Federation of American Hospitals®

Charles N. Kahn III
President and CEO

August 19, 2013

Honorable Dave Camp
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Camp:

The Federation of American Hospitals (FAH), representing America's more than 1,000 investor-owned and managed hospitals and health systems, appreciates the opportunity to comment on the Committee on Ways and Means' proposal to modernize beneficiary cost-sharing within Medicare.

The FAH supports the goal of the Committee's proposal -- to shore up the fiscal foundation of the Medicare program and sustain Medicare's promise of health coverage for seniors and the most vulnerable Americans -- and applauds your leadership in raising these particular policies for discussion.

As the important national conversation concerning entitlements continues, it is clear that the nation's changing demographics eventually will place increasing pressure on the Medicare program. In light of the expected growth in the number of Medicare beneficiaries, and the continued aging of the Medicare population, it certainly is reasonable for the Committee to carefully reexamine Medicare benefit design reforms that address these demographic pressures in a responsible manner.

The Committee's proposal comprises three policies which fit these criteria. All three of these policies – an increase in the Medicare Part B deductible, an increase in income-related premiums under Medicare Parts B and D, and the establishment of a copayment for home health care services – are included within the President's fiscal year 2014 proposed budget and warrant serious consideration. Going forward, it is important to examine these three policies within the context of the dramatic sustained slowdown in the growth rate of health care spending nationally, and in the Medicare program in particular.

In April, CMS's Office of the Actuary (OACT) projected a five-year (2011-2015) average growth rate in Medicare spending per beneficiary of 1.15 percent, and only .78 percent over the last three years of this period. Compared to overall economic growth, Medicare spending is growing at a rate well below GDP.

These stunning numbers were unimaginable just a few years ago. In fact, over the past five years, the Medicare Trustees, the Congressional Budget Office (CBO), and OACT each reduced their projections of future Medicare spending over the next decade by more than $1 trillion.

Indeed, there is compelling evidence that this historic spending slowdown is rooted in structural changes to the health care system, not just economic cycles, and as such these trends are durable and unlikely to revert to pre-recession levels. The Committee's proposed reforms could well reinforce these positive foundational trends, which already have succeeded in bending the health care cost curve.

The attached study, commissioned by the FAH and conducted by Dobson DaVanzo and Associates, documents this new health spending paradigm and describes the structural changes driving it -- a complex, dynamic set of numerous interrelated forces in the health care system, including major regulatory and legislative developments, market-based cost drivers, and delivery system reforms, to name just a few.

When compared to the CBO's most recent budget projections issued in May 2013, the Dobson DaVanzo study concludes that if the recent trend in health care spending growth continues -- and given the structural nature of the slowdown, there is every reason to believe that it will -- we could experience an additional $1 trillion in savings to the Medicare program between 2014 and 2023.

Realizing these savings depends upon many factors, including policymakers ensuring that the forces currently at work are allowed to mature and are not disrupted by counterproductive proposals such as additional blunt provider cuts.

Over the last three years, the cumulative effect of $95 billion in Medicare cuts to hospitals, on top of earlier reductions, already is taking its toll. The impact of these cuts, in part, is evidenced by a significant slowdown in hospital employment. The latest Bureau of Labor Statistics estimates indicate that the hospital sector lost approximately 4,500 jobs in July, which follows a reported loss of 9,000 jobs in May, placing these two months among the sector's worst performing months in a decade.

Hospitals' ability to meet the continuing needs of their communities also is made more difficult due to chronic Medicare underpayment to hospitals. Reports from the Medicare Payment Advisory Commission document that 2013 will be the eleventh consecutive year of Medicare hospital payments falling below the cost of care. Additional cuts could well jeopardize access to the hospital care that Medicare is obligated to provide to seniors.

We appreciate the Committee's thoughtful, serious leadership in engaging the public on the complicated, critical, and sensitive issues surrounding Medicare reform. The FAH thanks you for the opportunity to comment and welcomes the opportunity to work with you going forward.

With warm regards,

CNK
Enclosures: 1

cc: Ranking Member Sander Levin

Structural Changes Drive Health Care Spending Slowdown

Implications for Medicare Policy and Deficit Reduction

Dobson | DaVanzo

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Structural Changes Drive Health Care Spending Slowdown

Implications for Medicare Policy and Deficit Reduction

Submitted to:
Federation of American Hospitals (FAH)

Submitted by:

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Friday, June 14, 2013 — *Final Report*

Study Overview

Introduction and Study Purpose

Over the past decade, health care spending increases relative to GDP growth have slowed to near historic levels. The slowing growth rate of health care spending—observed for both national health care expenditures and spending in the Medicare program—has occurred gradually over this time period. This low growth rate is becoming more pronounced, as fluctuations in health care spending have dampened during the 2009 to 2012 period.

If Medicare spending trends from 2009 to 2012 continue through 2023, Medicare could save $2.6 trillion relative to the 2008 spending projections made by the Medicare Trustees.

Dobson | DaVanzo was commissioned by the Federation of American Hospitals (FAH) to investigate:

- The degree to which growth in national health care spending, and specifically Medicare spending, has decreased over the past several years compared to historical rates;
- Potential explanations for this decrease; and
- The implications of this decrease in spending growth for current and future Medicare policy, as well as ongoing efforts to reduce the federal deficit.

In this study overview and the supporting documentation attached in Appendix A, we:

- Review the historical growth in total health care and Medicare spending prior to 2013, as well as falling projections of future spending growth;
- Estimate the "savings" to the federal budget due to this slowdown and discuss why this trend may continue over the long term; and
- Examine reasons attributed to this slowdown through an analysis of the available literature.

Over the past five years, the Medicare Trustees, the Congressional Budget Office (CBO), and the Office of the Actuary (OACT) within the Centers for Medicare & Medicaid Services (CMS) have each reduced their projections of future Medicare spending during the next decade by over $1 trillion. If the recent trend in health care spending growth continues, the Medicare program could realize $2.6 trillion in savings over the period 2014 to 2023 in comparison to the 2008 projection levels for the same period.

While explanations for the recent slowdown in health care spending vary, the primary drivers are thought to be the "Great Recession" and structural changes to the health care

marketplace. Attribution of the slowdown in health care expenditures to economic forces varies widely, with estimates ranging from nearly 80 percent to roughly 30 percent. The ways in which explanatory models are calibrated and specified seems to influence analytic results (i.e., the greater the number of variables entered into the model, the lower the impact of the Great Recession).

The purpose of this analysis is to examine the drivers of structural changes in health care delivery underlying the recent slowdown in health care spending, and determine the extent to which these drivers might continue to "bend the cost curve" into the foreseeable future.

Background

Health care spending has increased faster than growth of the gross domestic product (GDP) since the 1960s. This excess or real growth in health care expenditures has three important societal consequences:

1) Federal deficit: Growth in health care spending increases the federal deficit and places financial pressures on state budgets.
2) Taxable income: Real wages for many workers fall as health care premiums increase relative to wages, leading to less taxable income for both states and the federal government, as well as less disposable income available to workers.
3) Opportunity costs: More public and private spending on health care leaves fewer dollars for purchasing other goods and services.

If health care continues to comprise a larger share of income that could be directed to other purposes as the U.S. GDP grows, broad-based pressures will mount to curtail health care expenditure growth. At some point, historic growth rates are not sustainable (e.g., 100 percent of the GDP cannot be devoted to health care).

However, as of late the federal deficit has been falling rapidly, and the slowdown in health care spending growth has been a major contributor. In 2012 the federal deficit was $1.1 trillion. As of May 2013, CBO projected the 2013 deficit to be approximately half as large, at $642 billion. CBO's May 2013 projection of the federal deficit had been lowered from an earlier February 2013 projection of $775 billion, with lower projected Medicare spending representing nearly 8 percent of this reduction.

Falling projections for the federal deficit and the relationship between the deficit and health care spending are changing the terms of congressional debates over the national debt. To the degree these falling projections are due to structural changes in the health care market, these trends could lead to long-term changes in entitlement policy. The nature of these emerging structural forces is described below.

Study Overview

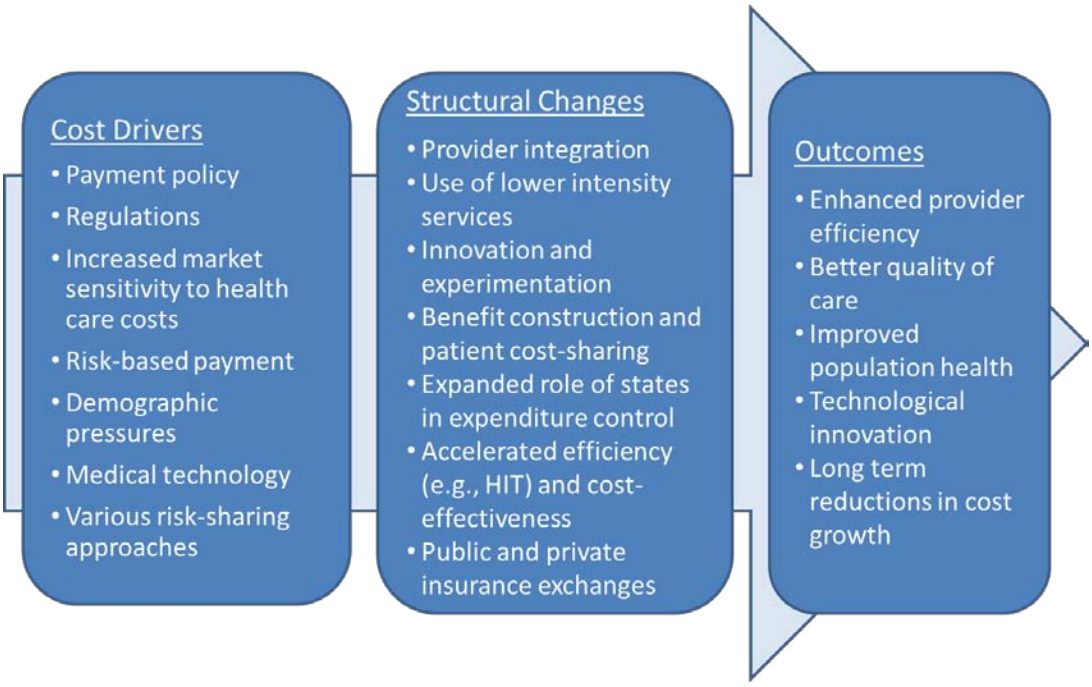
Structural Changes in Health Care May be Unprecedented

The diversity and intensity of current attempts to improve the efficiency of the U.S. health care system appear to be unprecedented in scale and scope, and could very well produce the desired results, given the wide perception that reducing health care expenditure growth is a key domestic policy goal.

The supporting documentation attached in Appendix A provides detail on the complexity of varying structural changes taking place throughout the health care industry. As these changes are unfolding, their impact is difficult to quantify, but the direction of the impact seems qualitatively important. The more permanent nature of these changes is also important, as many of both the cost drivers and structural changes are unlikely to revert to pre-recession levels (e.g. technological innovation, employer sensitivity to health care costs, increased role of states). The following framework is meant to be indicative of the complexity of a rapidly evolving structure in the health care marketplace.

In the framework presented in Exhibit 1, we conceptualize the dynamics of reducing the long-term growth rate of health expenditures over time as occurring in three phases: 1) cost drivers; 2) structural changes in response to these drivers; 3) and outcomes of the structural changes that have occurred and may continue into the future.

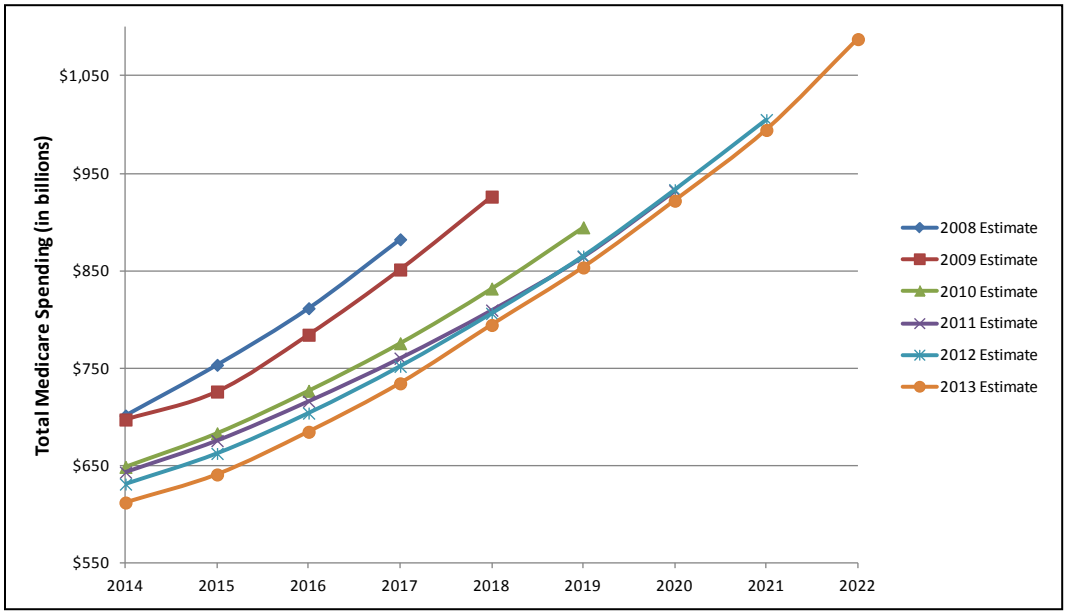
Exhibit 1: Conceptual Framework for the Dynamics of Bending the Cost Curve over Time



For example, risk-based payments and various risk-sharing approaches between payers and providers cause behavioral changes among providers, private payers, and patients. These changes include increases in provider integration and care coordination, greater use of lower intensity (lower cost) services, and potentially less generous health insurance benefits, among others. Structural changes in the health care marketplace, implemented in response to the drivers mentioned above, could lead to outcomes including greater provider efficiency, better patient outcomes and quality of care, and, ultimately, a lower rate of increase in health care costs over time.

Due in part to the effects of these structural changes, the Medicare Trustees have reduced their projections of future Medicare spending on an annual basis since 2008 (see Exhibit 2).

Exhibit 2: Medicare Trustees Spending Projections for Medicare (2014-2022)



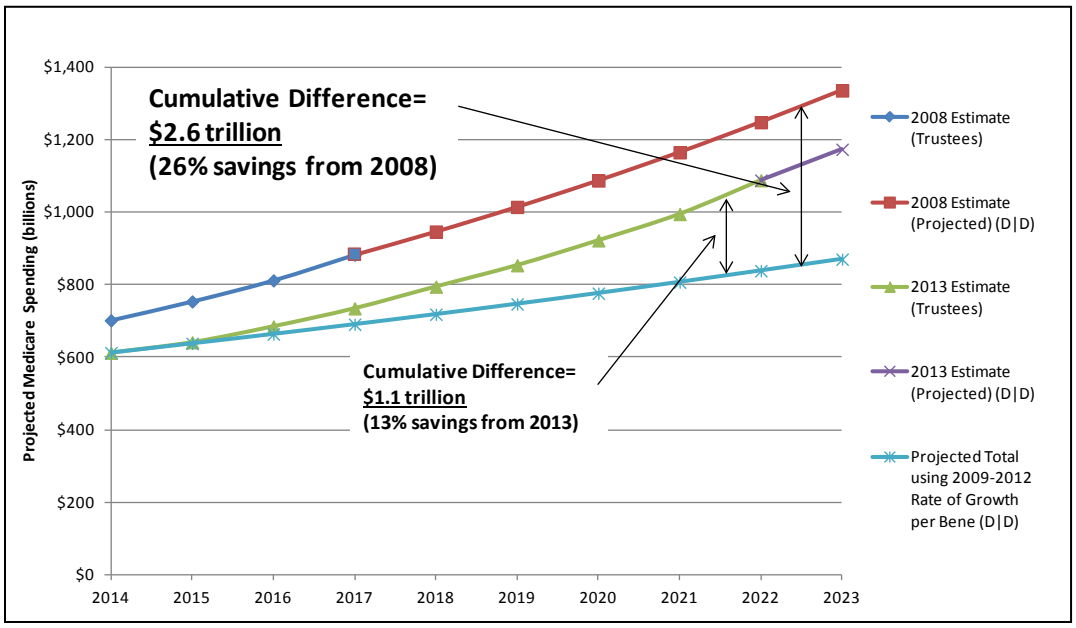
Source: Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2008 to 2013.

Exhibit 3 shows a comparison of three Medicare spending projections based on Medicare Trustees information for the 2014 to 2023 period:

1) Medicare baseline spending from 2014 to 2023 projected from 2008 projection levels
2) Medicare baseline spending from 2014 to 2023 projected in 2013
3) Projected Medicare spending from 2014 to 2023 if the annual growth rate in Medicare spending per beneficiary continues at the 2009-2012 rate

If the trend in Medicare spending growth over the period 2009 to 2012 were to continue through 2023, we estimate that Medicare spending could be $2.6 trillion lower than the 2008 Medicare Trustees projection levels (a savings of 26 percent from the 2008 baseline). Even compared to the recently released 2013 Medicare Trustees projections, we estimate that Medicare spending could be $1.1 trillion lower for the period 2014 to 2023 if this trend in Medicare spending growth were to continue (a savings of 13 percent from the 2013 baseline).

Exhibit 3: Projected Aggregate Medicare Savings (2014-2023) Based on Medicare Trustees Forecasts of Actual 2008 Baseline and 2013 Baseline Using 2009-2012 Medicare per Beneficiary Growth Rate



Note: D|D is Dobson | DaVanzo.
Source: Dobson | DaVanzo analysis of 2008 to 2013 Medicare Trustees estimates. The average growth rate from 2009-2012 was calculated using Trustees estimates of total Medicare expenditures from 2009-2012 (reported in the 2013 Medicare Trustees Report) divided by the number of Medicare beneficiaries in each year as reported in the 2013 Medicare Trustees report. See "Methods in Brief" for forecasting methodology.

Is This Time Different?

Since Medicare was enacted in 1965, health care expenditure increases have generally outpaced GDP growth. There have been several notable exceptions. In the early 1970s, the Nixon Administration's wage and price controls slowed health care spending growth, but this effort was successfully undermined by union and worker reaction to the policy. At the end of the Carter Administration in the late 1970s, a voluntary cost control effort led by the hospital industry also slowed health care spending growth. While this effort showed that health care cost growth can be constrained, it was short lived and ended in 1980. In the 1990s, the health maintenance organization (HMO) movement reduced the

rate of health care spending growth to GDP. This effort may have ultimately led to a permanent, long-term reduction in health care spending,[1] but a major backlash undermined the HMO effort as consumers lost faith in the health insurance industry's ability to manage care and control costs in an effective and equitable way.

In the period 2010 to 2012, national health care spending per capita has grown at the same rate as GDP, and Medicare spending has grown at a rate of 1 percent *below* GDP. The current slowdown in growth may be different from previous periods, as its causes are numerous and interrelated in complex ways. Indeed, "thousands of efforts to improve efficiency and quality are under way including programs sponsored by Medicare, Medicaid, commercial insurers, hospitals, and physicians."[2] If so, unlike the historic examples above, the current slowdown may not be a one-time event but rather may have enduring effects over time.

Adapting a political science framework, Exhibit 4 shows that the failure of previous reform efforts to control long-term health care spending can be explained by a combination of two factors that did not lead to structural changes: 1) lack of stakeholder economic investment, and 2) maintenance of previous stakeholder alliances and policy positions.[3] As the health care marketplace continues adapting to reforms enacted over the past decade, responds to secular trends in the employment market, and begins to implement a broad range of new policies under the Affordable Care Act (ACA), stakeholder alliances and policy positions will evolve and economic investments will grow, leading to a reconfiguration of the health care industry and lasting change (see bottom right corner).

Exhibit 4: Historic Health Care Reforms in Framework of Long-term Policy Impact

	Stakeholder Policy Positions and Alliances	
Stakeholder Economic Investments	**Stable**	**In Flux**
Modest	**Reversal of Reform** Nixon Administration Wage and Price Controls (early 1970s)	**Erosion of Reform** Carter Administration hospital-led voluntary cost control (late 1970s-1980)
Extensive	**Entrenchment of Aspects of Reform** Clinton-era HMO Movement (mid-1990s)	**Reconfiguration** Great Recession and Affordable Care Act (2008-)

Source: Adapted from Patashnik, E.M. (2008). Reforms at risk: What happens after major policy changes are enacted. Princeton, NJ: Princeton University Press.

[1] Fuchs, V.R. (2013). The gross domestic product and health care spending. *New England Journal of Medicine* Perspective: May 22.

[2] Pyenson, B., Fitch, K., Goldberg, S. (2009). Imagining 16% to 12%: A Vision for cost efficiency, improving healthcare quality, and covering the uninsured [Milliman Research Report]. Seattle, WA: Milliman.

[3] Patashnik, E.M. (2008). Reforms at risk: What happens after major policy changes are enacted. Princeton, NJ: Princeton University Press.

Study Overview

The health care spending slowdowns observed during the early and late 1970s, as well as the late 1990s, were undermined to varying degrees by the strength of interest groups, the continuity of stakeholder policy positions, and/or a lack of stakeholder economic investment in change. Cost drivers currently being put into place, however, may represent a departure from previous trends and could lead to a series of structural changes that exert long-term effects on health care spending.

Discussion

The past 10 years have seen an unprecedented series of developments directed at improving quality as well as delivery efficiency in health care. These activities have been numerous and complex. CMS now has the authority to move from demonstration activities to national implementation. The Agency is committed to moving demonstrations through a rapid-cycle evaluation process in order to decrease the time between concept development and broader program implementation. Similarly, system reforms and cost control activities are being undertaken by states given the necessity of balancing their budgets. State-based health insurance exchanges and the emergence of private health insurance exchanges, likewise, could impact health care expenditures through the premium review process. In addition, employer sensitivity to health care costs and efforts to reduce premiums through employee health insurance benefit design could dampen future cost growth in the private sector.

These forces, combined with strong price signals directed toward providers to become more efficient, may result in dynamics that produce a deflationary spiral in health care costs over the foreseeable future. Falling Medicare projections made by the Medicare Trustees, CBO, and OACT all confirm that health care spending is growing at a much lower rate over the 2014 to 2023 time period than originally thought at the onset of the Great Recession in 2008.

At this time, the processes are not yet complete. Public policy needs to support the vast array of efficiency and quality improvement activities underway, and observe which work and which do not. As the U.S. prepares for the cost pressures that will build from serving the aging Baby Boomer population, it is important that policymakers take careful measure of the forces currently in play before attempting massive system change with unknown consequences.

Study Overview

Methods in Brief

The findings of this study are based on two types of analyses:

1) A targeted review of the most recent literature on trends in health care spending, including articles published in peer-reviewed journals, government reports, and other forms of "grey" literature; and
2) Analyses of secondary data released by the Medicare Trustees, CBO, and OACT from 2008 to 2013.

For these three secondary data sources, we compared projected expenditure levels from 2008 estimates to most recent estimates (from either 2012 or 2013, depending on the source) in order to show "savings" to the Medicare program from spending levels forecasted in 2008 over the 10-year period 2014 to 2023.

When available, we used total Medicare expenditures for each year in our projections. When unavailable, we estimated future projected expenditure levels based on prior projections:

1) Medicare expenditures per beneficiary were calculated for five years prior to the last year of the projection by dividing total forecasted Medicare expenditures by the estimated total number of Medicare beneficiaries for each year (based on enrollment statistics from the Medicare Trustees 2013 annual report).
2) A compound annual growth rate in Medicare spending per beneficiary was calculated for five years prior to the last year of the projection.
3) This compound annual growth rate was reduced by 0.2 percent to account for the changing age structure of Medicare beneficiaries.[1]
4) This adjusted compound annual growth rate was then used to project Medicare expenditures per beneficiary for the years not included in the original forecast.
5) The forecasted per beneficiary spending was then multiplied by the estimated number of Medicare beneficiaries for each given year from the last year of the projection through 2023 (based on enrollment projections from the Medicare Trustees 2013 annual report).

We then combined the original 2008 estimates of future Medicare spending with our extrapolated projections of the 2008 estimates to create a 2008 baseline projection of Medicare spending over the period 2014 to 2023.

After creating the 2008 baseline estimate for the 2014 to 2023 timeframe, we estimated total Medicare spending from 2014 to 2023 if the rate of growth in spending per Medicare beneficiary remained at the same levels over this period as from 2009 to 2012 using the following three-step methodology:

1) A compound annual growth rate in Medicare spending per beneficiary from 2009 to 2012 was calculated using actual reported total Medicare expenditures divided by the number of Medicare beneficiaries for each year (based on enrollment statistics from the Medicare Trustees 2013 annual report).
2) This calculated compound annual growth rate was reduced by 0.2 percent to account for the changing age structure of Medicare beneficiaries.[1]
3) The adjusted compound annual growth rate was then used to forecast Medicare spending per beneficiary from 2014 to 2023.
4) The forecasted per beneficiary spending was then multiplied by the estimated number of Medicare beneficiaries for each year over the period 2014 to 2023 (based on enrollment statistics from the

Medicare Trustees 2013 annual report) to estimate total Medicare spending as if the rate of growth in spending per beneficiary remained at 2009 to 2012 levels.

The methodology described above to forecast future Medicare spending from 2014 to 2023 using the 2009 to 2012 growth rate in spending per beneficiary was adapted by Dobson | DaVanzo from a study recently published by David Cutler and Nikhil Sahni in *Health Affairs*. Below we highlight the differences between our analysis and the Culter/Sahni methodology:

	Cutler/Sahni Methodology*	**Dobson | DaVanzo Analysis**
Population	Total public health care spending	Total Medicare spending
Time Period Projected	2012-2021	2014-2023
Source Used	OACT	Medicare Trustees, CBO, and OACT
Growth Rate Used for Projection	2009-2012 per beneficiary spending	2009-2012 per beneficiary spending
Baseline Used in Savings Estimate	2012 OACT forecast	2008 Medicare Trustees, CBO, and OACT forecasts†

* Cutler, D., Sahni, N. (2013). If slow rate of health care spending growth persists, projections may be off by $770 billion. *Health Affairs* 32(5), 841-850.

† Projected forward at average spending per beneficiary growth rate in the 2008 Medicare Trustees 10-year projection, and 2013 Medicare Trustees projections of Medicare enrollees from 2014-2023.

The methodology used to forecast Medicare spending over the period 2014 to 2023, as described above, has several limitations. As the Medicare spending projections from 2008 were made prior to passage of the ACA, they do not reflect changes to the Medicare program or expected changes in Medicare enrollment that will occur in 2014 to 2023 due to the legislation. For example, the implementation of Medicaid expansion is likely to increase Medicare Part B enrollment—this increase in enrollment is not incorporated into our extrapolation of 2008 Medicare spending projections. However, we believe this trend has a minimal impact on our savings estimates.

In order to account for a reduction in the growth rate of average Medicare spending per beneficiary due to the enrollment of the Baby Boomers (who are younger, healthier, and therefore expected to incur lower Medicare costs than the average beneficiary), we reduced our projected annual growth rate in Medicare spending by 0.2% each year from 2014 to 2023.[1] We applied this adjustment to the 2008 baseline projection and to our 2013 projection of Medicare spending assuming the rate of growth in spending per beneficiary remains at 2009 to 2012 levels. This adjustment reflects current assumptions about near-term demographic trends in the Medicare population, but may not be consistent with the assumptions underlying the 2008 projections or fully capture the effects of this trend on Medicare spending.

Finally, the analyses presented in this study do not represent an independent actuarial analysis, but are projections of future Medicare spending based on prior and current Medicare spending levels forecasted in secondary data sources.

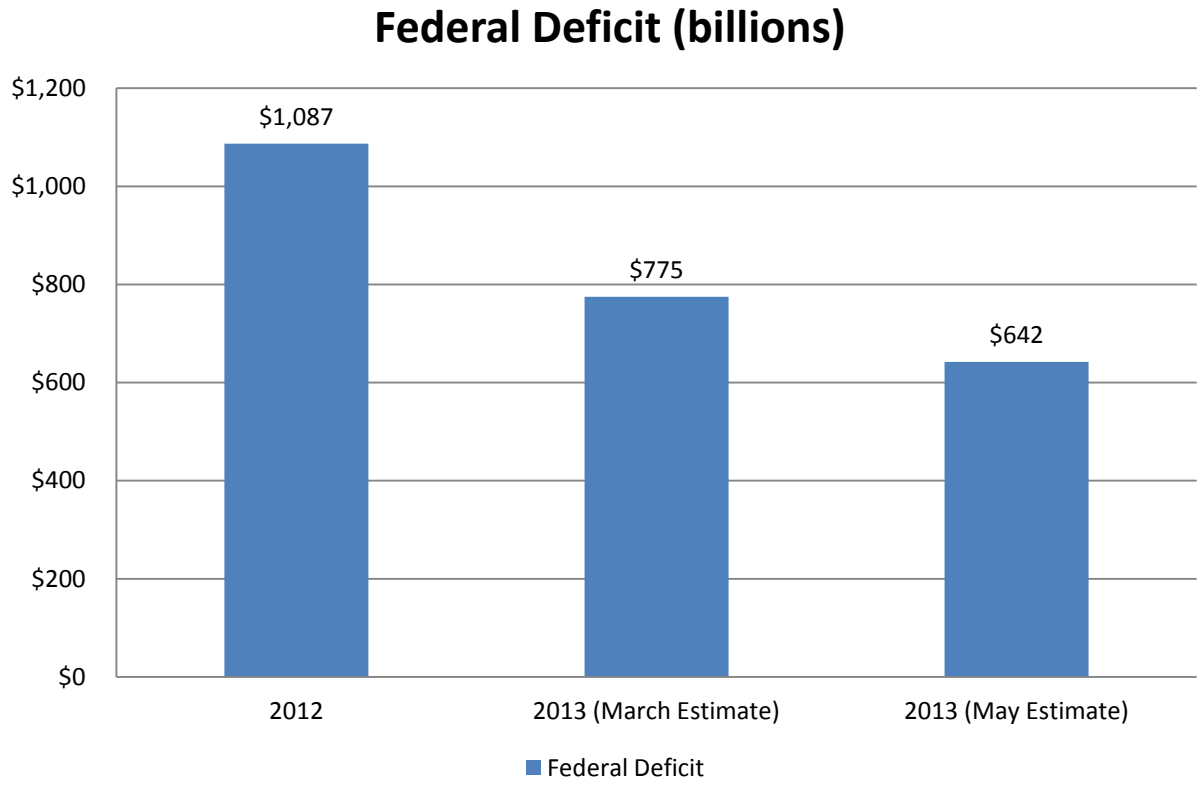
[1] Kronick, R., Po, R. (2013). Growth in Medicare spending per beneficiary continues to hit historic lows. *ASPE Office of Health Policy*.

Appendix A: Supporting Documentation

Dobson|DaVanzo

Actual and Projected Federal Deficits are Decreasing

- **The federal deficit has fallen by nearly half, from $1.1 trillion in 2012 to $642 billion in 2013**



Source: Congressional Budget Office (2013, May). Updated budget projections: Fiscal years 2013 to 2023 [Pub. No. 4722]. Washington, DC: CBO.

- **This decrease changes the terms of the deficit debate**
- **Reductions in Medicare and Medicaid spending have contributed substantially to this decrease**

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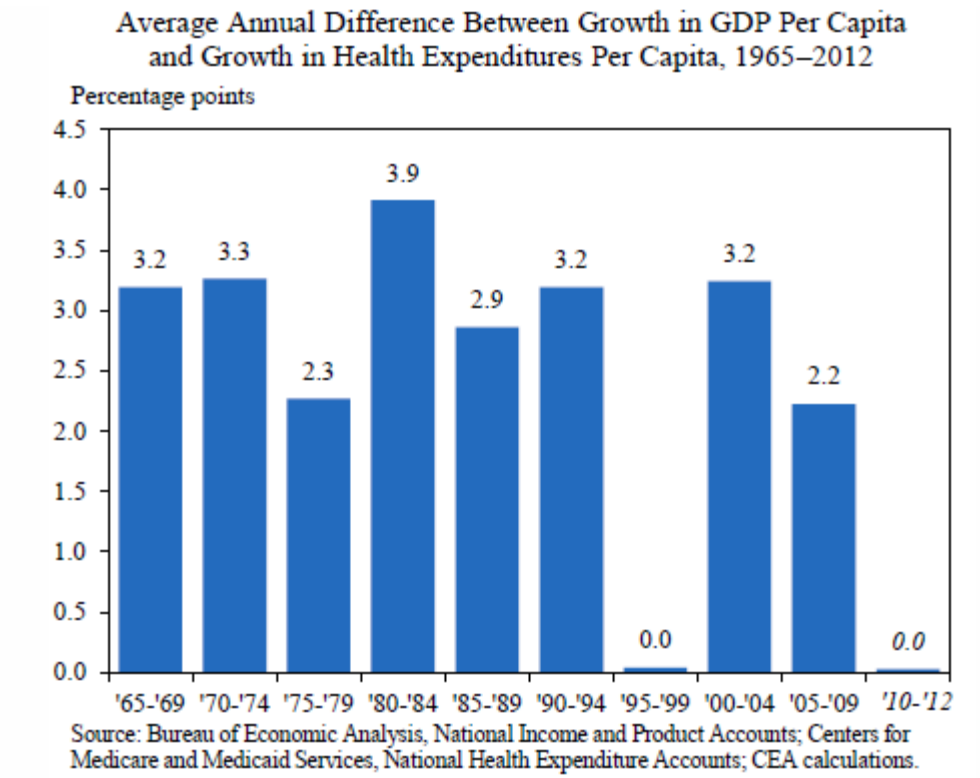
National Health Care Spending: Annual Growth Rate Above GDP Is Declining

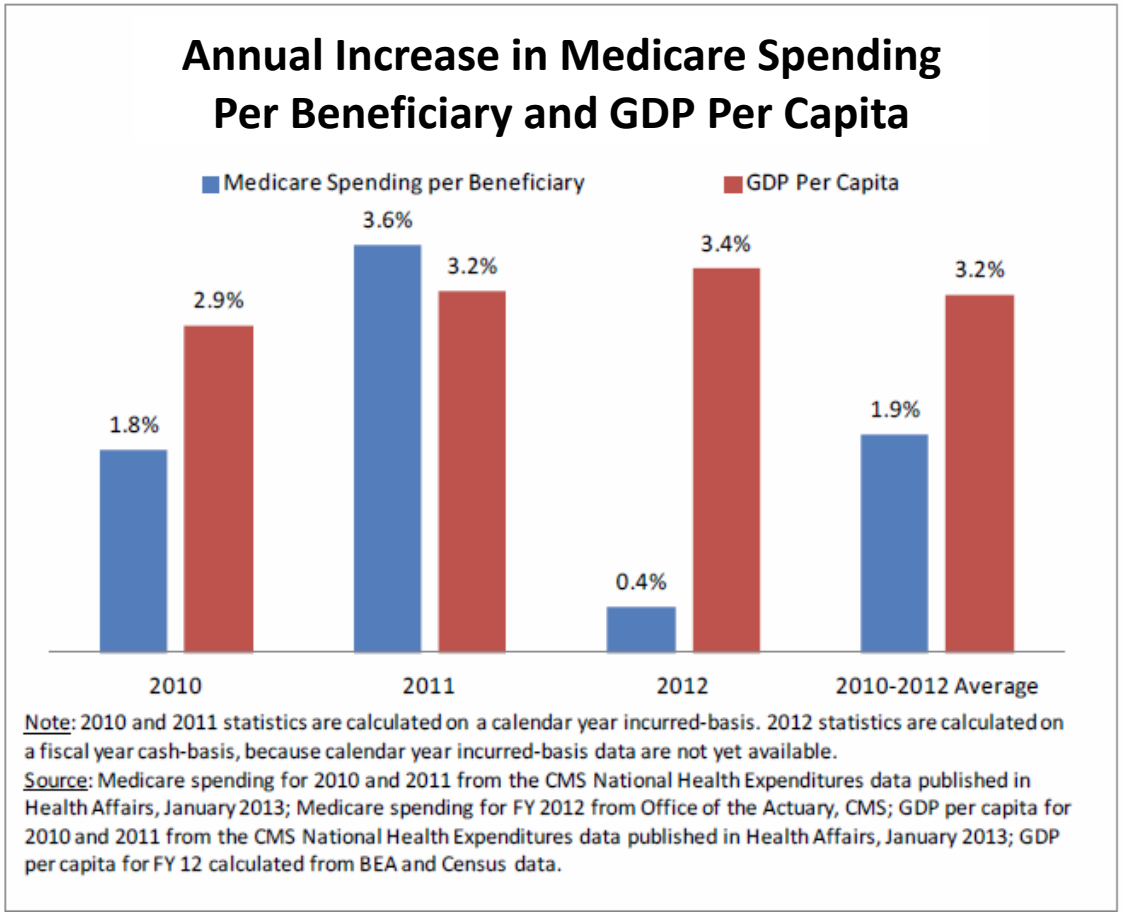


- **From 2010 to 2012, national health care spending per capita returned to the 1995 to 1999 growth rate, which is approximately the same as that for the gross domestic product (GDP) per capita[1]**
  - From 1970 to 2010, the average annual growth rate was approximately GDP +2 percent[2]

[1] The Council of Economic Advisors. (2013). The Affordable Care Act and trends in health care spending.
[2] Cutler, D., Sahni, N. (2013). If slow rate of health care spending growth persists, projections may be off by $770 billion. *Health Affairs* 32(5), 841-850.

Dobson | DaVanzo

Medicare Spending: Annual Growth Rate per Beneficiary Is Also Declining and Below the Growth Rate of GDP Per Capita



Note: 2010 and 2011 statistics are calculated on a calendar year incurred-basis. 2012 statistics are calculated on a fiscal year cash-basis, because calendar year incurred-basis data are not yet available.
Source: Medicare spending for 2010 and 2011 from the CMS National Health Expenditures data published in Health Affairs, January 2013; Medicare spending for FY 2012 from Office of the Actuary, CMS; GDP per capita for 2010 and 2011 from the CMS National Health Expenditures data published in Health Affairs, January 2013; GDP per capita for FY 12 calculated from BEA and Census data.

- **Medicare spending per beneficiary grew at an average rate of 1 percent below GDP per capita from 2010 to 2012**
  - In comparison, the average rate of growth was approximately GDP per capita +3 percent from 1970 to 2010[1]

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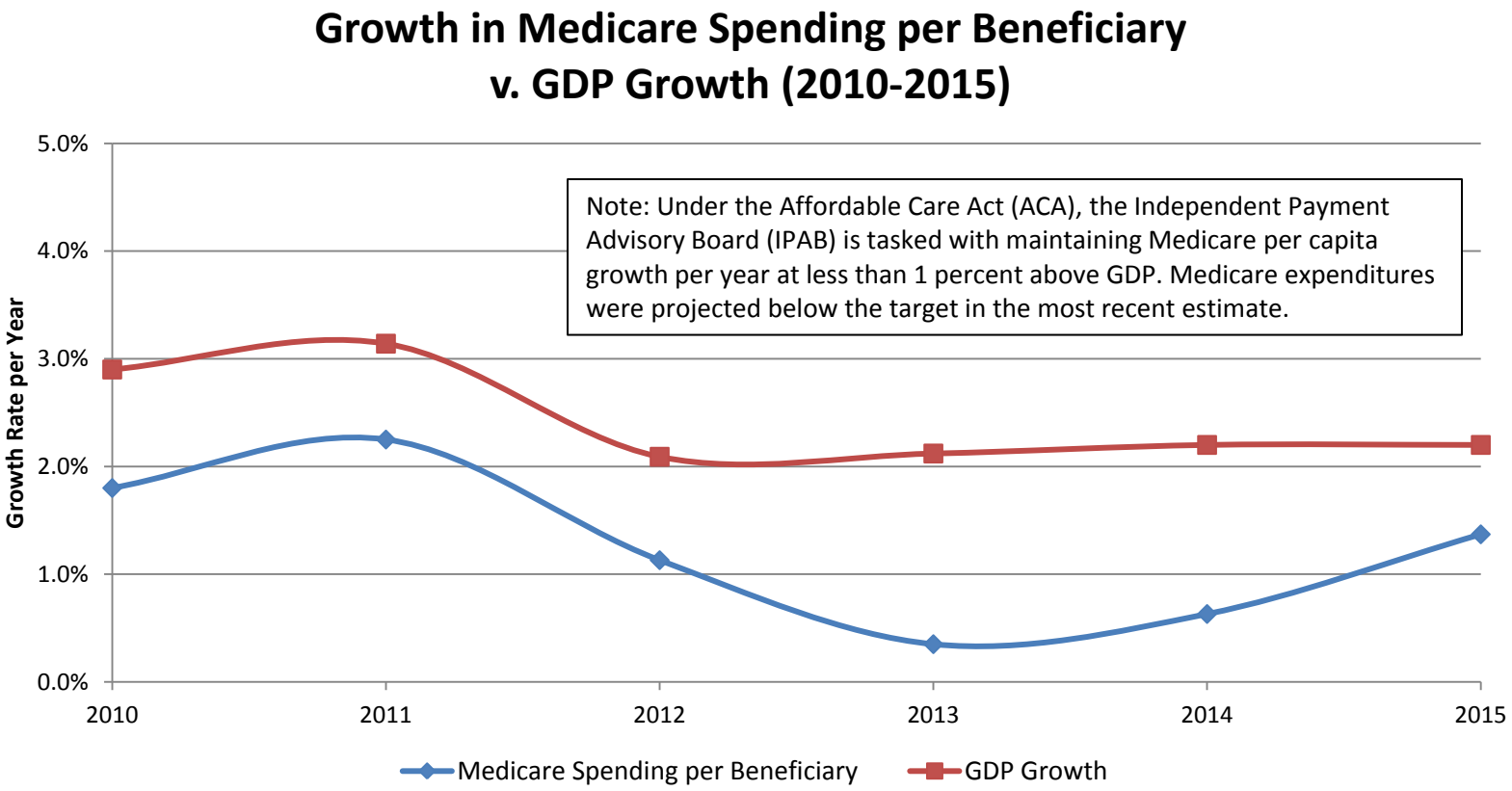
[1] Kronick, R., Po, R. (2013). Growth in Medicare spending per beneficiary continues to hit historic lows. *ASPE Office of Health Policy.*

Medicare Spending: Medicare Spending per Beneficiary Projected to Remain Low Through 2015 (OACT)



Note: OACT is the Office of the Actuary, Centers for Medicare & Medicaid Services (CMS).

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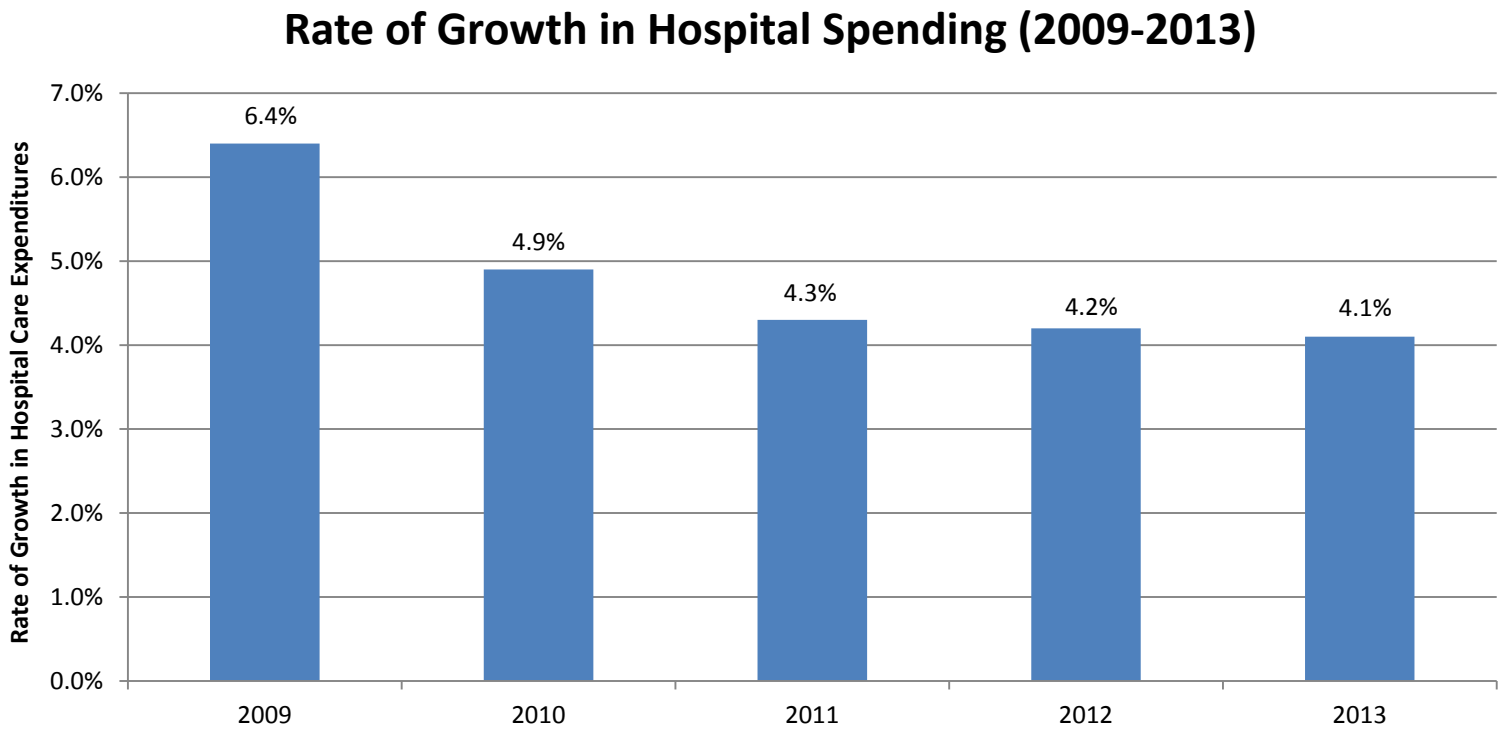
Source: OACT 2013; Kronick, R., Po, R. (2013). Growth in Medicare spending per beneficiary continues to hit historic lows. *ASPE Office of Health Policy.*

Hospital Spending: Annual Growth Rate is Declining

- **From 2009 to 2013, the annual rate of growth in hospital spending fell from 6.4 percent to 4.1 percent**



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group (2012). National Health Expenditure Projections 2011-2021.

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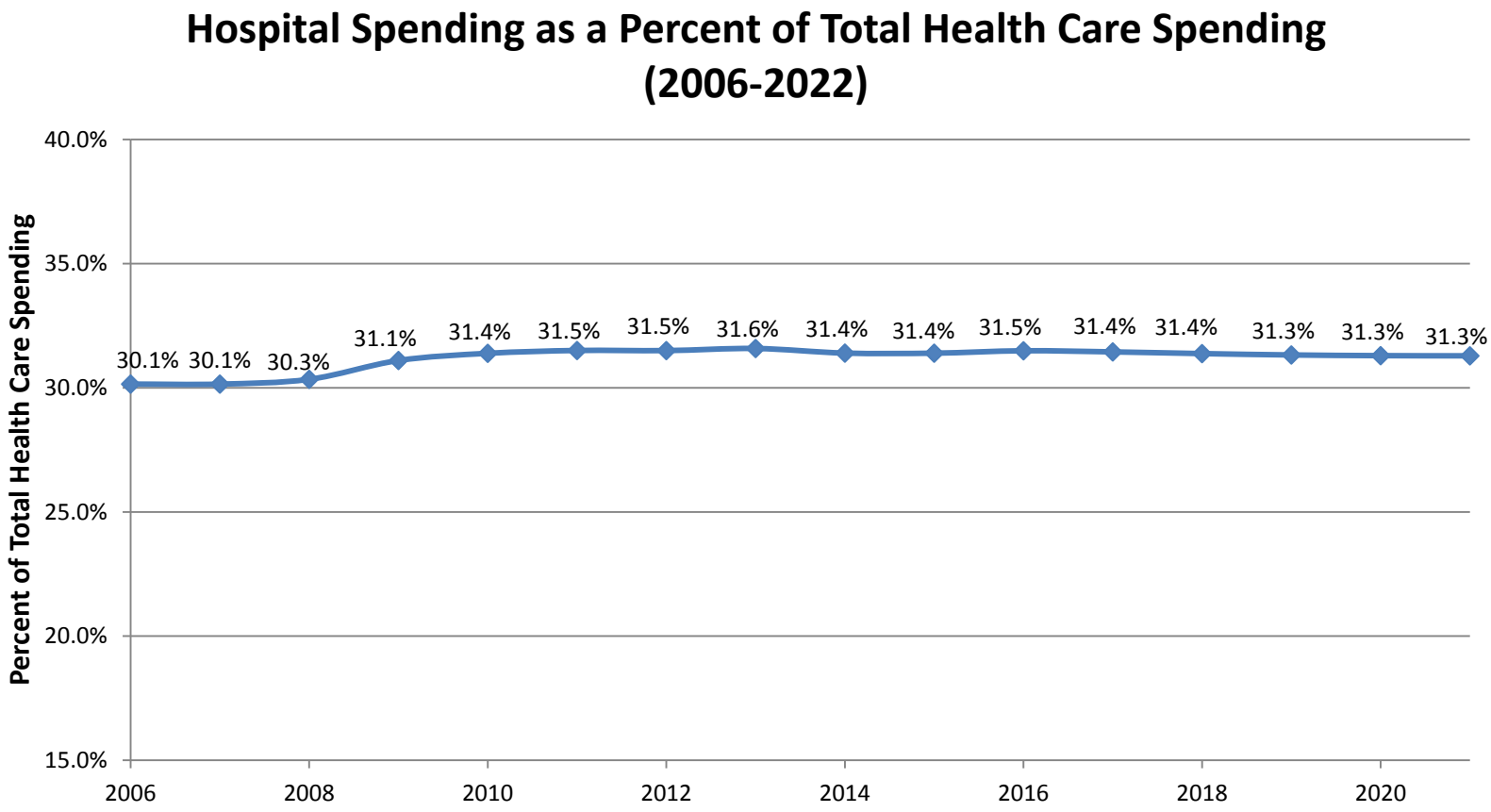
Hospital Spending: Projected to Remain Flat as Percent of Total Health Care Spending



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group (2012). National Health Expenditure Projections 2011-2021.

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Projections of Medicare Spending Are Falling Over Time

- **Actual and projected health care spending (both within the Medicare program and at the national level)—as shown by the Medicare Trustees, CBO, and OACT—have fallen over the past several years (2009-2012), a trend which may have begun as early as 2002**

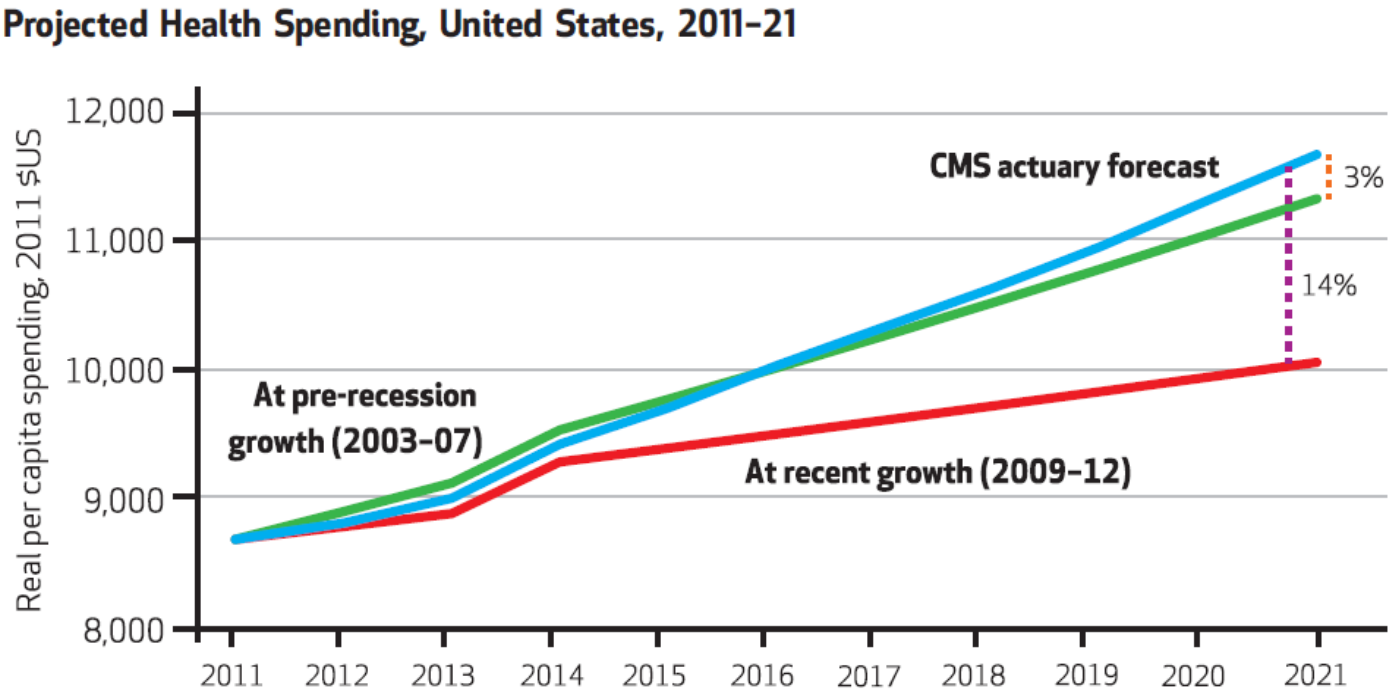
- **The reductions in health care spending estimated by this falling growth rate reflect a sizeable portion of current and future federal deficits**
  - Cutler and Sahni estimate that if growth in health care spending remains at 2009-2012 levels, public spending on health care will be $770 billion less from 2012-2021 compared to most recent OACT estimates[1]
  - This could **eliminate roughly one-fifth of the projected federal deficit** over the 2012-2021 time period[2]

[1] Cutler, D., Sahni, N. (2013). If slow rate of health care spending growth persists, projections may be off by $770 billion. *Health Affairs* 32(5), 841-850.
[2] Wayne, A. (2013). Health-care cost slowdown seen saving up to $770 billion. *Bloomberg.com.*

Dobson | DaVanzo

Cutler/Sahni: Continued Health Care Spending Slowdown Would Reduce the Federal Deficit

- **A continued slowdown in the current growth rate of health spending would eliminate *ONE-FIFTH* of the projected federal deficit over the 2012-2021 time period[1]**



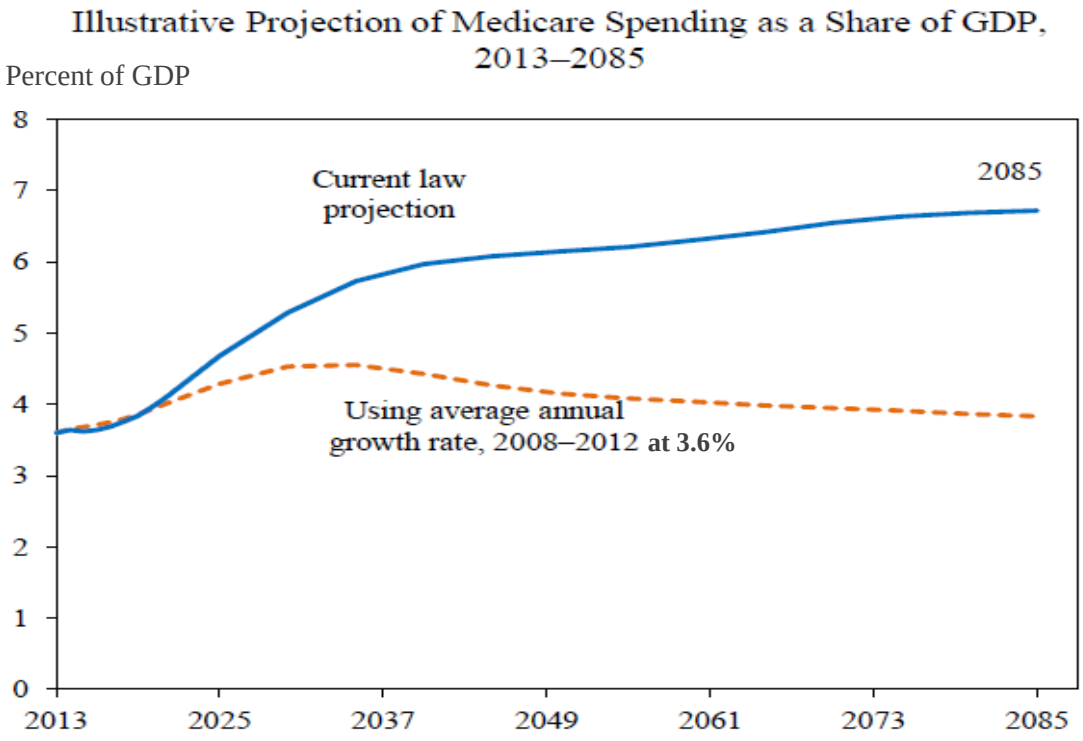
Source: Cutler, D., Sahni, N. (2013). If slow rate of health care spending growth persists, projections may be off by $770 billion. *Health Affairs* 32(5), 841-850.

Dobson | DaVanzo

[1] Wayne, A. (2013). Health-care cost slowdown seen saving up to $770 billion. *Bloomberg.com.*

Council of Economic Advisors: Medicare Spending Could Stabilize as Percent of GDP

- **If total Medicare spending were to continue growing at an annual rate of 3.6 percent (the five-year average from 2008-2012), Medicare spending could stabilize below 4 percent of GDP**



Source: The Council of Economic Advisors. (2013). The Affordable Care Act and trends in health care spending.

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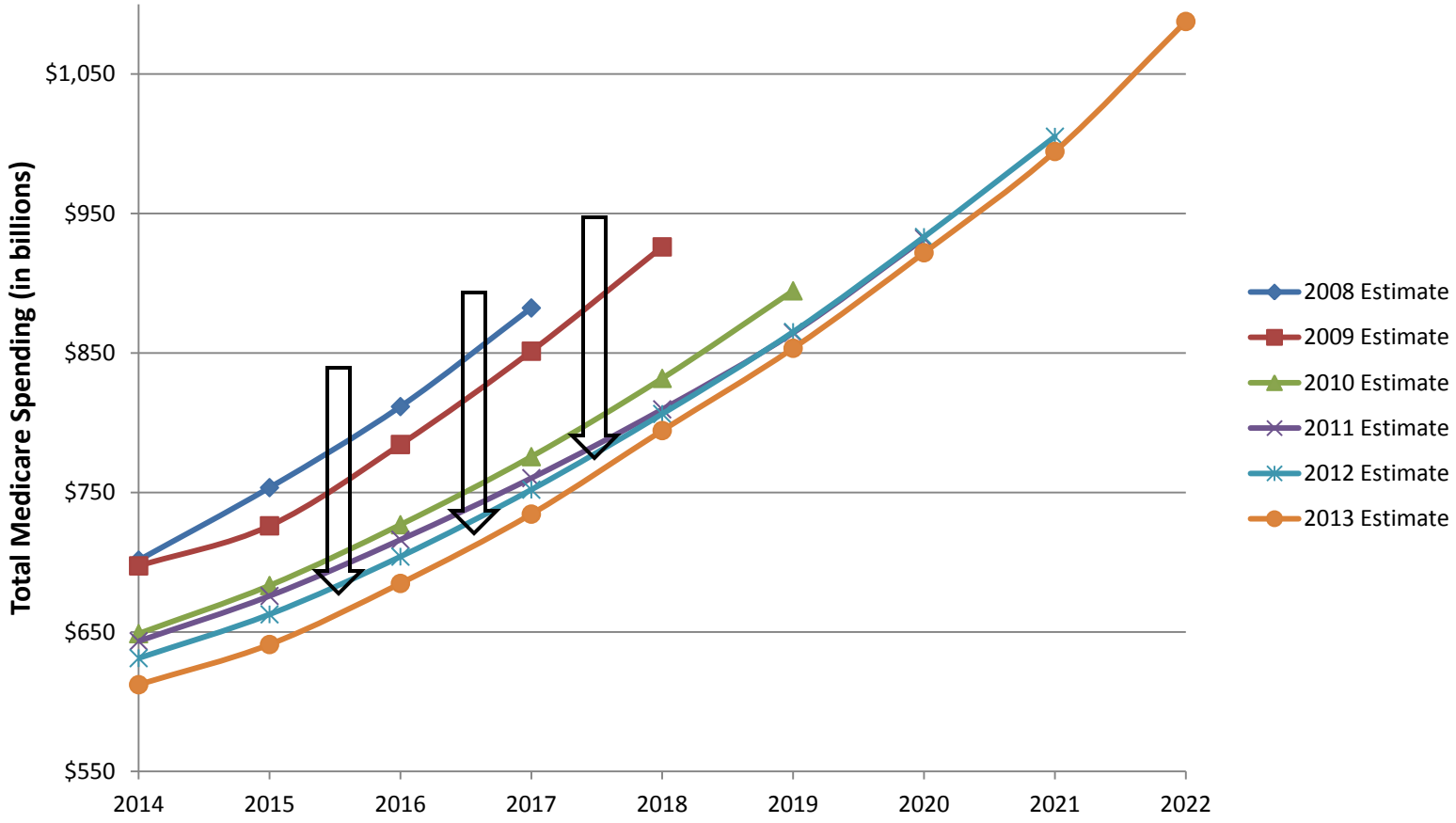
Medicare Trustees Have Continually Reduced Spending Projections for Medicare (2014-2022)



Source: 2008 to 2013 Medicare Trustees estimates.

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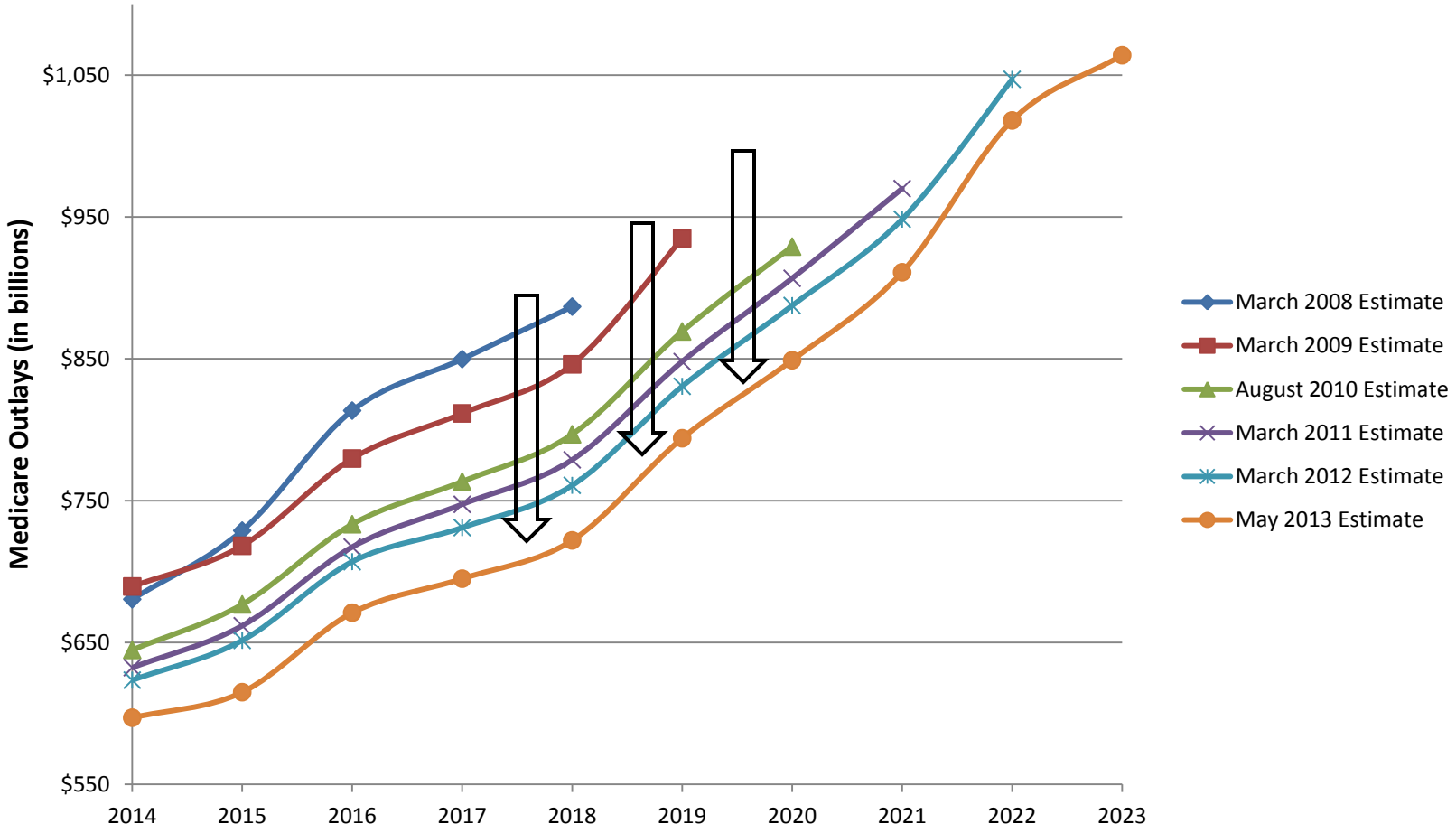
CBO Also Has Continually Reduced Spending Projections for Medicare (2014-2023)



Source: 2008 to 2013 Baseline CBO estimates.

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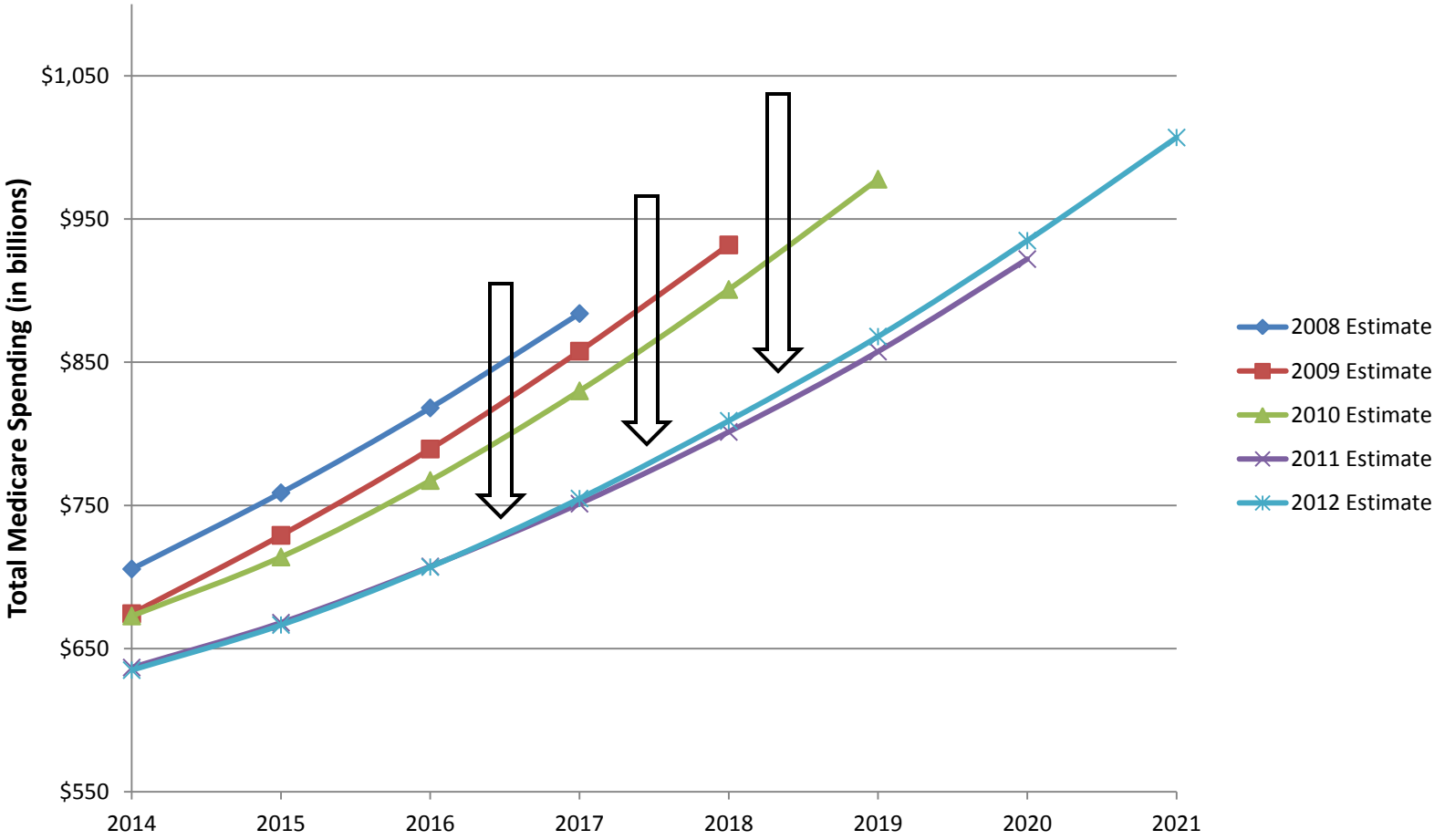
OACT Has Reduced Spending Projections Significantly for Medicare Since 2008 (2014-2021)



Source: 2008 to 2012 OACT estimates.

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Relative to 2008 Projection Levels, How Much Could Aggregate Medicare Spending Fall from 2014 to 2023 if Current Trends Continue?

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Current Trends Could Lead to Further Aggregate Projected Medicare Savings

- **Projections of Medicare spending from the Medicare Trustees, CBO, and OACT have fallen precipitously from 2008 (prior to the "Great Recession") to the most recent projections**
  - This represents "savings" to the Medicare trust fund from spending that was estimated in 2008
- **Further substantial aggregate "savings" are attainable if the growth in Medicare spending per beneficiary remains at 2009-2012 levels**
- **Our analysis finds the following aggregate projected savings for 2014-2023 compared to what was estimated prior to the "Great Recession" (2008 estimates):**
  - Medicare Trustees: $2.6 trillion
  - CBO: $2.4 trillion
  - OACT: $1.8 trillion

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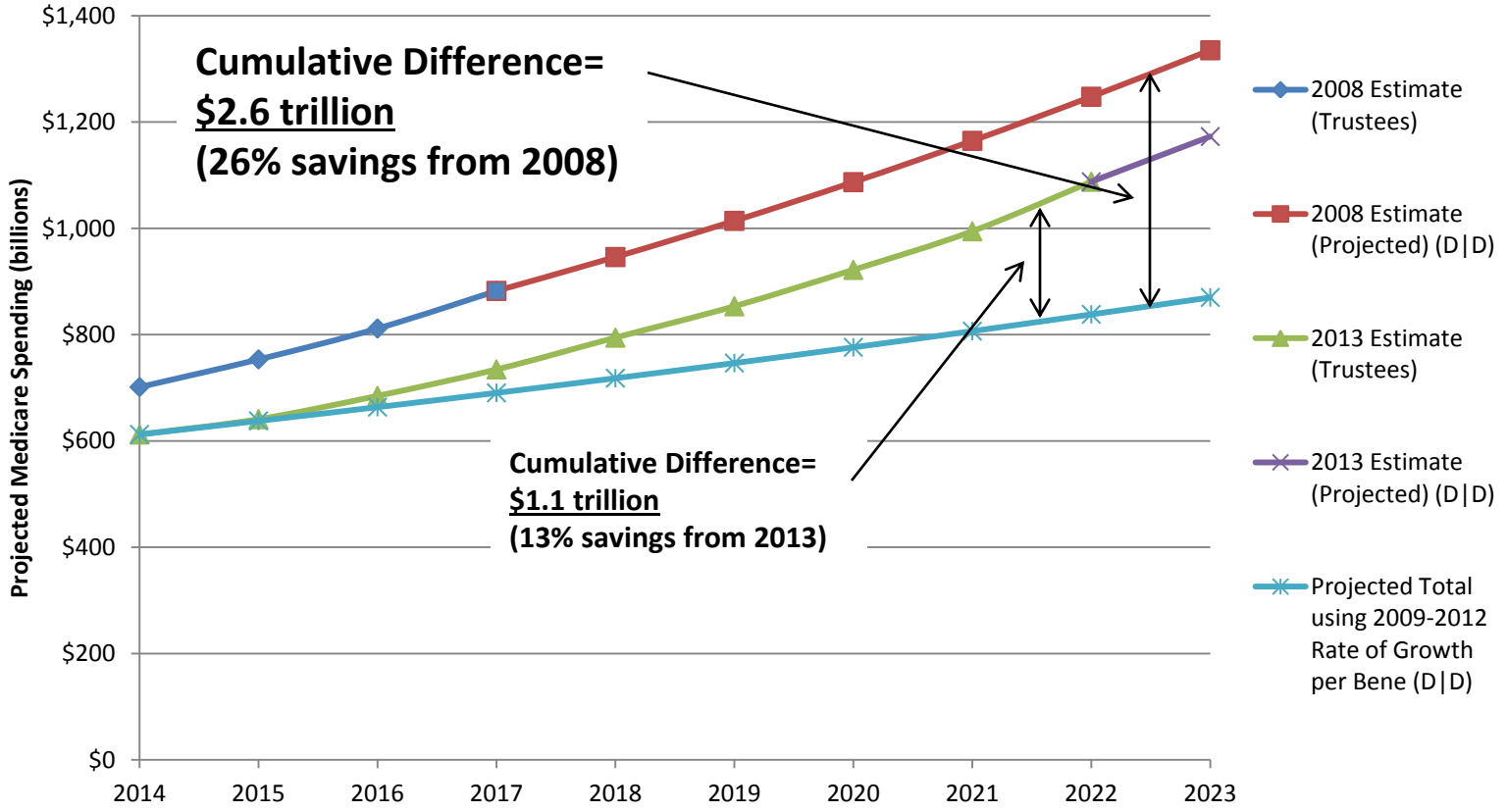
Projected Aggregate Medicare Savings (2014-2023) Based on 2008 Medicare Trustees Forecast: $2.6 Trillion



Note: D|D is Dobson | DaVanzo.

Source: Dobson | DaVanzo analysis of 2008 to 2013 Medicare Trustees estimates. The average growth rate from 2009-2012 was calculated using Trustees estimates of total Medicare expenditures from 2009-2012 (reported in the 2013 Medicare Trustees Report) divided by the number of Medicare beneficiaries in each year as reported in the 2013 Medicare Trustees report. See "Methods in Brief" for forecasting methodology.

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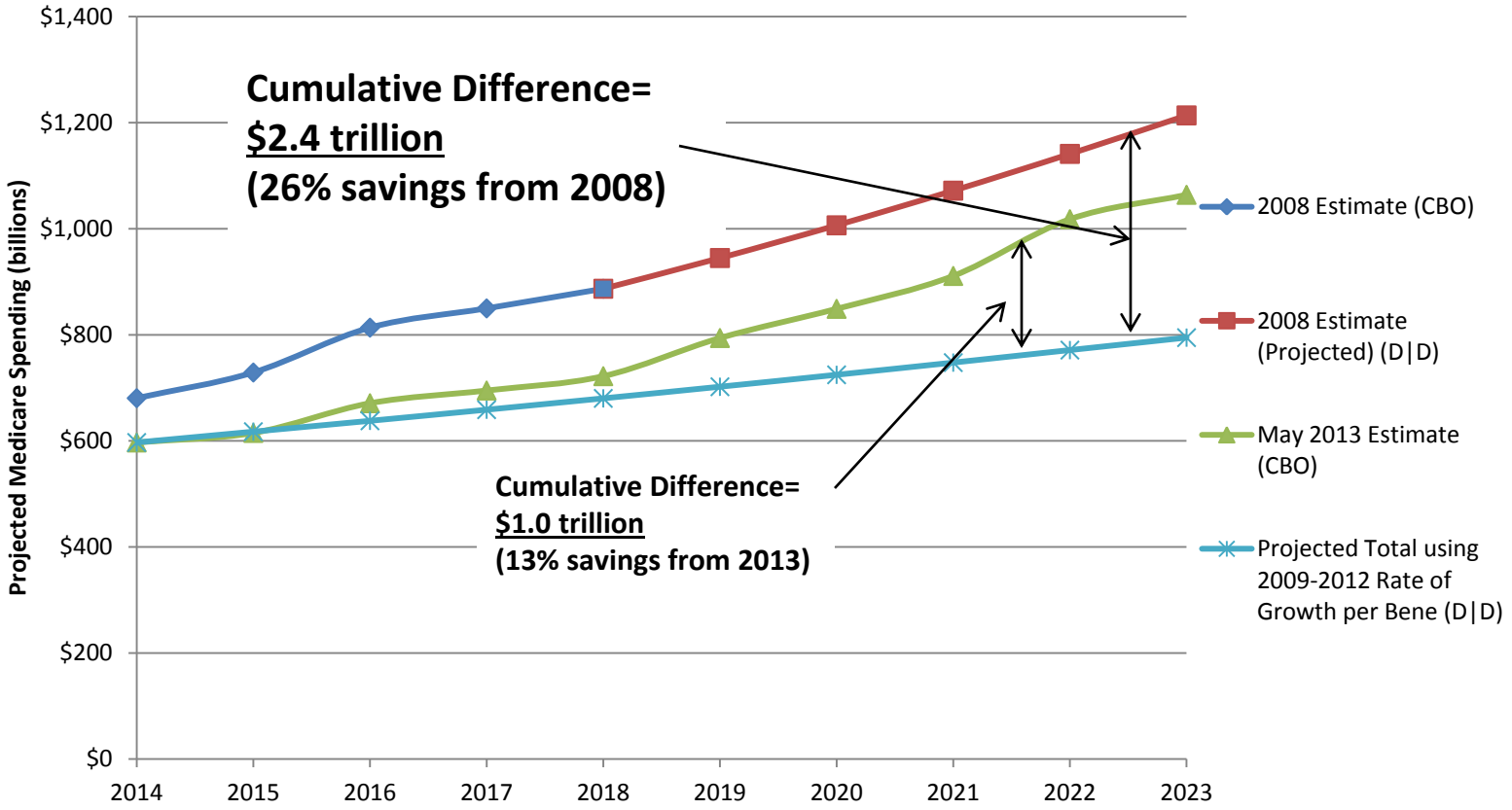
Projected Aggregate Medicare Savings (2014-2023) Based on 2008 CBO Forecast: $2.4 Trillion



Note: D|D is Dobson | DaVanzo.

Source: Dobson | DaVanzo analysis of 2008 to 2013 Baseline CBO estimates. The average growth rate from 2009-2012 was calculated using CBO estimates of total Medicare expenditures from 2009-2012 (reported in the May 2013 CBO baseline estimate) divided by the number of Medicare beneficiaries in each year as reported in the 2013 Medicare Trustees report. See "Methods in Brief" for forecasting methodology.

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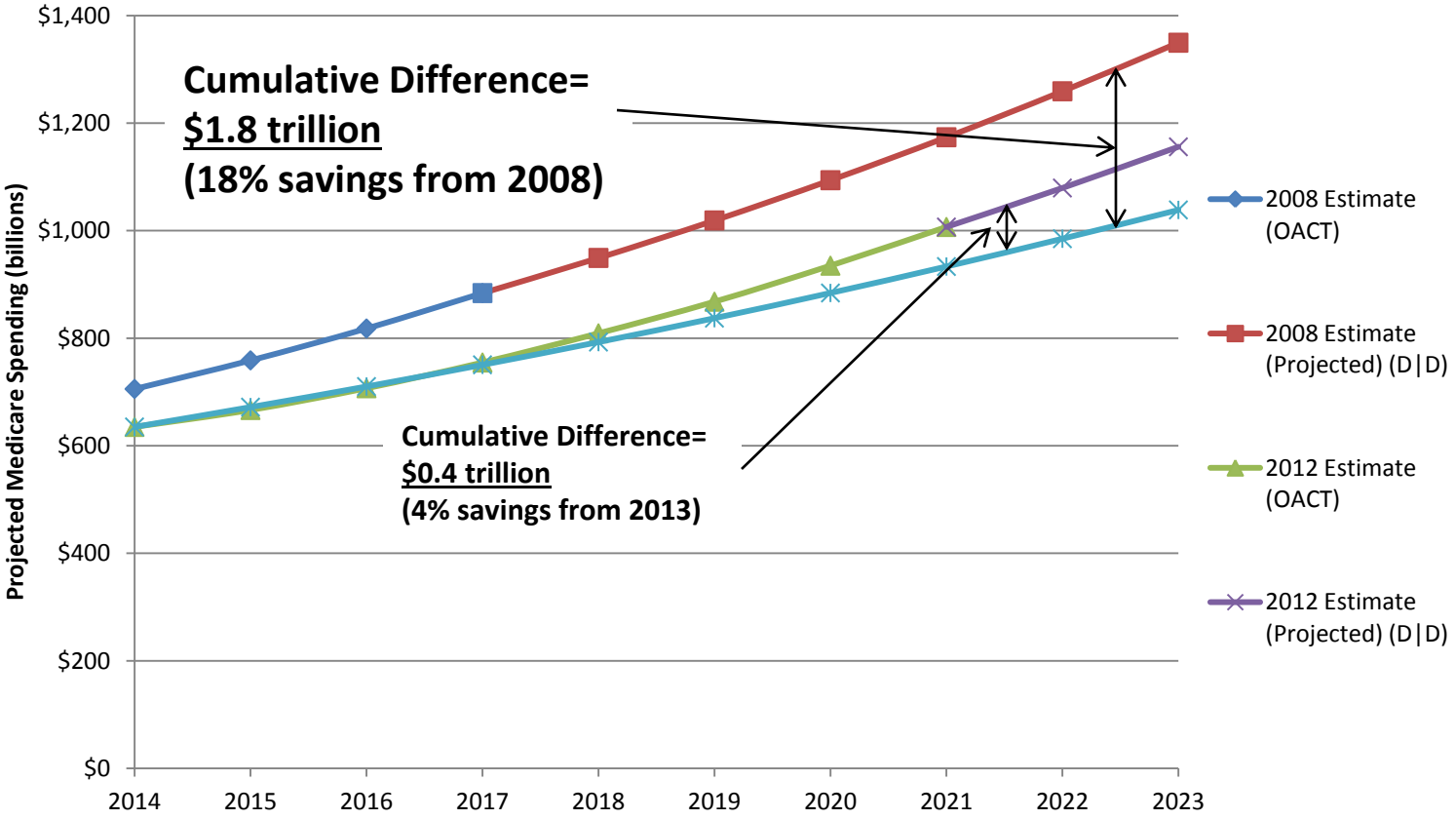
Projected Aggregate Medicare Savings (2014-2023) Based on 2008 OACT Forecast: $1.8 Trillion



Note: D|D is Dobson | DaVanzo.

Source: Dobson |DaVanzo analysis of 2008 to 2012 OACT estimates. The average growth rate from 2009-2012 was calculated using OACT estimates of total Medicare expenditures from 2009-2012 (reported in 2012 OACT estimates) divided by the number of Medicare beneficiaries in each year as reported in the 2013 Medicare Trustees report. See "Methods in Brief" for forecasting methodology.

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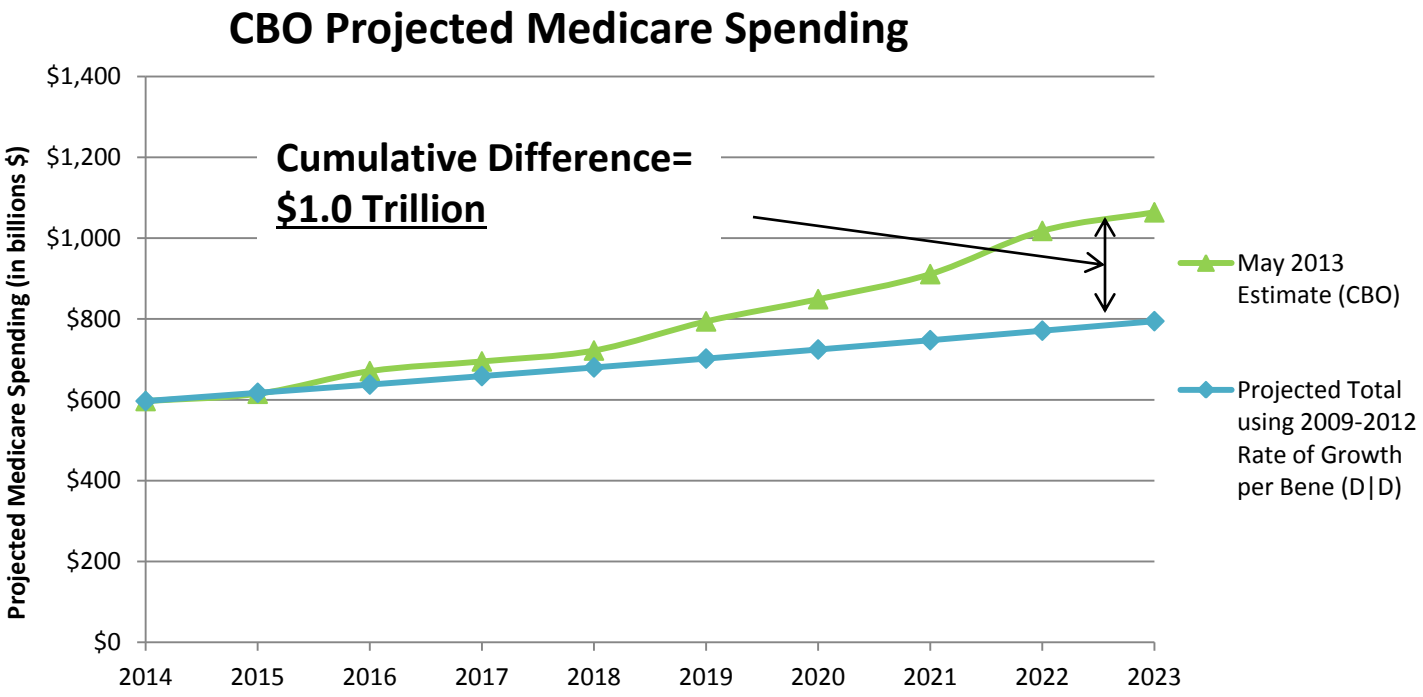
Slowdown in Medicare Spending Growth Could Further Reduce Federal Deficit by $1 Trillion

- **If Medicare spending per beneficiary grows at the average 2009-2012 rate, the cumulative federal deficit from 2014 to 2023 could be reduced by 16%**



Note: D|D is Dobson | DaVanzo.
Source: Dobson | DaVanzo analysis of the May 2013 CBO Budget Estimates. The average growth rate from 2009-2012 was calculated using CBO estimates of total Medicare expenditures from 2009-2012 (reported in the May 2013 CBO baseline estimate) divided by the number of Medicare beneficiaries in each year as reported in the 2013 Medicare Trustees report.

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How Can We Explain Decreasing Rates of Growth in Health Care Spending?

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Historical Aberrations in Health Care Spending Growth Rates Have Occurred

- **Health care spending increases have generally outpaced GDP growth since the enactment of Medicare with the following exceptions:**
  - The Nixon Administration—wage and price controls (early 1970s)
    - Health care spending growth slowed, but returned to high levels as the effort was successfully undermined by employer and union efforts
  - The Carter Administration—voluntary cost control effort led by the hospital industry (late 1970s-1980)
    - Spending growth slowed but again returned to high levels
  - The Clinton Administration—health maintenance organization (HMO) movement (early 1990s)
    - Reduced the rate of health care spending growth to GDP and may have led to a permanent reduction in health care spending[1]
    - HMOs were undermined by lack of consumer confidence in the health insurance industry's ability to manage care and control costs in an effective and equitable way

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[1] Fuchs, V. (2013). The gross domestic product and health care spending. *New England Journal of Medicine* Perspective: May.

Recent Slowdown in Health Care Spending is Likely Driven By Structural Factors

- **There is evidence that the slowing growth rate of health care spending has been influenced by structural changes to health care economy, such as payment policy, patient cost-sharing, and the diffusion of technology**

- **These structural changes may suggest a departure from the historical relationship between overall economic growth and health care spending observed over the past 50 years**
  - "…thousands of efforts to improve efficiency and quality are underway including programs sponsored by Medicare, Medicaid, commercial insurers, hospitals, and physicians"[1]

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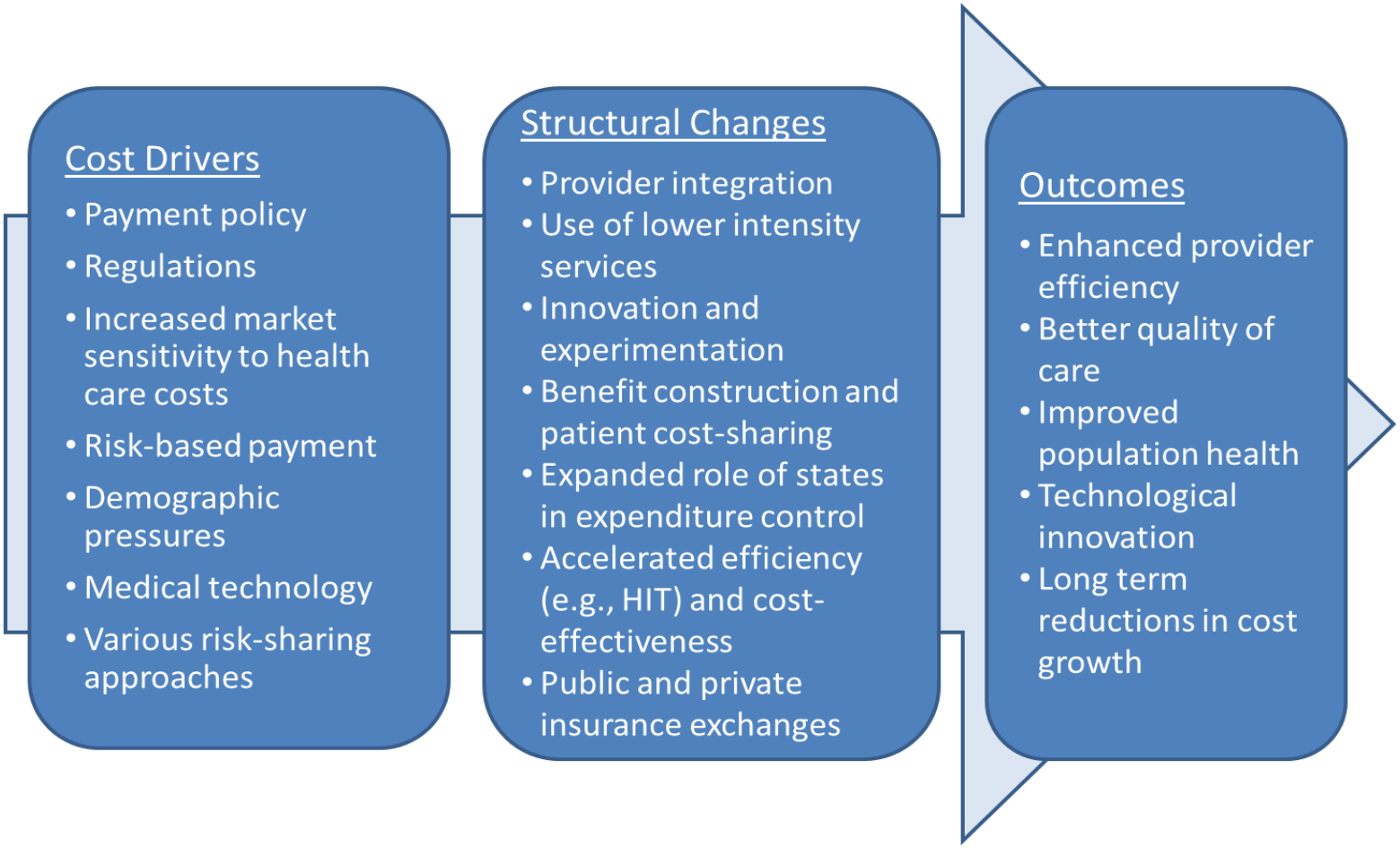
[1] Pyenson, B., Fitch, K., Goldberg, S. (2009). Imaging 16% to 12%: A Vision for cost efficiency, improving healthcare quality, and covering the uninsured [Milliman Research Report]. Seattle, WA: Milliman.

Recent Slowdown in Health Care Spending is Likely Driven By Structural Factors



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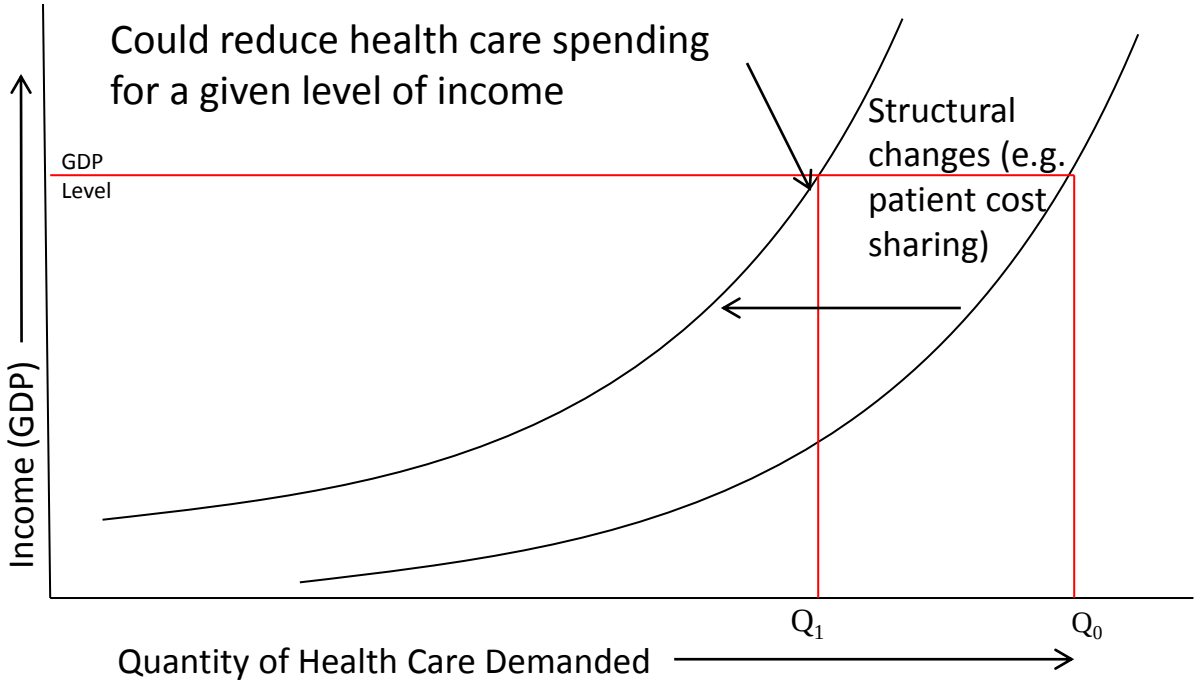
Structural Changes Could Reduce Health Care Spending as a Percent of GDP

- **The relationship between economic growth and health care spending may have fundamentally changed over the past five to 10 years**
  - Policymakers should encourage existing reform efforts to continue, but consider the implications of this changing relationship and the resulting slower health care spending growth in shaping current and future health care, entitlement reform, and deficit reduction policies



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Structural Changes Are Impacting Spending Slowdown

- **Improvement in hospital and health care provider efficiencies**
  - Improved care coordination
    - Reduced delivery system fragmentation
    - Use of best practices and preventative care protocols
    - Health information technology
    - Investments in coordination between providers and communities
  - Hospital and physician consolidation
  - Growth in community-based and palliative care
  - More appropriate use of services
  - Better targeting of technology and performing fewer low value procedures (e.g., prior authorization for advanced imaging)
  - Shift of care from physicians to non-physician clinical staff
  - Stronger primary care systems
  - Provider leadership in designing and implementing care delivery systems

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Structural Changes Are Impacting Spending Slowdown

- **CMS initiatives – many authorized by the ACA**
  - Medicare Shared Savings Program (MSSP), also known as ACOs
  - Value based purchasing (VBP) programs
  - Pay for performance (MA – SSRD)
  - Pay for reporting
  - Readmission reduction program
  - Care coordination/continuity of care and payment reforms
    - Partnership for Patients
    - Patient-centered medical homes
    - Bundled payments for acute and post-acute care
  - Program integrity initiatives
  - State health insurance exchanges
    - Reduce health insurance premiums through competition and negotiation[1]

[1] Somashekhar, S., Kliff, S. (2013, June 7). California, Ohio issue conflicting forecasts on health-care premiums. *Washington Post*, A5.

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Structural Changes Are Impacting Spending Slowdown

- **Prospective payment systems (e.g., IPPS)**
- **New payment reforms**
  - Incentives of fee-for-service (FFS) challenged by new payment systems
  - Alignment of financial incentives across providers
    - Medicare Advantage (MA)
    - Accountable care organizations (ACOs) and shared savings
    - Gainsharing
    - Patient-centered medical homes
  - Interactive effects and spillover of Medicare reforms and demonstrations to private sector and vice versa
  - Quality measurement and value-based purchasing
  - Bundled Payments for Care Improvement (BPCI) initiative

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Structural Changes Are Impacting Spending Slowdown

- **Shift from inpatient to outpatient care**
  - Medicare inpatient spending per beneficiary decreased by 1 percent from 2010 to 2011[1]
  - Inpatient days per capita decreased 12 percent from 2001 to 2011[2]
- **Diffusion of existing technologies in many parts of medicine**
- **Reductions in prescription drug costs due to fewer new drugs, growth in generic drugs, and tiered formularies**
- **Increased use of catastrophic health insurance**
- **Decreased access to capital**
- **Emergence of private health insurance exchanges**
  - Employer sensitivity to health care costs at a tipping point, causing shift from defined benefit to defined contribution health plans

[1] Medicare Payment Advisory Commission (2013, March). Report to the Congress: Medicare payment policy. Washington, DC: MedPAC.

[2] Cutler, D., Sahni, N. (2013). If slow rate of health care spending growth persists, projections may be off by $770 billion. *Health Affairs* 32(5), 841-850.

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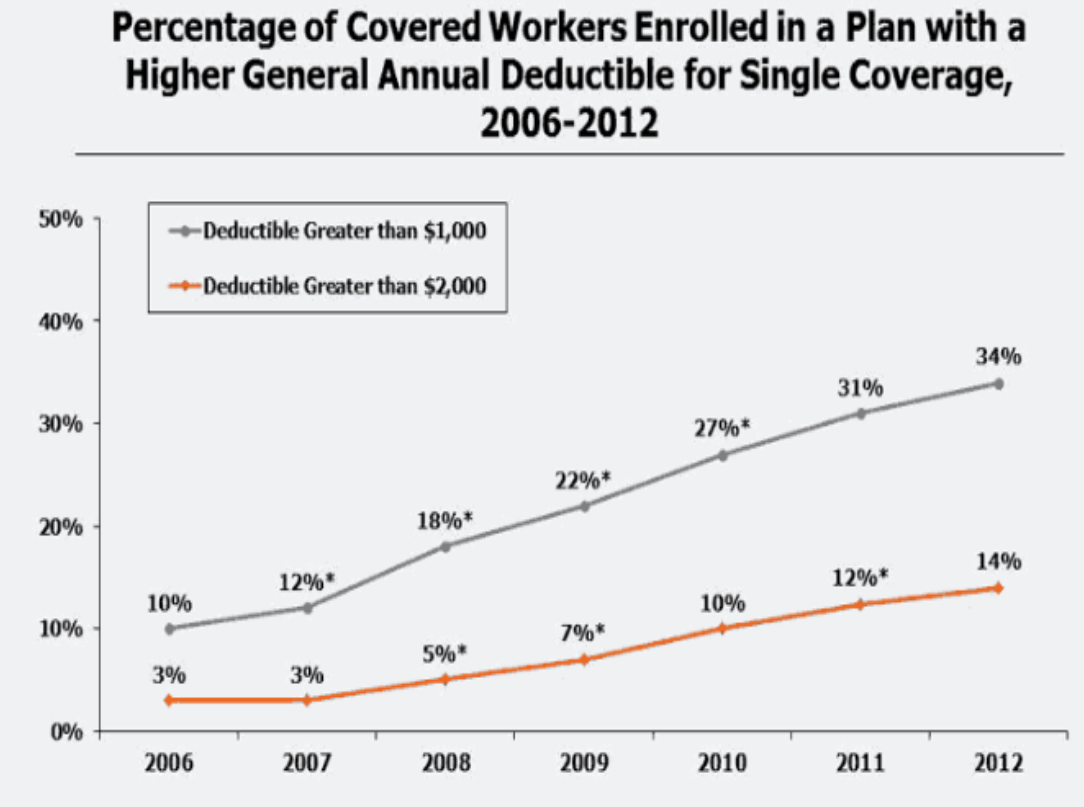
Structural Changes Are Impacting Spending Slowdown



- **Increase in consumer out-of-pocket costs**
  - The percentage of covered workers with a plan with a deductible greater than $1,000 has increased 24 percent since 2006[1]
  - Reductions in employer-sponsored health insurance benefit generosity may account for 20 percent of the slowdown in the growth of health care expenditures from 2007 to 2011[2]

Source: Kaiser Family Foundation 2012

[1] Kaiser Family Foundation, Health Research and Educational Trust. (2012). Employer health benefits: 2012 annual survey. Menlo Park (CA): KFF

[2] Ryu, A., Gibson, T., McKellar, R., Chernew, M. (2013). The slowdown in health care spending in 2009-11 reflected factors other than the weak economy and thus may persist. *Health Affairs* 32(5), 835-840.

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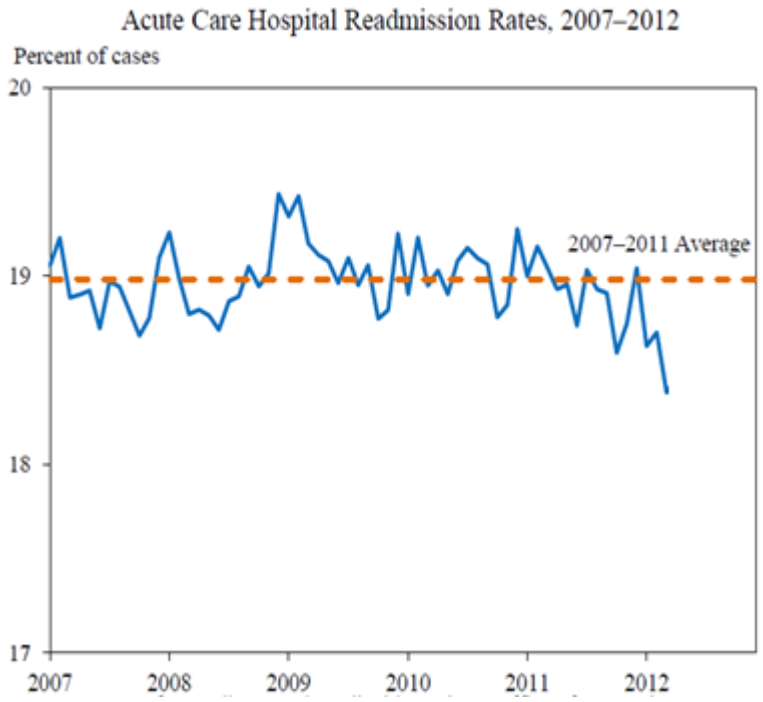
Structural Changes Are Impacting Spending Slowdown

- **Preventable readmissions and hospital-acquired infections combined account for 5 percent of national health care expenditures[1]**
- **Hospital readmissions in 2012 averaged 18.4 percent, or more than one half percentage point less than average readmission rates from 2007 to 2011[2]**
- **The Center for Disease Control and Prevention (CDC) has reported:**
  - A 41 percent reduction in central line-associated bloodstream infections from 2008 to 2011;
  - A 17 percent reduction in surgical site infections from 2008 to 2011; and
  - A 7 percent reduction in catheter-associated urinary tract infections from 2009 to 2011[3]



Source: Adapted from Centers for Medicare and Medicaid Services, Office of Enterprise Management.

[1] Cutler, D., Sahni, N. (2013). If slow rate of health care spending growth persists, projections may be off by $770 billion. *Health Affairs* 32(5), 841-850.
[2] Center for Medicare and Medicaid Services (2013). Medicare readmission rates showed meaningful decline in 2012. *Medicare and Medicaid Research Review* 3(2).
[3] Center for Disease Control and Prevention. The 2011 National and State Healthcare-associated Infections Standardized Infection Ratio Report.

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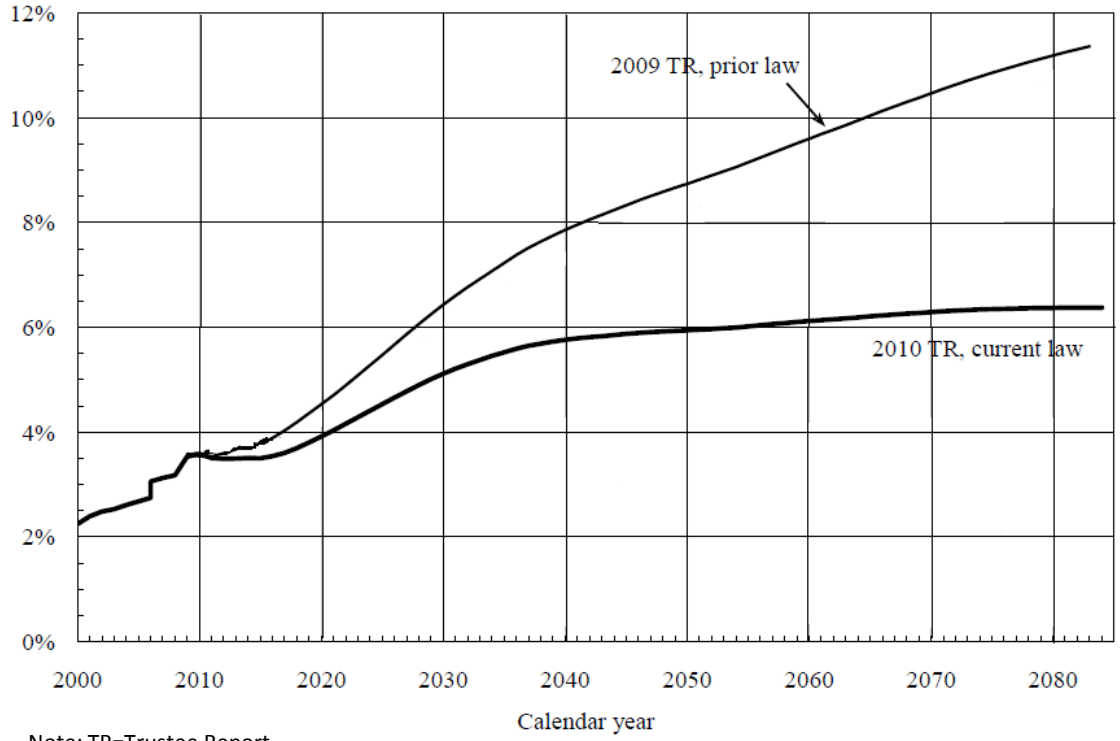
Long-term Effects of ACA Are Projected to Reduce Medicare Spending

Projections of Medicare Expenditures Under Current Law and Prior Law (as a % of GDP)



Note: TR=Trustee Report

- **As a catalyst for structural changes to the health care system, the ACA is projected to reduce Medicare spending by 32 percent in 2050 and 43 percent in 2080, compared to the Medicare Trustees' pre-ACA report**

Source: Adapted from Foster, R. (2011). The estimated effect of the Affordable Care Act on Medicare and total national health care expenditures. Testimony before the House Committee on the Budget.; Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2009 and 2010.

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What Factors Contribute to Growth in Health Care Spending?

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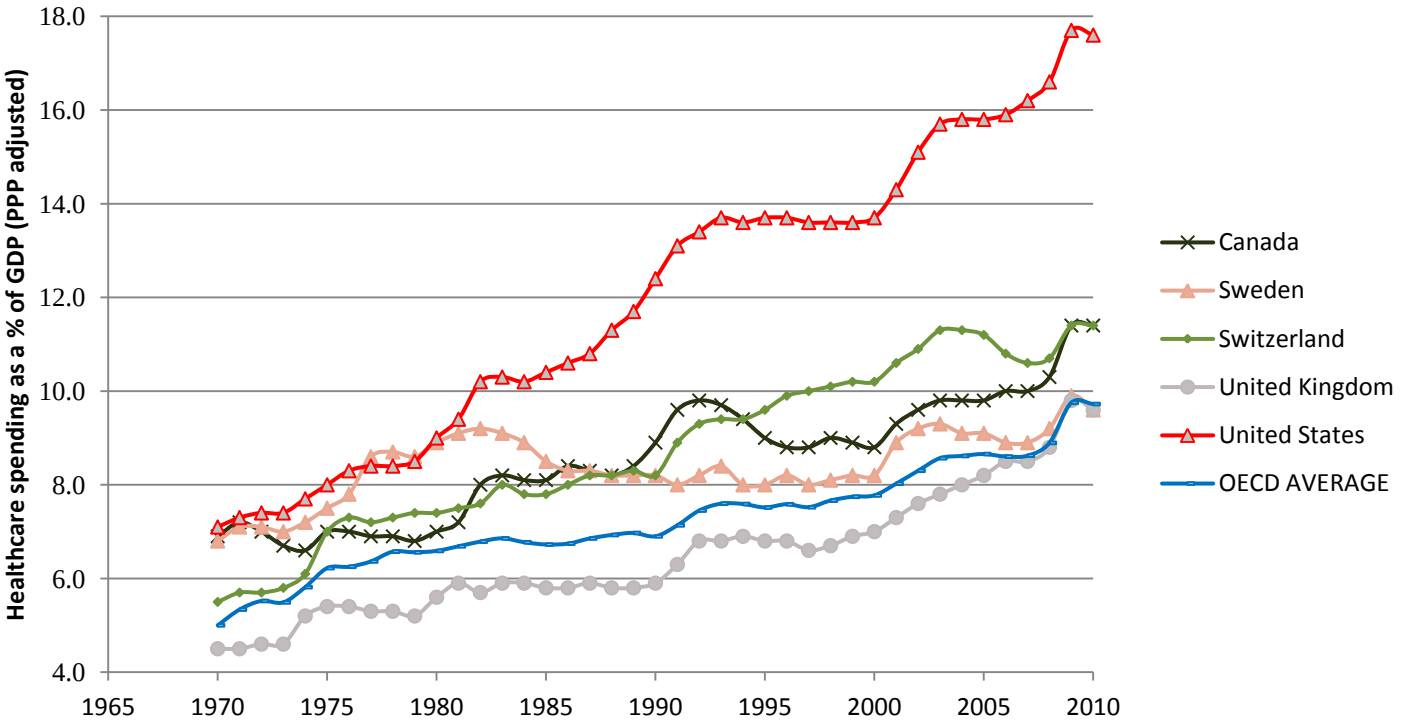
Economic Recession: No Clear Relationship between Health Care Spending Growth and GDP

- **Health care spending as a percent of GDP varies widely by country, and typically increases during periods of recession because GDP shrinks**



Note: OECD is Organization for Economic Cooperation and Development.
Source: Dobson| DaVanzo analysis of OECD Health Data 2012.

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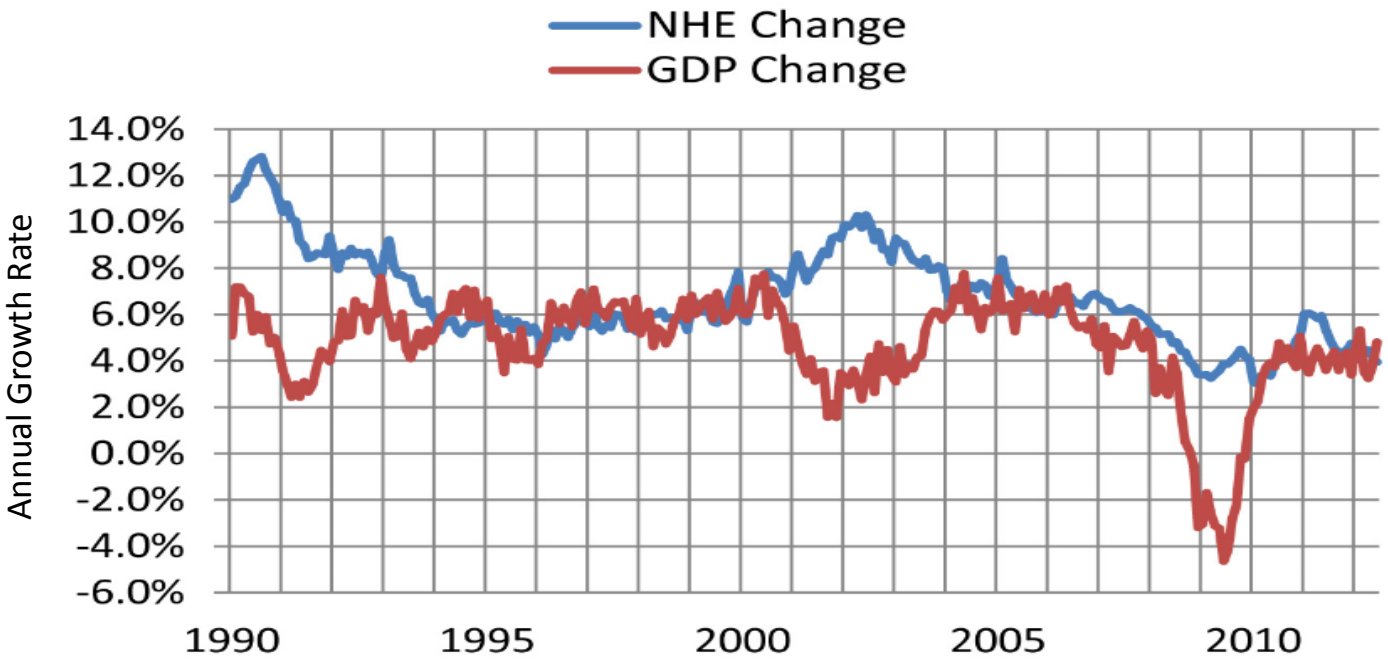
Economic Recession: No Clear Relationship between Health Care Spending Growth and GDP

- **Although health care spending as a percent of GDP depends in part on economic recession, the annual rate of growth in health care spending has fallen steadily from 13 percent in 1991 to ≈4 percent in 2009-2012**



Source: Altarum Institute Center for Sustainable Health Spending, Health Sector Economic Indicators SM: October 2012

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Patient Demographics: Age and Enrollment Will Drive Future Medicare Spending

- **The Medicare population will become younger on average as the "baby boomers" age into the program, which will reduce short term spending per beneficiary**
  - Changing age distribution of Medicare beneficiaries will cause spending per beneficiary to grow 0.2 percent per year less than if the age distribution were constant[1]
- **Overall growth in the size of the Medicare population, however, will have a large impact on total Medicare spending**
  - Number of Medicare beneficiaries projected to grow 3 percent annually over the next 10 years[1]

[1] Kronick, R., Po, R. (2013). Growth in Medicare spending per beneficiary continues to hit historic lows. *ASPE Office of Health Policy.*

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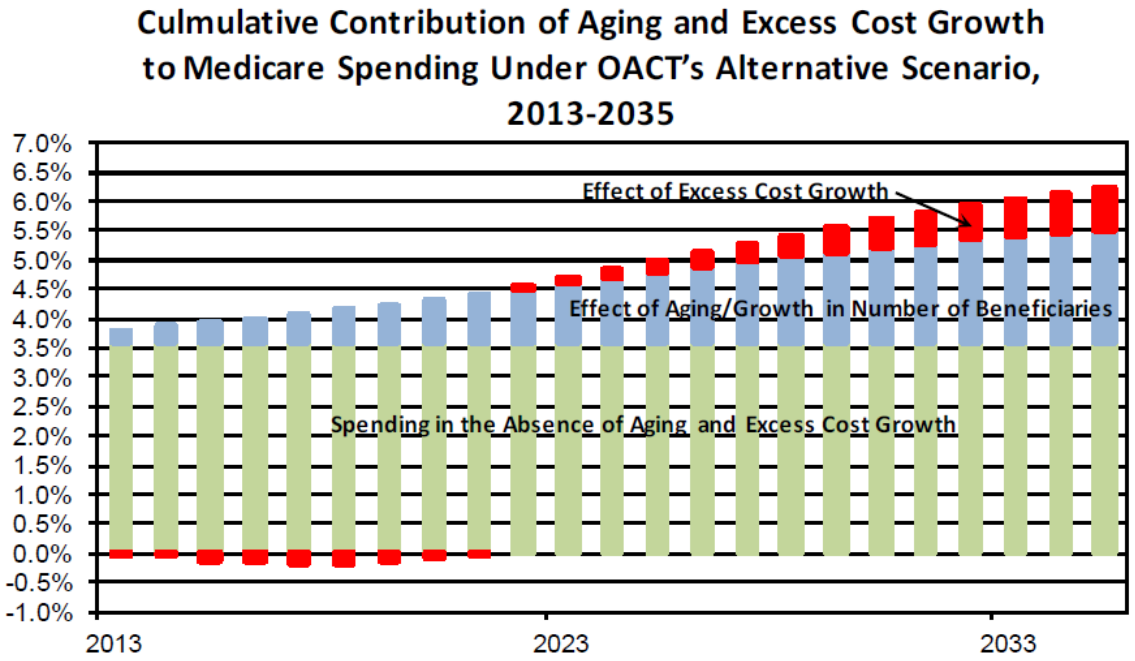
Patient Demographics: Age and Enrollment Will Drive Future Medicare Spending

- **Although structural changes have slowed excess cost growth, Medicare spending as a percent of GDP is projected to continue growing (above 3.5 percent) from 2013 to 2035 due primarily to the demographic effects of aging and growth in the number of beneficiaries (see blue bars below)**



Source: Kronick, R., Po, R. (2013). Growth in Medicare spending per beneficiary continues to hit historic lows. *ASPE Office of Health Policy.*

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How Much Does Each Factor Contribute to Health Care Spending Slowdown?

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Structural Nature of Spending Slowdown Has Major Implications for Policymakers

- **The rate of growth in health care spending has been declining since 2002**
  - Annual rates of growth in overall health spending for 2009-2011 (approximately 3 percent per year) were the lowest since reporting began in 1960[1]
- **The rate of growth in Medicare spending per beneficiary has also been declining since 2001[1]**
  - From 2009 to 2012, this rate grew at the historically low level of approximately 1 percent less than GDP per capita[2]
- **There is a debate as to whether this slowdown has been due to:**
  - Sustainable structural changes in the health care system, or
  - Economic factors associated with the recession
- **The implications of a continued slowdown in health care spending are important for developing future health care and entitlement policy**

[1] The Council of Economic Advisors. (2013). The Affordable Care Act and trends in health care spending.
[2] Kronick, R., Po, R. (2013). Growth in Medicare spending per beneficiary continues to hit historic lows. *ASPE Office of Health Policy.*

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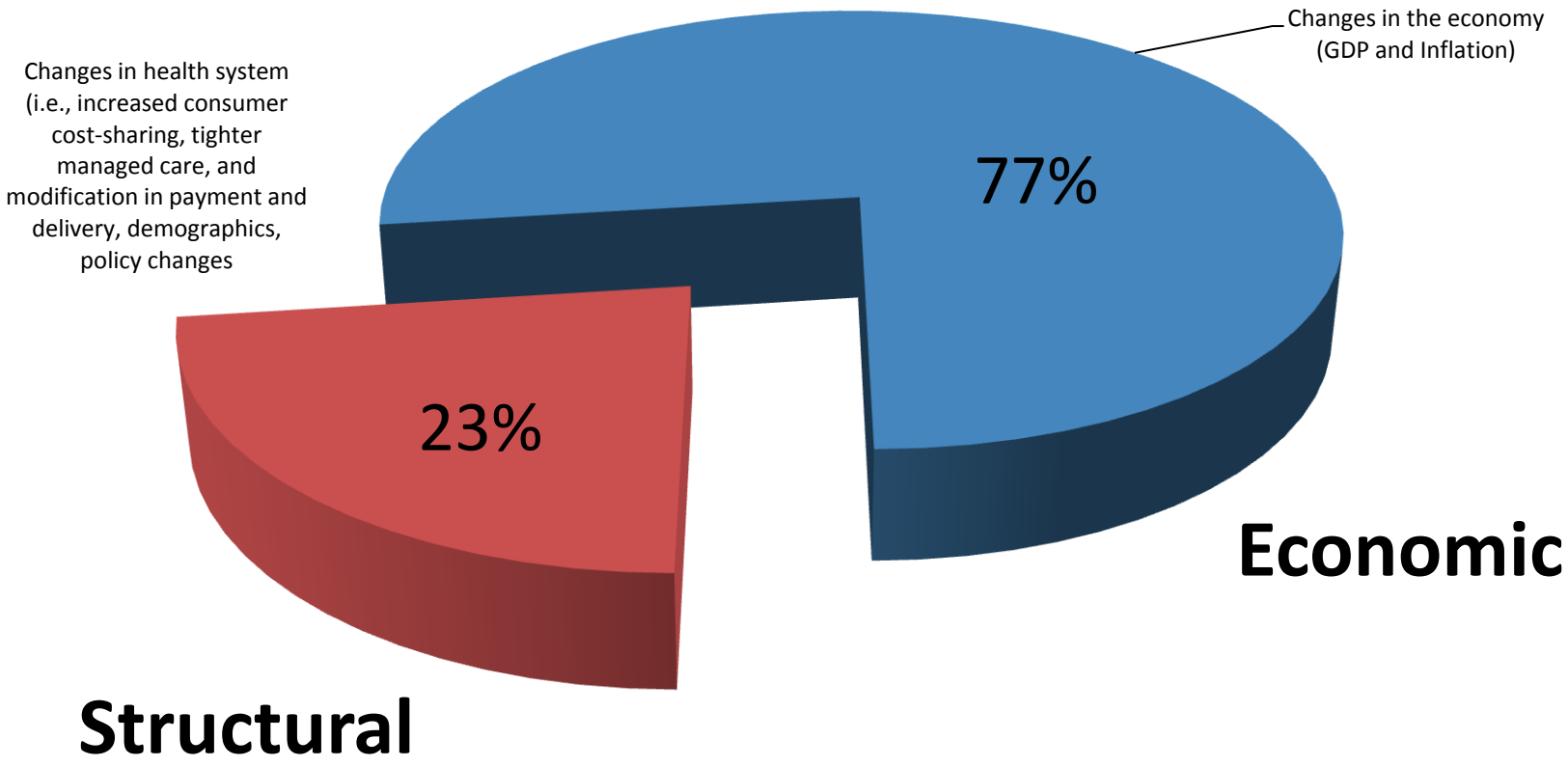
Kaiser/Altarum Attributes Slowdown in Growth of Health Care Spending More to Economic Factors



Source: Assessing the Effects of the Economy on the Recent Slowdown in Health Spending. (2013). Washington DC: Kaiser Family Foundation. http://www.kff.org/insurance/snapshot/chcm042213oth.cfm.

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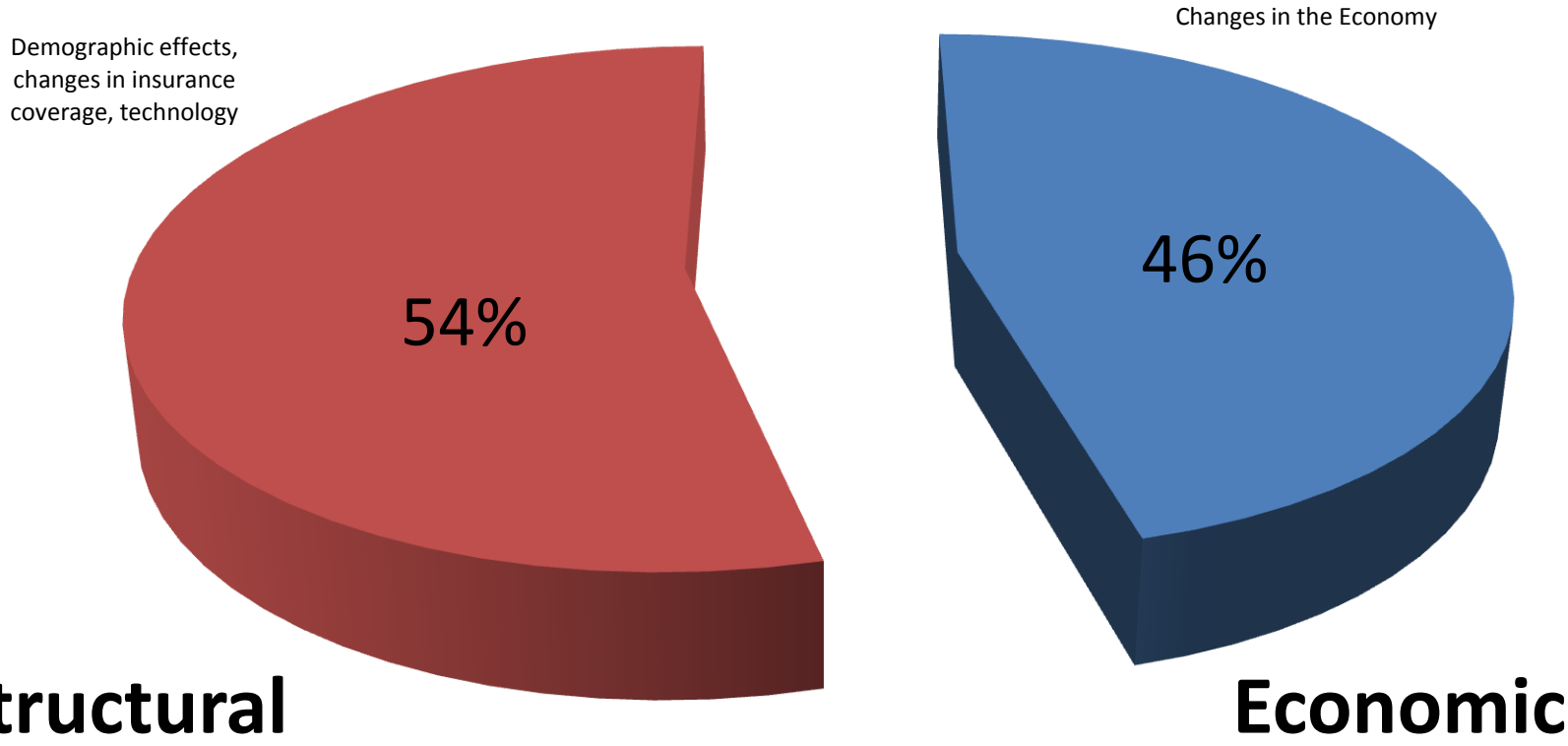
Smith, Newhouse, and Freeland Attribute Slowdown in Growth of Health Care Spending More to Structural Factors



Source: Smith S., Newhouse J.P. and Freeland M.S (2009). Income, Insurance and Technology: Why Does Health Spending Outpace Economic Growth? *Health Affairs* (Millwood), 28(5):1276–84

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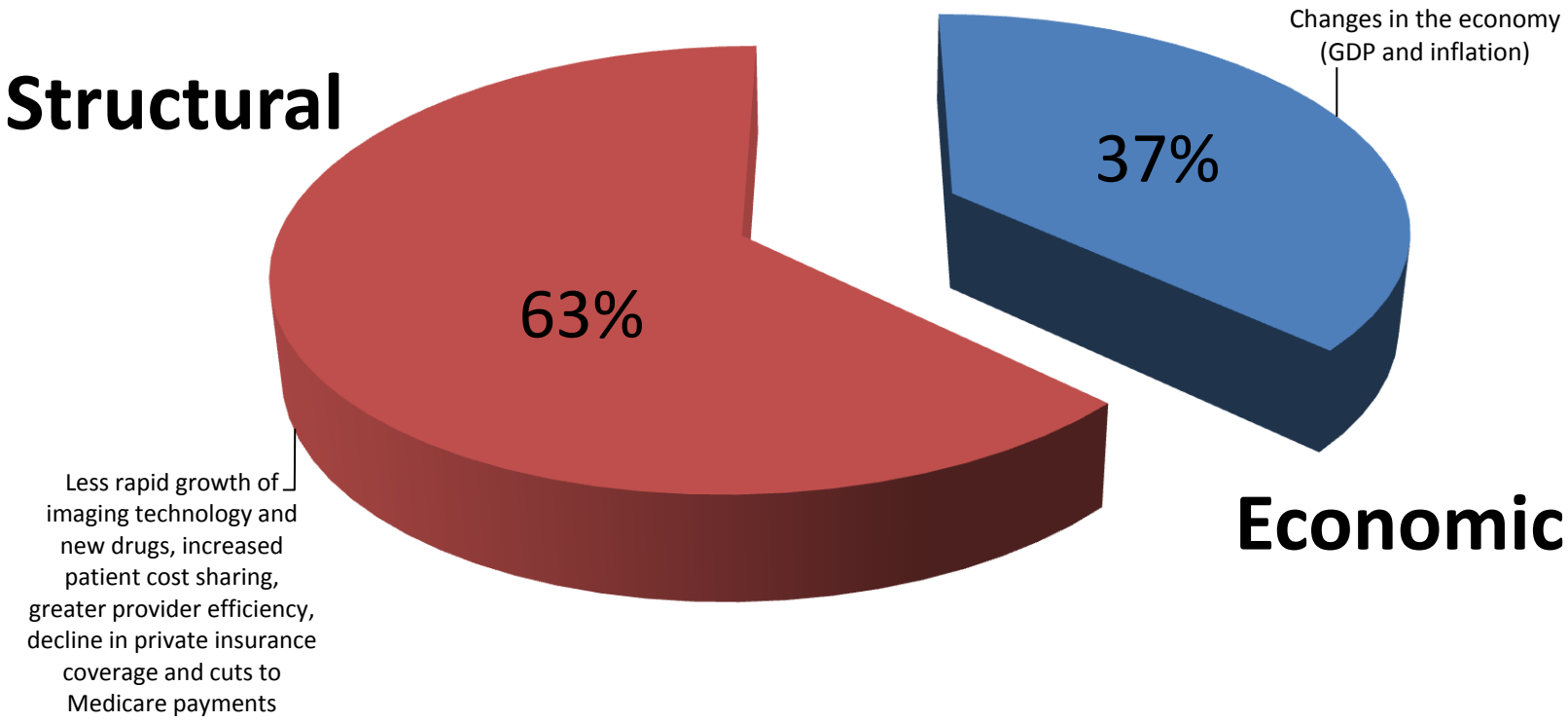
Cutler and Sahni Attribute Slowdown in Growth of Health Care Spending More to Structural Factors



Source: Cutler, D., Sahni, N. (2013). If slow rate of health care spending growth persists, projections may be off by $770 billion. *Health Affairs* 32(5), 841-850.

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