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MEDICARE PHYSICIAN PAYMENTS

Information on Spending Trends and Targets

Statement of A. Bruce Steinwald
Director, Health Care—Economic and Payment Issues

May 5, 2004

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Information on Spending Trends and Targets

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Highlights

Highlights of GAO-04-751T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

The Sustainable Growth Rate (SGR) system, implemented in 1998 and subsequently revised, is used to update Medicare's physician fees and moderate the growth in Medicare spending for physician services. SGR, and a predecessor system implemented in 1992, were designed to reduce physician fee updates if spending growth exceeded a specified target. Although spending growth slowed substantially under both systems, concerns about SGR arose when the system caused fees to decline by 5.4 percent in 2002.

GAO was asked to discuss (1) Medicare physician spending trends both before and after the implementation of spending targets and (2) the evolution and mechanics of the SGR system. This statement is largely based on GAO's previous work on Medicare spending trends and the SGR system.

What GAO Found

Medicare spending on physician services grew rapidly through the 1980s, at an average annual rate of 13.4 percent, even though physician fee increases were subject to some limits. The spending growth was driven by increases in the number of services provided to each beneficiary—referred to as volume—and an increase in the average complexity and costliness of those services—referred to as intensity. Recognizing that expenditure growth of this magnitude was not sustainable, the Congress attempted to impose fiscal discipline by establishing a system of spending targets for Medicare physician services along with a fee schedule beginning in 1992. Following the introduction of spending targets, volume and intensity growth slowed substantially during the 1990s. In recent years, under the SGR system, volume and intensity growth has increased, but not by the rates experienced during the 1980s before spending targets were in place.

SGR, the current system of spending targets, evolved from the target system that went into effect in 1992. Under the SGR system, physician fees are adjusted up or down, depending on whether actual spending has fallen below or has exceeded the target. Fees increase at least as fast as the costs of providing physician services as long as volume and intensity growth remains below a specified rate—currently, a little more than 2 percent a year. If volume and intensity grows faster than the specified rate, SGR lowers fee increases or causes fees to fall. Physicians raised concerns about SGR when fees dropped significantly in 2002, a decline that was, in part, a correction for fees that had been set too high in prior years because of errors in forecast estimates and other data. Congressional action averted fee reductions, and projected fee reductions, for 2003 through 2005. However, beginning in 2006, fees are projected to resume falling for several years, partly to recoup the excess spending accumulated from averted cuts in previous years and partly because real per beneficiary spending on physician services is projected to grow faster than allowed under SGR. A dilemma for policymakers posed by projected fee reductions is that while SGR's automatic responses work as intended from a budgetary perspective, the consequences for physicians and their patients are uncertain.

www.gao.gov/cgi-bin/getrpt?GAO-04-751T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7101.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss the Sustainable Growth Rate (SGR) system that Medicare uses to update physician fees and moderate the growth in spending for physician services. As you know, the current SGR system evolved from the Medicare Volume Performance Standard (MVPS) system, which, along with a fee schedule for physician services, was established in 1992. MVPS, and later SGR, were designed to reduce physician fee updates if spending growth exceeded a specified target. Under both systems, spending growth slowed substantially. However, concerns about SGR arose when the system and other factors caused fees to decline by 5.4 percent in 2002. In February of that year, we testified before this Subcommittee and discussed the reasons for the fee decline and potential SGR modifications.[1] Subsequent administrative and legislative actions modified or overrode the SGR system and resulted in fee increases for 2003, 2004, and 2005. Absent additional legislative action, fees are expected to fall by approximately 5 percent each year beginning in 2006 and continuing through 2012. These projected declines have raised concerns about the appropriateness of the SGR system for updating physician fees and physicians' continued participation in the Medicare program.

My comments today are intended to describe the current situation pertaining to physician fees and how we arrived at this juncture. Specifically, I will discuss (1) Medicare physician spending trends both before and after the implementation of spending targets and (2) the evolution and mechanics of the SGR system, explaining how it is designed to help control spending growth. My testimony is based on our previous work on Medicare spending trends and the SGR system—updated to include recent information on spending, fees, and projections—and was prepared during April 2004 according to generally accepted government auditing standards. In our February 2002 testimony, we discussed the need to maintain fiscal discipline to help ensure the long-term sustainability of the Medicare program for future generations. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires us to study the appropriateness of the factors used in SGR and consider alternatives to the system.[2] Our work on that study is currently underway.

[1]U. S. General Accounting Office, *Medicare Physician Payments: Spending Targets Encourage Fiscal Discipline, Modifications Could Stabilize Fees*, GAO-02-441T (Washington, D.C.: Feb. 14, 2002).

[2]See Pub. L. No. 108-173, §953, 117 Stat. 2066, 2427-28.

We look forward to working with the Subcommittee and others in Congress as policymakers seek to ensure appropriate physician payments.

In summary, Medicare spending on physician services grew rapidly through the 1980s, at an average annual rate of 13.4 percent, even though physician fee increases were subject to some limits. The spending growth was driven by increases in the number of services provided to each beneficiary—referred to as volume—and an increase in the average complexity and costliness of those services—referred to as intensity. Recognizing that expenditure growth of this magnitude was not sustainable, the Congress attempted to impose fiscal discipline by requiring the establishment of spending targets for Medicare physician services along with a fee schedule beginning in 1992. Following the introduction of spending targets, volume and intensity growth slowed substantially during the 1990s. In recent years, under the SGR system, volume and intensity growth has increased, but not by the rates experienced during the 1980s before spending targets were in place.

SGR, the current system of spending targets, evolved from the target system that went into effect in 1992. Under the SGR system, physician fee updates are adjusted up or down, depending on whether actual spending has fallen below or has exceeded the target. Over time, fees tend to increase at least as fast as the costs of providing physician services as long as volume and intensity growth remains below a specified rate—currently, a little more than 2 percent a year. If volume and intensity grows faster than the specified rate, SGR lowers fee increases or causes fees to fall. Physicians raised concerns about SGR when fees dropped significantly in 2002, a decline that was, in part, a correction for fees that had been set too high in prior years because of errors in forecast estimates and other data. Congressional action averted fee reductions, and projected fee reductions, for 2003 through 2005. However, beginning in 2006, fees are projected to resume falling for several years, partly to recoup the excess spending accumulated from averted cuts in previous years and partly because real per beneficiary spending on physician services is projected to grow faster than allowed under SGR. The dilemma for policymakers posed by projected fee reductions is that while SGR's automatic responses work as intended from a budgetary perspective, the consequences for physicians and their patients are uncertain.

Background

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) reformed the way Medicare pays for physician services in the traditional fee-for-service (FFS) program.[3] OBRA 1989 required the establishment of a physician fee schedule and a system of spending growth targets, known as MVPS, that became effective in 1992. In 1998, the SGR system of spending targets replaced MVPS. Both spending target systems were designed to moderate growth in the volume and intensity of services provided to beneficiaries.

Prior to the establishment of the fee schedule, Medicare payment rates for physician services were based on historical charges for these services.[4] The establishment of a fee schedule was an attempt to break the link between physicians' charges and Medicare payments. The fee schedule was not designed to reduce spending levels overall but to redistribute payments for services based on the relative resources used by physicians to provide different types of care. Under the fee schedule, Medicare pays for more than 7,000 physician services. [5] To arrive at Medicare's fee, the service's relative value is multiplied by a dollar conversion factor.

Currently, under SGR, the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, uses the dollar conversion factor to calculate Medicare fees and updates the conversion factor each calendar year to account for the change in the cost of providing physician services (as measured by the Medicare Economic Index (MEI)), adjusted for the extent to which actual spending aligns with spending targets. Fee updates represent the aggregate of increases and decreases across all services; the fees for specific services may rise or fall each year.

[3]See Pub. L. No. 101-239, §6102, 103 Stat. 2106, 2169-89.

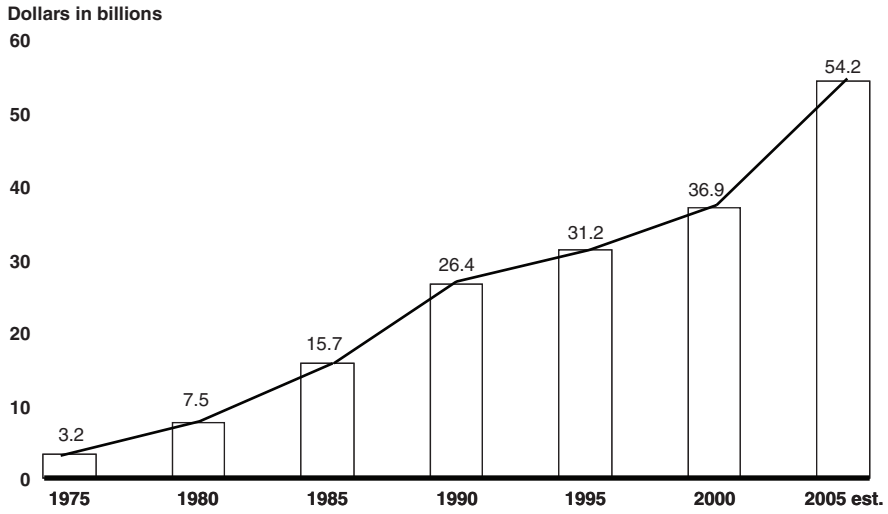
[4]Medicare paid physicians on the basis of "reasonable charge," defined as the lowest of the physician's actual charge, the customary charge (the amount the physician usually charged for the service), or the prevailing charge (based on comparable physicians' customary charges).

[5]The fee for each service is determined using a resource-based relative value scale—that is, the resources required for that service relative to the resources required to provide all other physician services adjusted for the differences in the costs of providing services across geographic areas.

Medicare Spending for Physician Services Grew Rapidly in 1980s, Slowed After Implementation of Spending Targets

In 1980, Medicare spending for physician services totaled $7.5 billion.[6] (See fig. 1.) By 2003, Medicare spending on these services totaled $47.9 billion. During much of this period, increases in both the volume and intensity of services physicians provided to each beneficiary were an important factor in spending growth.

Figure 1: Medicare Spending for Physician Services, 1975-2005



Sources: GAO analysis of data from CMS and the Boards of Trustees of the Federal Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds.

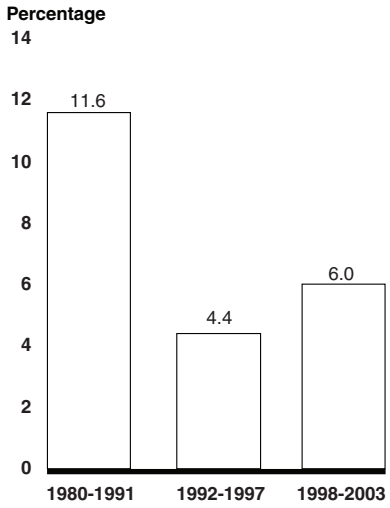
Notes: Amounts represent Medicare spending for aged and disabled beneficiaries in the traditional FFS program, net of beneficiary cost sharing. Spending for end stage renal disease (ESRD) patients is not included. Amounts for 1975-1990 are for the years ending June 30 and amounts for 1995-2005 represent calendar years. The estimate for 2005 is based on Trustees' projections under intermediate assumptions.

[6]This includes spending, net of beneficiary cost-sharing, for aged and disabled beneficiaries in the traditional FFS program.

In 1980s, Spending for Physician Services Grew Rapidly

Before the physician fee schedule was implemented, Medicare payments for physician services were largely based on historical charges. Experience in the 1980s repeated the experience of the prior decade: the Congress froze fees or limited fee increases, but spending continued to rise. From 1980 through 1991, for example, Medicare spending per beneficiary for physician services grew at an average annual rate of about 11.6 percent. (See fig. 2.)

Figure 2: Average Annual Change in Medicare Spending for Physician Services per Beneficiary, 1980-2003



Sources: GAO analysis of data from CMS and the Boards of Trustees of the Federal HI and SMI Trust Funds.

Notes: Amounts for 1980-1991 are for the years ending June 30 and represent weighted average Medicare spending for aged and disabled beneficiaries in the traditional FFS program, net of beneficiary cost sharing. Spending for ESRD patients is not included. Amounts for 1992-1997 and 1998-2003 are for calendar years and represent total allowed charges—Medicare spending, including beneficiary cost sharing—for aged and disabled beneficiaries in the traditional FFS program.

Total Medicare spending for physician services depends on the fee paid for each service, the number of beneficiaries served, the number of services provided to each beneficiary (volume), and the mix of those services—that is, the combination of more and less expensive services (intensity). Of these factors, physicians directly influence only the volume and intensity of services provided to beneficiaries.

Much of the spending growth resulted from increases in the volume and intensity of services. For example, from 1986 until 1992, physician payment rates grew by less than 2 percent annually, while the volume and intensity of services rose, on average, by almost 8 percent per year. In 1986, the Congressional Budget Office stated that "[b]oth the price and the volume of services must be controlled to constrain costs…."[7] In 1989, citing the need for spending targets to limit spending growth for physician services, the Secretary of Health and Human Services (HHS) testified that "Medicare physician spending has increased at compound annual rates of 16 percent over the past 10 years. And in spite of our best efforts to control volume and rein in expenditures, Medicare physician spending is currently out of control…. An expenditure target…sets an acceptable level of growth in the volume and intensity of physician services."[8]

In 1990s, Growth in Spending on Physician Services Slowed Under Spending Target Systems

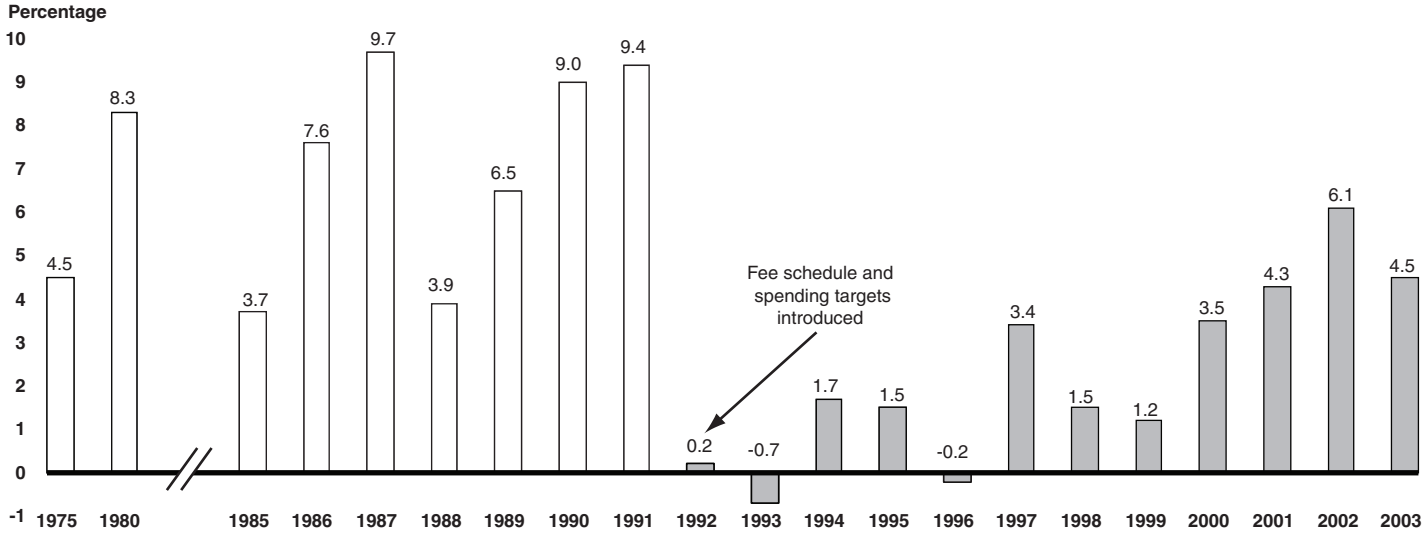
Annual spending growth during the 1990s was far lower than in the preceding 10 years. Beginning in 1992, the Congress introduced spending targets for physician services to help constrain the rise in Medicare spending for physician services. Unlike prior attempts to control spending, spending target systems sought to limit the growth in the volume and intensity of services each year.

From 1992 until 1999, the growth in the volume and intensity of physician services per Medicare beneficiary moderated. (See fig. 3.) During this time period, the average annual increase in Medicare spending due to changes in volume and intensity of services per beneficiary was about 1 percent, in contrast with the average annual growth of about 7 percent in the period from 1985 through 1991.

[7]Congressional Budget Office, *Physician Reimbursement Under Medicare: Options for Change* (Washington, D.C.: Apr. 1986).

[8]Testimony before the Subcommittee on Medicare and Long-term Care, Committee on Finance, U.S. Senate, 101st Congress, 1st Session (June 16, 1989).

Figure 3: Growth in Volume and Intensity of Medicare Physician Services per Beneficiary, 1975-2003



Sources: GAO analysis of data from CMS and the Boards of Trustees of the Federal HI and SMI Trust Funds.

Notes: Data are for aged and disabled beneficiaries in the traditional FFS program only. Data for ESRD patients are not included. From 1975 through 1992, volume and intensity of services changes are based on Medicare outlays for all physician services. From 1993 through 2003, volume and intensity of services changes are based on Medicare outlays for physician services covered by the fee schedule.

The moderation of volume and intensity growth slowed the rate of increase in spending on physician services. This spending grew from $25.6 billion in 1992 to $36.9 billion in 2000—an average annual rate of 4.7 percent. In contrast, from 1985 through 1991, total spending increased at an average annual rate of about 10.8 percent.

In 2000s, Spending Growth for Physician Services Rose but Remained Lower than Rates in the 1980s

Beginning in 2000, the growth in volume and intensity of services per Medicare beneficiary began to rise, although the average annual rate of growth remained substantially below that experienced before spending targets were introduced. From 2000 to 2003, volume and intensity rose at an average annual rate of 5 percent. CMS actuaries project an average annual growth in volume and intensity of 3 percent from 2004 through 2013. Total spending on physician services is projected to grow by an average of 8 percent a year from 2000 through 2005.

Under SGR and Prior System, Physician Fee Updates Are Mechanism To Bring Actual Spending in Line with Spending Targets

A target for spending on physician services serves as a budgetary control by automatically lowering fee updates in response to excess volume and intensity growth. Under Medicare's SGR spending target system and its MVPS predecessor, physician fees are adjusted annually to help bring actual spending in line with spending targets. Projected increases in volume and intensity, beyond what the current SGR targets allow, are expected to contribute to annual fee reductions for several years as the system tries to align spending with targets.

SGR System Evolved from Spending Target System Introduced with Physician Fee Schedule in 1992

The SGR system evolved from the MVPS system of spending targets, which was introduced with the physician fee schedule in 1992. The goal of MVPS was to provide an incentive for physicians to reduce volume and intensity growth and thus slow the high annual rate of increase in expenditures.[9] Under MVPS, if a year's actual spending growth exceeded the target, future payment rates would be reduced, relative to what they would have been if actual spending had equaled the target, to offset the excess spending. If a year's actual spending growth fell short of the target, future payment rates would be increased.

Concerns about the MVPS spending target prompted the Congress to create SGR's system of spending targets.[10] In its 1996 report to Congress, the Physician Payment Review Commission noted that, under MVPS, physician fees would fall over time unless there were continual declines in the volume and intensity of services provided.[11] In response to the system's perceived shortcomings, the Congress took action in 1997 to replace it with the SGR system.

[9]At that time, the Secretary of HHS defined "physician services" to include "services and supplies incident to physicians' services," such as laboratory tests and Medicare-covered outpatient prescription drugs. This definition remains today.

[10]The MVPS spending target was based, in part, on a 5-year historical trend in volume and intensity reduced by a specified number of percentage points. Because of this design and the fact that volume and intensity growth dropped dramatically after the adoption of the MVPS system, the target for future volume and intensity increases fell too.

[11]Physician Payment Review Commission, *1996 Annual Report to Congress* (Washington, D.C.: Physician Payment Review Commission, 1996).

SGR System Differs From Prior System in Important Ways

The SGR system was created in the Balanced Budget Act of 1997 (BBA)[12] and revised by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA)[13] and, most recently, by MMA.[14] Similar to MVPS, SGR sets spending targets for physician services and updates fees to bring spending in line with those targets. Under the SGR system, if spending exceeds the target, future fee updates are reduced. If spending falls short of the target, future fee updates are increased. By adjusting fees when prior-year spending has deviated from the target, SGR attempts to moderate the growth in total Medicare outlays for physician services.

Specifically, the SGR formula establishes expenditure targets as follows: from a base year—1996[15]—the targets are updated each year[16] to account for four factors: (1) changes in the number of Medicare beneficiaries in traditional fee-for-service; (2) growth in the costs of providing physician services, laboratory tests, and Medicare-covered outpatient prescription drugs; (3) growth in the overall economy, as measured by changes in real per capita gross domestic product (GDP); and (4) changes in expenditures that result from changes in laws or regulations. Spending and targets are estimated from data available in the fall, when CMS sets physician fees for the next calendar year. Because SGR spending targets are cumulative, the target set for a specific year is affected by the targets set in all prior years. BBRA required CMS, in calculating each year's SGR spending target and fee update, to revise the targets set for the two previous years using the most recent available data.[17]

SGR differs from MVPS in two key ways. The first relates to volume and intensity growth limits. MVPS relied, in part, on historical trends in volume and intensity growth to set new targets each year, whereas SGR ties allowable volume and intensity increases to the growth in real GDP per capita. Under SGR, real spending per beneficiary—that is, spending

[12]See Pub. L. No. 105-33, §4503, 111 Stat. 251, 433-34.

[13]See Pub. L. No. 106-113, App. F, §211(b), 113 Stat. 1501A-321, 348-49.

[14]See Section 601(b), 117 Stat. 2301.

[15]The base year is set equal to the 12-month period ending March 31, 1997.

[16]SGR changed from a fiscal year basis to a calendar year basis in 2000.

[17]The first year of fee updates to be based on revised targets was 2001. In setting the target for that year, CMS revised only the 2000 SGR target. According to CMS, the agency was not authorized to revise the 1998 or 1999 SGR targets.

adjusted for the underlying cost of providing physician services—is allowed to grow at the same rate that the national economy grows over time on a per-capita basis—currently projected to be about 2 percent annually. If volume and intensity grow faster, the annual increase in physician fees will be less than the estimated increase in the cost of providing services. Conversely, if volume and intensity grow more slowly than 2 percent annually, the SGR system permits physicians to benefit from fee increases that exceed the increased cost of providing services. To reduce the effect of business cycles on physician fees, economic growth is measured as the 10-year moving average change in real per capita GDP. This measure is projected to range from 2.1 percent to 2.5 percent during the 2005 through 2014 period.

A second difference is that MVPS compared target and actual expenditures in a single year, whereas SGR compares targets and actual expenditures cumulatively from a base year. The cumulative nature of SGR's spending targets increases the potential volatility of physician fee updates because the system requires that excess spending in any year be recouped in future years. Conceptually, this means that if spending has exceeded the SGR targets, fee updates in future years must be lowered sufficiently to offset the excess spending. Conversely, the system also requires that if spending has fallen short of the targets, fees must be increased to boost future spending.

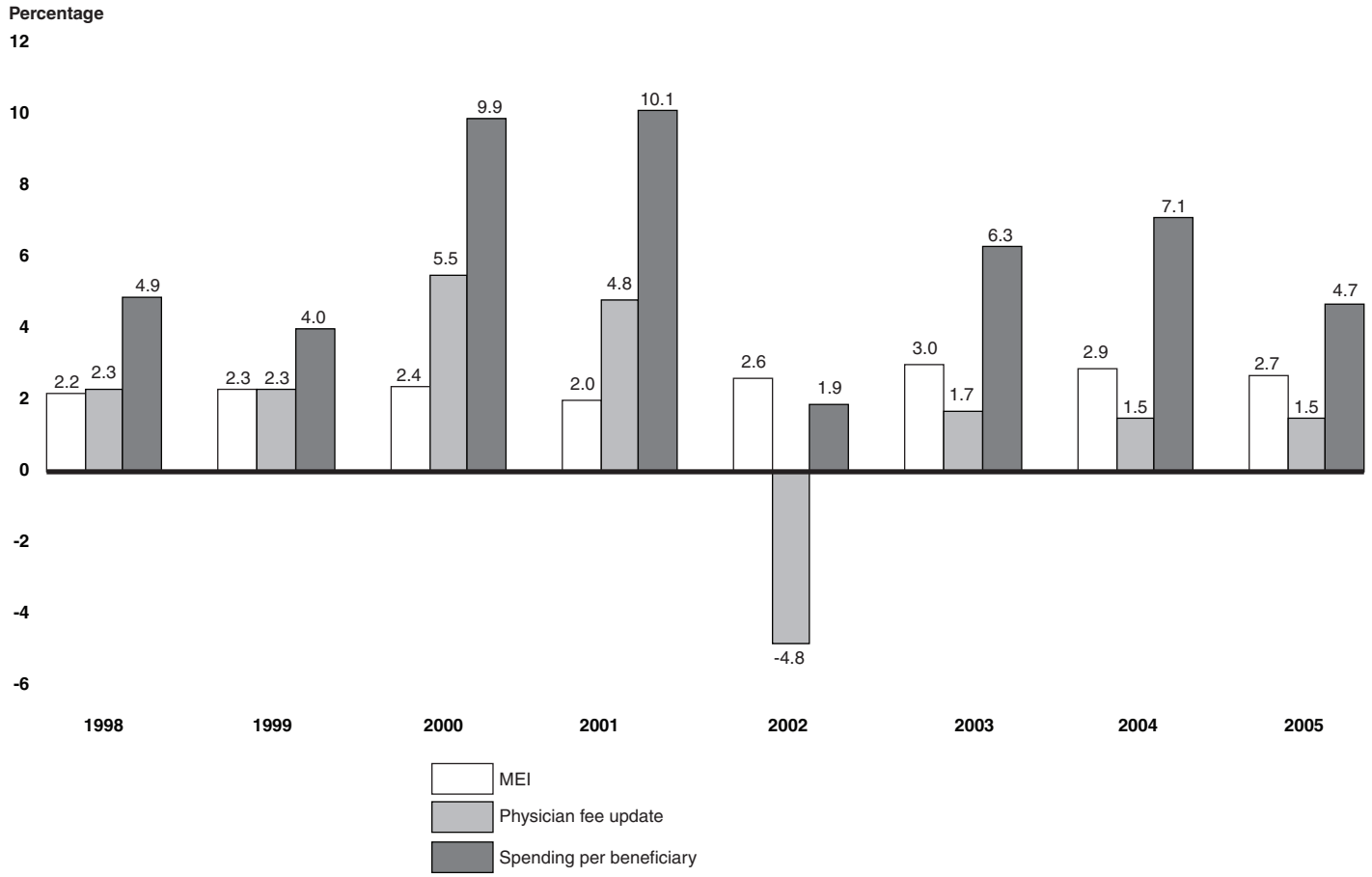
SGR limits how much fees can be adjusted when spending has missed the target. SGR's performance adjustment may decrease fees by as much as 7 percentage points below the percentage change in MEI when spending has exceeded the target and may increase fees by as much as 3 percentage points above the percentage change in MEI when spending has fallen short of the target. SGR adjustments to the fees are determined by how much the cumulative amount of spending on physician services since 1996 differs from the cumulative spending target since that base year.

Legislative Action Temporarily Avoided Fee Declines; Fees Projected to Decline Beginning in 2006

Since the introduction of the fee schedule in 1992 through 2001, physicians generally experienced real increases in their fees—that is, fees increased more than the increase in the cost of providing physician services, as measured by MEI. Specifically, during that period, fees increased by 39.7 percent, whereas MEI increased by 25.9 percent. In 2002, however, SGR reduced fees by 4.8 percent,[18] despite an estimated 2.6 percent increase in the costs of providing physician services. (See fig. 4.)

[18]CMS reduced 2002 fees by an additional 0.64 percent to offset an increase in spending projected to occur as a result of changes in the calculations used to determine the amount of resources associated with physician services. As a result of both the SGR reduction and this additional offset, 2002 fees declined by 5.4 percent.

Figure 4. Percentage Change in MEI, Fee Schedule Update, and Medicare Physician Services Spending Per Beneficiary, 1998-2005



Source: GAO analysis of data from the Boards of Trustees of the Federal HI and SMI Trust Funds.

Note: Spending per beneficiary represents Medicare spending for aged and disabled beneficiaries in the traditional FFS program, net of beneficiary cost sharing. Spending for end stage renal disease (ESRD) patients is not included.

SGR reduced fees in 2002 because estimated spending for physician services—cumulative since 1996—exceeded the target by approximately $8.9 billion, or 13 percent of projected 2002 spending. In part, the fee reduction occurred because CMS revised upward its estimates of previous years' actual spending. Specifically, CMS found that its previous estimates had omitted a portion of actual spending for 1998, 1999, and 2000. In addition, in 2002 CMS lowered the 2 previous years' spending targets based on revised GDP data from the Department of Commerce. Based on the new higher spending estimates and lower targets, CMS determined

that fees had been too high in 2000 and 2001. In setting the 2002 physician fees, the SGR system reduced fees to recoup previous excess spending. The update would have been about negative 9 percent if the SGR system had not limited its decrease to 7 percentage points below MEI. Because the previous overpayments were not fully recouped in 2002, and because of volume and intensity increases, by 2003, physicians were facing several more years of fee reductions to bring cumulative Medicare spending on physician services in line with cumulative targets.

However, CMS had determined that its authority to revise previous spending targets was limited. In 2002 CMS noted that the 1998 and 1999 spending targets had been based on estimated growth rates for beneficiary fee-for-service enrollment and real per capita GDP that actual experience had shown to be too low. If the estimates could have been revised, the targets for those and subsequent years would have been increased. However, at the time that CMS acknowledged these errors, the agency concluded that it was not allowed to revise these estimates.[19] Without such revisions, the cumulative spending targets remained lower than if errors had not been made.

In late 2002, the estimate of SGR called for a negative 4.4 percent fee update in 2003. With the passage of the Consolidated Appropriations Resolution of 2003,[20] CMS determined that it was authorized to correct the 1998 and 1999 spending targets. Because SGR targets are cumulative measures, these corrections resulted in an average 1.4 percent increase in physician fees for services for 2003.[21]

In 2003, MMA averted additional fee reductions projected for 2004 and 2005 by specifying an update to physician fees of no less than 1.5 percent for 2004 and 2005.[22] The MMA increases replaced SGR fee reductions of 4.5 percent in 2004 and an estimated 3.6 percent in 2005. Because MMA did

[19]BBRA required CMS to use actual, after-the-fact data to revise the estimates used to set the spending targets, beginning with the estimated spending target in 2000.

[20]See Pub. L. No. 108-7, Div. N, Title IV, §402, 117 Stat. 11, 548.

[21]The law allowed for a recalculation of prior years' spending targets, which resulted in a 1.7 increase in fees applied to spending on physician services provided on or after March 1, 2003. Over 12 months, the increase averaged 1.4 percent. CBO estimated that this provision would increase the baseline for Medicare spending by $800 million in 2003 and $53.4 billion over the 2003-2013 period.

[22]See Section 601(a), 117 Stat. 2300.

not make corresponding revisions to SGR's spending targets, SGR will reduce fees beginning in 2006, to offset the additional spending caused by MMA's fee increases. In addition, recent growth in volume and intensity, which has been larger than SGR targets allow, will further compound the problem of excess spending that needs to be recouped.

The 2004 Medicare Trustees Report announced that the projected physician update would be about negative 5 percent for 7 consecutive years beginning in 2006; the result is a cumulative reduction in physician fees of more than 31 percent from 2005 to 2012, while physicians' costs of providing services, as measured by MEI, are projected to rise by 19 percent.[23]

Concluding Observations

To a large extent, the physician fee cuts projected by Medicare's Trustees are required under SGR's system of cumulative spending targets to make up for excess spending in earlier years. MMA added to the excess spending by specifying minimum fee updates for 2004 and 2005 without resetting the spending targets for those years. As a result, physician fee cuts were postponed, not avoided.

In considering the projected fee cuts, however, it is important to recall that Congress originally established Medicare spending targets for physician services in response to runaway spending in the 1980s. The recent increase in volume and intensity growth suggests that Medicare faces a fundamental physician spending growth problem even if the SGR slate of missed spending targets were somehow wiped clean. Currently, projected Medicare spending for physician services exceeds what policymakers have specified—through the parameters of the SGR system—is the appropriate amount to spend. Because of expected increases in the volume and intensity of services provided by physicians, real spending per beneficiary is projected to grow by more than 3 percent per year. SGR, designed to promote fiscal discipline, allows such spending to grow by just over 2 percent per year. If the growth in real spending per beneficiary is not lowered through other means, SGR will mechanically reduce fee updates in an attempt to impose fiscal discipline and moderate total spending increases. Although this mechanical response may be desirable from a

[23]Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: Mar. 23, 2004).

budgetary perspective, any consequences for physicians and their patients are uncertain.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer questions you or other Subcommittee Members may have.

Contact and Acknowledgments

For further information regarding this testimony, please contact A. Bruce Steinwald at (202) 512-7101. James Cosgrove, Jessica Farb, Hannah Fein, and Jennifer Podulka contributed to this statement.

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