U.S. Health Reform—Monitoring and Impact

Slow Growth in Medicare and Medicaid Spending per Enrollee Has Implications for Policy Debates

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

IN BRIEF

Since about 2006, national health expenditure (NHE) growth has been slow relative to historic growth rates. Still, NHE continued to grow faster than gross domestic product (GDP) in most years and health spending was nearly 18 percent of GDP by 2017. Proposals to curb health spending growth and free up resources for other national priorities often target Medicare and Medicaid as the key drivers of health spending growth.

Annual spending growth between 2006 and 2017 averaged 5.2 percent for Medicare, 6.0 percent for Medicaid, and 4.4 percent for private health insurance, all exceeding the 3.2 percent average annual growth in GDP. The main reason that Medicare and Medicaid spending growth outpaced private insurance, however, was much faster enrollment growth in public programs compared to private coverage. From 2006 to 2017, growth in spending per enrollee in Medicare and Medicaid averaged 2.4 percent per year and 1.6 percent per year respectively, versus 4.4 percent per year for the privately insured. Over the same period, GDP per capita grew an average of 2.4 percent per year.

There was also considerable variation in the services contributing to spending growth across payers. Prescription drug spending was a major component of growth in Medicare spending per enrollee from 2006 to 2017, while spending on physician services and administrative costs were key drivers of growth in Medicaid spending per enrollee over the same period. For the privately insured, spending on hospital services was the most important driver of growth in spending per enrollee from 2006 to 2017.

The Centers for Medicare and Medicaid Services project much faster growth in Medicare and Medicaid spending per enrollee from 2017 to 2026 than we have seen in the past decade. These projections raise concerns about the sustainability of current trends and have been cited in proposals to dramatically restructure both programs. Based on our analysis of recent spending patterns by payer, however, we conclude that Medicare and Medicaid have successfully moderated growth in spending per enrollee over the last decade and thereby do not require major restructuring. We also use our analysis of spending growth by service type to consider alternative policy proposals to address spending growth for public and private payers.

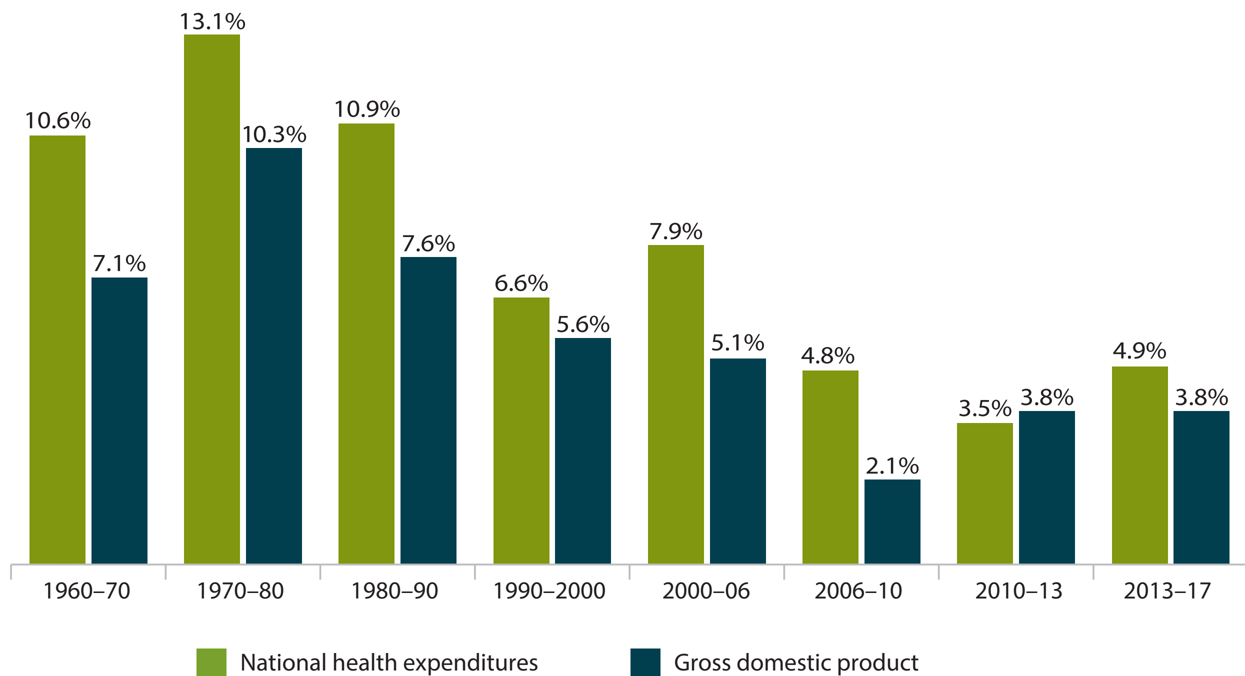
BACKGROUND

Recently released estimates show that national health expenditures (NHE) grew just 3.9 percent in 2017.[1] From 2007 to 2013, the average annual rate of health spending growth was below 4 percent, but increased to 5.2 percent in 2014 and 5.8 percent in 2015, largely because of the Affordable Care Act (ACA) coverage expansion and the introduction of costly new prescription medications for Hepatitis C. Health spending then grew 4.8 percent in 2016, so 2017 represents the second consecutive year of deceleration in spending growth.

From 1960 to 1990, NHE grew, on average, over 10 percent annually and exceeded average annual gross domestic product (GDP) growth by at least 2 percentage points (Figure 1/Table 1).[2] From 1990 to 2000, NHE growth fell to an average of 6.6 percent per year but still exceeded GDP growth by 1 percentage point. Spending grew an average of 7.9 percent per year from 2000 to 2006 and then slowed to 4.8 percent per year from 2006 to 2010, largely because of the Great Recession. As GDP growth rebounded following the recession, health spending slowed even further. NHE growth averaged 3.5 percent per year from 2010 to 2013 while GDP grew at an average annual rate of 3.8 percent.

Considerable attention has been given to the slowdown in spending growth and the possible reasons that it persisted well after the end of the Great Recession.[3,4,5,6] The recession caused a sharp decline in employer-sponsored insurance coverage and increased uninsurance and Medicaid enrollment.

Figure 1. Average Annual Growth of National Health Expenditures and Gross Domestic Product, 1960–2017



Source: Urban Institute analysis of the Centers for Medicare & Medicaid Services national health expenditure accounts.

Note: The 2000–10 period is divided to illustrate the effects of the recession, and the 2010–17 period is divided to reflect the effects of the Affordable Care Act.

Table 1. Growth in National Health Expenditures and Gross Domestic Product, 1960-2017

	Average annual growth in NHE	Average annual growth in GDP	NHE as a percent of GDP at end of period
1960-70	10.6%	7.1%	6.9%
1970-80	13.1%	10.3%	8.9%
1980-90	10.9%	7.6%	12.1%
1990-00	6.6%	5.6%	13.4%
2000-06	7.9%	5.1%	15.6%
2006-10	4.8%	2.1%	17.3%
2010-13	3.5%	3.8%	17.2%
2013-17	4.9%	3.8%	17.9%

Source: Urban Institute analysis of the Centers for Medicare & Medicaid Services national health expenditure accounts.

Note: The 2000–10 period is divided to illustrate the effects of the recession, and the 2010–17 period is divided to reflect the effects of the Affordable Care Act.

As a result, lower Medicaid provider payment rates and more limited use of services by the newly uninsured substituted for higher employer-sponsored insurance payment rates and contributed to slow spending growth from 2006 to 2010. Prescription drug spending also slowed as fewer new blockbuster drugs were introduced and use of generics increased.[7] Recession-related pressure on state budgets led to more aggressive efforts to contain Medicaid costs.[8,9,10] At the same time, private insurance deductibles increased rapidly, and private health plans increasingly implemented tiered networks.[11] These policies led to reduced use of services by the privately insured, also slowing spending.[12,13]

In the aftermath of the Great Recession, both public and private payers continued to focus on cost containment, and health spending growth remained low, averaging only 3.5 percent per year from 2010 to 2013. During this period, the Medicare payment provisions of the ACA were also implemented. These provisions reduced payment rate increases for institutional providers using a productivity index and lowered payments to Medicare Advantage plans.[14] In addition, the sequestration mechanism of the Budget Control Act of 2011 reduced Medicare payment rates even further.[15] States continued strong cost containment efforts in Medicaid because of budget constraints and private sector policies, including ever higher deductibles, continued.[9,10,11]

The first meaningful uptick in spending growth since 2002 occurred in 2014, when NHE grew by 5.2 percent from the previous year, and spending growth increased again in 2015 to 5.8 percent. This spike coincided with the ACA coverage expansion to approximately 13 million people in 2014, and 20 million by 2015.[16] In 2016, however, spending growth fell below 5 percent, suggesting that spending growth from the ACA expansions had stabilized. The most recent estimates confirm that spending growth in 2017 (3.9 percent) returned to a rate similar to that which preceded the ACA coverage expansion.

While they have not yet incorporated the most recent 2017 health spending estimates into their projections, the Centers for Medicare & Medicaid Services (CMS) actuaries predict increased growth in NHE over the next decade. Specifically, they project an average annual increase of 5.6 percent per year from 2017 to 2026, culminating in an estimated NHE growth rate of 6.1 percent in 2026, a rate not seen since 2007.[17] Underlying these projections are assumptions about spending growth by major payers including Medicare, Medicaid, and private health insurance. The projections indicate much faster annual spending growth among public payers from 2017 to 2026, averaging 7.6 percent for Medicare and 6.2 percent for Medicaid. Over the same period, private health insurance spending would grow, on average, by only 4.6 percent annually. These projections are particularly important given current debates surrounding the future of entitlement programs and their contributions to projected increases in federal deficits.

The Tax Cuts and Jobs Act of 2017 exacerbated the federal deficit, which is projected to average more than $1 trillion per year from 2019 to 2027.[18] The deficit and the resulting debt increase relative to the size of the economy are spurring calls to cut entitlement programs, including Medicare and Medicaid. The fiscal year 2018 House budget resolution called for major cuts in Medicare and Medicaid, possibly through premium support proposals for Medicare and block grants for Medicaid.[19] More recently, the Senate majority leader, Mitch McConnell, called for cuts in entitlement programs to reduce the deficit.[20] The most recent Medicare Trustees report raised further concerns by projecting that the Medicare hospital insurance trust fund would be depleted by 2026, three years sooner than projected in their previous report.[21]

But, though some see Medicare and Medicaid as the root cause of the federal government's spending problems, others see these programs as models for better and more efficient insurance coverage for the US population. As such, at least eight current proposals call for expanded public health insurance coverage through Medicare, Medicaid, or some combination thereof.[22] Thus, it seems critical to better understand recent health spending patterns by payer and what these patterns suggest about the likely trajectory of future health spending.

In this paper, we examine health spending growth for Medicare, Medicaid, and private health insurance from 2006 to 2017, using CMS estimates.[23] We analyze how enrollment and specific services contribute to spending growth for each major payer over this period. We then examine spending and enrollment projections for each major payer from 2017 to 2026 and consider how these predictions align with recent experience. Finally, we consider how both historic and projected spending patterns might inform cost containment strategies within and across payers, as well as policy proposals targeting the expansion or contraction of public programs.

Average Annual Growth in Spending, Enrollment, and Spending per Enrollee, 2006–17

As noted, by historical standards, health spending growth was generally quite slow over the period 2006-2017, with faster spending growth in 2014 and 2015 generally attributed to the ACA coverage expansions. Examining spending growth for the three major payers from 2006 to 2017, we find that Medicaid spending grew fastest, averaging 6.0 percent annually, Medicare spending grew an average of 5.2 percent

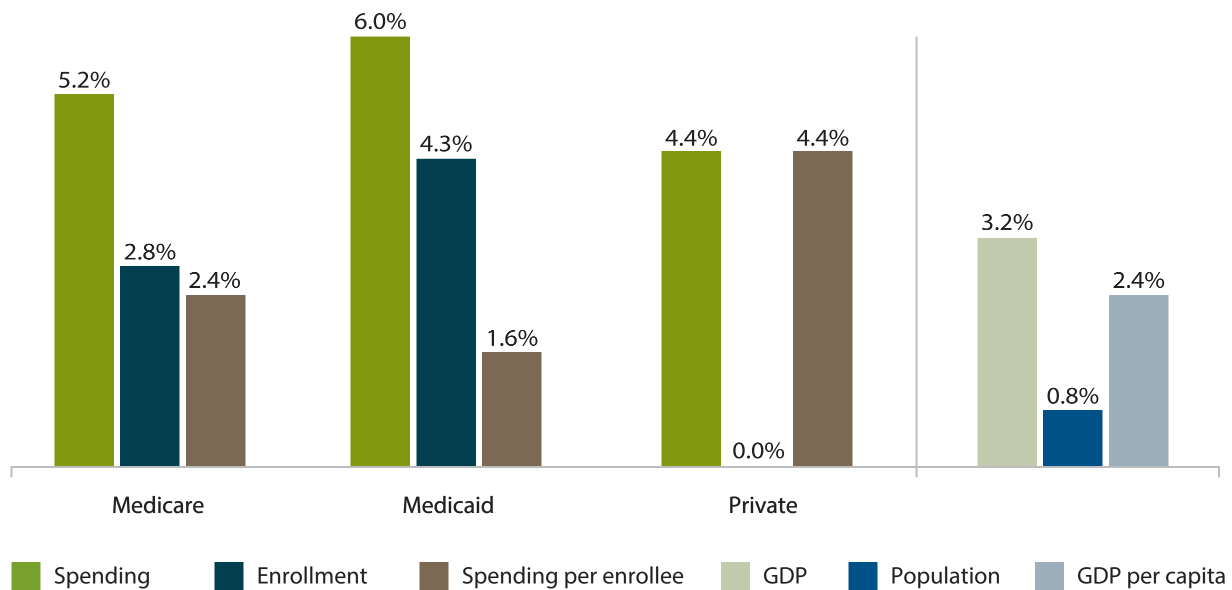
annually, and private health insurance spending growth averaged 4.4 percent annually (Figure 2/Table 2).

These averages, however, do not differentiate between spending growth from enrollment increases and growth associated with other factors. Over this period, Medicare enrollment grew an average of 2.8 percent annually, and Medicaid enrollment growth averaged 4.3 percent annually. In contrast, private health insurance enrollment stayed relatively flat. Medicare enrollment has grown more rapidly in recent years as the baby boom generation reaches age 65. Medicaid enrollment growth has increased for nearly a decade because of slow income growth and increasing disability incidence related to the aging of the population. Enrollment also increased during the Great Recession and then again with the ACA Medicaid expansion.

After accounting for the enrollment growth in these programs, Medicare and Medicaid have experienced much slower growth in spending per enrollee compared with private health insurance. From 2006 to 2017, spending per enrollee for Medicare and Medicaid grew by annual averages of 2.4 percent and 1.6 percent, respectively, while private health insurance spending per enrollee grew at an average of 4.4 percent per year. Moreover, growth in Medicare and Medicaid spending per enrollee was equal to or less than growth in GDP per capita over this period, while private spending per enrollee grew 2 percentage points faster than per capita growth in the economy as a whole.

Changes in the composition of enrollees in Medicare and Medicaid may have contributed to slower growth in spending per enrollee over this period. In Medicare, for example, faster enrollment growth among the lower-cost baby boom cohort has almost certainly had some effect on slowing growth in spending per enrollee. With the first boomers entering the program in 2011, however, it is difficult to disentangle these effects from major payment policy changes occurring at the same time. Though the recession and the ACA coverage expansion increased Medicaid enrollment among a younger, nondisabled, and lower-cost population, there has been an offsetting increase in older and disabled enrollees driven by the baby boom cohort. At the same time growth in enrollment of children has been extremely slow. Thus, it is unclear whether compositional changes in Medicaid enrollment contributed to slower or faster growth in spending per enrollee over this period. For total NHE, the CMS actuaries attribute only a small share of per capita spending growth to changes in the age and sex distribution of the population, about 0.5 percentage points of the 3.2 percent growth in 2017. We conclude that compositional shifts likely played only a modest role in spending growth patterns by payer as well when compared to the major drivers of changing prices and utilization.

Figure 2. Average Annual Growth in Spending, Enrollment, and Spending per Enrollee for Medicare, Medicaid, and Private Health Insurance, 2006–17



Source: Urban Institute analysis of the Centers for Medicare & Medicaid Services national health expenditure accounts.

Note: GDP is gross domestic product.

Table 2. Spending, Enrollment, and Spending per Enrollee in Medicare, Medicaid and Private Insurance, 2006-2017

	Year				
	2006	2010	2013	2017	2006-2017
Medicare					
Spending (in millions)	$403,690	$519,801	$589,861	$705,859	
Average annual growth rate		6.5%	4.3%	4.6%	**5.2%**
Enrollment (in millions)	42.4	46.6	51.3	57.2	
Average annual growth rate		2.4%	3.3%	2.8%	**2.8%**
Spending per enrollee	$9,521	$11,155	$11,498	$12,340	
Average annual growth rate		4.0%	1.0%	1.8%	**2.4%**
Medicaid					
Spending (in millions)	$306,680	$397,410	$445,204	$581,864	
Average annual growth rate		6.7%	3.9%	6.9%	**6.0%**
Enrollment (in millions)	45.6	54.0	58.9	72.6	
Average annual growth rate		4.3%	2.9%	5.4%	**4.3%**
Spending per enrollee	$6,725	$7,359	$7,559	$8,015	
Average annual growth rate		2.3%	0.9%	1.5%	**1.6%**
Private					
Spending (in millions)	$737,150	$864,321	$947,148	$1,183,910	
Average annual growth rate		4.1%	3.1%	5.7%	**4.4%**
Enrollment (in millions)	197.0	185.8	187.5	197.3	
Average annual growth rate		-1.5%	0.3%	1.3%	**0.0%**
Spending per enrollee	$3,742	$4,652	$5,051	$6,001	
Average annual growth rate		5.6%	2.8%	4.4%	**4.4%**

Source: Urban Institute analysis of the Centers for Medicare & Medicaid Services national health expenditure accounts.

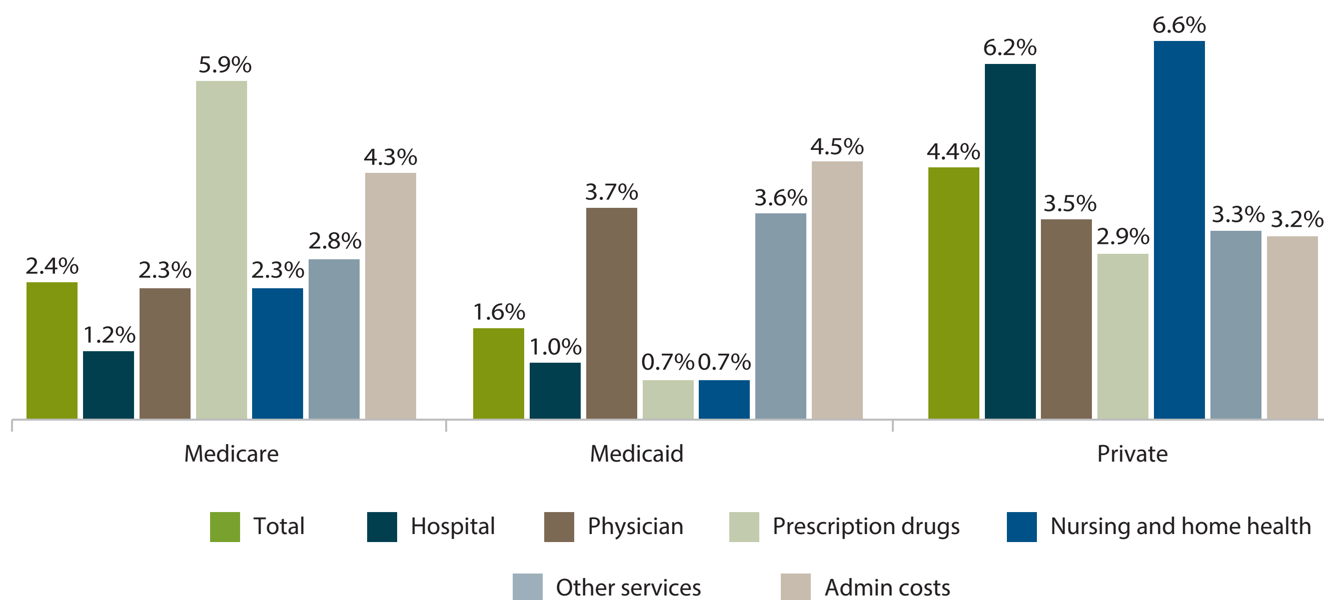
Note: Average annual growth rates for 2010, 2013, 2017 are from the prior year displayed in the table.

Average Annual Growth in Spending per Enrollee by Service Category, 2006–17

Patterns of per enrollee spending growth obscure wide variation in spending growth on services both within and across payers. Though Medicare spending per enrollee grew at an average of 2.4 percent per year from 2006 to 2017, spending per enrollee on prescription drugs and administrative costs grew at average annual rates of 5.9 percent and 4.3 percent, respectively (Figure 3). In 2006, Medicare introduced its drug benefit, and after rapid spending growth during the program's phase-in, per enrollee drug spending growth stabilized at about 5 percent per year from 2008 to 2013 (data not shown), and then spiked in 2014 with the introduction of new drugs for Hepatitis C. Growth in the Medicare Advantage program contributed to the relatively rapid increase in spending on administrative costs.

In contrast to Medicare, growth in Medicaid spending per enrollee on prescription drugs averaged only 0.7 percent per year from 2006 to 2017, though the Medicaid program also experienced significant growth in 2014 and 2015 because of new Hepatitis C drugs. Early in this period, growth in Medicaid drug spending per enrollee was slowed by the shift of drug spending from Medicaid to Medicare for dually eligible beneficiaries with the introduction of the Medicare drug benefit. Slow growth in Medicaid drug spending can also be partially attributed to expanded manufacturer rebates under the ACA. Medicaid spending per enrollee on physician services grew at an average of 3.7 percent annually, with the highest growth rates in 2013 and 2014 coinciding with the temporary fee bump for primary care required under the ACA. Other health services, which include dental, durable medical equipment, and other professional services, grew

Figure 3. Average Annual Growth in Spending per Enrollee by Service Category, 2006–17



Source: Urban Institute analysis of the Centers for Medicare & Medicaid Services national health expenditure accounts.

Notes: Prescription drug spending is adjusted for rebates. Other services include dental; durable medical equipment; nondurable medical products; offices of other health practitioners including chiropractors, optometrists, and mental health practitioners (except physicians); offices of physical, occupational, and speech therapists; audiologists; podiatrists; and all other health practitioners.

an average of 3.6 percent annually. Of all Medicaid spending, administrative costs grew the fastest over this period at an average of 4.5 percent annually, which largely reflects growth in Medicaid managed care.

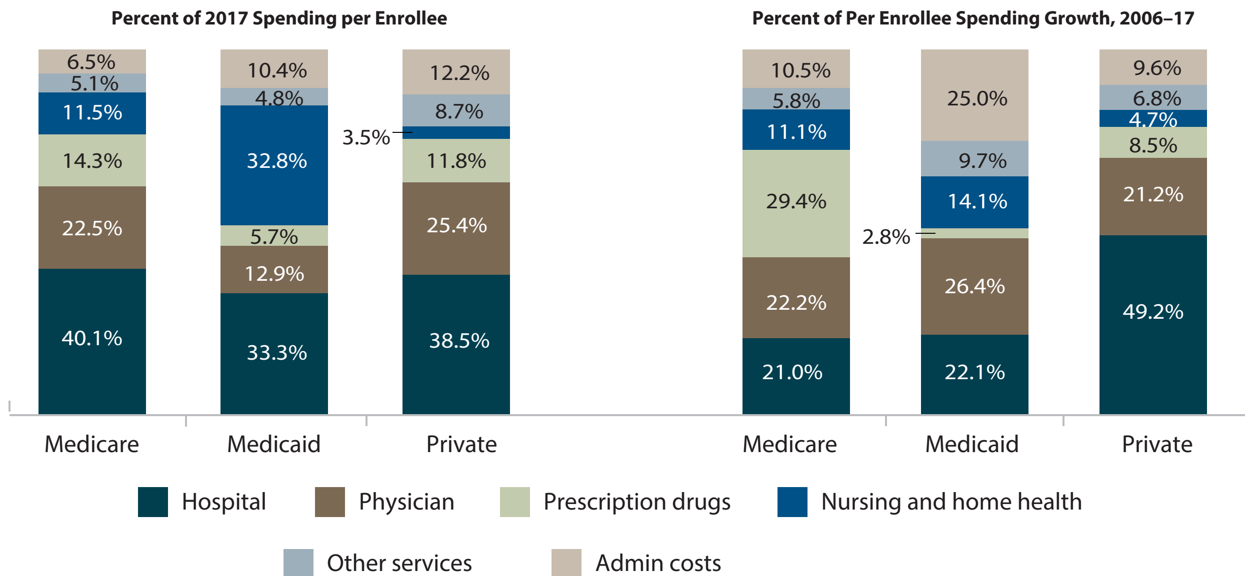
For private insurers, hospital expenditures grew rapidly over this period at an average of 6.2 percent per year, compared with slow growth in hospital spending for both public programs. Private insurers do not have the same bargaining power with hospitals as do Medicare and Medicaid and thus pay much higher prices to hospitals than either program.[24,25] In addition, the ACA and the Budget Control Act of 2011 severely limited the Medicare payment rate increases to hospitals and other institutional providers. Private insurers also saw rapid growth in spending on nursing and home health services over this period, but these services still represented a small share of private insurance expenditures (3.5 percent in 2017).

We also estimated the share of the total change in spending per enrollee attributed to each service. First, we calculated spending per enrollee overall and for each service in 2006 and 2017, as well as the change over time.[26] We then divided the change in spending per enrollee for each service by the total change in spending per enrollee (Figure 4). Prescription drugs represent the largest share (29 percent) of growth in Medicare spending per enrollee from 2006 to 2017, followed by physician and hospital services (22 and 21 percent, respectively). At 29 percent, drug spending constituted a much larger share of growth in Medicare spending per enrollee than of total spending per enrollee in 2017 (14 percent). On the contrary, hospital spending constituted a much larger share of Medicare spending per enrollee in 2017 (40 percent) than of per enrollee spending growth (21 percent).

For Medicaid, physician and hospital services (26 and 22 percent, respectively) account for almost 50 percent of the growth in spending per enrollee from 2006 to 2017, while prescription drug spending accounts for only 3 percent of that spending growth. Administrative costs represent about 25 percent of the growth in spending per enrollee over this period, which is striking given that those costs only accounted for about 10 percent of spending in 2017. Physician services show a similar pattern, representing about 26 percent of growth in Medicaid spending per enrollee from 2006 to 2017, but only 13 percent of spending per enrollee in 2017. Hospital and nursing home spending, however, account for about two-thirds of total Medicaid spending per enrollee in 2017, but just over one-third of spending growth from 2006 to 2017.

Hospital services account for the most growth in spending per enrollee by private insurers at nearly 50 percent, followed by physician services at 21 percent. Prescription drugs accounted for approximately 9 percent of growth in spending

Figure 4. Distribution of Spending per Enrollee in 2017 and Growth in Spending per Enrollee from 2006 to 2017, by Service Category



Source: Urban Institute analysis of the Centers for Medicare & Medicaid Services national health expenditure accounts.

Notes: Prescription drug spending is adjusted for rebates. Other services include dental; durable medical equipment; nondurable medical products; offices of other health practitioners including chiropractors, optometrists, and mental health practitioners (except physicians); offices of physical, occupational, and speech therapists; audiologists; podiatrists; and all other health practitioners.

per enrollee by private insurers from 2006 to 2017. Unlike the two public programs, the share of private health insurance spending growth attributed to each service is relatively close to the share of total spending per enrollee in 2017, with the exception of hospital services. Hospital spending accounted for 49 percent of per enrollee spending growth, but only 39 percent of spending per enrollee in 2017.

Projected Average Annual Growth in Spending, Enrollment, and Spending per Enrollee, 2017–26

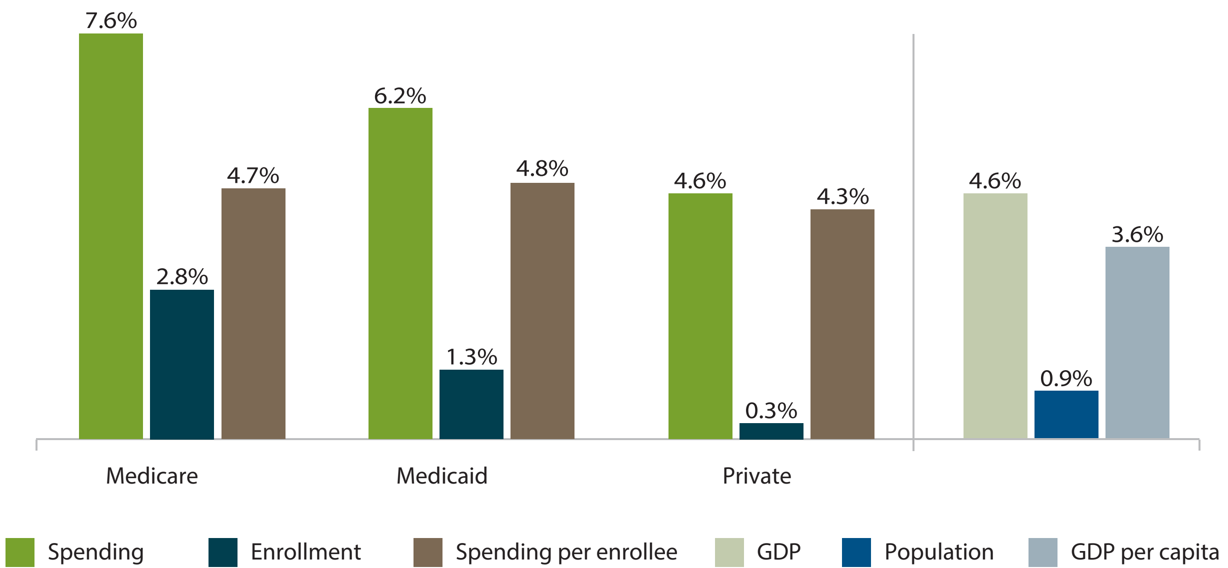
As shown in figure 2, spending grew faster in public programs than in private health insurance between 2006 and 2017, but after accounting for enrollment growth, spending per enrollee grew slower in Medicare and Medicaid than private insurance. However, CMS projects growth in spending per enrollee in Medicare and Medicaid will exceed growth in spending per enrollee in private health insurance between 2017 and 2026 (Figure 5). CMS expects spending per enrollee to grow at an average annual rate of 4.7 percent for Medicare and 4.8 percent for Medicaid. These projections reflect increases in the average annual growth of per enrollee spending (2.3 percentage points and 3.2 percentage points for Medicare and Medicaid, respectively) compared with the 2006–17 period. Moreover, CMS expects growth in both public programs' spending per enrollee to exceed growth in GDP per capita by just over 1 percentage point and growth in private spending per enrollee to remain fairly stable, compared with the prior period, at approximately 4.3 percent per year.

While the detailed assumptions driving these projections are not reported, the estimates clearly suggest a belief that the slow growth in Medicare and Medicaid per enrollee spending from 2006 to 2017 will not continue over the next decade. Unless there is a strong basis for anticipating a reversal of the ongoing trend over the last decade or more, however, these projections may well be an overestimate of growth in public program spending in the coming years.

DISCUSSION

Health spending growth in the United States has often been deemed unsustainable as health care consumes an ever increasing share of GDP and crowds out spending on other goods and services.[27] Moreover, even as health spending relative to GDP continues to grow, the US does not have better outcomes than other industrialized nations that dedicate a much smaller share of their economy to health spending.[28] Public programs in particular are often the

Figure 5. Projected Average Annual Growth in Spending, Enrollment, and Spending per Enrollee for Medicare, Medicaid and Private Health Insurance, 2017–26



Source: Urban Institute analysis of Centers for Medicare & Medicaid Services national health expenditure accounts.

Note: GDP is gross domestic product.

target of cost containment efforts aimed at reducing federal spending and reigning in national health spending growth. Most recently, calls to cut entitlement programs have been motivated by a soaring federal deficit and projections that the Medicare trust fund will soon be depleted.

In this paper, we used CMS data to show that high rates of spending growth in Medicare and Medicaid from 2006 to 2017 were largely driven by increases in enrollment and that growth in spending per enrollee in both programs has been below that in private insurance and below growth in GDP per capita over the last decade or so. Thus, these programs appear to have been relatively successful at moderating spending growth compared to private insurance. These patterns do not support drastic calls to restructure Medicare and Medicaid in order to slow national health spending growth, and may actually provide some support for efforts to expand public programs or borrow some of their cost containment strategies for use in the private sector.

Of course, the conclusion above is only valid if the slower growth rates of the last decade or so are sustainable and current CMS projections suggest that this may not be the case. In fact, the most recent CMS projections suggest significant increases in growth in spending per enrollee in public programs from 2017 to 2026. These projections could materialize if continued economic prosperity leads private and public payers to ease up on cost containment efforts and if inflationary pressures increase input prices. The CMS projections also incorporate an expectation that a new wave of blockbuster drugs will emerge over the next decade. Moreover, the aggressive Medicare payment policies that have characterized the last decade may be hard to sustain, especially in the face of rising input prices. In general, the current CMS projections appear consistent with the view that the recession and sluggish recovery were the dominant reasons for the slow growth in spending in recent years, and that a return to higher rates is inevitable.[29,30]

Some would argue, however, that the recent slowdown in spending growth involved more fundamental structural changes to the health care system, which suggests that the projections could be overstated.[3,4,5,6] The slower growth in recent years seems to be due to higher deductibles, health plans with more limited provider networks, and aggressive payment policies in public programs. Together, such policies have reduced the flow of revenues to providers and may have caused them to adjust their cost structures. There are no clear signs that a reversal of these policies is on the horizon and therefore there is limited justification for the large projected increases in per enrollee spending growth in Medicare and Medicaid over the next decade.

Regardless of the accuracy of these projections, recent spending patterns can still inform policy debates. Extremely slow spending growth on hospital care for both Medicare and Medicaid compared to rapid growth among private insurers clearly indicates the importance of hospital prices

and the negotiating power (i.e., administered pricing) of public payers in the face of growing hospital concentration. Moreover, there is little evidence that increases in private prices are a response to cuts in public payment rates (e.g., cost shifting). A 2011 review of the evidence by Austin Frakt notes that, "to the extent it has occurred at all, cost shifting is at a low rate. Instead, the vast majority of public payers' shortfalls are accommodated by cost cutting, not cost shifting."[31] This may seem like encouraging evidence in support of expanding public coverage or capping provider payment rates from private insurers, but there are concerns about how providers will respond if a larger share of the market pays substantially lower rates. The extent to which high prices reflect market concentration and inefficiency versus higher quality is not always clear, so pricing regulations could have unintended consequences for quality and innovation.[32,33]

Rapid spending growth on prescription drugs in Medicare compared to both Medicaid and private insurers also has important policy implications. Medicare's inability to negotiate with manufacturers or to deny coverage for low-value treatments is an important contributor to rising drug prices and spending, and ending these restrictions should be an important component of any cost-containment reform.[34] In addition, the growth in administrative costs in both Medicare and Medicaid in recent years is notable and seems largely due to the shifting of more individuals to managed care within each of these programs. While additional research is needed to understand whether and how the shift toward private plans has contributed to the slower spending growth in other services, some recent evidence on Medicare Advantage suggests that these plans have been successful at lowering costs without sacrificing quality.[35] There is, however, still room to reduce the costs of the Medicare Advantage program by lowering the fee-for-service benchmarks that determine payments to Medicare Advantage plans.[36]

Finally, though Medicare and Medicaid together represent a large and growing share of the federal budget and are therefore important factors in the current deficit challenge, we conclude that recent health spending patterns do not justify calls for major restructuring of these programs to lower national health spending. We do not intend to suggest that there is no room for modest policy proposals aimed at further containing costs in both public programs. For example, the Congressional Budget Office has recently released estimates of several reasonable approaches, including limiting state use of provider taxes in Medicaid, modifications to Medicare cost-sharing and restrictions on Medi-gap policies, and modest part B and part D premium increases.[37] But on the whole, our analysis suggests that the high spending growth in Medicare and Medicaid largely reflects growth in enrollment and not rapid increases in spending per enrollee. Thus, major reductions in Medicare and Medicaid spending growth would likely require restrictions on enrollment, which would reduce insurance coverage and cause significant medical and financial hardship.

NOTES

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