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The Sustainable Growth Rate (SGR) and Medicare Physician Payments: Frequently Asked Questions

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Summary

This report responds to frequently asked questions about the Sustainable Growth Rate (SGR) system for updating Medicare physician fee schedule payments (MPFS) and the recent legislative efforts to repeal and replace the SGR. Frequently asked questions address the background of the SGR, the need for congressional overrides (also referred to as "doc fixes"), and current legislative activity.

For additional information, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn.

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Frequently Asked Questions

What is the Sustainable Growth Rate (SGR), and why has it required repeated congressional attention?

Established as part of the Balanced Budget Act of 1997 (P.L. 105-33), the Sustainable Growth Rate (SGR) is the statutory method for determining the annual updates to the Medicare physician fee schedule (MPFS).[1] In essence, if actual expenditures are within a "sustainable" expenditure target, payment updates are calculated according to a predetermined formula. If, however, the actual experience exceeds the sustainable target, future updates are reduced to bring spending back in line with the target over time.[2]

In the first few years of the SGR system, the actual expenditures did not exceed the targets and the updates to the physician fee schedule were close to the Medicare economic index (MEI, a price index of inputs required to produce physician services). Beginning in 2002, the actual expenditure exceeded allowed targets, and the discrepancy has grown with each year. However, with the exception of 2002, when a 4.8% decrease was applied, Congress has enacted a series of laws to override the reductions.

How many SGR override bills have there been?

From 2003 through April 2014, 17 laws have been passed that override the SGR-mandated reductions in the MPFS (see **Table 1**). These laws have provided short-term "patches" of as long as two years (Medicare Modernization Act, MMA, P.L. 108-173, from 2003 through 2004) and as short as one month (the Temporary Extension Act, P.L. 111-144, from March 1-31, 2010, and the Physician Payment and Therapy Relief Act of 2010, P.L. 111-286, from December 1-31, 2010).

[1] For details, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn.

[2] Specifically, if a weighted combination of annual and cumulative expenditures is less than the weighted annual and cumulative spending target for the period, the annual update is increased according to an established calculation, and if the weighted combination of annual and cumulative spending exceeds the weighted annual cumulative spending target over a certain period, a different calculation is applied that results in across-the-board payment reductions in the physician fee schedule. The expenditure targets are "sustainable" in that they keep relatively constant the share of Medicare physician expenditures in relation to national income, as measured by gross domestic product (GDP) per capita.

Table 1. SGR Override ("Doc Fix") Legislation
(2003-2014)

Date	Act	Legislated Payment Level Update
2003	Consolidated Appropriations Resolution of 2003 (CAR; P.L. 108-7)	1.4%
2004 & 2005	Medicare Modernization Act of 2003 (MMA; P.L. 108-173)	1.5% in 2004, 1.5% in 2005
2006	Deficit Reduction Act of 2005 (DRA; P.L. 109-171)	0.2%
2007	Tax Relief and Health Care Act of 2006 (TRHCA; P.L. 109-432)	0%
Jan.-June 2008	Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA; P.L. 110-173)	0.5%
July-Dec. 2008	Medicare Improvement for Patients and Providers Act of 2008 (MIPPA; P.L. 110-275)	0% Jul-Dec 2008, 1.1% in 2009
Jan. 1-Feb. 28, 2010	Department of Defense Appropriations Act (P.L. 111-118)	0%
Mar. 1-Mar. 31, 2010	Temporary Extension Act (P.L. 111-144)	0%
Apr. 1-May 31, 2010	Continuing Extension Act (P.L. 111-157)	0%
June 1-Nov. 30, 2010	Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (P.L. 111-192)	2.2%
Dec. 1-Dec. 31, 2010	Physician Payment and Therapy Relief Act of 2010 (P.L. 111-286)	0%
2011	Medicare and Medicaid Extenders Act (P.L. 111-309)	0%
Jan. 1-Feb. 29, 2012	Temporary Payroll Tax Cut Continuation Act of 2011 (P.L. 112-78)	0%
March 1-Dec. 31, 2012	Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96)	0%
2013	American Taxpayer Relief Act (P.L. 112-240)	0%
Jan. 1-March 31, 2014	Pathway for SGR Reform Act of 2013 (P.L. 113-67)	0.5%
Apr. 1-March 31, 2015	Protecting Access to Medicare Act of 2014 (P.L. 113-93)	0%

Source: Compiled by the Congressional Research Service based on information derived from the Legislative Information System.

What have been the MPFS payment level increases, if any, under the SGR overrides?

The SGR-override bills passed into law generally have either kept payments at the current level (by providing for a 0% change) or increased payment levels from 0.2% to 2.2% (see **Table 1**).

Why are MPFS payment levels projected to fall when overrides expire?

When actual spending exceeds target spending under the SGR calculation, current statute requires that the overage be recouped to bring actual spending back in line with target spending. Under the SGR system, this additional spending would be recouped by reductions to payment rates in subsequent years. As CBO explains, if the SGR system were allowed to function as established,

"over the long run the cumulative cost would be close to zero, because allowing the SGR formula to be implemented would lead to recapturing the additional spending that occurred during the period when the SGR was overridden."[3] The statutory language that established the SGR system also included a limit (7% decrease) on how much payment levels could change from year to year, to temper any potential disruptive impacts. (Following such a course was described as a "clawback" approach.)

The aggregate effect of several years of overrides meant that the cumulative overage continued to grow,[4] leading to an alternate ("cliff") approach. With each override, Medicare physician expenditures continued to grow faster than the target level, as set forth under the law. With the aforementioned limit on how much payment levels could change from year to year, the length of time required to recoup the overage grew with each override (specifically, the period required to recoup the overage and not incur a cumulative cost began to exceed 10 years). Beginning with the Tax Relief and Health Care Act of 2006 (P.L. 109-432) and with each override act since, the legislation has specified that the payment rate update in the year that the override expires "shall be calculated as if that freeze (or increase) had not been enacted." As CBO notes, "Unlike clawback legislation, which limits future rate reductions to no more than 7 percent in any given year, cliff provisions can result in a very large rate reduction in the year following a short-term rate adjustment." In recent years, CMS actuaries have estimated "cliff" reductions of 27.4% (for January 1, 2012), 26.5% (for January 1, 2013), and 20.1% (for January 1, 2014).[5] Each of these was averted by congressional action.

Have any of the previous patches expired prior to the passage of a subsequent piece of legislation that provided the next override?

This has happened three times:

- the Temporary Extension Act (P.L. 111-144) was signed into law on March 2, 2010, after the prior override expired on February 28, 2010;
- the Continuing Extension Act (P.L. 111-157) was signed into law on April 15, after the prior override expired on March 31, 2010; and
- the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (P.L. 111-192) was signed into law on June 25, 2010, after the prior override expired on May 31, 2010.

Medicare is prohibited from paying electronic claims earlier than the 14th day after the date of receipt and from paying non-electronic claims earlier than the 29th day after the date of receipt.[6] Thus, the first two instances required no additional action by Congress; however, the third instance required a provision that made the SGR payment override retroactive to June 1, 2010.

[3] See CBO, "Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies Relative to CBO's March 2012 Baseline," July 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43502-SGR%20Options2012.pdf.

[4] Hahn, op. cit.

[5] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/index.html?redirect=/sustainablegratesconfact/01_overview.asp.

[6] See Social Security Act Section 1842(c)(3).

Why hasn't this problem been addressed permanently?

There are two primary reasons why this problem persists: (1) although a number of proposals to replace the SGR system have been proposed, there has been no consensus nor broad support for any long-run alternative until recently (see below), and (2) the cost of any permanent change has been daunting because the CBO baseline must assume current law, which in recent years has estimated that a reduction in payment rates under the MPFS would occur for several subsequent years. In addition to the impact on federal outlays, any change in the payment update formula would also have implications for beneficiaries; because Part B beneficiary premiums must cover about 25% of Part B program costs, any overall increase in spending results in a proportional increase in premiums.[7]

The lack of a viable alternative payment model has hampered attempts to repeal and replace the SGR system. Repealing the SGR system would require the adoption of an additional method for determining how Medicare physician payments would be modified from year to year. Given that the SGR[8] was created to replace another system that failed to constrain the rate of growth in Medicare physician expenditures (Medicare volume performance standard, or MVPS), attempts to create an update methodology that would successfully contain Medicare growth have so far been unproven.

While the SGR methodology determines the change in the Medicare physician payments from year to year, it does not determine the basis for those payments. While the current MPFS is a fee-for-service based payment system (i.e., doctors are paid for each service they provide), an "SGR-type" methodology also could be applied to payments based on alternate payment systems, including bundled payments for episodes of care, capitation payments, performance- or incentive-based payments, or some other payment system. Given the acknowledged shortcoming of fee-for-service based payment, which rewards the volume of care provided while being indifferent to the quality of care, most efforts to repeal the SGR system have been closely tied to Medicare physician payment reform. However, there are few (if any) comprehensive alternative payment models that have proven successful at providing incentives for high-quality care while tempering the growth rate of health care expenditures.

For many years, the cost of SGR repeal has contributed to the lack of progress in repealing and replacing the status quo. For example, in 2007, CBO testified that, depending on the replacement method for determining year-to-year changes in the payment rates, the 10-year impact on direct federal spending could range from $177.4 billion (for a 10-year freeze of the payment level), to $262.1 billion (for an automatic increase tied to the Medicare Economic Index [MEI], an index similar to the CPI but based on medical care inputs), to $330.5 billion (for an automatic increase based on MEI together with a hold-harmless provision to protect beneficiaries from higher premiums as a result of the higher level of Medicare physician spending).[9] In recent years, CBO scores for SGR repeal have been lower (see next question).

[7] For details on Medicare Part B premiums, see CRS Report R40082, *Medicare: Part B Premiums*, by Patricia A. Davis.

[8] The "sustainable" notion of the SGR was that it attempted, in part, to tie the rate of growth in Medicare physician expenditures to the rate of growth in the GDP. Successfully keeping Medicare physician expenditures to the SGR target growth rate would have meant that the share of the GDP going to Medicare physician expenditures would be relatively stable. Instead, having actual expenditures exceed the SGR target indicates that Medicare physician expenditures have consumed an increasing proportion of the GDP in recent years.

[9] http://www.cbo.gov/publication/18392.

How have recent CBO scores for an SGR repeal changed and why?

Repealing or fixing the SGR could be costly from a federal budgetary perspective, although recent CBO estimates of replacement proposals have fluctuated. (See **Table 2**.) In summary, CBO scores for a 10-year freeze of MPFS payment levels were lower in 2013 and 2014 compared with 2012 estimates, but 2015 estimates have been increasing, even when adjusted for the additional year in the estimate window.

Table 2. Selected CBO Scores for Freezing MPFS Payment Levels

(10- and 11-year windows)

Date of Estimate	Score ($ billions)	Years
July 2012	273.3	10[a]
February 2013	138.0	10[b]
May 2013	139.1	10[c]
December 2013	116.5	10[d]
November 2014	118.9	10[e]
February 2015	137.4	11[f]
March 2015	141.9	11[g]

Source: Compiled by the Congressional Research Service based on information derived from the Congressional Budget Office (CBO).

a. http://www.cbo.gov/publication/43502.

b. http://www.cbo.gov/publication/43907, p. 31.

c. http://cbo.gov/sites/default/files/cbofiles/attachments/44184_May_2013_SGR.pdf.

d. http://www.cbo.gov/publication/44940.

e. http://www.cbo.gov/publication/49770

f. http://www.cbo.gov/publication/49923

g. http://www.cbo.gov/publication/50013.

On February 5, 2013, CBO released a report stating that its estimate of the cost of overriding the SGR with a 10-year freeze in payments had fallen to $138.0 billion compared with its July 2012 estimate of $273.3 billion.[10] The cost of "holding payment rates through 2023 at the levels they are [in 2013] would raise outlays for Medicare (net of premiums paid by beneficiaries) by $14 billion in 2014 and about $138 billion (or about 2 percent) between 2014 and 2023." CBO provided the following reasoning for the reduced cost:

> The estimated cost of holding payment rates constant is much lower relative to this baseline than was the case under previous CBO baselines, primarily because of lower spending for physicians' services in recent years. Under the sustainable growth rate, future payment updates depend on the difference between spending in prior years and spending targets established in law. Actual spending has been lower than projected—and lower than the spending targets inherent in the sustainable growth rate—for the past three years. Because actual spending has been lower than spending targets, CBO now estimates that payment rates will increase beginning in 2015. Those higher payment rates narrow the difference

[10] http://www.cbo.gov/publication/43502.

> between growth under current law and a freeze at current levels, thereby reducing the estimated cost of restricting the payment rates.[11]

CBO's May 2013 baseline projections raised the estimate slightly to $139.1 billion for a 10-year freeze.[12] In December 2013, CBO issued another score indicating that a 10-year freeze in MPFS payment levels would add $116.5 billion over 10 years.[13] A November 2014 document showed a score of $118.9 for a 10-year freeze.[14]

On February 3, 2015, CBO released a document showing that the cost of an 11–year freeze (2015-2025) in MPFS payment levels would add $137.4 billion to direct spending; with 1% increases in the payment level each year through 2025, the score would increase to $191.8 billion.[15] On March 12, 2015, the CBO released a score of the President's FY2016 budget, which included a score of $141.9 billion for an 11-year freeze of MPFS payments.[16]

What SGR bills were introduced in the 113th Congress and how do they differ?

Each of the three committees of jurisdiction passed bills in 2013 that would repeal the SGR system for determining Medicare physician payment updates. On July 22, 2013, the Energy and Commerce Committee passed H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013,[17] by a 51-0 vote. On December 12, 2013, the Senate Finance Committee passed S. 1871, the SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013,[18] by unanimous voice vote, and the Ways and Means Committee passed H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013.[19]

While there are differences among the three bills, they share several overarching concepts. First, each of the bills would provide an initial period of payment stability: the Energy and Commerce bill would increase MPFS payments by 0.5% each year from 2014 to 2018, the Senate Finance Committee bill would freeze the payments (0% increase) for 10 years from 2014 to 2023, and the Ways and Means bill would increase payments by 0.5% in 2015 and 2016.[20] Second, they each establish the development of new payment systems while maintaining fee-for-service payment in a manner similar to the existing system. Third, they each create incentives for physicians to transition to the new payment systems over time, generally by establishing different rates of increase over time for the new payment systems compared to fee-for-service. While these bills are generally non-specific about the details of the new payment systems, the bills establish criteria for the adoption and dissemination of such models, with attention to the ability of the new payment system to achieve broad provider participation, attract covered beneficiaries, and reduce spending while maintaining quality of care or improving quality of care without increasing spending.

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[11] http://www.cbo.gov/publication/43907, p. 31.

[12] http://cbo.gov/sites/default/files/cbofiles/attachments/44184_May_2013_SGR.pdf.

[13] http://www.cbo.gov/publication/44940.

[14] http://www.cbo.gov/publication/49770.

[15] http://www.cbo.gov/publication/49923.

[16] http://www.cbo.gov/publication/50013.

[17] http://docs.house.gov/meetings/IF/IF14/20130722/101205/BILLS-113DiscussionDraftpih-DiscussionDraft.pdf.

[18] http://www.finance.senate.gov/legislation/details/?id=a275e061-5056-a032-5209-f4613a18da1b.

[19] On January 24, 2014, the CBO scored H.R. 2810 at $121 billion over 10 years.

[20] The Pathway for SGR Reform Act of 2013 increased payments by 0.5% for January 1, 2014, through March 31, 2014.

The bills also vary in which non-SGR provisions are included; S. 1871 includes several health care and human service program extenders (including provisions in Medicare, Medicaid, and CHIP). These are provisions that extend current policies beyond current expiration dates. H.R. 2810 as reported by the Energy and Commerce Committee includes provisions that would modify evidentiary rules and practices regarding medical malpractice claims. None of these bills include budgetary offsets.

On February 6, 2014, H.R. 4015 and S. 2000, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014, were introduced in the House and Senate, respectively.[21] H.R. 4015 and S. 2000 proposed five years of 0.5% payment increases for the Medicare physician fee schedule before freezing payments at that level for five additional years. Changes to the payment level in subsequent years would be determined by many factors, including participation in alternative payment models (APM) and provider performance in the newly created Merit-Based Incentive Payment System (MIPS) for those who choose to remain in the fee-for-service payment system. MIPS would subsume some of the current physician payment incentives (e.g., the meaningful use criteria for electronic health records and the value-based payment modifier), while others would be sunset (e.g., certain quality reporting incentives). As an incentive for providers to choose to participate in alternate payment models, payment rate increases would be greater for APMs (1.0% per year beginning in 2024) than for the FFS/MIPS system (0.5% per year beginning in 2024).

On March 11, 2014, the Medicare SGR Repeal and Beneficiary Access Improvement Act of 2014 (S. 2110) was introduced in the Senate. Title I of S. 2110 is identical to S. 2000, while Title II includes provisions that would extend various Medicare, Medicaid, and other human services programs. H.R. 4015 was passed by the House on March 14, 2014, and includes an offset through an amendment introduced by then-Chairman Camp.

How does CBO score the SGR bills introduced in the 113th Congress?

The CBO scores for recent bills reflect a range of costs, with Title I of S. 1871 (dealing with the SGR) adding $111.5 billion[22] to direct federal spending from 2014 to 2023, while H.R. 2810 as considered by the Ways and Means Committee would add $121 billion.[23] CBO initially scored H.R. 2810 as reported by the Energy and Commerce Committee as adding $175 billion[24] over the same period, but revised the figure to $146 billion, reflecting subsequently enacted legislation as well as modifications specified in the physician fee schedule final rule for 2014.

CBO has scored S. 2000[25] and H.R. 4015 (as introduced)[26] as adding $138.4 billion to direct spending from 2014 to 2024 (11 years, rather than the typical 10). S. 2110, which includes many

[21] H.R. 4015 is more detailed than either of the versions of H.R. 2810 reported by the Energy & Commerce or the Ways & Means Committees. In addition to the SGR repeal, H.R. 4015 contains sections addressing quality measure development, care management for beneficiaries with chronic care needs, ensuring accurate valuation of services under the physician fee schedule, expanding the availability of Medicare data, and other issues. S. 2000 is more detailed than S. 1871 with respect to the repeal of the SGR and the proposed replacements, but does not include any of the health care program extenders that were present in S. 1871.

[22] Including the health care program extenders and other provisions in Title II of the bill would result in an aggregate score of $150.4 billion for the entire bill, http://www.cbo.gov/publication/45045.

[23] http://www.cbo.gov/publication/45040.

[24] http://www.cbo.gov/publication/44578.

[25] http://www.cbo.gov/publication/45148.

[26] http://www.cbo.gov/publication/45149.

health care program extenders, would increase direct federal spending by $180.2 billion over 11 years.[27]

On February 3, 2015, CBO updated the estimate of H.R. 4015 and S. 2000 as introduced on February 6, 2014. The new estimate, reflecting an 11-year (2015-2025) window 1 year later than the prior score, increased to $174.5 billion.[28]

What are the offsets included in the doc fix bills?

Only H.R. 4015, as passed by the House on March 14, 2014, includes an offset through an amendment introduced by then-Chairman Camp. This proposed offset would delay the penalty for the individual mandate under the ACA for five years.[29] The CBO scored the amended version of H.R. 4015 as reducing direct federal spending by $31.1 billion over the 11 years from 2014 to 2024, as the delay of the individual mandate penalty would reduce spending by $169.5 billion, more than offsetting the direct cost of the SGR repeal and replace provisions ($138.4 billion).[30]

Who or what "paid for" the prior doc fix bills?

There is no clear answer to this question, largely because (1) not all doc fix bills have been offset, and (2) every doc fix bill has contained additional provisions that added to direct federal spending. In some cases, the amount of the SGR override was a small percentage of the overall bill (e.g., MMA, which created the Part D benefit).

Aren't health program extenders typically part of the doc fix bills?

In recent years, the doc fix bills have included provisions that have extended expiring health care programs. For instance, S. 2110 contains several health care program extenders, as does S. 1871, which was reported by the Finance Committee. However, S. 2000, H.R. 2810, and H.R. 4015 do not include any provisions extending health care programs about to expire. The override bill that was eventually passed (the Protecting Access to Medicare Act of 2014; P.L. 113-93) included some health program extenders.

When does the current doc fix patch expire?

The Pathway for SGR Reform Act of 2013 (P.L. 113-67), Division B of the Continuing Resolution Act (H.J.Res. 59), provided for a 0.5% increase in MPFS payments for January 1, 2014, through March 31, 2014. The Protecting Access to Medicare Act of 2014 (PAMA; P.L. 113-93) extended this override, at the existing payment level, through March 31, 2015.

What action has the 114th Congress taken regarding the SGR?

On January 21 and 22, 2015, the Health Subcommittee of the Energy and Commerce Committee held a two-day hearing entitled, "A Permanent Solution to the SGR: The Time Is Now." While committee members and witnesses[31] were unanimous in their stated desire to find a permanent

[27] http://www.cbo.gov/publication/45187.

[28] http://www.cbo.gov/publication/49923.

[29] For more information, see CRS Report R43854, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Namrata K. Uberoi.

[30] http://www.cbo.gov/publication/45180.

[31] http://energycommerce.house.gov/hearing/permanent-solution-sgr-time-now.

replacement for the SGR, there was no consensus on whether the cost should be fully, partially, or not at all offset.

On March 13, 2015, the chairs and ranking Members of the House Ways and Means and the Energy and Commerce Committees released a "Bipartisan Joint Committee Statement on the Sustainable Growth Rate" that included the following:

> Last year, the Ways and Means and Energy and Commerce Committees came together, on a bipartisan basis, to propose a permanent alternative to the broken SGR system. We are now engaging in active discussions on a bipartisan basis—following up on the work done by leadership—to try to achieve an effective permanent resolution to the SGR problem, strengthen Medicare for our seniors, and extend the popular Children's Health Insurance Program.[32]

Should Congress not come to agreement on a bill that the President signs into law (whether it be the outcome of the current negotiations or a separate bill altogether), another temporary patch would be required if Congress wants to override the reduction in the MPFS set to occur on April 1, 2015.

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[32] http://waysandmeans.house.gov/news/documentsingle.aspx?DocumentID=398181.