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Growth In US Health Spending Remained Slow In 2010; Health Share Of Gross Domestic Product Unchanged From 2009

ABSTRACT Medical goods and services are generally viewed as necessities. Even so, the latest recession had a dramatic effect on their utilization. US health spending grew more slowly in 2009 and 2010—at rates of 3.8 percent and 3.9 percent, respectively—than in any other years during the fifty-one-year history of the National Health Expenditure Accounts. In 2010 extraordinarily slow growth in the use and intensity of services led to slower growth in spending for personal health care. The rates of growth in overall US gross domestic product (GDP) and in health spending began to converge in 2010. As a result, the health spending share of GDP stabilized at 17.9 percent.

Total US health spending reached \$2.6 trillion, or \$8,402 per person, in 2010 (Exhibit 1).¹ After historically low growth in 2009, aggregate health care spending in 2010 increased 3.9 percent—only 0.1 percentage point faster than the rate of growth in 2009 (3.8 percent) (Exhibit 2). In the first full year following the longest and most severe recession since the Great Depression, the US economy began to recover as growth in nominal gross domestic product (GDP) increased at a rate of 4.2 percent (3.0 percent real growth). Because nominal health spending and GDP grew at comparatively similar rates in 2010, health spending as a share of GDP remained steady at 17.9 percent (Exhibit 1).

The slow growth in health spending in 2009 and 2010 was influenced by slower growth in the use of health care goods and services as consumers remained cautious about their spending—in part because of losses in private health insurance coverage, lower median household income, and future financial uncertainty. Slower growth in spending for hospital care and physician and clinical services, along with record low growth in spending for prescription drugs, reflected

slower growth in the use of these goods and services.

From a payer perspective, continued slow growth in private health insurance and out-of-pocket spending² (which grew just 2.4 percent and 1.8 percent, respectively) and decelerations in Medicare and Medicaid spending growth (which slowed to 5.0 percent and 7.2 percent, respectively) contributed to overall low growth in 2010 (Exhibit 3).³

Health Care And The Economy

The recession that lasted from December 2007 through June 2009 had a powerful impact on most sectors of the economy, and health care was no exception. Overall economic output slowed substantially in 2008 and declined in 2009 (the first decline in nominal GDP since 1949), and health spending growth slowed to historically low rates from 2008 through 2010.

Economic recessions tend to have a lagged impact on health spending. The reasons for such lags include the health sector's reliance on insurance contracts that are negotiated a year or more in advance; consumers' ability to maintain insurance coverage after losing a job by means of

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

EXHIBIT 1

National Health Expenditures (NHE), Aggregate And Per Capita Amounts And Share Of Gross Domestic Product (GDP), Selected Calendar Years 1980–2010

Spending category	1980	1990	2000	2007	2008	2009	2010
NHE, billions	\$255.8	\$724.3	\$1,377.2	\$2,297.1	\$2,403.9	\$2,495.8	\$2,593.6
Health consumption expenditures	235.7	675.6	1,289.6	2,153.4	2,250.1	2,349.5	2,444.6
Personal health care (PHC)	217.2	616.8	1,165.4	1,914.6	2,010.2	2,109.0	2,186.0
Hospital care	100.5	250.4	415.5	692.5	729.3	776.1	814.0
Professional services	64.6	208.1	390.2	618.6	652.6	671.2	688.6
Physician and clinical services	47.7	158.9	290.9	461.8	486.6	502.7	515.5
Other professional services	3.5	17.4	37.0	59.5	63.6	66.0	68.4
Dental services	13.4	31.7	62.3	97.3	102.4	102.5	104.8
Other health, residential, and personal care ^a	8.5	24.3	64.6	107.7	113.3	122.0	128.5
Home health care ^b	2.4	12.6	32.4	57.8	61.5	66.1	70.2
Nursing care facilities and continuing care retirement communities ^{b,c}	15.3	44.9	85.1	126.4	132.7	138.7	143.1
Retail outlet sales of medical products	25.9	76.5	177.6	311.5	321.0	334.9	341.6
Prescription drugs	12.0	40.3	120.9	236.2	243.6	256.1	259.1
Durable medical equipment	4.1	13.8	25.1	34.3	34.9	35.2	37.7
Other nondurable medical products	9.8	22.4	31.6	41.0	42.5	43.6	44.8
Government administration ^d	2.8	7.2	17.1	30.2	29.5	29.6	30.1
Net cost of health insurance ^e	9.3	31.6	64.2	139.7	137.8	134.7	146.0
Government public health activities	6.4	20.0	43.0	69.0	72.7	76.2	82.5
Investment	20.1	48.7	87.5	143.7	153.8	146.3	149.0
Research ^f	5.4	12.7	25.5	41.9	43.4	45.7	49.3
Structures and equipment	14.7	36.0	62.1	101.7	110.4	100.6	99.8
Population (millions)	230.4	253.8	282.3	301.2	303.9	306.3	308.7
NHE per capita	\$1,110	\$2,854	\$4,878	\$7,628	\$7,911	\$8,149	\$8,402
GDP, billions of dollars	\$2,788.1	\$5,800.5	\$9,951.5	\$14,028.7	\$14,291.5	\$13,939.0	\$14,526.5
NHE as percent of GDP	9.2	12.5	13.8	16.4	16.8	17.9	17.9
Implicit price deflator for GDP	47.8	72.3	88.7	106.2	108.6	109.7	111.0
Real GDP, billions of chained dollars ^g	\$5,834.0	\$8,027.1	\$11,216.4	\$13,206.4	\$13,161.9	\$12,703.1	\$13,088.0
NHE, billions of 2005 dollars ^h	\$535.2	\$1,002.3	\$1,552.2	\$2,162.4	\$2,213.9	\$2,274.6	\$2,336.8
PHC deflator ⁱ	31.4	63.1	85.0	106.5	109.3	112.3	115.3

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. ^aIncludes 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. ^bIncludes freestanding facilities only. Additional services of this type provided in hospital-based facilities are counted as hospital care. ^cIncludes care provided in nursing care facilities (NAICS 6231), continuing care retirement communities (NAICS 62331), and nursing facilities operated by state or local governments or the Department of Veterans Affairs. ^dIncludes 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. ^eNet 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). ^fResearch 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. ^gChain-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. ^hDeflated using the implicit price deflator for GDP (2005 = 100.0). ⁱPHC 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.

a spouse's policy or another program (such as coverage made available by the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA); and the availability of coverage through public programs such as Medicaid and the Children's Health Insurance Program.⁴

The lagged slowdown in health spending growth from the recent recession occurred more

quickly than was the case in previous recessions. This was the result of a combination of factors, including the highest unemployment rate in twenty-seven years,⁵ a substantial loss of private health insurance coverage, employers' increased caution about hiring and investing during the recovery,⁶ and the lowest median inflation-adjusted household income since 1996.⁷

EXHIBIT 2
National Health Expenditures (NHE), Average Annual Growth From Prior Year Shown, Selected Calendar Years 1980–2010

Spending category	1980	1990	2000	2007	2008	2009	2010
NHE	13.1%	11.0%	6.6%	7.6%	4.7%	3.8%	3.9%
Health consumption expenditures	13.4	11.1	6.7	7.6	4.5	4.4	4.0
Personal health care (PHC)	13.2	11.0	6.6	7.3	5.0	4.9	3.7
Hospital care	14.0	9.6	5.2	7.6	5.3	6.4	4.9
Professional services	12.6	12.4	6.5	6.8	5.5	2.9	2.6
Physician and clinical services	12.8	12.8	6.2	6.8	5.4	3.3	2.5
Other professional services	17.0	17.5	7.8	7.0	6.9	3.8	3.6
Dental services	11.0	9.0	7.0	6.6	5.2	0.1	2.3
Other health, residential, and personal care ^a	20.4	11.1	10.3	7.6	5.2	7.7	5.3
Home health care ^b	26.9	18.1	9.9	8.6	6.4	7.5	6.2
Nursing care facilities and continuing care retirement communities ^{b,c}	14.2	11.4	6.6	5.8	4.9	4.5	3.2
Retail outlet sales of medical products	9.4	11.4	8.8	8.4	3.0	4.3	2.0
Prescription drugs	8.2	12.8	11.6	10.0	3.1	5.1	1.2
Durable medical equipment	8.8	13.0	6.2	4.6	1.7	0.8	7.3
Other nondurable medical products	11.4	8.6	3.5	3.8	3.7	2.6	2.6
Government administration ^d	14.1	10.0	9.1	8.5	-2.5	0.4	1.7
Net cost of health insurance ^e	17.3	13.1	7.3	11.8	-1.4	-2.2	8.4
Government public health activities	16.9	12.0	8.0	7.0	5.3	4.9	8.2
Investment	10.0	9.2	6.0	7.3	7.1	-4.9	1.9
Research ^f	10.8	8.9	7.2	7.4	3.4	5.3	7.9
Structures and equipment	9.7	9.4	5.6	7.3	8.6	-8.9	-0.8
Population (millions)	0.9	1.0	1.1	0.9	0.9	0.8	0.8
NHE per capita	12.0	9.9	5.5	6.6	3.7	3.0	3.1
Gross domestic product (GDP), billions of dollars	10.4	7.6	5.5	5.0	1.9	-2.5	4.2
Implicit price deflator for GDP	7.0	4.2	2.1	2.6	2.2	1.1	1.2
Real GDP, billions of chained dollars ^g	3.2	3.2	3.4	2.4	-0.3	-3.5	3.0
NHE, billions of 2005 dollars ^h	5.7	6.5	4.5	4.9	2.4	2.7	2.7
PHC ⁱ	7.9	7.2	3.0	3.3	2.6	2.7	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. ^aIncludes 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. ^bIncludes freestanding facilities only. Additional services of this type provided in hospital-based facilities are counted as hospital care. ^cIncludes 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. ^dIncludes 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. ^eNet 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). ^fResearch 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. ^gChain-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. ^hDeflated using the implicit price deflator for GDP (2005 = 100.0). ⁱPHC 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.

Although medical goods and services are generally viewed as necessities, the latest recession had a dramatic effect on their utilization. On average, between 2007 and 2009, growth in the use and intensity of health care goods and services contributed 1.3 percentage points to the annual growth in personal health care spending (4.8 percent). This was much lower than its average contribution of 3.2 percentage points between 2000 and 2006, when personal health

care spending grew 7.3 percent, on average.⁸

Even though the recession officially ended in 2009, its impact on the health sector appears to have continued into 2010: Growth in the use and intensity of services represented just 0.1 percentage point of the 3.7 percent growth in personal health care spending in 2010 (Exhibit 4).⁹

EXHIBIT 3

National Health Expenditures (NHE), Amounts And Average Annual Growth From Previous Year Shown, By Source Of Funds, Selected Calendar Years 1980–2010

	1980 ^a	1990	2000	2007	2008	2009	2010
SOURCE OF FUNDS							
NHE, billions	\$255.8	\$724.3	\$1,377.2	\$2,297.1	\$2,403.9	\$2,495.8	\$2,593.6
Health consumption expenditures	235.7	675.6	1,289.6	2,153.4	2,250.1	2,349.5	2,444.6
Out-of-pocket	58.4	138.7	201.8	287.3	294.0	294.4	299.7
Health insurance	142.2	439.5	920.3	1,610.2	1,700.7	1,793.3	1,870.8
Private health insurance	69.1	234.3	459.6	776.2	807.6	828.8	848.7
Medicare	37.4	110.2	224.3	432.3	466.9	499.8	524.6
Medicaid	26.0	73.7	200.5	326.4	343.8	374.4	401.4
Federal	14.5	42.6	116.9	185.9	202.9	247.5	269.5
State and local	11.5	31.1	83.6	140.5	141.0	127.0	131.9
Other health insurance programs ^b	9.7	21.4	35.9	75.4	82.4	90.3	96.1
Other third-party payers and programs and public health activity ^c	35.0	97.5	167.5	255.9	255.4	261.8	274.1
Investment	20.1	48.7	87.5	143.7	153.8	146.3	149.0
AVERAGE ANNUAL GROWTH FROM PRIOR YEAR SHOWN							
NHE	13.1%	11.0%	6.6%	7.6%	4.7%	3.8%	3.9%
Health consumption expenditures	13.4	11.1	6.7	7.6	4.5	4.4	4.0
Out-of-pocket	8.9	9.0	3.8	5.2	2.3	0.2	1.8
Health insurance	16.2	11.9	7.7	8.3	5.6	5.4	4.3
Private health insurance	16.2	13.0	7.0	7.8	4.0	2.6	2.4
Medicare	17.2	11.4	7.4	9.8	8.0	7.0	5.0
Medicaid	17.3	11.0	10.5	7.2	5.3	8.9	7.2
Federal	17.7	11.4	10.6	6.8	9.1	22.0	8.9
State and local	16.7	10.4	10.4	7.7	0.3	-9.9	3.9
Other health insurance programs ^b	11.4	8.2	5.3	11.2	9.3	9.6	6.5
Other third-party payers and programs and public health activity ^c	12.9	10.8	5.6	6.2	-0.2	2.5	4.7
Investment	10.0	9.2	6.0	7.3	7.1	-4.9	1.9

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. ^aAverage annual growth, 1970–80. ^bIncludes health-related spending for Children's Health Insurance Program (CHIP), Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs. ^cIncludes 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.

Affordable Care Act Provisions In 2010

The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (enacted in March 2010)—together known as the Affordable Care Act of 2010—introduced widespread changes to the health care system that are expected to affect both the delivery and the financing of care. The most prominent provisions, such as the expansion of Medicaid and the creation of the health insurance exchanges, will not be implemented until 2014. However, some provisions were effective in 2010: changes to Medicare provider rates (effective October 1, 2009); a Medicare prescription drug rebate for beneficiaries who reach the coverage gap or “doughnut hole” (effective January 1, 2010); increased Medicaid rebates for brand-name prescription drugs and the introduction of drug rebates for Medicaid managed care plans (effective January 1,

2010); small-business tax credits for offering employer-sponsored insurance (effective January 1, 2010); the establishment of temporary health insurance plans—or high-risk pools—that cover preexisting conditions (effective July 1, 2010); and the extension of dependent coverage for adult children up to age twenty-six (effective September 23, 2010).¹⁰

Based on recent health spending projections, health spending growth for 2010—excluding the impacts of the Affordable Care Act—was estimated at 3.7 percent.¹¹ Thus, the projected net effect of the act's provisions on health spending growth in 2010 was approximately 0.2 percentage point. This was largely due to the provisions that affected Medicare spending. Most of the other 2010 provisions either had a negligible impact on overall spending or shifted the distribution of spending without affecting the overall rate of growth.

Sponsors Of Health Care

The recent economic recession and legislative changes, such as the Affordable Care Act and the American Recovery and Reinvestment Act of 2009, have had a noticeable impact on the businesses, households, and governments that bear the financial burden of health care costs. These entities sponsor health care payments through insurance premiums, direct out-of-pocket expenditures, or dedicated or general taxes. Total government (both the categories of federal government and of state and local governments) financing of health care equaled \$1.2 trillion in 2010 (Exhibit 5) and represented 45 percent of all US health spending (up from 41 percent in 2007). The federal government's share increased substantially in the past three years—rising to 29 percent in 2010, up from 23 percent in 2007—with Medicaid enrollment increasing rapidly and the federal government paying a higher share of Medicaid benefits through enhanced federal matching rates, as mandated by the Recovery Act (Exhibit 6). In contrast, state and local governments' share of total health spending declined, from 18 percent in 2007 to 16 percent in 2010.

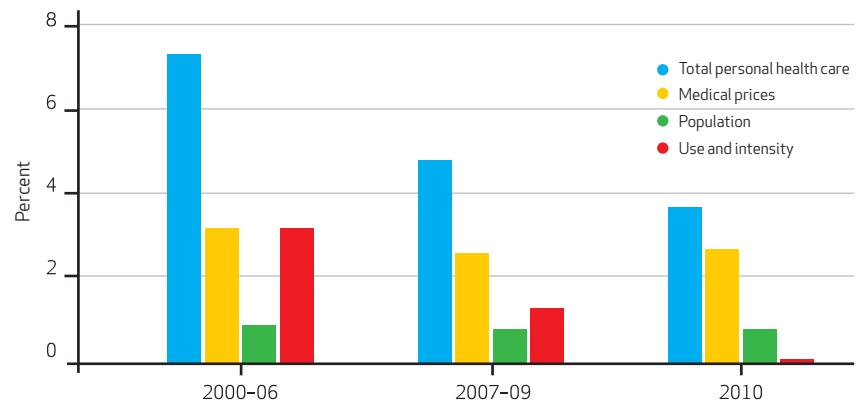
In 2010 private businesses financed 21 percent—\$534.5 billion—of the nation's total health care bill (Exhibit 6). That share has gradually decreased since 2001, when it was 25 percent. The majority of health care financing from private businesses is related to employers' contributions to private health insurance premiums (77 percent of private businesses' health spending) and payroll tax-based employer contributions to the Medicare Hospital Insurance (Part A) Trust Fund (15 percent).

Both types of contributions by employers experienced much slower average annual growth between 2008 and 2010 than between 2000 and 2007. Employers' contributions to private health insurance premiums slowed from an average growth of 6.5 percent between 2000 and 2007 to an average growth of 1.1 percent in the later period. Employers' payroll-tax contributions to the Medicare Hospital Insurance Trust Fund, which grew 3.9 percent on average in the earlier period, declined 1.9 percent on average in the later period. Both changes were a result of recession-related job losses.

Total spending by households was \$725.5 billion in 2010, which represented 28 percent of national health spending (Exhibit 6)—a historic low. After negligible growth in 2009, household spending grew 2.8 percent in 2010. Individuals' payroll-tax contributions (for employed individuals), self-employment contributions, and voluntary premiums paid to the Medicare Hospital Insurance Trust Fund increased 3.7 percent in

EXHIBIT 4

Factors Accounting For Growth In Personal Health Care Spending, Selected Periods 2000-10



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. As a residual, the category of use and intensity includes any errors in measuring prices or total spending.

2010, following a decline of 3.5 percent in 2009. Two-fifths of all spending on health care by households was financed from direct out-of-pocket payments, whose growth accelerated from 0.2 percent in 2009 to 1.8 percent in 2010. Approximately one-third of household spending was attributable to employees' contributions to private health insurance or individual-policy premiums, which also rose faster in 2010 after slow growth in 2009.

Hospital Care

Overall spending for hospital services reached \$814.0 billion in 2010 (Exhibit 1), representing an increase of 4.9 percent over 2009. In contrast, from 2008 to 2009, spending for hospital services had risen by 6.4 percent. The deceleration of 1.5 percentage points in the hospital spending growth rate from 2009 marked the fourth consecutive year of relatively slow growth. As a result, annual growth in hospital spending averaged 5.5 percent between 2007 and 2010, compared to 7.4 percent between 2003 and 2006. A similar trend occurred in hospital price growth, which averaged 3.0 percent annually between 2007 and 2010, compared to 4.4 percent between 2003 and 2006.¹²

Private health insurance spending for hospital services—which, at 35 percent, was the largest share of hospital spending—decelerated from growth of 4.8 percent in 2009 to growth of

EXHIBIT 5

National Health Expenditures (NHE), Levels And Annual Growth, By Type Of Sponsor, Calendar Years 2007-10

Type of sponsor	Expenditures, \$ billions				Percent change from previous year		
	2007	2008	2009	2010	2008	2009	2010
NHE	2,297.1	2,403.9	2,495.8	2,593.6	4.7	3.8	3.9
Businesses, households, and other private	1,364.3	1,407.8	1,402.8	1,429.9	3.2	-0.4	1.9
Private business	523.5	531.4	529.8	534.5	1.5	-0.3	0.9
Employer contributions to private health insurance premiums	397.3	404.9	412.0	414.1	1.9	1.8	0.5
Other ^a	126.2	126.5	117.8	120.4	0.3	-6.8	2.2
Household	668.9	703.1	705.5	725.5	5.1	0.3	2.8
Household private health insurance premiums ^b	231.8	252.5	256.2	263.1	8.9	1.5	2.7
Medicare payroll taxes and premiums ^c	149.9	156.6	154.9	162.8	4.5	-1.1	5.1
Out-of-pocket health spending	287.3	294.0	294.4	299.7	2.3	0.2	1.8
Other private revenues ^d	171.9	173.4	167.4	169.9	0.8	-3.4	1.5
Government	932.8	996.1	1,093.1	1,163.7	6.8	9.7	6.5
Federal government	529.8	582.4	684.0	742.7	9.9	17.4	8.6
Employer contributions to private health insurance premiums	24.6	25.1	26.8	28.5	2.0	6.5	6.3
Employer payroll taxes paid to Medicare HI Trust Fund	3.6	3.8	3.9	4.0	5.7	4.5	2.8
Medicare ^e	173.8	198.7	237.4	254.0	14.4	19.5	7.0
Medicaid ^f	191.6	209.2	254.8	278.1	9.1	21.8	9.2
Other programs ^g	136.2	145.7	161.1	178.0	7.0	10.6	10.5
State and local government	403.0	413.6	409.1	421.1	2.6	-1.1	2.9
Employer contributions to private health insurance premiums	118.6	121.4	127.9	134.1	2.3	5.4	4.9
Employer payroll taxes paid to Medicare HI Trust Fund	10.6	11.0	11.3	11.4	4.0	2.2	1.0
Medicaid	144.9	145.3	130.5	135.9	0.3	-10.2	4.2
Other programs ^h	128.9	136.0	139.4	139.6	5.5	2.5	0.1

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. ^aIncludes employer Medicare Hospital Insurance (HI) payroll taxes, temporary disability insurance, workers' compensation, and worksite health care. ^bIncludes employee contributions to employer-sponsored health insurance and individually purchased health insurance. ^cIncludes employee and self-employment payroll taxes and premiums paid to Medicare HI and Supplementary Medical Insurance Trust Funds and premiums paid for the preexisting condition insurance program (PCIP). ^dIncludes health-related philanthropic support, nonoperating revenue, investment income, and privately funded structures and equipment. ^eIncludes 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 HI Trust Fund payroll taxes and premiums, Medicare Supplementary Medical Insurance premiums, state phase-down payments, Medicaid buy-ins, and taxation of benefits. ^fIncludes Medicaid buy-ins for the Medicare premiums of people eligible for both Medicaid and Medicare (dual eligibles). ^gIncludes 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. ^hIncludes 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.

2.2 percent in 2010. This was the slowest rate of increase since 1996. In 2010, consumers continued to postpone medical care, as demonstrated by a decline in median inpatient admissions and slowing growth in emergency department visits, outpatient visits, and outpatient surgeries.¹³ A recent survey found that 72 percent of short-term acute care hospitals experienced a reduced volume of elective procedures as a result of the recession.¹⁴

Hospital spending by Medicare and Medicaid, which accounted for 28 percent and 19 percent of total hospital spending in 2010, respectively, experienced diverging trends. Medicare hospital spending increased 4.6 percent—a deceleration from growth of 5.3 percent in 2009. That was primarily because of slower growth in Medicare Advantage payments, which resulted from an adjustment to payment rates.¹⁵ However, Medic-

aid spending increased 11.2 percent in 2010, compared to an increase of 10.4 percent in 2009. The change was caused in part by a large amount of supplemental payments (additional reimbursement payments above standard state Medicaid rates but below upper-payment-limit rates) to hospitals in the last quarter of 2010.¹⁶

Physician And Clinical Services

Total spending for physician and clinical services—a category that includes services provided in physician offices and outpatient care centers and by independently billing hospital-based physicians and independently billing laboratories—reached \$515.5 billion in 2010 (Exhibit 1). However, that spending grew at a historically low rate—just 2.5 percent, down from 3.3 percent in 2009. Although price growth remained stable

in 2010, at 2.3 percent,^{17,18,19} growth in use and intensity declined. The decrease was driven by a drop in physician visits because some people deferred going to see the doctor to reduce expenses²⁰ and because the flu season in 2010 was less severe than in 2009.²¹

Spending for physician services, which accounted for 81 percent of physician and clinical spending in 2010, grew 1.8 percent, slowing from growth of 2.5 percent in 2009. Meanwhile, spending for clinical services grew 5.5 percent, slowing from 7.0 percent in 2009. Since 2005, spending growth for clinical services has outpaced growth for physician services. Clinical services account for a growing share of total physician and clinical expenditures, rising from 17 percent in 2005 to 19 percent in 2010.

The largest payer of physician and clinical services is private health insurance, which accounted for 46 percent of these services in 2010, compared to 47 percent in 2009. The growth of private health insurance spending on physician and clinical services slowed to 0.9 percent in 2010. Along with the continued effects of declining private health insurance coverage, the slowdown was influenced by an increase in cost sharing among employer-based health insurance plans, with more expenses being passed on to the consumer.²² Out-of-pocket expenditures for physician and clinical services grew 3.2 percent in 2010, following a decline in 2009. Out-of-pocket spending accounted for a slightly larger share of spending on physician and clinical services—10 percent—in 2010 than in the previous year.

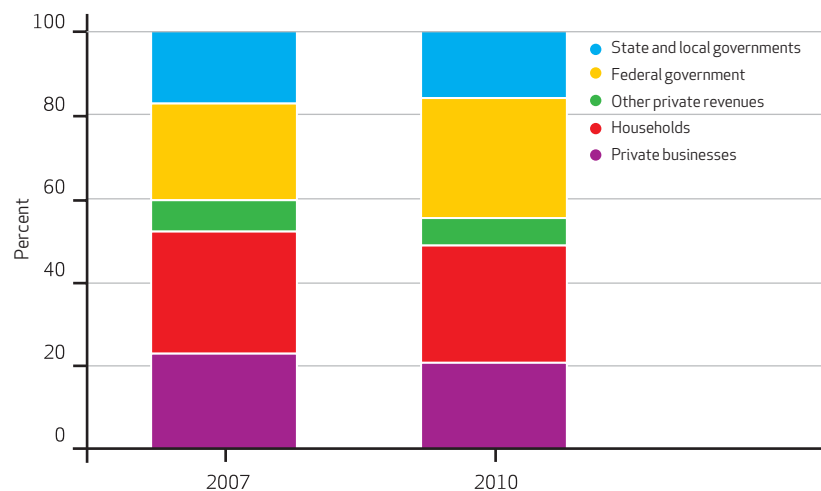
Medicare spending for physician and clinical services—the second largest payer (at 22 percent in 2010)—also experienced slower growth in 2010, increasing 2.8 percent compared to 7.4 percent in 2009. This deceleration was driven by slower growth in Medicare Advantage payments and a substantial slowdown in growth of the volume and intensity of services.

Prescription Drugs

Total US retail spending on prescription drugs accounted for the third-largest share—10 percent—of total national health spending, after hospital spending and spending on physician and clinical services. In 2010, total retail prescription drug spending grew only 1.2 percent, to \$259.1 billion (Exhibit 1). This historically low rate of growth in 2010 was driven by slower growth in the volume of drugs consumed, a continuing increase in the use of generic medications, the loss of patent protection for certain brand-name drugs, fewer new drug introductions than in previous years,²⁰ and an increase

EXHIBIT 6

Distribution Of National Health Expenditures (NHE) By Type Of Sponsor, 2007 And 2010



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

in Medicaid prescription drug rebates.

The volume of prescription medicines consumed increased at a historically low rate in 2010, with slower or declining demand recorded in nearly every major therapy area.²³ The number of prescriptions dispensed increased only 1.2 percent in 2010—a deceleration from 2.1 percent in 2009.²⁴ Similar to its effect on physician and clinical services spending, the decline in visits to physician offices contributed to slower growth in retail prescription drug purchases in 2010.²⁰

Additionally, in 2010 a number of older “blockbuster” brand-name prescription drugs lost patent protection, including Flomax, Effexor XR, Lovenox, and Aricept.²⁵ Declining sales for Prevacid and Valtrex (blockbuster drugs that lost patent protection in the fourth quarter of 2009) contributed to the deceleration in brand-name prescription drug spending from 2009 to 2010.^{26,27} The entrance into the market of generic competitors for these drugs (generic equivalents cost much less than their brand-name counterparts), combined with consumers’ increasing consciousness of cost, contributed to a further rise in the generic dispensing rate (excluding the category of “branded generics”),²⁸ from 66 percent in 2009 to 67 percent in 2010.²⁹ Consumers’ average copayment fell in 2010 because of the greater use of generic drugs, which typically require the lowest copays.²³

In 2010, aggregate private health insurance and out-of-pocket spending on prescription drugs declined, accounting for smaller shares of total retail prescription drug spending than

in 2009. Private health insurance spending, which accounted for 45 percent of total spending on retail purchases of prescription drugs in 2010, declined by 0.2 percent in 2010, while out-of-pocket spending (19 percent of prescription drug spending in 2010) declined by 4.1 percent.

Although Medicaid's share of retail prescription drug spending remained stable at 8 percent in 2010, spending grew more slowly, increasing just 0.3 percent after growth of 6.1 percent in 2009. Mandatory Medicaid prescription drug rebates that pharmaceutical manufacturers must extend to the Medicaid program increased markedly in 2010. This was because provisions of the Affordable Care Act increased such rebates for brand-name drugs and also extended rebates to Medicaid managed care plans at the same time. In turn, these rebates had the effect of reducing total spending for retail sales of prescription drugs in 2010, contributing to its historically low rate of growth.

Medicare expenditures for prescription drugs (including both Part D and non-Part D) increased 9.0 percent in 2010, compared to growth of 7.7 percent in 2009, and they represented 23 percent of total retail prescription drug spending. Spending for non-Part D drugs (which includes Part B-covered drugs under fee-for-service Medicare and any drug coverage provided by Medicare Advantage plans) experienced slower growth in 2010. However, spending growth for Part D prescription drugs (accounting for 88 percent of total Medicare prescription drug spending) accelerated. The faster growth in Part D prescription drug spending was due, in part, to the one-time, tax-free \$250 rebate checks paid to beneficiaries who reached the Medicare coverage gap or doughnut hole and to faster growth in Medicare payments for individual reinsurance (for enrollees who reach the catastrophic phase of the benefit).

Other Sites Of Care

HOME HEALTH CARE Home health care was one of the fastest-growing services in the National Health Expenditure Accounts in both 2009 and 2010. In 2010, home health spending grew 6.2 percent, to reach \$70.2 billion (Exhibit 1)—a somewhat slower pace than its growth of 7.5 percent in 2009. Home health care services consist of skilled nursing care in the home and a range of personal care services. They are sometimes viewed as a more desirable and less expensive alternative to institutional care.

In 2010, growth in Medicare and Medicaid home health spending slowed. Medicare home health spending accounted for 45 percent of total

Home health care was one of the fastest-growing services in both 2009 and 2010.

home health spending in 2010. Its growth decelerated from 11.1 percent in 2009 to 5.2 percent, in part because of concentrated efforts to reduce fraudulent billing activities by imposing limits on outlier payments in 2010. These efforts, coupled with a mandated reduction of 2.75 percent in the base episodic rate for home health agencies, contributed to the slowdown.³⁰

Faster growth in Medicare spending for home health-based hospice care (at \$12.0 billion, this made up 38 percent of total Medicare home health spending), at 8.3 percent in 2010, helped mitigate a deceleration in Part A and Part B free-standing home health expenditures, which grew 3.9 percent. Growth in Medicaid spending for home health services, which constituted 37 percent of total home health spending in 2010, slowed from 9.2 percent in 2009 to 7.8 percent in 2010. The slowdown occurred because of widespread provider payment cuts and benefit restrictions—results of weak economic conditions and reduced state revenues.³¹

NURSING CARE AND RETIREMENT FACILITIES

Spending for nursing care facilities and continuing care retirement communities—\$143.1 billion in 2010 (Exhibit 1)—grew 3.2 percent, a deceleration from 4.5 percent in 2009. This represented a continuation of the slowing trend following its recent peak in 2007 of 7.8 percent. Medicaid paid for the largest share of nursing care facility spending (32 percent in 2010). As a result, the tightening of state budgets contributed to the 2010 deceleration in overall nursing care facility spending growth.

Medicare

Total Medicare spending, which accounted for 20 percent of all national health spending in 2010, grew 5.0 percent—more slowly than the increase of 7.0 percent in 2009 (Exhibit 3). The primary reason was a large deceleration in the Medicare Advantage rate of growth. Spending for Medicare Advantage and other private health plans constituted one-quarter of total Medicare spending in 2010, with traditional fee-for-service spending accounting for the re-

For the first time in seven years, growth in total private health insurance premiums exceeded growth in total benefits.

mainder.

In 2010, 46.6 million beneficiaries were enrolled in Medicare—an increase of 2.5 percent over 2009. Following several years of declines, fee-for-service enrollment (35.3 million beneficiaries) increased 1.5 percent in 2010—the highest rate of growth since 2004. Correspondingly, growth in the number of beneficiaries enrolled in Medicare Advantage plans (11.3 million) slowed, increasing 5.6 percent in 2010 compared to 10.5 percent in 2009. The slower growth in Medicare Advantage enrollment in 2010 reflected the fact that fewer beneficiaries switched from fee-for-service to managed care. This was the first year of single-digit growth in Medicare Advantage enrollment since 2005.³²

Spending for traditional fee-for-service Medicare increased 5.0 percent in 2010—a slight acceleration from the growth of 4.5 percent in 2009. Per enrollee, fee-for-service spending increased only 3.5 percent, compared to 4.3 percent in 2009. The slowdown in per enrollee fee-for-service spending was a result of a substantial deceleration in spending for home health care services—which grew 10.4 percent in 2009 but only 5.7 percent in 2010—after restrictions on outlier payments were introduced. Other contributors to the deceleration in per enrollee fee-for-service spending included unusually low growth in the volume and intensity of physician and other Part B services, as well as low payment updates to Medicare providers.³⁰

Medicare Advantage spending increased 4.7 percent in 2010—a steep deceleration from growth of 15.6 percent in 2009. For the first time since the inception of Medicare managed care, spending per enrollee declined, decreasing 0.8 percent. These changes were the result of the adjustment made to Medicare Advantage payment rates in 2010, as mentioned above.¹⁵

Medicaid

Medicaid spending accounted for 15 percent of national health spending and totaled \$401.4 billion in 2010 (Exhibit 3). It increased 7.2 percent in 2010, following growth of 8.9 percent in 2009. This slowdown was driven primarily by reduced enrollment growth, which peaked during the first six months of 2009³³ and then decelerated, increasing 5.8 percent in 2010. In addition to slower enrollment growth, many states implemented provider rate cuts and freezes in 2010 that helped dampen spending growth.³⁴

Per enrollee, Medicaid spending rose 1.3 percent in 2010—about the same rate of growth as in 2009 (1.5 percent). The relatively slow growth in per enrollee spending in both years occurred because most of the enrollment growth was in the children and family eligibility groups, which tend to be less costly than the average for Medicaid. Children accounted for more than half of the growth in Medicaid enrollment from June 2009 to June 2010.³³

Medicaid spending growth slowed in 2010 for all service categories except hospital care, which grew 11.2 percent after increasing 10.4 percent in 2009. As explained above, the main reason for the faster growth was the increase in Medicaid supplemental payments to hospitals in the last quarter of 2010.

Federal and state Medicaid spending increased 8.9 and 3.9 percent, respectively, in 2010. The difference was due to approximately \$41 billion in enhanced federal aid to the states as the Recovery Act increased the Federal Medical Assistance Percentage. The increased federal matching rate, which began in the last quarter of 2008, helped cause state spending to decline, on average, 2.1 percent from 2007 through 2010, and federal spending to increase, on average, 13.2 percent, compared to the combined average growth of 7.1 percent over the same period. The increased federal support totaled \$82 billion from October 2008 through December 2010.

Private Health Insurance

In 2010 growth in total private health insurance spending (aggregate premiums) slowed slightly—to 2.4 percent, down from 2.6 percent in 2009—continuing a deceleration that began in 2003. This slowdown reflected reductions in enrollment, increases in cost sharing, and a shift by consumers to lower-cost plans.²²

Total spending on private health insurance benefits (goods and services) grew 1.6 percent in 2010 (compared to 3.7 percent in 2009)—the slowest rate of increase in the history of the National Health Expenditure Accounts. Growth in spending for private health insurance benefits in

2010 was more than three percentage points lower than its average annual growth of 5.1 percent between 2003 and 2010.

For the first time in seven years, growth in total premiums exceeded growth in total benefits. As a result, the private health insurance net cost ratio—the difference between premiums and benefits as a share of premiums—increased from 11.4 percent in 2009 to 12.1 percent in 2010.

Enrollment in private health insurance plans declined for the third consecutive year, falling 1.9 percent in 2010. Per enrollee, growth in private health insurance premiums decelerated from 5.7 percent in 2009 to 4.4 percent in 2010. In comparison, per enrollee spending on private health insurance benefits decelerated from 6.9 percent in 2009 to 3.7 percent in 2010. These decelerations were due, in part, to slower growth in elective hospital procedures,¹³ slower growth in the number of prescriptions dispensed,²⁴ and fewer physician office visits.²⁰

Out-Of-Pocket Spending

Out-of-pocket spending by consumers² increased 1.8 percent in 2010, accelerating from growth of 0.2 percent in 2009 but still slower than its average annual growth of 4.8 percent between 2000 and 2008. Faster growth in 2010 partially reflects higher cost-sharing requirements for some employees;²² consumers' switching to plans with lower premiums and higher deductibles or copayments, or both;²² and the continued loss of health insurance coverage and resulting higher out-of-pocket spending. Out-of-pocket spending growth for physician and clinical services and dental services increased in 2010 (following declines in 2009)

People decided to forgo care or seek less costly alternatives than they would have otherwise used.

but was mitigated by a decrease in out-of-pocket spending on prescription drugs.

Conclusion

Health care spending experienced historically low rates of growth in 2009 and 2010 as the impact of the recent recession continued to affect the purchasers, providers, and sponsors of health care. Persistently high unemployment, continued loss of private health insurance coverage, and increased cost sharing led some people to forgo care or seek less costly alternatives than they would have otherwise used. As a result, growth in the use and intensity of health care goods and services in 2010 accounted for a much smaller share of personal health care spending growth than in previous years. Finally, as businesses, households, and state and local governments financed a smaller share of total national health care spending during and just after the recession, the federal government financed a larger share. ■

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NOTES

- 1 All National Health Expenditure Accounts data are presented in nominal terms and thus are comparable to other dollar figures in nominal terms unless otherwise specified.
- 2 The National Health Expenditure Accounts definition of *out-of-pocket spending* includes direct spending by consumers for health care goods and services—such as copayments and deductibles—for people with any type of insurance coverage (private, Medicare, or Medicaid) and spending for care by the uninsured. It does

not include any premiums paid for coverage.

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 - 16 This is based on an analysis by the Centers for Medicare and Medicaid Services Office of the Actuary of CMS-64 quarterly expense reports. Supplemental payments were collected separately on the reports as of October 1, 2009.
 - 17 Price growth for physician and clinical services is measured using a blended index constructed from the Producer Price Indexes for offices of physicians and for medical and diagnostic laboratories.
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In this month's *Health Affairs*, Anne Martin and coauthors, all with the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS), take that agency's annual look back at national health spending in the previous year. They report that as a result of the recent recession and its aftermath, US health spending in 2009 and 2010 grew more slowly than in any other years in the fifty-one-year history of the National Health Expenditure Accounts. Overall, health spending accounted for 17.9 percent of the US gross domestic product in 2010, up just slightly—and essentially stable—over the previous year.

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Queries

1. In paragraph beginning “Additionally, in 2010,” you said: “The original wording that we submitted was approved for us to use by IMS Health as the definition for branded generics and includes very specific terminology that is distinctive to this industry. Please revert back to wording that was included in our original definition, specifically by reverting back to the term “off-patent”. The terms “off-patent” and “without patent protection” could have different meanings.” Please change the text now as needed. The version of your paper that reached the copy editors did not include the term “off-patent” so we cannot be sure what change you want to make here. Note that “loss of patent protection” appears above in this section.
2. Note 24, we had asked you to verify that this is a different item from the one cited in Note 29. You said for Note 29 “This comes from the same database as the one in note 24 (IMS National Prescription Audit), but it was not a published dataset. It was a special request extraction of data at a certain time for a certain year of data. IMS Health asked us specifically to cite it the way we originally submitted, with reference to the year 2010 (but not in the title), and to say that the data was extracted in October of 2011.” Can you add in Note 24 a comparable year in the item’s title? We assumed that 2011 Apr 7 here was the comparable extraction date.
3. Exhibit 4, we asked you several questions about this figure at the last stage, but you did not respond to our questions. We omitted “growth” from the key.
4. Exhibit 6, we noted that we were going to make several changes in the key (changing “State and local government” to “state and local governments,” “household” to “households,” and “private business” to “private businesses,” to match the text). You did not respond to that comment. We have made the changes now.