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is the slowdown in healthcare spending sustainable?

In these most political of times, it should come as no surprise that the recent slowdown in healthcare spending has also become a political issue, with the Democrats linking it to the Affordable Care Act—most notably President Clinton at the Charlotte convention.

To better understand the issue, we need to know how much healthcare spending has slowed, why it has been slowing, and most important, whether the slowdown is likely to continue.

The Numbers

In 2009, healthcare spending grew at a record low rate of 3.8 percent, and in 2010, it grew at a rate of 3.9 percent. The official numbers for 2011 are not yet available, but spending for 2011 is estimated to have grown at a somewhat higher rate of 5.2 percent, according to Altarum, a not-for-profit health systems research company. And the benefits consulting firm Aon Hewitt has estimated premium increases for employers and employees averaging 4.9 percent this year (“Analysis: Health Costs Jump Nearly 5% Nationwide This Year,” *Kaiser Health News*, Daily Health Policy Report, Oct. 4, 2012). However, the average monthly spending growth rate for 2012 is estimated to be down again, to 4.3 percent, only modestly above where it had been in 2009 and 2010.

Medicare costs also have been increasing slowly, especially Part B spending for physician services. Medicare spending increased 4.3 percent in calendar year 2010 (CY10) and 3.8 percent in fiscal year 2011 (FY10)—less than half the rate of increase that Medicare experienced from 2000 through 2009.

Why the Growth Rate in Spending Is So Slow

The most obvious reason that healthcare spending has been growing so slowly is the economy. From 2008 to 2010, the United States experienced the most severe recession since the Great Depression, and although the recession technically ended in 2010, the country has experienced anemic job growth since then, with job expansion having barely kept pace with population growth. Also disturbing is the fact that the rate of participation in the labor force by working adults is at its lowest level in 31 years, at less than 64 percent, indicating that the official unemployment rate would be even larger than it has been if so many adults hadn't become discouraged and stopped looking for work.^a

However, as journalists and economists have been noting for more than a year, the slowdown in healthcare spending far exceeds what one might predict based on the decline in per-person income, if predictions from past recessions are reliable indicators. This suggests that something else may be affecting healthcare spending in addition to job lull and declining incomes.

Nor is President Clinton the only one to suggest the slowdown is attributable to the ACA. Jonathan Blum, an administration appointee at CMS, was quoted in *The Washington Post* late last year as saying that the slowdown is evidence that the policies in the ACA are working (Montgomery, L., “Medicare Spending Growth Rising Slower but

a. With the official unemployment rate, individuals are counted as unemployed only if they are still looking for work. Therefore, unemployed people who stop looking for work technically cease to be counted as unemployed for purposes of calculating the official unemployment rate.

Enrollment Will Rise,” Dec. 11, 2011). Given how few of the changes in the ACA are operational now, yet alone in 2011, his claim seems at best premature. Also, there was evidence of a spending slowdown even before the 2008 election. Peter Orszag, the former director of the White House Office of Management and Budget, was more recently quoted in the *Congressional Quarterly* as attributing some of the slowdown in spending to structural changes currently under way—changes that include the use of computer software to support better clinical decision making and a willingness of clinicians to move away from fee-for-service payment (Reichard, J., “Deceleration in Health Spending: Is It Only the Weak Economy?” *CQ HealthBeat*, Aug. 7, 2012).

We are clearly in the midst of a changing clinical environment. Many hospitals are purchasing physician practices in an attempt to shore up their referral patterns and to increase the relative power of the hospital when negotiating with private payers. Private payers are also actively engaging in activities to slow spending, such as designating high-value clinicians and institutions and encouraging their enrollees to use them by lowering their cost share if they do.

So although there are indications of changes occurring that could support a slower spending environment, at least part of the explanation may be simpler and more direct. The assumption that changes in income provide a good basis for predicting changes in healthcare spending during a recession may be less valid when a recession is as severe as the one we have just experienced. We know from other analyses that changes in wealth, in addition to changes in income, affect spending. And changes in wealth may not have had the same impact in previous recessions as they have in the most recent one. Not only did many people see a major decline in the value of their 401(k)s and other stock portfolios, but the decline in housing values also was unusually large. Because home values are the single largest asset for the middle class, this recent decline may have much more profoundly affected middle class Americans’ sense of financial security and thus had a greater impact on their spending.

Will Slow Healthcare Spending Growth Continue?

This is the more important question and the more challenging one as well. Because it is unclear why healthcare spending has slowed, assuming it will continue to slow may be nothing more than that—an assumption, and potentially a foolhardy one at that.

We have seen slowdowns before. In the 1990s, healthcare spending grew at a slow pace, remaining at about 13 percent of the economy for the entire decade. This slow growth reflected two different trends: first, aggressive actions by employers and payers pursuing managed care, and second, slow growth in Medicare spending resulting from legislated changes in the 1997 Balanced Budget Act (BBA). But just as the public and the Congress pushed back on the aggressive actions of private payers by the late 1990s, hospitals, nursing homes, and other Medicare providers pushed the Congress to return some of the savings from the BBA. Taken together, these forces resulted in the rapid growth in spending that characterized much of the decade that followed.

The current situation may be different. The surplus has been replaced with high levels of debt and deficits. There is widespread agreement that health care can and should be provided more efficiently and that slower spending rates are indeed achievable. Thus far, lower future spending rates in Medicare are expected because the ACA legislated lower payment rates, not because costs are believed to be increasing more slowly. Unless there are changes that actually reduce those costs or unless the institutions affected by the payment reductions are able to pass those unreimbursed costs on to other payers, the slow rates of spending growth are unlikely to continue once the economy again starts experiencing robust economic growth. ●

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