



Medicare Physician Payment System SGR Reform Fact Sheet

SGR History and Background

- Created in 1997 as a target rate of growth in Medicare Part B spending for physician and non-physician practitioner (nurses, physical therapists, physician assistants, etc.) services. The SGR is used to establish payment updates – one of several factors that set Medicare physician payment rates each year.
- Designed to bring actual spending in-line with allowable spending over time; ties increases in the volume of services per Medicare beneficiary to growth in the GDP. Although adjustments are made for changes in law and regulation, these adjustments have not adequately reflected increased services resulting from technological innovation and Medicare benefit expansions (such as cancer screenings, diabetes management, etc.). This prompted annual payment cuts that were then exacerbated by Congressional actions that stopped the cuts but failed to adjust the target, thereby leading to ever larger projected payment cuts.
- The target was set with 1996 spending as the base year, and is a cumulative calculation from April 1, 1996. The payment update for a year is determined by comparing cumulative actual expenditures to cumulative target expenditures in the prior year. For example, the 2009 payment update was set by comparing actual expenditures from 1996-2008 to targeted expenditures from 1996-2008.
- If spending exceeds the SGR targets, then the physician payment update is less than the increase in the inflationary cost of providing a service.
- Includes drugs administered in a physician's office and laboratory tests (actual products), and physician services (set by the fee schedule). Adjusting the payment update ONLY applies to physician services (fee schedule) and not drugs or lab tests.
- It has taken nearly a decade for the Medicare physician payment system to recover from the 5.4% cut imposed due to the SGR in January, 2002. During that time, payment rates fell further and further behind inflation in medical practice costs.

Congressional Interventions to Stop SGR Cuts

Year Scheduled Rate Congressional Action

| | | | |
|----------------|----------------------|-----------------|----------------------|
| 2002 -5.4% cut | None | 2007 -5% cut | Freeze at 2005 level |
| 2003 -4.4% cut | 1.6% increase | 2008 -10.1% cut | 0.5% increase |
| 2004 -4.5% cut | 1.5% increase | 2009 -15% cut | 1.1% increase |
| 2005 -3.3% cut | 1.5% increase | 2010 -21% cut | |
| 2006 -4.4% cut | Freeze at 2005 level | | |

Removing Drugs from the Physician Payment System: Significant SGR Reform Cost Saver

- In addition to the payments physicians receive for administering drugs, the cost of the drug itself is included in the spending that is used to calculate the SGR. While the drug administration is a true physician service and should be included, the drug product is not a physician service and should not be included.
- Physicians have no control over Part B drug costs yet as the drug costs increase, physicians get penalized under the SGR.
- Spending on physician-administered drugs has grown at much higher rates than spending for all other physician services. Over the years, spending on physician administered drugs ballooned from \$1.8 billion to \$9.1 billion. This has contributed significantly to the deviation between target and actual spending, as well as to the large projected reductions in future physician payment rate updates.
- From the first quarter of 1997 through the first quarter of 2005, the average annual growth in Medicare spending on drugs included in the SGR was 22 percent compared with 6 percent for all services (including drugs) included in the SGR.
- Growth in Proportion of SGR Spending Consumed by Drug and Lab Costs:
 - 1996: Drugs – 4% Lab – 9% Fee Schedule – 88%
 - 2007: Drugs – 10% Lab – 8% Fee Schedule – 82%
 - 2019: Drugs – 15% Lab – 13% Fee Schedule – 73%
- Since 2001, overwhelming groups of bi-partisan members in current and past Congresses have joined the physician community in advocating for the retroactive removal of drugs from the physician payment system through administrative authority.
- It is not equitable or realistic to finance the cost of life-saving drugs through cuts in payments to physicians. In fact, steep physician payment cuts would restrict

access to the very drugs that these policies are intended to make more accessible.

- Removal of drugs from the SGR is a step toward preserving access to these important drugs and other critical physicians' services.
- The Administration's proposed physician payment schedule for 2010 retroactively removes drugs from the SGR formula.
- With this one action, it is estimated that the cost of eliminating the SGR debt burden and providing a payment freeze DECREASED by \$122 billion over 10 years. As a result, the cost of eliminating the debt burden and freezing current payment rates has fallen from \$285 billion over 10 years, to \$163 billion over 10 years.

Rebasing the SGR – Path to Permanent Reform

- While recent Medicare legislation has provided temporary relief from SGR cuts, the budgetary situation has been made worse in the long-run by simply moving the cuts to the next year. This increased the severity of the cuts and raised the cost of enacting a permanent solution.
- The only way to start on a path to permanently reform the physician payment system and repeal the SGR is to rebase – reset the baseline to present spending rather than 1996 rates.
- The primary purpose of a budget baseline is to provide policymakers with a clear forecast of projected spending and taxpayer obligations.
- The current physician payment baseline, based on 1996 expenditure levels, is no longer useful – it paints a false picture of actual Medicare spending. Medical technology, Medicare coverage and benefits, and the cost of running a medical practice have all changed drastically since 1996 yet the SGR has failed to adequately recognize those changes.
- Congress has ignored the baseline by interceding six times since 2003 to temporarily stop Medicare physician payment cuts. This has created a very large SGR debt burden that is impossible to eliminate if kept on the current path of kicking the can on reform to another year.
- Essentially, by temporarily stopping the SGR cuts through the approach of moving the cuts to future years, Congress has created an enormous “credit card” debt that has no hope of being paid off unless the SGR debt burden is eliminated and the physician payment system is rebased.

The longer Congress delays action, the more expensive SGR reform has become.

| Date of CBO Score | Freeze – 10 Year Score | MEI – 10 Year Score |
|-------------------|------------------------|---|
| February 28, 2002 | -- | \$126 billion (based upon 2001 and 2002 MedPAC recommendations) |
| May 5, 2004 | -- | \$95 billion |
| March 24, 2005 | \$48.6 billion | \$154.5 billion |
| March 24, 2006 | \$127.2 billion | \$218.2 billion |
| January 2007 | \$170.8 billion | \$252.2 billion |
| March 2007 | \$177.7 billion | \$262.1 billion |
| Marcy 14, 2008 | \$220.1 billion | \$288.1 billion |
| May 7, 2009 | \$285 billion | \$344 billion |

* Scores from December 2008 CBO Health Budget Options document not included due to inaccuracies in those scores. Those scores (\$318 billion/\$439 billion for a freeze and MEI update respectively) were significantly larger than the scores provided in May 2009.

** Scores assume a standard fix without a premium hold harmless.

*** In the FY 2003 Consolidated Appropriations, Congress averted a payment cut and provided physicians with a “fully funded” 1.6% update for 2003, which cost \$54 billion over 10 years. It is considered fully funded because the structure of the fix allowed the expenditure targets to be increased to accommodate the fix. Thus the SGR did not recoup the cost of this fix over time. This is one of the reasons why the 10 year cost of an MEI fix decreased from \$126 billion in 2002 to \$95 billion in 2004.

Why Rebasing SGR Should Not Be Subject to PAYGO

- The cut required by the SGR formula for January 1, 2010, is 21.5 percent. In the next several years, the cuts will total 40 percent.
- These cuts, if not stopped, will impair patient access. The vast majority of physician practices are small businesses, and cannot absorb these steep losses. No small business could survive under a business model that dictates steep cuts year after year.
- If action is not taken now to provide permanent relief, cuts will continue to grow and a solution will become even more expensive.
- Without a PAYGO exemption, it would be virtually impossible, due to the immense cost, to replace the SGR with a new Medicare physician payment system.
- The Administration’s proposal to remove drugs from the SGR formula has to be coupled with a legislative PAYGO exemption in order for the SGR debt burden to be eliminated – removing drugs from the formula alone will not get us on the path to permanent SGR reform.
- Physicians are the foundation of our health care system. Rebasing and repeal of the SGR would strongly support this foundation and pave the way for Medicare to fulfill its promise of high quality, cost effective health care to seniors and disabled persons, especially as Medicare prepares to begin enrolling the first wave of

baby boomers in 2011, with enrollment growing from 44 million in 2011 to 50 million by 2016.

- Since projected SGR cuts exacerbate ongoing physician shortages, rebasing and repeal of the SGR will favorably affect the future supply of physicians. The Council on Graduate Medical Education is predicting the country will face a shortage of 85,000 physicians by 2020, and the Association of American Medical Colleges (AAMC) reported in November, 2008, that there will be a shortage of at least 124,000 physicians by 2025 across all specialties.
- Adopting a new baseline will mean that billions of dollars each year that are spent providing a temporary SGR fix would be available for other important health reforms.
- Rebasing and repeal of the SGR provides stability to patients covered by other payers that tie their rates to Medicare including military members, their families, and retirees in TRICARE, retired Federal employees, and those enrolled in state Medicaid programs.
- Rebasing and repealing the SGR would bolster our struggling economy because it would help sustain the jobs of nearly three million individuals across the country employed by physicians and related businesses affected by the Medicare physician payment cuts.
- The stakes are too high to continue this cycle of eleventh hour temporary SGR fixes. Rebasing is a smart, realistic, and transparent approach to addressing rising health care costs because it allows accurate forecasts of what those costs are going to be.

Recent Legislative and Administration Actions Regarding the SGR

Administration's FY 2010 Proposed Budget

- Proposed to rebase the SGR – assumed a more realistic baseline in accordance with its “best estimate of what the Congress has done in recent years.”

House Budget Resolution (H.Con.Res. 85)

- Proposed to rebase the SGR – essentially mirroring Administration's proposal.
- Exempted SGR rebasing from PAYGO.

H.R. 2920 – Statutory Pay As You Go Act

- Exempted SGR rebasing from PAYGO.

Administration's Proposed 2010 Physician Payment System

- Retroactively removes drugs from the physician payment system – significantly decreases the cost of repealing the SGR and putting the Medicare physician payment system on a path towards permanent reform.

H.R. 3200 – America’s Affordable Health Choices Act of 2009

- Rebases SGR and exempts it from PAYGO.
- Retroactively removes drugs and laboratory tests from the physician payment system.

S. 1776 – Medicare Physicians Fairness Act of 2009

- Repeals the SGR and exempts it from PAYGO
- Sets future physician payment updates at zero, laying the foundation for a creating a new update system