and your Government will contribute an equal amount."[12]

Subsequent legislation has reduced that share and premium collections fell to less than 25% of program revenues in the early 1990s. The Balanced Budget Act of 1997 permanently set the Part B premium at about 25% of Part B costs per aged enrollee. General revenues still fund the remaining 75% of Medicare Part B, which puts enormous pressure on the federal budget year over year. In 2011, the majority of Medicare enrollees paid a premium of $96.40 per month.

Our proposal would raise the basic Part B premium for all enrollees by 2% of program costs every year for five years until the premium level enrollees paid reached a minimum level of 35% of the program's cost in 2019. The dollar amount of the monthly premium increase per year would be, on average, approximately just $15-20 a month. While this particular reform may be seen as a non-starter for some, this policy could easily be modified so that only new beneficiaries enrolling in the program would face higher premiums.

I know the conventional wisdom suggests that Congress will never change Medicare premiums or cost-sharing until the program's financial status is in a much more dire state. But I believe there is a small cluster of benefit modernization reforms and premium changes which are not only sound policy; I believe these

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[12] http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650730.asp

policies can improve the basic Medicare benefit for millions of Americans. I also think a number of reforms in this area win bipartisan support. The President's fiscal commission endorsed similar reforms.[13] For example, in his FY 2015 Budget, President Obama endorsed policies which would:

- Increase income-related premium under Medicare Parts B and D, and;
- Modify Part B deductible for new enrollees, and;
- Introduce a Part B premium surcharge for new enrollees who purchase near first-dollar Medigap coverage.[14]

Now I encourage members of this Committee to build on the good bipartisan foundation they laid by continuing to work with their colleagues in exploring a range of policies in this area. I realize that some provisions will make some group of people unhappy and provide targets to attack. But as we have discussed: the SGR status quo is broken, and the overall status quo in Medicare will lead to insolvency and fiscal turmoil for the federal budget. The most compassionate thing members can do is act now to fix SGR and adopt some common-sense reforms – not punt on these issues to another Congress for another day. As a former legislator, I realize that adopting reform policies will require courage and cooperation. But these reforms not only strengthen the Medicare program and improve the benefit by making it more fair and predictable, they can be modified

[13] http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf
[14] https://www.cbo.gov/sites/default/files/45250-Health_Programs_Proposals.pdf

and adjusted as needed, as members seek to build a balanced package of reforms to offset the SGR. So if there is a failure to agree on policies as offsets and pay for SGR reform, it will not be a failure of policy options or lack of needed analysis; it would be a failure of bipartisan will to succeed.

In closing, let us reflect on the fact that the Medicare program will turn 50 years-old this summer. This critical program has provided needed health care to millions of Americans over the past five decades. But Congress needs to act now to adopt targeted policies – like fixing the SGR and paying for it with solid reforms— if the program is going to be strengthened and sustained for the next 50 years. Medicare's financing problems didn't emerge overnight, and they won't be fixed in a single bill. But the SGR reform bill presents members of the committee and members of this Congress with a truly historic opportunity to take a solid step forward in fixing Medicare's larger financing problems while eliminating the "doc-fix."

I realize reform-minded members are facing entrenched conventional wisdom betting that Congress and the President won't be able to reach an agreement, and will be forced to temporarily patch the program later this spring. But there's no reason Congress and the president can't prove the cynics wrong. You have already proven it's possible to forge a bipartisan agreement to solve the SGR problem. Now what is needed is a willingness to sit down and work together in coming

weeks to agree to offsets which can pass both chambers of Congress. Neither Democrats, nor Republicans, nor the Administration might get exactly what they want in a final bill. But working together, you can show the American people that it is possible to tackle big problems while adopting meaningful solutions that get our government's books more in balance and strengthen the Medicare program.