

# **CBO TESTIMONY**

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**Statement of  
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Director**

## **Medicare's Payments to Physicians**

**before the  
Committee on Ways and Means  
Subcommittee on Health  
U.S. House of Representatives**

**February 28, 2002**

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WASHINGTON, D.C. 20515**



Chairwoman Johnson, Congressman Stark, and Members of the Committee, I am pleased to be here today to discuss Medicare payments to physicians. As you know, the fees that Medicare pays per physician service have fallen by 5.4 percent this year. What you might not know is that the Congressional Budget Office (CBO) projects that total Medicare payments to physicians will rise by 5.9 percent in fiscal year 2002. Although the average fee per service will continue to fall for the next several years, total Medicare payments to physicians will continue to increase.

The pattern of seemingly inexorable increases in Medicare spending for physicians' services spurred the creation of the sustainable growth rate (SGR) method to automatically link increases in Medicare physician spending per beneficiary to growth in the national economy. CBO estimates that the recent recommendation by the Medicare Payment Advisory Commission (MedPAC) would increase Medicare spending by \$126 billion over 10 years as a result of repealing the SGR system. Before discussing the reasons for that estimate, my testimony will review the relationship between Medicare payments to physicians, program spending, and the budget, as well as summarize the history of efforts to control Medicare spending for physicians' services.

## **PHYSICIAN FEES AND PHYSICIAN SPENDING**

Allow me to begin by reviewing the relationship between the fees Medicare pays to physicians, overall Medicare spending for physicians' services, total Medicare spending, and the economy. Fees are paid for each medical service. But the amount paid per service is only one of the components driving Medicare physician spending. One other factor is obvious: Medicare spending for physicians' services increases with the number of beneficiaries. In testimony before this Committee, I have highlighted the massive changes associated with the impending retirement of my generation. According to last year's report by the Medicare trustees, the number of Medicare beneficiaries will virtually double between 2000 and 2030. During the same period, the number of workers paying for Social Security and Medicare will increase by about 15 percent (see Figure 1).

## **IMPACT OF CHANGING DEMOGRAPHICS ON MEDICARE SPENDING**

The aging of the baby boomers has dramatic fiscal implications for Medicare (see Figure 2). If we spent the same *fraction* of gross domestic product (GDP) on each Medicare beneficiary in 2030 that we spend today—a proposition reflecting only the increased number of beneficiaries—Medicare spending would grow from today's 2.3

percent of GDP to 4.5 percent in 2030. The fiscal implications of the boomers' aging are compounded by the fact that health care costs measured per beneficiary routinely grow significantly faster than does the economy measured on a per capita basis. As a result, if current law remains unchanged, Medicare spending will climb to 5.4 percent of GDP by 2030.

Also projected to climb is spending for the “big three” programs for the elderly—Social Security, Medicare, and Medicaid—taken as a whole: between now and 2030, such spending as a share of GDP will virtually double. Transfers to the elderly will grow from 7.8 percent of GDP to 14.7 percent in 2030 (see Figure 3).

Let me underscore that that increase in spending of almost 7 percentage points of GDP will occur *under current law*. Proposals to increase payments to Medicare providers (such as MedPAC's recommendation to increase payments to physicians) or to expand Medicare benefits (such as proposals to create a Medicare prescription drug benefit) will exacerbate the long-term budgetary pressures projected for the next several decades. As this Committee knows, paying for those increased costs will require either dramatic reductions in spending, sizable tax increases, or large-scale borrowing.

## **MEDICARE SPENDING ON PHYSICIANS**

In addition to fees and growth in the number of beneficiaries, the number and type (or “intensity”) of the services provided by physicians determine total Medicare physician spending. Taken together, the number and type of physicians' services constitute their “volume.” Medicare physician spending measured per beneficiary equals fees times volume of services. Each year, Medicare sets fees for physicians' services using formulas in the Medicare Fee Schedule (MFS) and the SGR mechanism. However, because Medicare does not control the volume of services that physicians provide, its physician spending per beneficiary can grow even if fees are reduced.

Medicare spending for physicians' services grew faster than Medicare spending for all other services throughout the 1980s; in the 1990s, that trend reversed. From 1981 through 1990, spending for physicians' services grew at an annual rate of 13.7 percent; spending for all other services grew at a rate of 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, Medicare 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. In the 1990s, growth in the volume of physicians' services moderated. To the extent that there have been surges in that growth, the system has lowered the update—the annual adjustment to physicians' fees—to offset the higher spending.

## **A BRIEF HISTORY OF MEDICARE'S EFFORTS TO CONTROL PAYMENTS TO PHYSICIANS**

The chronology of payments to physicians under Medicare can be divided into three periods. The first, shortly after the program began in 1965, was characterized by a rapid rise in spending as physicians increased both their charges and the volume of services that they provided. Even when the Congress limited the growth of fees for physicians' services by pegging the annual fee update to the Medicare economic index, or MEI, spending continued to climb rapidly.<sup>1</sup> That experience led to the second period of physician payments, when the Congress froze fees and 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, and the Congress realized that limitations on the growth of fees alone—without regard to the volume of services that physicians provided—was not enough to control spending. That realization led to what is now the third period in Medicare's payments to physicians (beginning in 1992), a span distinguished by restraints on the uncontrolled growth in expenditures for physicians' services that Medicare experienced in the past.

### **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 increase their charges from year to year to boost their revenues, and those increases led to the spiraling expenditures of the first period of Medicare physician payments.

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1. The 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. The components of the index come from the Bureau of Labor Statistics. Changes in physicians' time are measured through changes in nonfarm labor costs. Labor productivity is also factored into the index.

As concerns grew about the program's rising costs, policymakers focused on restraining those fees. In 1972, the Congress 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 the Congress took further steps to limit spending through legislation enacted from 1984 through 1991, during the second period of physician payments. The Congress froze fees from 1984 through 1986; from 1987 through 1991, it updated them by amounts specified in legislation.

### **Limiting Beneficiary Liability**

Balance billing was another issue that prompted Congressional action during the 1980s. On average, liability for balance billing per beneficiary grew from \$56 in 1980 to a high of \$94 in 1986.<sup>2</sup> Subsequently, the Congress responded by imposing limits on such billing, which prevented physicians from raising their charges; beneficiaries thus in effect made up for the constraints on Medicare physician fees. Balance billing is currently restricted to 109.25 percent of Medicare's fees for participating physicians.<sup>3</sup>

The program's limits on balance billing protect beneficiaries' liability for physicians' charges. However, those limits reduce the potential usefulness of balance billing either as a safety valve or signal that Medicare's fees are below the level necessary to attract a sufficient number of doctors to serve Medicare enrollees.

### **Redistributing Income Among Physicians' Services**

Policymakers also took steps to redistribute payments among physicians. In the 1980s, many analysts believed that Medicare's reimbursement for physicians' services was distorted by factors that tended to overcompensate so-called procedural services at the expense of what were termed cognitive services. Before the MFS was adopted, fees varied widely, with physicians in different specialties and in different geographic regions receiving different payments for comparable services.

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2. Physician Payment Review Commission, *Annual Report to Congress* (March 1988).

3. Under Medicare's rules, the program pays 80 percent of the fee schedule, and beneficiaries or their supplemental insurer pays 20 percent. Balance billing occurs when beneficiaries pay more than 20 percent of the fee. A physician elects either to "participate" (that is, take Medicare fees as payment in full for all services) or to receive Medicare payments as a "nonparticipating" physician allowed to balance-bill patients up to the statutory limit. Fees for nonparticipating physicians are set at 95 percent of the fees for participating physicians. Nonparticipating physicians are permitted to bill up to 115 percent of their fees.

The response to those concerns was the implementation in 1992 of the Medicare Fee Schedule, which based payments for individual services on measures of the relative resources used to provide them. There are two parts of the formula for fees. One part is a set of weights 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 office visit with an established patient.) The other part is a fixed dollar amount, called 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 factor was set so that estimated expenditures under the MFS equaled estimates of what expenditures would have been under the earlier payment system. One thing the MFS was not designed to do, however, was control costs.

### **Controlling Volume**

In an attempt to control total spending for physicians' services driven by volume, the Congress also enacted a mechanism that tied the annual update to fees under the MFS 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 a 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), the approach provided a mechanism for adjusting fees to try to keep total physician spending on target.

The method for applying the VPS was fairly straightforward, but it led to updates that were unstable. Under the VPS 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 system 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. The Congress attempted to offset the budgetary effects of those increases by making successively larger cuts in fees, which further destabilized the update mechanism. 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 4).

That volatility led the Congress to modify the VPS in the Balanced Budget Act of 1997 (BBA), replacing it with the sustainable growth rate mechanism, the method 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 per person. The update under this approach is equal to the MEI adjusted by a factor that reflects cumulative spending relative to the target (the VPS did not use cumulative spending).

Policymakers saw the SGR approach as having the advantages of objectivity and stability in comparison with the VPS. From a budgetary standpoint, the SGR method, like the VPS, is effective in limiting total payments to physicians over time. GDP growth provides an objective benchmark; moreover, changes in GDP from year to year have been considerably more stable (and generally smaller) than changes in the volume of physicians' services.

### **PROBLEMS WITH THE CURRENT APPROACH**

A key argument for switching from the VPS approach to the SGR mechanism was that over time, the VPS would produce inherently volatile updates. But updates under the SGR method have proven to be volatile as well. Until 2002, that volatility has tended to be to the benefit of physicians. Overall, the update in the first three years during which the SGR method was in place was almost twice as high as the MEI over the same period. It is the reduction for 2002 that has raised concerns among physicians.

In 2002, for the first time since the MFS method was implemented in 1992, physicians' fees have been reduced, drawing objections from physicians and raising concerns about assertions that beneficiaries' access to physicians' services will be impaired. Several factors contributed to the fee reductions:

- As of November 2001, the cumulative spending target (that is, the allowed spending from April 1996 through December 2001) that was used to set the physician fee update for 2002 was \$302.7 billion. That target was \$1.5 billion lower than the amount expected a year earlier. The reduction was driven

largely by slower growth of GDP than had been estimated previously; also contributing, however, were revisions in some of the other factors that determine the spending targets.<sup>4,5</sup>

- In addition, cumulative spending for physicians' services far exceeded the spending target. The estimate of actual spending through 2001 that was made in November of that year and used to set the update for 2002 was \$311.6 billion—or \$8.9 billion (2.9 percent) above the corresponding target.
- A large part of that discrepancy, however, resulted from the omission previously of a portion of actual expenditures related to certain service codes, which by mistake were not counted (including, for example, chiropractic services). In March 2001, the Centers for Medicare and Medicaid Services (CMS) estimated that actual cumulative expenditures through 2001 would be \$303.9 billion—or \$7.7 billion less than the November 2001 estimate. Although part of that difference is attributable to the availability of more recent data on physician spending than those used for the initial estimate, the size of the discrepancy indicates that the effect of the previously omitted services was substantial.

Therefore, much of the reason for the large decline in Medicare physician fees this year may be related to a counting error. That error was a major factor in the large positive updates in fees for 2000 and 2001, which otherwise would not have occurred. The effects of that oversight should not be confused with basic problems associated with the update mechanism.

The BBA limited the maximum annual offset to the MEI to -7 percentage points, so the update for 2002 was -5.4 percent. Because actual spending exceeded the expenditure target by more than 7 percentage points for 2002, a portion of the past excess will lower the update for 2003. Currently, CMS projects negative updates through 2005 (see Figure 4).

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4. Centers for Medicare and Medicaid Services, "Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002; Final Rule," *Federal Register*, vol. 66, no. 212 (November 1, 2001), pp. 55312-55321.

5. Centers for Medicare and Medicaid Services, Office of the Actuary, "Estimated Sustainable Growth Rate and Final Conversion Factor for Medicare Payments to Physicians in 2002" (February 4, 2002), available at [www.hcfa.gov/pubforms/actuary/sgr/sgr2002f.pdf](http://www.hcfa.gov/pubforms/actuary/sgr/sgr2002f.pdf), compared with previous versions dated March 19, 2001, and November 21, 2000.

Because of changes to the relative payment amounts, or weights, for individual services for 2002, the -5.4 percent reduction in the conversion factor does not change all fees by the same amount. Indeed, payments for some services will increase in 2002, and payments for others will drop by more than 5.4 percent below last year's. Those varying effects occur because 2002 is the final transition year in the reform of the "practice expense" portion of the fee schedule, which redistributed income among physician specialties. Starting in 2003, little redistribution of physician payments is anticipated.

There are four general courses of action the Congress can take to address these issues. One possibility is to eliminate spending targets and determine the updates to fees without linking them to overall spending for physicians' services—that plan represents MedPAC's proposed approach. A second is to modify the SGR to reduce volatility. A third option is to legislate temporary relief from the reductions in fees generated by the current system. A fourth option is to make no changes to the current mechanism.

### **MEDPAC'S PROPOSAL**

In March 2001 and again this year, MedPAC recommended that the Congress discontinue using the SGR method for computing the update and replace it with a framework similar to that used for updating the fees of other types of providers. CBO estimates that implementing the MedPAC proposal would cost \$126 billion over 10 years. That estimate is virtually the same as the estimate of the CMS actuary.

Not only would the MedPAC recommendation lock in place the overstated payments and fees set in earlier years, but it would also increase annually the fees paid to physicians. For 2003 through 2005, the MedPAC recommendation would substitute positive updates for the reductions expected under current law. Total spending for physicians' services in the subsequent year would also be above the spending that would occur under current law.

The new framework that MedPAC is proposing would end the use of expenditure targets, opening the door to large spending increases driven by volume. MedPAC's proposal would base the update on the forecast for the MEI and on changes in productivity—without any limits on volume or total spending.

## **WHY PHYSICIANS ARE DIFFERENT FROM MEDICARE'S OTHER SERVICE PROVIDERS**

Physicians are unique among Medicare providers in being subject to an overall spending adjustment. By contrast, Medicare pays for most other services now through prospective payment systems that set a price for a bundle of services. Under those systems, the provider is free to make decisions about the volume of services provided to the patient, but the payment for the bundle is fixed.

Physicians are unique as well in their ability to determine the volume of services they can provide. They are the gatekeepers and managers of the health care system; they direct and influence the type and amount of care their patients receive. (Physicians, for example, can order laboratory tests, radiological procedures, and surgery.)

Moreover, the units of service for which physicians are paid under the MFS are frequently very small. The physician may therefore receive one payment for an office visit and a separate payment for individual services such as administering and interpreting x-rays—all of which can be provided in a single visit. That contrasts with the policy for hospitals, which receive payment for each discharge and no extra payment for additional services or days (except in extremely costly cases).

Further, once a physician's practice is established, the marginal costs of providing more services are primarily those associated with the physician's time. The current method of physician payment takes that unique role into account by explicitly linking the update in fees to the level of spending, which—as I said before—is determined by both fees and volume.

## **CONCLUSION**

In considering whether to change the current system for setting Medicare physician payments, the Congress confronts the prospect of reductions in the fees paid per service for the next several years. MedPAC's recommendation would increase the federal government's spending for physicians' services under Medicare by \$126 billion over the next 10 years. 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 growth in the economy.

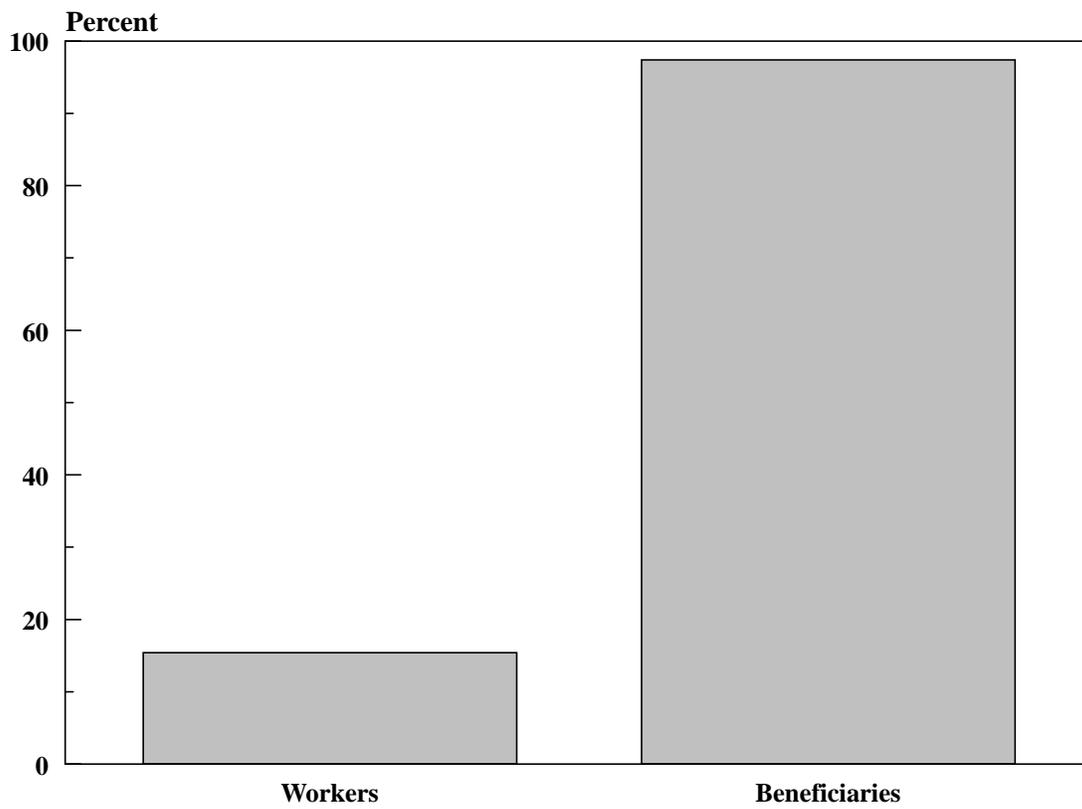
Maintaining access to care for Medicare beneficiaries is a key consideration in assessing Medicare's fee structure. MedPAC reports that the most recent systematic

data currently available about access to care are from 1999. In evaluating that information, MedPAC reports that it found no evidence of problems in beneficiaries' and physicians' views about access. However, the lack of timely data makes it hard to know whether and to what extent problems exist in access to care. More timely 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 payments to physicians will increase federal spending. Incorporating higher fees for physicians' services into Medicare spending as currently projected would add to the already substantial long-range costs of the program and to the fiscal challenge to the nation posed by the aging of the baby boomers. Raising fees would also increase the premium that beneficiaries must pay for Part B of Medicare (the Supplementary Medical Insurance program). Inevitably, over the long run, higher spending by Medicare for physicians' services will require reduced spending elsewhere in the budget, higher taxes, or larger deficits.

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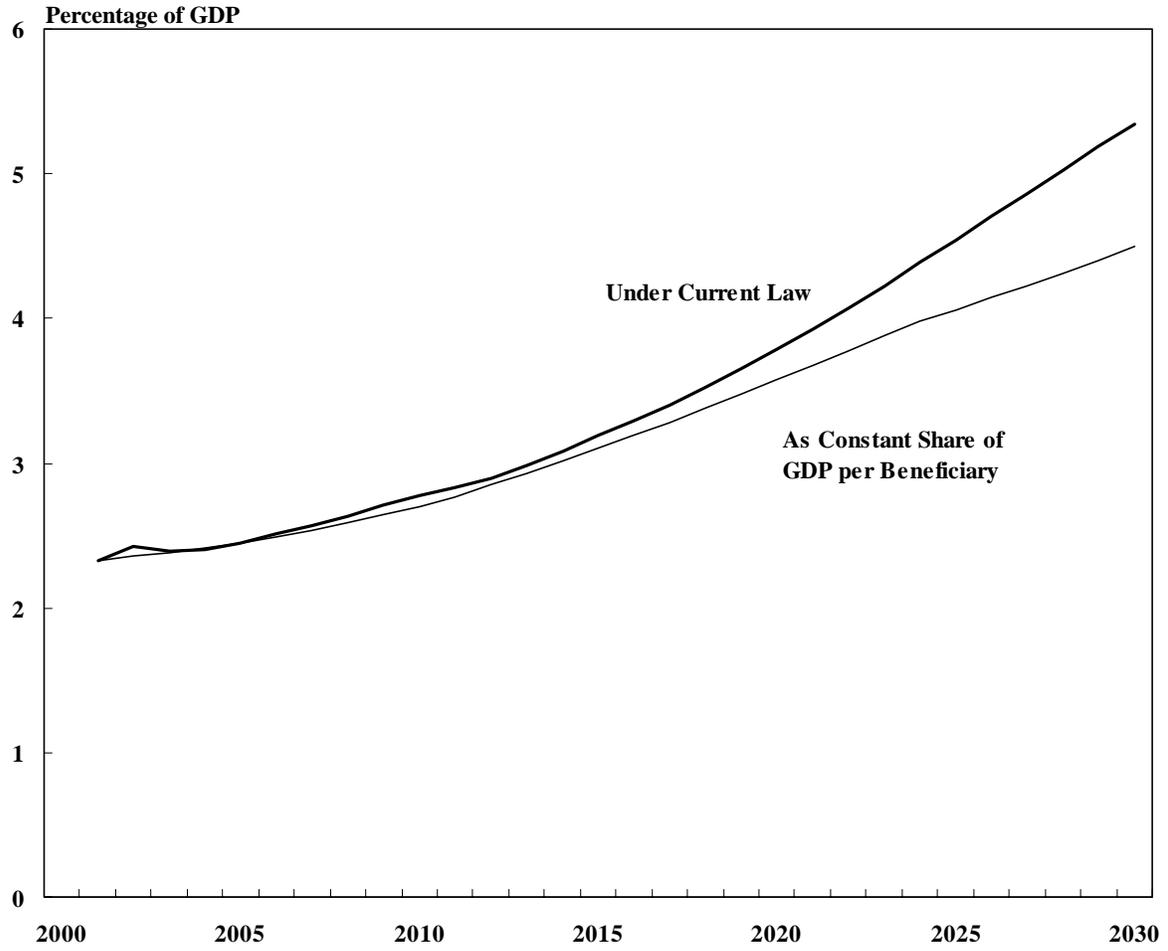
FIGURE 1. PERCENTAGE INCREASE IN BENEFICIARIES AND WORKERS, 2000-2030



SOURCE: 2001 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund.

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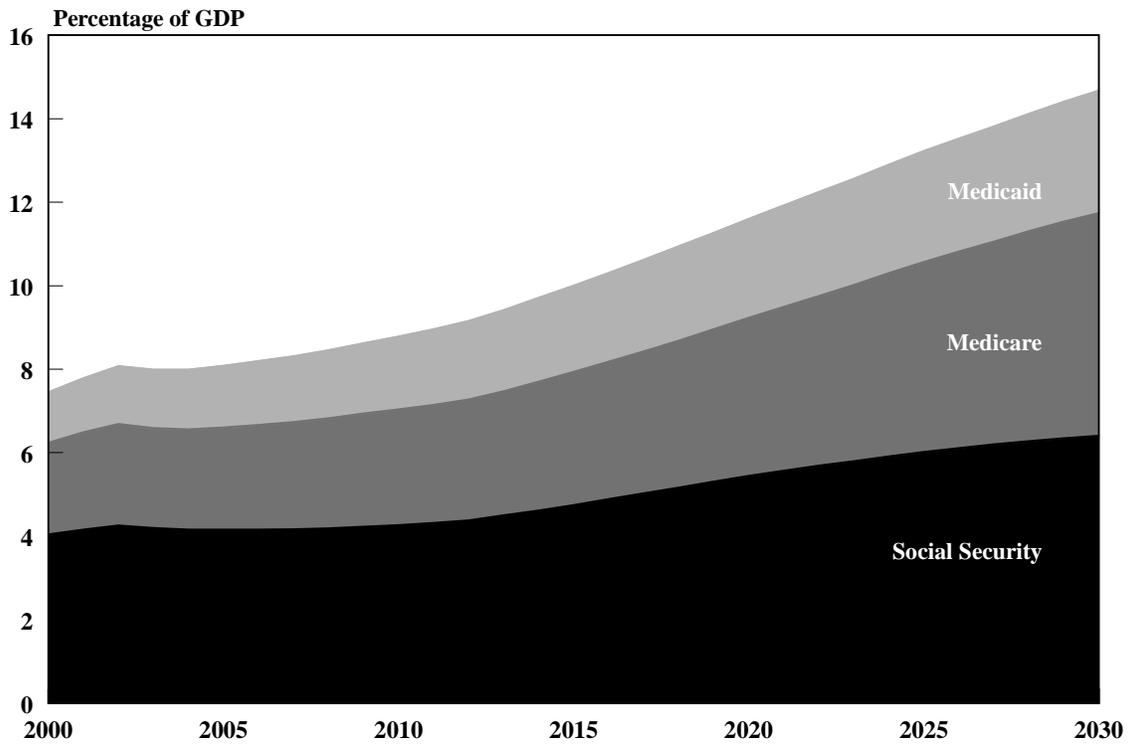
FIGURE 2. PROJECTED MEDICARE SPENDING UNDER ALTERNATIVE ASSUMPTIONS, 2001-2030



SOURCE: Congressional Budget Office.

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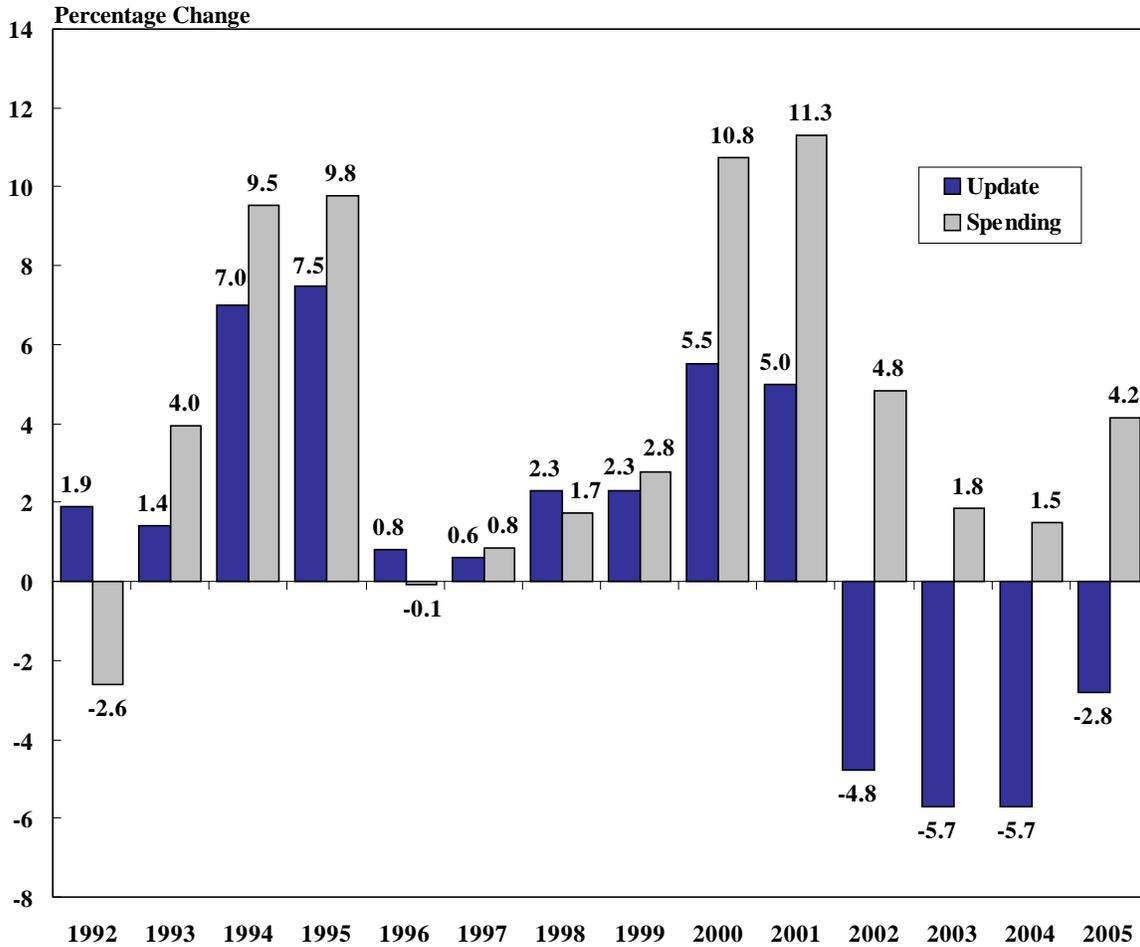
FIGURE 3. SPENDING FOR SOCIAL SECURITY, MEDICARE, AND MEDICAID, 2000-2030



SOURCE: Congressional Budget Office based on its midrange assumptions about growth in gross domestic product and program spending. For further details, see Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2003-2012* (January 2002), Ch. 6.

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FIGURE 4. COMPARISON OF ANNUAL PHYSICIAN UPDATES AND CHANGE IN MEDICARE PHYSICIAN SPENDING, 1992-2005



SOURCES: Centers for Medicare and Medicaid Services for updates and historical spending and Congressional Budget Office for projection of spending from 2001 through 2005.

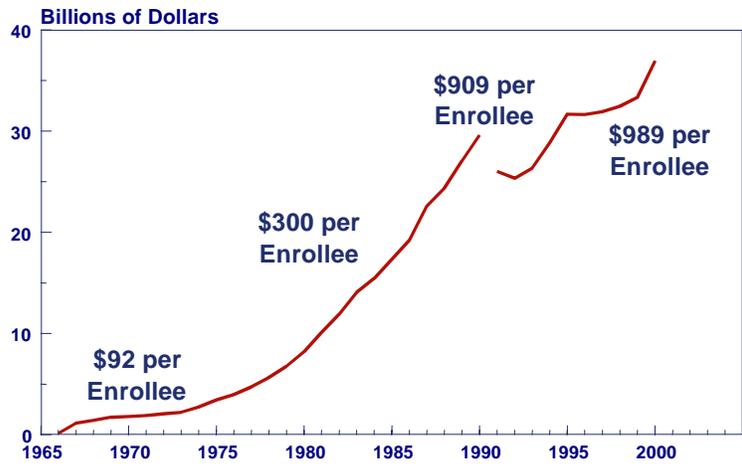
NOTE: The actual increase in the conversion factor, which is a fixed dollar amount that is multiplied by relative weights to calculate Medicare physician fees, is also affected by a budget-neutrality adjustment.

## **Charts Presented at the Hearing**





### Medicare Spending for Physicians' Services, 1966 to 2000

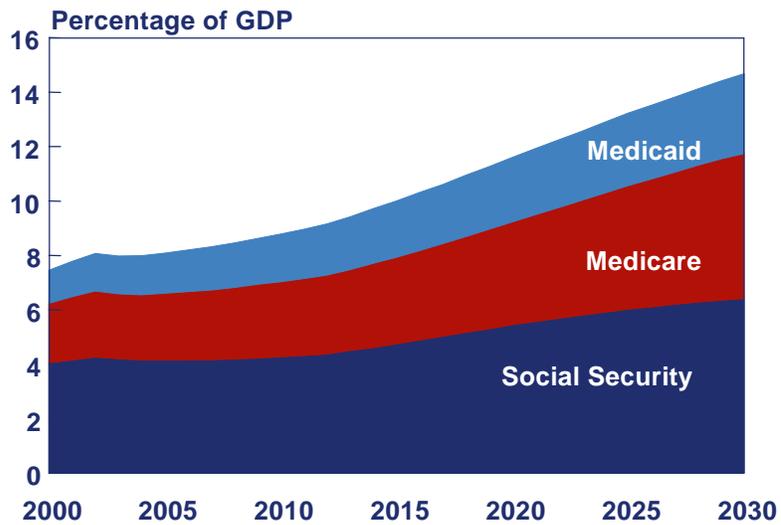


NOTE: Spending in 1991 and later years excludes spending for some services previously included in the measure.

W&M/SubComHealth (2-28-02)



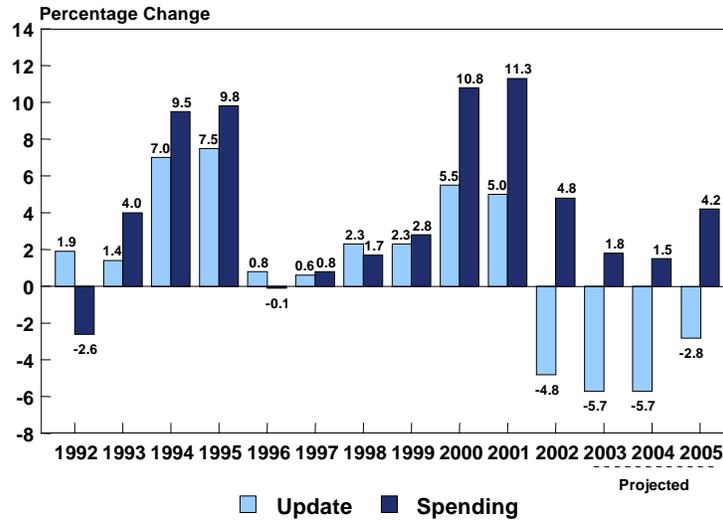
### Spending for Social Security, Medicare, and Medicaid, 2000-2030



W&M/SubComHealth (2-28-02)



## Comparison of Annual Physician Updates and Changes in Medicare Physician Spending, 1992-2005



W&M/SubComHealth (2-28-02)



