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WILL THE RECENT SLOWDOWN IN HEALTH CARE COST GROWTH IMPROVE MEDICARE'S FINANCING OUTLOOK?

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ABSTRACT

In recent years US health care spending growth has slowed. Analysts have sought to explain the causes of this slowdown and to understand its implications for Medicare's financial outlook. Some have suggested the slowdown reflects transformational change in the health care sector facilitated by the Affordable Care Act (ACA), possibly lessening the need for further legislation to shore up Medicare finances. Explaining the recent cost slowdown is likely to remain a subject of debate among experts for some time. Regardless of the outcome of that debate, however, the slowdown does not translate into a significant probability that further Medicare reforms can be avoided. Medicare's trust funds are now in weaker condition than projected before the cost slowdown. The cost slowdown preceded the ACA's passage and cannot be principally attributed to it. Going forward, Medicare costs are substantially more likely to be higher than the trustees' current projections than they are to be lower. Importantly, longstanding methodologies for projecting Medicare finances already assumed a substantial, enduring, long-term deceleration in national health cost growth. Nothing about the recent cost slowdown suggests that Medicare's long-term financial future will be more benign than now projected.

JEL codes: I13, I18

Keywords: Medicare, health costs, cost slowdown, Medicare trustees, trustees' projections, national health expenditures, Medicare finances, Affordable Care Act, health care spending, cost deceleration, recession, health cost inflation

In recent years the rate of US national health care spending growth has slowed relative to prior-year growth rates. Whereas per capita health consumption expenditures grew at an average annual rate of 6.7 percent in 2000–07, the growth rate was consistently less than 4 percent in each of the subsequent years of 2008–11.[1] Analysts have sought to explain the causes of this recent slowdown as well as to understand its potential implications for Medicare's financial outlook.

Some have suggested in particular that the recent cost growth slowdown reflects positive transformational change in the US health care system facilitated in part by the 2010 passage of the Affordable Care Act (ACA), which they also suggest may significantly lessen the need for further legislation to shore up Medicare finances. For example, on June 28, 2013, the Federation of American Hospitals (FAH) published an analysis asserting that Medicare spending is in a "deflationary spiral" that reflects "deep, foundational changes" in the US health care system. The FAH opined that the trend argued against further changes to reduce the growth of Medicare expenditures, stating that "what's working should be allowed to play out without interruption."[2]

The Obama White House has also credited the ACA for much of the recent deceleration in health care cost growth, furthering the suggestion that a continuation of these recent trends could brighten Medicare's financing outlook. In its annual Economic Report of the President (ERP), the White House Council of Economic Advisers (CEA) wrote that "there are signs that the Affordable Care Act has started to slow the growth of costs" and that "early responses to the Affordable Care Act

1. Testimony of Robert D. Reischauer, hearing on the 2013 Medicare Trustees Report, Subcommittee on Health of the House Committee on Ways and Means, June 20, 2013, http://waysandmeans.house.gov/uploadedfiles/reischauer_testimony_final_062013.pdf.

2. Federation of American Hospitals, "Structural Changes Drive Health Care Spending Slowdown: Implications for Medicare Policy and Deficit Reduction," *FAH Hospital Policy Blog*, June 18, 2013, http://fahpolicy.org/spending-slowdown-report/. Cutler and Sahni have also written that the slowdown is due primarily to a "host of fundamental changes" in the health care sector, and that if these trends continue, public-sector health care spending will be significantly less than currently projected. David Cutler and Nikhil Sahni, "If Slow Rate of Health Care Spending Growth Persists, Projections May Be Off by $770 Billion," *Health Affairs* 32, no. 5, http://content.healthaffairs.org/content/32/5/841.abstract.

may have contributed to the decline in per enrollee [Medicare] spending since 2010."[3] The CEA also published a graph indicating that if the annual growth rate of per beneficiary Medicare spending were to remain at its recent level of 3.6 percent per year, "then after 75 years Medicare spending would account for only 3.8 percent of GDP," significantly less than the Medicare trustees' current estimate of 6.5 percent of GDP.[4] Though the CEA was careful to caveat this illustration by writing, "This should not be interpreted as a forecast but rather an indication of how sensitive long-term projections are to the assumed rate of growth of Medicare spending per beneficiary,"[5] a number of outside readers interpreted the graph as suggesting that much of Medicare's financing challenges might be solved without further legislation, merely by proceeding forward to implement the provisions of the ACA.[6]

The idea that the recent deceleration in health care spending growth might, if continued, significantly improve the outlook for Medicare finances has also taken root in press coverage of program finances.[7] At the press conference announcing the release of the 2013 annual Social Security and Medicare Trustees Reports, two of the four questions posed by reporters pertained to the possible role of the recent health cost slowdown in changing the long-term Medicare outlook.[8]

Others have been more skeptical that the recent health cost slowdown has changed Medicare's financial outlook significantly for the better. The Committee for a Responsible Federal Budget (CRFB) termed the aforementioned CEA graph "the most misleading chart you'll see this week," and noted that the optimistic cost projection it contained assumed the permanent continuation of an unrealistically low nominal (i.e., not adjusted for inflation) rate of health care cost growth even

3. Council of Economic Advisers, "Reducing Costs and Improving the Quality of Health Care," in *2013 Economic Report of the President*, http://www.whitehouse.gov/sites/default/files/docs/erp2013/ERP2013_Chapter_5.pdf.

4. Social Security and Medicare Boards of Trustees, "Status of the Social Security and Medicare Programs: A Summary of the 2013 Annual Reports," accessed December 18, 2013, http://www.ssa.gov/oact/trsum/.

5. CEA, "Reducing Costs and Improving the Quality of Health Care."

6. See Jeff Spross, "Medicare Spending May Fix Itself, without Republicans' Budget Cuts," March 15, 2013, *ThinkProgress* (blog), http://thinkprogress.org/health/2013/03/15/1725941/medicare-already-fixed/, and Sarah Kliff, "Want to Debate Medicare Costs? You Need to See This Chart First," *Wonkblog, Washington Post*, March 15, 2013, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/03/15/want-to-debate-medicare-costs-you-need-to-see-this-chart-first/. Excerpt: "This data underscores how important the changes happening in our health-care system, right now, will be to the future of health-care spending. If they stick around, they could completely reorient the typical Washington discussion of Medicare as a budget-buster."

7. Zachary Goldfarb, "Obama's Summertime Push: Immigration and the Economy," *Washington Post*, July 7, 2013, http://www.washingtonpost.com/politics/obamas-summertime-push-immigration-and-the-economy/2013/07/07/5f83da0c-e585-11e2-aef3-339619eab080_story_1.html. Excerpt: "White House officials are hopeful that a slowdown in health-care costs will have staying power."

8. C-SPAN broadcast, "Social Security and Medicare Trustees Report," May 31, 2013, http://www.c-spanvideo.org/program/313083-1.

after general price inflation returns to nonrecession norms.[9] A recent *Fiscal Times* article also argued that "no matter how you look at it, even if health care cost growth is slowing slightly, Medicare will face a spending growth sustainability problem and will continue to be a contentious component of the national debate on entitlement reform."[10] At the Medicare trustees 2013 press conference, public trustee Robert Reischauer also stated that "even with a unified and concerted effort, further major legislative initiatives above and beyond the Affordable Care Act will be required . . . if we're going to put Medicare on a sustainable long-run path."[11] The Medicare trustees as a group cautioned in their 2013 report that Medicare's future costs "are likely to exceed those shown by the current-law projections," rather than offering reason to believe they might be lower.[12]

Quantifying and explaining the recent deceleration in health care spending is an inexact science that is likely to remain a subject of analysis and debate, which this paper does not attempt to resolve.[13] However, the public discussion of the recent deceleration's potential implications for Medicare financing has already underscored the need for wider understanding of (1) current methodologies for projecting Medicare finances; (2) the dependence of these projections on broader health spending trends, demographic trends, and other factors; and (3) how future Medicare financial outcomes may deviate from current projections.

Though a thorough explanation of the factors pertinent to the Medicare trustees' projection methodologies takes up the body of this paper, the summary conclusion can nevertheless be presented here: the recent deceleration in national health care cost growth does not translate into a significant probability that substantial further legislative changes to correct Medicare finances can be avoided. To the contrary,

9. Committee for a Responsible Federal Budget, "The Most Misleading Chart You'll See This Week," March 19, 2013, http://crfb.org/blogs/most-misleading-chart-youll-see-week. Medicare payments are determined in part by providers' input price growth, so nominal Medicare expenditure growth would not normally be expected to remain atypically low after general price inflation no longer remains so.

10. Nicole Vahlkamp, "Medicare: Demographics Trump Slowing Health Care Costs," *Fiscal Times*, May 28, 2013, http://www.thefiscaltimes.com/Articles/2013/05/28/Slowing-Growth-in-Health-Care-Costs-May-Not-Matter-for-Medicare.

11. C-SPAN broadcast, "Social Security and Medicare Trustees Report."

12. *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* [hereinafter *2013 Annual Report*], 5, http://downloads.cms.gov/files/TR2013.pdf.

13. Although of great interest in the health care policy debate, a complete analysis of the causes of the recent health care cost slowdown, as well as predictions about whether the slowdown will be sustained, are well beyond the scope of this study. This study focuses instead on a narrower but extremely important issue of government finance, specifically whether in light of the slowdown it should be expected that Medicare's financial challenges may be smaller than currently projected by the program's trustees. To answer this question it is necessary to understand how these Medicare projections are currently made, specifically the underlying assumptions with respect to future health care cost growth. As this paper shows, understanding these projection methodologies renders it quite clear that Medicare's financial challenges are likely to be at least as large as currently projected, an outcome expected under most reasonably possible scenarios.

such legislated corrections are overwhelmingly likely to be required under almost any realistic scenario, and will be much less potentially disruptive for beneficiaries, health care providers, and taxpayers if they are enacted soon rather than after a period of hopeful watching to see whether events may somehow render these difficult decisions unnecessary.

Current Medicare projection methodologies, in use since well before the ACA's passage, already assume a substantial long-term slowdown in the growth of national health care spending. In addition, almost all the currently projected positive effect of the ACA on Medicare finances is based on several of its provisions that have yet to take full effect. The responses of the medical and political systems to these cost-cutting provisions are not yet known and can only be projected at this time. And while the projected future outlook for Medicare finances has improved subsequent to the ACA's passage and the recent health cost slowdown, this financial improvement has not materialized to date. To the contrary, Medicare's trust funds are now in weaker condition than they were projected to be in 2007 before the oft-cited period of recent health cost deceleration.[14] On balance, actual Medicare costs are still substantially more likely to be higher than the trustees' current projections than they are to be lower, for a number of reasons that this report will explain in some detail.

PROJECTIONS OF MEDICARE FINANCING STRAINS UNDER CURRENT LAW

Before turning to a discussion of possible changes in Medicare's complex financing outlook, it is useful to understand that outlook under current projections. Medicare finances are complex in part because the program has two trust funds that are financed in quite different ways.

Medicare's Hospital Insurance (HI or "Part A") trust fund, which finances hospital stays, home health following hospital stays, skilled nursing facility services, and hospice care benefits, is financed in a manner somewhat analogous to the federal Social Security program. Like Social Security, Medicare HI is financed primarily by a mandatory payroll tax on workers' wages; unlike Social Security, Medicare's 2.9 percent tax has no income cap.[15] Single taxpayers with incomes above $200,000

14. *2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, 52, table III.B5, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2007.pdf. Compare the HI trust fund ratio to *2013 Annual Report*, 62, table III.B5. More details of this analysis are presented later in this paper.

15. The Social Security payroll tax of 12.4 percent applies only on annual wage income up to $113,700, an amount that is indexed annually for national average wage growth. *2013 Annual Report*, 141. Economists generally agree that the full amount of the payroll tax is paid by the worker from his total compensation, though nominally the tax is split evenly between the employer and the employee. Thus in the case of Medicare, 1.45 points of the base 2.9 percent tax are levied respectively upon each of the employer and the employee.

and married couples with incomes above $250,000 pay an additional 0.9 percent Medicare HI tax on their annual earnings, bringing their total HI payroll tax rate to 3.8 percent.[16] Medicare HI also receives revenue from the income taxation of Social Security benefits, from voluntary premiums paid by those who do not qualify for benefits based on their previous earnings, from interest payments from the federal government's general fund, and from other sources.

As they do for Social Security, the Medicare trustees make an annual determination of whether projected HI revenues are sufficient to finance future expenditures.[17] By law, Medicare HI is not permitted to spend in excess of its annual revenues and trust fund assets, which means that any projection of trust fund depletion portends (in the absence of corrective legislation) an interruption and thus an effective reduction in benefit payments.[18] In their 2013 report, the trustees projected that Medicare's HI trust fund will be depleted in 2026, at which point the program would only have sufficient revenues to finance 87 percent of scheduled benefit payments. The share of benefit payments that could be financed from incoming revenues would decline rapidly after 2026, falling to 71 percent by 2047.[19]

The trustees urged legislators to take early action to address the Medicare HI financing shortfall: "Taking action sooner rather than later will leave more options and more time available to phase in changes so that the public has adequate time to prepare."[20] The trustees estimated that if enacted immediately, the size of the changes required to preserve Medicare HI solvency over the next 75 years would equate to a 29 percent increase in its total projected tax receipts or a 23 percent reduction in projected program costs.[21] The currently projected slope of the HI program's revenue and cost curves highlights the desirability of acting promptly to address this financing shortfall. If instead legislators took the path of least resistance by waiting until 2026 to enact legislative modifications and by thereafter making only the minimum necessary changes, by 2047 the required revenue increase would be 41 percent or, alternatively, the required benefit reduction would be 29 percent.

Medicare's other trust fund, the Supplementary Medical Insurance (SMI) trust fund, finances physician, outpatient hospital, and home health benefits for Medicare

16. These higher-income taxpayers also pay a 3.8 percent tax on investment income termed the "Unearned Income Medicare Contribution," though revenue from this tax is not provided to the Medicare trust funds. Solomon M. Mussey, A.S.A. Director, CMS Medicare & Medicaid Cost Estimates Group, "Estimated Effects of the 'Patient Protection and Affordable Care Act,' as Amended, on the Year of Exhaustion for the Part A Trust Fund, Part B Premiums, and Part A and Part B Coinsurance Amounts," memorandum, April 22, 2010, http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_Medicare_2010-04-22.pdf, 1.
17. The same individuals serve as the boards of trustees for Social Security and for Medicare.
18. *2013 Annual Report*, 2.
19. Social Security and Medicare Boards of Trustees, "Status of the Social Security and Medicare Programs: A Summary of the 2013 Annual Reports," http://www.ssa.gov/oact/trsum/.
20. Ibid.
21. Ibid.

Part B and drug insurance coverage for Part D.[22] General federal government revenues finance roughly 75 percent of the costs of these voluntary-participation components of Medicare, with most of the remainder coming from beneficiary premiums. Both the premiums and general revenue contributions for these portions of Medicare are reestablished annually to cover expected costs. In effect, they are statutorily constructed so that the SMI trust fund remains solvent at all times.[23]

This technical solvency does not mean, however, that Medicare's SMI fund is immune to financial strains. Strains in Medicare SMI financing are simply manifested in different ways than they are in Medicare HI (Part A). Instead of threatening trust-fund depletion, SMI cost growth results in rising enrollee premiums and increased pressure on the general federal budget.[24] The more SMI costs rise, the more expenditures on other federal programs must be reduced to avoid an increase in taxpayer burdens and/or federal indebtedness.

These financing strains in Medicare SMI are very significant in practice. In 2012, Medicare SMI expenditures ($307 billion) exceeded those in Medicare HI ($267 billion), despite the greater degree of press attention devoted to the state of HI finances.[25] Not only do SMI expenditures exceed HI expenditures today, under current law they are projected to rise relatively faster in future years (see figure 1).[26]

Medicare's trustees project that under current law total program costs will rise substantially faster than the nation's economic output in future years, and especially over the next few decades, as the large baby boom generation joins the Medicare rolls. In 2013 total Medicare costs equaled roughly 3.6 percent of US gross domestic product (GDP). By 2035 total program costs are projected to have risen substantially to 5.6 percent of GDP, rising somewhat more slowly after that but still faster than economic output to 6.5 percent of GDP in 2087 (see figure 2).

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22. Medicare also has a Part C, the Medicare Advantage program, through which beneficiaries can receive care from private insurance plans. Financing for Part C is provided from both the HI and SMI trust funds.

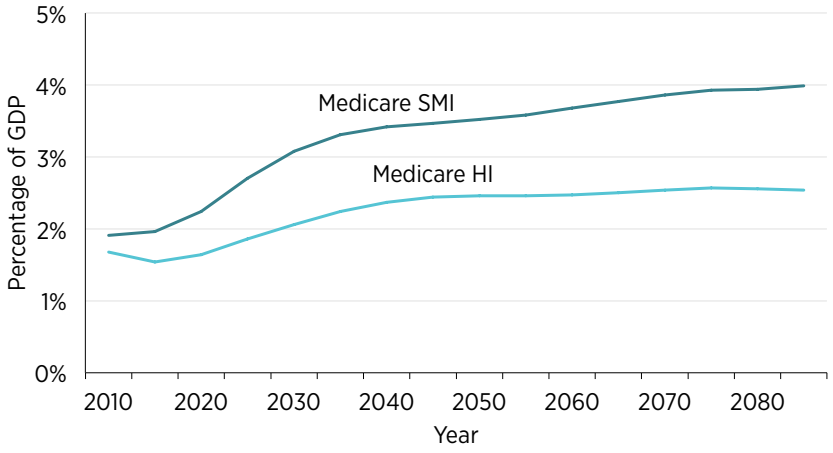
23. Medicare Part B general revenue financing is reset annually based on estimated costs for the following year under current law, together with a margin to maintain an adequate contingency reserve. This margin reflects estimates by the program's actuaries, incorporating the likelihood of lawmakers continuing to override scheduled reductions in physician payments that would occur under the program's Sustainable Growth Rate (SGR) formula, as has happened every year since 2003. The contingency margin is set to allow for a residual trust fund reserve of 15–20 percent of upcoming annual expenditures, to protect against possible "adverse events." Part D requires no contingency margin because the program has a flexible appropriation authority that permits continued payments if prior projections underestimated actual revenue needs. *2013 Annual Report*, 35, 38.

24. Since the Balanced Budget Act of 1997, Part B premiums have generally been indexed to growth in total per beneficiary expenditures. See *2013 Annual Report*.

25. See as but one example Lori Montgomery, "Medicare Trust Fund Projected to Last until 2026 as Health Costs Drop," *Washington Post*, May 31, 2013, http://www.washingtonpost.com/business/economy/medicare-trust-funds-life-extended-2-years-to-2026/2013/05/31/7efc7ca6-ca03-11e2-9245-773c0123c027_story.html.

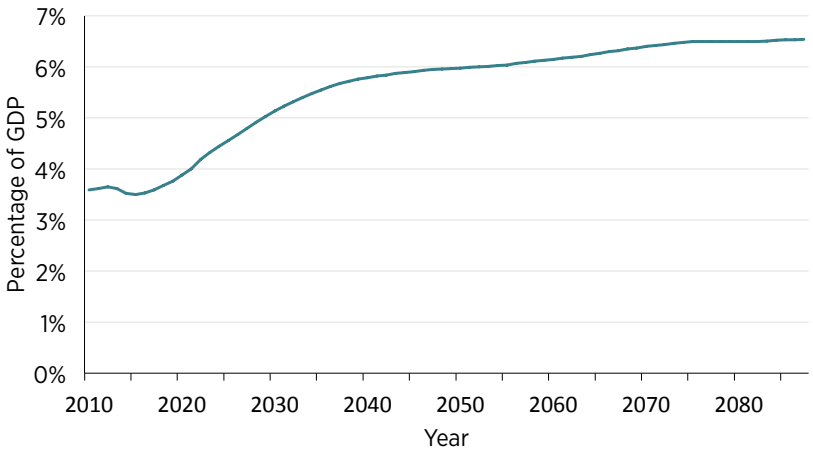
26. *2013 Annual Report*, 196.

FIGURE 1. PROJECTED MEDICARE COSTS BY TRUST FUND, AS A PERCENTAGE OF GDP



Source: 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *http://downloads.cms.gov/files/TR2013.pdf.*

FIGURE 2. TOTAL PROJECTED MEDICARE COSTS AS A PERCENTAGE OF GDP



Source: 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *http://downloads.cms.gov/files/TR2013.pdf.*

The roots of this projected cost growth accentuate the importance of taking early action to address Medicare financing strains. For the next few decades, the primary driver of program cost growth is projected to be demographics, a factor that must be confronted irrespective of health care cost inflation. The large baby boom generation will be entering the benefit rolls and collecting benefits for more years than any previous generation, because life expectancies have lengthened while Medicare's eligibility age of 65 has remained unchanged since the program's inception.[27] The ratio of taxpaying workers to beneficiaries has already begun to decline with the first boomers claiming benefits, and is projected to decline much further in future years. As of 2012 there were roughly 3.3 workers to finance each HI beneficiary's benefits, a ratio projected to decline to 2.3 by 2030.[28]

Policymakers cannot control demographics, but they can prudentially adjust program parameters to them. Providing future beneficiaries with substantial advance notice of any coming changes in eligibility criteria would afford them greater opportunities during their working careers to adjust their retirement planning. For these and other reasons it is better that the changes necessary to shore up Medicare finances be legislated sooner rather than later.

The other major factor driving Medicare's long-term cost growth is general health care cost growth per person, including provider input price increases (that in turn are translated by law into Medicare reimbursement rates) and growth in the number and complexity of health care services per beneficiary.[29] General health care cost growth per person has a smaller projected effect on costs than demographics does for the next few decades but becomes relatively more important afterward.[30] This factor also highlights the importance of early action to address Medicare finances. It is unlikely that policymakers will ever be able to achieve immediate, large reductions in national health expenditures; it is also doubtful that lawmakers will want to sharply and suddenly reduce Medicare payment rates relative to private health care sector levels.[31] Thus to address this driver of Medicare spending

27. Social Security Administration (SSA), "Medicare Benefits," http://www.socialsecurity.gov/pgm/medicare.htm; SSA, "History of SSA during the Johnson Administration 1963–1968," http://www.ssa.gov/history/ssa/lbjmedicare1.html; *2013 Annual Report*, table V.A4.—Cohort Life Expectancy, http://www.ssa.gov/OACT/TR/2013/lr5a4.html.

28. *2013 Annual Report*, 69.

29. Ibid., 5.

30. Social Security and Medicare Boards of Trustees, "Summary of the 2013 Annual Reports," 3; Congressional Budget Office, "The 2012 Long-Term Budget Outlook," 15, http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term_Budget_Outlook_2.pdf.

31. Most Medicare payment rates for health care services are already well below those prevailing in the private sector. In 2009, for example, Medicare rates for inpatient hospital services averaged only 67 percent of private health insurance rates. Similarly, physician payment rates under Medicare were about 80 percent of private rates. John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers," memorandum, May 31, 2013, 6–8, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2013TRAlternativeScenario.pdf.

growth, it is preferable to take earlier, more gradual actions to slow the growth of both private sector and Medicare expenditures, actions that can compound to produce substantial long-term savings with less potential risk of sudden disruptions for beneficiaries, health care providers, and taxpayers.

The Medicare trustees' long-term projections for program finances are subject to considerable uncertainty.[32] But if either the trustees' intermediate (best-guess) scenario turns out to be correct or the trustees are understating the future growth of Medicare costs under current law, then the policy imperative to take prompt action to correct the course of Medicare finances is clear. In these scenarios there is little to be gained by taking a "wait and see" approach with respect to further legislative corrections; doing so will only expose taxpayers, providers, and beneficiaries to larger and more sudden sacrifices.

Thus the question is prompted whether the recent deceleration in health care cost growth creates a reasonable likelihood that Medicare program finances might take a more benign path than its trustees now project—specifically, one that would render prompt legislative corrections unnecessary. As this paper will further substantiate, this question can be answered firmly in the negative.

THE RECENT DECELERATION IN HEALTH CARE EXPENDITURE GROWTH

By 2008 US national health care expenditure growth had begun to slow significantly relative to historical patterns. Total national health expenditures (NHE), which had grown by more than 6 percent annually each year in 2000–07 and substantially more rapidly in previous decades, grew by less than 5 percent in 2008 and less than 4 percent each year in 2009–11 (see figure 3).[33]

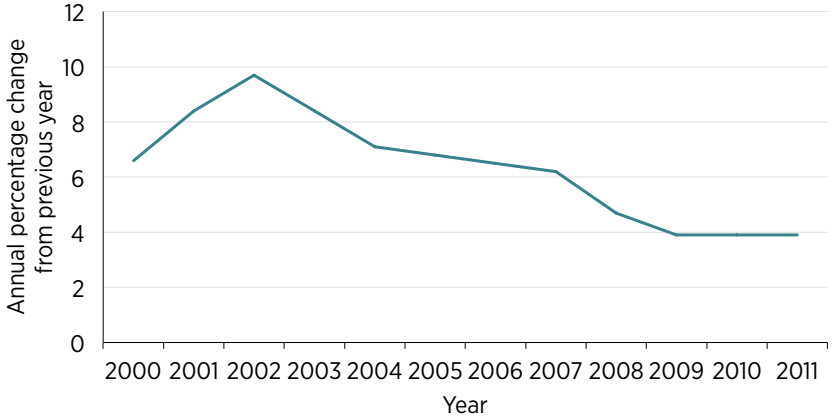
The causes of this cost growth slowdown are not fully understood and are still being explored and debated by health experts. Of particular interest is whether the cost growth slowdown primarily represents a one-time, temporary event or whether a significant portion of it is likely to extend into the future. Because this cost growth deceleration coincided with a recession-induced slowdown in many other economic factors including economic output, general price inflation, and personal income growth, experts have sought to determine how much of the deceleration was a direct consequence of the Great Recession and how much of it is attributable to independent factors.

This paper makes no attempt to resolve the ongoing debate over how much of the health cost slowdown resulted directly from the recession, and how much of it

32. *2013 Annual Report*, 2.

33. CMS, table 1: National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960–2011, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

FIGURE 3. ANNUAL PERCENTAGE GROWTH IN NATIONAL HEALTH EXPENDITURES



Source: Centers for Medicare and Medicaid Services (CMS), table 1: "National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960–2011," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

reflects independent changes taking place in the health care sector. The Kaiser Family Foundation finds that "much of the decline in health spending growth in recent years was fully expected given what was happening more broadly in the economy."[34] On the other side of the debate, health economists David Cutler and Nikhil Sahni have concluded that only 37 percent of the slowdown can be attributed to the recession, with 55 percent "unexplained."[35] Medicare trustee Reischauer has stated that the body of research literature on the issue has found that "somewhere between one-third and seventy-five percent" of the slowdown is attributable to the recession.[36] This wide

34. Specifically, Kaiser estimates that "about three-quarters (77 percent) of the recent decline in health spending growth can be explained by changes in the broader economy." Henry J. Kaiser Family Foundation, "Assessing the Effects of the Economy on the Recent Slowdown in Health Spending," April 22, 2013, http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/. Also consistent with this general view, the CMS Office of the Actuary has written that "the recent recession had an immediate and noticeable effect on the health sector because of high unemployment, loss of private health insurance coverage, and a reduction in the resources available to pay for health care. All of these factors contributed to historically low growth in aggregate health spending during 2009–11." The CMS also notes that "although some provisions of the [Affordable Care Act] were in effect in 2010 and 2011, the impact on aggregate health spending growth was minimal in these years. The most prominent provisions of the act will not be implemented until 2014." Micah Hartman et al., "National Health Spending in 2011: Overall Growth Remains Low, but Some Payers and Services Show Signs of Acceleration," *Health Affairs* 32, no. 1 (2013): 87–99, doi:10.1377/hlthaff.2012.1206.

35. Cutler and Sahni, "If Slow Rate of Health Care Spending Persists."

36. Response of Robert D. Reischauer to reporter's question, C-SPAN broadcast, "Social Security and Medicare Trustees Report." Since the original draft of this study was prepared, a working paper was released by the CBO that is susceptible to the misinterpretation that the recession had no significant

range reflects the considerable disagreement among analysts as to the causes of the recent health expenditure slowdown.

Many experts are interested to know how much of the cost slowdown relates to recent changes in national health care policy and practices that might continue to produce further cost savings in future years. Manhattan Institute Fellow Avik Roy has argued that, in addition to the recession, another important factor has been that individual out-of-pocket costs have risen as more employers are offering health savings accounts and as health insurance deductibles have increased.[37] Others have credited the 2010 ACA with either directly creating or inspiring cost savings within the broader health care sector. As mentioned earlier, the CEA has written that "there are signs that the Affordable Care Act has started to slow the growth of costs,"[38] while a study performed for the FAH credits the ACA with being a "catalyst for structural changes to the health care system" that are slowing the growth of health care costs.[39]

Regardless of the quality of the policy decisions reflected in the ACA, it is clear that they are not the primary reason for the recent deceleration in national health expenditure growth, which was already in motion several years before the ACA and readily visible by 2008. Moreover, as the Kaiser Family Foundation has noted, "the bulk of the Medicare savings included in the ACA . . . have yet to be realized" because they have yet to take effect.[40] Reischauer notes that "the direct impacts of many of the Act's cost restraining measures may not be felt for several years," though he also states that "employers, providers and insurers have begun to prepare by taking anticipatory actions that undoubtedly have already dampened spending growth somewhat."[41] Still, anticipatory actions in response to the "signal" the ACA is giving to health care providers cannot explain such health cost deceleration as was

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effect on the growth of Medicare spending. The working paper examines instead the narrower question of whether the recession affected "beneficiaries' demand for services." As the recession could have precipitated slower nominal spending growth for a number of reasons in addition to directly dampening beneficiary demand, it should not be concluded that the working paper found the lack of a relationship between reduced Medicare spending growth and the recent recession. See Michael Levine and Melinda Buntin, "Why Has Growth in Spending in Fee-for-Service Medicare Slowed?," working paper (Washington, DC: CBO, August 2013), http://www.cbo.gov/sites/default/files/cbofiles/attachments/44513_MedicareSpendingGrowth-8-22.pdf.

37. Avik Roy, "It's the Cost-Sharing, Stupid: Heath Care Spending Is Slowing Because Americans Control More of Their Health Dollars," *Forbes.com*, June 16, 2013, http://www.forbes.com/sites/theapothecary/2013/06/16/its-the-cost-sharing-stupid-health-care-spending-is-slowing-because-americans-control-their-own-health-dollars/. Increasing the direct out-of-pocket costs to consumers lowers demand for health care and thereby lowers costs.

38. Council of Economic Advisers, *2013 Economic Report of the President*.

39. Al Dobson et al., *Structural Changes Drive Health Care Spending Slowdown: Implications for Medicare Policy and Deficit Reduction* (Vienna, VA: Dobson DaVonzo & Associates, June 14, 2013).

40. Henry J. Kaiser Family Foundation, "Assessing the Effects of the Economy on the Recent Slowdown in Health Spending."

41. Testimony of Reischauer, hearing on the 2013 Medicare Trustees Report.

taking place as early as 2008. Even the CEA is careful to note that the ACA cannot be credited with the cost deceleration that was underway by that time; it credits the ACA only with making a positive contribution to the deceleration since 2010.[42]

In sum, while experts disagree as to the origins and the future implications of the recent deceleration in national health expenditures, such a deceleration is widely acknowledged to have taken place. The next section of this study explores what the recent deceleration has meant for Medicare's financing outlook.

IMPLICATIONS OF RECENT EVENTS FOR PRESENT AND FUTURE MEDICARE FINANCING

The significance of the recent health cost slowdown for Medicare can perhaps best be understood by separating effects between those that have been witnessed to date and those that are projected for the future.

While future projections for Medicare costs and general NHE are both highly uncertain, it is clear that the recent cost slowdown has not improved the current state of Medicare finances relative to earlier projections. To the contrary, Medicare is now in weaker financial condition than was projected before the recent health cost slowdown.

The reason is that, while health care cost growth has slowed in nominal terms relative to prior projections, it has not slowed *relative* to other critical factors such as national economic output and Medicare's revenue base. What has happened is not so much that health care cost growth has slowed in a unique way but that most major economic factors, from GDP growth to wage growth, have slowed as well. Relative to the trustees' 2008 projections, for example, total Medicare costs as a percentage of GDP have risen rather than fallen. In other words, though there has been a health cost slowdown in nominal dollar terms, Americans are actually spending a higher proportion of their economic output on Medicare than previously projected (see figure 4).

That the NHE deceleration was not as precipitous as the underlying deceleration in economic output during the recent recession is visible in figure 5, which compares annual NHE growth to GDP growth.[43]

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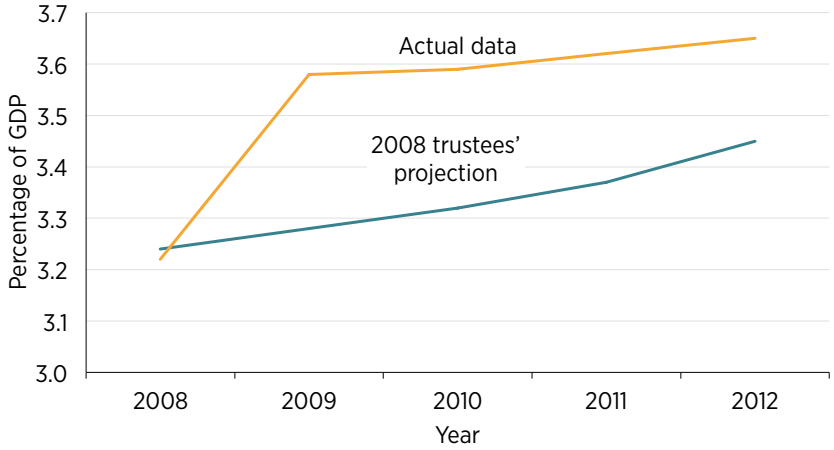
42. Council of Economic Advisers, "Reducing Costs and Improving the Quality of Health Care."

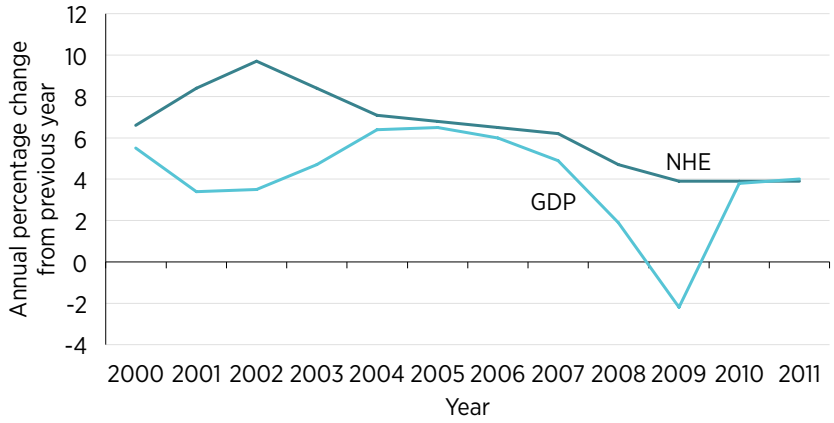
43. CMS, table 1, National Health Expenditures. These data reflect GDP as it was calculated by the Bureau of Economic Analysis (BEA) at the time the CMS analysis was released. Since then the BEA has modified its methods of computing GDP, changing for example its treatment of intellectual property, among other modifications. See BEA, "Changes to How the U.S. Economy Is Measured Roll Out July 31," *BEA blog*, July 23, 2013, http://blog.bea.gov/2013/07/23/gdp_changes/. Because this study describes Medicare trustees' methods for projecting the future growth of NHE and Medicare expenditures that were developed under previous BEA methods of calculating GDP, premodification GDP figures are used throughout this study to preserve consistency.

FIGURE 4. TOTAL MEDICARE EXPENDITURES AS A PERCENTAGE OF GDP, ACTUAL VS. PROJECTED



Sources: 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2008.pdf*; 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *http://downloads.cms.gov/.files/TR2013.pdf*.

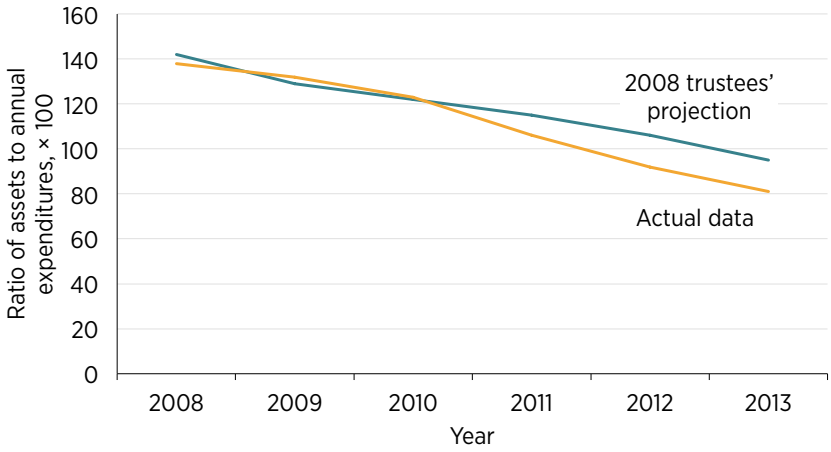
FIGURE 5. ANNUAL PERCENTAGE GROWTH IN NHE AND GDP



Source: Centers for Medicare and Medicaid Services, table 1: "National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960–2011," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

As a result of these relative growth differentials, Medicare's finances are now weaker by virtually any measure than the 2008 trustees report projected them to be for 2013. At the start of 2013, for example, Medicare's HI trust fund exhibited a "trust fund ratio" (the ratio of trust fund assets to annual expenditures) of 81 percent, meaning that there were sufficient assets in the HI trust fund to finance about

FIGURE 6. MEDICARE HI TRUST FUND RATIO, ACTUAL VS. PROJECTED



Sources: 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2008.pdf*; 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *http://downloads.cms.gov/.files/TR2013.pdf*.

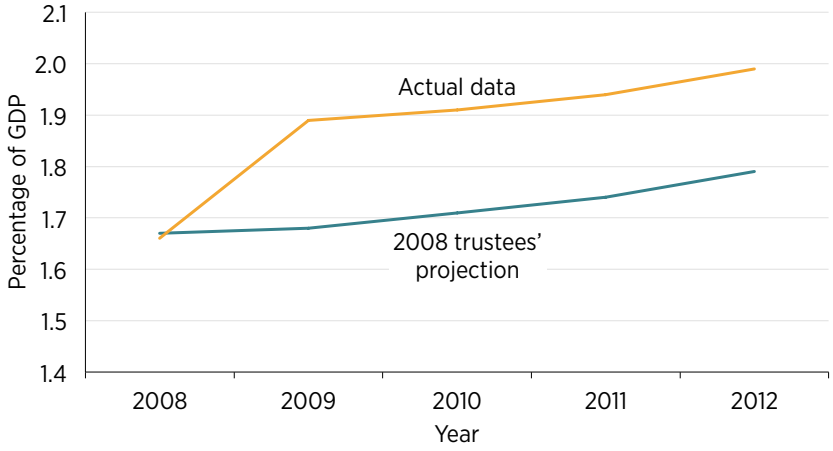
10 months' worth of benefit payments. This ratio is significantly lower than the projection of 95 percent that was made for the start of 2013 in the 2008 trustees report (see figure 6).[44]

That Medicare HI's current financial condition is now weaker than projected before the recent cost slowdown is not simply an artifact of the specific projections made in 2008. The 2007 trustees report, the other most recent report released before the cost slowdown had fully materialized, projected a 2013 HI trust fund ratio of 106 percent, also significantly higher than the recently recorded level of 81 percent.[45] In sum, the Medicare HI trust fund is now in weaker financial condition than was projected before the cost slowdown.

Medicare SMI finances are also more problematic than they were projected to be before the recent cost slowdown. As explained earlier, financing strains in Medicare SMI are manifested in different ways than they are in HI—that is, not in lower trust fund balances but in greater pressures on the general federal budget as well as in rising enrollee premiums. Total Medicare SMI costs as a percentage of US economic output have substantially exceeded projections made in the 2008 trustees report, as shown in figure 7. SMI expenditures, then projected to average 1.73 percent of GDP over 2009–12, have actually averaged 1.93 percent.

44. Specifically, the HI trust fund balance at the start of 2013 was $220.4 billion, or roughly 81 percent of expected 2013 HI expenditures of $270.5 billion. The 2008 trustees report had anticipated higher nominal HI expenditures of $315.6 billion in 2013, but also a significantly higher HI trust fund balance of $301.1 billion at the start of the year. This decline further substantiates the point that any financial gains of lower-than-projected Medicare HI costs to date have been more than offset by slower revenue growth.
45. *2007 Annual Report*, 15.

FIGURE 7. MEDICARE SMI EXPENDITURES AS A PERCENTAGE OF GDP, ACTUAL VS. PROJECTED



Sources: 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2008.pdf*; 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *http://downloads.cms.gov/.files/TR2013.pdf*.

Whatever the long-term implications of the recent deceleration in national health expenditures, to date they have not improved the finances of either Medicare HI or SMI relative to prior projections. The cost deceleration is to an undetermined extent one symptom of a generally weak economy that has harmed Medicare finances more than the nominal cost deceleration has improved them.

Whether the recent cost deceleration will improve Medicare's long-term future financial outlook remains to be seen. Medicare's long-term outlook is a function of many factors, including the growth in the number and complexity of health care services, as well as interactions between the provisions of Medicare law and the rate of input price growth materializing in the health care sector generally. A subsequent section of this paper will explain how long-term Medicare projections are currently derived from projections of broader health care expenditure trends.

Under current law an important factor in projections of Medicare's financing outlook is the set of ambitious provider reimbursement reductions legislated as part of the 2010 ACA. These provisions will reduce the growth of most Medicare provider reimbursements by the annual rate of growth in national nonfarm multifactor productivity, currently estimated by the Centers for Medicare and Medicaid Services (CMS) actuary to equal 1.1 percentage points per year.[46] These aggressive annual reductions in provider payment growth remain controversial, and there is significant disagreement within the expert community about how the medical and

46. *2013 Annual Report*, 5.

political systems will respond to them.[47] Even under the assumption that they are successfully implemented, concerns have been raised about the proceeds of these savings being spent on an ambitious new federal health entitlement enacted under other provisions of the ACA, instead of being kept available to improve the federal government's ability to finance Medicare.[48]

Viewed narrowly from the perspective of Medicare, however, successful implementation of the ambitious cost-containment provisions of the ACA would substantially improve Medicare's financial outlook relative to the state of the law before their enactment. Total Medicare costs are now projected to be 6.5 percent of GDP under current law in 2087 as opposed to 9.8 percent of GDP under the contrasting assumption that various cost-saving provisions of current law (including those of the ACA) are largely overridden.[49] The 2009 Medicare trustees report, the last issued before the ACA's passage, projected that total Medicare costs would be still higher, exceeding 11 percent of GDP by 2080.[50] Medicare HI's currently projected trust fund depletion date of 2026 is also a substantial postponement relative to the pre-ACA projection of 2017 made in the 2009 Medicare trustees report.[51]

In sum, the financing outlook for Medicare, if viewed separately from the remainder of the federal budget, has improved significantly relative to pre-ACA projections, assuming that the ACA's ambitious cost-saving provisions are fully implemented. However, this outlook is but a projection of future events, as opposed to a measurement of an actual improvement in the state of Medicare finances at this time. By

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47. *2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2010.pdf. See the Statement of Actuarial Opinion, 281–83: "The best available evidence indicates that most health care providers cannot improve their productivity to this degree—or even approach such a level—as a result of the labor-intensive nature of these services. . . . For these reasons, the financial projections shown in this report for Medicare do not represent a reasonable expectation for actual program operations in either the short range (as a result of the unsustainable reductions in physician payment rates) or the long range (because of the strong likelihood that the statutory reductions in price updates for most categories of Medicare provider services will not be viable)." For an in-depth discussion of this subject, see Technical Review Panel on the Medicare Trustees Reports, "Uncertainty Associated with Certain Provisions of Current Medicare Law," *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections: 2010–2011 Technical Review Panel on the Medicare Trustees Reports*, December 2012, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TechnicalPanelReport2010-2011.pdf.

48. Charles Blahous, "The Fiscal Consequences of the Affordable Care Act" (Mercatus Center at George Mason University, Arlington, VA, April 2012), http://mercatus.org/sites/default/files/The-Fiscal-Consequences-of-the-Affordable-Care-Act.pdf.

49. *2013 Annual Report*, 5.

50. *2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* [hereinafter *2009 Annual Report*], 35, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2009.pdf.

51. *2009 Annual Report*; *2013 Annual Report*.

contrast, Medicare's financial condition has *not* improved to date as a result of the recent deceleration in national health care spending or anything else; it has instead become weaker. Analysis of the implications for Medicare finances of the health cost slowdown must take care to distinguish between hoped-for effects that have yet to materialize, and a state of play that has remained highly problematic to date.

CURRENT ASSUMPTIONS REGARDING FUTURE DECELERATION IN HEALTH CARE COST GROWTH

Going forward, there is little reason to expect that the recent deceleration in health cost growth portends an improvement in Medicare's long-term finances relative to the trustees' current projections. To understand this situation fully requires some familiarity with the methodology by which these projections are made.

The first step that the trustees take to project the long-term growth of Medicare spending is to perform a highly uncertain projection of long-term NHE growth. This calculation is important because (1) increases in Medicare reimbursement rates are largely a function of the input price increases facing providers in the health care sector, and (2) the average number and complexity of health services per Medicare beneficiary are assumed to increase at the same rate as in the health care sector overall.

Since the 2001 Medicare trustees report, the trustees have projected that per capita US health expenditures will grow at an average rate of per capita GDP growth plus 1 percentage point over years 25–75 of their long-range projection period.[52] This projection follows a recommendation made by the 2000 Medicare Technical Review Panel appointed to advise the trustees on (among other things) long-term Medicare projections. Subsequent Medicare technical panels have upheld this recommendation of an average health care cost growth rate of per capita GDP growth plus 1 percentage point.[53]

Importantly, the trustees' assumed "GDP plus 1 percent" rate is a long-term average of rates that do not remain constant over time. These growth rates are higher in the early part of the valuation period and move downward later, approximately converging to per capita GDP growth (i.e., plus 0 percent) at the end of the 75-year period. Without this assumed deceleration, total US health expenditures would continue to grow faster than total US economic output, to the point where ultimately the US economy would be devoted to nothing other than health care. This projection would be loosely tantamount to a projection that eventually US citizens would all be homeless, naked, and starving but equipped with outstanding health care.[54]

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52. Growth rates for earlier years are based on recent data trends and gradually converged to the assumed long-term growth rates in the 25th year.

53. *2013 Annual Report*, 13–16.

54. This formulation is borrowed from similar statements made by Richard Foster, formerly CMS's chief actuary.

Such absurd results are avoided by taking account of the elasticities associated with health cost growth—basically, the sensitivity of health cost growth to changes in other economic factors. One of these elasticity factors is price elasticity, which has the effect of reducing the tendency to consume additional medical services as medical prices rise. In layman's terms, the higher that health care prices become, the less we are inclined to further increase our health care spending (all other things being equal). The trustees assume that the medical price elasticity factor will reach −0.6 by the end of their 75-year valuation period.[55] Based on this and other elasticity factors, they project overall US health spending growth to increase at a rate of per capita GDP growth plus 1.2 percentage points in 2037, gradually declining to GDP plus 0.3 percentage points by 2087, and to GDP plus 0 percent afterward.[56]

Translating these broader NHE projections into Medicare financial projections requires an accounting for various provisions of law. Critical here are the aforementioned reductions in the growth of Medicare provider reimbursement rates under the ACA. The growth of Medicare payment rates is calculated on the basis of provider "input price" growth, minus an annual adjustment factor established by the ACA that is estimated by the CMS actuary to be 1.1 percentage points each year.[57] Nationally, average costs per patient—which reflect price growth as well as growth in the number and complexity of services—are projected to grow at an average rate of per capita GDP growth plus 1.4 percentage points over years 25–75.[58] This 1.4 percentage point differential is derived as follows: as mentioned earlier, NHE is projected to grow 1 percentage point faster than per capita GDP on average during this period. At the same time, provider productivity is projected to grow by 0.4 percent per year. Were it not for these productivity improvements, health care expenditure growth would be greater, all other things being equal. Factoring in these projected annual productivity gains produces a projection that average costs per Medicare patient will rise on average by per capita GDP growth plus 1.4 percentage points (1.0 + 0.4%) over years 25–75.[59]

This cost growth rate of per capita GDP plus 1.4 percentage points is translated into a rate of growth for most categories of Medicare payments by subtracting the ACA's annual 1.1 percent reimbursement adjustments—producing, if all other things were equal, an estimate that Medicare payments in these categories would grow at an

55. *2013 Annual Report*, 181.

56. Ibid., 209f. There are various theoretically possible paths to such a convergence of per capita health expenditures with per capita GDP that each involve different mixes of provider input (both labor and nonlabor) prices, productivity improvements, volume and intensity growth, and other factors. Such convergence in aggregate growth does not necessarily imply that each component of cost growth has leveled off.

57. Input prices are essentially the prices faced by providers, including both labor and nonlabor costs, when providing medical services.

58. It is always important to bear in mind the distinction between medical price growth and medical cost growth. Medical costs can grow for a number of reasons other than price growth, for example because of technological advances or changes in the number and mix of services provided.

59. This calculation reflects a recommendation of the 2010–11 Medicare Technical Review Panel. *2013 Annual Report*, 5f.

average rate of per capita GDP growth plus 0.3 percentage points over years 25–75 of the trustees' projection period. But the trustees, again following a recommendation of the 2010–11 Medicare Technical Review Panel, project that these annual reimbursement cuts would reduce the growth in the volume and intensity of Medicare services by a further 0.1 percentage point per year.[60] Incorporating this effect, the trustees arrive at a projection that costs in most categories of Medicare services will grow at an average rate of per capita GDP growth plus 0.2 percentage points over years 25–75.[61]

Again, this GDP plus 0.2 percent growth rate for most Medicare costs is an average over years 25 through 75 of the projection period (2037 through 2087). Annual rates are higher in the early part of the period and lower later on. As a result, the cost growth rate in these Medicare categories is projected to be lower than per capita GDP growth late in the valuation period. The rate is projected to be about GDP plus 0.4 percent in 2037, but to slow to GDP minus 0.5 percent in 2087 as shown in figure 8. After that it is projected to decline further to GDP minus 0.8 percent.[62]

The contours of these projections have caused many analysts to question whether the annual payment rate adjustments contained in the ACA will prove sustainable over the long term.[63] Continuing these adjustments forever would mean, under current projection methods, that Medicare reimbursement rates would not only fall far below the levels paid in the private sector, but would not even keep up with growth in overall consumer prices. Expenditures per beneficiary in these parts of Medicare would also shrink relative to per capita GDP. Some analysts do not believe this outcome to be realistic from either an economic or a political perspective, as it would likely involve significant disruptions of Medicare beneficiaries' access to care.[64] The

60. Technical Review Panel on the Medicare Trustees Reports, *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections,* 51. Excerpt: "The Panel examined several possible mechanisms by which lower Medicare price growth could affect Medicare V&I (volume and intensity) growth over the long run, recognizing the substantial uncertainty associated with such an exercise. The Panel concluded that the various factors would tend to have largely offsetting effects but judged that the overall, net impact of the lower payment rates would likely slow Medicare V&I growth slightly (for example, by 0.1 percentage point annually)."

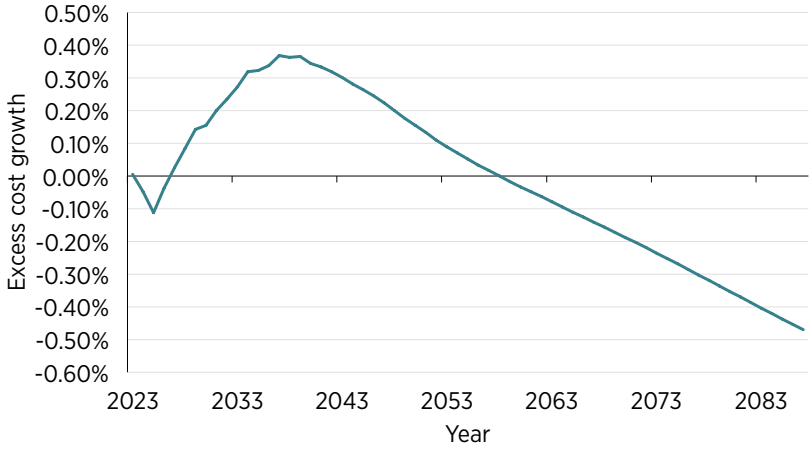
61. These categories include all Part A payments and many categories of Part B payments, but not Part D payments. As a result, per the specifications of the ACA, per capita Medicare costs are projected to grow more rapidly in Part D, and somewhat more rapidly in Part B, than they are in Part A. This projected growth (along with continued population aging) is why the projections shown in figure 2 depict total Medicare spending growing faster than total GDP over the long term, despite Part A per capita expenditures growing more slowly than per capita GDP.

62. *2013 Annual Report*, 16. For specific years see Stephen K. Heffler, Todd G. Caldis, and Sheila D. Smith, "The Long-Term Projection Assumptions for Medicare and Aggregate National Health Expenditures," memorandum, June 6, 2013, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProjectionMethodology2013.pdf.

63. *2010 Annual Report*, Statement of Actuarial Opinion, 281–83.

64. Testimony of James D. Capretta Before the Heath Subcommittee of the House Energy and Commerce Committee, "Saving Seniors and Our Most Vulnerable Citizens from an Entitlement Crisis," March 6, 2013, http://democrats.energycommerce.house.gov/sites/default/files/documents/Testimony-Capretta-Health-Entitlement-Crisis-2013-3-6.pdf.

FIGURE 8. PROJECTED MEDICARE PART A EXCESS (RELATIVE TO PER CAPITA GDP) COST GROWTH



Source: Centers for Medicare and Medicaid Services, table 1: "National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960–2011," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

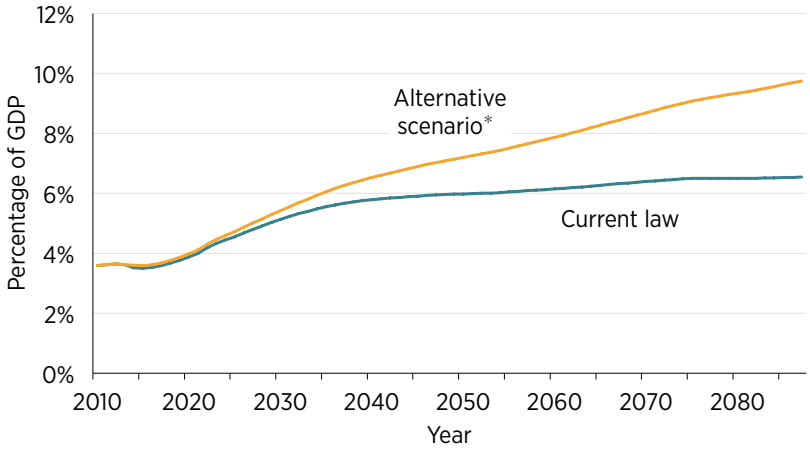
trustees do not take a position on this controversy, but they do acknowledge it by presenting an illustrative alternative scenario (see figure 9) in which these provisions of the ACA are partially phased out over the years 2020–34.[65]

If (as under current projections) all Medicare Part A costs per beneficiary and many Part B costs shrink dramatically relative to per capita GDP, this relative decline in the generosity of care that Medicare beneficiaries receive may cause widespread concern and thereby render it more likely that current-law cost restraints (including the ACA's provider reimbursement reductions) will be legislatively overridden at some point, causing total Medicare costs to be higher than the trustees' current projections. The trustees have addressed this issue in the report by stating explicitly that "Medicare's actual future costs . . . are likely to exceed those shown by the current-law projections in this report."[66]

It is possible that the recent deceleration in national health care cost growth may render these long-term projections of cost growth, at per capita rates slower than

65. *2013 Annual Report*, 4. This illustrative alternative legislative scenario should not be confused with the trustees' "low-cost" and "high-cost" alternative scenarios that employ different assumptions for demographic and economic factors including health cost inflation. The assumptions used for these scenarios are shown on p. 13 of the 2013 trustees report and the resulting alternative cost projections are shown on p. 67. It bears emphasis that the "low-cost" scenario employs a number of assumptions that are extremely unlikely when taken together, such as long-term annual real wage growth that nearly doubles the average over the last five business cycles, and US fertility rates rising permanently to 2.3, among others.
66. Ibid., 5. This assessment reflects the significant likelihood that nonphysician payment rates will become inadequate as a result of the productivity adjustments as well as the near certainty that the "sustainable growth rate" (SGR) mechanism for physician payment updates will be replaced, or at least continually overridden by new legislation, as it has been every year since 2003.

FIGURE 9. TOTAL MEDICARE COSTS UNDER TRUSTEES' ALTERNATIVE SCENARIOS



** Alternative to SGR, ACA productivity adjustments and the Independent Payment Advisory Board, a body established under the ACA to facilitate Medicare cost savings.*

Note: To perform the illustration shown in this figure, the CMS actuary must assume that the IPAB's recommendations are overridden in addition to the ACA's payment rate adjustments.

Source: 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *http://downloads.cms.gov/.files/TR2013.pdf.*

GDP growth in most Medicare payment categories, somewhat more plausible for a longer period of time. But it should not be inferred from this possibility that the trustees' current projections are likely to overstate the size of Medicare's financing strains or to lessen the likelihood that further legislative corrections of the program's financing outlook will be necessary.[67] Even with the recent deceleration in health care cost growth, for example, per capita health expenditure cost growth continued to exceed US per capita GDP growth on average during the 2008–11 period for which data are available.[68] There is nothing in the recent health cost deceleration that suggests that future per capita costs in many Medicare categories

67. To solve the Medicare financing shortfall, such legislative corrections would need to close the financing gap seen under current-law projections as well as make up, in a politically sustainable way, for likely legislative overrides of other cost-cutting provisions of current law. These current-law provisions might include ones that some experts believe will prove to be untenable over the long term (e.g., the ACA's productivity adjustments) in addition to provisions that have already been demonstrated to be untenable (e.g., the physician payment cuts under the SGR formula).

68. CMS, "National Health Expenditures"; Index Mundi, Historical Data Graphs, Economy: GDP per Capita (PPP): United States, http://www.indexmundi.com/g/g.aspx?c=us&v=67. Historically per capita NHE growth has tended to well exceed per capita GDP growth. A simple graph from the Kaiser Family Foundation illustrating this point can be found at http://kff.org/health-costs/slide/average-annual-growth-rates-for-nhe-and-gdp-per-capita-for-selected-time-periods/ ("Average Annual Growth Rates for NHE and GDP, Per Capita, for Selected Time Periods"). This graph shows that per capita NHE growth exceeded per capita GDP growth by 2.2 percentage points during the 1970s, by 3.0 percentage points during the 1980s, by 1.1 point during the 1990s, and by 2.5 points from 2000 through 2011.

will grow substantially slower than per capita GDP over periods lasting decades, as would be required for the trustees to be overestimating Medicare's long-term financing challenge.

On the other hand, it should be recognized that it is quite possible for Medicare financial projections to move in either direction, positively or negatively, in future trustees reports. Specifically it is possible that the recent deceleration in health care cost growth could produce interim projections in which the Medicare HI trust fund depletion date is postponed beyond 2026, just as it is possible that the 2026 projection could move earlier. But two points should be understood about this significant potential variability in the near-term projections. The first is that movement in the 2026 date does not translate into a lack of necessity of Medicare financing corrections; such corrections would still be needed and be less disruptive for program participants if enacted sooner rather than later. The second key point is that movement in the 2026 date would not change the reality that the trustees' long-term projections, for the reasons presented here, are far more likely to understate eventual actual system costs than to overstate them.

SUMMARY AND CONCLUSIONS

Current methodologies for projecting Medicare finances have assumed since well before the ACA's passage that national health expenditure growth would eventually decelerate to converge with broader economic growth trends. Under projections for current law, the ACA's Medicare provider payment reductions would be overlaid on decelerating national health cost growth, eventually resulting in per capita expenditure growth in many categories of Medicare spending that is substantially lower than per capita GDP growth over the long term. These projections have led to controversy over the long-run sustainability of the ACA's ambitious cost-reduction mechanisms.

The most optimistic of the reasonable scenarios is that a further continuation of the recent deceleration of national health care cost growth could improve the near-term outlook while rendering current long-term projections more plausible for a longer period of time in the absence of legislative changes, but it should nevertheless be remembered that under these projections, prompt and substantial additional financing corrections would still be called for to sustain Medicare finances. That Medicare's long-term finances might actually prove more benign than under the trustees' current projections is extremely unlikely. Due to these various factors in combination, there is no appreciable likelihood that the recent deceleration in health care cost growth portends a future in which Medicare finances might be fully corrected without significant additional legislated reforms.