

ACA Implementation—Monitoring and Tracking

What Drove the Recent Slowdown in Health Spending Growth and Can It Continue?

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INTRODUCTION

The latest estimates of national health spending are generating considerable buzz with the finding that the growth in health spending has remained slow for a third straight year. According to the Centers for Medicare and Medicaid Services, health spending grew at a record low rate of 3.9 percent in 2011.¹ The news was even more striking when combined with the fact that the economy grew at a rate of 4.0 percent. Health spending grew at 3.9 percent in both 2009 and 2010, but economic growth was negative in 2009 (-2.2 percent) as a result of the recession and had recovered to 3.8 percent in 2010. Thus, while the slow rate of growth was attributed to the recession in 2009 and to a sluggish recovery in 2010, the most recent estimates have many analysts wondering if the slowdown in health spending growth is here to stay. In fact, the typically cautious Congressional Budget Office lowered its Medicare and Medicaid forecasts in February 2013 to reflect the latest spending trends.²

In this paper, we review the trends in health spending growth over the last decade and show that growth began to slow well before the most recent recession. We discuss commonly cited drivers of the slowdown in spending growth—some argue that cyclical economic factors have been the primary cause, while others point to more fundamental structural changes to the health system. We conclude by suggesting that the slowdown in health spending over the last decade was likely driven by a variety of changes occurring in response to a decade of declines in real incomes and the shifting distribution of health insurance coverage. The implications for future spending growth will depend on whether the changes that slowed health spending growth over the last decade will be maintained or extended as the economy recovers and the Affordable Care Act expands health insurance coverage.

TRENDS IN HEALTH SPENDING GROWTH, 2000–11

Figure 1 displays the annual growth in nominal health consumption expenditures and gross domestic product from 2000 to 2011 using data from the Centers for Medicare and Medicaid Services.³ As noted, growth in health spending slowed considerably during the recent recession, falling from 6.0 percent in 2007, to 3.9 percent in 2011. But spending growth was already falling prior to the recession's start in 2007. Spending growth peaked at 9.5 percent in 2002, and declined to 7.1 percent in 2004. From 2004 to 2007, modest declines in the rate of health spending growth continued leading up to the recession.

Table 1 presents the trends in private health insurance, Medicare, Medicaid, and out-of-pocket (OOP) spending and enrollment from 2000 to 2011. The trend in private spending growth generally mirrors the trend in national health spending with a peak in 2002, and a decline through 2009. Slight increases in spending growth occurred in 2010 and 2011. Some of the decline in private spending growth reflects a drop in private coverage. Thus, the slowdown in private per-enrollee spending is less pronounced than that in total spending.

With the exception of a spike in spending growth due to the addition of Medicare Part D drug coverage in 2006, Medicare spending growth generally declined from 2004 through 2010. Moreover, growth in Medicare enrollment skewed towards a younger, lower-cost population has contributed to a decline in Medicare per-enrollee spending growth that is even more pronounced than the trend in overall spending.

Medicaid spending growth also slowed down during much of the last decade, with the large drop in 2006 due to a shift in dual eligible drug spending to Medicare. While Medicaid spending grew at a rate of 8.8 percent at the peak of the recession in 2009, much of this was due to recession related increases in enrollment. Per-enrollee Medicaid spending growth continued to decline because of faster growth among lower-cost enrollees and state implementation of a variety of cost-containment policies.

Finally, a slowdown in OOP spending growth appears to have occurred beginning in 2003, although the pattern is somewhat less consistent than for the other sources of payment. OOP spending growth was particularly low during the recession, but has been rising in the last two years.

DRIVERS OF THE SLOWDOWN IN SPENDING

Analysis and commentary surrounding the national health spending estimates have suggested some potential drivers of the slowdown in spending growth. Slower growth in private spending has been attributed, in part, to a shift towards higher deductibles and tiered networks.⁴ A variety of payment policies for imaging, home health, durable medical equipment and Medicare Advantage have contributed to slower Medicare spending growth.⁵ State Medicaid programs have also tightened payment policies, expanded managed care, and increased community-based long-term care alternatives under intense budgetary pressures.⁶ Moreover, slower growth in prescription drug spending has affected all payers due to the development of fewer blockbuster drugs, the adoption of tiered formularies, and increased substitution of generics for brand-name drugs.⁷

There is also a general consensus that the more dramatic slowdown in spending growth at the end of the decade was due to the recent recession.⁸ An analysis by the Kaiser Family Foundation and the Altarum Institute, for example, attributes 77 percent of the recent decline in health spending growth to the economy.⁹ Rising unemployment rates and corresponding declines in employer-sponsored insurance coverage have caused individuals to cut back on use of health care services.¹⁰ Extreme budgetary constraints have forced state Medicaid programs to aggressively contain costs. Under financial pressure from slow revenue growth, hospitals have slowed the growth in their expenses to maintain operating margins.¹¹

But, the pre-recession slowdown in health spending and low growth rates since the end of the recession in 2009 have led to considerable speculation that more fundamental structural changes in the health care market

have contributed to the spending trends.¹² Some contend that a shift toward salaried employment of physicians may be altering the practice patterns that developed under a fee-for-service system.¹³ Others have pointed to new models of care delivery and payment, including patient-centered medical homes and accountable care organizations (ACOs) as potential contributors to the slowdown in cost growth.¹⁴ Finally, some have suggested that the ACA has already started to have a moderating effect on spending growth.¹⁵

Little concrete evidence exists, however, to support the argument that such structural changes have been major drivers of recent spending trends. For example, while salaried employment of physicians may promote efficiency gains, some fear that increased market power could lead to higher prices and costs.¹⁶ And although medical homes and ACOs may ultimately contribute to slower cost growth, it is not likely that these models had sufficient market penetration to do so in the early part of the last decade. Similarly, the ACA includes a number of important cost-containment provisions, but none are likely to have had meaningful effects on spending growth in 2010 or 2011.

Thus, although the pre-recession spending slowdown may have been a spontaneous response to consistent growth in health care costs that exceeded the growth in incomes, we suggest that a decade-long slowdown in economic activity was a major contributor. Specifically, we propose that declines in real incomes and a shift towards less generous insurance arrangements have slowed the growth in provider revenues and forced cost-containment efforts. Some of the more recent payment and delivery system reforms may help to sustain this slow growth, but this remains to be seen.

ECONOMIC CHANGE AND SLOWING HEALTH CARE COSTS

After a period of very strong economic growth in the late 1990s, the US economy entered a decade of very slow economic growth in 2000. The unemployment rate was 4.0 percent in 2000, but grew to 6.0 percent in 2003 during the first recession of the decade (Figure 2). There was a modest recovery in the next few years that lowered the unemployment rate to 4.6 percent in 2006. Beginning in 2007, the nation entered the Great Recession and unemployment surged, peaking in 2010 at 9.6 percent, and remaining high in 2011.

Figure 3 shows that declines in real incomes began in 2000, reflecting these periods of high unemployment. Real incomes never fully recovered at the peak of the economic recovery in the mid-2000s, and declined thereafter. As a result, real median household incomes are about 10 percent below their 2000 levels, and real per capita incomes about 5 percent below 2000 levels.

Examined somewhat differently, as shown in Figure 4, there was an increase in the non-elderly US population from 245.1 million in 2000, to 266.4 million in 2011. On net, all of this population increase was among those with incomes below 200 percent of the federal poverty level (FPL), a group that saw an increase from 80.6 million to 106.7 million people. Both middle- and high-income groups declined slightly. Several studies focused on previous time periods have established rising aggregate incomes as an important component in explaining the increase in health spending growth over time.¹⁷ Thus, it also seems likely that declining real incomes have contributed to the recent slowdown in health spending growth.

There have also been major changes in coverage over the last decade, again tied to the economy. As shown in Table 2, there has been a large decline in employer-sponsored insurance (ESI), from 70.5 percent in 2000, to 59.9 percent in 2011 for adults, and from 66.6 percent in 2000, to 54.9 percent in 2011 for children. Overall, 14.2 million fewer people had ESI in 2011 than in 2000, despite an increase of 21.3 million in the US population. This was due, in part, to rising health care costs placing financial pressure on businesses which were already facing slow or declining growth in revenue. But other changes contributed to a shift in the coverage distribution, including faster growth in migration to the South and West regions (19.3 million) than to the Northeast and Midwest (2.0 million), where the former regions have

much lower levels of ESI. Similarly, there was an increase in employment (20.2 million) in low-ESI industries such as agriculture, construction, and wholesale/retail trade, and a decline in employment (18.6 million) in high-ESI industries, such as finance and manufacturing.¹⁸

The decline in ESI led to an increase in Medicaid enrollment. There was an increase of 19.3 million individuals on Medicaid; in 2000, 8.4 percent of the non-elderly population was on Medicaid; by 2011, 15.0 percent were in the program. Similarly, the percentage of the population that was uninsured increased from 14.8 percent to 18.0 percent between 2000 and 2011, reflecting an increase of 11.7 million individuals. At the same time, there was an increase in the elderly population because of the aging of the baby boom generation. By 2010, the Medicare population was growing at about 2.4 percent per year (Table 1), with overall population growth of about 1 percent. Thus, the share of the population over age 65 and covered by Medicare has been slowly increasing.

These changes in coverage mean that there has been a movement from private insurance plans, which pay providers relatively well, to Medicaid and Medicare, which pay considerably less. For example, recent data show that private insurance pays hospitals and physicians about 30 percent and 20 percent, respectively, above Medicare.¹⁹ Medicaid payment rates are almost always lower than Medicare. In addition, there has been an increase in the uninsured population and the need for hospitals and physicians to provide uncompensated care. These coverage changes add to the pressure that income reductions place on the system.

Some evidence suggests that the real income declines and coverage changes described above did put pressure on provider revenues. Hospital operating revenue growth per adjusted admission was declining through much of the last decade. At the same time, however, hospital expenses also grew slowly, suggesting that providers have been able to cut costs in response to revenue constraints.²⁰ It is not clear, however, whether such cuts reflect efficiency gains or changes to services that could affect access to care. Physicians also saw a decline in earnings over this period, averaging \$167,478 from 2001 through 2005, and falling to \$157,751 from 2006 through 2010.²¹ This financial pressure may have led to additional cost-containment efforts.

CONCLUSION

A growing body of evidence indicates that the decline in health spending growth pre-dated the most recent recession, but there is little consensus on what caused the slower growth. Others have suggested, no doubt correctly, that a variety of changes, including Medicare payment policy, growth in patient cost-sharing, and state efforts to contain Medicaid costs, contributed to slower spending growth. We propose, however, that these were not simply spontaneous changes and, specifically, that declining real incomes and a shift from private to public coverage likely forced these and other policy changes. Provider responses to the resulting slower revenue growth then further contributed to the decline in health care spending growth. The question remains, however, whether the slower trend in health spending growth is sustainable. On this front, history is not encouraging. Health spending growth has rebounded after every major attempt at cost containment and this creates understandable skepticism that the most recent slowdown will be lasting.²²

While a number of delivery system changes, including salaried employment of physicians, patient-centered medical homes, and ACOs, are on the rise, their ability to extract cost-savings over time is unclear. There are concerns, for example, that provider consolidation accompanying the development of ACOs could exact higher prices from payers over time.²³ Moreover, if the cost-containment efforts by hospitals and physicians that occurred in the past decade were prompted by slow

economic growth and declines in insurance coverage, the motivation to contain costs may diminish as the economy recovers and coverage expands because of the ACA.

Current projections for the economic recovery are relatively modest, however. Real GDP is expected to grow only 3.4 percent in 2014 and at an annual rate of 3.6 percent from 2015 to 2018. The projections for 2019 to 2023 are even weaker at an expected annual rate of 2.2 percent.²⁴ Furthermore, while insurance coverage is expected to expand substantially under the ACA, those gaining coverage will largely be enrolled in Medicaid or subsidized exchange plans. Historically, state Medicaid programs have been relatively aggressive in their cost-containment efforts and the competition to enroll individuals whose subsidies are based on the second-lowest cost plan is expected to keep costs low in the exchange, as well.

A modest economic recovery and increasingly cost-conscious payers may therefore place continued pressure on providers to find ways to operate more efficiently and expand upon the changes to the delivery system over the past decade. The ACA is already tightening Medicare payments to hospitals and other providers. In addition, a collection of ACA demonstrations, including bundled payment mechanisms, value-based purchasing, and shared savings programs, are on the horizon. If these and other emerging reforms prove to be effective, then perhaps a return to the historically high rates of health spending growth will not materialize.

NOTES

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About the Authors and Acknowledgements

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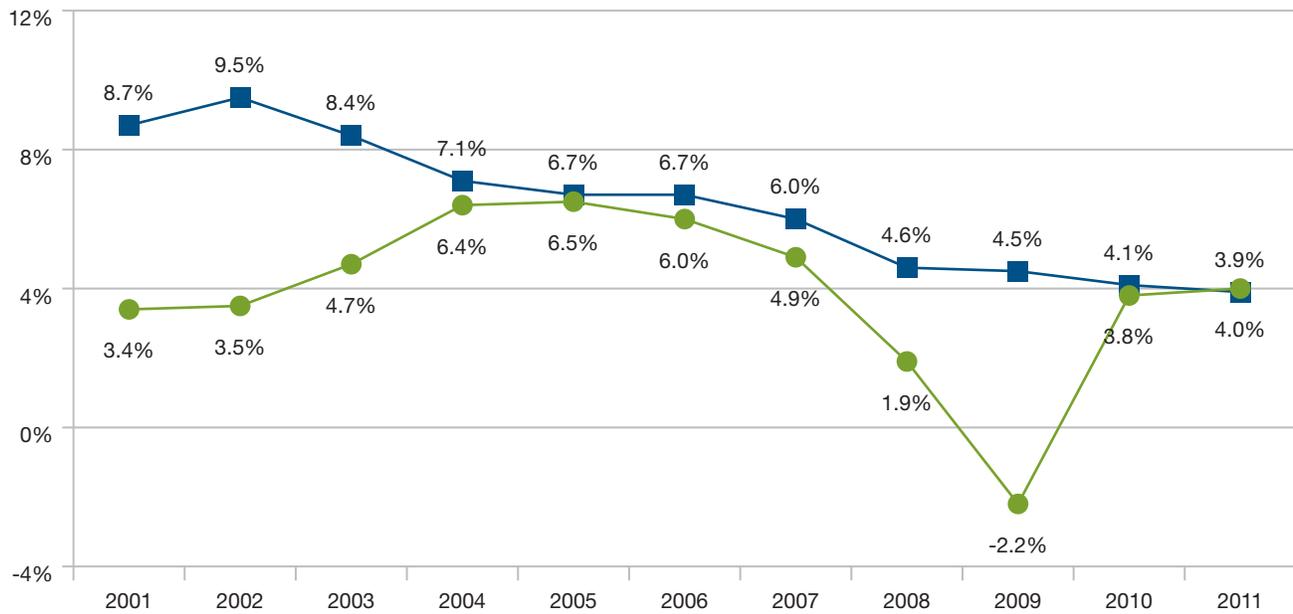
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FIGURE 1: Annual Percent Change in Health Spending and GDP, 2000–11

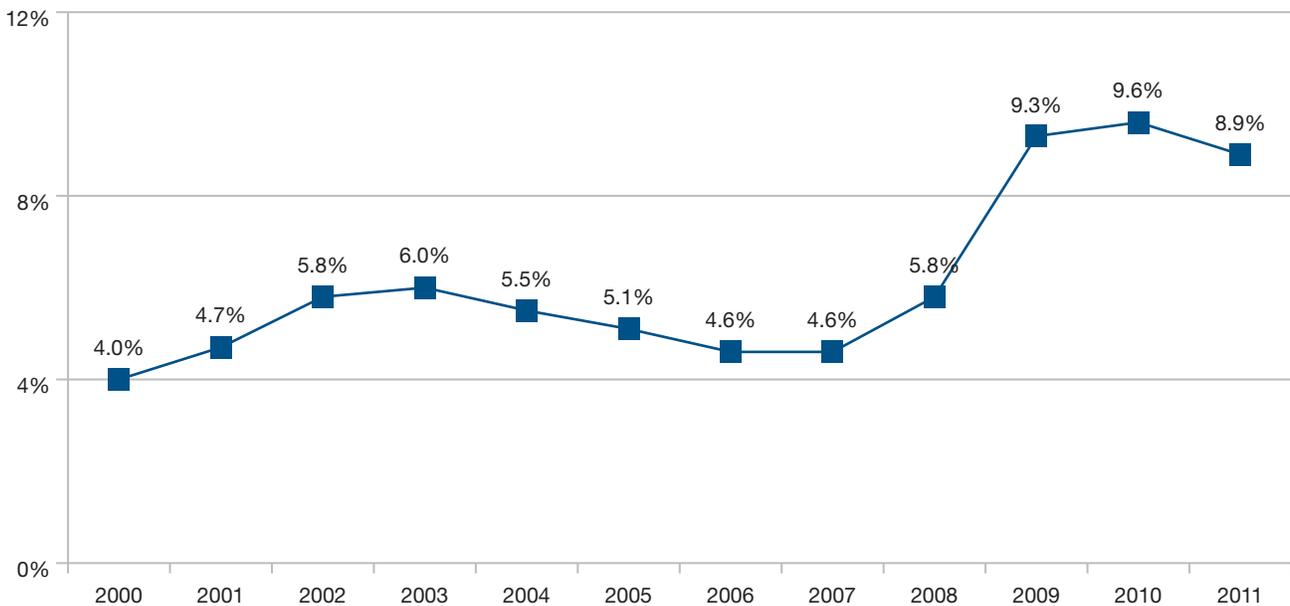


■ HEALTH CONSUMPTION EXPENDITURES ● GDP

SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

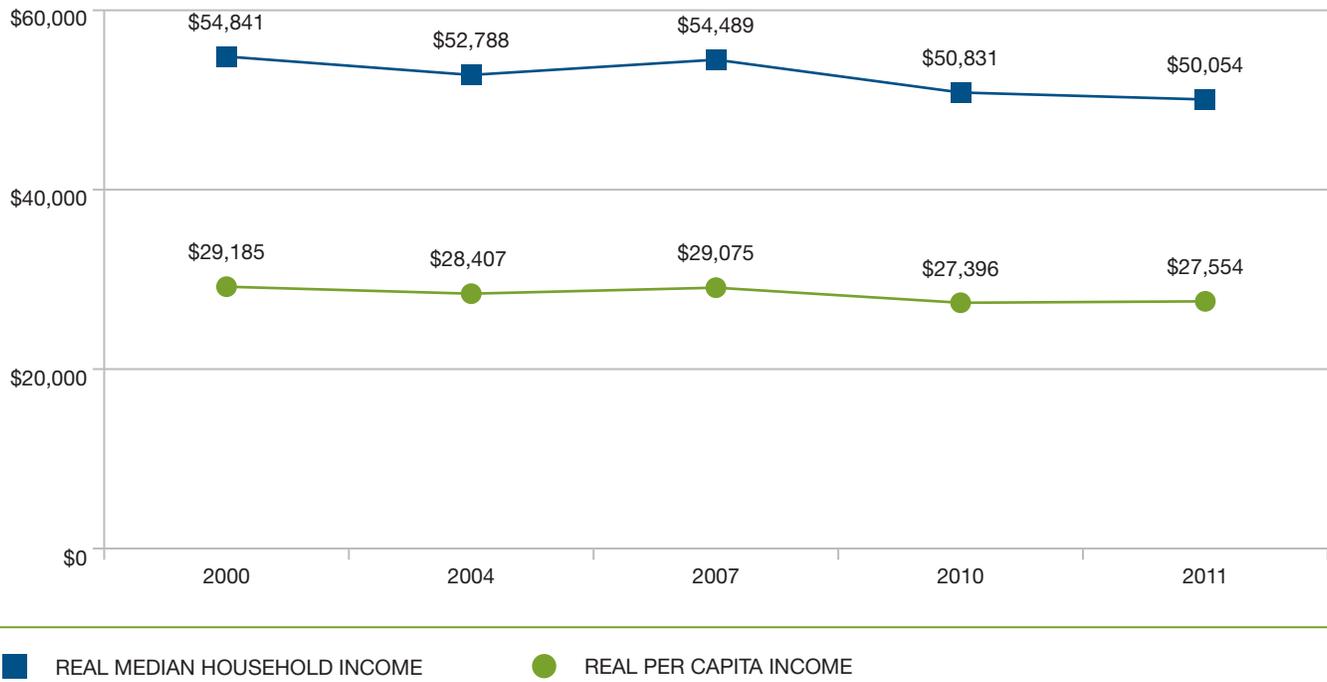
NOTE: Estimates of growth in spending and GDP are in nominal terms.

FIGURE 2: National Unemployment Rate, 2000–11



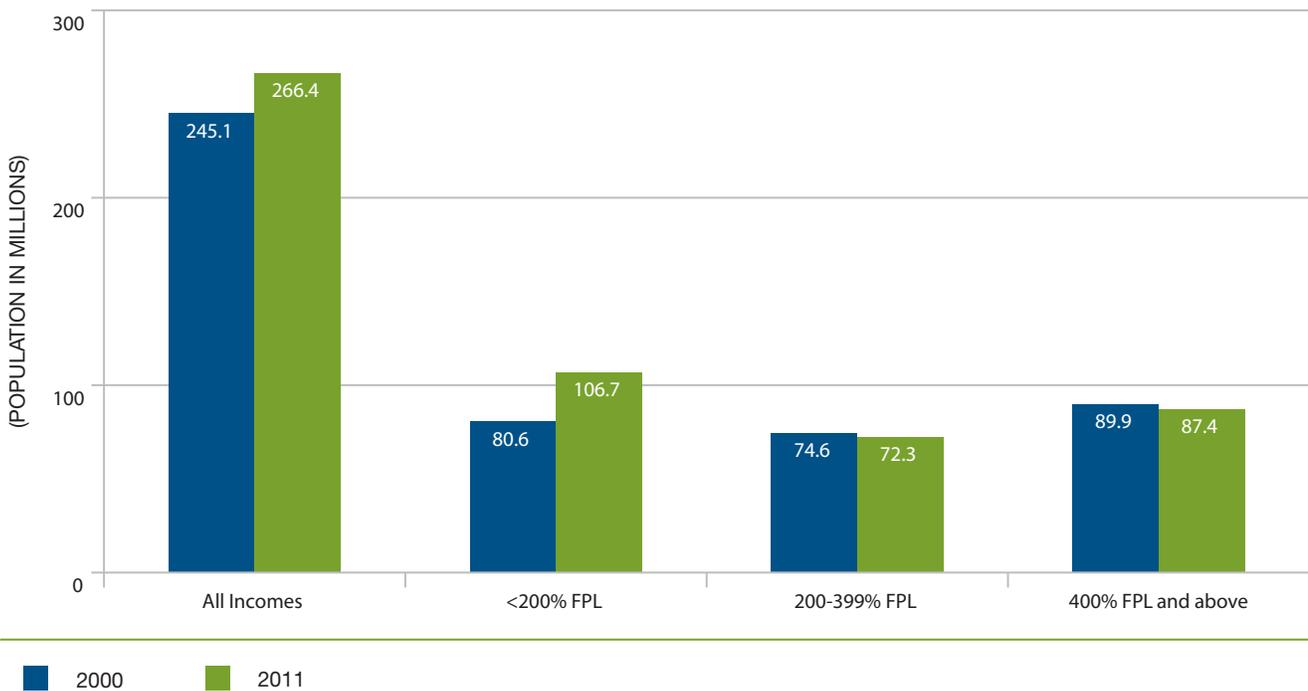
SOURCE: Bureau of Labor Statistics: Current Population Survey: Labor Force Statistics. U.S. Department of Labor.

FIGURE 3: Real Personal Income, 2000–11



SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.
 NOTE: Income in 2011 CPI-U-RS adjusted dollars.

FIGURE 4: Net Change in Population by Income, 2000–11



SOURCE: Urban Institute analysis of the 2001–12 ASEC Supplements to the Current Population Survey.
 NOTES: Family income is counted by health insurance unit, which includes members of the nuclear family who can be covered under one health insurance policy (policyholder, spouse, children under age nineteen, and full-time students under age twenty-three). This corresponds to the family unit used for determining eligibility for public coverage as well as for the purchase of private insurance. Excludes persons aged 65 and older, and those in the armed forces.

TABLE 1: Annual Percent Change in Spending and Enrollment, by Payer, 2000–11

| | Annual Percentage Change in Spending and Enrollment | | | | | | | | | | | Average Annual Growth Rate | | |
|--|---|-------|-------|-------|------|-------|------|-------|-------|-------|-------|----------------------------|---------|---------|
| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2000–11 | 2000–05 | 2006–11 |
| Private Health Insurance Spending | 9.4% | 11.7% | 9.7% | 7.3% | 6.6% | 5.3% | 5.0% | 3.9% | 3.2% | 3.4% | 3.8% | 6.3% | 8.9% | 3.9% |
| Private Health Insurance Enrollment | 0.1% | 0.2% | -0.9% | -0.6% | 0.5% | 0.3% | 0.3% | -0.8% | -3.2% | -1.8% | 0.5% | -0.5% | -0.2% | -1.0% |
| Per Enrollee Private Health Insurance Spending | 9.4% | 11.6% | 10.6% | 7.9% | 6.0% | 5.0% | 4.8% | 4.8% | 6.5% | 5.3% | 3.2% | 6.8% | 9.1% | 4.9% |
| Medicare Spending | 10.2% | 7.1% | 6.5% | 10.1% | 9.2% | 18.8% | 7.4% | 8.0% | 6.9% | 4.3% | 6.2% | 8.5% | 8.6% | 6.5% |
| Medicare Enrollment | 0.8% | 1.3% | 1.5% | 1.5% | 1.7% | 2.2% | 2.1% | 2.5% | 2.5% | 2.4% | 2.4% | 1.9% | 1.4% | 2.4% |
| Per Enrollee Medicare Spending | 9.3% | 5.8% | 4.9% | 8.5% | 7.4% | 16.3% | 5.2% | 5.3% | 4.3% | 1.8% | 3.7% | 6.5% | 7.2% | 4.1% |
| Medicaid/CHIP Spending | 12.2% | 11.1% | 8.6% | 8.2% | 6.4% | -0.6% | 6.4% | 5.9% | 8.8% | 5.9% | 2.5% | 6.8% | 9.3% | 5.9% |
| Medicaid/CHIP Enrollment | 9.6% | 10.8% | 6.5% | 3.4% | 2.9% | 0.0% | 0.6% | 3.4% | 7.1% | 4.8% | 3.2% | 4.7% | 6.6% | 3.8% |
| Per Enrollee Medicaid/CHIP Spending | 2.4% | 0.3% | 1.9% | 4.7% | 3.4% | -0.6% | 5.7% | 2.5% | 1.6% | 1.0% | -0.7% | 2.0% | 2.5% | 2.0% |
| Out-of-Pocket Spending | 3.6% | 6.2% | 6.5% | 5.1% | 5.8% | 3.3% | 5.3% | 2.4% | 0.1% | 2.1% | 2.8% | 3.9% | 5.4% | 2.5% |
| Population | 1.1% | 1.1% | 0.7% | 1.0% | 0.7% | 1.0% | 1.0% | 1.0% | 0.7% | 1.0% | 0.6% | 0.9% | 0.9% | 0.9% |
| Per Capita OOP Spending | 2.5% | 5.0% | 5.8% | 4.0% | 5.1% | 2.3% | 4.3% | 1.4% | -0.5% | 1.1% | 2.1% | 3.0% | 4.5% | 1.7% |

SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. Estimates of spending growth are in nominal terms.

NOTE: We calculate the average annual growth rate from 2000–05 and 2006–11 in order to remove the effects of the introduction of Medicare Part D from the overall trend.

TABLE 2: Health Insurance Coverage Distribution, by Age and Year, 2000–11

| Non-elderly (0–64) | | | | | | |
|--------------------------------|--------------|-------------|--------------|-------------|-------------------------|-------------------------|
| Coverage Type | 2000 | | 2011 | | 2000–11 | |
| | (Millions) | % | (Millions) | % | Percentage Point Change | Change in Millions |
| Coverage Type | 245.1 | 100% | 266.4 | 100% | | 21.3^a |
| Employer | 169.8 | 69.3% | 155.6 | 58.4% | -10.9%* | -14.2 ^a |
| Medicaid/CHIP | 20.7 | 8.4% | 40.0 | 15.0% | 6.6%* | 19.3 ^a |
| Medicare/TRICARE/Other Federal | 5.5 | 2.2% | 7.7 | 2.9% | 0.7%* | 2.2 ^a |
| Private Nongroup | 12.9 | 5.3% | 15.2 | 5.7% | 0.4%* | 2.3 ^a |
| Uninsured | 36.3 | 14.8% | 47.9 | 18.0% | 3.2%* | 11.7 ^a |
| Adults (19–64) | | | | | | |
| Coverage Type | 2000 | | 2011 | | 2000–11 | |
| | (Millions) | % | (Millions) | % | Percentage Point Change | Change in Millions |
| Coverage Type | 168.8 | 100% | 188.0 | 100% | | 19.2^a |
| Employer | 119.0 | 70.5% | 112.6 | 59.9% | -10.6%* | -6.4 ^a |
| Medicaid/CHIP | 8.0 | 4.8% | 16.5 | 8.8% | 4.0%* | 8.5 ^a |
| Medicare/TRICARE/Other Federal | 4.1 | 2.5% | 6.5 | 3.5% | 1.0%* | 2.4 ^a |
| Private Nongroup | 9.8 | 5.8% | 12.1 | 6.4% | 0.6%* | 2.3 ^a |
| Uninsured | 27.8 | 16.5% | 40.3 | 21.4% | 5.0%* | 12.5 ^a |
| Children (0–18) | | | | | | |
| Coverage Type | 2000 | | 2011 | | 2000–11 | |
| | (Millions) | % | (Millions) | % | Percentage Point Change | Change in Millions |
| Coverage Type | 76.3 | 100% | 78.4 | 100% | | 2.1^a |
| Employer | 50.8 | 66.6% | 43.0 | 54.9% | -11.7%* | -7.8 ^a |
| Medicaid/CHIP | 12.6 | 16.5% | 23.4 | 29.9% | 13.4%* | 10.8 ^a |
| Medicare/TRICARE/Other Federal | 1.3 | 1.7% | 1.1 | 1.4% | -0.3%* | -0.2 ^a |
| Private Nongroup | 3.1 | 4.0% | 3.1 | 4.0% | -0.1% | 0.0 |
| Uninsured | 8.5 | 11.1% | 7.6 | 9.7% | -1.4%* | -0.8 ^a |

SOURCE: Urban Institute analysis of the 2001 and 2012 ASEC Supplement to the Current Population Survey.

NOTE: Excludes persons aged 65 and older and those in the Armed Forces. * Indicates change in percent of people is statistically significant at the 5 percent level. "a" indicates change in numbers of people is statistically significant at the 5 percent level.