

**Review of the  
Long Range Assumptions  
of the Medicare Trustees'  
Projections**

**Interim Report**

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**Prepared by:  
2010 Technical Review Panel  
on the Medicare Trustees Report**

# Interim Report of the Technical Review Panel on the Medicare Trustees Report

February 2011

In August 2010, the Secretary of the Department of Health and Human Services (HHS) established a panel of technical experts to review the assumptions and methods used by the Medicare Board of Trustees to prepare forecasts of the financial status of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds under current law. The Panel was asked to focus its immediate attention on the long-range Medicare expenditure growth rate assumption and to report to the Secretary and the Board of Trustees in the winter of 2011 so that its recommendations could be considered by the Board in preparing the 2011 Medicare Trustees Report.

The Technical Panel was chartered under the Federal Advisory Committee Act (FACA). To elicit nominations of technical experts who might be willing to serve, a public notice was published in the July 30, 2010 *Federal Register*. From the resulting list of nominees, the Assistant Secretary for Planning and Evaluation, under the authority granted by the Secretary, appointed the following actuaries and economists to the nine-member Panel:

- John Bertko, F.S.A., M.A.A.A. (Co-chair)
- Joseph Newhouse, Ph.D. (Co-chair)
- Barry Bosworth, Ph.D.
- Michael Chernew, Ph.D.
- John Cookson, F.S.A., M.A.A.A.
- Uwe Reinhardt, Ph.D.
- Geoffrey Sandler, F.S.A., M.A.A.A.
- Louise Sheiner, Ph.D.
- Cori Uccello, F.S.A., M.A.A.A.

Donald Oellerich, of the HHS Office of the Assistant Secretary for Planning and Evaluation, was selected to serve as the Executive Director of the Panel.

Independent technical panels periodically review the assumptions and methods underlying the Medicare financial projections used in the annual Trustees Reports, both to ensure that the existing projections are reasonable and, when possible, to offer recommendations for refinements and other improvements. One of the most important assumptions is the long-range per capita growth in Medicare expenditures. The 2000 Medicare Technical Review Panel, in a finding reaffirmed by the 2004 Panel, recommended that the long-range per capita Medicare expenditure growth rate assumption, prior to demographic impacts, be equal to the per capita GDP growth plus 1 percentage point (i.e., GDP+1). This assumed long-range Medicare expenditure growth rate was adopted by the Board of Trustees and was used for the 2001 through 2009 Trustees Reports.

For the 2010 report, however, the Trustees adopted a slower per capita growth assumption to reflect the provisions of the Affordable Care Act (ACA)<sup>1</sup> that could ultimately affect Medicare's long-range cost

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<sup>1</sup> The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), is commonly referred to as the Affordable Care Act.

growth. The ACA introduced many significant changes to reduce Medicare costs and increase program revenues, including a permanent reduction in the annual Medicare payment rate updates for most types of providers equal to the increase in economy-wide multifactor productivity. The Trustees particularly noted the impact on long-range Medicare expenditure growth rates associated with this annual payment update reduction (estimated as 1.1 percent each year) for hospitals and for other Part A and most non-physician Part B services. The Affordable Care Act also included numerous research and development initiatives aimed at reducing costs, introducing new methods of health care delivery, and increasing the quality of care. In light of these ACA-mandated changes, the Trustees used for the 2010 report a current-law long-range growth rate assumption of per capita GDP minus 0.1 percentage point (i.e., GDP-0.1) for Part A services (and a corresponding reduction for affected Part B services). As part of its charter, the current Technical Panel was asked to review this long-range expenditure growth assumption.

The Panel held four public meetings, during which time members reviewed the underpinnings of the prior per capita growth assumption (GDP+1) and the provisions of the Affordable Care Act that might, in the long term, warrant a change in the projected growth rate. The meetings were held on the following dates, either at the Hubert H. Humphrey Building in Washington, D.C. or at the headquarters for the Centers for Medicare & Medicaid Services (CMS) in Baltimore:

- November 23, 2010
- December 13-14, 2010
- January 10, 2011
- January 28, 2011

During its proceedings, the Panel heard presentations from the following individuals and offices:

- HHS CMS Office of the Actuary (OACT)
- Congressional Budget Office (CBO)
- HHS Office of Finance
- HHS CMS Center for Medicare and Medicaid Innovation
- Panel members
- Public Trustees

The Panel found that, without further study, it would not be able to recommend changes to the long-range growth rate assumption in time for potential use by the Trustees in the 2011 report. In particular, the Panel noted the extreme difficulty involved in developing a long-range average per capita growth assumption, due to the many uncertainties that surround not only the long-term evolution of the U.S. health care system but also its interaction with the provisions of the Affordable Care Act. Over the course of the next 8 to 10 months, the Panel will continue its review of the long-range Medicare spending growth assumption under current law, considering both possible improvements to the existing assumption methodology as well as alternative methods based on a “bottom up” analysis of relevant factors.

In response to its mandate to assess the reasonableness of the long-range cost growth assumption in the 2010 Medicare Trustees Report, the Panel considered the rationale for the GDP-0.1 assumption and reached the following conclusion:

**Finding 1:** The Panel finds that the current-law long-range growth assumption of per capita GDP minus 0.1 percentage point for Part A (and the corresponding reduction for affected Part B services), as used by the Trustees in their 2010 report, is not unreasonable in light of the provisions of the Affordable Care Act.

The current long-range Medicare cost growth assumptions under current law were derived in two steps. First, a “baseline” long-range growth rate assumption was developed consistent with methods used in prior reports and before consideration of the effects of the Affordable Care Act. This long-range baseline projection (year 25 through year 75) was prepared in aggregate for each of Medicare Parts A, B, and D, rather than by individual category of service. The long-range baseline growth rates were derived from a computable general equilibrium (CGE) model, subject to the constraint that the 75-year HI actuarial balance had to be the same as calculated under the GDP+1 assumption. In between the 10<sup>th</sup> and 25<sup>th</sup> years of the projection, the baseline growth rates for Parts A, B, and D were assumed to grade smoothly from their level in the 10<sup>th</sup> year to the long-range growth rates estimated for the 25<sup>th</sup> year. The first 10 years of the projection period (the “short-range”) employed a detailed price, quantity, intensity, and population methodology that separately projected spending for each service category for Medicare Parts A, B, and D.

Second, the “baseline” projection was adjusted for specific Affordable Care Act provisions affecting annual increases in Medicare payment rates for all Part A and most non-physician Part B services. In particular, the baseline GDP+1 growth assumption was adjusted downward for affected providers by the projected 1.1-percent annual increase in economy-wide multifactor productivity, as required by the Affordable Care Act. This basis for the Medicare cost growth rate assumptions was chosen primarily to incorporate the ACA provisions in a straightforward manner, in part due to consideration of the uncertainty associated with the long-range application of the productivity adjustments and in part due to the difficulty of modeling such consequences. Purposely not considered were the potential effects of sustained slower Medicare payment increases on provider participation; beneficiary access to care; utilization, intensity, and quality of services; and other factors. Similarly, the possible changes in payment mechanisms, delivery systems, and other aspects of health care that could arise in response to the payment limitations and the ACA-directed research activities were not modeled. The long-range growth rate assumed for Part D, Medicare prescription drug coverage, was not affected by the Affordable Care Act.

The Panel considered a number of issues as it examined the current methods and assumptions related to the long-range projections:

- Historical cost growth
- Affordable Care Act provisions, particularly the productivity-related fee update reductions
- Potential long-term changes in health care delivery in response to cost controls, development of new payment systems, and service delivery systems
- Potential changes to service use and to the development and application of new technologies
- “Natural brakes” that might slow per capita growth from current levels to the level of GDP plus 1 percentage point, including the effects of cost sharing and premiums,

changes in diffusion of cost-saving technology and practices, and possible regulatory changes allowed under law

- Spillovers between the commercial and public sectors
- International health care spending experience
- The potential for the interaction among many of these factors and current law—e.g., the potential that the natural brakes assumed by the 2000 and 2004 Panels to reduce growth from current levels to GDP plus 1 percentage point may put more or less pressure on growth in the context of current law
- Comparison of past and future Medicare payment rates to payment rates in other parts of the U.S. health sector and to those made by other countries
- The functional form of the long-range assumption—specifically, whether a “GDP+X” form should continue to be used

Based on the considerations described above, the Panel finds that the per capita expenditure growth assumptions used by the Trustees in the 2010 report are not outside the range of reasonable long-range per capita growth assumptions.

**Recommendation 1:** The Panel recommends that alternative long-range per capita growth assumptions be included in the report for 2011, as they were for 2010, to demonstrate the considerable uncertainty in projecting current-law health care cost growth for the next 25, 50, or 75 years. Additionally, the Panel recommends continued use of a supplemental analysis, similar to the “illustrative alternative projection” in the 2010 report, for the purpose of illustrating the higher Medicare costs that would result under the assumptions that (1) the effects of the productivity adjustments last for only the first 10 to 25 years of the projection period and (2) the physician payment reductions required under the current “sustainable growth rate” (SGR) formula continue to be overridden by Congress. This “illustrative alternative” provides important information to the Congress and the public on how assumptions about the payment update reductions in the Affordable Care Act and under the SGR formula affect the long-term projections.

Projecting health care costs for the next 10, 25, 50, or 75 years is a daunting task. The Panel finds that there is considerable uncertainty in the direction of future health trends, evolution of the health care delivery and payment systems, technological innovation and diffusion, and demand for and access to health services. Moreover, future economic and demographic trends may vary from the Trustees’ intermediate assumptions and may, accordingly, result in Medicare expenditures that are higher or lower than expected. Therefore, the Panel recommends that the Trustees continue to demonstrate the uncertainty that exists under current law by clearly presenting projections using alternative long-term growth rates, such as the current high-cost and low-cost alternatives, that reflect possible variations in economic, demographic, and health cost growth factors in the future. The Panel also recommends continued use of a set of alternative assumptions about payment updates, as in the “illustrative alternative projection,” to show the possible future cost for Medicare if the physician payment reductions and productivity adjustments are not maintained as called for under current law. Both types of alternative projections provide important indicators to policy makers and the public of the range of possible significant costs of the Medicare program and the funding necessary to meet these costs.