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ISSUE BRIEF

Medicare Spending Limits: Issues and Implications

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Introduction

Each year from 2009 through 2012, the federal budget deficit far exceeded $1 trillion. As a share of gross domestic product (GDP), deficits of that size have not occurred since World War II, and budget analysts warn that continued large deficits would hobble economic growth and increase the likelihood of a fiscal crisis. Deficits are projected to be below $1 trillion in 2013 and lower thereafter, but the U.S. Congress is still facing intense pressure to reduce the federal deficit and debt, and grow the economy.

Given its sheer size, Medicare is likely to be a part of any major budget compromise. Medicare currently accounts for over one-sixth of federal non-interest spending, about $600 billion in 2013. The Affordable Care Act of 2010 (ACA) is projected to significantly slow Medicare spending growth going forward. But, even so, Medicare's share of federal noninterest spending is projected to grow to over one quarter over the next 25 years, primarily because of increases in the number of beneficiaries, but also due to increases in spending per beneficiary (Congressional Budget Office 2012a).

Several major deficit reduction proposals include provisions that would set an explicit limit on the growth in Medicare spending. The proposed limits are, without exception, pieces of much larger proposals. In some cases, the spending limit is included as a "backstop," meaning that other core components of the proposal are expected to slow the growth in Medicare spending, but, in case they do not, the spending limit ensures federal savings. In other cases, spending limits are included as a mechanism to trigger policymakers to take painful, but needed, steps in the future.

For most of Medicare's history, spending per beneficiary has grown more rapidly than GDP per capita (Exhibit 1). Some experts have argued for a change in law that would bring Medicare spending growth in line with growth in the economy, and advocate for a limit on Medicare spending growth. But there is little consensus as to how tight the limit should be, how it should be enforced, and whether the limit should apply just to Medicare, all federal health care spending, or even total health spending, including public and private payments.

This issue brief has three goals:

- *Describe limits that are already in place*. Limiting Medicare spending growth is not a new idea. The Sustainable Growth Rate (SGR), for example, has been in place since 1997, and is designed to limit the growth in Medicare physician spending per beneficiary. The historical experience with SGR, and with other existing limits, provides a context for understanding and differentiating among proposed new limits.

- *Describe recent proposals to limit Medicare spending, and the differences among these proposed limits*. There are crucial differences among the various limits that have been proposed in some of the leading deficit reduction packages. Proposed limits differ in: 1) the scope of spending to which the limit applies, 2) how the limit is defined, and 3) the consequences of exceeding the limit.

- *Compare Medicare spending growth, historical and projected, with various limits under different scenarios*. The analysis of historical and projected spending growth, relative to possible target growth rates, helps to illustrate the extent to which projected Medicare spending could exceed various limits, the magnitude of the corrections that would be required, and the implications for program spending, beneficiaries and other stakeholders.

Existing Limits on Medicare Spending

The current Medicare program already includes limits of various types on program spending (Exhibit 2). An examination of these limits is useful for assessing the implications of alternative approaches that are under consideration to further limit Medicare spending growth.

Sustainable Growth Rate (SGR). The SGR was enacted in 1997 as part of the Balanced Budget Act (BBA), with deficit reduction as its primary goal. It is designed to automatically limit the growth in Medicare spending on physician services by comparing cumulative actual expenditures on physician services with a cumulative target (Congressional Research Service 2011). The target accounts for overall economic growth, increases in the number of beneficiaries, and any expansions of benefits.

The SGR is designed as an "autopilot"; if actual expenditures exceed the target, the law specifies that physician fees are to be reduced so that spending eventually comes back in line with the target. Because of rapid growth in spending on physician services, and slow growth in the economy in the early 2000s, cumulative actual expenditures have exceeded the target every year since 2002, setting automatic physician fee cuts in motion (Exhibit 3). However, with the exception of 2002, Congress has intervened to override these cuts before they could be implemented.

The SGR offers several lessons. First, putting Medicare payment policy on autopilot was intended to circumvent a political process so that constraints would be implemented. But, the experience of the SGR suggests that lawmakers will intervene to override automatic cuts if the effects are perceived to be deeply unpalatable. Second, a spending limit will only work well if the presence of the limit produces a constructive response. When the SGR was first implemented, policymakers hoped that physicians would respond collectively to the limit by limiting unwarranted utilization (Laugesen 2009). That hope was unfounded—the organized response to the SGR has been calls for overrides and repeal from the physician community and policymakers alike. Third, even though the SGR has been overridden repeatedly, and has been broadly criticized for its potential effect on physician fees and ultimately access and quality of care for beneficiaries, it has not been a complete failure. Medicare physician fees, even with the overrides, have grown at a rate close to or equal to zero, and, so, the SGR has likely helped keep Medicare physician spending growth lower that it would otherwise have been.

General Revenue Funding Warning. Medicare has two types of financing sources: "dedicated" financing sources (payroll taxes and beneficiary premiums), and general federal revenues. The Medicare Modernization Act of 2003 (MMA) included a provision intended to limit the share of total Medicare outlays that could be financed out of general revenues to 45 percent. Under the formula, general revenues could be kept below 45 percent either by limiting total Medicare outlays, or increasing payroll taxes or beneficiary premiums.[1]

The General Revenue Funding Warning is an example of a trigger—if the Medicare Board of Trustees projects that the general revenue share will exceed 45 percent of total outlays, the President is required to submit legislation to Congress that would address the excess, and Congress is required to consider the legislation under expedited procedures (Moon 2005).

The General Revenue Funding Warning trigger has been activated every year since 2007 (see Exhibit 4), but the process set forth in the MMA has not occurred. President Obama has objected on constitutional grounds to the requirement that he submit legislation, and has not done so. President George W. Bush also objected on constitutional grounds to the requirement that he submit legislation, but he did so in 2008. Congress, for its part, did not take up Bush's 2008 proposal, and the House of Representatives waived the General Revenue Funding Warning process for the rest of the 110th Congress and all of the 111th Congress (Congressional Research Service 2012). While technically the General Revenue Funding Warning is now in effect, it has had no demonstrable impact.

Independent Payment Advisory Board (IPAB). The Affordable Care Act authorized the creation of the IPAB, which will consist of 15 expert members appointed by the President and confirmed by the Senate (Ebeler, Neuman, and Cubanski 2011). IPAB is a trigger—if Medicare spending per beneficiary grows faster than a target, then IPAB is required to develop recommendations to achieve a specified reduction in Medicare spending known as the "applicable percentage".[2] Unlike the General Revenue Funding Warning, IPAB's recommendations take effect automatically unless blocked by Congress.

IPAB was established to impose greater discipline on Medicare spending, by authorizing a panel of experts to make recommendations insulated from political pressures. Some see it as the Congress delegating a very difficult process to an entity that might better be able to withstand criticism, like the process for closing excess military bases. Others see it as a backstop if hoped-for savings from initiatives such as payment reform do not materialize. Still others view IPAB as inappropriately encroaching on Congress' responsibilities.

It is too early to know what effect, if any, IPAB will have. The Congressional Budget Office (CBO) projects that the IPAB trigger will probably not be activated over the next decade, because the projected rate of growth in Medicare spending per beneficiary is below the target growth rate. But, even if the trigger is activated, IPAB faces several hurdles. The House of Representatives has passed legislation that would repeal the ACA, and has also specifically targeted IPAB for repeal (Congressional Budget Office 2012b). The House Rules adopted by the 113th Congress explicitly state that the IPAB provision of the ACA does not apply to the 113th Congress. Given the intensity of opposition to IPAB by some legislators, confirmation of nominees by the Senate may be difficult regardless of their qualifications. As of March 2013, no members have been confirmed to serve on IPAB, nor even nominated. And, even if members of IPAB are appointed and they submit recommendations, Congress may still override the recommendations or dissolve the body entirely.

The Medicare (Part A) Hospital Insurance Trust Fund (HI Trust Fund). The HI trust fund was originally conceived as a financing mechanism, and is not generally described as an explicit limit on spending, which makes it different from the other spending limits. The Treasury Department maintains the HI trust fund as a separate account on the federal books. HI trust fund expenditures pay for Medicare services under Part A, mainly inpatient hospital care and other institutional care. Income comes mostly from hospital insurance payroll taxes and from interest earned on holdings.

In practice the HI trust fund acts as a hard cap on Part A expenditures. By definition, Part A expenditures cannot exceed income plus any reserves, which makes it like an interest-bearing checking account with no overdraft protection. If the HI trust fund were ever completely depleted, the Treasury Department would not be able to pay medical providers the full amounts owed them (Congressional Research Service 2009). Such a default would undermine creditworthiness of the U.S. government, and could have serious negative consequences for hospitals, providers and beneficiaries.

The fact that insolvency of the HI trust fund is nearly inconceivable is what makes it so effective as a spending limit. In 1982, the Medicare Trustees projected that insolvency had crept to within five years (Congressional Research Service 2009). That alarm paved the way for dramatic reforms that overhauled hospital payments and significantly slowed the growth in Part A spending. In 1997, the projected insolvency date again crept within five years. In that year, Congress passed a sweeping deficit-reduction law that included major savings in Part A. Both the 1982 and 1997 reforms led to slowdowns that are clearly visible in overall Medicare spending trends (see Exhibit 1). Most recently, the ACA increased revenues to the HI trust fund and reduced expenditures, which pushed the projected date of insolvency 12 years further into the future (Medicare Trustees 2012). The Medicare Trustees project that, if there are no changes in law, the HI trust fund will become insolvent in 2024. If the past is any guide, Congress will step in before that occurs and either increase revenues, reduce expenditures, or both.

Proposed New Limits

Several recent deficit-reduction proposals include provisions to impose a new limit on Medicare spending growth (Exhibit 5):

- National Commission on Fiscal Responsibility and Reform ("Simpson-Bowles"),
- the President's 2013 Budget,
- the 2013 House Budget Resolution ("Path to Prosperity"),
- Protect Medicare Act ("Domenici-Rivlin"), and
- Bipartisan Options for the Future ("Wyden-Ryan").

The first three proposals—Simpson-Bowles, the President's budget, and the Path to Prosperity—are sweeping deficit reduction packages. Simpson-Bowles sets broad targets for increased federal revenues and reduced expenditures, and lists policies that could achieve those targets. The President's Budget and the Path to Prosperity are more specific in their policy proposals, but they leave out details that would have to be specified if their proposals were turned into legislation. The last two proposals—Domenici-Rivlin and Wyden-Ryan—focus on the Medicare program.

Each of these proposals includes a Medicare spending limit as just one component of a larger plan to reform Medicare and reduce the deficit. And they all include a target growth rate based on growth in nominal GDP per capita.

The proposed limits differ in other key ways.

- ***Growth targets.*** Two proposals—Domenici-Rivlin and Wyden-Ryan—would use growth in nominal GDP per capita plus one percentage point (GDP+1) as the target growth rate for Medicare spending. Two others—the 2013 House Budget Resolution and the Presidents' budget—would use growth in nominal GDP per capita plus half a percentage point (GDP+0.5). Simpson-Bowles proposes two types of targets. The first would equal growth in *total* GDP+1, in contrast with the other targets which are all based on per capitas. Simpson-Bowles also proposed a target based on per capita GDP+1, but that target would only be used in conjunction with a spending limit for a specific federal health program, such as Medicare.[3]

- ***Scope of spending subject to the limit.*** Simpson-Bowles is by far the broadest—it would limit the growth in total federal health care spending, including Medicare, Medicaid, exchange credits, and the forgone revenues from the tax exclusion for employer-sponsored coverage. The other proposals would apply the limit more narrowly to Medicare spending, although several of the proposals include other provisions that would affect other federal health programs.

- ***Caps vs. triggers.*** Domenici-Rivlin and the 2013 House Budget Resolution would impose caps with a specific automatic correction, while the other three proposals would use triggers to set in motion a policymaking process. The Simpson-Bowles and Wyden-Ryan proposals would trigger action by Congress and the President if spending limits are exceeded, but do not specify how the President or Congress would be compelled to act.

- ***Consequences if the limit is exceeded.*** Under Domenici-Rivlin and the 2013 House Budget Resolution, beneficiary out-of-pocket premiums would increase if the target growth rate were exceeded.[4] Under Wyden-Ryan and Simpson-Bowles, an open-ended policymaking process would be triggered, which could result in a wide range of corrections.[5] Under the President's budget, IPAB would formulate a policy response, which would presumably be limited to adjustments to Medicare payment policy because the ACA places limits on the nature of recommendations that IPAB is allowed to make.

Growth in Medicare Spending vs. GDP: Lessons from the Last Decade

The effects of limiting Medicare spending growth depend on how Medicare spending growth is defined and measured, and the target against which it is compared. Exhibit 6 uses spending and economic data from the last decade to illustrate the differences among some of the spending measures and growth targets that have been proposed.

From 2004 through 2013, annual growth in GDP per capita averaged 2.9 percent, while annual growth in Medicare spending per beneficiary averaged 5.0 percent. That rate of Medicare spending growth—GDP plus 2.1 percentage points—exceeds the limits that have been proposed, including both GDP+1 and GDP+0.5. Two factors explain almost all the difference between growth in Medicare spending per beneficiary and growth in GDP per capita over the last decade: 1) the implementation of Part D prescription drug coverage, which raised average annual spending growth by 1.6 percentage points, and 2) the Great Recession, which lowered average annual economic growth by 0.5 percentage points.

Had a limit been in place and enforced during the period from 2004 through 2013, a significant reduction in Medicare expenditures would have been required to bring spending down below the limit.

During the last decade, there was an even larger gap between growth in total Medicare spending, and growth in total GDP. The annual growth in total Medicare spending averaged 7.4 percent, while annual growth in total GDP averaged 3.8 percent, a gap of 3.6 percentage points. The growth gap is larger for totals than for per capitas because of the difference in population growth rates. The overall U.S. population has been growing at about 1 percent a year, while the Medicare beneficiary population has been growing at about 2.5 percent a year.

The last decade highlights three key considerations when assessing proposed limits:

- First, limiting growth in total spending, rather than per beneficiary spending, is more stringent because it does not automatically account for the fact that the Medicare beneficiary population will grow rapidly over the next several decades. A limit on total spending would, however, have a larger impact on controlling total federal spending.

- Second, a major expansion of benefits, such as Part D, would likely push spending above the limit and require an offsetting correction, unless the spending target is increased as well. The SGR is an example of a spending limit that automatically incorporates new

benefits into the calculation of the spending target; that kind of automatic exemption allows for new benefits to be added to the program more easily, but weakens the effect of the limit.

- Third, basing the spending target on actual GDP, rather than potential GDP, would lead to tighter spending limits during and after a downturn such as the Great Recession. Potential GDP is a measure of the hypothetical output of the economy at full employment, which grows at a fairly stable rate. Growth in actual GDP is more volatile, falling during recessions and rising during booms. Basing a target on growth in actual GDP corresponds more closely to federal revenues, but is more likely to require a spending correction. Using potential GDP instead would partially shield the Medicare program from cuts because of economic slowdowns.

Growth in Medicare Spending vs. GDP: A Preview of the Next Decade

The next decade (2014-2023) differs in interesting and important ways from the last decade. The projected annual growth in Medicare spending per beneficiary is 3.5 percent, nearly half a percentage point *below* projected annual growth in GDP per capita (3.9 percent) (see Exhibit 7).[6] This more favorable outlook is attributable both to changes in Medicare and in the economy.

Medicare spending growth per beneficiary is projected to be much slower in the coming decade than it was in the last decade (3.5 percent vs. 5.0 percent). The biggest reason for the projected slowdown is the fact that Part D was implemented in the last decade, and projections assume that no such benefit expansion occurs in the next decade. The other reason for the projected slowdown is the ACA, which significantly reduced payments to Medicare Advantage plans and permanently slowed the rate of increase in the prices that Medicare pays to most providers. The Medicare provisions in the ACA will slow annual growth in Medicare spending per beneficiary by around one percentage point. In addition, the economy is projected to grow faster in the coming decade than in the last decade: the projected annual growth in GDP per capita over the next decade is 1 percentage point higher than the last decade (3.9 percent vs. 2.9 percent), which increases projected spending targets.

If Medicare spending and the economy follow current projections, then Medicare spending would not hit any of the proposed spending limits over the next 10 years. But this projected scenario assumes that benefits are not expanded, that Medicare spending does not rise more rapidly than projected, the Medicare cuts in the ACA are kept in place, and the economy continues to recover. The simulations presented in the next section quantify what would happen if some part of this scenario diverged from current projections.

What If a New Spending Limit Were Put in Place Today?

The impact of putting a new spending limit in place is highly sensitive to the specifics of the spending limit, economic trends, and Medicare policy choices. Exhibit 8 illustrates the implications of using different spending limits using "base case" projections of growth in Medicare spending and GDP. Exhibit 9 illustrates the effects of using just one type of spending limit, but under various policy and economic scenarios. For all of these simulations, spending limits are assumed to be in place from 2014 through 2023.

The effects of spending limits are simulated by comparing projected growth in Medicare spending with growth allowed under the limit. For scenarios in which spending exceeds the limit, the required spending reductions are calculated, and are assumed to be achieved in one of two ways: increases in beneficiary premiums throughout all of 2014-2023, or reductions in provider payment rates throughout all of 2014-2023. There are countless other ways to reduce federal Medicare spending; this analysis is intended to be illustrative to provide a sense of the magnitudes of the corrections that would be required to stay within a limit.

Over the course of the next decade, the difference between GDP+0.5 and. GDP+1 turns out to be fairly minor, and of far less consequence than other differences, including: (1) whether the limit is based on a comparison of *total* or *per capita* growth rates for Medicare or GDP; and (2) whether the limit is based on a comparison of a 5-year moving average or a cumulative target. Other factors could also affect whether the spending limit is hit, including a reversal in the economy, or changes that result in an increase in Medicare spending, such as legislation that undoes Medicare savings enacted in the ACA, changes in legislation that expands benefits, or the introduction of expensive, new, breakthrough drugs or technologies covered by Medicare.

By far the most important factor in determining whether spending is likely to exceed target growth rates is whether the target is based on per capita spending or total spending. If Medicare spending *per beneficiary* is limited to grow at GDP *per capita* plus 1 percentage point, spending would not exceed the target over the 2014-2023 time period. However, if instead the growth in *total* Medicare spending were limited to *total* GDP plus 1 percentage point, spending would exceed the target by between $50 billion and $240 billion over the same time period, depending on the specific limit.

The SGR, IPAB, and all but one of the proposed Medicare spending limits listed in Exhibit 5 are based on per capitas. The per capita approach fits with the view that it is acceptable for the number of beneficiaries to increase. The HI trust fund, the General Revenue Funding Warning, and one version of the Simpson-Bowles proposal are limits based on total spending. Limiting total spending is a more stringent approach because it does not automatically account for the fact that the Medicare beneficiary population will grow rapidly over the next several decades; however, it would have a larger impact on controlling total federal spending.

The methodology used for calculating spending limits – either a 5-year moving average or cumulative total – also has a substantial impact on whether the limit is breached. This distinction seems arcane, but it turns out to be highly consequential. For example, over 2014-2023, a per capita *cumulative* limit of GDP+0.5 is not projected to require any correction, but a per capita *5-year moving average* limit would require a $30 billion correction. Under a moving average limit, average annual growth in GDP over a 5-year period is compared with average annual growth in Medicare spending over the same 5-year period. Shorter windows (e.g. 3 years) and longer windows (e.g. 10 years) are also possible. With each passing year, the window moves forward, hence the "moving" in "moving average." Under a cumulative limit, both the spending target and actual spending are accumulated totals—each year's target and actual spending are added to the accumulated sums from all years since the limit was put in place.

Limits based on moving averages tend to be stricter than limits based on cumulatives, because of wide variations in the growth in spending from year to year (see Appendix Table 1). Suppose that spending in one year grows at a rate far below the target and in the next year it grows at a rate far above the target. Under a cumulative limit, those two years will offset each other in all future comparisons of actual spending and the target, and a correction might be avoided. But, under a moving-average limit, the window for the moving average will, at some point, move beyond the low-spending year but still include the high-spending year, which may require a correction.[7]

Of the proposed Medicare spending limits listed in Exhibit 5, only the President's budget is clear on which method would be used—the President's budget strengthens IPAB, and, as spelled out in law, IPAB uses a limit based on a 5-year moving average. The other proposals do not specify whether the proposed limit would be cumulative or a moving-average. That detail would clearly have to be spelled out in legislative language, and it merits some attention even at the proposal phase.

Differences in the target growth rates (GDP vs. GDP+0.5 vs. GDP+1) can make a big difference, but only in scenarios where Medicare spending growth consistently exceeds the target. Under an IPAB-type limit (5-year moving average, per capita), there is not a huge difference between GDP+0.5 and GDP+1: spending exceeds the target by $27 billion under GDP+0.5 and does not exceed the target under GDP+1 over the 2014-2023 time period. The differences in target growth rates become much more consequential in the scenarios where spending consistently exceeds the target, such as when the limit is based on totals rather than per capitas.

Potential Implications for Beneficiaries and Providers

Projected spending could exceed the target if any one of the following occurs: the economy goes into a recession, the Medicare provisions in the ACA are repealed, or Medicare spending grows significantly faster than projected for some other reason.

Exhibit 9 illustrates the effects of varying economic and policy conditions on Medicare spending relative to a target, and the implications for beneficiaries and providers that could occur as a result. The analysis uses just one type of spending limit (5-year moving average, per capita) and three target growth rates (GDP, GDP+0.5, and GDP+1). In the first scenario, we assume the Medicare provisions in the ACA are repealed, which would increase annual Medicare spending growth by close to 1 percentage point. In the second scenario, we assume that another recession occurs (annual growth in GDP per capita equals 2.9 percent rather than 3.9 percent). In the last scenario, we assume that Medicare spending grows 2 percentage points faster than the base case (5.5 percent rather than 3.5 percent)—this difference in growth rates matches the difference between the Medicare Trustees' "intermediate" and "high-cost" sets of assumptions, and the higher growth rate is similar to the growth in per beneficiary Medicare spending over the past decade.

In the worst-case scenario, in which another recession occurs and spending growth is 2 percentage points faster than the base case, spending exceeds the targets by amounts ranging from roughly $550 billion (GDP+1) to almost $900 billion (GDP) over the period from 2014 to 2023. If the limit required beneficiaries to offset spending above the limit, then beneficiaries would pay, on average, between $70 to $110 more in out-of-pocket premiums per month over the entire 10-year period. Alternatively, if the law required automatic reductions in provider payment rates, then providers would see payment rates reduced by 7 percent to 12 percent over the entire 10-year period. To put those corrections in context, the average Part B monthly premium over the 2014-2023 period is projected to be around $140, and a reduction of 7 percent to 12 percent in provider payment rates is roughly as large as the accumulated effect of 10 years of ACA reductions.

This analysis simulates Medicare spending and economic growth over the next ten years, based on current CBO projections. Even over that 10-year budget window, projections carry uncertainty. Just five years ago, few would have predicted passage of the ACA and Medicare's current surprisingly slow rate of spending growth. Beyond the 10-year budget window, there is even less certainty, which complicates the discussion of spending limits. Medicare spending beyond the 10-year window might fall well below current projections, making proposed spending limits obsolete. Or, spending beyond the 10-year window might far exceed current projections, in which case proposed limits would require drastic cuts, or that they be abandoned. Moreover, policymakers' views on how best to rein in spending growth will undoubtedly evolve. "Automatic" corrections specified in law today are likely to drift farther and farther from the mark as the years go by.

Discussion

New limits on Medicare spending growth are included in many of the proposals under consideration to reduce the federal deficit. The current proposals vary in a number of ways that can have important implications for whether and when the limit is hit, whether the limit is enforced, and, if so, the effects on providers and beneficiaries. The historical evidence suggests that the success of efforts to limit Medicare spending vary widely. The General Revenue Funding Warning, at one extreme, has been repeatedly brushed aside and almost totally inconsequential. The SGR cap has been more consequential, and has helped rein in Medicare spending for physician services, even though it has routinely been overridden. The Hospital Insurance trust fund, though not generally viewed as a spending limit, has proven very effective in prompting Congress to rein in Medicare spending growth.

The effect of any new Medicare spending limit will depend on a number of factors. The specifics of the limit are, obviously, important, including: is the limit based on total or per capita spending; is the target based on GDP+0.5 or GDP+1; how are the targets and actuals calculated; and is the limit adjusted automatically to account for an expansion of benefits, such as the implementation of Part D in 2006? But, perhaps even more important is the proposed process for taking action if the limit is exceeded, and the proposed consequences for beneficiaries and other stakeholders if the limit is exceeded. IPAB, for example, would keep spending within the limit by changing payments to providers; beneficiaries are insulated somewhat by the prohibition against IPAB recommending benefit reductions or increases in cost sharing. The 2013 House Budget Resolution, in contrast, would keep spending within the limit by increasing premiums paid by beneficiaries. Those differences reflect fundamentally different views on the appropriate way to rein in growth in Medicare spending.

CBO projects that over the next decade, Medicare spending per beneficiary will grow somewhat below the rate of growth in GDP per capita. In that case, limiting per-beneficiary spending growth to GDP+1, or even GDP, would have little impact. But the proposed spending limits, and their proposed consequences, still matter. Spending growth would exceed proposed targets if the Medicare provisions in the ACA are repealed, the economy falls back into recession, or if Medicare spending grows faster than projected because of some unforeseen reason. The point of a spending limit, of course, is to protect the finances of the Medicare program in exactly such scenarios. But using a spending limit to ensure Medicare's finances increases the risks faced by beneficiaries, providers, or both.

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Endnotes

[1] A more intuitive way to describe the General Revenue Funding Warning is as a limit on total Medicare outlays—they can be no more than 1.82 times the revenues from dedicated financing sources (1.82=1/(1-0.45)).

[2] The target growth rate for 2015 through 2019 equals a 5-year moving average of a blend of the Consumer Price Index for all goods and services (CPI-U) and the growth in the medical care component of the CPI (CPI-M). For years 2020 and beyond, the target will equal growth in nominal GDP per capita plus one percentage point.

[3] In February 2013, Simpson and Bowles released the broad outlines of a new deficit reduction proposal ("A Bipartisan Path Forward to Securing America's Future," http://momentoftruthproject.org/publications/bipartisan-path-forward-securing-americas-future). The newer proposal proposes reductions in federal health programs, and proposes that "these reforms should be backed up by a cap on the budgetary commitment to health care, limiting per capita growth close to the growth of the economy."

[4] According to a CRS analysis of the 2013 House Budget Resolution, if Medicare spending exceeds GDP+0.5, then "..Medicare beneficiaries would pay increased premiums to make up the difference." (Report R42441, March 29, 2012)

[5] Based on experience with the General Revenue Funding Warning, the President cannot be compelled to propose legislation. And while Congress can commit itself (or future Congresses) to take future action, such commitments vary widely in the degree to which they are binding.

[6] Our analysis focuses on the next decade because detailed projections are available over that window. Beyond that window, spending projections become highly uncertain and sensitive to modeling assumptions (Rettenmaier, and Saving 2012). Our Medicare spending projections follow CBO's "alternative fiscal scenario," which assumes that the SGR is overridden and that physician fees are frozen at 2012 levels. To calculate projected Medicare spending, we start with "Mandatory Benefits, net of recoveries, adjusted for timing shifts" from the CBO February 2013 Medicare baseline. We then add projected administrative expenses and subtract projected beneficiary premium payments and divide by projected enrollment in Medicare Parts A or B. We convert those projections to calendar year. To this, we add CBO's estimate of the increase in Medicare outlays, net of premiums, from freezing physician fees at their 2012 levels, also converted to calendar years.

[7] Spending limits are a type of one-sided bet—they only "pay off" (i.e. require a correction) if spending exceeds the target. Moving averages are a more volatile measure of spending growth than cumulatives. Because of the one-sidedness of the bet, the more volatile measure (the moving average growth rate) will tend to require larger corrections than the more stable measure (cumulative growth).

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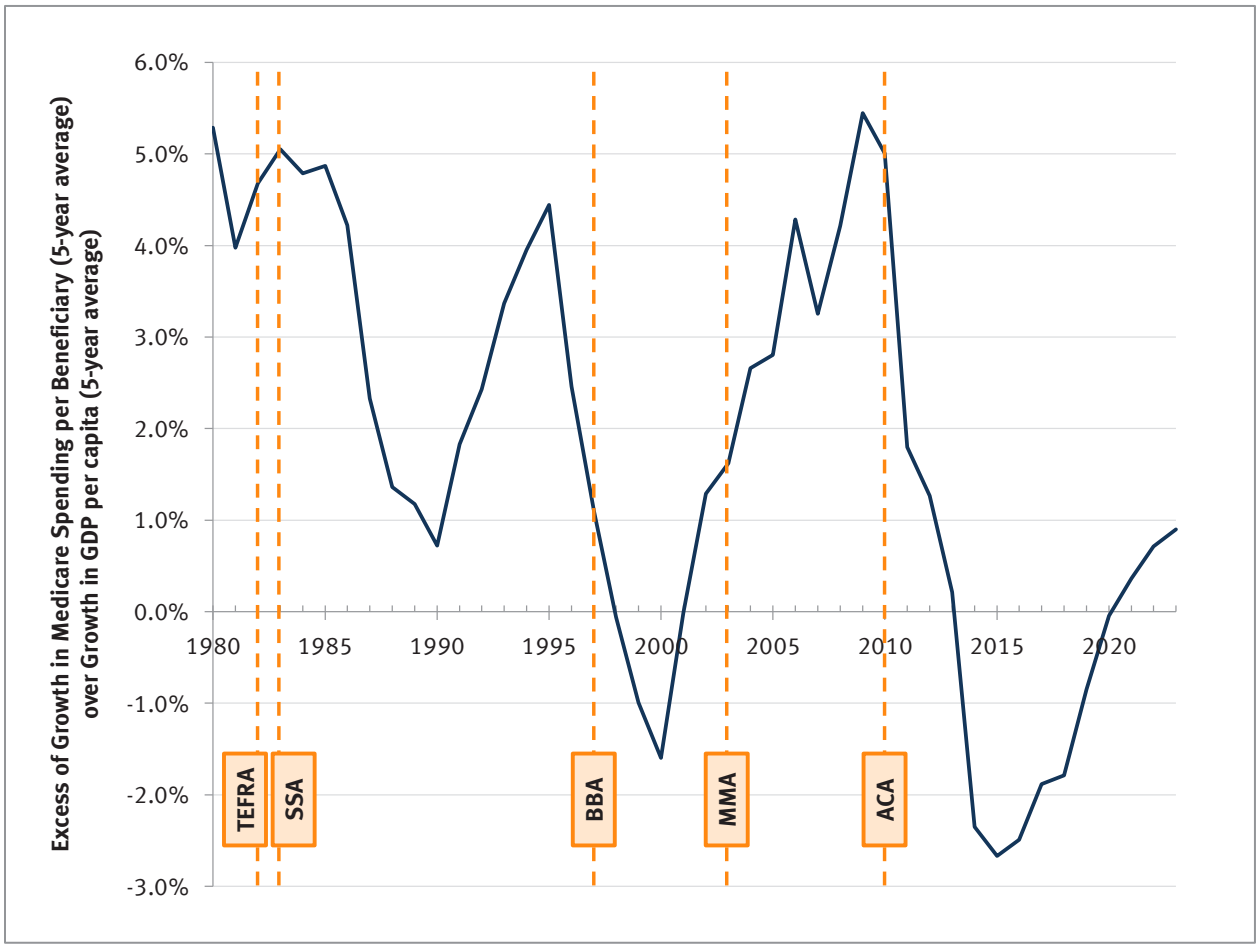
Exhibit 1. The Gap between Medicare Spending Growth and GDP Has Varied Widely, but Is Projected to be Narrower Over the Next Decade



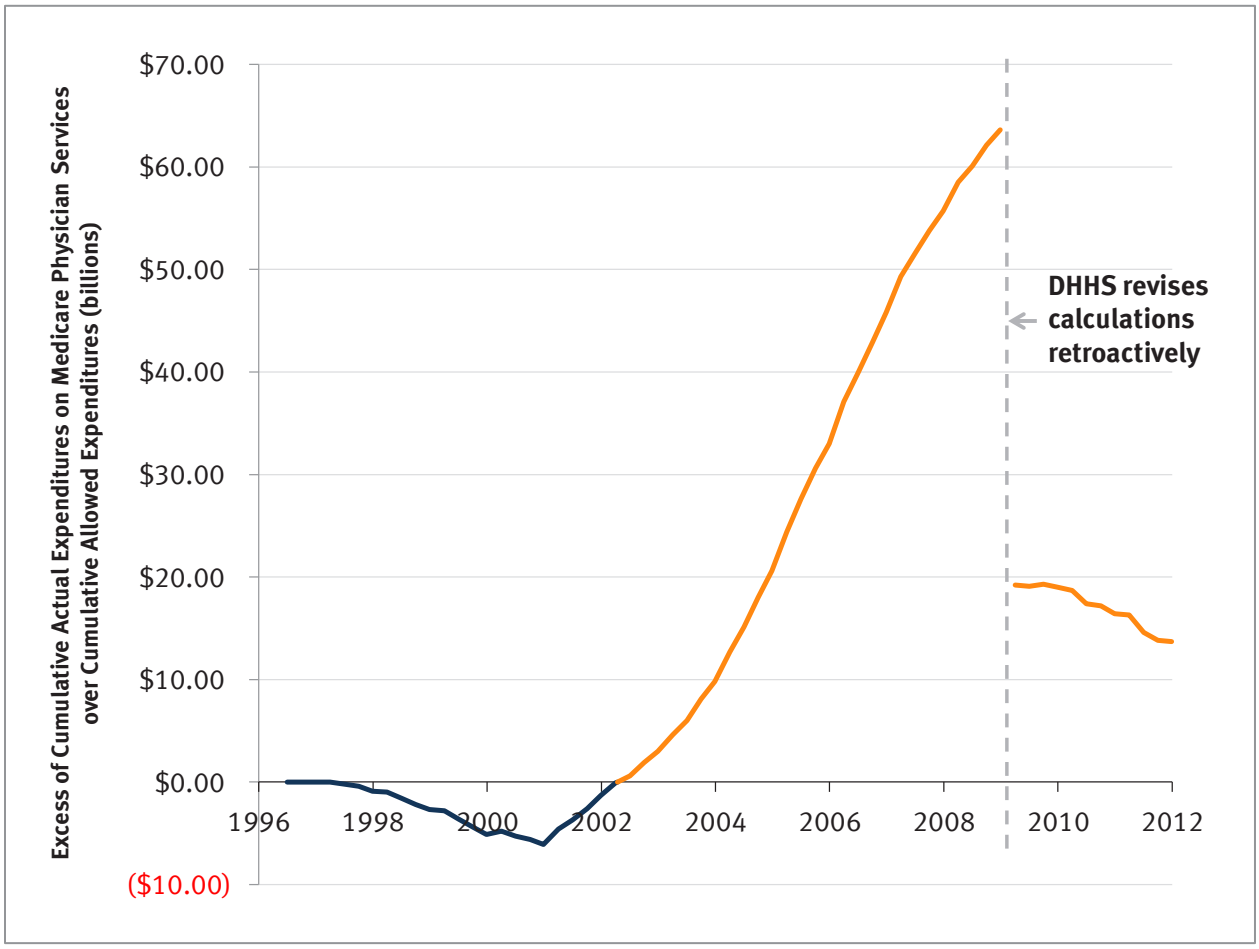
Source: Author's analysis using historical Medicare spending data from the Medicare Trustees, historical GDP from the Bureau of Economic Analysis, and projected Medicare spending and GDP from the Congressional Budget Office.
Note: The vertical blue dashed lines indicate major federal legislation affecting Medicare. Projected Medicare spending assumes that the sustainable growth rate (SGR) mechanism is overridden and that physician fees are frozen at their 2012 levels.

Exhibit 2. Limits on Federal Spending on Medicare: Currently in Place

Provision	Scope of Spending Subject to Limit	Growth Target	Cap or trigger?	Consequence if Limit is Exceeded	Has Limit been Exceeded?
Hospital Insurance Trust Fund (HI Trust Fund)	Cumulative benefit payments for services covered under Medicare Part A	Cumulative income to the HI trust fund from payroll taxes and interest	Cap	The federal government would only pay medical providers a portion of the amounts due.	No. The Medicare Trustees project that, beginning in 2024, the HI Trust Fund will have insufficient funds to pay full benefits.
Sustainable Growth Rate (SGR)	Cumulative Medicare benefit payments for services provided by physicians	Cumulative spending target, adjusted for the number of beneficiaries, and overall economic growth	Cap	Physician fees are required by law to be automatically reduced. However, these automatic reductions have been overridden by Congress every year since 2004.	Yes, every year since 2002.
Excess General Revenue Funding Warning	General revenue share of total Medicare spending	45%	Trigger	The President must propose legislation that reduces the general revenue funding share , and Congress must consider that legislation under expedited procedures.	Yes, every year since 2009.
Independent Payment Advisory Board (IPAB)	5-year average growth in Medicare spending per beneficiary	5-year average growth in a blend of CPI-U and CPI-M (2015-2019), or GDP per capita plus 1 percentage point (2020 and beyond)	Trigger	IPAB must propose changes to the Medicare program that reduce spending growth. "The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums … increase Medicare beneficiary cost-sharing … or otherwise restrict benefits or modify eligibility criteria." These changes take effect, unless Congress passes legislation that modifies or blocks them.	Determinations have not yet been made.

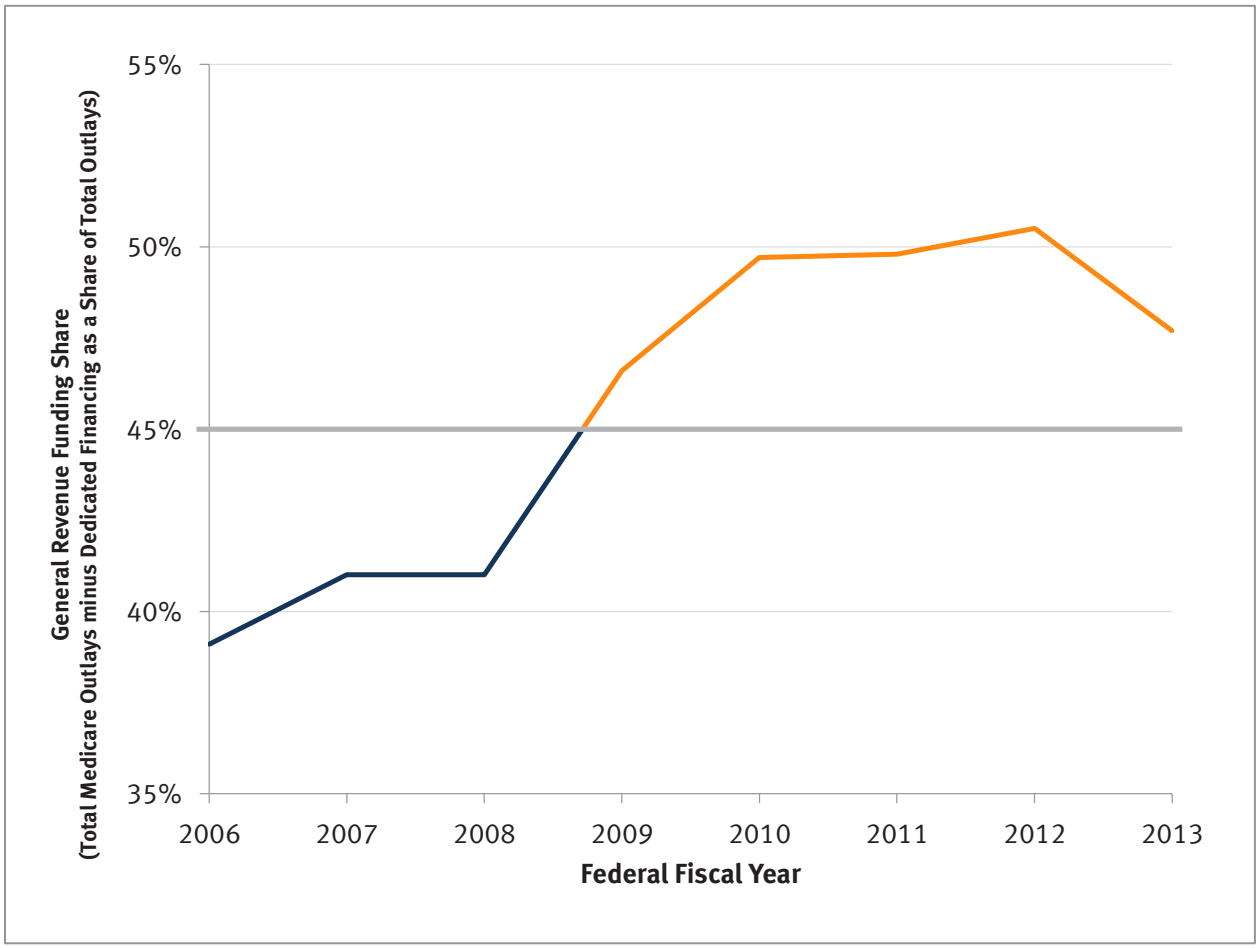
Sources: Author's analysis.
Notes: The "general revenue share" equals total Medicare outlays minus dedicated financing sources divided by total Medicare outlays. CPI-U is the consumer price index, all urban consumers. CPI-M is the medical care component of the CPI-U.

Exhibit 3. The Cap on Medicare Spending on Physician Services Has Been Exceeded



Source: Centers for Medicare & Medicaid Services. 2011. "Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2012." Online: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/sgr2012f.pdf.
Note: The cumulative actual expenditures and the cumulative targets underwent a major revision in 2009 when the Secretary of Health and Human Services retroactively removed Part B drugs from both the target and actuals.

Exhibit 4. The 45% Excess General Revenue Limit Has Been Exceeded



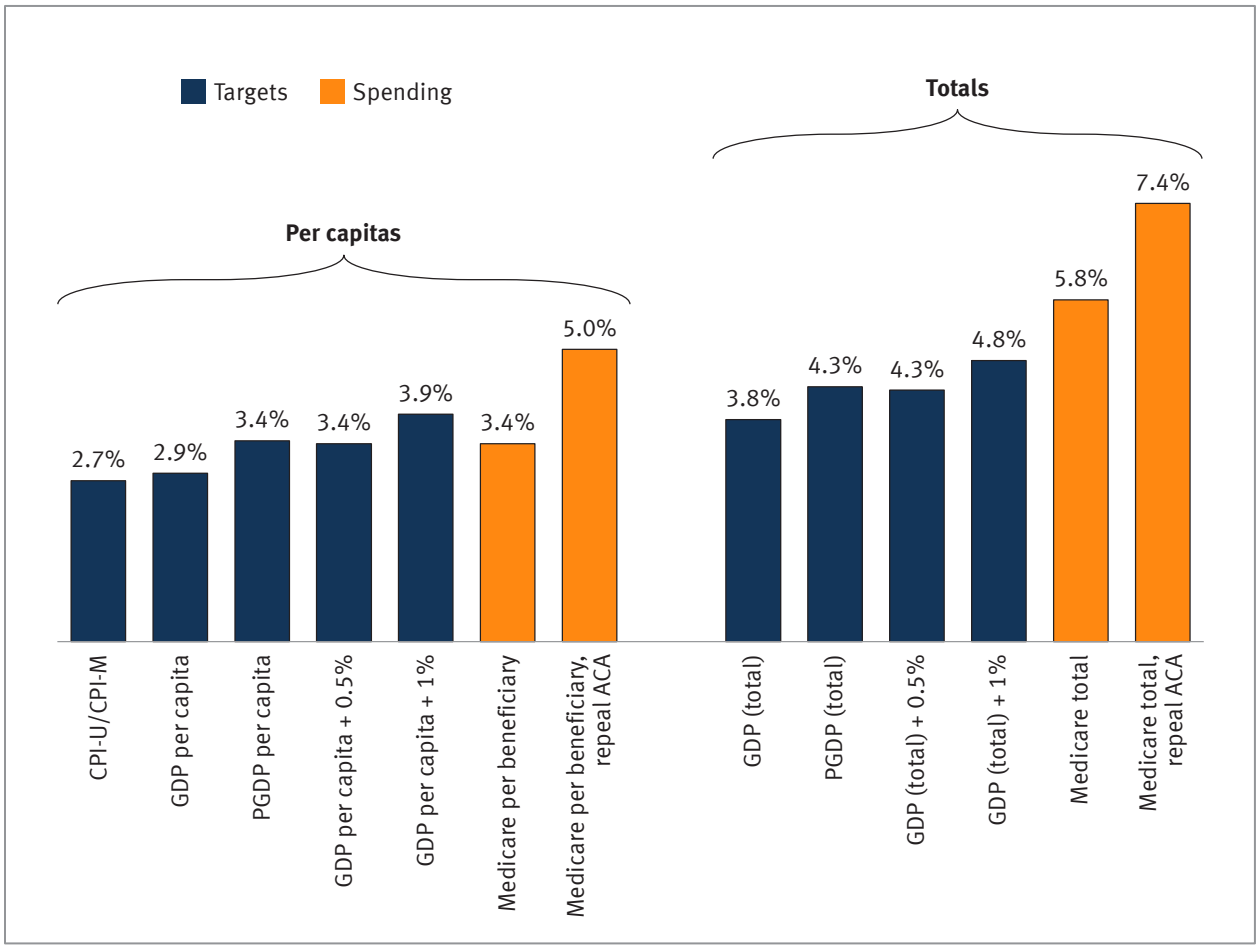
Source: Congressional Budget Office, March baselines for the Medicare program (various years).

Exhibit 5. Limits on Medicare Spending in Leading Deficit Reduction Proposals

Proposal	Spending Measure	Limit	Cap or trigger?	Consequence if Limit is Exceeded
National Commission on Fiscal Responsibility and Reform ("Simpson-Bowles")	Growth in total federal health care costs	Growth in total GDP plus 1 percentage point	Trigger	"Congress and the President [would be required] to consider further actions that make more substantial structural reforms."
President's 2013 budget	Assumes current law provisions pertaining to IPAB (see Exhibit 2).	GDP per capita plus 0.5 percentage point, based on 5-year average growth	Trigger	IPAB would be given "additional tools like the ability to consider value-based benefit design and policies that promote integrated and coordinated care."
House Budget Resolution for 2013 ("Path to Prosperity")	Growth in Medicare spending per beneficiary.	Growth in GDP per capita plus 0.5 percentage point.	Cap	Beneficiary premiums would increase
Protect Medicare Act ("Domenici-Rivlin")	Growth in Medicare spending per beneficiary	Growth in GDP per capita plus 1 percentage point	Cap	Beneficiaries with income above 150 percent of FPL would pay higher premiums.
Bipartisan Options for the Future ("Wyden-Ryan")	Growth in Medicare spending per beneficiary	Growth in GDP per capita plus 1 percentage point	Trigger	"Congress would be required to intervene and could implement policies that change provider reimbursements, program overhead, and means-tested premiums."

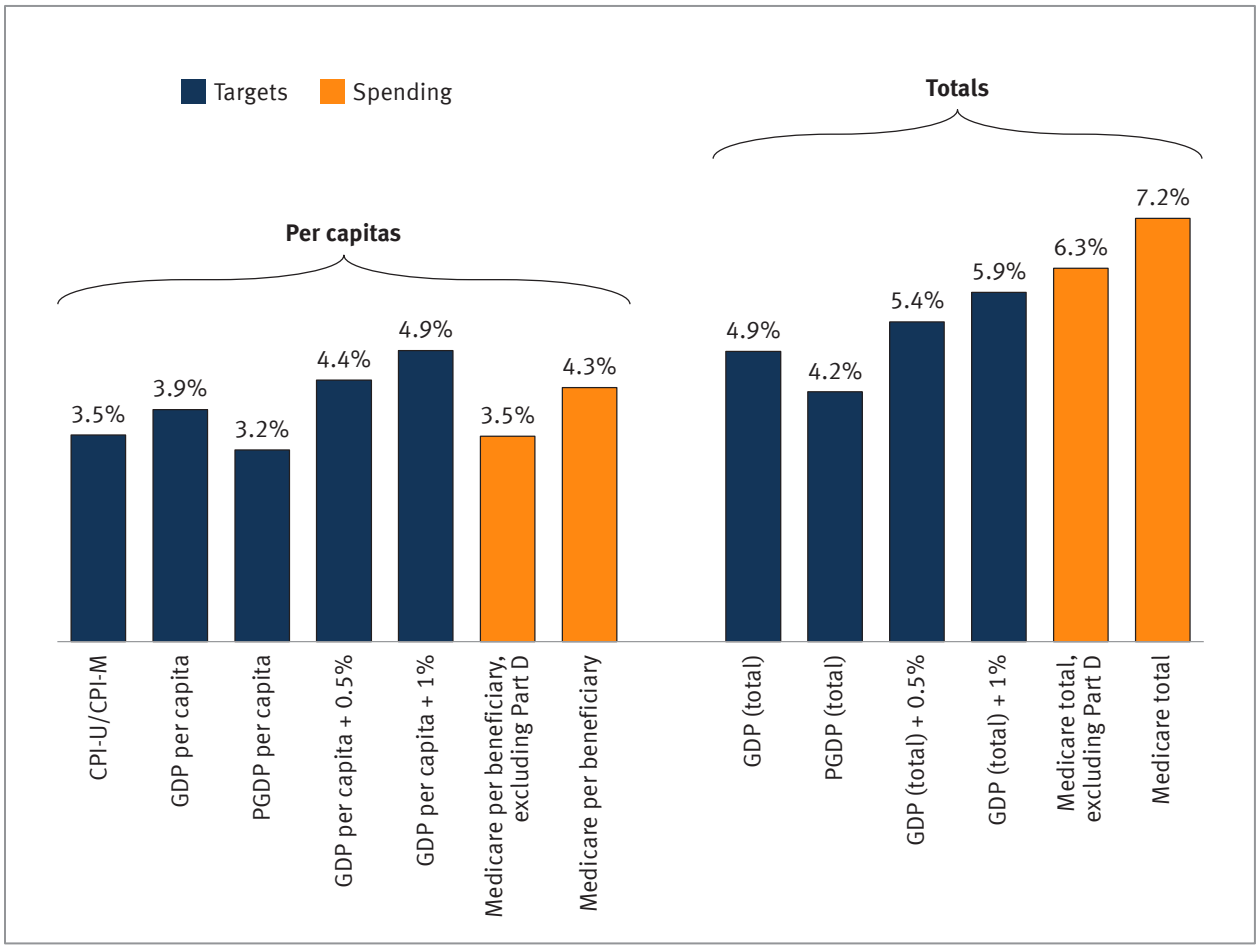
Sources: Author's analysis.

Exhibit 6. Annual Rates of Growth in Medicare Spending (Red) and Various Spending Targets (Blue), 2004-2013



Source: Author's analysis of historical Medicare spending and enrollment data from the Medicare Trustees, historical economic data from the Bureau of Economic Analysis, and inflation data from the Bureau of Labor Statistics.

Exhibit 7. Annual Rates of Growth in Medicare Spending (Red) and Targets (Blue) Projected for 2014-2023



Source: Author's analysis using projections of economic growth, inflation, and Medicare spending and enrollment from the Congressional Budget Office.

Note: Projected Medicare spending assumes that the sustainable growth rate (SGR) mechanism is overridden and that physician fees are frozen at their 2012 levels.

Exhibit 8. Simulated Effects of Various Limits on Medicare Spending if Limits Were in Place from 2014 through 2023

Spending Limit			Aggregate projected spending in excess of target over 10 years (in billions)	Illustrative Effects if Spending Exceeds Target	
Per Capita, or Total Medicare Spending?	Based on 5-year Moving Average or cumulative spending over 10-year period?	Target growth rate		Option #1: Increase beneficiary premiums throughout the period ($/month)	Option #2: Reduce provider payment rates throughout the period (%)
Per capita	5-Year Moving Average	GDP	$84	$11	-1%
		GDP+0.5	$27	$3	0%
		GDP+1.0	$0	$0	0%
	Cumulative	GDP	$0	$0	0%
		GDP+0.5	$0	$0	0%
		GDP+1.0	$0	$0	0%
Total	5-Year Moving Average	GDP	$602	$76	-8%
		GDP+0.5	$410	$51	-5%
		GDP+1.0	$236	$30	-3%
	Cumulative	GDP	$309	$39	-4%
		GDP+0.5	$165	$21	-2%
		GDP+1.0	$49	$6	-1%

Source: Author's analysis.
Notes: Projected Medicare spending assumes that the sustainable growth rate (SGR) mechanism is overridden and that physician fees are frozen at their 2012 levels.

Exhibit 9. Simulated Effects of a Medicare Spending Limit Under Alternative Scenarios, Such as Another Recession or if Medicare Spending Grows Faster than Projected, 2014 - 2023

Economic and Policy Scenario			Spending Limit		Illustrative Effects if Spending Exceeds Target	
Is there Another Recession?	Does Medicare Spending Grow Faster than Projected?	Are the Medicare provisions in the ACA repealed?	Target growth rate	Aggregate projected spending in excess of target over 10 years (in billions)	Option #1: Increase beneficiary premiums throughout the period ($/month)	Option #2: Reduce provider payment rates throughout the period (%)
No	No	No	GDP	$84	$11	-1%
			GDP+0.5	$27	$3	0%
			GDP+1.0	$0	$0	0%
		Yes	GDP	$239	$30	-3%
			GDP+0.5	$104	$13	-1%
			GDP+1.0	$37	$5	0%
No	Yes	No	GDP	$542	$68	-7%
			GDP+0.5	$414	$52	-5%
			GDP+1.0	$306	$38	-4%
Yes	No	No	GDP	$254	$32	-3%
			GDP+0.5	$169	$21	-2%
			GDP+1.0	$89	$11	-1%
	Yes	No	GDP	$878	$110	-12%
			GDP+0.5	$703	$88	-9%
			GDP+1.0	$553	$70	-7%

Source: Author's analysis.
Notes: In the recession scenario, annual growth in GDP per capita is 1 percentage point slower (2.9 percent instead of 3.9 percent). In the faster Medicare spending growth scenario, Medicare spending per beneficiary grows 2 percentage points faster (5.4 percent instead of 3.4 percent). All limits are based on per capitas using 5-year moving averages. Projected Medicare spending assumes that the ACA is left in place, and the sustainable growth rate (SGR) mechanism is overridden and that physician fees are frozen at their 2012 levels.

Appendix Table 1. Annual Growth in Medicare Spending per Beneficiary and GDP per Capita

Year	Annual rate of growth in GDP per capita		Annual rate of growth in Medicare spending per beneficiary		Difference between growth in Medicare spending per beneficiary and growth in GDP per capita	
	1-year	5-year moving average	1-year	5-year moving average	1-year	5-year moving average
1975	8.1%	8.4%	8.5%	13.3%	0.4%	4.9%
1976	10.4%	9.1%	23.1%	13.9%	12.7%	4.8%
1977	10.1%	9.3%	17.7%	14.4%	7.6%	5.0%
1978	11.8%	9.6%	14.3%	14.8%	2.5%	5.2%
1979	10.5%	10.2%	11.8%	15.1%	1.4%	4.9%
1980	7.8%	10.1%	10.1%	15.4%	2.3%	5.3%
1981	11.1%	10.3%	17.2%	14.2%	6.2%	4.0%
1982	3.1%	8.8%	14.2%	13.5%	11.1%	4.7%
1983	7.7%	8.0%	12.0%	13.1%	4.3%	5.0%
1984	10.3%	8.0%	10.3%	12.7%	0.1%	4.8%
1985	6.3%	7.7%	9.0%	12.5%	2.7%	4.9%
1986	4.8%	6.4%	7.7%	10.6%	2.9%	4.2%
1987	5.2%	6.9%	6.9%	9.2%	1.6%	2.3%
1988	6.7%	6.7%	6.2%	8.0%	-0.5%	1.4%
1989	6.5%	5.9%	5.6%	7.1%	-0.9%	1.2%
1990	4.7%	5.6%	5.1%	6.3%	0.4%	0.7%
1991	2.2%	5.1%	10.7%	6.9%	8.5%	1.8%
1992	4.7%	4.9%	9.3%	7.4%	4.6%	2.4%
1993	4.0%	4.4%	8.2%	7.8%	4.2%	3.4%
1994	5.2%	4.2%	7.3%	8.1%	2.1%	4.0%
1995	3.7%	3.9%	6.6%	8.4%	2.9%	4.4%
1996	4.7%	4.5%	3.3%	6.9%	-1.5%	2.5%
1997	5.3%	4.6%	3.1%	5.7%	-2.2%	1.1%
1998	4.6%	4.7%	3.0%	4.6%	-1.6%	-0.1%
1999	5.4%	4.7%	2.8%	3.7%	-2.6%	-1.0%
2000	2.8%	4.6%	2.7%	3.0%	-0.1%	-1.6%
2001	2.3%	4.1%	8.8%	4.1%	6.5%	0.0%
2002	2.5%	3.5%	6.8%	4.8%	4.3%	1.3%
2003	3.8%	3.4%	3.8%	5.0%	0.0%	1.6%
2004	5.4%	3.4%	8.0%	6.0%	2.6%	2.7%
2005	5.5%	3.9%	6.1%	6.7%	0.6%	2.8%
2006	5.0%	4.4%	18.9%	8.7%	13.9%	4.3%
2007	3.8%	4.7%	3.0%	8.0%	-0.8%	3.3%

Year	Annual rate of growth in GDP per capita		Annual rate of growth in Medicare spending per beneficiary		Difference between growth in Medicare spending per beneficiary and growth in GDP per capita	
	1-year	5-year moving average	1-year	5-year moving average	1-year	5-year moving average
2008	0.9%	4.1%	5.8%	8.3%	4.9%	4.2%
2009	-3.1%	2.4%	5.7%	7.9%	8.7%	5.4%
2010	3.2%	2.0%	1.6%	7.0%	-1.6%	5.0%
2011	3.2%	1.6%	2.1%	3.6%	-1.1%	2.0%
2012	2.8%	1.4%	2.2%	3.5%	-0.6%	2.0%
2013	1.8%	1.6%	-1.8%	1.9%	-3.5%	0.4%
2014	3.9%	3.0%	1.7%	1.2%	-2.1%	-1.8%
2015	4.8%	3.3%	1.0%	1.0%	-3.8%	-2.2%
2016	4.7%	3.6%	3.7%	1.4%	-1.0%	-2.2%
2017	4.0%	3.8%	2.5%	1.4%	-1.6%	-2.4%
2018	4.0%	4.3%	3.5%	2.5%	-0.5%	-1.8%
2019	3.5%	4.2%	3.5%	2.8%	0.0%	-1.4%
2020	3.7%	4.0%	3.4%	3.3%	-0.3%	-0.7%
2021	3.6%	3.8%	5.0%	3.6%	1.4%	-0.2%
2022	3.6%	3.7%	4.7%	4.0%	1.1%	0.3%
2023	3.5%	3.6%	4.8%	4.3%	1.3%	0.7%

Source: Author's analysis.

Notes: Medicare spending for 2011 and beyond is projected, assuming that the sustainable growth rate is overridden and physician fees are frozen at their 2012 levels.

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