

# TRENDS

## Health Spending Growth Slows In 2003

The rate of growth was slower in 2003 than in 2002, but health care remains a \$1.7 trillion enterprise in the United States.

**by Cynthia Smith, Cathy Cowan, Art Sensenig, Aaron Catlin, and the Health Accounts Team**

**ABSTRACT:** The pace of health spending growth slowed in 2003 for the first time in seven years, driven in part by a slowdown in public spending growth. U.S. health care spending rose 7.7 percent in 2003, much slower than the 9.3 percent growth in 2002. Financial constraints on the Medicaid program and the expiration of supplemental funding provisions for Medicare services drove the deceleration. U.S. health spending accounted for 15.3 percent of U.S. gross domestic product in 2003, an increase of 0.4 percentage points from 2002.

NATIONAL HEALTH spending increased 7.7 percent to \$1.7 trillion in 2003, or \$5,670 per person (Exhibit 1).<sup>1</sup> Public funding has played an important role in recent trends in health spending. Government funding for health care accounted for an increasing share of growth between 1998 and 2001 and served as the driver for the deceleration in spending in 2003 (Exhibit 2). This pattern reflects in part the implementation of the Balanced Budget Act (BBA) of 1997, which slowed Medicare spending growth in 1998 and 1999, followed by the expansionary effects of both the Balanced Budget Refinement Act (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) in 2000 through 2002. The public sector's smaller contribution to 2003's spending increase reflects both the expiration of supplemental funding provisions to Medicare providers and sharply slower growth in Medicaid payments. Total public spending growth slowed markedly, from 9.7

percent in 2002 to 6.6 percent in 2003 (Exhibit 3).

In contrast to the pronounced deceleration in public-sector spending, growth in private-sector spending remained relatively stable in 2003: It rose 8.6 percent, compared with 9.0 percent in 2002. Private spending accounted for two-thirds of the overall spending increase in 2003. Total private spending (\$913.2 billion) primarily consisted of private health insurance spending (\$600.6 billion) and out-of-pocket payments from consumers (\$230.5 billion). Aggregate out-of-pocket spending grew 7.6 percent in 2003, at nearly the same rate as overall health spending but faster than in recent years.

Although total health spending growth decelerated to 7.7 percent in 2003, it remains faster than the pace recorded between 1993 and 2000, a period of historically slow growth, as enrollment shifted from indemnity to managed care plans. In addition, health spending outpaced overall economic growth in 2003 by

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**EXHIBIT 1**
**National Health Expenditures (NHE), Aggregate And Per Capita Amounts, And Share Of Gross Domestic Product (GDP), Selected Calendar Years 1970–2003**

Spending category	1970	1980	1993	1997	1999	2001	2002	2003
NHE, billions	\$73.1	\$245.8	\$888.1	\$1,093.1	\$1,222.2	\$1,426.4	\$1,559.0	\$1,678.9
Health services and supplies	67.3	233.5	856.3	1,055.8	1,180.2	1,373.8	1,499.8	1,614.2
Personal health care	63.2	214.6	775.8	959.2	1,065.6	1,235.5	1,342.9	1,440.8
Hospital care	27.6	101.5	320.0	367.6	393.4	446.4	484.2	515.9
Professional services	20.7	67.3	280.7	352.2	397.7	464.4	503.0	542.0
Physician and clinical services	14.0	47.1	201.2	241.0	270.9	315.1	340.8	369.7
Other professional services	0.7	3.6	24.5	33.4	36.7	42.6	46.1	48.5
Dental services	4.7	13.3	38.9	50.2	56.4	65.6	70.9	74.3
Other personal health care	1.3	3.3	16.1	27.7	33.7	41.1	45.3	49.5
Nursing home and home health	4.4	20.1	87.6	119.6	122.9	134.9	143.1	150.8
Home health care <sup>a</sup>	0.2	2.4	21.9	34.5	32.3	33.7	36.5	40.0
Nursing home care <sup>a</sup>	4.2	17.7	65.7	85.1	90.7	101.2	106.6	110.8
Retail outlet sales of medical products	10.5	25.7	87.5	119.8	151.6	189.7	212.6	232.1
Prescription drugs	5.5	12.0	51.3	75.7	104.4	140.8	161.8	179.2
Durable medical equipment	1.6	3.9	12.8	16.2	17.2	18.4	19.6	20.4
Other nondurable medical products	3.3	9.8	23.4	27.9	30.0	30.5	31.1	32.5
Program administration and net cost of private health insurance	2.8	12.1	53.3	61.3	73.3	90.9	105.7	119.7
Government public health activities	1.4	6.7	27.2	35.3	41.2	47.4	51.2	53.8
Investment	5.7	12.3	31.8	37.2	42.0	52.6	59.2	64.6
Research <sup>b</sup>	2.0	5.5	15.6	18.7	23.7	32.9	36.5	40.2
Construction	3.8	6.8	16.2	18.5	18.3	19.7	22.7	24.5
Population (millions)	210.2	230.4	264.8	277.6	284.1	290.3	293.2	296.1
NHE per capita	\$348	\$1,067	\$3,354	\$3,938	\$4,302	\$4,914	\$5,317	\$5,670
GDP, billions of dollars	\$1,039	\$2,790	\$6,657	\$8,304	\$9,268	\$10,128	\$10,487	\$11,004
NHE as percent of GDP	7.0%	8.8%	13.3%	13.2%	13.2%	14.1%	14.9%	15.3%
Implicit price deflator for GDP	27.5	54.0	88.4	95.4	97.9	102.4	104.1	106.0
Real GDP, billions of dollars	\$3,772	\$5,162	\$7,533	\$8,704	\$9,470	\$9,891	\$10,075	\$10,381
Real NHE <sup>c</sup> , billions of dollars	\$265.3	\$454.7	\$1,004.8	\$1,145.6	\$1,248.8	\$1,393.0	\$1,497.7	\$1,583.9
Personal health care deflator <sup>d</sup>	16.0	34.4	81.6	92.2	96.7	103.9	107.9	111.8

**SOURCES:** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

<sup>a</sup> Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

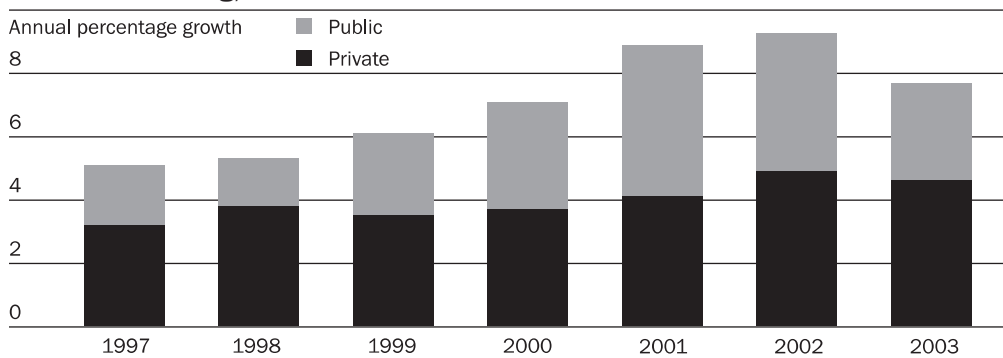
<sup>b</sup> Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

<sup>c</sup> Deflated using the implicit price deflator for GDP (2000=100.0).

<sup>d</sup> Personal health care (PHC) implicit price deflator is constructed from the Producer Price Index for hospital care, Nursing Home Input Price Index for nursing home care, and Consumer Price Indices specific to each of the remaining PHC components.

nearly three percentage points. As a result, health care spending represented 15.3 percent of GDP in 2003, up from 14.9 percent in 2002. After adjusting for economywide inflation, health spending increased 5.8 percent in 2003, compared with average growth of 6.9 percent between 2000 and 2002.<sup>2</sup>

Personal health care spending growth (7.3 percent) can be disaggregated into the growth in prices, in population, and in intensity and use. Together, economywide and medical-specific inflation accounted for more than half of the growth in personal health care spending (3.6 percent). Population growth and the re-

**EXHIBIT 2****Annual Growth In National Health Expenditures And Contribution Of Public And Private Sources Of Funding, 1997–2003**

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

sidual that accounts for increases in use and intensity, improvements in medical technology, and any errors in revenue or price measurement accounted for 1.0 percentage point and 2.5 percentage points, respectively.<sup>3</sup>

**Sources Of Funds**

■ **Public funding.** Accounting for 16 percent or \$267.0 billion of total health care spending, Medicaid spending decelerated sharply, from 12.1 percent in 2002 to 7.1 percent in 2003, its first deceleration since 1997. In the face of persistent revenue shortfalls, states initially safeguarded Medicaid spending by relying on state reserves, taxes, and tobacco funds before resorting to more austere measures to control spending. To control growth in Medicaid spending and enrollment in 2003, thirty-four states tightened eligibility and restricted benefits for these programs, which rank as the second-largest item in most state budgets after education.<sup>4</sup>

More than half of Medicaid spending is for services provided by hospitals and nursing homes, and decreased upper payment limit (UPL) payments were another factor contributing to the slowdown in Medicaid payments for these services.<sup>5</sup> When combined with other cost containment measures, recent changes in the method used to determine the UPL have resulted in lower payment limits, which greatly affected Medicaid spending in

some states in 2003.<sup>6</sup> To help alleviate state fiscal pressures, a federal relief package passed in 2003 granted a temporary increase of 2.95 percent to the Federal Medical Assistance Percentage (FMAP) rate, which affected reimbursement for several services.

Medicare spending was \$283.1 billion in 2003, an increase of 5.7 percent over 2002 and 4.3 percent per enrollee. This compares with Medicare spending growth of 10.8 percent in 2001 and 7.6 percent in 2002. Recent trends in spending have been affected by a series of legislative changes. The BBA contributed to a drop-off in Medicare spending growth in 1998 and 1999, followed by a rebound as the provisions of the BBRA and BIPA were implemented. These laws primarily affected hospitals, nursing homes, and home health agencies. The slowdown in growth in 2003 was evident in Medicare spending for hospital services, which increased 5.3 percent in 2003 compared with growth of 7.0 percent in 2002. Medicare spending for nursing home services slowed more sharply than any other service, increasing just 1.3 percent in 2003 compared with an 11.4 percent increase in 2002. Much of this deceleration can be attributed to the expiration of some of the provisions of the BBRA and BIPA that provided for additional payments.<sup>7</sup>

■ **Private health insurance and out-of-pocket spending.** Private health insurance premium growth decelerated for the first time

### EXHIBIT 3

#### National Health Expenditures (NHE), Amounts And Average Annual Growth, By Source Of Funds, Selected Calendar Years 1970–2003

Source of funds	1970 <sup>a</sup>	1980 <sup>b</sup>	1993 <sup>b</sup>	1997 <sup>b</sup>	1999 <sup>b</sup>	2001 <sup>b</sup>	2002	2003
NHE, billions	\$73.1	\$245.8	\$888.1	\$1,093.1	\$1,222.2	\$1,426.4	\$1,559.0	\$1,678.9
Private funds	45.4	140.9	497.7	589.8	671.9	771.8	841.0	913.2
Consumer payments	40.6	126.4	445.0	522.8	598.5	698.6	763.7	831.1
Out-of-pocket payments	25.1	58.2	146.9	162.0	184.7	202.0	214.2	230.5
Private health insurance	15.5	68.2	298.1	360.7	413.7	496.6	549.5	600.6
Other private funds	4.8	14.5	52.7	67.0	73.4	73.1	77.4	82.1
Public funds	27.6	104.8	390.4	503.2	550.3	654.6	718.0	765.7
Federal	17.6	71.3	274.4	360.0	386.2	463.8	508.6	541.7
Medicare	7.7	37.4	148.3	209.4	213.0	248.8	267.7	283.1
Medicaid <sup>c</sup>	2.8	14.5	76.8	94.8	108.4	131.8	148.4	158.7
Other federal <sup>d</sup>	7.1	19.4	49.3	55.8	64.7	83.2	92.4	99.8
State and local	10.0	33.5	116.0	143.3	164.1	190.8	209.4	224.0
Medicaid <sup>c</sup>	2.4	11.5	44.8	64.7	78.4	91.9	102.4	109.9
Other state and local <sup>d</sup>	7.6	22.0	71.1	78.6	85.7	99.0	107.1	114.1
<b>Average annual growth from prior year shown</b>								
NHE	10.6%	12.9%	10.4%	5.3%	5.7%	8.0%	9.3%	7.7%
Private funds	8.5	12.0	10.2	4.3	6.7	7.2	9.0	8.6
Consumer payments	8.0	12.0	10.2	4.1	7.0	8.0	9.3	8.8
Out-of-pocket payments	6.9	8.8	7.4	2.5	6.8	4.6	6.0	7.6
Private health insurance	10.2	15.9	12.0	4.9	7.1	9.6	10.6	9.3
Other private funds	14.0	11.6	10.4	6.2	4.6	-0.2	5.8	6.2
Public funds	15.4	14.3	10.6	6.6	4.6	9.1	9.7	6.6
Federal	20.1	15.0	10.9	7.0	3.6	9.6	9.7	6.5
Medicare	— <sup>e</sup>	17.2	11.2	9.0	0.9	8.1	7.6	5.7
Medicaid <sup>c</sup>	— <sup>e</sup>	17.7	13.7	5.4	6.9	10.3	12.6	6.9
Other federal <sup>d</sup>	9.6	10.6	7.4	3.1	7.7	13.4	11.1	8.0
State and local	10.2	12.8	10.0	5.4	7.0	7.8	9.7	7.0
Medicaid <sup>c</sup>	— <sup>e</sup>	16.8	11.0	9.6	10.1	8.2	11.4	7.4
Other state and local <sup>d</sup>	7.2	11.2	9.5	2.5	4.4	7.5	8.2	6.6

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

**NOTE:** Numbers may not add to totals because of rounding.

<sup>a</sup> Average annual growth, 1960–1970.

<sup>b</sup> Average annual growth from prior year shown.

<sup>c</sup> Includes State Children's Health Insurance Program (SCHIP) expansion (Title XIX).

<sup>d</sup> Includes SCHIP (Title XXI).

<sup>e</sup> Not applicable; Medicare and Medicaid became effective in July 1966.

since 1996, growing 9.3 percent in 2003 compared with 10.7 percent in 2002. Spending for private health insurance benefits rose 8.2 percent in 2003 compared with 9.5 percent in 2002. Net cost (the difference between premiums and benefits) as a share of premiums increased from 11.9 percent in 2001 to 12.8 percent in 2002 and 13.6 percent in 2003. This is higher than the share has been since 1984, which suggests that administrative costs and insurer profits accelerated as benefit growth decelerated.<sup>8</sup>

In 2003, health insurance enrollment declined by nearly a percentage point for the

third year in a row. This decline was likely caused primarily by job losses in specific sectors coupled with some reduction in take-up rates for employer-sponsored health insurance. Although a modest recovery in job growth began in the latter half of 2003, most of the job growth was concentrated in industries that traditionally were less likely to offer health insurance. Also, persistently high growth in per worker premiums means that fewer workers enroll in health insurance plans. Despite this, health benefits on average are accounting for a larger share of labor compensation. The health benefit share of compensation climbed to 7.1 percent in 2003,

even higher than the average 6.9 percent recorded in the 1993–1994 period, when employers were more aggressively evaluating alternatives to conventional insurance coverage.<sup>9</sup>

The continued increases in health benefit costs have renewed interest in point-of-care cost sharing and consumer-directed health plans. Employers have passed more of the costs for private health insurance on to the employee through higher copayments and deductibles. For example, in preferred provider organizations (PPOs), the most popular type of health insurance plan, single coverage deductibles have increased more than 50 percent to \$275 for preferred providers, and even more for nonpreferred providers.<sup>10</sup> More employers are offering high-deductible health plans as a means of influencing consumers to restrain spending. In 2003, 17 percent of large employers offered such plans to at least some of their employees; thus far, less than 1 percent of Americans have enrolled.<sup>11</sup>

Out-of-pocket spending increased 7.6 percent in 2003 compared with 6.0 percent in 2002, the only major source of funding in the National Health Accounts with accelerated growth in 2003. In the recent soft labor market, employers have been more willing to pass on cost increases to employees by increasing copayments for physician visits, requiring separate hospital deductibles, and raising drug plan copayments. Partly as a result of increasingly using three- and four-tier prescription drug plans, 23 percent of all out-of-pocket spending was related to prescription drug purchases by 2003, up from 17 percent in 1998. Faster growth in out-of-pocket payments reflects two forces: the changing benefit structure in employer-sponsored health insurance plans that require more cost sharing, and the rising number of uninsured Americans.<sup>12</sup>

### Spending By Service

The deceleration in health care spending was widespread among services, although the pace of deceleration varied greatly.<sup>13</sup> Prescription drug spending growth slowed more sharply than growth of any other service, increasing 10.7 percent in 2003 compared with

14.9 percent in 2002. Hospital services accounted for the largest share of the slowdown during the same period; only spending for physician services, free-standing home health agency services, and sales of other nondurable products accelerated.

■ **Hospitals.** In 2003 hospital spending represented almost one-third of total national health spending. At \$515.9 billion, it increased 6.5 percent in 2003 following 8.5 percent growth in 2002. This marks the first deceleration in hospital spending growth since 1998 (Exhibit 4). The slowdown was largely attributable to the deceleration in public spending growth. Collectively, public payers account for 58 percent of total hospital spending, with Medicare accounting for 30 percent; Medicaid and the State Children's Health Insurance Program (SCHIP) accounting for 17 percent; and other federal, state, and local programs accounting for the rest.

Together, spending for hospital services by Medicare, Medicaid, and all other public payers grew 5.3 percent in 2003, following growth of 8.4 percent in 2002. Medicaid spending growth for hospital services slowed dramatically in 2003, falling more than six percentage points to 5.3 percent. The deceleration reflected actions in many states that froze payments to hospitals and tightened eligibility requirements as states wrestled with budget shortfalls. Medicare spending growth also slowed as supplemental funding provisions expired; it rose 5.3 percent in 2003, following growth of 7.0 percent in 2002.

Hospital spending by private payers remained relatively stable, increasing 8.4 percent in 2003 compared with 8.6 percent in 2002. This was driven in part by hospital input costs, which continued to grow at faster rates than during most of the 1990s. Payroll for hospital workers—a combination of employment, hours worked, and earnings—rose more than 8 percent for the third consecutive year.<sup>14</sup>

■ **Physicians.** Spending for physician services rose 8.5 percent in 2003 to \$369.7 billion, similar to the 8.2 percent increase in 2002. Private sources account for two-thirds of payments for physician services, and in 2003

**EXHIBIT 4**
**National Health Expenditures (NHE), Average Annual Growth From Prior Year Shown, Selected Calendar Years 1970–2003**

Spending category	1970 <sup>a</sup>	1980	1993	1997	1999	2001	2002	2003
NHE	10.6%	12.9%	10.4%	5.3%	5.7%	8.0%	9.3%	7.7%
Health services and supplies	10.4	13.2	10.5	5.4	5.7	7.9	9.2	7.6
Personal health care	10.5	13.0	10.4	5.5	5.4	7.7	8.7	7.3
Hospital care	11.7	13.9	9.2	3.5	3.5	6.5	8.5	6.5
Professional services	9.5	12.5	11.6	5.8	6.3	8.1	8.3	7.8
Physician and clinical services	10.1	12.9	11.8	4.6	6.0	7.8	8.2	8.5
Other professional services	6.6	17.1	15.9	8.1	4.8	7.9	8.0	5.3
Dental services	9.1	11.1	8.6	6.6	6.0	7.9	8.0	4.8
Other personal health care	7.2	10.0	13.0	14.5	10.3	10.5	10.1	9.2
Nursing home and home health	17.2	16.3	12.0	8.1	1.4	4.8	6.1	5.4
Home health care <sup>b</sup>	14.5	26.9	18.6	12.1	-3.4	2.1	8.5	9.5
Nursing home care <sup>b</sup>	17.4	15.4	10.6	6.7	3.2	5.7	5.3	4.0
Retail outlet sales of medical products	7.8	9.4	9.9	8.2	12.5	11.9	12.0	9.2
Prescription drugs	7.5	8.2	11.8	10.3	17.4	16.1	14.9	10.7
Durable medical equipment	9.7	8.9	9.7	6.0	3.3	3.4	6.4	4.0
Other nondurable medical products	7.4	11.4	6.9	4.4	3.7	0.9	2.0	4.4
Program administration and net cost of private health insurance	8.6	15.9	12.0	3.6	9.4	11.3	16.3	13.2
Government public health activities	13.2	17.4	11.3	6.7	8.1	7.2	7.9	5.1
Investment	12.9	7.9	7.6	4.0	6.2	11.9	12.7	9.1
Research <sup>c</sup>	10.9	10.8	8.4	4.7	12.5	17.9	11.0	10.0
Construction	14.1	6.1	6.9	3.4	-0.5	3.6	15.5	7.7
Population	1.2	0.9	1.1	1.2	1.2	1.1	1.0	1.0
NHE per capita	9.3	11.9	9.2	4.1	4.5	6.9	8.2	6.6
GDP total	7.0	10.4	6.9	5.7	5.6	4.5	3.5	4.9
Implicit price deflator for GDP	2.7	7.0	3.9	1.9	1.3	2.3	1.7	1.8
Real GDP	4.2	3.2	3.0	3.7	4.3	2.2	1.9	3.0
Real NHE <sup>d</sup>	7.7	5.5	6.3	3.3	4.4	5.6	7.5	5.8
Personal health care deflator <sup>e</sup>	4.1	8.0	6.9	3.1	2.4	3.6	3.9	3.6

**SOURCES:** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

<sup>a</sup> Average annual growth, 1960–1970.

<sup>b</sup> Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

<sup>c</sup> 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.

<sup>d</sup> Deflated using the implicit price deflator for GDP (2000=100.0).

<sup>e</sup> Personal health care (PHC) implicit price deflator is constructed from the Producer Price Index for hospital care, Nursing Home Input Price Index for nursing home care, and Consumer Price Indices specific to each of the remaining PHC components.

growth accelerated to 9.4 percent, up from 8.2 percent in 2002. Consumers’ copayments for physician services edged upward, causing out-of-pocket spending to rise 8.3 percent in 2003 compared with 5.1 percent in 2002.

In contrast to growth in private spending, growth in public spending for physician ser-

vices decelerated from 8.1 percent to 6.7 percent. The Medicare sustainable growth rate (SGR) formula yielded updates in physician fee schedule payments of 5.9 percent in 2001, a drop of 4.8 percent in 2002, and 1.6 percent growth for 2003. The update for 2003 was initially set to decline 4.4 percent, but the Con-



solidated Appropriations Resolution revised estimates of prior-year SGRs to increase 2003's payments for services 1.6 percent in March 2003.<sup>15</sup> In 2002 the decline in the Medicare payment update was offset by increasing visits, procedures, and tests, which resulted in an increase of 5.7 percent in Medicare spending. In 2003, volume and intensity growth slowed compared with growth in 2002, as physicians received a slightly higher Medicare payment update. This led to a slightly faster 6.9 percent growth rate in Medicare spending for physician services in 2003.

■ **Nursing home facilities and home health agencies.** Spending for services provided by freestanding skilled nursing facilities rose 4.0 percent in 2003 to \$110.8 billion, slightly slower than the average annual spending growth of 5.3 percent in 2000–2002.

Medicaid is the largest public source of funding for nursing home facilities, accounting for roughly half of their spending. Medicaid nursing home spending growth slowed to 1.0 percent in 2003 following 8.1 percent growth in 2002, in part as states incorporated more restrictive UPLs. Also, a number of states are pursuing longer-term strategies to enable people to receive services through home and community-based waivers and other programs.<sup>16</sup>

Medicare nursing home spending also decelerated greatly in 2003: It increased only 1.3 percent in 2003 following three years of rapid growth that averaged 16.2 percent per year between 1999 and 2002. Lower Medicare payment rates were in effect in 2003 as temporary add-ons to Medicare funding expired in October 2002.<sup>17</sup> Faster growth in net revenues more than offset the expiration of these add-ons and contributed to 8.3 percent growth in private payments in 2003.

Like the nursing home industry, home health care also was affected by changes to Medicare payment rates. Medicare spending fell \$4.5 billion between 1997 and 2000. An easing of payment limits helped increase Medicare spending for free-standing home health agencies by \$3.1 billion between 2000 and 2002, before legislation slowed growth in payments in 2003. Legislation slowed growth

through a 7 percent cut in Medicare home health payments and the expiration of a 10 percent add-on to payments for rural home health care providers, contributing to a slowdown in Medicare spending growth from 14.7 percent in 2002 to 9.9 percent by 2003.<sup>18</sup> Medicare spending for hospice services provided by home health agencies has risen rapidly in the past few years, nearly doubling from \$2.3 billion in FY 2000 to \$5.0 billion in FY 2003.

In the aggregate, an increase in private spending led to overall growth in home health payments of 9.5 percent in 2003, following 8.5 percent growth in 2002. After being overshadowed by growing public spending in the past few years, private spending increased 8.0 percent in 2003 as public payments decelerated. Signaling continued high demand for services, annual aggregate work hours rose 8.9 percent in 2003 following 9.6 percent growth in 2002; this came on the heels of 4 percent growth during the 1999–2001 period.<sup>19</sup>

■ **Prescription drugs.** In 2003, retail sales of prescription drugs rose 10.7 percent to \$179.2 billion, or 11 percent of national health spending (Exhibit 5). This increase in sales is consistent with average annual growth recorded between 1992 and 1997 but was much less than the 14.9 percent growth measured in 2002. The 2003 growth also represents the fourth consecutive year of deceleration following the peak in 1999, the same year in which drug approvals peaked. Among the factors contributing to slower growth in 2003 were a drop-off in the growth of prescriptions dispensed, including the conversion of Claritin to over-the-counter (OTC) status; increased availability and consumption of lower-price generic drugs; an expansion in use of tiered copayment plans; and a shift in drug sales to other non-U.S. pharmacies.

An important factor driving slowing growth in 2003 was the reduction in growth in use of prescription drugs. The number of prescriptions sold rose only half the 2002 rate—1.7 percent per capita compared with 3.5 percent in 2002—in part as more plans raised copayments and as prescription growth from newly approved drugs declined.<sup>20</sup> The slowing

# EXHIBIT 5 Expenditures For Health Services And Supplies, By Type Of Service And Source Of Funds, Calendar Year 2003

Spending category	Private funds				Public funds			
	Total	Total <sup>a</sup>	Out-of-pocket	Private health insurance	Total	Medicare	Federal and state Medicaid <sup>b</sup>	Other public
Health services and supplies (billions)	\$1,614.2	\$892.6	\$230.5	\$600.6	\$721.7	\$283.1	\$268.6	\$169.9
Personal health care	1,440.8	809.2	230.5	518.7	631.5	274.9	250.0	106.6
Hospital care	515.9	215.1	16.3	177.4	300.8	156.4	87.5	56.8
Professional services	542.0	356.0	83.8	238.9	186.1	80.7	67.6	37.7
Physician and clinical services	369.7	246.8	37.6	183.6	123.0	73.8	26.4	22.8
Other professional services	48.5	34.9	13.3	18.8	13.6	6.9	2.6	4.2
Dental services	74.3	69.4	32.9	36.5	4.9	0.1	4.2	0.6
Other personal health care	49.5	4.9	— <sup>c</sup>	— <sup>c</sup>	44.6	— <sup>c</sup>	34.4	10.2
Nursing home and home health	150.8	58.6	37.5	15.7	92.2	26.6	61.0	4.6
Home health care <sup>d</sup>	40.0	15.1	6.6	7.3	24.9	12.9	9.9	2.1
Nursing home care <sup>d</sup>	110.8	43.5	30.9	8.5	67.3	13.7	51.0	2.5
Retail outlet sales of medical products	232.1	179.6	92.9	86.7	52.5	11.2	33.9	7.4
Prescription drugs	179.2	136.0	53.2	82.9	43.2	2.8	33.9	6.4
Durable medical equipment	20.4	12.8	9.0	3.8	7.6	6.6	0.0	1.0
Other nondurable medical products	32.5	30.7	30.7	— <sup>c</sup>	1.7	1.7	— <sup>c</sup>	— <sup>c</sup>
Program administration and net cost of private health insurance	119.7	83.3	— <sup>c</sup>	81.9	36.4	8.2	18.6	9.6
Government public health activities	53.8	— <sup>c</sup>	— <sup>c</sup>	— <sup>c</sup>	53.8	— <sup>c</sup>	— <sup>c</sup>	53.8

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

**NOTE:** Numbers may not add to totals because of rounding.

<sup>a</sup> Includes other private funds.

<sup>b</sup> Includes Medicaid State Children's Health Insurance Program (SCHIP) expansion (Title XIX).

<sup>c</sup> Not applicable.

<sup>d</sup> Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

growth in use can also be attributed to the switch of Claritin to OTC status in November 2002, continued diversion of sales to non-U.S. pharmacies, and a drop in consumption of estrogen products. The switch of Claritin to OTC status simultaneously slowed overall sales of prescription drugs (before rebates) by 0.8 percentage points and sped up growth in OTC sales to 4.4 percent, the highest rate of growth since 1999.<sup>21</sup> According to IMS Health, consumers also diverted \$1.1 billion in U.S. sales to Canadian pharmacies in 2003.<sup>22</sup>

Following the campaign for the switch of Claritin to OTC status, many health plans in-

creased consumer copayments for nonsedating prescription antihistamines by moving them from the second to the third tier, or completely off plan formularies.<sup>23</sup> More plans also have adopted three-tier drug copayment plans in the past few years, and in 2003 they covered nearly two-thirds of covered workers. By design, plans also have steadily increased copayments more for second- and third-tier drugs than for first-tier drugs, prompting consumers to choose lower-cost drugs.<sup>24</sup> When offered a choice, consumers opt for a generic drug almost 90 percent of the time in chain drug stores, the largest component of the retail in-



dustry.<sup>25</sup> Generic drugs accounted for nearly all of the 2003 growth in prescriptions filled, and their sales grew at twice the rate of brand-name drug sales.<sup>26</sup>

Private health insurance sponsors also have tried to reduce their costs by reducing benefits or passing on more costs to consumers. In particular, seniors' managed care plans have reduced benefits for brand-name drugs in the past few years, shifting more expenses from private health insurance to consumers' pockets.<sup>27</sup> Private health insurance spending for prescription drugs slowed greatly in 2003, increasing only 7.4 percent following growth of 15.5 percent in 2002. Out-of-pocket spending for prescription drugs outpaced that of private insurance by nearly four percentage points in 2003, although it decelerated slightly to 11.5 percent from 11.9 percent in 2002.

More than three-quarters of prescription drug payments occur in the private sector. In the public sector, Medicaid is the largest payer, accounting for 19 percent of such payments in 2003. Medicaid spending for prescription drugs rose 17.5 percent in 2003, similar to growth in the past two years. This occurred in part because cost sharing is not as pronounced in Medicaid as in the private sector, and because states were more limited in the tools they could use to curtail spending growth.

### Concluding Comments

Health spending increased 7.7 percent in 2003, the first slowdown in seven years, spurred by a drop of 3.1 percentage points in public spending growth. A pronounced deceleration in Medicaid spending and the expiration of supplemental funding provisions to Medicare providers each had a large impact on overall public spending in 2003.

Although growth in total health spending decelerated in 2003, this was faster than growth in both the aggregate economy and employee compensation, which suggests an increasing burden on sponsors and employers. In the past, persistent gaps between health spending growth and economic growth—similar to the one experienced recently—have prompted policy changes by both govern-

ments and employers. Continued rapid increases in health insurance premiums require trade-offs from employers, possibly through slowing wage gains, reducing health benefits, or shifting more health care costs to workers. For those small employers that experience the largest premium rate increases, it may mean dropping coverage altogether. If the job market doesn't improve, employers have even less incentive to continue to shoulder rising health care costs. Competition may force employers to shift a larger share of costs to workers, who then must weigh the benefits of health care against the value of other discretionary purchases. As fiscal problems continue in many states, budget constraints may continue to affect publicly funded health coverage.

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### NOTES

1. Estimates of total U.S. health spending are measured annually in the Centers for Medicare and Medicaid Services National Health Accounts. Health expenditures are based on census data and sample surveys of health services and products that are reconciled with payments made by public and private sources. Estimates are presented in a matrix identifying the type of service or product and the end payers and are generally reported in nominal terms. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 does not affect these estimates.
2. Deflated by the GDP implicit price index.
3. There are many criticisms of commonly used price measures, including their general inability to measure shifts in care or to account for improvements in quality. There have also been technical problems in measuring different medical components of the Consumer Price Index (CPI) and Producer Price Index (PPI). The CMS annually constructs a personal health care deflator

- that uses the best available data for each service component.
4. National Association of State Budget Officers, "The Fiscal Survey of States: April 2004," June 2004, [www.nasbo.org/Publications/fiscsurv/2004/fsapril2004.pdf](http://www.nasbo.org/Publications/fiscsurv/2004/fsapril2004.pdf) (17 November 2004).
  5. Upper payment limit (UPL) programs allow states to reimburse hospitals and nursing homes owned by county and municipal governments at "enhanced" rates. Federal matching funds on state Medicaid spending for nursing homes are collected by the states; nursing homes then remand a portion of the UPL funds back to the state governments, which then may use these funds for other uses. Disproportionate-share hospital (DSH) payments work in a similar fashion by providing additional payments to state and county hospitals serving a disproportionate share of low-income people.
  6. U.S. Government Accountability Office, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, Pub. no. GAO-04-228 (Washington: GAO, 2004).
  7. CMS Press Release, "Medicare: Hospital Inpatient Prospective Payment Systems and 2004 FY Rates, Final Rule," *Federal Register* (1 August 2003): 45345-45672.
  8. J. Grossman and P. Ginsburg, "As the Health Insurance Underwriting Cycle Turns: What Next?" *Health Affairs* 24, no. 6 (2004): 91-102.
  9. Bureau of Labor Statistics, "Employer Costs for Employee Compensation," [data.bls.gov/cgi-bin/surveymost?cc](http://data.bls.gov/cgi-bin/surveymost?cc), selecting Civilian, All Workers, Health Insurance (28 September 2004).
  10. Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2003 Annual Survey* (Menlo Park, Calif.: Kaiser/HRET, 2003), 3.
  11. Ibid.; and R. Lieber, "Healthy Trend—New Way to Curb Medical Costs," *Wall Street Journal*, 23 June 2004.
  12. U.S. Bureau of the Census, *Income, Poverty, and Health Insurance Coverage in the United States: 2003*, Current Population Reports no. P60-226, August 2004, [www.census.gov/prod/2004pubs/p60-226.pdf](http://www.census.gov/prod/2004pubs/p60-226.pdf) (22 September 2004).
  13. For a description of what services are covered in each category, see CMS, "Category Definitions: National Health Expenditures," 17 September 2004, [cms.hhs.gov/statistics/nhe/quick-reference](http://cms.hhs.gov/statistics/nhe/quick-reference) (12 October 2004).
  14. Bureau of Labor Statistics, Current Employment Statistics survey, [data.bls.gov/labjava/outside.jsp?survey=ce](http://data.bls.gov/labjava/outside.jsp?survey=ce) (17 November 2004). Authors multiplied "all employees" by "average weekly hours" and "average hourly earnings" to derive "total payroll."
  15. CMS, "Medicare Physician Fee Schedule for 2003," Press Release, 27 February 2003, [cms.hhs.gov/media/press/release.asp?Counter=712](http://cms.hhs.gov/media/press/release.asp?Counter=712) (18 October 2004).
  16. Services provided through home and community-based waivers are captured in other personal health care expenditures.
  17. CMS, "CMS Health Care Industry Market Update, Nursing Facilities" (Baltimore: CMS, May 2003), 9.
  18. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington: MedPAC, March 2004), 114.
  19. BLS, Current Employment Statistics Survey data calculated for home health services.
  20. Prescription data from IMS Health, National Prescription Audit Survey, 2003. Population data are from the Bureau of the Census.
  21. The percentage-point decline measures the loss in sales in the prescription antihistamine class between 2002 and 2003, including the impact on sales of other prescription antihistamines that were frequently moved to higher tiers. All antihistamine prescription sales are assumed to have occurred in the retail market. IMS Health, "Leading Twenty Therapeutic Classes by U.S. Sales," February 2004, [imshealth.com/ims/portal/front/articleC/0,2777,6599\\_42720942\\_44304299,00.html](http://imshealth.com/ims/portal/front/articleC/0,2777,6599_42720942_44304299,00.html) (18 October 2004).
  22. IMS Health, "Pricing and Reimbursement Review, 2003" (Cambridge, Mass.: IMS, June 2004). National Health Accounts estimates of prescription drug spending measure retail sales of U.S. pharmacies but not purchases by U.S. citizens through foreign pharmacies.
  23. Verispan, "Verispan Reports: OTC Alternatives Hurting Prescription Antihistamines," Press Release (Yardley, Pa.: Verispan, July 2003).
  24. Kaiser/HRET, *Employer Health Benefits: 2003 Annual Survey*, 114-117. The first tier typically entails the lowest copayment for a generic drug, a higher copayment for preferred brand-name or other generic drugs, and the highest copayment for nonpreferred brand-name drugs.
  25. M. Johnsen, "Generic Substitution Efforts May Yield Diminishing Returns," *Drug Store News* (February 2004): 44-45.
  26. IMS Health, "Pricing and Reimbursement Review, 2003." Figures cited include generics and brand-name generics.
  27. L. Achman and M. Gold, "Trends in Medicare+Choice Benefits and Premiums" (New York: Commonwealth Fund, April 2003).