The Heritage Foundation

ISSUE BRIEF

No. 4134 | JANUARY 24, 2014

Replacing the Medicare SGR: Getting the Policy and the Financing Right

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This year, Medicare physicians face a 24 percent pay cut. The reason: Congress updates Medicare doctors' payments by a formula called the Sustainable Growth Rate (SGR). While complex, the SGR formula attempts to limit the growth in Medicare physician payment to growth in gross domestic product (GDP). If physician payments are less than GDP growth in any given year, then physician payments automatically increase the following year. If physician payments exceed the GDP growth in any given year, they are automatically reduced the next year. Because physician payment has outpaced economic growth, payment cuts are routinely triggered.

Policy Failure. In 1997, Congress created the SGR update formula to replace its failed "volume performance standards" to control volume and the "unsustainable" growth in Medicare Part B spending. This exercise in government central planning has proven to be an epic policy failure.

Policy failures are pricey. Beginning in 2003, Congress stopped the SGR-mandated physician payment cuts from going into effect on 15 occasions. But, under current law, delays have a cumulative effect and result in even deeper cuts and higher costs the following year. Thus far, according to congressional staff estimates, Congress has spent almost $150 billion on these temporary "doc fixes" over the past 10 years.[1] Among physicians, the anger, anxiety, and frustration of wrestling with Washington's metastasizing bureaucracy is incalculable. Patients are, of course, shortchanged.

A New Beginning? Congressional leaders want to repeal the SGR entirely and replace it with an alternative payment program. The House Energy and Commerce Committee, the House Ways and Means Committee, and the Senate Finance Committee have developed alternative payment proposals. They are structured to provide payment stability over the next few years and increase physician payment based on quality measures or performance standards.

The House Ways and Means and Senate Finance Committee proposals would repeal the SGR, freeze physician payment until 2023 (zero update), encourage physician participation in "alternative payment models" (APMs), and create a value-based performance (VBP) payment program. For medical professionals not participating in APMs, enrollment in the VBP would be compulsory. There, medical professionals would have their performance assessed on the provision of quality, their use of resources, clinical improvement and "meaningful use" of electronic health records. Bonus payments would be funded from a budget-neutral pool and paid out to physicians based on a composite score of performance in these categories.

The House Energy and Commerce Committee bill would tie pay increases to quality measures and clinical practice guidelines set by medical professional organizations. Doctors would get positive or negative pay adjustments depending upon their compliance

This paper, in its entirety, can be found at
http://report.heritage.org/ib4134

Produced by the Center for Health Policy Studies

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with these standards. The bill would also give doctors the opportunity to participate in APMs.

The Policy Problem. When Congress enacted Medicare in 1965, it enshrined in statute the right relationship between government power and medical professionalism: "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."[2] Members of Congress must now find a way to preserve this principle and reverse the trend toward government control over the practice of medicine.

As Scott Gottlieb, MD, a resident fellow at the American Enterprise Institute, has warned, the Ways and Means and Senate Finance proposal gives the Secretary of Health and Human Services authority to establish "applicable appropriate use criteria" determining conditions for advanced imaging and electrocardiogram services—and to expand such criteria for all other medical services. Says Gottlieb, "It should be clear to everyone by now that the delivery of medical care isn't something that can be micromanaged from Washington or be administered by a Secretary of Health and Human Services with wide latitude to interpret and reinterpret the rules."[3]

Paying doctors for the *quality* rather than the *quantity* of services makes perfect sense. Indeed, free-market transactions, combined with transparency of price and performance in an information-driven environment, routinely deliver quality as well as quantity in virtually every other sector of the economy. While America needs a better system for paying Medicare doctors, Congress should also secure iron-clad protection from government interference in the practice of medicine. And, as it stands, no proposal yet provides such a guarantee.

The Funding Problem. Beyond securing the right relationship between government and the practice of medicine, cost is also a crucial problem. Broadly speaking, the House and Senate measures reflect the conventional belief that "delivery reforms"—such as value-based purchasing or "pay for performance" models—will yield significant savings. Time will tell. But the Congressional Budget Office (CBO) review of such measures is not promising:

> Results from demonstrations of value-based payment systems were mixed. In one of four demonstrations examined, Medicare made bundled payments that covered all hospital and physician services for heart bypass surgeries; Medicare's spending for those services was reduced by about 10 percent under the demonstration. Other demonstrations of value-based payment appear to have produced little or no savings for Medicare.[4]

Any permanent SGR fix entails higher Medicare costs. But CBO also says the 10-year costs of SGR repeal, for a variety of reasons, have gotten progressively lower, falling from $316 billion in August 2012 to $116.5 billion today.[5] For the period 2014–2023, however, CBO estimates that the House Ways and Means bill would increase Medicare costs by $121.1 billion.[6] Over the same period, CBO says the Senate Finance Committee version would hike costs by $148.6 billion.[7]

Offsetting these costs is a must. In 10 of the 15 occasions since 2003 when Congress blocked the SGR, lawmakers offset those costs with health savings, mostly by tightening up Medicare's price con-

1. House Ways and Means and Senate Finance Committee Staff, "SGR Repeal and Medicare Physician Payment Reform," October 30, 2013, p. 1.
2. 42 U.S. Code § 1395.
3. Scott Gottlieb, "This 'Doc Fix' Would Be Bad for Your Health," *The Wall Street Journal*, December 11, 2013.
4. Congressional Budget Office, "Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination and Value Based Payment," January 18, 2012, http://www.cbo.gov/publication/42860 (accessed January 22, 2014).
5. Mary Agnes Carey, "Congress Is Poised to Change Medicare Payment Policy. What Does That Mean for Patients and Doctors?," *Kaiser Health News*, January 16, 2014, http://www.kaiserhealthnews.org/stories/2014/january/16/congress-doc-fix-sustainable-growth-rate-SGR-legislation.aspx?utm (accessed January 22, 2014).
6. Congressional Budget Office, "H.R. 2810: Medicare Patient Access and Quality Improvement Act of 2013, as reported by the House Ways and Means Committee on December 12, 2013," January 24, 2014, p. 1.
7. Carey, "Congress Is Poised to Change Medicare Payment Policy."

trols or payments. But Medicare providers already face a stunning $716 billion in 10-year payment reductions due to Obamacare, which will worsen seniors' problems in accessing care. Likewise, Congress should dismiss raids on discretionary accounts, such as the Overseas Contingency Operations Fund for Afghanistan and Iraq, that yield only temporary spending relief.

Long-term savings must be secured through structural Medicare reforms.[8] The simplest of these is to combine Medicare Parts A and B, rationalize cost sharing and Medi-gap coverage, and give seniors protection from catastrophic costs. That change alone, CBO estimates, would secure $114 billion in savings from 2014 to 2023,[9] or nearly enough pay for the SGR repeal. Other structural changes, which have attracted past bipartisan support, include the further reduction of taxpayer subsidies for upper-income retirees and gradually raising the normal Medicare age of eligibility to 67, preferably 68.[10]

A Golden Opportunity. The repeal of the Medicare SGR presents Congress with a golden opportunity to strengthen the doctor–patient relationship, guarantee greater transparency in medical pricing and performance, inspire clinical innovation, and promote personalized medicine.[11] The danger is that Congress will inadvertently further compromise physicians' professional independence, force doctors into greater compliance with an already rigid regulatory regime, and add another layer of administrative complexity that will make Medicare practice progressively worse.

In repealing the SGR, Congress should secure medical practice from federal supervision or control and finance the cost of repeal with real, long-term savings. These can be secured only through structural changes in the Medicare program.

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8. Robert E. Moffit and Rea S. Hederman, "Medicare Savings: 5 Steps to a Down Payment on Structural Reform," Heritage Foundation *Issue Brief* No. 3908, April 12, 2013, http://www.heritage.org/research/reports/2013/04/medicare-savings-5-steps-to-a-downpayment-on-structural-reform.
9. Congressional Budget Office, "Options for Reducing the Deficit: 2014–2023," November 2013, http://www.cbo.gov/budget-options/2013/44687 (accessed January 22, 2014). For an account of the status quo costs of the current structure, see also Robert E. Moffit and Drew Gonshorowski, "Double Coverage: How It Drives Up Medicare Costs for Patients and Taxpayers," Heritage Foundation *Backgrounder* No. 2805, June 4, 2013, http://www.heritage.org/research/reports/2013/06/double-coverage-how-it-drives-up-medicare-costs-for-patients-and-taxpayers.
10. 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.
11. 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.