



Real Possibilities

**TESTIMONY BEFORE THE
HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH**

“A Permanent Solution to the SGR: The Time is Now”

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Summary

Permanently repealing the sustainable growth rate formula will bring stability and predictability to health care providers and the Medicare beneficiaries they serve. Congress should also address “health extenders”, particularly:

- The Qualifying Individual (QI) program
- The therapy caps exception process
- Funding for community-based resources

In addition to the reimbursement reforms in the tri-committee bill last Congress, other system reforms recommended by AARP to help reduce Medicare spending include:

- Accelerate and expand competitive bidding for durable medical equipment;
- Equalizing Medicare payments for physician services between hospital outpatient and office settings;
- Recoup overpayments to Medicare Advantage plans;
- Increase support for transitional care and chronic care management;
- Ensure full and effective use of all highly skilled clinicians.

Congress should give strong consideration to the following prescription drug proposals that could save at least \$150 billion:

- Provide rebates for drugs provided to Medicare Part D low-income support beneficiaries who are dually eligible for Medicare and Medicaid;
- Enable the Secretary of Health and Human Services to negotiate for lower prescription drug prices;
- Reduce the exclusivity period for biologic drugs;
- Prohibit pay-for-delay agreements between brand-name pharmaceutical maker and generic manufacturers;
- Stop Risk Evaluation and Mitigation Strategies (REMS) from being used to block generic drug and biosimilar product development.

Statement

Chairman Upton, Ranking Member Pallone, Chairman Pitts, Ranking Member Green, and members of the Committee, thank you for holding this hearing on reforming Medicare physician reimbursement, and for inviting AARP to speak from the Medicare beneficiary's perspective. My name is Eric Schneidewind, and I am the AARP President-elect. AARP is a non-partisan organization of over 38 million members ages 50+, many of whom are Medicare beneficiaries.

For over a decade, millions of Medicare beneficiaries have heard annual warnings that their health care provider would stop seeing them if the schedule payment cuts due to the sustainable growth rate occur. While Congress has intervened each time to prevent the cuts, Medicare beneficiaries remain fearful of losing access to their doctor. Thanks to the tireless work of many of the legislators and staff here today, we are closer than we've ever been to finally replacing this broken reimbursement system.

During the previous Congress, AARP was pleased to work with Committee staff from both chambers and both parties in developing what became H.R. 4015. Permanently repealing the sustainable growth rate formula will bring stability and predictability to health care providers and the Medicare beneficiaries they serve. Moreover, the reimbursement reforms in the bicameral bill are a significant step toward improving quality and value in Medicare. We applaud the move toward more coordinated care; the streamlined quality reporting system; the greater use of quality measurement; and greater data transparency, among other improvements.

Specifically, we support the creation of the merit-based incentive payment system (MIPS). This system will consolidate quality reporting programs, while reimbursing providers for the quality of care they provide, not the volume of care. A robust set of quality measure will be necessary to effectively implement MIPS. We urge the Committee, though, to revise the measure development process established in the bill, and require that *all* new final, approved measures be endorsed by a consensus-based entity before inclusion in MIPS. This will ensure that quality measures are based on standard definitions and are compatible with one another, and within the larger health system. This will limit confusion, as well as build support and create buy-in from stakeholders, including beneficiaries.

We also support encouraging participation in alternative payment models (APM). While some health care providers may always need to operate within a fee-for-service system, alternative models, such as shared savings or bundled payments, should be encouraged. Incentivizing the adoption of APMs is necessary to spur the shift away from fee-for-service.

Additionally, we support expanding claims data availability to improve care. In particular, we support allowing Qualified Entities to share analyses and information more broadly. Expanding the availability of beneficiary-protected Medicare claims data will provide valuable insights into the quality, value, and outcomes of medical care. These insights can lead to a range of benefits, including creating better comparison-shopping tools, to helping providers pursue quality improvement and patient safety initiatives and enabling payers and providers to work together to build higher-performing networks.

However, the final bill introduced last Congress did not include important “health extenders” which are usually included with the annual “doc fix” legislation. Three provisions in particular are crucial to ensuring beneficiaries have access to needed care and services, and should be made permanent along with permanent SGR repeal legislation.

First, the Qualifying Individual (QI) Program pays Part B premiums for beneficiaries with incomes between 120 percent and 135 percent of the Federal Poverty Line - about \$14,000 to \$15,750 - and less than \$7,160 in assets for an individual. Most Medicare beneficiaries pay a monthly Part B premium of \$104.90, an out-of-pocket cost that low-income QI recipients cannot afford. This program has consistently been extended for periods in concert with SGR extensions. We urge the Committee to make the QI program permanent as part of SGR reform legislation. Failure to make the program permanent would seriously threaten vulnerable Medicare beneficiaries’ economic security and access to health care.

Second, Medicare therapy caps serve as a significant barrier to accessing needed care for people with long-term, chronic conditions, most notably for those who require long-term therapy services. Today, Medicare coverage for outpatient therapy services -- including physical, speech-language pathology, and occupational care -- is limited through arbitrary per-beneficiary payment caps imposed by the Budget Control Act of 1997. In 2005, Congress developed an exceptions process that allows people with Medicare to receive Medicare-covered therapy services above the cap when medically necessary. We urge Congress to repeal the Medicare therapy caps as part of an SGR reform package to

ensure access to needed care for older adults and people with disabilities. In the absence of full repeal, we ask that Congress make the therapy cap exceptions process permanent.

Third, we support permanently extending funding for critical community-based resources that are also expiring. This includes outreach and enrollment assistance to low-income Medicare beneficiaries, including an estimated 2.3 million individuals eligible for the Medicare Part D Low-Income Subsidy who are not enrolled in the program. As well as Aging and Disability Resource Centers (ADRC), the “no-wrong door” network of long-term care services and supports information and referral services.

AARP will not consider SGR repeal legislation “complete” unless these beneficiary protections are included.

Even if the policy provisions are agreed upon, a question still remains on the need for budget offsets. In light of current and future savings in the Medicare program, Congress would be justified in not fully offsetting the costs of a permanent repeal at this time. Other bills are being discussed without offsets. SGR repeal is of equal or greater necessity, and should not be delayed due to budget rules.

As the Committee considers legislation, it is important to remember that half of all Medicare beneficiaries live on an income of less than \$23,500 per year, and on average already spend 17 percent of their income on health care. Moreover, as recently as 2010, Medicare premiums and cost sharing consumed 26 percent of the average Social Security benefit. The typical Medicare beneficiary cannot afford to pay more out of pocket.

Additionally, standard beneficiary premiums are established to cover 25 percent of Part B spending. Given this, one quarter of any increase in Medicare Part B spending over current law, including physician pay updates like those proposed in H.R. 4015, will automatically be borne by beneficiaries in the form of higher premiums. Proposals to shift even more costs to Medicare beneficiaries are unfair, considering many older adults and people with disabilities have a limited income. Further, proposals to shift greater costs to seniors are an inequitable way to increase Medicare payments for providers.

AARP has long advocated for responsible solutions for slowing Medicare spending growth and improving the long-term fiscal health of the program, including delivery system reforms and program integrity efforts. The bicameral bill made substantial improvements in these areas, and represents significant structural change to the Medicare program. Other system reforms recommended by AARP to help reduce Medicare spending include:

- Accelerate and expand competitive bidding for durable medical equipment.
Competitive bidding is already saving Medicare and beneficiaries billions of dollars. Additional categories, such as home oxygen, clinical lab services, and non-durable products, could save billions more.
- Equalize Medicare payments for physician services between hospital outpatient and office settings. Equalizing Medicare payments for similar physician visits regardless of setting could save about \$9 billion over 10 years.
- Recoup overpayments to Medicare Advantage plans. “Up-coding”, or inflating a patient’s risk score to receive a higher risk-adjusted payment, have cost Medicare \$70 billion over 5 years.

- Increase support for transitional care and chronic care management. Improved transitional care post hospital discharge will reduce costly readmissions.
- Ensure full and effective use of all highly skilled clinicians. Increasing the supply of and more effectively using the services of nurse practitioners, physicians' assistants, and physicians, could improve consumers' access to care and reduce Medicare spending.

In addition, while lawmakers have considered shifting costs to beneficiaries, there has been little talk of reforming one of the most expensive areas of health care: prescription drugs. AARP firmly believes any discussion of budget offsets for Medicare reimbursement reform should include savings from prescription drugs. We urge you to give strong consideration to the following prescription drug proposals that could save at least \$150 billion – savings that would roughly offset the cost of the SGR fix:

- *Rebates* - AARP supports the Medicare Drug Savings Act requiring prescription drug manufacturers to provide rebates for drugs provided to Medicare Part D LIS beneficiaries who are dually eligible for Medicare and Medicaid. This legislation focuses on constructively reducing costs, and has been estimated to save \$141 billion over the next ten years, without negatively impacting Medicare Part D benefits or shifting costs on to Medicare beneficiaries.
- *Secretarial Negotiation* - Currently, the Part D program relies upon negotiations conducted by individual prescription drug plan sponsors to obtain lower drug prices. AARP has consistently supported legislation that would enable the Secretary of Health and Human Services to use the bargaining power of Medicare's 49 million beneficiaries to further negotiate for lower prescription drug prices, which is

especially important where there are no generic alternatives or competition in the class from other brands.

- *Biologic Drugs* - AARP supports reducing the exclusivity period for biologic drugs. Biologic drugs are some of the most expensive drugs on the market, and they hold the promise of treating some of the most serious diseases—such as multiple sclerosis, rheumatoid arthritis, cancer and others—that often affect older populations. Were the exclusivity period reduced from twelve years to seven years, it could result in billions of dollars in savings not only for beneficiaries and the Medicare program, but for employers and other health care payers.
- *Pay-for-Delay Agreements* - AARP urges Congress to take action on the Preserve Access to Affordable Generics Act sponsored by Senators Klobuchar and Grassley last Congress. This bipartisan bill would make it presumptively illegal for brand-name drug manufacturers to use pay-for-delay agreements to keep less expensive generic equivalents off the market. The CBO expects that enacting this legislation would accelerate the availability of lower-priced generic drugs and generate over \$4.7 billion in savings between fiscal years 2012 and 2021.¹
- *Risk Evaluation and Mitigation Strategies (REMS)* - AARP also supports addressing the loophole in FDA required Risk Evaluation and Mitigation Strategies (REMS). Unfortunately, REMS are increasingly being used to block access to samples of reference products to halt generic drug and biosimilar product development. The CBO has scored a proposal to ensure appropriate use of REMS to protect patient safety while maintaining access to generic drugs and biosimilars as saving Medicare \$753 million over ten years.

¹ Klobuchar: New Report Underscores Need for Legislation to Crack Down on Anti-Competitive Pay-for-Delay Deals, July 11, 2013, http://www.klobuchar.senate.gov/newsreleases_detail.cfm?id=345314&

Again, thank you for holding this hearing and for making SGR and Medicare reimbursement a priority at the start of the 114th Congress. SGR reform will bring stability to Medicare provider payments and help ensure beneficiary access to care. AARP welcomes the progress that has already been made and looks forward to working with you to get physician payment reform across the finish line. I am happy to answer any questions.