

**\*\*\*TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING ON THURSDAY, JUNE 20 2013 AT 9:30 AM\*\*\***

**Statement of Robert D. Reischauer<sup>1</sup>**

**Subcommittee on Health of the Committee on Ways and Means**

**U.S. House of Representatives**

**June 20, 2013**

Chairman Brady, Ranking Member McDermott, and members of the subcommittee, I appreciate this opportunity to discuss with you issues related to the 2013 Annual Trustees Report of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. In his statement, my fellow Public Trustee Dr. Charles P. Blahous covered the basic operations of Medicare and the Trustees' current law projections of the program's financial situation over the next 75 years. My statement focuses on a related topic, one not examined in any depth in the Trustees Report. It is the implications the apparent slowdown in per capita national health spending might have for the financial challenge facing the Medicare program.

My statement first reviews the slowdown and its possible causes. Next it speculates a bit about whether the slowdown will continue or whether spending growth will bounce back. Finally it discusses what this may mean for Medicare's future financial situation.

The slowdown: As has been widely reported, the growth of per capita health spending has slowed in recent years. This slowdown appears to have started around the middle of the last decade and therefore predates the advent of the Great Recession. While the slowdown has not proceeded in a monotonic fashion, it has been evident across all of the major types of coverage—employer/union sponsored plans, Medicare, Medicaid and individual policies.

The following table shows the CMS Office of the Actuary's most recent estimates of the annual rates of growth of per capita health consumption expenditures during the last three plus decades.

<u>1980-1990</u>	<u>1990-2000</u>	<u>2000-2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>
10.1%	5.6%	6.7%	3.7%	3.6%	3.3%	3.2%

Private analysts have suggested that the spending growth in 2012 remained subdued. The growth rates of the past few years are the lowest recorded in over half a century.

---

<sup>1</sup> Distinguished Institute Fellow and President Emeritus of the Urban Institute and Public Trustee of the Social Security and Medicare Trust Funds. The views expressed in this statement should not be attributed to the Urban Institute, its sponsors, staff, or trustees or the other Trustees of the Medicare Trust Funds.

As the table on the next page reports, fiscal year 2012 per beneficiary spending in Medicare grew by less than half a percent and all of the program’s components contributed to this outcome. Over the three year period 2009 to 2012, the annual growth rate of per beneficiary spending was a modest 1.9 percent. Notwithstanding these slow growth rates and the 2013 Trustees Report’s projections which push out by two years—from 2024 to 2026—the date at which the HI Trust Fund is expected to be depleted, the fundamental financial challenge facing the program and the imperative for further cost restraint and reform remain largely unchanged.

### Medicare Results for FY 2012

Total Medicare		Parts C (Medicare Advantage)	
Spending	4.1%	Spending	7.8%
Number of Beneficiaries	3.6	Number of Beneficiaries	7.8
<b>Per beneficiary spending</b>	<b>0.4</b>	<b>Per beneficiary spending</b>	<b>0.0</b>
Parts A + B (Fee for Service)		Parts D (Prescription Drugs)	
Spending	3.0%	Spending	3.6%
Number of Beneficiaries	2.0	Number of Beneficiaries	3.9
<b>Per beneficiary spending</b>	<b>1.0</b>	<b>Per beneficiary spending</b>	<b>-0.4</b>
(Payment rates)	(0.1)		
<b>(Volume and intensity)</b>	<b>0.9</b>		

10

Possible explanations for the slowdown: Analysts have pointed to a number of factors that have contributed to the slowdown in health care spending. Some have had a broad impact across the entire sector while the effect of others was more narrowly concentrated in one area like Medicaid.

First and foremost among the explanations for the spending slowdown is the Great Recession and financial collapse of 2008-9 and the slow subsequent recovery. Analysts have estimated that somewhere between 37 percent and 77 percent of the slowdown is attributable to the weak economy. Many workers lost their jobs and, with their jobs, their employer sponsored health insurance. Finding themselves uninsured or covered by individual policies with higher cost sharing and more restricted benefits or on Medicaid with more limited access to providers, these

workers and their families reduced their use of health care services. Economic uncertainty, anemic wage growth, and the collapse of house values caused even those who were not directly affected by job loss to be more cautious about their discretionary health expenditures.

While some think that the recent economic problems shouldn't have had a large impact on Medicare spending, it is worth remembering that Medicare beneficiaries were strained as well. They received no Social Security COLAs for two years. The collapse of equity values decimated the value of many retirees' IRAs and 401K plans. And historically low interest rates reduced their income from CDs, bonds and other savings vehicles.

Employers, facing weak demand for their products and workers, constrained by slow wage growth and feeling financially insecure, sought ways to reduce their health premium costs. An increasing fraction of workers were offered, often as their only option, high deductible insurance plans or experienced a reduction in the generosity of their traditional plans. Between 2006 and 2012 the fraction of employees with high deductible plans grew from 4 percent to 19 percent and the fraction with plans that had general deductibles of \$1,000 or more grew from 10 percent to 34 percent. With more "skin in the game" it is not surprising that the growth of utilization moderated.

A second factor that has contributed to the recent spending slowdown relates to technology. Compared to past periods, the last few years have been a period during which relatively few major new technologies—drugs, devices, procedures, and other interventions—have been introduced. Furthermore, the diffusions of newer technologies, like advanced imaging, seem to have run their courses. Nowhere is this more evident than in the pharmaceutical arena where fewer new blockbuster drugs have been introduced while significant numbers of widely used branded drugs have come off patent and have been faced with competition from low cost generics.

Changes in policy are a third factor that explains a portion of the recent spending slowdown. The fiscal challenges facing most states caused them to adopt policies that moderated the per beneficiary growth of their Medicaid spending. Whereas per beneficiary Medicaid spending rose at just under 3 percent a year from 2005 to 2007, the growth rate averaged only 1.1 percent between 2007 and 2011 even as the rolls swelled.

While the Affordable Care Act enriched some Medicare benefits thus boosting costs, it also cut the payment rates of some providers and reduced the annual updates most categories of providers received thereby helping to dampen the growth of program spending. Probably of more significance was the signal that the Act gave to the broader health care sector about the emphasis policy was going to place on cost growth moderation in the future. The various demonstrations and pilot programs, the IPAB, the Cadillac tax and other measures made providers and insurers aware that business as usual—cost unconscious care—would not be acceptable going forward.

While the direct impacts of many of the Act's cost restraining measures may not be felt for several years, employers, providers and insurers have begun to prepare by taking anticipatory actions that undoubtedly have already dampened spending growth somewhat.

While less amenable to measurement, changes in the views of the provider community, particularly its leaders, have probably been an important contributor to the slowdown in per capita health spending. In contrast to the past, there is now widespread appreciation among leaders that health care cannot be provided without concern for its costs and the efficiency with which it is delivered. Similarly, there is little dispute now that a significant fraction of care is of marginal or no value. There is even a growing acceptance of the notion that care quality can and should be measured and the results should be disseminated and factor in to payment rates. It is also widely understood that the cost of equivalent care varies widely from provider to provider and little of this variation is attributable to input cost differences or differential outcomes or quality. Finally, leaders in the provider community have realized that, if they don't come up with mechanisms that incentivize high quality, cost effective care, others will impose change on them. All of this amounts to a sea change in attitudes which has spurred hospitals, physician groups, insurers, employers, and others to undertake innumerable efforts designed to moderate cost growth and improve care quality. Some of these initiatives have already helped to dampen cost growth.

Finally and most speculatively, consumer attitudes about health care seem to have begun to shift in ways that may have begun to reduce cost growth. Consumers have become more informed and more sophisticated decision makers thanks to the proliferation of information available through the Internet and the increased attention devoted to health in the traditional media (newspapers, TV, and radio). There is a growing awareness that more health care and more expensive and newer intervention do not always lead to improved outcomes.

Will the slowdown continue? There are too many uncertainties to predict with any confidence whether the spending slowdown will continue. Some of the factors that have contributed to the moderation of cost growth should abate while the impact of others could strengthen.

On balance, there are reasons to be cautiously optimistic about the future course of health care spending but also reasons not to be complacent or to think that whatever bend might have been put in the cost curve will be sustained without further actions.

The economy is recovering, albeit slowly. This will boost wages and incomes which, in turn, will increase the demand for health care services. But no one is predicting tight labor markets or rapidly rising incomes. It is unlikely, therefore, that workers will want to devote a significant portion of any modest future increases in compensation they may receive to reacquire the less restrictive and more costly health insurance policies they enjoyed in the past. Many have probably adjusted to more restrictive networks, higher cost sharing, generic drugs and lower

levels of utilization. Even if this is not the case, employers cognizant of future costs they may face, will be reluctant to move in the direction of enriching the health insurance they offer.

While one hopes that there will be significant advances in medical technology, scientists, entrepreneurs and venture capitalists realize that the bar is being raised, although very gradually. To gain widespread utilization in the future, expensive new technologies will increasingly have to demonstrate that they are significantly more effective or patient friendly than existing, cheaper interventions or be subject to step therapy regimes which will reduce their market potential.

Over the next decade, policy, if adhered to, should exert an ever stronger moderating impact on cost growth as many of the measures contained in or induced by the Accountable Care Act and other recent legislation are fully implemented. Where successful, the insurance exchanges could offer a variety of innovative, cost conscious insurance products in a competitive marketplace. For the first time significant numbers of individuals will be able to trade off their preferences for bearing risk, accepting narrow provider networks, and foregoing cutting edge therapies as well as amenities against their willingness to pay higher premiums. What we learn from the exchange experiences could significantly affect the forms of insurance offered by employers. The Cadillac tax should encourage many employers and their employees to start discussing how much each is willing to pay for generous coverage. Over the long run, this could lead to a significant scaling back of some employer sponsored policies and put more pressure on providers to contain costs.

There is every reason to believe that increasing numbers of providers and other stakeholders will focus their attention on costs and quality as more find themselves facing new payment arrangements that incentivize them to coordinate care, provide care more efficiently and bear some of the financial risk associated with excessive cost growth.

The gradual demographic transition that is taking place in the provider community is a final reason to be guardedly optimistic about the possibility that the recent spending slowdown can be sustained over the next decade or so. The skills and interests of younger cohorts of health professionals are more congruous with the institutional structures that will be required by a reformed health system. They are more digitally proficient and more comfortable working as members of teams of health professionals. Seeking a better work-life balance, younger health professionals, especially those in two career families, are more willing to work in organizations large enough to support the complex informational and financial infrastructure required by modern medicine and to provide more flexible work schedules.

To balance this optimism, it is worth pointing to a few of the risks that could cause spending growth to rebound. Prime among these is the possibility that breakthroughs in genomic science, nanotechnology, stem cell research and other cutting edge technologies could lead to an explosion of new expensive interventions. On the other hand, the mining of big data could lead to a better understanding of which specific interventions are most effective for which patients

and under what circumstances. That could result in better targeting of care and lower overall utilization.

A second development that might boost the pace of future spending growth is the increased provider market power that could develop from the consolidation and integration that will probably take place as the health care system undergoes reform. The complexity and cost of modern medicine requires operations of a minimum scale to be efficient. The Affordable Care Act seeks to encourage integrated or coordinated care and the use of information technology to manage that care which small and fragmented providers find challenging. Operations of a significant size are also presumed by new payment arrangements that require providers to share risk when quality falls below or costs rise above certain thresholds, a burden that small organizations are ill equipped to bear. While provider consolidation and integration may be required for improved care quality and efficiency, in some areas this may give these organizations more power to set prices. Some metropolitan areas will be large enough to support robust health markets where a number of large providers compete aggressively. But in many smaller metropolitan areas and in non-metropolitan regions of the country one or a few providers may have an inordinate influence over prices and spending growth.

The increase in the demand for health services that will occur with the implementation of the Affordable Care Act could be a third threat to the continuation of the spending slowdown. In some areas where many are uninsured or under-insured temporary shortages of providers might develop. This could cause prices and spending to rise. On the other hand, the increased demand could be spur an expansion of new, more efficient delivery organizations like “minute clinics,” the more intensive use of expensive equipment that could bring down unit prices and an expanded reliance on nurse practitioners, physician assistants and other non MD health professionals where their contributions have proven to be effective.

The implications of a continued slowdown for Medicare: Some might ask whether the future pace of growth of overall health care spending has much relevance for Medicare’s future fiscal situation. After all, unlike employer sponsored insurance, individual insurance or even the policies that will be offered on the exchanges, Medicare is a system with administered prices whose course is set by legislation not market forces. Legislation and regulation, not market place negotiations with providers, also define the other program parameters and cost saving measures that determine Medicare’s overall and per capita spending. Because Medicare makes up such a large fraction of the overall health care market and because its enrollees constitute such a well-regarded component of American society, few providers can afford or would want to forego their Medicare business under any circumstances.

Doesn’t this suggest that Medicare is free to set its own course with respect to future cost growth independent of whatever is happening in the rest of the health care marketplace? The answer to this question is a resounding “No.” Nowhere is this illustrated more clearly than in the

appropriate reluctance Congresses and Presidents have shown toward adhering to the discipline required by the Sustainable Growth Rate (SGR) formula. Notwithstanding the fact that the projections in the Trustees Report assume, as they must following current law, that the SGR will impose a 24.7 percent reduction in the physician fee schedule on January 1, 2014, the Report notes that it is a “virtual certainty” that this reduction will be overridden. This judgment is based on the experience since 2003 and an appreciation of the disruptive consequences that a sudden, sharp reduction that would leave Medicare payment rates far below those of other payers would have. In short, what happens in the private market place constrains what Medicare can do.

For several years, the Trustees Reports have expressed caution with respect to the long run sustainability of the major cost-reduction measures required by the Affordable Care Act. The most important of these are the reductions in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity and the IPAB. While the Trustees believe that these measures can be sustained, this will occur only if the health sector can transition to more efficient models of care delivery. Such a transition will not happen unless private payers as well as Medicare continue to pursue cost saving innovations aggressively and providers respond to incentives to moderate cost growth and improve quality.

In conclusion, Medicare’s ability to moderate the growth of its costs over the long run depends critically on the private sector’s success in its efforts to slow its spending and vice versa.