CHAPTER 8

Reviewing the estimated payment update for physician services

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In this chapter

- Updating payments for 2002
- Replacing the sustainable growth rate system

Medicare payments for physician services are updated annually based on the so-called sustainable growth rate system, which is designed to control overall spending. The Medicare Payment Advisory Commission (MedPAC) believes this system fails to account adequately for changes in the cost of physician services and that policymakers should consider alternatives to the system if policies to control spending are necessary. Accordingly, the Commission recommends replacing the sustainable growth rate system with an update method that better accounts for the cost of providing care. In the meantime, this chapter fulfills MedPAC's requirement to review the Health Care Financing Administration's (HCFA's) preliminary estimate of the update for 2002. Based on this review, the Commission concludes that this estimate of the update appears reasonable. The Commission notes that the update for 2002 may ultimately be lower—perhaps significantly lower—than HCFA's estimate of −0.1 percent, which could raise concerns about the adequacy of payments and beneficiary access to care. Such an update would limit physician spending for the first time since enactment of the sustainable growth rate system, and it also illustrates the Commission's concern that updates under the system are not closely related to the cost of providing physician services.

Medicare's payments for physician services are made according to a fee schedule that assigns relative weights to services, reflecting resource requirements. These weights are adjusted for geographic differences in practice costs and multiplied by a dollar amount—the conversion factor—to determine payments. The conversion factor is updated annually, based on a formula designed to control overall spending over time while accounting for some of the factors that affect the cost of providing care.

Calculating the update to the conversion factor is a two-step process. First, HCFA must estimate the sustainable growth rate (SGR), which is the target rate of growth in spending for physician services and is based on a formula defined in law. The SGR is a function of projected changes in:

- input prices for physician services,[1]
- enrollment in traditional Medicare,
- real gross domestic product (GDP) per capita, and
- spending attributable to changes in law and regulations.

Second, HCFA calculates the update to the conversion factor. This update is a function of:

- the change in input prices for physician services,[2]
- a legislative adjustment required by the Balanced Budget Refinement Act of 1999 (BBRA),[3]
- an adjustment to account for expected changes in physician behavior in response to payment changes,[4] and
- an adjustment factor that increases or decreases the update as needed to align actual spending with target spending determined by the SGR.[5]

Updating payments for 2002

Under the BBRA, the Secretary is required to make publicly available, by March 1 of each year, an estimate of the SGR and conversion factor update for the succeeding year.

HCFA's estimate of the SGR for 2002 is 6.0 percent (Miller 2001b). As discussed below, this estimate appears reasonable, but it is based on limited data. When re-estimating the SGR this fall, HCFA's use of more complete data will be important.

HCFA then calculated a preliminary update for 2002 of −0.1 percent. Pending re-estimation of the SGR and the collection of data necessary to calculate the update, this preliminary estimate also appears reasonable.

Estimate of the sustainable growth rate for 2002

HCFA's preliminary estimate of the SGR for 2002 of 6.0 percent is based on estimates of a change in input prices for physician services of 1.5 percent, growth in traditional Medicare enrollment of 0.4 percent, growth in real GDP per capita of 2.4 percent, and growth in spending due to law and regulations of 1.5 percent (Table 8-1). This estimate of the SGR for 2002 is lower than HCFA's current estimate of the SGR for 2001, which is 7.0 percent (HCFA 2001). The two SGRs are different largely because HCFA projects less growth in traditional Medicare enrollment in 2002 than in 2001.

Change in input prices

By law, the change in input prices in the SGR is a weighted average of the expected changes in input prices for physician services and laboratory services. HCFA's estimate of this factor is based in part on the Medicare Economic Index (MEI), which is 1.8 percent. The estimate also accounts for changes in payment rates for laboratory services; under the Balanced Budget Act of 1997, these rates will not change in 2002.

A change in input prices of 1.8 percent is slightly lower than in recent years (HCFA 2001). Since 1992, when the physician fee schedule was introduced, the MEI has ranged from 2.0 percent to 3.2 percent (Figure 8-1). One reason for the drop in the MEI is that growth in input prices is expected to slow generally in 2002 (Standard and Poor's DRI 2000). Also, the Bureau of Economic Analysis has revised its methods for calculating productivity growth. (Measures of labor inputs in the MEI are adjusted downward for productivity growth.) This change has shifted estimates of productivity growth upward and reduced estimates of the change in prices for labor inputs measured by the MEI.[6]

1 For purposes of the SGR, physician services include services commonly performed by a physician or in a physician's office. In addition to services paid under the physician fee schedule, these services include diagnostic laboratory tests. To estimate this factor, HCFA uses a weighted average of the Medicare Economic Index (MEI), a measure of changes in input prices for physician services, and the change in payment rates for laboratory services legislated by the Congress. Unlike input price indexes for other services, HCFA adjusts the Medicare Economic Index for growth in the productivity of labor inputs used to provide physician services.

2 For purposes of the update, physician services include only those services paid for under the physician fee schedule.

3 This adjustment maintains the budget neutrality of a technical change introduced to avoid volatility in the conversion factor.

4 The behavioral response adjustment is based on a HCFA assumption that physicians will increase the volume of services to offset a portion of revenue reductions associated with implementation of resource-based practice expense payments (HCFA 1998).

5 The update adjustment factor has two components that account for the difference between target and actual spending. The first component is an adjustment for the difference between target and actual spending in the year before the update occurs, or 2001 in the case of the update for 2002. The second component is an adjustment for the cumulative difference between target and actual spending since April 1996. By law, the first component is weighted to be the most important component of the update adjustment factor.

6 See Chapter 2 of MedPAC's March 2001 report to the Congress for further discussion of MEI issues.

TABLE 8-1

HCFA estimates of factors in sustainable growth rates, 2001-2002

Factor	2001	2002
Change in input prices	1.9%	1.5%
Growth in traditional Medicare enrollment	2.9	0.4
Growth in real GDP per capita	1.5	2.4
Growth in spending due to law and regulations	0.5	1.5
Sustainable growth rate	7.0	6.0

Note: GDP (gross domestic product). The sustainable growth rate is a function of the four factors shown.

Source: HCFA estimates.

Growth in traditional Medicare enrollment

HCFA's forecast of growth in total Medicare Part B enrollment for 2002 is 0.9 percent. Net of growth in Medicare+Choice (M+C) enrollment, Part B enrollment for beneficiaries in traditional Medicare is expected to grow by 0.4 percent.

The forecast growth rate for M+C enrollment of 3.4 percent may be too high or too low. On one hand, for the year ending February 1, 2001, average monthly enrollment in M+C plans fell by 1.5 percent over the previous year, including a 10 percent drop in January. On the other hand, implementation of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) could lead to higher M+C enrollment because the law increased M+C payment rates.[7]

It is too early to analyze the BIPA's effects on M+C enrollment, but further information on enrollment in M+C for 2002 will be available this summer when M+C plans notify HCFA about their contracting plans. This information, combined with additional data on M+C enrollment in 2001, will help HCFA revisit its estimates of enrollment growth before publishing the final update for 2002.

Growth in real gross domestic product per capita

HCFA's estimate of growth in real GDP per capita of 2.4 percent is based on the President's budget proposal for fiscal year 2002. This estimate is consistent with the forecast of real GDP growth for 2002 from the Congressional Budget Office (CBO 2001). The estimate assumes an end to the current economic slowdown and a rebound by next year.

Growth in spending due to law and regulations

For the 2002 update, the factor that accounts for changes in law and regulations reflects provisions in the BIPA that established or increased Medicare Part B coverage for Pap smears, pelvic examinations, glaucoma examinations, colonoscopy, and mammography. The law also established coverage for medical nutrition therapy services for certain beneficiaries with diabetes or renal disease and included other provisions that will lead to greater spending.

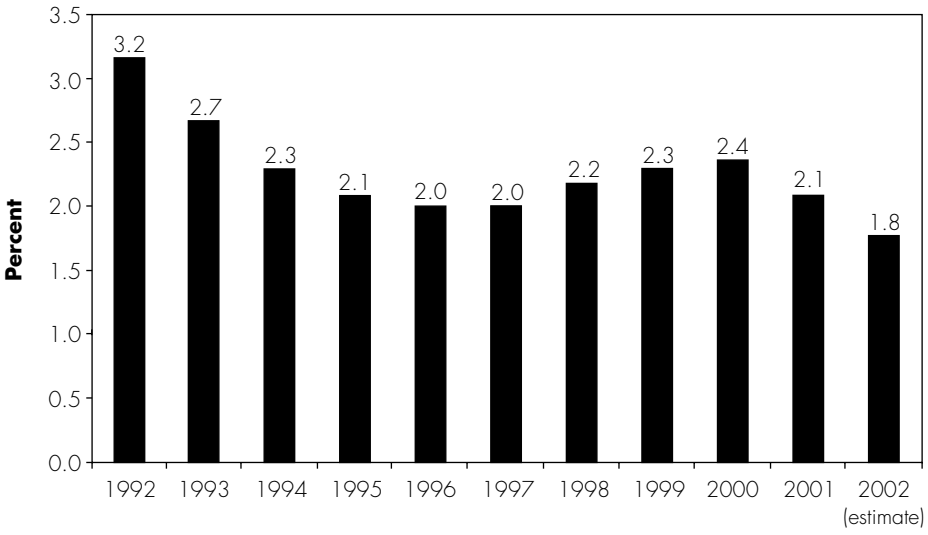
Estimate of the update for 2002

HCFA's estimate of the 2002 update to payments for physician services is −0.1 percent (Miller 2001a). This estimate is based on reasonable estimates of the factors in the statutory formula (Table 8-2, see page 130), but it is lower than the estimated change in input prices for physician services.

Specifically, the change in input prices of 1.8 percent is the estimate of the MEI discussed above. The update adjustment factor of −1.5 percent would reduce the update because estimated spending for physician services is greater than the target determined by the SGR. The legislative adjustment of −0.2 percent is required under the BBRA. Finally, the volume and intensity adjustment of −0.2

FIGURE 8-1

Medicare Economic Index, 1992–2002



Source: HCFA.

7 For further information on M+C payment rates, see p. 113 of MedPAC's March 2001 report to the Congress.

TABLE 8-2

HCFA estimate of the update for physician services for 2002

Factor	Percentage
Change in input prices	1.8%
Update adjustment factor	−1.5
Legislative adjustment	−0.2
Volume and intensity adjustment	−0.2
Update	−0.1

Note: The update is a function of the four factors shown.

Source: HCFA estimates.

percent is based on a HCFA assumption that physicians will provide more services to offset lower payments associated with implementation of resource-based practice expense payments to physicians.

The estimate of the update adjustment factor is negative because HCFA's estimates of actual spending for physician services are greater than the target determined by the SGR. This difference means that HCFA's estimates include growth in real GDP per capita that is less than growth in the volume and intensity of physician services per beneficiary. Without further analysis, reasons for this difference are unclear, but HCFA's estimates assume that volume growth per beneficiary started to exceed growth in real GDP per capita in 2000 and that the difference will widen in 2001.[8]

An update less than the estimated change in input prices may raise concerns about the adequacy of payments and beneficiary access to care, but it is unclear whether the update HCFA has estimated would lead to access problems. The updates for 2000 and 2001 (of 5.4 percent and 4.5 percent, respectively) were somewhat generous in that they were higher than the estimated change in input prices. However, if the final update for 2002 published this fall is substantially lower than HCFA's estimate, it may affect access.

An update lower than HCFA's estimate is possible for two reasons. First, the current economic slowdown may lead to lower growth in real GDP than HCFA estimates, lowering the SGR for 2001. Second, volume growth may be higher than HCFA expects, raising the estimate of actual spending for 2001. Such changes in target and actual spending would have a direct effect on the update because the difference between target and actual spending in 2001 is the most important component of the update adjustment factor for next year.

Replacing the sustainable growth rate system

Regardless of whether HCFA's estimate of the 2002 update under the SGR system is technically reasonable, MedPAC has concluded that the SGR system is not an appropriate method for updating payments for physician services (MedPAC 2001). Accordingly, the Commission has recommended that the Congress replace the SGR system with an annual update based on factors influencing the unit costs of efficiently providing physician services.

MedPAC's recommendation would correct three problems. First, although the SGR system accounts for changes in input prices, it fails to account for other factors affecting the cost of providing physician services, such as scientific and technological advances and new federal regulations. Second, it is difficult to set an appropriate expenditure target with the SGR system because spending for physician services is influenced by many factors not explicitly addressed, including shifts of services among settings and the diffusion of technology. The SGR system attempts to sidestep this problem with an expenditure target based on growth in real GDP, but such a target helps ensure that spending is affordable without necessarily accounting for changes in beneficiaries' needs for care. Third, enforcing the expenditure target is problematic. An individual physician reducing volume in response to incentives provided by the SGR system would not realize a proportional increase in payments. Instead, the increase in payments would be distributed among all physicians providing services to Medicare beneficiaries.

These problems with the SGR system can have serious consequences. Updates under the SGR system will nearly always lead to payments that diverge from costs because actual spending is unlikely to be the same as the target. When this occurs, payments will either be too low, potentially jeopardizing beneficiary access to care, or too high, making spending higher than necessary. Also, the SGR system only applies to services paid under the physician fee schedule, including services provided in physicians' offices. It does not apply to facility payments, such as payments to hospital outpatient departments and ambulatory surgical centers. Because physicians can provide many services in their offices or in facilities, updates constrained by an expenditure target that apply only to one setting could create financial incentives that inappropriately influence clinical decisions about where services are provided.

Given these problems with the SGR system, the Commission has recommended that the Congress consider a new approach to updating payments for physician services that more fully accounts for changes in the unit costs of providing those services. In considering updates of other Medicare payments, MedPAC uses an update framework that addresses both the appropriateness of the current level of payment and changes in

8 HCFA warns that the estimates of actual spending may change because data the agency used to calculate the preliminary estimate of the update for 2002 were based only on complete claims through the second quarter of 2000.

costs expected to occur during the coming year. The Commission believes elements of this framework could provide a promising basis for developing a new approach for updating payments to physicians. ■

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