

Testimony of
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U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health Hearing on
“A Permanent Solution to the SGR: The Time is Now”

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Chairman Pitts, Ranking Member Green: I am delighted to participate in this hearing and commend you for diving into such a complex subject so early in the congressional session. This committee has the rare opportunity of restarting a bipartisan process, which can accomplish two important goals at once. You can replace the Medicare Sustainable Growth Rate (SGR) physician payment formula, thereby halting the unfortunate budgetary practice of creating an expensive temporary patch on the formula every year. At the same time, you can begin phasing in new payment incentives that will nudge Medicare and, indeed, the whole health delivery system, toward high-quality, more cost-effective delivery of care.

The SGR should be fixed—permanently. Bipartisan, bicameral cooperation can solve a problem that everyone wants solved. The SGR formula, with its pending [21 percent cut](#) to Medicare physician-fee-schedule payments, creates unnecessary uncertainty for Medicare providers. Keeping the formula in the law but postponing its impact every year makes our legislative process look ridiculous. Now is the time to stop kicking this problem down the road and get it fixed.

Replacing the SGR can advance payment reform. It can move health care delivery away from fee-for-service (FFS), which rewards volume rather than value, and toward higher quality and less waste. The tri-committee bill from 2014 included promising approaches to do just that, especially by proposing that future Medicare payment rate updates for physician-fee-schedule providers be contingent on participation in Alternative Payment Models (APMs) beginning in 2023. The tri-committee bill provides a good

foundation that can be strengthened. For example, my colleagues at the Bipartisan Policy Center (BPC) are releasing two [papers](#) today, which recommend accelerating the introduction of higher payments for providers that participate in alternative payment mechanisms (APMs) to 2018, and applying the incentives to all Medicare providers. The recommendations also include encouraging the transition to organized systems of care by making patient-centered medical homes (PCMHs) available nationwide and counting them as APMs. BPC recommends developing bundled payment as an APM to engage specialists in payment reform and enhance provider experience in partnering with other providers and sharing risk. BPC also recommends strengthening Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP) by adopting (1) prospective benchmarks, (2) prospective attribution, (3) a smaller set of quality measures more focused on patient health outcomes, (4) a patient-choice model that better engages beneficiaries in their care, and (5) a more viable pathway to taking on risk for spending and outcomes, including a transition from historical benchmarks to regional, risk-adjusted benchmarks.¹

These changes could alleviate many challenges that providers are struggling with today as they work to implement new models of care. For instance, “historical” or after-the-fact attribution of beneficiaries to an ACO makes it difficult for providers to know and be accountable for the population of patients they serve. Resetting ACO benchmarks every contract period may make the task of reducing cost and improving quality continuously too hard for providers to sustain. The long-term promise of these models won’t be realized if unrealistic short-term pressures for savings make it unlikely that many providers can succeed. These are all fixable problems that can be addressed as part of SGR reform.

Payment reform is still a work-in-progress with many details to be developed. Nevertheless, Congress can develop a road map that gives providers more certainty that it is worth investing in the infrastructure necessary to develop APMs, and that the future of health care delivery is rooted in new models of care.

¹ Bipartisan Policy Center, *Transitioning to Organized Systems of Care*, “[Medical Homes, Payment Bundles, and the Role of Fee-for-Service](#),” and “[Near-Term Recommendations to Improve Accountable Care Organizations in Medicare](#).” January 21, 2015.

These types of reforms have the most potential to deliver on the promise of improved healthcare delivery and should be at the heart of any SGR fix.

BPC is not alone in suggesting strengthening the tri-committee bill. In November, 2013, several of my Brookings colleagues and I submitted [comments](#) to the Senate Finance Committee on the proposed SGR Repeal and Medicare physician payment reform.² We strongly endorsed the basic thrust of the tri-committee bill and urged beefing it up in several dimensions. We recommended decoupling value-based payments (VPB) from fee-for-service payments. If VBP payments are add-ons to the physicians FFS payment, they risk intensifying the incentive to increase the volume of services rather than reducing it. We urged greater clarity in defining eligible APMs and up-front bonus payments to help physicians handle the initial costs of revamping the way they practice. We also supported accelerated development of APMs, introducing additional payment reforms, such as bundled payments for post-acute care, more aggressive efforts to develop and use improved performance measures, and delivery of more timely Medicare beneficiary data to physicians to help them track their performance and identify opportunities for improvement.

SGR reform must not add to future deficits. Cost growth in health care has slowed in recent years, which makes projected health care spending appear less daunting than it has in the past. Nevertheless, Medicare spending under a new payment model would be higher—about \$144 billion higher over ten years (more if the Medicare extenders are included) than under the current, unrealistic SGR formula. Fixing the SGR must be paid for – that’s just good budgeting. Congress should not establish a bad precedent by yielding to the temptation to waive the PayGo rules just to make it easier to get something as important as fixing the SGR done.

Paying for SGR is also an opportunity to find offsets that also demonstrate good health policy. Out of the many proposals for reforming health care it should be possible to put together a balanced set of

² Fontenot, et al. “Comment on Proposed SGR Repeal and Medicare Physician Payment Formula.” The Brookings Institution, November 12, 2013. <http://www.brookings.edu/research/opinions/2013/11/12-medicare-physician-payment-reform>

savings sufficient to offset the projected ten year costs of replacing the SGR with payments more likely to reward health care value.

In February, 2014, my colleagues at Brookings and I offered a [list of reforms](#) that we thought would move health care delivery toward more cost-effective spending and provide savings to offset the cost of repealing and replacing the SGR.³ These included reforming Medicare supplemental insurance to eliminate first dollar coverage; creating a single deductible and an out-of pocket limit for hospital and ambulatory care (Parts A and B) and modifying Medicare copayments; using competitive bidding to set payments and improve quality, starting with lab tests; rewarding beneficiaries for using generic drugs; raising the Medicare premium for higher income individuals; paying for post-acute care in the setting most appropriate to the patient's needs (not necessarily where the acute care occurred); and several others.

In November, 2014, the non-partisan Committee for a Responsible Federal Budget, on whose board I serve, released a [comprehensive list of offsets](#) that are designed to reduce health spending and bend the cost curve. These include many similar proposals, including encouraging the use of generic drugs, modernizing the Medicare Parts A and B cost-sharing rules, expanding the use of bundled payments; and restricting first dollar coverage in Medigap plans.⁴

In fixing the SGR and finding ways of paying for it, it is important to keep in mind the larger context of Medicare reform; it is a vital program upon which millions of seniors and people with disabilities depend on for health care. It must be preserved, strengthened, and modernized. In 2013, I joined former senators Pete Domenici, Tom Daschle and Bill Frist at the Bipartisan Policy Center in developing a [set of recommendations](#) to modernize the basic Medicare benefit and accelerate payment and delivery reforms.⁵

Included in this report are a variety of proposals that we believe would not only reduce costs, or at least

³ McClellan, M. Rivlin, A., Fontenot, K. "Paying for a Permanent, or Semi-Permanent, Medicare Physician Payment Fix." *Health Affairs*. February 2014. <http://healthaffairs.org/blog/2014/02/14/paying-for-a-permanent-or-semi-permanent-medicare-physician-payment-fix/>

⁴ The Committee for a Responsible Budget. "The Prep Plan: Paying for Reform and Extension Policies." November 17, 2014. <http://crfb.org/document/prep-plan-paying-reform-and-extension-policies>.

⁵ Rivlin, A. Frist, B. Domenici, P., Daschle, T. Bipartisan Policy Center. "A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment." Bipartisan Policy Center. April 2013. <http://bipartisanpolicy.org/library/health-care-cost-containment/>

not increase them, but also improve the Medicare program for beneficiaries. Let me share just a few examples:

- We developed a budget-neutral reform of Medicare’s beneficiary cost-sharing, which would combine the Part A and Part B deductibles, but also give all beneficiaries new protection against catastrophic out-of-pocket costs and ensure that all beneficiaries could see a doctor for only a copayment, even if the combined deductible isn’t yet met.
- We proposed to limit supplemental coverage, expand income-related premiums, and then invest a portion of the savings in providing new cost-sharing assistance to low-income beneficiaries who are near-poverty. These changes also relate to our proposal to allow providers who participate in APMs – or what we called Medicare Networks – to offer incentives (such as primary care cost-sharing discounts) to patients to improve care coordination, patient choice, and engagement.
- We suggested ways to create stronger incentives for beneficiaries of the Part D Low-Income Subsidy to use high-quality, lower-cost drugs, when available.

As these overlapping lists make clear, responsible non-partisan health policy analysts have worked hard to identify reforms that would offset the cost of SGR repeal and there is considerable convergence in their views. Not everyone who has endorsed a package of offsets would defend all of the component parts individually. Cutting spending is always difficult and compromises are necessary to reach an agreement. But it should be possible for Congress to agree on a balanced list of offsets that are consistent with moving toward more cost-effective delivery.

That being said, finding sufficient offsets will be a heavy lift and it may prove impossible to find enough. In that situation, a [semi-permanent fix](#), as my Brookings colleagues and I termed it, would be far better than another one-year patch.

A semi-permanent fix could include a five-year period of payment stability, which would cost roughly \$50 to 60 billion, and it should be paired with the structural reforms we discussed earlier – giving

physician-fee-schedule providers stronger incentives to participate in APMs and strengthening the new payment models themselves. One policy option that has been included in Democratic and Republican congressional budget proposals, as well as administration budget proposals, is an expansion of income-related premiums for higher-income Medicare beneficiaries. That alone could pay for a semi-permanent fix, while putting the health care system on a course of greater quality and efficiency for all beneficiaries and taxpayers.

Mr. Chairman and members of the Committee, we are at a critical juncture in health care. While cost growth has come down a great deal, we have experienced similar declines in the past only to see another round of rapid cost growth follow on its heels. It is absolutely critical that we keep the momentum going on health reform by demonstrating concretely to health care providers our commitment to move away from our current, antiquated, fee-for-service payment models in Federal programs. The single most important thing we can do as the Federal government is set this as a clear direction in Medicare, and the proposals you are now considering can move us in that direction.

Thank you again for the opportunity to share my thoughts on the SGR, payment reform, and our health care system. SGR is a tough problem, but it's an even bigger opportunity for the country. I urge all of the members of the committee, majority and minority, to work together to fix it this year. On behalf of my colleagues at BPC and Brookings, we look forward to continued dialogue and helping however we can.

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