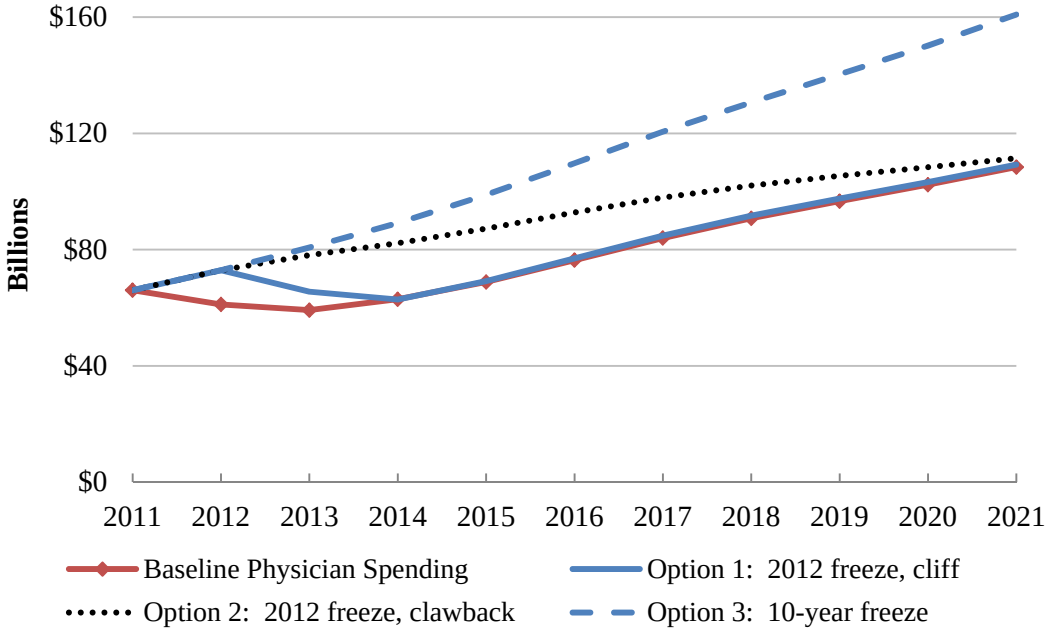
Medicare's Payments to Physicians:
The Budgetary Impact of Alternative Policies

The Congressional Budget Office (CBO) projects that, under current law, payment rates for physician services will be reduced by 29.4 percent in 2012. That large reduction called for under current law follows several years of legislative action to either maintain or increase physician payment rates under the Medicare program when those rates were otherwise scheduled to decrease under the provisions of law known as Medicare's Sustainable Growth Rate (SGR) mechanism. Such legislative actions have overridden the SGR.

Two types of SGR changes—often called the "clawback" and the "cliff"—have been enacted since the Congress began overriding scheduled reductions in physician payment updates in 2003 (see the appendix for a description of such provisions). Analysts have also discussed a 10-year freeze in payment rates. Figure 1 compares federal spending for physicians' services in Medicare under illustrative options—for those three types of SGR changes—with the amount of such spending in CBO's current-law baseline. (The CBO baseline assumes no further legislative changes, allowing the SGR mechanism to operate as it is currently in law.) The red notched line in Figure 1 represents CBO's projection of spending under the March 2011 baseline. Options 1, 2, and 3 show the effects of a cliff policy following a one-year freeze (solid blue line), a clawback policy that would freeze payment rates in 2012 by overriding the current cliff and then use the SGR mechanism to recapture spending during the next several years (dotted black line), and a 10-year freeze that would set payment rates at the 2011 level through 2021(dashed blue line). Tables 1 through 3 provide several variations of each option; the path of spending would be similar to the illustrative example in Figure 1 for the same type of option (clawback, cliff, or 10-year replacement of the SGR mechanism).

Figure 1
Baseline Spending and
Selected SGR Options



CBO Estimate of Changes in Net Federal Outlays from Alternative SGR Proposals

Cliff Options. Options in Table 1 would use the cliff mechanism to override the projected 29.4 percent reduction in 2012 and would return to the payment rate that would have been calculated in the year immediately following the override, adjusted for changes in the targets and payment rates. The amount of spending in 2012 under a given payment policy would affect the calculation of the target and update for the following year. That calculation can yield updates that vary from baseline, resulting in either savings or costs in the years following the new cliff (see the appendix for further details). The updates to physician payments in these options would range from 0 percent to 2 percent, with some options maintaining those updates until 2016.

Table 1:	***By Fiscal Year, in Billions of Dollars***											
Cliff Options	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2012-2016**	**2012-2021**
0% Update for 2012												
cliff: -34% in 2013	12.0	5.6	-0.1	0.2	0.5	0.7	0.7	0.8	0.7	0.7	**18.3**	**22.0**
0% Update for 2012-2013												
cliff: -38% in 2014	12.0	19.1	6.4	-1.5	-1.6	-1.6	-1.6	-1.6	-1.6	-1.7	**34.5**	**26.5**
0% Update for 2012-2014												
cliff: -41% in 2015	12.0	19.1	23.0	6.0	-4.1	-3.7	-3.5	-3.5	-3.6	-3.9	**56.0**	**37.7**
0% Update for 2012-2016												
cliff: -44% in 2017	12.0	19.1	23.0	26.1	28.8	5.7	-6.5	-5.4	-5.2	-5.7	**109.0**	**91.9**
MEI Update for 2012												
cliff: -34% in 2013	12.1	5.7	-0.1	0.2	0.5	0.6	0.7	0.7	0.7	0.7	**18.5**	**21.8**
MEI Update for 2012-2013												
cliff: -39% in 2014	12.1	19.6	6.5	-1.6	-1.7	-1.7	-1.7	-1.6	-1.7	-1.7	**35.0**	**26.6**
MEI Update for 2012-2014												
cliff: -43% in 2015	12.1	19.6	24.1	6.3	-4.3	-3.9	-3.8	-3.7	-3.8	-4.1	**57.9**	**38.6**
MEI Update for 2012-2016												
cliff: -47% in 2017	12.1	19.6	24.1	28.1	32.4	6.8	-7.1	-5.9	-5.7	-6.2	**116.4**	**98.3**
Note: CBO's MEI Projection	*0.4%*	*0.6%*	*1.2%*	*1.5%*	*1.9%*	*2.1%*	*2.2%*	*2.1%*	*1.9%*	*1.9%*		
1% Update for 2012												
cliff: -35% in 2013	12.3	5.8	-0.1	0.2	0.5	0.6	0.6	0.6	0.6	0.7	**18.6**	**21.7**
1% Update for 2012-2013												
cliff: -39% in 2014	12.3	20.1	6.7	-1.7	-1.7	-1.8	-1.7	-1.7	-1.7	-1.8	**35.6**	**26.8**
1% Update for 2012-2014												
cliff: -43% in 2015	12.3	20.1	24.6	6.4	-4.4	-4.1	-3.8	-3.8	-3.9	-4.2	**59.1**	**39.4**
1% Update for 2012-2016												
cliff: -47% in 2017	12.3	20.1	24.6	28.4	32.2	6.7	-7.0	-5.9	-5.7	-6.2	**117.7**	**99.5**
2% Update for 2012												
cliff: -35% in 2013	12.6	6.0	-0.2	0.1	0.4	0.5	0.5	0.5	0.6	0.6	**18.9**	**21.5**
2% Update for 2012-2013												
cliff: -40% in 2014	12.6	21.0	7.0	-1.9	-1.9	-1.9	-1.9	-1.9	-1.9	-2.0	**36.9**	**27.4**
2% Update for 2012-2014												
cliff: -45% in 2015	12.6	21.0	26.3	7.0	-4.6	-4.3	-4.1	-4.1	-4.2	-4.5	**62.4**	**41.2**
2% Update for 2012-2016												
cliff: -49% in 2017	12.6	21.0	26.3	30.8	35.6	7.7	-7.5	-6.3	-6.0	-6.5	**126.4**	**107.7**

Notes:

Components may not add to totals because of rounding.

MEI = Medicare Economic Index.

Estimates are net federal outlays, which include the effect on fee-for-service Medicare spending, payments to Medicare Advantage plans, Part B premiums, Medicaid payments to primary care providers, and TRICARE for Life. If legislation is part of a set of Medicare policy changes, there would be an interaction with the Independent Payment Advisory Board (IPAB). IPAB interactions are not calculated on a provision-by-provision basis and are not included in these estimates.

Clawback Options. Clawback options could come with or without recoupment. Recoupment refers to whether the additional spending that results from one year (or a few years) of overriding the reductions in payment rates scheduled under current law would be offset by reductions to payment rates in subsequent years. Over the long term (longer than 10 years), a "with recoupment" provision would have a cumulative cost of close to zero, because allowing the SGR formula to be implemented would lead to recapturing the excess spending.[1]

The clawback options shown in Table 2 assume recoupment. Those options are similar to legislation enacted between 2004 and 2006. The options shown in the table would require that legislation specify that the override of reductions to payment rates is not considered a change in law or regulation for the purposes of the SGR. Accordingly, the SGR expenditure targets would remain the same, the difference between cumulative spending and the cumulative expenditure targets would be larger than is estimated under current law, and payment rates would be lower in the future than they would otherwise have been. Furthermore, the maximum adjustment factor would apply throughout the budget window. That maximum annual adjustment, set in law, is the Medicare Economic Index (MEI) minus 7 percent.

Table 2:	***By Fiscal Year, in Billions of Dollars***											
Clawback Options with Recoupment	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2012-2016**	**2012-2021**
0% Update for 2012	12.0	16.8	16.8	15.9	14.2	11.9	9.6	7.5	5.2	2.6	**75.8**	**112.5**
0% Update for 2012-2013	12.0	19.1	20.6	19.8	18.3	16.2	14.0	12.1	10.0	7.6	**89.9**	**149.8**
0% Update for 2012-2014	12.0	19.1	23.0	23.6	22.3	20.4	18.4	16.6	14.6	12.3	**100.1**	**182.4**
MEI Update for 2012	12.1	17.0	17.1	16.2	14.4	12.2	9.8	7.7	5.5	2.9	**76.8**	**114.9**
MEI Update for 2012-2013	12.1	19.6	21.1	20.4	19.0	16.9	14.7	12.8	10.7	8.3	**92.3**	**155.8**
MEI Update for 2012-2014	12.1	19.6	24.1	25.0	23.8	21.9	19.9	18.3	16.3	14.1	**104.6**	**195.1**
Note: CBO's MEI Projection	*0.4%*	*0.6%*	*1.2%*	*1.5%*	*1.9%*	*2.1%*	*2.2%*	*2.1%*	*1.9%*	*1.9%*		
1% Update for 2012	12.3	17.3	17.4	16.5	14.8	12.5	10.2	8.2	5.9	3.3	**78.3**	**118.4**
1% Update for 2012-2013	12.3	20.1	21.7	21.0	19.6	17.5	15.4	13.6	11.4	9.1	**94.7**	**161.8**
1% Update for 2012-2014	12.3	20.1	24.6	25.5	24.3	22.5	20.5	18.9	16.9	14.7	**106.9**	**200.4**
2% Update for 2012	12.6	17.8	17.9	17.1	15.4	13.2	10.9	8.8	6.6	4.1	**80.8**	**124.2**
2% Update for 2012-2013	12.6	21.0	22.8	22.2	20.9	18.9	16.8	15.0	12.9	10.6	**99.6**	**173.7**
2% Update for 2012- 2014	12.6	21.0	26.3	27.4	26.3	24.6	22.7	21.1	19.2	17.1	**113.7**	**218.5**

Notes:

Components may not add to totals because of rounding.

MEI = Medicare Economic Index.

Estimates are net federal outlays, which include the effect on fee-for-service Medicare spending, payments to Medicare Advantage plans, Part B premiums, Medicaid payments to primary care providers, and TRICARE for Life. If the legislation is part of a set of Medicare policy changes, there would be an interaction with the Independent Payment Advisory Board (IPAB). IPAB interactions are not calculated on a provision-by-provision basis and are not included in these estimates.

[1] The long-term cost might not be exactly equal to zero because of interactions with payment rates in the Medicare Advantage program.

Other Options that Replace or Restructure the SGR. The last set of options, shown in Table 3, would either replace or restructure the SGR. However, the list is not exhaustive.

The SGR could be replaced with a specified update—a freeze, the MEI, 1 or 2 percent—in each year through 2021.

Options that "Reset the SGR" would forgive all spending that has accrued above the cumulative targets and set both the cumulative target and cumulative spending to zero as of December 31, 2010. Those options would use calendar year 2011 as the base period for future application of the SGR and would specify an update in 2012 equal to the MEI. The subsequent options would reset the SGR as described above, but increase the target either by 1 or 2 percent, with other factors in the target remaining unchanged.

The final option shown below reflects the Fiscal Commission's policy recommendations, under which payment rates to physicians would be frozen in 2013, decreased by 1 percent in 2014, and then subject to an SGR that could be reset in 2015, using the 2014 spending level as the base. [2] The option shown below also assumes a freeze of payment rates in 2012.

Table 3: Replace or Reset Options	*By Fiscal Year, in Billions of Dollars*											
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2012-2016**	**2012-2021**
Specified Updates:												
0% Update Through 2021	12.0	19.1	22.9	26.1	28.8	31.3	33.9	37.4	41.1	45.1	**108.9**	**297.6**
MEI Update Through 2021	12.1	19.6	24.1	28.1	32.4	36.7	41.6	47.7	54.3	61.4	**116.4**	**358.1**
Note: CBO's MEI Projection	*0.4%*	*0.6%*	*1.2%*	*1.5%*	*1.9%*	*2.1%*	*2.2%*	*2.1%*	*1.9%*	*1.9%*		
1% Update Through 2021	12.3	20.1	24.8	28.4	32.2	35.7	39.4	44.3	49.6	55.3	**117.8**	**342.1**
2% Update Through 2021	12.6	21.0	26.3	30.8	35.6	40.2	45.3	51.7	58.6	66.2	**126.4**	**388.5**
Reset Options:												
Reset SGR Targets at 2010 Spending Level	12.1	17.6	18.6	19.4	19.9	20.1	20.4	21.1	22.2	23.6	**87.8**	**195.2**
Reset SGR Targets at 2010 Spending Level and use GDP+1% in Target[b]	12.1	18.0	19.9	21.8	23.8	25.4	27.3	29.8	32.8	36.2	**95.6**	**247.0**
Reset SGR Targets at 2010 Spending Level and use GDP + 2% in Target[c]	12.1	18.3	21.0	24.2	27.7	30.9	34.5	38.9	43.8	49.6	**103.3**	**301.0**
Fiscal Commission SGR Policy:												
Freeze Update through 2013, -1% Update for 2014, reinstate the SGR in 2015 at 2014 Spending Level	12.0	19.1	22.5	26.0	28.7	29.5	29.7	30.2	31.2	32.7	**108.4**	**261.7**

Notes:

Components may not add to totals because of rounding.

MEI = Medicare Economic Index.

Estimates are net federal outlays, which include the effect on fee-for-service Medicare spending, payments to Medicare Advantage plans, Part B premiums, Medicaid payments to primary care providers, and TRICARE for Life. If the legislation is part of a set of Medicare policy changes, there would be an interaction with the Independent Payment Advisory Board (IPAB). IPAB interactions are not calculated on a provision-by-provision basis and are not included in these estimates.

a. Payment rate updates beginning in 2013 would be negative.
b. Payment rate updates beginning in 2013 would be negative for most of the remaining years, but would then be zero.
c. Payment rate updates beginning in 2013 would be negative for a few years, but would then be positive.

[2] http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf . This description and the estimate in Table 3 has been updated to correct a mistake contained in the original version of the CBO document that was posted on June 14, 2011.

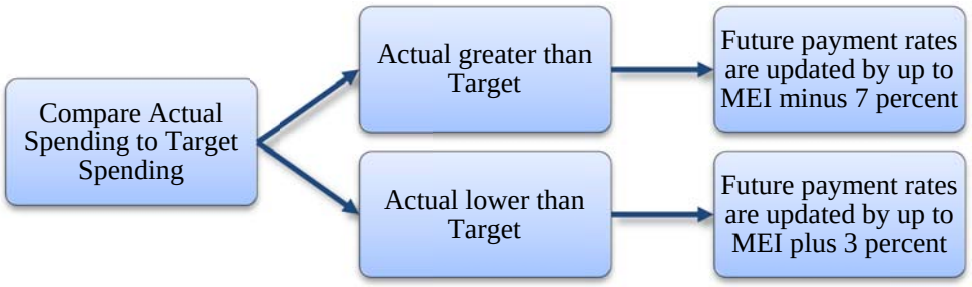
Appendix

Background

Medicare's payments for physicians' services, which are covered under Part B of Medicare, are based on a fee schedule that specifies the amount to be paid for each type of service. Those fees, or payment rates, are updated annually by a formula called the Sustainable Growth Rate (SGR) mechanism. The SGR is intended to control spending on Medicare physicians' services. It does so by setting an overall target amount of spending for physicians' services and adjusting payment rates annually to reflect differences between actual spending and the spending target. [3]

Targets and spending are measured on both an annual and a cumulative basis. Over a period of years, the formula will bring future spending in line with the targets by reducing payment rates if past spending has exceeded the targets and by increasing payment rates if past spending has been below the targets. The formula limits the amount of an increase in payment rates to inflation plus 3 percent, and it limits a decrease in payment rates to inflation minus 7 percent, as shown below in Figure A. Inflation is measured by the Medicare Economic Index (MEI).[4]

Figure A



Since 2002, spending measured by the SGR has consistently been above the targets established by the formula, requiring future payment rate reductions.[5] Because the formula limits these future reductions to MEI minus 7 percent, excess spending will take many years to be recaptured.[6]

Recent Legislation Affecting the SGR

Cumulative spending exceeded target spending in 2001, and payment rates were reduced by 4.8 percent in 2002 to begin to recapture excess spending. At that time, both CBO and the Centers for Medicare and Medicaid Services (CMS) projected continued future reductions to payment rates. The Congress has taken actions to override the reductions in each year since

[3] The target is the product of the growth in fee-for-service enrollment; inflation-based update factors; real GDP per capita; and changes in law or regulation.

[4] The MEI measures changes in the cost of physicians' time and operating expenses; it is a weighted sum of the prices of inputs in those two categories. Changes in the cost of physicians' time are measured using changes in nonfarm labor costs and changes in "all-factor" productivity.

[5] Spending measured by the SGR includes physicians' services and services incident-to physician visits. That includes laboratory services. Physician-administered drugs were initially included, but were removed in 2009; the effects of that change are discussed below.

[6] The current cliff combined past overrides, which were at the maximum of MEI minus 7 percent, into the 29.4 percent reduction.

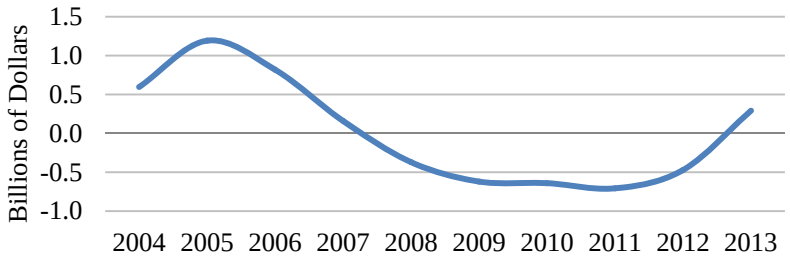
2003. The Consolidated Appropriations Act of 2003 (P.L. 108-7) enabled CMS to change the definition of the base year, which increased targets and allowed more spending under the fee schedule. That action replaced a scheduled 4.4 percent reduction with a 1.4 percent increase. However, projected payment rate updates in subsequent years were still negative, which prompted the Congress to enact a series of laws that prevented those reductions for a period of one month to two years.

Since 2004, the Congress has used two strategies—commonly known as clawbacks and cliffs—to hold down the 10-year cost of legislation to provide a short-term freeze or a short-term increase in payment rates for physicians' services.

Clawback Legislation. In the case of the clawback approach, the legislation providing for a short-term adjustment in payment rates also overrides the provision in underlying Medicare law that requires that the SGR target be adjusted to accommodate changes in spending that result from changes in law or regulatory action. The effect of that override is that the additional spending that results from the adjustment in payment rates (compared with the spending that would have occurred if the scheduled reduction in payment rates had gone into effect) is counted as excess spending above the target. Under current law, application of the SGR mechanism will eventually recoup (or claw back) that excess spending through further reductions to payment rates in subsequent years.

Legislation enacted from 2004 through 2006 adjusted the updates to payment rates for the coming year, preventing scheduled reductions, and allowed the SGR mechanism to recoup the additional spending resulting from that higher payment rate. That means that, during the years after a temporary override of the SGR formula, payment rates would be reduced toward and then below the baseline level (projected at the time of the legislative override). As a result, the mechanism could recoup the excess spending within the 10-year budget window, lowering the 10-year cost of legislation that took that approach. Figure B illustrates the estimated cost over 10 years of one such piece of legislation that was enacted in 2004.[7]

Figure B
Estimated Cost of P.L. 108-173
Clawback Legislation



[7] In Figure B, the legislation increased payment rates for 2004 and 2005. The reductions to payment rates thereafter were larger than projected under prior law for several years, but spending was projected to remain above baseline levels through 2007. Those larger reductions to payment rates were projected to reduce spending below baseline levels in 2008, and spending was projected to remain below baseline levels through 2012. Those savings from 2008 through 2012 were expected to offset the higher costs in the other years of the 10-year budget window.

Clawbacks were used in each of the following laws:

2004 The Medicare Modernization Act (P.L. 108-173) allowed for updates of 1.5 percent in both 2004 and 2005; and

2006 The Deficit Reduction Act (P.L. 109-362) froze payment rates at the 2005 level for 2006.

The budgetary effect of those legislative actions to override the adjustment to spending targets to accommodate changes in legislation was twofold: First, Medicare's spending for physicians grew more in the short run than it would have otherwise. Second, because the legislation did not adjust the spending target, the gap between cumulative spending and the cumulative target became larger than it would have otherwise been. Specifically, each time the clawback approach was used, more of the subsequent years became subject to the maximum reduction of MEI minus 7 percent. Since payment rates in years subject to the maximum reduction under the baseline would not be reduced below the levels in then-current law, there could be no offsetting savings for a further payment increase until an even-later year that was not subject to the maximum reduction in the baseline. By 2007 the clawback mechanism could not recoup the cost of a one-year override within the 10-year budget window.

Cliff Legislation. In the case of the cliff mechanism, the legislation providing for a short-term adjustment in payment rates also overrides the provision in current law that would cap the reduction at MEI minus 7 percent in the year following the adjustment. Further, the cliff mechanism specifies that the payment rate update in the year that the override expires "shall be calculated as if that freeze (or increase) had not been enacted."[8] Unlike clawback legislation, which limits future rate reductions to no more than 7 percent in any given year, cliff provisions can result in a very large rate reduction in the year following a short-term rate adjustment. Each year the difference between the legislated payment rate and the rate in the year the override expires has grown. The current projection of a 29.4 percent cliff at the start of calendar year 2012 reflects the cumulative effect of all reductions called for under the SGR formula but overridden by legislative action since 2007.

Cliffs have been used in the following legislation since 2007:

2007 The Tax Relief and Health Care Act (P.L. 109-432) froze payment rates at the 2006 level;

2008 The Medicare, Medicaid, and SCHIP Extension Act (P.L. 110-173) allowed for a 0.5 percent increase for January-June of 2008;

2009 The Medicare Improvements for Patients and Providers Act (P.L. 110-275) increased payment rates by 0.5 percent for July-December of 2008 and by 1.1 percent for 2009;

2010 P.L. 111-118, P.L. 111-144, and P.L. 111-157, froze payment rates at the 2009 level through June of 2010; P.L. 111-192 and P.L. 111-286 increased payment rates by 2.2 percent through December of 2010; and

2011 An Act to Extend Certain Expiring Medicare and Medicaid Provisions (P.L. 111-309) froze payment rates for 2011 at the December 2010 level.

[8] To date, the laws employing the cliff mechanism have permitted adjustment of target spending to accommodate the additional spending that results from the freeze or increase to payment rates. Thus, the Congress has not enacted legislation that combines the clawback and cliff mechanisms.

In 2007, when the cliff mechanism was first enacted, cumulative spending exceeded the cumulative target by so much that payment rates were projected to be subject to the maximum reduction for most of the 10-year budget window. Under those circumstances, returning payment rates to the baseline level in the year that the adjustment expires, and then subjecting payment rates in each subsequent year to the maximum reduction, results in projected spending in those years that would equal projected spending under the then-current baseline. In other words, the estimated cost of the cliff mechanism would be zero in the years following the freeze or increase. As a result, the total cost of the cliff policy over the 10-year budget window would equal the amount of additional spending during the year(s) subject to the temporary freeze (or increase).

Factors Affecting 2011 Legislative Estimates

CBO initially concluded that having no effect on payment rates and spending in years after expiration of an adjustment was an intrinsic attribute of cliff-type legislation. However, that outcome is a special case that will occur only if updates (and, therefore, payment rates) will be identical under both baseline and post-policy projections. As a practical matter, they will be identical only if updates for all years after expiration are projected to be at the maximum reduction under baseline (MEI minus 7 percent).

CBO now estimates that the cumulative effect of past cliff legislation will be a 29.4 percent reduction in payment rates for physicians' services in January 2012. CBO also projects that updates to payment rates will **not** be subject to the maximum reduction during the rest of the 10-year budget window. This is because of two recent developments: the removal of physician-administered drugs from the SGR formula in 2009 (through regulation), and substantially slower-than-expected growth in Medicare spending for physicians' services in 2010.

Removal of Physician-Administered Drugs. The SGR mechanism compares actual spending and target spending for physicians' services as well as for services furnished "incident to" a physician visit, such as physician-administered drugs and laboratory services. To the extent that spending for incident-to services grows faster than the SGR targets, payment rates for physicians' services will be reduced to compensate for that increase.[9] Spending for physician-administered drugs has grown faster than physician services; consequently, this spending has contributed to spending exceeding the targets. A regulatory action in November 2009 removed those physician-administered drugs from the incident-to category.[10] That action was applied both retrospectively—spending for physician-administered drugs was removed from the measure of cumulative spending subject to the SGR mechanism and from the cumulative spending targets—and prospectively.

[9] Incident-to services payments are not subject to updates determined by the SGR.
[10] Federal Register, Vol. 74, Number 226, November 25, 2009, page 61961.

The effect of that regulatory action was to reduce the gap between actual and target spending. Because the SGR mechanism recaptures the excess of cumulative actual spending over target spending by reducing updates to payment rates, the smaller gap means that future updates to payment rates will tend to be higher than they would have been before physician-administered drugs were removed from the incident-to category.

2010 Spending for Physicians' Services. The growth in Medicare physician spending in 2010 was lower than in recent years, and the amount of physician spending was lower than the 2010 target. Because the SGR formula compares both annual and cumulative spending to target spending, lower spending in 2010 decreases the amount that has to be recaptured by the SGR and, therefore, reduces the downward pressure on future updates to payment rates for physicians' services.

Effects of Changes on Budget Estimates. As a result of those changes, taken together, and in contrast with past estimates, CBO's projection of physician payment rate updates in the March 2011 baseline does **not** include several years of maximum reductions following the 2012 cliff. That outcome significantly changes estimates of the effect of new cliff options on physician spending. Estimates for cliff legislation enacted prior to 2011 had no spending changes within the 10-year budget window beyond the effects in the cliff year, primarily because the payment rate updates that followed the cliff were at the maximum reduction level. That is, although additional spending from a freeze (or increase) in payment rates contributed to overall spending exceeding the target, the SGR mechanism could not close that gap within the 10-year budget window because payment rate updates could not go below the maximum reduction (MEI minus 7 percent). Thus, there were no additional changes to payment rates later in the 10-year budget window relative to those projected in CBO's baseline. With CBO's current baseline projections, cliff legislation would have a budgetary impact in later years of the budget window.

Current Cliff Estimates

The effect of cliff legislation relative to the March 2011 CBO baseline will include either costs or savings in years after the cliff. In general, the cliff mechanism will result in projected spending in subsequent years that does not equal projected spending under current law because the key specification of the cliff mechanism—the instruction to calculate the payment rate as if the override had never occurred—results in both the annual target and the payment rate for the cliff year being different from the amounts that will occur under current law. If the implied payment rate in subsequent years is lower than CBO's current-law projection, the cliff override policy would result in savings in those years; if the implied payment rate is higher than CBO's current-law projection, there would be costs in those years.

Changes to the Target. The annual target in the cliff year would be different from the target under current law because the adjustment of the target for changes in law is applied as the weighted average of the percentage changes in the effects of law on services paid using the physician fee schedule and on other incident-to services. Those weights will be different in the cliff year than they were in the year(s) of the override. Whether the new annual target for the cliff year would be higher or lower than the annual target for that year under current law will

determine whether target amounts would be permanently higher or lower than under current law, and will strongly influence whether there would be costs or savings during the period from the cliff year through the end of the budget window.[11]

Changes to the Payment Rate. The payment rate in the cliff year would be different from current law because some of the factors in the formula for the update would change as a result of the override in the previous year(s). Specifically, the formula takes into account the difference between annual spending in the override year and the annual target for that year.[12] Compared with current law, the override would result in changes in the amounts of annual spending in the override year, the target for that year, and the difference between those amounts.

Changes in the payment rate in the cliff year from the payment rate that will apply under current law would affect the path—that is, the series of annual updates—by which spending subject to the SGR would be brought in line with annual and cumulative targets. Changes in that path could affect whether spending in any given year would be higher or lower than under current law. However, changes in the payment rate in the cliff year have a much smaller effect than changes in annual targets on whether there would be costs or savings during the period from the cliff year through the end of the 10-year projection period. This is illustrated in Table 1.

[11] The difference between cumulative spending and cumulative targets is also a factor in the formula that will bring annual and cumulative spending in line with annual and cumulative targets. That difference will be changed in the override year by the same amount as the change in the difference between annual spending and the annual target.

[12] The payment rate update is the product of the MEI and the Update Adjustment Factor (UAF), where the UAF is subject to limits (plus 3 percent or minus 7 percent). For information on the UAF, see http://www.cms.gov/SustainableGRatesConFact/Downloads/sgr2012p.pdf.