



REPLACING MEDICARE'S UNSUSTAINABLE SUSTAINABLE GROWTH RATE

A Better Way to Determine Doctors' Pay

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EXECUTIVE SUMMARY*

Clashes over U.S. health care policy are legion, with the furor unleashed by the Affordable Care Act merely the most prominent recent example. Yet on the question of reforming how Medicare pays doctors—determined, at present, by the Sustainable Growth Rate (SGR) mechanism—there is rare bipartisan accord on the need for change.

First enacted in 1997, the SGR was intended as a means to tie cost increases in Medicare, already one of the nation's most costly programs, to trends in the overall economy. In practice, Congress has proved reluctant to implement the SGR's approach to budget restraint: lower payments to individual doctors, as determined not by the law of supply and demand but by an arbitrary price-fixing formula. Indeed, since 2002 the congressional budget process has annually included the so-called doc fix—arbitrary upward adjustments to Medicare physician reimbursement rates—thereby reversing its own SGR-imposed cost-control mandates.

The result: as Medicare consumes an ever-larger share of U.S. economic output, the SGR system fails to meet its goal of ensuring that Medicare's spending on physicians grows more slowly than a broad economic index.¹ The Sustainable Growth Rate is, in short,

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anything but sustainable. Despite such shortcomings, efforts to replace the SGR, which, to date, have largely consisted of minor tweaks, fail themselves to attract sufficient support. As Congress approaches its latest deadline for fixing the SGR, on March 31, 2015, policymakers happily need not search far and wide for a better alternative. An existing government program, based in price and quality competition tied to consumer choice,² has already restrained cost growth³ without centrally led interventions: Medicare Part C, otherwise known as Medicare Advantage (MA).

This paper proposes a practical alternative to the current system: setting Medicare reimbursement rates through comparison with the closest available approximation of actual market prices for health care, those experienced by patients enrolled in the substantial and growing Medicare Advantage program. In this proposal, MA, which permits those 65 and older to choose from among a group of private insurance plans, would serve as a source of benchmark pricing for so-called Medicare fee-for-service (FFS) patients—the majority of Medicare enrollees whose health care providers are reimbursed, at a predetermined price, for each individual service performed. The plan offered herein combines the potential for predictability—of the sort health care providers much prefer—with the potential for cost controls originally envisioned by the SGR approach.

I. MEDICARE PHYSICIAN PAYMENTS: A BRIEF HISTORY

Though widely considered a failure, the SGR is an improvement over the way Medicare used to pay for physician services. Before the 1990s, Medicare paid physicians based on prevailing charges in the private market. Providers quickly realized how to game the

system: raise charges across the board to coax higher payments out of Medicare. In 1989, the Physician Payment Review Commission's report to Congress observed: “[R]elative payments based on screens for ‘customary, prevailing, and reasonable’ charges has serious problems. It conforms neither to patterns that would promote efficiency in medical practice, nor to those that one might infer to be fair among physicians or among beneficiaries.”⁴

In the same year, the Omnibus Budget Reconciliation Act (OBRA) of 1989⁵ created Medicare's first physician fee schedule, which considered the “relative value” of services to determine reimbursements. It assigned relative value units (RVUs) to each service, based on a crude estimate of the cost of providing the service (not the value of the service to the patient). It then used a uniform conversion factor (CF), and multiplied that by the number of RVUs, to determine the dollar amounts paid for the service. OBRA also created the Volume Performance Standard

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(VPS), a precursor to the SGR, which controlled the growth rate of payment updates (i.e., annual changes to the CF). Under the VPS, payment updates were determined by whether the volume of services in a given year grew faster than a target rate, determined by the secretary of Health and Human Services. When volume grew faster than the target, payment updates were lower or negative—and vice versa, when volume grew slower.

Criticized for contributing to high Medicare spending growth in the early 1990s, the VPS nevertheless helped slow growth rates. In the 1990s, per-beneficiary outlays grew, on average, by 6 percent annually; in the 1980s, growth averaged 11 percent.⁶ While the rise of managed care certainly helped slow health care spending in the 1990s, its impact on traditional

Medicare was largely indirect (such as on the practice patterns of hospitals and doctors). Indeed, Medicare managed-care plans were not yet a significant part of the U.S. health care system.⁷

Though growth rates were lower in the early 1990s than in the previous decade, lawmakers still considered them too high: in the VPS's six years of operation (1992–97), Medicare's per-beneficiary outlays exceeded real GDP growth by 4.5 percentage points and Medicare Economic Index (MEI) growth by 5.7 percentage points.⁸ In 1997, a new physician payment update system, the SGR, was created, as part of the Balanced Budget Act.

The SGR

At present, Medicare's physician fees are determined by assigning a relative value to each Part B service, and then multiplying that value by a CF to determine the dollar payment. The SGR is, in other words, a formula for annually updating the CF by a specified percentage. The SGR allows for increases in physicians' costs, the number of Medicare FFS beneficiaries, FFS benefit changes, and the ten-year average rate of growth in real GDP per capita.

The SGR's adoption marks the first time that Medicare physician spending was tied to the growth of the real (i.e., inflation-adjusted) economy. The goal: Medicare Part B spending should not grow faster than the Medicare FFS population, benefits offered, and the economy.

Under the SGR, once the conversion factor is set for the year, payments are made at the predetermined level, even if the total quantity of services is higher than projected. Meanwhile, the "sustainable" in Sustainable Growth Rate refers to another adjustment: if one year's total spending is higher than projected, the following year's CF is adjusted downward to make up the difference.

In the first few years of operation, the SGR's payment updates accurately tracked physician operating costs;

over the first four years, per-beneficiary costs also rose, on average, by a mere 2.5 percent annually.⁹ Eventually, though, utilization of Medicare Part B services began to rise faster. In response, the Department of Health and Human Services, as prescribed by the SGR, cut physician reimbursements by 4.8 percent in 2002¹⁰—the last time that Congress would allow HHS to abide by the SGR's formula.

In the ensuing years, Congress's dance around the SGR has followed a consistent pattern. Costs rise above projections. The SGR responds with mandated cuts to the CF and, thus, to physician payments. Congress then overrides the mandates—something it has done 17 times since 2002.¹¹ Each time it does so, the accumulated "sustainability gap" between Medicare's actual spending on physicians and that mandated by the SGR widens further. On April 1, 2015, the SGR will, yet again, require Congress to cut doctors' pay—now by a staggering 21.2 percent.¹²

II. THE SGR'S FLAWS

There are at least three fundamental flaws with the existing SGR system. Such flaws combine to dictate Medicare procedure-by-procedure reimbursement fees, which are pushed down to the point that they are both politically unacceptable and risk paying less than market value for care provided.

The first is that the SGR focuses on overall spending without addressing the complexity of services. The SGR's target is, as mentioned, based on four factors, including a ten-year moving average of real GDP per capita. When cumulative annual actual expenditures exceed cumulative "allowed" expenditures, the SGR's payment update for physicians automatically falls.¹³

This creates a free-rider problem. On the one hand, individual physicians have an incentive to increase the volume and complexity of services provided to earn higher reimbursements in a given year. On the other hand, individual physicians face no incentive to reduce the level of care provided in order to maintain

higher future payment rates, in part because such benefits would largely accrue to others (in the form of a payment update). Under such incentives, physicians who cut volume by delivering more efficient care are implicitly punished.

The SGR's second fundamental flaw is its effort to tie Medicare spending to real GDP per capita. "[T]he SGR's explicit link to the size of the economy," observes Chris Jacobs of America Next, a think tank, "means that in economic downturns, the target—and thus physician reimbursement levels—will actually decline."¹⁴ While

switching to a ten-year moving average of GDP growth (from the original annual GDP growth figure) somewhat loosens the relationship between the two, a prolonged, ten-year slowdown in GDP

growth would make payment increases significantly smaller or possibly negative. Congress's repeated dance around SGR updates suggests that this may not be politically palatable.

The SGR's third major flaw is that physician payment updates have typically been lower than MEI increases.¹⁵ While actual physician payment updates do account for the cost of inputs to physician services (as measured by MEI), physician payment updates have nevertheless not kept pace with the cost of providing physician services—even after accounting for the aforementioned 17 congressional overrides to SGR-mandated reimbursement cuts.

III. PREVIOUS SGR REPLACEMENT EFFORTS

The flaws and vagaries of the existing, improvised SGR system have not gone unnoticed by Congress, which has been pressured annually to "fix" it. But attempts to do more than apply a short-term patch

have foundered on twin shoals: (1) congressional procedure; and (2) failure to introduce a reliable pricing benchmark that can lead to reimbursement rates that limit cost increases in ways that don't starve Medicare—lifeline, as it is, for older Americans.

In July 2013, for example, the Senate Finance Committee and House Ways and Means Committee proposed eliminating the SGR and tying future payment increases instead to performance measures. SGR replacement bills in both the House and Senate took shape. Ultimately, various factors prevented either bill

from passing, including their lack of real cost offsets¹⁶ and the political distraction of the government shutdown.

Congress's response to the SGR's flaws has instead, as discussed, been to apply tempo-

rary "doc-fix" patches. The majority of these quick fixes were not only offset with spending reductions that often reduced the rate of Medicare spending growth but also introduced various sensible reforms, such as adjusting bundled payments for end-stage renal disease to better align with utilization¹⁷—all of which suggests that even a less bureaucratic replacement option does not eliminate the need to offset implementation costs.

Problems with Previous SGR-Replacement Bills

In many standard SGR-replacement proposals, physician payments would be determined by a predetermined formula (i.e., administrative pricing). Some recent proposals have even tried to tie future payment increases to quality metrics—a noble goal. All, however, suffer from their failure to tackle the SGR's major flaws.

Cost-control formulas, notably, are useful only insofar as they are implemented as mandated. In practice, administrative pricing inevitably runs into political

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objections; the ease with which Congress can override such formulas further weakens their long-term viability.

All legislation can, of course, be overridden. Yet the extent to which payment schedules rely on “pre-ordained” formulas certainly affects the extent to which laws *will* be overridden. In the SGR’s case, because Congress established the formula—and has, implicitly, routinely acknowledged its flaws by overriding it—it likewise falls upon Congress to fix the SGR when undesirable outcomes (i.e., payment reductions) occur. If physician reimbursements were based not on administrative pricing but instead on actual market prices, congressional overrides would become less likely, for prices would (necessarily) better align with actual costs.

Another important hurdle in the SGR-replacement debate involves the need to offset increased spending: the Congressional Budget Office, for instance, recently estimated the additional cost of two modest replacement proposals at \$137–\$168 billion through 2024.¹⁸

IV. A DIFFERENT PROPOSAL

Against this background of false starts and short-term fixes, it *is* possible to identify the elements of a truly sustainable Medicare reimbursement system. Ironically, the key elements to be mined are found in Medicare itself—specifically, in the Medicare Advantage (MA) program.

MA offers Medicare enrollees a choice of various private health insurance plans, which pay doctors according to their own negotiated arrangements rather than through the traditional Medicare fee-for-service system that the SGR has struggled to reform. By their very nature, MA plans provide the framework to determine what has been so difficult for Congress to set: plausible, acceptable health care prices. Herein lies the heart of the solution: a proposal to use prices negotiated in a commercial marketplace, between

private insurers and private health care providers, as the basis for the price at which the U.S. government reimburses any doctor who accepts fee-for-service Medicare patients. The following are steps that such a reform might take.

First, Adopt Competitive Bidding

Tying FFS reimbursements to market-based cost determinants confers many advantages; but doing so within the program’s existing structure would be inadvisable. Because insurers’ so-called bids are still compared with a benchmark (which is tied to FFS costs) before payments are made, current Medicare Advantage bids and costs do not reflect competitive, market-based prices. And because MA payments are tied to FFS costs, tying FFS payments to MA costs would create a recursive loop.

The solution: shift to a competitive bidding system, creating a new MA benchmark based on bids, not FFS costs. MA plans would then compete directly on cost (as well as other factors, such as quality and patient satisfaction). Depending on the specific proposal (there have been many), the current FFS program could serve as a competitor or remain a second option. (One such recent proposal estimated cost savings of \$339 billion over ten years.)¹⁹

Medicare Advantage: A Successful Model

Encouragingly, Medicare Advantage already offers a successful, market-based model for paying physicians to care for Medicare beneficiaries. Under MA, beneficiaries are allowed to enroll in private-sector coverage instead of the standard FFS program. Many plans are provided at no additional premium above the Medicare Part B premium that FFS beneficiaries pay; they have lower co-payments and deductibles than the FFS program; and limits on total out-of-pocket spending. Additional benefits, such as disease-management and weight-loss programs, are often included.

Often, Medicare Part A and Part B benefits (physician and hospital services) and Part D benefits (outpatient

prescription drugs) are combined into a single plan. MA plans are then reimbursed by Medicare, based on a predetermined benchmark (tied to FFS costs)—plans' bids stand in relation to the benchmark, as well as enrollees' risk scores. With more than 60 percent of MA enrollees in HMO plans,²⁰ which feature tight networks and greater care management and coordination, Medicare Advantage is generally considered to be a managed-care alternative to FFS Medicare.

The fact that MA plans develop their own payment structure offers a fine opportunity to eliminate SGR's administrative pricing in favor of a more market-based alternative—one that is consistent, permanent, and not subject to budgetary whims. Indeed, a more comprehensive SGR replacement plan would make the MA bidding process competitive, tying FFS's physician reimbursement schedule to MA (rather than the other way around).

At present, MA bids are not true bids: one plan's bid does not affect payments made to others. MA plans submit a monthly premium amount and are then paid a fixed monthly amount independent of other plans' bids.²¹ Payment is based primarily on each enrollee's county of residence;²² enrollees pay the difference, if any, between that amount and the monthly premium "bid."

Medicare Part D prescription drug plans, on the other hand, offer truly competitive bids. All plans submit bids; all plans are then paid based on the average of all bids. Such bids are binding, too: bidders must offer the plan they bid, at the price they bid. This deters plans from bidding too high (for fear of losing customers) and too low (for fear of losing money). The aforementioned average, weighted by enrollment, prevents insurers from submitting

phantom plans with high bids and low (or zero) expected enrollment merely to artificially increase the average.²³

In short, Medicare Part D bidding participants face incentives to cut costs in ways that allow them to continue to attract enrollees. The result: enrollees have high levels of satisfaction, more beneficiaries have drug coverage, and government spending is far lower than initial projections.²⁴ The authors propose to make MA bids more competitive

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still—and use the results of that competition as a basis for calculating the FFS conversion factor.

Under such a proposal, MA plans would submit bids for each service area, with payment based on the average bid for that service area. (Unlike costs for prescription drugs, physician and hospital costs vary significantly by region.) Competitive bidding would also produce market-based prices for provision of Medicare Part A and Part B services. Such prices would, in turn, be used to calculate a CF for FFS payments.

Next, the average MA bid would be combined with the ratio of Part B to total FFS utilization to calculate the **conversion factor**:

$$CF = \frac{(Part\ B\ Share\ of\ FFS\ Spending) * (MA\ Average\ Bid)}{Projected\ Part\ B\ Utilization}$$

CF represents the conversion factor used to calculate physician payments. **Part B utilization** is calculated on a per-enrollee basis.

The ratio of physician to hospital costs, it should be noted, is not fixed. For example, more intensive physician care for outpatients with chronic conditions

can reduce their need for inpatient hospital care. A payer responsible for *both* types of costs would have an incentive to allocate resources differently, if doing so reduced overall costs.

Ideally, the authors would calculate the shares of Medicare Part A and Part B spending from market-based data, such as actual spending choices by MA plans. If increasing Part B volume (through, say, improved primary care access) reduced Part A volume, the authors would not penalize such an arrangement. As such, the authors would use only the historical Medicare Part B share of FFS spending, as stated in the above formula, if market-based data were not available.

Why such an approach? First, as noted, market-based pricing more closely approximates the actual cost of providing services. Second, MA plans can structure payment and delivery of services in a more holistic manner, whereas FFS's reimbursements are largely siloed, with little thought for how physician spending may increase or reduce costs elsewhere.

Under an MA plan, for example, overweight patients at risk for cardiovascular disease may receive more frequent cholesterol screenings because of the plan's particular payment structure. The latter may well reduce heart attacks and other related problems, resulting in savings to the health care system through

lower inpatient costs. The ensuing changes in practice patterns may, in turn, affect how providers practice outside the MA program, resulting in still more efficient care across the board. And by virtue of their use of provider networks, MA reimbursements undoubtedly do a better job of accounting for provider quality and performance.

Whether implementing the authors' proposal or, indeed, any proposal, policymakers need not bet the farm. It may be possible to run a short-term experiment, in a handful of areas, pitting current and reform models against each other. At experiment's end, examine cost and outcome data to determine the "winner." While such an approach would not, of course, guarantee that Congress selects the more successful policy, it would at least provide valuable evidence.

V. CONCLUSION

Some of the numerous proposals espoused to date to replace the Sustainable Growth Rate mechanism represent improvement over the status quo. Yet all such proposals seek to preserve the SGR's fatal flaw: its centralized pricing system. Because of this, a truly market-based alternative, such as that outlined in Section IV, would likely perform best. At a minimum, policymakers should allow a market-based SGR replacement plan to compete alongside others in a well-crafted, short-term experiment.

ENDNOTES

- ¹ The SGR takes into account growth in the economy as a whole as well as a measure of provider costs.
- ² See Joseph P. Newhouse and Thomas G. McGuire, "How Successful Is Medicare Advantage?," *Milbank Quarterly* 92, no.2 (2014): 351–94; J. Z. Ayanian et al., "Medicare Beneficiaries More Likely to Receive Appropriate Ambulatory Services in HMOs than in Traditional Medicare," *Health Affairs* 32, no. 7 (2013): 1228–35; and Jon Kaplan et al., "Alternative Payer Models Show Improved Health-Care Value," Boston Consulting Group (May 14, 2013), https://www.bcgperspectives.com/content/articles/health_care_payers_providers_alternative_payer_models_show_improved_health_care_value.
- ³ Medicare Payment Advisory Commission, "The Medicare Advantage Program: Status Report" (March 2013), p. 331, http://www.medpac.gov/documents/reports/mar14_ch13.pdf?sfvrsn=0.
- ⁴ Physician Payment Review Commission, "Physician Payment Review Commission Annual Report to Congress" (1989), p. xiii, <https://archive.org/stream/physicianpayment00phys#page/n17/mode/2up>.
- ⁵ H.R. 3299. 101st Cong. U.S. G.P.O. (1989) (enacted), <http://www.gpo.gov/fdsys/pkg/STATUTE-103/pdf/STATUTE-103-Pg2106.pdf>.
- ⁶ Authors' analysis of data in the supplemental tables of the 2014 Medicare Trustees Report.
- ⁷ A wealth of literature supports the notion that managed care has spillover effects. See Katherine Baicker et al., "The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization," *Journal of Health Economics* 32, no. 6 (2013): 1289–1300; Michael Chernew, Philip DeCicca, and Robert Town, "Managed Care and Medical Expenditures of Medicare Beneficiaries," *Journal of Health Economics* 27, no. 6 (2008): 1451–61; and Laurence C. Baker, "Managed Care Spillover Effects," *Annual Review of Public Health* 24, no. 1 (2003): 435–56.
- ⁸ Authors' analysis of data from the supplemental tables of the 2014 Medicare Trustees Report; real GDP data from Bureau of Economic Analysis; Physician Medicare Economic Index increase from <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/sgr2015p.pdf>.
- ⁹ *Ibid.*
- ¹⁰ *Ibid.*
- ¹¹ Jim Hahn, "The Sustainable Growth Rate (SGR) and Medicare Physician Payments: Frequently Asked Questions," Congressional Research Service (March 21, 2014), pp. 1–2, <http://www.ncsl.org/documents/statefed/health/SGRfaqs3212014.pdf>.
- ¹² Adam Borden, "CMS Releases CY 2015 MPFS Final Rule; Rates Set Through March with SGR Issue Looming" (November 4, 2014), <http://avalere.com/news/cms-releases-cy-2015-mpfs-final-rule-rates-set-through-march-with-sgr-issue>.
- ¹³ Centers for Medicare and Medicaid Services, "Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2010," p. 1, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/downloads/sgr2010f.pdf>.
- ¹⁴ Chris Jacobs, "Medicare's Sustainable Growth Rate: Principles for Reform," Heritage Foundation (July 18, 2013), p. 3, http://thf_media.s3.amazonaws.com/2013/pdf/bg2827.pdf.
- ¹⁵ Note that the MEI does not simply compute "pure" increases in costs. Productivity gains, e.g., are captured in the wage component of the index and are reflected in volume of RVUs (more productive physicians bill for more procedures). The MEI, since its inception, includes a productivity adjustment to avoid double-counting.
- ¹⁶ Committee for a Responsible Federal Budget, "Three Out of Four Doc Fix Plans Would Worsen the Debt" (March 13, 2014), <http://crfb.org/blogs/three-out-four-doc-fix-plans-would-worsen-debt>.
- ¹⁷ See Austin Frakt, "How Congress Is Holding the Line on Medicare Prices" (April 30, 2014), <http://theincidentaleconomist.com/wordpress/the-upshot-how-congress-is-actually-holding-down-medicare-spending>; and Committee for a Responsible Federal Budget, "Actually, the SGR Has Slowed Health Care Cost Growth" (March 13, 2014), <http://crfb.org/blogs/actually-sgr-has-slowed-health-care-cost-growth>.
- ¹⁸ Committee for a Responsible Federal Budget, "CBO Releases New Doc Fix Estimates" (January 27, 2014), <http://crfb.org/blogs/cbo-releases-new-doc-fix-bill-estimates>.
- ¹⁹ Roger Feldman, Robert Coulam, and Bryan Dowd, "Competitive Bidding Can Help Solve Medicare's Fiscal Crisis," *American*

Enterprise Institute (February 2012), https://www.aei.org/wp-content/uploads/2012/02/-competitive-bidding-can-help-solve-medicares-fiscal-crisis_081704430956.pdf.

²⁰ Kaiser Family Foundation, "Fact Sheet: Medicare Advantage" (May 2014), <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet>.

²¹ Technically, plans can submit a bid lower than the county benchmark, but there is little incentive to do so. If the bid is lower than the benchmark, the plan must "rebate" 75 percent of the difference to enrollees in the form of additional benefits, lower co-pays, and/or a partial rebate of their Part B premium; the government keeps the remaining 25 percent by reducing its payment to the MA plan. However, if a plan bids exactly the benchmark and finds its costs to be lower, it can keep the difference.

²² This is true, on average. In practice, the payment for each enrollee is the county benchmark multiplied by a risk adjustment factor based on that enrollee's diagnosis history and demographic characteristics. The enrollee's payment is *not* affected by this adjustment; the enrollee pays the difference between the plan's bid premium and the county benchmark. The purpose of risk adjustment is to avoid rewarding plans for attracting healthy enrollees and penalizing plans that attract sicker enrollees. We do not propose eliminating risk adjustment, although we may propose improvements to it in the future.

²³ Currently, each plan is paid 74.5 percent of the national average bid, multiplied by a drug-specific risk adjustment factor for each enrollee. Enrollees pay the bid for the plan they select, minus 74.5 percent of the national average bid. In other words, enrollees pay 25.5 percent of the national average bid, plus or minus any difference between the average and the bid of the plan they actually select.

²⁴ Douglas Holtz-Eakin and Robert Book, "Competition and the Medicare Part D Program," American Action Forum (September 11, 2013), <http://americanactionforum.org/research/competition-and-the-medicare-part-d-program>.

