

National Healthcare Spending Slows for Second Straight Year

A recent analysis conducted by the Office of the Actuary at the *Centers for Medicare & Medicaid Services* (CMS) has found that, although healthcare spending rose to \$3.5 trillion in 2017, the U.S. *national health expenditure* (NHE) growth rate slowed, declining from 4.8% in 2016 to 3.9% in 2017.¹ Of note, this is the second consecutive year that healthcare spending has slowed, reaching its lowest increase in growth since 2013.² This growth has been somewhat slower than the growth rate of the overall economy, which was 4.2% in 2017; however, healthcare spending was still a large percentage of the U.S. *gross domestic product* (GDP), at 17.9%.³ According to the *CMS Forecast Summary*, from 2017 to 2026, growth rates are projected to rise at an increasing rate, effectively increasing the percent of GDP and total expenditures, and resulting in the U.S. continuing to be the highest spender on healthcare, compared to other high-income countries.⁴ This *Health Capital Topics* article will review this CMS analysis, as well as the various healthcare spending components examined by the agency.

From 2009 to 2013, the NHE had record low rates, with 2013 seeing a 3.6% growth rate (often attributed to the poor economy during the *Great Recession*).⁵ Transitioning into 2014, healthcare spending rose dramatically, largely due to retail prescription drugs, rising from a growth rate of 2.4% in 2013 to 12.2% in 2014.⁶ The leading source of the high prescription expenditures was the introduction of *Sovaldi* and *Harvoni*, expensive treatments for Hepatitis C (a viral, chronic disease of the liver, affecting approximately 3 million Americans).⁷ To quantify the effect of these treatments on NHE growth, sales of these treatments were approximately \$12.3 billion higher in 2014 than in the previous year.⁸ Additionally, the large hike in healthcare expenditures that occurred in 2014 was partly due to the impact of *Medicaid Expansion*, in those states that chose to expand Medicaid coverage, and the introduction of private health insurance Marketplace plans.⁹ This expanded coverage effectively increased utilization of healthcare goods and services as those newly insured individuals sought out treatment that they had forgone when they were not covered by healthcare insurance.¹⁰ Despite this high period of increased healthcare expenditures, the impacts of *Medicaid Expansion* and increase in Marketplace enrollment eventually started to slow after 2015, as the amount of newly enrolled individuals utilizing medical goods and services started to decline.¹¹ In addition, the considerable

spending on Hepatitis C drugs declined in 2015, as those who took the new medications were cured (and thus ceased purchasing the drugs), effectively reducing the NHE rate back down to 4.8% in 2016.¹²

In 2017, growth rates stagnated more quickly than expected, as CMS initially projected a 4.6% growth rate of NHE for the year, rather than the 3.9% growth that was experienced.¹³ The deceleration in spending growth was fundamentally due to a decrease in the use of hospital care, physician and clinical services, and retail prescription drugs (the three largest categories for healthcare goods and services spending).¹⁴ In 2017, there was a decrease in the residual use and intensity (i.e., utilization) of these goods and services, effectively decreasing from 2.1% in 2016 to 1.1% in 2017.¹⁵ Likewise, both hospital care and physician and clinical services cost growth fell from 5.6% in 2016 to 4.6% and 4.2%, respectively.¹⁶ A factor that likely contributed to the lower utilization and growth rate of services was the increase in the number of high-deductible health plans, which often shifts additional financial strain onto healthcare consumers, leading to a reduction in preventative and clinical visits.¹⁷ In 2017, approximately 40% of Americans had high-deductible plans, compared to only 25% in 2010.¹⁸ In addition, spending on retail prescription drugs dropped from 2.3% to 0.4% from 2016 to 2017.¹⁹ This was the slowest rate of growth in retail prescription drugs since 2012,²⁰ and is due to the shift to lower-cost generic drugs and the decline in the volume of high-cost drugs.²¹ Another significant factor in the decreased growth in retail prescriptions was the tightening of prescriptions written and dispensed, likely as a result of concern regarding the opioid epidemic.²²

The two largest payors of total healthcare spending, the federal government (e.g., Medicare) and households (together responsible for 56% of total spending), had a decrease in expenditure growth in 2017.²³ Federal spending slowed for the third consecutive year, after an increase of 10.9% in 2014, to 3.2% in 2017, due to (as noted above) 10.2 million people gaining coverage through Medicaid and 8.7 million people gaining coverage through private health insurance as a result of the *Patient Protection and Affordable Care Act* (ACA).²⁴ Medicare spending grew 4.2% in 2017, minimally lower than the 4.3% growth rate in 2016; however, Medicaid spending decelerated more significantly in 2017 to 2.9% from 4.2% in 2016.²⁵ In previous years, Medicaid

Expansion was funded entirely by the federal government; however, beginning in 2017, states were required to fund 5% of the associated costs, effectively lowering Medicaid expenditures for the federal government while increasing costs for the state and local governments.²⁶ In addition to federal spending, there was a deceleration in household spending, from a 4.8% growth in 2016 to an only 3.8% increase in 2017,²⁷ likely driven by the decreased growth in out-of-pocket spending.²⁸

Under the current healthcare structure, spending is forecasted to grow at a rate of 5.5% each year, from 2017 to 2026, a more rapid rate than is currently occurring.²⁹ Healthcare spending is projected to grow 1% faster than the GDP per year during this period, rising from 17.9% in 2017 to 19.7% in 2026.³⁰ Under this projected growth model, NHE will total approximately \$5.7 trillion by 2026.³¹ This projected growth is based on economic and demographic factors such as the increase in prices for healthcare goods and services, and expenditures due to the aging population switching from commercial insurance to Medicare. In addition, this growth reflects the rise of incentive payments to physicians beginning in 2019 through the *Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015* (MACRA).³² Further, Medicaid will contribute to this expected growth due to an increasing projected rise in aged and disabled individuals.³³

Despite this notable decrease in spending growth, the U.S. still spends significantly more per person on healthcare-related expenses compared to other countries, and approximately 31% more than the next highest per capita spender – Switzerland.³⁴ In addition, healthcare

accounts for almost 18% of the U.S. GDP, while in other developed countries healthcare spending is 9.6% to 12.4% of GDP, indicating that the U.S. spends more on healthcare than other comparable income nations.³⁵ Despite the outsized spending of the U.S., health outcomes are lower than comparable countries, indicating deficiencies within the U.S. healthcare system.³⁶

For the second straight year, the growth rate of NHE has slowed, dropping considerably from the large growth rate in 2014 and 2015 with the enactment of the ACA and introduction of Hepatitis C drugs. The decrease in NHE is largely due to an adjustment from the initial impact of the ACA, as well as a decrease in services utilized. However, in the future, projections expect total healthcare expenditures to continue to increase as prices increase, reaching approximately \$5.7 trillion in 2026.³⁷ Although expenditures are projected to increase, the combination of various healthcare reforms may help to reduce NHE in the future. For example, the continued effort to lower pharmaceutical spending could reduce NHE, such as the proposed Medicare Part B payment model that would utilize an *International Pricing Index* (IPI).³⁸ Additionally, the increased implementation and modification of certain *value-based reimbursement* (VBR) initiatives could also play an impact in reducing NHE such as *accountable care organizations* (ACOs) and *bundled payment models*, moving away from traditional volume-based reimbursement. Nevertheless, healthcare spending may also be dependent on the state of the economy and healthcare advancements, which can effectively increase or decrease NHE, neutralizing the predictability of healthcare expenditures.

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