

CBO TESTIMONY

**Statement of
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Director**

Medicare's Physician Fee Schedule

**before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives**

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Chairman Bilirakis, Congressman Brown, and Members of the Subcommittee, I am pleased to be here today to discuss Medicare's payments to physicians. Those payments now represent 19 percent of Medicare's total spending—in 2003, \$47 billion of its total expenditures of \$249 billion.¹

The aging of the baby-boom generation will have dramatic fiscal implications for the Medicare program's overall spending. If the nation spent the same *fraction* of gross domestic product (GDP) on each Medicare beneficiary in 2030 that is spent today—a proposition that reflects only the increased number of beneficiaries at that point—Medicare spending in that year would claim a 5.4 percent share of GDP, more than double today's share of 2.5 percent, CBO projects. The fiscal implications of the boomers' aging are compounded by the fact that health care costs per beneficiary routinely grow significantly faster than the economy as measured on a per capita basis. Consequently, if current law remains unchanged, Medicare spending could climb to 7.5 percent of GDP—or higher—by 2030.

As you know, the sustainable growth rate (SGR) method is used to establish Medicare's payment rates for physicians' services. If the SGR mechanism had been left to operate, it would have reduced those rates in each of the past few years. With the exception of 2002, however, policymakers have acted to prevent such reductions. Most recently, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or MMA (Public Law 108-173), specified increases of 1.5 percent in payment rates for physicians' services for both 2004 and 2005. The Congressional Budget Office (CBO) estimates that that provision of the MMA will increase payments to physicians by a total of about \$2 billion during those two years.

Under current law, however, that provision will not significantly affect projected spending over the next 10 years because after 2005, the SGR method will again be used to establish payment rates. In addition, the SGR mechanism will offset that \$2 billion increase in spending in subsequent years. As a result, payment rates will be subject to the maximum annual reduction under the SGR method (about 5 percent) in 2006 and 2007 and will be held below the projected rate of increase in physicians' costs for most, if not all, years through 2014. The Medicare trustees recently concluded that under their assumptions, physician fees would be subject to the maximum reduction for an even longer period—each year from 2006 through 2012.

1. Budgetary numbers are on a fiscal year basis; years noted in discussions of the sustainable growth rate mechanism are calendar years.

The Medicare Payment Advisory Commission (MedPAC) recently recommended that the 2005 update to payment rates for physicians' services be set at the change in input prices minus an adjustment for productivity. The Senate-passed version of the pending budget resolution (S. Con. Res. 95) contains a Sense of the Senate provision that endorses permanently adopting that approach to updating physician fees. Such updates would increase Medicare spending by about \$95 billion through 2014 if they were implemented in 2005, by CBO's estimate, and by \$90 billion if they were implemented in 2006. Before addressing those projections, however, I will review the relationship between Medicare's payments to physicians and the program's spending and summarize the history of efforts to control Medicare spending for physicians' services.

Medicare's Payments to Physicians and Its Total Spending

Let me begin by reviewing the relationship between the fees that Medicare pays to physicians, the program's overall spending for physicians' services, and its total expenditures. Medicare pays a fee for each medical service. But the amount paid per service is only one of the components contributing to Medicare's physician spending. Another factor is the number of beneficiaries. According to the Medicare trustees' 2004 report, the number of Medicare beneficiaries will nearly double between now and 2030, rising from 39 million to 72 million.

In addition to fees and growth in the number of beneficiaries, the average number and type (or "intensity") of the services provided by physicians contribute to total Medicare physician spending. Taken together, the average number and type of physicians' services constitute their "volume." Medicare physician spending per beneficiary is thus equal to fees times the volume of services. Each year, Medicare sets fees for physicians' services using formulas in the Medicare fee schedule for physicians' services and the SGR mechanism. However, because Medicare does not control the volume of services that physicians provide, physician spending per beneficiary can grow even if fees are reduced.

Throughout the 1980s, Medicare's spending for physicians' services grew faster than its spending for all other services; in the 1990s, that trend reversed. From 1981 through 1990, spending for physicians' services grew at an average annual rate of 13.7 percent, whereas spending for all other services grew by 11.1 percent per year. By 1990, Medicare's total payments to physicians were more than three-and-a-half times greater than they had been 10 years earlier, and the average physician was

receiving more than two-and-a-half times as much in Medicare payments. Indeed, the program's payments per physician increased almost twice as fast as did the nation's economy during the 1980s. That rapid growth led policymakers to add expenditure targets to the formulas used to set the overall level of physician fees in order to control total spending for physicians' services.

Previous Approaches to Medicare Physician Payments

The history of payments to physicians under Medicare can be divided into three periods. Shortly after the program began in 1965, spending rose rapidly as physicians increased both their charges and the volume of services that they provided. Legislation subsequently limited the growth of fees for physicians' services to the rise in the Medicare economic index, or MEI, but spending continued to climb rapidly.² That experience led to the second period of physician payments, starting in 1984, when legislation froze fees or limited increases in them to less than the rise in the MEI.

Despite those actions, spending for physicians' services continued to grow throughout the 1980s. Limits on the growth of fees alone—without regard to the volume of services that physicians provided—proved ineffective in controlling expenditures. Beginning in 1992, further restraints were imposed on the growth of Medicare's spending for physicians' services, leading to the third period of physician payments (as discussed below).

Abandoning the Charge-Based System

When Medicare was created in 1965, the program paid physicians fees that were based on their charges, the method of payment then used by private insurers. In addition, Medicare permitted physicians to bill beneficiaries for the amount of their charges that exceeded the fee that Medicare paid, a practice known as "balance billing." The charge-based reimbursement system gave physicians the incentive to raise their charges from year to year to boost their revenues, and those increases led to a rate of growth in spending that averaged 13 percent annually from 1967 through 1974.

2. The Medicare economic index measures changes in the costs of physicians' time and operating expenses; it is a weighted sum of the prices of inputs in those two categories. Most of the components of the index come from the Bureau of Labor Statistics. Changes in the costs of physicians' time are measured through changes in non-farm labor costs. Changes in productivity are also factored directly into the index.

As concerns grew about the program's rising costs, policymakers focused on restraining fees. In 1972, they mandated that the annual update to physicians' fees be limited to the increase in the MEI, a provision that was implemented in 1975. Tying increases in fees to growth in the MEI was not sufficient to keep total payments from rising, however, and lawmakers took further steps to limit spending from 1984 through 1991. The Congress froze fees from 1984 through 1986; from 1987 through 1991, it raised them by amounts specified in legislation. The effect of those actions was that spending grew at an average annual rate of 15 percent from 1975 to 1991.

Limiting Beneficiaries' Liability

Balance billing also prompted Congressional action during the 1980s. On average, liability for balance billing per beneficiary grew from \$56 a year (in nominal terms) in 1980 to a high of \$94 in 1986.³ In effect, beneficiaries contributed to offsetting the constraints on Medicare physician fees. The Congress responded by imposing limits on such billing, which prevented physicians from raising their charges. Total charges by so-called nonparticipating physicians are currently restricted to 109.25 percent of Medicare's fees for participating physicians.⁴

The program's limits on balance billing constrain beneficiaries' liability for physicians' charges. But those limits also reduce the potential usefulness of balance billing as a signal that Medicare's fees are below the level necessary to attract a sufficient number of doctors to serve Medicare enrollees.

Redistributing Payments Among Physicians' Services

In attempting to control Medicare's expenditures, policymakers also took steps to redistribute payments among physicians' services. In the 1980s, many analysts believed that Medicare's reimbursement of such services was distorted by factors that led to overcompensation of so-called procedural services (for example, surgeries) at

3. Physician Payment Review Commission, *Annual Report to Congress* (March 1998).

4. Under Medicare's rules, the program pays 80 percent of the amount on the fee schedule, and beneficiaries or their supplemental insurer pays 20 percent. Balance billing occurs when beneficiaries pay more than 20 percent of the scheduled fee. A physician elects either to "participate" (that is, to take Medicare fees as payment in full for all services) or to receive Medicare payments as a "nonparticipating" physician, who is allowed to bill patients for the balance of the charges up to the statutory limit. Fees for nonparticipating physicians are set at 95 percent of the amount on the fee schedule. The Medicare program will pay 80 percent of that amount (which is 76 percent of the amount on the fee schedule.) The total charge is limited to 115 percent of the fee for nonparticipating physicians (115 percent of 95 percent is 109.25 percent of the amount on the schedule). Beneficiaries pay the difference—which can be as much as 33.25 percent (109.25 percent minus 76 percent) of the fee schedule amount.

the expense of what were termed cognitive services (such as office visits). Fees varied widely, with physicians in different specialties and in different geographic regions receiving different payments for comparable services.

The response to those concerns was the implementation in 1992 of a physician fee schedule, which bases payments for individual services on measures of the relative resources used to provide them. The formula for each fee has two parts. One part is a weight—the “relative value”—that indicates the resource costs of each service relative to all others. (For example, a CAT scan has a higher relative value than an intermediate-level office visit with an established patient.) The other part is a fixed dollar amount known as the conversion factor, which is multiplied by each relative weight to calculate the fee to be paid for each service.

The fee schedule was intended to promote equity and to be budget neutral—in 1992, the conversion factors were set so that estimated expenditures under the schedule equaled estimates of what expenditures would have been under the earlier payment system. The fee schedule was not designed to control Medicare’s spending—it merely redistributed that spending among physicians’ services.

Controlling Volume

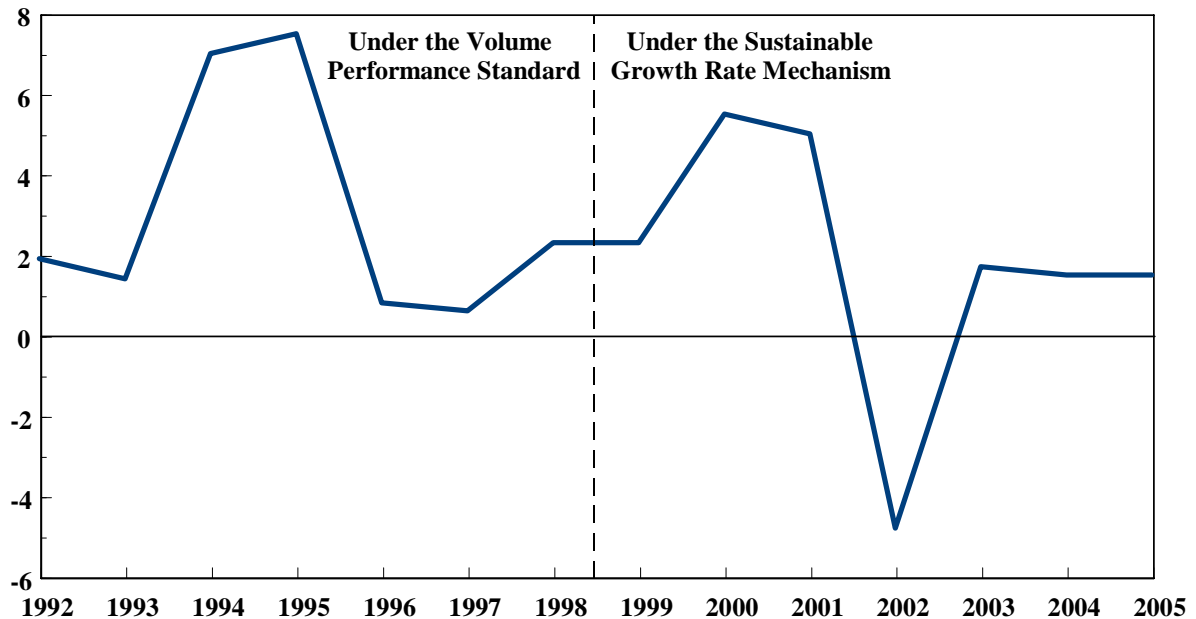
In an attempt to control volume-driven growth in total spending for physicians’ services, policymakers also enacted a mechanism that tied the annual update of fees for services on the physician fee schedule to the trend in total spending for physicians’ services relative to a target. Under that approach, the conversion factor was to be updated annually (to reflect increases in physicians’ costs for providing care, as measured by the MEI) and adjusted by another factor to counteract changes in the volume of services provided per beneficiary. The introduction of expenditure targets to the update formula initiated the third period in physician payments. Known as the volume performance standard (VPS), it provided a mechanism for adjusting fees to try to keep total spending for physicians’ services within budgetary targets.

The VPS led to updates that were unstable. Under that approach, the expenditure target was based on the historical trend in volume. Any excess spending relative to the target triggered a reduction in the update two years later. But the VPS depended heavily on the historical-volume trend, and the decline in that trend in the mid-1990s led to large increases in Medicare’s fees for physicians’ services.

Figure 1.

Annual Payment Rate Updates for Services on the Medicare Physician Fee Schedule, 1992 to 2005

(Percentage change in rates)



Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Policymakers attempted to offset the budgetary effects of those increases by making successively larger reductions to the updates. Indeed, between 1992 and 1998 (the years that the VPS was in effect), the MEI varied from 2.0 percent to 3.2 percent, but the annual update to physician fees varied much more widely, from a low of 0.6 percent to a high of 7.5 percent (see Figure 1).

Medicare's spending for services on the physician fee schedule grew at an average annual rate of 3.2 percent during the 1992-1998 period, but the changes in spending varied substantially from one year to the next, ranging from a reduction of 2.6 percent in 1992 to increases of almost 10 percent in both 1994 and 1995. That volatility led the Congress and the President to modify the VPS in the Balanced Budget Act of 1997, replacing it with the sustainable growth rate mechanism in place today.

The SGR Approach

Like the VPS, the SGR method uses a target to adjust future payment rates and to control growth in Medicare’s total expenditures for physicians’ services. In contrast to the VPS, however, the target under the SGR mechanism is tied to growth in real (inflation-adjusted) GDP per capita—a measure of growth in the resources that society has available for each person. The update under that approach is equal to the MEI adjusted by a factor that reflects cumulative spending relative to the target. (Cumulative spending was not part of the VPS method.)

Policymakers saw the SGR approach as objective and stable by comparison with the VPS. From a budgetary standpoint, the SGR method, like the VPS, could be effective in limiting total Medicare payments to physicians over time. The growth rate of GDP provides an objective benchmark; moreover, changes in GDP from year to year have been considerably less volatile (and generally smaller) than changes in the volume of physicians’ services.

How the SGR Mechanism Works

The SGR mechanism establishes year-by-year and cumulative expenditure targets for Medicare’s combined spending for physicians’ services (that is, services on the physician fee schedule) and services furnished “incident to” (in connection with) a physician visit (such as diagnostic laboratory services and physician-administered drugs). Those targets are updated each year to reflect inflation—primarily in physicians’ costs (as measured in the MEI)—as well as changes in the size of the economy (as measured by real GDP per capita), growth in the number of Medicare enrollees in the fee-for-service sector, and any changes in expenditures that stem from new laws and regulations.⁵ The adjustment for changes in the economy’s size is, in essence, an allowance for increases in the number of services being furnished per enrollee and shifts in the mix of services toward those that are more technologically advanced and (frequently) higher priced. Thus, the SGR mechanism establishes expenditure targets that, on a per-beneficiary basis, are both adjusted for inflation and add in an allowance for increases in real spending.

The SGR mechanism also has a self-correcting adjustment feature. If spending for services subject to the SGR method deviates from the expenditure targets—that is, if real growth in spending per beneficiary is faster or slower than the change in per

5. The adjustment of SGR expenditure targets for inflation also reflects changes in the prices of “incident-to” services, which are included in the calculation of spending subject to the SGR.

capita GDP—the annual updates to payment rates for physicians’ services will be adjusted so that over a period of several years, cumulative spending will be brought back into line with the cumulative expenditure target.

The update to payment rates combines an adjustment for inflation (the MEI) with an “update adjustment factor” based on the relationship between previous spending and the expenditure targets. That factor takes into account both the relationship between cumulative spending and the cumulative expenditure target and the relationship between spending in the prior year and the current year’s expenditure target. The update formula gives more weight to the latter relationship than to the former. Consequently, if cumulative spending exceeds the cumulative target (as it currently does), the SGR mechanism under current law will reduce payment rates each year until spending in the most recent year is below the expenditure target for that year. At that point, the updates to payment rates may become positive, but the increases will be set to keep annual spending below the year-by-year expenditure targets until cumulative spending and the cumulative target converge.

In any event, the update adjustment factor is constrained by law to fall between a 3 percent increase and a 7 percent reduction. CBO projects that the MEI will average between about 2 percent and 2.5 percent over the long run (through 2014). Therefore, the annual update to payment rates for services on the physician fee schedule will tend to range between increases of about 5 percent and reductions of about 5 percent. (See the appendix for an example of the SGR method.)

Recent Legislation Affecting Application of the SGR Method

Spending for physicians’ services subject to the SGR mechanism has grown at an average rate of about 6 percent a year since the 1996/1997 base year (April 1996 through March 1997). By the end of 2002, such spending had exceeded the cumulative target by about \$17 billion, CBO estimates; in the next few years, expenditures in excess of the target would have grown by another \$10 billion. As a result, physician payment rates for 2003 were scheduled to drop by 4.4 percent (after falling by 5.4 percent in 2002). In the Consolidated Appropriations Resolution, 2003 (P.L. 108-7), the Congress responded to that imminent reduction by allowing the Administration to boost the cumulative target, thereby producing a 1.6 percent increase in payment rates for physicians’ services for 2003.

Through 2003, that spending exceeded the higher target by about \$6 billion, CBO estimates. If it had been allowed to operate, the SGR method would have reduced

payment rates again, this time for 2004. However, the Medicare Modernization Act replaced that scheduled reduction in rates with increases of 1.5 percent in both 2004 and 2005—but it left the cumulative target intact, specifying that those increases were not to be considered changes in law or regulation for the purpose of adjusting the expenditure target. Thus, spending for physicians' services will continue to exceed the cumulative target. Unless it is modified again, the SGR method will reduce payment rates for several years beginning in 2006 and will keep updates below inflation through at least 2014.

Baseline Projections of Spending Subject to the SGR Mechanism

On a per-beneficiary basis, the SGR expenditure target has grown from about \$1,300 in the base year (1996/1997) to \$1,850 in 2004.⁶ Under CBO's economic and technical assumptions, the target in 2014 will be about \$2,900 per beneficiary. That figure represents a nominal increase of 120 percent in per-beneficiary spending over the 1996-2014 period and a real increase—above and beyond the rise in physicians' input costs—of 45 percent per beneficiary, or an average of 2.1 percent a year. That real increase reflects both the allowance for increases in per capita GDP and adjustments for changes in laws and regulations.

Under CBO's assumptions about the number of beneficiaries in the fee-for-service and Medicare Advantage sectors of the Medicare program, year-by-year expenditure targets will grow from \$62 billion in 2004 to \$121 billion in 2014, by CBO's estimate. Medicare spending for services subject to the SGR mechanism over that period will rise from \$66 billion to \$121 billion, an increase averaging about 6.3 percent per year (see Figure 2).

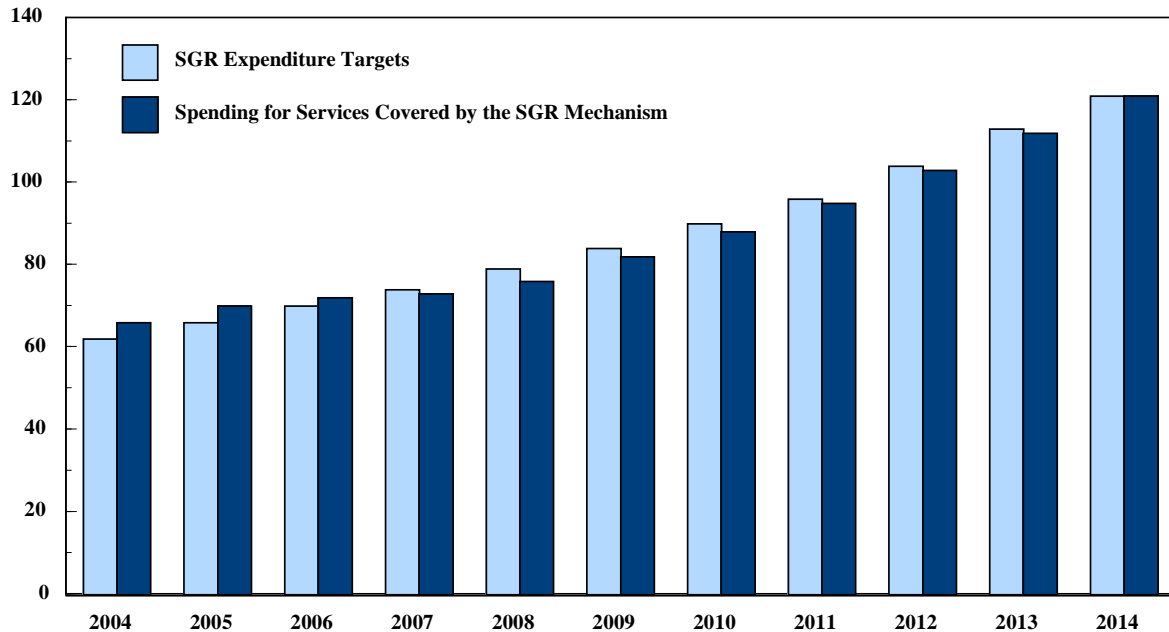
As a result of the updates for 2004 and 2005 specified in the MMA, spending subject to the SGR mechanism will exceed the year-by-year expenditure targets by about \$4 billion in both of those years, CBO estimates. Therefore, the amount of cumulative SGR-applicable spending that exceeds the cumulative target will grow from about \$5 billion at the end of 2003 to \$13 billion at the end of 2005. Accordingly, the SGR mechanism will reduce physician payment rates in 2006 and 2007 and hold updates below inflation through 2014. As a result, CBO estimates that the

6. The following discussion characterizes the expenditure targets and spending for services subject to the SGR mechanism in terms of expenditures by the Medicare program. The amounts used in rate-setting calculations include both the Medicare program's share and beneficiaries' cost-sharing obligations. Therefore, the amounts used in those calculations are about 25 percent larger than the Medicare program's share alone.

Figure 2.

SGR Expenditure Targets and Projected Spending for Physicians' Services, 2004 to 2014

(Billions of dollars)



Source: Congressional Budget Office.

Note: The sustainable growth rate (SGR) method is used to establish Medicare's payment rates for some physicians' services.

excess of cumulative spending over the cumulative targets will peak at \$15 billion at the end of 2006 and then decline—to about \$5 billion in 2014.

Incident-to Services and the “Effective Target” for Physicians' Services

As noted earlier, the SGR expenditure targets encompass both spending for services on the physician fee schedule and services incident to a physician visit. Including so-called incident-to services under the SGR mechanism was intended to make physicians accountable for spending for the services that they control. The mechanism, however, affects payment rates only for services on the physician fee schedule. Moreover, the SGR mechanism will adjust payment rates for physicians' services to offset any difference in spending that results when the rate of growth of spending for incident-to services deviates from the growth rate of the SGR expenditure targets.

The SGR expenditure targets are adjusted for changes in both physicians' costs and the prices of incident-to services. CBO projects, however, that spending for incident-to services will grow faster, on a per-beneficiary basis, than the adjustments for inflation and the GDP-based allowance for volume and technology. Therefore, spending for incident-to services will grow more rapidly than the SGR expenditure targets, and payments for those services will consume an increasing share of the target, rising from \$12 billion in 2004 (20 percent of the \$62 billion expenditure target) to \$28 billion in 2014 (23 percent of the \$121 billion target). In turn, the effective expenditure target for services on the physician fee schedule will decline from 80 percent of the SGR target in 2004 to 77 percent in 2014, CBO estimates. That decline in the share of the SGR expenditure target accounted for by physicians' services implies that the annual rate of growth of the effective target for physicians' services will be almost half a percentage point lower, on average, than the growth in the SGR target as a whole.

Spending for Physicians' Services

To get a sense of the pressure that the SGR mechanism will put on updates, it is instructive to compare the cumulative amount by which spending exceeds the expenditure targets—all of which will ultimately be recovered, under current law, by holding down updates to physicians' fees—with the effective expenditure target for physicians' services in the succeeding year. The \$5 billion by which cumulative spending for services subject to the SGR mechanism exceeded the cumulative target at the end of 2003 represents 10 percent of the effective target for physicians' services in 2004. That proportion will shoot up to 22 percent of the effective target for such services in 2006 and—when the cumulative excess peaks at \$15 billion at the end of 2006—will reach 25 percent of the effective target in 2007.

Given the extent to which projected expenditures before 2006 exceed the expenditure targets, CBO expects that the updates to payment rates for 2006 and 2007 will be subject to the maximum reduction of about 5 percent. Although the maximum reduction could be applied for more than two years, CBO's projections show that in 2007, spending subject to the SGR mechanism will fall slightly below the expenditure target for that year (cumulative spending will still exceed the cumulative target by more than \$14 billion at the end of 2007). At that point, the "prior-year" component of the update adjustment factor will begin to partially offset the negative contribution of the factor's "cumulative" component. CBO therefore expects that the maximum reduction will cease to be applied to payment rates for physicians' services within a few years after 2007—possibly as early as 2008. Although the update to payment rates could be positive in real terms in some year during the 2008-2014

period, CBO expects that, on average, the SGR mechanism will result in real reductions in physician payment rates for the 2008-2014 period as a whole.⁷

Spending per Beneficiary for Physicians' Services

CBO expects that the long-term trend of increases in the number of physicians' services provided per beneficiary and in the intensity of those services will continue. In turn, the annual rate of growth of spending per beneficiary will be higher than the update to the payment rate for services on the physician fee schedule.

CBO expects that spending per beneficiary for physicians' services in 2014 will be higher in real terms than it was last year—despite the real reductions in payment rates over the next decade. Medicare spent about \$1,400 per beneficiary in 2003 for services on the physician fee schedule. By 2014, CBO projects, Medicare spending for those services will have grown by 56 percent, to about \$2,200 per beneficiary. About 16 percentage points of that increase simply keep those payments on a par with inflation in physicians' costs as measured by the MEI. Over the 2003-2014 period, however, Medicare spending per beneficiary for physicians' services will grow at a pace that exceeds increases in physicians' costs by an average annual rate of 1.7 percent, CBO estimates.

Annual changes in Medicare spending for physicians' services will vary substantially around that average over the coming decade. In 2006 and 2007, CBO projects, Medicare will spend less for physicians' services, on a per-beneficiary basis, than it did in the previous year. Spending per beneficiary will increase each year, beginning in 2008, but it will not exceed the 2005 level until 2009 (see Figure 3).

Budgetary Implications of Illustrative Options

The prospect of reductions in Medicare payment rates for physicians' services has generated considerable interest in the costs associated with modifying the SGR mechanism. To date, proposals have generally taken one of three forms:

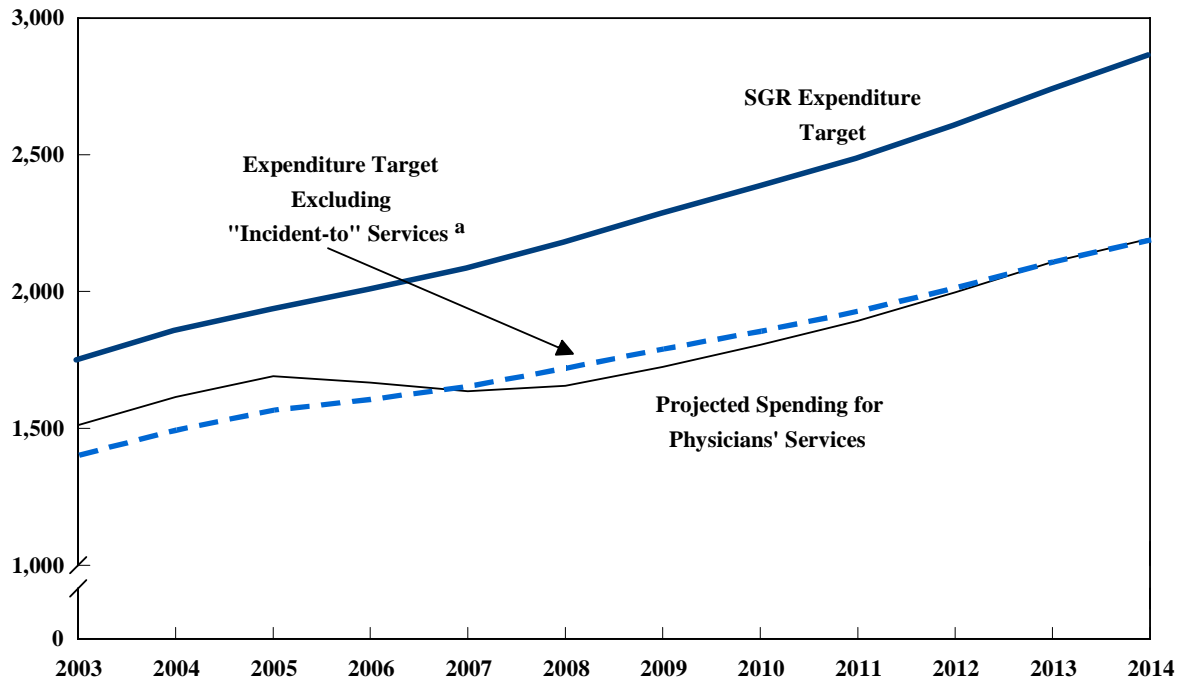
- Accelerate spending in the near term, and allow the SGR mechanism to recoup the additional spending in subsequent years;

7. In fact, physician payment rates will be reduced in real terms for the entire 2004-2014 period because the 1.5 percent increases in payment rates for 2004 and 2005 are below the expected increases of 3.1 percent and 2.6 percent, respectively, in physicians' costs as measured by the MEI. The updates in 2006 and 2007—which CBO expects will be set at the maximum reduction of about 5 percent—will also be substantially lower than the projected rise in the MEI, which CBO estimates will be 1.8 percent in each of those years.

Figure 3.

SGR Expenditure Targets and Projected Spending for Physicians' Services per Beneficiary, 2003 to 2014

(Dollars per beneficiary)



Source: Congressional Budget Office.

Note: The number for 2003 is an actual figure. SGR = sustainable growth rate.

a. Services that are furnished in connection with a physician visit and that physicians control (such as diagnostic laboratory services and physician-administered drugs).

- Increase the SGR expenditure targets (or increase the effective target for physicians' services); or
- Replace the SGR method with annual updates based on inflation.

Recent legislation provides examples of the first two approaches. The increase of 1.5 percent in physician payment rates for 2004 and 2005 that was enacted in the MMA accelerated spending into those years, but those increases will be recouped in subsequent years (unless the SGR mechanism is modified). Conversely, the Consolidated Appropriations Resolution, 2003, allowed the expenditure targets to be increased. Those contrasting approaches account for the difference between the negli-

gible cost over 10 years of the MMA's provision and the \$54 billion cost of the increase in the expenditure targets.

Several methods for increasing the SGR expenditure targets have been proposed. CBO has developed estimates for three such approaches as well as for replacing the SGR targets with annual updates based on inflation.

Adjust the SGR expenditure targets to recognize the 1.5 percent updates in 2004 and 2005 as a change in law. By CBO's estimate, that change would result in increases each year in Medicare spending for physicians' services on a per-beneficiary basis and would increase overall Medicare spending by \$45 billion through 2014.

Remove spending for physician-administered prescription drugs from the SGR expenditure target. Although the SGR expenditure targets are adjusted for changes in the prices of a market basket of prescription drugs, shifts in the quantity and in the mix of drugs administered—toward the use of more recently introduced and more expensive drugs—tend to result in spending that grows faster than the inflation adjustment. Removing spending for physician-administered prescription drugs from the SGR expenditure target would leave laboratory services as the primary source of charges in the category of services that are incident to a physician visit. That approach would increase the proportion of the SGR expenditure target attributable to physicians' services as well as increase the effective target for such services. CBO estimates that eliminating prescription drugs from the calculation of the SGR expenditure target would not change spending until 2008—because updates to physician payments would still be subject to a 1.5 percent increase in 2005 and the maximum reduction of about 5 percent in 2006 and 2007. In total, this approach would increase Medicare outlays through 2014 by about \$15 billion.

Increase the allowance for volume and intensity to the rate of growth of GDP per capita plus 1 percentage point, beginning with the calculation of the SGR for 2005. As noted earlier, the SGR mechanism provides an allowance equaling the rate of growth of GDP per capita for changes in spending attributable to increases in volume and intensity. That allowance has proved to be extremely constraining. Adopting a more generous allowance of GDP per capita plus 1 percentage point—which was considered when the SGR formula was being developed—would have no effect on spending in 2006 and 2007 because updates in those years would still be subject to the maximum 5 percent reduction. However, it would increase physician payment rates in 2008 and subsequent years and increase Medicare spending by an estimated \$35 billion over the 2008-2014 period.

Adjust payment rates for inflation. The Senate-passed version of the pending budget resolution for 2005 includes a Sense of the Senate provision that endorses permanent adoption of an inflation-based update for payment rates for physicians' services. Such an update, which is similar to one proposed by MedPAC for 2005, would be set at the change in input prices minus an adjustment for productivity. CBO estimated that use of that method for updates would raise net federal mandatory outlays by about \$95 billion through 2014 if the update was applied to payments for physicians' services beginning in 2005. If the change was effective for services beginning in calendar year 2006—the first year that physicians would face a nominal decrease in payments under current law—net federal outlays would increase by \$90 billion through fiscal year 2014, by CBO's estimate. The average annual increase in spending for services subject to the SGR mechanism would grow to 7.6 percent over the 2004-2014 period.

Conclusions

In considering whether to change the current system for setting Medicare physician payments, policymakers confront the prospect of reductions in the fees paid per service and in the money doctors earn per patient for the next several years. Replacing the SGR method with updates based on inflation would increase Medicare spending by \$90 billion or more over the next decade. In contrast, other approaches might have the potential to lessen the volatility in the update without dismantling the mechanism for linking physician fees to total spending for physicians' services or to growth in the economy.

Maintaining access to care for Medicare beneficiaries is a key consideration in assessing the program's fee structure. In evaluating the most recent systematic data about access to care (from 2002), MedPAC reported that it found no evidence at the national level of problems in beneficiaries' and physicians' views about access. But the lack of timely data makes it hard to know whether and to what extent problems exist in access to care—much less to know how to modify policies to maintain such access. More-recent data on that issue would be an important improvement over the current situation and could assist the Congress in its deliberations.

Changes that increase Medicare's payments to physicians will boost federal spending. Incorporating higher fees for physicians' services into Medicare spending as currently projected would add to the already substantial long-run costs of the program and to the fiscal challenge posed by the aging of the baby boomers. Raising fees would also increase both beneficiaries' cost-sharing obligations and the pre-

mium that they must pay for Part B of Medicare (the Supplementary Medical Insurance program). Inevitably, over the longer term, higher spending by Medicare for physicians' services will require reduced spending elsewhere in the budget, higher taxes, or larger deficits.

Appendix: Application of the Sustainable Growth Rate Method

On March 4, 2004, the Centers for Medicare and Medicaid Services (CMS) published its *Estimated Sustainable Growth Rate and Conversion Factor for Medicare Payments to Physicians in 2005*. That notice estimated that the application of the sustainable growth rate (SGR) method would result in a reduction of 3.6 percent in the conversion factor for services on the physician fee schedule. However, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or MMA (Public Law 108-173) requires that payment rates be increased by the larger of 1.5 percent or the update as calculated using the SGR method—therefore, the update will be 1.5 percent. (A final notice updating those calculations will be published on November 1, 2004.)

This discussion summarizes the calculations in that notice that lead to the estimate that application of the SGR method will produce a reduction of 3.6 percent in payment rates in 2005.

The Expenditure Target for 2005

The SGR expenditure target for 2004 is \$77.3 billion. (That amount includes both spending by the Medicare program and cost-sharing obligations of beneficiaries for all physicians' services subject to the SGR mechanism—that is, services on the physician fee schedule and so-called incident-to services, as discussed in the main text.)¹ The SGR expenditure target for 2005 is calculated on the basis of CMS's estimates of four factors:

- Changes in fees for services subject to the SGR mechanism, which CMS estimates as a weighted average of the change in physicians' costs, adjusted for changes in productivity (as measured by the Medicare economic index, or MEI) and the change in prices for incident-to services. That weighted average will be 2.6 percent in 2005, according to CMS's estimates;
- Changes in enrollment in Medicare's fee-for-service sector, which CMS estimates will be -0.2 percent;

1. The discussion in the main text characterized the expenditure targets and spending for services subject to the SGR mechanism in terms of expenditures by the Medicare program. Therefore, the amounts used in those calculations are about 20 percent smaller than the combination of the Medicare program's share and beneficiaries' cost-sharing obligations.

- The estimated 10-year average annual growth in real (inflation-adjusted) gross domestic product per capita, which CMS estimates will be 2.2 percent; and
- The effect of changes in law or regulations—CMS estimates no such changes and therefore no effect.

Those factors are multiplied ($1.026 * 0.998 * 1.022 * 1.000 = 1.046$) to yield a sustainable growth rate of 4.6 percent and an expenditure target for 2005 that is 4.6 percent larger than the expenditure target for 2004—or \$80.8 billion.

CMS's estimate of the cumulative SGR expenditure target from April 1996 through December 2004 is \$531.9 billion. Actual spending for services subject to the SGR method will be \$83.4 billion in 2004, CMS estimates, and \$543.8 billion cumulatively from April 1996 through December 2004.

Update to the Conversion Factor for Services on the Physician Fee Schedule

CMS's estimate that applying the SGR method will produce a 3.6 percent reduction in payment rates in 2005 reflects the combined effects of three factors:

- The MEI, which CMS estimates will be 2.8 percent;
- The update adjustment factor (discussed below), which CMS estimates will be -7.0 percent; and
- A “transitional adjustment” factor of 0.8 percent, as specified by the Balanced Budget Refinement Act of 1999. (The law specified transitional adjustment factors for each year from 2001 through 2005.)

Those factors are multiplied ($1.028 * 0.93 * 1.008$) to yield an update factor of -3.6 percent. The MMA specified that the update should be the larger of the amount calculated using the SGR method (-3.6 percent) or an increase of 1.5 percent. Therefore, payment rates for services on the physician fee schedule will be increased by 1.5 percent for 2005.

CMS used the following formula to calculate the update adjustment factor (which is often referred to as the performance adjustment factor) for 2005:

$$0.75 * (\text{Target}_{2004} - \text{Actual}_{2004}) / \text{Actual}_{2004}$$

plus

$$0.33 * (\text{Target}_{\text{cumulative}} - \text{Actual}_{\text{cumulative}}) / [\text{Actual}_{2004} * (1 + \text{SGR}_{2005})].$$

That is,

$$0.75 * (\$77.3 \text{ billion} - \$83.4 \text{ billion}) / \$83.4 \text{ billion}$$

plus

$$0.33 * (\$531.9 \text{ billion} - \$543.8 \text{ billion}) / [\$83.4 \text{ billion} * (1.046)].$$

Those amounts reduce to (0.75 * -7.3 percent) + (0.33 * -13.6 percent) = -10.0 percent. However, because the update adjustment factor cannot be less than -7.0 percent (nor more than 3.0 percent), the update adjustment factor for 2005 will be set at -7.0 percent.

