Perspectives on the Sustained Growth Rate Formula (SGR)

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In 1997, Congress changed the formula by which the annual change in Medicare Physician Fee Schedule (MPFS) was determined since the previous formula was not effectively controlling fees. The new sustained growth rate formula (SGR) allowed for smaller utilization increases and was tied to the economy as a whole, measured by the gross domestic product (GDP). Policymakers were concerned about the cost of a steadily increasing volume of services, and since total spending is determined by price x volume, under the new SGR aggregate cap, fees would grow more slowly or be reduced if the volume of services increased. One of several fundamental flaws with the SGR is that it focuses entirely on price controls, disregarding the other reasons that spending might outpace income growth such as the increasing number and complexity of medical interventions, the effects of an aging population, and expansion of Medicare benefits.

To make matters worse, the formula calls for all excess spending since the formula was developed in 1998 to be made up, as well. As Vladek (1) points out, this is a cumulative, prospective formula in which a $20 billion dollar excess in physician fees since 1998 would require a "21% reduction in physicians' fees if it were to be made up in one year. Those reduced fees would then be the basis for payment levels in all subsequent years." Thus, the budgetary cost of eliminating the SGR would not be just the $20 billion in excess fees in the example above, but "$20 billion per year compounded by inflation, times 10 years." Despite the fact that the SGR adjustment has been overridden each year since 2003, the projected budget assumes that physician fees will eventually decrease to SGR levels, and everything above this is extra spending. Thus, the legislated cuts are large, and grow steadily larger as they are deferred. The projected cut for 2012 was 27.4% before Congress intervened to postpone the adjustment.

There are several potential disincentives from a Congressional perspective to eliminating the SGR. Budgetary projections by the Congressional Budget Office (CBO) are based on SGR mandated fee cuts, and abandoning those cuts would be scored as a "spending increase." Under the present system, Aaron (2) writes that "replacing the SGR with a formula tied 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 added amount of interest on the increased debt." Leaving the fees at their present level with no future adjustments would "cost" $300 billion over 10 years. Therefore, elected officials are naturally reluctant to abandon the formula entirely, especially during an election year. Some analysts thought that the best hope for SGR reform was to address the issue in the Affordable Care Act (ACA), but it was removed from the reform bill by Congress to hold down the projected expense. Indeed, even if key provisions of the ACA are not upheld, the SGR might be used to promote key ACA strategies, since the threat of full implementation would probably incentivize a change in practice patterns by driving physicians into ACO and/or other aggregated health care delivery models.

In this way, the SGR could finally achieve the desired policy makers' goal of turning Medicare away from fee-for-service medicine.

Aside from projected budgetary uncertainties, another major flaw of the SGR is through misaligned incentives. Ali Alhassani and colleagues (3) explained: "(SGR) cuts are applied evenly across all states and across all specialties and services (with the potential exception of fees for primary care)," and so "some health care providers will receive cuts in pay despite the fact that they contributed little to the increases in the volume of services delivered that resulted in the SGR-dictated cuts." Practically speaking, the SGR neither affects nor is driven by the spending of individual physicians. In a scenario reminiscent of ecologist Hardin's *The Tragedy of the Commons* (4), individual physicians might conceivably increase their spending since little they do as individuals will affect overall spending (or an increase in the SGR), but their fees will be affected by what other physicians do as a group. This reality is why many analysts see payment systems pushing more responsibility (risk) to individual physicians through bundled payments and ACO affiliations as the model of the future.

Although almost no one likes the SGR, there is no consensus on how to move forward, and the political reality is such that it will be impossible to simply repeal it without offering other cost-saving measures. The Medicare Payment Advisory Commission (MedPAC) has advocated repeal of the SGR since 2001, and in October 2011 voted to recommend replacing the SGR with legislated physician fee schedule adjustments, and paying for it by reducing specialists' fees by 5.9% for each of three years and then freezing fees for the next 7 years. Primary care services would be frozen for all 10 years. Projected savings to Medicare would be $100 billion over 10 years, even though the cost of physician services would be expected to double during this period because of the expansion of the Medicare population and continued increase in delivered services. MedPAC commissioners clearly want Congress to use an SGR fix to leverage long-term reforms in the payment system. In a "JCAAI-New News You Can Use Alert" on September 19, 2011 this proposal was described as threatening "the very fabric of the healthcare delivery system in the United States," and the Allergy/Immunology community was urged to contact their Representatives.

The AMA (5) recommends a three-prong approach by: "repealing the SGR, implementing a five year period of stable Medicare physician payments that keep pace with the growth in medical practice costs, and transition to an array of Payment models designed to enhance care coordination, quality, appropriateness and costs."

Others have suggested more of a free-market model by indexing physician reimbursement to inflation to make payments more stable and predictable, reinstating balance billing (eliminated in 1989) so that providers could bill for the real cost of services not reimbursed by Medicare, requiring fee transparency so that patients know ahead of time what charges will be, and tasking MedPAC to make recommendations to Congress on how regional and specialty-based Medicare payment inequities might be addressed.

The future remains uncertain, but the SGR survives. In this election year, it seems doubtful that anyone will want to risk the potential political fall-out associated with meaningful reform, but the cost of ignoring the problem continues to mount.

1. Vladeck, Bruce C. Fixing Medicare's Physician Payment System. N Eng J Med 2010; 362;21 1955-57
2. Aaron, Henry J. The SGR for Physician Payment-An Indispensable Abomination. N Eng J Med 2010; 363;5: 403-5
3. Alhassani, Ali, et al. The Sources of the SGR "Hole". N Eng J Med 2012; 366;4: 289-91
4. Hardin, Garrett. The Tragedy of the Commons. Science 1968; 162: 1243-48
5. Wilson, Cecil B. Summary Statement of the AMA presented to the House Energy and Commerce Committee Subcommittee on Health RE: The Need to Move Beyond the SGR, May 5, 2011