United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
Tuesday, July 25, 2006

MEDICARE PHYSICIAN PAYMENTS

Trends in Service Utilization, Spending, and Fees Prompt Consideration of Alternative Payment Approaches

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July 25, 2006

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Highlights

Highlights of GAO-06-1008T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

In 2002, the system Medicare uses to determine annual changes to physician fees—the sustainable growth rate (SGR) system—reduced fees by almost 5 percent. Subsequent administrative and legislative actions averted fee declines in 2003 through 2006. Absent additional actions, fee reductions are projected for 2007 through 2015. Consequently, the appropriateness of the SGR system has been questioned. At the same time, there are concerns about the impact of increased physician services spending on the long-term fiscal sustainability of Medicare.

GAO was asked to discuss the SGR system and Medicare physician payments. This statement addresses (1) how the SGR system is designed to moderate the growth in spending for physician services, (2) why physician fees are projected to decline under the SGR system, (3) trends in the use of services provided by physicians and spending for those services from 2000 through 2005, and (4) options for revising or replacing the SGR system. This statement is based on two GAO reports: *Medicare Physician Services: Use of Services Increasing Nationwide and Relatively Few Beneficiaries Report Major Access Problems* (GAO-06-704, July 21, 2006), and *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms* (GAO-05-85, Oct. 8, 2004).

www.gao.gov/cgi-bin/getrpt?GAO-06-1008T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7101 or steinwalda@gao.gov.

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What GAO Found

To moderate Medicare spending for physician services, the SGR system sets spending targets and adjusts physician fees based on the extent to which actual spending aligns with specified targets. If growth in the number of services provided to each beneficiary—referred to as volume—and in the average complexity and costliness of services—referred to as intensity—is high enough, spending will exceed the SGR target. While the SGR system allows for some volume and intensity spending growth, this allowance is limited. If such growth exceeds the average growth in the national economy, as measured by the gross domestic product per capita, fee updates are set lower than the estimated increase in the average cost of providing physician services. A large gap between spending and the target may result in fee reductions.

There are two principal reasons why physician fees are projected to decline under the SGR system. Recent growth in spending due to volume and intensity increases has been more than double that allowed under the SGR system, resulting in excess spending that must be recouped through reduced fee updates. Legislative actions that specified minimum updates for 2004 through 2006 have also contributed to future physician fee cuts. These actions, which averted fee reductions, did not revise the spending targets. Therefore, the SGR system must offset the additional spending resulting from the excess volume and intensity and the minimum fee updates by reducing fees beginning in 2007.

From 2000 through 2005, Medicare spending for services provided by physicians grew rapidly. Our analysis of Medicare claims submitted during the first 28 days of April in these years shows that an increasing proportion of beneficiaries obtained services and the volume and intensity of the services provided increased. While Medicare physician fees rose by 4.5 percent over the period, program spending on physician services per beneficiary grew by approximately 45 percent. The number of physicians billing Medicare and total allowed charges per billing physician also increased, as did the proportion of claims for which physicians accepted Medicare payment as payment in full.

Potential alternatives to the SGR system cluster around two basic approaches: (1) ending the use of spending targets as a method for updating physician fees and encouraging fiscal discipline and (2) retaining spending targets but modifying the current SGR system to address perceived shortcomings. Either approach could be complemented by focused efforts to moderate volume and intensity growth directly. Because multiple years of projected 5 percent fee cuts are incorporated in Medicare's budgeting baseline, almost any change to the SGR system is likely to increase program spending above the baseline.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss Medicare's payments to physicians and consider potential payment reforms to help moderate spending growth while ensuring that beneficiaries have appropriate access to high-quality physician services and physicians receive fair compensation for providing those services. As you know, Medicare uses a system based on spending targets, known as the sustainable growth rate (SGR) system, to annually update physician fees. From 1999—the first year that the SGR system was used to update Medicare's physician fees—through 2001, annual fee increases ranged from 2.3 percent to 5.5 percent. However, in 2002 the SGR system reduced physician fees by nearly 5 percent. Fee declines in subsequent years were averted only by administrative and legislative actions that modified or temporarily overrode the SGR system.[1] In the absence of additional administrative or legislative action, the Medicare trustees project that the SGR system will likely reduce fees by about 5 percent per year for 9 years beginning in 2007.[2]

The potential for a sustained period of declining fees has raised policymakers' concerns about the appropriateness of the SGR system for updating physician fees and about physicians' continued participation in the Medicare program. At the same time, there are also concerns about Medicare spending growth and the long-term fiscal sustainability of the program.

As you requested, my comments today describe the issues that Medicare faces in annually updating physician fees, recent growth in the provision of physician services, and considerations for potential physician fee update reforms. Specifically, I will discuss (1) how the SGR system is designed to moderate the growth in spending for physician services, (2) why physician fees are projected to decline under the SGR system, (3) trends in the use of services provided by physicians and spending for

[1]For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) specified a minimum update of 1.5 percent for both 2004 and 2005. Pub. L. No. 108-173, § 601(a)(1), 117 Stat. 2066, 2300.

[2]Boards of Trustees of the Federal Hospital Insurance (HI) and Federal Supplementary Medical Insurance (SMI) Trust Funds, *2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: May 1, 2006).

those services from 2000 through 2005, and (4) options for revising or replacing the SGR system.

My testimony today is based on two previously issued GAO reports. Specifically, my comments on the SGR system, its projected effect on physician fees, and potential alternatives for that system are based on findings contained in our October 2004 report on the SGR system.[3] We updated these findings to include information on Medicare physician fee updates and spending in 2005 from the 2006 report of the Medicare trustees.[4] My comments on trends in physicians' provision of services and spending for those services are derived from our July 2006 report on Medicare physician services.[5,6] To study trends, we analyzed 100 percent of physician claims for services performed during the first 28 days of April in each year from 2000 through 2005. Whereas our 2004 report included all physician services regardless of whether they were performed by a physician or a physician replacement—such as physician assistant—our 2006 report focused exclusively on services performed by a physician. All references to physicians, beneficiaries, services, and spending in this statement pertain exclusively to Medicare's traditional fee-for-service (FFS) program, except where otherwise noted. Our work to update our 2004 report was performed during July 2006; all work was done according to generally accepted government auditing standards.

In summary, the SGR system is designed to apply financial brakes whenever spending for physician services and certain other items and services commonly performed by physicians or furnished in a physician's office exceeds predefined spending targets. The SGR system allows for some increases in the number of services delivered to each beneficiary—known as volume—and the complexity or costliness of those services—known as intensity. However, if spending growth caused by increases in volume and intensity exceeds the average growth in the national economy,

[3]GAO, *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms*, GAO-05-85 (Washington, D.C.: Oct. 8, 2004).

[4]Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

[5]GAO, *Medicare Physician Services: Use of Services Increasing Nationwide and Relatively Few Beneficiaries Report Major Access Problems*, GAO-06-704 (Washington, D.C.: July 21, 2006).

[6]Unless otherwise noted, the term "physician services" in this statement refers to items and services listed in Social Security Act § 1848(j)(3).

as measured by the gross domestic product (GDP) per capita, the SGR system reduces fee updates to help moderate spending growth.

There are two principal reasons why physician fees are projected to decline under the SGR system beginning in 2007. One reason is that volume and intensity spending increases have been growing at more than double the rate allowed under the SGR system. The other reason is that legislation mandated minimum physician fee updates for the years 2004 through 2006, but did not raise the spending targets for those years. The SGR system, which is designed to keep spending in line with its targets, must reduce fees beginning in 2007 to offset the excess spending attributable to both volume and intensity increases and the legislated fee updates.

From 2000 through 2005, Medicare spending for physician services grew rapidly. Our analysis of Medicare claims shows that an increasing proportion of beneficiaries obtained care from physicians and the volume and intensity of the services provided increased from April 2000 to April 2005. Similarly, the number of physicians billing Medicare and the total allowed charges per billing physician also increased.

In general, proposals to reform Medicare's method for updating physician fees would either (1) eliminate spending targets and establish new considerations for the annual fee updates or (2) retain spending targets, but modify certain aspects of the current system. Either approach could be complemented by focused efforts to moderate volume and intensity growth directly.

Medicare faces the challenge of moderating the growth in spending for physician services while ensuring that physicians are paid fairly so that beneficiaries have appropriate access to their services. Concerns have been raised that access to physician services could eventually be compromised if the SGR system is left unchanged and the projected fee cuts become a reality. Although the trend could be reversed if fees were to decline substantially, our analysis of data from April 2000 to April 2005 indicates that in recent years beneficiary access to physicians and the services they provide has increased. The increased use of physician services, however, raises concerns about the accompanying growth in Medicare spending for those services.

Because multiple years of projected 5 percent fee cuts are incorporated in Medicare's budgeting baseline, almost any change to the SGR system is likely to increase program spending above the baseline. As policymakers consider options for updating physician fees, it is important to be mindful of the serious financial challenges facing Medicare and the need to design policies that help ensure the long-term sustainability and affordability of the program.

Background

Although the current focus of concern is largely on the potential for several years of declining physician fees, the historic and continuing challenge for Medicare is to find ways to moderate the rapid growth in spending for physician services. Before 1992, the fees that Medicare paid for those services were largely based on physicians' historical charges.[7] Spending for physician services grew rapidly in the 1980s, at a rate that the Secretary of Health and Human Services (HHS) characterized as out of control. Although Congress froze fees or limited fee increases in the 1980s, spending continued to rise because of increases in the volume and intensity of physician services. From 1980 through 1991, for example, Medicare spending per beneficiary for physician services grew at an average annual rate of 11.6 percent.

The ineffectiveness of fee controls alone led Congress to reform the way that Medicare set physician fees. The Omnibus Budget Reconciliation Act of 1989[8] required the establishment of both a national fee schedule[9] and a system of spending targets, which together first affected physician fees in 1992.[10] From 1992 through 1997, annual spending growth for physician services was far lower than in the previous decade. The decline in spending growth was the result in large part of slower volume and

[7]Medicare paid physicians on the basis of "reasonable charge," defined as the lowest of the physician's actual charge, the customary charge (the amount the physician usually charged for the service), or the prevailing charge (based on comparable physicians' customary charges).

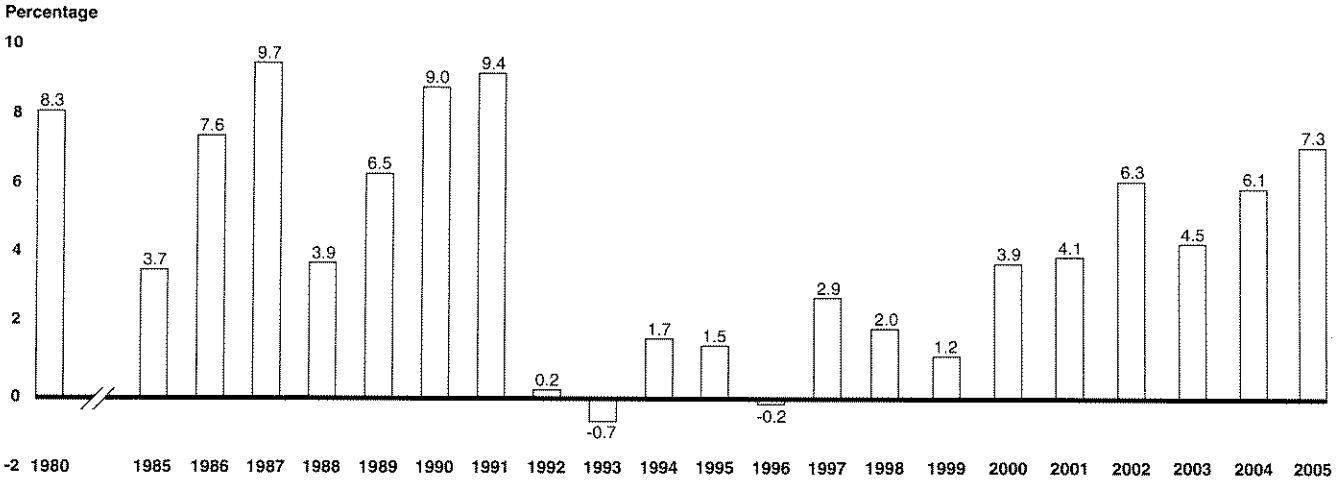
[8]See Pub. L. No. 101-239, § 6102, 103 Stat. 2106, 2169-89.

[9]Medicare sets fees for more than 7,000 physician services based on the resources required to provide each service, adjusted for differences in the costs of providing services across geographic areas.

[10]The first system of spending growth targets, known as the Medicare Volume Performance Standard (MVPS), was in effect from 1992 through 1997. In 1998, the SGR system of spending targets replaced MVPS.

intensity growth. (See fig. 1.) Over time, Medicare's spending target system has been revised and renamed. The SGR system, Medicare's current system for updating physician fees, was established in the Balanced Budget Act of 1997 (BBA) and was first used to adjust fees in 1999.[11]

Figure 1: Growth in Volume and Intensity of Medicare Physician Services per Beneficiary, Selected Years, 1980-2005



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

Note: Represents combined effect of volume and intensity growth. Data are for beneficiaries in the traditional FFS program. Spending for end-stage renal disease patients is not included. From 1980 through 1992, volume and intensity of services changes are based on Medicare outlays for all physician services. From 1993 through 2005, volume and intensity of services changes are based on Medicare outlays for physician services covered by the fee schedule.

Following the implementation of the fee schedule and spending targets in 1992 through 1999, average annual growth in volume and intensity of service use per beneficiary fell to 1.1 percent. More recently, volume and intensity growth has trended upward, rising at an average annual rate of more than 5 percent from 2000 through 2005. Although this average annual rate of growth remains below that experienced before spending targets were introduced, the recent increases in volume and intensity growth are a reminder that inflationary pressures continue to challenge efforts to moderate growth in physician expenditures.

[11]See Pub. L. No. 105-33, § 4503, 111 Stat. 251, 433-34. BBA set a specific fee update for 1998. See BBA, § 4505, 111 Stat. 435-37.

SGR System Designed to Limit or Reduce Physician Fee Updates in Response to Excess Growth in Volume and Intensity

The SGR system establishes spending targets to moderate spending increases caused by excess growth in volume and intensity. Services covered by the SGR system's spending targets include physician services and other items and services, such as clinical laboratory services, specified by the Secretary of HHS, that are commonly performed or furnished by physicians or in a physician's office. The SGR system's spending targets do not cap expenditures for SGR-covered services. Instead, spending in excess of the target triggers a reduced fee update or a fee cut. In this way, the SGR system applies financial brakes to spending for SGR-covered services and thus serves as an automatic budgetary control device. In addition, reduced fee updates signal physicians collectively and Congress that spending because of volume and intensity has increased more than allowed.

To apply the SGR system, every year the Centers for Medicare & Medicaid Services (CMS) follows a statutory formula to estimate the allowed rate of increase for spending on SGR-covered services and uses that rate to construct the spending target for the following calendar year.[12] The sustainable growth rate is the product of the estimated percentage change in (1) input prices for physician services and other SGR-covered services;[13] (2) the average number of Medicare beneficiaries in the traditional fee-for-service program; (3) national economic output, as measured by real (inflation-adjusted) GDP per capita; and (4) expected expenditures for physician services and other SGR-covered services resulting from changes in laws or regulations. SGR spending targets are cumulative. That is, the sum of all spending for SGR-covered services since 1996 is compared to the sum of all annual targets since the same year to determine whether spending has fallen short of, equaled, or exceeded the SGR targets. The use of cumulative targets means, for example, that if actual spending has exceeded the SGR system targets, fee updates in future years must be lowered sufficiently both to offset the accumulated excess spending and to slow expected spending for the coming year.

[12]This allowed rate is the sustainable growth rate from which the SGR system derives its name. We use the abbreviation SGR when referring to the system and the full term of sustainable growth rate when referring to the allowed rate of increase.

[13]CMS calculates changes in physician input prices based on the growth in the costs of providing physician services as measured by the Medicare Economic Index, growth in the costs of providing laboratory tests as measured by the consumer price index for urban consumers, and growth in the cost of Medicare Part B prescription drugs included in SGR spending.

Under the SGR system, the volume and intensity of physician services and other SGR-covered services—that is, spending per beneficiary adjusted for the estimated underlying cost of providing those services—is allowed to grow at the same rate that the national economy grows over time on a per capita basis. When the SGR system was established, economic growth was seen as a benchmark that would allow for affordable increases in volume and intensity. Currently, the SGR system's benchmark for volume and intensity growth is projected to be about 2.2 percent annually.[14] Consequently, volume and intensity growth that exceeds 2.2 percent causes Medicare SGR-covered spending to exceed the SGR system's target, while slower volume and intensity growth leads to spending that falls below the SGR target.

If cumulative spending on SGR-covered services is in line with the SGR system's target, the physician fee schedule update for the next calendar year is set equal to the estimated increase in the average cost of providing physician services as measured by the Medicare Economic Index (MEI). If cumulative spending exceeds the target, the annual physician fee update will be less than the change in MEI or may even be negative. Conversely, if cumulative spending falls short of the target, physicians benefit because the update will exceed the change in MEI. The SGR system places limits on the extent to which fee updates can deviate from MEI. In general, with an MEI of about 2 percent, the largest allowable fee decrease would be about 5 percent and the largest fee increase would be about 5 percent.

[14]To reduce the effect of business cycles on physician fees, MMA modified the SGR system to require that economic growth be measured as the 10-year moving average change in real per capita GDP beginning in 2003.

Rapid Growth in Volume and Intensity and Legislated Minimum Updates Contribute to Projected Decline in Medicare Physician Fees under SGR System

Recent growth in spending due to volume and intensity increases has been larger than SGR targets allow, resulting in excess spending that must be recouped by reducing fees to lower future spending. From 2000 through 2005, based on an analysis of physician services claims from April of each year, average annual growth in the volume and intensity of Medicare physician services exceeded 5 percent—more than double the approximately 2.2 percent growth rate permitted under the SGR system. To offset the resulting excess spending, the SGR system calls for reductions in physician fees.

Additional downward pressure on physician fees arises from the growth in spending for other Medicare services that are included in the SGR system, but that are not paid for under the physician fee schedule. Such services include laboratory tests and many Part B outpatient prescription drugs that physicians provide to patients.[15] Because physicians influence the volume of services they provide directly—that is, fee schedule services—as well as other items and services commonly performed by physicians or furnished in a physician's office, expenditures for both types of services were included when spending targets were introduced. To the extent that spending for these other services grows larger as a share of overall SGR spending, additional pressure is put on fee adjustments to offset excess spending and bring overall SGR spending in line with the system's targets. This occurs because the SGR system attempts to moderate spending only through the fee schedule, even when the excess spending is caused by expenditures for SGR-covered services which are not paid for under the fee schedule.

Legislated minimum updates for 2004 through 2006 have also contributed to future physician fee cuts. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)[16] and the Deficit Reduction Act of 2005 (DRA)[17] averted fee reductions projected for 2004 through 2006 by specifying minimum updates to physician fees for those years. The MMA-specified minimum annual increase of 1.5 percent

[15]Most of the Part B drugs that Medicare covers fall into three categories: those typically provided in a physician office setting (such as chemotherapy drugs), those administered through a durable medical equipment item (such as a respiratory drug given in conjunction with a nebulizer), and those that are patient administered and covered explicitly by statute (such as certain immunosuppressives).

[16]Pub. L. No. 108-173, §601 (a)(1), 117 Stat. 2066, 2300.

[17]Pub. L. No. 109-171, §5104(a)(2), 120 Stat. 4, 40-1 (2006).

replaced SGR system fee reductions of 4.5 percent in 2004 and 3.3 percent in 2005. DRA had the effect of replacing a fee reduction of 4.4 percent in 2006 with a 0.2 percent fee increase. These legislated minimum fee updates have resulted in additional aggregate spending. Because neither MMA nor DRA made corresponding revisions to the SGR system's spending targets, the SGR system must offset the additional spending by reducing fees beginning in 2007.

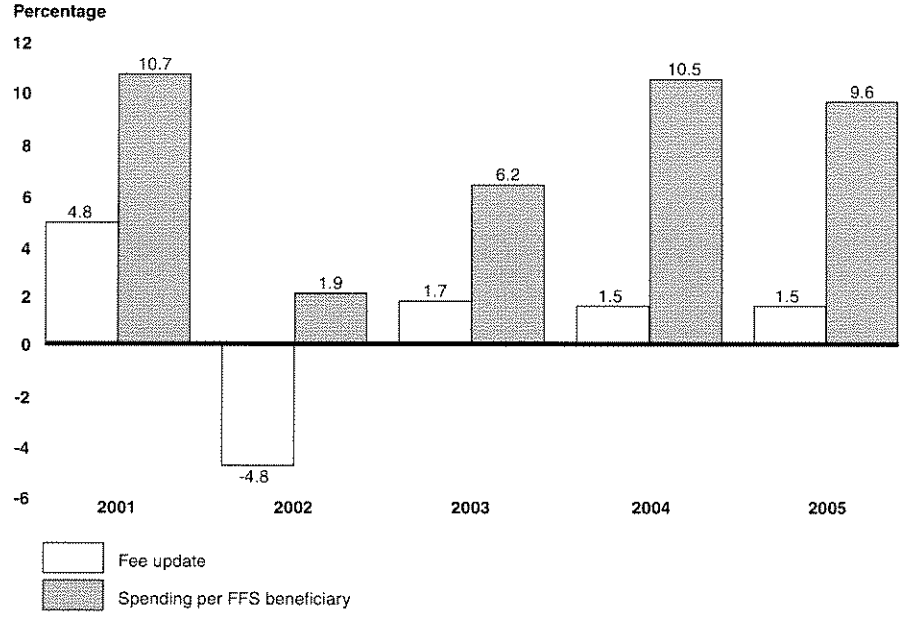
Medicare Spending on Physician Services Increased Substantially as Physicians Provided More Services and More Costly Types of Services

From 2000 through 2005, Medicare spending on physician services grew far faster than the growth in physician fees and the number of eligible beneficiaries. Our analysis of Medicare claims data for services provided during the first 28 days of April of each year indicates that from April 2000 to April 2005 a growing percentage of beneficiaries obtained services from physicians. Among those beneficiaries who obtained such services, there were increases in the average number of services provided. Overall, the volume of services provided increased as well as the intensity (and thus costliness) of the services provided. Our analysis also found that the number of physicians billing Medicare and allowed charges per physician increased over the period as did the proportion of claims for which physicians accepted Medicare payment as payment in full.

Growth in Spending for Physician Services Exceeded Growth in Medicare Fees

From 2000 through 2005, while Medicare physician fees rose by 4.5 percent, program spending on physician services grew by nearly 60 percent. On a per beneficiary basis, spending for physician services grew by approximately 45 percent. Annual per beneficiary spending increases ranged from a low of 2 percent in 2002 to a high of about 11 percent in both 2001 and 2004. (See fig. 2.) It is important to note that even in 2002, a year in which fees were reduced by nearly 5 percent, Medicare spending per beneficiary for physician services went up.

Figure 2: Percentage Change from Previous Year in Physician Fee Update and Physician Services Spending per Beneficiary, 2001-2005



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

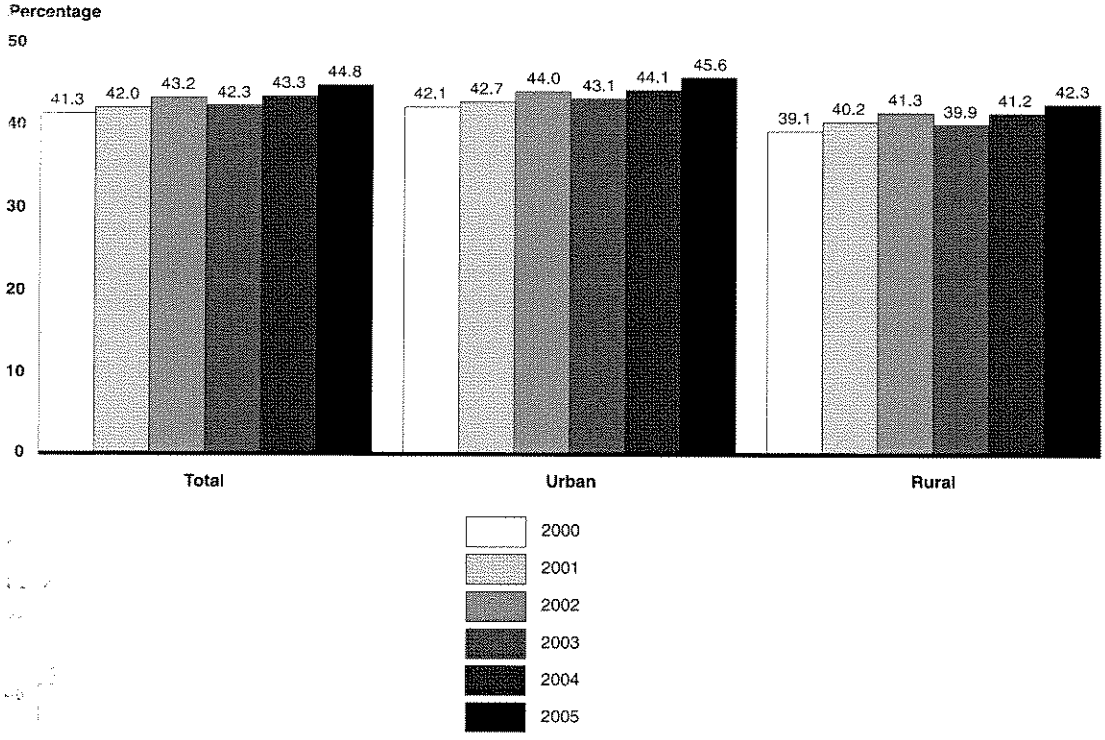
Note: Spending per beneficiary represents Medicare spending for beneficiaries in the traditional FFS program, net of beneficiary cost sharing. Spending for end-stage renal disease patients is not included. The physician fee schedule update figures shown do not reflect additional required adjustments,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

Proportion of Beneficiaries Receiving Physician Services Grew

In general, the proportion of beneficiaries who received services from a physician rose during the period covered in our review. (See fig. 3.) Specifically, from 2000 through 2005, the proportion of beneficiaries receiving services during the month of April rose from about 41 percent to about 45 percent. Although this measure declined slightly in April 2003, the proportion of beneficiaries receiving services remained a percentage point higher than in April 2000 and the upward trend resumed in 2004.

Nationwide, this measure increased in both urban and rural areas.[18] The proportion of beneficiaries receiving services rose from about 42 percent in April 2000 to about 46 percent in April 2005 in urban areas and from about 39 percent in April 2000 to about 42 percent in April 2005 in rural areas.

Figure 3: Percentage of Medicare Beneficiaries Receiving Physician Services in April, 2000-2005



Source: GAO analysis of Medicare Part B claims and enrollment data from CMS.

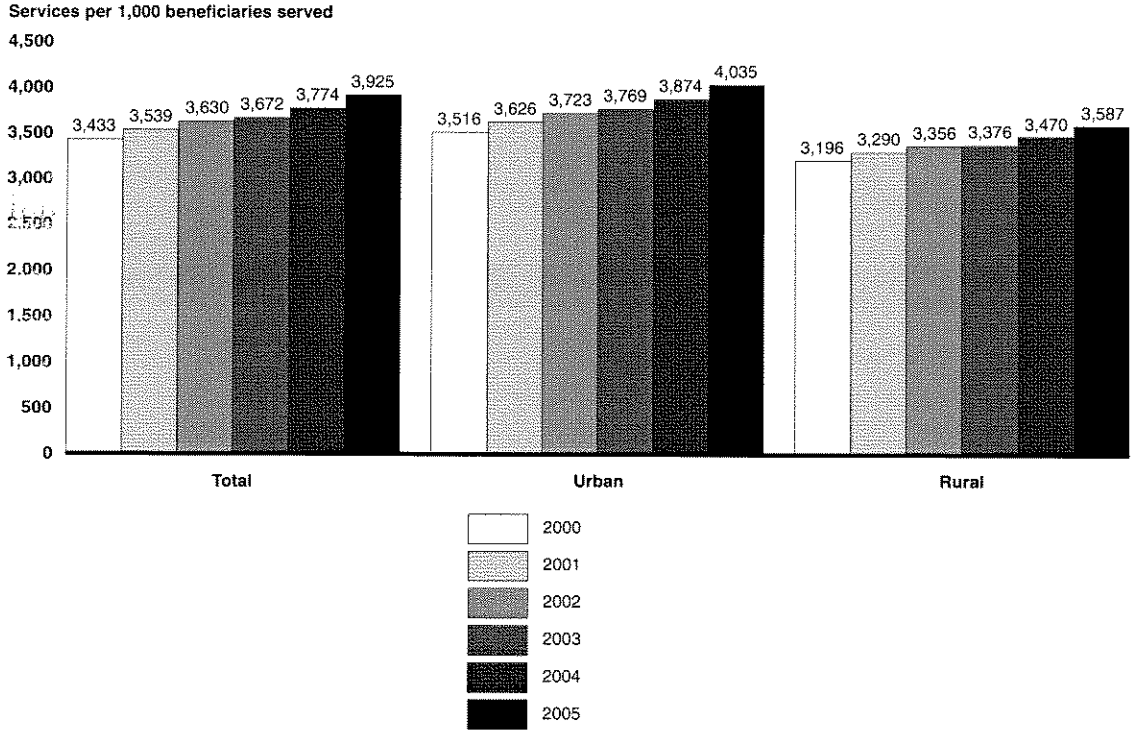
Note: Beneficiaries were included if they received a physician service in the first 28 days of April.

[18]Using the Office of Management and Budget's system for defining metropolitan statistical areas, we classified the nation's counties as urban or rural. We consolidated the urban counties and rural counties in each state and the District of Columbia, and created 99 geographic areas. There were 51 urban areas and 48 rural areas. There are no rural areas in New Jersey, Rhode Island, and the District of Columbia.

Physician Services Increased in Volume and Intensity

From April 2000 to April 2005, an increasing number of services were provided to beneficiaries who were treated by a physician. Specifically, in that period, the average number of services provided per 1,000 beneficiaries who were treated rose by 14 percent—from about 3,400 to about 3,900. (See fig. 4.) The number of services provided per 1,000 beneficiaries was higher in urban areas (3,516 services per 1,000 beneficiaries who received services in 2000) relative to rural areas (3,196 services per 1,000 beneficiaries who received services in 2000). However, in percentage terms, the urban and rural areas experienced similar increases in the number of services per treated beneficiary—15 percent in urban areas, compared with 12 percent in rural areas.

Figure 4: Number of Physician Services Provided per 1,000 Medicare Beneficiaries Served in April, 2000-2005



Source: GAO analysis of Medicare Part B claims and enrollment data from CMS.

Note: Beneficiaries and services were included if services were provided during the first 28 days of April.

Because there were increases in both the proportion of beneficiaries obtaining services from physicians and the number of services provided to each beneficiary who obtained care, the overall volume of services increased from 2000 through 2005. That is, the number of physician services per beneficiary, including beneficiaries who obtained care and those that did not, increased. Volume generally increased across broad categories of services—evaluation and management, procedures, imaging services, and tests. On average, volume for all physician services increased at an annual rate of 4.4 percent. (See table 1.) The volume of evaluation and management services, a category that includes office visits, increased at an average annual rate of 2.4 percent. There was a small average annual decline in the volume of major procedures (less than 1 percent), although minor procedures grew at an average annual rate of 6.3 percent. Volume grew most rapidly (9.1 percent average annual rate) for tests.

Table 1: Changes in Volume and Intensity of Physician Services Provided per Medicare Beneficiary, April 2000 to April 2005

Type of service	Annual percentage change in the number of services per beneficiary (volume)	Annual percentage change in the intensity of services per beneficiary, as measured in relative value units (RVU)
All services	4.4	5.2
Evaluation and management services	2.4	3.7
Procedures	5.7	4.3
Major	-0.7	2.3
Minor	6.3	5.2
Imaging	6.9	10.5
Tests	9.1	13.9

Source: GAO analysis of Medicare Part B claims and enrollment data from CMS.

Notes: Services were included in the calculation of average annual percentage changes if the services were provided during the first 28 days of April. To account for complexity of services, we used RVU weights for 2005.

From April 2000 to April 2005, the services that physicians provided to beneficiaries also increased in intensity. The fee schedule expresses this intensity through relative value units (RVU), which account for the amount of physician time, expertise, and resources required to deliver a service

compared to other services.[19] Because Medicare's fee for a service is based on the number of RVUs associated with it, more intense services are also more costly. Overall, physician services per beneficiary rose in intensity, as measured in RVUs, at an average annual rate of about 5 percent. Intensity increases occurred among all categories of services, including major procedures. Intensity grew most rapidly among imaging services (10.5 percent average annual rate) and tests (13.9 percent average annual rate). Thus, taken as a whole, beneficiaries' increased utilization of physician services has manifested itself in both increased volume and increased intensity of services for the 6 years reviewed.

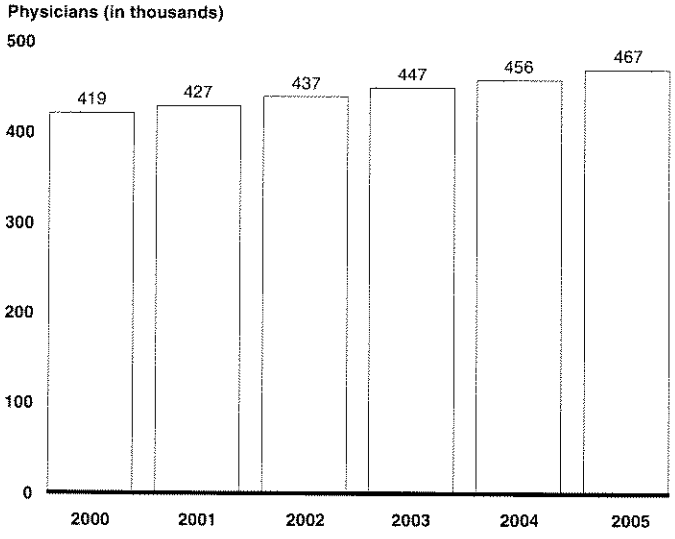
Number of Physicians Serving Medicare Beneficiaries and Allowed Charges per Physician Increased

An increasing number of physicians billed Medicare from April 2000 to April 2005. (See fig. 5.) In April 2000, the number of physicians billing Medicare was about 419,000, and in April 2005, that number had increased to a little more than 467,000. While Medicare experienced an 11 percent increase in the number of physicians billing the program, the number of beneficiaries in Medicare—FFS and managed care combined—rose by 8 percent.[20]

[19]The relative intensiveness or complexity—as measured by the costliness—of each service is compared to a benchmark service, defined as a midlevel office visit. For example, if a midlevel office visit had an RVU value of 1.000, a service with 1.475 RVUs is estimated to be 47.5 percent more costly to provide than the midlevel office visit; while a service with 0.925 RVUs is estimated to be 7.5 percent less costly than the midlevel office visit. In this way, RVU weights quantify the complexity of services provided.

[20]Because the majority of physicians serving FFS Medicare beneficiaries also likely serve beneficiaries in Medicare managed care, we report the change in the total number of Medicare beneficiaries—FFS and managed care combined. The number of FFS beneficiaries increased by 13 percent, an increase driven in part by a decline of about 18 percent in the number of enrollees in managed care, from 6.8 million to 5.6 million.

Figure 5: Number of Physicians Billing Medicare for Services Provided to Medicare Beneficiaries in April, 2000-2005



Source: GAO analysis of Medicare Part B claims data from CMS.

Notes: Physicians were included if they served a beneficiary in the first 28 days of April. We counted each occurrence of the unique physician identification number once.

On average, total allowed charges per physician billing Medicare increased by about 41 percent from April 2000 to April 2005.[21] A portion of this increase can be attributed to the changes in Medicare's fees, which increased by about 4.5 percent over the period. However, most of the increase was the result of physicians providing more services and more intense, and thus more costly, services.

Proportion of Services for Which Physicians Accepted Medicare Payment in Full Increased

From April 2000 to April 2005, the vast majority of Medicare physician services were performed by participating physicians—that is, physicians who formally agreed to submit all claims on assignment.[22] The percentage of services submitted by participating physicians increased from 95 percent to over 96 percent. (See fig. 6.) By submitting all Medicare claims on assignment, these physicians agreed to accept Medicare's fee as

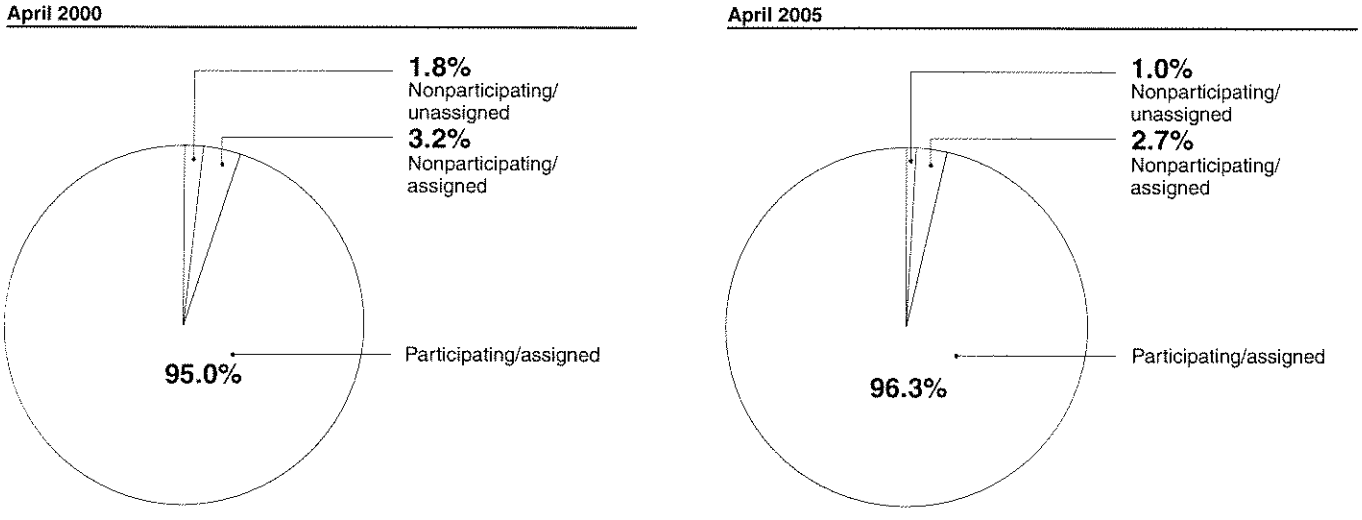
[21]Includes charges for services that were provided during the first 28 days of April in 2000 and 2005.

[22]Physicians may decide annually whether they will be Medicare participating physicians.

payment in full for all of the services they provided. This includes the coinsurance amount (usually 20 percent) paid by the beneficiary. Nonparticipating physicians could choose for each service they provided to submit an assigned claim, thereby accepting Medicare's fee as payment in full, or an unassigned claim. Nonparticipating physicians who submitted an unassigned claim could charge the beneficiary an additional amount, within set limits, for that service—a practice referred to as balance billing.

During the same period, the overall percentage of services paid on assignment—that is, services performed by both participating and nonparticipating physicians who accepted assignment—also increased. In April 2000, 98.2 percent of services were paid on assignment, and in April 2005, 99.0 percent of services were paid on assignment. Fewer beneficiaries were likely to be subject to balance billing for physician services in 2005 than in 2000 as the percentage of services for which physicians were permitted to balance bill Medicare beneficiaries fell from 1.8 percent to 1.0 percent.

Figure 6: Proportion of Physician Services by Medicare Participation and Assignment Status, April 2000 and April 2005



Source: GAO analysis of Medicare Part B claims data from CMS.

Note: Services were included if they were provided during the first 28 days in April.

Alternatives for Updating Physician Fees Would Eliminate Spending Targets or Revise Current SGR System

The projected sustained period of declining physician fees and the potential for beneficiaries' access to physician services to be disrupted have heightened interest in alternatives for the current SGR system. In 2005, we testified that potential alternatives cluster around two basic approaches.[23] One approach would end the use of spending targets as a method for updating physician fees and encouraging fiscal discipline. The other would retain spending targets but modify the current SGR system to address its perceived shortcomings.

Eliminate Spending Targets, Base Fee Updates on Physician Cost Increases

The Medicare Payment Advisory Commission (MedPAC) has recommended replacing the SGR system with a system that bases the annual fee updates on changes in the cost of efficiently providing care as measured by MEI.[24,25] Under this approach, efforts to control aggregate spending would be separate from the mechanism used to update fees.

The advantage of eliminating spending targets would be greater fee update stability. Although basing physician fee updates on changes in MEI would limit the annual increases in the price that Medicare pays for each service, this approach does not contain an explicit mechanism for constraining aggregate spending resulting from increases in the volume and intensity of services physicians provide. If no other actions were taken, Medicare spending for physician services would rise relative to projected spending under the SGR system.

An annual fee update system based on MEI that considered multiple objectives, such as the moderation of spending growth or quality of care improvements, could be implemented. For example, H.R. 3617, introduced in 2005, would base physician fee updates on the MEI and also gradually phase in a pay-for-performance system under which fee updates would be linked to quality and efficiency performance objectives.[26] In 2005 testimony, MedPAC stated that fee updates for physician services should

[23]GAO, *Medicare Physician Payments: Considerations for Reforming the Sustainable Growth Rate System*, GAO-05-326T (Washington, D.C.: Feb. 10, 2005).

[24]See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2001, 2002, 2003, and 2004).

[25]MedPAC suggested that other adjustments to the update might be necessary, for example, to ensure overall payment adequacy, correct for previous MEI forecast errors, and address other factors.

[26]See H.R. 3617, 109th Cong. § 2 (2005).

not be automatic, but should be informed by changes in beneficiaries' access to services, the quality of services provided, the appropriateness of cost increases, and other factors, similar to those that are considered for other provider payment updates.[27]

Retain Spending Targets, Modify Current SGR System

An alternative approach for modifying the current SGR system would retain spending targets but modify one or more elements of the system. The key distinction of this approach, in contrast to basing updates on MEI, is that fiscal controls designed to moderate spending would continue to be integral to the system used to update fees. Although spending for physician services would likely also rise under this approach, the advantage of retaining spending targets is that the fee update system would automatically work to moderate spending if volume and intensity growth began to increase above allowable rates.

As presented in our 2004 report,[28] the SGR system could be modified in a number of ways. For example, Congress could raise the allowance for increased spending due to volume and intensity growth by some factor above the percentage change in real GDP per capita. The Secretary of HHS could, under current authority, consider excluding Part B drugs from the definition of services furnished "incident to" physician services for the purposes of the SGR system. DRA mandated that MedPAC study a variety of SGR reforms, such as setting regional, instead of national, spending targets.[29] The effects on overall Medicare spending for physician services, relative to projected spending under the current SGR system, would depend on whether the reforms simply allowed for higher fees or provided meaningful incentives for physicians to moderate volume and intensity growth.

[27]Medicare Payment Advisory Commission, *Medicare Payments to Physicians*, testimony before the Subcommittee on Health, House Committee on Energy and Commerce (Nov. 17, 2005).

[28]GAO-05-85.

[29]See Pub. L. No. 109-171, § 5104(c), 120 Stat. 4, 41.

Mr. Chairman, this concludes my prepared statement. We look forward to working with the Subcommittee and others in Congress as policymakers seek to moderate program spending growth while ensuring appropriate physician payments. I will be happy to answer questions you or the other Members of the Subcommittee may have.

Contact and Acknowledgements

For further information regarding this testimony, please contact A. Bruce Steinwald at (202) 512-7101 or steinwalda@gao.gov. James Cosgrove, Assistant Director; Todd Anderson; Jessica Farb; and Eric Wedum contributed to this statement. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

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Statement

of the

American Medical Association

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

RE: **Medicare Physician Payment: How to Build a Payment System that Provides Quality, Efficient Care for Medicare Beneficiaries**

July 25, 2006 and July 27, 2006

Division of Legislative Counsel
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