



Diagnosing Health Care Spending Growth

BRIEFLY

While personal health care expenditure growth is decelerating, it continues to outpace increases in GDP and governmental budgets. Over the next decade, the Centers for Medicare and Medicaid Services projects that hospital care will account for 25 percent of the growth in health care spending, physicians and clinical services for 22 percent, and prescription drugs for 18 percent.

With increases in health care expenditure continuing to outpace inflation and GDP growth, policy makers and patients are looking to health care industries and government programs for cost cutting measures.

This brief documents the role of various services in the overall growth of health care spending, on both the state and national level. In addition, we examine the impact of Medicare Part D on the Medicaid program and total health care spending.

BACKGROUND

Rapid advances in technology, increased utilization, growth in prices, demographic changes, and the expansion of health care programs are a few of the many factors contributing to the growth in health care spending. In 1995, national health expenditure totaled \$990.2 billion. In 2005, health care spending rose to an estimated \$1,936.5 billion. And by 2014, the Centers for Medicare and Medicaid Services (CMS) projects that spending will reach \$3,585.7 billion (CMS, 2005b).

This rapid growth in health care spending “presents a major competitiveness challenge for businesses and strains the budgets of the federal and state government” (WashACE, 2005, p. 1).

However, cost-curbing measures must be balanced against the value of improved care. Much of the pressure to increase spending is a result of the high value that consumers place on improving their health status. Therefore, “As personal income increases and advances in science and technology provide attractive new treatment opportunities, it is natural for health care spending to rise” (WashACE, 2005, p. 3).

NATIONAL HEALTH CARE SPENDING

In 2005, CMS released a ten-year health care spending projection report. According to their estimates, growth in national health spending is anticipated to remain at around 7 percent through 2006, largely as a result of the growth in public sector spending (Heffler et al., 2005, p. 74).

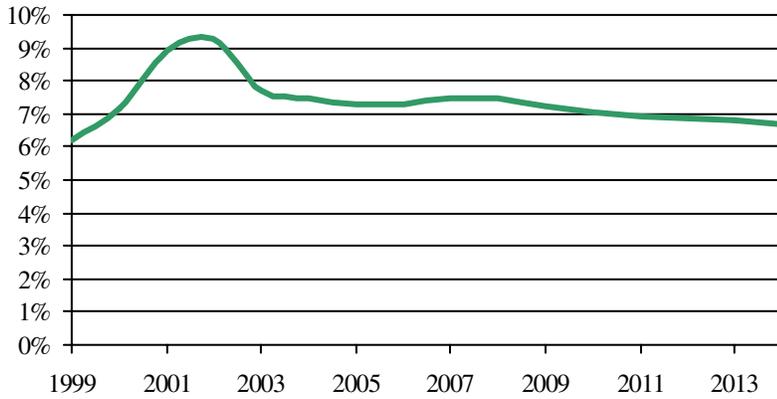
While health care expenditure remains high, the growth rate continues to decelerate from the 9.3 percent spending increase reported in 2002. Still, health care spending is growing faster than the economy and by 2014 total spending is projected to constitute 18.7 percent of GDP (Heffler et al., 2005, p. 74). See Figure 1.

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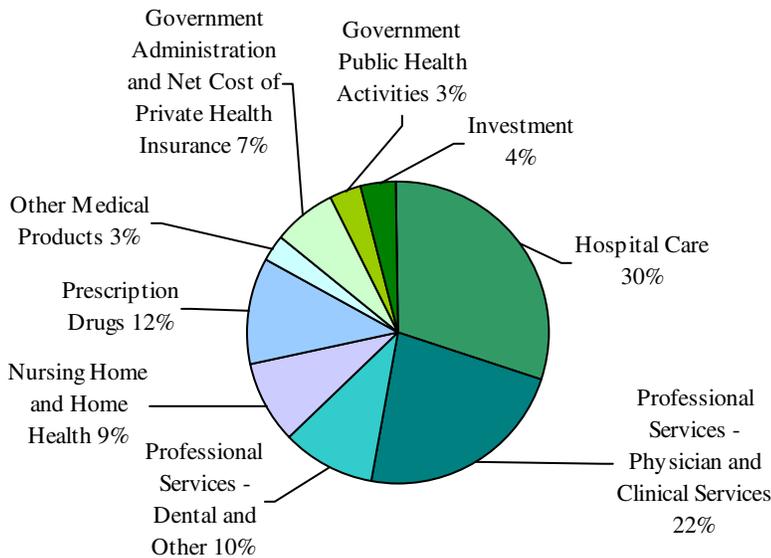


Figure 1. Annual Increase in Health Care Expenditure



Source: CMS, 2005b

Figure 2. National Health Expenditure by Service, 2005



National Health Expenditure (Billions)	\$
National Health Expenditure (Billions)	\$ 1,936.5
Hospital Care	\$ 588.6
Professional Services - Physician and Clinical Services	\$ 425.7
Professional Services - Dental and Other	\$ 197.9
Nursing Home and Home Health	\$ 170.9
Prescription Drugs	\$ 223.5
Other Medical Products	\$ 57.0
Government Administration and Net Cost of Private Health Insurance	\$ 135.4
Government Public Health Activities	\$ 63.6
Investment	\$ 74.0

Source: CMS, 2005b

Expenditure Breakdown

In 2005, an estimated 30 percent of national health expenditure went towards hospital care. An additional 22 percent was spent on physician and clinical services and another 12 percent on prescription drugs. Dental and other services accounted for 10 percent of expenditure, and nursing home and home health for another 9 percent. See Figure 2.

Hospitals. In 2005, hospital care cost \$588.6 billion dollars (CMS, 2005b). And in addition to being a major source of health care spending, hospital care is one of the largest contributors to spending growth. Hospital expenditure accounted for 28 percent of total health care spending increases between 2000 and 2003 and 27 percent of increases between 2003 and 2005. However, spending is projected to decline to 25 percent of health care growth between 2005 and 2014 (CMS, 2005b). See Figure 3.

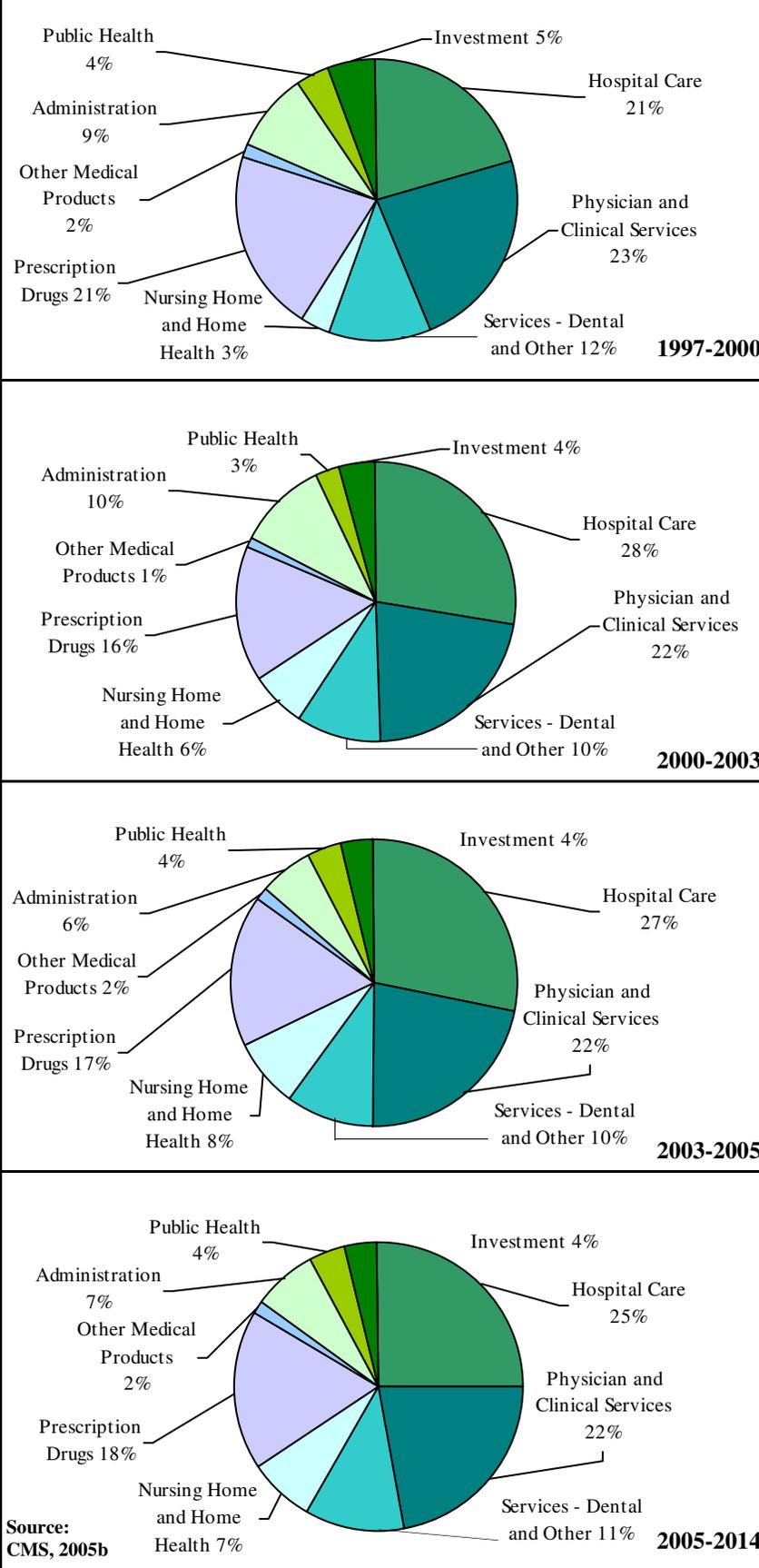
Recently accelerating Medicare and Medicaid spending is a leading contributor to growth in hospital care. Between 2005 and 2014, the CMS projects that hospital spending will grow an average of 6.2 percent a year (Heffler et al., 2005, p. 83).

Physician Services. Over the next decade, physician and clinical services will account for an estimated 22 percent of total health care spending growth (CMS, 2005b).

Spending on physician and clinical services is estimated to increase from \$425.7 billion in 2005 to \$782.5 billion in 2014, with annual growth rates ranging from 6.6 to 7.4 percent (Heffler et al., 2005, p. 75-76; CMS, 2005b). However, these projections may underestimate future growth in spending since Congress is expected to pass legislation preventing physician spending cuts in Medicare from going into effect (Heffler et al., 2005, p. 81).



Figure 3. Percent of Personal Health Care Expenditure Increase Attributable to Each Service



Prescription Drugs. Between 1997 and 2000, increased prescription drug spending accounted for 21 percent of health care expenditure growth, as compared to only 12 percent between 1993 and 1997. However, prescription drug spending has since declined as a source of growth. Between 2005 and 2014, prescription drug expenditure is projected to account for 18 percent of increases in health care spending (CMS, 2005b).

The turnaround in drug spending growth has largely been attributed to one-time measures such as the non-sedating antihistamine Claritin switch to over-the-counter status and the drop in consumption of estrogen products (Heffler et al., 2005, p. 78). But growth is expected to continue to dampen as a result of increased availability and consumption of lower-cost generic drugs, the increased use of the tiered-copayment drug plans and the drop-off in the growth of prescriptions dispensed (Heffler et al., 2005, p. 79; Smith et al., 2005, p. 191). Still, the demand for prescription drugs is expected to remain strong.

In 2006, prescription drug spending is projected to grow 11.6 percent, of which 0.5 percentage point is attributed to the introduction of Medicare Part D. Increases in drug prices are projected to account for 2.4 percentage points of the forecasted growth rate (Heffler et al., 2005, p. 79-80).

Total prescription drug spending in 2006 is estimated to reach \$249.3 billion – of which Medicare drug spending will account for \$69.9 billion (p. 79).

Dental and Other Services. Spending on dental and other services is projected to increase from \$197.9 billion in 2005 to \$378.8 billion in 2014 (Heffler et al., 2005, p. 75). Growth in dental and other services spending is projected to account for 11 percent of personal health care expenditure increases over this period (CMS, 2005b).



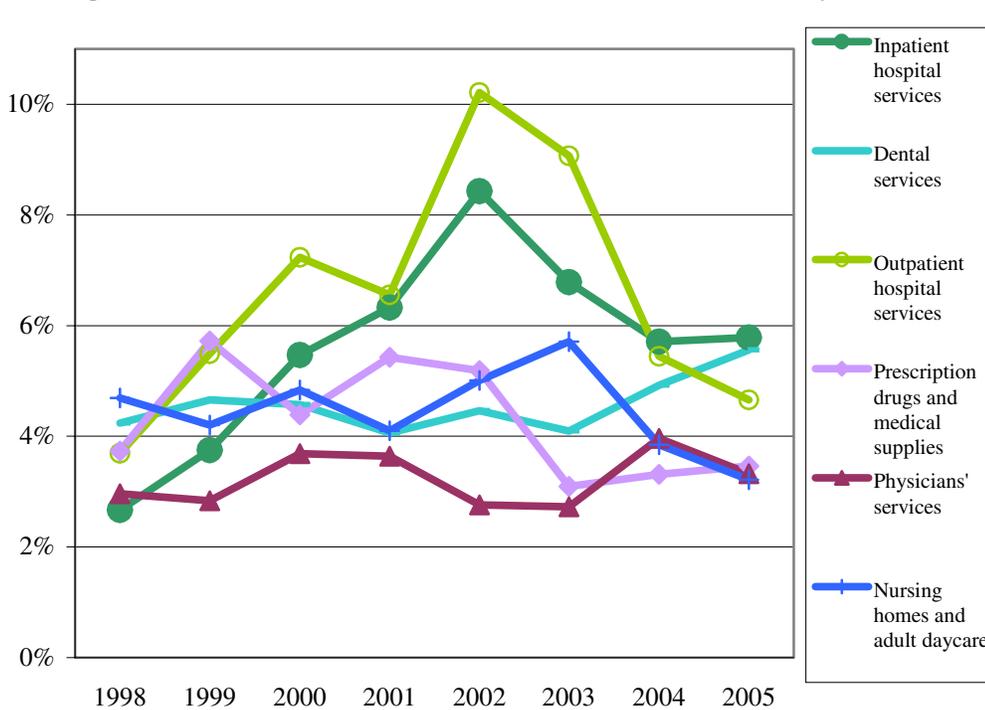
Home Health and Nursing Homes. Spending on nursing homes and home health will increase from \$170.9 billion in 2005 to \$290.5 billion in 2014 (Heffler et al., 2005, p. 75). Nursing home expenditure will account for approximately three fifths of this increase.

Nursing home spending grew an estimated 4.2 percent in 2004. (Heffler et al., 2005, p. 84). By 2014, spending growth will increase to 5.5 percent (p. 76).

Home health care spending accelerated to an estimated 13.0 percent growth in 2004, largely as a result of increased public sector spending. But by 2014, CMS projects that growth will slow to 7.3 percent (Heffler et al., 2005, p. 76).

Between 1993 and 1997, nursing home and home health expenditures accounted for 16 percent of health care spending growth. However, between 1997 and 2000, spending on nursing homes and home health accounted for a mere 3 percent of health care increases. Since this drop, compared to other services, nursing home and home health expenditures account for a relatively small—though slowly increasing—source of health care spending growth (CMS, 2005b).

Figure 4. Medical Care CPI: Annual Percent Increase By Service



Source: Bureau of Labor Statistics and WRC calculations

Changes in Price

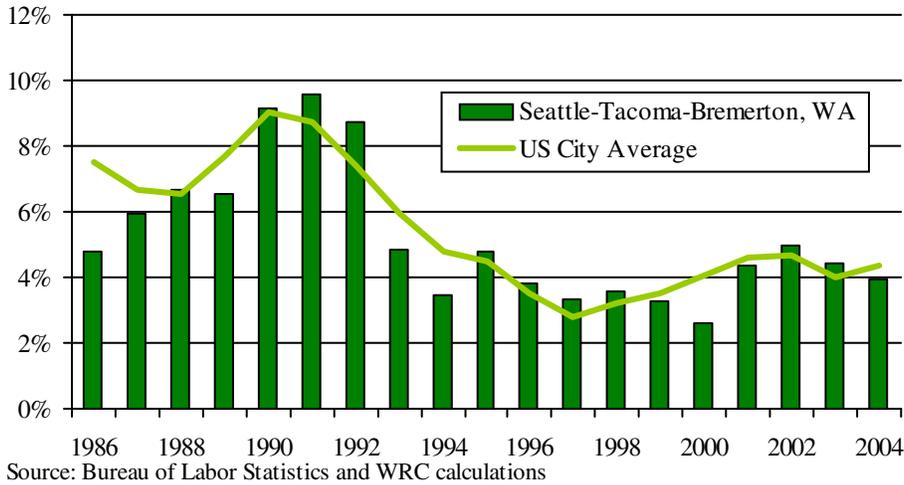
Since expenditure is a function of both price and quantity, personal health care expenditure growth can be attributed to increase in price, increases in quantity, or both.

The difficulty in pinpointing the source of spending growth can be seen in the case of prescription drugs. According to the Kaiser Institute, factors driving increases in prescription drug spending include (2005a):

- Utilization: The number of prescription drugs used increased 68 percent from 1994 to 2004.
- Price: Retail prescription prices increased an average of 8.3 percent a year between 1994 and 2004, although this does not reflect rebates, discounts and other payments that lower the prescription cost.
- Changes in Types of Drugs Used: The use of newer, higher-priced brand name drugs.



**Figure 5. Medical Care CPI Regional Comparison:
Annual Percent Increase**



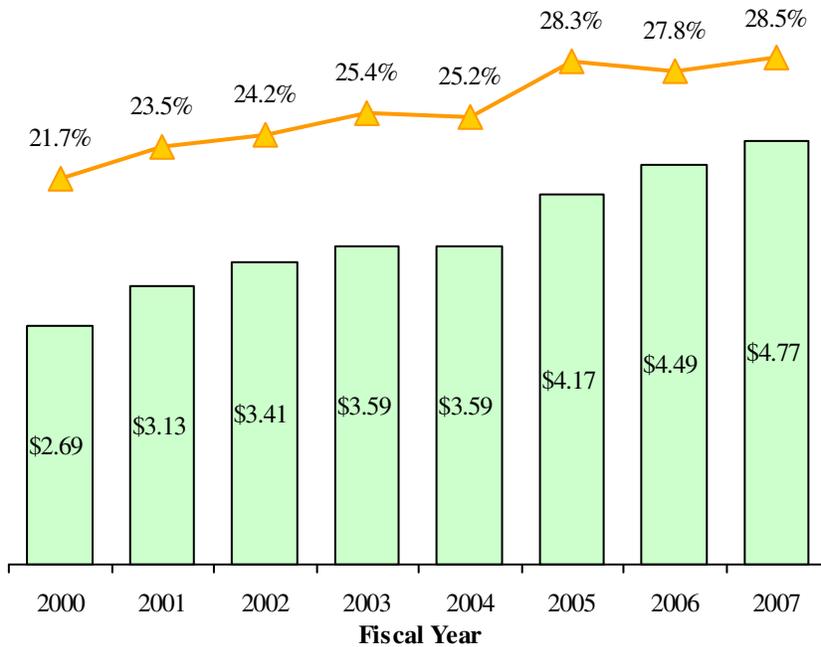
Disentangling the separate effects of changes in quantity, quality, and price on expenditures is difficult. However, the Bureau of Labor Statistics does estimate price indexes for various components of medical spending as part of the Consumer Price Index (CPI).

In recent years, inpatient and outpatient hospital services have seen the greatest growth in price, an average of 6.1 and 6.4 percent per year from 2002 to 2005 respectively. Over the same period, physician services and drug prices were both up an average of 3.3 percent per year. See Figure 4.

WASHINGTON HEALTH CARE SPENDING

Despite heightened alarm, Washington health care expenditures are in line with the national trend. For example, for the year 2000, the breakdown of personal health care expenditure by service was nearly identical, although Washingtonians spent slightly more on dental services and slightly less on hospital care (CMS, 2005d).

Figure 6. Washington State Health and Related Costs*
(appropriated state dollars in billions and as a percent of all state fund expenditures)



*Includes direct health costs such as Medicaid, Basic Health, public health; plus long-term, institutional, and behavioral health costs.

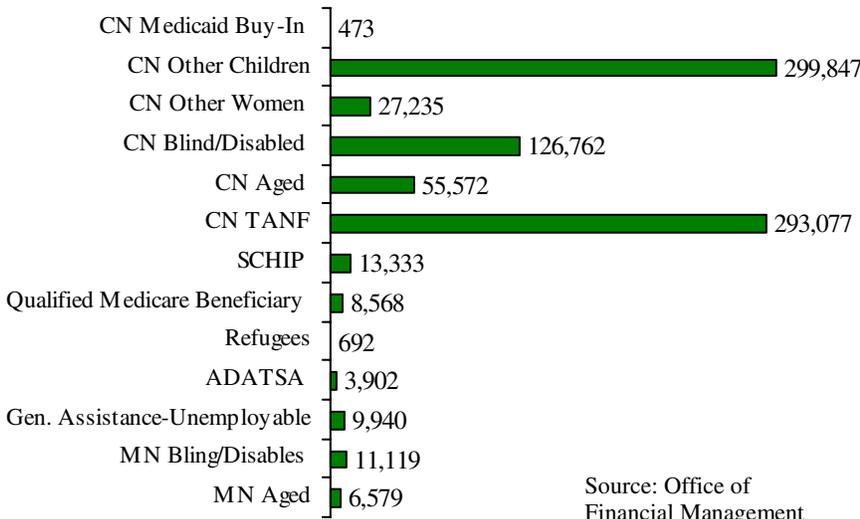
Source: Office of Financial Management; Office of the Governor

By some measures, Washington has fared slightly better than the national average. Between 1986 and 2004, the price of medical care in greater Seattle increased 0.24 percentage points a year less than the average US city (5.20 percent vs. 5.45 percent). See Figure 5.

Still, Washington faces similar pressures from cost and enrollment increases. And like the rest of the nation, health care expenditure in Washington has been increasing as a percent of total state expenditures. In 2000, health related costs totaled \$2.7 billion and accounted for 21.7 percent of state expenditures. By 2005, health related expenditures increased to \$4.17 billion and accounted for 28.3 percent of the budget. See Figure 6.



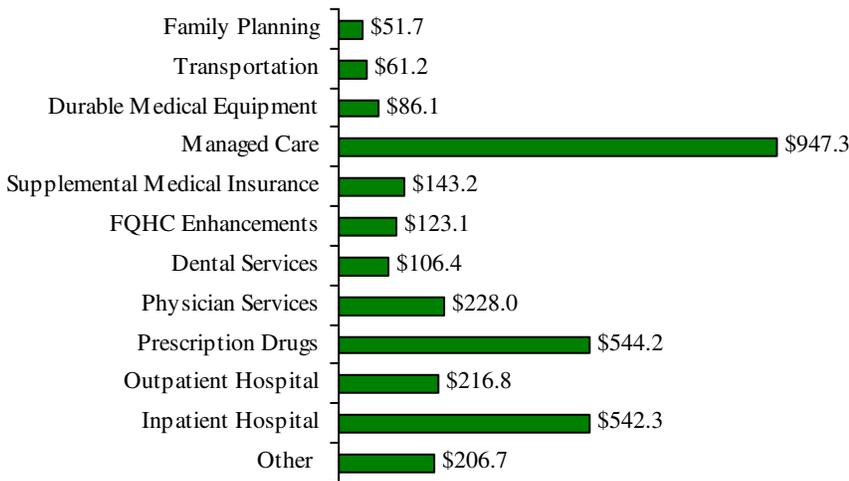
Figure 7. Washington FY 2005 Average Monthly Medical Assistance Eligibles



Programs. Most Washington state government health expenditures go towards employee compensation, the basic health plan and medical assistance. For the 2005-2007 biennium, the OFM projects spending on these three programs will total \$9.66 billion (WashACE, 2005, p. 11). The majority of this funding will go towards the Medical Assistance Administration (MAA). The top four MAA expenses are: inpatient hospital care, hospital outpatient services, prescription drugs and physician services (DSHS, 2004b, p. 4).

Coverage. The MAA provides medical assistance to over one million low-income residents (DSHS, 2004a, p. 4). This assistance is provided primarily through Medicaid — a health insurance program financed by the state and federal governments (p. 4).

Figure 8. Estimated Washington FY 2005 State & Federal Medical Assistance Expenditure (in millions)



*FQHC stands for Federally Qualified Health Centers

Total Expenditure: \$3,257,141,000
Source: Office of Financial Management

The two largest Medical Assistance programs are TANF and Other Children. TANF (Temporary Assistance for Needy Families) provides aid to children and the adults caring for them. Other Children provides medical services to children under 200 percent of the Federal Poverty Level who are not eligible for TANF or SSI. In 2005, an estimated 293,077 Washington residents were eligible for TANF and another 299,847 were eligible for Other Children. TANF eligibility is projected to increase 0.34 percent in 2006 and 3.08 percent in 2007. Likewise, Other Children eligibility

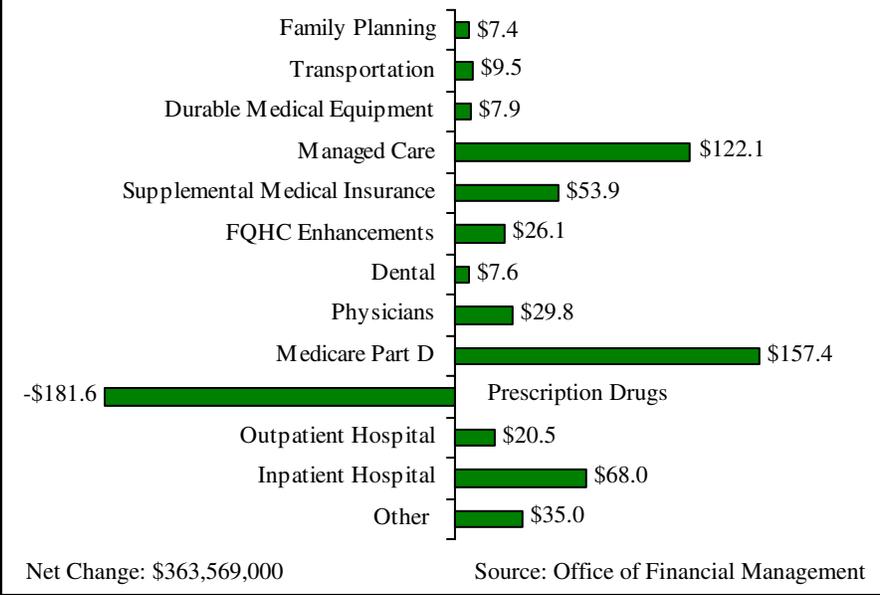
is projected to increase 12.44 percent in 2006 and 5.90 percent in 2007. See Figure 7.¹

While Medicaid enrollment in Washington has grown rapidly, DSHS recently reported that this trend is leveling, changes to child eligibility notwithstanding (2004b, p. 12). Still, other pressures remain. Population growth, longer life spans, an aging population, and advancements in life-

¹ Note: In the chart, CN stands for Categorically Needy and refers to federally matched Medicaid programs providing broad medical coverage. MN stands for Medically Needy and refers to programs covering the aged, blind, and persons with disabilities as well as persons with resources or income above CN limits (DSHS, 2005b).



Figure 9. Estimated Change in Washington Medical Assistance Expenditure, FY 2005 to FY 2007 (in millions)



saving medical technologies have resulted in an increased number of persons living with chronic illnesses, cognitive impairments, and developmental and functional disabilities requiring assistance (DSHS, 2004a, p. 7-8). According to the DSHS, these factors have contributed to “an increasing demand for improvement and expansion of the state's long term care systems” (p. 8).

However, budget constraints make continued financial increases difficult. Pending policy and finance reform at the state and federal level, Washington ultimately faces “a choice between cutting eligibility, cutting benefits, or cutting both” (DSHS, 2004a, p. 10 & 12).

Rising Costs. Health care cost increases will continue to outpace

other economic segments for some time (DSHS, 2004b, p. 15). In fact, absent changes in the law, Washington State spending on Medicaid as a share of GSP is projected to grow 50 percent by 2014 (WashACE, 2005, p. 14).

While the federal government covers about half of Washington’s Medicaid costs, the state’s share has been rising by as much as half a billion dollars a biennium (DSHS, 2004a, p. 7). And DSHS warns that the “looming” federal deficit increases the likelihood that states will be required to take on additional funding responsibility in the future (2004b, p. 11).

Increased Utilization. While health care spending increases are partially associated with medical inflation, “they are actually more closely tied to increases in service utilization, i.e., a lot more services are being provided and they are very expensive” (DSHS, 2004b, p. 15).

Cost Reductions. Many reforms and programs have been implemented in Washington in an attempt to curb rising health care costs. In 2004 the MAA included an extensive list of such changes in its 2006-2011 strategic plan (DSHS, 2004b, p. 29-31). These cost reduction strategies include:

- Joint development of a state preferred drug list
- The Washington Medicaid Integration Project
- The Medicaid Architectural Project, seeking ways to coordinate and consolidate funding and operations
- Reduce adult dental services
- Expand disease management/care coordination techniques
- Continued eligibility verification
- Change children’s medical premiums
- Use Priorities of Government for budget decisions
- Increase efforts to find mistakes and areas of confusion through “Right The First Time!”

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In addition, in 2005 Governor Gregoire and the legislature passed Senate Bill 6088, creating the “Prescription Drug Purchasing Consortium” to pool the buying power of state and local agencies, businesses, labor organizations, and uninsured consumers.

Medicare drug benefit’s impact on state Medicaid spending

With the initiation of prescription drug coverage by Medicare in 2006, Medicaid drug expenditures will drop. However, the state will be required to contribute much of these savings to the Medicare program.

Impact on Medicaid. According to the Congressional Budget Office (CBO), national Medicaid spending on prescription drugs rose by an annual inflation-adjusted rate of 15 percent between 1998 and 2004. With the introduction of Medicare Part D, this spending is expected to experience a onetime drop of roughly 50 percent (2005a). See Figure 9.

Combined state and federal Medicaid spending growth accelerated from 7.1 percent in 2003 to an estimated 7.9 percent in 2004. But after the introduction of Part D in 2006, this growth is expected to decelerate from 9.1 percent in 2007 to 8.1 percent in 2014 (Heffler et al., 2005, p. 81).

Medicare Part D. Under the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, Medicare part D was created to establish a new prescription drug program. On January 1 2006, after a series of transitional steps, this benefit became available to all Medicare enrollees wanting to participate. A variety of different benefit options are offered so members can choose from a list of their state approved Prescription Drug Plans (PDP). For those who qualify, Medicare Part D includes a Low-Income Subsidy (LIS) that will help pay participant costs such as premiums, deductibles and coverage gaps.

Medicare Part D shifts many of the prescription drug costs from Medicaid to Medicare. This is because, under the new plan, those eligible for both Medicaid and Medicare Part D will receive coverage through Medicare. While this will reduce state Medicaid prescription drug costs, a large portion of the savings will be returned by states to fund Medicare. This state contribution, referred to as a clawback, is a monthly payment made by each state to the federal government. The clawback amount is set at 90 percent of estimated state savings in 2006, declining annually by 1 2/3 percentage points until it reaches 75 percent of estimated savings in 2015.

The Kaiser Commission on Medicaid and the Uninsured estimate that, for FY 2006, states will pay an average monthly clawback of \$99.32 per capita (Kaiser, 2005b).

The actual impact of Medicare Part D on state budgets and Medicaid is still unclear. While the November 2003 CBO projections estimated that Medicare Part D would result in approximately \$145 billion in savings for Medicaid and other federal programs, the March 2005 updates deemed these estimates not readily identifiable (CBO, 2005c). In Washington, the Office of Financial Management projects that, while prescription drug spending will decrease \$181,591,000 between FY 2005 and FY 2007, cost savings will be offset by \$157,414,000 in Medicare Part D payments.



And with prescription drug assistance becoming federalized, states lose some of their ability to customize programs and contain costs. According to Federal Funds Information for States, “Unlike Medicaid drug costs, states will have almost no power to control their clawback costs, which will be a function primarily of overall drug cost increases nationwide” (FFIS, 2005). In addition, no federal match will be available for states that choose to continue to provide specific drugs not covered by Part D plans (Kansas Department of Social and Rehabilitation Services, 2004).

In March 2005, the CBO released updated estimates of the fiscal impact of the MMA. According to their calculations, net Medicare spending for Part D will total \$593 billion over the 2004-2013 period, \$41 billion more than originally estimated. An additional \$258 billion in spending is projected for 2014 and 2015 (CBO, 2005c).

Impact on Drug Spending. The major impact of Medicare Part D is to shift prescription drug payment from Medicaid to Medicare. In 2005 Medicare drug spending constituted 2 percent of total drug spending. By 2006, Medicare will pay for 28 percent. Still, this increase is projected to have only a minor impact on total prescription drug spending because costs associated with increased utilization will be nearly offset by new price discounts (CMS, 2005b).

Even with the introduction of Part D, over the 2007-2014 period, the Centers for Medicare and Medicaid Services expect aggregate prescription drug spending growth to decelerate (Heffler et al., 2005, p. 77-78).

CONCLUSION

While personal health care expenditure growth is decelerating, it continues to outpace increases in GDP and governmental budgets. Continued growth in spending poses a challenge to both the private and public sectors. Still, cost curbing measures must be balanced against the value of improved care.

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