



Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System

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Summary

Each year since 2002, the statutory method for determining the annual updates to the Medicare physician fee schedule, known as the sustainable growth rate (SGR) system, has resulted in a reduction in the reimbursement rates (or a “negative update”). With the exception of 2002, when a 4.8% decrease was applied, Congress has passed a series of bills to override the reductions. However, these actions have required almost yearly attention from the Congress.

The SGR system was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians’ services. While the fee schedule limits the amount that Medicare will pay for each service, there are no limits on the volume or mix of services. The SGR system was intended to serve as a restraint on aggregate spending. If expenditures over a period are less than the cumulative spending target for the period, the update is increased. However, if spending exceeds the cumulative spending target over a certain period, future updates are reduced to bring spending back in line with the target.

In the first few years of the SGR system, the actual expenditures did not exceed the targets and the updates to the physician were close to the Medicare economic index (MEI, a price index of inputs required to produce physician services) in the first two years (2.3% in 1998 and 1999, compared with a MEI of 2.2% in 1998 and 2.3% in 1999). For the next two years, in 2000 and 2001, the actual physician fee schedule update was more than twice the MEI for those years (5.5% update vs. MEI of 2.4% in 2000, 5.0% update vs. MEI of 2.1% in 2001). However, beginning in 2002, the actual expenditure exceeded allowed targets and the discrepancy has grown with each year, resulting in a series of ever-larger cuts under the formula.

Some criticisms of the SGR system point to purported flaws in the technical details behind the formula, while others have just expressed displeasure with the resultant outcome. Although modifications have been proposed to replace the SGR system, no proposal has garnered sufficient support and almost all proposals would be expensive to implement compared against the current baseline, which necessarily assumes that significant cuts to the fee schedule will occur.

Legislative activity in the current session of Congress includes S. 1776, H.R. 3961, H.R. 3590, and H.R. 3326. S. 1776 would have (1) set the update to the conversion factor at 0% for 2010 and in subsequent years, and (2) sunset the SGR system immediately. On October 21, 2009, the cloture motion to proceed to the bill was not invoked by the Senate by a vote of 47-53. H.R. 3961 would create two categories of physician services (evaluation, management, and preventive services in one category with all other physician services in the other), each with its own separate target growth rate and conversion factor update. CBO has estimated that implementing the bill would increase direct spending by about \$210 billion over the 2010-2019 period. On November 19, 2009, the House passed H.R. 3961 by a vote of 243-183, but the Senate has yet to take up the bill. The health care reform bill under consideration in the Senate, an amendment in the form of a substitute to H.R. 3590, no longer contains any provisions that address this issue after the manager’s amendment repealed the original section. The FY2010 Defense Appropriations Act delays the implementation of the reductions for two months, until February 28, 2010.

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Introduction

Each year since 2002, the statutory method for determining the annual updates to the Medicare physician fee schedule, known as the sustainable growth rate (SGR) system, has resulted in a reduction in the reimbursement rates (or a “negative update”).¹ With the exception of 2002, when a 4.8% decrease was applied, Congress has passed a series of bills to override the reductions. However, these actions have required almost yearly attention from the Congress. This report provides a background on the Medicare fee schedule, the SGR system and the annual updates, and discusses recent proposals to address this issue.

Background on the Medicare Fee Schedule

Medicare payments for Part B services² provided by physicians and certain non-physician practitioners are made on the basis of a fee schedule.³ For each of the over 7,000 tasks and services for which physicians bill Medicare, the Center for Medicare and Medicaid Services (CMS) assigns relative values that reflect physician work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs.⁴ The adjusted relative values are then multiplied by a conversion factor to derive the actual payment amount in dollars. Medicare pays providers the lesser of the actual charge for the service or the allowed amount under the fee schedule.

Updates and the Sustainable Growth Rate (SGR) System

The SGR system was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians’ services. While the fee schedule limits the amount that Medicare will pay for each service, there are no limits on the volume or mix of services. The SGR system was intended to serve as a restraint on aggregate spending. While the SGR targets are not limits on expenditures, they represent a “sustainable” trajectory for cumulative spending on Medicare physician services from April 1996 forward. The annual fee schedule update thus reflects the success or failure in meeting the goal. If expenditures over a period are less than the cumulative spending target for the period, the update is increased. However, if spending exceeds the cumulative spending target over a certain period, the update for a future year is reduced, with the goal to bring spending back in line with the target.

¹ 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds, p. 22. <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf>

² For detail on fee-for-service Medicare and other Medicare background information, see CRS Report R40425, *Medicare Primer*, coordinated by Hinda Chaikind.

³ Social Security Act, Sec. 1848. [42 U.S.C. 1395w–4]. In some instances, special rules apply to the calculation of Medicare fees for some services including anesthesia, radiology, and nuclear medicine.

⁴ The determination of the relative value units affects all payments under the fee schedule. Refinements in existing values and establishment of values for new services have been included in the annual fee schedule updates. This refinement and update process is based in part on recommendations made by the American Medical Association’s Specialty Society Relative Value Update Committee (RUC) which receives input from approximately 100 specialty societies. The law requires a review every five years.

Expenditure targets have been a factor in the calculation of Medicare physician payment updates since the current fee schedule was first implemented in 1992. Originally, two and then three conversion factors were used for different categories of services (surgical, primary care, and other nonsurgical services). However, under the Medicare Volume Performance Standard (MVPS) method, targets were set (and typically exceeded) each year; there was no cumulative goal and no significant consequence to exceeding the expenditure target. The current SGR method for calculating annual updates was created partly in response to the shortcomings of the prior method.

The Balanced Budget Act of 1997 (BBA97, P.L. 105-33) replaced the MVPS with the SGR, with the objective of creating a *sustainable* growth path for Part B expenditures. First, BBA 97 added a cumulative spending criteria that resulted in actual consequences for failing to meet expenditure targets; beginning with April 1, 1996 as the starting point, actual program expenditures are compared to growth targets to determine annual updates. Second, BBA 97 introduced the rate of growth in the per capita amount of the gross domestic product (GDP) into the SGR calculation and also provided for the use of a single conversion factor instead of three.⁵ By tying the expenditure targets to the growth in GDP per capita, this system attempted to hold Medicare physician expenditures to a level that would not consume an ever-increasing share of national income.

Since the conversion factor applies to all services, the update to the conversion factor is the key component for determining how reimbursements change from year to year.

Conversion Factor Calculation

The annual update to the conversion factor calculation is based on (1) the Medicare Economic Index (MEI), which measures the weighted average annual price changes in the inputs needed to produce physician services,⁶ (2) the Update Adjustment Factor (UAF), used to equate actual and target (allowed) expenditures, and (3) allowed expenditures, equal to the actual expenditures updated by the SGR.

Sustainable Growth Rate (SGR)

The SGR sets both the cumulative and allowed expenditures under the UAF formula and consists of the following components:

- the estimated percentage changes in physicians fees,
- the estimated percentage changes in the number of fee-for-service beneficiaries,
- the estimated percentage growth in real gross domestic product (GDP) per capita (10-year moving average), and
- the estimated percentage changes resulting from changes in laws and regulations.

⁵ The Balanced Budget Refinement Act of 1999 (BBRA 99, P.L. P.L. 106-113) incorporated an adjustment for the prior year into the UAF update calculation; it also moved from a fiscal year to a calendar year system.

⁶ For more information on the components used to calculate the MEI and quarterly historical data, see <http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/mktbskt-economic-index.pdf>

One important implication of the way this formula was constructed is that sustainable growth in Medicare physician expenditures should be equivalent to the rate of growth in the economy (i.e., the growth in GDP per capita). In addition, the formula implies that increases in managed care enrollment relative to fee-for-service Medicare would result in a slightly lower SGR.

Update Adjustment Factor

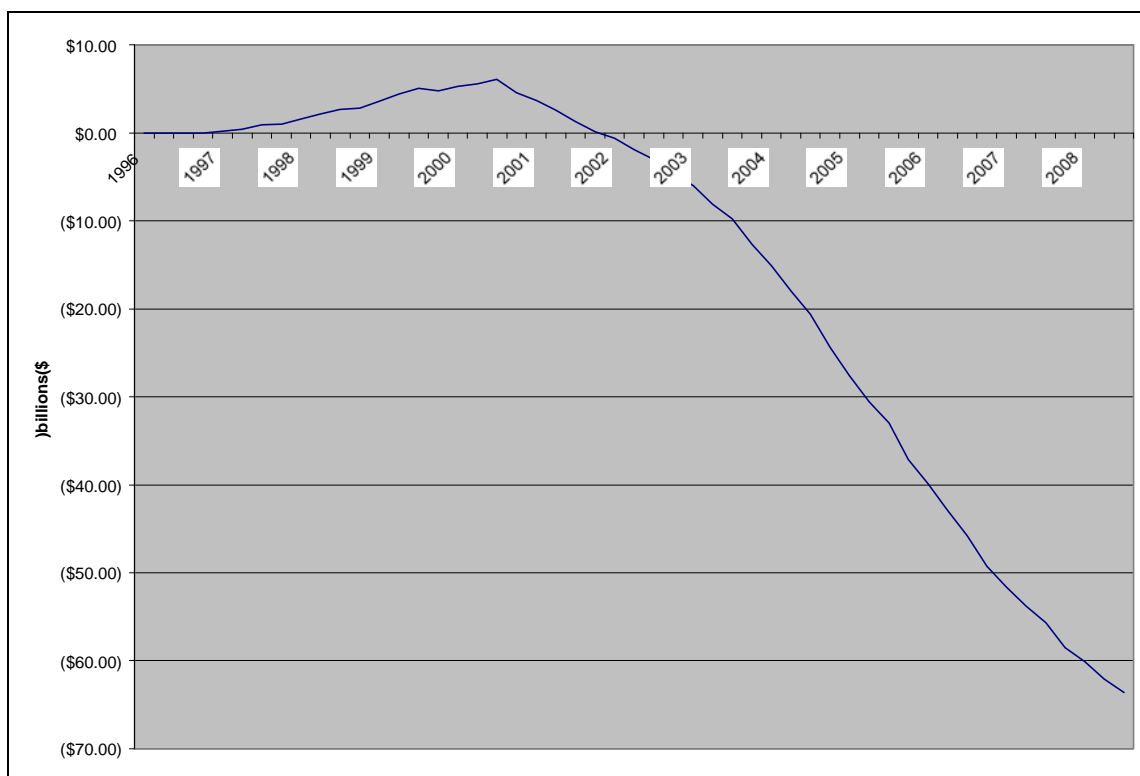
The update adjustment sets the conversion factor at a level so that projected spending for the year will meet allowed spending by the end of the year. The adjustment factor is the sum of (1) the prior year adjustment component; and (2) the cumulative adjustment component. Use of both the prior year adjustment component and the cumulative adjustment component allows any deviation between cumulative actual expenditures and cumulative allowed expenditures to be corrected over several years rather than a single year. As originally established, the adjustment factor can not be less than minus 7% or more than plus 3%. Thus, despite calculations which would have led to larger reductions, the UAF adjustment has been minus 7% for the last several years. The caps on the adjustment limit the annual reduction or increase. Thus, the gap between cumulative actual spending and cumulative allowed spending grows larger each year and is exacerbated whenever Congress overrides the reductions, since the targets are never modified under current law.

Historical Updates and Legislative Overrides

Under the update formula, if actual expenditures do not exceed target expenditures, the update generally would be positive and payments would increase for all services under the fee schedule subject to the single conversion factor. In the first few years of the SGR system, the actual expenditures did not exceed the targets. (See **Figure 1**.) As a consequence, the updates to the physician fee schedule were close to the MEI in the first two years (2.3% in 1998 and 1999, compared with MEI of 2.2% in 1998 and 2.3% in 1999).⁷ For the next two years, in 2000 and 2001, the actual physician fee schedule update was more than twice the MEI for those years (5.5% update vs. MEI of 2.4% in 2000, 5.0% update vs. MEI of 2.1% in 2001). However, beginning in 2002, the actual expenditure exceeded allowed targets and the discrepancy has grown with each year.

⁷ See Table 6, Actual Past Medicare Economic Index Increases and Physician Updates for 1992–2009, and Estimated Values for 2010, in CMS publication, “Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2010.”

Figure 1. Difference Between Cumulative Allowed and Actual Expenditures for Physician Services Under the SGR System
1996-2008



Source: CRS figure from CMS data contained in “Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2010.” Available at <http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2010p.pdf>

Notes: This graph shows the difference between *cumulative* allowed expenditures and actual expenditures for physician services. The 2008 figures for both allowed and actual expenditures are CMS estimates.

As a consequence of exceeding the target, the formula dictated a reduction in the fee schedule in 2002. Although reductions have been called for every year since, Congress has passed legislation that has overridden the cuts each year since. (See **Table 1.**)

Table 1. Summary of Updates and Legislative Activity
2002-2009

Year	Formula update	Actual update	Legislation	Notes
2002	-4.8%	-4.8%		
2003	-4.4%	1.4%	Consolidated Appropriations Resolution of 2003 (CAR)	The update was 1.7% but was effective on March 1, 2003 so the average update for the year was 1.4%.
2004	-4.5%	1.5%	Medicare Modernization Act of 2003 (MMA, P.L. 108-173)	
2005	-3.3%	1.5%	MMA	
2006	-4.4%	0.2%	Deficit Reduction Act of 2005 (DRA, P.L. 109-171)	Although the DRA froze the conversion factor update, refinements to the RVUs resulted in a 0.2% update for the year.
2007	-5.0%	0%	Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432)	
Jan-Jun 2008	-10.1%	0.5%	Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173)	Physicians who voluntarily reported on certain quality measures during July 1, 2007-December 31, 2007, were eligible for a bonus payment of 1.5% in 2008 per TRHCA.
Jul-Dec 2008	-10.6% reduction from June 2008 level	0% (0.5% from 2007 level)	Medicare Improvement for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275)	See above.
2009		1.1%	MIPPA	Physicians who voluntarily reported on certain quality measures during 2008 were eligible for a bonus payment of 1.5% in 2009 per MMSEA.

Source: 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds, p. 22. <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf>, and CMS, Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2010, <http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2010p.pdf>

In addition to overriding the payment reductions, Congress has also included provisions in several of the laws to increase Medicare physician payments in other ways. For example, the Congress has altered the geographic adjustment factor for physician work, one component used in making regional adjustments to payments under the physician fee schedule. MMA set a floor on the work geographic adjustment index at 1.0 for 2004-2006, thereby slightly increasing the payment amounts in some areas. TRHCA extended this provision through 2007, MMSEA extended it

through June 30, 2008, and MIPPA extends it through December 2009. In addition, beginning January 1, 2009, MIPPA also raised the work geographic adjustment in Alaska to 1.5.

Some of the bills also modified the cap on the conversion factor, which has led to the current situation where the consequence of not overriding the reduction would lead to cuts in excess of the 7% cap. TRHCA specified that the override of the reduction that would have been implemented under the statutory formula was to be treated as if it did not occur. Therefore, the starting base for the 2008 calculation was 5% below the actual 2007 conversion factor. MMSEA overrode the reduction for the first six months of 2008 and provided for a 0.5% increase for that period. However, the legislation again specified that the override of the statutory formula was to be treated as if it did not occur. MIPPA again specified that the override of the statutory formula was to be treated as if it did not occur. As a result, CMS estimates that a reduction of 21.2% will be necessary in 2010 unless Congress acts again to override the current situation.⁸

Analysis and Criticisms of SGR System

The experience in recent years has been that the volume and the intensity of physician services provided to Medicare beneficiaries are growing at more than double the rate allowed under the SGR system.⁹ Payment reductions as called for under the update formula have required almost annual interventions by Congress and the SGR system has been criticized (and defended) amid calls for its repeal. While some of the criticisms of the SGR system point to purported flaws in the technical details behind the formula, others have just expressed general displeasure with the outcome.

General and Conceptual Concerns

One commonly asserted criticism is that the SGR system treats all services and physicians equally in the calculation of the annual payment update to the detriment of physicians who are “unduly” penalized. The expenditure target is a nationwide aggregate and the annual updates are applied uniformly; there is no direct link between individual behavior and the subsequent update. Thus, actions might be individually rational (physicians provide and bill for additional services and collect greater reimbursement) yet collectively detrimental (the annual update is reduced).¹⁰ An individual physician who controls or reduces volume does not see a resulting increase in payments.

⁸ CMS press release, “CMS Announces Payment, Policy Changes For Physicians Services To Medicare Beneficiaries In 2010,” October 30, 2009. <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3539&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

⁹ U.S. Government Accountability Office (GAO), *Medicare Physician Payments: Trends in Utilization, Spending and Fees Prompt Consideration of Alternative Payment Approaches*, testimony of Bruce Steinwald before House Energy and Commerce Committee, July 25, 2006.

¹⁰ Often referred to as the tragedy of the commons: while it may be individually rational for each herder to let livestock graze on the common field (to preserve his own), the collective consequence of many such individual decisions is that the common fields are overgrazed and all herders suffer from the degradation or depletion of the common good.

Others point out that there is no ability to distinguish between appropriate volume increases (for instance, due to changes in disease conditions that increase demand) and inappropriate volume increases (for instance, when tests or procedures are provided that are not necessary).

Technical Concerns

The inclusion of some items and services in the expenditure targets has also been called into question. Specifically, physicians have argued that Part B drug spending should be excluded from the calculation because physicians have no control or influence on the price of these drugs, although CMS is preparing to address this in its implementation of the 2010 proposed rule changes.¹¹

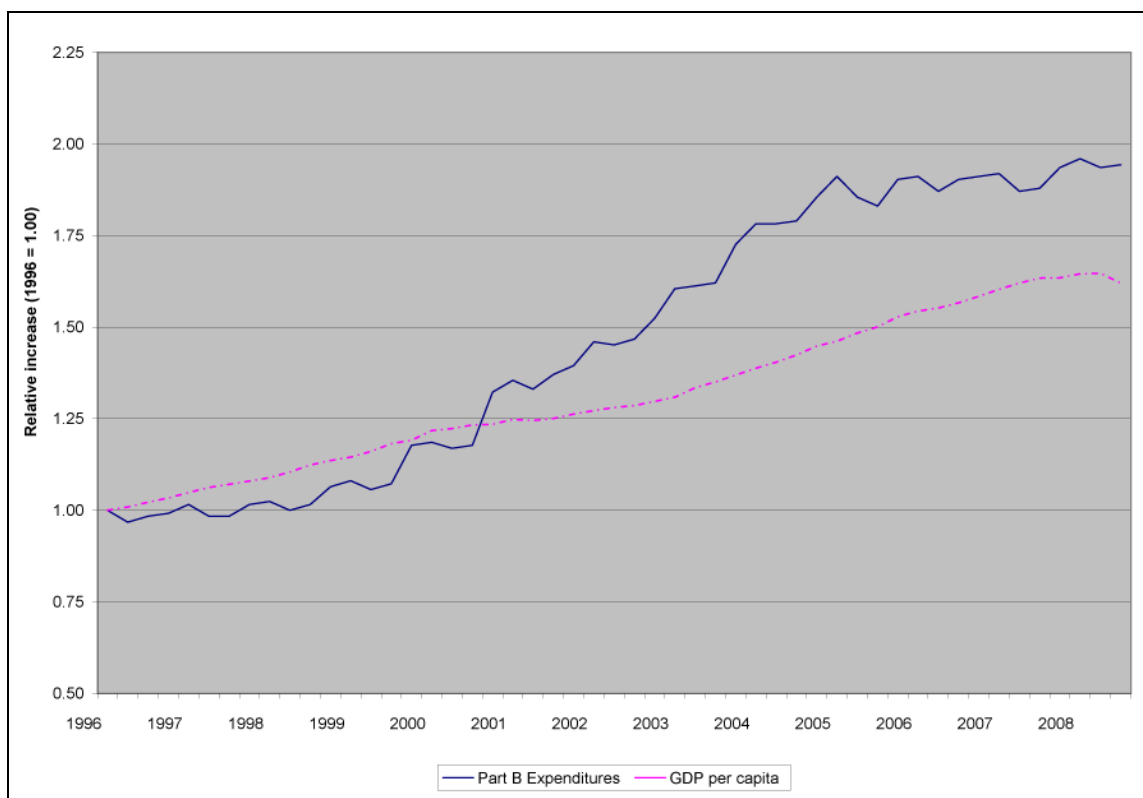
Additionally, the targets may not be not adequately modified to reflect scientific and technological innovations or site-of-service shifts, and providers have often stated that actual increases in practice costs exceed those allowed under the system. The impact of legislative and regulatory changes also may not be fully reflected in the SGR calculation.

Per Capita Gross Domestic Product (GDP) and the Annual Update

The SGR is based on a number of factors, including the changes in the price of inputs required to produce physician services (such as rent, staff and supplies), the change in the number of Medicare fee-for-service beneficiaries, the effect of laws and regulations on part B expenditures, and the rate of growth in the per capita gross domestic product, calculated as a 10-year moving average.

¹¹ See CMS Final Rule, *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010*, to be published in the *Federal Register* on November 25, 2009.

Figure 2. Relative Increase in Part B Expenditures vs. per Capita GDP
1996-2008

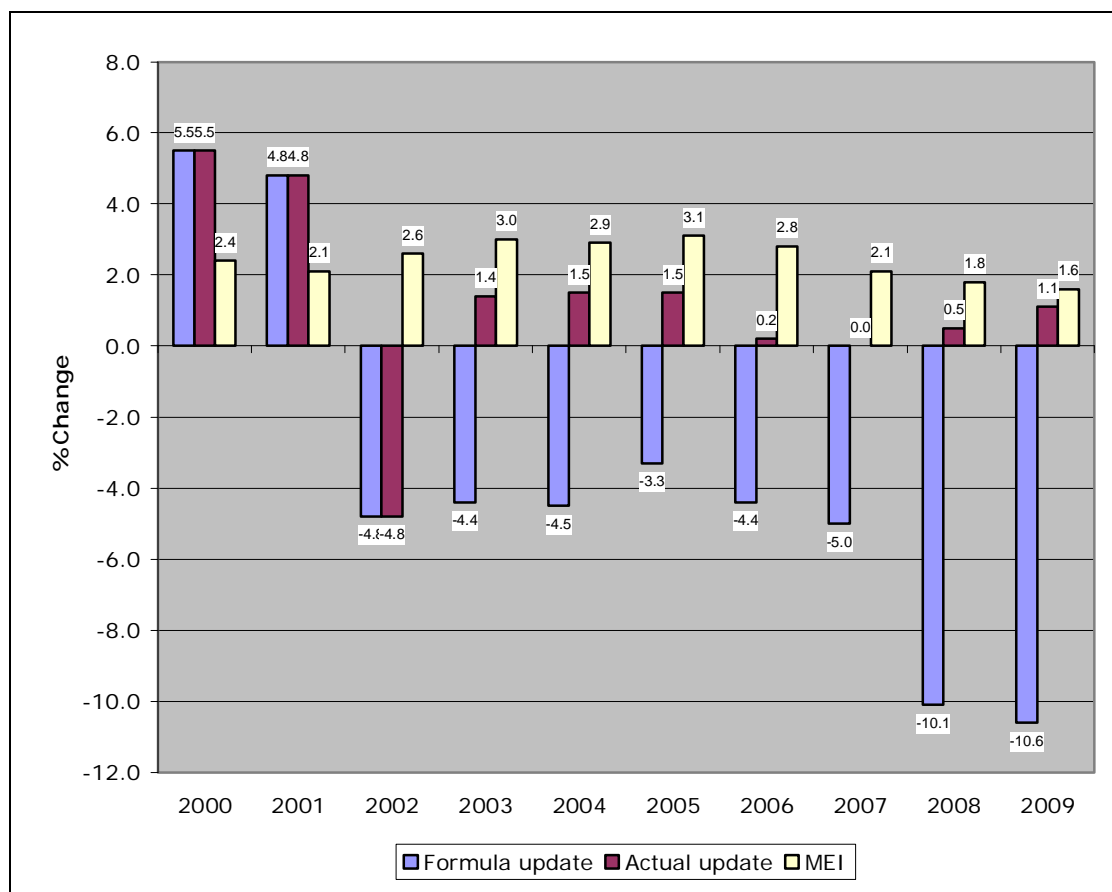


Source: CMS, “Estimated Sustainable Growth Rate and Conversion Factor for Medicare Payments to Physicians in 2010” <http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2010p.pdf> and U.S. Department of Commerce, Bureau of Economic Analysis, *National Income and Product Accounts*, Table 7.1. “Selected Per Capita Product and Income Series in Current and Chained Dollars” (<http://www.bea.gov/national/nipaweb/IndexP.htm#P>).

Notes: The lines are based on quarterly data that are not seasonally adjusted. The uneven pattern of Medicare Part B expenditures reflects typical seasonal variation in health care use, which tends to increase with colder temperatures.

The rate of growth in per capita GDP has a significant impact on the determination of the annual update. As can be seen in **Figure 2**, from 1997 through 2000, per capita GDP grew faster than part B expenditures, at more than 4% annually; part B expenditures were relatively stable from 1996 to 1998 and then started to increase in 1999 and 2000. However, economic growth slowed at the turn of the century (as can be seen in the flatter slope in the growth of per capita GDP during the period from 2000-2003), while part B expenditures grew at a faster rate from 2000 on. Because the comparison of actual to target expenditures includes a significant component that is cumulative (rather than just a comparison of the current period), the updates were positive during the early years of the SGR system but then became negative as a result of this imbalance. (See **Figure 3**.)

Figure 3. Formula Updates, Actual Updates, and the Medicare Economic Index
2000-2009



Source: 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance And Federal Supplementary Medical Insurance Trust Funds, p. 22. <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf>, and CMS, Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2010, <http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2010p.pdf>.

Notes: MMSEA included a six-month override of the SGR update (-10.1%) for the first half of 2008. MIPPA provided for an 18-month override of the SGR update that would have taken effect on July 1, 2008 (-10.6%) that included the second half of 2008 and all of 2009. See also **Table I**.

Thus, the relative health of the economy effectively masked the increases in total part B expenditures for the first few years under the SGR system, but as the economy slowed and expenditures continued to increase, the updates as determined under the SGR system have turned negative in order to bring projected actual expenditures back in line with target expenditures.

Potential Modifications and Alternatives

Although a number of modifications to the SGR system have been proposed, there is no consensus around a long-run alternative. In addition, any permanent change would likely be quite costly because the Congressional Budget Office (CBO) baseline must assume that a reduction in the conversion factor will occur for the next several years as required under current law. In addition to the impact on federal outlays, any change in the update formula will also have

implications for beneficiaries; because Part B beneficiary premiums must cover 25% of Part B program costs, any overall increase in spending results in a proportional increase in premiums.¹²

Suggested modifications have ranged from modifying the current formula to replacing the formula and linking updates to payment adequacy and/or quality measures. While a change in the formula would require legislation, some observers have suggested that there are things CMS could do administratively to ease the impact of the current formula. Proponents argue that these changes, such as removing Part B drugs from the calculation, could somewhat moderate the negative updates that are predicted.

The Medicare Modernization Act of 2003 (MMA) required that GAO study “the appropriateness of the sustainable growth rate formula” and “the stability and predictability of such updates and rate and alternatives.”¹³ In a 2005 report, the GAO categorized options for alternatives around two themes: (1) proposals that end the use of spending targets and separate fee updates from explicit efforts to moderate spending growth; and (2) proposals that retain spending targets but modify the current SGR system to address perceived shortcomings.¹⁴ The first approach emphasizes stable fee updates, while the second automatically adjusts fee updates if spending growth deviates from a predetermined target. GAO stated that “the choice between the two approaches may hinge on whether primary consideration should be given to stable fee increases or to the need for fiscal discipline within the Medicare program.” The second approach would end targets as an explicit measure for moderating spending growth. Updates would be based on cost increases with the possibility of specifically addressing high volume service categories such as medical imaging.

The Deficit Reduction Act of 2005 (DRA) required MedPAC to submit a report to Congress on mechanisms that could be used to replace the SGR system, including “such recommendations on alternative mechanisms to replace the sustainable growth rate system as the Medicare Payment Advisory Commission determines appropriate.”¹⁵ In its March 2007 report, MedPAC described two possible paths: one path would eliminate the SGR and emphasize the development and adoption of approaches for improving incentives for physicians and other providers to furnish lower cost and higher quality care, while the second path would add a new system of expenditure targets in addition to these approaches.¹⁶ However, MedPAC did not make any recommendations in favor of any single alternative to the SGR, citing “significant disagreement ... within the Commission about the utility of expenditure targets” and stating that the complexity of the issues made it difficult to recommend any option with confidence. MedPAC did stress in the report that “a major investment should be made in Medicare’s capability to develop, implement, and refine payment systems to reward quality and efficient use of resources while improving payment equity.” Examples cited by MedPAC include pay-for-performance programs for quality, improving payment accuracy, and bundling payments to reduce overutilization.

¹² For details on Medicare Part B premiums see CRS Report R40082, *Medicare: Part B Premiums*, by Jim Hahn.

¹³ P.L. 108-173, Section 953(a).

¹⁴ U.S. Government Accountability Office, *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms*, GAO-05-85, October 8, 2004.

¹⁵ P.L. 109-171, Section 5104(c).

¹⁶ Medicare Payment Advisory Commission, *Assessing Alternatives to the Sustainable Growth Rate System*, March 2007.

MedPAC has also recommended updating payments for physicians' services based on the estimated change in input prices for the coming year less an adjustment for savings attributable to increased productivity. Specifically, input prices would be measured using the MEI (without regard to the CMS adjustment for productivity increases). The recommended productivity adjustment would be that used across all provider services.¹⁷

In March 2008, CBO issued cost estimates for a variety of approaches for dealing with the physician payment issue.¹⁸ Proposals with modest costs assumed a freeze for the second half of 2008 (as opposed to a 10.6% reduction), with reductions in future years to hold future rates at current law levels. More costly alternatives would freeze or increase payments over the 10-year budget window. For example, increasing payments by the MEI each year through 2018 would increase federal spending by \$288.1 billion for the FY2008-2018 period. Coupling this with a provision excluding this change from beneficiary premium calculations ("premium hold-harmless") would increase federal spending by \$364.3 billion over the same period.

Figure 3 shows that in each year since 2002, the MEI has been greater than the update as determined under the SGR formula and the actual update that physicians have received as a result of congressional intervention.

Recent Legislative Activity

H.R. 3162 (110th Congress)

Summary

The Children's Health and Medicare Protection Act of 2007 (CHAMP, H.R. 3162) was introduced on July 24, 2007. Section 301 of Title III would have modified the SGR system by eliminating the single conversion factor currently applied to all physician services and would have established separate target growth rates and conversion factors for each of six newly created service categories.¹⁹ The six categories of physician services would have been the following: evaluation and management services for primary care and for preventive services; other evaluation and management services; imaging services and diagnostic tests; major procedures; anesthesia services; and minor procedures and other services.

The provision would have replaced the single SGR computation with separate target growth rates for each of the service categories created above. Beginning with 2008, the target growth rate for each service category would have been computed and applied separately using the same method for computing the sustainable growth rate under current law except that (1) "physicians' services" would refer to the physicians' services included in the appropriate service category, (2) the estimate of the annual average percentage growth in real gross domestic product per capita for the

¹⁷ MedPAC, Report to the Congress, Medicare Payment Policy, March 2008.

¹⁸ http://www.cbo.gov/ftpdocs/90xx/doc9055/03-14-SGR_Options.pdf

¹⁹ This summary and discussion includes only the proposed modifications to the Medicare physician update methodology in the CHAMP Act relevant to the ongoing discussions regarding proposed solutions. For complete details, please see CRS Report RL34122, *H.R. 3162: Provisions in the Children's Health and Medicare Protection Act of 2007, Provisions in the Children's Health and Medicare Protection Act of 2007*.

applicable period would have been increased by 0.03, and (3) a national coverage determination would be treated as a change in regulation and thus incorporated into the Secretary's estimate of the percentage change in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) resulting from changes in law and regulations.

Beginning with 2008, the conversion factors would be computed and updated separately for each service category. In 2008, the conversion factors would have been based on the single 2007 conversion factor multiplied by the appropriate update for the category. In subsequent years, the conversion factor for each category would have been based on the conversion factor for the service category adjusted by the appropriate update. The provision would have established a floor for updates so that the conversion factors for each service category would be no less than 0.5% for 2008 and 2009.

The Committee on Ways and Means amended and reported the bill on Aug. 1, 2007 and the House passed the bill the same day by a vote of 225-204.²⁰ The bill was never taken up by the Senate.

Brief Analysis

The approach to modifying the SGR as proposed in H.R. 3162 attempted to address, among other things, the criticism that the current update calculation penalized (or rewarded) all physicians identically regardless of the individual's or the specialty's contribution towards meeting or exceeding the aggregate expenditure target. Thus, even though imaging services have grown faster than other types of physician services (including evaluation and management services, tests, major procedures, and other procedures) the resulting impact on the annual update factor applies to all services across all specialties. However, others have countered that this delineation may not be appropriate and the CHAMP approach went too far. For example, some of the increase in imaging services may have allowed for the earlier detection of disease conditions such as cancer, which may have produced savings for other services and specialties (e.g., nuclear medicine and oncology services).

S. 1776 (111th Congress)

Summary

S. 1776, the Medicare Physician Fairness Act of 2009, was introduced on October 13, 2009. The bill would have (1) set the update to the conversion factor at 0 for 2010 and in subsequent years, and (2) sunset the SGR system immediately. On October 21, 2009, the cloture motion to proceed to the bill was not invoked by the Senate by a vote of 47-53.²¹

Brief Analysis

Setting the update to the conversion factor at 0 would have effectively frozen the Medicare physician fee schedule at 2009 levels in perpetuity, barring other changes. No replacement to the

²⁰ <http://clerk.house.gov/cgi-bin/vote.asp?year=2007&rollnumber=787>.

²¹ http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00325

SGR method for determining annual updates was proposed as a substitute. The periodic review of RVUs and the subsequent reallocation of weights would still have affected the relative reimbursements across services, however, because such adjustments are implemented in a budget neutral manner, the physician reimbursements would not have increased overall as a result of this bill.

H.R. 3961 (111th Congress)

Summary

H.R. 3961, the Medicare Physician Payment Reform Act of 2009 was introduced on October 20, 2009. The proposals in this bill share some of the same approaches and objectives as Section 301 of the CHAMP Act, but also differ significantly in a few important ways. First, rather than creating six different categories of physician services, the bill would create two categories of service beginning in 2011, each with its own separate target growth rate and conversion factor update. The two categories of service would be (1) evaluation, management, and preventive services, and (2) all other services. Target expenditures for the E&M and preventive services category would be allowed to grow at the rate of growth of per capita GDP plus 2%, while the target expenditures for the all other category would be allowed to grow at the rate of growth of per capita GDP plus 1%. Second, the year 2009 would be established as the new baseline year for calculating expenditure targets (rather than 1996 under current law) for each of the two categories of services. Third, only physician services would be included in the calculation of actual and target growth expenditures; services provided incident to the physician visit (such as laboratory services), would not be included. Fourth, during the transition to the calculations required for the new method of calculating targets and updates, the 2010 update would be the percentage increase in the Medicare economic index (MEI). In its final rule for 2010 Medicare physician payments, CMS specified that the MEI will be 1.2%.²²

On November 19, 2009, the House passed H.R. 3961 by a vote of 243-183.²³

Brief Analysis

The impact of this bill would be felt not only by physicians but also by other parts of the Medicare program, the Department of Defense TRICARE program, and beneficiaries under Medicare Part B. CBO estimates that enacting H.R. 3961 would increase direct spending by about \$210 billion over the 2010-2019 period.²⁴ Not only would physician reimbursements under the Medicare physician fee schedule increase, but expenditures under the Medicare Advantage (MA) program would increase because per beneficiary spending for fee-for-service beneficiaries would increase as a result of the bill, raising the “benchmarks” that Medicare uses to determine the capitation payments for beneficiaries enrolled in Medicare Advantage plans. TRICARE expenditures would rise because its physician reimbursements are based on Medicare’s physician

²² The MEI measures the weighted-average annual price change for various inputs needed to produce physicians’ services. The calculation of the 2010 MEI is given in Table 33 of the final 2010 Medicare physician payment rule issued by CMS. http://www.federalregister.gov/OFRUupload/OFRData/2009-26502_PI.pdf.

²³ <http://clerk.house.gov/evs/2009/roll909.xml>

²⁴ CBO Cost Estimate, “H.R. 3961—Medicare Physician Payment Reform Act of 2009,” November 4, 2009, <http://www.cbo.gov/ftpdocs/107xx/doc10704/hr3961.pdf>.

fee schedule. Furthermore, since Medicare Part B beneficiary premiums are required to cover 25% of total Part B expenditures, the increases in physician reimbursements as a result of changing the update calculation would put pressure on future Part B premiums to rise.

The proposed modification might reduce the likelihood that future expenditures exceed the target expenditures, since the growth rates would be more generous under this bill than under current law, but this might lead to an increase in the total expenditures of the Medicare Part B program. While the SGR has been heavily criticized, a fundamental assumption was that tying physician expenditure growth to the rate of growth in GDP per capita could lead to a sustainable growth path. By allowing the two categories to grow at GDP per capita plus 1% or 2%, this bill would appear to allow for a situation where physician expenditures grow and consume a greater percentage of the national income.

A Senate Amendment in the form of a Substitute to H.R. 3590 (111th Congress)

Section 3101 of the Senate health care reform bill, an amendment in the form of a substitute to H.R. 3590, would have overridden the reduction in the annual update to the conversion factor used in the determination of the Medicare fee schedule and provided an increase of 0.5% in 2010. The conversion factor for 2011 and for subsequent years would have been computed as if the increase in 2010 had never applied. CBO estimates that this provision would have cost \$7.2 billion in 2010 and \$4.1 billion in 2011, with no other budgetary impact in subsequent years. However, the manager's amendment contained several additions and modifications to the bill, including Section 10310, which repealed Section 3101. On December 24, 2009, the Senate passed the amended bill by a vote of 60-39.²⁵

Brief Analysis

Much as other recent overrides have done, the original provision (Section 3101) would have increased Medicare physician payments slightly in the short term while increasing the cost of addressing this problem in the future because another year's worth of actual expenditures that exceed target expenditures would have contributed to the total amounts that would have to be recouped under the current SGR system. However, the manager's amendment struck this section, and thus the health care reform bill as passed by the Senate does not include any provisions that address the SGR situation.

Department of Defense Appropriations Act, 2010 (H.R. 3326)

On December 16, 2009, the House passed H.R. 3326, the FY2010 Defense Appropriations bill. One of the provisions in Section 1011 of the bill delays the application of the update to the conversion factor until February 28, 2010.²⁶ Another provision in the same section reduces the

²⁵ http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00396

²⁶ For roll call details, see <http://clerk.house.gov/cgi-bin/vote.asp?year=2009&rollnumber=985>

amount of monies available in the Medicare Improvement Fund by \$1.55 billion.²⁷ The Senate passed the bill on December 19, 2009,²⁸ and the bill was signed into law²⁹ that day.

Brief analysis

The bill delays the payment reductions from taking effect for two months.

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²⁷ Section 188 of MIPPA established the Medicare Improvement Fund (MIF), available to the Secretary to make improvements under the original fee-for-service program under Parts A and B for Medicare beneficiaries.

²⁸ For roll call details, see http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00384

²⁹ P.L. 111-118.