Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:
Anne Martin, David Lassman, Lekha Whittle, Aaron Catlin and the National Health Expenditure Accounts Team
Recession Contributes To Slowest Annual Rate Of Increase In Health Spending In Five Decades
Health Affairs, 30, no.1 (2011):11-22

doi: 10.1377/hlthaff.2010.1032

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/30/1/11.full.html

For Reprints, Links & Permissions:
http://healthaffairs.org/1340_reprints.php

E-mail Alerts : http://content.healthaffairs.org/subscriptions/etoc.dtl

To Subscribe: http://content.healthaffairs.org/subscriptions/online.shtml

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © 2011 by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of *Health Affairs* may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution

Downloaded from content.healthaffairs.org by *Health Affairs* on January 6, 2011
at PHRMA

By Anne Martin, David Lassman, Lekha Whittle, Aaron Catlin, and the National Health Expenditure Accounts Team

DOI: 10.1377/hlthaff.2010.1032
HEALTH AFFAIRS 30,
NO. 1 (2011): 11–22
©2011 Project HOPE—
The People-to-People Health Foundation, Inc.

Recession Contributes To Slowest Annual Rate Of Increase In Health Spending In Five Decades

ABSTRACT In 2009, US health care spending grew 4.0 percent—a historically low rate of annual increase—to $2.5 trillion, or $8,086 per person. Despite the slower growth, the share of the gross domestic product devoted to health spending increased to 17.6 percent in 2009 from 16.6 percent in 2008. The growth rate of health spending continued to outpace the growth of the overall economy, which experienced its largest drop since 1938. The recession contributed to slower growth in private health insurance spending and out-of-pocket spending by consumers, as well as a reduction in capital investments by health care providers. The recession also placed increased burdens on households, businesses, and governments, which meant that fewer financial resources were available to pay for health care. Declining federal revenues and strong growth in federal health spending increased the health spending share of total federal revenue from 37.6 percent in 2008 to 54.2 percent in 2009.

Anne Martin (anne.martin@cms.hhs.gov) is an economist in the Office of the Actuary, Centers for Medicare and Medicaid Services , in Baltimore, Maryland.

David Lassman is a statistician in the CMS Office of the Actuary.

Lekha Whittle is an economist in the CMS Office of the Actuary.

Aaron Catlin is a deputy director of the National Health Statistics Group, CMS Office of the Actuary.

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

National health spending grew 4.0 percent in 2009, to $2.5 trillion—or $8,086 per person—representing the slowest rate of growth in the fifty-year history of the National Health Expenditure Accounts (Exhibits 1 and 2). (As explained below, the estimates through 2008 presented here reflect a recently completed comprehensive revision.) This historically low rate followed growth of 4.7 percent in 2008—the second-slowest rate during the past fifty years.

Nonetheless, the share of US gross domestic product (GDP) devoted to health care rose one percentage point—to 17.6 percent in 2009 (Exhibit 1)—which is the largest one-year increase in the history of the national health accounts. The increase was mainly due to a 1.7 percent decline in the current-dollar GDP,[1] its largest drop since 1938. For purposes of comparison, the health spending share of GDP increased 0.7 percentage point in 1991 and 2001, during the two most recent recessions, and 0.8 percentage point in the recession of 1982.

The recession that ended officially in June 2009 profoundly influenced total health spending in 2009. Many consumers decreased their use of health care goods and services partly because they had lost employer-based private health insurance coverage, and partly because their household income had declined.[2] The slowdown in the growth of overall health spending in 2009 was primarily due to a deceleration in private health insurance spending, a decline in spending on structures and equipment in the health care system, and slower growth in out-of-pocket spending.

Several factors partially offset the slowdown—most notably, a rapid increase in Medicaid enrollment, which increased the program's rate of spending (Exhibit 2). Additionally, other private revenues—which include nonoperating revenue of health care providers—increased in 2009, after declining in 2008, when hospitals' invest-

Downloaded from content.healthaffairs.org by *Health Affairs* on January 6, 2011
at PHRMA

EXHIBIT 1

National Health Expenditures (NHE), Aggregate And Per Capita Amounts And Share of Gross Domestic Product (GDP), Selected Calendar Years 1980–2009

Spending category	1980	1990	2000	2005	2006	2007	2008	2009
NHE, billions	$255.7	$724.0	$1,378.0	$2,021.0	$2,152.1	$2,283.5	$2,391.4	$2,486.3
Health consumption expenditures	235.6	675.3	1,288.5	1,890.3	2,016.9	2,135.1	2,234.2	2,330.1
Personal health care (PHC)	217.1	616.6	1,164.4	1,692.6	1,798.8	1,904.3	1,997.2	2,089.9
Hospital care	100.5	250.4	415.5	606.5	648.3	686.8	722.1	759.1
Professional services	64.5	207.9	389.0	559.4	588.4	619.4	652.2	674.9
Physician and clinical services	47.7	158.9	290.0	419.6	441.6	462.6	486.5	505.9
Other professional services	3.5	17.4	37.0	53.1	55.4	59.5	63.4	66.8
Dental services	13.3	31.5	62.0	86.8	91.4	97.3	102.3	102.2
Other health, residential, and personal care[a]	8.5	24.3	64.7	96.5	102.1	108.3	113.3	122.6
Home health care[b]	2.4	12.6	32.4	48.7	52.6	57.8	62.1	68.3
Nursing care facilities and continuing care retirement communities[b,c]	15.3	44.9	85.1	112.1	117.0	126.5	132.8	137.0
Retail outlet sales of medical products	25.9	76.5	177.6	269.3	290.4	305.6	314.7	328.0
Prescription drugs	12.0	40.3	120.9	201.7	219.8	230.2	237.2	249.9
Durable medical equipment	4.1	13.8	25.1	30.4	31.9	34.4	35.1	34.9
Other nondurable medical products	9.8	22.4	31.6	37.2	38.7	41.1	42.3	43.3
Government administration[d]	2.5	6.2	17.1	26.8	28.3	29.2	29.2	29.8
Net cost of health insurance[e]	9.5	32.5	64.0	114.7	127.2	132.8	134.8	133.2
Government public health activities	6.4	20.0	43.0	56.2	62.6	68.8	72.9	77.2
Investment	20.1	48.7	89.6	130.7	135.2	148.4	157.2	156.2
Research[f]	5.4	12.7	25.5	40.3	41.4	41.9	43.2	45.3
Structures and equipment	14.7	36.0	64.1	90.4	93.8	106.4	114.0	110.9
Population (millions)	230.4	253.8	282.5	296.1	299.0	302.0	304.8	307.5
NHE per capita	$1,110	$2,853	$4,878	$6,827	$7,198	$7,561	$7,845	$8,086
GDP, billions of dollars	$2,788.1	$5,800.5	$9,951.5	$12,638.4	$13,398.9	$14,061.8	$14,369.1	$14,119.0
NHE as percent of GDP	9.2	12.5	13.8	16.0	16.1	16.2	16.6	17.6
Implicit price deflator for GDP	47.8	72.2	88.6	100.0	103.3	106.3	108.6	109.6
Real GDP, billions of chained dollars[g]	$5,839.0	$8,033.9	$11,226.0	$12,638.4	$12,976.2	$13,228.9	$13,228.8	$12,880.6
NHE, billions of 2005 dollars[h]	$535.5	$1,002.8	$1,554.5	$2,021.0	$2,084.2	$2,148.2	$2,201.6	$2,268.2
PHC deflator[i]	31.4	63.1	85.0	100.0	103.0	106.5	109.3	112.2

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. **NOTE** Numbers might not add to totals because of rounding. [a]Includes expenditures for residential care facilities (North American Industry Classification System, or NAICS, 623210 and 623220), ambulance providers (NAICS 621910), medical care delivered in nontraditional settings (such as community centers, centers for senior citizens, schools, and military field stations), and expenditures for Medicaid's home and community-based waiver programs. [b]Includes freestanding facilities only. Additional services of this type provided in hospital-based facilities are counted as hospital care. [c]Includes care provided in nursing care facilities (NAICS 6231), continuing care retirement communities (NAICS 623311), and nursing facilities operated by state or local governments or the Department of Veterans Affairs. [d]Includes all administrative costs (federal, state, local government employees' salaries, contracted employees including fiscal intermediaries, rent and building costs, computer systems and programs, other materials and supplies, and other miscellaneous expenses) associated with Medicare, Medicaid, Children's Health Insurance Program (CHIP), Department of Defense, Department of Veterans Affairs, Indian Health Service, workers' compensation, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, and other federal programs. [e]Net cost of health insurance is calculated as the difference between calendar-year incurred premiums earned and benefits paid for private health insurance. This includes administrative costs and, in some cases, additions to reserves, rate credits and dividends, premium taxes, and plan profits or losses. Also included in this category is the difference between premiums earned and benefits paid for the private health insurance companies that insure the enrollees of the following programs: Medicare, Medicaid, CHIP, and workers' compensation (health portion only). [f]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. [g]Chain-type measures of real output and prices prevent overstating real GDP growth for periods after the reference year and understating real GDP growth for periods before the reference year. [h]Deflated using the implicit price deflator for GDP (2005 = 100.0). [i]PHC implicit price deflator is constructed from the Producer Price Indexes for hospitals, offices of physicians, medical and diagnostic laboratories, home health care services, and nursing care facilities; and Consumer Price Indexes specific to each of the remaining PHC components.

ment income fell (data not shown). Prescription drug spending growth was another factor: Spending growth increased more rapidly in 2009 than in 2008, as a result of more rapid growth in the prices of drugs and in the number of prescriptions dispensed (Exhibit 3).

The federal government's share of health care spending increased just over three percentage points in 2009, to 27 percent (Exhibit 4). Federal health spending increased 17.9 percent between 2008 and 2009 and 9.6 percent between 2007 and 2008 (Exhibit 5). In contrast, the shares of spending of households (28 percent in 2009), private businesses (21 percent), and state and

Downloaded from content.healthaffairs.org by Health Affairs on January 6, 2011
at PHRMA

EXHIBIT 2

National Health Expenditures (NHE), Amounts And Average Annual Growth From Previous Year Shown, By Source Of Funds, Selected Calendar Years 1980–2009

	1980[a]	1990	2000	2005	2006	2007	2008	2009
SPENDING AMOUNTS								
NHE, billions	$255.7	$724.0	$1,378.0	$2,021.0	$2,152.1	$2,283.5	$2,391.4	$2,486.3
Health consumption expenditures	235.6	675.3	1,288.5	1,890.3	2,016.9	2,135.1	2,234.2	2,330.1
Out-of-pocket	58.4	138.8	202.1	263.8	272.1	289.4	298.2	299.3
Health insurance	142.2	439.2	918.8	1,410.5	1,513.7	1,597.5	1,681.8	1,767.4
Private health insurance	69.0	233.9	458.2	697.2	733.6	763.8	790.6	801.2
Medicare	37.4	110.2	224.4	339.9	403.1	431.4	465.7	502.3
Medicaid	26.0	73.7	200.5	309.5	307.1	327.0	343.1	373.9
Federal	14.5	42.6	116.9	177.7	174.2	186.2	202.4	247.0
State and local	11.5	31.1	83.6	131.9	132.9	140.7	140.7	127.0
Other health insurance programs[b]	9.7	21.4	35.8	63.8	69.9	75.2	82.4	90.0
Other third-party payers and programs and public health activity[c]	35.0	97.4	167.5	216.0	231.1	248.3	254.1	263.3
Investment	20.1	48.7	89.6	130.7	135.2	148.4	157.2	156.2
AVERAGE ANNUAL GROWTH FROM PRIOR YEAR SHOWN								
NHE	13.1%	11.0%	6.6%	8.0%	6.5%	6.1%	4.7%	4.0%
Health consumption expenditures	13.4	11.1	6.7	8.0	6.7	5.9	4.6	4.3
Out-of-pocket	8.9	9.0	3.8	5.5	3.2	6.3	3.1	0.4
Health insurance	16.2	11.9	7.7	8.9	7.3	5.5	5.3	5.1
Private health insurance	16.2	13.0	7.0	8.8	5.2	4.1	3.5	1.3
Medicare	17.2	11.4	7.4	8.7	18.6	7.0	7.9	7.9
Medicaid	17.3	11.0	10.5	9.1	−0.8	6.5	4.9	9.0
Federal	17.7	11.4	10.6	8.7	−1.9	6.9	8.7	22.0
State and local	16.7	10.4	10.4	9.6	0.8	5.9	0.0	−9.8
Other health insurance programs[b]	11.4	8.2	5.3	12.3	9.5	7.6	9.5	9.2
Other third-party payers and programs and public health activity[c]	12.9	10.8	5.6	5.2	6.9	7.5	2.3	3.6
Investment	10.0	9.2	6.3	7.9	3.4	9.8	6.0	−0.6

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Numbers might not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Average annual growth, 1970–80. [b]Includes health-related spending for Children's Health Insurance Program (CHIP) (Titles XIX and XXI), Department of Defense, and Department of Veterans Affairs. [c]Includes health-related spending for worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

local governments (16 percent) fell by roughly one percentage point each between 2008 and 2009.[3]

Revisions In The National Health Expenditure Accounts

This paper reflects changes resulting from the most recent comprehensive revision of the National Health Expenditure Accounts. Every five years the estimates in the accounts are benchmarked to incorporate information from the quinquennial economic census and other sources of comprehensive health spending data.[4,5] Concurrently, definitions, methods, and data sources are reevaluated.

Notable revisions included the addition of spending estimates for privately operated ambulance services; the addition of spending in residential mental health and substance abuse facilities; and the removal of spending for the administration of philanthropic organizations, including foundations, voluntary health agencies (such as the American Red Cross and American Cancer Society), and United Way of America. Other modifications included shifts within payers and services to more properly align spending with categorical definitions, improved source data and methods, and the renaming of some service and payer categories.[4]

Changes due to the comprehensive revision and other routine revisions resulted in an additional $52.6 billion—or an additional 2.2 percent—spent on health care in 2008 compared to last year's report.[6] As a result of this revision and a revision to the GDP, the health

Downloaded from content.healthaffairs.org by Health Affairs on January 6, 2011
at PHRMA

EXHIBIT 3

National Health Expenditures (NHE), Average Annual Growth From Prior Year Shown, Selected Calendar Years 1980–2009

Spending category	1980	1990	2000	2005	2006	2007	2008	2009
NHE	13.1%	11.0%	6.6%	8.0%	6.5%	6.1%	4.7%	4.0%
Health consumption expenditures	13.4	11.1	6.7	8.0	6.7	5.9	4.6	4.3
Personal health care (PHC)	13.2	11.0	6.6	7.8	6.3	5.9	4.9	4.6
Hospital care	14.0	9.6	5.2	7.9	6.9	5.9	5.2	5.1
Professional services	12.6	12.4	6.5	7.5	5.2	5.3	5.3	3.5
Physician and clinical services	12.8	12.8	6.2	7.7	5.3	4.8	5.2	4.0
Other professional services	17.0	17.5	7.8	7.5	4.4	7.4	6.6	5.3
Dental services	11.1	9.0	7.0	7.0	5.3	6.5	5.1	−0.1
Other health, residential, and personal care[a]	20.4	11.1	10.3	8.3	5.8	6.1	4.6	8.3
Home health care[b]	26.9	18.1	9.9	8.5	8.0	9.9	7.5	10.0
Nursing care facilities and continuing care retirement communities[b,c]	14.2	11.4	6.6	5.7	4.3	8.1	5.0	3.1
Retail outlet sales of medical products	9.4	11.4	8.8	8.7	7.8	5.2	3.0	4.2
Prescription drugs	8.2	12.8	11.6	10.8	9.0	4.7	3.1	5.3
Durable medical equipment	8.8	13.0	6.2	3.9	5.2	7.6	2.3	−0.8
Other nondurable medical products	11.4	8.6	3.5	3.4	4.0	6.0	3.1	2.2
Government administration[d]	14.6	9.5	10.6	9.4	5.6	3.1	0.1	2.0
Net cost of health insurance[e]	17.0	13.1	7.0	12.4	10.9	4.4	1.5	−1.2
Government public health activities	16.9	12.0	8.0	5.5	11.4	9.9	6.0	5.9
Investment	10.0	9.2	6.3	7.9	3.4	9.8	6.0	−0.6
Research[f]	10.8	8.9	7.2	9.6	2.6	1.3	3.1	4.8
Structures and equipment	9.7	9.4	5.9	7.1	3.7	13.5	7.1	−2.7
Population (millions)	0.9	1.0	1.1	0.9	1.0	1.0	0.9	0.9
NHE per capita	12.0	9.9	5.5	7.0	5.4	5.0	3.8	3.1
Gross domestic product (GDP), billions of dollars	10.4	7.6	5.5	4.9	6.0	4.9	2.2	−1.7
Implicit price deflator for GDP	7.0	4.2	2.1	2.4	3.3	2.9	2.2	0.9
Real GDP, billions of chained dollars[g]	3.2	3.2	3.4	2.4	2.7	1.9	0.0	−2.6
NHE, billions of 2005 dollars[h]	5.7	6.5	4.5	5.4	3.1	3.1	2.5	3.0
PHC deflator[i]	7.9	7.2	3.0	3.3	3.0	3.4	2.6	2.7

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** 1980 shows average annual growth, 1970–80. Percentage changes are calculated from unrounded numbers. [a]Includes expenditures for residential care facilities (North American Industry Classification System, or NAICS, 623210 and 623220), ambulance providers (NAICS 621910), medical care delivered in nontraditional settings (such as community centers, centers for senior citizens, schools, and military field stations), and expenditures for Medicaid's home and community-based waiver programs. [b]Includes freestanding facilities only. Additional services of this type provided in hospital-based facilities are counted as hospital care. [c]Includes care provided in nursing care facilities (NAICS 6231), continuing care retirement communities (NAICS 623311), and nursing facilities operated by state or local governments or the Department of Veterans Affairs. [d]Includes all administrative costs (federal, state, and local government employees' salaries, contracted employees including fiscal intermediaries, rent and building costs, computer systems and programs, other materials and supplies, and other miscellaneous expenses) associated with: Medicare, Medicaid, Children's Health Insurance Program (CHIP), Department of Defense, Department of Veterans Affairs, Indian Health Service, workers' compensation, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, and other federal programs. [e]Net cost of health insurance is calculated as the difference between calendar-year incurred premiums earned and benefits paid for private health insurance. This includes administrative costs, and in some cases additions to reserves, rate credits and dividends, premium taxes, and plan profits or losses. Also included in this category is the difference between premiums earned and benefits paid for the private health insurance companies that insure the enrollees of the following programs: Medicare, Medicaid, CHIP, and workers' compensation (health portion only). [f]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. [g]Chain-type measures of real output and prices prevent overstating real GDP growth for periods after the reference year and understating real GDP growth for periods before the reference year. [h]Deflated using the implicit price deflator for GDP (2005 = 100.0). [i]PHC implicit price deflator is constructed from the Producer Price Indexes for hospitals, offices of physicians, medical and diagnostic laboratories, home health care services, and nursing care facilities; and Consumer Price Indexes specific to each of the remaining personal health care components.

spending share of GDP was revised upward by 0.4 percentage point in 2008; approximately 80 percent of this revision was attributable to the revision in health spending.[5]

Impact Of The Recession On Health Spending

Although health care spending has grown at a slower rate every year since 2002, the deceleration, or slowdown in the rate of growth, was more pronounced in 2008 and 2009 because of the severe economic recession. In contrast to prior recessions, when there was usually a lag before health care spending growth slowed,[6] the recession that lasted from December 2007 to June 2009 had a more immediate impact on the health care sector.

Downloaded from content.healthaffairs.org by Health Affairs on January 6, 2011
at PHRMA

The substantial number of jobs lost since the beginning of the recession contributed to a higher rate of unemployment than in recent recessions. In December 2009 the unemployment rate reached 10.0 percent—an increase of 2.6 percentage points over the December 2008 rate of 7.4 percent.[7] Additionally, between December 2007 and December 2009, nonfarm employment fell 3.1 percent.[8] These job losses caused many people to lose employer-sponsored health insurance and, in some cases, to forgo health care services they could not afford.[2]

In response to the recession, Congress passed the American Recovery and Reinvestment Act, informally known as the stimulus package or the Recovery Act. Although enacted in February 2009, it contained some provisions that were retroactive for Medicaid to October 1, 2008. This legislation provided funding for various programs related to health care, including an estimated $34 billion in additional federal matching funds for Medicaid in 2009.

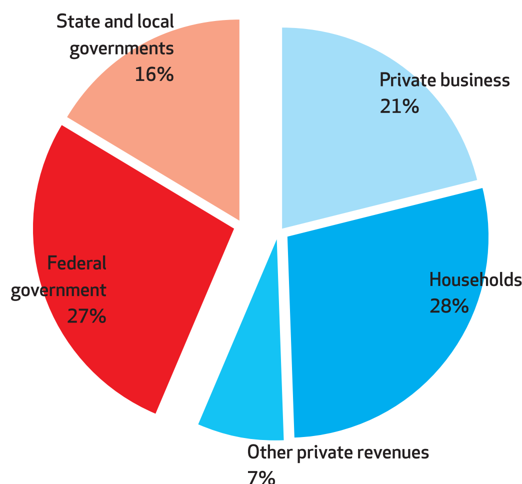
The Recovery Act also extended Consolidated Omnibus Budget Reconciliation Act (COBRA) premium subsidies for 2009. These subsidies offered a temporary reduction in premiums to people who had lost their jobs but chose to retain employer-sponsored health insurance coverage. Other health-related spending associated with the Recovery Act included funding for health information technology (IT), prevention and wellness programs, community health centers, Indian Health Service facilities, and National Institutes of Health (NIH) research and facilities.

Slower growth in health spending during 2009 was influenced primarily by a deceleration in spending growth for private health insurance—from 3.5 percent in 2008 to 1.3 percent in 2009 (Exhibit 2)—as private health insurance enrollment declined 3.2 percent, or by 6.3 million enrollees (data not shown). A deceleration in consumer out-of-pocket spending growth—from 3.1 percent in 2008 to 0.4 percent in 2009—also contributed to the slowdown in overall 2009 health spending growth. This was most notable in the out-of-pocket spending growth rates for dental services, nursing care facilities and continuing care retirement communities (hereafter referred to as nursing care facilities), and physician and clinical services, all of which declined in 2009 (data not shown).

Faster growth in Medicaid spending—from 4.9 percent in 2008 to 9.0 percent in 2009 (Exhibit 2)—was driven by the addition of 3.5 million new enrollees; it partially offset the slower growth experienced by most other payers.[9] These changes in enrollment occurred at the same time that the number of uninsured people increased by 3.8 million (from 42.7 million in 2008 to 46.5 million in 2009).

EXHIBIT 4

National Health Expenditures (NHE) By Type Of Sponsor, 2009



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTE** Sum of pieces might not add to 100 percent because of rounding.

The recession also had an impact on providers, who reduced their spending for capital investments by 2.7 percent in 2009, thereby contributing to the slowdown in overall health spending growth (Exhibit 3). Investment in structures and equipment by private providers fell by 4.3 percent, with a corresponding decline of 1.1 percent by state and local government providers. Investment in structures and equipment by federal providers increased 14.2 percent, in part as a result of funding from the Recovery Act (data not shown).

Although the recession affected the health sector less severely than other sectors of the economy, the burden it placed on households, governments, and businesses was more prominent in 2009 than in 2008, as fewer resources were available to pay for health care. For households, a decline in personal income[1] contributed to an increase in the share of personal income spent on health, which reached 6.2 percent in 2009 (up from 6.0 percent in 2008).

Like households, the federal government faced declining revenues in 2009. Revenues went down 18.2 percent in 2009,[1] while spending for health care grew 17.9 percent. Thus, health spending as a share of total federal revenue increased from 38 percent in 2008 to 54 percent in 2009. Although slight, state and local government health care spending as a share of total state and local revenue also increased, from 26 percent in 2008 to 27 percent in 2009. The change was mainly due to decreased revenue.[1]

Health care financing by private businesses

Downloaded from content.healthaffairs.org by *Health Affairs* on January 6, 2011
at PHRMA

EXHIBIT 5

National Health Expenditures (NHE), Amounts And Annual Growth, By Type Of Sponsor, Calendar Years 2006–09

	Expenditures, $ billions				Percent change		
Type of sponsor	2006	2007	2008	2009	2007	2008	2009
NHE	2,152.1	2,283.5	2,391.4	2,486.3	6.1	4.7	4.0
Business, households, and other private	1,283.8	1,358.8	1,406.0	1,403.1	5.8	3.5	−0.2
Private business	492.0	511.4	521.0	518.3	3.9	1.9	−0.5
Employer contributions to private health insurance premiums	376.3	390.6	395.9	397.5	3.8	1.4	0.4
Other[a]	115.7	120.8	125.2	120.8	4.4	3.6	−3.5
Household	634.9	671.2	707.2	708.4	5.7	5.4	0.2
Household private health insurance premiums[b]	218.9	228.1	247.1	247.6	4.2	8.4	0.2
Medicare payroll taxes and premiums[c]	143.9	153.8	161.8	161.5	6.9	5.2	−0.2
Out-of-pocket health spending	272.1	289.4	298.2	299.3	6.3	3.1	0.4
Other private revenues[d]	156.9	176.2	177.8	176.4	12.3	0.9	−0.8
Government	868.2	924.7	985.4	1,083.2	6.5	6.6	9.9
Federal government	494.6	525.0	575.5	678.4	6.1	9.6	17.9
Employer contributions to private health insurance premiums	24.3	24.6	25.1	26.8	1.5	2.0	6.5
Employer payroll taxes paid to Medicare HI Trust Fund	3.4	3.6	3.7	3.9	3.0	3.7	7.2
Medicare[e]	157.5	168.6	192.3	233.1	7.1	14.1	21.2
Medicaid[f]	179.6	192.0	208.8	254.3	6.9	8.7	21.8
Other programs[g]	129.8	136.2	145.6	160.3	4.9	6.9	10.1
State and local governments	373.6	399.7	410.0	404.8	7.0	2.6	−1.3
Employer contributions to private health insurance premiums	110.3	116.6	118.6	123.4	5.8	1.7	4.0
Employer payroll taxes paid to Medicare HI Trust Fund	10.0	10.6	11.3	11.6	6.9	5.9	2.7
Medicaid	137.0	145.1	145.0	130.5	5.9	0.0	−10.0
Other programs[h]	116.5	127.3	135.0	139.3	9.3	6.1	3.2

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Numbers might not add to totals because of rounding. Percentage changes are calculated from unrounded data [a]Includes employer Medicare Hospital Insurance (HI) payroll taxes, temporary disability insurance, workers' compensation, and worksite health care. [b]Includes employee contributions to employer-sponsored health insurance and individually purchased health insurance. [c]Includes employee and self-employment payroll taxes and premiums paid to Medicare Hospital Insurance and Supplementary Medical Insurance Trust Funds. [d]Includes health-related philanthropic support, nonoperating revenue, investment income, and privately funded structures and equipment. [e]Includes trust fund interest income, and federal general revenue contributions to Medicare less the net change in the trust fund balance and payments for the Retiree Drug Subsidy. Excludes Medicare Hospital Insurance Trust Fund payroll taxes and premiums, Medicare Supplementary Medical Insurance premiums, state phase-down payments, Medicaid buy-ins, and taxation of benefits. [f]Includes Medicaid buy-ins for the Medicare premiums of people eligible for both Medicaid and Medicare (dual eligibles). [g]Includes health-related spending for maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, Indian Health Service, federal workers' compensation, other federal programs, public health activities, Department of Defense, Department of Veterans Affairs, research, and structures and equipment. [h]Includes health-related spending for state phase-down payments, maternal and child health, public and general assistance, Children's Health Insurance Program (CHIP) (Titles XIX and XXI), vocational rehabilitation, other state and local programs, public health activities, research, and structures and equipment.

declined 0.5 percent in 2009 as a result of a decrease in employer contributions to the Medicare Hospital Insurance Trust Fund and a deceleration in employers' contributions to private health insurance premiums.

Price And Nonprice Drivers

Price factors, such as increased prices for prescription drugs, affect spending growth in personal health care services.[10] So do nonprice factors, such as growth in the population and in the use of medical services, as well as their intensity—for example, when a physician provides more technically complex services to care for a patient.

In 2009, personal health care spending increased 4.6 percent—a deceleration from 4.9 percent growth in 2008. Price factors accounted for 60 percent of the 4.6 percent change, while nonprice factors accounted for the remaining 40 percent (Exhibit 6).

Despite a sharp deceleration in overall economywide prices (from a growth rate of 2.2 percent in 2008 to a rate of 0.9 percent in 2009),[1] medical price growth remained comparatively stable: It increased from 2.6 percent in 2008 to 2.7 percent in 2009. Growth in nonprice factors fell noticeably during the recession, mostly because people reduced their consumption of health services.

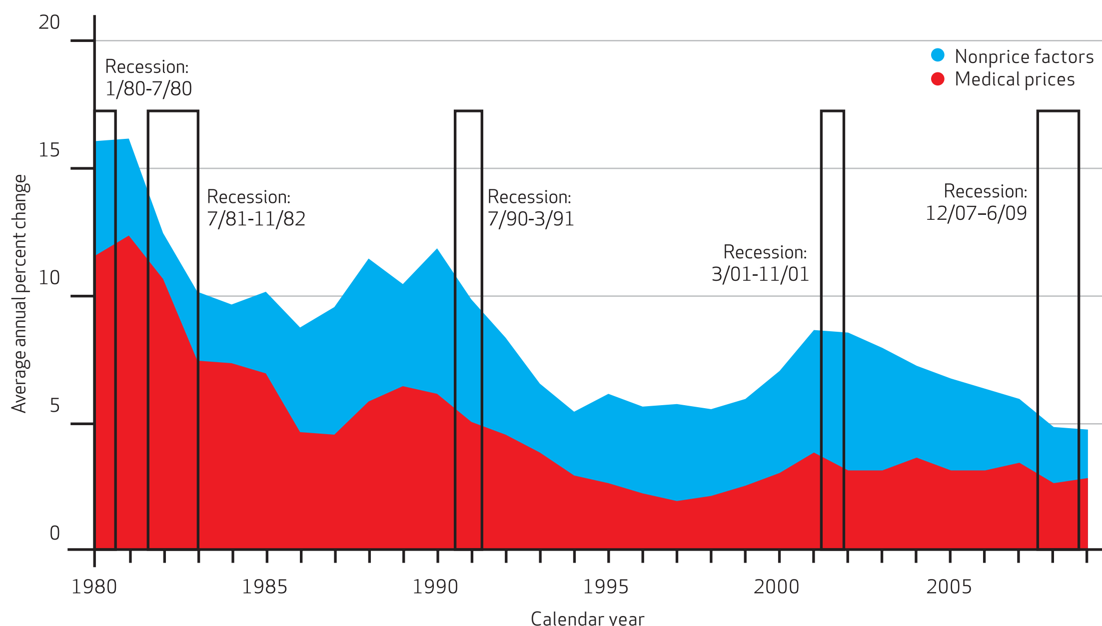
Hospital Care

Overall spending for hospital services reached $759.1 billion in 2009 (Exhibit 1). This was an increase of 5.1 percent—approximately the same rate of growth as in 2008 but much slower than the trend between 1999 and 2007, when spend-

Downloaded from content.healthaffairs.org by Health Affairs on January 6, 2011
at PHRMA

EXHIBIT 6

Factors Accounting For Growth In Personal Health Care Spending, Calendar Years 1980–2009



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 personal health care chain-type index constructed from the Producer Price Indexes for hospitals, offices of physicians, medical and diagnostic laboratories, home health care services, and nursing care facilities; and Consumer Price Indexes specific to each of the remaining personal health care components. Nonprice factors include population growth and changes in the use and intensity of services. As a residual, nonprice factors also include any errors in measuring prices or total spending.

ing increased an average of 7.2 percent per year. A similar trend occurred in hospital price growth, which remained steady at 3.0 percent in 2008 and 2009—below the average annual rate of 3.9 percent between 1999 and 2007 (data not shown).[11]

In 2009, private health insurance spending, which constituted the largest share of hospital spending (35 percent), decelerated from a growth rate of 5.6 percent in 2008 to 2.7 percent in 2009. The change occurred because fewer people were covered by private health insurance, particularly through their employers, and because many hospitals experienced a moderate to significant decrease in inpatient admissions, as people likely put off medical procedures they could no longer afford.[12,13]

At the same time, Medicaid hospital spending accelerated (from a growth rate of 3.3 percent in 2008 to 10.2 percent in 2009). Not only did enrollment in Medicaid increase considerably, but some enrollees used hospital emergency departments as a substitute for primary care providers.[14]

Other private revenues received by hospitals increased slightly in 2009, growing 0.8 percent. That increase followed a 9.9 percent decline in 2008, when a number of hospitals reported substantial losses in investment income as a result of the recession.[6] A recent survey of nonfederal, short-term acute care hospitals indicated that since 2008, half of the respondents had experienced a reduction in their nonoperating income, and just under half had experienced reduced access to capital as a result of the recession.[15]

Physician And Clinical Services

Spending on physician and clinical services totaled $505.9 billion in 2009 (Exhibit 1). The rate of growth for this spending slowed to 4.0 percent, down from 5.2 percent in 2008 (Exhibit 3) and was the slowest rate of growth since 1996. The deceleration was driven by slower growth in the use and intensity of services, which was partially offset by faster growth in prices for the services, from 1.0 percent in 2008 to 2.3 percent in 2009.[16,17]

Spending for physician services alone, which accounted for 81 percent of this combined category, increased 3.3 percent in 2009, while spending for clinical services increased 7.3 per-

Downloaded from content.healthaffairs.org by *Health Affairs* on January 6, 2011
at PHRMA

cent. Since 2005, spending growth for clinical services has generally outpaced that for physician services, consistent with recent reports that retail clinics (a subset of all clinics) have increased in popularity because of their convenience and lower costs.[18]

The recession had several notable effects on the growth in physician and clinical services spending in 2009. One was that after only a slight increase in 2008, the number of visits to physician offices declined in 2009.[19] A recent survey indicated that 36 percent of Americans saw health professionals less often in 2009 as a result of the recession.[20] Of those who reported a decrease in the number of visits, 59 percent indicated that it was primary care physicians whom they visited less.[20]

Contributing to the deceleration in overall spending on physician and clinical services was a deceleration in private health insurance spending. In 2009, private health insurance spending—which accounted for 47 percent of physician and clinical services spending—increased 1.9 percent, compared to a 4.5 percent growth rate in 2008 (data not shown). This slowdown was influenced by a decline in the number of people with private health insurance.

At the same time, out-of-pocket spending—which accounted for a 9 percent share of physician and clinical spending in 2009—decreased 1.0 percent (data not shown). This first decline since 1995 was due to the fact that people had become more cautious about health spending.[21]

Retail Prescription Drugs

Retail prescription drug expenditures grew 5.3 percent in 2009, reaching $249.9 billion (Exhibits 1 and 3). Faster growth in both prescription drug prices and use led to accelerated growth in spending in 2009—after an increase of 3.1 percent in 2008, the slowest rate of growth since 1961.

In 2009, despite the economic downturn, the number of prescription drugs dispensed rebounded to prerecession rates of growth. From 0.9 percent in 2008, the rate accelerated to 2.1 percent in 2009, which was more in line with the average annual rate of 2.2 percent between 2002 and 2007.[22] The H1N1 (swine flu) pandemic and the resulting sales of Tamiflu contributed to this trend: The number of prescriptions dispensed for this drug increased 114.7 percent between 2008 and 2009.[23]

Retail prescription drug prices, as measured by the Consumer Price Index for prescription drugs, rose 3.4 percent in 2009 compared with 2.5 percent in 2008.[24] Even with this acceleration, price growth in 2009 was slower than that experienced between 2000 and 2006, when price growth averaged 4.1 percent. Analysis indicates that faster growth in prices for brand-name medications and a slower decline in price growth for generic drugs were partly responsible for an acceleration in overall prescription drug prices in 2009.

In 2009, despite the economic downturn, the number of prescription drugs dispensed rebounded to prerecession rates of growth.

Mitigating some of the price growth in 2009 was an increase in the dispensing rate of generic prescriptions—excluding brand-name generics[25]—from 63 percent in 2008 to 66 percent in 2009.[22] Because generic drugs often cost 30–80 percent less than their brand-name counterparts,[26] increased use of generic drugs generally reduces the growth in overall prescription drug prices. The loss of patent protection in 2009 for several notable brand-name drugs—including Topamax, Imitrex, and Prevacid—contributed to the increased dispensing rate of generic drugs.[27]

Medicare

Spending for Medicare totaled $502.3 billion in 2009, which represented 20 percent of total national health spending (Exhibit 2). Total Medicare spending grew at the same rate in 2008 and 2009 (7.9 percent), while total enrollment in the program grew 1.9 percent in 2009—a rate that has remained fairly stable over time. Per enrollee, Medicare spending growth increased 0.8 percentage point faster in 2009 than in 2008, from 5.1 percent to 5.9 percent.

We present spending for Medicare fee-for-service (Parts A, B, and D) and Medicare managed care—otherwise known as Medicare Advantage (Parts C and D)—separately in this analysis because of their differing payment mechanisms and enrollment trends.

In 2009, Medicare fee-for-service expenditures increased 5.5 percent to $377.0 billion—

Downloaded from content.healthaffairs.org by *Health Affairs* on January 6, 2011
at PHRMA

Federal Medicaid spending increased 22.0 percent in 2009—the highest rate of growth since 1991.

an acceleration from the 2008 growth rate of 4.4 percent (data not shown). Enrollment in fee-for-service Medicare continued to fall in 2009, as beneficiaries chose to enroll in, or switch to, Medicare Advantage plans. Per enrollee, fee-for-service spending growth accelerated from 4.7 percent in 2008 to 6.9 percent in 2009.

Spending for hospital services exerted the largest influence on the overall acceleration in Medicare fee-for-service spending: It rose 5.1 percent in 2009, up from 3.5 percent in 2008 (data not shown). Increases in the use of both inpatient and outpatient services played a role in this change.[28] Faster Medicare fee-for-service spending growth for physician and clinical services also contributed to the acceleration, with the growth rate increasing from 1.7 percent in 2008 to 4.9 percent in 2009. This is primarily attributable to a 1.1 percent update in the physician fee schedule and an increase in the volume and intensity of services.[28]

Medicare Advantage spending reached $125.3 billion in 2009 and accounted for 25 percent of total Medicare spending (data not shown). That share has steadily increased since 2003, when these plans represented 13 percent of total Medicare spending. Total Medicare Advantage spending grew 15.8 percent in 2009, down from a rate of 21.4 percent in 2008 and well below the recent peak growth of 49.4 percent in 2006. Enrollment accounted for more than four-fifths of the growth in Medicare Advantage spending: It increased 13.1 percent in 2009. Per enrollee, Medicare Advantage spending increased only 2.3 percent in 2009—3.3 percentage points slower than the comparable figure for 2008.

Medicaid

Total federal and state Medicaid spending accounted for 15 percent of national health spending and totaled $373.9 billion in 2009 (Exhibit 2). Rising unemployment and rapid increases in Medicaid enrollment—two direct effects of the recession—were the main contributors to a sharp acceleration in Medicaid spending growth, from 4.9 percent in 2008 to 9.0 percent in 2009.[29]

Enrollment grew 7.4 percent in 2009. Meanwhile, average per enrollee Medicaid spending rose 1.5 percent,[9] principally because most new beneficiaries were in the low-cost categories of children or nonelderly, nondisabled adults—groups that were most likely to be affected by unemployment and the loss of private health insurance.[30]

In 2009, slower growth in Medicaid spending for services provided by nursing care facilities and home health care agencies was outweighed by accelerated growth in all other services. Nursing care facility and home health care agency services are used disproportionately by the aged, whose enrollment in Medicaid was less likely to be affected by the overall economic slowdown. Medicaid hospital spending, which accounted for 36 percent of total Medicaid spending in 2009, grew 10.2 percent after a 3.3 percent increase in 2008, again reflecting a large increase in enrollment (data not shown).

Federal Medicaid spending increased 22.0 percent in 2009—the highest rate of growth since 1991 (Exhibit 2). State spending decreased 9.8 percent—the largest decline in the program's history. The difference is due to the approximately $34 billion from the Recovery Act for enhanced federal aid to the states for Medicaid through the Federal Medical Assistance Percentage (FMAP).

Private Health Insurance

As the unemployment rate continued to climb through 2009, the number of people enrolled in private health insurance plans decreased by 3.2 percent. As a result, private health insurance spending accounted for a slightly smaller share of total health spending in 2009 (32 percent) than in 2008 (33 percent). Total private health insurance premium growth decelerated from 3.5 percent in 2008 to 1.3 percent in 2009—the slowest rate in the history of the national health accounts (Exhibit 2). Private health insurance spending on benefits also decelerated in 2009 to 2.8 percent, from 4.4 percent in 2008 (data not shown).

Per enrollee, private health insurance premiums increased 4.7 percent in 2009, accelerating slightly from a growth rate of 4.5 percent in 2008. This indicates that the loss of enrollment during the recession was the driving factor in the

Downloaded from content.healthaffairs.org by *Health Affairs* on January 6, 2011 at PHRMA

deceleration of total private health insurance spending growth. However, growth in per enrollee spending on benefits (6.3 percent in 2009) increased more rapidly than premiums, as spending on prescription drugs accelerated and as plans spent more on benefits for existing enrollees.[31] As a result, the net cost of private health insurance (or the difference between premiums and benefits) fell from 12.4 percent of total private health insurance spending in 2008 to 11.1 percent in 2009, continuing a decline that began in 2004.

Out-Of-Pocket Spending

Out-of-pocket spending by consumers—including deductibles, copayments, and the purchase of goods and services not covered by insurance—increased only 0.4 percent in 2009 (Exhibit 2), when it accounted for 12 percent of national health spending. This slower rate of growth compared to 2008 was due mainly to declines in out-of-pocket spending for dental services, services provided by nursing care facilities, and physician and clinical services—sectors that account for a relatively large share of out-of-pocket spending. These declines were largely the result of decreased use, as consumers delayed getting medical care because of recession-related drops in household income and loss of health insurance.[21]

Cost sharing was reported to have increased in 2009, as employers responded to the economic downturn.[32] However, this increase was partially offset by reduced household income, which caused people to be more cautious in their spending.

Conclusion

The economic recession that officially began in December 2007 and ended in June 2009 was the longest of all recessions since World War II.[33] The health care sector felt its effects more quickly than was the case in past recessions, leading total national health spending in 2009 to grow at a historically low rate.

Although the recession contributed greatly to slower health spending growth, the burden of financing health spending increased for households, businesses, and governments as the resources available to pay for that care declined. By the end of 2009, the United States was devoting just over one-sixth of its available financial resources to its health care system—a system that in 2010 embarked on an ambitious reform aimed at expanding coverage, improving health outcomes, and slowing spending growth. ■

The authors thank the other members of the National Health Expenditure Accounts Team: Joseph Benson, Cathy Cowan, Bridget Dickensheets, Micah Hartman, Patricia McDonnell, Olivia Nuccio, and Benjamin Washington. The opinions expressed here are the authors' and not necessarily those of the Centers for Medicare and Medicaid Services. The authors also thank Richard Foster, Stephen Heffler, John Poisal, Christopher Truffer, Mary Carol Barron, Catherine Curtis, and two anonymous peer reviewers for their helpful comments.

NOTES

1 Data used to calculate the health spending share of revenues reflects adjustments by the Office of the Actuary, Centers for Medicare and Medicaid Services, to personal income, federal government receipts, and state and local government receipts. Bureau of Economic Analysis. National economic accounts: NIPA, Tables 1.1.5, 1.1.9, 2.9, 3.2, and 3.3 [Internet]. Washington (DC): BEA; [cited 2010 Oct 3]. Available from: http://www.bea.gov/national/nipaweb/SelectTable.asp

2 Lusardi A, Schneider DJ, Tufano P. The economic crisis and medical care usage. Cambridge (MA): National Bureau of Economic Research; 2010 Mar. (Working Paper No. 15483).

3 The remaining 7 percent of health care spending came from other private sources of revenue, such as nonprofit providers' investment income and all providers' revenue that did not come from patient care.

4 Centers for Medicare and Medicaid Services. National health expenditure accounts: comprehensive revision article [Internet]. Baltimore (MD): CMS; [cited 2011 Jan 6]. Available from: http://www.cms.gov/NationalHealthExpendData/downloads/benchmark2009.pdf

5 The comprehensive revisions affected all years from 1960 to 2008. For these years, spending levels were revised between −0.9 percent and 2.2 percent of total national health spending, and growth rates were revised between −0.3 percent and 0.7 percent. For 2008, the health share of the GDP was revised from 16.19 percent to 16.64 percent. Of this 0.45-percentage-point difference, 0.36 percentage point was due to a revision in national health spending, and 0.08 percentage point was due to a revision in the GDP.

6 Hartman M, Martin A, Nuccio O, Catlin A, National Health Expenditure Accounts Team. Health spending growth at a historic low in 2008. Health Aff (Millwood). 2010;29(1):147–55.

7 US Department of Labor, Bureau of Labor Statistics. Labor force statistics from the Current Population Survey, series ID LNS14000000 [Internet]. Washington (DC): BLS; [cited 2010 Oct 1]. Available for download from: http://data.bls.gov/cgi-bin/srgate

8 US Department of Labor, Bureau of Labor Statistics. Employment, hours, and earnings from the Current Employment Statistics survey, series ID CEU0000000001 [Internet]. Washington (DC): BLS; [cited 2010 Nov 4]. Available for download from: http://data.bls.gov/cgi-bin/srgate

9 Based on an unpublished analysis by the CMS Office of the Actuary of enrollment from the Medicaid Statistical Information System (MSIS); enrollment was estimated for states that did not report in 2009. Centers for Medicare and Medicaid Services.

Downloaded from content.healthaffairs.org by *Health Affairs* on January 6, 2011
at PHRMA

MSIS data [Internet]. Baltimore (MD): CMS; [cited 2010 Nov 5]. Available from: http://www.cms.gov/MedicaidDataSourcesGenInfo/02_MSISData.asp

10 Personal health care is that part of national health spending that does not include government spending on the administration of health programs and public health; the net cost of private health insurance; spending on noncommercial research; or investment in structures and equipment.

11 US Department of Labor, Bureau of Labor Statistics. Producer Price Index industry data, series ID PCU622- - -622- - - [Internet]. Washington (DC): BLS; [cited 2010 Oct 1]. Available for download from: http://data.bls.gov/cgi-bin/srgate

12 American Hospital Association. The economic crisis: ongoing monitoring of impact on hospitals [Internet]. Chicago (IL): AHA; 2009 Nov 11 [cited 2010 Oct 13]. Available from: http://www.aha.org/aha/trendwatch/2009/09nov-econimpsurvresults.pdf

13 American Hospital Association. Hospital statistics: 2011 ed. Chicago (IL): Health Forum; 2010.

14 Sack K. As Medicaid payments shrink, patients are abandoned. New York Times. 2010 Mar 15.

15 American Hospital Association. Hospitals continue to feel lingering effects of the economic recession [Internet]. Chicago (IL): AHA; [cited 2010 Oct 13]. Available from: http://www.aha.org/aha/content/2010/pdf/10june-econimpact.pdf

16 Physician and clinical services are deflated using a blended index constructed from the Producer Price Indexes for offices of physicians and for medical and diagnostic laboratories. US Department of Labor, Bureau of Labor Statistics. Producer Price Index for offices of physicians, series ID PCU6211- -6211- - [Internet]. Washington (DC): BLS; [cited 2010 Oct 1]. Available for download from: http://data.bls.gov/cgi-bin/srgate

17 US Department of Labor, Bureau of Labor Statistics. Producer Price Index for medical and diagnostic laboratories, series ID PCU6215- -6215- -[Internet]. Washington (DC): BLS; [cited 2010 Oct 1]. Available for download from: http://data.bls.gov/cgi-bin/srgate

18 Mehrotra A, Liu H, Adams J, Wang M, Lave J, Thygeson M, et al. Comparing costs and quality of care at retail clinics with that of other medical settings for 3 common illnesses. Ann Intern Med. 2009;151(5):321–8.

19 Based on CMS Office of the Actuary unpublished analysis of data from IMS Health. National disease and therapeutics index. Falls Church (VA): IMS Health; 2010 Jun.

20 American Optometric Association. Fourth annual American Optometric Association American Eye-q survey: executive summary [Internet]. St. Louis (MO): AOA; [cited 2010 Sep 20]. Available from: http://wyoming.aoa.org/documents/American_Eye-Q_Executive_Summary_2009.pdf

21 Johnson A, Rockoff JD, Mathews AW. Americans cut back on visits to doctor. Wall Street Journal. 2010 Jul 29.

22 Based on CMS Office of the Actuary unpublished analysis of data from IMS Health. Method of payment report. Falls Church (VA): IMS Health; 2010 Jun.

23 2009 top 200 branded drugs by total prescriptions. Drug Topics [serial on the Internet]; 2010 Jun 17 [cited 2010 Oct 13]. p. 1–3. Available from: http://drugtopics.modernmedicine.com/drugtopics/data/articlestandard//drugtopics/252010/674969/article.pdf

24 US Labor Department, Bureau of Labor Statistics. Consumer Price Index—All Urban Consumers: prescription drugs, series ID CUUR0000SEMF01 [Internet]. Washington (DC): BLS; [cited 2010 Oct 3]. Available for download from: http://data.bls.gov/cgi-bin/srgate

25 These are “products that are either novel dosage forms of off-patent products produced by a manufacturer that is not the originator of the molecule, or a molecule copy of an off-patent product with a trade name.” Lamb E. Branded generics: misunderstood, but lucrative. Pharmacy Times [serial on the Internet]. 2008 Oct 1 [cited 2010 Dec 16]. Available from: http://www.pharmacytimes.com/issue/pharmacy/2008/2008-10/2008-10-8707

26 Medco Health Solutions. The great healthcare debates: prescriptions for meaningful reform; 2009 drug trend report [Internet]. Franklin Lakes (NJ): Medco Health Solutions; 2009 May [cited 2010 Dec 20]. Available from: http://filecache.drivetheweb.com/mr4enh_medco/177/download/2009+DRUG+TREND+REPORT.pdf

27 Medco Health Solutions. Solving the healthcare cost/quality equation; 2010 drug trend report [Internet]. Franklin Lakes (NJ): Medco Health Solutions; 2010 May [cited 2010 Dec 20]. Available from: http://medco.mediaroom.com/index.php?s=64&cat=5

28 Boards of Trustees. 2010 annual report of the boards of trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds [Internet]. Baltimore (MD): CMS; 2010 Aug [cited 2010 Oct 1]. Available from: http://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf

29 Council of State Governments. Medicaid enrollment and spending: 2009–2010 fiscal year update [Internet]. Lexington (KY): The Council; 2010 Feb [cited 2010 Oct 1]. Available from: http://www.csg.org/policy/documents/TIA_FF_Medicaid_Enrllmt_Spndng_000.pdf

30 Smith VK, Gifford K, Ellis E, Rudowitz R, O’Malley Watts M, Marks C. The crunch continues: Medicaid spending, coverage, and policy in the midst of a recession [Internet]. Washington (DC): Kaiser Commission on Medicaid and the Uninsured; 2009 Sep [cited 2010 Oct 1]. Available from: http://www.kff.org/medicaid/upload/7985.pdf

31 Berry E. Health plans’ profits decline along with membership numbers. American Medical News [serial on the Internet]. 2009 Aug 24 [cited 2010 Sep 8]. Available from: http://www.ama-assn.org/amednews/2009/08/24/bisb0824.htm

32 Claxton G, DiJulio B, Whitmore H, Pickreign J, McHugh M, Finder B, et al. Job-based health insurance: costs climb at a moderate pace. Health Aff (Millwood). 2009;28(6):w1002–12. DOI: 10.1377/hlthaff.28.6.w1002.

33 National Bureau of Economic Research. Business cycle dating committee [Internet]. Cambridge (MA): NBER; 2010 Sep 20 [cited 2010 Sep 26]. Available from: http://www.nber.org/cycles/sept2010.html

Downloaded from content.healthaffairs.org by Health Affairs on January 6, 2011
at PHRMA

ABOUT THE AUTHORS: ANNE MARTIN, DAVID LASSMAN, LEKHA WHITTLE & AARON CATLIN

Anne Martin is an economist at the Centers for Medicare and Medicaid Services (CMS).

Coauthors Anne Martin, David Lassman, Lekha Whittle, and Aaron Catlin of the Centers for Medicare and Medicaid Services (CMS) present the annual report on national health spending. They are all part of the National Health Expenditure Accounts Team within the National Health Statistics Group in the CMS Office of the Actuary. Findings for the year 2009 demonstrate how the economic recession slowed the rate of health spending growth to a historic low. A major cause of that slowdown, the report says, was high unemployment and general financial insecurity among Americans.

Martin, the lead author, says that the consequences of this economic downturn on health spending were felt much faster than in previous economic slumps. "This time," she says, "we saw a more immediate impact and a more severe impact as well."

Martin, an economist, works on historical and state-based national health spending estimates. Prior to joining CMS in 1997, she was an analyst at the Bureau of Labor Statistics, responsible for the development of the Producer Price Index for physicians, medical laboratories, and home health care agencies. She earned a bachelor's degree in economics from the University of Maryland Baltimore County.

David Lassman is a statistician at CMS.

Lassman is a statistician who works on historical and state-based national health spending estimates. Before he joined CMS in 2007, he was a statistician at the US Census Bureau, where he worked on the quarterly services survey—the first government indicator to directly address the services sector. He earned bachelor's degrees in economics and business from Lafayette College and a master of business administration degree from Syracuse University.

Lekha Whittle is an economist at CMS.

Whittle is an economist who also works on historical and state-based national health spending estimates. Before joining CMS in 1994, she was an analyst with PriceWaterhouse. She earned a bachelor's degree in economics and finance from the University of Maryland College Park and a master of policy sciences degree from University of Maryland Baltimore County.

Aaron Catlin is a deputy director of the National Health Statistics Group, CMS.

Catlin is a deputy director of the National Health Statistics Group at CMS. He directs the historical and age-based estimates from the National Health Expenditure Accounts. He earned a bachelor's degree in economics from the University of Maryland and a master of science in management degree from the University of Maryland University College.

Downloaded from content.healthaffairs.org by *Health Affairs* on January 6, 2011
at PHRMA