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The Sustainable Growth Rate Formula and Health Reform

By Paul N. Van de Water

Some critics of the new health reform law contend that the Congressional Budget Office (CBO) cost estimate understates the law's true cost because the law doesn't fix Medicare's flawed sustainable growth rate (SGR) payment formula for physicians. Since Congress is certain to enact a fix, these critics contend, its cost should be part of the health reform law. That claim, however, is mistaken. The cost of fixing the SGR formula is entirely unrelated to health reform and would exist with or without the new law.

What is the sustainable growth rate formula?

Enacted as part of the Balanced Budget Act of 1997, the sustainable growth rate formula determines how much Medicare pays for services that physicians provide. Under the SGR, cumulative Medicare spending on physicians' services is supposed to follow a target path that depends on the rates of growth in physicians' costs, Medicare enrollment, and real gross domestic product per person. If spending in a given year exceeds the SGR target for that year, then the amounts paid to physicians for each service they provide are supposed to be reduced in the following year to move total spending back towards the target path.[1]

Was the SGR originally expected to save much money?

No. CBO and Congress originally expected the SGR formula to lower physician payment rates only modestly below the levels they would have attained under previous Medicare law. When Congress enacted the SGR in 1997, the volume and complexity of physicians' services were growing more slowly than they had been earlier, and many forecasters assumed that those lower rates of growth would continue. (The complexity of services is important because Medicare pays physicians higher rates for more complex services.) CBO estimated that the SGR formula would save only $12 billion over the 1998-2007 period — less than 5 percent of the total Medicare savings in the 1997 Balanced Budget Act.[2]

What actually happened?

At first, payment rates for physicians under the SGR formula kept pace with, or even exceeded, increases in physicians' costs. By 2002, however, the increase in the volume and complexity of physicians' services began to return to its long-term trend, and the SGR formula produced a 4.8-percent cut in payment rates — a larger cut than had been anticipated. Since 2003, Congress has regularly prevented the full cuts required by the SGR from going into effect, although it has not changed the underlying SGR formula or the cumulative spending targets, which are still in law. Because the SGR's designers greatly underestimated the increase in the volume and complexity of doctors' services, the formula requires cuts in physician payments that become more severe with each passing year. In 2010, the SGR calls for a stunning *21.2-percent* reduction in physician payment rates,[3] though Congress is expected to prevent this cut from taking effect.

What's wrong with the SGR?

The SGR approach is fundamentally flawed because it attempts to limit Medicare spending for physicians'

services by restraining payment rates *without* limiting the growth in the volume and complexity of services.[4] The Medicare Payment Advisory Commission (MedPAC) sums up the problems as follows: the SGR formula "does not provide incentives for individual physicians to control volume growth, and is inequitable to those physicians who do not increase volume unnecessarily. And it continues to call for substantial negative updates through at least 2016. Such reductions in physician payment rates, if they take place, would threaten beneficiaries' access to physician services."[5]

Should the cost of the health reform law include the cost of fixing the SGR?

No. Congress probably won't let the full SGR cuts take effect or offset the cost of scrapping them. But that cost is neither part of, nor in any way a result of, health reform. *The federal government will incur this cost regardless of health reform, not because of it*. If Congress repealed the health reform law tomorrow, the full cost of fixing the SGR formula would remain. To be sure, it would be better if Congress offset the cost of cancelling the SGR cuts. But that issue is separate from the question of how much health reform itself reduces the deficit.[6]

Some critics allege that, in the CBO cost estimate, health reform is "credited with 'savings' from a cut in doctors' pay."[7] This charge is incorrect. Since the SGR formula is currently in law and is not changed by health reform, the CBO estimate of the legislation includes neither the cost of fixing the SGR nor the savings that would occur if the SGR cuts are allowed to go into effect.

Does the SGR experience prove Congress never lets Medicare savings take effect?

No. The SGR is the exception — not the rule. The vast majority of the provisions enacted in the past 20 years to produce Medicare savings were successfully implemented. Virtually all of the Medicare savings in the 1990, 1993, and 2005 budget reconciliation bills took effect, as did nearly four-fifths of the savings in the 1997 Balanced Budget Act.[8] Most of the Medicare savings provisions in the health reform legislation are similar to the types of Medicare provisions that Congress has allowed to take effect, and differ markedly from the poorly designed SGR mechanism.

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[1] Medicare Payment Advisory Commission, *Payment Basics: Physician Services Payment System*, October 2009.

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

[3] Jim Hahn, *Medicare Physician Payment Update and the Sustainable Growth Rate (SGR) System*, Congressional Research Service, March 18, 2010.

[4] James R. Horney and Paul N. Van de Water, *House-Passed and Senate Health Bills Reduce Deficit, Slow Health Care Costs, and Include Realistic Medicare Savings*, Center on Budget and Policy Priorities, December 4, 2009.

[5] MedPAC, *Report to the Congress: Improving Incentives in the Medicare Program*, June 2009, p. 253.

[6] Paul N. Van de Water and James R. Horney, *Health Reform Will Reduce the Deficit*, Center on Budget and Policy Priorities, March 25, 2010.

[7] For example, Jeffrey H. Anderson, "(Doc) Fixing the Books," *National Review Online*, April 7, 2010. Available at http://healthcare.nationalreview.com/post/?q=NmZmMTAxYjgyN2I0NzAwNmRmOTc5NjdkNjg2MDc4ZmU .

[8] Horney and Van de Water.