

Congress of the United States

House of Representatives COMMITTEE ON WAYS AND MEANS

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March 21, 2002

The Honorable Thomas Scully
Administrator
Centers for Medicare and Medicaid Services
Hubert Humphrey Building, Room 314-G
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Mr. Scully:

The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT) and the Congressional Budget Office (CBO) project significant negative updates to physician payments under the Sustainable Growth Rate (SGR) system over five years. Specifically, CMS projects the following updates after this year's 5.4% decrease: -5.7% in 2003, -5.7% in 2004, -2.8% in 2005, -0.1% in 2006. Under these assumptions, the physician conversion factor in 2005 will be less than the conversion factor in 1993.

We believe this significant drop in the baseline is premised on several actuarial assumptions that are at best open to debate, and at worst, specious. The magnitude of these projected, successive and significant cuts to physician payments makes the score of *any* modification of the sustainable growth rate formula extremely high. For example, under the current baseline, a policy which absorbs this year's cut but freezes physician payments at zero updates (notwithstanding rising practice costs) could cost more than \$40 billion over 10 years. In addition, we believe that CMS could and should use its administrative authority to correct errors or recognize newer and more accurate data when calculating the SGR. In order to enact a reform of physician payments that preserves Medicare beneficiaries' access to high quality care, while also safeguarding scarce taxpayer dollars, we must work together.

Measures CMS could take to help us fix the baseline:

1. Change measure of physician productivity
2. Revise assumed behavioral response of physicians to rate decreases
3. Account for other factors affecting physician income, like tax changes
4. Adjust for professional liability insurance cost increases
5. Account for costs of new benefits
6. Correct errors in target expenditures in 1998 and 1999.

1. Change measure of physician productivity.

CMS currently adjusts the Medicare Economic Index (MEI) to account for changes in physician productivity using a measure based only on labor productivity. A labor-only adjustment has been part of the MEI since this index was first used to pay for physician services in 1975. The Bureau of Labor Statistics (BLS) began publishing measures of multi-factor productivity in 1983 as a means to capture the joint effects of multiple inputs, like labor, office space, medical materials and supplies, and equipment. A labor-only productivity adjustment implies that non-labor inputs have no effect of productivity. We believe that the production of physician services is affected by both labor and non-labor inputs.

CMS has absolutely no data (not even one study) to link the current measure of labor productivity to productivity for *physician services*. Therefore, the productivity measure currently used is a guess based on the entire economy and may have absolutely no relation to the improved productivity of physicians over time. Indeed, we believe there will be diminished productivity gains in physician activities, since the fixed resources (e.g. time required to examine, diagnose and treat a patient) can only be compressed so much, whereas there is greater room for labor to continue to become much more efficient in the production of "widgets".

In light of the inadequate data on physician productivity, we urge CMS to use a multi-factor productivity measure, which includes labor, office space, medical materials and supplies, and equipment, as recommended by the Medicare Payment Advisory Commission (MedPAC). The Secretary could use MedPAC's policy standard multi-factor productivity adjustment of 0.5 percent, or a 10-year moving average measure of multi-factor productivity growth as measured by BLS.

2. Revise assumed behavioral response of physicians to rate decreases.

CMS and CBO assume that physicians increase volume/intensity of services to offset about 30 percent of any rate decrease. Consequently, relatively larger rate decreases are needed to reach desired total expenditures under the SGR system. This behavioral offset assumption is exacerbated by the SGR system. It creates a downward spiral effect in rates because the higher volume, assumed through the behavioral offset to rate reductions, must be countered under the SGR with still further rate reductions in subsequent years.

Current assumptions are based on OACT analysis of 6 to 8 year-old data from 1994 to 1996 -- before implementation of the sustainable growth rate system. Although the OACT study states that the SGR system changed the long-term financial incentive for physicians to increase their volume and intensity, CMS has not analyzed data after implementation of the SGR system to determine if a 30 percent offset is justified.

Under the Medicare Volume Performance Standard, which preceded the SGR system, volume and intensity increases in one year led to a larger allowance in future years. The SGR system severed the link to past volume and intensity increases, replacing it with increases in real per capita Gross Domestic Product. Furthermore, CMS assumes that a 30 percent offset will continue to apply over many years of rate decreases, although *no* analysis has been done to estimate the effect of multiple years of rate decreases, especially of the magnitude projected under current law.

While we recognize that the behavioral offset assumption does not affect total expenditures under the SGR system, it does affect the trade-off between payment rate updates and volume/intensity. If CMS removed the behavioral offset, physician updates would change dramatically. The CMS Office of the Actuary estimates that, while the projected update for 2003 would remain unchanged, the update in 2004 would increase by over one-third (37 percent), from -5.7% to -3.6%. Instead of a negative update of -2.8 percent in 2005, physicians would enjoy a positive update of 2.5 percent in 2005 – an almost 200 percent increase in the update in that year. These findings illustrate the profound cumulative effect that the behavioral offset has on projected physician updates.

CBO uses a 30 percent offset for a single-year response to rate decreases, but makes no assumptions about the size of offsets when multiple years of rate decreases occur.

Numerous studies undermine the 30 percent annual behavioral offset assumption, especially over an extended period like the 5 years of rate reductions projected by CMS:

- In testimony before the House Ways and Means Committee, Dr. Paul Ginsburg from the Center for Studying Health System Change reported constraints on physician capacity that call into question physicians' ability to increase volume (February 28, 2002).
- A forthcoming study of California emergency departments (Lambe, et. al., *Trends in the Use and Capacity of California's Emergency Departments, 1990-1999*, *Annals of Emergency Medicine*, April 2002) reports significant increases in patients needing critical emergency care while the number of emergency departments decreased significantly in the 1990s. These results help explain the perception that emergency department capacity is insufficient to meet growing demand.
- Some physician unwillingness to participate in the Medicare+Choice program illustrates one response to low Medicare payment rates, as documented in studies by the Commonwealth Fund (*Physician Withdrawals: A Major Source of Instability in the Medicare+Choice Program*, January 2002) and Mathematica Policy Research (MedPAC, *Health Plans' Selection and Payment of Health Care Providers*, 1999, May 2000).

- Low Medicaid payment rates have reduced the number of participating physicians and the number of Medicaid patients seen by participating physicians (American Academy of Pediatrics, *Pediatrician Participation in Medicaid/SCHIP, 2000*; *Okla. Doctors Sue State Over Medicaid Pay, Access Woes*, American Medical News, September 24, 2001).
- Surgeons and many other specialists would find it difficult to increase volume because most of their work is done on referral, or is covered by global payments.

Actuarial assumptions about physician behavior run counter to generally accepted economic principles. Indeed, the assumption that lower prices leads to higher volume is counter-intuitive. Most economists argue that when prices are artificially capped or reduced, there is less incentive – not more – for suppliers to produce that product or service.

Economists also argue that system-wide spending targets under the SGR system do not provide direct incentives to *individual* physicians to limit their own volume and intensity of services. An individual physician who reduces volume in response to the incentives from the SGR system would not gain a proportionate increase in payments, because payment increases would be shared among *all* physicians who serve Medicare beneficiaries. Contrary to the system-wide goal of restraining volume growth, an individual physician has incentives to increase volume under the SGR system. As such, the SGR system is unlike other Medicare prospective payment systems where increased efficiency results in maximizing profit for the particular facility or provider.

(Table 1 summarizes findings from studies of behavioral offset and access issues, which are attached.)

3. Account for other factors affecting physician income, like tax changes.

If one accepts the argument that physicians have target incomes -- which the behavioral offset theory appears to hold -- cuts to marginal tax rates (included in the recently enacted Economic Growth and Tax Relief Reconciliation Act of 2001) will increase after-tax income and could lead to volume decreases. If CMS assumes a behavioral offset to prices decreases, they should also include behavioral offsets to other factors that affect income. Tax cuts lead to increased physician income and could lead many physicians to reduce volume and intensity of services provided.

4. Adjust for professional liability insurance cost increases.

CMS could allow a one-time increase to the MEI to account for increases in professional liability insurance until a long-term solution can be found. CMS estimates professional liability insurance costs increases of 7.3 percent in 2001, 4.0 percent in 2002, and 4.6 percent in 2003. According to the Office of the Actuary, professional liability insurance cost is given a weight of 3.2 percent in the total MEI. This weight is

based on expenditure data for self-employed physicians in the 1996 American Medical Association (AMA) Socioeconomic survey. The MEI was re-based and revised in 1998, for use in the CY 1999 update. Prior to that, the weight for professional liability insurance was based on 1989 data, and was higher, 4.78 percent.

These assumptions on malpractice costs appear too low. *Medical Liability Monitor*, a monthly newsletter reporting on professional liability since 1975, estimates that the average increase in malpractice insurance premiums was about 15 percent per year in 2001 and 2002 for three specialties that comprise 46 percent of all physicians. In a recent survey of state chapters by the American College of Emergency Physicians, almost two-thirds (65 percent) responded that chapter members believe there is a current crisis in obtaining medical malpractice insurance and over three-fourths (77 percent) believe that there is a current crisis in maintaining this insurance.

Considering that premiums for 2002 are expected to rise in 2002 due to continued claims severity, we ask that you re-examine your assumptions about both the costs and weight of malpractice insurance in the MEI.

4. Account for costs of new benefits.

Currently CMS only includes new coverage decisions in the SGR's law and regulation section if the coverage is attributable to statutory changes. However, national coverage decisions made by CMS are not added to the target. For example, CMS's coverage of Positron Emission Tomography (PET) added more than 40 codes, but these codes are not included in the target. As a result, physicians' payments are reduced for spending increases that are associated with new technologies or services that have been approved and publicized by federal officials.

While most of the expenditures included in the SGR pool are for physician services, about 11% are for other services including lab tests and physician-administered drugs. Spurred mostly by the addition of 40 new drugs, spending on outpatient drugs in Medicare grew from 3.7 percent of spending in the SGR pool in 1996 to 6.6 percent in 2000 -- a net spending increase of \$550 million a year or about 1 percent of SGR spending. However, the SGR targets are not increased to account for the growing costs of these drugs, but physician updates are reduced as a result.

5. Correct errors in target expenditures for 1998 and 1999.

CMS has not corrected errors in projected targets for 1998 and 1999 resulting from erroneous estimates of GDP growth and fee-for-service (FFS) enrollment. Revising these estimates would raise the targets each year because of the cumulative nature of the SGR, and would increase the physician update.

The Balanced Budget Refinement Act of 1999 (BBRA) authorized the adjustment of prior years' SGR component factors to reflect more recent data, beginning with the SGR for FY 2000. While the law does not require CMS to correct data errors for 1998 and 1999, it does not preclude CMS from administratively correcting the data for 1998 and 1999. Because the CMS baseline does not include 1 million fee-for-service beneficiaries (as it over-estimated growth in Medicare+Choice enrollment), the SGR calculations are made as if these 1 million beneficiaries do not exist. Clearly these beneficiaries are visiting physicians and consuming services. The AMA estimates that these data errors have removed \$20 billion to date from Medicare funding for physician services by artificially lowering spending targets. CMS has the clear legislative authority to correct such errors and should do so.

In conclusion, we believe that the cumulative effect of questionable assumptions and uncorrected errors greatly exacerbates the physician spending baseline, thereby making it more difficult for Congress to enact a reasonable solution to the significant and successive payment cuts. We hope you can revisit these assumptions and make appropriate modifications, using your administrative power. We look forward to working with you and your staff on this matter, as we develop legislative solutions to complement your administrative changes.

Best Regards,



Bill Thomas
Chairman, Ways and Means Committee



Nancy L. Johnson
Chairman, Ways and Means
Subcommittee on Health

cc: Dan Crippen
Director
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Attachment

Table 1. Studies of Estimated Effects of Change in Volume and Intensity of Physician Services Resulting from a Price Change and Access Issues

Author	Study period and sample	Estimated behavioral offset	
		For a price decrease	For a price increase
Christensen, Congressional Budget Office, 1992	1976-78, Colorado general practitioners and internists	50 percent offset	33 percent offset
Nguyen and Derrick, Health Services Research, 1997	1989-90, Medicare physician data for individual physicians	40 percent offset, varied by specialty group. Authors caution that income effect omitted; therefore may have over-estimated size of behavioral response.	No significant offset for practices not receiving a price decrease (no one got price increase)
McCall, <i>Health Care Financing Review</i> , 1993.	1987-1988, Medicare claims data from 4 states. Effects of OBRA 87	Physicians with largest fee reductions or who were most financially dependent on the procedures with rate decreases did not change volume of over-priced procedures.	Not studied
Physician Payment Review Commission (PPRC), 1993	1991-92, physician specialty within a Medicare carrier	36 percent	No analysis
Mitchell and Cromwell, <i>Health Services Research</i> , 1995.	1985-1989, Medicare physician claims data from 11 states over 5 years. Effects of OBRA 87 price reductions for 11 surgical procedures on surgical services	28 percent for hip replacements 16 percent for CABG surgeries 19 percent for cataract operations No effect or reduced volume for remaining 8 procedures	No analysis
PPRC, 1991 and 1992	Effects of OBRA 87 and OBRA 89	30-40 percent	No analysis
Verrilli and Zuckerman, Urban Institute, 1995	1986-91 and 1991-92, by broad type of service group	Volume and intensity growth slowed during first year of fee schedule	
Office of the Actuary, CMS, 1998	1994-96, sample of Medicare physicians	Approximately 30 percent. No significant effect in 1994-95 for all specialties.	No significant offset

Author	Study period and sample	Estimated behavioral offset
Paul Ginsburg, Center for Studying Health System Change, Testimony before Ways and Means Committee, February 2002	Surveys of households and physicians in 12 communities	Current constraints on capacity indicated by long waits for medical check-ups and appointments when ill, with Medicare beneficiaries more likely than privately insured non-elderly to report lengthy waits. Number of physicians willing to treat all new Medicare patients declined from almost 72 percent in 1997 to 68 percent in 2001; decline in primary care was from 65 percent to 61 percent.
Commonwealth Fund, <i>Physician Withdrawals: A Major Source of Instability in the Medicare+Choice Program</i> , January 2002	Medicare data on primary care provider turnover rates in 38 states and 7 Medicare+Choice study sites, 1999 to 2000	Payment issues were one of the key reasons for network instability. Providers considered payments insufficient to cover the cost of care at all study sites. Claims denials and payment delays also contributed to provider dissatisfaction with plans.
Mathematica Policy Research for MedPAC, <i>Health Plans' Selection and Payment of Health Care Providers</i> , 1999, May 2000	Random sample of 150 HMOs and 80 intermediaries in 20 large markets nationwide	One-third of intermediate entities reported that maintaining or expanding the number of providers willing to serve Medicare beneficiaries was difficult; 44 percent of these said that it was a major problem. Low Medicare payment rates and compensation cited as the source of the difficulty
American Academy of Pediatrics <i>Pediatrician Participation in Medicaid/SCHIP</i> , 2000	Survey of fellows of the academy	58 percent of pediatricians reported that low reimbursement was a very important reason for limiting participation in Medicaid. Over 80 percent of pediatricians nationwide reported that Medicaid payments do not cover their overhead costs, and 67 percent are accepting all new Medicaid patients. Oklahoma's pediatricians have sued their state to get Medicaid rates increased in order to encourage participation in the program. Fully 91 percent of Oklahoma's pediatricians report that Medicaid payments do not cover their overhead costs, and less than half (48 percent) are accepting all new Medicaid patients.

Author	Study period and sample	Estimated behavioral offset
Lambe et al., <i>Trends in the Use and capacity of California's Emergency Departments</i> , Annals of Emergency Medicine , April 2002 [forthcoming]	Emergency departments in California, 1990-1999	Significant increase in patients who need emergency care leaves little room for treatment of patients with less urgent conditions. Critical visits to emergency departments increased by 59 percent, urgent visits by 36 percent, non-urgent visits declined 8 percent.