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National Health Spending In 2012: Rate Of Health Spending Growth Remained Low For The Fourth Consecutive Year

ABSTRACT For the fourth consecutive year, growth in health care spending remained low, increasing by 3.7 percent in 2012 to $2.8 trillion. At the same time, the share of the economy devoted to health fell slightly (from 17.3 percent to 17.2 percent) as the nominal gross domestic product (GDP) grew by 4.6 percent. Faster growth in hospital services and in physician and clinical services was mitigated by slower growth in prices for prescription drugs and nursing home services. Despite an uptick in enrollment growth, Medicare spending growth slowed slightly in 2012, mainly due to lower payment updates. For Medicaid, slowing enrollment growth kept spending growth near historic lows. Growth in private health insurance spending also remained near historically low rates in 2012, largely influenced by the nation's modest economic recovery and its impact on enrollment.

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The **National Health Expenditure Accounts Team** is recognized in an acknowledgment at the end of the article.

Total U.S. health care spending increased by 3.7 percent to $2.8 trillion (Exhibit 1), or $8,915 per person, in 2012.[1] Growth in national health spending has remained fairly stable since 2009, increasing between 3.6 percent and 3.8 percent annually. This low rate of increase followed a steady slowdown that began in 2003 after the most recent peak of 9.7 percent in 2002. The relative stability since 2009 primarily reflects the lagged impacts of the recent severe economic recession. In particular, income and employment growth was modest over this period, and there was a slow recovery from private health insurance enrollment losses that occurred during 2008–10.

Gross domestic product (GDP), which measures the nation's overall economic output, increased at approximately the same rate as did health spending in both 2010 and 2011. In 2012, nominal—that is, not adjusted for inflation—GDP grew almost 1 percentage point faster than did health spending. As a result, the share of the economy devoted to health care in 2012 fell slightly from its 2011 level (from 17.3 percent to 17.2 percent) (Exhibit 2). For 2011 the health spending share of GDP was 0.6 percentage point lower than previously reported due to a large upward revision to GDP.[2]

The Affordable Care Act (ACA), which was enacted in March 2010, had a minimal impact on overall national health spending growth through 2012. However, several provisions implemented in 2010 and 2011 continued to affect the payers and programs that financed health care spending in 2012, including increased Medicaid rebates for prescription drugs, the Medicare drug coverage gap ("doughnut hole") discount program, coverage for dependents under age twenty-six, and the minimum medical loss ratio provision. (The latter establishes the minimum amount of premium revenue that insurers must spend on medical claims and health care quality improvements.)[3] In 2012 a provision of the ACA reduced Medicare payment updates for most providers, thereby contributing to slower growth in Medicare spending in 2012.[4]

EXHIBIT 1

National Health Expenditures (NHE), Aggregate And Per Capita Amounts, Share Of Gross Domestic Product (GDP), And Annual Growth, By Source Of Funds, Calendar Years 2007–12

Source of funds	2007[a]	2008	2009	2010	2011	2012
EXPENDITURE AMOUNT						
NHE, billions	$2,302.9	$2,411.7	$2,504.2	$2,599.0	$2,692.8	$2,793.4
Health consumption expenditures	2,158.7	2,257.3	2,358.0	2,449.6	2,534.9	2,633.4
Out of pocket	293.6	300.7	300.7	305.6	316.1	328.2
Health insurance	1,611.8	1,703.2	1,798.5	1,873.9	1,943.4	2,014.4
Private health insurance	777.7	807.8	833.1	859.6	888.8	917.0
Medicare	432.8	467.9	499.9	520.2	546.2	572.5
Medicaid	326.2	344.9	375.4	398.1	407.7	421.2
Federal	185.8	203.5	248.1	267.5	248.3	237.9
State and local	140.4	141.4	127.3	130.7	159.4	183.3
Other health insurance programs[b]	75.1	82.6	90.2	96.0	100.7	103.8
Other third-party payers and programs and public health activity	253.3	253.4	258.8	270.2	275.4	290.8
Investment	144.2	154.4	146.2	149.4	157.8	160.0
Population (millions)	301.1	303.9	306.5	309.0	311.0	313.3
GDP, billions of dollars	$14,480.3	$14,720.3	$14,417.9	$14,958.3	$15,533.8	$16,244.6
NHE per capita	7,649	7,936	8,170	8,411	8,658	8,915
GDP per capita	48,093	48,437	47,037	48,409	49,944	51,843
Prices (2009 = 100.0)						
Chain-weighted NHE deflator	95.7	97.7	100.0	102.7	105.2	106.9
GDP price index	97.3	99.2	100.0	101.2	103.2	105.0
Real spending						
NHE, billions of chained dollars	$ 2,406	$ 2,469	$ 2,504	$ 2,531	$ 2,561	$ 2,612
GDP, billions of chained dollars	14,877	14,834	14,418	14,779	15,052	15,471
NHE as percent of GDP	15.9	16.4	17.4	17.4	17.3	17.2
ANNUAL GROWTH						
NHE	6.3%	4.7%	3.8%	3.8%	3.6%	3.7%
Health consumption expenditures	6.1	4.6	4.5	3.9	3.5	3.9
Out of pocket	5.9	2.4	-0.0	1.6	3.5	3.8
Health insurance	6.0	5.7	5.6	4.2	3.7	3.7
Private health insurance	5.1	3.9	3.1	3.2	3.4	3.2
Medicare	7.2	8.1	6.8	4.1	5.0	4.8
Medicaid	6.3	5.8	8.8	6.1	2.4	3.3
Federal	6.7	9.6	21.9	7.8	-7.2	-4.2
State and local	5.7	0.7	-10.0	2.7	22.0	15.0
Other health insurance programs[b]	7.4	9.9	9.2	6.4	4.9	3.1
Other third-party payers and programs and public health activity	6.7	0.0	2.1	4.4	1.9	5.6
Investment	9.9	7.1	-5.3	2.2	5.7	1.4
Population	0.9	0.9	0.9	0.8	0.7	0.7
GDP, billions of dollars	4.5	1.7	-2.1	3.7	3.8	4.6
NHE per capita	5.3	3.8	3.0	3.0	2.9	3.0
GDP per capita	3.5	0.7	-2.9	2.9	3.2	3.8
Prices (2009 = 100.0)						
Chain-weighted NHE deflator	3.3	2.0	2.4	2.7	2.4	1.7
GDP price index	2.7	1.9	0.8	1.2	2.0	1.7
Real spending						
NHE, billions of chained dollars	2.9	2.6	1.4	1.1	1.2	2.0
GDP, billions of chained dollars	1.8	-0.3	-2.8	2.5	1.8	2.8

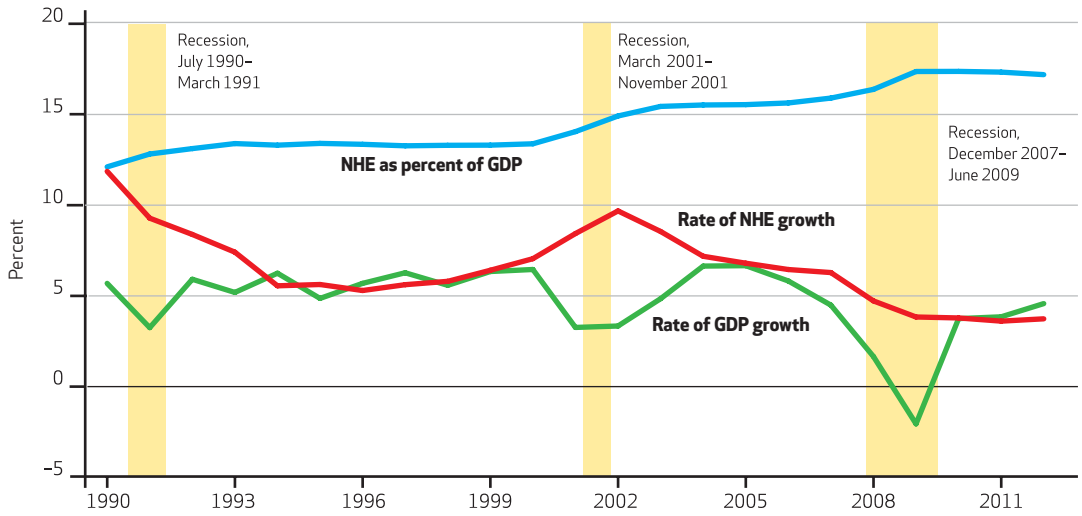
SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and US Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** Definitions, sources, and methods for NHE categories can be found at CMS.gov. National Health Accounts methodology paper, 2012: definitions, sources, and methods [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2014 [cited 2014 Jan 6]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-12.pdf. Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2006–07. [b]Includes health-related spending for Children's Health Insurance Program (CHIP) Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs.

Health Spending Highlights In 2012

National health expenditures increased by 3.7 percent in 2012 compared to 3.6 percent in 2011 (Exhibit 1).[5] Personal health care spending (health care goods and services), which accounted for 85 percent of overall national health

EXHIBIT 2

Growth In National Health Expenditures (NHE) And Gross Domestic Product (GDP), And NHE As A Share Of GDP, 1990–2012



SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; US Department of Commerce, Bureau of Economic Analysis; and National Bureau of Economic Research.

spending, increased by 3.9 percent in 2012, only 0.4 percentage point faster than it grew in 2011 (Exhibit 3). The remaining 15 percent of national health spending consists of health-related expenditures for public health activities, government administration and the net cost of health insurance, and investment in noncommercial research and in structures and equipment. In 2012 slower growth in investment in health-related equipment, a decline in noncommercial research due to the expiration of funding from the American Recovery and Reinvestment Act of 2009, and slower growth in the net cost of private health insurance partially offset the faster growth in personal health care spending.

The uptick in personal health care spending growth in 2012 was influenced primarily by hospital services, for which spending increased 4.9 percent in 2012 (compared to a 3.5 percent increase in 2011) as a result of increased growth in both nonprice factors (which include the use and intensity of services) and prices. Spending for physician and clinical services increased 4.6 percent in 2012 (from 4.1 percent growth in 2011) and was the second-largest contributor to the acceleration in personal health care spending growth. The faster growth in physician and clinical services' spending was driven primarily by increases in the volume and intensity of services provided.[6]

Partially offsetting some of the increased growth in spending for hospital care and physician and clinical services in 2012 was slower growth in spending for prescription drugs and nursing home care. Prescription drug spending increased at a low rate of 0.4 percent in 2012, down from 2.5 percent growth the prior year, mainly due to a slowdown in price growth as an unusually large number of high-volume, high-cost drugs lost patent protection, which led to increased sales of lower-cost generics. Nursing home spending growth in 2012 slowed to 1.6 percent (from 4.3 percent in 2011) as Medicare reduced payments for skilled nursing facilities to adjust for a large increase in payments that occurred in 2011.

Spending among health care payers varied in 2012, with faster growth in Medicaid and out-of-pocket spending, but slightly slower growth in private health insurance and Medicare spending. Medicaid spending growth (federal and state and local combined) remained relatively low but accelerated from 2.4 percent growth in 2011 to 3.3 percent in 2012 as some states withdrew previous payment cuts or expanded care (Exhibit 1).[7] Slightly faster growth in out-of-pocket spending (from 3.5 percent in 2011 to 3.8 percent in 2012), largely attributable to increased cost sharing,[8] was evident in the accelerated growth for out-of-pocket spending for hospital and physician and clinical services. This growth was moderated by reduced out-of-pocket spending on prescription drugs that was influenced by the so-called patent cliff, or the wave of brand-name patent expirations that occurred in 2012, resulting in lower prices for previously

EXHIBIT 3

National Health Expenditures (NHE) Amounts And Annual Growth, By Spending Category, Calendar Years 2007–12

Spending category	2007[a]	2008	2009	2010	2011	2012
EXPENDITURE AMOUNT						
NHE, billions	$2,302.9	$2,411.7	$2,504.2	$2,599.0	$2,692.8	$2,793.4
Health consumption expenditures	2,158.7	2,257.3	2,358.0	2,449.6	2,534.9	2,633.4
Personal health care	1,921.0	2,017.1	2,117.4	2,192.9	2,271.2	2,360.4
Hospital care	692.5	729.0	776.8	812.6	840.8	882.3
Professional services	618.6	652.8	672.4	694.2	720.9	752.3
Physician and clinical services	461.8	486.5	503.2	519.0	540.1	565.0
Other professional services	59.5	64.0	66.8	69.8	73.1	76.4
Dental services	97.3	102.4	102.5	105.4	107.7	110.9
Other health, residential, and personal care	107.7	113.5	122.5	128.1	132.3	138.2
Home health care	57.8	62.3	67.2	71.2	74.0	77.8
Nursing care facilities and continuing care retirement communities	126.4	132.6	138.5	143.0	149.2	151.5
Retail outlet sales of medical products	318.0	326.9	339.9	343.9	354.0	358.3
Prescription drugs	235.9	242.6	254.5	255.7	262.2	263.3
Durable medical equipment	34.3	34.9	35.0	37.0	39.1	41.3
Other nondurable medical products	47.8	49.5	50.3	51.2	52.8	53.7
Government administration	29.3	29.4	29.8	30.5	32.8	33.6
Net cost of health insurance	142.6	139.2	136.7	150.9	157.6	164.3
Government public health activities	65.9	71.5	74.1	75.3	73.3	75.0
Investment	144.2	154.4	146.2	149.4	157.8	160.0
Noncommercial research	42.4	44.0	45.4	49.1	49.7	48.1
Structures and equipment	101.7	110.4	100.9	100.3	108.2	111.9
ANNUAL GROWTH						
NHE, billions	6.3%	4.7%	3.8%	3.8%	3.6%	3.7%
Health consumption expenditures	6.1	4.6	4.5	3.9	3.5	3.9
Personal health care	6.2	5.0	5.0	3.6	3.6	3.9
Hospital care	6.2	5.3	6.6	4.6	3.5	4.9
Professional services	5.7	5.5	3.0	3.2	3.8	4.4
Physician and clinical services	5.2	5.3	3.4	3.1	4.1	4.6
Other professional services	8.2	7.6	4.4	4.6	4.6	4.5
Dental services	6.4	5.2	0.1	2.8	2.2	3.0
Other health, residential, and personal care	5.9	5.4	7.9	4.6	3.3	4.5
Home health care	9.9	7.8	8.0	5.8	4.1	5.1
Nursing care facilities and continuing care retirement communities	7.8	4.9	4.5	3.2	4.3	1.6
Retail outlet sales of medical products	5.8	2.8	4.0	1.2	3.0	1.2
Prescription drugs	5.1	2.8	4.9	0.4	2.5	0.4
Durable medical equipment	6.2	1.6	0.4	5.6	5.6	5.6
Other nondurable medical products	9.2	3.6	1.7	1.8	3.0	1.8
Government administration	1.8	0.5	1.3	2.4	7.3	2.7
Net cost of health insurance	4.3	−2.4	−1.8	10.4	4.5	4.2
Government public health activities	8.3	8.5	3.6	1.6	−2.6	2.3
Investment	9.9	7.1	−5.3	2.2	5.7	1.4
Noncommercial research	2.3	3.8	3.0	8.1	1.2	−3.1
Structures and equipment	13.5	8.5	−8.6	−0.5	7.8	3.4

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Exhibit 1 notes). Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2006–07.

expensive brand-name drugs.

Total private health insurance premiums grew 3.2 percent in 2012—the fifth consecutive year of low growth—in part as a result of the continued effects of the modest economic recovery on enrollment in private health insurance plans. The movement of enrollees to high-deductible health plans, which typically have lower premiums and higher cost sharing,[9] also contributed to low growth in private health insurance premiums in 2012. Medicare growth slowed only slightly (from 5.0 percent in 2011 to 4.8 percent in 2012) because of a one-time payment reduction for skilled nursing facilities as well as reduced fee-for-service payment updates for hospitals and most other providers.

Factors Accounting For Growth

National health spending growth can be disaggregated into five broad factors: economywide inflation, medical-specific inflation, population change, shifts in the age and sex mix of the population, and other nonprice factors (which include changes in the use and intensity of services and errors in measuring prices or total spending). On a per capita basis, national health spending increased 3.0 percent in 2012. Although per capita spending growth remained fairly stable in 2012, the factors underlying that growth were more varied.

Medical price growth, which includes overall economywide inflation and medical-specific inflation, slowed to 1.7 percent in 2012 (from 2.4 percent growth in 2011) and accounted for just over half of the 3.0 percent increase in per capita health spending (Exhibit 4). This represents a substantially smaller portion of health spending growth attributable to price growth compared to 2011, when price growth accounted for approximately 80 percent of overall per capita health spending growth (2.9 percent). The availability of lower-cost generic drugs and changes in Medicare payments for nursing home and physician services contributed to this slower overall price growth.

Nonprice factors include population growth (which has historically remained steady near 1.0 percent growth per year), demographic shifts in the population (also steady at approximately 0.5 percent growth per year), and other nonprice factors such as changes in the use and intensity of services. After three years of historically low growth, growth in other nonprice factors rebounded in 2012 and accounted for roughly one-quarter of the 3.0 percent increase in per capita national health expenditures. Some of the increase in other nonprice factors was reflected in hospital services as well as in physician and clinical services.

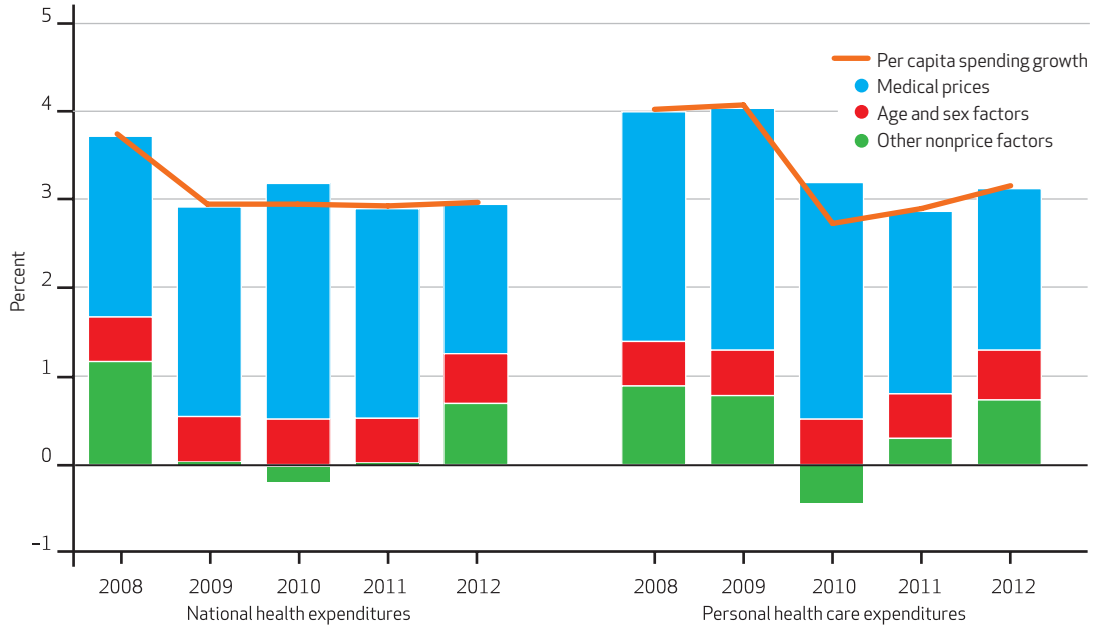
Sponsors Of Health Care

As the main sponsors of health care, US households; private businesses; and federal, state, and local governments are responsible for financing the nation's health care bill. In 2012 households accounted for the largest share of spending (28 percent), followed by the federal government, private businesses, and state and local governments (Exhibit 5).

Household health spending includes out-of-

EXHIBIT 4

Factors Accounting For Growth In Per Capita National Health Expenditures And Personal Health Care Expenditures, Calendar Years 2008–12



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Medical price growth, which includes economywide and excess medical-specific price growth (or changes in medical-specific prices in excess of economywide inflation), is calculated using the chain-weighted national health expenditures (NHE) deflator for NHE and the chain-weighted personal health care (PHC) deflator for PHC expenditures. As a residual, the category of other nonprice factors includes use and intensity and any errors in measuring prices or total spending.

EXHIBIT 5

National Health Expenditures (NHE) Amounts, Annual Growth, And Percent Distribution, By Type Of Sponsor, Calendar Years 2007–12

Type of sponsor	2007[a]	2008	2009	2010	2011	2012
EXPENDITURE AMOUNT						
NHE, billions	$2,302.9	$2,411.7	$2,504.2	$2,599.0	$2,692.8	$2,793.4
Businesses, household, and other private revenues	1,373.0	1,414.4	1,413.9	1,443.0	1,495.3	1,564.7
Private businesses	522.6	528.1	528.6	530.7	552.8	578.6
Household	678.0	712.6	717.0	736.9	759.7	792.4
Other private revenues	172.4	173.7	168.3	175.4	182.8	193.7
Governments	929.9	997.3	1,090.3	1,156.0	1,197.4	1,228.7
Federal government	530.3	584.9	683.8	734.0	736.1	731.6
State and local governments	399.6	412.4	406.5	422.0	461.3	497.2
ANNUAL GROWTH						
NHE	6.3%	4.7%	3.8%	3.8%	3.6%	3.7%
Businesses, household, and other private revenues	6.0	3.0	−0.0	2.1	3.6	4.6
Private businesses	4.4	1.1	0.1	0.4	4.2	4.7
Household	5.8	5.1	0.6	2.8	3.1	4.3
Other private	12.5	0.8	−3.1	4.2	4.2	6.0
Governments	6.7	7.2	9.3	6.0	3.6	2.6
Federal government	6.4	10.3	16.9	7.3	0.3	−0.6
State and local governments	7.0	3.2	−1.4	3.8	9.3	7.8
PERCENT DISTRIBUTION						
NHE	100%	100%	100%	100%	100%	100%
Businesses, household, and other private revenues	60	59	56	56	56	56
Private businesses	23	22	21	20	21	21
Household	29	30	29	28	28	28
Other private	7	7	7	7	7	7
Governments	40	41	44	44	44	44
Federal government	23	24	27	28	27	26
State and local governments	17	17	16	16	17	18

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Exhibit 1 notes). Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2006–07.

pocket payments, contributions to private health insurance premiums, and contributions to Medicare through payroll taxes and payment of premiums. The household share of health spending has remained steady at 28 percent since 2010. Out-of-pocket spending, which reflects direct consumer payments such as copayments and deductibles and spending on noncovered services, represents the largest component of household health spending. Faster household spending growth in 2012 (4.3 percent compared to 3.1 percent growth in 2011) was due mostly to increased contributions to insurance premiums for both private health insurance and Medicare. For Medicare, faster growth in contributions to premiums was due to the expiration of Medicare's "hold-harmless" provision, which prohibited increases to Part B premiums in 2010 and 2011, when Social Security's cost-of-living adjustment was zero.

The share of health care spending financed by private businesses has remained fairly steady since 2009 at about 21 percent. In 2007, prior to the start of the recession, the rate of health spending growth for private businesses was 4.4 percent. This trend slowed during 2008–10 as a result of recession-related job losses and declines in private health insurance enrollment. As the economy began to improve, and as private health insurance enrollment also began to increase slightly, health spending by private businesses experienced a slight acceleration, growing by 4.2 percent in 2011 and 4.7 percent in 2012.

The federal government's share of health spending has diminished in recent years, from 28 percent in 2010, to 27 percent in 2011, and to 26 percent in 2012. This was caused by a substantial slowdown in spending from 7.3 percent growth in 2010 to 0.3 percent in 2011 followed by a decline of 0.6 percent in 2012. The reduction in the federal government's share of health care over this period reflects the expiration in June 2011 of the Medicaid enhanced matching rates for states funded through the American Recovery and Reinvestment Act. For 2012 this reduction also reflects the expiration of the Early Retirement Reinsurance Program, a temporary

The reduced drug spending growth rate was driven largely by a slowdown in overall prices paid for retail prescription drugs.

program for employers who provided health insurance coverage to retirees older than age fifty-five who were not eligible for Medicare.

State and local governments' share of total health care spending increased from 16 percent in 2010, to 17 percent in 2011, and to 18 percent in 2012. This spending growth was much faster in 2011 and 2012 (9.3 percent and 7.8 percent, respectively) than it was during 2008–10. In 2011 and 2012 the states' portion of total Medicaid spending increased markedly because states stopped receiving additional aid from the federal government in the form of enhanced matching rates.[7]

Hospital Care

Spending for hospital care increased by 4.9 percent in 2012, reaching $882.3 billion—a 1.5-percentage-point increase over its 2011 growth rate (Exhibit 3). The faster growth in 2012 is attributed to both price and nonprice factors. Price growth, as measured by the Producer Price Index for hospital services, picked up slightly in 2012, increasing 2.5 percent compared to 2.1 percent growth in 2011.[10] At the same time, nonprice factors, which include factors such as use and intensity of services, grew faster in 2012 than in 2011 (data not shown).

Private health insurance (36 percent share) and Medicare (27 percent share) were the sources of payment for nearly two-thirds of all hospital care, and spending growth for both accelerated in 2012. Private health insurance payments to hospitals accelerated from 4.5 percent in 2011 to 5.8 percent in 2012, in part the result of a slight increase in the number of people covered by private health insurance and faster growth in per enrollee spending for hospital services.

Medicare spending for hospital services increased by 4.5 percent in 2012 compared to 3.6 percent in 2011, fueled by an influx of new enrollees, which also led to faster growth for other Medicare services. Partially offsetting this acceleration were provisions of the ACA that reduced growth in fee-for-service hospital payments.[4]

Medicaid hospital spending also grew faster in 2012, increasing by 4.1 percent compared to 1.7 percent in 2011. However, growth in Medicaid hospital spending during 2007–10 was much higher, averaging 7.3 percent annually. The higher growth during this period was due to increased enrollment that occurred because of the recession as well as to enhanced federal funding mandated by the American Recovery and Reinvestment Act of 2009. In 2011, as the economy continued to improve, overall Medicaid enrollment growth slowed, and enhanced federal funding expired, contributing to slower hospital spending growth.

Physician And Clinical Services

Spending on total physician and clinical services grew by 4.6 percent in 2012 to $565.0 billion (Exhibit 3). This rate was faster than in 2011, when spending grew by 4.1 percent. Although growth in prices slowed slightly (from 1.4 percent in 2011 to 1.2 percent in 2012),[11] acceleration in the use and intensity of physician services contributed to faster overall physician spending growth. A recent study indicated that the number of office visits per day increased during much of 2012, notably for primary care providers.[12]

Physician services, which accounted for 80 percent of physician and clinical services spending, grew by 4.0 percent in 2012, up from 3.5 percent in 2011. Spending for clinical services, which increased at a higher rate than spending for physician services for eight consecutive years, grew 7.1 percent in 2012 compared to 6.6 percent in 2011. Spending growth for clinical services has since 2005 been driven primarily by growth in spending for services at freestanding ambulatory surgical and emergency centers and kidney dialysis centers. As demand for lower-cost and more convenient alternatives for care has increased in recent years, so, too, has the number of urgent care centers (including ambulatory surgical and emergency centers).[13,14]

Private health insurance and Medicare accounted for the largest proportion of all physician and clinical services payments (just over two-thirds in 2012). Private health insurance and out-of-pocket payments for physician and clinical services increased at a faster rate in 2012 than in 2011, while growth in Medicare and Medicaid spending slowed. The growth in private health insurance spending was driven by increases in visits to doctors' offices as compared to the years immediately following the recession,

which officially ended in June 2009.[6] Medicare physician spending growth decelerated as a result of both slower growth in the volume and intensity of services provided and a 0.0 percent payment update in 2012, which followed a 0.9 percent payment update in 2011.[15]

Prescription Drugs

Total retail prescription drug spending growth slowed in 2012, increasing by only 0.4 percent to $263.3 billion (compared to 2.5 percent growth in 2011; Exhibit 3). This reduced growth rate was driven largely by a slowdown in overall prices paid for retail prescription drugs as numerous brand-name blockbuster drugs (most notably Lipitor, Plavix, and Singulair) lost patent protection in late 2011 and in 2012 and as generic versions became available.[16] Strong growth in prices for specialty drugs, which are used to treat complex conditions and are typically more expensive than traditional brand-name drugs, moderated some of this slowdown.[17]

Prescription drug use picked up in 2012 as the number of dispensed prescriptions increased by 1.4 percent compared to 0.5 percent growth in 2011.[18] Much of this increased utilization was driven by the availability of lower-cost generic drugs, which, for almost three-quarters of all dispensed prescriptions, cost $10 or less per prescription.[16] The share of dispensed prescriptions that were generic (excluding branded generics) increased by almost 8 percentage points in 2012 (from 69.7 percent in 2011). This is in contrast to annual increases in the generic dispensing rate of 3 percentage points or less for 2009–11.[18]

Private health insurance[19] (44 percent share) and out-of-pocket payments (18 percent share) combined paid for almost two-thirds of all prescription drug spending in 2012. Spending for both of these payers declined in 2012, with private health insurance spending falling by 2.1 percent and out-of-pocket payments dropping 0.2 percent. These decreases resulted from private health insurance plans' continued movement to three- or four-tier coinsurance or copayment structures, which charge less for generics and more for higher-cost drugs.[9,20] These decreases are also attributable to the more popular and previously expensive blockbuster drugs' being available on a lower tier as generics.

Medicare alone is the second-largest contributor to total retail prescription drug spending (26 percent share). Medicare's spending for prescription drugs continued to grow more quickly than did overall drug spending and increased by 7.9 percent in 2012 (compared to 7.3 percent in 2011).[21] This growth was influenced in part by continued strong growth in Part D enrollment; an increased share of Part D enrollees who reach the catastrophic phase of the benefit; and increased utilization for these enrollees for whom Medicare heavily subsidizes the cost of drugs.[15,22]

On a per enrollee basis, private health insurance premium growth remained persistently low in both 2011 and 2012.

Private Health Insurance

Private health insurance represented the largest payer (33 percent share) of total national health expenditures in 2012. Spending for private health insurance premiums reached $917.0 billion in 2012-an increase of 3.2 percent and near the 3.4 percent growth in 2011 (Exhibit 1). During 2008–12, growth remained low, averaging 3.2 percent annually—the lowest rates experienced since 1986. This compares to 6.0 percent average annual growth during the prior four-year period (2003–07). Enrollment in private health insurance plans reached 188.0 million in 2012, increasing by 0.8 million individuals, or 0.4 percent. However, private health insurance enrollment was still 9.4 million lower in 2012 than it was in 2007; this declining enrollment was a major factor in the slow growth in overall private health insurance spending over the past several years.

On a per enrollee basis, private health insurance premium growth remained persistently low in both 2011 and 2012, increasing by 2.8 percent and 2.7 percent, respectively. Per enrollee spending growth for medical benefits accelerated slightly, from 2.9 percent in 2011 to 3.2 percent in 2012, both near historic lows.

Net enrollment gains in high-deductible plans contributed to the slow growth in premiums. Enrollment in high-deductible health plans, which generally have lower premiums and higher cost sharing than other more popular plans, accounted for 19 percent of all covered workers and 31 percent of the under-sixty-five insured population in 2012.[8,9,23]

The slightly faster rate of growth for private health insurance medical benefits in 2012 was

Medicaid enrollment growth peaked in 2009 at 7.3 percent and slowed each year thereafter.

primarily due to increased growth in spending for hospital care and for physician and clinical services. These two services combined accounted for 72 percent of total private health insurance benefit spending in 2012. Partially offsetting the acceleration from these benefits was a 2.1 percent decline in private health insurance spending for retail prescription drugs (accounting for 15 percent of total private health insurance benefit spending), as several aforementioned blockbuster drugs moved to generic status.

The net cost of private health insurance, or the difference between premiums and benefits, remained relatively unchanged at $110 billion in 2012. However, because spending for medical benefits grew faster than did premiums, the net cost ratio, or the share of premiums attributed to nonmedical expenses, dropped from 12.4 percent in 2011 to 12.0 percent in 2012.

Medicare

Medicare accounted for 20 percent of national health spending in 2012, with expenditures reaching $572.5 billion (Exhibit 1). Overall, Medicare spending growth slowed slightly, increasing by 4.8 percent in 2012 compared to 5.0 percent in 2011. Growth in fee-for-service expenditures, which accounted for nearly three-quarters of total Medicare spending, slowed from 4.3 percent in 2011 to 2.7 percent in 2012. Medicare Advantage spending accounted for the remainder, increasing 10.9 percent in 2012—a faster rate than in 2011, when growth was 7.0 percent.

Enrollment in Medicare for all beneficiaries (fee-for-service and Medicare Advantage) jumped 4.1 percent in 2012—the largest one-year increase in enrollment in thirty-nine years—and more than half of these enrollees joined Medicare Advantage. The noticeable increase in total Medicare enrollment reflected the oldest members of the baby-boom generation, who became eligible to enroll in Medicare in 2011.

Total Medicare spending per enrollee grew by 0.7 percent in 2012—slower than the 2.5 percent rate of growth in 2011. This slowdown was largely due to a prominent decline in spending for nursing home care, which declined by 2.2 percent in 2012 following an increase of 9.9 percent the year before. This in turn was driven primarily by a one-time payment reduction to skilled nursing facilities, which followed a large increase in payments in 2011 corresponding to the introduction of the new payment system. In 2012 this reduction was applied to skilled nursing facility rates to recalibrate payments for the newly implemented payment system.[15]

For Medicare fee-for-service, per enrollee spending growth decelerated from 2.7 percent in 2011 to 0.6 percent in 2012. In addition to the decline in skilled nursing facility spending, slower growth in fee-for-service spending was influenced by spending trends for prescription drugs, physician and clinical services, and hospital care. For beneficiaries with traditional fee-for-service Medicare, prescription drug spending growth slowed because of the increased use of popular lower-cost generic drugs. Slower growth in the volume and intensity of physician services and inpatient hospital admissions contributed to slower fee-for-service Medicare physician and hospital spending in 2012. Finally, for all Part A and most Part B providers, the ACA reduced payment updates in 2012, most notably for hospitals.

The acceleration in Medicare Advantage spending growth in 2012 was driven by a 10.0 percent increase in enrollment. On a per enrollee basis, however, Medicare Advantage spending growth slowed to 0.8 percent in 2012 (from 1.6 percent growth in 2011), partially as a result of the implementation of the ACA's new payment mechanism. That mechanism links benchmark payment rates to fee-for-service costs, and its implementation effectively lowered the increase in total Medicare Advantage payments. In addition, the ACA required quality ratings of plans to factor into payments beginning in 2012.

Medicaid

Medicaid spending by both federal and state governments reached $421.2 billion in 2012, accounting for 15 percent of total national health expenditures (Exhibit 1). Medicaid spending increased by 3.3 percent in 2012, following a low 2.4 percent growth rate in 2011. These were the two slowest annual rates of growth in the history of Medicaid (excluding 2006, when Medicare Part D was implemented, changing the way Medicaid paid for some beneficiaries' prescription drugs). These growth rates were due primarily

to slower enrollment growth and to efforts by states to control costs following the expiration of enhanced federal matching rates.[7]

Since the end of the recession in June 2009, Medicaid enrollment growth slowed as the overall economy experienced a modest recovery through 2012. Most recently, Medicaid enrollment growth peaked in 2009 at 7.3 percent and slowed each year thereafter (4.9 percent in 2010, 3.2 percent in 2011, and 1.9 percent in 2012).[24] On a per enrollee basis, Medicaid spending increased by just 1.3 percent in 2012 after declining 0.7 percent in 2011, driven partially by states' efforts to reduce costs; continued expansion of community-based long-term care; and expanded use of managed care.[7]

Hospital care and other health, residential, and personal care services together accounted for just over half of all Medicaid spending in 2012. Medicaid hospital spending (37 percent share) grew by 4.1 percent in 2012 following slower growth of 1.7 percent in 2011. Other health, residential, and personal care services (including Medicaid home and community-based waivers, rehabilitation services, and nonemergency medical transportation services, among others) grew by 5.1 percent in 2012, accelerating from 2.7 percent growth in 2011.

For the second year in a row, the federal government's portion of Medicaid spending declined (4.2 percent reduction in 2012 and 7.2 percent reduction in 2011), largely because of the expiration of the enhanced federal matching rates. These enhanced matching rates caused the share of Medicaid financed by the federal government to increase to approximately 67 percent in 2010. In 2012 this share fell to 56 percent, similar to its share immediately before the recent recession began. Concurrently, state and local Medicaid spending increased substantially (from just 2.7 percent growth in 2010, to 22.0 percent in 2011, and 15.0 percent in 2012). This increase reflects the end of additional funding from the American Recovery and Reinvestment Act of 2009.

Conclusion

In 2012 the economy continued to modestly improve, and GDP grew faster than health care spending, causing the health spending share of the economy to fall slightly—from 17.3 percent to 17.2 percent. Spending growth for personal health care goods and services accelerated in 2012 as trends for hospital services and physician and clinical services more than offset one-time impacts that helped decelerate growth, such as numerous patent expirations for brand-name retail prescription drugs and a Medicare payment reduction for skilled nursing facilities. From a payer perspective, Medicaid spending growth accelerated somewhat in 2012 after experiencing low growth in 2011, while Medicare and private health insurance spending growth slowed slightly. These mixed trends produced the fourth consecutive year of low overall health spending growth and led to a relatively stable health spending share of GDP. However, this pattern is consistent with historical experience when health spending as a share of GDP often stabilizes approximately two to three years after the end of a recession and then increases when the economy significantly improves. Recently, however, the question has arisen about whether a more fundamental change is occurring within the health sector and whether this stability will endure. From our perspective, more historical evidence is needed before concluding that we have observed a structural break in the historical relationship between the health sector and the overall economy. ■

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NOTES

1 Unless otherwise specified, all National Health Expenditure Accounts data are presented in nominal terms.

2 In July 2013 GDP was revised upward by $458.1 billion for 2011 as a result of a comprehensive revision to the National Income and Product Accounts by the Bureau of Economic Analysis. Thus, the health spending share of GDP, which would have been 17.9 percent had GDP not been revised, is now 17.3 percent for 2011.

3 The "Minimum Medical Loss Ratio for Insurers" provision of the Affordable Care Act requires plans to report the proportion of premium dollars spent on clinical services, quality, and other costs (effective for 2010) and to provide rebates to consumers if the share of the premium spent on clinical services and quality is less than 85 percent for plans in the large-group market and 80 percent for plans in the individual and small-group markets (effective January 1, 2011).

4 The Affordable Care Act mandated that productivity adjustments be added to market-basket updates for certain providers beginning in payment year 2012. Fiscal year 2012 productivity adjustments began in October 2011 for inpatient hospitals, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. Calendar

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