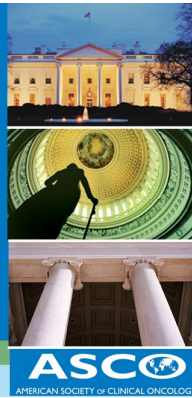


POLICY

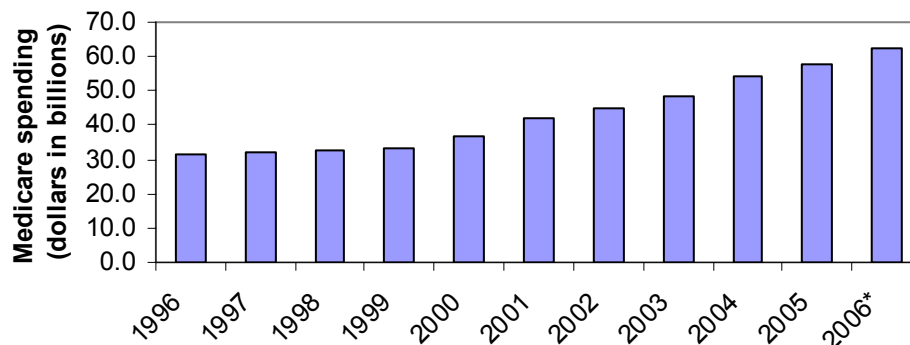


IN FOCUS

SUSTAINABLE GROWTH RATE (SGR)— UNSUSTAINABLE THREAT TO MEDICARE ACCESS

Amidst growing constraints on the federal budget and continuing concerns about health care expenditures, policymakers are re-evaluating Medicare's payment policies. Key among these are "pay for performance" based programs and overall strategies for cost containment. One of these, the Sustainable Growth Rate, is now at the center of significant controversy among policymakers, providers and health care analysts. From the perspective of policymakers, the SGR has not achieved its intended purpose of keeping physician spending in check (see Figure 1). For physicians, the legislated formula has meant annual threatened decreases to Medicare payment rates and concerns that their ability to continue serving Medicare beneficiaries may be impaired. As Medicare expenditures in all sectors escalate, policies such as the SGR and other means of controlling growth will continue to be front and center on Capitol Hill.

Figure 1. Medicare spending for physician services 1996-2006



Note: Chart reflects fee-for-service spending only and does not reflect beneficiary coinsurance.
Source: MedPAC June 2006 Data Book: Healthcare spending and the Medicare program.

*Projected spending for 2006. All other figures reflect historical data.

What is SGR?

The sustainable growth rate (SGR) is a statutorily defined formula intended to limit increases in Medicare physician payments. For the past five years, application of the SGR formula has threatened to impose significant reductions in physician payment rather than just constraining increases. To forestall such reductions, Congress has enacted specific annual corrections, but failure to address the issue systematically and permanently creates uncertainty and undermines both provider and beneficiary confidence in the Medicare program as a reliable source of payment.

SGR Rationale and Methodology

Congress enacted SGR in 1998 as a means of controlling the escalating costs of Medicare Part B. Under SGR, physician payments are linked to predetermined spending targets in the hope that physicians will have a collective incentive to restrain costs. The SGR calculation depends on four factors: (1) inflation in Medicare costs; (2) number of beneficiaries; (3) strength of the overall economy as measured by the gross domestic product; and (4) Medicare laws or regulations affecting coverage or scope of benefits. When Part B spending is less than the SGR target, physicians are to receive larger fee increases; correspondingly, if spending exceeds the target, physician payments decline. The law provides that payments may not increase more than 3 percent or decrease more than 7 percent in a given year.

Consequences of SGR

The SGR system has failed to restrain Medicare spending, primarily because there is no incentive for the individual physician to meet the collective targets. The increased spending is attributable to volume increases in the following: office visits, with a shift toward longer and more intensive visits; more use of minor procedures; more frequent and complex imaging services; more laboratory and other tests; and more use of prescription drugs in physician offices. There is no obvious way to restrain these volume increases under the current system. The persistent failure to meet the SGR target has created a series of annual crises in which the projected decreases in physician payment prompt concerns that physicians may refuse to accept new Medicare patients. As a result, Congress has been forced to respond with adjustments on a yearly basis, a pattern that most observers believe cannot continue indefinitely. Moreover, the annual adjustments have failed to keep pace with inflation for a number of years, and, for 2006 and 2007, rates were frozen at the 2005 level. Despite these severe restrictions on physician payments, Part B expenditures have consistently exceeded projections; Part B spending increased 11 percent in 2005, the latest year for which data are available.

Challenges of SGR Reform

A permanent solution to the SGR problem is a major policy goal, but the impediments to reform are substantial. Conceptually, it is difficult to devise a new approach that will more effectively link individual performance with program savings, including addressing the issue of burgeoning volume. The greatest hurdle to reform, however, is its projected cost. The Congressional Budget Office (CBO) has estimated that elimination of the SGR would bear a cost of \$49.7 billion over a five-year period; if physician payment rates kept pace with medical inflation, CBO estimates the ten-year cost would be \$218 billion. With Congress operating on “pay as you go” rules, the fix would thus require significant revenue increases (tax or premium hikes) or reductions in other program benefits or costs or a combination of the two. The political difficulties associated with any of these options cannot be overstated.

Prospects for Reform

Notwithstanding the challenges, SGR reform is likely to occur because the current system is indefensible. It is an almost certain candidate for inclusion in any “omnibus” Medicare legislation. Such comprehensive legislative reconsideration of the Medicare program occurs every few years with the last being the Medicare Modernization Act of 2003. Thus Medicare is overdue for such legislation, which is likely to occur late in this session of Congress. The contours of an approach more focused on individual action are suggested by the various “pay for performance” plans being developed by the Medicare program, including the current bonus payments for reporting compliance with specialty-specific measures.

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The American Medical Association (AMA) has taken the lead on SGR reform on behalf of the profession as a whole. ASCO has been working with the AMA and other medical specialty groups and will continue to do so to achieve a satisfactory resolution to the SGR problem, urging its inclusion in any comprehensive legislation pertaining to Medicare.