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MEDICARE PHYSICIAN PAYMENTS

Concerns about Spending Target System Prompt Interest in Considering Reforms

GAO-05-85

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Highlights

Highlights of GAO-05-85, a report to congressional committees

Why GAO Did This Study

Concerns were raised about the current system Medicare uses to determine annual changes to physician fees—the sustainable growth rate (SGR) system—when fees were reduced by 5.4 percent in 2002. Subsequent administrative and legislative actions modified or overrode the SGR system, resulting in fee increases for 2003, 2004, and 2005. However, projected fee reductions for 2006-2012 have raised new concerns about the SGR system. Policymakers are considering whether to eliminate spending targets or modify them.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required that GAO study SGR and potential alternatives to the system. This report examines (1) how the SGR system is designed to control spending for physician services, (2) what concerns have been raised about the SGR system and its components, (3) what affects the stability and predictability of physician fee updates under the SGR system, and (4) what alternatives to the current SGR system exist. GAO reviewed relevant laws and regulations and interviewed officials and organizations representing physicians. On the basis of this information, GAO identified potential alternatives to the SGR system and requested illustrative simulations of fee updates and spending on physician services from the Centers for Medicare & Medicaid Services (CMS).

www.gao.gov/cgi-bin/getrpt?GAO-05-85.

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 to cause spending to exceed the SGR target, fee updates are set lower than inflation in the cost of operating a medical practice. A wide enough gap between spending and the target results in fee reductions.

Physician groups are dissatisfied with SGR as a system to update physician fees. For example, they question the fairness of including rapidly growing spending for physician-administered drugs in the SGR system's definition of physician services expenditures. The groups also contend that the allowance for growth in volume and intensity is too low and lacks the flexibility to allow for factors outside physicians' control.

Fee updates under the SGR system have varied widely within an allowed range largely because of annual fluctuations in the growth of the volume and intensity of services that physicians provide to beneficiaries. Certain system design features, such as the use of cumulative spending targets and the need to estimate data, also reduce the stability and predictability of updates. However, MMA's revision of the allowance for growth in volume and intensity of services from an annual change to a 10-year moving average will help to make future updates more stable and predictable.

Possible alternatives to the SGR system cluster around the two broad approaches under consideration: (1) end the use of spending targets and separate fee updates from explicit efforts to moderate spending growth or (2) retain spending targets but modify the current SGR system to address perceived shortcomings. CMS projects that either of the two approaches will result in higher aggregate spending, thereby increasing the difficulty of addressing Medicare's long-run financial challenges. The first approach emphasizes stable fee updates, while the second approach automatically adjusts fee updates if spending growth deviates from a predetermined target. While seeking to pay 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. In this context, the choice between the two approaches may hinge on whether primary consideration should be given to stable fee increases or to the need for fiscal discipline within the Medicare program.

CMS agreed with the concluding observations in the draft report. Groups representing physicians commented that overall, the draft report offered a good analysis of problems with the SGR system, but did not fully reflect their concerns. We modified the draft as appropriate.

Contents

Abbreviations

BBA	Balanced Budget Act of 1997
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
CBO	Congressional Budget Office
CMS	Centers for Medicare & Medicaid Services
CPI-U	consumer price index for urban consumers
ESRD	end-stage renal disease
FFS	fee-for-service
GDP	gross domestic product
HHS	Department of Health and Human Services
HI	Hospital Insurance
MedPAC	Medicare Payment Advisory Commission
MEI	Medicare Economic Index
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MVPS	Medicare volume performance standard
OACT	Office of the Actuary
PAF	performance adjustment factor
PPRC	Physician Payment Review Commission
SGR	sustainable growth rate
SMI	Supplementary Medical Insurance

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Congressional Committees

Physicians and others raised concerns about the current system Medicare uses to determine annual changes to physician fees when those fees were reduced by 5.4 percent in 2002. This reduction was triggered, in part, because spending on physician services had exceeded predetermined spending targets and Medicare's system for updating fees—the sustainable growth rate (SGR) system—called for a reduction in fees to impose fiscal discipline.[1] Subsequent administrative and legislative actions modified or overrode the SGR system, resulting in fee increases for 2003, 2004, and 2005. Absent additional action, however, fees are expected to fall by approximately 5 percent each year beginning in 2006 and continuing through 2012 as the SGR system attempts to offset previous excess spending and align actual spending with the system's spending targets. According to physician groups, such a decline in fees would likely discourage many physicians from treating Medicare beneficiaries. As a result of these concerns, policymakers are interested in considering the appropriateness of current spending targets and the SGR system as a method for determining physician fee updates. Essentially, they are considering whether to eliminate spending targets or retain them, while making modifications to the system.

Although the current focus of concern is largely on the potential for declining physician fees, the historic challenge for Medicare has been to find ways to moderate the rapid growth in spending for physician services under the Medicare Supplementary Medical Insurance (SMI)—or Part B—program. In the 1980s, attempts to moderate spending by limiting physician fees without addressing aggregate expenditures for physician services were unsuccessful because increases in the number of services physicians provided per beneficiary—known as volume—and the average complexity and costliness of those services—known as intensity—continued to drive up spending. As a result, in the Omnibus Budget Reconciliation Act of 1989,[2] the Congress required the establishment of a

[1]The SGR system reduced fees by 4.8 percent. Additional adjustments resulted in a total fee reduction of 5.4 percent.

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

national Medicare physician fee schedule and a system for annually updating fees that included spending targets. The fee schedule and spending targets first affected physician fees in 1992. The SGR system, Medicare's current system for updating physician fees, was established in the Balanced Budget Act of 1997 (BBA) and was implemented in 1998.[3] Both the SGR and its predecessor system provided for cumulative fee updates that generally exceeded cumulative increases in physicians' cost of providing services.[4] Since the establishment of the national fee schedule and spending targets, the growth in spending for Medicare physician services has slowed substantially. Nonetheless, recent increases in physician expenditures due to volume and intensity growth are a reminder that the historic challenge of moderating spending growth has not disappeared.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required us to study certain adjustments to physician fees, including the SGR system and alternatives to the system.[5] As discussed with the committees of jurisdiction, this report examines (1) how the SGR system is designed to control spending for physician services, (2) what concerns have been raised about the SGR system and its components, (3) what affects the stability and predictability of physician fee updates under the SGR system, and (4) what alternatives to the current SGR system exist.

In addressing these objectives, we analyzed Medicare expenditure data from the Medicare Trustees' 1998 and 2004 annual reports.[6] We also reviewed laws and regulations pertaining to the SGR system and its predecessor spending target system and interviewed officials at the

[3]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. Physician fees were first affected by the SGR system in 1999.

[4]Specifically, from 1992 through 2001, fee updates resulting from the SGR and its predecessor system, increased by 39.7 percent, whereas input prices increased by 25.9 percent. These updates do not reflect other required adjustments, such as those for legislated changes and for budget neutrality.

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

[6]Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *1998 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (Washington, D.C.: Apr. 28, 1998), and *2004 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: Mar. 23, 2004).

Centers for Medicare & Medicaid Services (CMS), the agency responsible for administering Medicare; the Congressional Budget Office (CBO); the Medicare Payment Advisory Commission (MedPAC);[7] and organizations representing physicians, including the American Medical Association, the Medical Group Management Association, the Alliance for Specialty Medicine, and the American College of Physicians. On the basis of these document reviews and interviews, we identified potential alternatives to the SGR system. We requested illustrative simulations of fee updates and total spending under these alternatives from the CMS Office of the Actuary (OACT).[8] Total spending includes expenditures from all sources—that is, government outlays and beneficiary spending, including monthly Part B premiums, deductibles, and coinsurance payments.[9] Because the simulation estimates produced by CMS OACT include total spending from all sources, the estimated spending changes will differ from CBO's cost estimates for the same alternatives. CBO, which is responsible for estimating how legislated changes would affect federal spending, does not include beneficiary spending when it estimates the cost of SGR alternatives. CMS OACT and CBO estimates may also differ as the result of differences in the underlying assumptions used by the two agencies. Our analyses apply only to spending affected by the SGR system—that is, physician spending in the traditional fee-for-service (FFS) program. We assessed the reliability of the Medicare expenditure data and data used for the simulations under alternatives to the SGR system by interviewing agency officials knowledgeable about the data and who are responsible for producing the projections for the SGR system. We determined that the data were sufficiently reliable for the purposes of our study. We performed this work from January 2004 through September 2004 in accordance with generally accepted government auditing standards.

[7]MedPAC is an independent federal body that advises the Congress on issues affecting the Medicare program.

[8]CMS OACT has the program responsibility to calculate Medicare's spending targets for physician services and annual physician fee updates. In producing these simulations, CMS OACT used the agency's assumptions regarding the various factors that affect the SGR system, such as projected fee-for-service enrollment.

[9]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.

Results in Brief

To help impose fiscal discipline and moderate Medicare spending for physician services, the SGR system sets spending targets and adjusts fees paid to physicians based on the extent to which actual spending aligns with specified targets. SGR system targets are designed to allow real spending per beneficiary—that is, spending per beneficiary adjusted for the estimated underlying cost of providing physician services—to grow at the same rate that the national economy (as measured by the rate that real gross domestic product (GDP)) grows over time on a per capita basis—currently estimated to be about 2.3 percent annually.[10] If Medicare spending for physician services remains on target, the annual increase in physician fees is set equal to the estimated change in physicians' cost of providing services.[11] However, if growth in the volume and intensity of services provided is high enough to cause spending to exceed the SGR system target, future fee updates are set below the estimated increase in physicians' average cost for providing services—in other words, physicians receive fee increases that are lower than the Medicare Economic Index (MEI). If the gap between spending and the target is wide enough, the SGR system results in fee reductions. Conversely, if volume and intensity growth is low enough to cause spending to fall below the target, the SGR system benefits physicians by producing fee increases that exceed the change in their cost of providing services. Under the SGR system's cumulative spending targets, excess spending that is not offset in one year accumulates in succeeding years until it is recouped.

Physician groups are dissatisfied with SGR as a system to update physician fees and have raised various concerns about its components. In general, they note that expenditures for physician services constitute Medicare's only spending that is subject to a target system. Physician groups report that under this system, fee updates—which are explicitly linked to spending controls—have caused payment rates in recent years to fall behind physicians' cost of providing services. Among specific concerns, physician groups question the fairness of reducing fee updates for physician services to offset rapidly growing expenditures for certain outpatient drugs that are covered by Medicare Part B and that are largely physician administered. The groups also contend that the SGR system's

[10]This rate incorporates the 10-year moving average of real GDP per capita.

[11]The change in the cost of providing physician services is measured by the Medicare Economic Index (MEI). MEI measures input prices for resources needed to provide physician services. It is designed to estimate the increase in the total cost for the average physician to operate a medical practice.

allowance for spending growth due to volume and intensity increases—the growth rate of real GDP per capita—is too low and inflexible. Physician groups contend that as a result, factors outside physicians' control—such as any future declines in the FFS population's average health status and introduction of new, effective medical technology—may cause spending to exceed the SGR system targets and thus lead to reduced fee updates. Additional concerns include whether CMS's method used to account for spending increases due to changes in laws and regulations—which can change payments or expand the extent and number of Medicare-covered services—is sufficiently complete, accurate, and transparent.

For several reasons, fee updates under the SGR system have varied—within a specified range—and have been difficult to predict accurately.[12] A principal cause of variation within this range has been annual fluctuations in the growth of the volume and intensity of services that physicians provide to beneficiaries. Since the SGR system was implemented in 1998, volume and intensity growth has ranged from 1.2 percent in 1999 to 6.1 percent in 2002. Two system design characteristics also reduce the stability and predictability of updates. First, the SGR system is designed to respond to fluctuating volume and intensity growth by adjusting fee updates to keep cumulative spending in line with the targets. Attempting to control cumulative spending tends to amplify the variation in annual updates. For example, if spending has exceeded the spending target, the SGR system must reduce future updates both to slow future spending growth and to recoup previous excess spending. Second, uncertainty in estimates of data used in the SGR system makes long-term estimates of fee updates less predictable and causes updates to vary from year to year as new data become available and estimates of data used in the SGR system are revised.

Alternatives to the SGR system we identified cluster around the two approaches that policymakers are considering. One approach would end the use of spending targets—separating fee updates from efforts to moderate spending growth. MedPAC is a proponent of this approach and since 2001 has recommended tying fee updates to estimated changes in physicians' cost of providing services. It has further recommended that Medicare seek to control spending growth by, among other things,

[12]The SGR system permits annual physician fee updates to vary by as much as 7 percent below to 3 percent above the estimated change in physicians' cost of providing services as measured by MEI.

identifying and addressing the utilization of rapidly growing services, such as diagnostic imaging. The other approach includes alternatives that would retain spending targets but modify the current SGR system to address perceived shortcomings. These modifications could include removing the Part B prescription drug expenditures that are currently counted in the SGR system; resetting the targets by not requiring the system to recoup previous excess spending; using annual, rather than cumulative, targets to dampen the fluctuation in fee updates; and modifying the allowance for increased spending due to volume and intensity growth. The advantage of eliminating spending targets would be greater fee update stability and predictability, whereas the advantage of retaining spending targets as part of the system for updating fees is that the system would automatically work to moderate spending if volume and intensity growth began to increase above allowable rates. However, either approach compared to current law, under which fees are projected to be reduced by as much as 5 percent or more for several years, will be very expensive—ranging from 4 percent to 23 percent higher cumulative spending over the 10-year period from 2005 to 2014. Given the importance of the long-term sustainability and affordability of the Medicare program, examining the impact of spending over a longer period may be appropriate when contemplating modifications or alternatives to the SGR system.

CMS agreed with our concluding observations and expressed its commitment to pay physicians appropriately to ensure that Medicare beneficiaries have access to high-quality health care. Groups representing physicians commented that overall, a draft of our report offered a good analysis of problems with the SGR system, but indicated it did not fully reflect the extent of their concerns. Some of the issues the groups raised were outside the scope of our report. We modified the report as appropriate.

Background

Medicare spending per beneficiary on physician services has varied substantially—both among geographic areas and in its growth over time. The geographic variation in spending—unrelated to beneficiary health status or outcomes—provides evidence that health needs alone do not determine spending. Consequently, policymakers have deemed it both reasonable and desirable to question the appropriateness of current and projected physician services spending and to explicitly consider the affordability of such spending when setting physician fees. The implementation of a national fee schedule and spending targets in 1992, for example, was designed, in part, to address issues of affordability and program sustainability by slowing spending growth. Moderating this

growth remains part of the larger effort to ensure future Medicare program sustainability.

Some Spending on Physician Services May Be Unnecessary, as Suggested by Unwarranted Regional Variation in Use of Physician Services

In 1989, the Physician Payment Review Commission (PPRC) reported that from 1979 through 1989 (the decade prior to the establishment of spending targets), Medicare spending on physician services per beneficiary more than tripled, rising much more rapidly than general inflation.[13] At that time, PPRC recommended an expenditure target for controlling aggregate spending on physician services. The target was to apply initially to all physician services nationally and later to evolve to separate targets for regions, categories of physician services, or both.

Then, as now, utilization of physician services varied widely by geographic area, while the Medicare patient populations in these areas differed little from one another in their illnesses. Some studies report that variation in service use indicates that in some parts of the country compared with others, there was either overuse or underuse of services. Recent studies of Medicare expenditures show that regional variation in the use of medical services remains and that the spending disparities among areas are explained by physicians' discretionary practices rather than by differences in patient populations' health status.[14]

Physician Service Expenditures Have Grown Less Rapidly after Spending Targets and Fee Schedule Were Established

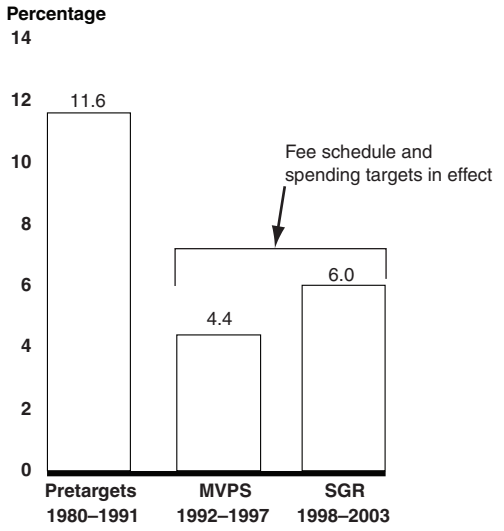
Three periods from 1980 to the present describe Medicare's recent experience in spending for physician services. Figure 1 shows growth in Medicare spending per beneficiary for physician services during the three periods. In the first period, 1980 through 1991, Medicare's payment rates for physician services were based on historical charges for these services, and limits were placed on fees and fee updates but not on aggregate

[13]PPRC, established by the Congress in the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, §9305, 100 Stat. 82, 190-91 (1986), was charged with advising the Congress on methods to reform payment to physicians under the Medicare program and with making recommendations annually. Subsequent legislation expanded PPRC's responsibilities to include, among other things, setting standards for expenditure growth and updating fees and monitoring beneficiary access and financial liability. In 1997, BBA dissolved PPRC and the Prospective Payment Assessment Commission and formed MedPAC. BBA, §4022, 111 Stat. 350-355.

[14]John E. Wennberg, Elliot S. Fisher, and Jonathan S. Skinner, "Geography And The Debate Over Medicare Reform," *Health Affairs* Web Exclusive, February 13, 2002; E.S. Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine* (2003): 273–287; and E.S. Fisher et al.,"The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* (2003): 288–298.

spending. In the 1992 through 1997 period, physician services were paid under a national fee schedule, and the first spending target system—called the Medicare volume performance standard (MVPS)—set an allowable growth rate for aggregate spending that was used to adjust physician fees. From 1998 on, services continue to be paid under a fee schedule and the SGR system replaced the MVPS system and uses a different method to set an acceptable growth rate for aggregate spending.

Figure 1: Average Annual Percentage Change in Medicare Spending for Physician Services per Beneficiary, 1980–2003



Source: 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: Spending changes for 1980 through 1991 are for the years ending June 30 and represent average Medicare spending for beneficiaries in the traditional FFS program, net of beneficiary cost sharing. Spending for end-stage renal disease (ESRD) patients is not included. Spending changes for 1992 through 1997 and 1998 through 2003 are for calendar years and represent changes in total allowed charges—Medicare spending, including beneficiary cost sharing—for beneficiaries in the traditional FFS program.

In the 1980s, 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). Under this system, payment inconsistencies existed among physicians by services, specialties, and locations. The system also had an inflationary bias, as a rise in customary charges could increase prevailing charges over

time.[15] During this decade, expenditures for physician services grew rapidly: from 1980 through 1991, Medicare spending per beneficiary for physician services grew at an average annual rate of 11.6 percent. Although the Congress froze fees or limited fee increases in the 1980s, spending continued to rise because there were no limits on growth in the volume and intensity of services physicians provided to beneficiaries.

Recognizing that the expenditure growth of the 1980s was not sustainable, the Congress reformed the way Medicare paid for physician services in the traditional FFS program by requiring the establishment of a national fee schedule for physician services and a system for controlling aggregate physician service spending, MVPS. The establishment of a fee schedule in 1992 was an attempt to break the link between physicians' charges and Medicare payments. The fee schedule was designed to pay for services based on the relative resources used by physicians to provide different types of care and to address the inflationary bias of the charge-based system. The adoption of a spending target system was an attempt to control spending growth attributable to increases in the volume and intensity of physician services.

Under MVPS, a performance standard for a given year was set, indicating a growth rate for expenditures that should not be exceeded. The extent to which actual expenditure growth fell above or below the performance standard helped to determine the update to physician fees 2 years later. For example, in 1993, CMS compared actual spending in 1992 with the performance standard for 1992; the difference largely determined the update to physician fees in 1994.[16] The performance standard was based on changes in four factors: the number of FFS Medicare beneficiaries, practice cost inflation, the historical growth in volume and intensity, and laws and regulations that could affect spending for physician services.[17]

From 1992 through 1997—the period that MVPS was used to set fee updates—annual spending growth for physician services was far lower than in the preceding decade. The decline in spending growth during this

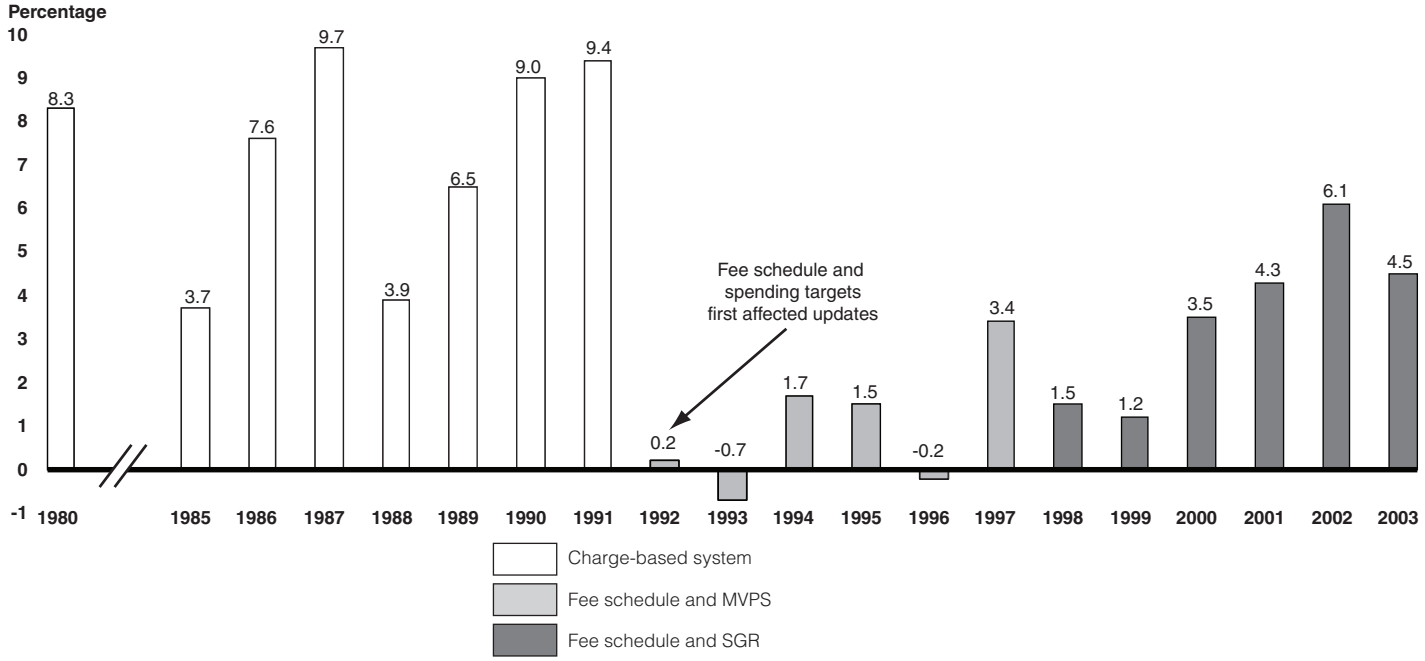
[15]Beginning in 1975, increases in prevailing charges were limited to the change in MEI.

[16]Under MVPS, the fee updates depended on both the change in MEI and the difference between actual spending and the performance standard.

[17]Inflation was measured as a weighted average of input price increases, estimated by MEI for physician services and the consumer price index for urban consumers (CPI-U) for laboratory services.

period was the result, in large part, of slower volume and intensity growth. For example, from 1985 through 1991, spending per beneficiary grew at an average annual rate of 10.8 percent; during that period, volume and intensity of service use per beneficiary rose an average 7 percent annually. From 1992 through 1997, the growth in spending per beneficiary fell to 4.4 percent; during that period, average annual growth in volume and intensity of service use per beneficiary fell to 1 percent. (See fig. 2.)

Figure 2: Growth in Volume and Intensity of Medicare Physician Services per Beneficiary, 1980–2003



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

Notes: Data are for beneficiaries in the traditional FFS program only. Data for ESRD patients are not included. From 1980 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.

Concerns about the MVPS spending targets arose in 1995 when physician fees were expected to fall over time unless there were continual declines in the volume and intensity of services provided.[18, 19] In response to the

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

system's perceived shortcomings, the Congress took action in BBA in 1997 to replace it with the SGR system.[20] In 1998 and 1999, the first 2 years of the SGR system, volume and intensity growth remained similar to the rate under MVPS. However, from 2000 through 2003, volume and intensity growth rose at an average annual rate of about 5 percent.[21] Over the 1998–2003 SGR system period,[22] the average growth in volume and intensity of services per Medicare beneficiary was higher than the average for the 1992–1997 MVPS period—but substantially below that experienced before spending targets were introduced. Since the introduction of the SGR system, total spending on physician services is projected to grow by an average of 8 percent a year from 2000 through 2005.

Controlling Spending for Physician Services Part of Larger Challenge to Maintain Fiscal Discipline in Medicare

In 2003, Medicare spending for physician services totaled nearly $48 billion,[23] which accounted for about one-sixth of program spending overall. We and others have argued for the need for additional fiscal discipline in Medicare.[24] Within the next 10 years, the federal budget will experience significant increases in spending pressure, due primarily to known demographic trends and rising health care costs. Expected technological advances—involving new drugs and diagnostic procedures, among other things—may improve health outcomes but will likely increase the price tag of a Medicare program that is already unsustainable

[19]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.

[20]The SGR system was revised by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), (Pub. L. No. 106-113, App. F, §211(b), 113 Stat. 1501A-321, 348-49) and by MMA (see §601(b), 117 Stat. 2301).

[21]This recent growth in volume and intensity for physician services is higher than the 3 percent a year that CMS OACT is projecting for 2005 through 2014.

[22]In 2002, a year in which physicians' fees fell by 5.4 percent, volume and intensity grew by 6.1 percent, the largest growth in a single year since the fee schedule and spending targets were introduced.

[23]This figure does not include spending associated with Medicare's private plan option.

[24]GAO, *Medicare: Financial Challenges and Considerations for Reform*, GAO-03-577T (Washington, D.C.: Apr. 10, 2003); Congressional Budget Office, *Medicare's Long-Term Financial Condition*, testimony before the Joint Economic Committee (Apr. 10, 2003); Office of Management and Budget, *Analytical Perspectives*, *Budget of the United States Government*, *Fiscal Year 2005* (Washington, D.C.: Feb. 2, 2004); and Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, *2004 Report of the Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds*.

in its present form. In light of physician service expenditures' significant contribution to aggregate spending, containing their growth plays an important role in helping to address the program's long-range and fundamental financing problem.

SGR System Designed to Adjust Fee Updates to Bring Actual Spending for Physician Services in Line with Spending Targets

The SGR system is designed to impose fiscal discipline and to moderate spending for physician services by adjusting annual fee updates to bring spending in line with targets. The SGR system, similar to the predecessor MVPS system, relies on spending targets because earlier attempts to achieve fiscal discipline through limits on fee increases did not control the spending that resulted from volume and intensity growth. The SGR system uses a formula specified in statute to establish each year an allowed spending growth rate, a spending target, and a fee update. Like MVPS, the SGR system includes an allowance for volume and intensity increases but, unlike MVPS, ties the allowance to a measure of the growth of the national economy.

Spending Targets for Physician Services Used to Encourage Fiscal Discipline

As noted, spending targets were established—first under MVPS and later under the SGR system—because policymakers contended that the fee schedule alone would not have adequately constrained expenditure growth for physician services. The fee schedule limits payment for individual services but does not moderate spending growth resulting from volume and intensity increases. Although the SGR system's spending target does not cap expenditures for physician services, it serves as a budgetary control by automatically lowering fee updates in response to excess spending due to volume and intensity growth. In addition, reduced fee updates serve as a signal to physicians collectively and to the Congress that spending due to volume and intensity has increased more than allowed.

An additional reason for spending targets was advanced by PPRC in its 1995 report to the Congress.[25] PPRC explained that spending targets were intended, in part, to create a collective incentive for physicians. Specifically, the report stated that spending targets "provid[e] the medical profession with a collective incentive to reduce inappropriate care by, for instance, developing and disseminating practice guidelines that promote cost-effective practice styles."

[25]Physician Payment Review Commission, *1995 Annual Report to Congress*.

SGR System Sets Allowable Spending Growth and Targets for Physician Services

Every year, CMS must estimate the allowed rate of increase in spending for physician services and use that rate to construct the annual spending target for the following calendar year.[26] The sustainable growth rate is the product of the estimated percentage change in (1) input prices for physicians' services; [27, 28] (2) the average number of Medicare beneficiaries in traditional FFS; (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. CMS's current estimate of the sustainable growth rate for 2005 is 4.6 percent, based on the agency's estimates of the four factors. (See table 1.)

Table 1: CMS's Estimate of the 2005 Sustainable Growth Rate and Its Determinants, as of March 2004

	Estimated percentage change
Sustainable growth rate determinants	
Input prices for physician services[a]	2.6
Traditional FFS Medicare enrollment	-0.2
Real GDP per capita	2.2
Expenditures for physician services resulting from changes in laws and regulations	0.0
Estimated 2005 sustainable growth rate	4.6[b]

Source: CMS OACT.

[a]For purposes of the sustainable growth rate, physician services include services paid for by the fee schedule as well as laboratory services and certain Medicare-covered Part B outpatient drugs.

[b]The sustainable growth rate is computed as the product of the percentage change in the four factors. The percentage changes are expressed in decimal form relative to 1.0. For example, a percentage change of 2.6 percent is expressed as 1.026. Therefore, the sustainable growth rate is computed as (1.026) x (0.998) x (1.022) x (1.0) = 1.046 , or 4.6 percent.

[26]This allowed rate is the sustainable growth rate from which the SGR system derives its name. For the purposes of this report, 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.

[27]CMS calculates changes in physician input prices based on the growth in the costs of providing physician services as measured by MEI, growth in the costs of providing laboratory tests as measured by CPI-U, and growth in the cost of Medicare Part B prescription drugs included in SGR spending.

[28]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.

To set each year's spending target, the SGR system increases the previous year's spending target by the sustainable growth rate for the given year.[29] For example, target spending for 2004 was $77.3 billion. Target spending for 2005 is 4.6 percent higher, or $80.9 billion. Under the SGR system, every annual target depends on the targets set in all previous years since the base year 1996.[30] BBRA required CMS, in calculating each year's SGR system spending target, to first revise the targets set for the 2 previous years using the most recent available data for all elements of the target—that is, revisions to figures for input prices for physician services, FFS beneficiary enrollment, real GDP per capita, and expenditures due to relevant new laws and regulations.[31, 32]

SGR System Adjusts Fee Updates to Align Spending with Target

Every fall, CMS determines whether the fee update for the following calendar year must be adjusted to help align spending with targets.[33] To do so, the agency compares actual spending, measured cumulatively since 1996, to the cumulative value of the annual targets, measured over the same period. If the two are equal, the fee update is set to equal the estimated increase in physicians' average cost of providing services—as measured by MEI. Otherwise, a performance adjustment factor (PAF) is used to increase or decrease the update relative to MEI in order to help bring spending back in line with the targets. (See app. I for the formula used to calculate the PAF.) The PAF is subject to limits and may not cause the update to be set at more than 3 percent above MEI or 7 percent below MEI. In part because of these limits, adjustments to realign actual cumulative spending with cumulative targets are spread out over more than 1 year.[34]

[29]The SGR system changed from a fiscal year basis to a calendar year basis in 2000.

[30]The base year is the 12-month period ending March 31, 1997.

[31]See BBRA, §211(b), 113 Stat. 1501A348-49.

[32]Revisions to targets first affected fee updates in 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.

[33]Estimates of the fee update for the following year are made in the spring. The final fee update is announced in November.

[34]The formula used in the SGR system spreads the recoupment of excess spending over several years. Statutory limits on the PAF can increase the time necessary to recoup excess spending.

For example, in projecting the update for 2005, CMS estimated that cumulative spending from 1996 through 2004 ($543.8 billion) exceeded the cumulative value of the annual targets during the same period ($531.9 billion) by approximately $11.9 billion. The estimated $11.9 billion difference is due to two components of accumulated excess spending and needs to be offset: first, excessive growth in volume and intensity in 2003 and 2004, and second, the additional spending attributable to MMA. MMA replaced a fee reduction for 2004 with a minimum 1.5 percent increase, but it did not adjust SGR system targets to account for the additional spending.[35] Because of the large discrepancy between spending and the target, the SGR system calls for the maximum PAF reduction. In conjunction with an estimated MEI of 2.8 percent, the application of the PAF would produce a fee update of negative 4.4 percent.[36] In addition to MEI and the PAF, fees are sometimes subject to other adjustments, including those set by law. For 2005, there is an additional adjustment of 0.8 percent, which results in an estimated SGR system fee update for 2005 of negative 3.6 percent. (See table 2.) However, this negative update will be overridden by an MMA-specified minimum update of 1.5 percent for 2005. The resulting fee update is applied to the fee schedule's "conversion factor," a dollar amount that translates each service's relative value into an actual disbursement amount. [37, 38]

[35]See MMA, §601(a)(1), 117 Stat. at 2300.

[36]For 2005, the product of the change in input prices multiplied by the PAF is equal to

[(1+.028) x (1 – 0.07)] –1 = -0.044, or - 4.4 percent.

[37]The fee for each service is determined using a resource-based relative value scale in which the resources required for a service are valued in relation to the resources required to provide all other physician services adjusted for the differences in the costs of providing services across geographic areas. To arrive at a fee, the service's relative value is multiplied by the dollar conversion factor.

[38]The update to the dollar conversion factor represents the aggregate of increases and decreases across all services. Because the relative value of individual services can change yearly, fee changes for specific services may be different than the overall fee update.

Table 2: Estimated 2005 Fee Update, as of March 2004

	Percentage change
Estimated 2005 fee update under SGR system[a]	-3.6
Update based on:	
• Change in input prices for physician services (MEI)[b]	2.8
• PAF	-7.0
• BBRA required adjustment[c]	0.8
2005 fee update as specified in MMA[d]	1.5

Source: CMS OACT.

[a]Update is computed as the product of the change in input prices, the PAF, and the BBRA-required adjustment; all are expressed in decimal form. That is, 2005 fee update = [(1+0.028) x (1 – 0.07) x (1+ 0.008)] –1 = -0.036 or -3.6 percent.

[b]For purposes of the fee update, physician services include only services paid for under the fee schedule.

[c]This adjustment, required by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), maintains the budget neutrality of a technical change to the conversion factor.

[d]The actual fee update for 2005 is the greater of the calculated update of –3.6 percent or 1.5 percent as legislated by MMA.

Under SGR's system of cumulative spending targets, excess spending that is not offset in one year accumulates in succeeding years until it is recouped. For 2005, MMA increased actual spending but did not adjust the target for this additional spending. Now the gap between actual spending and the target will result in an additional deficit that under the SGR system will have to be recouped through negative updates in future years.

SGR System Ties Allowed Increases in Volume and Intensity to Growth in National Economy

The parameters of the SGR system allow spending due to the volume and intensity of physician services to increase, but limit that growth to the same rate that the national economy (GDP) grows in real terms (that is, adjusted for inflation) over time on a per capita basis. Under the SGR system, if the volume and intensity of physician service use grows faster than the national economy, the annual increase in physician fees will be less than the estimated increase in the cost of providing services. Conversely, if volume and intensity grows more slowly, the SGR system permits physicians to benefit from fee increases that exceed the increased cost of providing services. To reduce the effect of yearly business cycles on physician fees, MMA required that economic growth be measured as the 10-year moving average change in real GDP per capita for each year

beginning in 2003.[39] 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 and also one that represented a significant improvement over the benchmark included in the previous MVPS system. In its 1995 annual report to the Congress, PPRC stated that limiting real expenditure growth to 1 or 2 percentage points above GDP would be a "realistic and affordable goal."[40] Ultimately, BBA specified the growth rate of GDP alone. This limit was an indicator of what the nation could afford to spend on volume and intensity increases. Whether this rate is a sufficient and appropriate allowance for volume and intensity increases is uncertain. Currently, volume and intensity is projected to grow by more than 4 percent per year, whereas the allowance for this growth under the SGR system is about 2.3 percent annually. Such excess volume and intensity growth is a key contributing factor to negative fee updates.

Various Concerns Raised about SGR System and Its Components

Physician groups are dissatisfied with SGR as a system to update physician fees and have raised various concerns about its key components. Noting that physicians are uniquely subject to a system of fee updates that are explicitly linked to spending controls, the groups contend that the SGR system has caused payment rates in recent years to fall behind physicians' cost of providing services. The groups' concerns with specific SGR system components center on the following issues: the fairness of including Medicare-covered outpatient drugs in the calculation of physician service expenditures; the appropriateness of tying allowable volume and intensity increases to the average growth in real GDP per capita; and the completeness, accuracy, and transparency of the method used to account for spending increases due to changes in laws and regulations.

[39]See MMA, §601(b), 117 Stat. at 2301.

[40]Physician Payment Review Commission, *1995 Annual Report to Congress.*

Physicians Dissatisfied That Medicare Spending for Physician Services Is Subject to Spending Targets

Physician groups are concerned that physicians are the only Medicare provider type whose annual payment updates are subject to a spending target system. Payment rate updates for hospitals and other institutional providers, they note, are typically based on changes in the cost of providing services. However, as CBO, MedPAC, and others have noted, physicians are different from other providers in certain ways, which helps to provide a rationale for the application of targets solely to physician expenditures. Specifically, they note that physicians determine the services they deliver to their patients and influence the care delivered by other providers. In addition, under Medicare payment policies, physicians receive a separate payment for each service they provide. Thus, they can boost income by increasing the volume or intensity of services they provide. For example, a physician may follow up a patient's visit by scheduling another visit, even when such a follow-up visit is discretionary and could be substituted with a telephone call. In contrast, Medicare typically pays institutional providers a fixed amount for a bundle of services; under this arrangement, no inherent incentive exists to provide extra services, as doing so would not increase payments.

Physicians Question Fairness of Including Part B Outpatient Drugs in Calculation of Physician Service Expenditures

One of physician groups' chief concerns is that through fee schedule updates, the SGR system holds physicians accountable for the escalating growth in Medicare expenditures for the majority of Part B-covered drugs.[41] (Drugs included in the SGR system are largely physician administered and do not include all Part B-covered drugs.) The groups contend that the SGR system should not include these drugs in the calculation of aggregate physician service expenditures or the spending targets. Although the targets account for increases in the drugs' prices, the targets do not explicitly account for increases in their utilization or the substitution of more expensive drugs for less expensive ones. Physician groups note that the use of the outpatient drugs currently covered by Medicare is largely nondiscretionary and that physicians should not be penalized for prescribing these drugs. To the extent that expenditures for these Medicare-covered outpatient drugs grow faster than real GDP per capita—which is the SGR system's allowance for volume and intensity increases—other physician spending must grow more slowly or aggregate

[41]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).

spending will exceed the targets and fee updates for physician services will be reduced.

In 2002, Medicare covered approximately 450 outpatient prescription drugs. The drugs that account for most of Medicare's Part B drug expenditures are physician administered, such as those for cancer chemotherapy, accounting for 80 percent of total Medicare spending for Part B drugs in 2001. In 2001, oncologists submitted about 42 percent of prescription drug claims, while urologists accounted for 17 percent.

Part B prescription drugs are not covered by the physician fee schedule,[42] but the expenditures for most Part B drugs are included in the SGR system expenditures because, at the time spending targets were first introduced, the Secretary of Health and Human Services (HHS) included these drugs as services and supplies "incident to" physicians' services. Since that time, Medicare spending for all Part B drugs has grown substantially, from about $700 million in 1992 to an estimated $8.5 billion in 2002. Much of the spending growth has resulted from increases in utilization and the substitution of newer, more expensive medications. Because SGR-covered Part B drug expenditures have grown more rapidly than other physician service expenditures, drug expenditures as a proportion of allowable spending under the targets have grown from 8.7 percent in 2002 to an estimated 12.3 percent in 2004. Such rapid growth in drug expenditures increases the likelihood that actual spending will exceed SGR system targets. Moreover, because only payments for services included in the physician fee schedule are offset when physician service spending deviates from the spending targets, the increase in the share of total expenditures attributed to prescription drugs magnifies the adjustment that must be made to the update to bring spending in line with the targets.

[42]In general, payment for covered outpatient prescription drugs is made under Medicare Part B and is equal to either 85 percent or 95 percent of the average wholesale price, depending on the drug. MMA provided for the implementation of a new payment methodology beginning in 2005. See MMA, §303, 117 Stat. 2233-2255. The legislation also establishes a new voluntary prescription drug benefit program under a new Part D of Title XVIII of the Social Security Act that will be effective January 1, 2006.

Physicians Concerned That Key Spending Drivers Are Not Included in SGR System's Allowance for Volume and Intensity Growth

Physician groups have expressed concern that the SGR system's allowance for volume and intensity growth—the 10-year moving average growth in real GDP per capita—is both too low and inflexible. They contend that tying the allowance to GDP results in targets that do not adequately account for appropriate increases in the demand for physician services and changes in medical practice, such as the following:

- *A sicker beneficiary population*. Physician groups reason that although health status drives demand for services, the GDP growth allowance would not account for any increases in physician spending that could be due to greater care demands per beneficiary.
- *Technological advances*. The groups note that new, expensive medical technologies can provide meaningful health gains for Medicare beneficiaries but that these technology costs are likely to grow faster than GDP.
- *Site-of-service shifts*. The groups note that patients with complex conditions formerly treated in hospitals are increasingly treated in physician offices and that treating such patients, who may require frequent office visits and costly procedures, is likely to contribute to volume and intensity growth.

The MVPS system provided an explicit opportunity to address some of these concerns procedurally. In addition to the allowance for volume and intensity growth specified in statute, the MVPS system also provided specific authority for the HHS Secretary to recommend revising the allowed increase based on factors such as changes in technology and concerns about access to physician services. Under the MVPS system, the Secretary never exercised the authority to make recommendations other than implementing the MVPS default formula, but it still remained an option.

Transparency Lacking in Process for Estimating Changes in Medicare Spending for Physician Services due to Laws and Regulations

The SGR system is designed to account for changes in law and regulation that could affect aggregate spending for physician services. For example, for 2005, CMS estimates that increased spending resulting from MMA's coverage of a preventive physical examination for new beneficiaries, cardiovascular screening blood tests, and diabetes screening tests, among other new increases, will be almost fully offset by new MMA-required payment adjustments for Part B drugs, which will lower physician service spending. Physician groups we spoke with contend that the process for developing such estimates may not be accurate or complete.

Assessing the accuracy and completeness of these estimates is difficult, as CMS's process for identifying the applicable statutory and regulatory changes and the methods used to arrive at dollar estimates are not fully transparent. Either data are lacking to quantify the effects of changes or consensus is lacking on the assumptions and interpretations made about the changes and their effects. Currently, CMS does not use a formal mechanism for soliciting input from physician groups or other experts before obtaining public comment when future fees are announced in the Federal Register.[43] Physician groups contend that at least including physician representatives in the process of assessing changes in laws and regulations would improve CMS's analysis of effects and would be more efficient than waiting for the public comment period.

Variable Growth in Provision of Physician Services and Certain SGR System Design Elements Reduce Stability and Predictability of Physician Fee Updates

Fee updates under the SGR system have varied widely within an allowed range, principally because of annual fluctuations in the growth of the volume and intensity of services that physicians provide to beneficiaries. Two of the SGR system's design characteristics—the cumulative nature of spending targets and the use of estimated data elements in the spending target—also serve to reduce the stability and predictability of updates. The MMA provision that revised the allowance for growth in service volume and intensity from real GDP per capita growth rates each year to a 10-year moving average will reduce some of the swings in future SGR system updates.

Fluctuating Volume and Intensity Growth Is a Principal Cause of Instability of Fee Updates

Annual fluctuations in the growth of the volume and intensity of services that physicians provide to beneficiaries have been a principal cause of the instability of physician fee updates. Since the SGR system was implemented in 1998, volume and intensity growth has ranged from 1.2 percent in 1999 to 6.1 percent in 2002. (See fig. 2.) It is uncertain how much physicians' discretion in the provision of their services contributes to the fluctuation in volume and intensity growth.

[43]CMS is required to publish the final conversion factor update for the upcoming calendar year by November 1. In the period prior to publishing the final update—a period that usually runs from August to October—CMS collects public comments in response to its proposed rule. It is at this time that physician groups are able to submit formal comments on CMS's estimate of this factor.

Several studies have found that physicians respond to reduced fee updates by increasing the volume and intensity of services they provide to help maintain their total Medicare income.[44] In estimating future spending and fee updates, both CMS and CBO assume that physicians will compensate, through volume and intensity increases, for a portion of any fee reductions. Consequently, both CMS and CBO project that for example, a 1 percent fee reduction would cause aggregate spending to fall by less than 1 percent. In addition, CBO assumes that physicians will respond to fee increases by reducing volume and intensity.

Physician groups contend that volume and intensity growth is a necessary response to increased demand caused by factors outside of physicians' control as noted earlier, such as the declining health status of Medicare beneficiaries, Medicare coverage of new benefits, and changing medical technology and practices that encourage beneficiaries to schedule more appointments with physicians. As long as the contributing factors are not fully understood and predictable, unexpected volume and intensity fluctuations will result in uncertain fee updates year to year.

SGR System's Cumulative Targets Increase Potential Fluctuation of Physician Fee Updates

The cumulative nature of the SGR system's spending targets increases the potential fluctuation of physician fee updates, as the system requires that excess spending in any year be recouped in future years. Conceptually, this means that if actual spending has exceeded the SGR system targets, fee updates in future years must be lowered sufficiently to both offset the accumulated excess spending and slow expected spending for the coming year. Conversely, the system also requires that if spending were to fall short of the targets, fees would need to be increased so that future spending would be raised to align with target spending.

Estimation of the 2005 fee update illustrates how excess spending that is not addressed affects future fee updates. In 2004 actual expenditures under the SGR system are estimated to be $83.4 billion, whereas target expenditures for the same year will be $77.3 billion. As a result, 2005 fee updates need to offset a $6.1 billion deficit from excess spending in 2004 (plus accumulated excess spending of $5.8 billion in past years) and to

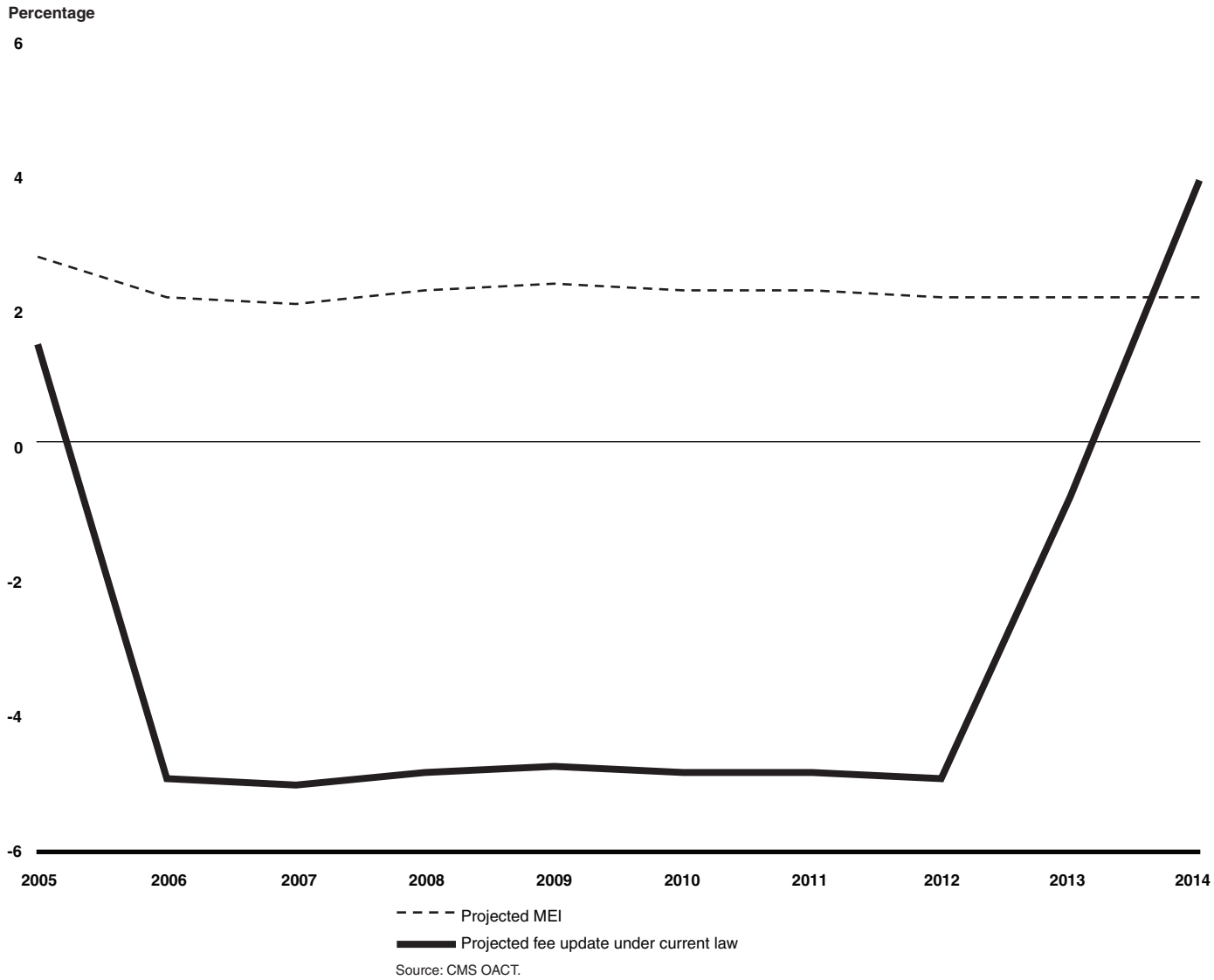
[44]CMS OACT has analyzed the results of these studies. See Office of the Actuary, Centers for Medicare & Medicaid Services, "Physician Volume and Intensity Response Memorandum," August 13, 1998.

realign the year's expected spending with target spending.[45] Because the SGR system is designed to offset accumulated excess spending over a period of years, the deficit for 2004 and preceding years will reduce fee updates for multiple years.

According to projections made by CMS OACT, maximum fee reductions will be in effect from 2006 through 2012. Fee updates will be positive in 2014. (See fig. 3.)

[45]The 2005 fee update will be higher than allowed by the SGR system owing to an MMA minimum update of 1.5 percent.

Figure 3: Projected MEI and Fee Update under Current Law



Source: CMS OACT.

Note: Projections are as of July 2004.

Uncertainty in Estimates of Underlying SGR System Data Elements Decreases Stability and Predictability of Physician Fee Updates

The stability of fee updates under the SGR system depends, in part, on CMS's ability to accurately estimate current spending and annual changes in the four factors that determine the sustainable growth rate: input prices, FFS enrollment, the 10-year moving average of real GDP per capita, and expenditures due to changes in laws and regulations. If reality proves different from these estimates, then the estimates are revised to incorporate more complete data, thereby contributing to the year to year fluctuation in fee updates. For example, in the fall of 2004, when CMS determines the update for 2005, the agency must estimate cumulative expenditures through the end of 2004 based on incomplete data. If actual spending is underestimated, the 2005 update will be set higher than it would have been set without the estimation error. This underestimate will be corrected, because in setting a fee update, the SGR system requires CMS to revise the spending estimates and the sustainable growth rates for the 2 preceding years. Therefore, when more complete spending data become available, the agency will revise its previous cumulative spending estimates through 2004 and reduce future fee updates relative to what they would have been if spending had not been underestimated.

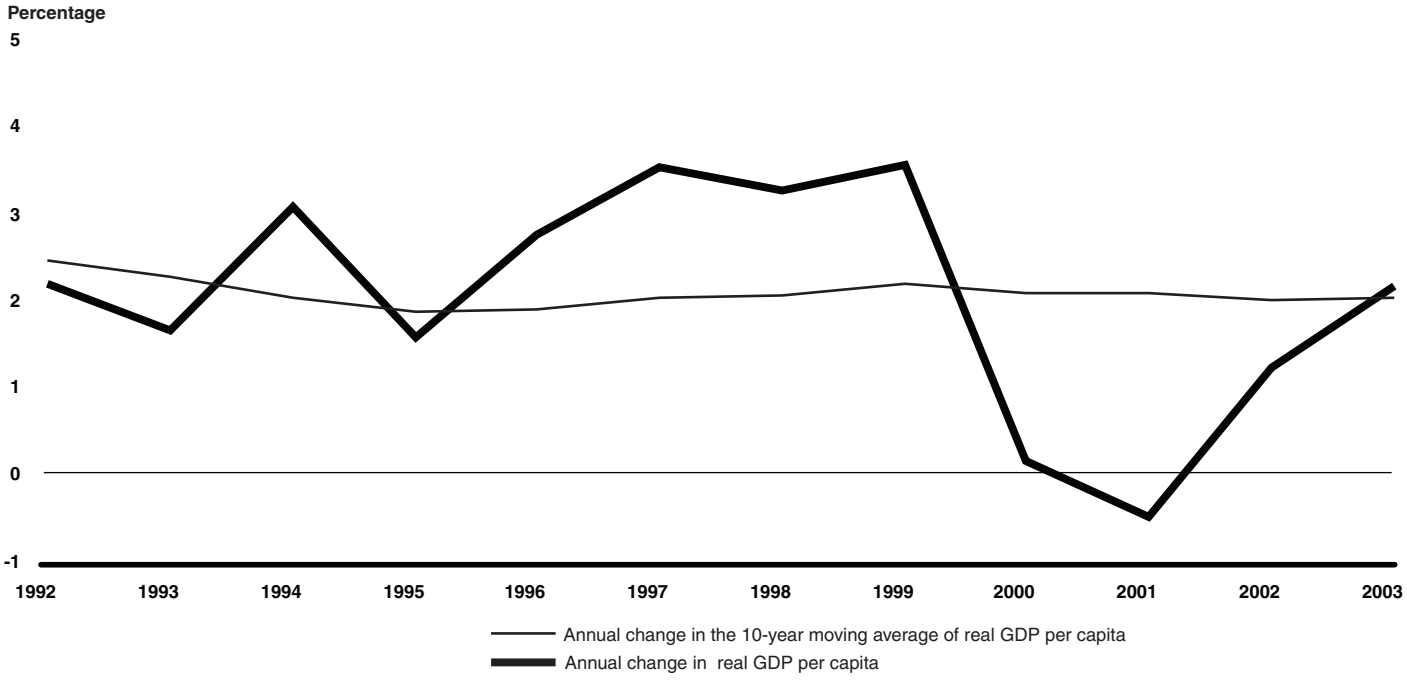
Uncertainty in long-term projections of FFS enrollment, in conjunction with the cumulative nature of the SGR system's targets, makes long-term estimates of fee updates less predictable. Because the SGR system offsets accumulated excess spending by reducing the update for the fee paid for each service, a decline in the number of services results in less spending being offset. For example, currently, CMS estimates that over the next 10 years, enrollment in FFS will decline as more beneficiaries join private plans. CMS projects that the percentage of Medicare beneficiaries in the FFS program will decline from about 85 percent in 2005 to 67 percent in 2014. With fewer beneficiaries in FFS, fewer services would be provided. Therefore, the SGR system would call for more severe update reductions to offset accumulated excess spending relative to what would have occurred if FFS enrollment had remained stable. In contrast, CBO projected that FFS enrollment will increase over the 10-year period at about the same rate as the increase in overall Medicare enrollment.[46] With more beneficiaries in FFS, and thus more services provided, update reductions would not need to be as severe to offset accumulated excess spending. Therefore, under CBO's FFS projection, positive fee updates would be expected to return sooner than under CMS's FFS projection.

[46]In its March 2004 baseline CBO projected the percentage of beneficiaries in FFS would remain relatively flat at about 86 percent to 87 percent over the 2005–2014 period.

Switching to the 10-Year Moving Average of Real GDP Per Capita Will Increase Stability and Predictability

MMA changed the SGR system formula to use a 10-year moving average of real GDP per capita, which is currently 2.3 percent. As noted in our 2002 testimony, this change will eliminate much of the cyclical variation in this factor that occurred in previous years under the formula when the SGR system target was tied to the yearly change in real GDP per capita.[47] (See fig. 4.) Including a more stable measure of economic growth in the SGR system formula will help increase the stability of fee updates.

Figure 4: Annual Percentage Change in Real GDP Per Capita and 10-Year Moving Average Change in Real GDP Per Capita, 1992–2003



Source: GAO's analysis of data from the Bureau of Economic Analysis and the U.S. Census Bureau.

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

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 we identified 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 could include one or more of the following options: removing the Part B prescription drug expenditures that are currently counted in the SGR system; resetting the targets and not requiring the system to recoup previous excess spending; using annual, rather than cumulative, targets; raising the allowance for increased spending due to volume and intensity growth; and permitting some flexibility in setting the volume and intensity allowance.

The alternatives discussed in this section—intended to be illustrative—would all increase fees and thus aggregate spending—both government outlays and beneficiary cost sharing—for physician services relative to projected spending under current law.[48] Most changes would require new legislation; one exception is the removal of Part B prescription drugs from the spending targets, which could be done administratively. We used CMS OACT's projections to provide a sense of the magnitude of the effect that potential alternatives might have on physician fee updates, aggregate spending for physician services, and real spending for physician fee schedule services per beneficiary (indicating a level of services beneficiaries receive excluding prescription drugs and other non-fee-schedule services, such as laboratory tests).[49, 50] To simplify comparisons among the discussed alternatives and current law, all of the projections

[48]The projection under current law, which is used as a comparison to projections under various options, assumes that the fee updates determined by the SGR system will not be altered by any legislative action. However, many parties, such as the Medicare Trustees, believe it is unlikely that the projected negative fee updates will be allowed to take effect.

[49]The projections are included to aid comparisons among the various options and are not intended to serve as predictions for what would occur if the SGR system was replaced or modified. In addition, there is a degree of uncertainty surrounding any projection and that uncertainty tends to increase with the number of years for which the projection is made.

[50]For some of these options we present, CBO has developed budget scores, which are specific cost estimates that include only federal expenditures and exclude spending from other sources, such as beneficiary cost sharing. When available, we present CBO's cost estimates for the options.

use the same assumptions regarding volume and intensity growth for physician services and future FFS enrollment.[51]

Eliminate Spending Targets, Base Fee Updates on Physician Cost Increases

In its March 2001 report to the Congress, MedPAC 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.[52] 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. However, CMS OACT estimates that this approach, compared with the current law projection, would result in cumulative expenditures that are 22 percent greater over a 10-year period.

MedPAC reported that its recommendation could be implemented, in part, by basing the update on forecast changes in MEI. It suggested that other adjustments to the update might be necessary, for example, to ensure overall payment adequacy or correct for previous MEI forecast errors. In subsequent annual reports to the Congress, MedPAC has continued to recommend a physician fee update based on MEI.[53] In its March 2004 report, for example, MedPAC stated that current Medicare payments for physician services were adequate and recommended an update of approximately 2.6 percent for 2005 to "help maintain physician willingness and ability to furnish services to Medicare beneficiaries."[54] MedPAC's recommendation contrasts with the 1.5 percent minimum update provided for by MMA and the negative 3.6 percent update specified by the SGR system. 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.

[51]Volume and intensity growth for physician services alone is projected to be 3 percent per year. Overall volume and intensity growth—that is, including outpatient prescription drugs and other services included under the SGR system—is projected at about 4 percent per year.

[52]Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2001).

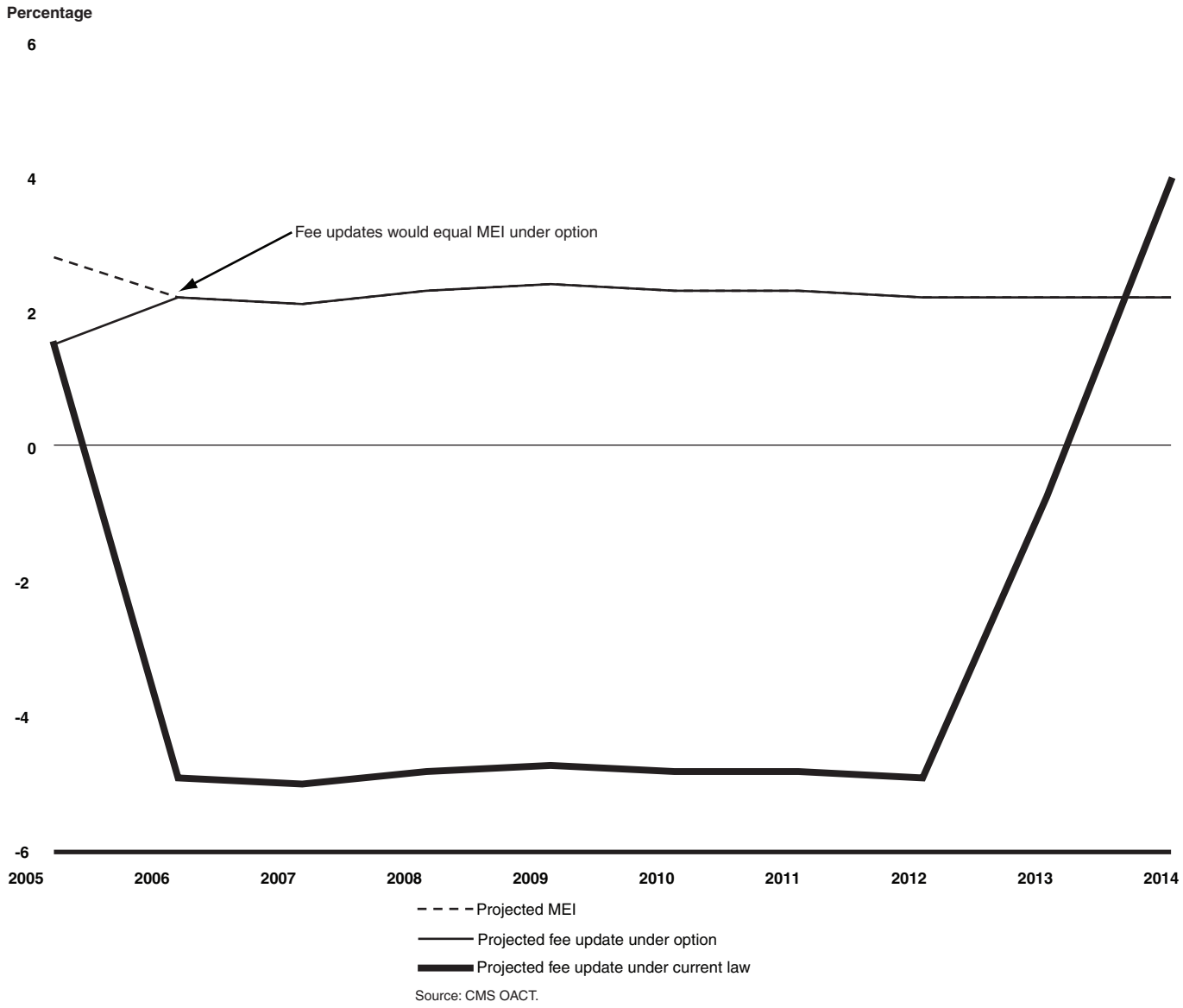
[53]Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2002, 2003, and 2004).

[54]Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2004).

Basing the update on MEI would result in positive and relatively stable fee updates. (See fig. 5.) According to CMS OACT simulations, such an approach would likely produce fee updates that ranged from 2.1 percent to 2.4 percent over the period from 2006 through 2014. Because physician fees would increase each year during the entire period, rather than decreasing each year until positive updates returned in 2014 as they would under the current SGR system, Medicare spending for physician services would rise. For the 10-year period from 2005 through 2014, CMS OACT estimates that this approach would result in cumulative expenditures that are 22 percent greater than projected under current law.[55] (See fig. 6.) CMS OACT projects that under current law the net present value of total Medicare spending (both federal and beneficiary) over the next 75 years on all Part B services will be $16.9 trillion. If physician fee updates are based on the change in MEI, CMS OACT estimates that the net present value of total Medicare spending (both federal and beneficiary) over the next 75 years on Part B services would equal $19.1 trillion. Real spending per beneficiary would increase from $2,157 in 2005 to $2,802 in 2014, compared with real spending per beneficiary under current law, which would decrease to $1,774 in 2014. (See fig. 7.)

[55]In May 2004 testimony before the Subcommittee on Health, House Committee on Energy and Commerce, CBO estimated that if this option went into effect in 2005, it would raise net federal mandatory outlays by about $95 billion over the 2005–2014 period. CBO's estimates differ from those of CMS OACT in that CBO's estimates exclude beneficiary cost sharing and are based on different underlying assumptions about the various factors that affect the SGR system.

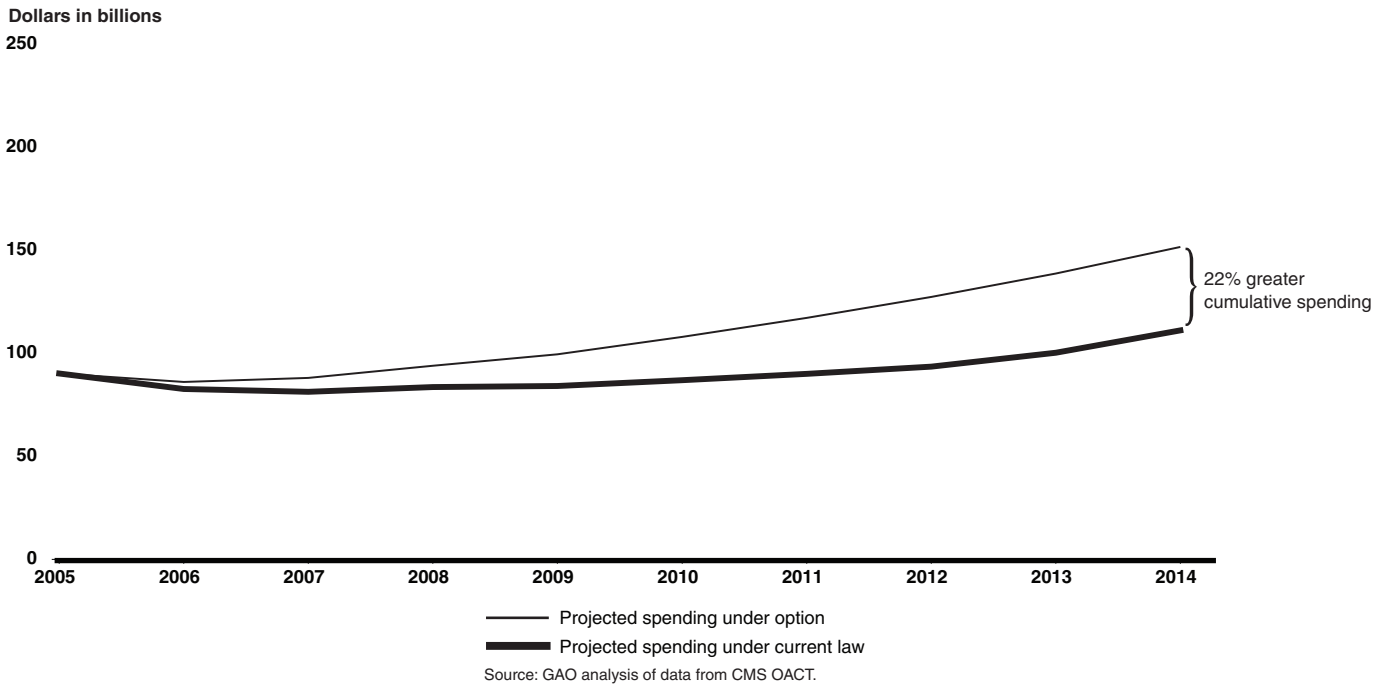
Figure 5: Projected MEI and Fee Updates under Current Law and under Option of Eliminating Spending Targets and Tying Fee Updates to MEI



Source: CMS OACT.

Note: Projections are as of July 2004.

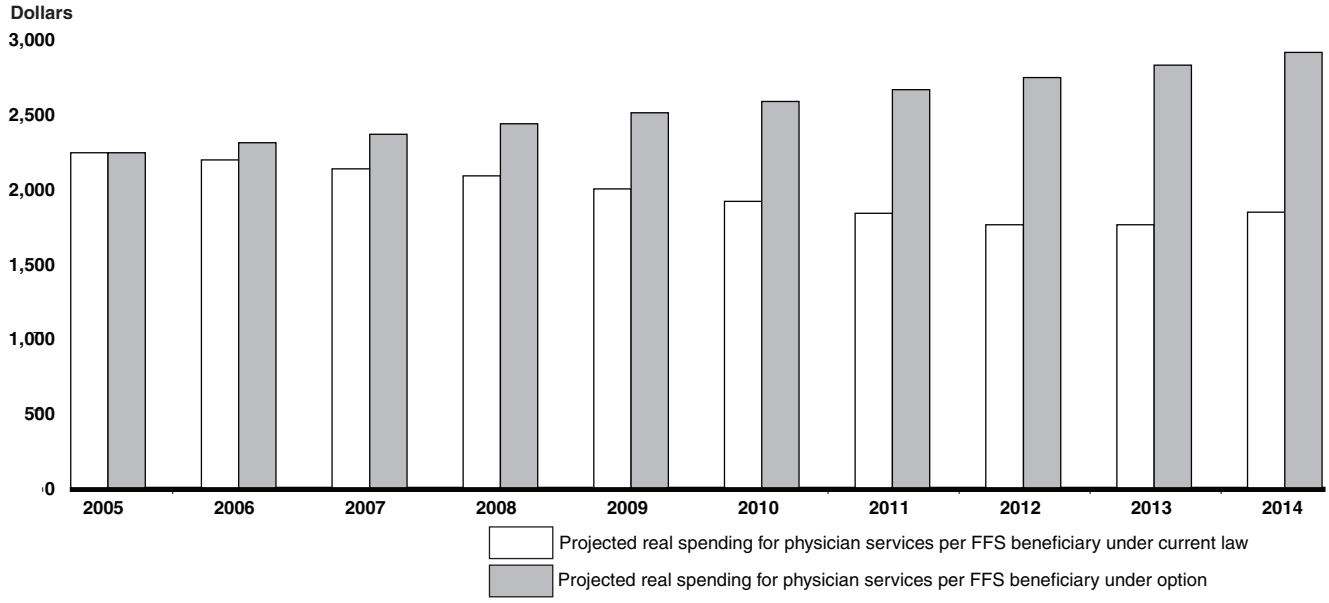
Figure 6: Projected Aggregate Spending under Current Law and under Option of Eliminating Spending Targets and Tying Fee Updates to MEI



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Aggregate spending includes all expenditures for physician services—both government outlays and beneficiary cost sharing.

Figure 7: Projected Real Spending for Physician Fee Schedule Services per FFS Beneficiary under Current Law and under Option of Eliminating Spending Targets and Tying Fee Updates to MEI



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Real spending per beneficiary for physician fee schedule services includes both government outlays and beneficiary cost sharing and is adjusted by MEI. Spending for non-fee-schedule services—laboratory services and certain Medicare-covered Part B outpatient drugs—is excluded.

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 physician provide. In 2001, when MedPAC first recommended eliminating the SGR system, it stated that volume and intensity increases had not been a major concern since 1992. It added, however, that if volume and intensity growth reemerged as a concern, Medicare might address the problem by trying to achieve appropriate use of services through outcomes and effectiveness research, disseminating practice guidelines and other tools for applying this research, and developing evidence-based measures to assess the application of the research findings.

Since MedPAC's 2001 report, volume and intensity growth has increased considerably. (See fig. 2.) Subsequent MedPAC reports and testimony have discussed trends in the use of physician services and have identified particular services—such as diagnostic imaging—that are growing rapidly,

but the reports have not made recommendations for addressing volume and intensity growth. However, in 2004 testimony, MedPAC stated that it planned to study the efficacy of private insurers' strategies for controlling spending for high-growth services and whether Medicare might be able to emulate them.[56]

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. The advantage of retaining spending targets as part of the system for updating fees is that the system would automatically work to moderate spending if volume and intensity growth began to increase above allowable rates. Although many options are possible under this approach, six are discussed below. All six would produce fee updates that are higher during the 10-year period from 2005 through 2014 than those projected under current law but would also result in higher aggregate spending ranging from 4 percent to 23 percent more, depending on the modification.

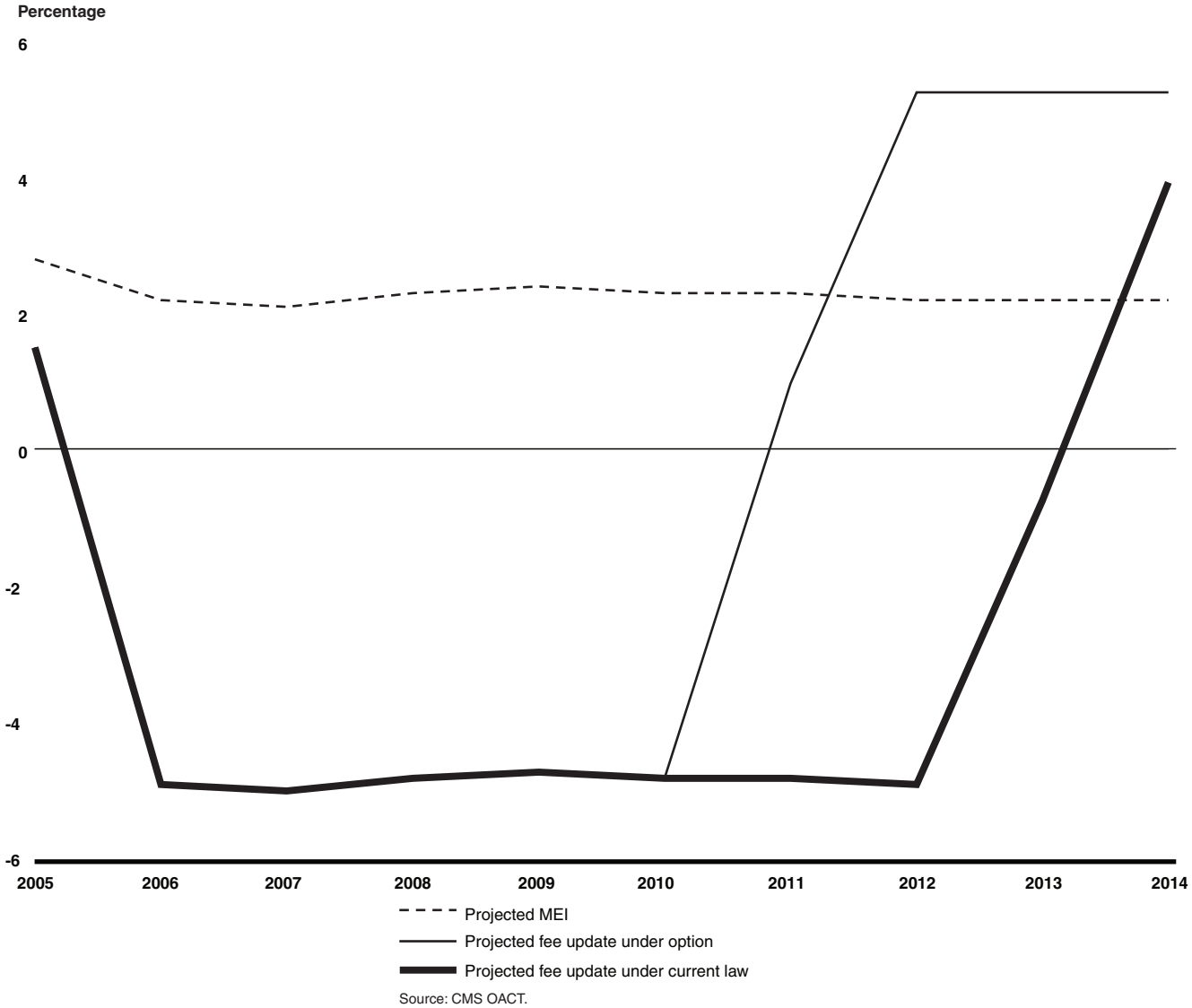
[56]Medicare Payment Advisory Commission, *Payment for Physician Services in the Medicare Program*, testimony before the Subcommittee on Health, House Committee on Energy and Commerce (May 5, 2004).

Remove Part B 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. As discussed earlier, 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. (See fig. 8.) There would be a positive update in 2011—3 years earlier than is projected under current law. From 2012 through 2014, fees would increase by approximately 5 percent per year. CMS OACT estimates 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.[57] (See fig. 9.) Real spending per beneficiary would increase from $2,157 in 2005 to $2,240 in 2014, compared with real spending per beneficiary under current law, which would decrease to $1,774 in 2014. (See fig. 10.)

[57]In May 2004 testimony, CBO estimated that this option would raise net federal mandatory outlays by about $15 billion through 2014. CBO's estimates differ from those of CMS OACT in that CBO's estimates exclude beneficiary cost sharing and are based on different underlying assumptions about the various factors that affect the SGR system.

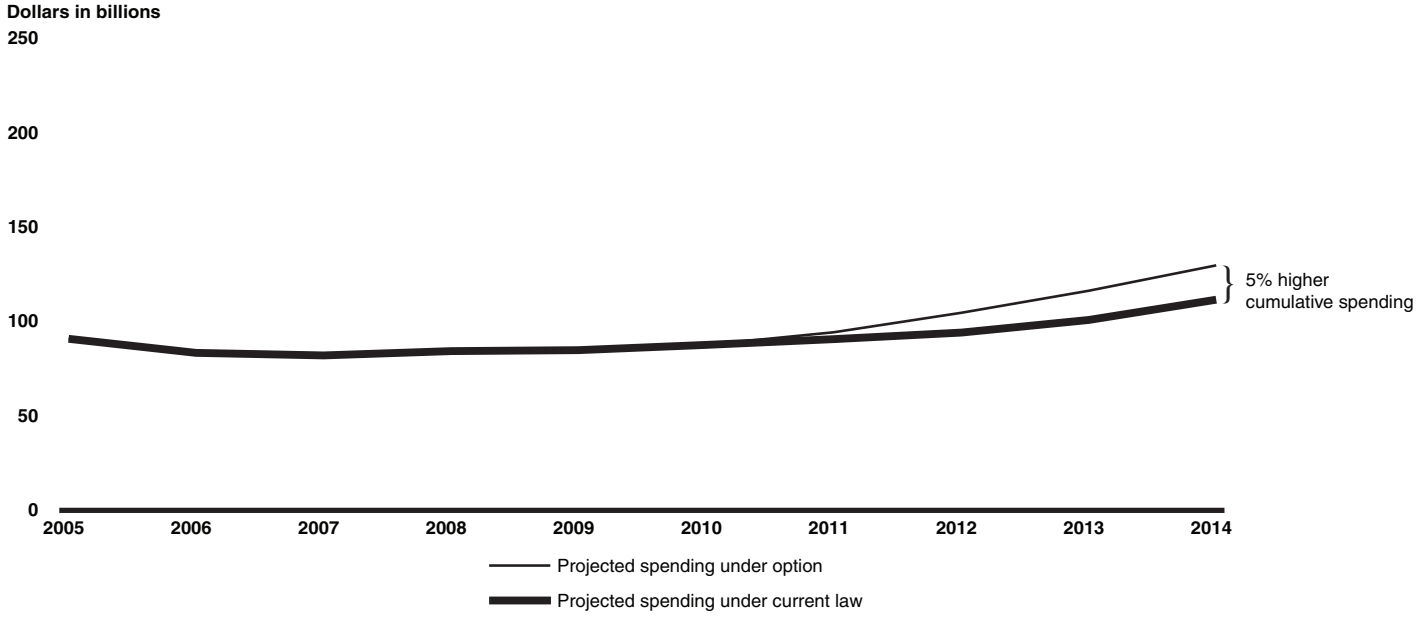
Figure 8: Projected MEI and Fee Updates under Current Law and under Option of Not Including Any Part B Drugs in the SGR System Beginning in 2005



Source: CMS OACT.

Notes: Projections are as of July 2004. Projected updates under the option will be equal to projected updates under current law through 2010.

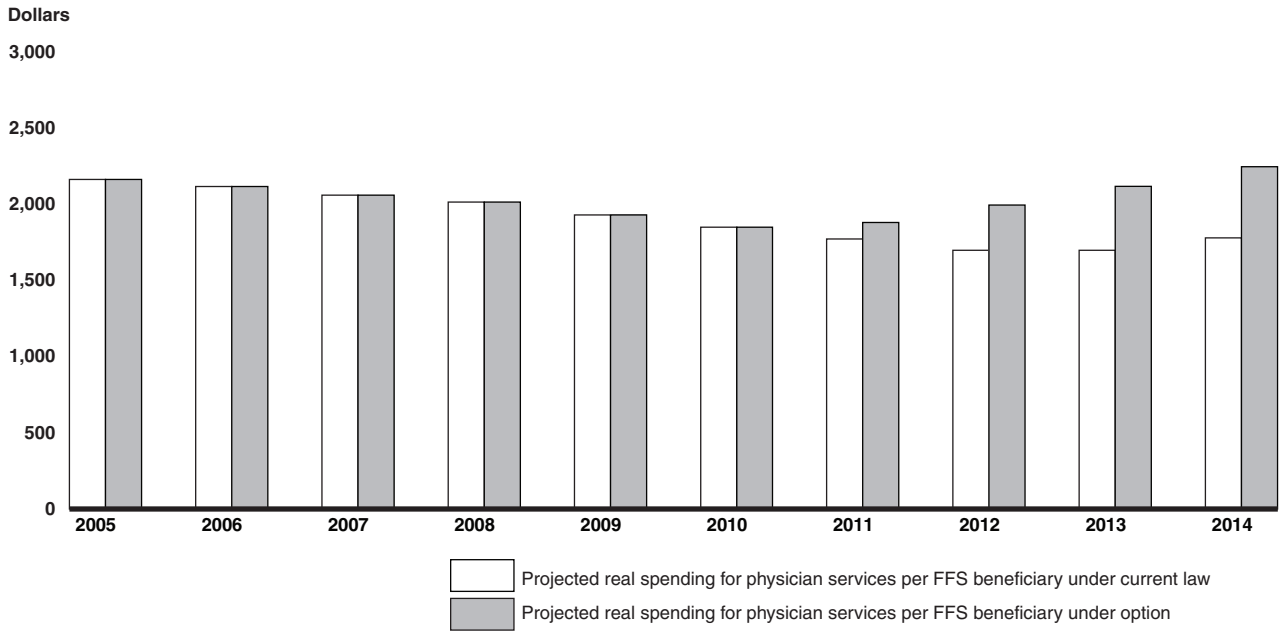
Figure 9: Projected Aggregate Spending under Current Law and under Option of Not Including Any Part B Drugs in the SGR System Beginning in 2005



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Aggregate spending includes all expenditures for physician services—both government outlays and beneficiary cost sharing. The line depicting the projection under current law includes all spending included in the SGR system. Under the option of not including any Part B drugs in the SGR system, spending for Part B drugs will occur even though it is not included in the SGR formula. To ensure comparability between the two projections, we included aggregate spending for both remaining SGR-covered services and Part B drugs in the line depicting the projection under the option.

Figure 10: Projected Real Spending for Physician Fee Schedule Services per FFS Beneficiary under Current Law and under Option of Not Including Any Part B Drugs in the SGR System Beginning in 2005



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Real spending per beneficiary for physician fee schedule services includes both government outlays and beneficiary cost sharing and is adjusted by MEI. Spending for non-fee-schedule services—laboratory services and certain Medicare-covered Part B outpatient drugs—is excluded.

Base Future SGR System Targets on Actual Spending from a Recent Year

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.[58] 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.

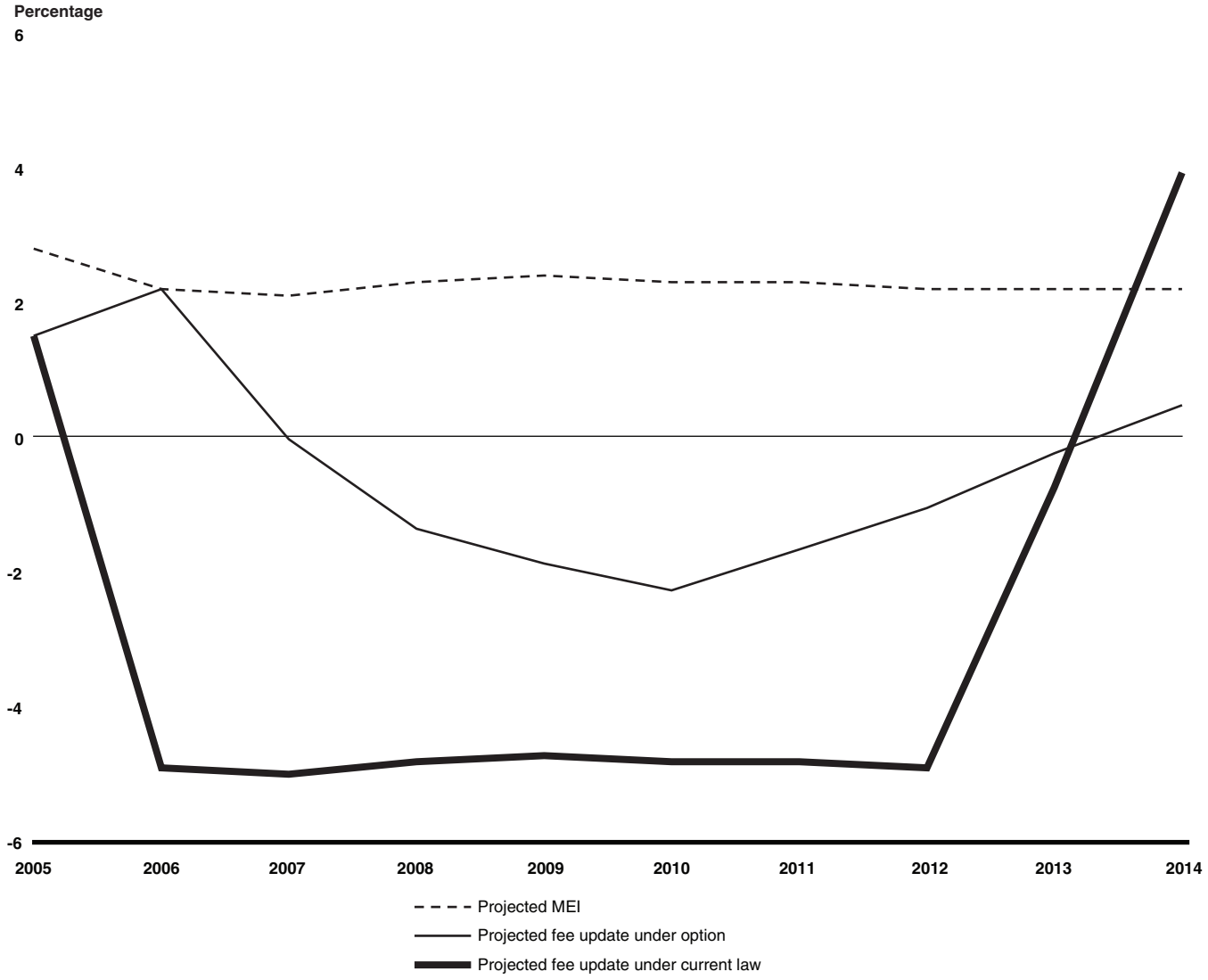
MMA avoided a fee decline in 2004, and a projected fee decline for 2005, by stipulating a minimum update of 1.5 percent in each of those 2 years, but the law did not similarly adjust the spending targets to account for the additional spending that would result from the minimum update. Consequently, under the SGR system the additional MMA spending and

[58] GAO-02-441T.

other accumulated excess spending will have to be recouped through fee reductions beginning in 2006. If policymakers believe that the resulting negative fee updates are inappropriately low, one solution is to use actual spending from a recent year as a basis for setting future SGR system targets. Using such an approach, policymakers could essentially forgive the accumulated excess spending attributable to MMA and other factors. The effect would be to increase future updates and, as with other alternatives presented here, overall spending.

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. (See fig. 11.) 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 fig. 12.) Real spending per beneficiary for physician services would grow from $2,157 in 2005 to $2,334 in 2014, compared with real spending per beneficiary under current law, which would decrease to $1,774 in 2014. (See fig. 13.)

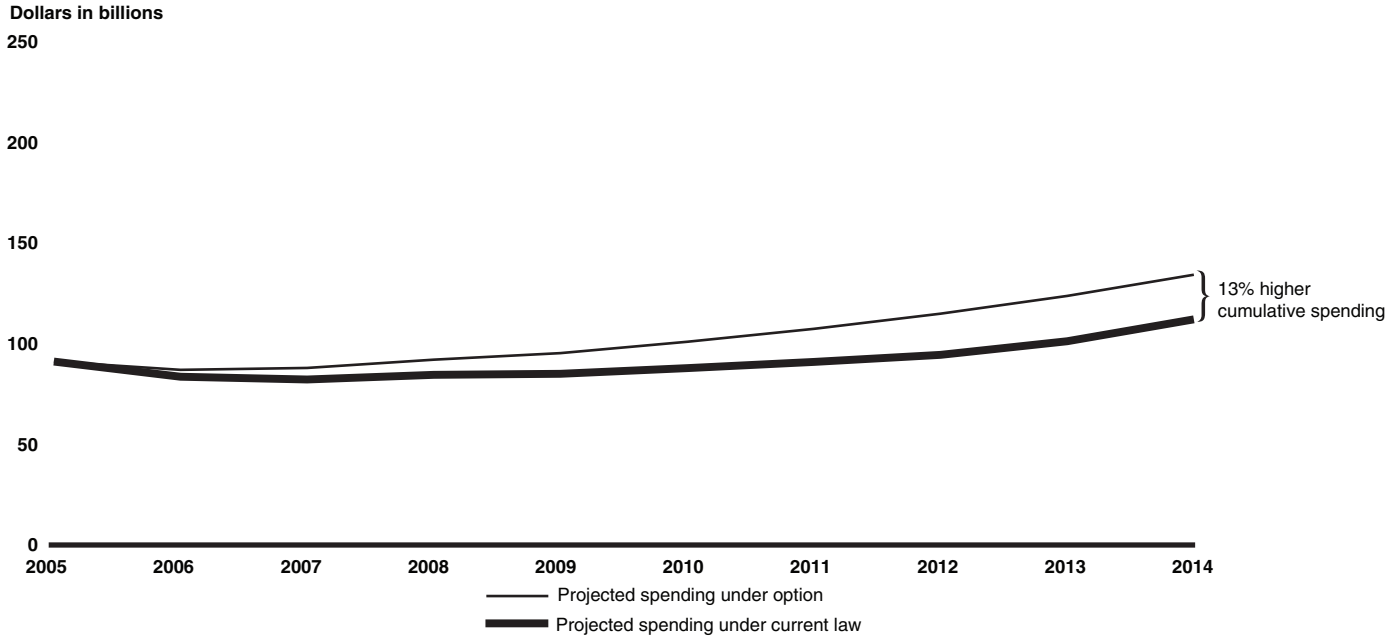
Figure 11: Projected MEI and Fee Updates under Current Law and under Option of Resetting the Cumulative Spending Target Equal to Cumulative Actual Spending as of 2006



Source: CMS OACT.

Notes: Projections are as of July 2004. Projection under option of eliminating accumulated excess spending assumes that the physician fee update would equal MEI in 2006.

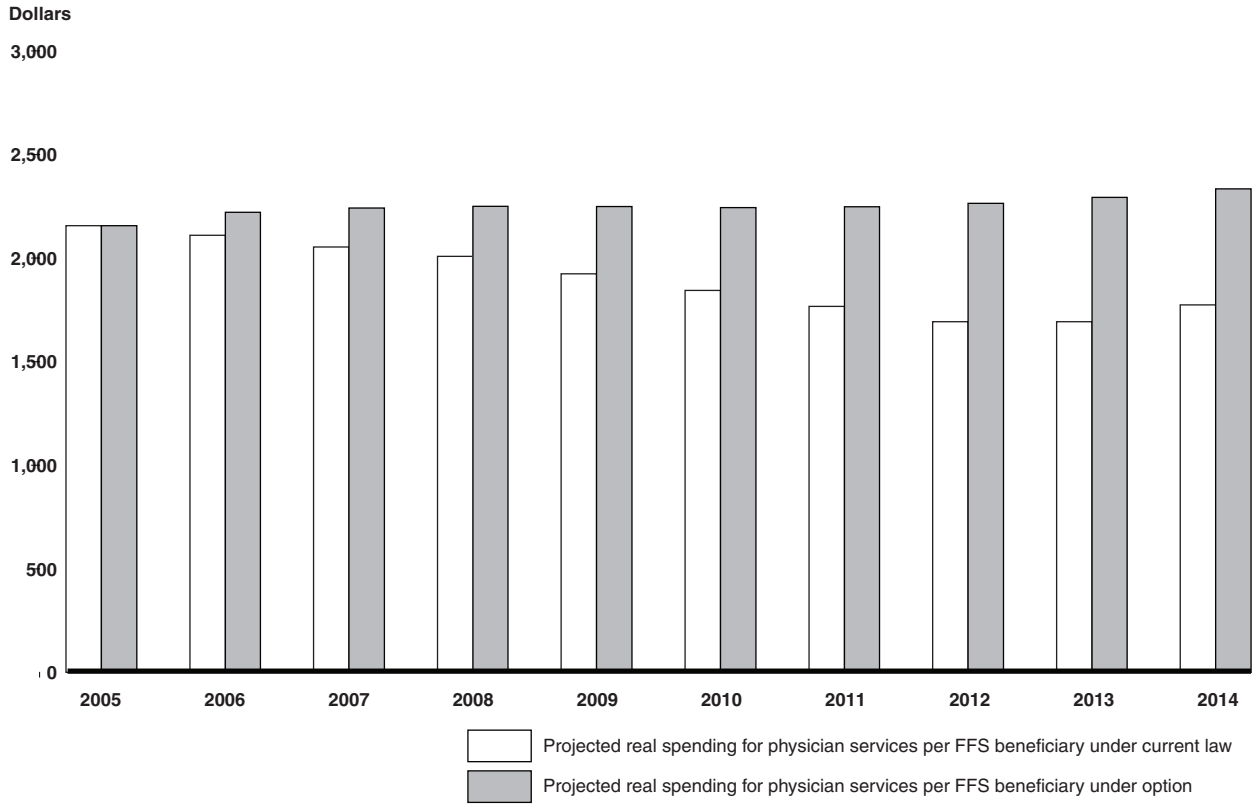
Figure 12: Projected Aggregate Spending under Current Law and under Option of Resetting the Cumulative Spending Target Equal to Cumulative Actual Spending as of 2006



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Aggregate spending includes all expenditures for physician services—both government outlays and beneficiary cost sharing. Projection under option of eliminating accumulated excess spending assumes that the physician fee update would equal MEI in 2006.

Figure 13: Projected Real Spending for Physician Fee Schedule Services per FFS Beneficiary under Current Law and under Option of Resetting the Cumulative Spending Target Equal to Cumulative Actual Spending as of 2006



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Projection under option of eliminating accumulated excess spending assumes that the physician fee update would equal MEI in 2006. Real spending per beneficiary for physician fee schedule services includes both government outlays and beneficiary cost sharing and is adjusted by MEI. Spending for non-fee-schedule services—laboratory services and certain Medicare-covered Part B outpatient drugs—is excluded.

Eliminate the Cumulative Aspect of Spending Targets

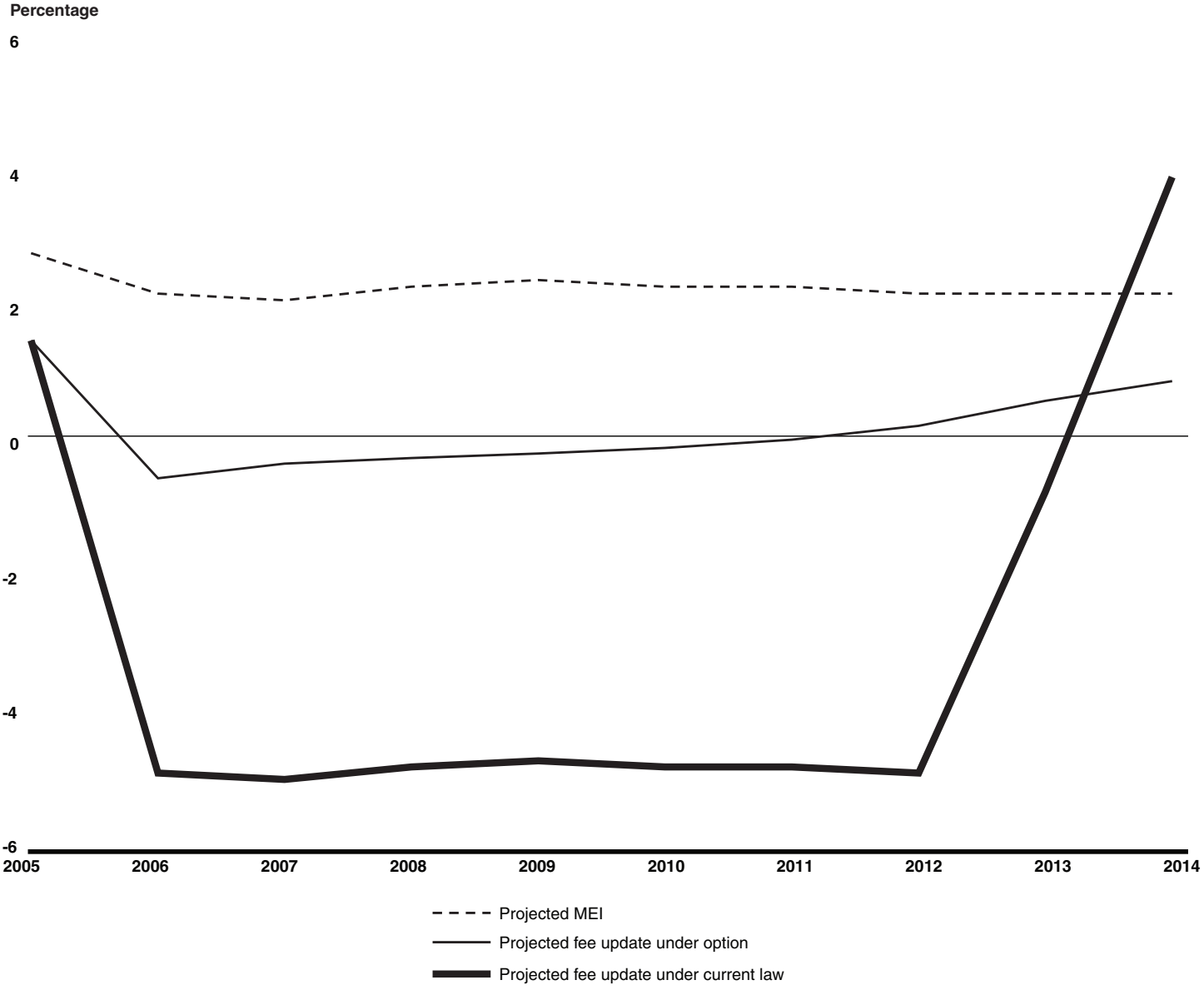
One option for reducing the fluctuation in fee updates would be to eliminate the cumulative aspect of the SGR system's spending targets and return to a system of annual targets, as was used under MVPS. As previously discussed, the cumulative aspect of the SGR system's spending targets—although rigorous as a budgetary tool—can produce updates that swing from the maximum fee reduction to the maximum fee increase. In contrast, MVPS's annual spending target approach traded off some fiscal control for increased fee stability. The MVPS update for a year depended, in part, on whether actual spending 2 years earlier had exceeded or fallen short of the annual spending target for that year. For example, the MVPS

update for 1996, which was determined in 1995, was affected by the relationship between actual and target spending in 1994. In principle, under MVPS excess spending from a single year, up to a limit specified by its update formula, was required to be recouped. Excess spending that could not be made up within those limits would, in essence, be forgiven.[59]

According to CMS OACT simulations, eliminating the cumulative aspect of the SGR system would result in fee updates that vary less than projected updates under current law. For example, under an MVPS-like system of annual targets, from 2006 through 2014, the largest negative update would be negative 0.6 percent instead of negative 5.0 percent under current law, and the largest positive update would be 0.9 percent instead of 3.9 percent. (See fig. 14.) Fees would be essentially flat over the period, instead of swinging from large fee declines to fee increases as they are expected to do under the SGR system. Relative to spending projected under current law, under an MVPS-like system total spending would be greater each year from 2006 through 2014. CMS OACT estimates that cumulative expenditures over the 10-year period from 2005 through 2014 would be 15 percent higher than under current law. (See fig. 15.) Real spending per beneficiary would increase from $2,157 in 2005 to $2,442 in 2014, compared with real spending per beneficiary under current law, which would decrease to $1,774 in 2014. (See fig. 16.)

[59]Both the SGR and MVPS systems provided for updates that could exceed MEI if spending fell below their respective targets.

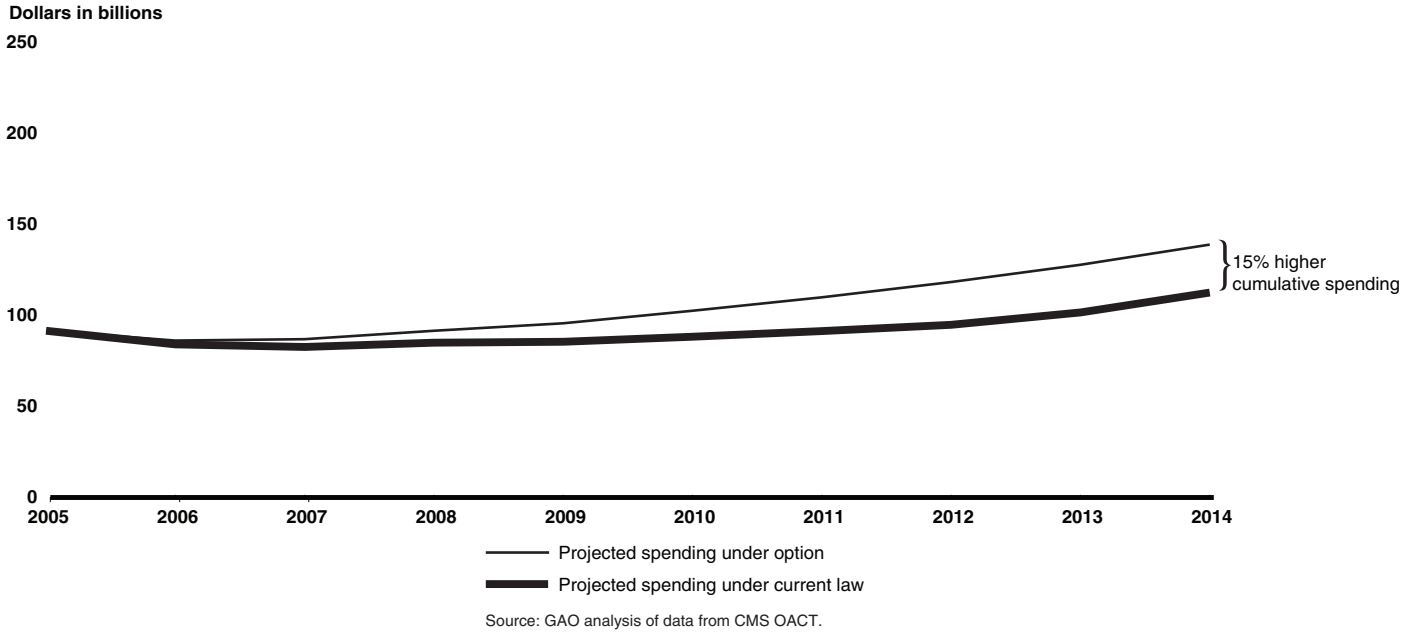
Figure 14: Projected MEI and Fee Updates under Current Law and under Option of Eliminating the Cumulative Aspect of Spending Targets



Source: CMS OACT.

Note: Projections are as of July 2004.

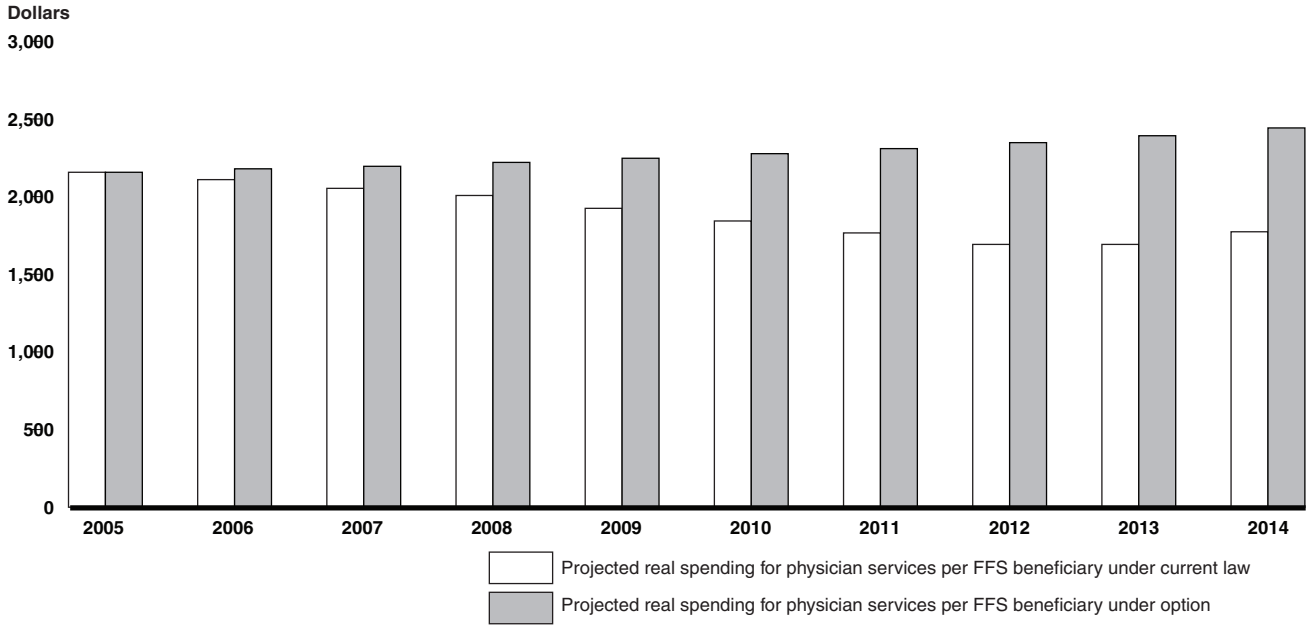
Figure 15: Projected Aggregate Spending under Current Law and under Option of Eliminating the Cumulative Aspect of Spending Targets



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Aggregate spending includes all expenditures for physician services—both government outlays and beneficiary cost sharing.

Figure 16: Projected Real Spending for Physician Fee Schedule Services per FFS Beneficiary under Current Law and under Option of Eliminating the Cumulative Aspect of Spending Targets



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Real spending per beneficiary for physician fee schedule services includes both government outlays and beneficiary cost sharing and is adjusted by MEI. Spending for non-fee-schedule services—laboratory services and certain Medicare-covered Part B outpatient drugs—is excluded.

Modify Allowance for Volume and Intensity Growth

If policymakers agree with physician groups that the current SGR system's allowance for volume and intensity growth does not adequately account for appropriate spending increases that result from technological innovation or changes in medical practice, the allowance could be increased 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 projected volume and intensity growth is higher—about 3 percent per year for physician services alone, and about 4 percent per year including Part B drugs. To offset the increased spending associated with the higher volume and intensity growth, the SGR system will reduce updates below the increase in MEI. In its 1997 report to the Congress, PPRC recommended adopting an

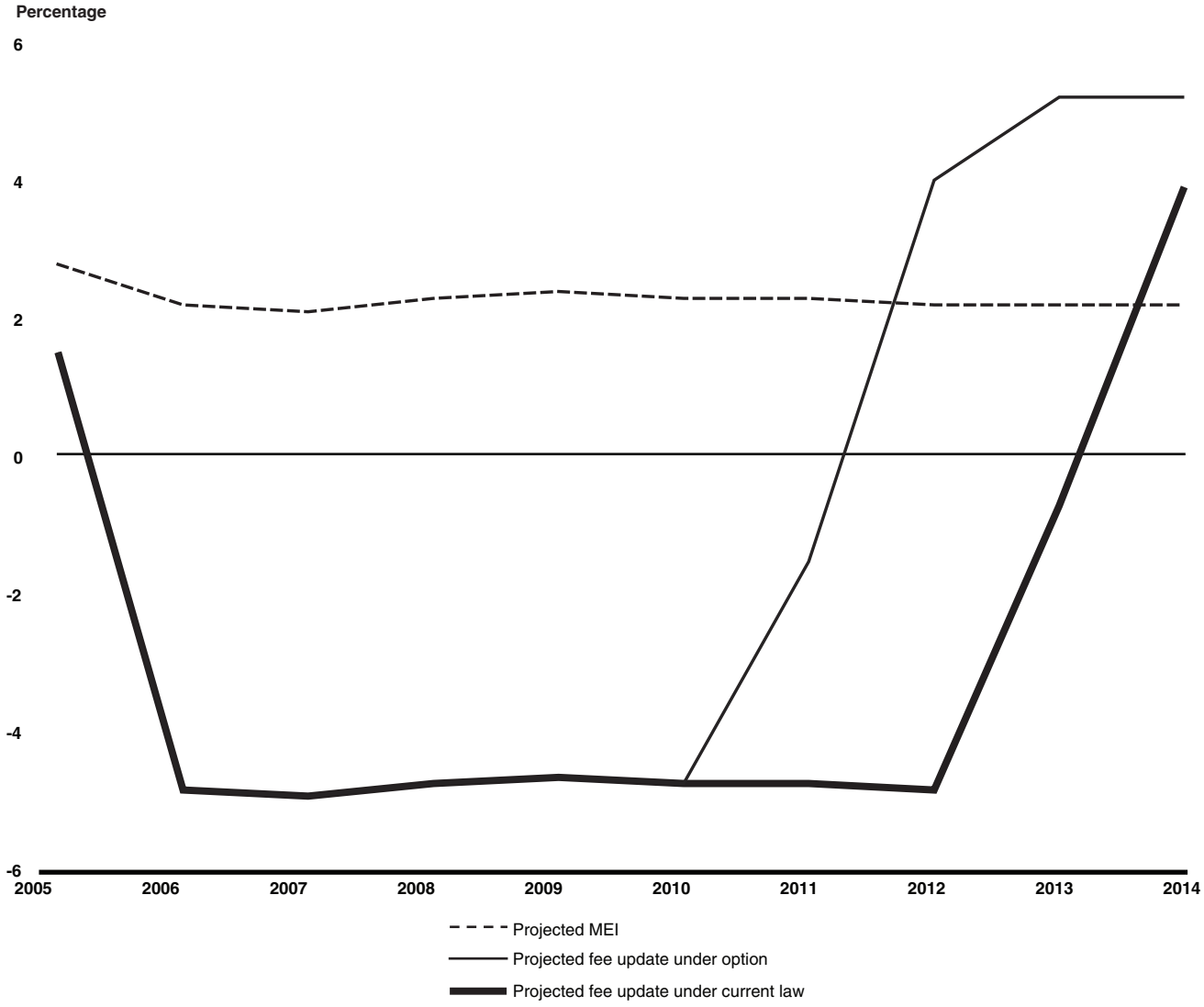
allowance equal to real GDP per capita plus 1 or 2 percentage points "to allow for advancements in medical capabilities."[60]

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. (See fig. 17.) 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 estimates that cumulative expenditures over the 10-year period would increase by 4 percent more than under current law.[61] (See fig. 18.) Real spending per beneficiary would change little from $2,157 in 2005 to $2,158 in 2014, compared with real spending per beneficiary under current law, which would decrease to $1,774 in 2014. (See fig. 19.)

[60]Physician Payment Review Commission, *1997 Annual Report to Congress* (Washington, D.C.: 1997), 248.

[61]In May 2004 testimony, CBO estimated that this option would raise net federal mandatory outlays by about $35 billion over the 2008–2014 period. CBO's estimates differ from those of CMS OACT in that CBO's estimates exclude beneficiary cost sharing and are based on different underlying assumptions about the various factors that affect the SGR system.

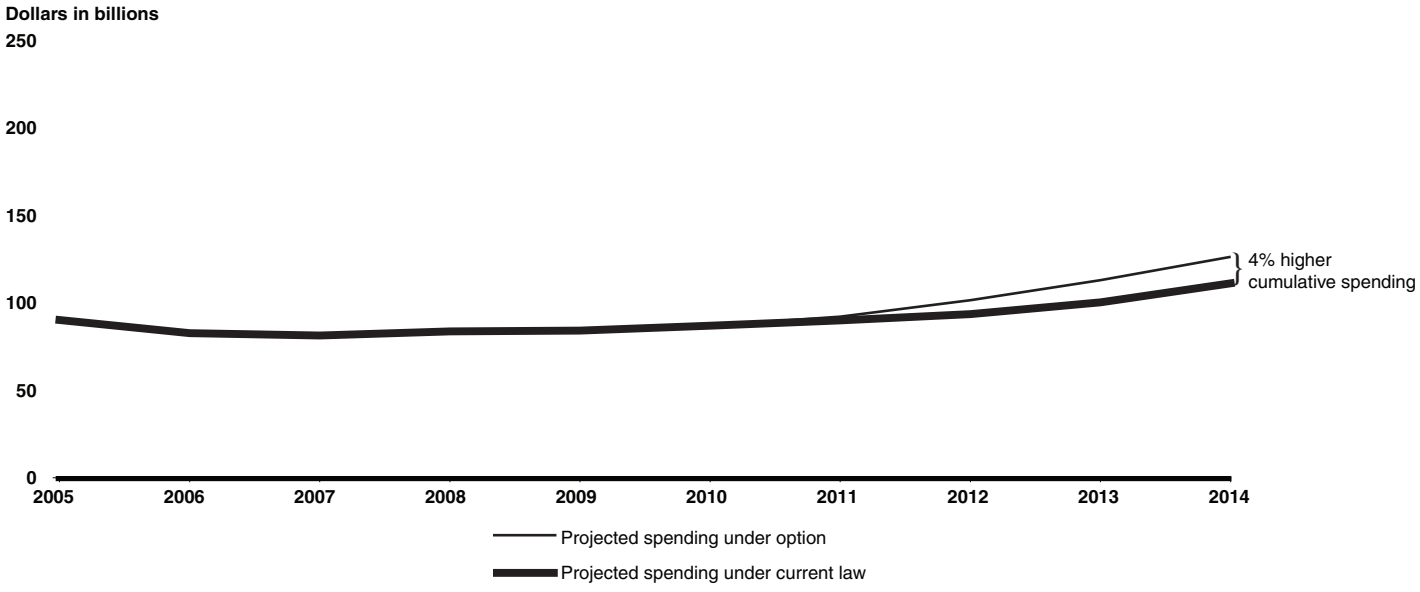
Figure 17: Projected MEI and Fee Updates under Current Law and under Option of Increasing Volume and Intensity Growth Allowance to GDP Plus 1 Percentage Point



Source: CMS OACT.

Notes: Projections are as of July 2004. Projected updates under the option will be equal to projected updates under current law through 2010.

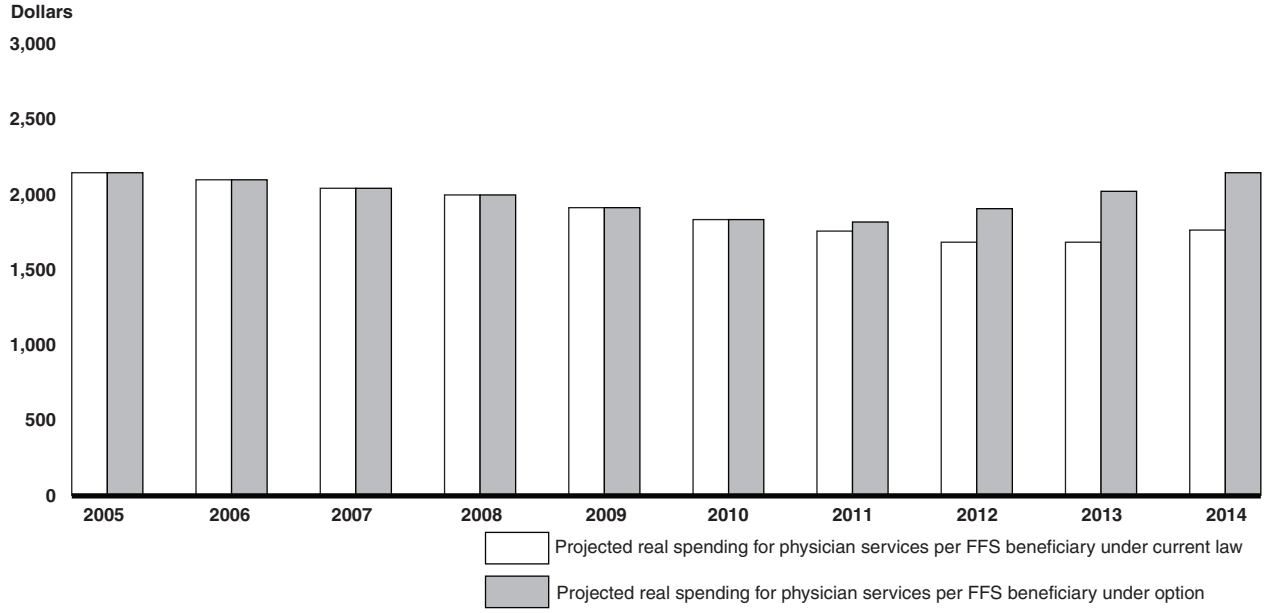
Figure 18: Projected Aggregate Spending under Current Law and under Option of Increasing Volume and Intensity Growth Allowance to GDP Plus 1 Percentage Point



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Aggregate spending includes all expenditures for physician services—both government outlays and beneficiary cost sharing.

Figure 19: Projected Real Spending for Physician Fee Schedule Services per FFS Beneficiary under Current Law and under Option of Increasing Volume and Intensity Growth Allowance to GDP Plus 1 Percentage Point



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Real spending per beneficiary for physician fee schedule services includes both government outlays and beneficiary cost sharing and is adjusted by MEI. Spending for non-fee-schedule services—laboratory services and certain Medicare-covered Part B outpatient drugs—is excluded.

Congress could also modify the SGR system's allowance for volume and intensity growth by providing flexibility similar to that afforded by the MVPS system. Although that earlier system of spending targets specified a default volume and intensity increase, it also allowed the HHS Secretary to recommend a different increase if changes in medical technology, beneficiary access to physician services, or other factors warranted an allowance that was higher or lower than the default increase.

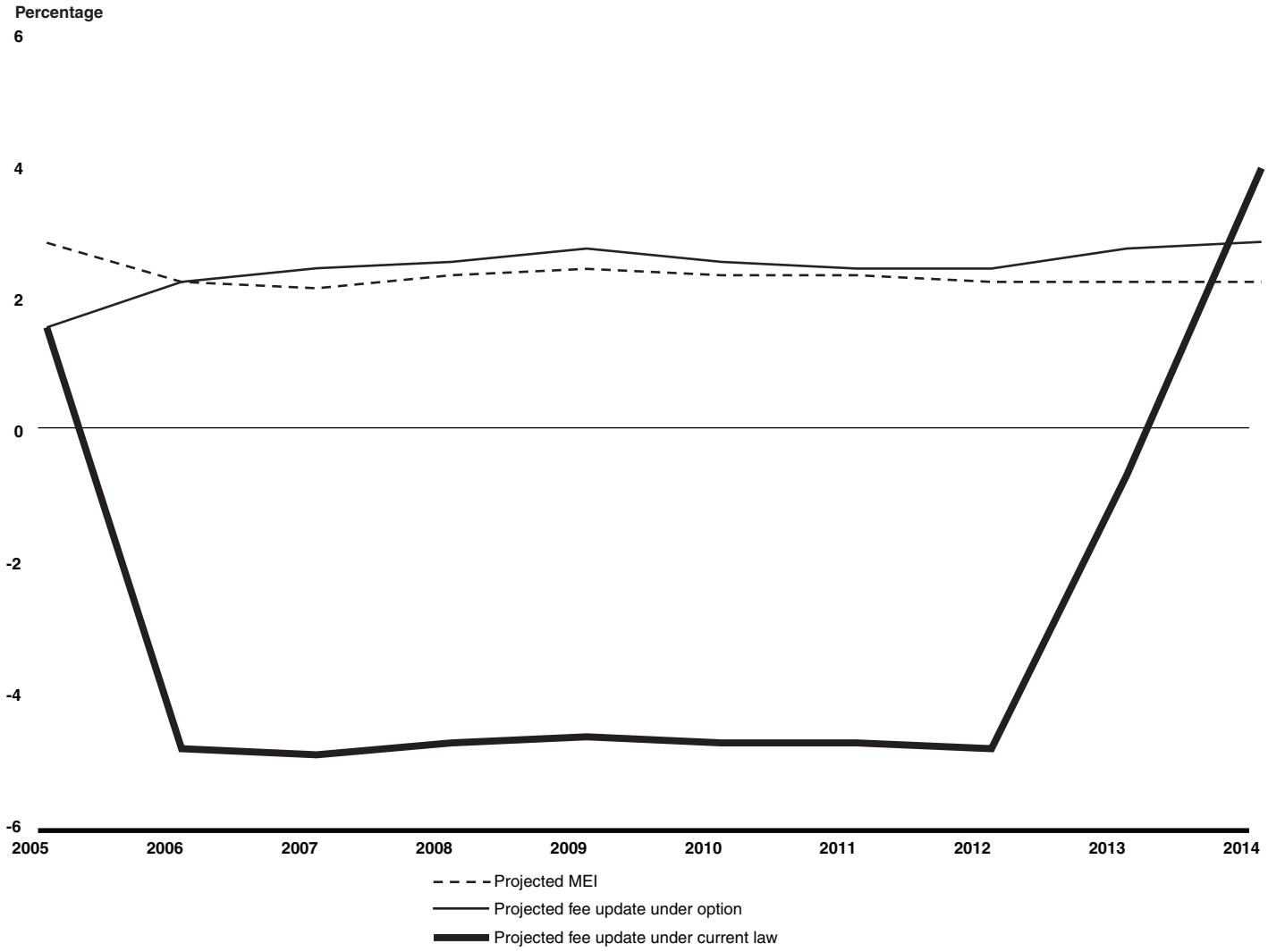
Combine Options

Two alternatives illustrate the effects of combining individual options. For example, together the Congress and CMS could modify the SGR system by removing Part B drugs, resetting the base, and increasing allowed volume and intensity growth to GDP plus 1 percentage point.[62] According to CMS

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

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. (See fig. 20.) CMS OACT projects that the combined options would increase aggregate spending by 23 percent over the 10-year period (see fig. 21.) and that real spending per beneficiary for physician services would increase from $2,157 to $2,866, compared with real spending per beneficiary under current law, which would decrease to $1,774 in 2014. (See fig. 22.)

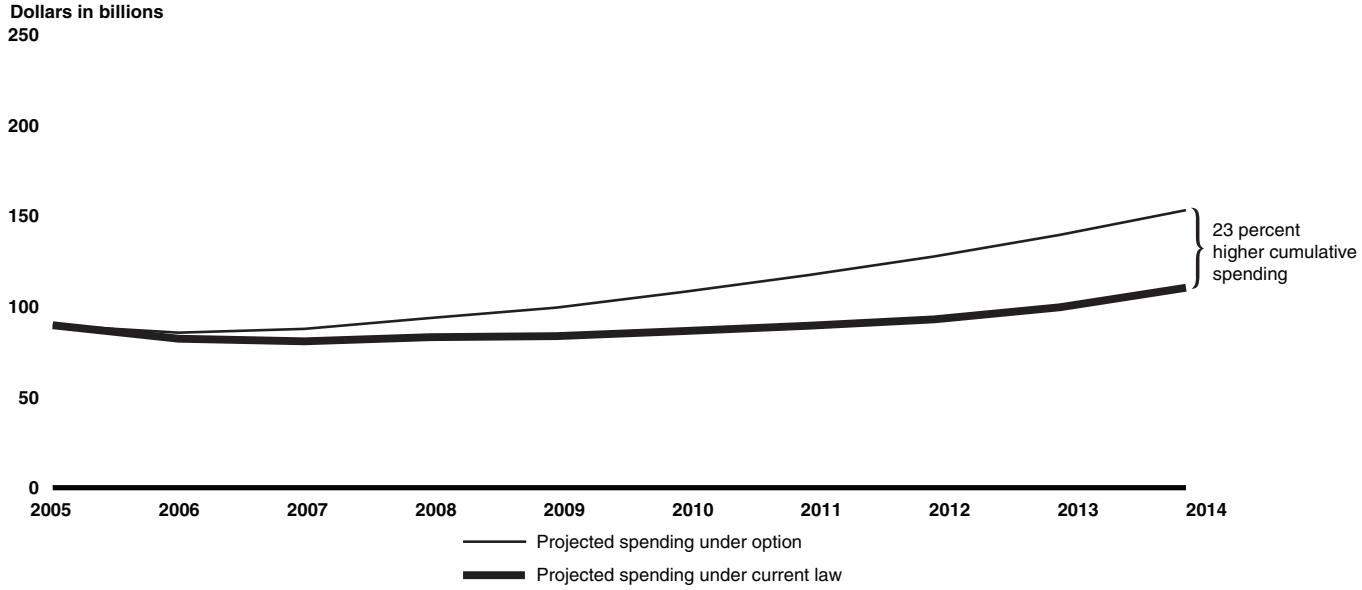
Figure 20: Projected MEI and Fee Updates under Current Law and under Combination of Options of Resetting the Cumulative Spending Target Equal to Cumulative Actual Spending as of 2006, Not Including Any Part B Drugs in the SGR System Beginning in 2005, and Using GDP Plus 1 Percentage Point



Source: CMS OACT.

Notes: Projections are as of July 2004. Projection under combination of options of resetting the cumulative spending target equal to cumulative actual spending as of 2005, removing Part B drugs from the SGR system beginning in 2005, and using GDP plus 1 percentage point assumes that the physician fee update would equal MEI in 2006.

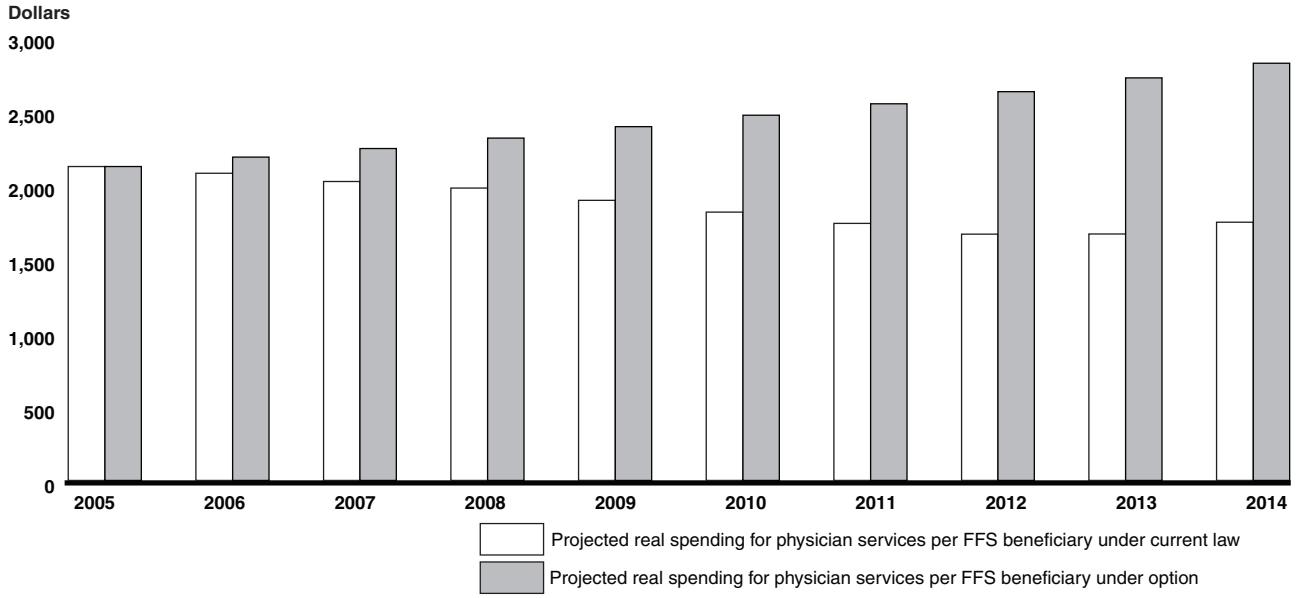
Figure 21: Projected Aggregate Spending under Current Law and under Combination of Options of Resetting the Cumulative Spending Target Equal to Cumulative Actual Spending as of 2006, Not Including Any Part B Drugs in the SGR System Beginning in 2005, and Using GDP Plus 1 Percentage Point



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Aggregate spending includes all expenditures for physician services—both government outlays and beneficiary cost sharing. Projection under combination of options of resetting the cumulative spending target equal to cumulative actual spending as of 2005, not including any Part B drugs in the SGR system beginning in 2005, and using GDP plus 1 percentage point assumes that the physician fee update would equal MEI in 2006. The line depicting the projection under current law includes all spending included in the SGR system. Under the option of not including any Part B drugs in the SGR system, spending for Part B drugs will occur even though it is not included in the SGR formula. To ensure comparability between the two projections, we included aggregate spending for both remaining SGR-covered services and Part B drugs in the line depicting the projection under the option.

Figure 22: Projected Real Spending for Physician Fee Schedule Services per FFS Beneficiary under Current Law and under Combination of Options of Resetting the Cumulative Spending Target Equal to Cumulative Actual Spending as of 2006, Not Including Any Part B Drugs in the SGR System Beginning in 2005, and Using GDP Plus 1 Percentage Point

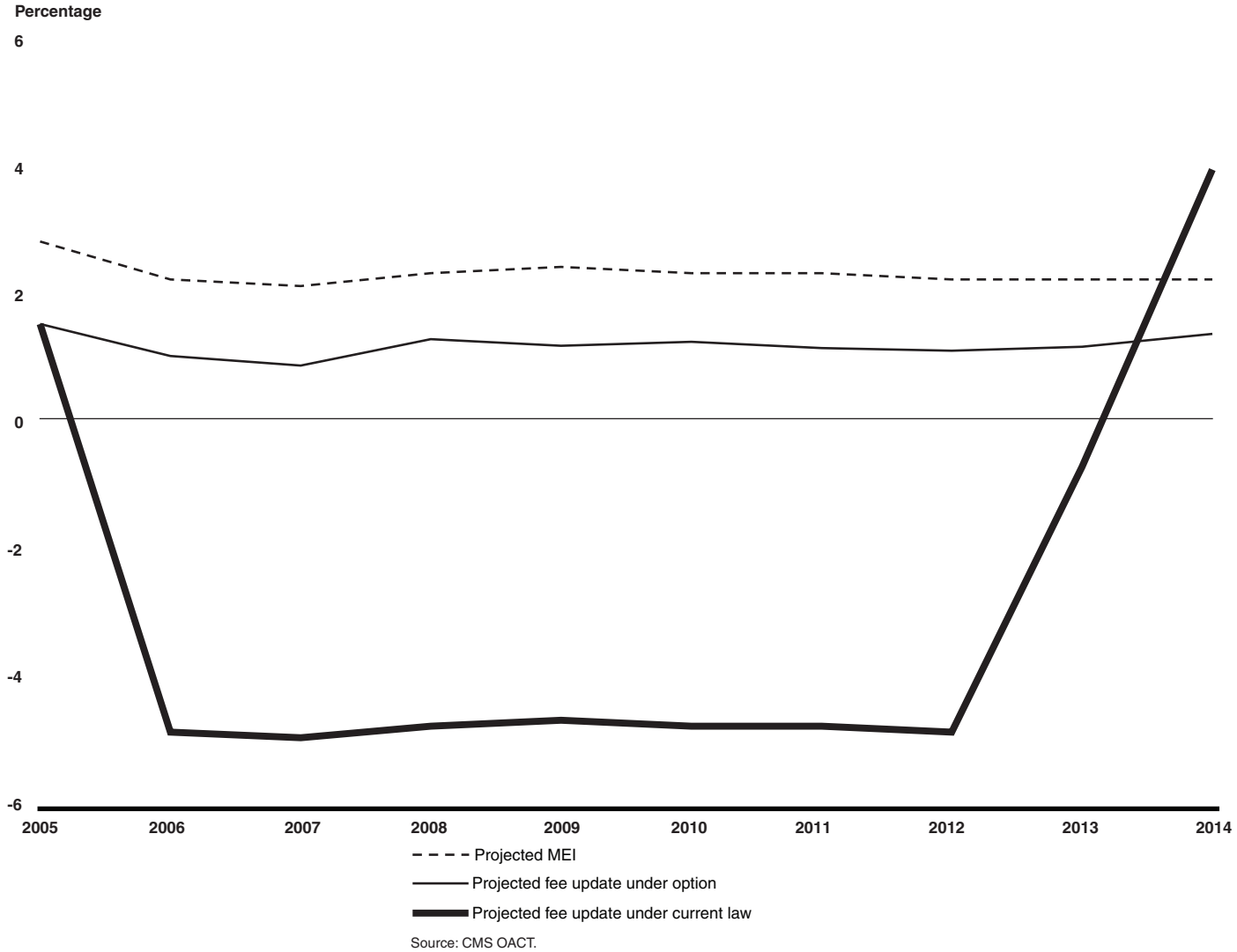


Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Projection under combination of options of resetting the cumulative spending target equal to cumulative actual spending as of 2005, removing Part B drugs from the SGR system beginning in 2005, and using GDP plus 1 percentage point assumes that the physician fee update would equal MEI in 2006. Real spending per beneficiary for physician fee schedule services includes both government outlays and beneficiary cost sharing and is adjusted by MEI. Spending for non-fee-schedule services—laboratory services and certain Medicare-covered Part B outpatient drugs—is excluded.

Another example of combined options could involve removing Part B drugs and implementing an MVPS-like system of annual targets, but not increasing the volume and intensity allowance. CMS OACT simulations project that this combination would result in fee updates that range from 0.8 percent to 1.3 percent over the period from 2006 through 2014. (See fig. 23.) Over the 10-year period from 2005 through 2014, cumulative spending for physician services would exceed those projected under current law by 18 percent. (See fig. 24.) Real spending per beneficiary for physician services would increase from $2,157 to $2,615, compared with real spending per beneficiary under current law, which would decrease to $1,774 in 2014. (See fig. 25.)

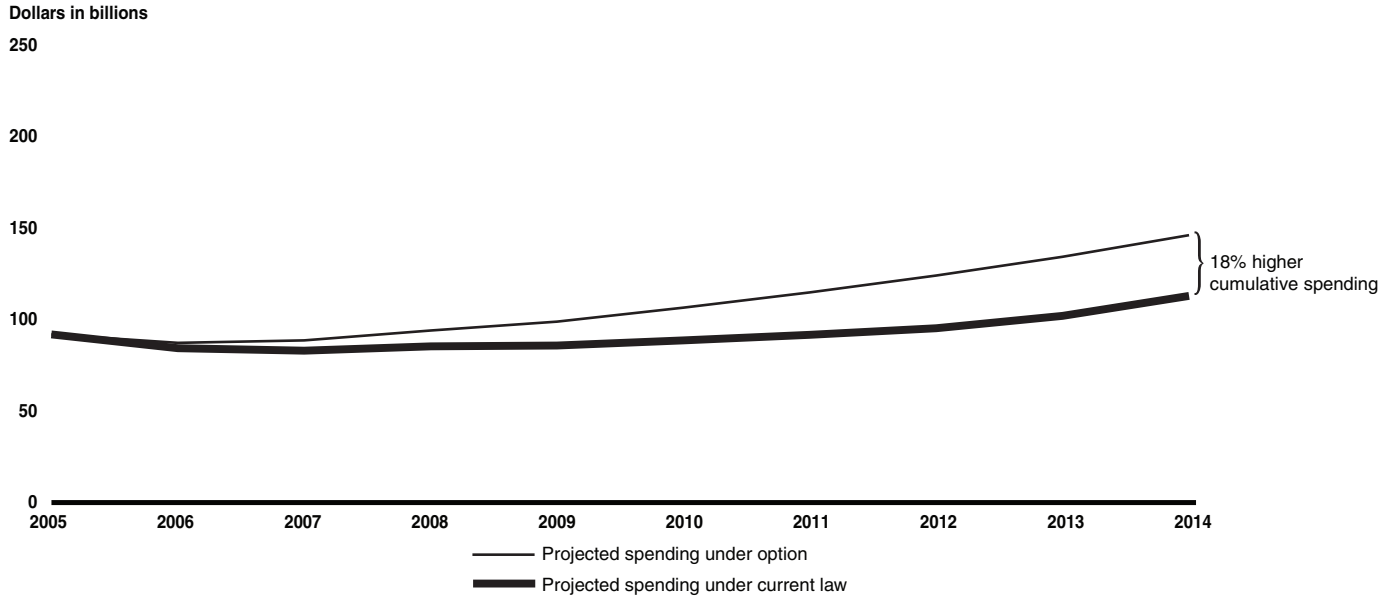
Figure 23: Projected MEI and Fee Updates under Current Law and under Combination of Options of Not Including Any Part B Drugs in the SGR System Beginning in 2005 and Eliminating the Cumulative Aspect of Spending Targets



Source: CMS OACT.

Note: Projections are as of July 2004.

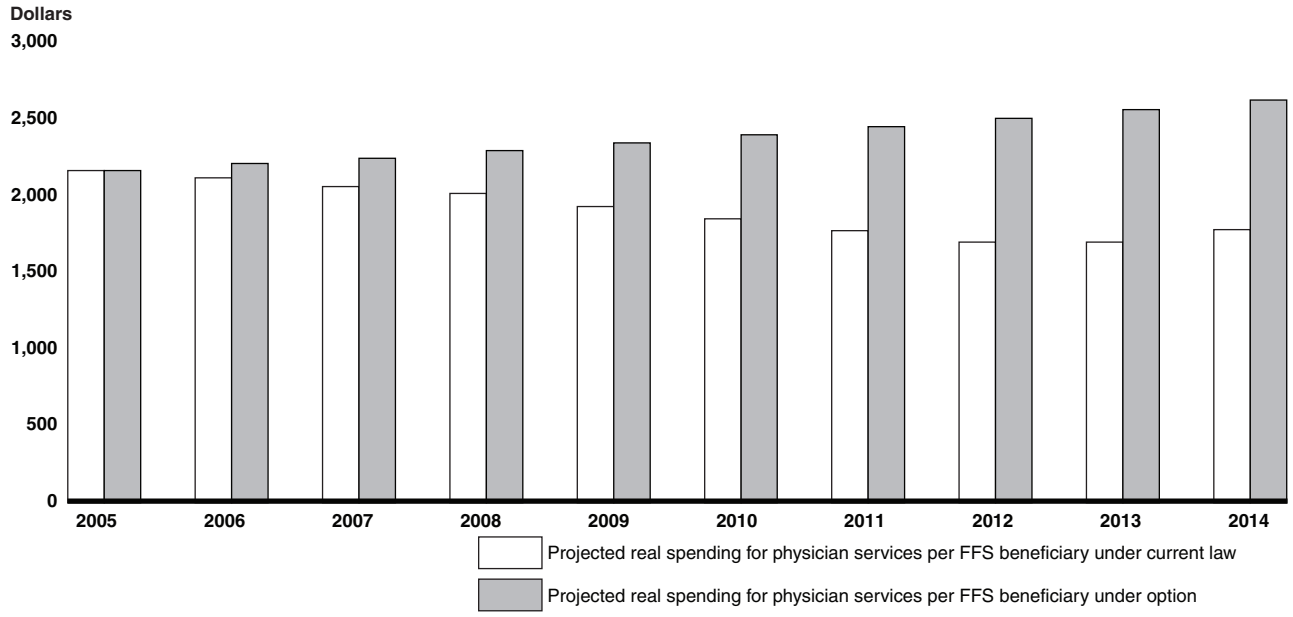
Figure 24: Projected Aggregate Spending under Current Law and under Combination of Options of Not Including Any Part B Drugs in the SGR System Beginning in 2005 and Eliminating the Cumulative Aspect of Spending Targets



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Aggregate spending includes all expenditures for physician services—both government outlays and beneficiary cost sharing. The line depicting the projection under current law includes all spending included in the SGR system. Under the option of not including any Part B drugs in the SGR system, spending for Part B drugs will occur even though it is not included in the SGR formula. To ensure comparability between the two projections, we included aggregate spending for both remaining SGR-covered services and Part B drugs in the line depicting the projection under the option.

Figure 25: Projected Real Spending for Physician Fee Schedule Services per FFS Beneficiary under Current Law and under Combination of Options of Not Including Any Part B Drugs in the SGR System Beginning in 2005 and Eliminating the Cumulative Aspect of Spending Targets



Source: GAO analysis of data from CMS OACT.

Notes: Projections are as of July 2004. Real spending per beneficiary for physician fee schedule services includes both government outlays and beneficiary cost sharing and is adjusted by MEI. Spending for non-fee-schedule services—laboratory services and certain Medicare-covered Part B outpatient drugs—is excluded.

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. Under the current SGR system, fees are projected to fall by about 5 percent per year for the next several years. Total payments to physicians will continue to rise because of expected increases in volume and intensity. However, on a per capita basis, real spending per beneficiary will decline, raising concerns that a sustained period of falling fees could discourage some physicians from participating in the Medicare program and serving beneficiaries. These concerns have prompted policymakers to consider alternative approaches for updating physician fees.

One approach under consideration for solving the problem of declining fees is for Medicare to abandon the use of spending targets and separate the program's attempts to control spending from its method for adjusting physician fees each year. This is the approach that has been recommended by MedPAC. Although projected future fee increases would be positive and relatively stable, eliminating spending targets would increase spending. The extent to which spending growth would be moderated would depend upon the efficacy of separate efforts to address growth in volume and intensity.

Similarly, the other approach of retaining spending targets but modifying the SGR system to overcome its current perceived shortcomings, would also increase spending. These alternative approaches could also be augmented by separate efforts to moderate spending. Alternatives under this approach seek to preserve the fiscal discipline of spending targets while providing for reasonable fee updates. These alternative approaches could also be augmented by other efforts to moderate spending. To the extent that the growth in spending is moderated, physicians would benefit from an increase in fees that would be triggered under a spending target system.

Almost any change to the SGR system is likely to increase Medicare spending above the amount that is currently projected. Either of the two broad types of approaches discussed above—replacing the SGR system and revising the SGR system—could be implemented in a way that would likely generate positive fee updates. Therefore, the choice between the two approaches under consideration may hinge on whether primary importance should be given to stable fee increases or to the need for fiscal discipline within the Medicare program.

Agency and Industry Comments and Our Evaluation

Agency Comments

In written comments on a draft of this report, CMS agreed with our concluding observations that appropriately updating the physician payment rates requires a balance between adjusting physician fees in a stable and predictable manner and encouraging fiscal discipline with scarce Medicare resources. CMS expressed its commitment to ensuring that Medicare beneficiaries have access to high-quality health care and noted that achieving this goal requires paying physicians appropriately.

CMS mentioned several administrative actions it has taken to improve Medicare's payments to physicians, including specific adjustments to MEI that have both made the index a more accurate representation of inflation in physician practice costs and resulted in higher payments to physicians. In addition, the agency committed to considering further administrative actions and discussed ongoing efforts to implement various provisions of MMA that may reduce adverse incentives in the current payment system, allow the program to pay for higher quality care, and uncover innovative methods to control spending growth in the future. We have reprinted CMS's letter in appendix III.

Industry Association Comments

We obtained oral comments from officials representing the American Medical Association (AMA), the Medical Group Management Association (MGMA), the American College of Physicians (ACP), and the Alliance for Specialty Medicine (ASM). In discussing the draft report with these groups, their overall reaction was that the report was a good analysis of the problems with the SGR system; however, they raised a number of concerns about the draft report. The bulk of their comments focused on OACT's estimates of aggregate spending on physician services, the SGR system's use of MEI as a measure of input price inflation for physician services, and the draft's discussion of physicians' concerns about the SGR system. The rest of their comments pertained to either issues related to physician behavior or to topics outside the scope of our review. A summary of the physician groups' comments and our evaluation is provided below.

Representatives from all four groups commented on CMS OACT's estimates illustrating each option's additional aggregate spending over a 10-year period relative to current law spending over the same period. The groups were confused by the difference between CMS OACT's estimates and CBO's budget impact estimates, which were available for some of the options. CBO's budget scores—that is, cost estimates that show the impact of legislative changes on the federal budget—include only federal expenditures and exclude spending from other sources, such as beneficiary cost sharing. In contrast, CMS OACT's aggregate spending estimates include both federal outlays and beneficiary cost sharing. Because any changes to the SGR system that result in increased spending would not only affect taxpayers but also Medicare beneficiaries (through increased cost sharing and part B premiums), we believe it is appropriate to include the estimated increase in aggregate spending. Nevertheless, because our focus is on the relative costliness of each option, we revised the draft to highlight the proportional difference between current law

spending and the spending estimated for each option. In addition, we now include CBO's budget scores for each option, where available.

All four physician groups also expressed concern that the draft report did not discuss the use of MEI as a measure of input price inflation for physician services. The groups contended that MEI does not contain sufficiently current data on physician practice costs, stating that it does not account for or keep pace with the cost of items such as information technology. Examining MEI and other indices included in the SGR system was outside the scope of our report. Moreover, in responding to public comments on a federal regulation, CMS stated that the various expense categories constituting MEI capture all practice expenses and are based on the most recent available data. [63]

The physician groups commented that the projected payment reductions of 5 percent a year from 2006 through 2014 are unrealistically severe and that the draft report did not sufficiently emphasize the access problems that beneficiaries would experience in the event of these cuts. They further noted that the Congress has regularly made adjustments to the SGR system and would probably act again. We noted in the draft report that policymakers, physicians, and others are concerned about the impact that the projected fee reductions would have on beneficiary access to physician services, noting that the Medicare Trustees and other parties believe it is unlikely that the projected fee reductions will take place.

Representatives from both ACP and ASM asserted that we should include a discussion about the effect of the spending targets on physician behavior and volume and intensity. They noted that evidence is lacking that directly correlates the introduction of both spending targets and the physician fee schedule in 1992 with the corresponding drop in volume and intensity in that year. They believe this reduction was likely caused by something other than the spending target, such as initiatives aimed at correctly coding claims for physician services. ACP stated that for the Congress to evaluate any alternatives, there must be a discussion of how the SGR system affects the volume and intensity of physician services. As noted in the draft report, we do not claim that spending targets and the fee schedule influenced individual behavior and reduced the volume and intensity of physician services in the early 1990s, we noted that PPRC claimed that a spending target system would provide a collective incentive

[63]See 68 Fed. Reg. 63196, 63239-45.

for physicians to develop practice guidelines and control unnecessary utilization. Further, in the draft report we described spending targets as a method for automatically imposing fiscal discipline, not as a tool to modify the behavior of individual physicians.

Representatives from ACP further noted that while the draft report included a discussion of geographic variation in physician service use, it did not mention that the SGR system is a blunt instrument in that it applies nationally to all physicians. In a year in which fees are reduced, physicians in regions that could be characterized as low spending would receive the same fee reduction as physicians in higher-spending regions. We agree that the SGR system does not distinguish between physicians whose discretionary practice patterns result in higher Medicare spending and those physicians whose practice patterns do not. As we stated in the draft report, at the time PPRC recommended expenditure targets, it initially envisioned a national target that would apply to all physician services and later the evolution of separate targets that would apply to regions, categories of physician services, or both.

The physician groups raised additional topics that were beyond the scope of our study. For example, AMA contended that Medicare's new preventive benefits and government-sponsored health campaigns create a government-induced demand among beneficiaries for services that, in turn, could increase volume and intensity of service use. To date, studies have not been conducted on whether new benefits and federal health campaigns have directly affected Medicare beneficiaries' use of physician services. Our report notes, however, that the SGR system's allowance for volume and intensity growth, unlike that of the MVPS system, is inflexible and would not take such factors into account. ACP noted that increased spending on physician services may be appropriate, as it may result in other program savings, such as reduced spending for hospital care. Whether such savings have been or can be achieved would require research outside this study's scope.

We are sending copies of this report to the Secretary of Health and Human Services and interested congressional committees. We will also provide copies to others on request. In addition, this report is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have questions about this report, please contact me at (202) 512-7101 or James Cosgrove at (202) 512-7029. Other contributors to this report include Jessica Farb, Hannah Fein, and Jennifer Podulka.

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

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The Honorable Charles E. Grassley
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The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

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The Honorable Sherrod Brown
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Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Nancy L. Johnson
Chairman
The Honorable Pete Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Appendix I: Calculation of the Performance Adjustment Factor

Each year, CMS follows a statutory formula to compute a performance adjustment factor (PAF) and determines whether the physician fee update should be adjusted relative to the percentage change in the Medicare Economic Index (MEI) and, if so, by how much. (See fig. 26.) The PAF takes into account the difference between actual and target expenditures. If spending has equaled the targets, the PAF is equal to 1 and the update will equal the percentage change in MEI. If spending has been below the targets, the PAF is greater than 1, thus increasing the update. If spending has been above the targets, the PAF is less than 1, thus reducing the update. The PAF is a blend of the relative difference between target and actual spending in the current year, accounting for 75 percent, and the relative cumulative difference in expenditures from April 1996 through the current year, accounting for 33 percent. The weights were developed by the Centers for Medicare & Medicaid Services' (CMS) Office of the Actuary (OACT) and included in statute to minimize the volatility of both fee updates and the time required to align actual spending with the targets. Applying these weights causes the difference between cumulative actual expenditures and cumulative target expenditures to be adjusted over several years rather than during a single year. As a result, the fee update is less volatile than would be the case if the full adjustment were made in 1 year. The PAF is subject to statutory limits and may not cause the fee update to be set at more than 3 percent above MEI or 7 percent below MEI. These limits may further increase the time necessary to align spending with targets.

Figure 26: Formula Used to Determine the Performance Adjustment Factor in 2005

$$PAF_{2005} = \left[\left(\frac{Target_{2004} - Actual_{2004}}{Actual_{2004}}\right) \times 0.75\right] + \left[\left(\frac{Cumulative\ Target_{4/96\text{-}12/04} - Cumulative\ Actual_{4/96\text{-}12/04}}{Actual_{2004} \times (1+SGR_{2005})}\right) \times 0.33\right]$$

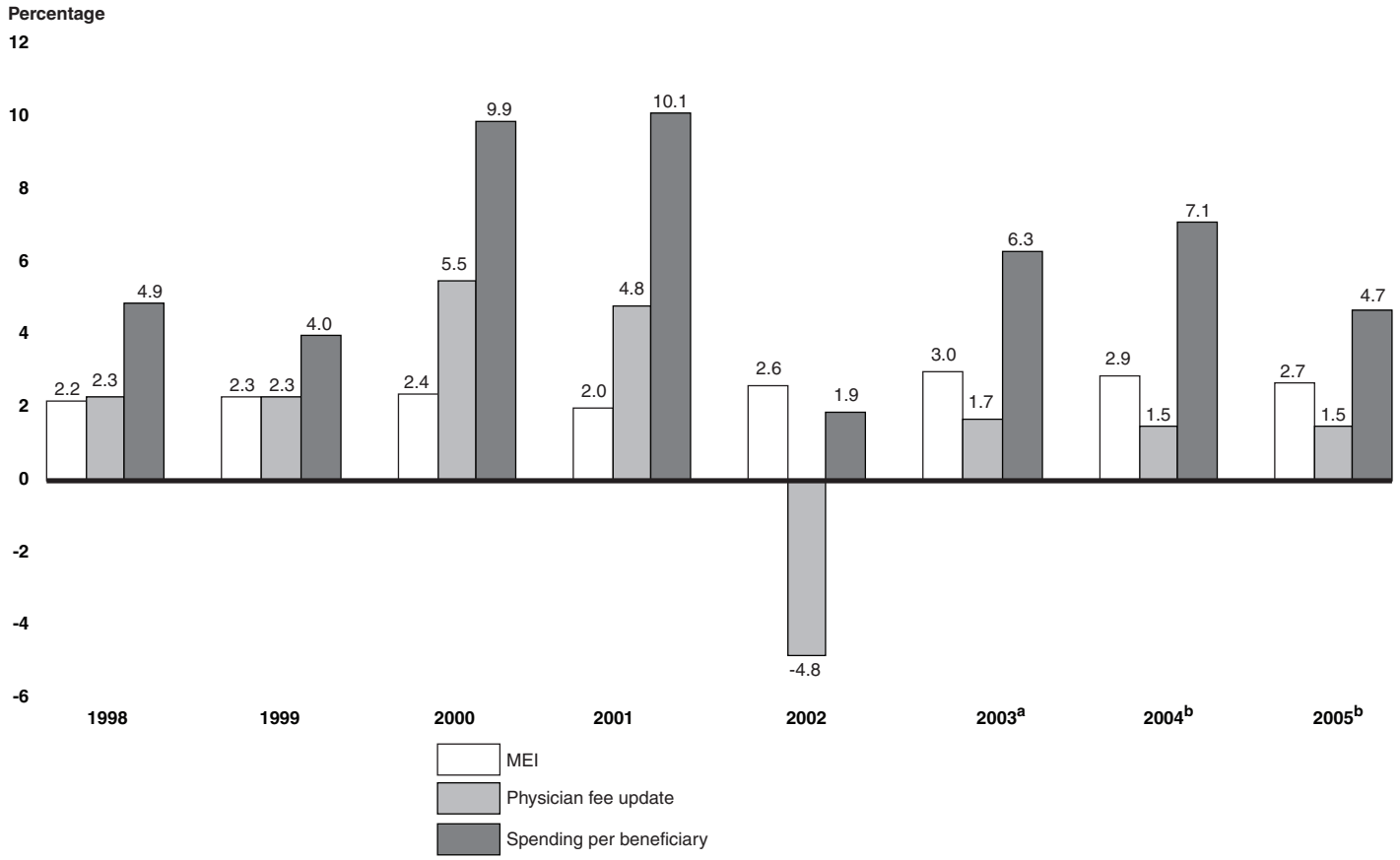
Source: CMS OACT.

Appendix II: Corrections to Prior Estimates Caused the SGR System's Cumulative Targets to Produce Negative Updates

Since the introduction of the fee schedule in 1992 through 2001, physicians generally experienced real increases in their fee updates—that is, fee updates increased more than the increase in the cost of providing physician services, as measured by MEI. Specifically, during that period, fee updates increased by 39.7 percent, whereas MEI increased by 25.9 percent. In 2002, however, the sustainable growth rate (SGR) system reduced fees by 4.8 percent,[1] despite an estimated 2.6 percent increase in the costs of providing physician services. (See fig. 27.)

[1]Some annual fee updates are adjusted for additional factors. For example, a budget neutrality adjustment is used to account for changes in the calculations used to determine the amount of resources associated with physician services. In 2002, CMS reduced the update by an additional 0.64 percent resulting in a total fee decline of 5.4 percent.

Figure 27: Percentage Change in MEI, SGR 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.

Notes: Spending per beneficiary represents Medicare spending for beneficiaries in the traditional FFS program, net of beneficiary cost sharing. Spending for end-stage renal disease patients is not included. The physician fee schedule update figures shown do not reflect additional required adjustments, such as those for legislated changes and for budget neutrality.

[a]The 1.7 percent fee update went into effect in March 2003.

[b]The physician fee updates of 1.5 percent for 2004 and 2005 were specified by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

In 2002, corrections to prior estimation errors caused the SGR system's cumulative targets to begin producing negative updates. The SGR system reduced fees in 2002 because estimated spending for physician services—cumulative since 1996—exceeded the target by about $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 gross domestic product (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 percent 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.

Despite its recognition of errors, 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 FFS enrollment and real GDP per capita; actual experience had shown these growth rates 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.[2] Without such revisions, the cumulative spending targets remained lower than if errors had not been made.

In late 2002, the estimate of the sustainable growth rate called for a negative 4.4 percent fee update in 2003. With the passage of the Consolidated Appropriations Resolution of 2003,[3] CMS determined that it was authorized to correct the 1998 and 1999 spending targets. Because SGR system targets are cumulative measures, these corrections resulted in an average 1.4 percent increase in physician fees for services for 2003.[4]

[2]BBRA required CMS to use the most recent data to revise the estimates used to set the spending targets, beginning with the estimated spending target in 2000. BBRA, §211(b)(5), 113 Stat. 348-49.

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

[4]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. The Congressional Budget Office 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.

The Medicare Prescription Drug, Improvement, and Modernization Act of 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 those 2 years.[5] The MMA increases replaced SGR system fee reductions of 4.5 percent in 2004 and an estimated 3.6 percent in 2005. The fee increases will result in additional aggregate spending. Because MMA did not make corresponding revisions to the SGR system's spending targets, its fee increases will require the SGR system to offset the additional spending by reducing fees beginning in 2006. In addition, recent growth in spending due to volume and intensity, which has been larger than SGR system targets allow, will further compound the excess spending that needs to be recouped.

[5]See MMA, §601(a), 117 Stat. 2300.

Appendix III: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Service

Administrator
Washington, DC 20201

DATE: SEP 27 2004

TO: A. Bruce Steinwald
Director, Health Care-Economic and Payment Issues
Government Accountability Office

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: Government Accountability Office's (GAO) Draft Report: *MEDICARE PHYSICIAN PAYMENTS: Concerns About Spending Target System Prompt Interest in Considering Reforms* (GAO-04-1027)

Thank you for the opportunity to review and comment on the draft report. We appreciate the interest of the Congressional Committees in the physician fee schedule (PFS) rates under the sustainable growth rate (SGR) system and the efforts of GAO to consider potential improvements to the system.

We agree with GAO that appropriately updating the physician payment rates requires a balance between adjusting physician fees in a stable and predictable manner and encouraging fiscal discipline with scarce Medicare resources. As a result of joint collaboration between Congress and the Administration, enactment of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) guarantees that the 2004 and 2005 physician fee schedule updates would be no less than 1.5 percent. The MMA improves access to high-quality care by recognizing that Medicare beneficiaries cannot get such care without paying physicians appropriately. As a result we have increased payments for doctors this year and will increase them again in 2005, instead of decreasing payment rates as would have been required by the Medicare law if the MMA had not been passed. As a result of the MMA, physicians will receive roughly 4 percent more in Medicare revenues in 2004 and 2005.

The Centers for Medicare & Medicaid Services (CMS) has taken several actions within its administrative authority to improve Medicare payments for physicians' services. For instance, CMS changed its policy to adjust the Medicare Economic Index (MEI) for multifactor productivity in place of labor productivity beginning in 2003. This change increased the PFS update by 0.7 percentage points for 2003. We estimate that the change to the MEI increased Medicare spending by $14.5 billion over ten years. For 2004, we increased the weight of malpractice costs in the MEI from 3.2 to 3.9 percent, a 21 percent increase. We also incorporated a 16.9 percent increase in malpractice premiums into the 2004 MEI. The increased

weight for malpractice in the MEI makes the index a more accurate representation of inflation in physician office costs.

The GAO report notes that CMS can take certain administrative actions to address the physician update situation. The report correctly notes that these administrative proposals will have significant long-term cost implications but will not have an impact in 2006 and the subsequent few years. Therefore, without a change in law, there will still be a reduction in physicians' fee schedule rates for 2006 and subsequent years. Nevertheless, as we consider changes to the physician fee schedule for 2006 and future years, we are committed to looking thoroughly at these suggestions.

The CMS is also currently working to implement numerous provisions of the MMA that make vital improvements to the Medicare program, such as adding important preventive benefits and taking steps to reward health professionals for avoiding complications and reducing costs. We are also investigating new approaches that may reduce adverse incentives in the current payment system and allow Medicare to pay for better rather than more care. We are implementing innovative coordinated care and disease management pilots and demonstration programs such as the Chronic Care Improvement Program that may provide insight on new and innovative ways to control expenditure growth in the future. Further, we are currently assessing the impact of provisions of the MMA on physician spending targets.

Once again, thank you for the opportunity to review this draft report and CMS looks forward to working with Congress on potential changes to the physician payment system that will control Medicare spending and lead to equitable updates to physician fee schedule payment rates, as well as ensuring access to high quality health care.

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