Economists, actuaries, and statisticians from the Centers for Medicare and Medicaid Services (CMS) recently conducted a full analysis of 2018 U.S. healthcare spending. The research found that the healthcare spending growth rate rose to 4.6% in 2018, from 4.2% in 2017, equating to approximately $11,172 per person. However, continued U.S. economic growth, which contributed to a growing overall gross domestic product (GDP) in 2018, resulted in the share of the economy devoted to healthcare actually declining from 17.9% in 2017 to 17.7% in 2018. This is the first time since 2013 that this share declined, although the ratio remained stagnant between 2016 and 2017.

Medical price growth, which had the quickest one-year increase since 2011, accounted for the majority of the increase in per capita spending, "more than offset[ing] slower growth in the use and intensity of health care goods and services." The authors attributed much of the medical price growth to the inflation across the U.S. economy, as well as medical-specific price inflation.

Total personal healthcare spending accounted for 84% of total national health expenditures (NHE) in 2018. However, the growth rate for total personal healthcare spending remained constant from 2017 to 2018, at 4.1%. Despite the overall stability of this segment, the trends within separate spending categories were mixed. The three largest goods and services categories together accounted for 73% of total personal healthcare expenditures: (1) hospital care (2) physician and clinical care; and, (3) retail prescriptions. Hospital care spending grew at approximately the same rate as in 2017 (4.5% in 2018, compared to 4.7% in 2017), while physician and clinical services spending decreased, from 4.7% in 2017 to 4.1% in 2018. Perhaps unsurprisingly, prescription drug spending increased 2.5% in 2018, much faster than the 2017 increase of 1.4%.

Importantly, the majority of the faster spending growth resulted from the growth in the net cost of health insurance. The net cost of health insurance grew much more rapidly in 2018, at a pace of 13.2%, compared to a rate of 4.3% in 2017. The reinstatement of the health insurance tax in 2018, following the one-year moratorium in 2017, primarily drove the faster growth rate of the net cost of health insurance in 2018. The tax was originally mandated by the 2010 Patient Protection and Affordable Care Act (ACA), beginning in 2013, and sunsetting in 2017. Section 201 of the Consolidated Appropriations Act of 2016 then suspended the collection of the health insurance provider fee for the 2017 calendar year.

The implications of this health insurance tax reinstatement are multifaceted. If payors pass the health insurance tax on to consumers in the form of higher premiums, it could spark lower enrollment in the exchanges and consequently contribute to a larger uninsured population. Further, this health insurance tax reinstatement disproportionately impacts Medicare Advantage beneficiaries. The Medicare Advantage market is highly competitive compared with other health insurer markets; consequently, Medicare Advantage payors cannot pass along the cost of the tax to enrollees, leaving Medicare Advantage payors with the choice of either paying the tax or leaving the market. Fewer Medicare Advantage payors in the market lead to less patient choice and higher premiums for Medicare Advantage beneficiaries, due to decreased competition in the marketplace. The Medicare Advantage market relies heavily on high levels of market competition to ensure better quality and lower prices for beneficiaries; market concentration suggests that taxpayers and beneficiaries will overpay. Of note, the health insurance tax was subsequently suspended for 2019, but not for 2020. The tax is estimated to increase all health insurance premiums by an average of 2.2% in 2020.

Importantly, the number of uninsured Americans grew by one million in 2018, marking the second year in a row of at least 30 million Americans being uninsured. The greater number of uninsured Americans may have contributed to the average slower rate in the use and intensity of healthcare services (1.3% in 2018 compared to 1.6% in 2017), as individuals without health insurance may utilize fewer services.

The Trump Administration has taken a number of steps to combat rising healthcare spending levels. Two recent Health Capital Topics articles, “Trump Administration Brings Transparency to Healthcare” (November 2019) and “Hospitals Sue to Keep Prices Secret” (December 2019), address the administration’s policies seeking to combat the rising costs of health prices (in particular, hospital prices) and the current litigation brought by hospitals against the administration related to those policies. Hospital prices in particular continue to be a leading factor in growth despite the use and intensity of service growth remaining stagnant. With hospital prices

(Continued on next page)
increasing by 2.4% in 2018, the Trump Administration may have ample support to pursue more aggressive agency action related to healthcare pricing. Healthcare spending growth trends will continue to be affected by regulatory decisions, including the future of Medicaid Expansion and the repeal of the Individual Mandate, as well as by economic and demographic trends.

2. Ibid.
5. Ibid.
7. Ibid, p. 11.
9. Ibid.
10. Ibid.
11. Ibid, p. 15.
12. Ibid.
13. 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. Ibid, p. 8; CMS includes in the net cost of health insurance other administrative costs such as: net additions to reserves, rate credits and dividends, advertising, sales commissions, etc. “Quick Definitions for National Health Expenditure Accounts (NHEA) Categories” Centers for Medicare and Medicaid Services, https://www.cms.gov/files/document/quick-reference-national-health-expenditure-category-definitions-0 (Accessed 12/17/19), p. 2.
14. The types of private health insurance for which net cost of insurance is estimated include fully insured group/commercial insurance, direct purchase or nongroup insurance, self-insured insurance, and the health portion of property and casualty insurance. Also included in the net cost of insurance are Medicare Advantage and stand-alone Medicare Part D plans, Medicaid managed care plans, Children’s Health Insurance Program (CHIP) managed care plans, and the majority of workers’ compensation insurance. Hartman, Martin, Benson, Catlin, and The National Health Expenditure Accounts Team, p. 10.
27. Internal Revenue Service, December 6, 2019.
30. Growth in the use and intensity of health care goods and services includes changes in both the use and the mix (or intensity) of the goods and services consumed. It is calculated as a residual and reflects growth in nominal health care spending less growth in the population, changes in the age and sex mix of the population, and medical price growth. As a residual, use and intensity cannot be estimated separately. The sum of the factors might not equal the total because of rounding. Ibid, p. 11, 16-17.
31. Ibid, p. 11.
Todd A. Zigrang, MBA, MHA, CVA, ASA, FACHE, is the President of Health Capital Consultants (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 25 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of “The Adviser’s Guide to Healthcare – 2nd Edition” [2015 – AICPA], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: The Accountant’s Business Manual (AICPA); Valuing Professional Practices and Licenses (Aspen Publishers); Valuation Strategies; Business Appraisal Practice; and, NACVA QuickRead. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); American Health Lawyers Associate (AHLA); the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Jessica L. Bailey-Wheaton, Esq., is Senior Vice President & General Counsel of HCC, where she focuses on project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions, and research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. She has presented before associations such as the American Bar Association and NACVA.

John R. Chwarzinski, MSF, MAE, is Senior Vice President of HCC, where he focuses on the areas of valuation and financial analysis of healthcare enterprises, assets and services. Mr. Chwarzinski holds a Master’s Degree in Economics from the University of Missouri – St. Louis, as well as, a Master’s of Science in Finance Degree from the John M. Olin School of Business at Washington University in St. Louis. He has presented before associations such as the National Association of Certified Valuators and Analysts; the Virginia Medical Group Management Association; and, the Missouri Society of CPAs. Mr. Chwarzinski’s areas of expertise include advanced statistical analysis, econometric modeling, and economic and quantitative financial analysis.

Daniel J. Chen, MSF, CVA, focuses on developing Fair Market Value and Commercial Reasonableness opinions related to healthcare enterprises, assets, and services. In addition he prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams. Mr. Chen holds the Certified Valuation Analyst (CVA) designation from NACVA.

Paul M. Doelling, MHA, FACHE, has over 25 years of healthcare valuation and operational management experience and he has previously served as an administrator for a number of mid to large-sized independent and hospital-owned physician practice groups. During that time, he has participated in numerous physician integration and affiliation initiatives. Paul has authored peer-reviewed and industry articles, as well as served as faculty before professional associations such as the Medical Group Management Association (MGMA) and the Healthcare Financial Management Association (HFMA). He is a member of MGMA, as well as HFMA where he previously served as President of the Greater St. Louis Chapter.