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Replacing Medicare's SGR: Four Bipartisan Options to Finance a Permanent Fix

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The new Congress must stop irresponsible federal spending. This applies to replacing the Medicare Sustainable Growth Rate (SGR) formula that annually updates Medicare physician payment with a workable alternative.

In 2014, House and Senate negotiators, representing three major congressional committees, worked long and hard to hammer out a compromise SGR replacement bill. While the bill is an improvement over the Medicare status quo, it fails to restore physicians' professional independence and patients' personal freedom[1] and neglects to offset the very large costs that will accompany any change. On April 1, 2015, Medicare physicians face a 21 percent pay cut under the SGR formula. The new Congress must revisit this issue, including the financing question.

No Deficits

Replacing the current SGR with a more rational Medicare physician payment system will increase Medicare spending. The Congressional Budget Office (CBO) estimates that the cost of the policy embodied in the compromise bill would be $144 billion over 10 years. If Congress were to base payment updates on medical inflation, it would cost $204 billion over the initial decade of implementation.[2]

This paper, in its entirety, can be found at **http://report.heritage.org/ib4334**

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Congress has a profound obligation to make sure that any permanent Medicare SGR fix is accompanied by *permanent,* not *temporary* savings. The most effective approach is to make *structural* reforms that will offset SGR replacement costs while simultaneously improving the Medicare program's overall financial condition.

Four Bipartisan Options to Secure Major Medicare Savings

There are at least four major structural changes that have attracted bipartisan support and would improve the functioning of the program and guarantee permanent savings in the future. These reforms are: benefit modernization, means-testing expansion, increasing eligibility age, and new competitive bidding in Medicare Advantage. While all differ in detail, these policy changes have all received bipartisan support at one time or another in Congress or have been endorsed by health policy analysts at both liberal and conservative public policy institutions.

1. **Modernize the traditional Medicare benefit structure.**[3] This can be done by combining Medicare Parts A (hospital payment) and B (physicians' payment) into one program with a single premium and deductible and a uniform cost-sharing system. At the same time, Congress should rearrange the relationship between Medigap or supplemental coverage and traditional Medicare to limit supplemental coverage of "first-dollar" coverage. This would reduce excessive utilization among beneficiaries that drives up Medicare costs and adds to premium costs for

both taxpayers and beneficiaries. Such a structural change should also add protection from catastrophic costs for seniors, which traditional Medicare does not currently provide.

Estimated Savings: The CBO estimates that these reforms would secure $114 billion in savings from 2014 to 2023.[4]

2. **Update the age of Medicare eligibility.**[5] Medicare's eligibility age, 65, was set in 1965 and based on the Social Security eligibility age that was set in 1935. In contrast to Medicare, Congress has already undertaken the process of raising the normal retirement age for Social Security to 67. Beneficiaries are living much longer now than they were in 1965. As the baby-boom generation enters Medicare, the ratio of workers to retirees is steadily shrinking, and Medicare's financing issues continue to worsen. At the very least, Congress should increase Medicare's age of eligibility to 67, matching the change made to Social Security eligibility.

   Ideally, Congress should go further and gradually raise the age of eligibility for both Social Security and Medicare to 68 and then index the normal age of eligibility for both programs to life expectancy. This simple recognition of America's new demographic realities is sound policy and would secure permanent Medicare savings.

   Estimated Savings: The CBO estimates that an increase in the age of Medicare eligibility to 67 would yield savings of $63.5 billion from 2014 to 2023.[6]

3. **Reduce taxpayer subsidies for wealthy Medicare recipients.**[7] Today, individuals with an annual income of $85,000 or couples with an annual income of $170,000 pay higher premiums for Medicare Part B (outpatient and physicians' services) and Medicare Part D (prescription drug coverage). In other words, about 5 percent of the Medicare population receives less in taxpayer subsidies for their benefits than all other Medicare recipients.

1. For a discussion of the principles that should guide such vital legislation, see Chris Jacobs, "Medicare's Sustainable Growth Rate: Principles for Reform," Heritage Foundation *Backgrounder* No. 2827, July 18, 2013, http://www.heritage.org/research/reports/2013/07/medicares-sustainable-growth-rate-principles-for-reform.
2. Congressional Budget Office, "Medicare's Payment to Physicians," November 14, 2014, http://www.cbo.gov/publication/49770 (accessed January 20, 2015).
3. Some variation of benefit modernization reforms—combining Medicare Parts A and B—has attracted bipartisan support. For example, the Bowles–Simpson Commission, the Bipartisan Policy Center, and The Heritage Foundation have endorsed varying proposals. For details, see Erskine Bowles and Alan Simpson et al., *A Bipartisan Path Forward to Securing America's Future*, Moment of Truth Project, April 2013, http://www.momentoftruthproject.org/sites/default/files/Full%20Plan%20of%20Securing%20America's%20Future.pdf (accessed January 20, 2015), and Robert E. Moffit, "The First Stage of Medicare Reform: Fixing the Current Program," Heritage Foundation *Backgrounder* No. 2611, October 17, 2011, http://www.heritage.org/research/reports/2011/10/the-first-stage-of-medicare-reform-fixing-the-current-program.
4. The CBO savings would be based on a single annual deductible of $550 for Medicare Parts A and B benefits, a uniform co-insurance rate of 20 percent, a restriction on supplemental health plans coverage of the $550 deductible, and an out-of-pocket cap of $5,500. Congressional Budget Office, "Options for Reducing the Deficit: 2014 to 2023," November 13, 2013, p. 211, https://www.cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-3.pdf (accessed January 20, 2015).
5. Increasing the age of Medicare eligibility has also attracted broad bipartisan support. For example, increasing the Medicare eligibility age to 67 was a key feature of the 1999 Breaux–Thomas Medicare reform and has been subsequently endorsed by analysts with the American Enterprise Institute and Representative Paul Ryan (R–WI), as well as former CBO Director Alice Rivlin, Clinton policy adviser William Galston, and Maya MacGuineas of the Committee for a Responsible Federal Budget. The change was also endorsed by former Senators Tom Coburn (R–OK) and Joseph Lieberman (I–CT).
6. Congressional Budget Office, "Options for Reducing the Deficit: 2014 to 2023," p. 219.
7. Different proposals for increasing the means testing for Medicare Parts B and D premiums have attracted support among leading Republicans and Democrats, such as Senator Claire McCaskill (D–MO), Senator Coburn, and President Barack Obama. The Coburn–McCaskill plan would set the initial threshold for higher payment for single individuals with an annual income of $50,000. For details on the Coburn–McCaskill plan, see press release, "Coburn and McCaskill Introduce Bipartisan Legislation to Means-Test Medicare Premiums," Office of Senator Claire McCaskill, June 24, 2013, http://www.mccaskill.senate.gov/media-center/news-releases/coburn-and-mccaskill-introduce-bipartisan-legislation-to-means-test-medicare-premiums (accessed January 20, 2015), and U.S. Department of Health and Human Services, "Fiscal Year 2015 Budget in Brief: Strengthening Health and Opportunity for All Americans," p. 63, http://www.hhs.gov/budget/fy2015/fy-2015-budget-in-brief.pdf (accessed January 20, 2015).

Today's upper-income thresholds for Medicare premium increases are very high, and will be indexed to inflation beginning in 2020. There is an emerging bipartisan consensus that taxpayers' subsidies should be reduced for the wealthiest Medicare recipients and that upper-income recipients should be required to pay more for their health benefits, though there remain differences on where the income threshold should be set.[8] Depending on the design of the reform, such a policy change could result in significant, and permanent, Medicare savings.

Estimated Savings: The Heritage Foundation's proposal to expand Medicare's upper-income "means testing" would yield an estimated savings of $538 billion from 2016 to 2025.[9]

4. **Use market-based bidding for Medicare Advantage payment.**[10] Medicare Advantage (MA), a program where private plans provide the Medicare benefit to beneficiaries, is the only competitor to traditional Medicare. MA has experienced rapid growth in enrollment over the past decade, with about 30 percent of all Medicare beneficiaries enrolled in MA in 2014. However, the program payment system is flawed. The private plans' bid to provide traditional Medicare coverage is tied to the administrative payment of the Medicare fee-for-service (FFS) system.[11] Thus, MA's payment reflects FFS's administrative payment instead of a real market price to provide Medicare's traditional benefits. As a result, the payment system results in unnecessary Medicare spending. In 2014, MA plans were paid an average of 6 percent more than traditional Medicare despite the average plan bid costing 2 percent less than traditional Medicare.[12] In reforming the payment system, Congress should detach MA plan payment from traditional Medicare spending. Instead, the new benchmark MA payment should be based on the average bid of all plans competing in a given geographic region.

Estimated Savings: This proposal has yet to be scored by the CBO. However, in President Obama's fiscal year 2010 budget, the same change to the MA benchmark payment was estimated to save $175 billion over ten years.[13] Though the MA program has undergone some significant changes because of the Affordable Care Act, it nonetheless stands to reason that this change would still produce significant savings.

8. Stuart M. Butler et al., "Saving the American Dream: The Heritage Foundation Plan to Fix the Debt, Cut Spending and Restore Prosperity," Heritage Foundation *Special Report* No. 91, May 10, 2011, p. 20, http://www.heritage.org/research/reports/2011/05/saving-the-american-dream-the-heritage-plan-to-fix-the-debt-cut-spending-and-restore-prosperity.
9. The updated Heritage Foundation proposal would reduce the taxpayer subsidy by 1.8 percent for every $1,000 increase in annual income over the initial thresholds. For the wealthiest seniors, couples with incomes in excess of $165,000 annually—3.5 percent of the total Medicare population—the taxpayer subsidy would be phased out entirely. Senior policy analyst Drew Gonshorowski of the Heritage Foundation Center for Data Analysis (CDA) updated the 10-year budgetary savings based on the April 2014 CBO baseline.
10. Using competitive bidding to set Medicare Advantage's benchmark payment was introduced by President Bill Clinton in 1999. It has since been endorsed by President Barack Obama, the Center for American Progress (a liberal think tank), and The Heritage Foundation. For details, see U.S. Office of Management and Budget, "A New Era of Responsibility: Renewing America's Promise," (Washington, DC: U.S. Government Printing Office, 2009), p. 28, http://www.whitehouse.gov/sites/default/files/omb/assets/fy2010_new_era/A_New_Era_of_Responsibility2.pdf (accessed January 20, 2015); Center for American Progress, "The Senior Protection Plan: $385 Billion in Health Care Savings Without Harming Beneficiaries," November 2012, p. 6, http://cdn.americanprogress.org/wp-content/uploads/2012/11/SeniorProtectionPlan.pdf (accessed January 20, 2015); and Robert E. Moffit and Alyene Senger, "Progress in Medicare Advantage: Key Lessons for Medicare Reform," Heritage Foundation *Backgrounder* No. 2945, September 4, 2014, http://www.heritage.org/research/reports/2014/09/progress-in-medicare-advantage-key-lessons-for-medicare-reform.
11. For further explanation of Medicare Advantage's financing, see Jeet S. Guram and Robert E. Moffit, "The Medicare Advantage Success Story—Looking Beyond the Cost Difference," *New England Journal of Medicine*, Vol. 361, No. 13 (March 29, 2012), pp. 1177–1179, http://www.nejm.org/doi/full/10.1056/NEJMp1114019 (accessed January 20, 2015).
12. Medicare Payment Advisory Commission, "Report to Congress: Medicare Payment Policy," March 2014, p. 332, http://www.medpac.gov/documents/reports/mar14_entirereport.pdf?sfvrsn=0 (accessed January 20, 2015).
13. U.S. Office of Management and Budget, *A New Era of Responsibility: Renewing America's Promise*, p. 28.

SGR Replacement Should Be Done Right

In funding an SGR replacement, Congress should avoid budgetary tricks or gimmicks, such as tapping "war savings" from the projected reductions in Overseas Contingency Operations (OCO) or changing the effective dates of certain spending provisions from one fiscal year to the next. Congress should also reject any proposal to pay for changes in Medicare provider payments that relies on tightening up Medicare price controls or manipulating administrative payments.

Permanently replacing the SGR is a bipartisan priority, but the change should be fully funded and not add to the nation's deficits. The most productive and fiscally responsible approach to financing a replacement of the SGR is to make structural changes that enhance Medicare's financial condition and improve its efficiency and effectiveness and that can attract broad bipartisan support.

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