

**PHYSICIAN FEE SCHEDULE: A REVIEW OF THE
CURRENT MEDICARE PAYMENT SYSTEM**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
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PHYSICIAN FEE SCHEDULE: A REVIEW OF THE CURRENT MEDICARE PAYMENT SYSTEM

WEDNESDAY, MAY 5, 2004

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Norwood, Wilson, Pitts, Ferguson, Barton (ex officio), Brown, Pallone, Stupak, Green, Capps, and Dingell (ex officio).

Also present: Representatives Otter, Fossella and Radanovich.

Staff present: Chuck Clapton, majority counsel; Jeremy Allen, health policy coordinator; Eugenia Edwards, legislative clerk; Bill O'Brien, projects assistant; Amy Hall, minority counsel; Bridgett Taylor, minority professional staff; Purvee Kempf, minority professional staff; and Jessica McNiece, minority staff assistant.

Mr. BILIRAKIS. This hearing will come to order.

I do want to start out by thanking our panelists. They are a most distinguished group, and I'm hoping that in addition to maybe helping us out on the history of the physician payment picture that they would also offer some suggestions on how we might be able to help address that problem.

The Chair is going to do something unusual, but with permission of the Minority, I'm going to waive my opening statement for the time being and recognize Doctor Norwood for an opening statement, because he has a pretty serious mark-up in one of the other committees and would like to get over there.

Charles, go ahead.

Mr. NORWOOD. Thank you very much, Mr. Chairman. I don't have to tell you how important this hearing is to me, and, unfortunately, I have four of my own bills about OSHA being marked up and will have to leave, but I appreciate you allowing me to go ahead. And, I also very much appreciate you holding this hearing today.

As we all know, everybody in this room knows, the physician payment update is a black cloud on Medicare's horizon that somewhere soon we have to address. Hopefully, this hearing will help us understand what the actual hurdles are that we are going to have to face.

Mr. Chairman, to me this is a fairly simple problem. Congress made a mistake. We put in law a formula for paying physicians

that was fundamentally flawed. I don't think anyone, anywhere, can ever make the case that Congress intended to cut payments to physicians year after year. And, the reason I know Congress didn't mean to do that is that they don't want seniors to not have doctors, and it's going to turn into, and is, an access problem.

The problem is that our good friend from CBO assumed that the cost of fixing that problem is going to be pretty high. We don't have a lot of money lying around to fix problems like this. To make matters worse, when CBO realizes that they were very wrong about the cost of the Prescription Drug Bill that's going to come to be—it's going to be that much more difficult, Mr. Chairman, to find the money to fix the physician payment.

Well, I've got a solution for you. The CBO makes assumptions about behavior every day. They make assumptions about the take-up rate of seniors in the Prescription Drug Plan, or assumptions about the economic growth that will flow from eliminating the estate tax. Well, I'm here to suggest to CBO that they make some assumptions about Congress' behavior. We are never going to let physicians get the cut that you are forecasting, it is simply not going to happen. It may be a last-minute fix, it may be the last day, but it is simply not going to happen for very practical political reasons. Members of Congress do not like it when senior citizens come to them and say I can't find a doctor in Medicare. It is not going to happen. These cuts will never go on.

So, here's my suggestion to you, Doctor Holtz-Eakin, it is time to change the baseline. The cut you are forecasting is not going to happen. Once you accept that, that you need to change the baseline and the cuts are not going to happen, then we can begin, perhaps, to fix this problem. But, if you persist in this fantasy that Congress is actually going to cut out providers of healthcare so they cannot furnish healthcare, it makes it very much harder on us to right the wrong that occurred in the formula.

Tell me at some point today what it is going to take to convince you. I would much rather us have a very nice conversation and continue all year long babbling back and forth about the fact that Congress is simply not going to stop paying physicians, even though you suggest it will happen gradually. I would much rather be nice and solve this problem. So, somewhere today tell me what it is going to take for me to convince you about this.

I am going to look forward to your answer, and I am going to, though I may not be sitting here, I promise you I will hear your answer.

And, with that, Mr. Chairman, I thank you for the time and I will yield back.

Mr. BILIRAKIS. Thank you for being nice.

The Chair recognizes the gentleman from Ohio, Mr. Brown.

Mr. BROWN. And, I want to mark this day, my friend, Mr. Norwood, for being so nice. Thank you, Charlie.

The Medicare Physician Payment formula is flawed and needs to be fixed, as Mr. Norwood says, we all think that, we all know that. The problem came to a head in 2001, when CMS announced that physicians will receive a 5.4 percent cut in their pay in 2002. There was nothing fair about this. It was a function of GDP and other factors wholly outside the control of the healthcare system.

The chairman and I introduced legislation to prevent the cut, revise the payment formula. Unfortunately, that bill did not become law.

2002, Congress gave CMS the authority to correct certain data errors in their calculation of the physician payment rates, which prevented another large cut, provided a small increase in 2003. That was payment relief, it was, in the opinion of virtually all of us, it was payment fairness. Physician payment amounts had been miscalculated, and it was appropriate to correct that miscalculation.

One of the only bright spots in the controversial Medicare Bill signed into law in December was the 2-year fix that gives physicians small payment, positive payment, updates this year and next, instead of the anticipated cuts. Prior to passage of that bill, Republican Mark Foley and I wrote a letter to Speaker Haskert with 160 signatures from members from both sides of the aisle, emphasizing the need for physician payment reform. That level of support is crucial, because the payment provisions in the Medicare Bill are a stop-gap measure.

If Congress doesn't act again, physicians will receive a deep payment cut in 2006, as we know, in fact, physicians face cuts of 5 percent a year for the next 6 years.

We need a permanent solution so that physicians won't confront potential cuts year, after year, after year, come lobbying Congress and have us do this each time. We need to de-link the payment formula from GDP. We need to stop penalizing physicians when drug costs increase. We need to stop holding physicians responsible for utilization increases, over which they have no control. We need to smooth out the payment changes, so that physicians are not riding a roller coaster when it comes to the reimbursement.

Fixing the physician payment formula will be expensive, relative to the status quo. That means this Congress needs to be more responsible, by going from a big budget surplus 3 years ago to a huge budget deficit today, when we don't have the money for physician payment, even though we need to do it, we don't have money for a lot of other things. And, somehow the doctors get in line, we take care of them when we often don't take care of the poor, we often don't take care of food safety rules, we often don't take care of other things we need to do in this Congress.

And, as long as this Congress on the one hand says to the AMA and to the doctors, we want to help you, as we should, I am one of those, joined by my friends on the other side of the aisle, but we will continue to insist on tax breaks that the average person making a million dollars in this country gets \$121,000 tax break, as long as we are speaking out of both sides of our mouths it is going to be very hard to fix this, and at the same time not ignore critical public health needs. We have no business helping physicians, which we should do, and not dealing with public health issues, which we are not doing, because, one, they don't have a good enough lobby, and second, because Republicans in this institution always worship at the altar of more tax cuts for the rich.

But, when we under pay physicians, we are not spending enough. We are robbing earned income from those professionals. Fixing the

payment formula gets us to a level playing field, which is where we should have been all along.

Some of the needed changes are statutory, some can be accomplished administratively. The Administration needs to continue to include the cost of physician-administered drugs in the SGR, even though these drugs clearly aren't physician services, as defined in the law. Spending on these drugs is increasing far more rapidly than spending on professional services, which means the distortions caused by these costs is getting worse over time.

I have also heard from physicians that the current spending calculation understates the impact of the new prescription drug law, and fails to account for national coverage decisions and other CMS policy changes.

I look forward to hearing the views of our witnesses on actions the Bush Administration can and should take to improve the accuracy of the physician payment formula. I'm sure we'll benefit from your views. I hope that this Congress will become more responsible fiscally, generally, so that we can deal with this issue long term, and fix it, and fix it right.

I yield back the balance of my time.

Mr. BILIRAKIS. The Chair recognizes Chairman Joe Barton.

Chairman BARTON. Thank you, Mr. Chairman, and once again I want to thank you for holding this series of hearings about Medicare and the healthcare issues of our country.

I want to apologize in advance. I have a hearing upstairs on the Alaska Natural Gas Pipeline that is going on simultaneously, so I'm going to be shuttling back and forth.

I think this is an important hearing. What to do about physician reimbursement under Medicare is a vacuous issue. I have been on the committee for 18 years. I was here in 1992 when we changed the system, from just kind of a normal fee increase to the various indexes that we are still having problems with, which is the purpose of today's hearing.

We haven't got it right yet. Hopefully, with this hearing today, and the input of the three gentlemen before us, the interest groups in the audience, we may yet do something that will get it right.

We have held, over the past 3 years in this subcommittee, numerous hearings, sponsored briefings, held press conferences on this issue, and how to do payments to physicians. This is a hearing today in the continuing effort to resolve the issue. Our three witnesses today are going to provide a unique perspective on the history and background of Medicare payments to physicians.

I don't know that anybody on the podium is anymore frustrated than the people in the audience, that year after year we try to get a system that works, and is fair, and we still have the problems that we are having this year.

We want to try to today understand and explain the creation of the current formula, and if you gentlemen can do that you will have done something. I spent about 30 minutes last night preparing for this meeting this morning, and I had visions of MEIs and all kinds of stuff dancing in my head when I woke up this morning. We have tried to get it right, yet we still have wide swings in payments to physicians. We've had 2 years in a row in which we've had to override the formula to give physicians some

increase, because the last 2 years had we not they would have had significant reductions in their reimbursement.

I have heard from many physicians in my district back in Texas about the impact back 2 years ago of the payment reductions. I have had several physicians that are very close to me decide to discontinue their practice because of the inability to be fairly reimbursed for their services.

We simply have to come up with a way that will ensure that Medicare beneficiaries have access to critical healthcare services and are not put at risk. I know we have a budget problem. For example, the result of last year's override of the formula is expected to cost the taxpayers \$54 billion over the next 10 years, in addition to what it would have had we not made that change last year.

We all know the Federal budget is in deficit, and that the Medicare program is facing increasing budgetary pressure over the next 10 years, as baby boomers begin to retire in greater numbers. So, we have a challenge before us. We need to design a solution that allows physicians to continue to provide care to current beneficiaries, without bankrupting the program for future generations.

I look forward to reading today's testimony and, hopefully, hearing as much of it as possible. I really am interested in the insights of the panel on how we can solve this problem. We hope to use the information from today's hearing to design a solution that will provide stable and predictable Medicare reimbursements for physicians.

I want to thank you again, Chairman Bilirakis, for your good work on this, and I really do encourage our three witnesses to do more than just regurgitate facts and figures from the past. If we can come up with a formula that works, this committee will work with the other committees and jurisdiction, and the House leadership, on a bipartisan basis to try to fix this. So, this is something of a nitty-gritty hearing, but it has the potential to really do some good for the country in the years ahead.

So, I thank you three gentlemen for being here, and I look forward to working together to try to find a solution. With that, I yield back, Chairman Bilirakis.

Mr. BILIRAKIS. The Chair thanks the gentleman, and now recognizes the gentleman from New Jersey, Mr. Pallone, for 3 minutes.

Mr. PALLONE. Thank you, Mr. Chairman.

I listened to what Mr. Norwood said, and I am not just responding to him, I am not trying to be personal about it, but I do believe that when he says that, you know, there's no money, and that, you know, the budget deficit, and where is the money going to come from to pay for this, I think it all has to do with Republican priorities, and what they have been doing here in terms of, not only the larger issue, but also the healthcare system.

Obviously, the main reason that there is not a lot of money out there for domestic priorities and for healthcare is because of the tax cuts that have gone mainly to the wealthy and the corporate interests, and also to the increased defense spending, and, you know, we are not here to get into the Iraq War, but all this has contributed to a huge deficit, and that made it so there is not a lot of money left for healthcare. Even within the healthcare system, the Republican priorities have been to help the HMOs, and to help

the drug companies, and so, you know, we have a Prescription Drug Bill that primarily gives the money to the drug companies and not benefits to the people, and doesn't have any cost controls, and then we have money going to HMOs. There is a chart here that I would like to submit for the record, that says, Medicare overpays managed care plans by \$1,080 per beneficiary in 2004. This is from MedPAC and CMS status. So again, where is the money left for the patient? Where is the money left for the physician, when, you know, our priorities are skewed in the wrong way? And, that's the problem.

I was pleased that this Congress approved the stop-gap legislation that provided 2 years of relief to the physicians in 2003 and 2005, but I believe that a permanent fix to the funding formula should be put in place so physicians can rely on stability in Medicare reimbursement, and so physicians do not have to fight each year with Congress to ward off future cuts.

For example, according to Medicare trustees, physicians face cuts of 5 percent each year, between 2006 and 2012, and this is outrageous. Unfortunately, the end result will be diminished access to care for Medicare beneficiaries, in order to make financial adjustments physicians and other healthcare providers may have to balance their patients, drop their Medicare payments, or leave Medicare entirely, or limit charitable care.

There are several issues in particular that have to be addressed when updating the fee schedule. The inclusion of drug spending as part of the sustainable growth rate must be adjusted. Drug spending is increased far more rapidly than any spending on physician services. And, the costs of physician administered drugs, even though drugs are not even a physician's service as part of the SGR, distorts the calculation of actual spending that should count toward the amount in Medicare reimbursement.

In addition, it is unfair for the SGR formula to be linked to the GDP. Physician fees adjustments should not be linked to the overall economy, because physician services and fees do not parallel the economic ups and downs.

We have a lot of other things to discuss here, Mr. Chairman, but I really think that it's wrong for the Republicans to say the money is not there. It is their priorities that have created this situation. This can be fixed, and it should be.

Mr. BILIRAKIS. The Chair thanks the gentleman, and will recognize Mr. Ferguson.

Ms. Capps stepped out.

Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman, and thank you calling the hearing today so that the committee can gain a better understanding of the Medicare formula that pays our physicians and other providers.

To describe the formula that determines the physician fee schedule as complicated would be an understatement. I am glad we are having this hearing, so the committee can better understand how this formula came about, what's wrong with it, and what should be done to fix it.

Thank you to our witnesses for coming today to provide incite.

I think everyone is in agreement that Congress needs to address the formula. For the past 3 years, we have had to pass fixes, because the physician costs were going up, physician payments were to go down under the current formula. That doesn't make much sense to me, and it almost is impossible to justify to my providers back home.

The various cost estimates for fixing the formula range from \$90 billion to \$126 billion over 10 years. That is not cheap, but Congress simply cannot allow the situation to continue. The way the formula is written now, every adjustment we give means larger cuts to reimbursement in the future.

One part of the formula that I am especially interested in hearing about today is the sustainable growth rate component. The sustainable growth rate system is supposed to rein in the volume of healthcare being provided, therefore, reining in costs. But, all indications show that the system doesn't work.

Finally, I think it's important that we not lose sight of the bottom line. If we don't fix this problem, physicians are going to leave Medicare, and that's not what anyone wants.

I hope the committee will hear from the provider community in future weeks about the real impact this formula has had on their ability to care for patients.

Thank you, Mr. Chairman, and I yield back the remainder of my time.

Mr. BILIRAKIS. The Chair thanks the gentleman and recognizes himself for his opening statement.

This is, as we have heard, a topic that every subcommittee member cares deeply about, and for that reason I am pleased that we have such technical expertise from members to draw on.

I know that most everyone here is familiar with the general problems associated with how Medicare reimburses physicians and other healthcare professionals under the Physician Fee Schedule. Payments decreasing, while the costs of practicing medicine are increasing, this is, obviously, an untenable situation. I know doctors in Florida who are really being squeezed right now, as they contend with declining reimbursements from Medicare, at the same time they are faced with skyrocketing medical malpractice insurance premiums.

That said, I want to point out that while the problem is easy to explain, the causes behind it and how potential solutions might work are complex, and that's why it's appropriate for us to have representatives from the three entities charged with advising Congress on healthcare policy, among other things, with us today.

This subcommittee has taken a lead role in attempting to change how Medicare pays for services covered under the Physician Fee Schedule. I joined a number of members of this subcommittee in introducing the first bill designed to help mitigate the impact of some of the cuts physicians have faced over the past several years, and I also worked with my colleagues to avert large cuts in reimbursements in years 2003 and 2004.

The Medicare Modernization Act included a 2-year solution to the problems of declining Medicare reimbursements. Under the new law, the physicians will be able to count on steady increases in their reimbursements in 2004 and 2005. Unfortunately, we did

not arrive at a more permanent solution to this very serious problem, and that's why we thought it was important to hold today's hearing. Our intention is that we focus on how we got to where we are today. More specifically, I hope we can focus on the history, as has already been said, of physician payment under Medicare, and why the SGR, the Sustainable Growth Rate, system was put in place, and how Congress has worked to address this problem over the past several years.

This hearing, as so many others have already indicated, will serve as a starting point for future subcommittee hearings and, eventually, congressional action that will ensure that physicians will receive fair, predictable payments under Medicare.

At the end of the day, I know that most of us are concerned that if we don't fix this problem soon Medicare patients will be the ones who suffer most.

Access problems will become a real issue, and I'm afraid we will face a physician supply problem for years if we allow prolonged cuts in payments under the Fee Schedule.

Today, the Health Subcommittee is taking the first step toward what we hope would be a good, reasonable, permanent solution.

Again, I want to thank our witnesses for joining us, and now I'm pleased to recognize the gentlelady from California, Ms. Capps, for an opening statement.

That's fair.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and I want to thank you and our ranking member for holding this hearing on physician reimbursement from Medicare. I think this is one of the most pertinent topics for our subcommittee and the full committee and, frankly, by the whole Congress.

It's been a decade since the Physician Fee Schedule was put into place in 1992, to help control increases in Medicare payments to physicians. Since 1997, the Fee Schedule has utilized the Sustainable Growth Rate system to set a spending target for Medicare expenditures for physician services. Despite the complicated formulas used to derive the SGR in the Physician Fee Schedule, the idea behind the formula is simple, if Medicare expenditures on physician services exceed the target in a given year CMS will decrease payment for physician services the next year. If expenditures fall short of the target, physician payments will increase. Medicare physicians have faced rate cuts since 2002 because of a number of factors, the weakened economy, data errors in previous years, and in the increase in the volume of services rendered, have all contributed to these increases.

While Congress enacted stop-gap measures in 2002 through 2005, it's clear that the system contains some inherent flaws that must be addressed to ensure the long-term viability of Medicare.

For sure, my hometown of Houston contains some of the best medical facilities in the world. The scope of the medical care offered at the Texas Medical Center is unmatched. Yet, I meet with physicians working in every medical specialty imaginable, who say that this system truly threatens our Medicare beneficiaries' access to the specialty care that they provide. If this happens, Medicare will

have failed its mission to provide equality equally in access to the healthcare for all American seniors.

And that, Mr. Chairman, is why I'm particularly glad we are having this hearing. We have an experienced and distinguished panel before us today to offer us explanations behind the current problems, and discuss with us various options for remedying these problems, and putting Medicare on a secure path to sustainability.

And, I know Mr. Pallone mentioned it, but I would like the panel particularly to see this chart that is available, where Medicare overpays managed care is correct. Overpayment of managed care by \$1,080 per year for 11 percent of Medicare beneficiaries seemed like it was an increase under the Medicare Reform Bill that was passed last year, and it is in effect now. I'm concerned if we sift through these facts looking at this and other reasons this morning, I think we can all agree that any actions we take need to ensure that the Medicare system provides for our seniors equal access to quality healthcare, whether you are in the fee-for-service, or whether you happen to join a managed care and it is paid \$1,000 more a year than fee-for-service.

With that, Mr. Chairman, again, I'm glad the witnesses are here, and I yield back my time.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF NEW MEXICO

Thank you, Mr. Chairman, for holding this hearing today on physician payment in Medicare. Medicine is no longer the desirable profession that it once was. Inconsistency and uncertainty in payment patterns by public payers including Medicare and Medicaid, combined with skyrocketing medical malpractice premiums, are a disincentive for people to enter medicine.

One problem that affects doctors everywhere is the Sustainable Growth Rate (SGR) formula that ties changes in physician payment in Medicare to general economic growth factors instead of medical inflation. Flaws in this formula require physicians to come back each year to ask Congress for a temporary fix that will allow them to continue to see Medicare patients. I know, because I hear from nearly all 2,200 of them in my district about this every year in one way or another. The SGR formula is so flawed and complicated that it may be time to throw it out and start over from scratch. While we took steps in the Medicare Modernization Act last year to cancel impending cuts and implement a 1.5% increase in 2004 and 2005, we need a permanent fix.

If we were to do this, one thing we may want to look at is adjusting Medicare payment rates to compensate for the patient mix in each state. In New Mexico, we have 21% of our population uninsured, 21% on Medicaid, and 13% on Medicare. This means 55% of the patients our physicians see pay them below the cost of providing services. These demographics, and our rural nature, make it hard to attract and retain doctors in New Mexico. If Medicare had some way to compensate doctors that takes into account patient mix, that would help to solve some of our problems.

But another problem we have in New Mexico is the Resource-Based Relative Value Scale that adjusts payments for physician services based on a variety of factors, including geography. I find it completely ludicrous to assume that a doctor in New Mexico's time, skill and intensity are somehow worth less than that of a doctor in a major metropolitan area. For instance, doctors in New Mexico are paid 12% less for their time, skill, and intensity for services than doctors in Manhattan. Why should it be 12 percent more work to look in someone's ear in Manhattan than it is in Albuquerque? Again, while we were able to set the floor on the work component of the Geographic Practice Cost Indicator at 1.0 for 2004, 2005, and 2006 in the Medicare bill, we need a permanent fix that compensates doctors in rural areas like New Mexico fairly compared to other states.

One by-product of the uncertainty doctors have with Medicare payment is a move toward employment by hospitals and health systems instead of private practice. In 1976 about 10% of doctors in New Mexico were employed, now about 60% are employed. Being employed by a hospital or health system provides a consistent, reli-

able source of income and also helps with malpractice insurance costs. While it is uncertain whether this trend is good or bad for our health care system, it is clear we are slowly driving the independent, private practice doctor out of business.

I would like to thank all the witnesses for being here today and look forward to learning more about this issue.

PREPARED STATEMENT OF HON. CHARLES "CHIP" PICKERING, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. Chairman, I thank you for holding this hearing today. A physician access crisis is looming for Medicare patients unless the Centers for Medicare and Medicaid Services (CMS) and Congress work together to implement a physician payment formula that adequately reflects increases in the costs of practicing medicine. I urge CMS to help in this effort by taking immediate administrative action to improve application of the current formula.

While a long-term change is needed, several important administrative alterations this year could reduce the cost of a long-term legislative solution. I urge CMS to exercise its authority immediately to remove Medicare-covered drugs and biologics from the physician payment formula.

Medicare payments to physicians are reduced when actual Medicare spending for physicians' services exceeds a pre-determined spending target, the sustainable growth rate (SGR). Currently, when CMS calculates actual spending on physicians' services, it includes the costs of Medicare-covered prescription drugs administered in physicians' offices. While administering the drug is a physician service which should be included in the target, the drug itself is not a physician service and, therefore, should not be included. Between 1996-2002, per enrollee spending on drugs grew 244% compared to 38% for physician services. As a result, including drugs in the SGR greatly increases the odds that Medicare spending on physicians' services will exceed the SGR target, triggering pay cuts that penalize physicians for providing important new drugs to their patients. I urge you to remove drugs from the SGR formula before a final physician payment rule is published for 2005.

I also urge CMS to ensure that government-induced increases in spending on physicians' services are accurately reflected in the SGR target. The government encourages greater use of physician services through legislative actions, as well as a host of other regulatory decisions. CMS should adequately reflect, in the SGR target, physician spending increases due to legislative mandates, new preventive screening benefits, Medicare drug discount cards and the new prescription drug benefit which tend to increase the use of physician services to save money elsewhere in the system.

I thank the Chairman and the staff for their hard work and look forward to working with the Committee on this issue.

Mr. BILIRAKIS. The Chair thanks the gentleman, and we'll go right into the panel. It consists of Mr. Bruce Steinwald, who is the Director for Health Care—Medicare Payments Issues, with the General Accounting Office. Welcome, sir. Doctor Douglas Holtz-Eakin, Director of CBO here in Washington, Congressional Budget Office, and Doctor Glenn Hackbarth, Chairman of MedPAC, the Medicare Payment Advisory Commission, located here in Washington. Thank you for being here, gentlemen.

Your written statement, of course, as you know, is a part of the record, and I'll turn the clock on 5 minutes for each of you, but, obviously, if you are on a roll we will let you continue. Hopefully, you can stay as close to the 5 minutes as you can.

Mr. Steinwald, why don't we start off with you.

STATEMENTS OF A. BRUCE STEINWALD, DIRECTOR, HEALTH CARE—ECONOMIC AND PAYMENT ISSUES, U.S. GENERAL ACCOUNTING OFFICE; DOUGLAS HOLTZ-EAKIN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE; AND GLENN M. HACKBARTH, CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. STEINWALD. Mr. Chairman and Members of the Subcommittee, I am pleased to be here with you today to discuss the system used to set and update fees paid to physicians under the Medicare Program.

In my prepared testimony, I have attempted to provide a concise history of this system, and the related spending trends, with emphasis on the use of spending targets to control growth in physician service expenditures.

In my remarks to you today, I want to focus on trends in the volume and intensity of physician services over the past several years, and the relationship between Medicare fees and physician spending per Medicare beneficiary over time.

I believe that an examination of these trends and relationships is vital to both understanding and confronting the difficult budgetary situation that you mentioned we are looking ahead to in 2006.

Please direct your attention to the first chart at the front of the room. It's on your left, on my right, and it is also Figure 3 on page eight of the written statement.

This chart shows trends in the volume and intensity of physician services per Medicare beneficiary from 1975 through 2003. Volume growth is simply the increase in the average number of services performed per beneficiary from year to year. Intensity is said to grow if over time more complex and, therefore, more expensive services tend to replace less complex, less expensive services. So, for example, more MRIs and fewer X-rays from 1 year to the next is an intensity increase. More MRIs without fewer X-rays is both an intensity and volume increase.

The chart represents national averages, and, therefore, does not show considerable variation across physician specialties, across geographic areas, or across Medicare beneficiaries.

I am focusing on volume and intensity because together they are what I would call the hidden culprit that has stymied past efforts to control spending on physician services, and it's a major source of the problem we face today.

As the chart shows, volume and intensity growth was substantial during the 1980's and early 1990's, despite various efforts made by the Congress during those years to control spending growth by limiting fees. In 1992, the charge-based system for setting fees was replaced by a Medicare Fee Schedule, and with it a targeting system for controlling spending for physician services was installed. And, as you can see, for several years thereafter volume and intensity were moderated, and because of this Medicare spending for physician services was under control.

With the new millennium, however, volume and intensity have begun to trend upward, and while the increases since 2000 are not as great as in the period before spending targets were in place, this

is a troubling trend and has created difficulties for Medicare payment policy that I will explain.

Now, please direct your attention to the second chart, which is also Figure 4 on page 13 of the written statement.

This chart portrays actual and projected experience under the current system of targets for Medicare physician service expenditures, which, as you know, is the Sustainable Growth Rate, or SGR system. For each year, the first bar shows the increase in the Medicare Economic Index, or MEI, which is the measure used to estimate increases in the cost of running a medical practice. The second bar shows the Fee Schedule update amount, that is, the average amount fees were changed in that year, as a result of the SGR system. And, the third bar shows the increase in spending on physician services per Medicare beneficiary in fee-for-service plans.

Please note that in every year spending per beneficiary increased more than either the MEI or the fee update, and sometimes substantially more, and, of course, this is due to increases in volume and intensity.

In the first SGR years, 1998 and 1999, the fee update was sufficient to cover average increases in practice costs, with modest additional revenues flowing to physicians through volume and intensity increases.

In 2000 and 2001, however, bad things began to happen. Based on inaccurate information, the fee updates for those years were set too high, over twice the increase in inflation, although this was not known at the time. In addition, volume and intensity trended upward, resulting in increases of about 10 percent in each year in spending per beneficiary on physician services. And, under the SGR system, this overspending in those 2 years would have to be recouped in future years.

By 2002, circumstances culminated in what might be called "perfect storm." Overspending in the two prior years, combined with other factors, led to massive downward pressure on fees. A negative update was put into effect in 2002 for the first time ever, and it would have been even larger if the SGR formula were not constrained in how much it can raise or lower fees in a single year. Consequently, policymakers faced the prospect of continued negative updates in future years.

As you know, Congress acted to ensure a positive update for 2003 in the Consolidated Appropriations Resolution of 2003, and acted again to ensure positive updates for 2004 and 2005 in the Medicare Modernization Act.

Please note that the modest positive updates for these years are accompanied by estimates of increases in physician service spending per beneficiary of about 6 percent per year, owing to the effect of projected volume and intensity increases.

Because of these increases, and the fact that the MMA mandated fee updates simply put off the requirements of SGR to balance spending with targets, rather than change the targets, fees are projected to decline under current law beginning in 2006 and for several years thereafter. As you know, the MMA also requires GAO to examine the SGR system and report to Congress on potential modifications and improvements, and we look forward to working with this committee and others in Congress as you deliberate on

potential legislative strategies concerning physician payment under Medicare.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions you or other committee members may have.

[The prepared statement of A. Bruce Steinwald follows:]

PREPARED STATEMENT OF A. BRUCE STEINWALD, DIRECTOR, HEALTHCARE—
MEDICARE PAYMENTS ISSUES, U.S. GENERAL ACCOUNTING OFFICE

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

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

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

SGR, the current system of spending targets, evolved from the target system that went into effect in 1992. Under the SGR system, physician fee updates are adjusted up or down, depending on whether actual spending has fallen below or has exceeded the target. Over time, fees tend to increase at least as fast as the costs of providing physician services as long as volume and intensity growth remains below a specified rate—currently, a little more than 2 percent a year. If volume and intensity grows faster than the specified rate, SGR lowers fee increases or causes fees to fall. Physicians raised concerns about SGR when fees dropped significantly in 2002, a decline

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

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

that was, in part, a correction for fees that had been set too high in prior years because of errors in forecast estimates and other data. Congressional action averted fee reductions, and projected fee reductions, for 2003 through 2005. However, beginning in 2006, fees are projected to resume falling for several years, partly to recoup the excess spending accumulated from averted cuts in previous years and partly because real per beneficiary spending on physician services is projected to grow faster than allowed under SGR. The dilemma for policymakers posed by projected fee reductions is that while SGR's automatic responses work as intended from a budgetary perspective, the consequences for physicians and their patients are uncertain.

BACKGROUND

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

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

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

MEDICARE SPENDING FOR PHYSICIAN SERVICES GREW RAPIDLY IN 1980S, SLOWED AFTER IMPLEMENTATION OF SPENDING TARGETS

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

In 1980s, Spending for Physician Services Grew Rapidly

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

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

Much of the spending growth resulted from increases in the volume and intensity of services. For example, from 1986 until 1992, physician payment rates grew by less than 2 percent annually, while the volume and intensity of services rose, on average, by almost 8 percent per year. In 1986, the Congressional Budget Office

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

⁴Medicare 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).

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

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

stated that “[b]oth the price and the volume of services must be controlled to constrain costs...”⁷ In 1989, citing the need for spending targets to limit spending growth for physician services, the Secretary of Health and Human Services (HHS) testified that “Medicare physician spending has increased at compound annual rates of 16 percent over the past 10 years. And in spite of our best efforts to control volume and rein in expenditures, Medicare physician spending is currently out of control... An expenditure target... sets an acceptable level of growth in the volume and intensity of physician services.”⁸

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

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

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

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

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

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

UNDER SGR AND PRIOR SYSTEM, PHYSICIAN FEE UPDATES ARE MECHANISM TO BRING ACTUAL SPENDING IN LINE WITH SPENDING TARGETS

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

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

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

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

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

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

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

SGR System Differs From Prior System in Important Ways

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

Specifically, the SGR formula establishes expenditure targets as follows: from a base year—1996¹⁵—the targets are updated each year¹⁶ to account for four factors: (1) changes in the number of Medicare beneficiaries in traditional fee-for-service; (2) growth in the costs of providing physician services, laboratory tests, and Medicare-covered outpatient prescription drugs; (3) growth in the overall economy, as measured by changes in real per capita gross domestic product (GDP); and (4) changes in expenditures that result from changes in laws or regulations. Spending and targets are estimated from data available in the fall, when CMS sets physician fees for the next calendar year. Because SGR spending targets are cumulative, the target set for a specific year is affected by the targets set in all prior years. BBRA required CMS, in calculating each year's SGR spending target and fee update, to revise the targets set for the two previous years using the most recent available data.¹⁷

SGR differs from MVPS in two key ways. The first relates to volume and intensity growth limits. MVPS relied, in part, on historical trends in volume and intensity growth to set new targets each year, whereas SGR ties allowable volume and intensity increases to the growth in real GDP per capita. Under SGR, real spending per beneficiary—that is, spending adjusted for the underlying cost of providing physician services—is allowed to grow at the same rate that the national economy grows over time on a per-capita basis—currently projected to be about 2 percent annually. If volume and intensity grow faster, the annual increase in physician fees will be less than the estimated increase in the cost of providing services. Conversely, if volume and intensity grow more slowly than 2 percent annually, the SGR system permits physicians to benefit from fee increases that exceed the increased cost of providing services. To reduce the effect of business cycles on physician fees, economic growth is measured as the 10-year moving average change in real per capita GDP. This measure is projected to range from 2.1 percent to 2.5 percent during the 2005 through 2014 period.

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

SGR limits how much fees can be adjusted when spending has missed the target. SGR's performance adjustment may decrease fees by as much as 7 percentage points

¹⁰The 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.

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

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

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

¹⁴See Section 601(b), 117 Stat. 2301.

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

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

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

below the percentage change in MEI when spending has exceeded the target and may increase fees by as much as 3 percentage points above the percentage change in MEI when spending has fallen short of the target. SGR adjustments to the fees are determined by how much the cumulative amount of spending on physician services since 1996 differs from the cumulative spending target since that base year.

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

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

SGR reduced fees in 2002 because estimated spending for physician services—cumulative since 1996—exceeded the target by approximately \$8.9 billion, or 13 percent of projected 2002 spending. In part, the fee reduction occurred because CMS revised upward its estimates of previous years' actual spending. Specifically, CMS found that its previous estimates had omitted a portion of actual spending for 1998, 1999, and 2000. In addition, in 2002 CMS lowered the 2 previous years' spending targets based on revised GDP data from the Department of Commerce. Based on the new higher spending estimates and lower targets, CMS determined that fees had been too high in 2000 and 2001. In setting the 2002 physician fees, the SGR system reduced fees to recoup previous excess spending. The update would have been about negative 9 percent if the SGR system had not limited its decrease to 7 percentage points below MEI. Because the previous overpayments were not fully recouped in 2002, and because of volume and intensity increases, by 2003, physicians were facing several more years of fee reductions to bring cumulative Medicare spending on physician services in line with cumulative targets.

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

In late 2002, the estimate of SGR called for a negative 4.4 percent fee update in 2003. With the passage of the Consolidated Appropriations Resolution of 2003,²⁰ CMS determined that it was authorized to correct the 1998 and 1999 spending targets. Because SGR targets are cumulative measures, these corrections resulted in an average 1.4 percent increase in physician fees for services for 2003.²¹

In 2003, MMA averted additional fee reductions projected for 2004 and 2005 by specifying an update to physician fees of no less than 1.5 percent for 2004 and 2005.²² The MMA increases replaced SGR fee reductions of 4.5 percent in 2004 and an estimated 3.6 percent in 2005. Because MMA did not make corresponding revisions to SGR's spending targets, SGR will reduce fees beginning in 2006, to offset the additional spending caused by MMA's fee increases. In addition, recent growth in volume and intensity, which has been larger than SGR targets allow, will further compound the problem of excess spending that needs to be recouped.

The 2004 Medicare Trustees Report announced that the projected physician update would be about negative 5 percent for 7 consecutive years beginning in 2006; the result is a cumulative reduction in physician fees of more than 31 percent from

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

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

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

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

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

2005 to 2012, while physicians' costs of providing services, as measured by MEI, are projected to rise by 19 percent.²³

CONCLUDING OBSERVATIONS

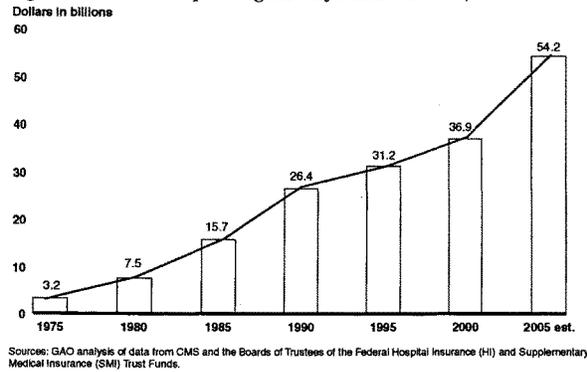
To a large extent, the physician fee cuts projected by Medicare's Trustees are required under SGR's system of cumulative spending targets to make up for excess spending in earlier years. MMA added to the excess spending by specifying minimum fee updates for 2004 and 2005 without resetting the spending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

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

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

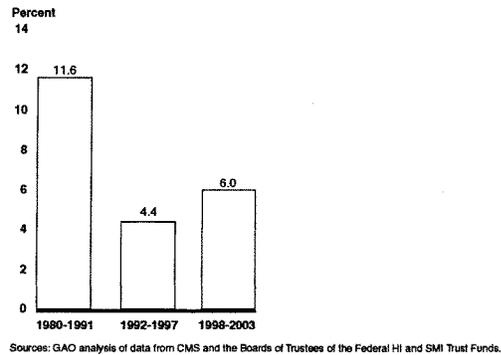
²³ Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: Mar. 23, 2004).

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



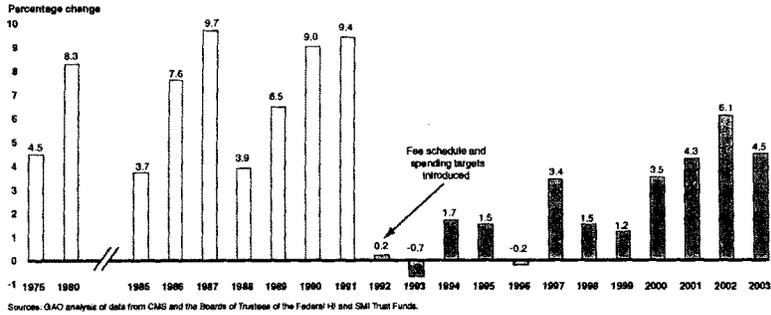
Notes: Amounts represent Medicare spending for aged and disabled beneficiaries in the traditional FFS program, net of beneficiary cost sharing. Spending for end stage renal disease (ESRD) patients is not included. Amounts for 1975-1990 are for the years ending June 30 and amounts for 1995-2005 represent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

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



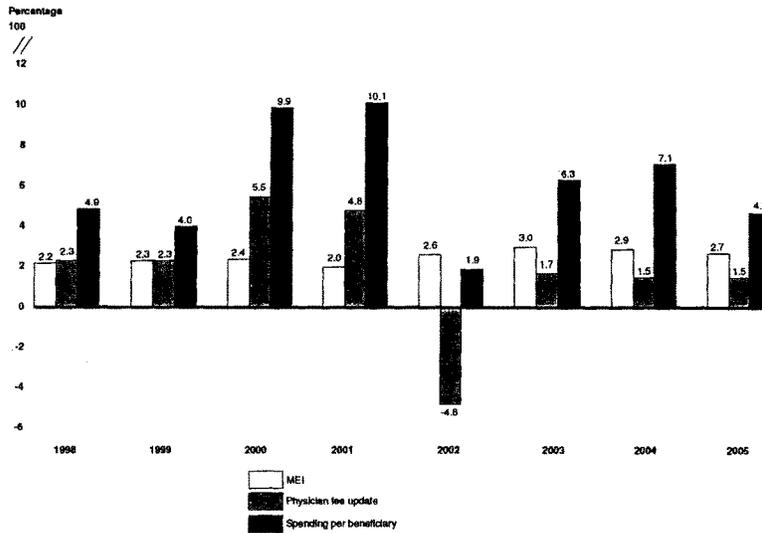
Notes: Amounts for 1980-1991 are for the years ending June 30 and represent weighted average Medicare spending for aged and disabled beneficiaries in the traditional FFS program, net of beneficiary cost sharing. Spending for ESRD patients is not included. Amounts for 1992-1997 and 1998-2003 are for calendar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

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



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

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



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

Mr. BILIRAKIS. Thank you very much, Mr. Steinwald. Doctor, please proceed.

STATEMENT OF DOUGLAS HOLTZ-EAKIN

Mr. HOLTZ-EAKIN. Mr. Chairman, Congressman Brown and Members of the Committee, thank you for the chance to be here today. We've submitted a prepared statement for the record. Let me make, simply, a few points in my opening remarks.

Over the long term, the projected growth of Medicare, and its sister program Medicaid, is the central budgetary challenge facing Congress. Medicare will double in size—spending on Medicare will double—simply due to the rising number of beneficiaries, even if per-capita costs remain the same.

Between now and 2030, Medicare will rise from 2.5 percent of GDP to over 5 percent of GDP, just due to the rise in the number of beneficiaries. If one includes projected increases in costs, the Medicare program will triple in size: spending will rise from 2.5 to 7.5 percent of GDP.

Medicare payments to physicians are just one part of this policy issue. At present, they constitute about $\frac{1}{5}$ of the \$250 billion spent on the Medicare program.

Congress has tried several methods to constrain the cost of Medicare physician services. For physicians, this has produced a relatively volatile history of updates to Medicare fees, which you can see in Figure 1 on the screens. The current method, the SGR, has annual and cumulative targets for physician spending, and uses physicians' fees to meet those targets. Left to operate as it stands, the mechanism will bring spending into line with the SGR targets over the budget window. Note, however, that as with the history that Mr. Steinwald pointed out, the projection is that spending will continue to rise, even in the face of the SGR, at an average rate of about 6.3 percent per year.

At the same time, however, physicians' fees for each service will be subjected to the negative updates in 2006 and 2007, and, on average, fee increases will be less than medical inflation through 2014.

The underlying issue is that physicians' fees contribute only a portion of the growth in spending. Physician spending will rise because of more beneficiaries, because of the increased incomes that both permit beneficiaries to want more services and afford doctors to provide them, leading to the increased volume and intensity as referred to by Mr. Steinwald. And, it will also increase through the costs of, not just physicians' fees, but those other services that are furnished incident to physician visits. The underlying issue is that the SGR targets only the physicians' fees. The increasing rise in the spending on services furnished incident to a visit means that physician spending per se becomes a smaller and smaller part of the SGR mechanism as time goes forward, as shown in the last of the three slides. The decline is about 3 percentage points of the total.

The recent legislative history suggests that the SGR may not be politically sustainable. The 2003 Omnibus and the Medicare Modernization Act both overrode the SGR to avoid negative updates.

The MMA legislated increases of 1.5 percent in 2004 and 2005. It also required GAO to examine the SGR system. But it did not change the cumulative SGR targets, so those updates simply represent a shift of spending from the future to the present.

In contrast, the 2003 Act actually increased the targets, providing not only an update of 1.6 percent to physicians, but an overall budget cost of \$54 billion over 10 years.

Any future legislation to avoid reductions in fees will involve a fundamental tradeoff. Allowing fees to rise, for example, at the rate of medical inflation, could cost as much as \$95 billion over a 10-year budget window. Shorter-term fixes might be less costly, but might simply defer the problem.

However, allowing the SGR to operate as in the baseline runs the risk of reducing access to physicians by Medicare patients.

I want to thank you for the chance to appear today, look forward to your questions, and I would ask the chairman for his guidance on the right time to answer questions by members in their opening statement.

[The prepared statement of Douglas Holtz-Eakin follows:]

PREPARED STATEMENT OF DOUGLAS HOLTZ-EAKIN, DIRECTOR, CONGRESSIONAL
BUDGET OFFICE

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

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

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

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

The Medicare Payment Advisory Commission (MedPAC) recently recommended that the 2005 update to payment rates for physicians' services be set at the change in input prices minus an adjustment for productivity. The Senate-passed version of the pending budget resolution (S. Con. Res. 95) contains a Sense of the Senate provision that endorses permanently adopting that approach to updating physician

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

fees. Such updates would increase Medicare spending by about \$95 billion through 2014 if they were implemented in 2005, by CBO's estimate, and by \$90 billion if they were implemented in 2006. Before addressing those projections, however, I will review the relationship between Medicare's payments to physicians and the program's spending and summarize the history of efforts to control Medicare spending for physicians' services.

Medicare's Payments to Physicians and Its Total Spending

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

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

Throughout the 1980s, Medicare's spending for physicians' services grew faster than its spending for all other services; in the 1990s, that trend reversed. From 1981 through 1990, spending for physicians' services grew at an average annual rate of 13.7 percent, whereas spending for all other services grew by 11.1 percent per year. By 1990, Medicare's total payments to physicians were more than three-and-a-half times greater than they had been 10 years earlier, and the average physician was receiving more than two-and-a-half times as much in Medicare payments. Indeed, the program's payments per physician increased almost twice as fast as did the nation's economy during the 1980s. That rapid growth led policymakers to add expenditure targets to the formulas used to set the overall level of physician fees in order to control total spending for physicians' services.

Previous Approaches to Medicare Physician Payments

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

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

Abandoning the Charge-Based System

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

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

As concerns grew about the program's rising costs, policymakers focused on restraining fees. In 1972, they mandated that the annual update to physicians' fees be limited to the increase in the MEI, a provision that was implemented in 1975.

Tying increases in fees to growth in the MEI was not sufficient to keep total payments from rising, however, and lawmakers took further steps to limit spending from 1984 through 1991. The Congress froze fees from 1984 through 1986; from 1987 through 1991, it raised them by amounts specified in legislation. The effect of those actions was that spending grew at an average annual rate of 15 percent from 1975 to 1991.

Limiting Beneficiaries' Liability

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

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

Redistributing Payments Among Physicians' Services

In attempting to control Medicare's expenditures, policymakers also took steps to redistribute payments among physicians' services. In the 1980s, many analysts believed that Medicare's reimbursement of such services was distorted by factors that led to overcompensation of so-called procedural services (for example, surgeries) at the expense of what were termed cognitive services (such as office visits). Fees varied widely, with physicians in different specialties and in different geographic regions receiving different payments for comparable services.

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

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

Controlling Volume

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

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

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

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

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

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

The SGR Approach

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

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

How the SGR Mechanism Works

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

The SGR mechanism also has a self-correcting adjustment feature. If spending for services subject to the SGR method deviates from the expenditure targets—that is, if real growth in spending per beneficiary is faster or slower than the change in per capita GDP—the annual updates to payment rates for physicians' services will be adjusted so that over a period of several years, cumulative spending will be brought back into line with the cumulative expenditure target.

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

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

will be set to keep annual spending below the year-by-year expenditure targets until cumulative spending and the cumulative target converge.

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

Recent Legislation Affecting Application of the SGR Method

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

Through 2003, that spending exceeded the higher target by about \$6 billion, CBO estimates. If it had been allowed to operate, the SGR method would have reduced payment rates again, this time for 2004. However, the Medicare Modernization Act replaced that scheduled reduction in rates with increases of 1.5 percent in both 2004 and 2005—but it left the cumulative target intact, specifying that those increases were not to be considered changes in law or regulation for the purpose of adjusting the expenditure target. Thus, spending for physicians' services will continue to exceed the cumulative target. Unless it is modified again, the SGR method will reduce payment rates for several years beginning in 2006 and will keep updates below inflation through at least 2014.

Baseline Projections of Spending Subject to the SGR Mechanism

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

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

As a result of the updates for 2004 and 2005 specified in the MMA, spending subject to the SGR mechanism will exceed the year-by-year expenditure targets by about \$4 billion in both of those years, CBO estimates. Therefore, the amount of cumulative SGR-applicable spending that exceeds the cumulative target will grow from about \$5 billion at the end of 2003 to \$13 billion at the end of 2005. Accordingly, the SGR mechanism will reduce physician payment rates in 2006 and 2007 and hold updates below inflation through 2014. As a result, CBO estimates that the excess of cumulative spending over the cumulative targets will peak at \$15 billion at the end of 2006 and then decline—to about \$5 billion in 2014.

Incident-to Services and the "Effective Target" for Physicians' Services

As noted earlier, the SGR expenditure targets encompass both spending for services on the physician fee schedule and services incident to a physician visit. Including so-called incident-to services under the SGR mechanism was intended to make physicians accountable for spending for the services that they control. The mechanism, however, affects payment rates only for services on the physician fee schedule.

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

Moreover, the SGR mechanism will adjust payment rates for physicians' services to offset any difference in spending that results when the rate of growth of spending for incident-to services deviates from the growth rate of the SGR expenditure targets.

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

Spending for Physicians' Services

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

Given the extent to which projected expenditures before 2006 exceed the expenditure targets, CBO expects that the updates to payment rates for 2006 and 2007 will be subject to the maximum reduction of about 5 percent. Although the maximum reduction could be applied for more than two years, CBO's projections show that in 2007, spending subject to the SGR mechanism will fall slightly below the expenditure target for that year (cumulative spending will still exceed the cumulative target by more than \$14 billion at the end of 2007). At that point, the "prior-year" component of the update adjustment factor will begin to partially offset the negative contribution of the factor's "cumulative" component. CBO therefore expects that the maximum reduction will cease to be applied to payment rates for physicians' services within a few years after 2007—possibly as early as 2008. Although the update to payment rates could be positive in real terms in some year during the 2008-2014 period, CBO expects that, on average, the SGR mechanism will result in real reductions in physician payment rates for the 2008-2014 period as a whole.⁷

Spending per Beneficiary for Physicians' Services

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

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

Annual changes in Medicare spending for physicians' services will vary substantially around that average over the coming decade. In 2006 and 2007, CBO projects,

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

Medicare will spend less for physicians' services, on a per-beneficiary basis, than it did in the previous year. Spending per beneficiary will increase each year, beginning in 2008, but it will not exceed the 2005 level until 2009 (see Figure 3).

Budgetary Implications of Illustrative Options

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

- Accelerate spending in the near term, and allow the SGR mechanism to recoup the additional spending in subsequent years;
- Increase the SGR expenditure targets (or increase the effective target for physicians' services); or
- Replace the SGR method with annual updates based on inflation.

Recent legislation provides examples of the first two approaches. The increase of 1.5 percent in physician payment rates for 2004 and 2005 that was enacted in the MMA accelerated spending into those years, but those increases will be recouped in subsequent years (unless the SGR mechanism is modified). Conversely, the Consolidated Appropriations Resolution, 2003, allowed the expenditure targets to be increased. Those contrasting approaches account for the difference between the negligible cost over 10 years of the MMA's provision and the \$54 billion cost of the increase in the expenditure targets.

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

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

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

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

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

Conclusions

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

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

Changes that increase Medicare's payments to physicians will boost federal spending. Incorporating higher fees for physicians' services into Medicare spending as currently projected would add to the already substantial long-run costs of the program and to the fiscal challenge posed by the aging of the baby boomers. Raising fees would also increase both beneficiaries' cost-sharing obligations and the premium that they must pay for Part B of Medicare (the Supplementary Medical Insurance program). Inevitably, over the longer term, higher spending by Medicare for physicians' services will require reduced spending elsewhere in the budget, higher taxes, or larger deficits.

Appendix: Application of the Sustainable Growth Rate Method

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

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

The Expenditure Target for 2005

The SGR expenditure target for 2004 is \$77.3 billion. (That amount includes both spending by the Medicare program and cost-sharing obligations of beneficiaries for all physicians' services subject to the SGR mechanism—that is, services on the physician fee schedule and so-called incident-to services, as discussed in the main text.)⁸ The SGR expenditure target for 2005 is calculated on the basis of CMS's estimates of four factors:

- Changes in fees for services subject to the SGR mechanism, which CMS estimates as a weighted average of the change in physicians' costs, adjusted for changes in productivity (as measured by the Medicare economic index, or MEI) and the change in prices for incident-to services. That weighted average will be 2.6 percent in 2005, according to CMS's estimates;
- Changes in enrollment in Medicare's fee-for-service sector, which CMS estimates will be -0.2 percent;
- The estimated 10-year average annual growth in real (inflation-adjusted) gross domestic product per capita, which CMS estimates will be 2.2 percent; and
- The effect of changes in law or regulations—CMS estimates no such changes and therefore no effect.

⁸The discussion in the main text characterized the expenditure targets and spending for services subject to the SGR mechanism in terms of expenditures by the Medicare program. Therefore, the amounts used in those calculations are about 20 percent smaller than the combination of the Medicare program's share and beneficiaries' cost-sharing obligations.

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

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

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

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

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

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

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

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

plus

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

That is,

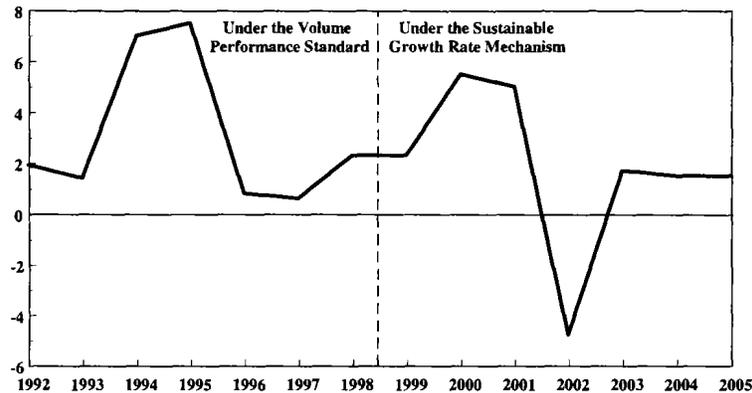
$$0.75 * (\$77.3 \text{ billion} - \$83.4 \text{ billion}) / \$83.4 \text{ billion}$$

plus

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

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

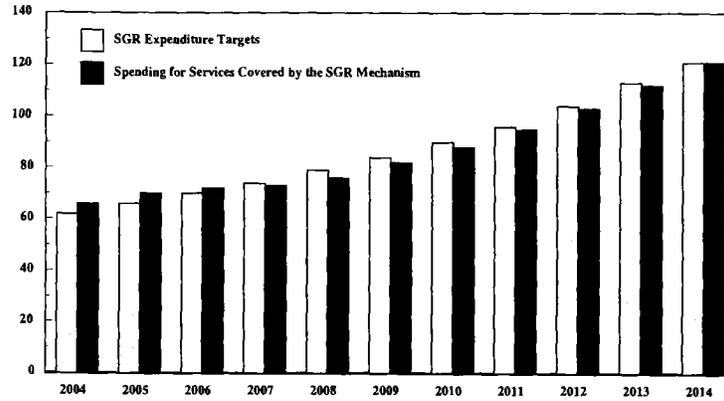
Figure 1.
Annual Payment Rate Updates for Services on the Medicare Physician Fee Schedule, 1992 to 2005
 (Percentage change in rates)



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

Figure 2.
SGR Expenditure Targets and Projected Spending
for Physicians' Services, 2004 to 2014

(Billions of dollars)

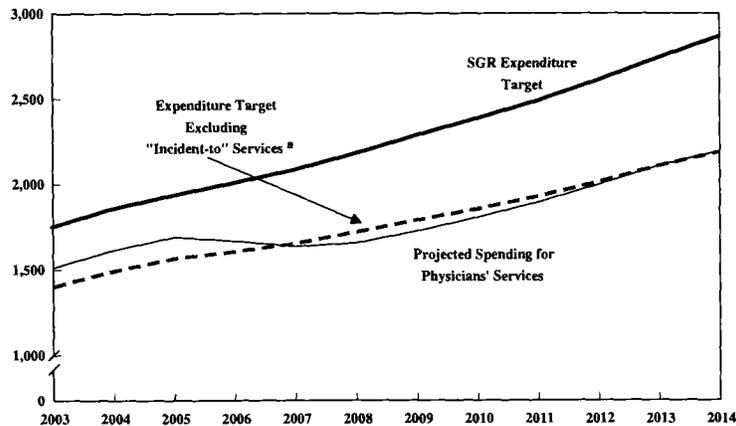


Source: Congressional Budget Office.

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

Figure 3.
SGR Expenditure Targets and Projected Spending
for Physicians' Services per Beneficiary, 2003 to 2014

(Dollars per beneficiary)



Source: Congressional Budget Office.

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

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

Mr. BILIRAKIS. Well, thank you, Doctor. You all are giving us an awful lot of time to inquire when our turn comes, which is really great.

Mr. Hackbarth.

STATEMENT OF GLENN M. HACKBARTH

Mr. HACKBARTH. Mr. Chairman, Congressman Brown, Members of the Committee, thank you for this opportunity. I'll try to keep my comments very brief.

Let me begin by stipulating to a couple points raised by my colleagues, Doug and Bruce. Unconstrained growth in the Medicare program in general, or Part B in particular, does pose a very serious problem for Congress and for the Nation as a whole.

In addition to that, the budget score attached to repeal of SGR is a very immediate and difficult problem for the Congress. I understand that, and the Commission as a whole understands that.

MedPAC's position, while we favor repeal of SGR, is not that any restraint on spending is inherently bad. Indeed, I would remind the committee that we recommended repeal of SGR before it began to produce negative updates for physicians. We recommended repeal right on the heels of it leading to significant increases in the update factor for physicians.

We think that SGR is a bad idea for three basic reasons. First of all, it could threaten access to quality care by disconnecting payments from the cost of producing the service. Second of all, it's inequitable. Any cuts in fees resulting from SGR are applied across the board to all physicians, and all specialties, in all areas of the country, regardless of whether they contributed to the problem. And, very closely related to that is the third flaw, which is the system does not provide any incentive to restrain growth in volume of care. The cuts operate across the board, so an individual physician making decisions, clinical decisions, has no incentive to alter those decisions. The cut happens to everybody, not to the individual.

Tinkering with the SGR curve, as some proposals suggest we do, may address the decline in the update factors mandated under existing law, reduce the negative updates, but they would not alter the second and third problems, namely, that the system is inherently inequitable and does not provide an incentive to restrain volume.

A better system, from our perspective, would be one that has not a rigid formula to determine update factors for physicians, but is based on the year-to-year evaluation of payment adequacy, and is coupled with more targeted efforts to reduce inappropriate volume of services and improved quality of care.

Repeal of SGR is prohibitively expensive, at least from the perspective of budget scoring, because SGR produces unrealistically low conversion factors, updates for physicians. As has been mentioned already by some members of the committee, few people believe that the projected cuts will ever occur. Yet, that is the baseline from which CBO must assess any proposal.

There are options that are much less expensive than outright repeal. For example, what Congress has done in the recent past, a one or 2-year override, or administrative adjustments in the underlying SGR curve. To the extent that these changes could forestall

large repeated cuts in physician payment, MedPAC supports their intent.

There should not, however, be any illusion that by retaining SGR we have a policy in place that would deal with our long-term fiscal problems and restrain growth and volume and intensity of service. A serious approach to volume requires more discriminating tools. Some services are growing rapidly, others are not. Some new services provide substantial benefit to patients, while others provide little benefit, at least relative to their cost. Some services are over used. Other services are under used. Some areas of the country are low cost and high quality, while others are the reverse.

It is simply not right to say that volume growth is, per se, a bad thing for the Medicare program. So, what kind of tools might be more discriminating and helpful in controlling bad volume, if you will, while permitting good volume? Without endorsing any of these, it's fairly easy to list the tools now being applied in various forms by private health plans, cost sharing, selective contracting with certain providers, incentive payments for individual or small groups of physicians, patient and provider education about appropriate standards of care, use of clinical standards to review claims or to include in prior authorization programs.

Obviously, some of these steps would be very controversial in the context of the Medicare program and difficult to administer.

So, what is MedPAC doing at this point? We are studying rapid growth, in particular, in imaging services, and how private payers are attempting to restrain that growth, while simultaneously maintaining, if not improving, quality. By imaging services, we are talking about X-rays, CAT scans, MRIs, and the like. It's an area where there's been very rapid growth, rapid innovation, but often it's a discretionary service, and there is, in fact, very significant variation in how imaging is used across local markets, and that's a well-documented fact.

At this point, MedPAC is not prepared to make specific recommendations based on our analysis, but recommendations may well be forthcoming in next year's cycle.

In addition, I would emphasize that MedPAC favors paying for quality as a long-term direction for the Medicare program. We've already recommended paying for quality in two areas, namely, private plans under Medicare Advantage, and for physicians in ESRD facilities in the end stage renal dialysis program.

With that, I'll stop, Mr. Chairman. Thank you for the opportunity.

[The prepared statement of Glenn M. Hackbarth follows:]

PREPARED STATEMENT OF GLENN M. HACKBARTH, CHAIRMAN, MEDICARE PAYMENT
ADVISORY COMMISSION

Chairman Bilirakis, Congressman Brown, Members of the Subcommittee. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss payment for physician services in the Medicare program.

Medicare expenditures for physician services are the product of the number of services provided, the type of service, and the price per unit of service. The number and type of services provided we refer to as service volume. The sustainable growth rate (SGR) system was meant to control the volume of physician services and hence total expenditures for physician services by setting the update (change in unit payment for the year) for physician services. The SGR is based on changes in: the num-

ber of beneficiaries in the Medicare fee-for-service program; input prices; law and regulation; and gross domestic product (GDP). The GDP, the measure of goods and services produced in the United States, is used as a benchmark of how much growth in volume society can afford. The basic SGR mechanism is to compare actual spending to target spending and adjust the update when there is a mismatch.

The SGR approach has three basic problems.

- It disconnects payment from the cost of producing services. The formula produces updates that can be unrelated to changes in the cost of producing physician services and other factors that should inform the update. If left alone, negative updates would provide a budget control but in so doing would produce fees that in the long run could threaten beneficiaries' access.
- It is a flawed volume control mechanism. Because it is a national target, there is no incentive for individual physicians to control volume. When fee reductions have occurred they have not consistently slowed volume growth and the volume of services and level of spending are still increasing rapidly.
- It is inequitable because it treats all physicians and regions of the country alike regardless of their individual volume influencing behavior.

The SGR formula has produced updates that in some years have been too high and in others too low. As we will discuss below, MedPAC has consistently raised concerns about the SGR—when it has set updates both above and below the change in input prices. In the Medicare Modernization Act (MMA), the Congress intervened to prevent the negative payment updates for 2004 and 2005 that would have occurred under the formula. But every time Congress acts to override a negative update, the formula automatically must lower updates in the future to make up for it. As a result, the current projection according to the trustees of the Medicare trust funds, is that annual updates of negative five percent will occur for seven consecutive years. The trustees characterize this series of updates as “unrealistically low” and in terms of budget scoring, these projections make alternatives to the SGR appear to be unrealistically expensive.

Instead of relying on a formula, MedPAC recommends a different course—one that involves explicit consideration of Medicare program objectives. Updates should be considered each year to ensure that payments for physician services are adequate to maintain Medicare beneficiaries' access to necessary high quality care. At the same time, the growth in the volume of physician services should be addressed directly. Volume growth differs across geographic areas and by service and ultimately is the result of individual physician's practice decisions. Is all the care being provided necessary? Dartmouth researchers and others have shown that often high quality care is not correlated with more services. We know the private sector is taking steps to control volume in services such as imaging with very high growth rates. Volume growth must be addressed by determining its root causes and specifying policy solutions. A formula such as the SGR that attempts to control volume through global payment changes treating all services and physicians alike is bad policy and will produce inequitable results.

In this testimony we will review how the SGR came about, explain the problems with it, look at our alternative for constructing yearly updates, and provide some thoughts on addressing volume growth. We understand the budget dilemma the Congress is facing. MedPAC is sensitive to the budget context and publishes the budget implications of its recommendations in its reports to the Congress. We are aware that our proposal will, because of the way the SGR and budget scoring works, be expensive from a scoring perspective. But relative to what is likely to happen (the Congress continuing to intervene to counteract the SGR's negative updates) it would be less so. When the budget score is an artifact of a comparison with an “unrealistically low” current law baseline, it should not prevent consideration of sensible policy alternatives.

HISTORICAL CONCERNS ABOUT PHYSICIAN PAYMENT

Medicare's payments for physician services are made according to a fee schedule, which includes payment rates for over 7,000 discrete services. It is designed to account for cost differences among services and geographic areas.

The Congress established the fee schedule as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA89). As a replacement for the so-called customary, prevailing, and reasonable (CPR) payment method that existed previously, it was designed to achieve several goals. First, the fee schedule decoupled Medicare's payment rates and physicians' charges for services. This was intended to end an inflationary bias that was believed to exist under the CPR method because it gave physicians an incentive to raise their charges.

Second, the fee schedule corrected distortions in payments that had developed under the CPR method. Evidence of those distortions came from William Hsiao and his colleagues at Harvard University who found that payments were lower, relative to resource costs, for evaluation and management services but higher for invasive, imaging, and laboratory services. Further evidence came from analyses, conducted by one of MedPAC's predecessor commissions, the Physician Payment Review Commission, that revealed wide variation in CPR-method payment rates by geographic area, that could not be explained by differences in practice costs.

A third element of the OBRA89 reforms is central to our testimony today. To allow for annual updates of the fee schedule's payment rates, the legislation established a formula based on achievement of an expenditure target. This approach to payment updates was a response to rapid growth in Medicare spending for physician services. From 1980 through 1989, annual growth in spending per beneficiary, adjusted for inflation, ranged widely, from a low of 1.3 percent to a high of 15.2 percent. The average annual growth rate was 8.0 percent.

Because over half of the increase in spending in the 1980s had been due to increases in the volume of services, the process for setting an expenditure target focused on growth in the volume of services. Based on a volume performance standard (VPS), it linked annual updates of the fee schedule's conversion factor to growth in the number and type of services physicians provide. If volume growth in a year exceeded that allowed by the VPS, the update was adjusted downward two years later.

Because of physicians' unique role in the health care system, the hope was that the VPS would give them a collective incentive to control the volume of services. Physicians order tests, imaging studies, surgery, drugs, and otherwise serve as gatekeepers of the health care system. In addition, the unit of payment in the fee schedule is quite small—the discrete service. By contrast, the unit of payment for most other sectors is larger. A large unit of payment, such as a hospital stay, gives providers more opportunities to respond to financial incentives and operate efficiently. They can economize on both the mix and quantity of services provided. They can also economize on the inputs used to produce services. A small unit of payment, such as a discrete service (e.g., an office visit), limits the reach of financial incentives to the mix and quantity of inputs.

Experience with the VPS formula showed that it had several methodological flaws that prevented it from operating as intended. For example, each year's VPS was a function of the historical trend in the rate of growth in the volume of services and progressively higher legislated deductions from those growth rates. As the result of a slowdown in the growth of the volume of services during the 1990s, the VPSs became unrealistically stringent.

The problems with the VPS formula prompted the Congress to replace it as part of the Balanced Budget Act of 1997. Under the SGR, the expenditure target is not a function of historical growth in the volume of services. Instead, the SGR target is based on growth in real GDP per capita and other factors—inflation in physicians' practice costs, changes in enrollment in fee-for-service Medicare, and changes in spending due to law and regulation. As noted, the real GDP factor was included in the SGR to link the expenditure target to growth in the national economy. This linkage was thought appropriate because volume growth for physician services is theoretically as unlimited as the demand for health care. This Congress decided to link to GDP as a benchmark of what the U.S. economy could afford.

THE PROBLEM WITH THE CURRENT UPDATE SYSTEM

Setting prices correctly in Medicare's payment systems is essential to maintain access to services for Medicare beneficiaries. The underlying problem with the current SGR system is that it attempts both to control total spending on physician services delivered to Medicare beneficiaries and to set prices accurately. These two goals can seldom be achieved simultaneously. If actual total spending for physician services differs from the expenditure target, to control it fees under the SGR system are adjusted upward or downward. When this occurs, payments are usually either too low, potentially jeopardizing beneficiaries' access to care, or too high, making spending higher than necessary. The SGR attempted to achieve both goals and failed, as did the Volume Performance Standard system before it.

An expenditure target approach, such as the SGR, assumes that increasing updates if overall volume is controlled, and decreasing updates if overall volume is not controlled, provides physicians nationally a collective incentive to control the volume of services. However, this assumption is incorrect because physicians do not respond to collective incentives but individual incentives. An efficient physician who reduces volume does not realize a proportional increase in payments. If anything in the short run an individual physician has an incentive to increase volume under such

a system and the sum of those individual incentives will result in an increase in volume overall and an eventual further reduction in fees. In fact, CMS makes exactly that assumption when it estimates the so-called behavioral response of physicians to lower payments—which is an increase in volume of services provided.

Over a longer period, if payments were clearly less than physicians' marginal cost of providing a service, we might see physicians cut back their Medicare practice and concentrate on other patients, devote more time to other professional or leisure activities, or leave practice altogether. Ultimately, we could see a shift in residency preferences away from those specialties most heavily dependent on Medicare. The result eventually would be decreased access for Medicare beneficiaries which could be very difficult to reverse.

Compounding the problem with the conceptual basis of the system, the SGR system has produced volatile updates. To control spending the SGR compares actual spending to an expenditure target. Experience has shown that the target can change abruptly, leading to volatility in the updates. In 2001, a reestimate of historical GDP lowered the spending target. The target then decreased even more when both actual and projected GDP went down. Updates went from increases in 2000 and 2001 of 5.4 percent and 4.5 percent, respectively, much larger than the increases in practice costs, to an unexpected large reduction in 2002 of 5.4 percent. This volatility illustrates the problem of trying to control spending with an update formula.

Despite this volatility, surveys in 2002 found that most beneficiaries were able to obtain physician care, and most physicians were willing to serve Medicare beneficiaries following the payment reduction. The CAHPS-FFS survey, sponsored by CMS, found that 90% of beneficiaries report that they "always" or "usually" got a timely appointment for routine care in the fall of 2002. A large physician survey—the National Ambulatory Medical Care Survey—found that among office-based physicians who commonly saw Medicare patients, 93% were accepting any new Medicare patients throughout 2002. Additionally, we have found that the supply of physicians furnishing services to Medicare beneficiaries has more than kept pace with the growth in the beneficiary population, through 2002. Further, in cases where we are able to analyze 2003 data, we find that access to physician care was good in 2003.

In the MMA, the Congress attempted to reduce the volatility problem. The GDP factor in the SGR is now a 10-year rolling average, which dampens the effects of yearly changes in GDP growth. However, there is another source of volatility which has not been controlled—estimating changes in enrollment in traditional fee-for-service Medicare. Here, we can anticipate reestimation of enrollment growth as CMS gains experience with shifts in enrollment from traditional Medicare to Medicare Advantage. Under the SGR, this could lead to continued volatility in spending targets and updates.

A DIFFERENT APPROACH TO UPDATING PAYMENTS

To address these problems, in our March 2002 report we recommended that the Congress replace the SGR system for calculating an annual update with one based on factors influencing the unit costs of efficiently providing physician services. Replacing the SGR system could allow updates more consistent with efficiency and quality care and would also uncouple payment updates from spending control. If total spending for physician services needs to be controlled, it is necessary to look at more than just the payment update mechanism. For example, by achieving appropriate use of services through outcomes and effectiveness research, as we suggested in our March 2001 report to the Congress, and by addressing volume growth directly as discussed in the next section.

A new system should update payments for physician services based on an analysis of payment adequacy which would include the estimated change in input prices for the coming year, less an adjustment for growth in multifactor productivity. Updates would not be automatic (required in statute) but be informed by changes in beneficiaries' access to physician services, the quality of services being provided, the appropriateness of cost increases, and other factors, similar to those MedPAC takes into account when considering updates for other Medicare payment systems. Furthermore, the reality is that in any given year Medicare might need to exercise budget restraints and MedPAC's analysis would serve as one input to Congress's decision making process.

We stress that payment updates should take into account productivity improvements that enable physicians to provide care more efficiently. Productivity gains are certainly possible in physician services. For example, Pope and Burge found that doubling the size of a physician practice increases productivity with no increase in practice expense per physician. Other gains might come from new technology, economies of scale, managerial skill, and changes in how care is delivered.

A DIFFERENT APPROACH TO CONTROLLING VOLUME

If payment rates are adequate and updated to account for changes in efficient physicians' cost, the remaining issue is controlling volume, which is important for both beneficiaries and taxpayers. For beneficiaries, increases in volume lead to higher out-of-pocket costs—copayments, the Medicare Part B premium, and any premiums they pay for supplemental coverage. For taxpayers, increases in volume lead to higher Part B expenditures supported with the general revenues of the Treasury.

The concern is that volume growth has accelerated recently (Figure 1). From 2000 to 2001 volume increased 5.4 percent and from 2001 to 2002 it increased by 5.6 percent. To be clear, this is growth in volume per beneficiary and does not reflect changes in Medicare payment rates. Preliminary data suggest that relatively high volume growth continued in 2003. Regardless of the direction of the annual update, volume growth continued, it increased both when the update increased and when it decreased.

Among the effects of this growth, is an increase in the monthly Part B premium. Because it is determined by average Part B spending for aged beneficiaries, an increase in the volume of services affects the premium directly. From 1999 to 2002 the premium went up by an average of 5.8 percent per year. By contrast, cost-of-living increases for Social Security benefits averaged only 2.5 percent per year during that period. What is more, since 2002 the Part B premium has gone up faster still—by 8.7 percent in 2003 and 13.5 percent in 2004. The projected increase of 17.3 percent for 2005 is even larger.

Volume growth also has implications for the federal budget. The Committee is aware of the growth of Medicare relative to the nation's output of goods and services as discussed in the Medicare trustees report. Increases in Medicare spending per beneficiary is an important reason for that growth, cited by the Congressional Budget Office and the General Accounting Office among others.

However, some of the root causes of volume growth may be amenable to policy action and some growth may be desirable. For example, growth arising from technology that produces meaningful gains to patients, or growth where there is currently underutilization of services may be beneficial. But one indicator that not all growth is good may be its variation. Among broad categories of services, growth in volume per beneficiary ranged from about 10 percent to over 30 percent, based on our analysis of data comparing 2002 with 1999 (Figure 2). Within these broad categories, growth rates were higher for services which researchers have characterized as discretionary (e.g., imaging and diagnostic tests). In imaging, for example, growth rates were over 15 percent a year for such services as magnetic resonance imaging, computed tomography, and nuclear medicine.

In addition, volume varies across geographic areas. As detailed in our June 2003 report to the Congress, the variation is widest for certain services, including imaging and tests. Researchers (e.g. Wennberg and Fisher) have reached several conclusions about such findings:

- Differences in volume among geographic areas is primarily due to greater use of discretionary services sensitive to the supply of physicians and hospital resources.
- On measures of quality, care is often worse in areas with high volume than in areas with lower volume. The high-volume areas tend to have a physician workforce composed of relatively high proportions of specialists and lower proportions of generalists.
- Areas with high levels of volume have slightly worse access to care on some measures.

All this suggests that volume may be too high in some geographic areas.

ADDRESSING THE VOLUME PROBLEM

Is it possible for Medicare to address problems with the volume of services without resorting to a formula to control spending? To seek answers to this question, MedPAC has begun to consider strategies used by private insurers to purchase services. In doing so, we have focused particularly on imaging services because of the wide variation in the volume of these services, geographically, and because of the rapid growth in that volume.

What we have found is that private insurers are confronting rapid growth in use of the services and concerns such as the following:

- proliferation of imaging equipment;
- lack of familiarity with new imaging modalities among non-specialist physicians;
- self-referral, including ordering of imaging studies by physicians who furnish the studies with equipment in their offices;

- direct-to-consumer marketing of imaging services and associated questions about the need for demand management;
- defensive medicine in response to physician concerns about professional liability; repetition of imaging studies; and
- poor quality of imaging equipment in some settings.

In adopting their purchasing strategies, private insurers are working to control growth in the cost and utilization of imaging services while ensuring access to appropriate care.

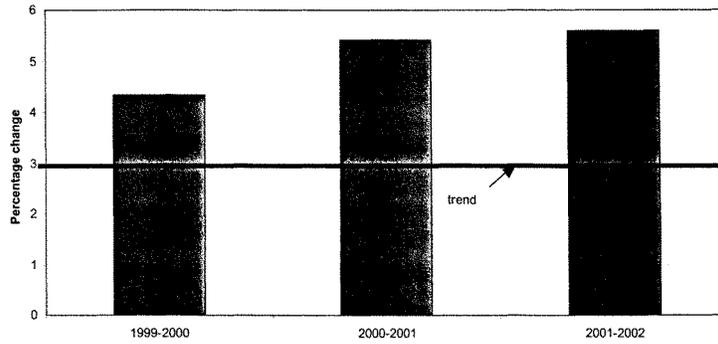
The strategies they are adopting are multiple, depending on the insurer they can include profiling, pre-authorization, beneficiary education, privileging, coding edits, and safety standards and site inspections. One study, based on site inspections, showed facilities failing at rates approaching 50 percent, depending on the type of practitioner offering the services. Reasons for the failures included age of the equipment and use of the incorrect equipment for the types of imaging studies conducted. Coding edits are rules invoked during claims processing to decide whether and how much to pay for billed services. Medicare has a set of these edits, developed under what is known as the Correct Coding Initiative. Private insurers often use Medicare's edits but then augment them with other edits to, for example, adjust payment downward when multiple services are billed on a single claim.

Whether Medicare should do more to emulate private insurers' strategies for purchasing imaging depends on the administrative feasibility of more closely aligning Medicare policy with the strategies of private insurers. It also depends on the effectiveness of those strategies for making the purchasing of imaging services more efficient. MedPAC plans to address these issues during the coming year.

Our other focus is on linking Medicare payment to quality to improve quality in fee-for-service Medicare and in care for Medicare beneficiaries furnished by private plans. In our March 2004 report we recommended two sectors where the Congress can act now—rewarding quality care in outpatient dialysis and Medicare Advantage. Those two areas have the requisite measuring systems in place to begin to pay for quality. We encourage a payment-for-quality approach that is budget neutral, rewards both improvement and attainment, and varies quality measures over time.

As discussed, higher volume does not correlate with higher quality. Thus, it may be possible to increase the quality of the care beneficiaries receive and at the same time provide incentives to control the volume of services. Expanding payment for quality to the physician sector, where payment is still by the individual services provided, will be a challenge. But it is a challenge that must be met to ensure high quality care for Medicare beneficiaries within a sustainable Medicare program.

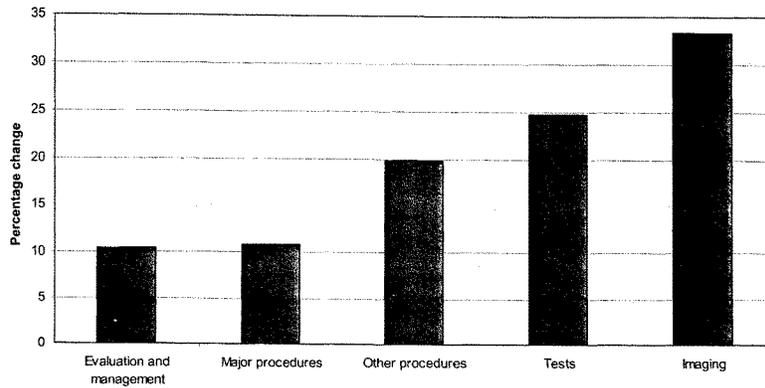
Figure 1: Growth in volume per beneficiary, all physician services



Source: MedPAC analysis of claims data for 100 percent of beneficiaries.

Note: The trend line represents the underlying trend in volume per beneficiary used by CMS actuaries to project volume for the report of the trustees of the Medicare trust funds.

Figure 2: Cumulative growth in volume per beneficiary, by type of service, 1999-2002



Source: MedPAC analysis of claims data for 100 percent of beneficiaries.

Mr. BILIRAKIS. Thank you, Mr. Hackbarth.

I would ask Mr. Steinwald and Doctor Holtz-Eakin first, do you take issue with, or have any comments regarding Mr. Hackbarth's testimony?

Mr. STEINWALD. I think the individual initiatives they have underway to look at ways of targeting unnecessary utilization and paying for quality are certainly worth pursuing.

MedPAC has endorsed the idea of doing away with SGR. As you know, we have a study underway right now looking at how SGR might be changed or modified, and we are not in the position now to comment on what changes might be made.

Mr. BILIRAKIS. Doctor?

Mr. HOLTZ-EAKIN. I would point out that the SGR is a budgetary device; it's not a health policy tool. To the extent that Congress chooses another device to identify increases in cost in Medicare, the main thing is to make sure that you reflect on the budget the implications of any changes in health policy, so that the costs are correctly recognized in decisions that Congress makes.

Mr. BILIRAKIS. Well, you know, we, obviously, are famous up here for many of our decisions resulting in not-intended bad consequences, if you will. And, certainly, we want to be careful here.

Mr. Hackbarth indicate some sort of a review, some sort of a system on—well, I guess you were talking about procedures that are used by doctors, and we want to be careful, of course, that we, in this ivory tower, are not going to be, basically, telling doctors how to practice medicine.

But, at the same time, I suppose that's something that's got to be done. Is that a doable thing, in such a way that it will not result in, in effect, doctors complaining that, yeah, we've had complaints about HMOs, for instance, managed care, basically, having to call a non-MD, if you will, to get permission to perform a certain procedure and that sort of thing, and I know that that's something that has taken place over the years. Is that a doable thing?

Go ahead, Mr. Hackbarth.

Mr. HACKBARTH. I believe it's doable. Let me emphasize again that we've not made specific recommendations about this, we are still in the process of working at the issues of how you would do it, feasibility for the program, and the like.

It is not possible to do it without controversy. None of the options we have in front of us to slow the increase in healthcare costs, in general or in Medicare in particular, can be done without controversy.

Can we do it without harming the quality of care for Medicare beneficiaries? Can we do it without harming access? I believe that the answers to those questions are yes. Will it be easy? No, it won't, but there aren't any easy solutions on the table.

Mr. BILIRAKIS. I've been in doctors' offices in one capacity or another, and, for instance, I've seen a family practitioner, general practice, maybe a half a dozen patients for the entire day, but maybe two dozen procedures, and then you would go to another family doctor and see 20 patients, or two dozen patients, or whatever the case might be, and 20 procedures, or in other words, one procedure, one or two procedures maybe per patient at the most.

Now, you know, who am I to say what the heck is necessary and what isn't, whether an echo cardiogram which is done almost routinely by this family practitioner is a good thing or a bad thing. But, those are the things that, as you indicate, you know, you talked about volume, Mr. Steinwald, and intensity, I guess that's what you were referring to, isn't it, that sort of thing?

Go ahead, sir.

Mr. STEINWALD. Yes, sir. Mr. Hackbarth was correct when he pointed out that the application of SGR is a very blunt instrument, and when there is a fee update it affects every physician equally. But, when there are volume and intensity increases, it's very unequally distributed across geographic areas and different areas of medicine. And, I think that is worth noting.

It's also worth noting, though, that those increases do represent real spending, and if you think back again toward the 1980's and early 1990's, when efforts were made to control spending by limiting fees, those efforts, essentially, did not work. Spending went up precipitously, even though fees were controlled.

And so, we believe it's important that you keep in mind that volume and intensity are as important to increases in physician spending, potentially more important, than the fee updates themselves.

Mr. BILIRAKIS. Does a lot of that take place as a result of maybe reductions in reimbursements and, consequently, more procedures to try to make up for it?

Go ahead, Doctor, first.

Mr. HOLTZ-EAKIN. Really three things on this. The first is that we do have some work underway, really trying to look at the behavioral response of physicians to changes in Medicare fees, how much do they change their volume and intensity to offset reductions, say, in fees.

The second is that I heard Mr. Hackbarth talk about two different kinds of reviews. The first would be an annual assessment of the appropriate rate of growth in spending, or the way the update would be done, and I'd point out that at the moment that's de facto how the system is operating. Each year Congress has taken a look at the SGR and elected to override it and provide an update that was different than the formula would indicate. That has budgetary consequences that the Congress understood when it made those decisions. And so, what an annual assessment would look like compared to that, I think would depend on the details.

And finally, the second kind of review was review of procedures and quality of care. I think any economist would recognize that going forward it may be the case that we will spend more on healthcare in the United States. We will be an older population, and we will be a richer population. The gold standard from an economist's point of view would be to make sure that we get the right quality per dollar and not overspend.

To the extent that these sorts of reviews provide information that allow people to make those decisions, that would be a useful thing. We'd have to look at specific recommendations when they come out.

Mr. BILIRAKIS. Well, my time has expired, but, again, I would say, as I will when we finish up here at the close of the hearing, that we would welcome suggestions from you. I know that we have

gotten some from MedPAC, but we would welcome any suggestions you may have. It's not like we go right down the line with everything you might recommend to us, but certainly we will seriously consider it, because this is a problem, and it's something that we have got to try to fix as much as we can, but we wanted to try to do it with as much expertise as possible. That's why we depend upon you.

I'm going to yield to Mr. Brown now.

Mr. BROWN. I thank the chairman.

Mr. Chairman, I would like to just ask unanimous consent that all members could submit questions to the panel. I have several that I'm probably not going to get to, and would like to do that if we could, and any other members.

Mr. BILIRAKIS. Well, and I might also add to that unanimous consent request that opening statements of all members of the subcommittee will be made a part of the record, and there is a statement that was given to us by the AMA which they would like to have placed in the record, without objection that will be the case.

Please continue, sir.

Mr. BROWN. Thank you, Mr. Chairman.

I think all of us want to see a long-term—well, not even long term, permanent fix to this, and that means finding a way to come up with the money. The money needs to come from somewhere. Some of us in this body neither news reports, nor actual evidence, would suggest that some of us actually care about budget deficits up here, and some of us care about long-term fiscal stability and would like to see a more consistent funding stream, if not statutorily dedicated to dealing with this issue, at least somewhere where we knew that money would be available for a permanent fix.

And, with that, I'd like to ask a series of questions to Mr. Hackbarth.

MedPAC recently issue a brief report detailing the overpayments to Medicare HMOs. If you could tell me on average, how much—this is the first of a couple of questions—how much more than fee-for-service is Medicare paying these plans first? Does this include risk adjustment, the adjustment for enrolling healthier than average seniors, and including the fact that HMOs get healthier than average senior enrollees, something we do know to be a fact, what would the overpayments be in that instance?

Mr. HACKBARTH. Congressman, maybe the easiest way to do it is by making reference to the graph that I think you held up at the beginning.

Part of the information here is based on MedPAC analysis. Another piece is not. The first part, and this is in the report that you referred to a minute ago, is that MedPAC analysis indicates that we pay 107 percent of the fee-for-service amount on behalf of beneficiaries enrolled in private health plans. That additional payment, that 7 percent additional payment, is attributable to a series of factors in the system, including the floors on payment that exist and are applied by geographic area, the minimum update provision in current law, and some very specific technical issues with how medical education payments are accounted for. Those factors comprise the bulk of that added 7 percent payment.

Then the second issue, that all assumes that the riskiness of the patients enrolled in private plans is identical to the general Medicare population, I would suggest. If, in fact, they are healthier than average, then there could be an additional overpayment.

Our source of information about whether, in fact, the private plan enrollees are healthier or not, is not MedPAC analysis, but CMS analysis that comes out of the Actuary's office there, and the exact number has been floating around recently, and so I don't want to get pinned to a particular number. It's really CMS' number.

But, the most recent estimates that I've heard of are in the neighborhood of 8 percent, and I think that's where the 15 percent total comes from, 7 percent from MedPAC analysis and another 8 percent based on the CMS analysis. The CMS is really the right place to go for the risk adjustment information.

Mr. BROWN. That 15 percent, according to the chart, is the difference between \$82.75 and \$71.95, so it is an overpayment of slightly less than \$1,100.

Mr. HACKBARTH. Yes.

Mr. BROWN. \$1,080 per beneficiary, and it seems to me that it would make sense to take some of the money going to HMOs, which only enroll 11 percent of beneficiaries, actually, a lower number than before even with the incentives that were given, that number, I assume, will go up with the drug bill, and use it to pay for part of the cost of fixing the problems. I would have taken approximately \$17 billion in overpayments to HMOs and PPOs, including the \$12 billion slush fund, and the overpayments to Medicare Advantage plans, as compared to fee-for-service Medicare, to help pay for some of the problems in the Physician Payment Formula. I know that's not your place to advocate, except your numbers, coupled with CMS numbers that the overpayment is 15 percent, roughly, and it's over \$1,000 per beneficiary times a large number of beneficiaries, is a lot of money that could go a major way toward solving this, but I also recognize the political realities if the insurance companies, with their friends in the drug industry, pretty much wrote the Medicare Bill, so to get this changed to pay for this is going to be a difficult hurdle.

Mr. HACKBARTH. Yes.

If I could, I'd like to be very clear about MedPAC's position on the role of private plans in Medicare. In fact, we support offering Medicare beneficiaries the option of enrolling in private health plans. We do that because we believe that private health plans have the potential to offer at least some Medicare beneficiaries something better than they can get through the traditional program.

Having said that, we believe that there ought to be a neutral choice between staying in traditional Medicare or enrolling in a private health plan, and our concern about the current payment system is that the choice is not neutral, because we are overpaying, from our perspective, the private plans.

I'd also like to be clear that, again, the number that's on this chart, the only number that's on this chart that is a MedPAC number is the 7 percent. The risk adjustment numbers we don't do specifically, and, frankly, I have some uncertainty about where that

estimate stands right now. And so, I think the staff has tried to take the most recent number and added it to ours, but this is not our analysis.

Mr. BILIRAKIS. So, that is not necessarily—you don't necessarily agree with the \$1,080 figure, is that right?

Mr. HACKBARTH. We've not specifically calculated that number ourselves. The one number that we have calculated is the 107 percent.

Mr. BROWN. These numbers aren't fabricated by Democrats, they are MedPAC, plus CMS.

Mr. HACKBARTH. Yes.

Mr. BILIRAKIS. Let's see, who is first, Ms. Capps, I guess.

Ms. CAPPS. Thank you, Mr. Chairman, and thank you for your testimony.

Mr. Holtz-Eakin, you made a comment in your testimony that you are here, the three of you, and that's why we are having the hearing, to discuss budgetary matters, not setting policy, and we wear more than one hat in this place. But that, I think, is an issue that sort of underlies some of what we are doing, and a part of the Balanced Budget Act of 1997, the formula for expandable growth rate was set into place. And now, we are also mindful that the cuts in physician payments could really jeopardize access to care for seniors. So, your primary concern certainly is that of many of us, and certainly of our constituents. And, MedPAC, you wear those kind of dual hats also. So, I want to ask some questions of you, Mr. Hackbarth, from that role, pointing to the ways in which we can be mindful of access to care.

The SGR is having some unintended consequences on physicians' ability to provide services throughout this country. Before the Medicare Modernization Act, the physicians' payments were set to decrease by 4.5 percent. Medicare law changed that and required an update for 2004 and 2005 of not less than positive 1.5 percent. However, we, the leadership in this Congress, have decided not to pay for this increase directly, and as a result physician payments over the next 10 years will need to be adjusted to account for this expenditure.

According to the Medicare Trustees Report, physicians are facing a 31 percent cut in fees between the years of 2006 and 2012, on top of the fact that the Medical Economic Index, the amount that doctors have to pay for services, as they are in corporations, offices, many times are expected to increase these costs will be increasing about 19 percent over this time. So, even though physicians' costs are going up, the reimbursement rate will be going down significantly, and this will jeopardize access to care, and it is leading to an exodus from providing—for physicians providing both Medicare and Medicaid services.

The current MedPAC report doesn't find significant problems with the beneficiaries' access to care, but as we're looking for these years out, between 2006 and 2012, this is what I'd like you to discuss. You certainly have to be mindful of that, that a 31 percent cut, that knowledge is not lost on medical students, or those in the practice now, and add to that an area like mine that is very adversely affected by gypsy rates and so-called "rural reimbursement rates," we have seen such an exodus of providers for Medicare/Med-

icaid, we call it Medi-Cal in California, this is what I'd like you to respond to, sorry for the long prologue, to see if there's a way we can measure beneficiary access. What steps are you taking to evaluate whether this access is adequate?

Mr. HACKBARTH. We use three types of tools, beneficiary surveys, surveys of physicians about their willingness to accept Medicaid patients, and we also look at the relationship between Medicare payment rates and private payment rates.

Let me just quickly summarize what we find there.

Ms. CAPPS. Yes.

Mr. HACKBARTH. On the beneficiary front, we find a high level of satisfaction currently at a national level with access to care. Indeed, Medicare beneficiaries are somewhat more satisfied than non-Medicare people in the age 55 to 64 age group.

Ms. CAPPS. Now, this is the Nation as a whole?

Mr. HACKBARTH. This is the Nation as a whole.

With regard to physicians, a very high percentage of physicians, in excess of 90 percent, are accepting at least some new Medicare patients. Between 70 and 75 percent, as I recall, are accepting all new Medicare patients who appear at their door. Now again, these are national numbers, and I'll come back to the local dimension in just a minute.

With regard to the relationship between Medicare payment rates and private payment rates, Medicare rates are, on a national basis, lower on average than private payment rates. That's, roughly, 80 percent of the private payment rates by our analysis.

Now, that varies by procedure. For evaluation and management, sort of the basic of evaluating a patient, Medicare fees are quite comparable to private fees, but Medicare fees are lower for procedures, surgical procedures and the like.

When we look at all of that information together, our conclusion on a national basis is that access is good to Medicare beneficiaries.

Having said that, I share your concern about what would happen to access if the sort of cuts that would be mandated under current law were allowed to occur.

Ms. CAPPS. If we're talking about 31 percent cuts, will this change your survey, say, 5 years from now?

Mr. HACKBARTH. Yes. My personal opinion is that that sort of cut would pose a significant hazard to access.

I would note, however, that when the one cut went into effect in 2002, of almost 5 percent, we did not find a significant adverse effect on access from that.

Ms. CAPPS. Although, this would be built upon that.

Mr. HACKBARTH. That's right, in that cut, the 2002 cut, it was on the heels of very large increases in the year 2000 and 2001.

Ms. CAPPS. Right, we are getting down to the bone.

But, I have just less than 2 minutes left, I wanted you to touch on two things. One, regional differences, because national surveys mean very little in our own communities, and second, the comment that you made about radiological services or some specialties, and what we chilling effect this can have on new technology.

Mr. HACKBARTH. Yes.

With regard to the variation in access, in fact, we've heard anecdotally, and seen some research by other organizations, indi-

cating that there are access problems in particular markets. It does not necessarily follow from that, though, that it's due to the Medicare payment rates. Some of the work shows that there are also some access issues for private patients in these same markets, and that can be attributable to the fact that there's been very rapid growth and the supply of physicians has not kept up, or there is at least temporary problem in the distribution of specialists, specialists for the population. So, yes, there are some local problems, it's not necessarily true that they are all the result of the Medicare payment system.

Ms. CAPPS. But, there is a relationship, however.

And then finally, what can we do to contain costs without discouraging the use of new medical technology?

Mr. HACKBARTH. Well, you know, that's sort of the \$64,000, or billion, or trillion dollar question for the Medicare program. As I said earlier in response to the chairman's question, it will not be an easy task to do.

I draw comfort from the fact that as we look at the Medicare program across the Nation, there is abundant evidence from researchers, including physician researchers, that there are areas of the country where a much less expensive style of medicine is practiced, yet the results, in terms of measurable quality, are as good or better than those achieved in the high-cost areas. That suggests to me that there is an opportunity, if we can reshape the system, and improve the appropriateness of the services, that we can have the gains from new technology, while also restraining some of the costs. But, it's a tricky thing.

Ms. CAPPS. There's no easy answer to that.

I think I've used my time, so thank you very much. I yield back.

Mr. BILIRAKIS. Mr. Stupak to inquire.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. Hackbarth, your last answer there to Ms. Capps, you said there's a change in some parts of the country you see lower costs, and you mentioned new technology, what about preventive healthcare, does that reduce costs in the long run, and does the current formula reflect the importance of preventive care?

Mr. HACKBARTH. Yes. I must confess that I am not the foremost expert on the research on the benefits of preventive care. I think the answer is, it's a very good thing, and it can help reduce costs.

There is, of course, added expense involved, and exactly how those two net out I can't tell you off the top of my head. But, in general, it's a good thing for people.

Mr. STUPAK. Sure.

Mr. HACKBARTH. Even if it does cost us a little bit more, it is the right thing to do.

Mr. STUPAK. Well, should this current formula be changed to reflect preventive care then in the cost savings?

Mr. HACKBARTH. Well, that's the point where I can't give you the definitive sort of opinion that you are seeking. I think estimating the net impact of, for example, new provisions offering screening services for Medicare beneficiaries is really not something that MedPAC does. CBO does that, and the Office of the Actuary in CMS.

Mr. STUPAK. Going back to this chart I think you have in front of you that Mr. Brown brought up, and you said that from your point of view there was at least a 7 percent overpayment there for HMOs and the private insurance here in Medicare. And, some of us might say it might be as high as 15 percent, all sort of the average, right, I mean, you get some that are higher, some are probably lower, but it's an average?

Mr. HACKBARTH. Yes.

Mr. STUPAK. If we have the HMOs here in a way with traditional Medicare, if they are getting more money do they provide more services, as a general rule then?

Mr. HACKBARTH. Generally, they provide more benefits. They have a more comprehensive benefit package, different cost sharing structure.

Mr. STUPAK. Then, is that amount, 7 percent, whatever number you want to use, do you think it's equal to the benefits being received by the beneficiaries? I mean, is it a good deal? If it's a good deal, why don't we switch more to the HMOs then?

Mr. HACKBARTH. I don't know the answer to that if the additional benefits are equal to the 7 percent.

Mr. STUPAK. What are some examples of these added benefits that you see?

Mr. HACKBARTH. You know, vision care, dental care, some prescription drug coverage, even in advance of Medicare including prescription drugs, things like that, and a different cost sharing structure, lower deductibles and co-payments at the point of service.

Mr. STUPAK. With the new Medicare Prescription Drug Bill that's supposed to go into effect in 2006, do you see a shift then in those HMOs providing that kind of benefit, or a shift to others? Any idea on how the new Medicare bill may impact the added benefits they may receive?

Mr. HACKBARTH. Well, again, that involves questions that are really maybe more in Doug's area than mine. It picks up on Medicare beneficiaries interest and willingness to pay for prescription drugs. So, those are not things that we look at specifically.

Mr. STUPAK. Do you gentlemen want to comment on that?

Mr. HOLTZ-EAKIN. In terms of the particular mix of services that the private plans might provide, the bill provides for a standard benefit or its actuarial equivalent, and what will be an actuarial equivalent one couldn't guess in advance.

Mr. STUPAK. Well, I was just sort of wondering out loud, too, what with the new decision year by the EEOC going do with the prescription drug coverage for retirees, and that's going to be sort of an interesting issue there.

I think you sort of alluded to this, Mr. Hackbarth, earlier in your statement, but how can the formula be changed to better reward efficiency? I guess that's the sort of issue we are all grappling with, is it, you know, more private than the HMOs, what can we do, do you have any suggestions?

Mr. HACKBARTH. As I said earlier in response to Congressman Brown, it is our belief at MedPAC that offering private plans to Medicare beneficiaries is an important thing to do. And, one of the advantages of that is that we pay a lump sum to those private plans and they have to work, in effect, within a fixed budget.

Mr. STUPAK. Sure.

Mr. HACKBARTH. And, because they have that lump sum payment, they have the potential to rearrange, if you will, services, payment rates, in a way different from Medicare, in a way that potentially can offer better benefits and higher quality for Medicare beneficiaries than the traditional program. They are more flexible because they are smaller, and not encumbered by the many rules that Medicare has.

Mr. STUPAK. The only concern I have with the HMOs is there's no really requirement that the overpayments go to the beneficiaries, and in my area, a very rural area, we don't have very much access to an HMO, so we can't take advantage of it, just because of where we live, in a rural area. So, my concern for the HMOs is, No. 1, there's no requirement or guarantee that the overpayment goes to the beneficiaries in light of services, second is that the rural areas it really doesn't help us much.

Mr. HACKBARTH. Yes, sir, and if I may, Mr. Chairman, we agree with that. That's why we emphasize that Medicare beneficiaries ought to have a choice. It's not going to be available for all beneficiaries. It's not the right thing for all beneficiaries. It ought to be a choice for everybody.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. Dingell has graced us with his presence. Did you want to inquire?

Mr. DINGELL. The various and gracious—

Mr. BILIRAKIS. We do have a vote on the floor, too.

Mr. DINGELL. I have no questions. I do have an opening statement which I request be inserted in the record.

Mr. BILIRAKIS. All right, without objection it will be the case.

Mr. DINGELL. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentlelady from New Mexico, any questions? No questions.

Thank you for coming, sir.

Mr. BILIRAKIS. Well, that being the case, and our timing is good, because we do have a vote on the floor, the hearing is adjourned, but again, we will have questions coming from both sides, and we would appreciate your prompt response to those, and I will reiterate, again you are in a position to be helpful here, so, please, let's not just talk about history and some of the good things, some of the bad things that have happened in the past, it's a case of trying to fix some of those bad things, if we will.

So, we appreciate inputs from you.

The hearing is adjourned.

Thank you so very much for coming.

[Whereupon, the hearing was adjourned at 11:19 a.m.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY

The American Association for Geriatric Psychiatry (AAGP) appreciates the opportunity to share our concerns with the Members of the Subcommittee on Health on the problems associated with the Medicare physician fee schedule. AAGP is a professional membership organization dedicated to promoting the mental health and well-being of older people and improving the care of those with late-life mental disorders. Our membership consists of 2,000 geriatric psychiatrists as well as other health care professionals who focus on the mental health problems faced by senior citizens.

Physicians who treat Medicare beneficiaries, as Medicare providers, accept a fee schedule that is, at baseline, often significantly lower than their “usual and customary” fee schedule for providing services to their self-paying patients. As you are aware, these physicians continue to face the prospect of additional across-the-board reductions in the fees paid by the program. Unlike many other payment “cuts” in Washington, these reductions are not simply reductions in a rate of increase, but are absolute reductions in fee levels. In 2002, fees were cut by 5.4 percent below 2001 levels. Although Congress has taken action since that time to hold off additional reductions on a temporary basis and in fact has provided for a positive update of 1.5% for 2004 and 2005, it is clear that a permanent resolution to the flawed formula governing physician payments must be enacted. This issue is most important because of the effect it will have on access to care for Medicare beneficiaries, especially for the vulnerable among them—those elderly and disabled persons who have multiple, complex medical conditions and limited financial resources.

As a result of the recent and projected reductions, many physicians are having to reevaluate their willingness to treat Medicare patients, as well as their willingness to be “participating physicians” who accept Medicare payment as payment-in-full for their services. Consequently, many Medicare patients are already having trouble finding physicians to treat them. A survey by the American Medical Association following the 5.4 percent cut in 2002 found that 24 percent of physicians had either placed limits on the number of Medicare patients they treated or planned to institute limits. In the case of geriatric psychiatrists—most of whose patients are enrolled in Medicare—the impact of these reductions is particularly severe and is causing at least some in our profession to consider leaving clinical practice altogether to enter other fields where their experience and expertise are valued more appropriately.

The impact on geriatric psychiatrists—and their patients—is compounded by the discriminatory reimbursement policies Medicare already imposes on consumers of mental health services. Under current law, Medicare requires beneficiaries to pay a 20 percent copayment for Part B services with the single exception of a requirement of a 50 percent copayment for outpatient mental health services. The lack of parity for mental health treatment is unconscionable—and of great consequence to older adults who feel more stigmatized by psychiatric illness than any other group. Despite widespread need, many seniors decline, delay, or drop out of treatment because of the high copayment. In addition, current law discriminates against the non-elderly disabled Medicare population, many of whom have severe mental disorders.

The result of these factors—declining reimbursement rates, existing discriminatory reimbursement for mental health care, and stigma—will undoubtedly compound the existing serious access problems for Medicare beneficiaries in need of mental health treatment—either in finding a physician to treat them or in “balance billing” charges by physicians who previously accepted assignment.¹ Shifting costs to beneficiaries—many of whom are low income—can make essential mental health care unaffordable.

The fee reductions that are forcing these choices stem from the mechanism for automatic annual fee “updates” that is currently part of the Medicare statute. For most types of providers, Medicare law incorporates a mechanism by which payment rates are automatically updated annually for inflation, in much the same way that Social Security and other Federal cash benefits are automatically increased by the cost of living adjustment (COLA) each year.

However, since the inception of Medicare physician payment reform in the early 1990s, updating physician fees has been handled somewhat differently from those of other providers. The payment reform law established a mechanism under which the annual inflation update for physicians’ services is automatically adjusted—above or below the rate of inflation—based on how actual Medicare spending for physicians’ services compares to an annual spending target computed by the Centers for Medicare and Medicaid Services (CMS) based on a formula set out in the law.

Until recently, this mechanism resulted in some relatively modest reductions below full inflation—as well as some “bonuses” above inflation. However, changes made in the “Balanced Budget Act of 1997” (BBA) tightened the annual spending targets, making it substantially more difficult for physicians to meet them.

¹ Although “balance billing” may provide a short-term safety valve that allows some physicians to continue treating Medicare patients, the additional amount that Medicare permits physicians to collect from beneficiaries under its balance billing limits will not fully offset the cumulative reductions in program payments in the future. Moreover, some States prohibit balance billing Medicare beneficiaries as a condition of licensure in the State, which leaves those physicians without this option.

Before the BBA, the annual spending target was based on a formula that included a reasonable allowance for spending increases due to changes in technology and other related factors affecting the “volume and intensity” of services provided by physicians. The BBA replaced this allowance with a much less generous proxy—the estimated increase in the gross domestic product (GDP)—which bears no relationship to the factors affecting volume and intensity of services provided. The impact of this change can be demonstrated quite simply. Where the volume and intensity allowances for 1992 and 1993 were 6.8 percent and 6.0 percent, respectively, the corresponding GDP allowances for 1999 and 2000 were 1.3 percent and 2.7 percent.

Furthermore, because the BBA made the new targets cumulative—so that a breach in one year’s target would have to be fully offset by corresponding expenditure reductions in later years—inaccurate CMS estimates of several components of the formula used to compute the spending targets for 1998 and 1999 have been carried forward, producing inappropriately low targets in each subsequent year.

For example, actual growth in the GDP for 1998 and 1999 was greater than the estimates on which CMS based its targets. Growth in the beneficiary population is another component of the target. CMS overestimated beneficiary migration from traditional Medicare into managed care plans during 1998, which had the effect of understating beneficiary enrollment growth in the traditional program. All of these forecasting errors resulted in lower targets than would have occurred if better data had been available.

Unfortunately, CMS interprets the law as precluding it from correcting these errors. Although AAGP takes no position on this arcane legal issue, we do think that it is fundamentally unfair to make physicians—and Medicare beneficiaries—pay for estimates that everyone agrees in hindsight were wrong.

Physicians want to serve all Americans. However, they simply cannot afford to accept an unlimited number of Medicare patients into their practices when they are facing continued payment reductions. These drastic cuts must be stopped before they devastate Medicare beneficiaries’ access to health care.

We commend the Congress for its action last year to avert the impending reductions in Medicare physician fees for 2004 and 2005. We note, however, that the legislation does not address the fundamental defects in the formula for setting annual Medicare spending targets for physicians’ services. We urge Congress to revisit this issue in the near future and—at a minimum—to replace the GDP component of the formula with a more realistic proxy for changes technology and other factors affecting the volume and intensity of the services furnished to Medicare beneficiaries.

Thank you again for the opportunity to share our views on this important issue. We look forward to working with you as you craft a correction to the Medicare physician payment formula.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF SURGEONS

We are pleased that the subcommittee is hosting this hearing on the Medicare physician fee schedule. Chairman Bilirakis has been a long-time champion of this issue, and we welcome his continued support for resolving the instability of the Medicare physician payment system.

The American College of Surgeons—an organization representing more than 66,000 surgeons dedicated to accessible, high-quality care for surgical patients—is grateful to the Chairman and the other distinguished Members of the Committee on Energy and Commerce Health Subcommittee who worked diligently to avert the 4.5 percent physician payment cut that was scheduled to take effect this year.

Surgeons historically have had particularly high Medicare participation rates. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA)¹ took an important first step in guaranteeing the profession’s continued participation in the program by guaranteeing a 1.5 percent increase in physician payments in 2004 and 2005. It is within this context that we offer the following comments.

PAYMENT ADEQUACY

Over the last 15 years, Medicare reimbursements for surgical services have declined steeply. Indeed, payments for many surgical procedures are less than half of what they were before the current physician payment system was implemented in 1992.² Because the price of medical liability insurance and other practice costs con-

¹ Pub. L. No. 108-173.

² Actual dollar amounts, without any adjustments made for inflation.

tinue to escalate, surgeons and other physicians find themselves struggling to keep up with the demands of an aging population.

Physician practices are essentially small businesses. As is true for many small enterprises, there are limited options available to physician practices for reducing overhead costs. Unlike other business, however, when faced with decreasing income and soaring expenses, doctors cannot simply charge higher rates for their services. To keep the operating doors open, practices must make tough choices. Some delay the purchase of new equipment. Others reduce the size of their staff. Many increase the percentage of non-Medicare patients they see.

While we were pleased to avoid another payment cut, it is important to recognize that a 1.5 percent increase does not keep pace with the inflationary costs of operating a practice. And, for surgical specialties in particular, the more recent crisis in the Medicare payment system comes on the heels of a series of steep reductions that were implemented over the past decade. For most surgical practices, there simply aren't too many cost cutting options left.

The College implores Congress to work with CMS in keeping physician participation in Medicare at optimal levels. We suggest the following Congressional action with regard to the sustainable growth rate (SGR) system. First, Congress should urge CMS to administratively take drugs out of the SGR. Second, the SGR must be revised to reflect changes attributable to changes in law and regulation. In addition, Congress must examine the adequacy of Medicare reimbursement for physician liability insurance costs and urge CMS to make necessary revisions in the malpractice relative value units (RVUs).

1. Sustainable Growth Rate

The SGR is an expenditure target. Along with the Medicare Economic Index (MEI) and a budget neutrality adjustment, SGR is one of three components used to calculate the fee schedule conversion factor, which determine changes in Medicare physician payments annually.

Pursuant to this formula, payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Instead, the SGR is designed to adjust the update to make actual and target expenditures equal over time. If outlays under the fee schedule are higher than the target, the update is decreased. Conversely, if outlays are lower than the target, the update is increased.

Specifically, the SGR is calculated each year on the basis of the weighted average percentage increase using four factors: reimbursements for physician services; Medicare fee-for-service enrollment; real per capita gross domestic product (GDP); and, spending due to changes in law and regulation.

The ultimate solution to the update problem is for Congress to fix the flawed formula that is used today to calculate the annual changes made to the conversion factor. We are pleased that the Medicare Payment Advisory Commission (MedPAC) renewed its support for such legislative action in its March 2004 report to Congress.

a. Physician-administered drugs—Congress should insist that CMS revise its calculation of the SGR because the inclusion of drug expenditures contravenes the statute. CMS continues to rely on an overbroad definition of “physicians’ services” that does not apply to the update adjustment factor. As a result, Medicare payments for physician services—even to those physicians who do not prescribe or administer the covered drugs—have been reduced over the years to offset costs associated with the introduction of new and more expensive therapies. (Meanwhile, the cost for the drugs is not affected.)

CMS has the authority to change the scope of the SGR. Pursuant to the Social Security Act (SSA), to calculate the update adjustment factor CMS compares allowed expenditures for physicians’ services against actual expenditures.³ The primary definition of “physicians’ services” includes a broad number of services. However, CMS exempted drugs from this definition in 1991. “Section 1848(j)(3) of the Act gives us the authority to specify that items and services be excluded from the fee schedule. Thus, we have decided to exclude the cost of drugs from the national fee schedule and to continue to pay for them under the ‘reasonable charge’ system.”⁴ While the definition of “physicians’ services” includes items and services that are not actually physician services, drugs are not one of those items.

It is important to note that the statute defines “physicians’ services” differently depending on which section it appears. At one time an alternate definition of “physicians’ services” applied to the calculation of the update adjustment factor, which included drugs. Between 1990 and 1997 CMS used this secondary definition to cal-

³ Social Security Act (“SSA”) § 1848(d)(3)-(4), 42 U.S.C. § 1395w-4(d)(3)-(4).

⁴ 56 Fed. Reg. 25792, 25800 (Jun. 5, 1991).

culate the update adjustment factor.⁵ Through the Deficit Reduction Act of 1997, however, Congress deleted this reference to this broader, secondary definition, thus restoring the primary definition of “physicians’ services”, which does not include drugs.⁶

CMS may not construe the statute to include drugs when comparing actual to allowed expenditures. It specifically excluded drugs and specified that they be paid under a special statutory methodology. There is no longer a statutory basis to include drugs in the calculation of the update adjustment factor. Congress should encourage CMS to conform its calculation of the SGR to statutory language.

b. Changes attributable to changes in law and regulation—The SGR reflects spending that results from changes in law and regulation. Unfortunately, CMS only includes changes in program benefits that are attributable to legislation. By excluding important benefit expansions that are made through national coverage decisions, CMS compares actual expenditure data that include these services against a spending target that does not include them, making it more likely that the target will be exceeded. We urge Congress to work with CMS to correct the SGR formula.

Regrettably, MMA exacerbated the problem by excluding the 1.5 percent update in 2004 and 2005 from the SGR calculation as a change in law. Obviously, the College was pleased that this important legislation provided physicians a positive payment update. However, Congress undermined the methodology by preventing the SGR from reflecting legitimate spending increases which originated in the law.

Due to this omission, CMS will compare actual expenditure data that include an increase in physician payments against a spending target that does not include them. Expenditures will far exceed the target and result in years of negative updates. Furthermore, the score of future legislation to correct the formula will now be artificially inflated because CMS disregarded the cost of the 2004 and 2005 updates at the direction of Congress. We strongly urge Congress to change this provision. Legislation is necessary to properly adjust the SGR to reflect this change.

2. Medical liability insurance costs

The College strongly supports legislation to stabilize volatile jury awards and rising premiums. We remain fervent advocates for HR 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003. Until that meaningful liability reform is enacted the liability crisis will persist. Its impact on Medicare physician payments must be addressed immediately.

The growing cost of liability insurance is a primary concern for most surgeons, and for many other specialists, as well. In a growing number of states, surgeons are having difficulty obtaining medical liability insurance, and for those who are able to find coverage the cost is often prohibitively high. The large premium increases and declining number of liability insurance carriers are forcing many surgeons to make difficult decisions about limiting the scope of their practice, moving to other states, or retiring early. Medicare payment cuts only add more financial pressure to make these decisions.

The College appreciates CMS’ recognition of the growing liability crisis and is pleased that the agency has responded by implementing an increase in the Medicare Economic Index (MEI) update for professional liability insurance of 20.61 percent in the 2004 Physician Fee Schedule.⁷ While we support this increase, there is a heightened concern that specialties being hit the hardest by rising insurance costs are not getting the help they need.

MedPAC fails to adequately consider that those specialties experiencing the greatest liability premium hikes are coincidentally the same groups who have been experiencing net pay decreases for a number of years. This results from the transition to a single conversion factor, followed by the phase-in to resource-based practice expenses. Certain surgical specialties—such as neurosurgeons, general surgeons, thoracic surgeons, and those in obstetrics-gynecology and orthopaedics—pay the highest premiums and are suffering disproportionately from the current escalation in premium rates. Yet, any MEI adjustment applies broadly and cannot direct funds to those who are actually experiencing these increases—even if the faulty SGR system did not eliminate the benefits of such an adjustment entirely.

As CMS begins to revise the malpractice relative value units, we cannot overstate the importance of addressing this problem. The resource-based payment system

⁵See Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508 (applying the subsection (f) definition of “physicians’ services” to the update adjustment factor).

⁶Pub. L. No. 105-33. Prior to 1990, the annual update of the conversion factor was based on the subsection (j) definition of “physicians’ services”. See section 6102 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239.

⁷69 Fed. Reg. 1084, 1095 (Jan. 7, 2004).

must reflect the costs involved. Since the Medicare fee schedule is used as the basis for determining payments for many insurers, it is critical for the entire health care system—not just Medicare—to account for these costs appropriately. Professional liability premiums are a major resource “input,” the cost of which falls outside physicians’ control.

Congress should encourage continued collaboration between CMS and the medical specialty societies on this issue. It is necessary to determine whether the current method of allocating RVUs is appropriate. Alternative mechanisms may better account for physicians’ costs. We are encouraged that CMS has previously expressed interest in reviewing alternative methodologies during refinement of malpractice RVUs.⁸ The agency should present options and invite public comment on various approaches to refinement.

CONCLUSION

One of the greatest achievements of the Medicare program is the access to high-quality care it has brought to our nation’s senior and disabled patients. This level of access cannot be expected to continue uninterrupted in the face of continued cuts and growing liability premiums. We cannot emphasize enough how important it is for Congress to take steps to ensure that physician payment adequately reflects the cost of doing business.

Thank you for your consideration of Medicare payment policies, including the adequacy of reimbursement for physicians. The College appreciates this opportunity to present its views and looks forward to working with you to ensure continued access to Medicare.

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC) is pleased to submit for the record testimony to the House Energy and Commerce Subcommittee on Health on the need to replace the Sustainable Growth Rate (SGR) methodology used to calculate the update for Medicare payments under the Physician Fee Schedule (“physician payment update”). The AAMC appreciates the Subcommittee’s interest in this issue of great importance to both Medicare beneficiaries and the physicians who provide their medical care. The AAMC supports replacement of the SGR with a methodology that assures adequate payments and stable updates for physicians who participate in Medicare. Appropriate and stable physician payments will help ensure that Medicare beneficiaries have access to the complex and specialized care provided by academic physicians.

The AAMC represents the country’s 126 accredited medical schools and nearly 400 major teaching hospitals and health systems, 94 academic/professional societies representing approximately 105,000 faculty members, and the nation’s medical students and residents.

THE ROLE OF ACADEMIC PHYSICIAN IN SERVING PATIENTS AND MEDICARE BENEFICIARIES

Academic physicians serve a unique, multifaceted role within the physician community, as well as within the larger healthcare system. As experts in their particular fields of medicine, academic physicians provide patients and referring physicians with cutting-edge clinical expertise. Academic physicians also educate and train the medical students, residents, and other health professionals who will become the next generation of caregivers. In addition, many academic physicians conduct clinical research that generates more effective, efficient, and compassionate healthcare for all Americans, including aging Americans. For example, a number of breakthroughs in research conducted by academic physicians, such as retinal transplants, inner ear implants, the development of a surgical procedure to prevent urinary incontinence in men with cancerous prostates, and others, now benefit many seniors, providing improved diagnostic and therapeutic services.

With their clinical expertise, participation in clinical research, and knowledge of innovative technologies, academic physicians frequently partner with teaching hospitals to provide inpatient and outpatient care for patients with complex, multiple, or acute health problems that can not be managed elsewhere in the community. Among the AAMC teaching hospital members that partnered with academic physicians in 2002 (most recent data available), about five of every six hospitals (85 percent) provided geriatric-specific services (e.g., treatment for Parkinson’s or Alz-

⁸64 Fed. Reg. 59379, 59386 (Nov. 2, 1999).

heimer's disease). While AAMC teaching hospital members represented just 6 percent of all hospitals in 2002, nearly one-half (42 percent) maintained arthritis treatment centers, 84 percent performed open heart surgeries, 79 percent operated certified trauma centers, and 86 percent provided radiation therapy services for patients with cancer and related conditions.

Nearly one-sixth of all physicians providing Medicare services are academic clinical physicians, rendering them vital to preserving healthcare access for Medicare beneficiaries.

Academic physicians also partner with AAMC teaching hospital members to provide nearly one half (43.3 percent in 2001) of the nation's hospital-based charity care. By comprising a significant segment of America's healthcare safety net, academic physicians and their teaching hospital partners assure healthcare access for the poor and underserved, including Medicare beneficiaries who are dually eligible for Medicaid or who are unable to pay for their care. In 1999, faculty practices provided an average of \$12 million in charity care. (In contrast, in 2001, one-quarter (29 percent) of all physicians did not provide any charity care and 27 percent of the country's specialists did not provide charity care services, according to the Center for Studying Health System Change Community Tracking Survey which includes a survey of physicians.)

CALCULATING ANNUAL PHYSICIAN UPDATES: THE SUSTAINABLE GROWTH RATE (SGR) METHODOLOGY

Each year, the Centers for Medicare and Medicaid Services (CMS) calculates the "Medicare Physician Update" by determining the difference between actual spending on physician services and an annual spending target. In general, when spending exceeds the annual target, CMS issues a "negative physician update." When spending falls below the annual target, CMS issues a "positive physician update."

CMS calculates the annual spending target using the SGR methodology. Passed as part of the Balanced Budget Act of 1997 (BBA), the SGR methodology was intended to set annual spending targets to control government expenditures for Medicare physician services as well as account for increases in the cost of providing those services.

The AAMC is concerned that the SGR has failed to establish an equitable balance between fiscal management of the Medicare program and the actual cost of caring for Medicare patients. For example, from 1996 to 2004 the cost of providing physician services, as measured by the Medicare Economic Index (MEI), climbed an average of 2.3 percent. However, the physician update grew an average of 1.1 percent over that same period. This shortfall occurred despite intervention by Congress to increase the physician payment update in CYs 2003-2005.

RECENT CONGRESSIONAL ACTION AVERTS PROJECTED MEDICARE CUTS FOR PHYSICIANS

The AAMC appreciates Congress' efforts to avert the harmful impact of the flawed SGR methodology. Congress acted twice in 2003 to address reductions in the Medicare physician updates for CYs 2003, 2004, and 2005.

As part of the "Consolidated Appropriations Resolution for FY 2003" passed in February 2003, Congress gave CMS the legal authority to revise the CY 2003 physician update from negative 4.4 percent to positive 1.6 percent, avoiding a sharp and significant drop in payments to physicians. In December, Congress similarly averted projected cuts in the CY 2004 and CY 2005 physician updates as part of the "Medicare Prescription Drug, Improvement and Modernization Act of 2003" (P.L. 108-173). Because of Congress' quick action to prevent potentially devastating cuts, the Medicare physician payment update for CY 2004 and CY 2005 are set at "not less than 1.5%."

When these favorable, yet short-term "fixes" expire in CY 2006, the physician update calculation reverts to the SGR methodology. Both the Congressional Budget Office (CBO) and Medicare Trustees anticipate the SGR formula will once again trigger dramatic cuts to physician payment updates. In fact, the Medicare Trustees project the problematic SGR will produce cuts of 5% per year from 2006 through 2012.

THE IMPACT OF FEE SCHEDULE REDUCTIONS ON FACULTY PRACTICE PLANS AND THE NEED FOR STABLE, ADEQUATE MEDICARE PAYMENTS

Stable and adequate Medicare physician payments are critical to ensuring that seniors have continued access to the professional services provided by academic physicians. In light of the fact that faculty practice revenues, on average, represented about 36 percent of medical school revenue in 2002, unstable Medicare payments

could jeopardize beneficiary access to faculty professional services, as well as academic medicine's core missions of medical education, research and clinical services.

Changes to the fee schedule have both direct and indirect impacts on faculty practices. In terms of a direct impact, a change in the physician update is not necessarily translated into a proportionate change in actual payments. Since payments under Part B are calculated on a service-specific basis, and a variety of factors are used to calculate each specific payment, the change in payment for individual services typically varies from the annual change in physician update.

The variation occurs among specialties and institutions. An impact analysis by the University Health Consortium (UHC)/AAMC Faculty Practice Solutions Center found that despite the 1.6 percent increase in the CY 2003 update, several academic physician specialties, on average, saw their Medicare payments actually decrease:

Specialty	Average Payment Change
Nephrology (Kidneys)	-2.6%
Orthopedic Surgery	-1.4%
Ophthalmology (Glaucoma)	-0.2%
Colon/Rectal Surgery	-0.1%

Another UHC/AAMC analysis provides an example of how the change in actual payments to academic physicians often varies from the change in the update. Focusing on relevant data submitted by a cohort of academic physician practice groups, the mean impact of the negative 5.4 percent update in CY 2002 across those institutions was negative 5.8 percent (Attachment A), with some practices reporting a decline of nearly 8 percent. A similar analysis of the 1.6 percent physician update in 2003 shows a mean change across the cohort practice groups of just 0.5 percent (Attachment B).

Academic physicians also face the indirect impact of a negative physician update when community-based physicians begin limiting the number of Medicare beneficiaries they serve. According to a 2001 Center for Studying Health System Change Community Tracking Survey which includes a survey of physicians, over one-third (35 percent) of primary care physicians limited the number of new Medicare patients in their practice, while 16 percent did not accept any new Medicare patients. Among specialists, 27 percent of physicians limited their number of new Medicare patients.

The increased volumes of Medicare services, coupled with unstable and often declining reimbursement rates, place financial pressures on academic physician practices, endangering their fiscal viability and ability to maintain their societal missions, including providing care to Medicare beneficiaries.

Increased financial pressures on academic physicians also creates a "ripple effect" that extends to their medical schools. Declining revenue ultimately causes academic physicians to devote more time to generating additional clinical revenue, which may force them to either reduce the time they spend mentoring medical students and residents or spend less time on research, thereby slowing the pace of life-saving and cost-saving innovations.

Increased clinical productivity demands and/or subsequent reductions in education and research time can frustrate physicians that enter academic medicine because they are committed to a career that combines two or three of these activities. Growing frustration can ultimately result in an academic physician's resignation, relocation, and/or a decision to leave academic medicine. It can also hinder efforts to replace retiring physicians and place an organization's education, research, and patient care missions at risk.

In addition, the volatility, instability, and inadequacy of Medicare payments also affects payments from payers beyond Medicare. Many private payers and some Medicaid programs tie their reimbursement systems to Medicare.

REVISING THE PHYSICIAN UPDATE METHODOLOGY

The need for an alternative physician payment system is obvious, given the drastic cuts that will resume in 2006 under the SGR methodology. The AAMC enthusiastically welcomes the opportunity to work together with Congress, the Administration, and the physician community to develop a more workable reimbursement system. The AAMC also urges any SGR reform efforts to carefully consider the data sets, proxies, and indicators necessary to generate adequate, equitable, and fiscally responsible physician payments.

For example, the past few years have demonstrated that the country's volatile gross domestic product (GDP) does not contribute to adequate and stable physician

payments. Physicians have faced rising costs of caring for Medicare beneficiaries despite downturns in the national economy. Because the current payment formula failed to account for this phenomenon in 2002, CMS cut the physician update by 5.4 percent, while the cost of care (MEI) rose by 2.6 percent. Additionally, sudden and unexpected changes in the GDP trigger similarly dramatic and unanticipated fluctuations in the physician update. The 2002 update of negative 5.4 percent represented a substantial and sudden drop from a positive 4.5 percent update in 2001. This volatility jeopardizes the ability of academic physician practices to make sound, long-term financial decisions and further endangers already fiscally strained medical schools, research programs, and teaching hospitals.

Another flaw in the current SGR methodology is its failure to reflect changes in Medicare laws and regulations. Despite the fact that Medicare statute requires CMS to account fully for legislative and regulatory changes in the SGR, the agency appears to have underestimated the physician cost implications of newly mandated screening benefits. Similarly, coverage decisions are completely excluded from the SGR calculation, despite the potential that increased patient demand would increase expenditures for physician services.

The AAMC is also concerned that, while Medicare law does not define physician-administered drugs as “physician services,” CMS includes those costs in the annual calculation of actual physician spending. Given the growth in life-saving outpatient drug therapies, drug costs help push actual spending on physician services beyond the SGR target, and physicians subsequently face a negative physician update. Eliminating physician-administered drugs from the cost of doctors’ services would more accurately reflect actual Medicare spending on physicians. Some may argue that including drugs in the actual spending calculation is a way to discourage inappropriate drug prescribing by physicians. The AAMC has not seen data that indicates such patterns. If indeed data exists that indicates inappropriate prescribing patterns, the AAMC welcomes the opportunity to work with Congress and the Administration to address the issue in an educational manner that improves the quality of care for beneficiaries.

Finally, CMS should consider that the most recently enacted Medicare provisions will likely increase spending on physician services. For example, increased beneficiary access to drugs may lead to more physician visits for monitoring drug efficacy or side effects. Expanded screening benefits provided under the law will also drive an increase in actual spending. These increased costs to the Medicare program cannot be linked inherently to physician behavior.

CONCLUSION

In conclusion, Medicare beneficiaries rely on academic physicians and academic medical centers to provide high quality, innovative, and accessible healthcare. They also rely on academic physicians to develop the clinical advances and train the new generation of physicians that will assure a high quality of life for all American seniors. The AAMC looks forward to working with Subcommittee members in devising a long-term solution to replace the current SGR methodology and assure adequate and stable Medicare physician payment updates.

PREPARED STATEMENT OF DOUGLS K. REX, M.D., FACG, PRESIDENT, AMERICAN COLLEGE OF GASTROENTEROLOGY

The American College of Gastroenterology (ACG or *the College*) has long recognized the flawed nature of the Medicare program’s sustainable growth rate (SGR) formula and the futility in the end result. ACG urged the Centers for Medicare and Medicaid Services (CMS) as early as January 2000, of the inescapable need to remedy the formula’s inherent and devastating inaccuracies.

The College is pleased to see that the Committee is laying the foundation for the debate on how to repair the dreadful physician payment situation created by the SGR formula. It is encouraging to see that many Members of both chambers are in agreement that the current situation is unsustainable, especially with CMS and other agencies projecting a forty percent cut in physician fee payments by 2014 under the SGR.

Meanwhile, the cost of practicing medicine is only increasing. The soaring cost of medical liability insurance is well documented, and this Congress has rightly taken the lead on tackling the issue head-on. Nevertheless, there are other factors contributing to rising costs, including a shortage of skilled nurses and periodic upgrades for computer hardware and software. In this manner—insurance, personnel and capital costs—practicing medicine is like any other business, but the similarities end

there. Few if any other professions have had such a heavy-handed federal pricing pressure driving down practice fees for the last fifteen years.

Furthermore, no other medical specialty has seen its primary volume procedures cut so drastically during this time period as gastroenterology. Relative value units (RVUs) for GI procedures have been slashed as a result of CMS' practice expense and site-of-service policies, inevitable products of the SGR spending targets. This, in turn, has cut the Medicare physician reimbursement level for a diagnostic colonoscopy by one-third since 1997. All told, the Medicare physician reimbursement rate for a diagnostic colonoscopy has been cut by 60% since 1987, down to just \$205.73 in 2004.

In fact, Medicare reimbursement for colonoscopy has been driven so low that now even Medicaid pays physicians more for the procedure in about two-thirds of the states. If Medicare is the lowest payer for services, access for the program's 40 million beneficiaries will suffer. In its Report to Congress this past March, MedPAC tried to address the access issue but said that "(B)ecause most surveys do not compare access measures between Medicare beneficiaries and privately insured people, it is difficult to determine the extent to which access problems, such as appointment delays, are unique to the Medicare population." Evidence from in-house surveys of ACG members suggests that Medicare patients are waiting significantly longer for GI endoscopic procedures than private pay patients, with a significant number of gastroenterologists not accepting new Medicare patients. Other data suggests that falling payments are having an impact on access. Although Congress enacted a colorectal cancer screening benefit to Medicare as part of the Balanced Budget Act of 1997 (BBA), and added colonoscopy to the benefit as part of the Medicare, Medicaid, and SCHIP Benefits Improvement & Protection Act of 2000 (BIPA), the rate of growth for this procedure among fee-for-service Medicare beneficiaries fell by 25 percent from from 2001-2002 compared to 1999-2001 (percent change in units of service per beneficiary, March 2004 MedPAC Report to Congress, page 113).

The SGR formula is fatally flawed because it is only based on meeting fiscal and budgetary outcomes and fails to consider its own impact on patient and physician outcomes and behavior. First, it confines physician payments within a budget baseline along with other non-physician health services, such as drugs and biologicals. Therefore, increases in non-physician payment Part B services prompt automatic reductions in the SGR. Tying the SGR baseline to the gross domestic product (GDP) can produce similar problems. Yet, even within the physician payment funding pool, the inherent failings of the SGR formula are apparent. This past year, CMS rebased and revised the Medicare Economic Index (MEI), including revisions to the three valuation components within the MEI. In the end, CMS recognized the growing cost of practice liability insurance (PLI), however, it came at the expense of the physician work RVUs and practice expense RVUs. CMS's actions amounted to a cosmetic reshuffling of the deck in a zero-sum game and did nothing to actually address the problems associated with skyrocketing PLI expenses.

Numerous Members of Congress have suggested making changes to how the SGR is computed, such as by removing drug costs from the SGR baseline and untying the SGR from GDP. The College agrees with these proposed solutions. In the Committee's future deliberations on this matter, however, the College also encourages the Committee to have the Congressional Budget Office or the General Accounting Office develop an improved way to score the benefits of preventive health procedures, such as screening colonoscopy to prevent or detect colorectal cancer, to reflect the net savings by reducing Medicare expenditures in the out years by avoiding surgeries, hospital stays, chemotherapy and other related services. By enacting the colorectal cancer screening benefit back in 1997 and including colonoscopy in 2000, Congress recognized the importance of employing preventive care to stop this very deadly but highly preventable cancer. Now it is time that Medicare payment policies reflect the intent of Congressional health policies and stop the downward spiral in Medicare payment to physicians for performing this procedure. The existence of the sustainable growth rate makes this difficult to do outside of a targeted Congressional action.

The American College of Gastroenterology is a physician organization representing gastroenterologists and other gastrointestinal specialists. Founded in 1932, the College currently numbers more than 8,000 physicians among its membership. While the majority of these physicians are gastroenterologists, the College's membership also includes surgeons, pathologists, hepatologists and other specialists in various aspects of the overall treatment of digestive diseases and conditions. The College has chosen to focus its activities on clinical gastroenterology—the issues confronting the gastrointestinal specialist in treatment of patients. The primary activities of the College have been, and continue to be educational

MEDICARE PAYMENT ADVISORY COMMISSION
June 15, 2004

MICHAEL BILIRAKIS
*Chairman, Subcommittee on Health
 Committee on Energy and Commerce
 U.S. House of Representatives
 Washington, DC 20515-6115*

DEAR MR. BILIRAKIS: Thank you for the follow-up question on the subject of Physician Fee Schedule: A Review of the Current Medicare Payment System. The question, submitted by Congressman John B. Shadegg, is:

Question: The main goal of the sustainable growth rate is to control physician service volume by setting an aggregate rate target, and penalizing physicians by reducing their payments when total volume growth exceeds this rate. Since each individual physician can only control their own volume, and consumer and payer behavior has as much impact on volume as physician behavior, do you believe that an aggregate cap such as SGR could ever serve as an effective volume control to be met by thousands of individual physicians?

Response: The Commission considered these matters carefully in the March 2001 Report to the Congress: Medicare payment policy. In that report, we identified three problems with the SGR approach.

- It disconnects payment from the cost of producing services. The formula produces updates that can be unrelated to changes in the cost of producing physician services and other factors that should inform the update. If left alone, negative updates would provide a budget control but in so doing would produce fees that in the long run could threaten beneficiaries' access.
- It is a flawed volume control mechanism. Because it is a national target, there is no incentive for individual physicians to control volume. When fee reductions have occurred they have not consistently slowed volume growth and the volume of services and level of spending are still increasing rapidly.
- It is inequitable because it treats all physicians and regions of the country alike regardless of their individual volume influencing behavior.

In summary, the Commission believes that the SGR has not served as an effective volume control that can be met by the nation's physicians. We hope this is helpful. If we can be of further assistance, please do not hesitate to contact us.

Sincerely,

GLENN M. HACKBARTH, J.D.
Chairman

CONGRESSIONAL BUDGET OFFICE
July 6, 2004

Honorable MICHAEL BILIRAKIS
*Chairman, Subcommittee on Health
 Committee on Energy and Commerce
 U.S. House of Representatives
 Washington, DC 20515*

DEAR MR. CHAIRMAN: I am pleased to respond for the record to the following question from Congressman Shadegg regarding my testimony on May 5, 2004, on Medicare's physician fee schedule:

Question: The main goal of the Sustainable Growth Rate (SGR) is to control physician service volume by setting an aggregate rate target, and penalizing physicians by reducing their payments when total volume growth exceeds this rate. Since each individual physician can only control their own volume, and consumer and payer behavior have as much impact on volume as MD behavior; do you believe that an aggregate cap such as SGR could ever serve as an effective volume control to be met by thousands of individual physicians?

Response: Under current law, the Medicare program does not attempt to control the volume of physicians' services. Rather, the SGR method attempts to control growth in Medicare's total expenditures for physicians' services. The SGR method controls growth in spending by establishing year-by-year and cumulative expenditure targets and by adjusting future payment rates to bring spending in line with those targets. Those expenditure targets incorporate adjustments for inflation and changes in the number of beneficiaries enrolled in Medicare's fee-for-service program; they also provide an allowance for increases in spending per beneficiary for physicians' services based on the growth in real gross domestic product per capita.

The year-by-year expenditure targets also are adjusted to compensate for differences between actual spending and the expenditure targets.

Assuming no further change in current law, CBO projects that the SGR method will be effective over the coming decade in bringing Medicare's total expenditures for physicians' services in line with those expenditure targets. However, it will do so by adjusting payment rates in response to changes in the volume of physicians' services—not by controlling the volume of those services.

If you have any further questions, we would be pleased to answer them. The CBO staff contact is Chris Topoleski.

Sincerely,

DOUGLAS HOLTZ-EAKIN
Director

cc: Honorable John D. Dingell, Ranking Member

RESPONSE OF A. BRUCE STEINWALD, DIRECTOR, HEALTH CARE MEDICARE PAYMENT ISSUES, U.S. GENERAL ACCOUNTING OFFICE, TO QUESTION OF HON. JOHN B. SHAD-EGG

Question: The main goal of the Sustainable Growth Rate is to control physician service volume by setting an aggregate rate target, and penalizing physicians by reducing their payments when total volume growth exceeds this rate. Since each individual physician can only control their own volume, and consumer and payer behavior have as much impact on volume as MD behavior, do you believe that an aggregate cap such as SGR could ever serve as an effective volume control to be met by thousands of individual physicians?

Response: Although physicians' decisions play an important role in determining volume and intensity growth, it is unknown how a system of aggregate spending targets may influence the behavior of individual physicians. In its 1995 report to Congress, the Physician Payment Review Commission (a predecessor to the current Medicare Payment Advisory Commission) 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." What is known, as I discussed in my testimony statement, is that we observed a dramatic decrease in volume and intensity growth following the implementation of a fee schedule and spending targets for physician services in 1992. GAO is currently conducting a study of Medicare's sustainable growth rate system and will issue its report on the subject in September.

PREPARED STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

Chairman Bilirakis, Representative Brown and Members of the Subcommittee, the American Medical Association (AMA) appreciates the opportunity to provide our views today regarding the Medicare payment update formula for physicians' services.

The AMA would like to take this opportunity to commend you, Mr. Chairman, and each Member of the Subcommittee, for all of your hard work and leadership in recognizing the fundamental problems inherent in the Medicare physician payment update formula and enacting recent short-term "fixes" of the update formula. We deeply appreciate enactment of provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which greatly assist in averting access problems for Medicare beneficiaries, including replacement of the 4.5% Medicare physician pay cut for 2004 and another severe cut in 2005 with a positive 1.5% update in each of these years, as well as placing a floor on geographic adjustments and providing bonus payments for certain physician "scarcity" areas.

We also applaud your commitment to developing a long-term solution to the current flawed physician payment formula. The flaws in this formula led to a 5.4% payment cut in 2002, and additional cuts in 2003 through 2005 were averted only after Congress intervened. Further, the formula has produced payment updates that have failed to keep pace with the cost of practicing medicine. From 1991 through 2005, medical practice costs will have increased by 41%, yet, during the same time period, Medicare payments to physicians will have increased only by about 18% (see chart in Attachment A). Without intervention, the situation will worsen. The Medicare Trustees have projected that physicians and other health professionals face pay cuts of 5% a year from 2006 through 2012. The result, according to 2004 Annual Report

of the Medicare Board of Trustees, is a cumulative reduction of more than 31% in physician payment rates 2005 through 2012, while medical practice costs (MEI) during that time frame are expected to increase by 19%.

A physician access crisis is looming for Medicare patients unless action is taken to enact a long-term solution to the current physician payment formula. The MMA has made significant strides in improving the overall system for Medicare beneficiaries, including broad-scale improvements for care furnished to patients in rural areas as well as important new benefits. These critical improvements must be supported by an adequate payment structure for physicians' services. Physicians are the foundation of our nation's health care system, and continual cuts (or even the threat of repeated cuts) put Medicare patient access to physicians' services at risk and threaten to destabilize the program.

The AMA looks forward to working with Congress to achieve a successful solution to the problems with the current payment system. We are happy to have the opportunity today to address the historical problems with the formula.

THE SUSTAINABLE GROWTH RATE SYSTEM

Medicare pays for services provided by physicians and numerous other health care professionals on the basis of a payment formula that is updated annually in accordance with a sustainable growth rate (SGR). Under the SGR, enacted by the Balanced Budget Act of 1997 (BBA), the Centers for Medicare and Medicaid Services (CMS) establishes allowed expenditures for physicians' services based on certain factors set forth in the law: (i) inflation, (ii) fee-for-service enrollment, (iii) real per capita gross domestic product (GDP), and (iv) laws and regulations. CMS then compares allowed expenditures to actual expenditures. If actual expenditures exceed allowed expenditures in a particular year, then physician payments are reduced in the subsequent year. Conversely, if allowed expenditures are less than actual expenditures, physician payments increase.

PROBLEMS UNDER THE SUSTAINABLE GROWTH RATE SYSTEM

The flawed SGR system has led to payment volatility and substantial patient access concerns requiring Congressional intervention to avoid erosion of beneficiary access to care.

The vast majority of physician practices are small businesses, and, as such, do not have the economic and other necessary resources to absorb sustained losses or the steep payment fluctuations that have occurred under the SGR system. Further, the unpredictability of the SGR system makes it difficult for physician office practices, as small businesses, to project revenue into the future and make the necessary business and financial decisions needed to operate a sound business over time. For example, when these small medical practices experienced the 5.4 percent Medicare cut in 2002, physicians and non-physician practitioners were left with very few alternatives for maintaining a financially sound practice without limiting their Medicare patients' access in some way. It is also nearly impossible for physician practices to plan ahead since SGR estimates for future years (which are based on numerous factors that are impossible to predict), in addition to being quite grim, are also completely unreliable. It took strong efforts by Congress, in particular by this Committee, in addition to similar efforts by the Senate, the Administration and CMS to avoid another SGR-triggered pay cut in 2004 and 2005. While we greatly appreciate this effort, we do not believe Congress and the Administration (nor patients, physicians and other health care professionals) should have to struggle with the ill effects of such a system, year after year.

The Medicare Payment Advisory Commission (MedPAC) has recommended that the SGR be replaced with a system where updates are based on an assessment of increases in practice costs, adequacy of payment rates, and beneficiaries' access to care, and we agree. There are several fundamental problems with the SGR formula:

1. Payment updates under the SGR formula are tied to the gross domestic product, which bears little relationship to patients' health care needs or physicians' practice costs;
2. The SGR formula is highly dependent on projections that in effect require CMS to predict the unpredictable; and
3. Physicians are penalized with lower payments when utilization of services exceeds the SGR spending target, yet, the factors driving these increases are often beyond physicians' control (as further discussed below under "Administrative Action Needed.")

Problems with the Payment Formula Due to GDP

GDP Does Not Accurately Measure Health Care Needs

The SGR permits utilization of physicians' services per beneficiary to increase by only as much as GDP. The problem with this "relationship" is that GDP growth does not track the health care needs of Medicare beneficiaries. For example, when a slowed economy results in a decreased GDP, the medical needs of Medicare patients remain constant, or even increase, despite the economic downturn. Yet, physicians and numerous other health professionals, whose Medicare payments are tied to the physician fee schedule, are penalized with lower payments because of the decreased GDP.

Further, GDP does not take into account the aging of the Medicare population, technological innovations or changes in the practice of medicine. This is a key reason that MedPAC has recommended replacing the SGR system.

Use of GDP has also led to a system that relies on economic forecasts that nearly always need to be modified as additional data becomes available, and thus it is impossible to make accurate projections about payment update levels. For example, in March of 2001, CMS projected that physician payments would fall slightly by about -0.1 percent in 2002. CMS noted that this projection was based on very early information and could change before a final update was announced in January 2002. In fact, those estimates did change, and Medicare payments to physicians and other health care professionals were cut by 5.4 percent in 2002.

Technological Innovations Are Not Reflected in the Formula

The United States' population is aging and new technologies are making it possible to perform more complicated procedures on patients who are older and more frail than in the past. The Congressional Budget Office has said that recent Medicare volume increases are due to "increased enrollment, development and diffusion of new medical technology" and "legislative and administrative" program expansions. The SGR system's artificial cap on spending growth ignores such medical advances when it limits target utilization growth to GDP growth.

Both Congress and the Administration have demonstrated their interest in fostering advances in medical technology and making these advances available to Medicare beneficiaries through FDA modernization, increases in the National Institutes of Health budget, and efforts to improve Medicare's coverage policy decision process.

The only way for technological innovations in medical care to really take root and improve standards of care is for physicians to invest in those technologies and incorporate them into their regular clinical practice. The invention of a new medical device cannot, in and of itself, improve health care (physicians must take the time to learn about the equipment, practice using it, train their staff, integrate it into their diagnosis and treatment plans and invest significant capital in it. Although the Medicare hospital payment system allows an adjustment for technological innovations, the physician payment system does not do so. The physician payment system is the only fee structure of Medicare that is held to GDP, and no other Medicare payment system faces as stringent a growth standard.

Government efforts to foster technological innovations could be seriously undermined as physicians now face disincentives to invest in new medical technologies or to provide them to Medicare beneficiaries.

Site-of-Service Shifts Are Not Considered in the Formula

Another concern that is not taken into account in the SGR formula is the effect of the shift in care from hospital inpatient settings to outpatient sites. As MedPAC has pointed out in the past, hospitals have reduced the cost of inpatient care by reducing lengths-of-stay and decreasing staff, as well as by moving more services to outpatient sites, including physician offices. This trend, which has been encouraged by private payers because it saves money for both the government and patients, has increased the number and intensity of services as patients with increasingly complex conditions are treated in physicians' offices. This increased use and intensity, however, is not recognized in the SGR formula.

Beneficiary Characteristics Are Not Reflected in the Formula

A related factor that also is unrecognized in the SGR formula is changes over time in the characteristics of patients enrolling in the fee-for-service program. For example, increases in patients diagnosed with, or having complications due to such diseases as obesity, diabetes and end stage renal disease, require greater utilization of physicians' services. Yet, these types of changes in beneficiary characteristics are not reflected in the SGR.

Inability to Predict Payment Updates under the SGR

Instead of making payments more predictable for physicians and budgets more predictable for policymakers, use of the SGR has had the opposite effect. Future updates are dependent on forecasts of (i) GDP, (ii) how many beneficiaries will choose Medicare Advantage versus fee-for-service Medicare, (iii) the rate of medical practice cost inflation each year, (iv) the rate of utilization growth each year, and (v) spending changes that will occur as a result of legislative and regulatory changes, such as expanded coverage for preventive services.

None of these factors can be accurately predicted before they occur. As a result, policymakers cannot predict the impact of Medicare physician services on overall Medicare spending and medical practices cannot predict their revenue streams for the short- or long-term. Estimates of payment updates initially are based on incomplete data and such estimates can fluctuate significantly as more data becomes available. Indeed, the chart in Attachment B illustrates the numerous changes in CMS estimates of the SGR target beginning in the Fall of 1997 through Spring 2004.

ADMINISTRATIVE ACTION NEEDED TO CORRECT SGR IMPLEMENTATION PROBLEMS

Apart from the inherent problems in the physician payment formula, there are other problems with implementation of the SGR that seriously threaten patient access and inequitably affect payment updates due to factors that are beyond physicians' control. CMS could and should use its administrative authority to address these issues in the 2005 Medicare physician payment rule:

1. Remove Medicare-covered drugs and biologics from the physician payment formula

As discussed above, Medicare payments to physicians are reduced when actual Medicare spending for physicians' services exceeds a pre-determined spending target (the SGR). When CMS calculates actual spending on physicians' services, it includes the costs of Medicare-covered prescription drugs administered in physicians' offices. Although the physician's administration of the drug is clearly a physician service that by statute must be included in the pool, the drugs themselves are not "physicians' services" and drugs are not paid under the Medicare physicians fee schedule. Thus, it is inconsistent to include drugs in the SGR. In fact, in an interim final rule issued last year, (on the application of inherent reasonableness to Medicare Part B services), CMS chose to exclude drugs from the definition of "physicians' services." To include drugs as a "physicians' service" for certain purposes, but not for others, is inconsistent and inequitable. Indeed, this policy has been questioned by many legislators, including Subcommittee Chairman Bilirakis and former Committee Chairman Tauzin, who noted in a June 2003 letter to former Administrator Scully that "good public policy demands" elimination of these drugs from the SGR formula.

In the past, some CMS officials have argued that including drugs in the SGR was necessary to counter-balance incentives for over-utilization in the drug reimbursement system. While the AMA does not accept this premise, even if such incentives existed, they were surely eliminated by the reductions in payment for these drugs under the MMA. Thus, we urge the Subcommittee to reiterate the request that CMS reconsider its current policy in light of the changes made in the MMA.

Drug expenditures are continuing to grow at a very rapid pace. Between 1996 and 2002, per enrollee spending on drugs grew 244% compared to 38% for physicians services. This is partly due to a net increase in the number of drugs included in the SGR, from 365 in 1998 to 435 in 2002. Further, there is no end in sight, with over 650 drugs and biologicals in development, as reported in a study conducted for MedPAC. As a result, including drugs in the SGR greatly increases the odds that Medicare spending on physicians' services will exceed the SGR target, triggering pay cuts that penalize physicians for providing important new drugs to their patients. Essentially, physicians are being asked to finance drug costs through cuts in their Medicare payments even though they do not have the ability to control the factors that are causing increases in drug utilization.

These life-saving and quality-enhancing drugs have been developed with support from government policies such as expanded funding for the National Institutes of Health and streamlining of the drug approval process. In fact, it is this Administration's goal to accelerate the pace of drug development as evidenced in a Department of Health and Human Services (HHS) action plan developed last year and a recent Interagency Agreement between the National Cancer Institute and the Food and Drug Administration. In announcing the agreement last May, NCI and FDA officials described it as "an important step toward NCI's goal to eliminate suffering and death due to cancer by 2015" and said the collaboration "holds great promise for getting better cancer drugs to patients sooner."

The AMA shares and applauds these goals, but we must also note that Medicare's current policy of counting drugs in the SGR threatens to undermine these goals. More than half of all cancers diagnosed in the United States today are found in those over 65. Yet CMS's policy of including drugs in the SGR creates the distinct possibility that physicians will exceed the SGR target and be penalized with pay cuts if Medicare beneficiaries use of covered drugs continues to grow.

The medical profession does not condone inappropriate use of these drugs. Indeed, the AMA, in concert with specialties responsible for 96% of physician-administered drugs, has previously committed to work with CMS to develop and disseminate educational programs and guidance in any instances where the agency has evidence of misuse or abuse. We continue to believe that this option is better for everyone concerned than the current policy.

2. Ensure that government-induced increases in spending on physicians' services are accurately reflected in the SGR target

As discussed above, the government encourages greater use of physician services through legislative actions, as well as a host of other regulatory decisions. These initiatives clearly are good for patients and, in theory, their impact on physician spending is recognized in the SGR target. In practice, however, many are either ignored or undercounted in the target. For example, the new prescription drug benefit enacted under the MMA will significantly expand expenditures for physician services because beneficiaries who previously could not afford to purchase drugs will visit physicians to get prescriptions. Moreover, these patients will have to be monitored by the physician for the impact of the drugs and may need to be seen for other conditions discovered at the time of the visit.

Further, the MMA contains a number of other provisions that will increase physician spending. The Medicare prescription drug discount card will become available for beneficiaries in the next several weeks (June 2004) and is now expected to achieve significant out-of-pocket cost savings on drug purchases. The RAND Health Insurance Experiment demonstrated that when patients' out-of-pocket costs are reduced, their utilization of services will increase. Thus, lower out-of-pocket drug costs are likely to lead seniors to fill more prescriptions and utilize more drugs. This would also mean that more seniors will visit physicians' offices more often. Of course, these physicians' office visits would increase total physician spending, and additional spending likely would occur due to the fact that increased visits may trigger an array of other medically necessary services, including laboratory tests, to monitor the impact of the drug usage and treat conditions that might have otherwise gone undetected and untreated. All of these costs should be included in the calculation of the SGR target.

Further, the MMA establishes new Medicare benefits for (i) an initial preventive physical exam by a physician, which also includes adult immunizations, an electrocardiogram, pelvic exam, pap smear and mammogram, prostate and colorectal cancer screening, glaucoma, diabetes outpatient self-management training, and cardiovascular disease screening and other preventive services, (ii) cardiovascular screening blood tests, and (iii) diabetes screening tests. While these benefits will increase physician spending, additional spending will occur since these new services are certain to trigger ongoing care for a chronic condition or surgery for an acute condition.

CMS has not provided details of how estimates are calculated regarding the impact on physician spending due to changes in laws and regulations, and certain questions remain: How does CMS estimate the effects of new preventive benefits? Do these estimates include the costs of the new screening services only, or do they also include the costs of diagnostic tests and treatment plans ordered as a result of the screening? Are impacts estimated for multiple years as more beneficiaries take advantage of the new benefits, or do they only include the first year when the benefits may be significantly underutilized?

CMS should provide answers to these important questions. In addition, CMS should ensure that *all* increases in spending resulting from the new MMA benefits, including both the spending due to use of the new benefit, as well as additional services triggered by implementation of the new benefit, are included in the SGR target. In other words, all direct *and* indirect increases in spending resulting from use of these or any other new or expanded benefit should be included in the SGR.

In summary, CMS should adequately reflect, in the SGR target, physician spending increases due to such initiatives as the following: (i) legislative mandates, e.g., new preventive screening benefits, Medicare drug discount cards and the new prescription drug benefit; (ii) CMS coverage expansions for new procedures and technology; (iii) government "good health" policies, such as efforts to reduce health care disparities, streamlining drug approvals, fighting diabetes, improving women's

health; and (iv) federal “quality initiatives,” which tend to increase the use of physician services to save money elsewhere in the system.

3. *Ensure that the SGR fully reflects the impact on physician spending due to national coverage decisions*

When establishing the SGR spending target for physicians’ services, the law requires that impact on spending, due to changes in laws and regulations, be taken into account. The AMA believes that any changes in national Medicare coverage policy that are adopted by CMS pursuant to a formal or informal rulemaking, such as a Program Memorandum or a national Medicare coverage policy decision, constitute a regulatory change as contemplated by the SGR law, and must also be taken into account for purposes of the spending target.

CMS’ authority to make any regulatory change is derived from law—whether it is a law specifically authorizing Medicare coverage of a new service or a law that provides the Secretary of HHS with general rulemaking authority. Thus, any new coverage initiative is a direct implementation, by regulation, of a law. This is exactly what the SGR requires be taken into account “increases in spending due to “changes in law and regulations.”

When the impact of regulatory changes for purposes of the SGR is not properly taken into account, physicians are forced to finance the cost of new benefits and other program changes. Not only is this precluded by the law, it is extremely inequitable and ultimately adversely impacts beneficiary access to important services.

HHS and CMS actively promote utilization of newly-covered Medicare services through press releases and other public announcements. For example, the Secretary of HHS released a 2002 report highlighting the importance of medical innovations and new technology, especially new drugs, in helping seniors live longer and healthier lives. Further, another HHS release regarding Medicare coverage of sacral nerve treatment for urinary incontinence stated, “[u]rinary incontinence affects approximately 13 million adults in the United States, with nearly half of nursing home residents having some degree of incontinence. It is twice as prevalent in women as it is in men, and costs more than \$15 billion per year, including both direct treatment of the disease and nursing home costs.” The Secretary made a similar announcement when Medicare expanded its coverage of lymphadema pumps, stating, “[i]t’s important to make effective technologies available to Medicare beneficiaries when it helps them the most. This coverage decision simplifies Medicare policy to allow older Americans who need these pumps to get them more quickly and easily.”

While the AMA strongly supports Medicare beneficiary access to these important services, physicians and other practitioners should not have to finance the costs resulting from the attendant increased utilization.

Accordingly, CMS should ensure that the impact on utilization and spending resulting from all national coverage decisions is taken into account for purposes of the SGR spending target.

4. *Rebasing of the Medicare Economic Index*

The Medicare Economic Index (MEI) is a measure of medical inflation, and is a factor used by CMS to update Medicare payments to physicians each year. The AMA appreciates and agrees with CMS’ recent initiative to revise weights in the Medicare Economic Index (MEI) to reflect more current data and changes in the cost of practicing medicine. This initiative, however, does not address the broader problem that the MEI only measures changes in the prices for specific physician practice inputs, but there has been no effort to look at the inputs themselves and ensure that the market basket for which price changes are being measured is still the appropriate market basket.

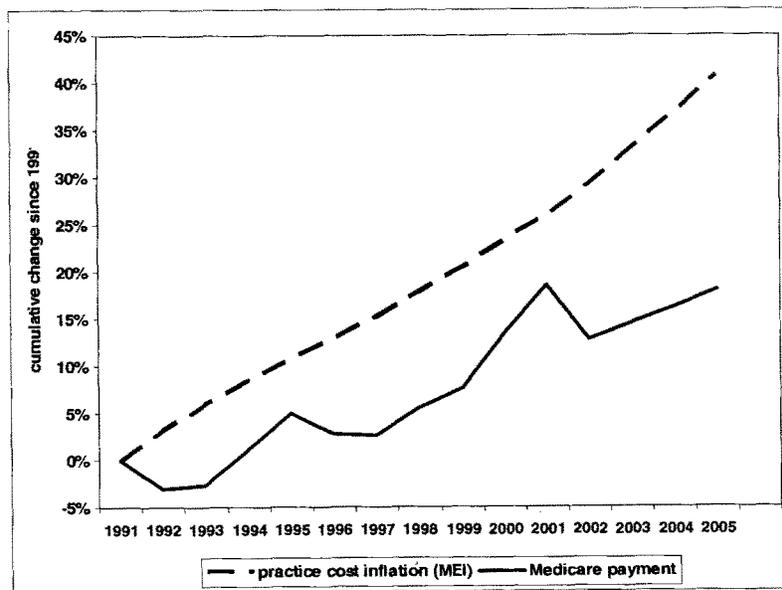
Inputs to the MEI may be vastly different now than when the MEI was first developed in the early 1970s, and thus additional inputs may be needed to ensure that the current MEI adequately measures the costs of practicing medicine. For example, physicians must comply with an array of government-imposed regulatory requirements, including those relating to fraud and abuse, billing errors, quality monitoring and improvement, patient safety, and interpreter services for patients with limited English proficiency. To ensure compliance with these initiatives, physicians have had to hire additional office staff to handle these additional responsibilities. Indeed, The Project Hope survey for the Medicare Payment Advisory Commission (MedPAC) in early 2002 found that “half of all physicians reported that their practice had hired additional billing and administrative staff in the past year, and more than 80% indicated that the practice had increased the training given to staff regarding billing and insurance matters.”

CMS should include in the MEI any additional inputs that are needed to ensure that the MEI adequately measures the costs of practicing medicine.

We appreciate the opportunity to provide our views, and look forward to working with the Subcommittee, Congress and the Administration to ensure an adequate and reliable Medicare physician payment system that keeps pace with the cost of practicing medicine.

Attachment A

Medicare Payments vs. Medical Practice Cost Inflation



From 1991 to 2005, medical practice cost inflation (MEI) will have increased by 41% whereas average Medicare physician payment rates will have increased by only 18%, or less than half the rate of inflation in practice costs.

Note: Assumes 1.5% update for 2005, and a 2.8% MEI (CMS estimate). Estimated Medicare pay changes from 1992-1996 are from Physician Payment Review Commission annual reports. Estimated pay changes for all other years are from AMA analyses of CMS final rules.

Attachment B

Changes in CMS Estimates of the SGR Targets

