



The Concord Coalition Series On  
**Health Care & Medicare**

---

Issue #2

By David Koitz

May 21, 2009

---

**The Long-Range Forecasts for Health Care Costs:  
Ominous and Maybe Even Optimistic**

*The financial condition of the Social Security and Medicare programs remains problematic. Projected long run program costs are not sustainable under current financing arrangements. Social Security's current annual surpluses of tax income over expenditures will begin to decline in 2011 and then turn into rapidly growing deficits as the baby boom generation retires. Medicare's financial status is even worse.*

If this sounds pretty ominous, it is. But it is not some right wing scare tactic. It is actually the opening lines from the 2008 annual report from the Board of Trustees of the Social Security and Medicare programs.<sup>1</sup> Yes, those trustees were all political appointees of the Bush Administration. But the conclusions they drew were not exclusively their's. Similar warnings emerged in the Clinton period. And the first trustees report from the Obama Administration, issued on May 12, 2009, shows that the situation has only gotten worse. Nor are the numbers exclusively those of the executive branch. Congress's budget arm, the Congressional Budget Office (CBO), has periodically issued similar warnings, again under the tenure of both Democratic and Republican agency heads. Most telling is that adverse trustees' forecasts about Medicare's financial condition transcend the Administrations of the past seven Presidents with nearly all projecting the program becoming "insolvent" within 25 years of the forecast. Most were only temporarily forestalled by incremental measures passed by Congress. Under the latest trustees' forecast, Medicare will again become insolvent<sup>2</sup>—by 2017—with the prospect of running a cumulative cash deficit of \$3.1 trillion over the next ten years.<sup>3</sup>

---

<sup>1</sup> Centers for Medicare and Medicaid Services, "The 2008 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," March 25, 2008.

<sup>2</sup> As used here, "insolvency" means the point at which the Medicare Hospital Insurance (HI) trust fund no longer has a balance of securities posted to it, and consequently the program would no longer be able to fully cover its benefit commitments. Technically, insolvency is projected only for the HI portion of the program, but operationally, all other parts of Medicare would be disrupted by suspension or curtailment of HI reimbursements.

<sup>3</sup> Centers for Medicare and Medicaid Services, "The 2009 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," May 12, 2009. The term "cash deficits" refers to the amounts by which program expenditures exceed Medicare taxes and premiums received by the Treasury.

The Administration’s trustees and Congress’ budget analysts are the two most prominent bodies making projections of health care costs. By law, the Medicare trustees, aided by the Office of the Actuary of the Centers for Medicare and Medicaid Services (CMMS) must make annual evaluations of the financial status of Medicare.<sup>4</sup> That office also makes 10-year projections of overall national health care expenditures. CBO makes similar short- and long-range projections.

While neither body has any prescient insights about the future, they base their outlooks on careful examinations of past and current health care trends. That said, the limitations in making long-range forecasts are enormous. As with caveats found in any investment prospectus, past performance is no guarantee of future results. Nonetheless, the rise of health care costs over the past half century is striking and to ignore the path they’ve taken up to this point would be foolhardy.

**Past Trends—The Baseline For Future Forecasts**

For decades the cost of health care has persistently exceeded the nation’s general rate of inflation as well as the growth of the economy. As a result, the aggregate amount the nation spends on health care has become an increasingly larger share of what it produces and spends, i.e., its gross domestic product, or GDP. The first table on the next page shows the rise in health care costs per person in the population, or what is

commonly referred to as “per capita.” For instance, in 2008 spending on health was \$7,804 on average per capita. The table compares this figure to the rate of inflation and the per capita growth of the economy (GDP). As it shows, health care costs have consistently outstripped inflation and the rise in per capita GDP. In the aggregate, national health expenditures, totaling nearly \$2.4 trillion in 2008, have grown from 5.2 percent of GDP in 1960 to 16.6 percent in 2008.

Because health care spending has risen so much faster than the economy, economists have come to express the rise in health care costs in terms of how much it exceeds the growth in GDP. They adjust those costs for population growth, and the changing age makeup of the population (older people consume more health care than younger people),

<b>The Growth of National Health Expenditures</b>			
	National health expenditures	GDP	National health expenditures as percent of GDP
	\$s in billions		
1960	27.5	526	5.2%
1970	74.9	1,039	7.2%
1980	253.4	2,790	9.1%
1990	714.0	5,803	12.3%
2000	1,353.6	9,817	13.8%
2007	2,241.2	13,808	16.2%
2008 (estimated)	2,378.6	14,291	16.6%
Source: Centers for Medicare and Medicaid Services, National Health Expenditures, historical series and projection series for 2008-2018.			

<sup>4</sup> Social Security ones are made by a similar body in SSA.

<b>The Rapid Rise in Per Capita Health Care Spending</b>				
Year	Per Capita Health Care Spending	Increase in Per Capita Health Care Spending	General Inflation	Increase in Per Capita GDP
		(Increase over prior decade, in percent) <sup>a</sup>		
1970	\$356	141%	33%	74%
1980	\$1,100	209%	96%	142%
1990	\$2,813	156%	51%	89%
2000	\$4,790	70%	23%	50%
2007	\$7,421	55%	20%	32%

Source: Centers for Medicare and Medicaid Services, National Health Expenditures, historical series, and the 2008 Economic Report of the President, February 2008.  
a. 2007 figures represent increase over prior 6-year period.

and then express them as a “per capita” cost of health care. The amount by which they have exceeded the per capita growth of GDP has been labeled “excess cost growth.”<sup>5</sup>

Analysis done by CBO shows that from 1975 through 2005 health care costs grew in a range of 1.5 to 2.6 percentage points faster than the economy (see the following table). While those numbers are seemingly small, with the per capita growth of the economy rising annually by less than 6 percent for two-thirds of the 1975 to 2005 period, a 1.5 to 2.6 percentage point larger growth rate for health care is significant. From 1990 through 2005, for instance, the economy grew at an average rate of 3.8 percent per capita. CBO’s analysis suggests that the growth in health care costs exceeded that by 1.5 percentage points. That translates into health care costs growing at a rate 39 percent faster than the economy.

As the table shows, the rates of excess cost growth were even larger for the government’s two largest health care programs, Medicare and Medicaid. For Medicare, the excess averaged 2.9 percentage points in the 1975-1990 period, and 1.8 percentage points in the 1990-2005 period. For Medicaid the figures were 2.9 and 1.3 percentage points respectively.

Whether looking at CBO’s excess cost growth for health care in the aggregate, or separately for Medicare or Medicaid, one observable trend is that the rate of excess cost growth in the more recent 15-year period was less than that of the preceding 15 years. For overall health care, for instance, the excess averaged 1.5 percentage points in the 1990-2005 period, whereas it averaged 2.6 percentage points in the 1975-1990 period. At

<sup>5</sup> As CBO describes it: “When analyzing historical trends in the growth of health care spending, it is useful to disaggregate the various components. Factors that affect spending on health care include general inflation; growth in the size of the population; and, to a lesser extent, changes in the age distribution of the population. Removing their effects reveals the amount of spending growth that is attributable to factors beyond inflation and demographics.” The term “excess cost growth” refers to “the extent to which growth in per capita spending on health care exceeds the growth in per capita GDP... (The phrase is not intended to imply that growth in per capita spending on health care is necessarily excessive. It simply measures that growth relative to the growth of the economy.) If per capita health care spending grows faster than per capita GDP, the share of the economy devoted to health care will rise.” See CBO, “The Long Term Budget Outlook,” December 2007.

first glance one might conclude that there was a let up in the rapid growth of health care costs. However, one obvious difference may be found in the slower rate that the economy grew in the later period. From 1990 to 2005, the economy’s per capita growth rate averaged 3.8 percent annually. In contrast, in the 1975-1990 period, it averaged 7.7 percent. The excess growth in health care costs in the earlier period of 2.6 percentage points represents 34 percent faster growth than the economy. When one compares the 1.5 percentage points excess growth rate for health care costs in the later period to the economy’s 3.8 percentage point growth rate, it shows health care costs grew at a 39 percent faster rate—seemingly little different than that of the earlier period. In effect, while the more recent period might have experienced smaller annual increases in health care costs, the spread between the rise in health care costs and that of the economy overall did not really change.

<b>Excess Cost Growth Per Capita in Total Health Care Spending, Medicare, Medicaid, and All Other Categories</b>				
Period	Total	Medicare	Medicaid <sup>a</sup>	All Other
(Percentage Points above GDP Growth Rate)				
1975 to 1990	2.6	2.9	2.9	2.4
1990 to 2005	1.5	1.8	1.3	1.4
1975 to 2005	2.1	2.4	2.2	2.0
Source: Congressional Budget Office. “The Long Term Outlook for Health Care Spending,” November, 2007.				
Note: Excess cost growth refers to the number of percentage points by which the growth of spending on Medicare, Medicaid, or health care generally (per enrollee or per capita) exceeded the growth of nominal gross domestic product (per capita). Figures are annual averages.				
a. For Medicaid, data are available through 2004.				

In a November 2007 paper, CBO takes a perspective more focused on health care factors in attempting to explain the smaller excess cost rate of the later period. The paper states—

*The slower growth in overall spending during the 1990s... may have reflected one-time changes (for instance, the spread of managed care) rather than a change in the underlying trend. In addition, rates of excess cost growth in Medicare and Medicaid are partly driven by changes in law and policy. Changes have included expansions of the programs as well as efforts to limit cost growth. Most notably, in 1983, Medicare introduced a prospective payment system, under which hospitals are paid a predetermined rate for each admission. The system reduced costs. Whether such changes will ultimately constitute one-time shifts or more permanent changes in cost growth rates is uncertain. As with other spending on health care, the rates of real per capita cost growth and excess cost growth for Medicare and Medicaid were lower from 1990 to 2005 than they were in the preceding 15 years. Because it is unclear whether the experience from the 1990s represented a one-time shift in the*

*level of costs or a change in the underlying trend and because the entire 30-year period was marked by substantial year-to-year volatility without any apparent trend, CBO uses the average from 1975 onward as the starting point for the projections of the future.*<sup>6</sup>

In its most recent long-term budget projections, CBO describes the main factors affecting the rise in health care costs this way—

*Most analysts agree that the most important factor contributing to the growth in health care spending in recent decades has been the emergence, adoption, and widespread diffusion of new medical technologies and services. Major advances in medical science allow providers to diagnose and treat illnesses in ways that were previously impossible. Many of those innovations rely on costly new drugs, equipment, and skills. Other innovations are relatively inexpensive, but their costs add up quickly as growing numbers of patients make use of them. Although technological innovation can sometimes reduce spending, in medicine such advances and the resulting changes in clinical practice have generally increased it.*

*Other factors that have contributed to the growth of health care spending include increases in personal income and the growth of insurance coverage. Demand for medical care tends to rise as real (inflation-adjusted) family income increases. Moreover, the growth of insurance coverage in recent decades, as evidenced by the substantial reduction in the percentage of health care spending that is paid out of pocket, has also increased the demand for medical care, because coverage reduces the cost of care for consumers. However, according to the best available evidence, increasing income and insurance coverage cannot explain much of the growth in health care spending in recent decades.*

*Another source of spending growth has been the aging of the population. Among adults, average medical spending generally increases with age, so as the population becomes older, health care spending per capita rises. However, over the past three decades, the effect of aging on health care spending has been relatively modest.*<sup>7</sup>

## **Medicare and Medicaid: Their Expanding Presence In the Nation's Health Care System**

In the following two tables, showing changes in how health care has been financed, it becomes readily apparent how significant the roles that Medicare and Medicaid have been in the growth of health care spending. Medicare and Medicaid do not own or operate hospitals or health facilities and do not employ doctors. Instead, they pay health

---

<sup>6</sup> CBO, "The Long Term Outlook for Health Care Spending," November, 2007.

<sup>7</sup> CBO, "The Long Term Budget Outlook," December 2007.

care providers across the nation to furnish services to eligible participants. They are intertwined with the nation's system of medical care in that much of their fee and payment schedules are derived and driven by what doctors and hospitals charge for health care services. Hence, they contribute to and are affected by the overall trends in the cost of health care services.

<b>The Growth of Medicare and Medicaid Expenditures, 1970-2007</b>					
Year	Medicare	Medicaid	Medicare & Medicaid Combined	Aggregate Expenditures for Medical Care	Medicare and Medicaid as Share of Aggregate Expenditures for Medical Care
\$s in billions					
1970	7.3	5.0	12.3	62.9	19.6%
1980	36.1	24.7	60.8	214.8	28.3%
1990	106.6	69.7	176.3	607.5	29.0%
2000	215.9	187.0	402.9	1,139.6	35.4%
2007	409.6	303.9	713.5	1,878.3	38.0%
Source: Centers for Medicare and Medicaid Services, National Health Expenditures, 2007					
Note: Figures represent spending for medical care directly (which is labeled as personal health care spending in national health care tabulations); they exclude various items captured in national health care expenditure tables such as certain administrative costs.					

<b>How Paying for National Health Expenditures Has Changed, 1960-2007</b>							
Year	Total	Share of Payments From:					
	NHE	Medicare	Medicaid	Private Insurers	Out of Pocket	Other Government	Other Private
1960		-0-	-0-	21.5%	46.9%	24.4%	7.3%
1970	100%	10.3%	6.9%	20.7%	33.2%	20.3%	8.5%
1980	100%	14.7%	10.3%	27.2%	22.9%	17.1%	7.9%
1990	100%	15.3%	10.3%	32.7%	19.1%	14.5%	8.1%
2000	100%	16.6%	14.8%	33.6%	14.3%	12.7%	8.1%
2007	100%	19.2%	14.7%	34.6%	12.0%	12.3%	7.2%
Share of GDP							
2008 (estimated)	16.6%	3.3%	2.5%	5.7%	1.9%	2.1%	1.2%
Source: Centers for Medicare and Medicaid Services, National Health Expenditures, historical series and projection series for 2008-2018.							

Where personal out-of-pocket spending accounted for nearly half of all national health expenditures in 1960, today third-party payments through Medicare, Medicaid, and private insurance finance nearly 70 percent. Out-of-pocket spending has fallen to 12 percent. In dollar terms, Medicare is the largest single payer. Its expenditures in 2008 of \$461 billion represented 15 percent of the total Federal budget and 3.3 percent of GDP. State-run Medicaid programs, financed jointly by the Federal and State governments, had

expenditures of \$361 billion, and as a group were the second largest source of funding. Together, Medicare and Medicaid expenditures now exceed the payouts for the total of all medical claims made to private insurers and account for \$2 out of every \$5 spent in the economy for medical care. For the nation’s health care providers, the two programs paid for half of the services furnished by non-Federal hospitals and \$3 out of every \$10 for services furnished by physicians.<sup>8</sup>

Many factors unrelated to privately funded medical care affect Medicare and Medicaid—notably public policy. However, in CBO’s examination of past trends, the agency attributes the principal growth to the same factors that have affected health care prices generally—

*Between 1975 and 2005, federal Medicare spending rose from 1.0 percent to 2.7 percent of GDP. Spending has grown in part because of increased enrollment in the program (from 25 million in 1975 to 43 million this year). However, the main factor driving Medicare’s cost growth has been that costs per beneficiary—once the effects of demographic changes are removed—grew 2.4 percentage points faster than per capita GDP between 1975 and 2005. That "excess cost growth" in Medicare has been due primarily to the same factors that have led to increases in health care spending in the nation as a whole—most notably, greater use of new medical technologies (in part because neither doctors nor patients have strong incentives to control costs). Legislative and administrative changes have also contributed to the growth in Medicare’s costs per enrollee...*

*Federal spending for Medicaid rose from 0.3 percent to 1.4 percent of GDP. Increased enrollment in the program and growth in the costs per beneficiary were the principal factors in that rise. Excess cost growth in Medicaid averaged 2.2 percentage points over the 1975–2004 period.*

### What Do The Projections Show?

<b>CMMS’s Projected Growth of National Health Expenditures, 2007-2018</b>				
2007	2008	2010	2015	2018
\$s in trillions				
\$2.2	\$2.4	\$2.6	\$3.5	\$4.4
Share of GDP				
16.2%	16.6%	17.1%	18.9%	20.3%
Source: Centers for Medicare and Medicaid Services, National Health Expenditures, historical series and projection series for 2008 and 2018.				

National health expenditure projections made by the Office of the Actuary of CMMS are issued periodically and have traditionally covered a 10-year future period. The last set

<sup>8</sup> CBO, 2009 Budget Update, and Centers for Medicare and Medicaid Services, National Health Expenditures, historical series and projection series for 2008-2018).

issued projects national health care spending doubling by 2018, rising from \$2.2 trillion in 2007 to \$4.4 trillion in 2018, with its share of GDP rising from 16.2 percent in 2007 to 20.3 percent in 2018. Through 2018, per capita growth is expected to outpace that of GDP by an annual average rate of 2.1 percentage points. And with pressure on Medicare spending arising from the retirement of the aging baby boom generation, the share of national health expenditures financed by the public sector will rise from 46 percent in 2008 to 52 percent in 2018.

In a report issued in November 2007, CBO made a number of longer-range projections extending out for a 75-year period. Its primary set shows national health spending rising from 15.5 percent of GDP in 2007 to 20.2 percent in 2017, not much different than the CMMS forecast. However, under the assumptions shown below, that share would double by 2035, to 31 percent of GDP. Thereafter, national health expenditures would continue to account for a steadily growing share of GDP, reaching 41 percent by 2060 and 49 percent by 2082, the end of the 75-year projection period.

<b>CBO's Long-Term Projections of National Health Expenditures, 2007-2082</b>					
	2007	2017	2035	2060	2082
	Share of GDP				
National Health Expenditures	15.5%	20.2%	30.7%	40.8%	48.9%
Medicare	2.7%	3.5%	6.5%	10.6%	14.8%
Medicaid	1.4%	2.0%	2.7%	3.3%	3.7%
All Other Spending on Health Care	11.4%	14.7%	21.5%	26.9%	30.4%
CBO, "The Long Term Outlook for Health Care Spending," November, 2007.					

CBO's projections assume that the average rate of excess cost growth of the past 30 years would continue through 2018, followed by a gradual slowing thereafter. The following table shows the underlying assumptions.

<b>CBO's Assumptions About Excess Cost Growth Over the Long Term</b>			
	2007 through 2018 (Historical Average)	Average Rate, 2018-2082	Rate in 2082
	(Percentage points above GDP Growth Rate)		
Medicare	2.4	1.7	1.1
Medicaid	2.2	0.9	0.2
All Other Spending on Health Care	2.0	0.6	0.1
CBO, "The Long Term Outlook for Health Care Spending," November, 2007.			
Note: Excess cost growth refers to the number of percentage points by which the growth of spending on Medicare, Medicaid, or health care generally (per beneficiary or per capita) is assumed to exceed the growth of nominal gross domestic product (per capita).			

As the table shows, there are fairly large differences in the assumed excess cost rates between Medicare, Medicaid, and the all-other category (mostly private) in the extended period of the projections. CBO explains—

*It may be difficult to envision how per capita Medicare and Medicaid spending could continue to grow more rapidly than other health care spending over such a long period, but changes in federal law are probably necessary to avoid that outcome. Furthermore, actions to reduce spending growth in the private sector could attenuate the incentives for the development and diffusion of new medical technologies for nonelderly people while having little effect on new technologies focused on diseases principally affecting the elderly.*

*That aspect of the projections may appear unrealistic, but it highlights the core problem—the unsustainability of current federal law. (The inherent tension in making long-term projections for a federal health care system that cannot be sustained in its current form must manifest itself in some way.) In reality, it is likely that changes in federal law as well as in practices in the private sector will slow the growth of health care spending such that growth in per capita Medicare and Medicaid spending does not diverge greatly from other spending on health care.*

### **Why No Action Has Been Taken**

Those long-range forecasts are no secret on Capitol Hill. Failure at the political level to alter the path we are on has little to do with lack of information, or even lack of consensus as to the magnitude of the problem. It has much to do with the reluctance of politicians to be the bearers of bad news.

Saying we can't afford what we've enacted does little to muster public support at the polls. If there is no immediate crisis, there is nothing for the public to feel — little to show that what lies ahead will have painful consequences for the economy, the budget, and families. It's too easy to say that projections are just projections; that no one really knows how reliable they are; that we can grow our way out of it; or that the projections are so distant into the future that it's not worth fretting about what may not happen. It's simply too easy to say it won't. As the argument goes: "If economists can't predict a recession a year away, how much faith can one place in 50-year prognostications?"

Then there is the political dimension. For partisan advantage it's too easy to accuse one side or the other of "slashing benefits" or "imposing huge tax increases." Entitlements have a way of sticking. The public becomes accustomed to them, and to suggest they are unaffordable is hard to defend against those who accuse the messenger of wanting to "destroy" Medicare and Medicaid. There's certainly no public outcry for slimmer entitlements, or for lower health care spending in general. Saying we need to consume less is a tough message for a politician to run on. It's too easy for opponents to say that retrenchment will hurt people; and there is not enough public understanding or acceptance of the circumstances that lie ahead.

## Consequences

The fact is that the political dynamic is as unsustainable as the numbers. If the current policy-making gridlock holds firm and the dire circumstances now foreseen do come about, there will be no “do-over” and no room for gradual moderation of the embedded entitlement promises. As with the current slide in economic conditions, when the status quo disintegrates, it happens fast. When the hammer comes down in the future, it will be because we can no longer borrow more from the world (and ourselves). It will likely mean vast benefit cuts, massive tax hikes, suffocating interest on our national debt... basically a stagnant or degenerating economy. It begs the question: how much longer can lawmakers stick their heads in the sand?

The one thing one can say with some certainty about long-range projections is that they will be wrong, but the likelihood that they will improve on their own such that health care costs no longer pose a serious threat to the economic wellbeing of retired baby boomers and the future generations of workers who would bear the burden of carrying them seems highly remote. In theory, the emergence of new less expensive treatments and potential efficiencies stemming from expansion of information technologies could produce significant cost savings, but the track record of past such improvements suggests other factors produce greater net costs. One series of long-range projections made by CBO shows that if the rates of excess cost growth of the past 30 years were to continue indefinitely, by 2052, half the economy would be devoted to health care. By 2075, the figure rises to 85 percent. It is hard to imagine how the economy, never mind health care alone, could ever absorb such increases. However, it was not CBO’s intent to pose it as a likely or credible path. It is clearly unrealistic, but it does provide a sense of the corrosive effects on the economy if health care costs are not reined in.

In CBO’s long-range baseline projection, health care expenditures absorb 37 percent of the economy by 2050 and 46 percent by 2075. The trustees only make projections for Medicare and they have the excess cost rate dropping somewhat sooner than CBO and eventually being eliminated. Where CBO has Medicare’s share of GDP reaching 15.5 percent of GDP by 2075, the trustees have it reaching 10.9 percent.

The notion that moderation of health care costs is inevitable is in fact what CBO and the trustees reflect in their primary forecasts. Both assume a decline in excess cost growth as a means of bringing a sense of reality to their numbers. They have no unique insights on the policy changes that will be taken to accomplish this, but the assumption in both cases is that lawmakers and economic forces in the health care industry will eventually slow the rate of health care cost increases. For President Obama and Congress, the ominous point in this assumption is that they will have to come up with substantial savings just to meet a baseline projection that is already unsustainable. If they want to add coverage, as is the current goal, they will have to find even more savings or come up with a means of paying for it.

Belaboring the varying dimensions of 75-year projections is an academic exercise. All are quite daunting. Even if the “excess cost growth” of health care were eliminated

immediately, the cost of health care would still comprise a growing share of the economy. Under such a scenario, CBO projects that Medicare's and Medicaid's share of GDP could grow by 26 percent by 2025 (from 5.4 percent this year to 6.8 percent then), driven by the rapid aging of society as the baby boomers enter their senior years. It should be clear, therefore, that the economic and fiscal strains of growing health care costs will confront us soon—in the next decade or two—not 50 or 75 years from now. All that the longer-range numbers do is extend what shows up in the earlier years.

To debate what could happen under variations of a 50- or 75-year series of numbers actually distracts from the more crucial point that what is nearly upon us matters most, and there is little to suggest that the upward spiral in health care costs over the past half-century will abate on its own. It will likely take far-reaching policy changes by governments at all levels to alter that course. And that, in turn, is unlikely to come about without the active involvement of the American people. Politicians must be willing to lead rather than pander, and their constituents must be willing to listen even if the message is not all about higher benefits and lower taxes. If the current economic downturn, the longest since WWII, has taught us anything, it is that debt-financed “good times” can't last forever.

The youngest of the 78 million baby boomers are 44; the oldest are 63. In two decades those still living will all be age 65 or older. A true paradox would be that the rising demand for health care from an aging baby boom generation would somehow reverse the trend of out-of-control health care prices. Think of that. What odds do you think Vegas would give it?