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MEDICARE PHYSICIAN PAYMENTS

Considerations for Reforming the Sustainable Growth Rate System

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February 10, 2005

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Highlights

Highlights of GAO-05-326T, a testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

Concerns were raised about the system Medicare uses to determine annual changes to physician fees—the sustainable growth rate (SGR) system—when it reduced physician fees by almost 5 percent in 2002. Subsequent administrative and legislative actions modified or overrode the SGR system to avert fee declines in 2003, 2004, and 2005. However, projected fee reductions for 2006 to 2012 have raised new concerns about the SGR system. Policymakers question the appropriateness of the SGR system for updating physician fees and its effect on physicians' continued participation in the Medicare program if fees are permitted to decline. At the same time, there are concerns about the impact of increased spending on the long-term fiscal sustainability of Medicare.

GAO was asked to discuss the SGR system. Specifically, this statement addresses the following: (1) how the SGR system is designed to moderate the growth in spending for physician services, (2) why physician fees are projected to decline under the SGR system, and (3) options for revising or replacing the SGR system and their implications for physician fee updates and Medicare spending. This statement is based on GAO's most recent report on the SGR system, *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms* (GAO-05-85).

www.gao.gov/cgi-bin/getrpt?GAO-05-326T.

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.

What GAO Found

To moderate Medicare spending for physician services, the SGR system sets spending targets and adjusts physician fees based on the extent to which actual spending aligns with specified targets. If growth in the number of services provided to each beneficiary—referred to as volume—and in the average complexity and costliness of services—referred to as intensity—is high enough, spending will exceed the SGR target. While the SGR system allows for some volume and intensity spending growth, this allowance is limited. If such growth exceeds the average growth in the national economy, as measured by the gross domestic product per capita, fee updates are set lower than inflation in the cost of operating a medical practice. A large gap between spending and the target may result in fee reductions.

There are two principal reasons why physician fees are projected to decline under the SGR system beginning in 2006. One problem is that projected volume and intensity spending growth exceeds the SGR allowance for such growth. Second, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) increased the update for 2004 and 2005—thus increasing spending—but did not raise the spending targets for those years. The SGR system, which is designed to keep spending in line with its targets, must reduce fees beginning in 2006 to offset excess spending attributable to both volume and intensity growth and the MMA provision.

In general, proposals to reform Medicare's method for updating physician fees would either (1) eliminate spending targets and establish new considerations for the annual fee updates or (2) retain spending targets, but modify certain aspects of the current system. The first approach emphasizes stable and positive fee updates, while the second approach automatically applies financial brakes whenever spending for physician services exceeds predefined spending targets. Either approach could be complemented by focused efforts to moderate volume and intensity growth directly. As policymakers consider options for updating physician fees, it is important to be mindful of the serious financial challenges facing Medicare and the need to design policies that help ensure the long-term sustainability and affordability of the program.

Madam 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. A brief look at the updates resulting from the SGR system since it was enacted by Congress puts current concerns in context. From 1999—the first year that the SGR system was used to update Medicare's physician fees—through 2001, annual fee increases ranged from 2.3 percent to 5.5 percent. However, in 2002 the SGR system reduced physician fees by nearly 5 percent. Fee declines in subsequent years were averted only by new legislation that modified or temporarily overrode the SGR system. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) specified a minimum update of 1.5 percent for both 2004 and 2005.[1] Absent additional administrative or legislative action, however, the SGR system is projected to reduce fees by about 5 percent per year for several years beginning in 2006. These projected declines have raised policymakers' concerns about the appropriateness of the SGR system for updating physician fees and about physicians' continued participation in the Medicare program. At the same time, there are concerns about Medicare spending growth and the long-term fiscal sustainability of the program.

My comments today are intended to describe the issues that Medicare faces in annually updating physician fees and potential approaches for addressing those issues. Specifically, I will discuss (1) how the SGR system is designed to moderate the growth in spending for physician services, (2) why physician fees are projected to decline under the SGR system, and (3) options for revising or replacing the SGR system and their implications for physician fee updates and Medicare spending. My testimony today is based on the findings contained in our October 2004 report on this subject.[2] This work was performed between January 2004 through September 2004 according to generally accepted government auditing standards.

In summary, the SGR system is designed to apply financial brakes whenever spending for physician services exceeds predefined spending

[1]Pub. L. No. 108-173, §601 (a)(1), 117 Stat. 2067, 2300.

[2]GAO, *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms*, GAO-05-85 (Washington, D.C.: Oct. 8, 2004).

targets. It does this by reducing physician fees or limiting their annual increase. Historically, efforts that limited fees but did not set spending targets failed to moderate spending growth. Increases in the number of services delivered to each beneficiary—known as volume—and the complexity or costliness of those services—known as intensity—caused continued increases in spending. The SGR system allows for some volume and intensity spending growth, but if such growth exceeds the average growth in the national economy, as measured by the gross domestic product (GDP) per capita, fee updates are reduced. There are two principal reasons why physician fees are projected to decline under the SGR system beginning in 2006. One reason is that projected spending growth attributable to volume and intensity increases exceeds the SGR allowance for such growth. The MMA is also partly responsible because it increased the update for 2004 and 2005—thus increasing spending—but did not raise the spending targets for those years. The SGR system, which is designed to keep spending in line with its targets, must reduce fees beginning in 2006 to offset the excess spending attributable to both volume and intensity increases and this MMA provision. In general, proposals to reform Medicare's method for updating physician fees would either (1) eliminate spending targets and establish new considerations for the annual fee updates or (2) retain spending targets, but modify certain aspects of the current system. Either approach could be complemented by focused efforts to moderate volume and intensity growth directly.

Background

Although the current focus of concern is largely on the potential for several years of declining physician fees, the historic challenge for Medicare has been to find ways to moderate the rapid growth in spending for physician services. Before 1992, the fees that Medicare paid for those services were largely based on physicians' historical charges.[3] Spending for physician services grew rapidly in the 1980s, at a rate that the Secretary of Health and Human Services (HHS) characterized as out of control. Although Congress froze fees or limited fee increases, spending continued to rise because of increases in the volume and intensity of physician services. From 1980 through 1991, for example, Medicare spending per beneficiary for physician services grew at an average annual rate of 11.6 percent.

[3]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).

The ineffectiveness of fee controls alone led Congress to reform the way that Medicare set physician fees. The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989)[4] established both a national fee schedule and a system of spending targets,[5] which first affected physician fees in 1992.[6] From 1992 through 1997, annual spending growth for physician services was far lower than the previous decade. The decline in spending growth was the result in large part of slower volume and intensity growth. (See fig. 1.) Over time, Medicare's spending target system has been revised and renamed. The SGR system, Medicare's current system for updating physician fees, was established in the Balanced Budget Act of 1997 (BBA) and was first used to adjust fees in 1999.[7]

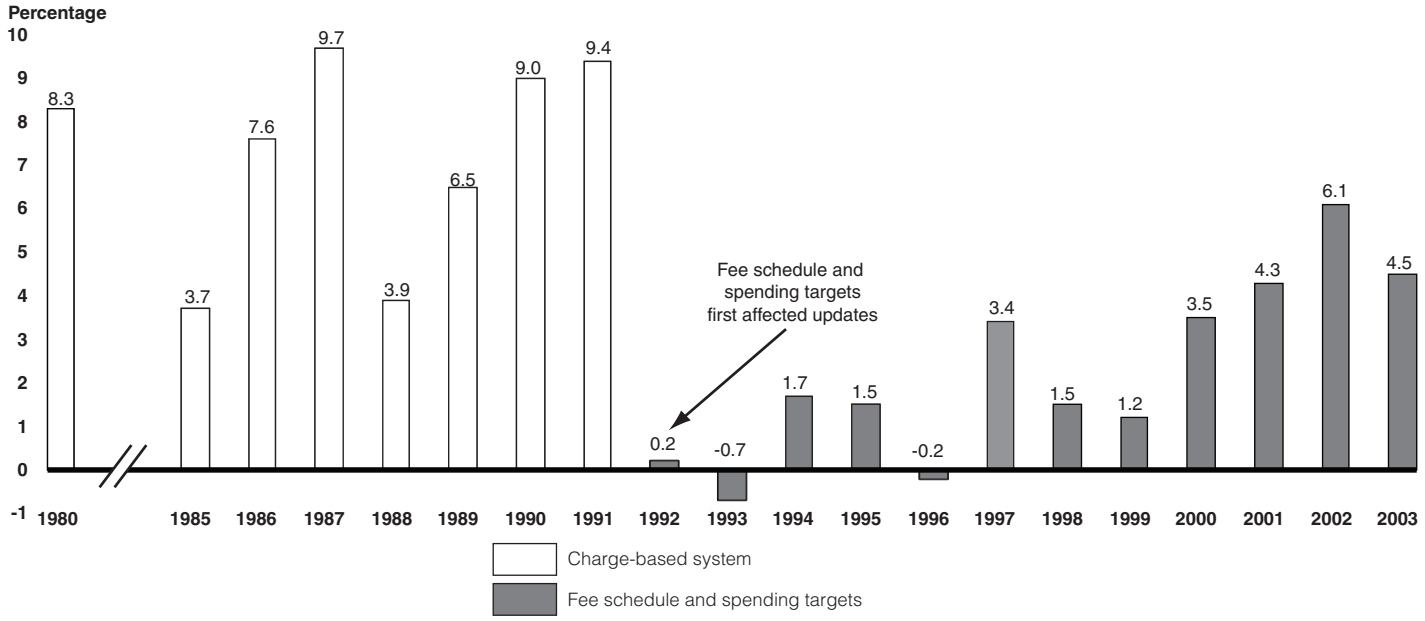
[4]See Pub. L. No. 101-239, §6102, 103 Stat. 2106, 2169-89.

[5]Medicare sets fees for more than 7,000 physician services based on the resources required to provide each service, adjusted for differences in the costs of providing services across geographic areas.

[6]The first system of spending growth targets, known as the Medicare Volume Performance Standard (MVPS), was in effect from 1992 through 1997. In 1998, the SGR system of spending targets replaced MVPS.

[7]See Pub. L. No. 105-33, §4503, 111 Stat. 251, 433-34. BBA set a specific fee update for 1998. See BBA, §4505, 111 Stat. 435-39.

Figure 1: Growth in Volume and Intensity of Medicare Physician Services per Beneficiary, 1980–2003



Source: GAO analysis of data from the Centers for Medicare and Medicaid Services (CMS) and the Boards of Trustees of the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds.

Notes: Data are for beneficiaries in the traditional fee-for-service (FFS) program only. Data for end stage renal disease patients are not included. From 1980 through 1992, volume and intensity of service changes are based on Medicare outlays for all physician services. From 1993 through 2003, volume and intensity of service changes are based on Medicare outlays for physician services covered by the fee schedule.

Following the implementation of the fee schedule and spending targets in 1992, through 1999, average annual growth in volume and intensity of service use per beneficiary fell to 1.1 percent. More recently volume and intensity growth has trended upward, rising at an average annual rate of about 5 percent from 2000 through 2003. Although this average annual rate of growth remains substantially below that experienced before spending targets were introduced, the recent increases in volume and intensity growth are a reminder that inflationary pressures continue to challenge efforts to moderate growth in physician expenditures.

SGR System Designed to Limit or Reduce Physician Fee Updates in Response to Excess Growth in Volume and Intensity

The SGR system establishes spending targets to moderate physician services spending increases caused by excess growth in volume and intensity. SGR's spending targets do not cap expenditures for physician services. Instead, spending in excess of the target triggers a reduced fee update or a fee cut. In this way, the SGR system applies financial brakes to physician services spending and thus serves as an automatic budgetary control device. In addition, reduced fee updates signal physicians collectively and Congress that spending due to volume and intensity has increased more than allowed.

To apply the SGR system, every year the Centers for Medicare & Medicaid Services (CMS) follows a statutory formula to estimate the allowed rate of increase in spending for physician services and uses that rate to construct the spending target for the following calendar year.[8] The sustainable growth rate is the product of the estimated percentage change in (1) input prices for physician services;[9, 10] (2) the average number of Medicare beneficiaries in the traditional fee-for-service (FFS) program; (3) national economic output, as measured by real (inflation-adjusted) GDP per capita; and (4) expected expenditures for physician services resulting from changes in laws or regulations. SGR spending targets are cumulative. That is, the sum of all physician services spending since 1996 is compared to the sum of all annual targets since the same year to determine whether spending has fallen short of, equaled, or exceeded the SGR targets. The use of cumulative targets means, for example, that if actual spending has exceeded the SGR system targets, fee updates in future years must be lowered sufficiently both to offset the accumulated excess spending and to slow expected spending for the coming year.

[8]This allowed rate is the sustainable growth rate from which the SGR system derives its name. We use the abbreviation SGR when referring to the system and the full term of "sustainable growth rate" when referring to the allowed rate of increase.

[9]CMS calculates changes in physician input prices based on the growth in the costs of providing physician services as measured by the Medicare Economic Index, growth in the costs of providing laboratory tests as measured by the consumer price index for urban consumers, and growth in the cost of Medicare Part B prescription drugs included in SGR spending.

[10]Under the SGR and MVPS systems, the Secretary of Health and Human Services defined physician services to include "services and supplies incident to physicians' services," such as laboratory tests and most Part B prescription drugs.

Under SGR, spending per beneficiary adjusted for the estimated 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 slightly more than 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, MMA modified the SGR system to require that economic growth be 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.

When the SGR system was established, GDP growth was seen as a benchmark that would allow for affordable increases in volume and intensity. In its 1995 annual report to Congress, the Physician Payment Review Commission stated that limiting real expenditure growth to 1 or 2 percentage points above GDP would be a "realistic and affordable goal."[11] Ultimately, BBA specified the growth rate of GDP alone. This limit was an indicator of what the 105th Congress thought the nation could afford to spend on volume and intensity increases.

If cumulative spending on physician services is in line with SGR's target, the physician fee schedule update for the next calendar year is set equal to the estimated increase in the average cost of providing physician services as measured by the Medicare Economic Index (MEI). If cumulative spending exceeds the target, the fee update will be less than the change in MEI or may even be negative. If cumulative spending falls short of the target, the update will exceed the change in MEI. The SGR system places bounds on the extent to which fee updates can deviate from MEI. In general, with an MEI of about 2 percent, the largest allowable fee decrease would be about 5 percent and the largest fee increase would be about 5 percent.

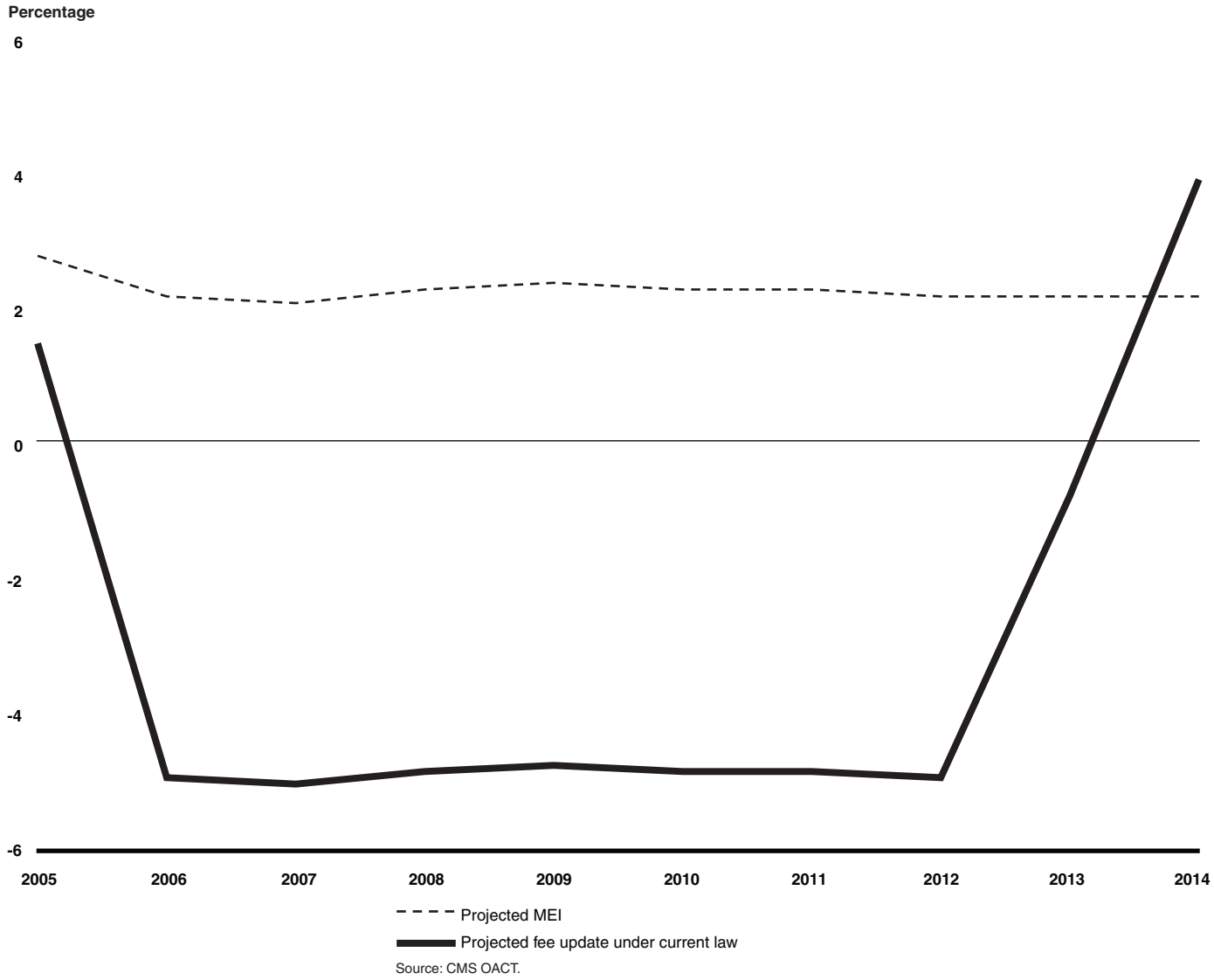
[11]Physician Payment Review Commission, *1995 Annual Report to Congress* (Washington, D.C.: 1995).

Continued Volume and Intensity Growth and Legislated Fee Updates Contribute to Projected Decline in Physician Fees

The 2004 Medicare Trustees Report announced that the projected physician fee 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.[12] According to projections made by CMS Office of the Actuary (OACT) in July 2004, maximum fee reductions will be in effect from 2006 through 2012, while fee updates will be positive in 2014. (See fig. 2.) There are two principal reasons for the projected fee declines: increases in volume and intensity that exceed the SGR's allowance—partly as a result of spending for Part B prescription drugs—and the minimum fee updates for 2004 and 2005 specified by MMA.

[12]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).

Figure 2: Projected MEI and Fee Update under Current Law



Source: CMS OACT.

Note: Projections are as of July 2004.

Volume and Intensity Growing Rapidly, Partly as a Result of Included Spending for Outpatient Drugs

Recent growth in spending due to volume and intensity increases has been larger than SGR targets allow, resulting in excess spending that must be recouped through reduced fee updates. In general, the SGR system allows physician fee updates to equal or exceed the MEI as long as spending growth due to volume and intensity increases is no higher than the average growth in real GDP per capita—about 2.3 percent annually. However, in July 2004, CMS OACT projected that the volume and intensity of physician services paid for under the physician fee schedule would grow by 3 percent per year. To offset the resulting excess spending, the SGR system will have to reduce future physician fee updates.

Additional downward pressure on physician fees arises from the growth in spending for other Medicare services that are included in the SGR system, but that are not paid for under the physician fee schedule. Such services include laboratory tests and many Part B outpatient prescription drugs that physicians provide to patients.[13] Because physicians influence the volume of services they provide directly—that is, fee schedule services—as well as these other services, defined by the Secretary of HHS as "incident to" physician services, expenditures for both types of services were included when spending targets were introduced. In July 2004, CMS OACT projected that SGR-covered Part B drug expenditures would grow more rapidly than other physician service expenditures, thus increasing the likelihood that future spending would exceed SGR system targets. To the extent that spending for SGR Part B drugs and other "incident to" services grows larger as a share of overall SGR spending, additional pressure is put on fee adjustments to offset excess spending and bring overall SGR spending in line with the system's targets. This occurs because the SGR system attempts to moderate spending only through the fee schedule, even when the excess spending is caused by expenditures for "incident to" services, such as Part B drugs, which are not paid for under the fee schedule.

[13]Most of the Part B drugs that Medicare covers fall into three categories: those typically provided in a physician office setting (such as chemotherapy drugs), those administered through a durable medical equipment item (such as a respiratory drug given in conjunction with a nebulizer), and those that are patient-administered and covered explicitly by statute (such as certain immunosuppressives).

MMA's Minimum Updates for 2004 and 2005 Contribute to Future Physician Fee Cuts

The MMA averted fee reductions projected for 2004 and 2005 by specifying an update to physician fees of no less than 1.5 percent for those 2 years. The MMA increases replaced SGR system fee reductions of 4.5 percent in 2004 and 3.3 percent in 2005 and thus will result in additional aggregate spending. Because MMA did not make corresponding revisions to the SGR system's spending targets, the SGR system must offset the additional spending by reducing fees beginning in 2006.

An examination of the SGR fee update that would have gone into effect in 2005, absent the MMA minimum updates, illustrates the impact of the system's cumulative spending targets. To begin with, actual expenditures under the SGR system in 2004 are estimated to be $84.9 billion, whereas target expenditures for 2004 were $77.1 billion. As a result, SGR's 2005 fee updates would have needed to offset the $7.8 billion deficit from excess spending in 2004 plus the accumulated excess spending of $5.9 billion from previous years to realign expected spending with target spending. Because the SGR system is designed to offset accumulated excess spending over a period of years, the deficit for 2004 and preceding years reduces fee updates for multiple years.

Alternatives for Updating Physician Fees Would Eliminate Spending Targets or Revise Current SGR System

The projected sustained period of declining physician fees and the potential for beneficiaries' access to physician services to be disrupted have heightened interest in alternatives for the current SGR system. In general, potential alternatives cluster around two approaches. One approach would end the use of spending targets as a method for updating physician fees and encouraging fiscal discipline. The other approach would retain spending targets but modify the current SGR system to address perceived shortcomings. These modifications include such options as removing the prescription drug expenditures that are currently counted in the SGR system; resetting the targets and not requiring the system to recoup previous excess spending; and raising the allowance for increased spending due to volume and intensity growth.

Alternatives to the SGR system would increase fees and thus aggregate spending—both government outlays and beneficiary cost sharing, including Part B premiums, for physician services relative to projected spending under current law.[14, 15] (See table 1.) While seeking to pay

[14]The Part B premium amount is adjusted each year so that expected premium revenues equal 25 percent of expected Part B spending. Beneficiaries must pay coinsurance—usually 20 percent—for most Part B services.

physicians appropriately, it is important to consider how modifications or alterations to the SGR system would affect the long-term sustainability and affordability of the Medicare program.

Table 1: Projected Effect on Fee Updates and Physician Services Spending under Current Law and Selected Potential Options for the SGR System, 2006 to 2014

Options	Minimum fee update	Years with negative fee update	Maximum fee update	Cumulative expenditures increase relative to current law
Current law	-5.0%	8	+3.9%	—
Eliminate spending targets	+2.1%	0	+2.4%	22%
Modify spending targets				
Set allowable growth to GDP+1 percent	-5.0%	6	+5.3%	4%
Reset spending base for SGR targets	-2.3%	6	+2.2%	13%
Remove Part B drugs	-5.0%	5	+5.3%	5%
Combine all three modifications	+2.2%	0	+2.8%	23%

Source: CMS OACT.

Eliminate Spending Targets, Base Fee Updates on Physician Cost Increases

In several reports to Congress, the Medicare Payment Advisory Commission (MedPAC) has recommended eliminating the SGR system of spending targets and replacing it with an approach that would base annual fee updates on changes in the cost of efficiently providing care as measured by MEI.[16, 17] Under this approach, efforts to control aggregate spending would be separate from the mechanism used to update fees. The advantage of eliminating spending targets would be greater fee update stability. According to CMS OACT simulations, such an approach would

[15]See GAO-05-85 for more information about these alternatives.

[16]See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2001, 2002, 2003, and 2004).

[17]MedPAC suggested that other adjustments to the update might be necessary, for example, to ensure overall payment adequacy, correct for previous MEI forecast errors, and to address other factors.

likely produce fee updates that ranged from 2.1 percent to 2.4 percent over the period from 2006 through 2014. (See table 1.) However, Medicare spending for physician services would rise, resulting in cumulative expenditures that are 22 percent greater over a 10-year period than under current law, based on CMS OACT estimates. Although MedPAC's recommended update approach would limit annual increases in the price Medicare pays for each service, the approach does not contain an explicit mechanism for constraining aggregate spending resulting from increases in the volume and intensity of services physicians provide. In 2004 testimony, MedPAC stated that fee updates for physician services should not be automatic, but should be informed by changes in beneficiaries' access to services, the quality of services provided, the appropriateness of cost increases, and other factors, similar to those that MedPAC takes into consideration when considering updates for other providers.[18]

Retain Spending Targets, Modify Current SGR System

Another approach for addressing the perceived shortcoming of the current SGR system would retain spending targets but modify one or more elements of the system. The key distinction of this approach, in contrast to basing updates on MEI, is that fiscal controls designed to moderate spending would continue to be integral to the system used to update fees. Although spending for physician services would likely also rise under this approach, the advantage of retaining spending targets is that the fee update system would automatically work to moderate spending if volume and intensity growth began to increase above allowable rates. The SGR system could be modified in a number of ways: for example, by raising the allowance for increased spending due to volume and intensity growth; resetting the base for the spending targets and not requiring the system to recoup previous excess spending; or removing the prescription drug expenditures that are currently counted in the SGR system.

Increase Allowance for Volume and Intensity Growth

The current SGR system's allowance for volume and intensity growth could be increased, through congressional action, by some factor above the percentage change in real GDP per capita. As stated earlier, the current SGR system's allowance for volume and intensity growth is approximately 2.3 percent per year—the 10-year moving average in real GDP per capita—while CMS OACT projected that volume and intensity growth would be

[18]Medicare Payment Advisory Commission, *Payment for Physician Services in the Medicare Program*, testimony before the Subcommittee on Health, House Committee on Energy and Commerce (May 5, 2004).

more than 3 percent per year. To offset the increased spending associated with the higher volume and intensity growth, the SGR system will reduce updates below the increase in MEI. According to CMS OACT simulations, increasing the allowance for volume and intensity growth to GDP plus 1 percentage point would likely produce positive fee updates beginning in 2012—2 years earlier than is projected under current law.[19] Because fee updates would be on average greater than under current law during the 10-year period from 2005 through 2014, Medicare spending for physician services would rise. CMS OACT estimated that cumulative expenditures over the 10-year period would increase by 4 percent more than under current law.[20] (See table 1.)

Reset Spending Base for Future SGR System Targets

In 2002, we testified that physician spending targets and fees may need to be adjusted periodically as health needs change, technology improves, or health care markets evolve.[21] Such adjustments could involve specifying a new base year from which to set future targets. Currently, the SGR system uses spending from 1996, trended forward by the sustainable growth rate computed for each year, to determine allowable spending.

MMA avoided fee declines in 2004 and in 2005 by stipulating a minimum update of 1.5 percent in each of those 2 years, but the law did not similarly adjust the spending targets to account for the additional spending that would result from the minimum update. Consequently, under the SGR system the additional MMA spending and other accumulated excess spending will have to be recouped through fee reductions beginning in 2006. If the resulting negative fee updates are considered inappropriately low, one solution would be, through congressional action, to use actual spending from a recent year as a basis for setting future SGR system targets and forgiving the accumulated excess spending attributable to MMA and other factors. The effect of this action would be to increase future updates and, as with other alternatives presented here, overall spending.

[19]We use GDP plus 1 percentage point as the allowance for volume and intensity growth for illustrative purposes only.

[20]In May 2004 testimony, CBO estimated that this option would raise net federal mandatory outlays by about $35 billion over the 2008–2014 period. Congressional Budget Office, *Medicare's Physician Fee Schedule*, testimony before the Subcommittee on Health, House Committee on Energy and Commerce (May 5, 2004).

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

According to CMS OACT simulations, forgiving the accumulated excess spending as of 2005—that is, resetting the cumulative spending target so that it equals cumulative actual spending—would raise fees in 2006. However, because volume and intensity growth is projected to exceed the SGR system's allowance for such growth, negative updates would return beginning in 2008 and continue through 2013. Resulting cumulative spending over the 10-year period from 2005 through 2014 would be 13 percent higher than is projected under current law. (See table 1.)

Remove Prescription Drugs from the SGR System

The Secretary of HHS could, under current authority, consider excluding Part B drugs from the definition of services furnished incident to physician services for purposes of the SGR system. Expenditures for these drugs have been growing rapidly, which, in turn, has put downward pressure on the fees paid to Medicare physicians. However, according to CMS OACT simulations, removing Part B drugs from the SGR system beginning in 2005 would not prevent several years of fee declines and would not decrease the volatility in the updates. Fees would decline by about 5 percent per year from 2006 through 2010. There would be positive updates beginning in 2011—3 years earlier than is projected under current law. (See table 1.) CMS OACT estimated that removing Part B drugs from the SGR system would result in cumulative spending over the 10-year period from 2005 through 2014 that is 5 percent higher than is projected under current law.[22]

Combine Multiple Spending Target Modifications

Together Congress and CMS could implement several modifications to the SGR system, for example, by increasing the allowance for volume and intensity growth to GDP plus 1 percentage point, resetting the spending base for future SGR targets, and removing prescription drugs. According to CMS OACT simulations, this combination of options would result in positive updates ranging from 2.2 percent to 2.8 percent for the 2006–2014 period. CMS OACT projected that the combined options would increase aggregate spending by 23 percent over the 10-year period. (See table 1.)

Concluding Observations

Medicare faces the challenge of moderating the growth in spending for physician services while ensuring that physicians are paid fairly so that beneficiaries have appropriate access to their services. Concerns have been raised that access to physician services could eventually be

[22]In May 2004 testimony, CBO estimated that this option would raise net federal mandatory outlays by about $15 billion through 2014. Congressional Budget Office, *Medicare's Physician Fee Schedule*, testimony before the Subcommittee on Health, House Committee on Energy and Commerce (May 5, 2004).

compromised if the SGR system is left unchanged and the projected fee cuts become a reality. These concerns have prompted policymakers to consider two broad approaches for updating physician fees. The first approach—eliminating targets—emphasizes fee stability while the second approach—retaining and modifying targets—includes an automatic fiscal brake. Either of the two approaches could be implemented in a way that would likely generate positive fee updates and each could be accompanied by separate, focused efforts to moderate volume and intensity growth. Because multiple years of projected 5 percent fee cuts are incorporated in Medicare's budgeting baseline, almost any change to the SGR system is likely to increase program spending above the baseline. As policymakers consider options for updating physician fees, it is important to be mindful of the serious financial challenges facing Medicare and the need to design policies that help ensure the long-term sustainability and affordability of the program. We look forward to working with the Subcommittee and others in Congress as policymakers seek to moderate program spending growth while ensuring appropriate physician payments.

Madam Chairman, this concludes my prepared statement. I will be happy to answer questions you or the 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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