The Sustainable Growth Rate: The History and Future of Medicare "Doc Fixes"

March 12, 2015

The Committee for a Responsible Federal Budget

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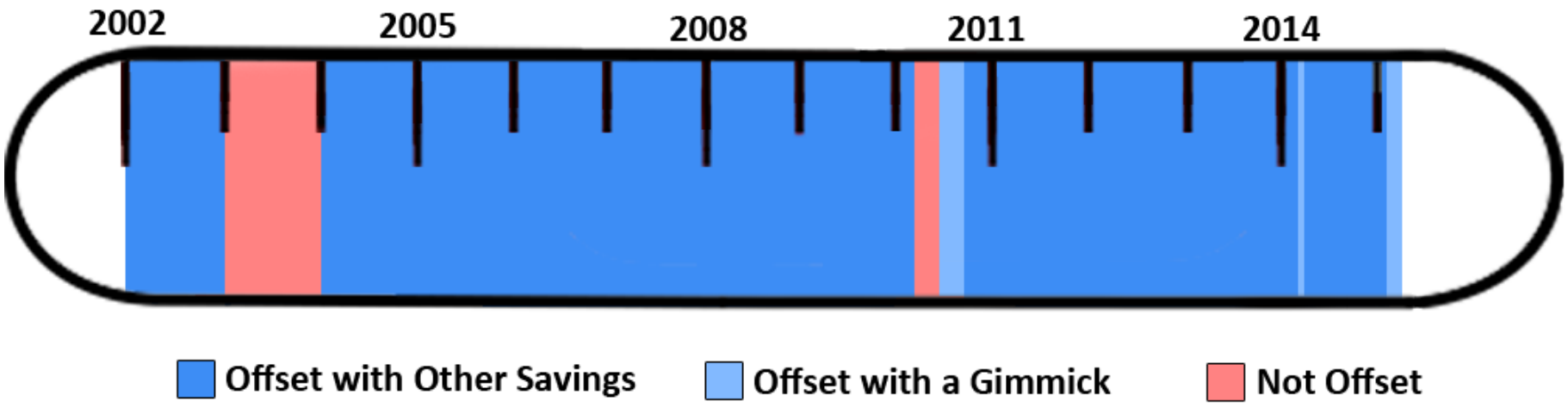
A QUICK HISTORY

- SGR created by Balanced Budget Act of 1997
- Goal to set Medicare physician payments in fiscally-responsible manner
- As 1990s health care slowdown evaporated, volume picked up, eventually requiring payment cuts in 2002.
- After one year of cuts, the doc fix ritual began

A QUICK HISTORY

- Recurring headache and lobbying bonanza
- Clearly failed as a way to set physician payments
- Since 2004, the SGR instead assumed the role of action-forcing mechanism
- Occasional gimmicks, pay-fors often come with a 10-year lag, but …

98% OF DOC FIXES HAVE BEEN OFFSET SINCE 2004



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A QUICK HISTORY

Year	Legislation	Payment Period	Scheduled Payment Update	Legislated Payment Update	Offset Over 10 Years?	Offset by Health Savings?
2003	Consolidated Appropriations Act, 2003	2003	-4.4%	1.4%	No	No
2004	Medicare Prescription Drug, Improvement, and Modernization Act	2004-2005	-4.5% (2004) -3.3% (2005)	1.5%	Yes	Yes
2005						
2006	Deficit Reduction Act of 2005	2006	-4.4%	0.2%	Yes	Yes
2007	Tax Relief and Health Care Act	2007	-5%	0%	Yes	Yes
2008	Medicare, Medicaid, and SCHIP Extension Act	Jan-June 2008	-10.1%	0.5%	Yes	Yes
2008	Medicare Improvement for Patients and Providers Act	July 2008-2009	-10.8% (2008) -16% (2009)	0% (2008) 1.1% (2009)	Yes	Yes
2009						
	DOD Appropriations Act, 2010	Jan-Feb 2010	-21%	0%	Yes	Yes
2010	Temporary Extension Act	Mar. 2010	-21%	0%	No	No
2010	Continuing Extension Act	Apr-May 2010	-21.2%	0%	No	No
	Preservation of Access to Care for Medicare Beneficiaries...Act^	June-Nov 2010	-21.2%	2.2%	Yes	Partially
	Physician Payment and Therapy Relief Act	Dec. 2010	-23%	0%	Yes	Yes
2011	Medicare and Medicaid Extenders Act	2011	-25%	0%	Yes	Yes
2012	Temporary Payroll Tax Cut Continuation Act	Jan-Feb 2012	-27.4%	0%	Yes	No
2012	Middle Class Tax Relief and Job Creation Act	Mar-Dec 2012	-27.4%	0%	Yes	Yes
2013	American Taxpayer Relief Act	2013	-26.5%	0%	Yes	Yes
2014	Pathway for SGR Reform Act^	Jan-Mar 2014	-20.1%	0.5%	Yes	Yes

^Doc fix technically paid for over ten years but partially does so with timing shifts or gimmicks.

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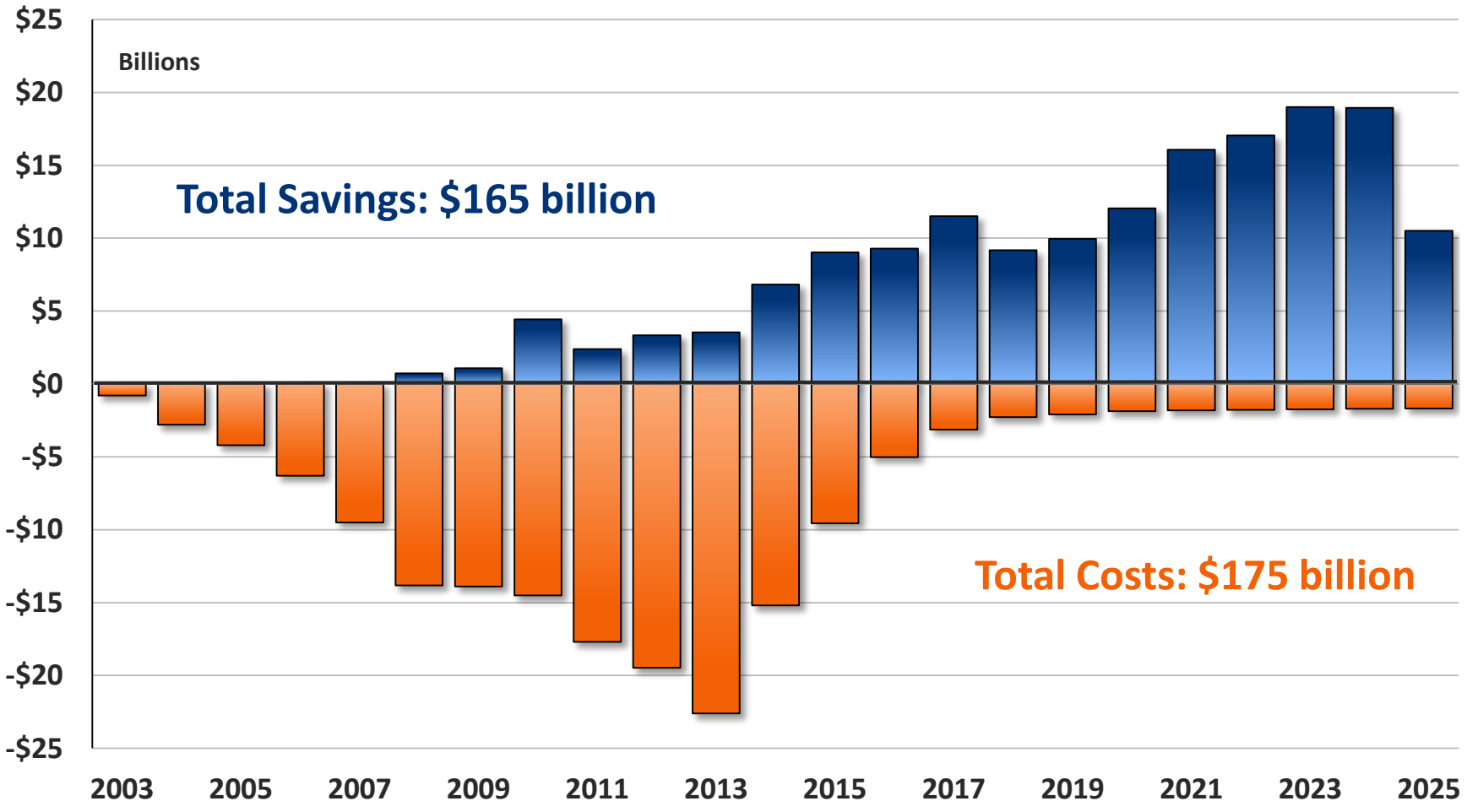
SURPRISING EFFICACY

"Here's the thing: The pressure on Congress to find a way to finance doctors' pay every year has actually reduced federal health spending in general and the Medicare budget in particular."

- *Margot Sanger-Katz, New York Times*

SGR HAS LED TO $165 BILLION OF DEFICIT REDUCTION



Note: Estimates are the cumulative totals of "doc fix" bills passed since 2002, as scored by the Congressional Budget Office before final passage, extrapolated beyond 10 years by CRFB.

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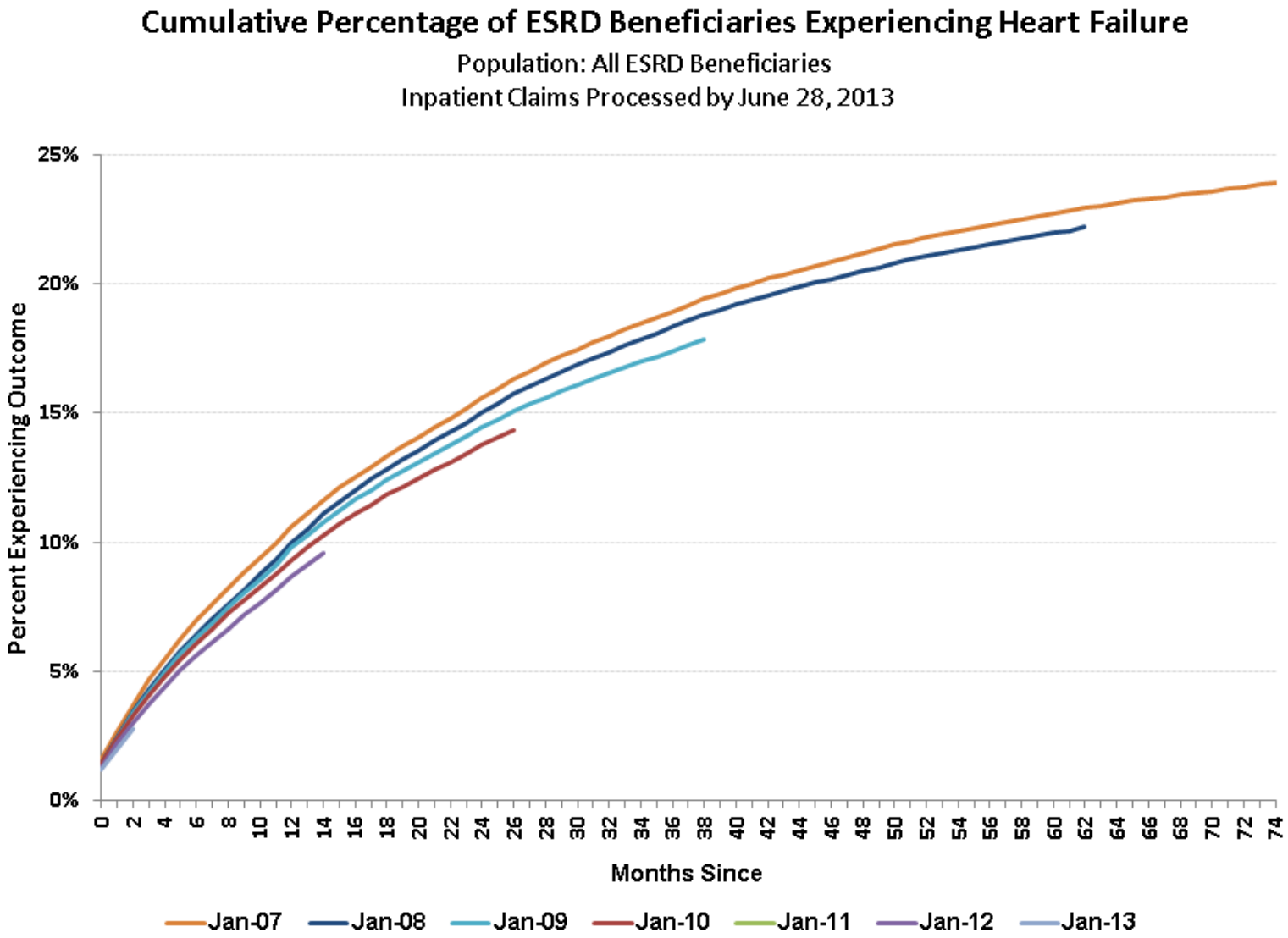
UNEXPECTED PERKS: ACTION-FORCING

- Doc fixes have been near the sole means of enacting forward-thinking health care reforms other than to pay for entitlement expansions
- Many reforms recommended by MedPAC, HHS' OIG, and President's budget likely never would have seen the light of day save for the need to offset doc fix patches
- Slowed Medicare physician payment growth, saving taxpayers another $60 billion
- Extended Medicare's solvency by 2 years

IMPORTANT REFORMS FROM DOC FIXES

- Setting clinical lab payments based on competitively-determined private market rates (HHS' OIG)
- Basing payment rates for nursing facilities in part of avoidable readmissions (MedPAC, President's Budget)
- Reducing overpayments to Medicare Advantage plans (MedPAC)
- Applying site-neutral payments for certain conditions treated in long-term care hospitals (MedPAC)
- Reducing reimbursement for hospital bad debts (President's Budget)
- Recapturing some excess ACA exchange subsidies
- Introducing bundled payments for end-stage renal disease care (GAO)

SGR REFORMS PRODUCED POSITIVE HEALTH OUTCOMES



Source: Centers for Medicare and Medicaid Services, graph courtesy of Jonathan Blum, CareFirst

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THE TRICOMMITTEE REFORM

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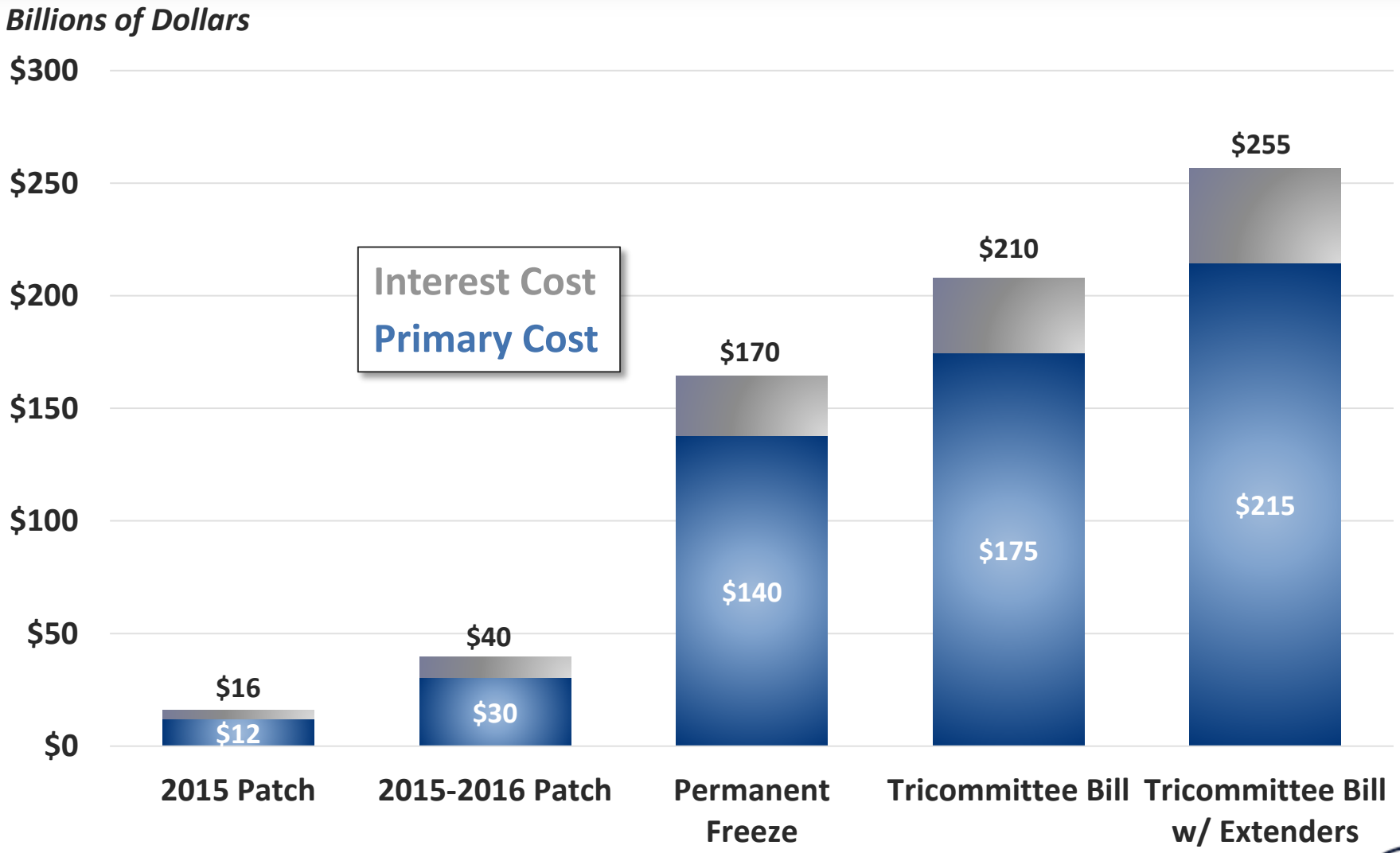
DETAILS OF THE TRICOMMITTEE REFORM

- 0.5% physician payment updates through 2018, then frozen until 2024
- Though underlying payment levels are frozen, adjustments are made through two mechanisms:
  - Merit-Based Incentive Payment System (MIPS): In a budget-neutral manner, adjusts physician payments based on quality, resource use, clinical practice improvement activities, and EHR meaningful use (phases up to 9% of payment at risk).
  - Alternative Payment Model (APM) program: 5% bonuses for providers earning a high percentage of their revenue through APMs (also encourages multi-payer alignment by basing requirements in part on non-Medicare revenues)
- In the long-run, payments for those with sufficient revenue from APMs would grow at 1% annually, and at 0.5% subject to MIPS-adjustments for all others.
- Funds for small physician practices to undertake clinical practice improvements
- Starts to develop qualified clinical decision support (CDS) mechanisms

A PERMANENT FIX TRUMPS A TEMPORARY PATCH

- Payment certainty for doctors
- Promise of Tricommittee reforms
- Less legislative and lobbying resources used up
- Opportunity to enact reforms that bolster the payment improvements in the Tricommittee bill

BUT A PERMANENT FIX IS COSTLY



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FINDING A RESPONSIBLE SGR FIX

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THREE PRINCIPLES FOR SGR REFORM

1. Permanently replace the SGR with a value-based payment system

2. Fully offset all costs relative to current law

3. Enact offsets that bend the health care cost curves and are gimmick-free

ONE SOLUTION: THE PREP PLAN

Policy	Ten-Year Cost
Enact Tricommittee SGR Reform and Extend Health Extenders	**$215 billion**
Reform Provider Incentives	**-$100 billion**
Expand the use of bundled payments and reform ACOs	-$50 billion
Equalize payments for similar services performed in different settings	-$30 billion
Encourage low-cost physician-administered drugs	-$10 billion
Reduce preventable readmissions and unnecessary complications	-$10 billion
Reform Beneficiary Incentives	**-$100 billion**
Modernize Medicare Part A and Part B cost-sharing rules	†
Provide reduced cost-sharing for low-income seniors	†
Restrict first-dollar coverage for Medigap plans	†
Encourage cash out of employer retiree health plans	†
Reduce Medicaid Costs	**-$15 billion**
Restore provider tax threshold to 5.5%	-$10 billion
Rebase Medicaid DSH payments	-$5 billion
Expand waivers for Medicaid cost-control	*
Total Offsets	**-$215 billion**

Estimates are rounded to the nearest $5 billion

* Less than $500 million in costs or savings

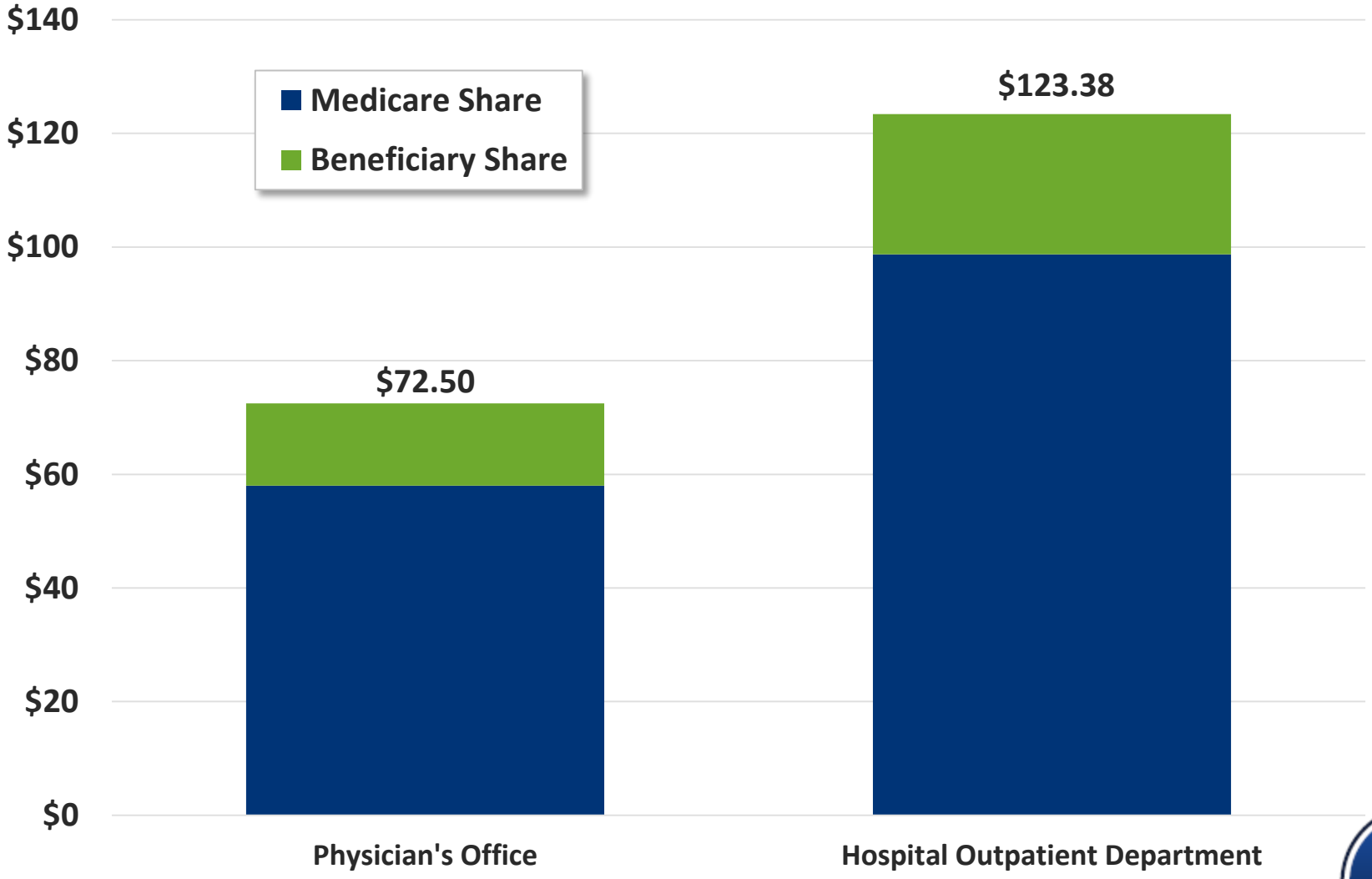
† Due to interactions, policies cannot be scored on an individual basis

PREP PLAN WOULD REFORM THE DELIVERY SYSTEM

- Bundle payments for inpatient care and 90 days of post-acute care
- Offer incentives for ACOs to take two-sided risk
- Attestation: Allow ACOs to offer financial rewards for seeing in-network providers and shared savings with beneficiaries who acknowledge their participation in the ACO. Such beneficiaries would be restricted from buying 1st-dollar Medigap supplemental insurance plans.

EQUALIZE PAYMENTS SO PATIENTS PAY THE SAME

Currently, a 15-minute visit in a hospital costs 70% than at a physician's office.



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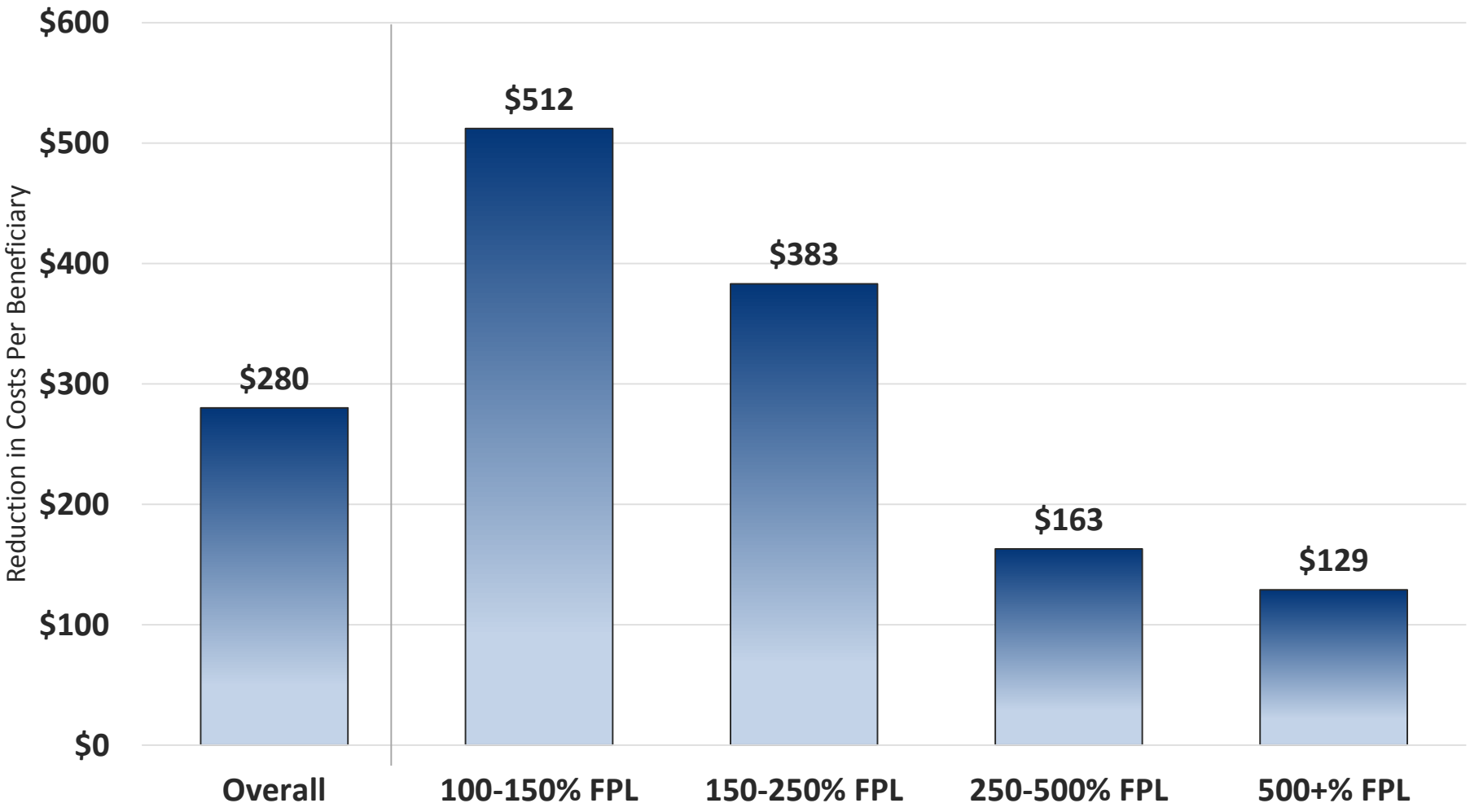
EXAMPLE OF BENEFIT REDESIGN

	100-150%	150-250%	250-500%	500%+
Deductible	$150	$300	$600	$700
Physician visits	Exempt from the deductible			
Normal coinsurance amount	20%			
First out-of-pocket threshold	-	-	-	$7,000
High-cost coinsurance amount	-	-	-	5%
Out-of-pocket maximum	$1,500	$3,000	$6,000	$9,000
Medigap First-Dollar Restriction	Cannot cover deductible, can only cover half of coinsurance up to out-of-pocket maximum			
ESI supplemental plan excise tax	20%, with option to instead cash out full value			

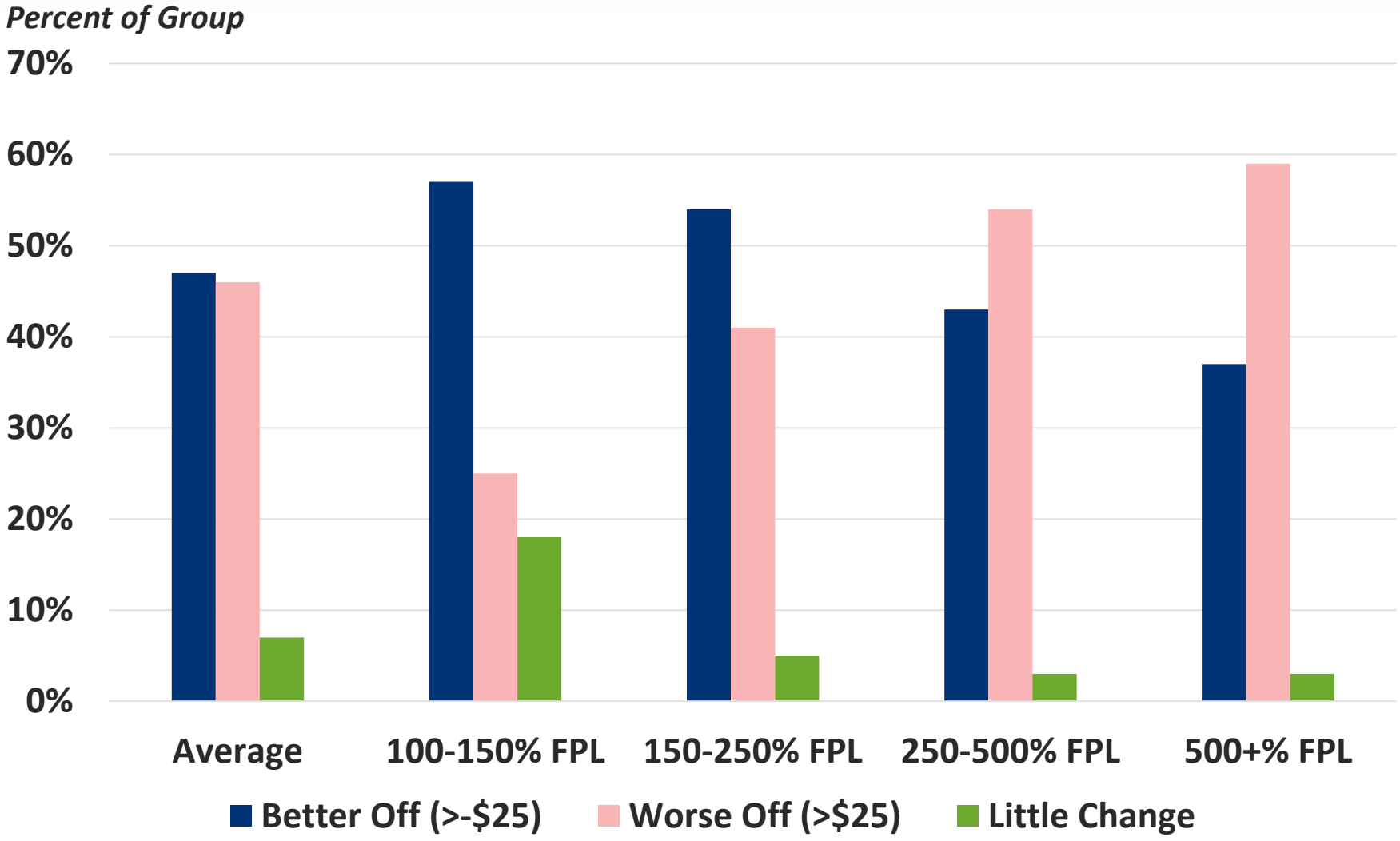
ILLUSTRATIVE BENEFIT REDESIGN LOWERS COSTS BY $280



Source: Actuarial Research Corporation

FPL=Federal Poverty Level

PROGRESSIVE CHANGES HELP THOSE CLOSE TO POVERTY



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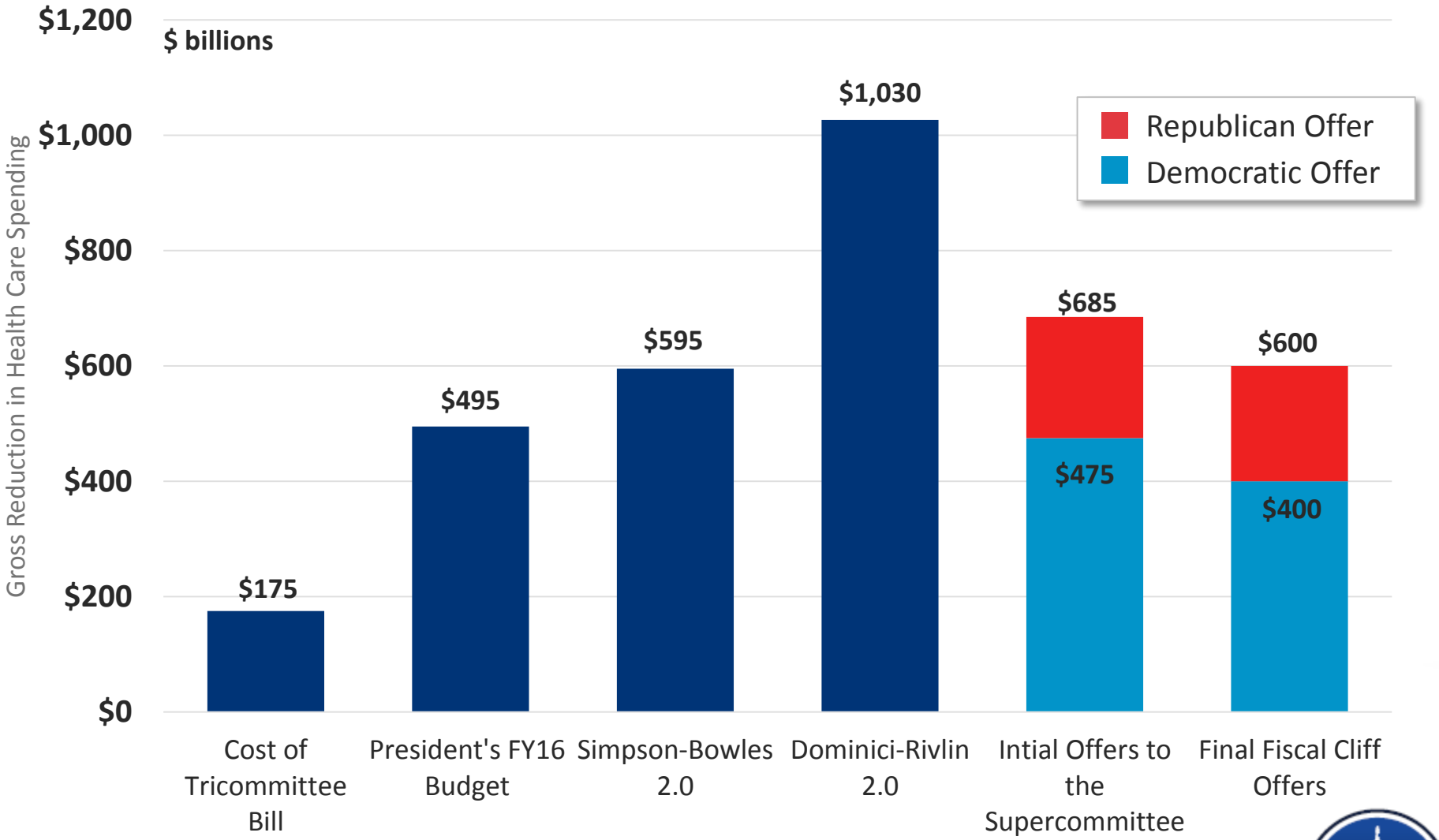
MANY PLANS INCLUDE MAJOR HEALTH SAVINGS



* Proposals aren't strictly comparable, since the budget windows differ.

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ALTERNATIVE OPTIONS ABOUND

Option	Ten-Year Savings
Increased means-testing	$20-$100 billion
Slow the growth of post-acute care payments	up to $75 billion
Reduce Medicare coverage of bad debts	$30-$55 billion
Equalize payments for similar services provided in different sites of care	$30 billion
Encourage the use of generic drugs for Part D low-income subsidy recipients	$25 billion
Further reduce Medicaid provider tax gimmick	$10-$65 billion
Reduce overpayments to Medicare Advantage to compensate for upcoding	$15 billion
Extend PREP Plan limits on supplemental insurance to FEHB and TRICARE for Life	$40 billion
Permanently extend Medicare sequester and Medicaid DSH cuts	$15 billion

And many, many others …

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