Public Health Policy Opinion

Elusive "Doc Fix": Groundhog Day 2015 for Sustainable Growth Rate (SGR)

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On Groundhog Day, Monday, February 2, 2015, across the United States, we watched Pennsylvania's most famous groundhog see his shadow, thereby predicting 6 more weeks of winter. On the same day – an equivalent of "Groundhog Day" in the legislative arena – the infamous "Doc Fix" or sustainable growth (SGR) rate reform has become an annual or even semiannual exercise (1). With numerous attempted fixes, we continue to play the same-catch up game with yet another temporary patch. The groundhog's predictions started in 1887; whereas, the first problems with the SGR formula started 110 years later with the passage of the Balanced Budget Act of 1997 (2) – an omnibus legislative package enacted by the U.S. Congress, using the budget reconciliation process to balance the federal budget by 2002. Unfortunately, the Balanced Budget Act of 1997 focused only on the reduction of health care expenditures with $160 billion in spending reductions between 1998 and 2002. In order to reduce Medicare spending, the act reduced payments to health service providers, mainly physicians and other practitioners. The Balanced Budget Act of 1997 has been problematic since its enactment. Despite the initial increases in physician payments due to high economic growth and low medical cost growth after passage of the Balanced Budget Act, the subsequent combination of a recession with declining Gross Domestic Product (GDP) and increasing medical costs led to automatic cuts from 2001 on, with cuts of 4.8% in 2002 and each year thereafter (1,3). Thus, since 2003, Congress has legislated an alternative to the automatic cuts scheduled under SGR legislation. However, without legislative action, payments to physicians under Medicare will face a cut of 21.2% effective April 1, 2015 (1,3). Thus, the Groundhog Day of medicine and Washington starts once again (1).

What Is the Origin of SGR?

As the result of the Balanced Budget Act of 1997 (2), the SGR system was put into place to control costs of Medicare payments for physicians. It replaced the Medicare volume performance standards (MVPS), used prior to the SGR, which was perceived as producing uncontrollable health care costs. The SGR was an attempt to control these escalating costs and balance the budget (3). The SGR was envisioned to ensure that a yearly increase in the expense per Medicare beneficiary is the same or below the growth in the gross domestic product (GDP) (4). Procedurally, the Medicare Payment Advisory Commission advises the U.S. Congress on the previous year's total expenditures and the current year's target expenditures by sending a report every year. Included in this report is a conversion factor that changes the payments for physician services for the upcoming year in order to match the target SGR. This essentially results in a decrease in the payments for

the next year if the expenditures for the previous year exceeded the target expenditures; however, if the expenditures were less than expected, the conversion factor would increase the payments to physicians for the next year. The silver lining in this legislation, which grossly punishes physicians to balance the budget of the United States, is that the implementation of the physician fee schedule update to meet the target SGR can be suspended or adjusted by Congress. In fact, Congress has stepped in with short-term legislation since 2003 to avert payment reductions. Consequently, these patches have kept physician payments below inflation over time, but, unfortunately, have also resulted in a huge divergence between the actual level of Medicare physician-related spending and the target in the SGR formula – enormously increasing the costs of fixing the SGR on a permanent basis to over $100 or $200 billion dollars.

What Is the SGR Formula?

There are 4 factors utilized in calculating the SGR.

1. The estimated percentage change in fees for physicians' services.
2. The estimated percentage change in the average number of Medicare fee-for-service beneficiaries.
3. The estimated 10-year average annual percentage change in real GDP per capita.
4. The estimated percentage change in expenditures due to changes in law or regulations.

Further changes were made with the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) (5). Since the MMA incorporated a 10 year annual average growth in real GDP per capita to calculate the SGR, the physician payment update is calculated using 2 factors: The update is calculated using one plus the Medicare Economic Index (MEI), which measures the weighted price change for various inputs involved with producing physician services (3), and one plus the update adjustment factor (UAF), which compares the actual and target expenditures, and is determined by a formula that includes the target and actual expenditures and the SGR. However, by law, the UAF is limited to -7% (3).

What Are the Issues with SGR

The SGR has been described as an outdated, inefficient process, which was not based on any evidence, affecting a single group of providers to balance the United States budget. Further, it disregards individual and group performance since it is merely a system of budget controls without giving an individual physician or group any incentives for performing more efficiently. Similar to Groundhog Day, the SGR also continues to make physician payments uncertain every year creating instability with the threat of payment cuts detrimental to Medicare physicians and the program. In addition, the multiple issues facing the SGR and physician payments distracts Congress and the administration from other legislative priorities, continues to hinder program improvement, and presents a recurring threat to health care for Medicare recipients.

Why is SGR Fix So Expensive?

As described earlier, physician payments were scheduled to be reduced except for late 1990s. Since 2001, physician payments have been facing actual reductions; however, actual reductions occurring only in 2002.

Based on the calculation methodology, SGR payments are measured against the "baseline" of spending. However, the legislative action to maintain current payments scores as a cost; further, Congress allegedly operates under a requirement to pay for the costs of new legislation, which may result in adjustments to other health-related payments with extensions of the SGR. As a result, some claim that the SGR creates pressure to hold down costs, though not in the way the SGR formula intended. In addition, it also created a legislative mess each year and causes tension for physicians and seniors (1,6,7). Thus, the need to offset spending may have led to a squeeze on physician payment rates over the past 12 years. Figure 1 compares the MEI essentially a measure of physician practice cost inflation, which is usually underestimated, to the actual physician payment updates from 1992 through scheduled 2015 changes. Since 2001, physician updates have been below the MEI. Overall directly or indirectly, physician payments have suffered with significant limits on increases in reimbursement for physician services (1,6,7).

Is Permanent Fix Feasible?

A permanent fix has been attempted on numerous occasions with the most recent occurring in 2014 (6,7). This was an unfortunate missed opportunity to fix the SGR (8). While a permanent fix is a huge challenge, the cost of last years' legislation was in the range of $150 billion over 10 years was the lowest estimated cost in years. At least 3 approaches were worked on in Con-

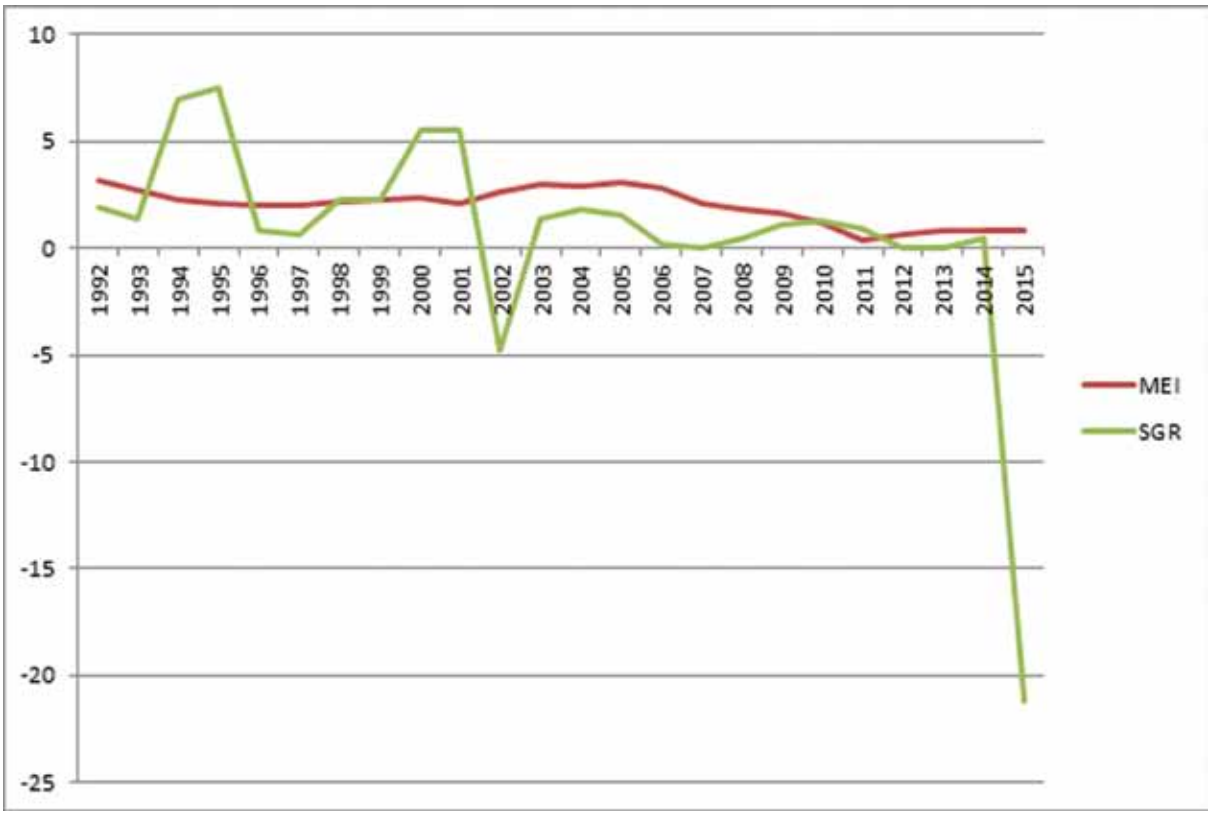

Fig. 1. *Medicare economic index and sustainable growth rate comparison.*

gress, unfortunately, there was no method that was agreed upon to pay for any of the fixes. Many consider this to have been a historic opportunity that was lost (6,7).

Supporters of managed care systems have proposed a variety of approaches to move away from fee-for-service system, which essentially is the centerpiece of affordable care (9-12). Various proposals include to transition payment models to ones that involve greater accountability for providers for the quality and cost of the care they deliver (11,12). However, these proposals have been in existence from before the Balanced Budget Act. To date, there is little compelling evidence that accountable care organizations, bundled payments, or patient-centered medical homes are effective either in reducing inefficiency of the U.S. health care industry or improving effectiveness (11,13). While proponents of these methods continue to push this ideology, it appears that other systems including England's that have already through such value-based reimbursement, along with a large investment in a national electronic health record system (11,14-19). Electronic health records and information technology (IT) have brought challenges in the U.K. and U.S. with escalating expenses and lack of functioning (14-20).

Implementation of ICD-10 may start on October 1, 2015, with disastrous consequences, based only on electronic media explosion and overwhelming advantage of health care IT industry without proven need, proven efficacy, but, with overwhelming evidence of intended and unintended adverse consequences (20-24).

The health care industry is so preoccupied by the economic mandate for health care that they are unable to balance it with the social mandate for health care (11). To understand health care needs, we need to separate basic health care needs from economic mandates. Basic health care needs are connected to the social mandate and may be cured by social mandates (11); however, the economic mandate is connected to complex health care needs. The United States contin-

ues to develop sophisticated institutions for delivering complex health care. At the same time, the U.S. may be developing unregulated mandates for basic health care needs (11). With affordable care, we have seen new challenges accessing primary care. The coverage gap continues to widen with some people losing elements of their existing coverage despite having health insurance.

Summary

In summary, the SGR continues to hang like Damocles sword over physicians. To understand health care needs, we need to separate basic health care needs from economic mandates, and health insurance from health care coverage. The SGR flux represents another meaningful uncertainty to this health care conundrum.

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