Research

Primer: The Sustainable Growth Rate

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Medicare accounted for an unsustainable 14 percent of federal spending in 2013.[1]Attempts by Congress and the Department of Health and Human Services to control costs have been largely unsuccessful, and the need for a solution to high spending will once again be revisited in the spring of 2015. One such effort to limit Medicare Part B spending, also known as the Sustainable Growth Rate (SGR), must be repeatedly addressed by Congress to avoid the major reimbursement cuts it requires. Congress must frequently pass legislation that nullifies or delays the mandated cuts to provider reimbursements in order to preserve Medicare beneficiary access to care.

This primer will give a brief overview of the SGR and discuss congressional actions taken to alter the pay schedule. Appendix 1 gives additional year by year detail on the SGR legislation, costs, and offsets.

Background on the SGR and Legislative Patching

Medicare Part B covers physician services, outpatient care and prescription drugs administered in an outpatient setting. The Centers for Medicare and Medicaid Services (CMS) sets the prices for all services (which are adjusted for factors like patient severity and geography) and any provider treating a Medicare patient must agree to accept CMS prices.

Part B spending depends on three factors: the number of beneficiaries, the volume of medical services, and prices paid by CMS for physician visits and accompanying services (laboratory testing and the like). The 1997 Balanced Budget Act introduced the Sustainable Growth Rate (SGR) mechanism to set expenditure targets for Part B spending. Since paying doctors in a fee-for-service fashion can incentivize them to increase the volume of medical services beyond what is necessary, Congress set up the SGR to cut reimbursements when spending grows too much.

The SGR “target” calculation takes into account beneficiary enrollment, past spending, inflation, GDP growth and any pertinent legislative changes. Reimbursement adjustments for the following year are then calculated by comparing actual spending to the SGR target in the reference year. If spending growth was below the target in the prior year, payment rates are increased for the next year, and if spending exceeds the target, payments are decreased.

In the first few years of implementation, spending growth came in below the target, and reimbursements were increased. The SGR mechanism first called for a reimbursement reduction in 2002 and physician reimbursements decreased by 4.8 percent. The next year, and every year thereafter, cuts were called for via the SGR calculation. Congress, however, enacted legislation that negated the cut, either doing so outright or by delaying it for that year but agreeing to make a larger cut the following year. The larger cut has yet to come, and the SGR reimbursement reduction scheduled for March 31, 2015, now stands at 21.2 percent.[2]

Paying for Avoiding Cuts

Congress's "PAYGO" procedural rule, adopted by the House of Representatives in 2006 and the Senate in 2008, demands that any increase in entitlement spending relative to the current law be accompanied by an offsetting tax increase or spending cut. There is agreement that the SGR is not an effective restraint on Medicare spending, but it has yet to be repealed as Congress is constrained by the "PAYGO" rule's required offsets.

Because current law requires cuts (21.2 percent for CY2015); repealing the SGR would equate–on paper–to increasing physician reimbursement by 21.2 percent. Even making a reimbursement reduction less than 21.2 percent would, technically, be an increase in spending and thus need to be paid for via corresponding spending cuts or tax increases. This would increase physician reimbursement costs quite a bit over 10 years. However, the cost, on paper, is less if one only makes the artificial increase of 21.2 percent for one year—as opposed to ten. As a result, Members of Congress put the fix in place for one year, find cuts to pay for that year alone (or less), and put themselves in the same difficult position 12 months later when even greater cuts are demanded by the formula. This has happened every year in the recent past.

Table 1 below shows actions taken on SGR and whether Congress included offsets for negating the cuts in each year.

Table 1: SGR Legislative Actions, 2002-2014

Year	SGR Target	Pre- legislation Conversion Factor	Physician Update	Cumulative	Fix	Offset	Cost of 1 Year Delay (Billions)	Cost to Fix (Billions)
2002	8.3 %	-4.8%	-4.8%		N/A	N/A	N/A	N/A
2003	7.30%	-4.4%	+1.4%*		H.J. Res 2	None	$53.4 (2003-2012)	
2004	6.60%	-4.5%	+1.8%*		Medicare Modernization Act	Yes	$2.8 (2004-2007)	
2005	4.20%	-3.3%	+1.5%		Medicare Modernization Act	Yes	$2.8 (2004-2007)	$48.6
2006	1.50%	-4.4%	+.2%		The Deficit Reduction Act of 2005	Yes	$1.5 (2006)	
2007	3.50%	-5%	0		Tax Relief and Healthcare Act	Yes	$5 (2007-2011)	$170.8

2008	4.50%	-5.3%	+.5%	-.10%	Medicare Medicaid and SCHIP Extension Act Jan-June of 2008	Yes	6.4 (2008-2017)	$177
					Medicare Improvements for Patients and Providers Act July-Dec.	Yes	9.4 (2008-2018)	
2009	6.40%	-11.5%	+1.1%	-11.5 %	The Medicare Improvements for Patients and Providers Act	Yes		$220
2010	8.90%	-5.9%	+1.3%*	-.21%	Department of Defense Appropriations Act, Temporary Extension Act, Continuing Extension Act, Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, Physician Payment and Therapy Relief Act	Yes		$285
2011	4.70%	-10.2%	+.9%*	-25%	An Act to Extend Certain Expiring Medicare and Medicaid Provisions	Yes	$14.9 (2011-2012)	$379
2012	4.8%	-3.3%	0	-27.4 %	Temporary Payroll Tax Cut Continuation	Yes	$3.6 (2012-2021)	
					Act of 2011, Middle Class Tax Relief and Job Creation Act of 2012	Yes	$17.9 (2012-2012)	$290

2013	1.3%	+1.4%	0	-26.5%	The American Taxpayer Relief Act of 2012	Yes	$25.2 (2013-2022)	
2014	-0.8%	+8.8%	+0.5%	-24.4%	Pathway to SGR Reform Act of 2013	Yes	$8.7 (Jan –April 2014)	$138
2015	-13.7%		0	-21.2%	Protecting Access to Medicare Act (PAMA) of 2014	Yes	-$1.2 (offsets result in savings)	$140.2

*weighted average

Where SGR Stands Today

Many headlines in 2014 proclaimed that fixing the SGR is "on sale", with CBO estimates coming in lower than in previous years. In 2011, the cost of freezing payments for 10 years was $298 billion. That cost has adjusted downward due to lower health care cost growth rates. The cost of repealing the SGR entirely is harder to estimate and dependent on whether reimbursements are frozen (estimated at $118.9 billion over ten years in 2014) or increased (estimated at $140.2 billion over ten years). Either way the lower score means that fewer corresponding cuts or revenue increases are needed to comply with PAYGO.

Two pieces of legislation were passed impacting SGR in the 2014 and 2015 calendar years. The Pathway to SGR Reform Act of 2013 provided a three month patch from January 1, 2014 to March 31, 2014; preventing the scheduled 24.4 percent rate cut to physicians while the Congress worked through a potential SGR repeal package. However, the offsets for this package could not be agreed upon in the three months allowed as part of the SGR patch. Instead, the Protecting Access to Medicare Act (PAMA) of 2014 was passed as a patch for April 2014-March 31, 2015, negating the Medicare cuts and providing a 0.5 percent increase in physician payment rates.[3]

Both pieces of legislation include offsets, as required by the above mentioned PAYGO. The Offsets for Pathway for SGR Reform Act was estimated to cost $8.7 billion[4]. The offsets included: realignment of the Medicare sequester for 2015, and changes to inpatient services for long term care. Offsets for PAMA 2014 included revaluing Medicare Physician Payments, establishing nursing home value based purchasing (VBP), creating market based clinical laboratory payment rates, and changing Medicare sequestration in out-years.[5]

Conclusion

The 114th Congress will have to find a solution to SGR in the spring of 2015. Last year, policy based agreements were made by both sides of the aisle, but the larger stumbling block is how to pay for the changes that would need to be made to repeal the SGR permanently. The current pay schedule is in place until March 31, 2015, providing a short window for SGR solution legislation.

Appendix 1

This appendix provides more detail on changes to and offsets for Sustainable Growth Rate legislative patches from 2002-2014.

2002:

Pre-legislation Update: -4.8 percent

Actual Update: -4.8 percent

2003:

Pre-legislation Update: -4.4 percent

Actual Update: +1.4 percent (weighted average)

The House Joint Resolution 2 negated the cut, instead, implementing an increase of 1.4 percent at a cost of $53.4 billion over 10 years without any offset. ,

2004, 2005:

Pre-legislation Update: -4.5 percent in 2004, -3.3 in 2005

Actual Update: +1.8 percent (weighted average) in 2004 and 1.5 percent in 2005

The Medicare Modernization Act instituted a 1.5 percent increase in each year 2004 and 2005. Although the increase was specified as 1.5 percent, an adjustment to the geographic indexing made the actual update average to 1.8 percent in 2004. This cost $2.8 billion from 2004-2007 and was offset by cuts to reimbursement amounts for outpatient drug, Durable Medical Equipment (DME), Home Health providers, Ambulatory Surgery Centers, and an increase in the Part B premium for high-income seniors.

2006:

Pre-legislation Update: -4.4 percent

Actual Update: +.2 percent

The Deficit Reduction Act of 2005 held 2006 payment rates at their 2005 level, overriding an impending reduction of 4.4 percent at a cost of $1.5 billion in 2006. This was offset by cuts to reimbursement for imaging procedures, Home Health providers, DME suppliers, and changes to Medicare Advantage risk adjustment.

2007:

Pre-legislation Update: -5 percent

Actual Update: 0

The Tax Relief and Healthcare Act (P.L. 109-432) froze rates at the 2006 level which was projected to cost $5 billion from 2007-2010. This, and other increases in Medicare spending in the bill, was partially offset by a change in the rule that allowed the HHS secretary to pay Medicare Advantage plans from a Medicare "stabilization fund."

2008:

Pre-legislation Update: -5.3 percent (but accumulated to 10 percent)

Actual Update: +.5 percent

The Medicare, Medicaid, and SCHIP Extension Act of 2007 increased physician payments by .5 percent from January through June at a cost of $6.4 billion over 10 years. This was offset by reductions in payment for outpatient prescription drugs and reimbursement reductions for inpatient rehabilitation facilities.

The Medicare Improvements for Patients and Providers Act of 2008 negated a 10 percent cut scheduled to go into effect in July, and increased rates 18 months, through the end of 2009. This bill increased Medicare spending by $11 billion in 2008, but reduced it in future years for a total 10 year cost of $9.4 billion. This and other Medicare spending increases were offset via Medicare Advantage cuts, the introduction of electronic prescribing, and fees for those who don't adopt it.

2009:

Pre-legislation Update: -11.5 percent

Actual Update: +1.1 percent

The July 2008 Medicare Improvements for Patients and Providers Act of 2008 negated the cut in 2009 and replaced it with a 1.1 percent increase in that year (offsets are described above). A bill introduced in July that froze payment rates was scored as costing $245 billion over 10 years.

2010:

Pre-legislation Update: -5.3 percent, (accumulated to 21 percent)

Actual Update: +1.3 percent (weighted average)

The Department of Defense Appropriations Act, the Temporary Extension Act, and Continuing Extension Act froze physician reimbursement rates at the 2009 level.

Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 and the Physician Payment and Therapy Relief Act increased physician reimbursement by 2.2 percent June through December. These were offset with by allowing CMS and the IRS to coordinate data efforts regarding providers with tax debt, prohibiting hospitals from adjusting claims that occurred prior to a patient's inpatient admission, and

reductions to bundled therapy payments.

2011:

Pre-legislation Update: 10.2 percent (accumulated to -25 percent)

Actual Update: .9 percent (weighted average)

An Act to Extend Certain Expiring Medicare and Medicaid Provisions froze payment rates for 2011 at the December 2010 level. Costs of 9.6 billion in 2011 and 5.4 billion in 2012 (total 14.9 billion) were offset with ACA changes including requiring overpayment of premium subsidies to be paid back, which would save 16 billion over 10 years.

2012:

Pre-legislation Update: -3.3 percent (accumulated to -27.4 percent)

Actual Update: 0

The Temporary Payroll Tax Cut Continuation Act of 2011 delayed the 27 percent cut until February, at a cost of 3.6 billion over 10 years. This was offset by an increase in fees paid to Government Sponsored Enterprises from lenders for assuming credit risk on the secondary mortgage market. The Middle Class Tax Relief and Job Creation Act of 2012 (H.R. 3630) delayed the SGR cuts for 10 more months at a cost of $17.9 billion. This was offset by reducing Medicare bad debt reimbursement ($6.9 billion), resetting clinical lab payment rates ($2.7 billion), rebasing Medicaid Disproportionate Share Hospital allotments ($4.1 billion), eliminating Medicaid payments to Louisiana ($2.5 billion), and reducing the health reform law's prevention fund ($5 billion).

2013:

Pre-legislation Update: +1.4 Percent (accumulated to -26.5 percent)

Actual Update: 0

The American Taxpayer Relief Act of 2012 delayed the cuts of 26.5 percent and froze rates. This was offset by Medicare Advantage Cuts, Cuts to Hospital Diagnosis Related Groups, Dialysis, Imaging, Diabetic Supplies, Rebasing Disproportionate Share Hospital payments

2014:

The cut reached 24.4 percent, and was avoided through the enactment of Pathway to SGR Reform Act of 2013 as well as the Protecting Access to Medicare Act, ensuring that reimbursement levels would not be cut in CY2014 and the first quarter of CY2015.

2015:

The cut is expected to accumulate to 21.2 percent.

**An earlier version of this Primer was written by Emily Egan, formerly AAF Senior Health Policy Analyst.*

[1] http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/