

# The Sustainable Growth Rate Formula for Setting Medicare's Physician Payment Rates

## Summary

The Supplemental Medical Insurance program (Part B of Medicare), which will cost about \$158 billion in 2006, pays for physicians' services, outpatient hospital services, durable medical equipment, physical therapy, and certain other outpatient services. About 38 percent of those expenditures are payments for services provided by physicians, which are based on a schedule of fees that specifies the amount to be paid for each type of service. Most of Medicare's payment rates are simply adjusted each year for inflation—but not those for physicians' services. Those rates are governed by a complex formula—the Sustainable Growth Rate (SGR) mechanism—that, unless overridden by legislation, will reduce fees by about 4 percent or 5 percent annually for at least the next several years.

Legislation has overridden the formula's results in each of the past four years, and the prospect of future, year-after-year rate reductions raises the question of whether the SGR formula is a viable mechanism—and if not, what alternatives might be appropriate. This brief describes the SGR mechanism and presents the potential budgetary effects of several other approaches. Many of the possible alternatives would be costly. For example, overriding the formula with a 1 percent rate increase in 2007 would raise outlays by \$6 billion over the next 10 years. Replacing the formula with an inflation index would cost more than \$200 billion over the coming decade.

Since the Medicare program was created in 1965, several methods have been used to determine how much it pays physicians for each covered service. Initially, the program compensated physicians on the basis of their charges and allowed them to bill beneficiaries for the full amount above what Medicare paid for each service. In 1975, Medicare payments were still linked to what physicians charged, but the annual increase in fees could not exceed the increase in the Medicare economic index, or MEI.<sup>1</sup> Because those changes were not enough to prevent total payments from rising more than policymakers desired, from 1984 through 1991 the yearly change in fees was determined by legislation.

Starting in 1992, the payment system based on physicians' charges was replaced by a fee schedule. That schedule bases payment for individual services on measures of the relative resources used to provide them. The schedule was not intended to control spending—it was designed to redistribute spending among various physician specialties. The fee schedule was updated annually by a combination

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1. The Medicare economic index measures changes in the cost 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 cost of physicians' time are measured using changes in nonfarm labor costs. Changes in "all-factor" productivity are also incorporated into the index as a way of accounting for improvements in physicians' productivity. The productivity adjustment to the MEI reduces its rate of growth.

of the MEI and an adjustment factor that was designed to counteract increases in the volume of services being delivered per beneficiary. That factor, known as the volume performance standard (VPS), was based on historical trends in volume. However, the VPS mechanism led to highly variable changes in payment rates, and the Congress replaced it with a new mechanism—the Sustainable Growth Rate (SGR)—starting in 1998.<sup>2</sup>

### Experience Under the SGR Mechanism

The SGR mechanism aims to control spending for physicians' services provided under Part B of Medicare. It does so by setting an overall target amount of spending (measured on both an annual and a cumulative basis) for certain types of goods and services provided under Part B; included are payments for physicians' services as well as payments that Medicare makes for items—such as laboratory tests, imaging services, and physician-administered drugs—that are furnished “incident to” (in connection with) physicians' services. Payment rates are adjusted annually to reflect differences between actual spending and the spending target—upward if spending is below the target, downward if spending is above the target.

Policymakers had two main goals when they adopted the SGR mechanism: ensuring adequate access to physicians' services and controlling federal spending for those services in a more predictable way than the VPS mechanism did. The SGR mechanism has a mixed record with regard to those goals.

More than 90 percent of physician and nonphysician providers agree to participate in Part B, and surveys generally show that beneficiaries do not experience significant difficulties in getting access to care. However, that situation may change if payment rates are significantly reduced, as will occur over the next several years if the SGR mechanism operates as currently specified in law.

From 1997 (when the SGR method was first used to measure expenditures) through 2005, spending per beneficiary on services paid for under the physician fee schedule grew by 65 percent, or about 6.5 percent per year. In contrast, per-beneficiary spending in the rest of Medicare (excluding Medicare Advantage, the program's managed

care option) grew by about 35 percent over the same period.

Aside from growth in Part B enrollment, which has averaged about 1 percent annually since 1997, the growth of spending subject to the fee schedule can be attributed mainly to increases in the fees themselves and in the volume and intensity of services being provided by physicians.<sup>3</sup> Since 1997, the fees that Medicare pays for each service have risen annually by an average of about 2 percent. Although some of the remaining growth has resulted from the addition of covered services, most of the rest is attributable to increases in the volume and intensity of services, which have averaged about 4.5 percent per year over the 1997–2005 period.

Since 2002, spending as measured by the SGR method has consistently been above the targets established by the formula. In 2005, expenditures counted under the method totaled \$94.5 billion, about \$14 billion more than the \$80.4 billion expenditure target for that year. At the end of 2005, total spending since the SGR mechanism was put into place stood at about \$30 billion above the SGR's cumulative target.<sup>4</sup> As a result, the SGR mechanism, under current law, will substantially reduce payment rates for physicians' services over the next several years. Payment rates could decline by a total of 25 percent to 35 percent during that period if physicians continued to provide services at the current rate.

### Projected Spending for Physicians' Services

Because of the impending reductions in payment rates required under current law, Medicare spending for services provided by physicians is projected to grow relatively slowly for the next several years. The Congressional Budget Office (CBO) estimates that the decline in payment rates will be slightly more than offset by increases in enrollment and by growth in the volume and intensity of services being delivered. As a result, CBO projects, Medicare spending for physicians' services will grow in coming

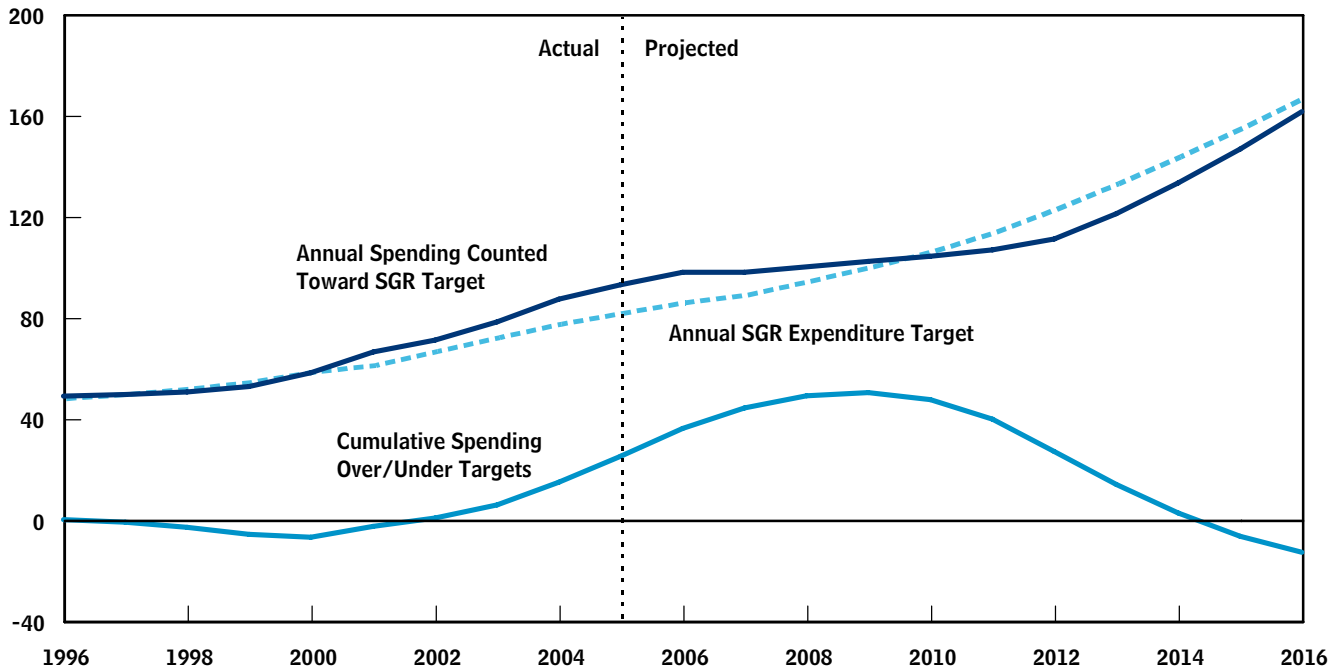
2. For a more detailed discussion of the history of payment rates, see the statement of Douglas Holtz-Eakin, Director, Congressional Budget Office, *Medicare's Physician Fee Schedule*, before the Subcommittee on Health of the House Committee on Energy and Commerce, May 5, 2004.

3. “Intensity” refers to the complexity of services utilized in delivering patient care. For example, use of a computerized axial tomography (CAT) scan rather than an x-ray represents an increase in intensity.

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

**Figure 1.****Sustainable Growth Rate Spending Compared with Expenditure Targets**

(Billions of dollars)



Source: Congressional Budget Office.

Note: SGR = sustainable growth rate.

years, but in 2012 it will be only 13 percent higher than it was in 2005, reflecting an average annual growth rate of less than 2 percent. In contrast, from 1997 through 2005, such spending grew by an average of about 7.7 percent annually.

Considerable evidence suggests that a reduction in payment rates leads physicians to increase the volume and intensity of the services they perform. Although their participation rates are currently very high, CBO also expects that some physicians will probably respond to continuing reductions in payment rates by declining to participate in the Medicare program.<sup>5</sup> Such responses to changes in payment rates do not explicitly affect CBO's projections

of spending for physicians' services over the long term because the SGR mechanism will adjust rates to offset changes in the volume of physicians' services furnished to Medicare patients. As a result, the reductions in payment rates could be larger or smaller than the estimated 25 percent to 35 percent if physicians collectively responded to continuing reductions in rates by substantially increasing or decreasing the volume and intensity of the services they furnish to Medicare beneficiaries.

From 1997 through 2001, cumulative spending governed by the SGR mechanism was slightly below the expenditure target set by the formula (see Figure 1). Starting in 2002, cumulative spending rose above the cumulative target. According to CBO's projections through 2016, if the current SGR mechanism is permitted to operate, the amount of spending above the cumulative target will continue to grow for several more years but will then shrink, as the annual growth in spending is slowed by the reductions in payment rates produced by the SGR mechanism. Toward the end of the period, CBO's projections show cumulative spending coming back in line with the cumu-

5. It is uncertain at what point such responses to declining payment rates would have a significant, negative effect on Medicare patients' access to physicians' services. Several organizations, including the Government Accountability Office, the Medicare Payment Advisory Commission, and the Center for Studying Health System Change, are monitoring changes in physicians' willingness to participate in Medicare and to accept new Medicare patients.

lative target.<sup>6</sup> The SGR mechanism is designed in such a way that if cumulative spending is viewed over a long enough period, it will equal the cumulative target.

## How the SGR Mechanism Works

The SGR mechanism consists of three components, each of which is based on a statutory formula:

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

### The Expenditure Targets

The SGR mechanism establishes both year-by-year and cumulative spending targets (the law refers to the target spending levels as "allowed expenditures"). Included in the targets is spending for services covered by the physician fee schedule and services provided "incident to" a visit to a physician. (That amount includes both spending by the Medicare program and cost-sharing obligations of beneficiaries.) The fee schedule determines how much physicians get paid for each of the services they provide. Services listed on the schedule accounted for about 85 percent of all spending counted toward the SGR target in 2005. Payment rates for the "incident-to" goods and services, which include laboratory tests and physician-administered drugs (such as chemotherapeutic formulations), are not determined by the physician fee schedule.<sup>7</sup>

The SGR method uses spending that occurred between April 1, 1996, and March 31, 1997, as the base for all future spending counted toward the targets. During that

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6. CBO projects that cumulative spending will fall slightly below the cumulative target in 2015 and remain below it for a short time. That projected path results from the gradual nature of the adjustments to bring spending in line with the SGR's expenditure targets.
  7. Payments for some services, such as laboratory tests, are based on their own fee schedules, which are usually updated annually for inflation. Payments for physician-administered drugs are based on market prices.

base period, the amount of spending counted under the method totaled \$48.9 billion. Each year, the spending target is updated from the base level to reflect the growth rate determined by the SGR formula. That formula produced a sustainable growth rate of 3.2 percent for 1998. Consequently, the expenditure target for that year was \$50.5 billion (\$48.9 billion multiplied by 1.032).

To produce a cumulative target, the annual targets are added together (along with the original base amount). The cumulative target in 1998 was \$99.4 billion (\$48.9 billion plus \$50.5 billion); according to the Centers for Medicare and Medicaid Services (CMS), the cumulative target in 2005 had reached \$611.8 billion.

### The Growth Rate

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

- First, it includes an adjustment for inflation that takes into account changes in the prices of goods and services used by physicians' practices and in the prices that Medicare pays for "incident-to" services. The change in the prices of goods and services used by physicians' practices is measured by the Medicare economic index, which incorporates an adjustment for changes in productivity, as measured by the change in "all-factor" productivity in the economy as a whole. (When productivity rises, that adjustment reduces the MEI below where it would have been if it had been based on price increases alone.) The MEI will be 2.6 percent for 2007, according to CMS's preliminary estimate.<sup>8</sup>

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8. CMS usually sets the payment rates for each year in November of the preceding year. It issues preliminary estimates of the updates during the course of the year.

The percentages shown above for the four factors used to determine the SGR for 2007 are such preliminary estimates, as contained in a letter sent by CMS to the Medicare Payment Advisory Commission on April 7, 2006. On August 8, 2006, CMS announced that it was reducing its estimate of the increase in the MEI for 2007 by 0.5 percent, but it did not address the other factors used in the SGR formula. The agency also announced that as a result of the change to the MEI, its estimate of the 2007 payment update had changed from -4.6 percent to -5.1 percent.

- Second, the rate incorporates changes in enrollment in Medicare's fee-for-service program, which, CMS estimates, will be a decline of 2.9 percent for 2007.
- Third, the SGR incorporates the estimated 10-year average annual growth rate of real (inflation-adjusted) gross domestic product (GDP) per capita—2.2 percent, in CMS's estimation.
- Fourth, the growth rate takes into account the impact of changes in law or regulation that would affect spending for services subject to the SGR mechanism (such as adding coverage for new benefits), which CMS estimates will be -1.0 percent.<sup>9</sup>

Those four factors are multiplied to yield an overall rate of growth that CMS estimates will be 0.7 percent in 2007:

Change in physicians' prices (1.026) x change in enrollment (0.971) x change in real GDP per capita (1.022) x changes in law or regulation (0.990) = 1.007

In 2006, the expenditure target for services covered by the physician fee schedule is \$81.7 billion. Increasing the 2006 target by 0.7 percent results in an expenditure target of \$82.3 billion for 2007.

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

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

Once a determination of the SGR has been made for a given calendar year, it is not necessarily fixed. If actual experience for one or more of the four growth factors differs from the estimates in the original calculation, the SGR for that year can be changed. In other words, if the SGR

for 2007 is set under the assumption that fee-for-service enrollment will decrease by 2.9 percent and in actuality it changes by a different amount, the SGR for that year will subsequently be adjusted. In that case, the rates paid in 2007 would not change, but the cumulative target for subsequent years would be adjusted. The SGR—and therefore the expenditure targets—for a particular year can be retroactively adjusted for up to two years.

### Annual Adjustments to Payment Rates

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

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

If actual spending is more than the targets, the update adjustment factor will be negative (that is, it will reduce the amount of the increase that would otherwise occur to reflect inflation); if actual spending is less than the targets, the update adjustment factor will be positive. The law sets an upper and lower limit on the update adjustment factor—it cannot exceed an increase of 3 percent or a reduction of 7 percent. For 2006, CMS determined that cumulative spending was about \$30 billion above the expenditure target and that the update adjustment factor determined by the formula would have been -21 percent; thus, the statutory limit of -7 percent was used. Consequently, in 2006, payment rates for physicians were scheduled to decrease by 4.4 percent; the inflation adjustment of 2.8 percent was more than offset by the update adjustment factor of -7 percent.<sup>10</sup> However, the Deficit

9. The reduction in the SGR for 2007 arising from changes in law or regulation is mainly attributable to provisions enacted in the Deficit Reduction Act (Public Law 109-362)—most notably, reductions in payment rates for imaging services.

10.  $(1 + 0.028) \times (1 - 0.07) = 0.956$ .

Reduction Act (P.L. 109-362) overrode the formula for 2006 and held payment rates at their 2005 level.

Looking forward, CBO estimates that spending for physicians' services will continue to exceed the cumulative target for the next several years. Unless it is modified again, the SGR method will reduce payment rates beginning in 2007 and keep updates below inflation through at least 2012. (As mentioned earlier, CMS has estimated that the reduction in 2007 will be 5.1 percent.)

It is important to note that under the SGR mechanism, the adjustment factor applies only to the physician fee schedule and not to payment rates for "incident-to" services, which make up about 15 percent of the spending counted toward the SGR targets. Consequently, the SGR mechanism will adjust payment rates for physicians' services in future years to offset any difference between the rate of growth of spending for "incident-to" services and the rate of growth of the expenditure targets. If spending for the "incident-to" services grows faster than the SGR targets, payment rates for physicians' services will be reduced to compensate for that increase. Before 2004, when changes were made in the way physician-administered drugs were paid for, such "incident-to" spending experienced several years of double-digit growth. The share of SGR-related spending accounted for by physician-administered drugs increased from about 7 percent in 2001 to 9 percent in 2005.

## Recent Legislation Affecting the SGR Mechanism

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

Spending continued to exceed the target in 2004, and if the SGR mechanism had been allowed to operate, the formula would have reduced payment rates in that year. The Congress and the President acted to prevent such a reduction. As part of the Medicare Modernization Act (P.L. 108-173), they replaced the scheduled rate reduction with increases of 1.5 percent in both 2004 and 2005.

The Deficit Reduction Act held 2006 payment rates at their 2005 level, overriding an impending reduction of 4.4 percent.

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

## Budgetary Implications of Changing the SGR Mechanism

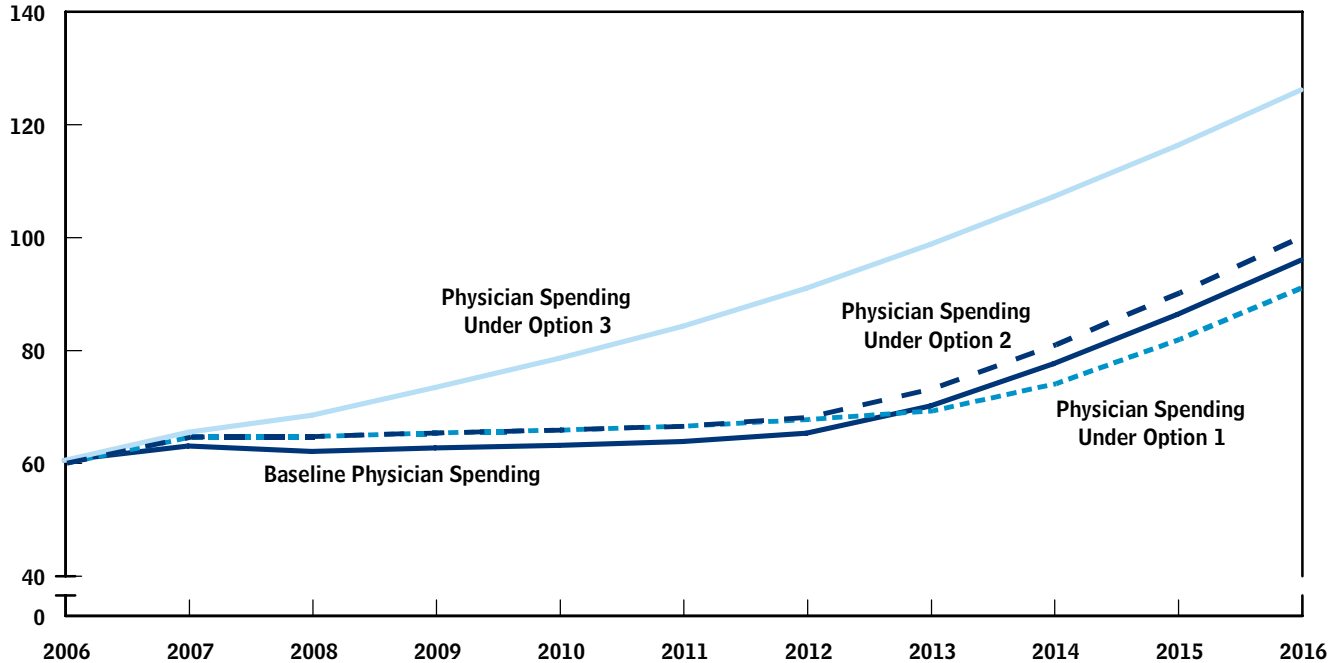
The Congress has a wide range of options for changing or replacing the SGR mechanism. In any such decision, an important question is whether payment rates in the future should be reduced to recoup the spending exceeding the SGR targets that has already occurred, along with any future spending above the targeted amounts. This brief presents estimates for three illustrative examples, including one that would eliminate the SGR mechanism and replace its targets with annual updates based on inflation (see Figure 2).<sup>11</sup> Each policy option would increase payments for physicians' services compared with the payments that would be made under current law, thereby also increasing the Part B premiums that beneficiaries pay

11. For a broader range of alternatives to the SGR mechanism than those presented here, see the statement of Donald B. Marron, Acting Director, Congressional Budget Office, *Medicare's Physician Payment Rates and the Sustainable Growth Rate*, before the Subcommittee on Health of the House Committee on Energy and Commerce (July 25, 2006), Appendix A.

**Figure 2.**

**Options for Changing Updates to Payment Rates for Physicians' Services**

(Billions of dollars)



Source: Congressional Budget Office.

Notes: Option 1: Increase payment rates by 1 percent in 2007 but do not treat the update as a change in law or regulation.

Option 2: Increase payment rates by 1 percent in 2007 and treat the update as a change in law or regulation.

Option 3: Allow payment rates to increase by the amount of medical inflation.

to the government and the payments that the government makes for beneficiaries enrolled in Medicare Advantage.<sup>12</sup> The following budget estimates reflect all three of those effects. (Figure 2, however, displays only gross changes in spending for physicians' services.)

*Option 1: Increase payment rates by 1 percent in 2007 but do not treat the update as a change in law or regulation.*

This option would override the update adjustment factor for 2007 and increase payment rates under the physician

fee schedule by 1 percent for that year. If that action was not considered a change in law or regulation, the SGR expenditure targets would remain the same, and the difference between cumulative spending and the cumulative expenditure targets under the option would be larger than that estimated under current law. Thus, the increase in spending attributable to the higher payment rate would eventually be recouped by the SGR mechanism, causing payment rates to be lower in the future than they would otherwise have been. Because the maximum adjustment factor of -7 percent is projected to apply for the next several years, recouping the costs of this option would begin after that period had ended.

Spending for physicians' services under this option would be higher through 2012 and lower in subsequent years than the amounts projected under current law. According to CBO's estimates, this option would increase net federal outlays by \$13 billion over the 2007–2011 period and by \$6 billion over the 2007–2016 period. Under this option, spending per beneficiary would be about

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

5 percent lower in 2016 than it would be under current law.

*Option 2: Increase payment rates by 1 percent in 2007 and treat the update as a change in law or regulation.* This option would override the update adjustment factor during 2007 and increase payment rates under the physician fee schedule by 1 percent for that year. If that action was considered a change in law or regulation, the SGR would be adjusted to account for the increased payment rate, and the difference between cumulative spending and the cumulative targets would be largely unchanged from the difference that would prevail under current law. The rise in spending resulting from this option would not be recouped by the SGR mechanism.

Spending for physicians' services under this alternative would be higher in every year than under current law. By CBO's estimates, this option would increase net federal outlays by \$13 billion over the 2007–2011 period and by \$31 billion over the 2007–2016 period. Under this option, spending per beneficiary would be about 5 percent higher in 2016 than it would be under current law.

*Option 3: Allow payment rates to increase by the amount of medical inflation.* This option would repeal the current SGR mechanism and boost payment rates each year by the Medicare economic index. Instead of being reduced by about 4 percent or 5 percent annually for the next several years, payment rates would rise by between 2 percent and 3 percent annually. Those updates would not be subject to further adjustments, and increases in spending would not be recouped.

Under this option, spending for physicians' services would grow at an average annual rate of about 7.4 percent over the next 10 years, CBO estimates, compared with a 4.5 percent increase as projected under current law. According to CBO's estimates, net federal outlays would rise by \$58 billion over the 2007–2011 period and by \$218 billion over the 2007–2016 period. Spending per beneficiary under this option would be about 30 percent higher in 2016 than it would be under current law.

## Medicare Spending in the Future

Setting appropriate fees for physicians' services entails a balancing of two factors: the need to pay providers enough to ensure beneficiaries' access to care and the

budgetary pressures created by ever-growing health care costs and an aging population. Continuing reductions in payment rates might, at some point, cause some physicians to decline to serve Medicare patients. But the task of setting payment rates for Medicare services must also be addressed in the context of challenging long-run budgetary trends. The aging of the baby-boom generation will significantly boost Medicare spending. If the nation spent the same fraction of GDP on each Medicare beneficiary in 2030 that is spent today—a proposition that reflects only the increased number of beneficiaries at that point (along with their projected mix by age and sex)—Medicare spending in that year would reach 5 percent of GDP, CBO projects, compared with its share today of 3 percent. The fiscal implications of the baby boomers' aging are compounded by the fact that health care costs per beneficiary have also been growing significantly faster than the economy as measured on a per capita basis. If those trends continue and current law remains unchanged, Medicare spending could climb to 7 percent of GDP—or higher—by 2030.

In this brief, budget estimates and growth rates not directly associated with the SGR mechanism are presented on a fiscal year basis. All expenditures and growth rates directly associated with the SGR mechanism are presented on a calendar year basis.

For further information on the SGR mechanism, see the statement of Donald B. Marron, Acting Director, Congressional Budget Office, *Medicare's Physician Payment Rates and the Sustainable Growth Rate*, before the Subcommittee on Health of the House Committee on Energy and Commerce, (July 25, 2006). See also the statement of Douglas Holtz-Eakin, Director, Congressional Budget Office, *Medicare's Physician Fee Schedule*, before the Subcommittee on Health of the House Committee on Energy and Commerce (May 5, 2004).

This brief was prepared by Geoffrey Gerhardt. It and other CBO publications are available at the agency's Web site ([www.cbo.gov](http://www.cbo.gov)).

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