MEDICARE AT 50: AN EVOLVING PROGRAM FACES THE FUTURE

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This testimony draws heavily on publications written by or co-authored with my former colleagues and grantees at the Commonwealth Fund.

The views presented here are those of the author and not necessarily those of AcademyHealth or the Commonwealth Fund or their directors, officers, or staff.

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Thank you, Chairman Collins, Senator McCaskill, and Members of the Committee, for this invitation to testify on the current state of Medicare and the challenges it faces as it enters its second 50 years. I am Stuart Guterman, a Senior Scholar in Residence at AcademyHealth. AcademyHealth is an organization that works to improve health and the performance of the health system by supporting the production and use of evidence to inform policy and practice.

I am glad to be able to speak to you on this topic, because I have been working on Medicare issues for a long time, at the Commonwealth Fund from 2005 until recently, the Centers for Medicare and Medicaid Services (CMS) and its predecessor, the Health Care Financing Administration, in the mid-1980s and again from 2002 to 2005, and at the Medicare Payment Advisory Commission (MedPAC) and its predecessor, the Prospective Payment Assessment Commission, from 1988 to 1999, as well as at the Congressional Budget Office (CBO). I have seen—and had the privilege of participating in—the innovative changes that the program has implemented over the years, and also been aware of the challenges faced by the program.

In addition, many of us with elderly parents or other loved ones know how they have been helped tremendously by Medicare's coverage and the access to care it provides—and also hindered by the program's shortcomings and the fragmented nature of health care provided in this country.

As Medicare celebrates its 50th anniversary, it has been a tremendous success in accomplishing its main goal: assuring the health and economic security of the nation's elderly and disabled. It is very popular with its beneficiaries, and has been influential in shaping the U.S. health system, improving the quality of care, and contributing to medical progress.

At the same time, Medicare faces considerable challenges. Rising costs, affecting both the federal budget and beneficiaries, are an ongoing challenge. Medicare's benefit package, while rated highly by beneficiaries for enabling their access to care and protection from financial hardship and medical debts, falls short in providing financial protection for beneficiaries with low incomes and serious health problems. Fragmentation of coverage into different plans for hospital, physician, and prescription drug benefits is confusing for beneficiaries and undermines coordination of patient care; and because Medicare covers only a portion of medical expenses, most beneficiaries supplement Medicare with other coverage, adding to complexity and administrative cost. Better strategies are also needed to serve the growing number of beneficiaries with complex care needs with physical and cognitive functional limitations and multiple chronic conditions—symptoms of an aging population.

We currently have an unprecedented opportunity—and a historic imperative—to continue to improve the program and its ability to serve its beneficiaries over the next 50 years. In this testimony, I first discuss Medicare's evolution over its first 50 years and then describe the issues that must be addressed to make the program more effective and viable into the future.

ORIGIN AND IMMEDIATE IMPACT

To consider Medicare's current state and the challenges it faces, we need to consider the environment in which it was enacted and the problems it was intended to address, as well as how it has changed over time. Medicare was enacted only after a long and contentious struggle. National health insurance was advocated by President Harry S. Truman in the late 1940s, but by the 1950s and early 1960s, efforts had focused on the particularly egregious needs of America's elderly population.[1]

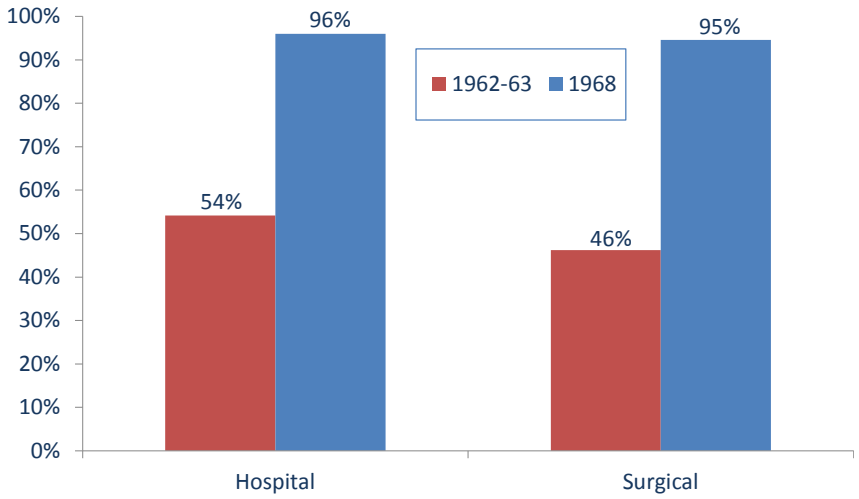
The elderly were of great concern because they tended to be in poorer health than younger Americans and have greater health care expenses. They also faced financial barriers that hindered access for the care they needed: in the mid-1960s, only about half of all Americans age 65 and older had health insurance. Employer-sponsored health insurance, the major vehicle for health insurance coverage in the U.S., was unavailable to many retirees; also, the elderly were less attractive to health insurers because they presented a greater risk for high costs.

On July 30, 1965, President Johnson signed the Social Security Amendments into law, creating Medicare (Title XVIII) and Medicaid (Title XIX). When the program was implemented in 1966, it had an immediate impact:

- Health insurance coverage for the elderly increased from about 50% to almost 100% (Exhibit 1).
- Access to health care for the elderly increased, and disparities by race declined sharply (Exhibit 2).

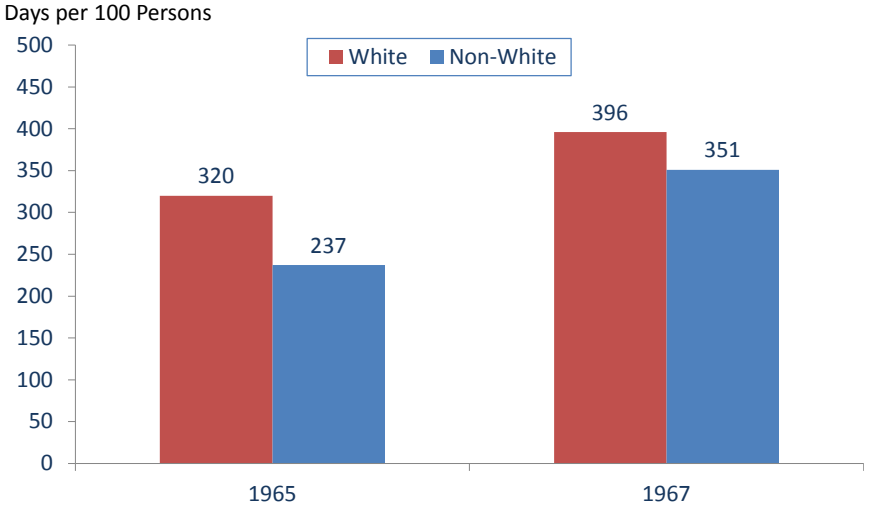
- Out-of-pocket spending by the elderly as a proportion of total charges fell from 77% to 47% (Exhibit 3).

Exhibit 1. Percentage of Persons Age 65 and Over With Hospital and Surgical Insurance, 1962-63 vs. 1968 [1]



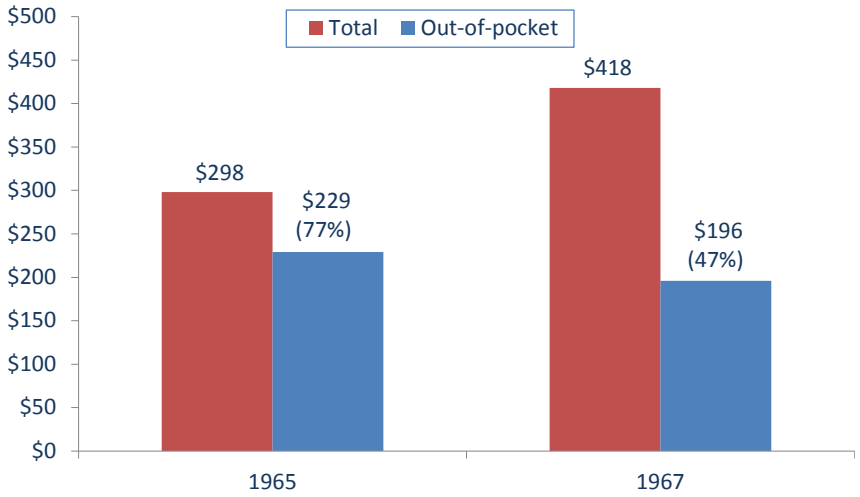
Source: R.A. Cohen et al. "Health Insurance Coverage Trends, 1959-2007: Estimates from the National Health Interview Survey." *National Health Statistics Reports* Number 17, July 1, 2009.

Exhibit 2. Short-Stay Hospital Utilization by Persons Age 65 and Over, by Race, 1965 and 1967 [2]



Source: R. Loewenstein. "Early Effects of Medicare on the Health Care of the Aged." *Social Security Bulletin* April 1971 34(4).

Exhibit 3. Mean Total Charges for Health Care and Out-of-Pocket Payments by Persons Age 65 and Over, 1965 and 1967[3]



Source: R. Loewenstein. "Early Effects of Medicare on the Health Care of the Aged." *Social Security Bulletin* April 1971 34(4).

Medicare also was instrumental in desegregating hospitals throughout the country, as receipt of Medicare payment was contingent on the elimination of segregation of hospital facilities and hospital staffs.[2]

MEDICARE COVERAGE

Original Medicare consisted of Hospital Insurance (HI, or Part A), which covered primarily hospital care for everyone eligible for Social Security retirement benefits and is financed by payroll taxes contributed to the Hospital Insurance Trust Fund, and Supplementary Medical Insurance (SMI, or Part B), which covered primarily physician and other ambulatory care for every Medicare-eligible person who does explicitly choose not to participate and is financed by a combination of premiums and general tax revenues.

The Social Security Amendments of 1972 extended Medicare eligibility to persons under age 65 who qualify for Social Security benefits as permanently disabled (coverage begins 24 months after eligibility for disability benefits) and persons with end-stage renal disease (ESRD; coverage begins in the fourth month after dialysis treatments and extends for 36 months after a kidney transplant). In 2014, 8.9 million of the 53.8 million Medicare beneficiaries were eligible because of their disability status or ESRD.[3]

The Medicare Modernization Act of 2003 made drug benefits available to Medicare beneficiaries beginning in 2006, under Medicare's prescription drug coverage (Part D) program. Part D coverage is voluntary, and available only through private prescription drug plans; premiums (heavily subsidized by Medicare) are paid directly to the plan, with additional subsidies available for beneficiaries with low incomes. In 2014, 37.8 million beneficiaries had prescription drug coverage through Medicare and another 2.7 million received retiree drug coverage under Part D.[4]

EXPANDING CHOICE FOR MEDICARE BENEFICIARIES

As an alternative to traditional Medicare, beneficiaries can obtain their Part A and Part B coverage (and Part D as well) through private health insurance plans. The Tax Equity and Fiscal Responsibility Act of 1982 created the Medicare Risk Program, making private health maintenance organizations (HMOs) and similar plans available to Medicare beneficiaries. Enrollment initially was small, but it grew rapidly in the mid-1980s as managed care became more popular in the private sector as well.

In 1997, the Balanced Budget Act created a new Medicare+Choice program to emphasize private plans as an option for beneficiaries. However, cuts in payment rates under traditional Medicare reduced private plan rates as well, causing many plans to leave the program. In addition, enrollment fell with the managed care backlash of the early 2000s.

The Medicare Modernization Act of 2003 created the current Medicare Advantage program, increasing plan payments and adding more types of plans. The sharply increased payment rates attracted more private plans, and the additional benefits that plans were able to offer because of the high payment rates attracted more beneficiaries. In 2015, an estimated 17.6 million beneficiaries—more than 30 percent of the Medicare population—obtain their Medicare benefits through private Medicare Advantage plans (Exhibit 4).[5]

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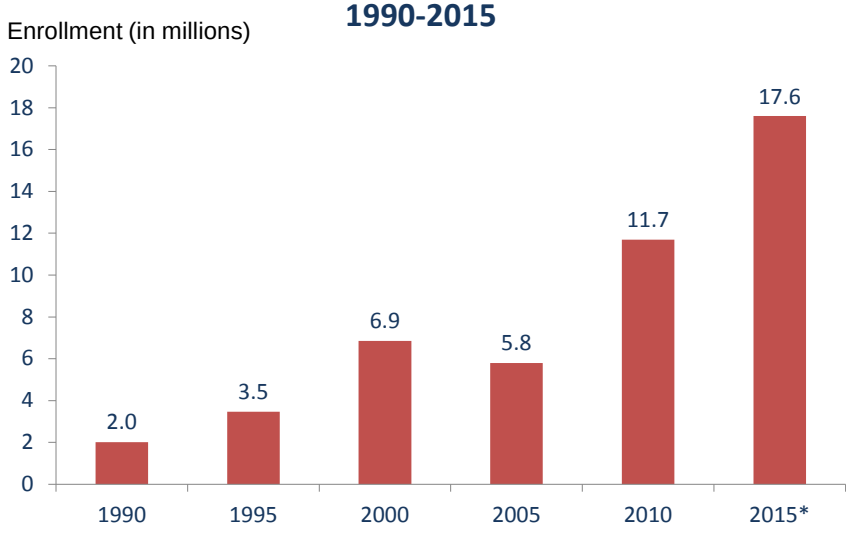
Exhibit 4. Medicare Enrollment in Private Health Plans, 1990-2015



*2015 projected.
Source: Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds. "2015 Annual Report." (Washington, DC: The Trustees, July 2015). Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf.

EARLY PAYMENT REFORMS

When Medicare was enacted in 1965, it adopted payment methods modeled after prevailing private insurance practices at the time. Hospitals were reimbursed for their allowable costs, and physicians were paid based on local prevailing charges. There were no incentives for providers to control costs—the more providers spent, the more they were paid. Over the years, Medicare has implemented changes in how it pays providers, generally moving from cost-based reimbursement to prospective payment; but it still pays predominately on a fee-for-service basis—the more services that are provided and the more complex they are, the more the provider gets paid, regardless of how much those services contribute to the health of the patient.

The Social Security Amendments of 1983 established a prospective payment system for inpatient hospital care, with payment based on prospectively set rates for cases in each diagnostic-related group (DRG). This was a dramatic change in how hospitals were paid: it established the hospital stay as the unit of payment, and provided higher payment rates for more costly types of patients and in areas with higher input costs, rather than basing payment on the hospital's own costs. DRGs changed the focus of hospital payment in the U.S.,[6] and they have been adopted widely in other countries, as well.[7] But they only include hospital services during the hospital stay, and so do not encourage coordination of care across providers and settings.

The Omnibus Budget Reconciliation Act of 1989 replaced reimbursement based on prevailing charges with a physician fee schedule based on a Resource-Based Relative Value Scale (RBRVS), which is intended to reflect the relative cost of providing each

physician service. In addition to setting the rates that Medicare would pay, this legislation limited the extent to which physicians could 'balance bill' patients for the difference between their own charges and the Medicare payment rate.

The RBRVS was intended to correct a perceived overemphasis on procedures relative to diagnostic services—but there has been persistent dissatisfaction with the process for setting the relative values. Nonetheless, it was widely adopted by private payers in the U.S.

FROM UTILIZATION REVIEW TO QUALITY IMPROVEMENT

Medicare has long had a mechanism in place to make sure that its funds were being used effectively and that its beneficiaries received care consistent with medical quality standards. The Social Security Amendments of 1972 created the Professional Standards Review Organization (PSRO) program to review the appropriateness of services reimbursed through Medicare—but the PSROs were viewed as primarily focused on utilization review rather than quality improvement.[8] Ten years later, the PSROs were replaced by Peer Review Organizations (PROs)—but the primary emphasis continued to be on utilization review.

In 1992, Medicare launched the Health Care Quality Improvement Program (HCQIP), shifting the focus of the PRO program to working with providers to improve health care.[9] In 2002, the HCQIP was expanded to include nursing homes and home health, and the PROs were renamed Quality Improvement Organizations (QIOs).

In the early 2000s, greater emphasis was put on the need to improve health care quality through measurement and payment.[10] Medicare has implemented a series of initiatives aimed at providing information on quality measures to empower beneficiaries in choosing providers and enable providers to identify areas in which their performance could improve, including quality measures for hospitals, physicians, nursing homes, home health agencies, and dialysis facilities. Expanded use of health information technology was encouraged in 2004 by the issuance of an Executive Order creating the Office of the National Coordinator for Health Information Technology and substantially enhanced by the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009.[11]

CONTINUING EVOLUTION

Medicare has made significant improvements in the original payment methods modeled on the private insurance payment practices of the 1960s, and recent actions by Congress and the Department of Health and Human Services (HHS) have focused on accelerating that change.[12] The Affordable Care Act of 2010 includes an array of provisions that are laying the foundation for fundamental Medicare payment reform, linking payment to patient outcomes and experiences of care, and giving providers an incentive to limit spending by rewarding reductions in the projected spending for their Medicare patients.[13]

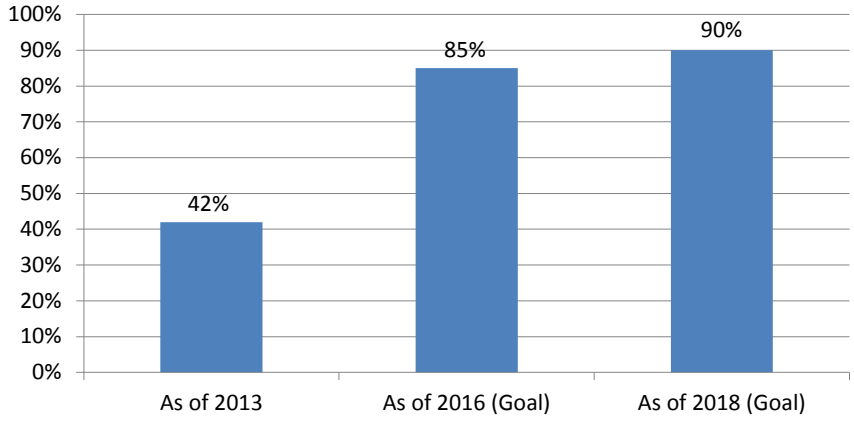
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), passed only a few months ago, pushed Medicare payment reform further forward by repealing

the sustainable growth rate formula (SGR), which was established to determine the annual update in Medicare physician payments.[14] The SGR was intended to counter the tendency of fee-for-service payment to reward volume and intensity rather than appropriateness, quality, and desirable outcomes, but it was widely criticized because it produced large, across-the-board cuts in physician fees, hindered attempts to reform payments, and failed to control cost growth. MACRA put in place modest increases in physician fees, with strong rewards for high performance and incentives to participate in alternative payment models that reward value.

In addition, the Secretary of HHS has set a goal of linking 85 percent of traditional Medicare provider payment to quality or value by the end of 2016, and 90 percent by the end of 2018.[15] A recent study indicates that, as of the end of 2013, 42 percent of provider payments in traditional Medicare are tied to the value of care. This represents significant progress, but much still remains to be done (Exhibit 5).[16] Many initiatives that were not included in that study are in place now or will soon be implemented, supporting expectations that the percentage will increase considerably over the next few years.

Also noteworthy is that Medicare Advantage plans, which cover over 30 percent of Medicare beneficiaries, are now financially rewarded for receiving a high rating based on their performance on measures of quality and patient experience.[17] Although little is known about how Medicare Advantage plans actually pay their providers, the addition of rewards for plan performance to the existing incentive for efficiency in a per-enrollee per-month payment system can be expected to support the move from volume to value in Medicare.

Exhibit 5. Percentage of Traditional Medicare Payment Tied to Quality or Value, and Goals for the Future



Source: Catalyst for Payment Reform. "First-of-Its-Kind Scorecard on Medicare Payment Shows Widespread Payment Reform." Press release, May 5, 2015; available at http://www.catalyzepaymentreform.org/images/Press_Release_Scorecard_on_Medicare_Payment_Reform_final.pdf; Sylvia M. Burwell. "Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care." *The New England Journal of Medicine* March 5, 2015 372(10):897-99.

ONGOING CHALLENGES

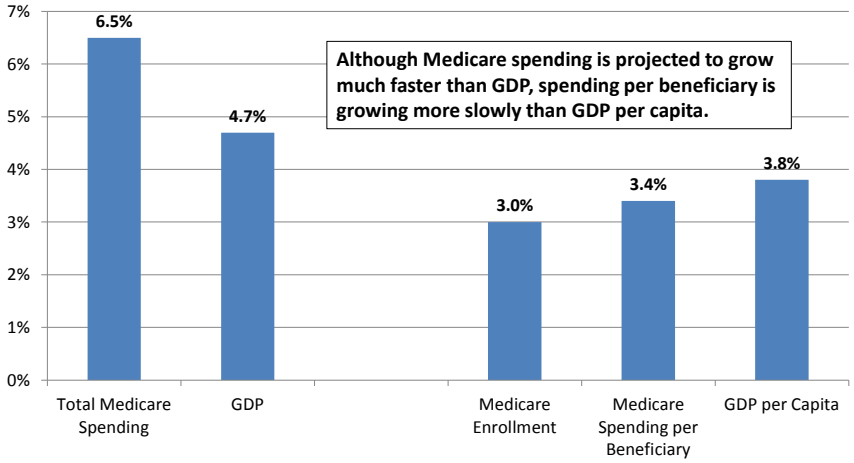
Despite its accomplishments, Medicare continues to face challenges, some of which are specific to Medicare and others—such as rising costs—that are faced by public programs and private payers alike. The future of the program and its ability to continue to provide access to high quality care to its beneficiaries will depend on how policymakers, health care providers, and beneficiaries themselves respond to these challenges—but success will require changes not only to Medicare, but across the health system.

Spending Growth. Medicare accounts for one-fifth of national health spending.[18] Like the rest of the health system, it has been plagued by rapidly rising costs. Medicare also is an important part of the federal budget, accounting for more than one-sixth of federal spending.[19] In 2009, Medicare was spending an average of $11,723 on

46.6 million beneficiaries, and the Medicare HI Trust Fund was projected to become insolvent by 2017.[20] Spending per beneficiary has slowed dramatically in recent years, growing at only a 1.3 percent annual rate from 2009 to 2014, and the projected solvency of the HI Trust Fund has been extended to 2030.[21]

Still, Medicare faces a great challenge as the "boomer" generation born after World War II ages into coverage—by 2030, the number of beneficiaries is projected to rise more than 50 percent, from 53.8 million to 81.7 million, prompting concern about how to respond to the rising share of the federal budget and the nation's resources that will be devoted to financing health care for the elderly and disabled. Although spending per beneficiary has been growing slowly in recent years, and is projected to grow slowly for the immediate future, the increasing number of beneficiaries will drive Medicare spending to grow faster than the economy as a whole (Exhibit 6).

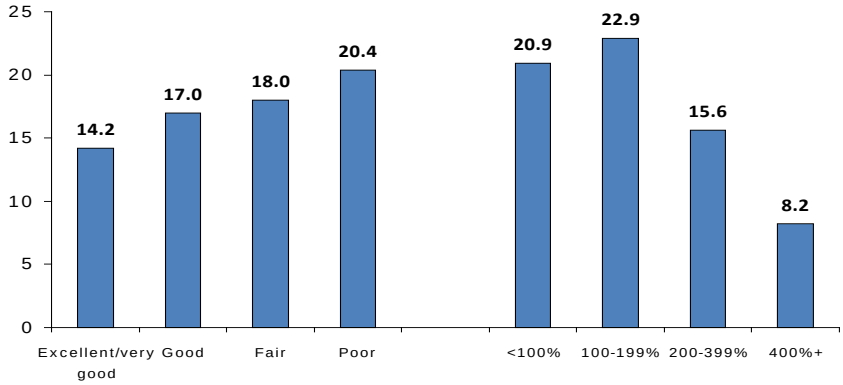
Exhibit 6. Projected Annual Growth Rates for Total Medicare Spending, GDP, Medicare Enrollment, Spending per Beneficiary, and GDP per Capita, 2013-2023



Source: Centers for Medicare & Medicaid Services, Office of the Actuary. National Health Expenditure Projections, 2013-2023.

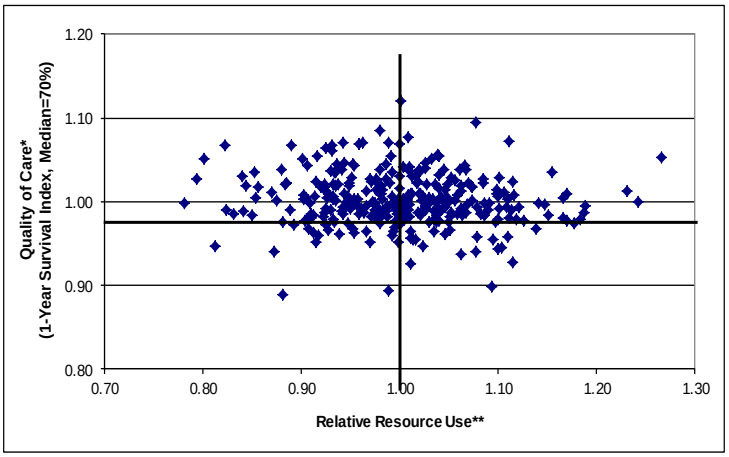
Policymakers are confronted, therefore, with the question of how to continue to slow the growth of total Medicare spending when the spending per beneficiary already is increasing so slowly. Shifting more of the cost of meeting their health care needs onto beneficiaries themselves is problematic, however, since the aged and disabled include some of the poorest and sickest Americans, and they are least prepared to bear that additional burden (Exhibit 7).

Exhibit 7. Median Out-of-Pocket Health Spending as a Percent of Income Among Medicare Beneficiaries, by Health Status and Income, 2006



SOURCE: T. Neuman, J. Cubanski, J. Huang, and A. Damico. "How Much Skin in the Game Is Enough? The Increasing Financial Burden of Health Spending for People on Medicare." Kaiser Family Foundation Data Spotlight, June 2011.

By now, the wide variation in both Medicare and private sector spending is well-documented.[22] In Medicare, particularly, the lack of association between high spending and better quality and outcomes across the U.S. indicates that there should be ways to control spending while maintaining quality (Exhibit 8). Supporting comprehensive payment and delivery system changes that produce lower costs and better value, not just in Medicare, but across the entire health system, would go a long way to increasing value.



xed to risk-adjusted 1-year survival rate (median=0.70).
k-adjusted spending on hospital and physician services using standardized national prices.
E. Fisher, J. Sutherland, and D. Radley, Dartmouth Medical School analysis of data from a 20% national sample of Medicare iciaries.

e: The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the al Scorecard on U.S. Health System Performance, 2008*, (New York: The Commonwealth Fund, July 2008).

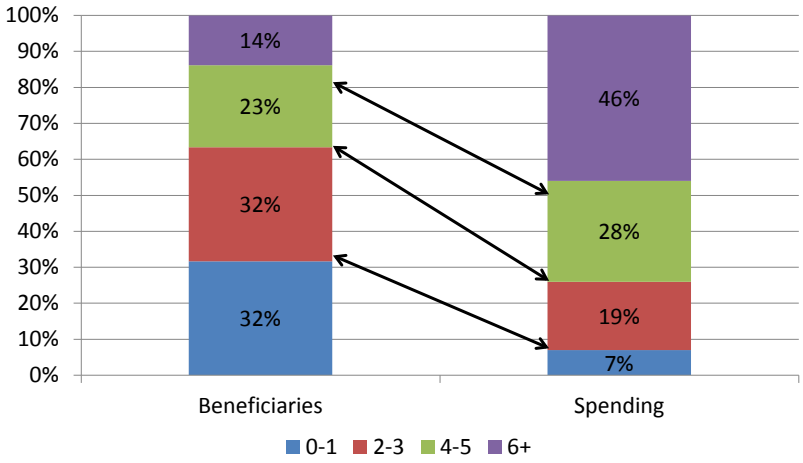
Benefit Design. Currently, Medicare beneficiaries who enroll in traditional Medicare must patch together multiple plans to receive adequate financial protection and prescription drug benefits. This creates complexity and confusion for beneficiaries and results in higher administrative expenses because of the multiple insurance carriers involved and the lack of integrated claims administration. The need to obtain coverage from multiple sources also makes it difficult for Medicare to incorporate value-based benefit designs that use patient cost-sharing to provide incentives to seek high-value care and compare alternative treatment choices. By offering separate medical and drug coverage, the current design creates a disincentive to achieve hospital and specialty care savings through appropriate medication management. The availability of first-dollar supplemental coverage in the current Medigap market makes it difficult for Medicare to adopt incentives for beneficiaries to register and seek care from primary care practices

and medical home teams or seek care from accountable health care systems with a track record of high quality and lower costs.

The combination of fragmented and first-dollar coverage thus raises total cost and confronts beneficiaries with complex choices at high administrative expense. And current benefits fail to protect beneficiaries from catastrophic out-of-pocket costs if they cannot afford private supplements. The only option available to beneficiaries who want integrated comprehensive coverage is to enroll in a private MA plan, with a more limited provider network. A more comprehensive Medicare benefit design that offered could simplify and strengthen beneficiary protection and complement the payment and system reforms that are needed to control costs and improve value.[23]

Care for Beneficiaries With Complex Conditions. A related issue is that Medicare itself was created primarily to provide acute care—essentially short-term treatment for a specific illness, injury, or procedure, and to aid in recovery from that condition. In 1960, life expectancy at birth in the U.S. was 70; in 2010, it was 79.[24] As both medical science and health care delivery have changed, so have the needs of Medicare beneficiaries. Now, 37 percent of Medicare beneficiaries have 4 or more chronic conditions—those beneficiaries account for 74 percent of total Medicare spending (Exhibit 9). Medicare increasingly has focused on improving the coordination of care across providers and settings, and hopefully, proposals will be developed to address those issues and to serve the needs of these beneficiaries more effectively and more efficiently.[25]

Exhibit 9. Beneficiaries with Multiple Chronic Conditions Account for a Disproportionate Share of Spending in Traditional Medicare (2009 Data)



Source: Centers for Medicare & Medicaid Services. "Chronic Conditions Among Medicare Beneficiaries Chartbook: 2012 Edition." Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf.

A notable gap in almost all proposed Medicare reforms is the absence of practical, affordable ideas for covering long term services and supports (LTSS) that are increasingly important for the aging Medicare population. While Medicaid pays for such care for impoverished beneficiaries, no comparable support is available for non-poor older and disabled Americans. Further, the fragmentation of acute care and LTSS makes it difficult to finance and deliver coordinated acute and LTSS. Solutions will likely require new sources of revenue that are difficult to find from public sources, and private insurance has struggled to fill this gap.[26]

Balancing the Roles of Traditional Medicare and Medicare Advantage. An ongoing issue is the appropriate balance between public traditional Medicare and private Medicare Advantage plans. A goal of the Medicare private plan program since its inception in 1982 has been to provide a more efficient model of care to beneficiaries than

the unorganized fee-for-service-based payment system used by traditional Medicare. Expecting that private plans had the potential to be more flexible and efficient than FFS Medicare in meeting the needs of their enrollees, Medicare originally set payment rates for these plans at 95 percent of per beneficiary costs in traditional Medicare in each county, but the tendency for private plan enrollees to be less costly than other beneficiaries meant that plan payments were higher than the same enrollees would have been expected to cost in traditional Medicare.[27]

The relationship between private plan payments and county-specific spending in traditional Medicare has been loosened somewhat, and payments to Medicare Advantage plans are now risk-adjusted to reflect the relative costliness of their enrollees. But Medicare Advantage plan payments overall still exceed traditional Medicare spending in much of the country, and that relationship varies not only by geographic area but also by type of plan. HMOs are the only type of MA plan with lower average costs per enrollee nationwide than traditional Medicare, and there is wide variation in both efficiency and quality among individual plans.[28]

A succession of policy changes over the past 30 years has resulted in substantial overpayment to Medicare Advantage plans relative to anticipated per beneficiary spending in traditional Medicare, and dilution and distortion of incentives to encourage the efficiency or effectiveness of which Medicare Advantage plans should be capable. The recent adjustments to payment policies has strengthened the relationship between plan payment and plan performance, and leveled the playing field between traditional Medicare and Medicare Advantage to some extent.[29] With more than 30 percent of

Medicare beneficiaries enrolled in private plans—a growing number, but still a minority—it becomes increasingly important to determine the appropriate balance between traditional Medicare and Medicare Advantage, and to develop policies that bring out the best in both programs for the benefit of this and future generations of Medicare beneficiaries and to ensure the continued viability of the Medicare program.

CONCLUDING THOUGHTS

Medicare has been successful in achieving its basic mission—providing access to care and stable coverage to aged and disabled Americans. But, as the country's largest purchaser of health services, it can do more to improve quality, promote more coordinated care, and control costs—both its own and throughout the health system. Because of Medicare's unique position, it can be an important testing ground for cost and quality innovations. Policies have been put in place that encourage such development, including expanding the power of the Secretary of Health and Human Services to put payment pilot programs on a "fast track" and to work with private payers and providers to establish multi-payer initiatives.

Medicare is a program that is extremely successful, popular, and important to its beneficiaries, but can be improved in several ways and, at the same time, fulfill its larger role as a key part of health care reform and a platform for improvements that can address the problems that it has in common with the rest of the health care system: the need for increased value for the dollars spent on care.

NOTES

[1] David Blumenthal, Karen Davis, and Stuart Guterman. "Medicare at 50—Origins and Evolution." *New England Journal of Medicine* January 29, 2015 372(5):479-86.

[2] David Barton Smith. "Racial and Ethnic Health Disparities and the Unfinished Civil Rights Agenda." *Health Affairs* March/April 2005 24(2):317-24.

[3] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds. *2015 Annual Report*. (Washington, DC: The Trustees, July 2015). Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf.

[4] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds. *2015 Annual Report*. (Washington, DC: The Trustees, July 2015). Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf.

[5] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds. *2015 Annual Report*. (Washington, DC: The Trustees, July 2015). Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf.

[6] Rick Mayes and Robert A. Berenson. *Medicare Prospective Payment and the Shaping of U.S. Health Care*. (Baltimore, MD: Johns Hopkins University Press, 2006).

[7] Reinhard Busse, Alexander Geissler, Wilm Quentin, and Miriam Wiley. *Diagnosis-Related Groups in Europe: Moving Towards Transparency, Efficiency, and Quality in Hospitals*. (New York, NY: McGraw-Hill, 2011).

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[13] Melinda Abrams, Rachel Nuzum, Mark Zezza, Jamie Ryan, Jordan Kiszla, and Stuart Guterman. "The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five Years." The Commonwealth Fund, May 2015. Available at http://www.common` wealthfund.org/~/media/files/publications/issue-brief/2015/may/1816_abrams_aca_reforms_delivery_payment_rb.pdf.

[14] Stuart Guterman. "With SGR Repeal, Now We Can Proceed With Medicare Payment Reform." The Commonwealth Fund Blog, April 15, 2015. Available at http://www.commonwealthfund.org/publications/blog/2015/apr/repealing-the-sgr.

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