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Compromise to Fix Medicare Payment Formula and Extend Children's Health Insurance Deserves Support

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House Republican and Democratic leaders have worked out compromise legislation that would: (1) permanently fix Medicare's flawed physician payment formula, which repeatedly threatens drastic 20- to 30-percent cuts in physician payment rates; (2) offset part of the cost of fixing the payment formula, primarily by trimming Medicare provider payments and modestly raising Medicare premiums for some high-income beneficiaries; and (3) extend funding and current policy for the Children's Health Insurance Program (CHIP) and several expiring Medicare and Medicaid provisions for two years. The compromise also makes permanent both the Qualifying Individual (QI) program, which defrays Medicare Part B premiums for low-income Medicare beneficiaries, and the Transitional Medicaid Assistance Program, which enables families receiving Medicaid to maintain that coverage for up to a year as they transition from welfare to employment. In addition, it extends the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program for two years and provides $7 billion in new funding for community health centers over the next two years.

The compromise isn't perfect. It would be better if policymakers fully offset the repair of the physician payment formula (known as the sustainable growth rate, or SGR) and extended CHIP for four years rather than two. But given that the likely alternative is another short-term patch that fails to fix the SGR and extends CHIP for only a very short time, if at all, the House should approve the compromise. An effort then should, and surely will, be made in the Senate to strengthen the CHIP component of the package by extending the program for four years.

Normally, we urge that tax and entitlement measures be fully paid for, and we'd have preferred that here as well. But there are special circumstances that justify the package without full offsets, as explained below.

Moreover, the package at long last replaces the current, highly dysfunctional Medicare physician payment formula. And the Medicare offsets, including the two that affect some Medicare beneficiaries, are modest, reasonable, and well targeted — something that may *not* be the case in the future if this package dissolves.

In addition, the package extends CHIP with program improvements enacted in 2009 and 2010 and with none of the program cuts in the recent proposal from the chairmen of the Senate Finance and House Energy and Commerce committees, which have jurisdiction over CHIP. The package

also extends the home visiting program, a highly regarded evidence-based program that can improve poor children's life chances.

The Offset Issue: Why the SGR Is a Special Case

Congress enacted the SGR formula in the 1997 Balanced Budget Act (BBA) with the goal of putting a slight downward push on the Medicare payment rate. The Congressional Budget Office estimated at the time that it would save only about $12 billion over the 1998-2007 period, just 3 percent of the BBA's total net Medicare savings.[1]

The formula turned out to be badly designed, however, and to produce severe unintended consequences. In many cases, it would have cut Medicare payments *below* doctors' actual costs of providing medical services. If allowed to take effect today, it would cause a 21-percent cut in physician reimbursement rates on April 1, almost surely triggering a large-scale exodus of doctors from Medicare.

Congress has responded by acting every year or two on a bipartisan basis to prevent these unintended deep cuts from taking effect by temporarily imposing an alternative payment formula. For the most part, these alternative formulas have frozen physician payment rates or held them below the rate of inflation. As a result, the current Medicare physician payment rate is a stunning 17 percent below the rate in 2001, adjusted for increases in the cost of producing physicians' services.[2]

In other words, while Congress did not allow the SGR's cuts to take effect, it has held physician reimbursement rates to levels that produced *much larger savings* than Congress in 1997 thought the SGR formula would produce.

Nevertheless, under budget rules, any increase in payment rates above the shrunken level that would result from implementing the unintended SGR cuts counts as a cost. Even freezing the physician payment rate year after year, with no adjustment for inflation, counts as having a substantial cost although it cuts doctors' payments in real terms.

The compromise package replaces the SGR formula with annual physician updates of 0.5 percent for five years and zero for the next five years — almost certainly lower than the increase that will occur in physicians' costs. (These very small annual increases or freezes, which constitute reductions in payment rates in inflation-adjusted terms, belie a misperception that physicians aren't being asked to make some sacrifices in the proposal.) The legislation also moves towards a performance-based reimbursement system for physicians and provides financial incentives for physicians to participate in alternative payment models. While the package doesn't offset the cost of raising payment rates from the SGR level to a hard freeze level, it does offset the cost of raising the rates *above* a freeze level. And the offsetting savings would grow over time.

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[1] Congressional Budget Office, *Budgetary Implications of the Balanced Budget Act of 1997*, December 1997.

[2] Centers for Medicare & Medicaid Services, *Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2015*, November 2014, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/SGR2015f.pdf.

It's highly unusual for Congress to pass a measure that turns out to produce massive, unintended savings if allowed to take full effect, especially when those unintended savings would weaken the program Congress was trying to shore up. Yet that's the situation with the SGR formula and why we view this as a special and unusual case. The solution in the compromise package seems relatively fiscally responsible and would finally address a dysfunctional part of Medicare law whose continuation weakens the program.

Effect on Medicare Beneficiaries

In addition to trimming payments to various Medicare providers, the package contains two changes affecting beneficiaries that would produce savings to help offset its cost. The principal change would raise Medicare Part B and D premiums by a combined $82 a month (in today's terms) starting in 2018 for a very small group of affluent beneficiaries — couples with incomes from $267,000 to $428,000 and singles from $133,500 to $214,000. The proposal would affect only about 2 percent of beneficiaries. (The median income of Medicare beneficiaries is just $26,000 a year.)

These income thresholds refer to beneficiaries' *current* incomes, not the incomes they earned before retiring. Many retirees with current incomes this high have extensive portfolios of financial assets. And people with portfolios large enough to produce this level of income in retirement generally have substantial wealth, likely in the millions of dollars. This group of people will not have difficulty affording the proposed premium increase. Nor are they likely to drop out of Medicare Part B, especially since they still would receive a federal subsidy for 25 percent or more of their premiums. (The package does not raise premiums for people with incomes *over* $428,000 for couples and $214,000 for singles in order to ensure that subsidies equal at least 20 percent of premium costs for all beneficiaries, thereby preserving support for Medicare as a universal social insurance program.)

The other beneficiary change that produces savings would bar *Medigap* supplement policies from covering the Part B deductible — which is $147 in 2015, well below the deductible in most private health insurance plans. This proposal would take effect in 2020 and apply only to new Medicare beneficiaries. (Currently, only about 12 percent of Medicare beneficiaries hold Medigap policies that would be affected by this proposal.[3]) Because Medigap policies would no longer pay the Part B deductible, Medigap premiums for the affected policies *would go down*. Most affected beneficiaries would *come out ahead* — the drop in their Medigap premiums would exceed the increase in their cost sharing for health services. Some others would come out behind. In both cases, the effect would be small — generally no more than $100 a year.

Moreover, the package would make permanent an important Medicaid beneficiary provision otherwise slated to expire — the Qualifying Individuals program — that picks up all of Medicare Part B premiums on behalf of low-income beneficiaries with incomes between 120 percent and 135 percent of the poverty line (roughly $14,100-$19,100 for singles and $15,900-$21,500 for couples). This would ensure that the more than half a million QI beneficiaries can continue to receive benefits, which are worth about $1,260 (the annual cost of Part B premiums in 2015).

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[3] Gretchen Jacobson, Jennifer Huang, and Tricia Neuman, *Medigap Reform: Setting the Context for Understanding Recent Proposals*, Kaiser Family Foundation, January 2014, https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8235-02-medigap-reform-setting-the-context-for-understanding-recent-proposals1.pdf.

The CHIP Extension

The compromise package would extend federal funding for CHIP for two years while ensuring that states have sufficient funding to sustain their CHIP programs and maintaining CHIP improvements enacted in the 2009 CHIP reauthorization law and the 2010 Affordable Care Act. The package contains none of the adverse policies in the recent proposal from the chairs of the Senate and House committees with jurisdiction over CHIP (Senator Orrin Hatch and Rep. Fred Upton), which would make substantial cuts and changes in CHIP that likely would result in substantial numbers of children now on CHIP becoming uninsured or facing higher out-of-pocket costs, while shifting costs to states.[4] Extending this successful program without any of the measures to cut it back would be a major accomplishment.

A four-year extension of funding and current policy for CHIP would be far preferable, however, to a two-year extension. Efforts are expected to secure that in the Senate, in order to ensure longer-term stability for the program and the children it serves.

The worst outcome for CHIP would be for the entire compromise to fall through and policymakers to take no action on CHIP now or to extend it for only a few months. If that occurs, serious risk will re-emerge that Congress will make cuts in the program as part of other legislation later in 2015. (This could occur, for example, as part of a budget reconciliation bill or a bill developed in a crisis atmosphere if the Supreme Court strikes down a large part of the Affordable Care Act.) CHIP is much better served by enacting a "clean" extension now — preferably for four years — than by rolling the dice on how it might fare in potentially contentious and dangerous budget showdowns later this year.

[4] See Edwin Park, "Hatch-Upton CHIP Proposal Moves Backwards on Children's Health Coverage," Center on Budget and Policy Priorities, February 26, 2015, http://www.cbpp.org/cms/index.cfm?fa=view&id=5276.