

# CBO TESTIMONY

Statement of  
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## Medicare's Payments to Physicians: Options for Changing the Sustainable Growth Rate

before the  
Committee on Finance  
United States Senate

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Mr. Chairman, Senator Grassley, and Members of the Committee, I am pleased to appear before you today to discuss Medicare’s payments to physicians.

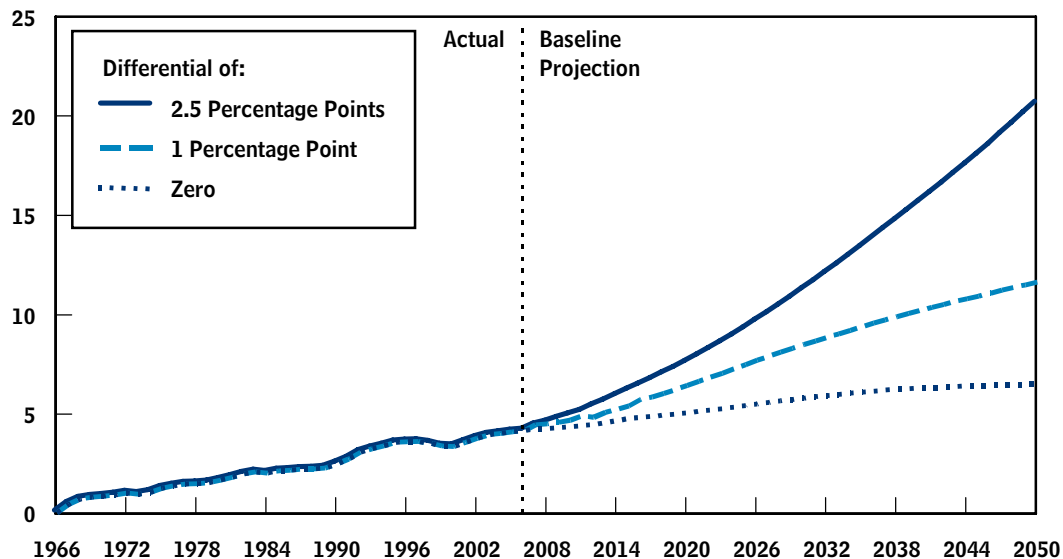
Since this is my first appearance before this Committee as Director of the Congressional Budget Office (CBO), I would also like to take the opportunity to underscore that the key long-term fiscal problem facing the nation involves projected health care costs (see Figure 1).

Policymakers face both challenges and opportunities in addressing projected growth in health care costs. Over long periods of time, cost growth per beneficiary in Medicare and Medicaid has tended to track cost trends in private-sector health markets. Many analysts therefore believe that significantly constraining the growth of costs for Medicare and Medicaid is likely to occur only in conjunction with slowing cost growth in the health sector as a whole. A variety of evidence suggests opportunities to constrain health care costs without adverse consequences. So a central challenge will be to restrain cost growth without harming incentives for innovation or Americans’ health (and perhaps even improving it). Moving the nation toward that possibility—which will inevitably be an iterative process in which policy steps are tried, evaluated and perhaps reconsidered—is essential to putting the country on a sounder long-term fiscal path.

**Figure 1.**

### Total Federal Spending for Medicare and Medicaid Under Different Assumptions About the Health Cost Growth Differential

(Percentage of gross domestic product)



Sources: Congressional Budget Office; Office of Management and Budget.

Note: The health cost growth differential refers to the number of percentage points by which the growth of annual health care spending per beneficiary is assumed to exceed the growth of nominal gross domestic product per capita.

With that broader point in mind, let me turn to the immediate topic of this hearing. The Supplementary Medical Insurance program (Part B of Medicare) uses a fee schedule to pay for covered medical services provided by physicians. According to CBO's projections, payments to physicians under the fee schedule will amount to \$60 billion in fiscal year 2007, or 14 percent of Medicare's total spending for benefits (\$425 billion) this year. Physicians' decisions, though, influence a much larger share of Medicare resources than suggested by that comparison.

The focus of my testimony is how physician fees are updated each year and potential options for changing that system. My testimony makes four main points:

- The current mechanism for updating payment rates for physicians' services—the Sustainable Growth Rate (SGR) method—entails a target level of expenditures (measured on both an annual and a cumulative basis) and a method for adjusting payment rates in an attempt to bring expenditures in line with the targets over time. If the SGR method operates as currently specified, CBO estimates that fees for physicians' services will be reduced by about 10 percent in 2008 and around 5 percent annually for at least several years after that.
- Legislation has prevented the reductions called for by the SGR mechanism from taking effect in recent years, and the Congress may choose to override the SGR mechanism again or may choose to change or replace it in the future. CBO's budget baseline assumes that the SGR mechanism will be implemented as currently specified, and replacing projected reductions in payment rates with annual increases would be costly. For example, repealing the SGR mechanism and allowing physician fees to rise in line with the Medicare economic index (MEI) would increase expenditures by an estimated \$262 billion over the next 10 years.<sup>1</sup>
- The SGR issue provides one illustration of the powerful role played by incentives in the health sector: Changes in fees will affect the behavior of physicians. For example, evidence suggests that fee reductions such as those implied by the SGR mechanism would result in a partially offsetting increase in the volume and intensity of services provided by physicians.<sup>2</sup> In addition, the future fee

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1. The Medicare economic index measures changes in the cost of physicians' time and 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 cost of physicians' time are measured using changes in nonfarm labor costs. Changes in "all-factor" productivity are also incorporated into the index as a way of accounting for improvements in physicians' productivity. As a result of the adjustment for productivity, the MEI is lower than the increases in input prices.

2. "Intensity" refers to the complexity of services utilized in caring for patients. For example, use of a computerized axial tomography (CAT) scan rather than an x-ray represents an increase in intensity.

schedule implied by the SGR mechanism could impair Medicare Part B beneficiaries' access to physicians.

- Finally, and perhaps most fundamentally, the task of setting payment rates for Medicare services must be addressed in the context of challenging long-run budgetary trends. In that context, it seems particularly useful to examine options for using the payment system to encourage the health system to deliver high-value and cost-effective care. Restructuring the SGR mechanism could offer an opportunity to provide stronger incentives toward this objective. Former administrator of the Centers for Medicare and Medicaid Services (CMS) Mark McClellan has described that objective as moving the fee-for-service system toward a “fee-for-value” one.

## Historical Background

Since the Medicare program was created in 1965, several ways of determining how much it pays physicians for each covered service have been used. Initially, the program compensated physicians on the basis of their charges and allowed them to bill beneficiaries for the full amount above what Medicare paid for each service. In 1975, Medicare payments were still linked to what physicians charged, but the annual increase in fees was limited by the Medicare economic index. Because those changes were not enough to prevent total payments from rising more than policymakers desired, from 1984 through 1991 the annual change in fees was determined by legislation.

Starting in 1992, the charged-based payment system was replaced by the physician fee schedule. The fee schedule bases payment for individual services on the estimated relative resources used to provide them. The schedule itself was not intended to control spending—it was designed to redistribute spending among various physicians' specialties. It was updated using a combination of the MEI and an adjustment factor designed to counteract changes in the volume of services being delivered per beneficiary. That adjustment factor, known as the volume performance standard (VPS), was based on the historical trend in volume. However, the VPS mechanism led to highly variable changes in payment rates, and the Congress replaced it with the current Sustainable Growth Rate method starting in 1998.<sup>3</sup>

## How the SGR Mechanism Works

The SGR mechanism aims to control spending on physicians' services provided under Part B of Medicare. It does so by setting an overall target amount of spend-

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3. For a more detailed discussion of the history of payment rates, see the statement of Douglas Holtz-Eakin, Director, Congressional Budget Office, *Medicare's Physician Fee Schedule*, before the Subcommittee on Health, House Committee on Energy and Commerce (May 5, 2004).

ing (measured on both an annual and a cumulative basis) on certain types of goods and services provided under Part B: payments for physicians' services as well as payments that Medicare makes for items—such as laboratory tests, imaging services, and physician-administered drugs—that are furnished in connection with physicians' services. Payment rates are adjusted annually to reflect differences between actual spending and the spending target—upward if spending is below the target, downward if spending is above the target.

The SGR mechanism consists of three components, all based on statutory formulas:

- Expenditure targets, which are established by applying a growth rate to spending during a base period;
- The growth rate; and
- Annual adjustments to payment rates for physicians' services, which are designed to bring spending in line with the expenditure targets over time.

### **The Expenditure Targets**

The SGR mechanism establishes both year-by-year and cumulative spending targets. Included in the targets is Medicare's spending on services covered by the physician fee schedule and services provided "incident to" a visit to a physician. The fee schedule determines how much physicians get paid for each of the services they provide. The "incident-to" goods and services include laboratory tests and physician-administered drugs, such as chemotherapeutic ones; payment rates for those services are not determined by the physician fee schedule.<sup>4</sup> Services on that fee schedule accounted for more than 80 percent of all spending counted toward the SGR target in 2006.

The SGR method uses spending that occurred between April 1, 1996, and March 31, 1997, as the base for all future spending counted toward the targets. During that base period, the amount of spending counted under the method totaled \$48.9 billion. Each year, the spending target is updated from the base level to reflect the growth rate determined by the SGR formula. That formula produced a sustainable growth rate of 3.2 percent for 1998. Consequently, the expenditure target that year was \$50.5 billion (\$48.9 multiplied by 1.032).

The annual targets are added together (along with the original base amount) to produce a cumulative target. The cumulative target in 1998 was \$99.4 billion (\$48.9 billion plus \$50.5 billion); according to CMS, the cumulative target in 2006 had reached \$693.3 billion.

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4. Payments for some services, such as laboratory tests, are based on their own fee schedules, which are usually updated annually for inflation. Payments for physician-administered drugs are based on market prices.

## The Growth Rate

The expenditure targets are updated each year by applying a growth rate (the SGR) designed to account for various factors that contribute to changes in Part B spending. That growth rate incorporates the following factors:

- First, it includes an adjustment for inflation that takes into account changes in the prices of goods and services used by physicians' practices and in the prices that Medicare pays for "incident-to" services. The change in prices of goods and services used by physicians' practices is measured by the Medicare economic index. CMS has determined that the aggregate of those factors will be 2.2 percent for 2007.<sup>5</sup>
- Second, the rate incorporates changes in enrollment in Medicare's fee-for-service sector, which CMS estimates will be a decline of 0.9 percent for 2007.
- Third, the SGR incorporates the estimated 10-year average annual growth rate in real (inflation-adjusted) gross domestic product (GDP) per capita, which CMS estimates at 2.0 percent.
- Fourth, the growth rate takes into account the effect of changes in law or regulation that would affect spending for services subject to the SGR mechanism—such as adding coverage of new benefits—which CMS has estimated at -1.5 percent for 2007. That figure will change, however, because recent legislation—the Tax Relief and Health Care Act (Public Law 109-432)—includes provisions that will cause changes in the SGR.<sup>6</sup>

Those four factors are multiplied to yield an overall growth rate of 1.8 percent in 2007:

Change in physicians' prices (1.022) x change in enrollment (0.991) x change in real GDP per capita (1.020) x changes in law or regulation (0.985) = 1.018

The expenditure target for services covered by the physician fee schedule in 2006 was \$81.7 billion. (That amount includes both spending by the Medicare program and cost-sharing obligations of beneficiaries.) Increasing the 2006 target by 1.8 percent results in an expenditure target of \$83.2 billion for 2007.

In essence, the SGR method allows spending per beneficiary to grow with inflation, with these additional adjustments:

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5. CMS usually sets the payment rates for each year in November of the preceding year.
  6. To date, CMS has not publicly announced what the new growth rate for 2007 will be. Before enactment of the Tax Relief and Health Care Act, the Deficit Reduction Act (P.L. 109-362) reduced payment rates for imaging services and made other changes affecting the SGR, contributing to the -1.5 percent change. CMS plans to release a revised estimate of the growth rate for 2007 later this month.

- A reduction that assigns the benefits of productivity improvements to the Medicare program (the MEI includes a productivity adjustment, which is the mechanism for assigning productivity gains to Medicare);
- An increase—which could be considered an allowance for growth in the volume and intensity of services—equal to the real change in GDP per capita; and
- An increase or decrease to reflect any changes in the coverage offered by the program.

Once a determination of the SGR has been made for a given calendar year, it is not necessarily fixed. If actual experience for one or more of the four growth factors differs from the estimates in the original calculation, the SGR for that year can be changed. In other words, if the SGR for 2007 is set assuming that fee-for-service enrollment will decrease by 0.9 percent and in actuality it changes by a different amount, the SGR for that year will subsequently be adjusted. In that case, the rates paid in 2007 would not change, but the cumulative target for subsequent years would be adjusted. The SGR—and therefore the expenditure targets—for a particular year can be retroactively adjusted for up to two years.

### **Annual Adjustments to Payment Rates**

The annual update to payment rates under the physician fee schedule involves two components: an inflation adjustment according to the MEI and an “update adjustment factor.” The adjustment factor is based on the relationship between actual spending for services subject to the SGR and the formula’s expenditure targets. If actual spending under the SGR does not deviate from the expenditure targets, payment rates under the physician fee schedule are simply increased by the MEI.

If actual spending deviates from the expenditure targets, annual updates to payment rates for physicians’ services are adjusted. Those adjustments are designed so that, over a period of several years, cumulative spending will be brought back into line with the cumulative expenditure target. The update adjustment formula takes into account both the relationship between spending in a given year and that year’s expenditure target and the relationship between cumulative spending and the cumulative expenditure target.

If actual spending is more than the targets, the update adjustment factor will be negative (that is, it will reduce the amount of the increase that would otherwise occur to reflect inflation); if actual spending is less than the targets, the update adjustment factor will be positive. The law sets upper and lower limits on the update adjustment factor—it cannot exceed an increase of 3 percent or a reduction of 7 percent. CMS determined that at the end of 2006, cumulative spending was about \$43 billion above the expenditure targets and that the update adjustment factor determined by the formula for 2007 would have been -25 percent; therefore, the statutory limit of -7 percent was used. Consequently, in 2007, payment rates for physi-



icians were scheduled to decrease by 5.0 percent: a 2.1 percent inflation adjustment was more than offset by an update adjustment factor of -7 percent.<sup>7</sup> However, the Tax Relief and Health Care Act overrode the formula for 2007 and held payment rates constant at their 2006 level.

It is important to note that under the SGR mechanism, the adjustment factor applies only to the physician fee schedule and not to payment rates for “incident-to” services, which last year accounted for about 18 percent of the spending counted toward the SGR targets. Consequently, the SGR mechanism will adjust payment rates for physicians’ services in future years to offset any difference between the rate of growth of spending for “incident-to” services and the growth rate of the SGR expenditure targets. If spending for the “incident-to” services grows faster than the SGR targets, payment rates for physicians’ services will be reduced to compensate for that increase. Prior to changes in the way physician-administered drugs were paid for in 2004, such “incident-to” spending experienced several years of double-digit growth. The share of SGR-related spending accounted for by physician-administered drugs increased from about 7 percent in 2001 to nearly 10 percent in 2006.

## **Experience Under the SGR Mechanism**

From 1997 (which is the starting point for measuring expenditures under the SGR method) through 2006, per-beneficiary spending on services paid for under the physician fee schedule grew by 75 percent, or 6.3 percent per year. In contrast, per-beneficiary spending on services paid for by Medicare on a fee-for-service basis grew by 40 percent, or 4 percent per year, over that same time period.

Increases in spending subject to the fee schedule can be attributed to increases in Part B enrollment, in the fees themselves, and in the volume and intensity of services being provided by physicians and to the addition of covered services. Since 1997, enrollment growth in Part B has averaged about 1 percent annually, and the fees that Medicare pays for each service have increased annually by an average of about 2 percent. Although some of the remaining increase has resulted from the addition of covered services, most of the rest is attributable to growth in the volume and intensity of services.

Because of that relatively rapid growth, spending measured by the SGR method has, since 2002, consistently been above the targets established by the formula. In 2006, expenditures counted under the SGR method totaled \$94.9 billion, \$13 billion more than the \$81.7 billion expenditure target for that year. Total spending since the SGR method was put into place in 1997 now stands at about \$43 billion

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7.  $(1 + 0.021) \times (1 - 0.07) = 0.94953$ .

above the system's cumulative target.<sup>8</sup> As a result, the SGR mechanism, under current law, will substantially reduce payment rates for physicians' services over the next several years. Payment rates could decline by nearly 40 percent by 2015 if physicians continue to provide services at the current rate.

## **Recent Legislation Affecting the SGR**

Since 2002, the SGR method has called for reductions in physician payment rates. In 2002, payment rates were cut by 4.8 percent, and CMS determined that rates would be further reduced by 4.4 percent in 2003. In the Consolidated Appropriation Resolution of 2003 (P.L. 108-7), the Congress responded to that imminent reduction by allowing the Administration to boost the cumulative SGR expenditure target, thereby producing a 1.6 percent increase in payment rates for physicians' services in 2003.

Spending continued to exceed the target and—if it had been allowed to operate—the SGR mechanism would have reduced payment rates in 2004. The Congress and the President acted to prevent such a reduction. As part of the Medicare Modernization Act (P.L. 108-173), they replaced the scheduled rate reduction with increases of 1.5 percent in both 2004 and 2005. The Deficit Reduction Act held 2006 payment rates at their 2005 level, overriding an impending reduction of 4.4 percent. The Tax Relief and Health Care Act again held overall payment rates constant for 2007.

The budgetary effect of legislative actions to override cuts in 2004, 2005, and 2006 was twofold. Federal spending on Medicare Part B benefits grew more than it would have otherwise. In addition, because of the specification that increases in the payment rates should not be considered a change in law or regulation for purposes of determining the expenditure target, the gap between cumulative spending and the cumulative target became larger than it would have been otherwise. Under the current SGR rules, growth in spending occurring as a result of those rate increases will eventually be recouped by future adjustments to payment rates. Consequently, the budgetary cost of any future legislative increases in payment rates was increased.

The budgetary effect of the legislation that overrode the cut scheduled for 2007 is different from that of previous legislative actions. The Tax Relief and Health Care Act specifies that holding the rates constant for 2007 should not affect payment rates in any year thereafter. That provision has the effect of allowing a rate reduction that is larger than what the SGR formula would normally allow. In order for 2008 payment rates to be unaffected by the 2007 change, they will have to decline by 10 percent from the 2007 levels. (From that point on, rates will decrease by

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8. Those figures include both spending by the Medicare program and beneficiaries' cost-sharing obligations for services. Cost sharing amounts to roughly 20 percent of the total spending counted under the targets.

about 5 percent annually for several more years.) In addition, the law specifies that increases in spending as a result of the rate change in 2007 should be considered the result of a change in law and regulation when determining the SGR expenditure target. Consequently, the increase in spending will not be recouped by future adjustments to payment rates.

The Tax Relief and Health Care Act contains two other provisions that could have an impact on payment rates for physicians' services. One is a voluntary program that will pay providers who comply with certain reporting requirements during part of 2007 a bonus of 1.5 percent of the payments they receive during that period. The law also appropriates \$1.35 billion to establish the Physician Assistance and Quality Improvement Fund, which is available for payments to physicians and initiatives to improve quality. That fund may be used to offset part of the rate reduction anticipated for 2008, but there is no explicit requirement in the law to do so. CBO assumes that the amount in the fund will be spent to enhance payments to physicians in 2008 but has made no explicit assumptions about exactly how it will be spent. Therefore, CBO's estimates of the cost of proposed changes to payment rates do not include any effect from spending from the fund. If, in the future, CMS announces that it plans to use the fund to help offset the 2008 rate reduction, CBO will incorporate that information into its estimates of the budgetary impact of proposed changes in rates.

## **Projected Spending for Physicians' Services**

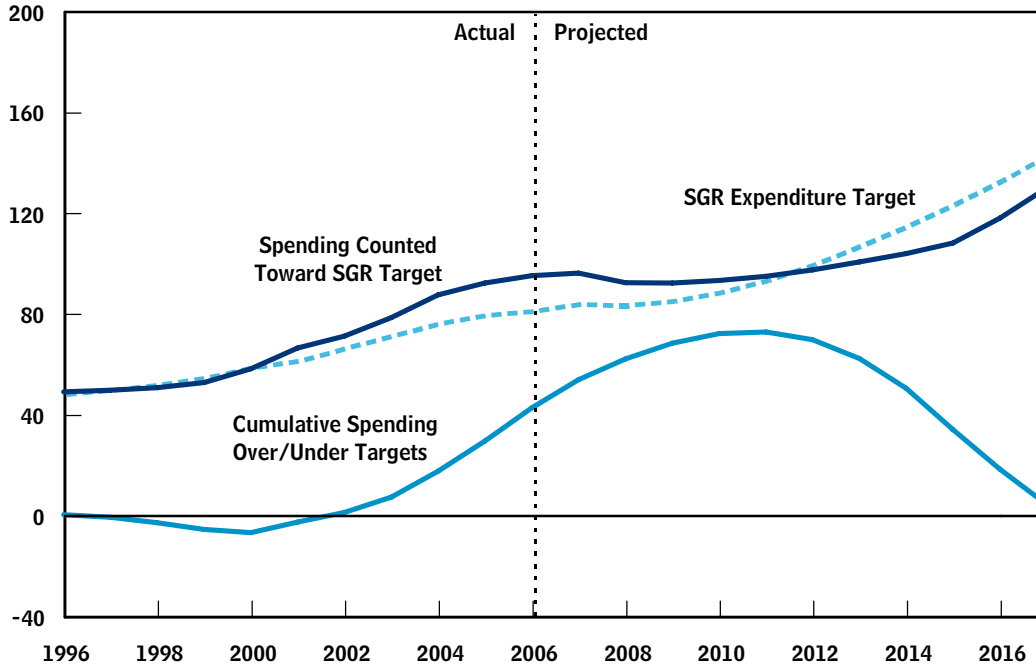
Looking forward, CBO projects that spending for physicians' services will continue to exceed the cumulative target for the next several years. If the SGR method is not modified again, it will reduce payment rates beginning in 2008 and will keep updates below inflation through at least 2015.

Because of the impending reductions in payment rates required under current law, Medicare spending on services provided by physicians is projected to grow relatively slowly for the next several years. CBO estimates that the decline in payment rates will be slightly more than offset by increases in enrollment and growth in the volume and intensity of services being delivered. As a result, CBO projects, Medicare spending on physicians' services will grow in coming years but in 2017 will be only 10 percent higher than it was in 2006, reflecting an average annual growth rate of about 1 percent. In contrast, from 1997 through 2006, such spending grew by an average of about 7.1 percent annually.

**Figure 2.**

## Sustainable Growth Rate Spending Compared with Expenditure Targets

(Billions of dollars)



Source: Congressional Budget Office.

Note: SGR = sustainable growth rate.

From 1997 through 2001, cumulative spending governed by the SGR mechanism was slightly below the expenditure target set by the formula (see Figure 2). Starting in 2002, cumulative spending rose above the cumulative target. According to CBO's projections through 2017, if the current SGR mechanism is permitted to operate, the cumulative deficit will continue to grow for several more years but will then decline as the annual growth in spending is slowed by the reductions in payment rates called for by the SGR mechanism. Toward the end of the period, CBO's projections show cumulative spending coming close to the cumulative target. The SGR mechanism is designed in such a way so that if viewed over a long enough period of time, cumulative spending will equal the cumulative target.

## Budgetary Implications of Changing the SGR

The Congress has a wide range of options for changing or replacing the SGR mechanism. In any such decision, an important question is whether payment rates in the future should be reduced to recoup the spending exceeding the SGR targets that has already occurred, along with any future spending above the targeted amounts. This testimony presents estimates for three illustrative examples, includ-

ing fully replacing the SGR targets with annual updates based on inflation. (The appendix includes estimates for a number of other options.) Each policy option would increase payments for physicians' services relative to those that would be made under current law, as well as payments that the government makes for beneficiaries enrolled in Medicare Advantage.<sup>9</sup> The policies would also increase beneficiaries' out-of-pocket costs because a 20 percent copayment is required for each service provided by a physician and premiums from beneficiaries finance about one-quarter of Part B's total cost. The budget estimates reflect all three of those effects. (The figures included below, however, focus solely on the gross changes in spending for physicians' services, not the net budgetary impact including all three effects.)

**Option 1: Freeze payment rates in 2008 and allow the SGR formula to determine updates in subsequent years.** This option would override the scheduled update for 2008 and hold overall payment rates under the physician fee schedule constant that year. In 2009 and subsequent years, payment rates would be determined by the SGR formula, under which the maximum adjustment factor of -7 percent would apply. In addition, if that action was not considered a change in law or regulation, the SGR expenditure targets would remain the same, and the difference between cumulative spending and the cumulative expenditure targets would be larger than is estimated under current law. Thus, the increase in spending attributed to the higher payment rate would eventually be recouped by the SGR mechanism, causing payment rates to be lower in the future than they would otherwise have been. Because the maximum adjustment factor is projected to apply for the much of the next 10 years, recouping the costs of this option would begin after that period has ended. This option is similar to what was enacted as part of the Deficit Reduction Act in 2006.

Spending for physicians' services under this option would be higher through 2016 and lower in subsequent years than the amount projected under current law (see Figure 3). According to CBO's estimates, this option would increase net federal outlays by \$22 billion over the 2008–2012 period and by \$34 billion over the 2008–2017 period. Under this option, spending per beneficiary would be about 5 percent lower in 2017 than it would be under current law.

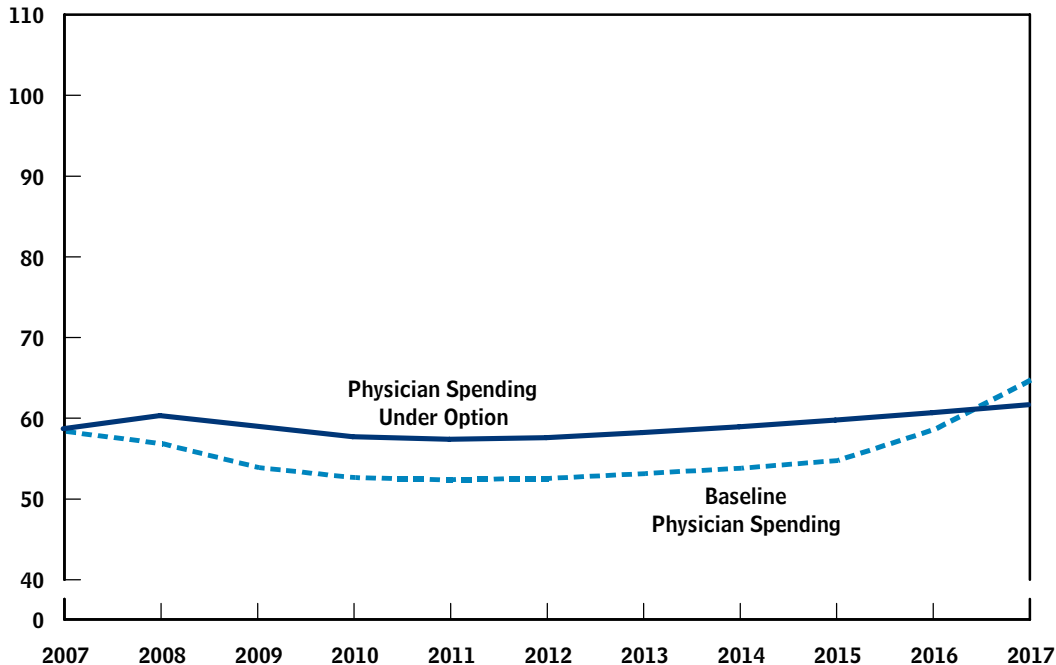
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9. Any increase in spending for physicians' services would increase the "benchmarks" that Medicare uses to determine how much the program pays for beneficiaries in the Medicare Advantage program. At the same time, about one-quarter of the changes in spending for physicians' services and for Medicare Advantage would be offset by changes in receipts from premiums that beneficiaries paid the government. However, legislation could specify that Part B premiums not be adjusted to reflect changes in spending resulting from changes in payment rates for physicians' services. Such a "premium hold-harmless" provision would increase federal costs by about 30 percent. The appendix includes estimates for several options that include such a provision.

**Figure 3.**

## Spending on Physicians' Services If Payment Rates Are Frozen in 2008 and the Sustainable Growth Rate Determines Subsequent Updates

(Billions of dollars)



Source: Congressional Budget Office.

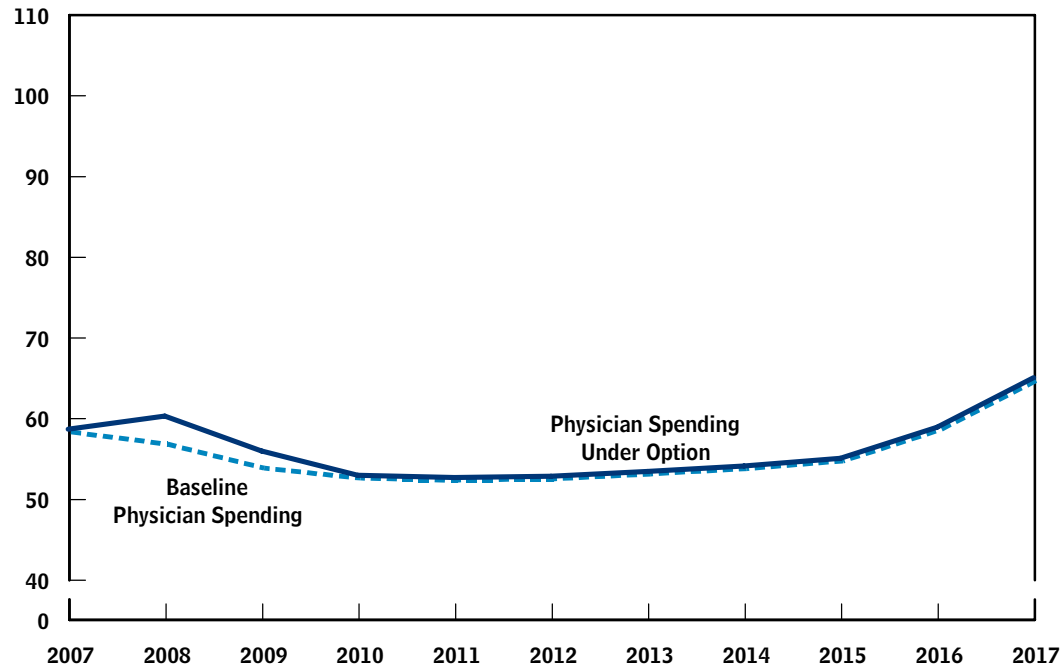
**Option 2: Freeze payment rates in 2008 and set payment rates in 2009 and beyond at the levels the SGR formula would specify under current law.** This option would override the update adjustment factor during 2008 and freeze overall payment rates that year. In 2009 and beyond, it would hold payment rates at their current-law levels, thus allowing rates to be reduced in 2009 by more than would be allowed under the SGR formula—around 15 percent that year. If that action was considered a change in law or regulation, the SGR would be adjusted to account for the increased payment rate, and the difference between cumulative spending and the cumulative target would be largely unchanged from that under current law. Spending increases resulting from this option would not be recouped by the SGR mechanism. This option is similar to what was enacted as part of the Tax Relief and Health Care Act of 2006.

Spending for physicians' services under this option would be higher than under current law for one calendar year (thus affecting two fiscal years) (see Figure 4). By CBO's estimates, this option would increase net federal outlays by \$4 billion over the 2008–2009 period. Under this option, spending per beneficiary would be the same in 2017 as it would be under current law.

**Figure 4.**

## Spending on Physicians' Services If Payment Rates Are Frozen in 2008 and Subsequent Rates Are Held at Current-Law Levels

(Billions of dollars)



Source: Congressional Budget Office.

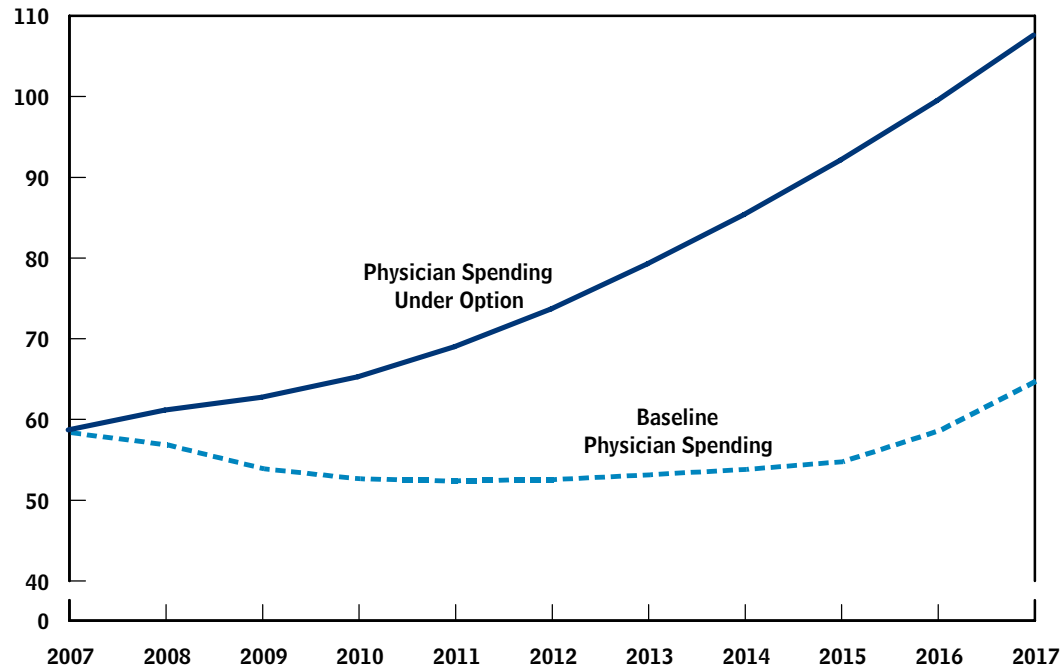
**Option 3: Allow payment rates to increase by medical inflation.** This option would repeal the current SGR mechanism and increase payment rates each year by the Medicare economic index. Instead of being reduced by approximately 10 percent in 2008 and about 5 percent annually for several years after that, payment rates would increase by around 2 percent annually. Those updates would not be subject to further adjustments, and spending increases would not be recouped.

Spending for physicians' services under this option would grow at an average annual rate of about 6 percent over the next 10 years, CBO estimates, compared with a 1 percent increase projected under current law. According to CBO's estimates, this option would increase net federal outlays by \$65 billion over the 2008-2012 period and by \$262 billion over the 2008-2017 period. Under this option, spending per beneficiary would be about 65 percent higher in 2017 than it would be under current law (see Figure 5).

**Figure 5.**

## Spending on Physicians' Services with the Sustainable Growth Rate Replaced by Updates Based on the Medicare Economic Index

(Billions of dollars)



Source: Congressional Budget Office.

### Potential Responses to Lower Payment Rates

In evaluating the SGR mechanism and potential changes to it, it is important to realize that significant reductions in payment rates for physicians' services could elicit changes in the behavior of both Medicare beneficiaries and physicians, affecting the volume and intensity of services that are provided. Beneficiaries, for example, who generally pay 20 percent of approved charges for covered services, could seek more (or more intensive) services if prices drop. However, because the vast majority of beneficiaries have supplemental insurance coverage (through a former employer, a medigap plan, or Medicaid) that insulates them from changes in the prices of Part B services, their response to such changes is likely to be small.

Physicians could respond to changes in payment rates in a number of ways. If Medicare's rates are reduced sufficiently, physicians could choose not to participate in the Part B program. At present, more than 90 percent of physicians and other providers have agreed to participate in Part B, and surveys generally show that beneficiaries have not faced significant difficulties in getting access to care.



That situation could change, however, if future payment rates are significantly reduced—as will occur if the SGR mechanism operates as currently specified in law.

Physicians could also respond to changes in payment rates by adjusting the supply of services they provide. Different models yield different predictions about how physicians would respond to a reduction in fees:

- Under a standard economic model in which physicians and physician groups maximize profits, a decline in the fees paid by Medicare would be predicted to lead to a decline in the quantity of services provided to Medicare beneficiaries.
- Under an alternative theory, physicians (through their recommendations about what treatments patients receive) respond to lower fees by inducing demand for their services to replace some or all of their lost income.
- Under a third method, physicians' responses are the net effect of two forces. A reduction in fees would, on the one hand, encourage physicians to do more work as a way to cushion their loss of income and would, on the other hand, encourage them to either shift to serving other types of patients or spend less time working—yielding a net effect that is ambiguous.

Much of the empirical work on the issue has examined changes in fees affecting limited types of services or procedures occurring over a short time span. That literature, which is limited in scope, has found both increases and decreases in the volume of services in response to fee reductions.

In contrast, broader studies focusing on changes in fees over longer periods and affecting all physicians tend to find an inverse relationship between changes in fees and volume—so when fees decline, volume increases. Those broader empirical studies, which are more useful for estimating the overall effects of fee changes in Medicare, tend to find that physicians respond to fee reductions by increasing volume and intensity, with elasticities of about -0.2.<sup>10</sup> In other words, a 1 percent reduction in fees would lead to a 0.2 percent increase in the volume or intensity of services that are provided—so spending would decline by about 0.8 percent instead of 1 percent.

CBO is currently examining the literature on physicians' responses to changes in fees and undertaking an empirical analysis of Medicare's experiences during the time period when the SGR mechanism has been in effect. The preliminary results, which are currently being reviewed, are in line with the previous literature. Note

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10. See Stephen Zuckerman and others, "Price Controls and Medicare Spending: Assessing the Volume Offset Assumption," *Medical Care Research and Review*, vol. 55, no. 4 (December 1998), pp. 457–483; and Memorandum from the Volume-and-Intensity Response Team, Health Care Financing Administration, Office of the Actuary, to Richard S. Foster, Chief Actuary, "Physician Volume and Intensity Response," August 13, 1998.

that behavioral reactions by physicians to fee changes are over and above an underlying trend (during the period when the SGR has been in effect) in which the volume and intensity of services have grown at an average of about 4.5 percent per year.

That type of response by physicians to changes in payment rates does not explicitly affect CBO's projections of spending on physicians' services over the long term because under the SGR mechanism, payment rates will automatically adjust to offset the effects of changes in volume and intensity. Thus, total costs will be governed by the SGR formula, but the nature of physicians' responses will affect the availability of services to Medicare beneficiaries, the intensity of utilization of those services, and the prices charged for them.

## **Encouraging Efficient Medical Practice**

Options for changing the SGR mechanism raise the broader possibility of moving the health system toward delivering better-value health care, which is an essential step toward putting the nation on a sound long-term fiscal path. If over roughly the next four decades, growth in health care costs per beneficiary continues to exceed growth in gross domestic product per capita by the same amount as over the past four decades, Medicare and the federal share of Medicaid will reach 20 percent of GDP in 2050, up from 4.5 percent today (as illustrated in Figure 1).

Better value could come from obtaining the same health outcomes at a lower cost or from better outcomes at currently projected spending levels. The first effect would directly improve the nation's projected fiscal imbalance. The second effect would mean that the revenues used to finance health programs were being put to more effective use.

Improving the quality of care provided through the health system will require changes in incentives. Recent initiatives, for example, aim to provide higher payments to those physicians who comply with "best practice" guidelines and other measures of quality. Medicare is introducing a voluntary reporting program that will collect quality measures for certain physicians' services. That program, under the Tax Relief and Health Care Act, is slated to begin in July 2007 and could be a foundation for future initiatives aimed at improving the quality of care under Medicare. CMS is also operating demonstration programs that link payments to the quality of care delivered to Medicare beneficiaries. Findings from those programs will provide valuable information about which paths are better suited to increase the value of the program.

The Congress could also lay the groundwork for other changes designed to discourage overuse of care under Medicare's fee-for-service method for compensating physicians—shifting the system toward payments tied to quality or efficiency. For example, doctors could be required or encouraged to participate in a system that evaluated usage patterns and provided feedback to individual doctors on their

practice patterns relative to their peers'. Another option involves grouping physicians into multispecialty units that would share some financial responsibility with Medicare for the utilization of care by patients served by the group. Some proposals envision placing doctors in a virtual group based on the hospital that their patients use (or on some other criterion); utilization across groups could then be aggregated and compared, and incentives could be created for physicians to economize on the services provided.

Systems for shifting incentives toward higher-value care require two changes to the underlying health infrastructure. The first is an information infrastructure to collect data on patients' conditions, the services ordered by physicians, and health outcomes and to distribute information back to individual doctors or groups. The second is an adequately funded effort, whether inside the government or outside it, to analyze the data, evaluate comparative effectiveness, and perhaps design and implement payment systems that reward the more efficient practice of medicine. The Congressional Budget Office will be examining both of those key steps in future reports. Even with such systems in place, shifting the incentives for providers will necessarily be an iterative process, in which both innovative medical interventions and payment mechanisms are tried, evaluated, and recalibrated.

In addition to creating the necessary infrastructure and altering incentives for providers, financial incentives could be changed for consumers. Despite the fact that Medicare's fee-for-service benefit package includes a deductible and 20 percent copayments for physicians' services, the vast majority of Medicare patients do not face those payments because they have some form of supplemental coverage. Such coverage reduces or eliminates incentives to weigh the cost of services against their potential benefits. CBO's 2007 *Budget Options* volume, which was released last Friday, includes an analysis of proposals that would decrease federal outlays by limiting the extent of such supplemental coverage and by making other changes in the cost-sharing requirements of Medicare's fee-for-service program, including the addition of catastrophic protection.



# Appendix:

## Budgetary Effects of Alternative Proposals for Medicare's Payments for Physicians' Services

**Table A-1.**

### Estimated Changes in Net Federal Outlays from Alternative Proposals for Changing Physician Payment Rates, Fiscal Years 2008 to 2017

(Billions of dollars)

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008- 2012	2008- 2017
Freeze Payment Rates in 2008 and Hold Future Rates at Current-Law Levels	2.5	1.7	0	0	0	0	0	0	0	0	4.2	4.2
Freeze Payment Rates in 2008 and 2009 and Hold Future Rates at Current-Law Levels	2.5	6.3	2.5	0	0	0	0	0	0	0	11.4	11.4
0 Percent Update in 2008	2.5	4.8	4.8	4.8	4.8	4.9	4.9	4.8	1.7	-3.6	21.7	34.4
0 Percent Update in 2008 and Premium Hold-Harmless	3.2	6.1	6.1	6.1	6.2	6.3	6.3	6.1	2.2	-4.6	27.7	44.1
0 Percent Update in 2008 and 2009	2.5	6.3	7.2	7.2	7.3	7.4	7.5	7.4	4.4	-0.9	30.6	56.2
0 Percent Update in 2008 and 2009 and Premium Hold-Harmless	3.2	8.1	9.2	9.3	9.4	9.5	9.6	9.4	5.6	-1.2	39.2	72.1
1 Percent Update in 2008	2.8	5.3	5.3	5.3	5.3	5.4	5.5	5.3	2.3	-3.1	23.9	39.3
1 Percent Update in 2008 and Premium Hold-Harmless	3.6	6.8	6.7	6.8	6.8	6.9	7.0	6.8	2.9	-3.9	30.6	50.4
1 Percent Update in 2008 and 2009	2.8	7.2	8.2	8.3	8.4	8.5	8.6	8.4	5.5	0.2	34.9	66.0
MEI Update in 2008	3.2	6.0	6.0	6.0	6.1	6.1	6.2	6.1	3.0	-2.3	27.2	46.4
MEI Update in 2008 and 2009	3.2	8.4	9.8	9.8	9.9	10.0	10.2	10.1	7.1	1.9	41.1	80.3

Continued

**Table 1.****Continued**

(Billions of dollars)

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008- 2012	2008- 2017
"Reset" SGR Targets at 2007 Spending Level <sup>a</sup>	3.2	8.0	10.4	12.6	15.1	18.7	23.3	29.0	32.0	32.6	49.2	184.8
Freeze Physician Payment Rates at 2007 Level Through at Least 2017	2.5	6.5	9.4	12.6	15.9	19.6	23.7	28.4	29.9	28.9	46.9	177.4
Automatic MEI Update (Replace SGR)	3.2	8.7	12.9	17.6	22.6	28.1	34.3	41.4	45.7	47.7	65.0	262.1
Automatic MEI Update (Replace SGR) and Premium Hold-Harmless	4.1	11.1	16.4	22.3	28.6	35.5	43.3	52.1	57.3	59.8	82.4	330.5

Source: Congressional Budget Office.

Notes: Estimates are based on the Congressional Budget Office's March 2007 baseline.

MEI = Medicare economic index; MA = Medicare Advantage; SGR = sustainable growth rate.

Except for the first two and last three options, estimates assume that the normal SGR mechanism would apply after the specified period. The first two options would allow for a larger reduction in payment rates than would otherwise be permitted by the SGR formula. In addition, increases in spending resulting from those two options would be considered a change in law or regulation and would not be subject to being recouped by the SGR mechanism. The other options except the last three would not be considered a change in law or regulation, so increases in spending would be subject to being recouped by the SGR mechanism.

Proposals that include a "premium hold-harmless" provision would exclude increases or decreases in spending attributable to them from calculations of the Part B premium.

- a. This option would forgive all spending that has accrued above the cumulative targets and set both the cumulative target and cumulative spending to zero as of December 31, 2006, using calendar year 2007 as the base period for future application of the SGR mechanism.