old plans, insurance rules will not be enforced for the next few years. The contention that "risk corridors" — which limit insurers' potential gains and losses in a risk-sharing arrangement — amount to an insurer bailout has caused some rethinking in the administration.

If Republicans gain a Senate majority in the fall, they will have an opportunity to negotiate entitlement reforms. They will continue to demand Obamacare's repeal, but they'll probably have more traction reforming Medicare than making major changes to the President's most personal political achievement.

Yet Republicans can be expected to advance targeted proposals to eliminate the ACA's most unpopular and unworkable aspects and substitute market-based alternatives. Such proposals will embrace the possibility of a more decentralized, less regulatory, and more consumer-driven model of health care. I believe that will be the direction of the next phase of health care reform in 2017, no matter who is elected President.

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

From the American Enterprise Institute, Washington, DC.

This article was published on May 7, 2014, at NEJM.org.

1. Antos JR, Pauly MV, Wilensky GR. Bending the cost curve through market-based incentives. N Engl J Med 2012;367:954-8.

2. Burr R, Coburn T, Hatch O. The Patient Choice, Affordability, Responsibility, and Empowerment Act: a legislative proposal. January 2014 (http://www.hatch.senate.gov/public/_cache/files/bf0c9823-29c7-4078-b8af-aa9a12213eca/The%20Patient%20CARE%20Act%20-%20LEGISLATIVE%20PROPOSAL.pdf).

3. Miller TP. Why the Patient CARE Act proposal is 'going to need a bigger boat.' AEI Health Policy Outlook. March 10, 2014 (http://www.aei.org/outlook/health/healthcare-reform/why-the-patient-care-act-proposal-is-going-to-need-a-bigger-boat).

4. Capretta JC, Moffit RE. How to replace Obamacare. National Affairs 2012;11:Spring:3-21 (http://www.nationalaffairs.com/publications/detail/how-to-replace-obamacare).

5. Capretta JC, Miller T. How to cover preexisting conditions. National Affairs 2010;4:Summer:110-26 (http://www.nationalaffairs.com/publications/detail/how-to-cover-pre-existing-conditions).

DOI: 10.1056/NEJMp1404298

The "Doc Fix" — Another Missed Opportunity

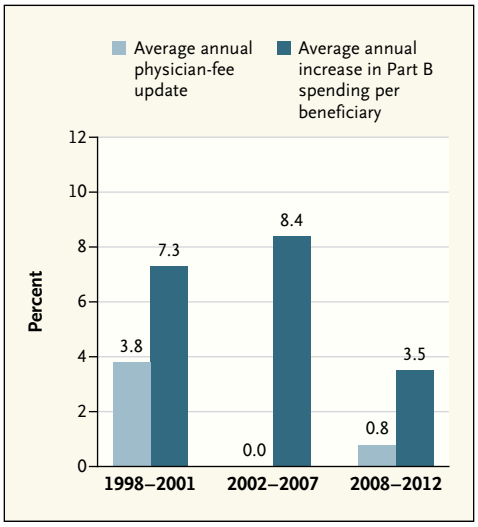
Stuart Guterman, M.A.

On April 1, 2014, President Barack Obama signed into law the Protecting Access to Medicare Act of 2014, averting the 24% across-the-board reduction in Medicare's physician fees mandated by the sustainable growth rate formula (SGR) used to set those fees each year.[1] This action provides relief to physicians, who would have faced a substantial reduction in Medicare revenues, and to beneficiaries, who would have faced potential disruption of access to needed care. That relief, however, is only temporary — this was the 17th time since 2002 that Congress has temporarily overridden SGR-mandated cuts — and the move represents a missed opportunity to permanently eliminate the SGR, an ongoing impediment to the alignment of payment incentives with health system goals.

In place since 1998, the SGR was designed to adjust the annual increase in Medicare fees on the basis of the cumulative level of physician spending relative to overall economic growth. The rationale was that since fee-for-service payment rewards the provision of more services and more invasive and expensive services, some mechanism was necessary to counter the tendency toward spending growth driven by increases in volume and intensity.

In its first few years, with the rapid economic growth of the late 1990s, the SGR produced relatively large increases in Medicare's physician fees.[2] As the economy slowed in the early 2000s, however, while physician spending continued to increase, the formula began to dictate reductions in those fees. Those cuts would have applied to every service, regardless of its potential benefit (or lack thereof), and to every physician (or other health care professional paid under Medicare's physician fee schedule), regardless of his or her own contribution to spending growth. In addition, the threat of a widening gap between physician fees paid by Medicare and those paid by private insurers raised concerns about preserving beneficiaries' access to care.

The SGR fails to address volume and intensity — the factors driving Medicare spending growth — directly, and its across-the-



Medicare Physician-Fee Updates and Increases in Part B Spending per Beneficiary, 1998–2012.

Data are from the Office of the Actuary of the Centers for Medicare and Medicaid Services and the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

board reductions in physician fees actually penalize individual physicians who do control their costs. As the bar graph illustrates, slower growth in physician fees does not necessarily result in slower growth in Medicare spending; in the early years of the SGR, when fees went up at a relatively generous rate, Part B spending per beneficiary (which includes physicians' services and other ambulatory care services) grew almost twice as rapidly, but from 2002 through 2007, when fees were held essentially constant, spending actually accelerated. More recently, physician fees have been allowed to increase somewhat, while increases in Part B spending per beneficiary have moderated.

The SGR mechanism also fails to provide incentives for improving the quality, appropriateness, or coordination of care. In fact, it both distracts attention from attempts to introduce such incentives and undermines the effectiveness of those that have been introduced. The continual prospect of sharp reductions in physician fees makes such incentives less credible; consider the likely reaction to a small potential bonus for performance improvement in the context of a scheduled 24% across-the-board cut.

For more than a decade, policymakers have called for repeal of the SGR. But the estimated cost of permanently eliminating the SGR-mandated physician-fee cuts was high, so Congress instead has repeatedly "kicked the can down the road" — deferring the scheduled cuts for a year or a fraction of a year at a time so the costs would appear more palatable. The result was at least as large an increase in Medicare's physician spending over the years, but in smaller pieces; and with each deferral of the scheduled cuts, future cuts — and the cost of eliminating them — became more daunting. In July 2012, the Congressional Budget Office (CBO) estimated that the federal cost of replacing the SGR even with a 10-year freeze on physician fees would be $271 billion.[3]

This time around, however, things promised to be different. With a recent slowdown in health care spending (especially Medicare spending), the CBO estimate of the cost of replacing the SGR with a 10-year fee freeze had decreased to $117 billion as of May 2013, a far less formidable barrier to action than earlier estimates.[4] By late 2013, all three congressional committees with jurisdiction over Medicare — the House Energy and Commerce Committee, the House Ways and Means Committee, and the Senate Finance Committee — had passed similar bills with essentially unanimous bipartisan support.

These bills would have replaced the SGR with an approach aimed at improving the current payment system while developing and encouraging participation in new payment models. Physicians and other professionals paid under the Medicare physician fee schedule would have had the opportunity to receive payment adjustments based on performance, and those who receive a substantial share of their revenues through alternative payment models that involve accountability for both spending and quality would have received additional payment.

Changes would have been made to improve the accuracy of the current fee schedule, with new information to be collected, and a new study conducted of the process for placing valuations on services. Efforts to increase transparency would have included publication, on the government's Physician Compare website, of utilization and payment data for practitioners, and the availability of claims data to assist in quality-improvement activities would have been expanded. The list of quality measures to be used in reporting and determining payment adjustments would have been improved, with input from professional organizations.

In the end, however, the bipartisan agreement fell apart over the lingering issue of how to pay for the SGR repeal. Although the bill would have improved payment accuracy, strengthened rewards for higher quality of care, and encouraged participation in alternative payment models involving accountability for spending and quality, the CBO estimates of the potential savings from these system improvements did not compare with the budgetary impact of eliminating the large SGR-mandated cut in physician fees

— and agreement could not be reached on other spending reductions to offset the cost of SGR repeal. Instead, the cost of a 1-year deferral of SGR cuts (estimated at $16 billion over 10 years) was combined with more targeted provisions that netted out to modest savings over the 10-year budget time frame.[5]

Despite the disappointing outcome, there is hope for more definitive action. There is still widespread agreement on the desirability of SGR repeal and on the essential elements of the bills passed out of the congressional committees last year. If Medicare spending per beneficiary continues to grow relatively slowly, and if the payment- and system-reform initiatives being implemented in both the public and the private sectors can produce more solid evidence of success, the CBO estimates of the cost of SGR repeal may become even more favorable.

There is also growing recognition that the current payment system, emphasizing greater volume and complexity rather than meeting patients' needs, must be replaced with one that rewards providers for more coordinated, effective, and efficient care. But it's hard to offer effective rewards for better care in the context of the steep across-the-board cuts in Medicare fees mandated by the SGR, which apply to all physicians regardless of the appropriateness, effectiveness, or cost of their care or their contribution to health outcomes.

The bill that was almost passed not only would have eliminated the greatest impediment to progress in that regard but also contained provisions that would have pushed Medicare — and perhaps the health system — in the right direction. It thus provides a good foundation for progress in the near future. Even with enactment of a bill like that described above, the process of weaning the health system from the current payment system to models rewarding more effective and efficient care will be difficult and slow; without strong legislation supporting that process, it will be much more so. We can only hope that the recent momentum will continue and Congress will use the next year to reach agreement on a more permanent solution.

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

From the Commonwealth Fund, Washington, DC.

This article was published on April 30, 2014, at NEJM.org.

1. Congress.gov. Protecting access to Medicare act of 2014, 113th Congress (2013–2014), H.R. 4302. March 26, 2014 (http://beta.congress.gov/bill/113th-congress/house-bill/4302).
2. Centers for Medicare and Medicaid Services, Office of the Actuary. Estimated sustainable growth rate and conversion factor, for Medicare payments to physicians in 2014. March 2013 (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/sgr2014p.pdf).
3. Congressional Budget Office. Medicare's payments to physicians: the budgetary impact of alternative policies relative to CBO's March 2012 baseline. July 2012 (http://www.cbo.gov/publication/43502).
4. *Idem*. Medicare's payment to physicians: the budgetary impact of alternative policies relative to CBO's 2013 baseline. May 14, 2013 (http://www.cbo.gov/publication/44184).
5. *Idem*. Cost estimate for the Protecting Access to Medicare Act of 2014. March 26, 2014 (http://www.cbo.gov/publication/45217).

DOI: 10.1056/NEJMp1401460