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Fixing the SGR While Protecting Medicare Beneficiaries

Testimony by

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Eliminating the Sustainable Growth Rate (SGR) under Medicare would constitute a major policy improvement. The SGR is widely recognized as a flawed policy; there is strong agreement that the limits it sets are too stringent and treat physicians unfairly. So far, however, the most that has been accomplished are short term fixes. The SGR has been modified 18 times since 2002, usually at the last minute. Numerous attempts to generate a permanent fix have stalled because of the cost estimates for doing so. Since technically the SGR is current law, any fix must address the cumulative impact of the formula which means a large budget price tag. Allowing the SGR to take effect would mean more than a 24 percent cut in payments for physicians because the “look back” effectively incorporates 15 years of flawed calculations. But many of the proposals to fix the SGR are often coupled with proposals to severely cut benefits in the Medicare program that would have a detrimental impact on beneficiaries. My testimony today will speak to the issues surrounding how to tackle the problem without making other undesirable policy changes.

Problems Generated by the Sustainable Growth Rate

The SGR has created instability in payment policy toward physicians and likely has contributed to a number of physicians declining to participate in Medicare or in limiting the number of Medicare patients they are willing to see. Critical providers of services to Medicare beneficiaries are threatened periodically with massive cuts in payments; and even when those reductions are eliminated at the last minute, the payment levels have been frozen or allowed to increase only modestly. It is no wonder that many physicians



are extremely mistrustful of participating in Medicare. While defections are not yet widespread, this is a major problem hanging over the program and should not continue.

The intent of the SGR was to provide discipline to the rapid growth in physician payments, but it has never helped with that issue. It is too broadly conceived—penalizing all physicians for growth in physician spending, for example. And other technical problems with the formula penalize physicians for events well beyond their control. Even very conscientious physicians need to find ways to offset the decline in real payments that have occurred over time, resulting in a situation in which the SGR actually encourages adding visits and upcoding to offset other losses. It needs to be replaced with a better mechanism for holding providers of services accountable.

The many activities now underway by CMS in its innovation demonstrations hold considerable promise of tackling the issues of paying for the right care in the right setting.

Early indications are that they will help over time with the issue of cost growth in Medicare, and likely improve the incentives that physicians face to provide quality care. Indeed, the recent slowdown in spending is likely attributable in part to the attention drawn to these efforts as well as to the weak economy. Whatever the reason, spending growth in Medicare does not carry the urgency it did just a few years ago. Care and



vigilance are necessary, but now is a particularly good time to eliminate a failed policy that promises only to alienate the provider community.

The Demand for Finding Savings to Offset the SGR Fix

Why is there a sense that there needs to be an offset to “pay” for this policy change? In the past, for example, not all of the temporary fixes have been offset by other cuts. And in many ways, this could be viewed as a technical adjustment that does not carry the same weight as introducing new spending policy. And with Medicare’s current slow rate of growth, it is appropriate to question why proposals to fix the SGR are tied to cuts in the program.

Historically, a tortured set of offsets to the costs of changing the SGR have been proposed. Usually what happens is only a temporary “fix” since that is not as costly. Why should Medicare beneficiaries be penalized for poor policy decisions made many years ago? If a more reasonable annual update policy had been adopted, there would be no need to find additional “revenues” because each annual update would have been part of the ordinary growth in Part B which, by statute, is covered by general revenues. Nothing about Medicare’s stability requires that the Part B change be covered by some type of benefit cuts elsewhere. Nonetheless, once again, the debate includes the issue of how to “pay” for what is in many ways an accounting artifact.



If There Must be Offsets, Why Medicare?

Many of the proposals to eliminate or replace the SGR have been paired with changes in the Medicare program that seek savings—usually at the expense of beneficiaries. Why should this desirable policy change be required to come from Medicare? A reasonable alternative would be to look for policies across the federal government that are similarly unwise for which repeal could generate savings. In the panoply of tax and spending policies, there are many examples. Closing tax loopholes that encourage inappropriate behavior on the part of taxpayers would be a good source of new revenues for example—and some of them essentially reflect the same type of unintended consequences from legislation or rules that do not work well in practice.

Part of the justification used for finding savings from Medicare is that it is viewed by some as too large. Certainly, Medicare has grown rapidly over time and needs to be examined for potential problems, but size does not automatically make it a desirable target. Health care spending for everyone has grown rapidly since the 1970s, and in fact, Medicare's per capita growth rates have been less than the rates of growth in the private insurance world over more than forty years. Medicare has been more successful at holding the line on spending growth than have other payers. Another source of growth in Medicare is from increases in the number of beneficiaries. Until the recent swelling of



enrollees from early Baby Boomers retiring, the reason for per capita growth has largely been the longer life expectancies of older Americans. This is an indication of the success of Medicare and not something to be rated a problem per se. Finally, the rate of growth on spending in Medicare has declined in recent years. Efforts to introduce new ways to control costs seem to be working. For all these reasons, Medicare should not be viewed as a runaway program.

The Problem of Paying for the Fix with Beneficiary Cuts

Beyond innovations to better control what spending occurs, most of the major options being discussed for reducing Medicare spending focus on increasing the share that beneficiaries pay or reducing the number of people eligible. Since people must still get care somewhere, such options are essentially ways of asking beneficiaries to pay more. For example, a higher age of eligibility is essentially a cut in benefits, especially for those who do not have access to subsidized insurance from employers or the federal government. Higher premiums or co-pays largely shift costs onto beneficiaries. Providing vouchers to purchase private insurance subject to limits on how fast federal subsidies can grow (an option referred to as premium support) is also a way to shift costs and risk onto beneficiaries. And even some of the “efficiencies” that limit access to care may be cost shifts if they do not truly improve the way that care is delivered but rather restrict access to needed services. Thus, most of the reforms under discussion would lower the share the federal government contributes to Medicare’s costs.



Are these the best strategies for supporting Medicare into the future? Medicare is in no way an overly generous program in terms of what it covers. Medicare pays only about 70 percent of the costs of the services it covers (and it fails to cover many important services). Beneficiaries (or their families or former employers) are responsible for the remainder. And just as costs to the federal government have risen over time, so have the costs to beneficiaries. They now pay a greater share of their incomes toward the costs of their care than ever before; incomes for all seniors have risen more slowly than the costs of health care that they must pay out of pocket.

And the problem is particularly severe for those with modest incomes whose resources keep them above eligibility for Medicaid or special low income protections, but low enough to make it difficult to afford care. One of the most urgent areas of need is for better low and moderate income protections for Medicare beneficiaries. In fact, often paired with a fix to the SGR has been a proposal to make the Qualified Individual (QI) program – that provides modest low income protections – a permanent part of Medicare. Good policy should actually take this even further, raising the very low limits on who gets aid.

Nonetheless, the proposals tend to move in the opposite direction—taking more out of the incomes of older and disabled Americans. For example, one option often proposed is to raise the Part B and D premiums to 35 percent of the costs of the insurance from their



current levels of 25 percent of costs. What does this mean for beneficiaries? A beneficiary with an income of \$18,000 per year is not eligible for any low income protections. If such a beneficiary faces the average out of pocket costs experienced by Medicare beneficiaries, that person would currently be spending nearly 15 percent of her income on Medicare (and even more on total healthcare costs). The premium increase of a little over \$500 per year would bring that burden to more than 17 percent of her income.

Other proposals sometimes discussed for Medicare would raise the cost sharing requirements, for example, by making home health benefits subject to the same type of requirements for other Part B services. Again, it is essential to consider whether this is sound policy. The users of home health services are among the most vulnerable beneficiaries: they are older and much sicker than on average and hence are less likely to be able to absorb that burden. Moreover, for these types of services, there is little evidence that cost sharing would curb unnecessary use. It is more likely that it would deter access to care for these most vulnerable of beneficiaries.

Raising the age of eligibility is another policy that can have unintended consequences in penalizing those least able to afford health care. Higher income beneficiaries are much more likely to either still be working or to have retiree benefits. Consequently, they would feel little burden. But those who cannot work because of poor health or whose skills make it difficult for them to remain in the labor force would be the ones most likely



penalized by such a change in eligibility. What sounds like an across-the-board change would not be so in practice. Further, raising the age of eligibility saves very little money since most beneficiaries in their mid-60s are healthier than average and tend to hold down the per capita costs of the program. Taking them out of the Medicare pool would result, for example, in higher Part B and D premiums for those who remain—another unintended consequence.

Even the increases aimed at “high income” beneficiaries would be painful for many who have already been asked to pay more out of pocket in recent years. The only way to get substantial savings from this is to continue to penalize those who by any other measure would be considered middle class since the number of truly high income beneficiaries is small.

Finally, it is important to recognize that any fix to the SGR that raises Medicare spending will result in higher costs to beneficiaries when the payments to physicians rise. For example, if costs to the federal government rise by \$10 billion, beneficiaries will experience approximately a \$2.5 billion increase in required cost sharing. Thus, even with no other policy change, beneficiaries will be paying more.



Other Approaches

As one of the most popular of federal programs, Medicare enjoys enormous support from the public at large. In fact, polling consistently indicates a willingness to pay higher taxes if necessary to support the program. Medicare offers basic insurance to our most vulnerable and needy citizens and does so with considerable efficiency. The design of the program is to reduce some of the inequality that arises in our economy by providing the same benefits to all who qualify regardless of the amount they have contributed to the program. Thus, when considering what tax increases or spending reductions could be used to pay for the SGR fix, it is important to consider options beyond Medicare.

If it is believed that Medicare is not sufficiently financed, any options under consideration for changing the program should include increasing the revenue stream into the program. Indeed, increasing taxes to support Medicare is consistent with the intent of the program as it was conceived in the 1960s. It was recognized even then that the ratio of workers to retirees would decline over time and that increases in health care spending occurred more rapidly than costs of other goods and services and wages. But the idea of fully funding the system to plan for these changes was rejected since it would create a drag on the economy. Rather, the intent was that tax rates would be adjusted upward periodically to keep the system sound. The growth of the economy—and incomes of workers—were expected to make it possible to fund health care spending for succeeding waves of seniors. Are we in a position today to afford higher contributions? That



question is certainly one that should be compared to the issue of whether beneficiaries can afford further cuts in benefits.

Conclusion

The Sustainable Growth Rate is poor public policy and ought to be fixed. But beneficiaries should not be penalized for the poor policy making that occurred fifteen years ago. The SGR should not be used as a rationale for reducing valuable benefits to our most vulnerable citizens.

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