



**CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE**

January 24, 2014

H.R. 2810
SGR Repeal and Medicare Beneficiary Access Act of 2013
As ordered reported by the House Committee on Ways and Means on December 12, 2013

SUMMARY

H.R. 2810 would replace the Sustainable Growth Rate (SGR) formula, which determines the annual updates to payment rates for physician services in Medicare, with new systems for establishing those payment rates. CBO estimates that enacting H.R. 2810 would increase direct spending by about \$121 billion over the 2014-2023 period. (The legislation would not affect federal revenues.) Pay-as-you-go procedures apply to this legislation because it would affect direct spending.

H.R. 2810 would impose an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) by preempting state laws governing the evidentiary rules and practices of medical malpractice claims. CBO estimates that the costs of the intergovernmental mandate would be small and would not exceed the threshold established in UMRA (\$76 million in 2014, adjusted annually for inflation). The bill contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 2810 is shown in the following table. The costs of this legislation fall within budget functions 570 (Medicare) and 550 (health).

	By Fiscal Year, in Billions of Dollars										2014-	2014-
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2018	2023

CHANGES IN DIRECT SPENDING												
Estimated Budget Authority	5.3	10.6	10.9	11.1	10.7	12.0	13.5	14.9	16.5	15.5	48.7	121.1
Estimated Outlays	5.3	10.6	10.9	11.1	10.7	12.0	13.5	14.9	16.5	15.5	48.7	121.1

Note: Components may not sum to totals because of rounding.

BACKGROUND AND MAJOR PROVISIONS

Medicare compensates physicians for services they provide on the basis of a fee schedule that specifies payment rates for each type of covered service. Payment rates are based on a measure of the resources required to provide a given service (measured in relative value units or RVUs), adjusted to account for geographical differences in input prices, and translated into a dollar amount by applying a “conversion factor.” The SGR formula determines the annual update to the conversion factor. Under current law, Medicare’s payment rates for physicians’ services are slated to drop by about 24 percent in April 2014, and CBO projects those payment rates will increase by small amounts in most subsequent years but will remain below current levels throughout the next 10 years.

The Bipartisan Budget Act of 2013 (enacted as Public Law 113-67 in December of last year) made multiple changes to the Medicare program, including providing for a temporary increase of one-half percent in payment rates for services on the physician fee schedule furnished during January through March of 2014. As a result, conforming changes would have to be made to the version of H.R. 2810 that was approved by the Committee on Ways and Means earlier in December for its provisions to have the intended effects on Medicare payment rates. This estimate reflects the assumption that the legislation will include such conforming changes.

H.R. 2810 would replace the SGR with new payment systems over the next several years. The major provisions of the new payment systems specified in H.R. 2810 are as follows:

- The bill would increase Medicare’s payment rates for services on the physician fee schedule by 0.5 percent for services furnished during calendar year 2015 and by another 0.5 percent for services furnished during 2016. (The Bipartisan Budget Act increased those payment rates by 0.5 percent for the first three months of calendar year 2014. This estimate assumes that conforming changes to H.R. 2810 would maintain payment rates at those levels for services on the physician fee schedule for the rest of calendar year 2014.)
- Payment rates for services on the physician fee schedule would remain at the 2016 level through 2023, but the amounts paid to individual providers would be subject to adjustment through one of two mechanisms, depending on whether the physician chooses to participate in a Value-Based Performance Incentive (VBP) program or an Alternative Payment Model (APM) program. (Both programs are described at greater length below.)

Payments to providers who participate in the VBP program would be subject to positive or negative performance adjustments financed through a funding pool, with the positive and negative adjustments designed to be offsetting so that they have no

net effect on overall payments. The performance adjustments could be as large as 4 percent of the amounts paid on the physician fee schedule for services provided by physicians participating in the VBP program in 2017, and that percentage would increase to between 10 percent and 12 percent in 2021 and subsequent years. The performance adjustment for an individual provider would depend on that provider's performance.

- Payments to providers who participate in an APM program (in particular, who receive a substantial portion of their revenue from alternative payment models) would receive, in 2017 through 2022, a lump-sum payment equal to 5 percent of their Medicare payments in the prior year for services paid on the physician fee schedule. Providers with revenue close to the APM revenue threshold would receive either no adjustment to their Medicare payments or the VBP performance adjustment if they reported measures and activities in that program. Providers would not be eligible for a lump-sum payment in 2023.
- For 2024 and subsequent years, there would be two payment rates for services paid on the physician fee schedule. For providers paid through the VBP program, payment rates would be increased each year by 1 percent. For providers paid through an APM, payment rates would be increased each year by 2 percent.

In addition, the bill would eliminate current-law penalties for providers who do not achieve meaningful use of electronic health records or satisfactorily report data on quality. However, physicians would have to meet standards for use of EHR and quality as part of the VBP program. Also, the bill would modify payment rates in certain California counties, adjust relative value units for certain physicians' services, and require the development of payment codes that would encourage care coordination and the use of medical homes.

Value-Based Performance Incentive Program

The legislation would establish a VBP that would measure the total performance of physicians and other medical providers based on information reported by those providers regarding quality measures, clinical practice improvement activities, resource use, and meaningful use of electronic health records. The Secretary of Health and Human Services would develop a methodology to assess total performance and determine a composite score. Beginning in 2017, providers with higher composite scores would receive positive performance adjustments and providers with lower composite scores would receive no or negative performance adjustments. The performance adjustments would not increase Medicare spending because reductions in payments made to providers with lower composite scores would be used to provide higher performance adjustments to providers with higher composite scores.

The Secretary would establish a funding pool to be used to distribute VBP payment adjustments by modifying the amount paid for each service based on the provider's composite score. The funding pool would rise from 4 percent of total payments under the physician fee schedule in 2017 to between 10 percent and 12 percent in 2021 and subsequent years.

Alternative Payment Model (APM) Program

From 2017 through 2022, certain providers who participate in eligible APMs would receive a lump-sum incentive payment equal to 5 percent of their aggregate payments from Medicare for the preceding year.

The legislation specifies the following types of Medicare-eligible APMs:

- Models that: 1) require the provider to bear financial risk, meet standards related to the use of electronic medical records, and meet quality measures comparable to the VBP program, and 2) are being tested through a demonstration program (or have been expanded after being tested) under Medicare or the Center for Medicare and Medicaid Innovation (CMMI); or
- A medical home program expanded after a successful demonstration conducted by CMMI that meets standards related to the use of electronic medical records and quality measures.

For 2017 and 2018, a provider would be eligible for the lump-sum payment of 5 percent if at least 25 percent of the provider's Medicare payments were for services furnished in an eligible APM. Providers who do not come within 5 percentage points of the Medicare share-of-revenue threshold would be subject to the rules of the VBP program. However, a provider who comes within 5 percentage points of meeting the threshold could choose between being paid the fee-schedule amount (without further adjustment) or being paid under the rules of the VBP program.

Beginning in 2019, the threshold for the share of revenue from eligible APMs necessary to be eligible for the lump-sum payment of 5 percent would rise, but the provider could count revenue from comparable non-Medicare APMs. Also beginning in that year, providers with revenue from an APM that is close to those thresholds would have a choice similar to that facing providers close to the thresholds in 2017 and 2018.

BASIS OF ESTIMATE

CBO estimates that enacting H.R. 2810 would increase direct spending by \$48.7 billion over the 2014-2018 period and \$121.1 billion over the 2014-2023 period, assuming enactment in the spring of 2014. Nearly all of the estimated increase in spending would stem from the specified updates to payment rates for services paid on the physician fee schedule. CBO estimates that maintaining current payment rates for the rest of 2014, providing 0.5 percent updates for 2015 and 2016, and then maintaining the 2016 level through 2023 would increase Medicare spending by \$118.4 billion over the 2014-2023 period.

In addition, CBO estimates that establishing the VBP and APM programs with the opportunity for providers to choose to participate in only one of the programs would increase Medicare spending by \$5.5 billion through 2023. That estimate largely reflects CBO's expectation that each provider will choose the program that is most attractive financially to that provider.

Other provisions in the bill would modify payment rates in certain California counties, adjust RVUs for certain physicians' services, require the development of payment codes that would encourage care coordination and the use of medical homes, and eliminate current-law penalties associated with not meeting quality or EHR standards. Those provisions would result in estimated net savings of \$2.8 billion through 2023.

CBO's estimate of the budgetary effects of the legislation incorporates the effects of: changes in Medicare spending for services furnished in the fee-for-service sector on payments to Medicare Advantage (MA) plans; changes in receipts from premiums paid by beneficiaries; an increased likelihood that the Independent Payment Advisory Board (IPAB) mechanism would be triggered; and changes in spending by the Department of Defense's TRICARE program owing to changes in Medicare payment rates:

- Spending for the MA program would rise because the "benchmarks" that Medicare uses to determine how much the program pays for MA enrollees are adjusted for changes in Medicare spending per beneficiary in the fee-for-service sector. There would be no impact on MA spending under H.R. 2810 until 2016 because the payment rates currently in effect through March of 2014 will be used to set benchmarks for 2015. The effect on MA would account for about \$42 billion of the total estimated increase in direct spending from the legislation over the 2015-2023 period.

- Beneficiaries enrolled in Part B of Medicare (which covers physicians' and other outpatient services) pay premiums that offset about 25 percent of the costs of those benefits. Such premium collections are recorded as offsetting receipts (a credit against direct spending). Therefore, about one-quarter of the gross increase in Medicare spending would be offset by changes in those premium receipts. Premiums for 2014 have been set, so changes to offsetting receipts for this legislation would begin in 2015. Over the 2015-2023 period, CBO estimates that aggregate Part B premium receipts would rise by about \$35 billion.
- For 2015 and subsequent years, the IPAB is obligated to make changes to the Medicare program that will reduce spending if the rate of growth in spending per beneficiary is projected to exceed a target rate of growth linked to the consumer price index and per capita changes in nominal gross domestic product. CBO's projections of the rates of growth in spending per beneficiary in its May 2013 baseline are below the target rates of growth for fiscal years 2015 through 2023. However, enacting H.R. 2810 would increase Medicare spending, which would increase the likelihood that the IPAB mechanism would be triggered. CBO estimates the expected value of the savings from triggering the IPAB mechanism would be a \$0.5 billion reduction in Medicare spending over the 2015-2023 period.
- The TRICARE program pays Medicare coinsurance and deductibles for military retirees. Those coinsurance and deductible payments would be higher under the legislation because the prices of physicians' services in Medicare would be higher. CBO estimates that the effect on TRICARE from the legislation would increase direct spending by about \$1 billion over ten years.

PAY-AS-YOU-GO CONSIDERATIONS

The Statutory Pay-As-You-Go (S-PAYGO) Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues for the current year and ten years beginning with the budget year as defined by the Balanced Budget and Emergency Deficit Control Act. Beginning in January 2014, the budget year is fiscal year 2015, so the following S-PAYGO estimates go through 2024. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

CBO Estimate of Pay-As-You-Go Effects for H.R. 2810, as ordered reported by the House Committee on Ways and Means on December 12, 2013

	By Fiscal Year, in Millions of Dollars												2014-	2014-
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2019	2024	
NET INCREASE IN THE DEFICIT														
Statutory Pay-As-You-Go Impact	5.3	10.6	10.9	11.1	10.7	12.0	13.5	14.9	16.5	15.5	16.2	60.7	137.3	

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 2810 would shield health care providers from liability claims based on any federal guidelines or standards developed, recognized, or implemented under any health care provision of the Affordable Care Act. That provision would impose an intergovernmental mandate as defined in UMRA because it would preempt state laws that allow for the use of such guidelines or standards in medical malpractice claims. While the preemption would limit the application of state laws, CBO estimates that it would not impose significant costs and would fall well below the threshold established in UMRA for intergovernmental mandates (\$76 million in 2014, adjusted annually for inflation).

ESTIMATED IMPACT ON THE PRIVATE SECTOR

This bill contains no new private-sector mandates as defined in UMRA.

PREVIOUS CBO ESTIMATE

On September 13, 2013, CBO estimated that enacting H.R. 2810 as ordered reported by the House Committee on Energy and Commerce on July 31, 2013, would cost about \$175 billion over the 2014-2023 period. We have subsequently reduced that estimate to \$146 billion, reflecting two final actions. First, the Centers for Medicare and Medicaid Services published a final rule that announced the update to the conversion factor for the physician fee schedule for 2014 and other current-law adjustments. The revised payment rates, as well as other information provided in the final rule, changed CBO's projections of Medicare payment rates for services provided on the physician fee schedule for 2014 and future years. Second, enactment of the Bipartisan Budget Act of 2013 temporarily sets updates to payment rates for services on the physician fee schedule to 0.5 percent from January 1, 2014, to March 31, 2014.

This estimate for the Ways and Means version of H.R. 2810 reflects both of those final actions. CBO's estimate for the version of H.R. 2810 approved by the Committee on Ways and Means is lower than CBO's estimate for the version of H.R. 2810 approved by the Committee on Energy and Commerce primarily because of lower annual updates to payment rates for services on the physician fee schedule and lower costs associated with payments made through APMs.

ESTIMATE PREPARED BY:

Federal Costs: Lori Housman

Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum

Impact on the Private Sector: Alexia Diorio

ESTIMATE APPROVED BY:

Holly Harvey

Deputy Assistant Director for Budget Analysis