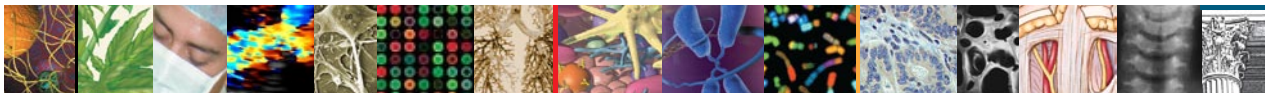

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Perspective

The SGR for Physician Payment — An Indispensable Abomination

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Congress has just extended the life of the sustainable growth rate (SGR) — the formula that Medicare uses to calculate physicians' fees — for 6 more months. The SGR was enacted in 1998 to hold down the growth of these fees. It replaced a formula with the same objective that wasn't working. It ties the annual growth of Medicare fees to growth of the real gross domestic product, Medicare caseloads, and practice costs. But it ignores the principal reason that health care spending outpaces income growth: the increasing number and complexity of medical interventions. The SGR purports to control total spending on physician services, but it controls only prices, even though spending is the product of the price and the number and intensity of services. According to the formula, the more the number and intensity of services grow in one year, the more prices must be cut in the next. To make matters worse, the formula calls for any excess of cumulative spending since the formula was enacted in 1998 to be made up as well. Thus, the implied price cuts can be large, and they grow if cuts are deferred. In 2010, the implied fee cut was 21%, with further annual cuts of around 5% in several succeeding years. Rather than cut fees, Congress has just suspended the application of the SGR formula and boosted fees by 2.2% effective June 1, 2010. As in years past, however, Congress left the formula on the books and promised to cut fees later.

The road that led to this short-term legislation is instructive. In 2009, committees of the House of Representatives proposed a permanent replacement for the SGR formula in draft health care reform legislation. Because budget projections are based on the assumption that SGR fee cuts will be implemented, abandoning these cuts is scored by the Congressional Budget Office as a spending increase. Thus, including the SGR fix raised the estimated cost of health care reform. The need to hold down the cost of reform led Congress to strip the SGR changes from the reform bill. They would come separately, Congressional leaders promised. But this promise went unfulfilled. Instead, the Senate leadership proposed suspending the SGR cuts for 19 months. That held down the estimated 10-year costs, since the cuts would apply for 8 years 4 months of the 10-year period used for budget estimation. That proposal was embedded in broader legislation, the overall cost of which stymied efforts to garner the 60 votes needed for Senate passage. In the

end, the Senate unanimously agreed to suspend the SGR fee cuts for just 6 months — not coincidentally, until just after the midterm elections (campaign contributors, please take note). The House eventually endorsed the same provision, which has become law.

As Vladeck has pointed out,[1] there is not much good to be said about the SGR formula. There is, if possible, even less to be said in praise of Congress's repeated "fixes." Each time, Congress declares that it will enforce the formula later, but not now — calling to mind the prayer of Augustine, the exuberant sinner who yearned for virtue: "God, make me chaste, but not just yet."

The sensible action, it might seem, would be to replace a flawed formula with something better. This course of action itself suffers from two flaws, both related to cost. First, it violates Schultze's law, defined by and named for Charles Schultze, former budget director and chair of the Council of Economic Advisers. This law, a riff on the Hippocratic Oath, adjures elected officials: "Do not be *seen* to do harm." Fixing the SGR formula violates this law. Budget projections reflect current law, which includes fee reductions implied by the SGR. Abandoning the formula boosts fees and, hence, projected deficits. For example, replacing the SGR with a formula that ties fees to the Medicare Economic Index, which is based on physicians' compensation and practice costs, would boost the 10-year deficit by $439 billion (by $556 billion if Medicare premiums were insulated from the effect of this shift) plus the amount of added interest on the increased debt.[2] Voting to increase the deficit is widely regarded as bad for officials' electoral health.

Second, the threat from growing budget deficits is more salient and immediate today than it was in 1998 when the SGR was enacted. Today, as then, however, Congress lacks effective instruments to slow the growth of spending within the current Medicare framework. Confronted with a genuine budget challenge, Congress will be loathe to abandon even a flawed instrument when doing so seems to aggravate the budget problem. Until some plausible alternative comes along, the SGR will live on, even as its targets become increasingly unrealistic.

Alternatives to the SGR may emerge from health care reform, however. The Patient Protection and Affordable Care Act includes a number of provisions intended to change the way that health care is organized and paid for. Among the more important are Sections 2704 and 3023, which aim to promote the study and use of bundled payments, sections 2706 and 3022 on accountable care organizations, sections 3001 and 3007 on value-based insurance design, section 3002 on reporting of quality measures, and section 3003 on the collection and feedback of information on the costs of providing various physicians' services.

In each case, the hope is that the reforms will both improve quality and save money. Studies or pilot programs to test them will take time to field and evaluate. Even if these innovations work as hoped, many, perhaps most, physicians will resist them. Behavioral and institutional change is difficult and costly. Whatever physicians think, the secretary of health and human services, the newly created Independent Medicare Advisory Board, or other entities will look for ways to promote reforms that promise to save money. The prospect of allowing all or most of the fee cuts implied by the SGR to take effect could one day be used to encourage physicians to join accountable care organizations, promote acceptance of bundled payments, and elicit cooperation with other health system reforms.

The SGR formula is unlikely ever to be fully enforced. But the relentless and growing challenge of reducing federal budget deficits will make it increasingly difficult for Congress to abandon the formula entirely. The threat of letting it take effect may yet be used as leverage to achieve other goals. Congress may one day emulate Vito Corleone and make physicians offers they can't refuse.

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1. Vladeck BC. Fixing Medicare's physician payment system. N Engl J Med 2010;362:1955-7.
2. Modify the sustainable growth rate formula for updating Medicare's physician payment rates. In: Budget options, volume I: health care. Washington, DC: Congressional Budget Office, 2008:112-3.