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Personal and National Healthcare Expenditures Grow in 2019

On December 16, 2020, the *Centers for Medicare & Medicaid Services* (CMS) released their *National Healthcare Expenditures* (NHE) report. The recent analysis conducted by the Office of the Actuary at CMS found that NHE grew 4.6% between 2018 and 2019.[1] This rate is essentially the same as in 2018 and is consistent with the growth reported since 2016.[2] In 2019, NHE was $11,582 per person, an increase from 2018 of over $400 per person.[3] Further, NHE comprised 17.7% of the U.S. *gross domestic product* (GDP), which is also similar to the proportion of 17.6% reported in 2018, and confirms that healthcare spending is increasing at a faster rate than the nation's GDP is growing.[4]

As was the case between 2017 and 2018, personal healthcare spending grew quickly between 2018 and 2019. As in 2018, this spending category accounted for 84% of total spending, but increased 5.2% in 2019, compared to only 4.1% in 2018.[5] The main factors for this increase were the growth in spending for:

(1) Hospital care (6.2% in 2019, 2% higher than 2018);

(2) Prescription drugs (5.7% in 2019, nearly 2% higher than 2018); and,

(3) Physician and clinical services (4.6% in 2019, 0.6% higher than 2018).[6]

This growth in spending was offset by declining net costs for health insurance,[7] due to the 2019 repeal of the *Health Insurance Tax* (HIT).[8] HIT was only in place between 2014 and 2016, and again in 2018 (with Congress suspending the HIT in 2017 and again in 2019), and was intended to be one way of paying for the coverage expansions included in the *Patient Protection and Affordable Care Act* (ACA).[9] The 2019 data are in contrast to 2018, when the net cost of health insurance[10] grew 13.2% from the reinstatement of HIT that year.[11] HIT was reinstated for the year 2020 but was permanently repealed as of late 2019 for all calendar years (CYs) after 2020.[12]

The 2019 suspension of HIT appeared to also have implications on the breakdown of spending by payor and on medical prices. Medicare spending increased more in 2019 than in 2018 (6.7% growth compared to 6.3%), while the growth in private insurance spending slowed (3.7% in 2019 versus 5.6% in 2018), and Medicaid spending decreased slightly (growth of 2.9% and 3.1% in 2019 and 2018, respectively).[13] Consistent with the increases in personal healthcare spending described above, personal spending for all three payors increased by 1% between 2018 and 2019, even though overall expenditure growth slowed for some.[14] As expected, medical prices grew at a slower rate (1.1%) than in 2018 (2.3%) from the suspension of HIT.[15] In this situation, however, unlike for payors, growth in personal healthcare prices was comparable between 2018 and 2019, while overall prices experienced lower increases.[16]

The report attributed several other factors to the growth in NHE. Interestingly, residual use and intensity[17] almost doubled its proportion of per capita growth in 2019 compared to 2018 (61% of the share compared to 34%, respectively), for a growth rate of 2.5% in 2019.[18] An aging population and other demographic factors accounted for 12% of per capita expenditures in 2019.[19] Faster growth in spending by the federal government and other private entities were offset by slowed increases in spending by private businesses, state and other local governments, and households.[20]

Growing healthcare costs have been recognized as a critical, but difficult, issue to tackle. Recent policy decisions by the Trump Administration have attempted to decelerate these rising costs. For example, in October 2020, CMS published the healthcare transparency final rule,[21] as a follow up to President Trump's June 2019 executive order on "*Improving Price and Quality Transparency*."[22] The healthcare transparency rule aims to lower costs by forcing hospitals to provide more transparent pricing information to consumers in order to allow patients to make more informed decisions regarding their care.[23]

The recent NHE report highlights the difficulty in changing the trajectory of these rising costs, however. It has long been known that an aging population could significantly accelerate healthcare costs.[24] This, together with the growing chronic disease burden in the U.S., has created other potential problems, including a shortage of physicians (especially in primary care and certain surgical specialties) and increased hospital and emergency department (ED) use.[25] Having multiple chronic conditions has been found to increase hospital use, a further contributor to rising costs that was highlighted in the NHE report.[26] In order to combat these issues, legislation and reimbursement structure changes

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(such as the shift to telemedicine) have focused on decreasing hospital readmissions and ED visits, in order to increase the quality of care given to patients while decreasing the costs of that care.[27]

Importantly, the 2019 NHE report does not take into account changes in NHE as a result of the COVID-19 pandemic. At the beginning of the declared *public health emergency* (PHE) in the U.S., hospital admissions fell dramatically.[28] For several months, hospitals did not perform many of their typical elective procedures and remained at low capacity.[29] By mid to late summer, however, admissions had rebounded to within 16% of pre-PHE numbers.[30] At the end of 2020, hospitalizations related to COVID-19 hit record highs, putting substantial stress on hospital capacity.[31] From the start of the PHE, healthcare systems, providers, and other care centers have been burdened with testing and treating COVID-19 patients, attempting to source scarce personal protective equipment (PPE) for their workers, and training staff to convert in-person services to telemedicine. Individuals with pre-existing conditions, who may be more likely to utilize hospital resources, were instead encouraged to remain in their homes whenever possible due to their increased risk of detrimental effects from COVID-19 infection.[32] How this PHE, as well as other legislative changes (such as HIT) put into place, will affect the 2020 NHE remains to be seen.

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1 "National Health Care Spending In 2019: Steady Growth For The Fourth Consecutive Year" By Anne B. Martin, et al., Health Affairs, Vol. 40, No. 1 (January 2021), p. 1.

2 *Ibid*; "National Health Care Spending In 2018: Growth Driven By Accelerations In Medicare And Private Insurance Spending" By Micah Hartman, Anne B. Martin, Joseph Benson, Aaron Catlin, and The National Health Expenditure Accounts Team, Health Affairs, Vol. 39, No. 1 (January 2020), p. 8.

3 Martin, et al., Vol. 40, No. 1, p. 1; Hartman, Martin, Benson, Catlin, and The National Health Expenditure Accounts Team, Vol. 39, No. 1, p. 8.

4 Martin, et al., Vol. 40, No. 1, p. 1, 9.

5 *Ibid*, p. 1; Hartman, Martin, Benson, Catlin, and The National Health Expenditure Accounts Team, Vol. 39, No. 1, p. 8.

6 Martin, et al., Vol. 40, No. 1, p. 1.

7 The net cost of health insurance is defined as the amount of insurance spending attributed to nonmedical expenses, including administration, taxes, and underwriting gains or losses. Martin, et al., Vol. 40, No. 1, p. 1.

8 Section 9010 of the Patient Protection and Affordable Care Act (ACA) imposes a fee on each covered entity engaged in the business of providing health insurance for United States health risks. "Affordable Care Act Provision 9010 - Health Insurance Providers Fee" Internal Revenue Service, December 6, 2019, https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010 (Accessed 12/17/20); Martin, et al., Vol. 40, No. 1, p. 1.

9 "ACA Provisions In New Budget Bill" By Katie Keith, Health Affairs, December 20, 2019, https://www.healthaffairs.org/do/10.1377/hblog20191220.115975/full/ (Accessed 12/17/20).

10 Health insurance costs are calculated for private health insurance including fully insured group or commercial insurance, direct-purchase or non-group insurance, and self-insured insurance and other insurance programs such as are Medicare Advantage and stand-alone Medicare Part D plans, Medicaid managed care plans, Children's Health Insurance Program managed care plans, the majority of workers' compensation insurance plans, and the health portion of property and casualty insurance. Martin, et al., Vol. 40, No. 1, p. 10.

11 Hartman, Martin, Benson, Catlin, and The National Health Expenditure Accounts Team, Vol. 39, No. 1, p. 8.

12 "Affordable Care Act Provision 9010 - Health Insurance Providers Fee" Internal Revenue Service, December 6, 2019, https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010 (Accessed 12/17/20); "Further Consolidated Appropriations Act, 2020" Pub. L. No. 116-94, § 502, 133 Stat. 2534, 3119 (December 20, 2019).

13 Martin, et al., Vol. 40, No. 1, p. 1.

14 Personal health care spending by payor does not include government administration and net costs of health insurance, which are both included in calculating total expenditures. "Martin, et al., Vol. 40, No. 1, p. 1, 3-4.

15 *Ibid*, p. 4.

16 *Ibid*.

17 Residual use and intensity reflects growth in nominal healthcare spending while excluding any growth in the population, changes in the demographic mix of the population, and medical price growth; it is calculated by removing the effects of population, demographic factors (age and time to death), and price growth from the nominal expenditure level.

18 Martin, et al., Vol. 40, No. 1, p. 4-5, 10.

19 *Ibid*, p. 4.

20 *Ibid*, p. 5-6.

21 "Transparency in Coverage Final Rule Fact Sheet (CMS-9915-F)" Centers for Medicare and Medicaid Services, October 29, 2020, https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f (Accessed 12/17/20).

22 "Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First" The White House, June 24, 2019, https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/ (Accessed 12/17/20).

23 For more details on this final rule and its provisions, see the November 2020 Health Capital Topics article entitled, "CMS Final Rule Brings Transparency to Healthcare Industry" Vol. 13, Issue 11 (November 2020), https://www.healthcapital.com/hcc/newsletter/11_20/HTML/PRICE/convert_price_transparency_final_rule_11.24.20.php (Accessed 12/17/20).

24 "The Effects Of Aging And Population Growth On Health Care Costs" By Daniel N. Mendelson and William B. Schwartz, Health Affairs, Vol. 12, No. 1 (Spring 2013), p. 119.

25 "An Aging Population And Growing Disease Burden Will Require A Large And Specialized Health Care Workforce By 2025" By Timothy M. Dall, et al., Health Affairs, Vol. 32, No. 11 (November 2013), p. 2013; "The Complexities of Physician Supply and Demand: Projections From 2018 to 2033" Association of American Medical Colleges, June 2020, p. vii.

26 "Health Care Utilization and Costs of Elderly Persons With Multiple Chronic Conditions" By Thomas Lehnert, et al., Medical Care Research and Review, Vol. 68, No. 4 (January 2011), p. 403-404.

27 See the October 2020 Health Capital Topics article entitled, "Valuation of Telemedicine: Reimbursement" Vol. 13, Issue 10.

28 "The Impact Of The COVID-19 Pandemic On Hospital Admissions In The United States" By John D. Birkmeyer, et al., Health Affairs, Vol. 39, No. 11 (November 2020), p. 2010.

29 *Ibid*.

30 *Ibid*

31 "New data, dashboard provide information on Covid-19 hospital capacity" By Pinar Karaca-Mandic, STAT News, December 10, 2020, https://www.statnews.com/2020/12/10/new-data-dashboard-provide-information-on-covid-19-hospital-capacity/ (Accessed 12/17/20); "COVID-19 Hospitalizations Hit Record Highs. Where Are Hospitals Reaching Capacity?" By Will Stone, NPR, November 10, 2020, https://www.npr.org/sections/health-shots/2020/11/10/933253317/covid-19-hospitalizations-are-surging-where-are-hospitals-reaching-capacity (Accessed 12/17/20).

32 Birkmeyer, et al., Vol. 39, No. 11, p. 2015; Lehnert, et al., Vol. 68, No. 4, p. 403-404.

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