CBO TESTIMONY

Statement of
Donald B. Marron
Acting Director

Medicare's Physician Payment Rates and the Sustainable Growth Rate

before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

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CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman, Congressman Brown, and Members of the Subcommittee, I am pleased to appear before you today to discuss the Sustainable Growth Rate (SGR) mechanism for setting Medicare's physician payment rates.

The Supplemental Medical Insurance program (Part B of Medicare) uses a fee schedule to pay for covered medical services provided by physicians. According to CBO's projections, payments to physicians under the fee schedule represent 16 percent of Medicare's total spending for benefits in fiscal year 2006—$60 billion of total expenditures of $375 billion.

Today, I am here to discuss how those fees are updated each year. My testimony will cover the following topics:

- The current mechanism for updating payment rates for physicians' services—the Sustainable Growth Rate method—has two key components: a target level of expenditures (measured on both an annual and a cumulative basis) and a method for adjusting payment rates in an attempt to bring expenditures in line with the targets over time. If the SGR method as currently specified is allowed to operate without legislative changes, the Congressional Budget Office (CBO) estimates that fees for physicians' services will be reduced by between 4 percent and 5 percent annually for at least the next several years.

- Legislation has prevented such cuts in recent years, and the Congress may choose to override the SGR mechanism again or may choose to change or replace it in the future. However, replacing projected reductions in payment rates with annual increases would be costly.

- Setting appropriate fees for physicians' services entails balancing the need to pay providers enough to ensure beneficiaries' access to care against the budgetary pressures created by ever-growing health care costs and an aging population.

- The Congress has a wide range of options for changing or replacing the SGR mechanism. One important question is whether payment rates in the future should be reduced to recoup the spending already incurred that exceeded the SGR targets, along with any future spending above the targeted amounts. I will discuss CBO's estimates of the impact of three illustrative approaches, including a one-year override of the scheduled 2007 reduction with the additional costs recouped in future years, a one-year override without such recoupment, and replacing the SGR mechanism with automatic updates to payment rates based on inflation.

The task of setting payment rates for Medicare services must 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 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 (along with their projected mix by age and sex)—Medicare spending in that year would reach a 5 percent share of GDP, compared with today's share of 3 percent, CBO projects. 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.

Historical Background

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

Starting in 1992, the charged-based payment system was replaced by the physician fee schedule. The fee schedule bases payment for individual services on measures of the relative resources used to provide them. The schedule itself was not intended to control spending—it was designed to redistribute spending among various physicians' specialties. The schedule was updated using a combination of the MEI and an adjustment factor designed to counteract changes in the volume of services being delivered per beneficiary. That adjustment factor, known as the volume performance standard (VPS), was based on the historical trend in volume. However, the VPS mechanism led to highly variable changes in payment rates, and the Congress replaced it with the current Sustainable Growth Rate method starting in 1998.[2]

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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. In practice, since there are usually gains in productivity from one year to the next, including the productivity adjustment as part of the MEI results in a smaller rate of growth than the price adjustments by themselves.

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, House Committee on Energy and Commerce (May 5, 2004).

Experience Under the SGR Mechanism

The SGR mechanism aims to control spending on physicians' services provided under Part B of Medicare. It does so by setting an overall target amount of spending (measured on both an annual and a cumulative basis) on certain types of goods and services provided under Part B: payments for physicians' services as well as payments that Medicare makes for items—such as laboratory tests, imaging services, and physician-administered drugs—that are furnished "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.

The Congress had two main goals when it adopted the SGR mechanism: ensuring adequate access to physicians' services and controlling federal spending on 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 if the SGR mechanism operates as currently specified in law.

From 1997 (which is when the SGR method started measuring expenditures) through 2005, per-beneficiary spending 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) grew by about 35 percent over that same time period.

Aside from growth in Part B enrollment, which has averaged about 1 percent annually since 1997, increases in 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. Since 1997, the fees that Medicare pays for each service have increased annually by an average of about 2 percent. Although some of the remaining increase has resulted from the addition of covered services, most of the rest is attributable to growth in the volume and intensity of services, which has averaged about 4.5 percent per year over the period.

Since 2002, spending measured by the SGR method has consistently been above the targets established by the formula. In 2005, expenditures counted under the SGR method totaled $94.5 billion, about $14 billion more than the $80.4 billion expenditure target for that year. Total spending since the SGR method was put into place in 1997 now stands at about $30 billion above the system's cumulative

target.[3] 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 continue 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 on services provided by physicians is projected to grow relatively slowly for the next several years. CBO estimates that the decline in payment rates will be slightly more than offset by increases in enrollment and growth in the volume and intensity of services being delivered. As a result, CBO projects, Medicare spending on physicians' services will grow in coming years, but in 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 exists 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 are likely to respond to continuing reductions in payment rates by declining to participate in the Medicare program.[4] Such responses to changes in payment rates do not explicitly affect CBO's projections of spending on physicians' services over the long-term because the SGR mechanism will adjust payment rates to offset changes in the volume of physicians' services furnished to Medicare patients. As a result, the reductions in payment rates will be smaller than the estimated 25 percent to 35 percent if the volume of physicians' services provided to Medicare participants declines because of either changes in the number of participating physicians or in the volume of services being provided.

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

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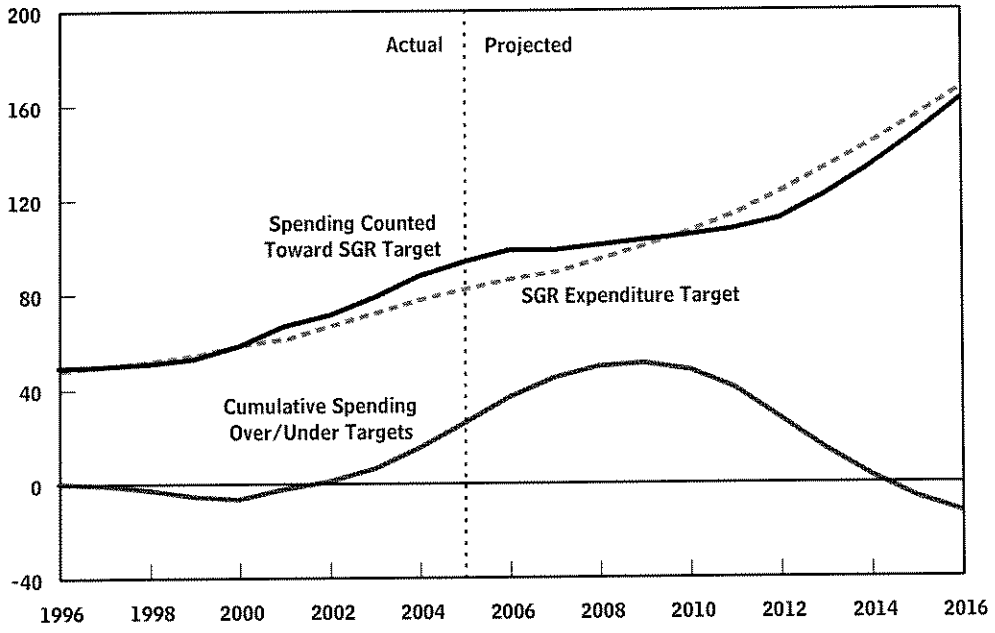
3. Those figures include both spending by the Medicare program and beneficiaries' cost-sharing obligations for services. Cost sharing amounts to roughly 20 percent of the total spending counted under the targets.

4. It is uncertain when 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 the willingness of physicians to participate in Medicare and to accept new Medicare patients.

Figure 1.

Sustainable Growth Rate Spending Compared with Expenditure Targets

(Billions of dollars)



Source: Congressional Budget Office.

Note: SGR = sustainable growth rate.

permitted to operate, the cumulative deficit 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 called for by the SGR mechanism. Toward the end of the period, CBO's projections show cumulative spending coming back into line with the cumulative target.[5] The SGR mechanism is designed in such a way so that if viewed over a long enough period of time, cumulative spending will equal the cumulative target.

How the SGR Mechanism Works

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

5. CBO projects that cumulative spending will fall slightly below the cumulative target in 2015 and remain below for a short period of time. That is the result of the gradual nature of the adjustments to bring spending in line with the expenditure targets.

- 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 Medicare's spending on services covered by the physician fee schedule and services provided "incident to" a visit to a physician. The fee schedule determines how much physicians get paid for each of the services they provide. The "incident-to" goods and services include laboratory tests and physician-administered drugs, such as chemotherapeutic ones; payment rates for those services are not determined by the physician fee schedule.[6] Services on that fee schedule accounted for about 85 percent of all spending counted toward the SGR target in 2005.

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

The annual targets are added together (along with the original base amount) to produce a cumulative target. The cumulative target in 1998 was $99.4 billion ($48.9 billion plus $50.5 billion); according to 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:

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6. 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.

- First, it includes an adjustment for inflation that takes into account changes in the prices of goods and services used by physicians' practices and in the prices that Medicare pays for "incident-to" services. The change in prices of goods and services used by physicians' practices is measured by the Medicare economic index, 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 be if based on price increases alone.) The aggregate of those factors will be 2.6 percent for 2007, according to CMS's estimate.

- Second, the rate incorporates changes in enrollment in Medicare's fee-for-service sector, 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 in real (inflation-adjusted) gross domestic product per capita, which CMS estimates will be 2.2 percent.

- Fourth, the growth rate takes into account the effect of changes in law or regulation that would affect spending for services subject to the SGR mechanism—such as adding coverage of new benefits—which CMS estimates will be -1.0 percent.[7]

Those four factors are multiplied to yield an overall growth rate 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**

The expenditure target for services covered by the physician fee schedule in 2006 is $81.7 billion. (That amount includes both spending by the Medicare program and cost-sharing obligations of beneficiaries.) 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;

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7. The reduction in the SGR due to changes in law or regulation is mainly attributable to provisions enacted in the Deficit Reduction Act (P.L. 109-362), most notably reductions in payment rates for imaging services.

- 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 (usually around November 1 of the preceding year), it is not necessarily fixed. If actual experience for one or more of the four growth factors differs from the estimates in the original calculation, the SGR for that year can be changed. In other words, if the SGR for 2007 is set assuming that fee-for-service enrollment will decrease by 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 MEI.

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

If actual spending is more than the targets, the update adjustment factor will be negative (that is, it will reduce the amount of the increase that would otherwise occur to reflect inflation); if actual spending is less than the targets, the update adjustment factor will be positive. The law sets 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 targets 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: a 2.8 percent inflation adjustment was more than offset by an update adjustment factor of -7 percent.[8] However, the Deficit Reduction Act overrode the formula for 2006 and held payment rates constant at their 2005 level.

Looking forward, CBO projects 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 will keep updates below inflation through at least 2012.

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 account for 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 growth rate of the SGR expenditure targets. If spending for the "incident-to" services grows faster than the SGR targets, payment rates for physicians' services will be reduced to compensate for that increase. Prior to changes in the way physician-administered drugs were paid for in 2004, such "incident-to" spending experienced several years of double-digit growth. The share of SGR-related spending accounted for by physician-administered drugs increased from about 7 percent in 2001 to 9 percent in 2005.

Recent Legislation Affecting the SGR

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

Spending continued to exceed the target and—if it had been allowed to operate—the SGR mechanism would have reduced payment rates in 2004. The Congress and the President acted to prevent such a reduction. As part of the Medicare Modernization Act (P.L. 108-173), they replaced the scheduled rate reduction with increases of 1.5 percent in both 2004 and 2005. The Deficit Reduction Act (P.L. 109-362) held 2006 payment rates at their 2005 level, overriding an impending reduction of 4.4 percent.

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8. $(1 + 0.028) \times (1 - 0.07) = 0.956$.

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

Budgetary Implications of Changing the SGR

With the application of the SGR mechanism in current law likely to reduce physician payment rates by between 4 percent and 5 percent annually for the next several years, various options have been put forward to modify that mechanism. This testimony presents estimates for three illustrative examples, including fully replacing the SGR targets with annual updates based on inflation (the appendix includes estimates for a number of other options). Each policy option would increase payments for physicians' services relative to those that would be made under current law and, thereby, also increase the Part B premiums that beneficiaries pay to the government and the payments that the government makes for beneficiaries enrolled in Medicare Advantage.[9] The budget estimates reflect all three of those effects. (The upcoming graphs, however, focus solely on the 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 during 2007 and increase the payment rate under the physician fee schedule by 1 percent 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 would be larger than is estimated under current law. Thus, the increase in spending attributed to the higher payment rate would eventually be recouped by the SGR mechanism, causing payment rates to be lower in the future than they would otherwise have been. Because the maximum adjustment factor of

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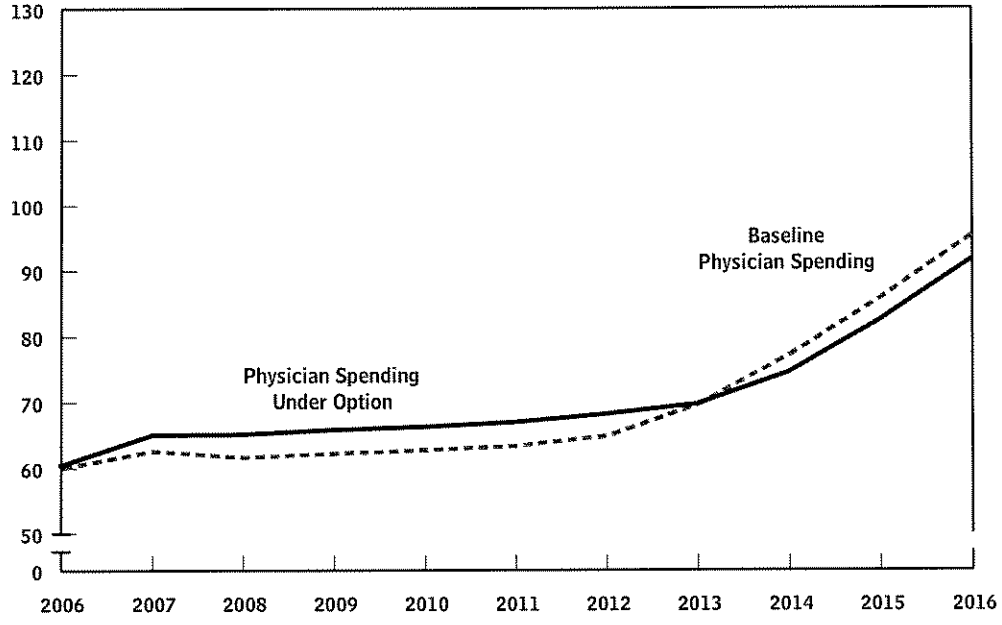
9. Any increase in spending for physicians' services would increase the "benchmarks" that Medicare uses to determine how much the program pays for beneficiaries in the Medicare Advantage program. At the same time, about one-quarter of the changes in spending for physicians' services and for Medicare Advantage would be offset by changes in receipts from premiums that beneficiaries pay the government. 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. But such a "premium hold-harmless" provision would increase federal costs by about 30 percent. The appendix includes estimates for several options that would include such a provision.

Figure 2.

Spending on Physicians' Services with a 1 Percent Update in 2007 That Is Not Considered a Change in Law or Regulation

(Billions of dollars)



Source: Congressional Budget Office.

-7 percent is projected to apply for the next several years, recouping the costs of this option would begin after that period has ended.

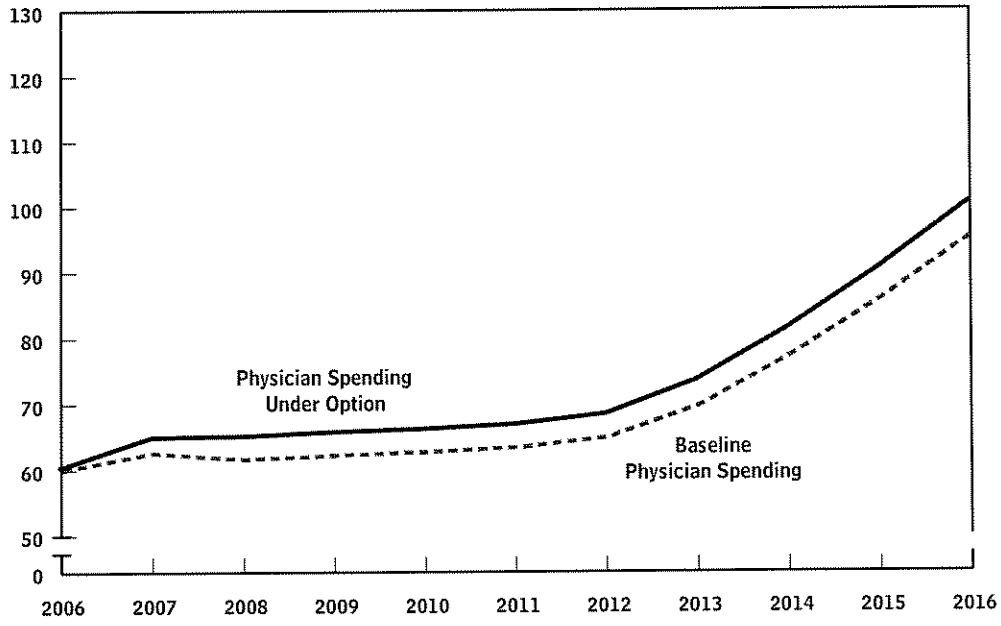
Spending for physicians' services under this option would be higher through 2012 and lower in subsequent years than the amount projected under current law (see Figure 2). According to CBO's estimates, this option would increase net federal outlays by $13 billion over the 2007-2011 period and by $6 billion over the 2007-2016 period. Under this option, spending per beneficiary would be about 5 percent lower in 2016 than it would be under current law.

Option 2: Increase payment rates by 1 percent in 2007 and do 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 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

Figure 3.

Spending on Physicians' Services with a 1 Percent Update in 2007 That Is Considered a Change in Law or Regulation

(Billions of dollars)



Source: Congressional Budget Office.

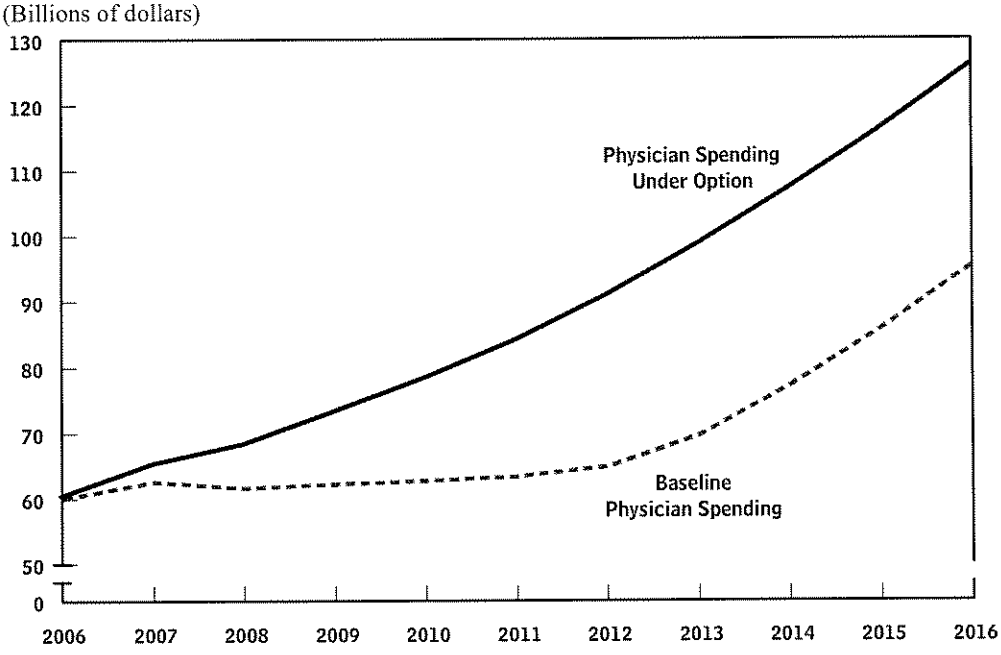
largely unchanged from current law. Spending increases resulting from this option would not be recouped by the SGR mechanism.

Spending for physicians' services under this option would be higher in every year than under current law (see Figure 3). 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 medical inflation. This option would repeal the current SGR mechanism and increase payment rates each year by the Medicare economic index. Instead of being reduced by 4 percent to 5 percent annually for the next several years, payment rates would increase by between 2 percent and 3 percent annually. Those updates would not be subject to further adjustments, and spending increases would not be recouped.

Figure 4.

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



Source: Congressional Budget Office.

Spending for physicians' services under this option 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 projected under current law. According to CBO's estimates, this option would increase net federal outlays by $58 billion over the 2007-2011 period and $218 billion over the 2007-2016 period. Under this option, spending per beneficiary would be about 30 percent higher in 2016 than it would be under current law (see Figure 4).

Appendix A

Budget Estimates for Proposals to Change Physician Payment Rates

Table A-1.

Estimated Changes in Net Federal Outlays from Alternative Proposals for Changing Physician Payment Rates

(Billions of dollars, by fiscal year)

Proposal	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2007-2011	2007-2016
0 Percent Update in 2007	1.1	2.4	2.4	2.5	2.5	2.2	-0.1	-2.3	-2.8	-3.2	10.8	4.7
0 Percent Update in 2007 and Premium Hold Harmless	1.7	3.1	3.1	3.1	3.1	2.7	-0.5	-3.0	-3.6	-4.0	14.1	5.6
0 Percent Update in 2007 and 2008	1.1	3.7	4.9	4.9	5.0	4.7	2.1	-2.5	-5.0	-5.7	19.6	13.2
0 Percent Update in 2007 and 2008 and Premium Hold Harmless	1.7	5.0	6.2	6.2	6.3	5.9	2.1	-3.6	-6.4	-7.3	25.4	16.1
0.5 Percent Update in 2007	1.2	2.7	2.7	2.7	2.7	2.5	-0.1	-2.6	-3.3	-3.6	12.0	4.9
1 percent Update in 2007	1.3	2.9	2.9	3.0	3.0	2.7	*	-2.7	-3.6	-4.0	13.1	5.5
1 Percent Update in 2007 and Premium Hold Harmless	2.0	3.7	3.7	3.8	3.8	3.4	-0.4	-3.6	-4.6	-5.1	17.0	6.6
1.5 Percent Update in 2007	1.4	3.2	3.2	3.2	3.2	3.0	0.3	-2.8	-3.8	-4.3	14.2	6.7
1.5 Percent Update in 2007 and Premium Hold Harmless	2.2	4.0	4.0	4.1	4.1	3.7	-0.1	-3.7	-4.9	-5.4	18.4	8.0
1.5 Percent Update in 2007 and 2008	1.4	4.9	6.5	6.5	6.6	6.4	3.7	-1.5	-5.9	-7.8	25.9	20.7
1.5 Percent Update in 2007 and 2008 and Premium Hold Harmless	2.2	6.6	8.2	8.2	8.3	8.0	4.2	-2.6	-7.9	-10.0	33.6	25.3
Automatic MEI Update (Replace SGR)	1.6	6.3	11.1	16.4	22.7	27.7	31.9	33.0	33.5	34.2	58.0	218.2
Automatic MEI Update (Replace SGR) and Premium Hold Harmless	2.4	8.3	14.3	20.9	28.7	35.0	39.8	41.1	41.7	42.5	74.7	274.7
Freeze Physician Payment Rates at 2006 Level Through at Least 2016	1.1	4.2	7.3	10.8	15.0	18.3	20.4	20.1	16.8	13.1	38.4	127.1

Source: Congressional Budget Office.

Notes: Except for the last three options, estimates assume that the SGR mechanism would apply after the specified period. They also assume that proposed changes to updates are not considered changes in law or regulation, and therefore increases in spending would be subject to being recouped by application of the SGR mechanism. Proposals that include a "premium hold-harmless" provision would exclude increases or decreases in spending attributable to them from calculations of the Part B premium.

* = cost or savings of less than $50 million.

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