The Heritage Foundation
LEADERSHIP FOR AMERICA

BACKGROUNDER

No. 2827 | JULY 18, 2013

Medicare's Sustainable Growth Rate: Principles for Reform

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Abstract

Congress may soon revisit the issue of Medicare physician reimbursement. Much of the discussion will focus on the sustainable growth rate (SGR), enacted in 1997 as a mechanism to update yearly Medicare physician payments. Under the SGR, the federal government computes an annual target for Medicare physician spending based in large part on annual changes in economic growth as measured by GDP. Physician spending exceeding the growth in GDP in any given year will result in an automatic, proportional cut in physician reimbursement the following year. Physician spending routinely exceeds annual targets, and the SGR has proven unworkable. Since 2003, Congress has blocked the SGR formula from going into effect because the applicable cuts would threaten seniors' access to care. For 2014, the formula calls for a reimbursement cut of almost 25 percent. Many policymakers have concluded that the SGR must be reformed. They are right, but Congress must ensure that any fundamental reform of the SGR is accompanied by fundamental Medicare reform.

Congress may soon revisit the issue of Medicare physician reimbursement payment. Much of the legislative discussion will focus on the sustainable growth rate (SGR) formula. The SGR was enacted as part of the Balanced Budget Act in 1997 as a mechanism to update yearly Medicare physician reimbursements. Under that formula, the federal government computes an annual target for Medicare physician spending based in large part on annual changes in economic growth as measured by gross domestic product (GDP).

Key Points

- The sustainable growth rate (SGR) was enacted in 1997 as a mechanism to update yearly Medicare physician reimbursements, an issue that Congress may soon revisit.
- Under the SGR, the federal government computes an annual target for physician spending based largely on annual changes in economic growth as measured by GDP. Physician spending exceeding the growth in GDP in any given year will result in a proportional, automatic cut in reimbursement the following year.
- Physician spending routinely exceeds annual targets, and Congress has blocked the SGR from taking effect because the applicable cuts would threaten seniors' access to care.
- For 2014, the SGR calls for a Medicare physician reimbursement cut of almost 25 percent. Many policymakers believe the SGR must be repealed or replaced.
- While the SGR should be reformed, Congress must ensure that any fundamental reform of the SGR is accompanied by fundamental Medicare reform.

This paper, in its entirety, can be found at **http://report.heritage.org/bg2827**

Produced by the Center for Health Policy Studies

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Physician spending exceeding the growth in GDP in any given year will result in a proportional and automatic cut in Medicare physician reimbursement the following year.

In theory, the SGR was a major improvement over the volume control updates that Congress enacted in 1989. In practice, the SGR mandated deep and politically unacceptable cuts in future years' Medicare payments. The reason: Physician spending routinely exceeded annual targets. It was quickly becoming clear that the SGR was unworkable. Since 2003, majorities in Congress have routinely blocked the fundamentally flawed SGR formula from going into effect because the applicable cuts would threaten seniors' access to care. For 2014, the formula calls for a Medicare physician reimbursement cut of almost 25 percent. Not surprisingly, many policymakers have concluded that the SGR must be repealed or replaced.

A Chance for Real Reform. The House Energy and Commerce Committee recently released a revised discussion draft of legislation regarding physician payment,[1] on the heels of a statement of principles initially released by the House Ways and Means and the Energy and Commerce Committees in February.[2] Likewise, the chair and Ranking Member of the Senate Finance Committee recently issued a request for "stakeholder" comment about the future of physician payment.[3]

While Congress's immediate focus on the SGR is right and proper, it should not be shortsighted. The SGR is merely representative of a much larger problem: Medicare's outdated system of administrative pricing, price controls, and inefficient central planning. This system both underpays and overpays doctors and other medical professionals, encourages cost shifting and gaming among providers, distorts the medical market, and undercuts the delivery of efficient and effective care. The overriding policy issue is whether Congress will view the SGR narrowly, as something to be "fixed"; or whether the debate can be the platform for a broader discussion of the need for a much better Medicare future, where administrative pricing is replaced by price competition, central planning is replaced by market-driven innovation, and the delivery of high-quality patient care is the product of the best professional judgment of members of the medical profession.

The ultimate policy objective, therefore, should be to transform Medicare into a defined-contribution ("premium support") system, based on the free-market principles of consumer choice and competition—a system where medical services are priced through private negotiations between plans and providers, reflecting the true market conditions of supply and demand. In the meantime, as part of a transition to such a program, Medicare physician payment should be frozen at current levels for three to five years. Any additional costs to the taxpayer should be offset by savings from well-vetted reforms of the current program, plus a lifting of existing payment caps, a requirement for transparent pricing, and expanded options for doctors and patients.

A Crude and Clumsy Attempt to Break Spending

The SGR mechanism, as noted, links aggregate Medicare payment to changes in the general economy as measured by GDP. If spending exceeds the GDP target, the SGR adjusts physician reimbursements downward; if spending remains below target, the SGR increases physician reimbursements accordingly.[4]

By linking specific Medicare payments to the general performance of the economy, Congress

1. House Energy and Commerce Committee discussion draft of Medicare physician payment legislation, June 28, 2013, http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/BILLS-113hr-PIH-SGRreform.pdf (accessed July 11, 2013).
2. House Energy and Commerce Committee and Ways and Means Committee joint framework for Medicare physician payment reform, "Overview of SGR Repeal and Reform Proposal," February 7, 2013, http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/20130207SGRReform.pdf (accessed July 11 2013).
3. News release, "Baucus, Hatch Call on Health Care Providers to Pitch in and Provide Ideas to Improve Medicare Physician Payment System," U.S. Senate Committee on Finance, May 10, 2013, http://www.finance.senate.gov/newsroom/chairman/release/?id=fba99c75-981f-4917-9836-ae49d47453a1 (accessed July 11, 2013).
4. Mark Miller, "Moving Forward from the Sustainable Growth Rate (SGR) System," testimony before the Finance Committee, U.S. Senate, at a hearing on "Advancing Reform: Medicare Physician Payments," May 14, 2013, p. 2, http://www.finance.senate.gov/imo/media/doc/MedPAC%20SGR%20testimony%20with%20attachments_SFC_5%2014%202013.pdf (accessed July 11, 2013).

established a fiscal target bearing little resemblance to the actual cost of medical goods and services. Other targets, such as the consumer price index (CPI) or the medical economic index, provide a clearer link to price inflation and general health cost growth. Moreover, the SGR's explicit link to the size of the economy means that in economic downturns, the target—and thus physician reimbursement levels—will actually decline.

The fact that the SGR remains an aggregate spending target also presents a collective action problem for the Medicare program. Because the SGR targets physician spending as a whole, and not the spending patterns of individual physicians or physician practices, individual doctors have a strong incentive to maximize their own volume of services performed, and thus their own reimbursement levels.[5]

For all these reasons, Congress has consistently modified the SGR targets over the past decade. While the slowdown in health costs surrounding the move to managed care plans in the late 1990s prevented the SGR targets from being hit in the program's first few years, spending soon exceeded the statutory targets. Although Congress allowed the SGR's reimbursement cuts to take effect in 2002, in 2003 (and each year since) Congress overrode the statutory reductions with a series of freezes, or modest payment increases, in SGR target levels.[6]

The annual, albeit temporary, payment increases mandated by Congress since 2003 have resulted in a series of fiscal cliffs for physicians and the Medicare program. Because prior Congresses overrode the SGR targets only for short periods, doctors have faced the prospect of increasingly large reimbursement cuts should Congress not forestall the reimbursement cuts.[7] For instance, should Congress not act before January 1, 2014, the SGR will reset at its lower, statutory target, resulting in an immediate reduction in reimbursement levels of over 24 percent, with additional cuts in succeeding years.[8] According to the Congressional Budget Office (CBO), permanently freezing SGR target levels would cost $139.1 billion over 10 years[9]—a significant sum, but about half the $273.3 billion that the CBO estimated an SGR freeze would cost in July 2012.[10]

As a mechanism to contain *costs,* therefore, the SGR has fallen short. While physicians have received below-inflation updates in Medicare payment levels since 2003, evidence strongly suggests that doctors have compensated for these lower reimbursement levels by increasing the volume of services provided. According to data from the Medicare Payment Advisory Commission, while physician updates grew by less than 10 percent between 2000 and 2011, overall physician spending per beneficiary grew by more than 70 percent over the same period, largely because the volume of services provided to beneficiaries rose rapidly.[11]

However, as a mechanism to control overall *spending* on Medicare, the SGR has provided an impetus for re-examining spending priorities within other portions of the Medicare program. While generally ineffective at controlling physician spending, the annual SGR target has nonetheless forced Washington policymakers continually to re-examine overall Medicare spending, and encouraged continued debate on structural Medicare reform as well as generated intense discussion on incremental but meaningful reforms in the current program.

5. Ibid., p. 3.
6. The full list of statutory adjustments to the SGR conversion factor enacted by Congress since 2003 can be found in amendments to the United States Code, 42 U.S.C. 1395w-4(d)(5) et seq.
7. Beginning with the Tax Relief and Health Care Act of 2006 (P.L. 109–432), Congress provided that temporary payment increases overriding the SGR cuts would not be used in setting the SGR targets for future years—thus ensuring a "cliff" when the target re-sets at the lower level.
8. The Centers for Medicare and Medicaid Services has estimated a preliminary SGR conversion factor update of 24.4 percent for calendar year 2014. Centers for Medicare and Medicaid Services, "Estimated Sustainable Growth Rate and Conversion Factor for Medicare Payments to Physicians in 2014," April 2013, p. 8, Table 5, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/sgr2014p.pdf (accessed July 11, 2013).
9. Congressional Budget Office, "Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies Relative to CBO's May 2013 Baseline," May 14, 2013, http://cbo.gov/sites/default/files/cbofiles/attachments/44184_May_2013_SGR.pdf (accessed July 11, 2013).
10. Congressional Budget Office, "Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies Relative to CBO's March 2012 Baseline," July 31, 2012, http://cbo.gov/sites/default/files/cbofiles/attachments/43502-SGR%20Options2012.pdf (accessed July 11, 2013).
11. Miller, testimony before Finance Committee, U.S. Senate, Figures 1 and 2, p. 4.

Members of Congress have generally insisted on paying for the annual "fixes" to the SGR, as such legislation would otherwise raise Medicare spending and increase the deficit. In 2009, the Senate considered legislation that would have permanently increased Medicare physician reimbursements without offsetting spending reductions.[12] When confronted with an unpaid "doc fix," a bipartisan majority of 53 Senators rejected this legislation,[13] which would have increased federal deficits by $247 billion over 10 years,[14] and up to $1.9 trillion over 75 years.[15]

Over and above the basic principle that Congress should not increase Medicare spending at a time of record deficits, the SGR has provided a vehicle to enact modest reforms to the Medicare program on an annual basis. For instance, legislation addressing the "fiscal cliff" expanded Medicare competitive bidding to diabetes supplies, and enacted new anti-fraud measures, to help finance a one-year "doc fix" for 2013.[16]

When considering SGR legislation this year, Congress must balance the competing interests of the physician community and the Medicare program as a whole. While the SGR has not slowed cost growth, and the annual "doc fix" exercise has caused uncertainty for physicians, the Medicare program as a whole faces massive deficits—the Medicare trust fund lost $105.6 billion over the past five years, deficits that are expected to continue and accelerate as the baby-boom generation retires.[17] Simply repealing the SGR without fundamentally reforming Medicare would have significant unintended consequences for future taxpayers and beneficiaries alike.

More or Less Government Control Over Medical Practice?

Designing a replacement for the SGR formula brings with it many of its own problems. Proposals to replace the SGR with a system of reimbursing doctors based on quality measures—"pay for performance," for example —will necessitate an even stronger role for the Medicare bureaucracy in dictating physician behaviors than the current flawed system.

Well before the creation of the SGR mechanism for updating reimbursement, Medicare physician payment has, over the past 25 years, been defined by the heavy hand of bureaucratic micromanagement. In 1989, Congress enacted a resource-based relative value system (RBRVS) for determining physician payments, which focused on determining the "right" payment for a particular service by calculating the cost of performing that service when compared to other services.[18]

Based on a "social science" measurement, the RBRVS attempted to quantify the "value units" of providing medical services, such as the time, energy, and effort that goes into providing a medical service, adjusted by geographic costs and malpractice expenses. A patient with a simple ear infection would require different amounts of a physician's time than a patient with chronic heart failure, for example, and the RBRVS intended to compensate doctors "fairly" for each service. Organized medicine, particularly the American Medical Association, initially endorsed the new fee schedule as a way of redistributing income from high-priced specialists to lower-paid general practitioners.

In theory, the RBRVS was widely hailed by its proponents as a "scientific" answer to the perennial

12. Medicare Physician Fairness Act of 2009, S. 1776 (111th Congress).
13. Senate Roll Call 325 of 2009, October 21, 2009, http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00325 (accessed July 11, 2013).
14. Congressional Budget Office, cost estimate for S. 1776, October 26, 2009, http://cbo.gov/sites/default/files/cbofiles/ftpdocs/106xx/doc10674/s1776greggltr.pdf (accessed July 11, 2013).
15. Andrew Rettenmaier and Thomas Saving, "How the Medicare 'Doc Fix' Would Add to the Long-Term Medicare Debt," Heritage Foundation *WebMemo* No. 2695, November 13, 2009, http://www.heritage.org/research/reports/2009/11/how-the-medicare-doc-fix-would-add-to-the-long-term-medicare-debt.
16. American Taxpayer Relief Act of 2013, Public Law 112–240, Sections 636 and 638.
17. Centers for Medicare and Medicaid Services, 2013 *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 31, 2013, p. 58, Table II.B4, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf (accessed July 11, 2013).
18. Section 6102 of the Omnibus Budget Reconciliation Act of 1989, Public Law 101–239, established a Medicare physician fee schedule based on the RBRVS, effective in January 1992.

problem of physician payment.[19] In practice, the result has been a highly politicized process of rent-seeking, as lobbyists of different provider groups feverishly scrambled to secure higher reimbursements through the political process. However well-intentioned, the past quarter century has demonstrated the failure of the RBRVS as an accurate method of compensating physicians who participate in Medicare. Even as the federal government attempts to find the "right" price of every physician service, it has seemingly failed to remember the value of any of them. Unsurprisingly, the creation of more than 7,000 separate procedure codes has not ensured that nearly 850,000 Medicare providers are being compensated fairly for their services.[20] Indeed, the RBRVS has failed in one of its central goals: Created 25 years ago to help increase the relative value of allegedly underpriced primary care services, the RBRVS system has only exacerbated price disparities between primary and specialist care.[21]

In the aftermath of this failure, some in Congress have proposed a new system no less audacious—and no less reliant on the hand of government. Instead of the RBRVS method of pricing services partially based on the archaic labor theory of value—that compensation for physician services should be determined by the amount of time and resources put into the work—the new proposals attempt to quantify the "value" to patients of a particular service by measuring its "effectiveness."

Pay for Performance or Compliance? Generally speaking, the new theory of pay-for-performance medicine attempts to determine physicians' "value" and thus reimbursement through compliance with, and performance on, a series of metrics and guidelines determined by federal bureaucrats, medical societies, or a combination of the two. For instance, the House's discussion draft discusses an "update incentive program" under which the Secretary of Health and Human Services (HHS) would be required to publish a "competency measure set" of quality measures, and then "develop and apply...appropriate methodologies for assessing the performance of fee schedule providers" on those measures.[22]

The language in the House discussion draft—linking Medicare physician pay to compliance with government-established guidelines—accelerates a troubling trend reinforced by Obamacare itself. The national health care law, with 165 provisions affecting Medicare,[23] not only retains the SGR, but, like the SGR, it also imposes a hard cap on the growth of all Medicare spending. It creates an Independent Payment Advisory Board (IPAB), which will have the power to enforce the cap, and recommend even more Medicare reimbursement cuts for physicians and other medical professionals. It creates new institutions to change Medicare payment and delivery through administrative action, such as the Center for Medicare and Medicaid Innovation, with demonstration programs designed to end traditional fee-for-service (FFS) payments. Beyond these new institutions, the health law creates new Medicare "quality" programs and extends the Physician Quality Reporting Initiative (PQRI), which will enforce new bonus and penalty payments for physician compliance. As the Congressional Research Service (CRS) reported in its first evaluation of the statute, the new law "makes several changes to the Medicare program that have the potential to affect physicians and how they practice in ways both small and large, immediately and over time."[24]

For example, Obamacare mandates a 2 percent reduction in Medicare physician payments for doctors that do "not satisfactorily submit data" to Washington officials,[25] and a 1 percent reduction

19. Robert E. Moffit, "Back to the Future: Medicare's Resurrection of the Labor Theory of Value," *Regulation* (Fall 1992), pp. 54–63.
20. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2013, p. 79, http://medpac.gov/documents/Mar13_EntireReport.pdf (accessed July 11, 2013).
21. Ibid., p. 95.
22. House discussion draft, pp. 3–5.
23. Centers for Medicare and Medicaid Services, *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, p. 2.
24. Patricia A. Davis et al., "Medicare Provisions in PPACA (P.L. 111-148)," Congressional Research Service *Report for Congress* No. R41196, April 21, 2010, http://assets.opencrs.com/rpts/11-148_20100421.pdf (accessed July 12, 2013).
25. Patient Protection and Affordable Care Act, Public Law 111-148, Section 3002(b).

for physicians who fail to follow bureaucrat-defined "cost" metrics.[26] In separate legislation also signed by President Obama, the Administration received the authority to reduce payments to physicians by a further 3 percent if they do not follow Washington-imposed guidelines for electronic health records.[27]

To their credit, the authors of the House discussion draft emphasize the role of medical specialty societies in determining quality metrics, thereby hoping to assuage concerns about federal bureaucrats' direct involvement in the practice of medicine. This does not, however, solve the fundamental problem. The entire premise of a Medicare pay-for-performance regime—which is really a payment for compliance—directly contradicts the opening verbiage of the original Medicare statute:

> Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.[28]

The threshold question is this: Should government officials "exercise any supervision or control" over the practice of medicine? It matters not whether *some* physicians choose to comply with Washington's mandates on their practices, or whether *some* leaders of *some* specialty societies see value in serving as arbiters of some new Medicare pay-for-performance structure. Under the original Medicare statute, *all* physicians should have the freedom to practice medicine using their own professional judgment in treating a patient, without meddling—whether in the form of new federal mandates, "quality" metrics, or other bureaucratic criteria—from either the federal government or its intermediaries.

The flaws in Medicare's pay-for-performance approach have been well defined elsewhere.[29] The myriad regulations and mandates that such criteria spawn interfere in the practice of medicine, placing an invisible barrier amid the already attenuated relationship between doctor and patient. Worse, the one-size-fits-all methodologies imposed by Washington-enforced mandates directly contradict the great promise of the growing movement toward personalized medicine.[30]

Despite its inherent flaws, a bureaucracy-driven compliance regime remains a shibboleth of leftist health policy analysts who believe that a new system of federal micromanagement can fix the flaws of the old one. Former Senator Tom Daschle (D–SD), President Obama's first choice for Secretary of HHS, wrote in 2008 that government interference in medical care was not the problem, it was the solution:

> We won't be able to make a significant dent in health-care spending without getting into the nitty-gritty of which treatments are the most clinically valuable and cost effective. That means taking a harder look at the real costs and benefits of new drugs and procedures.[31]

Obamacare epitomizes this governing philosophy of administrative control, giving the Secretary almost 2,000 separate orders with which to micromanage the health care system.[32] Members of Congress who rightly criticized Obamacare for granting the Secretary nearly unprecedented discretionary authority over the financing and delivery of medical care should be greatly concerned with

26. Ibid., Section 3007.
27. American Recovery and Reinvestment Act, Public Law 111–5, Section 4101(b).
28. 42 U.S.C. 1395.
29. Richard Dolinar and Luke Leininger, "Pay for Performance or Compliance? A Second Opinion on Medicare Reimbursement," Heritage Foundation *Backgrounder* No. 1882, October 5, 2005, http://www.heritage.org/research/reports/2005/10/pay-for-performance-or-compliance-a-second-opinion-on-medicare-reimbursement.
30. Ibid.
31. Tom Daschle, Scott Greenberger, and Jeanne Lambrew, *Critical: What We Can Do about the Health Care Crisis* (New York: Thomas Dunne Books, 2008), pp. 172–173.
32. Michael Leavitt, "Health Reform's Central Flaw: Too Much Power in One Office," *The Washington Post*, February 18, 2011, http://www.washingtonpost.com/wp-dyn/content/article/2011/02/17/AR2011021705824.html (accessed July 11, 2013).

enacting SGR replacement legislation that would further expand the Secretary's control.[33]

Principles for Congressional Action

As it has since 2003, Congress likely will consider legislation later this year addressing the deep cut mandated by the SGR formula. Absent changes in current law, a cut of nearly 25 percent will take effect on January 1, 2014.

Based on the proposals released to date, leaders on key committees intend to use this year's legislation to construct a permanent replacement for the SGR, with a new reimbursement model heavily focused on quality metrics. The goal of securing a higher quality of services for taxpayer dollars is clearly laudable. But Congress should remain mindful of the consequences of additional intrusion in the doctor–patient relationship, and of the fact that the SGR constitutes merely one piece of a larger entitlement structure in need of fundamental reform.

When considering Medicare physician payment legislation, Congress should:

- **Reject any provisions that micromanage the doctor–patient relationship.** Whether under the name of pay-for-performance, clinical guidelines, or quality metrics, programs emphasizing physician compliance with government-imposed standards are inconsistent with the original intent of the Medicare statute, which safeguards the professional independence and integrity of the medical profession and sacrosanct character of the doctor–patient relationship. Placing additional authority in the hands of government bureaucrats to dictate the practice of physicians undermines these principles as well as patient trust.

- **Restore balance billing and the right to private contracting.** Consistent with a return to free-market principles, Congress should remove the current statutory prohibitions on balance billing—when doctors bill patients for the part of the health-service charge not reimbursed by Medicare—while also repealing the oppressive restriction that prohibits doctors who engage in *any* transactions with beneficiaries outside Medicare's parameters from receiving Medicare reimbursements for two years.[34] Keeping the heavy hand of government out of the doctor–patient relationship requires removing regulatory restrictions that prevent senior citizens from engaging physicians on financial terms that both find fair and advantageous. When coupled with transparency guidelines ensuring that seniors clearly understand the prices and the terms of these contractual arrangements, balance billing and private contracting can remove many of the financial pressures imposed by Medicare's top-down, government-dictated pricing system.

- **Insist that fundamental, long-term SGR reform be paired with fundamental, long-term Medicare reform.** Experts on all sides of the political spectrum agree that the flawed SGR mechanism should be replaced. The best replacement for the SGR and the entire system of current Medicare financing lies in a defined-contribution (premium support) system that fundamentally reforms and enhances the entire Medicare program. In the short term, Congress can take several important incremental steps to re-structure the traditional Medicare program as part of a transition to a premium support system.[35] However, Congress should not attempt to enact a *fundamental* change to the SGR coupled solely with *incremental* reforms to the larger Medicare program. To do so would remove an impetus for the major structural reforms that Medicare needs in order to ensure its solvency for future generations.

Conclusion

Congress once again appears poised to grapple with a problem of its own making—namely, the SGR formula for physician reimbursement. Members in

33. For further information on the HHS Secretary's powers, see John S. Hoff, "Implementing Obamacare: A New Exercise in Old-Fashioned Central Planning," Heritage Foundation *Backgrounder* No. 2459, September 10, 2010, http://www.heritage.org/research/reports/2010/09/implementing-obamacare-a-new-exercise-in-old-fashioned-central-planning.
34. Section 4507 of the Balanced Budget Act, Public Law 105-33.
35. 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.

both the House and Senate have solicited proposals for alternatives, and have committed to considering SGR proposals this year.

However, when constructing alternatives to the SGR, Congress should heed the lessons of experience. The system of administrative pricing for Medicare physician payment, in effect for nearly 25 years, has proven cumbersome, bureaucratic, and unworkable. Moving further in the direction of pay-for-performance medicine, as some proposals have suggested, would merely substitute medical societies for the role currently played by omnipotent government bureaucrats, attempting to impose one-size-fits-all medical care from Washington.

Conversely, while the SGR has not succeeded in its initial goal of containing Medicare physician spending, the perennial "doc fix" bills have forced Congress to enact changes in the Medicare program, many of which constituted real progress in reforming entitlement spending. Completely repealing or replacing the SGR, without first ensuring fundamental reform of the entire Medicare program, would actively subvert attempts to make the program sustainable for future generations.

The SGR debate presents Members of Congress with both an opportunity and a challenge. The opportunity lies in enacting reforms that can expand market forces in Medicare and enhance the program's viability. The challenge lies in resisting the siren call that yet another form of federally micromanaged health care can succeed when all past iterations have failed. Seniors and future generations should hope that Congress chooses to embrace the opportunity and rise to the challenge.

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