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Perspective

The Sources of the SGR “Hole”

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Recently, the Centers for Medicaid and Medicare Services announced a scheduled cut in Medicare physician fees of 27.4% for 2012. This cut stems from the sustainable growth rate (SGR) formula

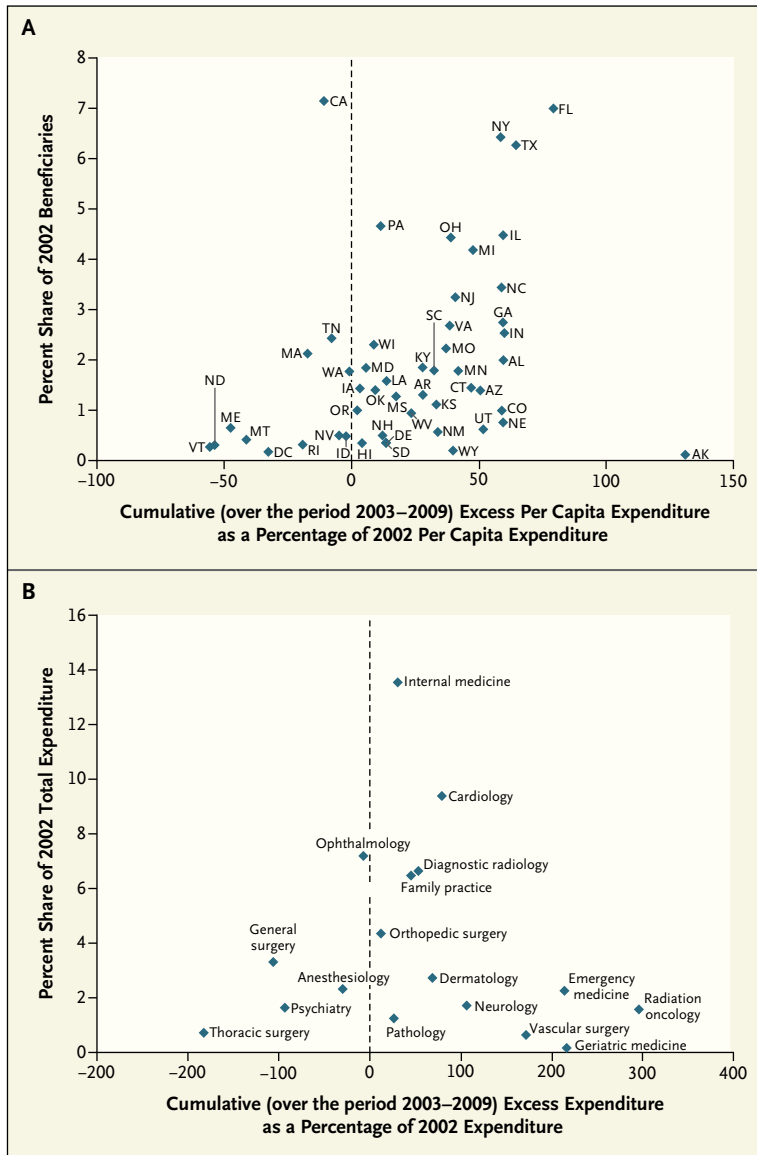
used by the physician-payment system. Implemented in 1998 to curb the growth in expenditures on physicians' services, the SGR formula is used to determine annual adjustments to payments for those services. The SGR system sets a target for aggregate nationwide expenditures on the basis of growth in the per capita gross domestic product, growth in the number of Medicare Part B enrollees, changes in physicians' fees, and changes in laws or regulations. The actual expenditures on physicians' services are then compared with the target, and prices are adjusted to achieve the cumulative target over time.

Almost every year since 2002, actual expenditures have surpassed the targets, and the SGR has

called for substantial cuts in payment rates. In 2002, prices were reduced by 4.2%, but from 2003 onward, Congress has intervened to prevent the SGR-mandated reductions. This may happen again. These interventions do not abolish the SGR but defer into the future the cuts it dictates. The continued deferment results in even larger mandated cuts to future physician fees. It's estimated that repealing the SGR and freezing physician fees at current levels instead of cutting them will cost about \$300 billion over 10 years.¹ In an era when policymakers are trying to take money out of Medicare to reduce the deficit, any repeal of the SGR would probably entail some level of fee cuts. Because the super committee that

was convened to address the budget deficit failed to reach agreement, physicians may face further fee cuts across the board. No one knows exactly what effect fee cuts of the magnitudes discussed would have, but because these cuts are applied evenly across all states and across all specialties and services (with the potential exception of fees for primary care), some health care providers will receive cuts in pay despite the fact that they contributed little to the increases in the volume of services delivered that resulted in the SGR-dictated cuts.

This fact highlights a key flaw in the SGR and raises doubt about the wisdom of collective responsibility. With these strategies, all providers face the same fee reductions regardless of their contribution to spending increases. When imaging services grow excessively, primary care fees get cut. When utilization in some states grows much faster than the SGR's al-



Estimated Excess Spending by State (Panel A) and by Selected Specialties (Panel B). Zero cumulative excess growth represents the sustainable growth rate (SGR) target; numbers to the right of zero indicate spending above the SGR target and numbers to the left indicate spending below the SGR target. Data for the national target and actual expenditures are from annual SGR reports to the Medicare Payment Advisory Commission; data on annual state and specialty expenditures are from the Medicare and Medicaid Statistical Supplement.² Because of accounting differences, the latter data were adjusted to match the national SGR estimates of total actual expenditures. No correction was made for relative value units or geographic fee adjustments, so the SGR deficits are underestimated for states and specialties with slower-than-average fee growth and are overestimated for those with faster-than-average fee growth; however, these adjustments are small relative to total growth. Not all specialties are included here; for complete data, see the Supplementary Appendix, available with the full text of this article at NEJM.org.

lowed growth, physicians in other states where use grew within the targeted range must share the same cuts.

To illustrate the level of inequity in this system, we broke down the national spending for Medicare physician services by state and by specialty and determined which states and specialties have contributed most to the SGR deficit between 2002, when the program was last balanced, and 2009. Although SGR spending targets are set on a national level, we computed state targets by applying the SGR's national target growth rate to each state's per capita expenditure, using 2002 as the base year. Our analysis is an approximation, because, unlike the SGR, we do not adjust for differential fee changes. Moreover, unlike the SGR, our data include laboratories and physician-administered drugs. For this reason, we exclude specialties in which physician-administered drugs accounted for more than 2% of the use of Part B drugs.

We compared the state targets for the years 2003 to 2009 to actual state expenditures and added the annual difference between these figures to get a cumulative difference between the state's spending and the SGR target. This cumulative difference was then divided by the 2002 per capita expenditure to determine the percentage growth since 2002.

There was considerable variation in estimated state performance (see Panel A of the figure). States that appear to have contributed the most to digging the SGR hole were the large states with relatively rapid spending growth (i.e., the states in the up-

per right-hand corner of Panel A) — New York, Florida, and Texas. Florida, for example, was home to 7% of Medicare Part B beneficiaries in 2002 and overshot its estimated per capita SGR target by 80%. In contrast, Alaska overshot its target by 110%, but since it has a small population, it contributed less to the SGR deficit. Several states most likely undershot their targets and therefore appear to the left of the vertical dotted line. Despite this varying spending growth, all states would face the same fee reductions if the SGR formula or broad fee cuts were enforced.

In addition to the wide variation by state, there is also considerable variation by specialty. Using a similar analysis, we computed estimated SGR targets for physician specialties to see which ones had probably contributed most to the SGR hole. Panel B of the figure shows the estimated variation in undershooting and overshooting of the SGR target by specialties (x axis), as well as each specialty's share of the total 2002 expenditures on physician services (y axis). Specialties with the highest excess growth and the largest share of total expenditures contributed to the SGR deficit the most; these include internal medicine, cardiology, diagnostic radiology, and family practice. Cardiology, for example, accounted for

about 10% of total expenditures on physician services in 2002 and overshot its SGR target between 2003 and 2009 by a total of 79% of 2002 expenditures. Meanwhile, general surgery undershot its estimated SGR target by 106% during the same period, but general surgeons would still face large fee cuts if the SGR were ever enforced.

We do not mean to suggest that the SGR physician-payment system should be restructured according to either state or specialty. For example, the arrival of new technologies in one area of medicine may justify faster growth in some specialties relative to others. Rather, our analysis illustrates that across-the-board cuts in fees are too blunt an instrument to restrain the growth of spending on physician services. In fact, any form of target expenditures for physicians who are not part of a coherent risk-bearing organization that is responsible for patient care will produce pathologies similar to those revealed in the graphs. Indeed, setting expenditure targets by state or specialty would fail to provide incentives for more efficient use of services, because the units are too large for physicians to feel individual responsibility to control volume. The state or specialty is not the correct unit of analysis for payment policy. Similarly, setting targets for groups of physicians who

are linked artificially through retrospective claims analysis but are unrelated through an explicit organizational form such as an accountable care organization will probably be ineffective.

We believe it is imperative that a post-SGR payment system encourage the creation of organizational structures that can accept global payments or payments bundled by episode of care. These alternative forms of reimbursement give provider organizations and physicians the incentives to capture gains from eliminating lower-value therapies and delivering higher-value health care. This approach is far superior to cost-containment strategies in which physician fees decrease in an arbitrary and across-the-board manner.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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1. Congressional Budget Office. Medicare's payments to physicians: the budgetary impact of alternative policies (http://www.cbo.gov/ftpdocs/122xx/doc12240/SGR_Menu_2011.pdf).

2. Centers for Medicare & Medicaid Services. Medicare & Medicaid statistical supplement (<https://www.cms.gov/MedicareMedicaidStatSupp/LT/list.asp>).

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