Gail R. Wilensky

healthcare spending: good news/bad news

The CMS actuaries published their annual estimates of healthcare spending and projections of future spending at the end of July. Their report contains good news and bad news—depending on your predilections and your views of the coming decade.

Healthcare spending in 2010 grew 3.9 percent, reaching $2.6 trillion. This growth rate is just below the previous historic growth rate of 4.0 percent in 2009. Because the economic growth rate is faster in 2010 than in 2009, healthcare spending as a share of the gross domestic product (GDP) remained at the same level—17.6 percent. The actuaries attributed the slow spending growth rate to two factors: slower Medicare spending growth primarily reflecting the lower payments to Medicare Advantage plans in 2010 legislated in the Affordable Care Act and slower growth in private spending because of continued job loss and, with it, loss of private health insurance coverage.

The projections for the coming decade are especially interesting. Not surprisingly, the actuaries project a jump in spending in 2014, the year when most of the coverage expansion from the Affordable Care Act takes place. Spending is projected to grow 8.3 percent in 2014 (compared with 5.5 percent in 2013). The increase in spending is projected mostly for prescription drugs and physician services rather than for hospital services because the newly insured will be younger and healthier, on average, than the general population and those are the services they tend to use.

After 2014, healthcare spending is projected to grow at a rate of 6.2 percent for the rest of the decade, about the rate it would have grown without the Affordable Care Act. Overall, spending will be about 0.1 percent higher than it would have been without the Affordable Care Act.

By 2020, healthcare spending is expected to account for about for 19.8 percent of the GDP. And the government's share of overall healthcare spending will have grown from almost 46 percent to almost 50 percent. Most of the growth will come from increased spending by Medicaid as a result of the Medicaid expansion in 2014. The share represented by private business will decline to 18 percent, while household spending will remain at about 26 percent.

What the Projections Suggest

The good news of the projections is that 30 million more people will be covered by insurance as of 2014, with a negligible increase in total healthcare spending. The small increase in spending is not that surprising because—as the actuaries indicated—the newly insured population will be a younger and healthier population.

The bad news is that healthcare reform was supposed to slow spending and improve quality as well as expand coverage. If the legislation "bent

the cost curve," it bent it *up* and not down—hardly the desired direction of change. Furthermore, the Affordable Care Act contains some provisions, including some of the out-year Medicare payment reductions, that the actuaries had questioned because of their potential impact on access. And there are costly changes that are not included in "current law"—such as reforming Medicare's payments to physicians. These factors suggest that the official projections may be more optimistic than what's likely to occur—a point that Social Security trustees have made repeatedly in their annual reports.

What's Next?

The United States has just barely averted a debt ceiling crisis, with much of the budget pressure now falling on a soon-to-be-appointed congressional committee, which will be charged with coming up with more than a trillion dollars of spending reductions. If there is no agreement on spending reductions, across-the-board spending cuts will be triggered, with few "sacred cows" spared. Medicare—although not Medicaid and Social Security—would see provider cuts of two percentage points across the board along with similar reductions to most other parts of government.

The challenge will be trying to get politicians and the American public to come together in support of spending reductions of this magnitude, including involving them in a dispassionate discussion of "entitlement reform" (or at least Medicare reform) 14 months before a major election, with an ideologically and politically divided Congress and a highly charged political environment. Because Medicaid and Social Security are excluded from the automatic cuts, it may be more accurate to say the more immediate focus will be on whether or how to change Medicare—which actually is not a bad point of focus given that Medicare is the bigger challenge and a dominant driver of future spending.

Since its very beginnings, efforts to slow spending in Medicare have targeted only providers, primarily by controlling payments to providers. Historically, this strategy has never had more than a short-term impact, but despite this fact, lawmakers keep returning to it: It was the primary tactic used to finance a large portion of the expansion in coverage in the Affordable Care Act, and will again be used if the congressional panel on debt reduction can't come up with alternative saving strategies by its Nov. 23 deadline.

To be sure, the Affordable Care Act makes some limited attempts also to change provider incentives, but as the current projections indicate, the actuaries aren't prepared to credit many savings to these yet-to-be-defined or implemented changes.

Some have ventured to suggest that beneficiaries be included in some of the planned entitlement reforms, although it's hard to tell how seriously such proposals might be considered. Examples include the premium support proposal by the Domenici-Rivlin Debt Reduction Task Force and the more controversial proposal by Rep. Paul Ryan (R-Wis.) to limit beneficiaries' options to a choice of private plans. Others propose changing beneficiary spending by limiting some or all first-dollar coverage available in Medicare supplementary coverage or by limiting some of the benefits or subsidies for higher-income beneficiaries.

Whether Congress will exhibit a new, unprecedented willingness to pressure seniors to consider cost and price when they use Medicare services remains unclear. This is hardly the most propitious time for major philosophical debates about Medicare and how to reform the program. But perhaps the urgency of the moment and concerns about more unpalatable alternatives will inspire more creative thinking than we've seen in the past. ●

Gail R. Wilensky, PhD, is a senior fellow at Project HOPE; a former administrator of HCFA, now CMS; and a former chair of the Medicare Payment Advisory Commission (gwilensky@projecthope.org).