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Health Spending Projections Through 2019: The Recession's Impact Continues

ABSTRACT **The economic recession and rising unemployment—plus changing demographics and baby boomers aging into Medicare—are among the factors expected to influence health spending during 2009–2019. In 2009 the health share of gross domestic product (GDP) is expected to have increased 1.1 percentage points to 17.3 percent—the largest single-year increase since 1960. Average public spending growth rates for hospital, physician and clinical services, and prescription drugs are expected to exceed private spending growth in the first four years of the projections. As a result, public spending is projected to account for more than half of all U.S. health care spending by 2012.**

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National health spending is estimated to have grown 5.7 percent and reached $2.5 trillion in 2009, despite a projected 1.1 percent decline in gross domestic product (GDP; Exhibits 1 and 2), up from 4.4 percent in 2008. The result is an expected rise in the health share of GDP of 1.1 percentage points, to 17.3 percent.[1] This projected rate of escalation would represent the largest one-year increase in the health share of GDP since the National Health Expenditure Accounts (NHEA) began tracking health spending in 1960, and it reflects the severity of the recession that began in 2007.[2]

As this paper was published, major health reform legislation that would change the course of these projections was proposed. Should reform come to pass, a second paper presenting projections based on the new law will be forthcoming.

These projections reflect the influence of the recession on underlying payer trends in 2009 (Exhibit 3). Health spending by public payers ($1.2 trillion) is projected to have grown much faster in 2009 (8.7 percent) than that of private payers (3.0 percent, to $1.3 trillion; Exhibits 4 and 5). A leading driver of the acceleration among public payers, up from 6.5 percent in 2008, is the expected growth in Medicaid enrollment (6.5 percent) and spending (9.9 percent) as a result of rising unemployment related to the recession.

The relatively low growth of private-payer spending in 2009 was influenced by private insurance enrollment that is expected to have declined 1.2 percent. The decline occurred despite a substantial boost from federal subsidies provided by the American Reinvestment and Recovery Act (ARRA) of 2009. These were intended to increase the take-up rate of coverage made available by the Consolidated Omnibus Budget Reconciliation Act (COBRA).[3,4]

Although the economy is expected to grow in 2010, private health spending growth is projected to slow further, to 2.8 percent. The slowdown in the rate of spending growth is due to reduced private health insurance enrollment, which in turn is a result of a continuing high rate of unemployment and the expiration of subsidies for coverage provided through COBRA.[3]

Public spending is also projected to grow more slowly, at 5.2 percent. Much of this projected slowdown in 2010 is attributable to a deceleration in Medicare spending growth to 1.5 percent, from 8.1 percent in 2009. Medicare spending is affected by a 21.3 percent reduction in Medicare payment rates to physicians, as called for in cur-

EXHIBIT 1

National Health Expenditures (NHE), Aggregate and Per Capita Amounts, And Share Of Gross Domestic Product (GDP), Selected Calendar Years 2007–2019

Spending category	2007	2008	2009[a]	2010[a]	2014[a]	2019[a]
NHE (billions)	$2,239.7	$2,338.7	$2,472.2	$2,569.6	$3,225.3	$4,482.7
Health services and supplies	2,089.7	2,181.3	2,306.2	2,395.0	3,003.2	4,169.7
Personal health care	1,866.4	1,952.3	2,068.3	2,141.7	2,677.1	3,709.0
Hospital care	687.6	718.4	760.6	788.9	996.3	1,374.5
Professional services	697.5	731.2	777.3	797.2	989.7	1,370.7
Physician and clinical services	472.6	496.2	527.6	535.8	646.8	882.0
Other prof. services	62.2	65.7	69.6	71.4	90.0	123.7
Dental services	96.4	101.2	104.4	107.9	135.7	180.4
Other PHC	66.3	68.1	75.7	82.2	117.2	184.6
Nursing home and home health	191.7	203.1	216.3	226.4	286.9	399.7
Home health care[b]	59.3	64.7	72.2	77.1	104.2	153.8
Nursing home care[b]	132.4	138.4	144.1	149.3	182.7	245.9
Retail outlet sales of medical products	289.7	299.6	314.1	329.1	404.3	564.1
Prescription drugs	226.8	234.1	246.3	260.1	322.1	457.8
Durable medical equipment	25.5	26.6	27.0	27.4	32.6	43.0
Nondurable medical products	37.4	39.0	40.8	41.6	49.5	63.3
Program administration and net cost of private health insurance	158.4	159.6	162.8	172.6	225.1	320.3
Government public health activities	64.8	69.4	75.2	80.8	101.0	140.3
Investment	150.0	157.5	166.0	174.6	222.1	313.0
Research[c]	42.5	43.6	48.0	51.3	65.9	91.2
Structures and equipment	107.5	113.9	117.9	123.3	156.2	221.8
NHE per capita	$7,423.1	$7,680.7	$8,046.7	$8,289.9	$10,048.0	$13,387.2
Population (millions)	301.7	304.5	307.2	310.0	321.0	334.8
GDP, billions of dollars	$14,077.6	$14,441.4	$14,282.5	$14,853.8	$18,488.2	$23,283.0
NHE, billions of 2005 dollars[d]	$2,108.7	$2,155.9	$2,249.7	$2,308.3	$2,674.1	$3,301.0
Chain-weighted GDP price index	1.06	1.08	1.10	1.11	1.21	1.36
PHC deflator[e]	1.07	1.10	1.14	1.17	1.32	1.58
NHE as percent of GDP	15.9%	16.2%	17.3%	17.3%	17.4%	19.3%

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis and U.S. Bureau of the Census. **NOTES** GDP is gross domestic product. Numbers may not add to totals because of rounding. [a]Projected. [b]Freestanding facilities only. Additional services are provided in hospital-based facilities and counted as hospital care. [c]Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls. [d]Deflated using GDP chain-type price index (2005 = 100.0). [e]Personal health care (PHC) chain-type index is constructed from the producer price index for hospital care, nursing home input price index for nursing home care, and consumer price indices specific to each remaining PHC component (2005 = 100.0).

rent law under the Sustainable Growth Rate (SGR) provisions.

Total projected health spending growth thus would slow from 5.7 percent in 2009 to 3.9 percent in 2010. For illustrative purposes only, we also project health spending based on a scenario in which Medicare physician payment rates are held constant for 2010–2019. Under this scenario, projected growth in overall health spending in 2010 would be 4.7 percent.[5]

Private health spending growth in a given year has historically been affected by changes in disposable personal income, both in the current year and a few years earlier.[6] The current recession, therefore, is expected to lead to continued low growth among private payers (averaging 3.9 percent) in 2011 and 2012. Public health care spending growth is projected to average 6.8 percent over that time. The net result is an expectation that public payers will pay for slightly over half of the health care purchased in the United States by 2012, compared to 47 percent in 2008.

Total health spending is expected to grow increasingly faster each year after bottoming out in 2010, reaching 7.0 percent by 2016. This acceleration is primarily a result of expected faster growth in disposable personal income associated with the economic recovery. By the final years of the projection period, an increasing number of baby boomers moving from private coverage into Medicare is expected to contribute to slowing private spending growth (from 7.2 percent in 2015 to 5.6 percent in 2019) and accelerating public spending growth (from 6.3 percent in 2015 to 7.6 percent by 2019).

For 2009–2019, health spending is expected to grow at an average annual rate of 6.1 percent (1.7 percentage points faster than GDP) and to climb

EXHIBIT 2

National Health Expenditures (NHE), Average Annual Percentage Growth From Prior Year Shown And Over The Projection Period, Selected Calendar Years 2007–2019

Spending category	2007[a]	2008	2009[b]	2010[b]	2014[b]	2019[b]	Projection period 2009–2019[b]
NHE	6.0	4.4	5.7	3.9	5.8	6.8	6.1
Health services and supplies	5.8	4.4	5.7	3.8	5.8	6.8	6.1
Personal health care	5.9	4.6	5.9	3.5	5.7	6.7	6.0
Hospital care	5.9	4.5	5.9	3.7	6.0	6.6	6.1
Professional services	5.9	4.8	6.3	2.6	5.6	6.7	5.9
Physician and clinical services	5.8	5.0	6.3	1.5	4.8	6.4	5.4
Other prof. services	6.5	5.6	5.9	2.7	6.0	6.6	5.9
Dental services	6.2	5.1	3.2	3.3	5.9	5.9	5.4
Other PHC	5.8	2.6	11.2	8.5	9.3	9.5	9.5
Nursing home and home health	7.6	6.0	6.5	4.7	6.1	6.9	6.3
Home health care[c]	11.8	9.0	11.7	6.8	7.8	8.1	8.2
Nursing home care[c]	5.8	4.6	4.1	3.6	5.2	6.1	5.4
Retail outlet sales of medical products	4.6	3.4	4.8	4.8	5.3	6.9	5.9
Prescription drugs	4.5	3.2	5.2	5.6	5.5	7.3	6.3
Durable medical equipment	3.3	4.1	1.7	1.5	4.5	5.7	4.5
Nondurable medical products	5.9	4.2	4.7	2.0	4.4	5.0	4.5
Program administration and net cost of private health insurance	4.3	0.7	2.0	6.0	6.9	7.3	6.5
Government public health activities	7.1	7.1	8.2	7.5	5.8	6.8	6.6
Investment	9.4	5.0	5.4	5.2	6.2	7.1	6.4
Research[d]	1.6	2.6	10.2	6.7	6.5	6.7	6.9
Structures and equipment	12.9	5.9	3.6	4.6	6.1	7.3	6.2
NHE per capita	5.0	3.5	4.8	3.0	4.9	5.9	5.2
Population	1.0	0.9	0.9	0.9	0.9	0.8	0.9
GDP	5.1	2.6	-1.1	4.0	5.6	4.7	4.4
NHE, 2005 constant dollars[e]	3.1	2.2	4.3	2.6	3.7	4.3	3.9
Chain-weighted GDP price index	2.9	2.1	1.3	1.3	2.0	2.4	2.1
PHC deflator[f]	3.4	3.0	3.2	2.8	3.1	3.6	3.3

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** GDP is gross domestic product. Growth rates are calculated consistent with the National Health Expenditure Accounts methodology. For example, the 2019 growth rate above is equal to the level of 2019 expenditures over the level of 2014 expenditures raised to the one-fifth power (the average growth over five years); 2019 growth rate is shorthand for 2014–2019 growth rate. [a]Growth from 2006 through 2007. [b]Projected. [c]Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care. [d]Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls. [e]Deflated using GDP chain-type price index (2005 = 100.0). [f]Personal health care (PHC) chain-type index is constructed from the producer price index for hospital care, nursing home input price index for nursing home care, and consumer price indices specific to each of the remaining PHC components. (2005 = 100.0).

to $4.5 trillion by 2019. The health care sector's share of GDP is projected to grow from 16.2 percent in 2008 to 19.3 percent by 2019. Because of continued influence from the recession and demographic changes, private spending is projected to grow at a slower average annual rate over the eleven-year period than public spending. The public share of health spending is projected to increase to 52 percent of all health spending by 2019.

Model And Assumptions

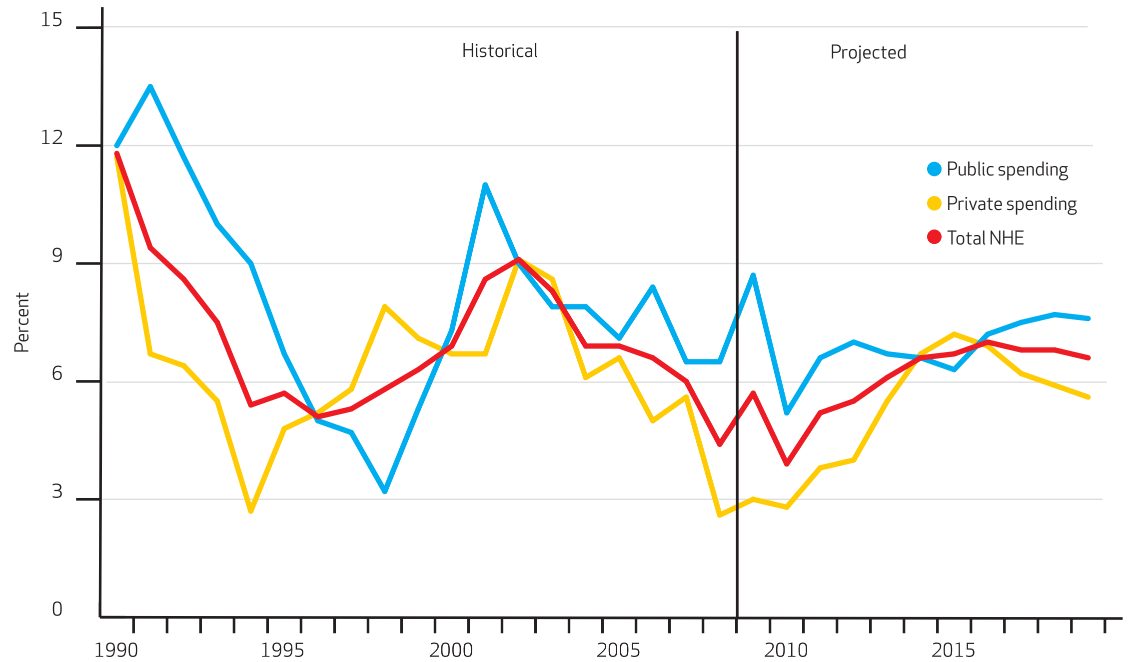
These projections are generated within a "current-law" framework that incorporates actuarial and econometric modeling techniques, as well as judgments about future events and trends that influence health spending. The projections do not include the estimated impacts of any health care reform proposals. They also do not include the impact of the fiscal year 2010 Department of Defense Appropriations Act. This law froze Medicare physician payment rates for the first two months of 2010 and extended the government's subsidization of COBRA coverage available.[3]

The projections for private and public spending use the economic and demographic assumptions from the 2009 *Medicare Trustees Report*, updated to reflect the latest macroeconomic data.[6,7] The Medicare projections are based on the annual trustees report and account for only the direct impacts of cuts to physician payment rates as required under the SGR system.[8]

A second set of projections is produced to re-

EXHIBIT 3

Growth In Public And Private National Health Expenditures (NHE), 1990–2019



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

flect an alternative scenario in which constant Medicare physician fee schedule rates for 2010–2019 are assumed. The assumptions that underlie this scenario are consistent with a supplemental memorandum to the *Medicare Trustees Report* that contains similar analysis.[8]

Projections are inherently uncertain, and the degree of uncertainty grows larger with each ad-

EXHIBIT 4

National Health Expenditures (NHE), Aggregate Amounts By Source Of Funds, Selected Calendar Years 2007–2019

Source of funds	2007	2008	2009[a]	2010[a]	2014[a]	2019[a]
NHE (billions)	$2,239.7	$2,338.7	$2,472.2	$2,569.6	$3,225.3	$4,482.7
Private funds	1,201.0	1,232.0	1,268.8	1,303.9	1,583.7	2,154.4
Consumer payments	1,030.0	1,060.9	1,092.3	1,121.4	1,353.0	1,826.2
Out-of-pocket payments	270.3	277.8	283.5	292.1	348.1	465.6
Private health insurance	759.7	783.2	808.7	829.3	1,004.8	1,360.6
Other private funds	171.0	171.1	176.5	182.5	230.7	328.2
Public funds	1,038.7	1,106.7	1,203.4	1,265.7	1,641.6	2,328.3
Federal	755.3	816.9	918.6	965.7	1,206.9	1,728.5
Medicare	432.2	469.2	507.1	514.7	672.8	977.8
Medicaid	185.7	201.3	247.7	274.4	310.3	445.8
Other federal[b]	137.4	146.4	163.9	176.6	223.8	304.8
State and local	283.4	289.8	284.8	300.0	434.8	599.8
Medicaid	143.2	143.0	130.7	137.6	241.5	348.5
Other state and local[b]	140.3	146.8	154.2	162.3	193.3	251.3
Total Medicaid[c]	328.9	344.3	378.3	412.0	551.7	794.3

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTE** Numbers may not add to totals because of rounding. [a]Projected. [b]Includes Children's Health Insurance Program (CHIP) (Title XIX and XXI). [c]Subset of public funds; includes both the federal and the state and local portion of Medicaid.

EXHIBIT 5

National Health Expenditures (NHE), Average Annual Percentage Growth From Prior Year Shown And Over The Projection Period, By Source Of Funds, Selected Calendar Years 2007–2019

Source of funds	2007[a]	2008	2009[b]	2010[b]	2014[b]	2019[b]	Projection period 2009–2019[b]
NHE	6.0%	4.4%	5.7%	3.9%	5.8%	6.8%	6.1%
Private funds	5.6	2.6	3.0	2.8	5.0	6.3	5.2
Consumer payments	4.8	3.0	3.0	2.7	4.8	6.2	5.1
Out-of-pocket payments	6.0	2.8	2.1	3.0	4.5	6.0	4.8
Private health insurance	4.4	3.1	3.3	2.5	4.9	6.3	5.1
Other private funds	10.8	0.1	3.2	3.4	6.0	7.3	6.1
Public funds	6.5	6.5	8.7	5.2	6.7	7.2	7.0
Federal	6.4	8.2	12.4	5.1	5.7	7.4	7.1
Medicare	7.1	8.6	8.1	1.5	6.9	7.8	6.9
Medicaid	6.1	8.4	23.0	10.8	3.1	7.5	7.5
Other federal[c]	4.8	6.5	11.9	7.7	6.1	6.4	6.9
State and local	6.5	2.2	−1.7	5.3	9.7	6.6	6.8
Medicaid	6.1	−0.1	−8.6	5.3	15.1	7.6	8.4
Other state and local[c]	6.9	4.6	5.0	5.3	4.5	5.4	5.0
Total Medicaid[d]	6.1	4.7	9.9	8.9	7.6	7.6	7.9

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES**: Growth rates are calculated consistent with the National Health Expenditure Accounts methodology. For example, the 2019 growth rate above is equal to the level of 2019 expenditures over the level of 2014 expenditures raised to the one-fifth power (the average growth over five years); 2019 growth rate is shorthand for 2014–2019 growth rate. [a]Average annual growth from 2006 through 2007. [b]Projected. [c]Includes Children's Health Insurance Program (CHIP) (Title XIX and XXI). [d]Subset of public funds; includes both the federal and the state and local portion of Medicaid.

ditional projection year. The volatility of recent macroeconomic conditions and the uncertainty surrounding the timing and magnitude of the economic recovery increase the uncertainty of the projections presented in this paper.

Factors Accounting For Growth

There are two primary drivers of growth in aggregate personal health care spending, which is a subset of national health spending that includes only the purchase of health care goods and services. These drivers are medical prices and utilization, followed by smaller effects from population growth, and the age-sex mix. Medical prices are influenced by economywide factors and "relative medical price inflation," which is the difference between medical and economywide price inflation.[6] Steady growth is projected in medical prices, at 3.2 percent, in 2009. Coupled with low economywide price inflation during the recession, this growth results in a spike in relative medical price inflation in 2009 to 1.9 percent (from 0.9 percent in 2008). For 2010–2019, economywide and relative medical price inflation are projected to average 2.1 percent and 1.2 percent, respectively, as economywide price inflation accelerates with the economic recovery.

Utilization, which includes both the volume and the intensity (or complexity) of services, is projected to have grown 1.5 percent in 2009, compared to 0.3 percent in 2008. Partially influencing the expected increase were the use of services associated with treatments for the H1N1 (swine flu) virus and higher-than-average takeup rates among those eligible for subsidized coverage provided through COBRA.[9,10] In 2010, utilization growth is projected to slow to 0.2 percent because of a decrease in the number of people with private health insurance coupled with employers passing more coverage cost increases to employees in the form of higher deductibles and copayments.[11] After 2010, growth in the use of health care is projected to accelerate as demand responds to the economic recovery.

The effects of population growth and the changing age-sex mix are expected to be minor, contributing 0.9 percent and 0.4 percent, respectively, to annual growth for 2009–2019.

Payer Outlook

MEDICARE Medicare spending is projected to have increased 8.1 percent in 2009 and to have reached $507.1 billion (Exhibits 4 and 5). This growth is lower than that of 2008 (8.6 percent) and is related to decelerations in growth for prescription drug and hospital spending.

In 2010, Medicare spending growth is projected to slow to 1.5 percent, due principally to the 21.3 percent reduction in physician payment rates driven by the SGR formula and mandated

in current law. As Medicare managed care payment rates and spending are affected by changes in fee-for-service payment rates, the decrease in physician payment rates in 2010 would result in slower growth in managed care payments across most services. Holding physician payment rates constant in 2010 would result in 5.1 percent projected growth in Medicare spending. [12]

For 2011–2019, Medicare spending growth is expected to average 7.4 percent, partially because of greater enrollment growth as the oldest baby boomers become eligible. Under the illustrative scenario in which physician payment rates are held constant for 2011–2019, annual Medicare spending growth is projected to average 7.7 percent—0.3 percentage point faster than under current law.

MEDICAID Federal and state Medicaid spending combined is projected to have grown 9.9 percent and to have reached $378.3 billion in 2009 (Exhibits 4 and 5). This would constitute the fastest rate of Medicaid growth since 2002, when it was 10.7 percent. Largely a result of rising unemployment, rapidly increasing Medicaid enrollment growth of 6.5 percent is expected to have been the principal driver of the 2009 spending acceleration. Enrollment increases are projected to be most notable among nondisabled children and adults during the recession as working parents become unemployed and lose access to employer coverage. For 2010, the growth rates in enrollment and spending are expected to remain comparatively high (5.6 percent and 8.9 percent, respectively) as a result of expected continued high rates of unemployment.

By 2012, Medicaid spending growth is projected to slow to 7.0 percent, as the economy is expected to improve and enrollment growth decelerates. Medicaid growth is then projected to average 7.5 percent per year for 2013–2019. Contributing to faster Medicaid spending growth is an increasing share of aged beneficiaries in the program, who tend to be more costly than other eligibility groups.

PRIVATE HEALTH INSURANCE Growth in private health insurance premiums reflects the combination of changes in enrollment and premiums per enrollee. It is projected to have increased slightly, from 3.1 percent in 2008 to 3.3 percent in 2009, and to have reached $808.7 billion in 2009 (Exhibits 4 and 5). This steady rate of growth is the net result of a reduction in the number of people with private health insurance coverage due to job losses, somewhat offset by an increase in the takeup rate of COBRA as a result of government subsidization of these premiums. Based on relatively high projected rates of unemployment, expected slower price growth, and the expiration of the COBRA subsidies, a deceleration in private health insurance premium spending is expected in 2010 (2.5 percent).

By 2015, premium growth is projected to reach 7.1 percent. This more rapid rate of growth is expected to reflect an improving economy and increasing private health insurance enrollment beginning in 2012.

Private health insurance premium spending per enrollee is projected to have grown 4.6 percent in 2009, up from 3.6 percent in 2008. This acceleration resulted in part from an increase in the proportion of people with high-cost claims—many of whom have temporary COBRA coverage—as well as an increase in the number of people with the H1N1 virus.[9,13] Private health insurance benefit spending trends are influenced by the same factors and thus are expected to experience similar rates of growth.

OUT-OF-POCKET SPENDING Out-of-pocket spending is projected to have grown 2.1 percent in 2009, down from 2.8 percent in 2008, and to have reached $283.5 billion (Exhibits 4 and 5).[14] Recessionary effects contributed to this trend. It is projected that there was a slowdown in growth in the demand for services that involve sizable out-of-pocket costs. At the same time, enrollment growth in Medicaid, with its minimal cost sharing, is projected to have increased.

In 2010, out-of-pocket spending growth is projected to rebound slightly to 3.0 percent. This is partly a result of employers' greater willingness to pass on more of the increases in health costs to employees through higher cost sharing.[15] Although growth in out-of-pocket spending has historically been lower than growth in private health insurance spending, the two are expected to grow at roughly 6.0 percent for the second half of the projection period because of projected continuing increases in cost sharing.

Medical Services Outlook By Sector

HOSPITAL SERVICES Hospital spending growth is projected to have accelerated from 4.5 percent in 2008 to 5.9 percent in 2009, as spending reached $760.6 billion (Exhibits 1 and 2). Growth in hospital spending by public payers is anticipated to have accelerated to 8.0 percent in 2009 from 6.2 percent in 2008. Medicaid hospital spending growth is expected to have been the principal driver, with a projected acceleration of 6.1 percentage points in growth due to recession-related increases in enrollment.

For private payers, hospital spending growth is projected to have increased from a twelve-year low of 2.3 percent in 2008 to 3.1 percent in 2009. This is due partially to a rebound in hospital institutional investment returns (a revenue source used to fund patient care)[16] and increased

demand for services associated with the H1N1 virus.[17] The impact of these factors on spending growth is anticipated to have more than offset the impact of recession-related reductions in demand for hospital services, particularly for nonemergency procedures.[18]

In 2010, hospital spending growth is projected to slow to 3.7 percent. This deceleration is driven primarily by a projected 2.8-percentage-point slowdown in public spending growth. This slowdown, in turn, is associated with projected lower increases in Medicare managed care payment rates and an expected slowing of Medicaid spending.[12] Private spending growth is likewise projected to slow in 2010, somewhat less dramatically, to 1.7 percent in lagged response to slower income growth caused by the recession.

Hospital spending growth is projected to accelerate after 2010 and to reach a projection-period high of 7.0 percent in 2016. This acceleration is expected to be driven mainly by faster private spending growth as projected incomes rise. After 2016, and related to the shift of the oldest baby boomers into Medicare, public and private hospital spending trends are expected to diverge. By 2019, public spending growth for hospital services is projected to accelerate to 7.3 percent, while private spending growth is projected to slow to 4.8 percent.

PHYSICIAN AND CLINICAL SERVICES Spending growth for physician and clinical services is expected to have accelerated to 6.3 percent in 2009, up from 5.0 percent in 2008, with expenditures having reached $527.6 billion (Exhibits 1 and 2). This acceleration is primarily driven by projected growth in Medicaid, which is projected to have grown 10.3 percent in 2009 compared to 8.9 percent in 2008. Also contributing is a projected increase in growth in private spending, from 3.6 percent in 2008 to 4.7 percent in 2009, in part as a result of care associated with H1N1.[9]

Under current law, physician and clinical spending growth is expected to decelerate to 1.5 percent in 2010. This deceleration is driven by the projected 6.1 percent decrease in Medicare spending, which results from the 21.3 percent Medicare physician payment rate reduction called for by the SGR provisions. Under the 0 percent SGR illustration, total physician and clinical spending growth is still projected to slow in 2010, but only to 4.1 percent, primarily because of slower Medicare managed care rate increases. Private spending growth in 2010 is projected to slow as well, to 2.4 percent. This is due in part to effects of the recession and to employer plans' higher cost-sharing requirements.[19]

Driven largely by the improving economy, physician and clinical spending growth is expected to begin accelerating in 2011 and to reach 6.6 percent by 2017. Factors similar to those influencing hospital spending are expected to influence this type of spending as well. Trends in public and private physician and clinical services spending growth diverge for the last three years of the projection, averaging 7.6 percent and 6.1 percent, respectively, for 2017–2019.

PRESCRIPTION DRUGS Prescription drug spending is expected to have grown 5.2 percent in 2009, an acceleration of 2.0 percentage points from 2008, and to have reached $246.3 billion (Exhibits 1 and 2). Growth in the use of prescription drugs per person is expected to rebound from an actual decrease in 2008 to 0.9 percent in 2009, driven by an increase in the use of antiviral drugs related to the H1N1 virus.[20]

Another factor in the expected 2009 acceleration is higher price growth for brand-name drugs, as the Consumer Price Index for prescription drugs has increased from 2.5 percent in 2008 to a projected 3.4 percent rate in 2009.[21] By 2011, drug spending growth is expected to accelerate to 5.6 percent, corresponding to an upward trend in use that is due to projected improving economic conditions.

In 2012 and 2013, accelerating drug spending growth is expected to exhibit a temporary pause as many top-selling brand-name drugs lose patent protection.[22] Because of the expected shift to the less expensive versions of these drugs when their patents expire, prescription drug price growth is expected to decelerate from 3.0 percent in 2011 to 1.9 percent in 2012.[6] Price growth is expected to remain at lower-than-historical levels into 2013, as prices for these blockbuster drugs and their generic versions are anticipated to continue to fall as the number of generic competitors increases.[23] As a result, prescription drug spending growth is projected to be 4.7 percent in 2012 and 5.4 percent in 2013.

Prescription drug spending growth is anticipated to accelerate through 2019, reaching 7.7 percent that year. Increases in drug prices are expected to account for about half of this growth. Also, expected increases in the number of new drug approvals, as well as an increase in the share of expensive specialty drugs, are projected to result in accelerating growth over this time frame.[24]

Conclusion

This paper was written amid two significant events, either or both of which could lead to important changes in U.S. health care.

First, the economic recession is projected to have major effects on the health care system, contributing not only to slower spending growth in the next several years but also to a shift of

payment sources, primarily from private health insurance and out-of-pocket spending to Medicaid. How quickly economic growth rebounds, and to what extent, will affect the growth of health care spending over the next decade.

Second, Congress is deliberating health care legislation that could greatly affect the health care system. Should such legislation ultimately be signed into law, there would undoubtedly be many changes in health care delivery and financing. These could include the number of people with insurance, the sources of payment for health care, and the growth rate of national health spending. As a result, many facets of these projections could change dramatically. Should reform come to pass, therefore, a second paper presenting projections based on the new law will be forthcoming. ■

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NOTES

1. National Health Expenditure Accounts and gross domestic product data are presented in nominal terms unless otherwise specified.
2. Hartman M, Martin A, Nuccio O, Catlin A. Health spending growth at a historic low in 2008. Health Aff (Millwood). 2010;29(1):147–55.
3. These projections are based on the laws and regulations in effect as of 15 December 2009, except for Medicare projections, which are based on laws and regulations in effect as of 29 October 2009.
4. COBRA provides people the option of purchasing health insurance through their former employer for up to eighteen months after their employment ends. The federal subsidies provided by the American Reinvestment and Recovery Act pay 65 percent of the premium for up to nine months for people who involuntarily leave their jobs.
5. In practice, it is very likely that Congress will override the physician payment reduction, as it has for 2003–2009.
6. For a complete description of the projections model, the data used, and its theoretical basis, see Centers for Medicare and Medicaid Services. Projections of national health expenditures: methodology and model specification [Internet]. Baltimore (MD): CMS; 2010 Feb 4. Available from: http://www.cms.hhs.gov/NationalHealthExpendData/downloads/projections-methodology.pdf
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8. The effects of a reduction in physician reimbursement of this size are difficult to predict. No secondary effects of the 21.3 percent reduction in physician payment rates are assumed in these projections. For more information, see Clemens MK, Lizonitz JM, Murugesan SM. Projected Medicare Part B expenditures under two illustrative scenarios with alternative physician payment updates [Internet]. Baltimore (MD): CMS; 2009 May [cited 2009 Dec 4]. Available from: http://www.cms.hhs.gov/ReportsTrustFunds/downloads/AlternativePhysicianUpdate.pdf
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12. Medicare Advantage payment rates have been set for 2010 based on the 21.3 percent physician payment cut under the SGR. A subsequent change to the physician payment rate for 2010 would not affect these payment rates in 2010.
13. People with relatively higher medical costs are expected to be more likely to purchase COBRA coverage than people with relatively lower costs; thus, as the number of people with private health insurance declines during the recession, it is anticipated that the average cost per enrollee would increase, excluding other factors.
14. Out-of-pocket spending consists of direct spending by consumers for health care goods and services, including coinsurance and deductibles; enrollee premiums for private health insurance and Medicare are not in this funding category.
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