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POLICY FORUM

Repeal of the Medicare Sustainable Growth Rate: Direct and Indirect Consequences

Jeffrey Clemens, PhD, and Stan Veuger, PhD

In 2013, US health care spending totaled about $3 trillion, or more than $9,000 per person [1]. This corresponded to 17.4 percent of GDP, a much larger share than one sees in other countries [1, 2]. The largest financer of this medical care was the federal government: the Medicare program for the elderly and disabled accounted for 26 percent of all hospital expenditures and 22 percent of all outpatient care [1], and states' Medicaid programs received $265 billion in federal funding [3]. Beyond this direct role, the federal government influences health care and health insurance markets through their tax treatment, subsidy arrangements, and regulation.

The federal government's role as the largest financer of health care, which has expanded in recent years through the Medicare Modernization Act of 2003 and the Patient Protection and Affordable Care Act of 2010, positions it to substantively shape the sector's long-run trajectory. As the single largest purchaser of health care services, its decisions regarding the generosity and structure of payments exert systemwide influence. In this context, we consider the implications of the recent repeal and replacement of the Medicare Sustainable Growth Rate (SGR) through the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) [4].

From SGR to MACRA

The SGR. The SGR, enacted through the Balanced Budget Act of 1997, was the product of a congressional effort to constrain growth in Medicare's spending on physician services. The underlying formula was meant to generate reductions in fee-for-service payment rates when Medicare's total spending on physicians' services grew more quickly than a target growth rate. It made allowances for modest fee increases, changes in the number of Medicare beneficiaries, and GDP growth, among other factors [5].

For most of the SGR's existence, actual expenditures grew faster than target expenditures. The SGR's formula has thus typically called for reductions in Medicare's fee-for-service payment rates [6]. Political pressure from physician organizations wary of reduced compensation [7] and from beneficiaries concerned about access to care [8] led Congress to enact a series of temporary measures to keep these cuts from materializing. These so-called "doc fixes" were typically legislated to last for a single year, making their renewal an annual or more frequent event. Because they did not alter

the underlying SGR formula, the divergence between doc fix payments and those called for by the formula gradually widened. The reductions in Medicare fee-for-service payment rates that would occur if there were a lapse in the doc fix thus became increasingly dramatic over time, approaching 30 percent in some years [9].

The large size of the cuts implied by the SGR made permanent repeal look costly. Simultaneously, the implied cuts' size made it unpalatable, to physicians and Medicare beneficiaries alike, for Congress to allow them to be implemented. It is precisely these forces that sustained the doc fix "ritual" for so long. Recognizing its annual inevitability, the Congressional Budget Office (CBO) incorporated these fixes into its (more realistic) "alternative" fiscal scenario for forecasting deficits and debt [6]. The CBO's forecast of the cost of long-term repeal finally decreased, however, when the growth rate of medical spending declined in recent years. In 2015, Congress finally repealed the SGR (or, technically, turned it into a mechanism that produces fixed annual updates, explained below) [4].

The MACRA. What, then, replaces the SGR? There are two key elements of the MACRA that will directly affect physicians' payments and practices. The first is a new procedure to determine the updates to Medicare's physician fees: instead of annually improvised updates, fees are now scheduled to increase by 0.5 percent per year through 2019 and then to remain flat from 2020 through 2025 [4]. The SGR repeal thus brings an end to the recurring uncertainty in Medicare physician pay and the need for congressional intervention to avert sudden, large payment rate cuts.

The repeal's second element is the introduction of a "merit-based incentive payment system" (MIPS). Starting in 2019, the MIPS will fold a number of current incentive systems into a single, modified approach to rewarding physician groups that excel according to its criteria for providing high-value care. These bonuses and penalties are cost-neutral; money flows from underperformers to outperformers [10]. The goal of these new incentive payments is, of course, to induce physician groups to provide higher-quality care without increasing resource usage. The measures upon which groups will be scored include the "meaningful use" electronic health record (EHR) program, the Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VBPM) program. The scoring will also incorporate an evaluation of clinical practice improvement activities [11]. As of September 2015, the secretary of the Department of Health and Human Services (HHS) had yet to announce more detailed implementation guidance and assessment criteria. But the size of bonus payments and penalties derived from MIPS scores is written into the law: they will grow to range from +27 percent to -9 percent in 2022. Physician groups will also be offered the chance to opt out of the MIPS. To do so, a large enough percentage of their revenue must come from qualifying alternative payment mechanisms (APMs). Qualifying alternative mechanisms must more tightly link physician income to performance and require "sufficient" quality reporting.

The range of mechanisms that will be deemed qualifying remains to be fully determined by the secretary of HHS.

Presumably the MIPS will bear a significant similarity to Medicare's Pioneer accountable care organizations (ACOs), which, thus far, appear to have delivered promising savings [12]. Because the Pioneer ACOs voluntarily participated in the initiative, however, the extent to which these first-movers' successes will be replicated by later entrants is unclear [13, 14]. In general, of course, it is quite difficult to design mechanisms that make it pay to reduce revenue [15].

Probable Effects

The repeal of the SGR and the expansion of the MIPS will have direct, wide-ranging impacts on physician payments and practices. Importantly, these changes are likely to exert influence beyond the Medicare program.

As practitioners are well aware, Medicare's fee schedule plays a central role in many contracts between physicians and private third-party payers [16, 17]. Specifically, contracted payments are regularly negotiated relative to Medicare's payment menu, typically with relatively high payment rates for physician groups with substantial market power and relatively low payment rates for small group practices. Recent research [18] finds that, consistent with the conventional wisdom, Medicare's payments do indeed exert significant influence over private payments. The study, conducted by one of us and another coauthor, investigated how private payments responded to Medicare's substantial 1998 change in payments for surgical procedures relative to "other" medical services [18]. Using a large database of private sector claims, the study found that private payment changes tracked Medicare's payment changes virtually dollar for dollar with essentially no lag. The relationship was particularly strong in markets dominated by relatively small group practices. Anecdotal evidence suggests that other sorts of reforms, for example Medicare's Multiple Procedure Payment Reduction policy for diagnostic imaging services, have also been incorporated into private payment models [19].

It may only be a matter of time, then, until the elimination of the SGR and the introduction of the MIPS influence both the overall generosity and the underlying structure of private-sector payments. These changes in payments should, in turn, be expected to influence both the overall quantity and kinds of care physicians provide [20]. Further, it is likely that the reduced uncertainty about future compensation will induce higher levels of investment and an increased willingness to hire [21] (also S.R. Baker, N. Bloom, S.J. Davis, unpublished data, 2015).

That said, other elements of the law may make future policies and regulations less predictable. The changes packaged into the MIPS, for example, may affect physician

incentives in subtle ways. Little can be said, however, until the components of the new incentive system have been more completely designed and revealed. Where significant revenues are at stake, one would certainly expect physicians' practices to organize in ways that are likely to be rewarded. The system's capacity to measure and reward true underlying quality, whatever one believes that is, will thus be crucial. The effectiveness of these efforts and their impacts on care quality for both the publicly and privately insured remain to be seen.

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Jeffrey Clemens, PhD, is an assistant professor in the Department of Economics at the University of California, San Diego, in La Jolla and a faculty research fellow at the National Bureau of Economics Research. He is currently on sabbatical as a visiting scholar at the Stanford Institute for Economic Policy Research. His research interests are in the

intersections between health economics and public finance, the economics of redistribution and social insurance, and state and local government finances.

Stan Veuger, PhD, is a resident scholar in economic policy studies at the American Enterprise Institute for Public Policy Research in Washington, DC, and the editor of *AEI Economic Perspectives*. His research areas are public finance and political economy, and he also writes frequently for general audiences on topics including health care policy, fiscal policy, politics, and popular culture.

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