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National Health Spending In 2013: Growth Slows, Remains In Step With The Overall Economy

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ABSTRACT In 2013 US health care spending increased 3.6 percent to $2.9 trillion, or $9,255 per person. The share of gross domestic product devoted to health care spending has remained at 17.4 percent since 2009. Health care spending decelerated 0.5 percentage point in 2013, compared to 2012, as a result of slower growth in private health insurance and Medicare spending. Slower growth in spending for hospital care, investments in medical structures and equipment, and spending for physician and clinical care also contributed to the low overall increase.

Total spending for health care in the United States increased 3.6 percent to $2.9 trillion in 2013, or $9,255 per person (Exhibit 1). The increase in 2013 was slower than that of 4.1 percent in 2012 and continued a pattern of low growth—between 3.6 percent and 4.1 percent for five consecutive years.[1] The low rate of health care spending growth coincides with modest overall economic growth since the end of the recent severe recession, which averaged 3.9 percent since 2010. As a result, the health spending share of the gross domestic product (GDP) remained stable at 17.4 percent in 2013.

In 2013 slower growth in both private health insurance and Medicare contributed to the 0.5-percentage-point slowdown in health care spending growth. Private health insurance premium growth slowed from 4.0 percent in 2012 to 2.8 percent in 2013 (Exhibit 1). Growth in private health insurance benefits slowed from 4.4 percent in 2012 to 2.8 percent in 2013, largely driven by slower growth in hospital services and physician and clinical services.

Medicare spending growth decelerated from 4.0 percent in 2012 to 3.4 percent in 2013, primarily as a result of slower growth in enrollment, the impacts of the Affordable Care Act (ACA), and the federal budget sequestration of 2013. The ACA affected Medicare spending through lower fee-for-service payment updates and adjustments in Medicare Advantage benchmark payment rates, both of which contributed to reduced Medicare spending growth. Additionally, the slower growth in overall health care spending in 2013 was influenced by a deceleration in investment in medical structures and equipment as the medical sector held back on spending, in part because of uncertain economic conditions and cost control efforts by providers (Exhibit 2).[2,3]

Although average health spending growth has exceeded overall economic output over the history of the National Health Expenditure Accounts, the similarity in the growth rates between the two experienced in 2012 and 2013 is not unique, based on an analysis of recent historical trends (Exhibit 3). Growth in health spending and GDP have tended to converge several years after the end of economic recessions; as a result, the health spending share of GDP stabilizes at those times.

During 1994–2000 and 2004–07 health spending and GDP grew at similar average annual rates. This resulted in an increase in the health spending share of GDP of less than one-tenth of a percentage point and a half-percentage point, respectively, over these periods.[4] Similarly, during 2012–13 the health sector's share of GDP did not increase.

This contrasts with 1990–93, 2001–03, and 2008–11—three periods that contained reces-

EXHIBIT 1

National Health Expenditures (NHE), Aggregate And Per Capita Amounts, Share Of Gross Domestic Product (GDP), And Annual Growth, By Source Of Funds, Calendar Years 2007–13

Source of funds	2007[a]	2008	2009	2010	2011	2012	2013
EXPENDITURE AMOUNT							
NHE, billions	$2,303.9	$2,414.1	$2,505.8	$2,604.1	$2,705.3	$2,817.3	$2,919.1
Health consumption expenditures	2,158.8	2,258.9	2,359.5	2,454.5	2,548.0	2,653.6	2,754.5
Out of pocket	293.7	300.9	300.9	306.2	317.3	328.8	339.4
Health insurance	1,611.8	1,702.3	1,797.9	1,875.7	1,952.4	2,029.1	2,102.9
Private health insurance	777.7	808.0	833.1	862.2	899.4	935.7	961.7
Medicare	432.8	467.1	499.7	519.9	544.7	566.6	585.7
Medicaid	326.1	344.7	374.9	397.6	407.5	423.7	449.4
Federal	185.7	203.4	247.7	266.7	247.8	243.7	258.8
State and local	140.4	141.3	127.2	131.0	159.7	180.0	190.6
Other health insurance programs[b]	75.2	82.5	90.2	95.9	100.9	103.1	106.1
Other third-party payers and programs and public health activity	253.3	255.7	260.7	272.5	278.3	295.7	312.2
Investment	145.1	155.3	146.3	149.7	157.3	163.7	164.6
Population (millions)	301.1	303.9	306.5	309.0	311.0	313.2	315.4
GDP, billions of dollars	$14,477.6	$14,718.6	$14,418.7	$14,964.4	$15,517.9	$16,163.2	$16,768.1
NHE per capita	7,652	7,944	8,175	8,428	8,698	8,996	9,255
GDP per capita	48,084	48,432	47,040	48,429	49,894	51,610	53,160
Prices (2009 = 100.0)							
Chain-weighted NHE deflator	95.8	97.7	100.0	102.7	105.2	106.9	108.3
GDP price index	97.3	99.2	100.0	101.2	103.3	105.2	106.7
Real spending							
NHE, billions of chained dollars	$ 2,404	$ 2,471	$ 2,506	$ 2,535	$ 2,571	$ 2,635	$ 2,695
GDP, billions of chained dollars	14,874	14,830	14,419	14,784	15,021	15,369	15,710
NHE as percent of GDP	15.9	16.4	17.4	17.4	17.4	17.4	17.4
ANNUAL GROWTH							
NHE	6.3%	4.8%	3.8%	3.9%	3.9%	4.1%	3.6%
Health consumption expenditures	6.1	4.6	4.5	4.0	3.8	4.1	3.8
Out of pocket	5.9	2.4	0.0	1.8	3.6	3.6	3.2
Health insurance	6.0	5.6	5.6	4.3	4.1	3.9	3.6
Private health insurance	5.1	3.9	3.1	3.5	4.3	4.0	2.8
Medicare	7.2	7.9	7.0	4.0	4.8	4.0	3.4
Medicaid	6.3	5.7	8.8	6.1	2.5	4.0	6.1
Federal	6.7	9.5	21.8	7.7	–7.1	–1.7	6.2
State and local	5.7	0.7	–9.9	2.9	21.9	12.8	5.9
Other health insurance programs[b]	7.4	9.8	9.2	6.4	5.1	2.2	2.9
Other third-party payers and programs and public health activity	6.7	0.9	2.0	4.5	2.1	6.3	5.6
Investment	10.3	7.0	–5.8	2.3	5.1	4.0	0.5
Population	0.9	0.9	0.9	0.8	0.7	0.7	0.7
GDP, billions of dollars	4.5	1.7	–2.0	3.8	3.7	4.2	3.7
NHE per capita	5.3	3.8	2.9	3.1	3.2	3.4	2.9
GDP per capita	3.5	0.7	–2.9	3.0	3.0	3.4	3.0
Prices (2009 = 100.0)							
Chain-weighted NHE deflator	3.3	2.0	2.3	2.7	2.4	1.6	1.3
GDP price index	2.7	1.9	0.8	1.2	2.1	1.8	1.5
Real spending							
NHE, billions of chained dollars	2.9	2.8	1.4	1.2	1.4	2.5	2.3
GDP, billions of chained dollars	1.8	–0.3	–2.8	2.5	1.6	2.3	2.2

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and US Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Note 20 in text). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2006–07. [b]Includes health-related spending for Children's Health Insurance Program (CHIP) Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs.

sions and the years immediately following—when health care spending increased at a much faster average annual rate than GDP. Accordingly, the share of the economy devoted to health care increased substantially during those three periods—by 2.0 percentage points, 2.1 percentage points, and 1.5 percentage points, respectively.

EXHIBIT 2

National Health Expenditures (NHE) Amounts And Annual Growth, By Spending Category, Calendar Years 2007–13

Spending category	2007[a]	2008	2009	2010	2011	2012	2013
EXPENDITURE AMOUNT							
NHE, billions	$2,303.9	$2,414.1	$2,505.8	$2,604.1	$2,705.3	$2,817.3	$2,919.1
Health consumption expenditures	2,158.8	2,258.9	2,359.5	2,454.5	2,548.0	2,653.6	2,754.5
Personal health care	1,921.0	2,017.3	2,117.9	2,196.2	2,281.8	2,379.3	2,468.6
Hospital care	692.5	728.9	776.8	814.9	849.9	898.5	936.9
Professional services	618.6	652.8	672.4	694.2	721.5	752.0	777.9
Physician and clinical services	461.8	486.5	503.2	519.0	540.8	565.3	586.7
Other professional services	59.5	64.0	66.8	69.8	73.1	76.8	80.2
Dental services	97.3	102.4	102.5	105.4	107.6	110.0	111.0
Other health, residential, and personal care	107.7	113.5	122.5	128.5	132.5	140.1	148.2
Home health care	57.8	62.3	67.2	71.2	73.8	77.1	79.8
Nursing care facilities and continuing care retirement communities	126.4	132.6	138.5	143.0	149.2	152.2	155.8
Retail outlet sales of medical products	318.1	327.1	340.3	344.4	354.8	359.4	370.0
Prescription drugs	236.0	242.7	255.0	256.2	263.0	264.4	271.1
Durable medical equipment	34.3	34.9	35.0	37.0	39.1	41.3	43.0
Other nondurable medical products	47.8	49.5	50.3	51.2	52.8	53.7	55.9
Government administration	29.3	29.4	29.8	30.5	32.8	34.2	37.0
Net cost of health insurance	142.6	140.7	137.8	152.3	160.0	165.3	173.6
Government public health activities	65.9	71.5	74.0	75.5	73.5	74.8	75.4
Investment	145.1	155.3	146.3	149.7	157.3	163.7	164.6
Noncommercial research	42.5	44.0	45.2	48.7	49.3	48.0	46.7
Structures and equipment	102.7	111.2	101.1	101.0	108.0	115.7	117.9
ANNUAL GROWTH							
NHE	6.3%	4.8%	3.8%	3.9%	3.9%	4.1%	3.6%
Health consumption expenditures	6.1	4.6	4.5	4.0	3.8	4.1	3.8
Personal health care	6.2	5.0	5.0	3.7	3.9	4.3	3.8
Hospital care	6.2	5.3	6.6	4.9	4.3	5.7	4.3
Professional services	5.7	5.5	3.0	3.2	3.9	4.2	3.4
Physician and clinical services	5.2	5.3	3.4	3.1	4.2	4.5	3.8
Other professional services	8.2	7.6	4.4	4.6	4.7	5.0	4.5
Dental services	6.4	5.2	0.1	2.8	2.1	2.2	0.9
Other health, residential, and personal care	5.9	5.5	7.9	4.9	3.1	5.8	5.8
Home health care	9.9	7.8	8.0	5.8	3.7	4.5	3.4
Nursing care facilities and continuing care retirement communities	7.7	4.9	4.5	3.2	4.3	2.0	2.4
Retail outlet sales of medical products	5.9	2.8	4.0	1.2	3.0	1.3	2.9
Prescription drugs	5.2	2.8	5.0	0.5	2.6	0.5	2.5
Durable medical equipment	6.2	1.6	0.4	5.6	5.6	5.6	4.2
Other nondurable medical products	9.2	3.6	1.7	1.8	3.0	1.8	4.0
Government administration	1.8	0.5	1.2	2.4	7.3	4.3	8.2
Net cost of health insurance	4.3	–1.4	–2.0	10.5	5.0	3.4	5.0
Government public health activities	8.3	8.5	3.5	1.9	–2.7	1.8	0.8
Investment	10.3	7.0	–5.8	2.3	5.1	4.0	0.5
Noncommercial research	2.4	3.7	2.5	7.9	1.2	–2.7	–2.6
Structures and equipment	14.0	8.3	–9.1	–0.2	7.0	7.1	1.9

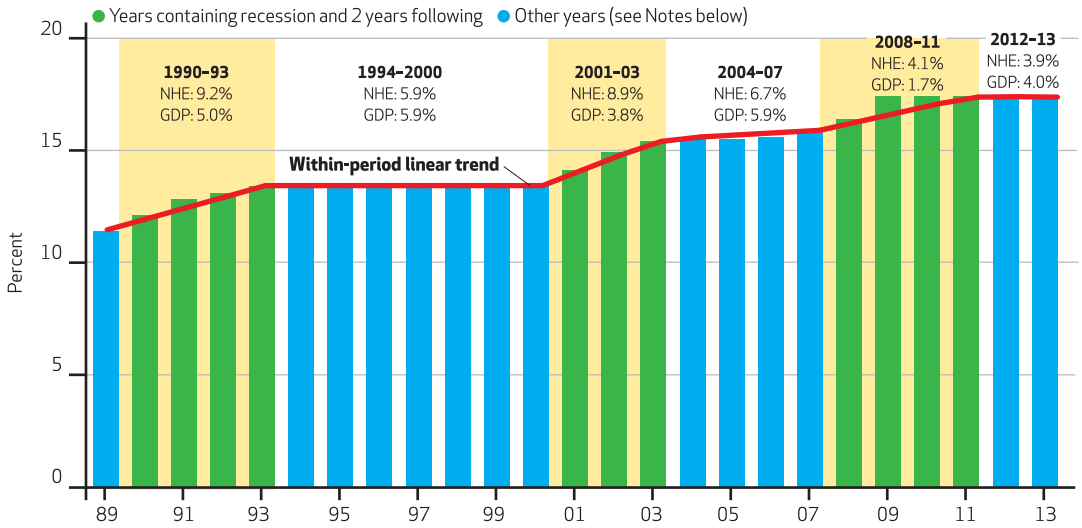
SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Note 20 in text). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2006–07.

Factors Accounting For Growth

National health spending growth can be disaggregated into economywide price inflation, medical-specific price inflation, and three nonprice factors: changes in population, shifts in the age and sex mix of the population, and a residual that primarily reflects the use and intensity of services.[5] On a per capita basis, national health spending growth slowed from 3.4 percent in 2012 to 2.9 percent in 2013 (Exhibits 1 and 4). Medical prices and residual use and intensity were almost equally responsible for the deceler-

EXHIBIT 3

National Health Expenditures (NHE) As A Share Of Gross Domestic Product (GDP), 1989–2013



SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; National Bureau of Economic Research; and US Department of Commerce, Bureau of Economic Analysis. **NOTES** Health spending was grouped into the following two categories for selected periods between 1990 and 2013: "recession and aftermath," or years during which three or more months were in recession, and two additional years after the official end of the recession; and "between recessions," or year 3 after the official end of each recession and all subsequent years until the next recession began. We selected these groupings based on a historical analysis suggesting that recessions tend to have a lagged impact on the health sector that is strongest 2–3 years after the end of the recession. Growth rates were calculated using nominal dollars. Growth for each period reflects the average annual change between the year before the period and the last year of the period. For example, the growth for the period 1990–93 is calculated as the average annual growth from 1989 to 1993.

ation (Exhibit 4).

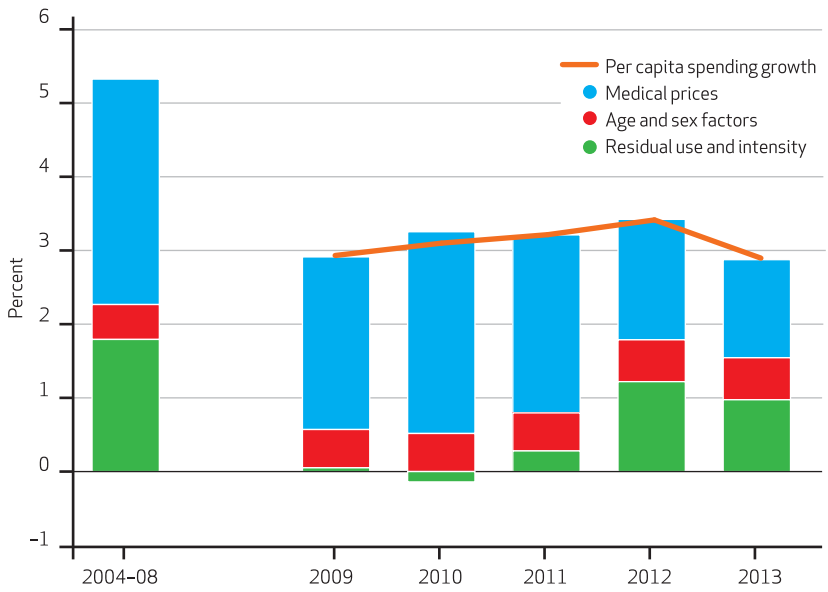
Medical price growth increased just 1.3 percent in 2013, following growth of 1.6 percent in 2012. The slower growth in 2013 reflected slower growth in prices for physician and clinical services, hospital care, and nursing care facilities and continuing care retirement communities and declines in the prices for home health care and the net cost of insurance. The 1.3 percent medical price growth in 2013 was slightly less than the 1.5 percent growth in economywide prices (as measured by the GDP price index), which suggests that excess medical-specific price inflation declined compared to economywide inflation in that year.

Growth in the use and intensity of services also decelerated slightly, from 1.2 percent in 2012 to 1.0 percent in 2013. The slowdown was in part due to lower growth in the use and intensity of hospital services.

A broader view shows that the relatively stable and historically low growth in aggregate health spending during 2009–13 masks the variation that occurred between medical prices and residual use and intensity. During 2009–11 per capita health spending grew 3.1 percent each year, on average, with use and intensity of services accounting for just 0.1 percentage point of the average annual growth during this period. By com-

EXHIBIT 4

Factors Accounting For Growth In Per Capita National Health Expenditures, Selected Calendar Years 2004–13



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Medical price growth, which includes economywide and excess medical-specific price growth (or changes in medical-specific prices in excess of economywide inflation), is calculated using the chain-weighted national health expenditures (NHE) deflator for NHE. "Residual use and intensity" is calculated by removing the effects of population, age and sex factors, and price growth from the nominal expenditure level.

parison, use and intensity grew, on average, 1.8 percent during 2004–08, when per capita health spending growth was 5.3 percent. This reduction in the contribution of use and intensity between these two periods was largely due to a significant loss of private health insurance coverage, a decline in total investment in medical structures and equipment as well as changes in types of investments, and reduced demand for health care services as a result of financial uncertainty caused by the recession.[6]

In 2012 and 2013 per capita health spending continued to grow slowly (averaging 3.1 percent). However, growth in use and intensity increased on average 1.1 percent per year, which was higher than the rates of growth in use and intensity in 2009–11. Medical price growth, however, was much lower in 2012 and 2013: It averaged 1.5 percent per year, compared to average increases of 2.5 percent per year in 2009–11. This slowdown was due in part to the ACA-mandated productivity adjustments to Medicare fee-for-service payments, the budget sequestration, and the impacts of the ACA-mandated medical loss ratio and rate reviews on the net cost of private health insurance.[7]

The ACA And The Sequester

Two notable pieces of legislation affected growth trends in 2013, particularly for Medicare. The ACA, which was enacted in 2010, was designed to be implemented over multiple years, with implementation of the major coverage provisions beginning in 2014. A few key provisions exerted downward pressure on health spending growth in 2013, including the productivity adjustments to Medicare fee-for-service payments, reduced Medicare Advantage base payment rates, increased Medicaid prescription drug rebates, and the medical loss ratio requirement for private insurers. At the same time, other provisions—such as early Medicaid expansion initiatives, a temporary increase in Medicaid primary care provider payments, reducing the size of the Medicare Part D doughnut hole, and the implementation of drug industry fees—exerted upward pressure on health spending growth.

Budget sequestration was implemented March 1, 2013, as mandated by the Budget Control Act of 2011. Notable impacts of budget sequestration on the health sector included an across-the-board 2 percent reduction in spending on Medicare benefits in 2013 and reduced funding for federal research, federal public health activities, and other selected federal programs. Some programs—such as Medicaid, the Children's Health Insurance Program (CHIP), and health care programs sponsored by the Department of Veterans Affairs—were exempt from sequestration.

Growth in health spending and GDP have tended to converge several years after the end of economic recessions.

Medicare

Medicare accounted for 20 percent of national health spending in 2013, when expenditures reached $585.7 billion (Exhibit 1). Total Medicare spending growth slowed in 2013, increasing 3.4 percent compared to 4.0 percent in 2012. This slowdown was primarily attributable to slower Medicare enrollment growth and the impacts of the ACA and sequestration. Per enrollee spending growth was similar in 2012 and 2013.

Fee-for-service expenditures, which accounted for 72 percent of total Medicare spending, increased 1.7 percent in 2013—a growth rate similar to the 1.8 percent growth in those expenditures in 2012. Medicare Advantage spending, which accounted for the remainder of Medicare spending, decelerated in 2013, increasing 7.8 percent after growing 10.6 percent in 2012.

In 2013 total Medicare enrollment (both fee-for-service and Medicare Advantage) increased by 1.6 million beneficiaries, or by 3.2 percent, to 51.3 million enrollees. This was a slowdown from the enrollment growth of 4.1 percent in 2012, when a higher-than-average increase occurred as the oldest members of the baby-boom generation became eligible to join Medicare. Enrollment growth slowed for both the fee-for-service and Medicare Advantage programs in 2013. However, the number of enrollees increased at a much faster rate for Medicare Advantage (a growth rate of 9.4 percent) than for fee-for-service (a growth rate of only 1.0 percent).

Per enrollee growth in total Medicare spending was relatively flat: It increased just 0.2 percent in 2013 after a growth rate of less than 0.1 percent in 2012, as relatively younger and healthier baby boomers continued to join the program. The low growth in total Medicare spending per beneficiary is in part attributable

to Medicare Advantage spending per enrollee, which declined 1.4 percent after growing only 0.5 percent in 2012. The slower growth in total Medicare Advantage expenditures and decline in per enrollee spending in 2013 was due primarily to an ACA-mandated payment-mechanism change that reduced benchmark payment rates to be more in line with fee-for-service costs.[8]

Fee-for-service per enrollee growth also remained low (an increase of 0.7 percent in 2013, after a decline of 0.3 percent in 2012), as a result of slower increases in outpatient hospital utilization, a decline in the volume and intensity of physician services, the budget sequestration, and the continued impacts of the ACA-mandated payment update reductions.[9]

Private Health Insurance

In 2013, 189.3 million people in the United States (or 60 percent of the population) were covered by private health insurance. Aggregate private health insurance premiums grew at a slower rate in 2013 than in 2012, increasing just 2.8 percent to $961.7 billion (33 percent of total health care spending) compared to an increase of 4.0 percent in 2012 (Exhibit 1). Slower premium growth in 2013 reflected numerous factors, including low overall enrollment growth; a continuing shift to enrollment in consumer-directed high deductible plans and other benefit design changes; historically low underlying benefit cost trends; and the impact of several provisions of the ACA, such as the medical loss ratio requirement and rate review.

Private health insurance enrollment increased 0.7 percent in 2013—the third straight year of positive growth—albeit low, following a significant enrollment decline of 11.2 million individuals in 2008–10, which was due mainly to the recession. From 2011 to 2013, the slight rebound in enrollment (an additional 3 million covered individuals during the period) resulted in total private health insurance enrollment levels that were well below the pre-recession peak of 197.5 million in 2007. At the same time, enrollment in consumer-directed high-deductible plans—which cost 9–12 percent less than the average preferred provider organization plan—increased, further dampening the growth in private health insurance premiums.[10] In 2013 these plans insured 20 percent of covered workers, compared to 17 percent in 2011.[10]

Changes in plan design and several provisions of the ACA also contributed to slower growth in private health insurance premiums in 2013. A recent study indicated that changes to plan design resulted in a 1.9-percentage-point reduction in premiums, compared to what they would have been without the changes.[11] In addition, the medical loss ratio requirement and rate review mandated by the ACA put downward pressure on premium growth.

Private health insurance benefit expenditures increased 2.8 percent in 2013, compared to 4.4 percent in 2012, and reached $846.0 billion. The slow growth in 2013 was driven primarily by low spending growth for hospital services and physician and clinical services and a decline in retail prescription drugs. Combined, these expenditures accounted for 87 percent of total private health insurance medical benefits.

Some of this slower growth in private health insurance benefit spending may be due to the increased enrollment in high-deductible health plans. Consumers enrolled in high-deductible plans tend to use services at a lower rate than those enrolled in plans with lower or no cost sharing.[12] A recent report found that 38 percent of workers with employer-sponsored single coverage were enrolled in a plan with an annual deductible of $1,000 or more in 2013, up from 34 percent in 2012.[10]

Medicaid

Total Medicaid spending by the federal government and state and local governments reached $449.4 billion in 2013 (Exhibit 1) and accounted for 15 percent of total national health expenditures. Medicaid spending increased 6.1 percent in 2013, following growth of 2.5 and 4.0 percent in 2011 and 2012, respectively. Those were the two slowest annual rates of growth in the history of Medicaid except for 2006, when the implementation of Medicare Part D changed the way in which Medicaid paid for some beneficiaries' prescription drugs.

In 2013 Medicaid enrollment grew 2.7 percent. This was the first acceleration since the most recent recession, during which Medicaid enrollment growth peaked at 7.6 percent in 2009 and slowed each year thereafter (6.9 percent in 2010, 4.5 percent in 2011, and 1.8 percent in 2012). Some of the increase in 2013 was due to new beneficiaries who enrolled as a result of early Medicaid expansion in some states.[13]

Medicaid spending per enrollee increased 3.3 percent in 2013 after growing 2.1 percent in 2012. This acceleration was driven by growth in some provider reimbursement rates and by some states' expanding benefits.[14]

Hospital care and other health, residential, and personal care services together accounted for just over half of all Medicaid spending in 2013. Medicaid spending for hospital care (36 percent of total Medicaid spending) grew 4.5 percent in both 2012 and 2013. Spending

for other health, residential, and personal care services (including Medicaid home and community-based waivers, rehabilitation services, and nonemergency medical transportation services) grew 9.3 percent, accelerating from its 8.6 percent growth in 2012.

Both physician and clinical services (11 percent share) and government administration and the net cost of private health insurance (together, 9 percent share) also contributed to the overall acceleration in Medicaid spending in 2013. Physician and clinical services spending growth accelerated from 2.7 percent in 2012 to 10.1 percent in 2013, as a result of the temporary increase in payments to primary care physicians mandated by the ACA.[15] Government administration and the net cost of insurance together grew 11.3 percent in 2013, compared to 4.8 percent in 2012. This was partially a result of large increases in managed care programs and states' preparations for expanding Medicaid.

Medicaid spending growth for the federal government and state and local governments returned to more typical patterns in 2013: Federal spending increased 6.2 percent, and state and local spending increased 5.9 percent. This more characteristic pattern of similar growth rates followed two years of substantial increases in state and local Medicaid spending (12.8 percent in 2012 and 21.9 percent in 2011) and declines in federal Medicaid spending (–1.7 percent in 2012 and –7.1 percent in 2011). These growth patterns reflected the end of additional federal funding that had been mandated by the American Recovery and Reinvestment Act of 2009, which increased the Federal Medical Assistance Percentage from October 2008 through June 2011.

Out-Of-Pocket Spending

Out-of-pocket spending by consumers, which includes direct consumer payments such as copayments and deductibles and spending on noncovered services, was $339.4 billion, or 12 percent of national health expenditures, in 2013 (Exhibit 1). Out-of-pocket spending gradually declined from a 15 percent share of health spending in 1998. It grew 3.2 percent in 2013—slightly slower than its growth of 3.6 percent in both 2011 and 2012—or almost two and a half times as fast as the average annual growth rate of 1.4 percent during 2008–10, the period during and just after the most recent recession.

Faster growth in 2011–13 compared with 2008–10 reflects a modestly improved economy; higher cost sharing for group health insurance plans; and increased enrollment in consumer-directed health plans that have higher deductibles, higher copayments, or both.

Hospital Care

Expenditures for hospital care reached $936.9 billion in 2013, an increase of 4.3 percent (Exhibit 2). This was slower than the 5.7 percent rate of growth in 2012. Overall, hospital spending was influenced by decelerations in growth for both price and nonprice factors (such as residual use and intensity). Hospital prices (as measured by the Producer Price Index) increased at a slower rate of 2.2 percent in 2013, compared to 2.5 percent in 2012.[16] The use of hospital inpatient services also contributed to the slower growth in 2013, as the number of inpatient days declined by 1.6 percent[17] and discharges decreased by 1.4 percent.[18]

Private health insurance spending growth for hospital services decelerated sharply from 7.5 percent in 2012 to 4.0 percent in 2013, and Medicare spending growth for hospital services slowed from 3.8 percent in 2012 to 2.6 percent in 2013. These two payers accounted for almost two-thirds of total hospital spending in 2013.

Slower growth in private health insurance spending for hospital care is attributable in part to increased cost-sharing requirements and a shift in enrollment toward higher deductible plans. For example, among covered workers with separate cost sharing for a hospital admission, the average patient cost-sharing charge per day increased 19.5 percent in 2013, while the average cost sharing for an outpatient surgery episode increased by 10 percent.[10,19]

The low rate of increase for Medicare hospital spending in 2013 reflected the impacts of the ACA's productivity adjustments, reductions in inpatient hospital readmissions, overall lower use of both inpatient and outpatient services, and the impacts of sequestration. Medicare spending growth for fee-for-service inpatient hospital care remained low, increasing only 0.6 percent in both 2012 and 2013. Fee-for-service outpatient hospital spending growth slowed from 8.4 percent in 2012 to 4.4 percent in 2013.

Physician And Clinical Services

Spending for physician and clinical services[20] grew 3.8 percent in 2013 to $586.7 billion (Exhibit 2)—a slowdown from 2012, when spending grew 4.5 percent. Slower price growth (from 1.2 percent in 2012 to less than 0.1 percent in 2013) contributed to the deceleration.[21] Price growth of less than 0.1 percent in 2013 was the slowest rate since 2002. This was due in part to reductions in payments to Medicare providers resulting from the sequester and a zero-percent payment update for 2013.[9]

Spending for physician services, which accounted for 80 percent of physician and clinical

The key question is whether health spending growth will accelerate once economic conditions improve significantly.

services expenditures, grew 3.7 percent in 2013, down slightly from growth of 4.1 percent in 2012. Clinical services spending increased 4.1 percent in 2013, compared to 6.1 percent in 2012. Although the 4.1 percent increase was the lowest rate since 2001, spending for clinical services grew at a higher rate than expenditures for physician services for the ninth consecutive year. The 2-percentage-point decline in clinical services spending growth was due, in part, to slower growth in spending for freestanding ambulatory surgical and emergency centers.

Private health insurance and Medicare accounted for the largest proportion of all physician and clinical services payments (just over two-thirds in 2013). Spending by both of these payers increased at lower rates in 2013 than in 2012, while growth in Medicaid and out-of-pocket spending (the two next-largest payers) accelerated.

The slowdown in Medicare spending was driven by the trend for physician fee-for-service spending, which decelerated from growth of 2.6 percent in 2012 to less than 0.1 percent in 2013. The physician fee schedule declined 0.6 percent in 2013, in part as a result of the American Tax Relief Act of 2012, which provided a 0 percent payment update for physicians in 2013.[9] In contrast, Medicaid spending growth for physician and clinical services increased from 2.7 percent in 2012 to 10.1 percent in 2013, primarily as a result of temporary increases in payments to primary care physicians.[15]

Retail Prescription Drugs

In 2013 total spending growth for retail prescription drugs accelerated, increasing 2.5 percent to $271.1 billion (Exhibit 2). This increase compares to low growth of just 0.5 percent in 2012, which was largely due to the one-time impact of the "patent cliff"—when blockbuster drugs worth $35 billion in annual sales lost their patent protection in 2012 and became available in generic form.[22] The result was lower overall prices paid for these drugs.[23] Factors influencing the faster growth in prescription drug spending in 2013 included price increases for brand-name and specialty drugs,[24] increased spending on new medicines, and increased utilization.

In recent years, specialty drug prices grew at double-digit rates, while generic prices continued to fall.[25] According to a major pharmacy benefit manager, increased prices for brand-name drugs, especially for specialty drugs, was the most significant factor explaining growth in 2013.[26]

Higher prices for specialty drugs were due in part to expensive new medicines—in particular, those used to treat multiple sclerosis and cancer—as well as more rapid price increases for existing specialty drugs.[26,27] Although specialty drugs accounted for less than 1 percent of prescriptions dispensed, they represented almost 28 percent of total pharmacy-related prescription drug spending in 2013.[26] Additionally, more new drugs were launched in 2013 than in any of the previous ten years, which led to increased spending.[27]

Utilization, measured as the number of prescriptions dispensed, increased 1.6 percent in 2013, accelerating slightly from growth of 1.2 percent in 2012.[27] These growth rates represent a rebound from the ten-year low of 0.7 percent in 2011 and reflect, in part, increased demand. Additionally, increased utilization was influenced by the greater availability of lower-cost generic drugs, which occurred primarily because of the large number of high-cost medications that recently lost patent protection and became available in generic form.

Typically, generic drugs cost 80–85 percent less than brand-name versions of the same medication.[28] In 2011 the share of dispensed prescriptions that was generic (excluding branded generics) was 73 percent. In 2012 it was 77 percent, and in 2013 it reached 80 percent.[27] Furthermore, private health insurance plans' continued movement to three- or four-tier coinsurance or copayment structures, which charge less for generics and more for higher-cost drugs, has contributed to the low prescription drug spending growth.[10]

Medicare spending on prescription drugs (that is, expenditures for drugs covered mainly under the Part D benefit with some additional coverage under the Part B benefit) increased 10.7 percent in 2013 and reached $74.6 billion. This was a faster rate of growth than in 2012, when spending grew 6.6 percent.

Medicare accounts for 28 percent of total retail prescription drug spending—a share that in-

EXHIBIT 5

National Health Expenditures (NHE) Amounts, Annual Growth, And Percent Distribution, By Type Of Sponsor, Calendar Years 2007–13

Type of sponsor	2007[a]	2008	2009	2010	2011	2012	2013
EXPENDITURE AMOUNT							
NHE, billions	$2,303.9	$2,414.1	$2,505.8	$2,604.1	$2,705.3	$2,817.3	$2,919.1
Businesses, household, and other private revenues	1,372.5	1,416.8	1,415.2	1,446.6	1,508.4	1,592.7	1,652.8
Private businesses	522.6	530.5	530.3	533.7	560.4	587.3	610.9
Household	678.0	713.0	717.3	738.3	764.5	801.5	823.8
Other private revenues	171.9	173.3	167.6	174.6	183.5	203.9	218.1
Governments	931.4	997.3	1,090.6	1,157.5	1,196.9	1,224.6	1,266.3
Federal government	530.7	583.6	682.8	733.1	733.1	731.5	757.5
State and local governments	400.8	413.7	407.9	424.5	463.7	493.1	508.8
ANNUAL GROWTH							
NHE	6.3%	4.8%	3.8%	3.9%	3.9%	4.1%	3.6%
Businesses, household, and other private revenues	6.0	3.2	–0.1	2.2	4.3	5.6	3.8
Private businesses	4.4	1.5	0.0	0.6	5.0	4.8	4.0
Household	5.8	5.2	0.6	2.9	3.6	4.8	2.8
Other private revenues	12.5	0.8	–3.3	4.2	5.1	11.1	7.0
Governments	6.7	7.1	9.4	6.1	3.4	2.3	3.4
Federal government	6.4	10.0	17.0	7.4	0.0	–0.2	3.5
State and local governments	7.1	3.2	–1.4	4.1	9.3	6.3	3.2
PERCENT DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, household, and other private revenues	60	59	56	56	56	57	57
Private businesses	23	22	21	20	21	21	21
Household	29	30	29	28	28	28	28
Other private revenues	7	7	7	7	7	7	7
Governments	40	41	44	44	44	43	43
Federal government	23	24	27	28	27	26	26
State and local governments	17	17	16	16	17	18	17

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Note 20 in text). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2006–07.

creased from just 2 percent in 2005 (one year before the introduction of Part D). Spending on Part D drugs accelerated to a 10.5 percent growth rate in 2013 (from 5.3 percent in 2012). This was driven in part by continued strong growth in Part D enrollment and by increased subsidies for the expanding number of Part D enrollees who reached the catastrophic phase of the benefit.[29]

Medicaid spending on prescription drugs also accelerated in 2013, increasing 4.7 percent compared to 1.1 percent in 2012. Total Medicaid prescription drug expenditures reached $21.2 billion in 2013 and accounted for 8 percent of total retail prescription drug spending.

Sponsors Of Health Care

As the main sponsors of health care, households; private businesses; and the federal government and state and local governments are responsible for financing the nation's health care bill. In 2013 households accounted for the largest share of spending (28 percent), followed by the federal government, private businesses, and state and local governments (Exhibit 5).

Household health spending, which includes out-of-pocket payments, contributions to private health insurance premiums, and contributions to Medicare through payroll taxes and payment of premiums, grew 2.8 percent in 2013—a slower rate of growth than the 4.8 percent rate in 2012. This slowdown was due in part to the low rate of increase in employee contributions to private health insurance premiums, which grew just 2.2 percent in 2013. Despite the slower growth in 2013, the household share of health spending has remained steady at 28 percent since 2010.

Health care spending financed by private businesses—a category that includes the employer share of contributions to private health insurance premiums, workers' compensation, temporary disability insurance premiums, contribu-

tions to the Medicare Hospital Insurance Trust Fund, and health care provided directly at the worksite—increased 4.0 percent in 2013, contributing to an average annual rate of 4.6 percent during 2011–13. This rate of increase is much higher than the average increase of 0.7 percent during 2008–10 caused by recession-related job losses and declines in private health insurance enrollment during and just after the recession. The private business share of overall health spending has remained fairly steady since 2009, at about 21 percent.

Federal government spending for health care increased 3.5 percent in 2013. This was influenced in part by an increase in Medicaid payments to primary care physicians mandated by the ACA and paid entirely by the federal government. State and local government spending increased 3.2 percent in 2013. This increase followed strong growth of 6.3 percent in 2012 and 9.3 percent in 2011 that was due largely to the expiration in June 2011 of the Medicaid enhanced matching rates for states funded through the American Recovery and Reinvestment Act.

The federal government's share of health spending has diminished in recent years, from 28 percent in 2010 to 27 percent in 2011 and 26 percent in both 2012 and 2013. This reduction was caused primarily by the expiration of Medicaid enhanced matching rates. In the same period, state and local governments' share of total health care spending increased from 16 percent in 2010 to 17 percent in 2011; it remained relatively stable through 2013. Together, overall government spending for health care increased 3.4 percent in 2013 and accounted for 43 percent of overall health care spending.

Conclusion

During the past five years, health care spending grew at historically low rates, between 3.6 percent and 4.1 percent each year. During 2010–13, this slow growth mirrored that of the overall economy, which increased 3.7–4.2 percent per year. The result was a stable health spending share of GDP, at 17.4 percent. The recent similarity between national health care spending and GDP growth is consistent with historically observed patterns as the economy moves further from the end of the recession.

The key question is whether health spending growth will accelerate once economic conditions improve significantly; historical evidence suggests that it will. However, in the near term, the health sector will undergo major changes that will have a substantial impact on the consumers, providers, insurers, and sponsors of health care.

More notable provisions of the ACA, such as those related to the health insurance Marketplaces and the Medicaid expansion, will affect the future health care spending trend through the expansion of health insurance to people who were previously uninsured and the availability of plans with more comprehensive benefits for those who previously had coverage.[30] At the same time, there have been and will continue to be forces that keep medical price growth low, particularly for Medicare. In addition, shifts to private coverage with higher deductibles could continue to have an effect. The balance of these and many other factors over the next few years will determine how the historically low health spending growth from 2009 to 2013 is viewed: as the temporary aftermath of the great recession or the beginning of a new era. ■

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NOTES

1 Health spending estimates for years before 2013 differ from those published January 6, 2014, and reflect new and revised source data that were unavailable for previous vintages of the National Health Expenditure (NHE) Accounts. Most notably, the 2012 NHE growth rate was revised from 3.7 percent to 4.1 percent, mainly because of upward revisions to hospital care and investment in structures and equipment categories.

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4 For further description of the selection of the periods for analysis, see the Exhibit 3 notes.

5 Residual use and intensity is calculated by removing the effects of population, age-sex factors, and price growth from the nominal expenditure level.

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