
National Health Projections Through 2008

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Health spending is expected to resume its rise as a share of gross domestic product (GDP) in the projection period, following 6 years of near stability, increasing from 13.5 percent in 1997 to an estimated 16.2 percent by 2008. This implies an approximate doubling of health spending, from \$1.1 trillion in 1997 to \$2.2 trillion by 2008. We anticipate a reversal in recent patterns of growth in public and private health spending, with private spending expected to accelerate while Medicare spending slows in response to the implementation of the Balanced Budget Act (BBA) of 1997.

INTRODUCTION

Each year, the Office of the Actuary in HCFA produces a 10-year projection of health spending. The objective of these projections is twofold—to present the latest actuarial forecasts of Medicare spending within the context of the health sector as a whole and to apply current research to the evaluation of trends in health spending in a way that may provide a fruitful context

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for analysis of policy and business issues.

This projection is based on an analysis of historical trends in the health sector, within the matrix of health spending by types of services (e.g., physician services, drugs) and by sources of funds (e.g., Medicare, private health insurance), which make up the national health accounts (NHA). Projections are generated within a model framework that incorporates actuarial, economic, and judgmental factors.

We incorporate Medicare projections generated by HCFA's Office of the Actuary for the 1999 Medicare Trustees Reports and Medicaid projections that are consistent with the assumptions in these reports. Macroeconomic and demographic assumptions are based on the intermediate set of projections of the 1999 Annual Report of the Social Security and Medicare Boards of Trustees to Congress (Board of Trustees, Federal Hospital Insurance Trust Fund, 1999; Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, 1999; Board of Trustees, Federal Old-Age and Survivors Insurance and Disability Trust Funds, 1999).

Given the completion of these projections in the spring of 1999, we were unable to incorporate the most recent update of

the NHA, completed in September 1999. Thus, our historical data extend through 1997 and do not include the recent revisions back to 1995. For this reason, the history presented here is not completely consistent with that presented in “National Health Expenditures, 1998” (Cowan et al., 1999). Despite the historical differences, the projected trends discussed in this article are still expected to apply.

Private health expenditures and public spending other than Medicare and Medicaid are forecast within a largely econometric model of the health sector that relates growth in real per capita health spending to macroeconomic indicators and projected trends in Medicare and Medicaid spending. The model projection is adjusted to incorporate the effect of recently available data and to reflect the influence of trends that are not measurable and are not formally included in our model of the health sector.

PROJECTION HIGHLIGHTS

Over the period 1993-1997, growth in real per capita health care spending has been unusually slow in comparison with previous experience. In evaluating project-

ed growth over the coming decade, we can split our projection interval into two periods. The first period is marked by a pronounced acceleration (1998-2000) in health spending. This is followed by a projected mild deceleration from 2001-2008. Over the entire 11-year period, we anticipate that growth will be substantially faster than recent experience but will remain below the historical average.

Major health sector developments affecting projected growth in health spending include:

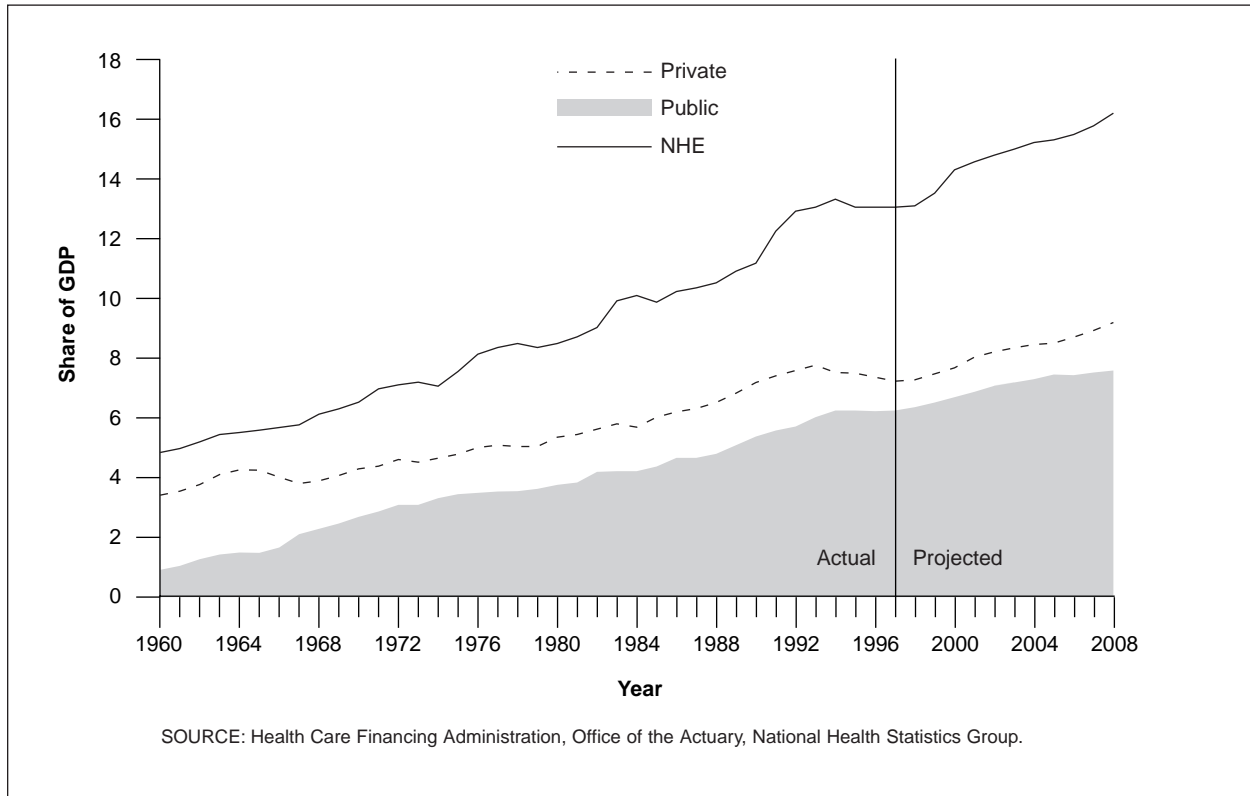
- The impact of managed care.
- The private health insurance underwriting cycle.
- The effect of a rising uninsured population.
- The impact of the BBA on Medicare spending.

Major macroeconomic and demographic factors affecting projected growth in nominal health spending include:

- Growth in real per capita income.
- Economywide inflation.
- Population growth and aging.

Additional detailed information from the 1999 national health expenditures (NHE) projections can be found online at www.hcfa.gov/stats/NHE-Proj/.

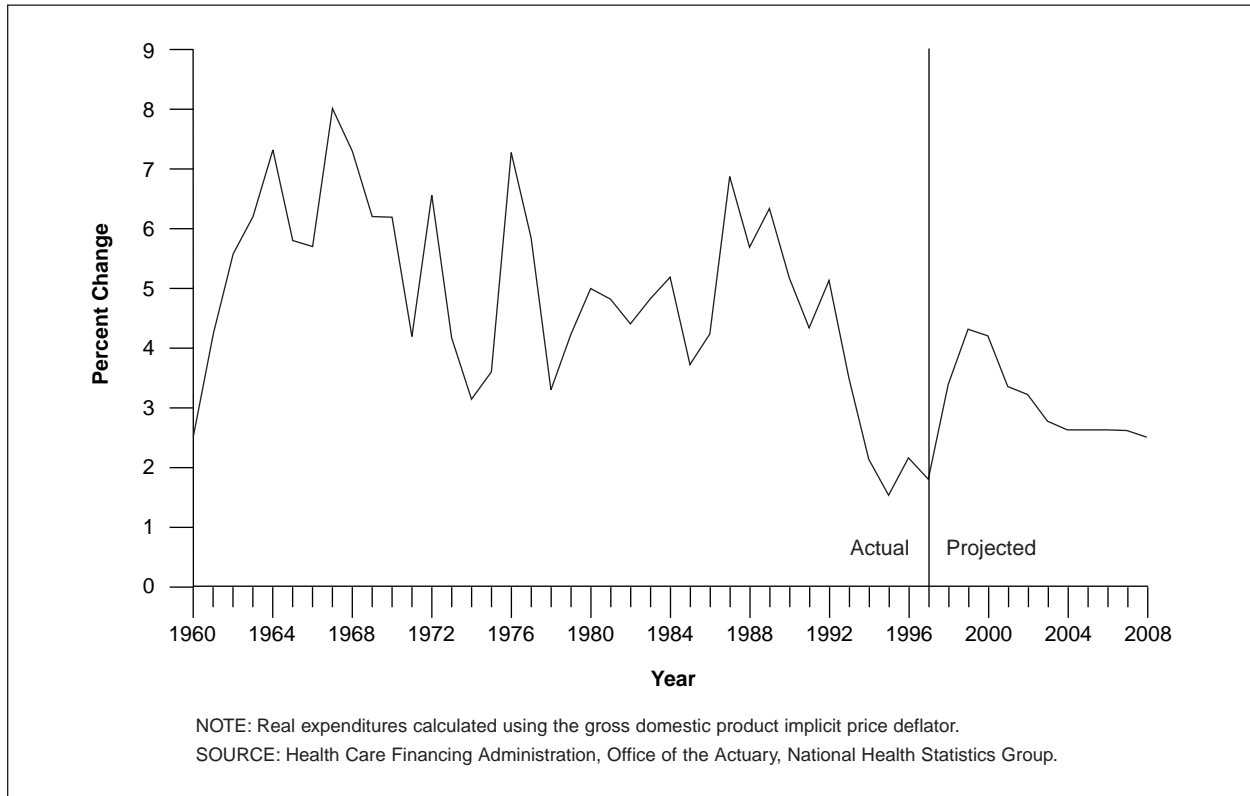
Figure 1
National Health Expenditures as a Share of Gross Domestic Product (GDP): 1960-2008



Health Spending as a share of GDP

- Health spending is expected to resume its rise as a share of GDP in the projected period, following 6 years of near stability, rising from 13.5 percent in 1997 to 16.2 percent by 2008. Over this period, health spending in nominal dollars is expected to approximately double, climbing from \$1.1 trillion in 1997 to \$2.2 trillion in 2008.
- The recent sustained period of no growth in health spending as a percentage of GDP has been the result of a number of concurrent developments. Structural changes, centered around the expansion of managed care, have been the major transforming force in health markets in recent years and have played a major role in restraining growth in health spending. However, the effect of this phenomenon on the health sector's share of GDP has been augmented by a downturn in the "underwriting cycle" for private health insurance (PHI) premiums and a business cycle expansion that has lifted growth in GDP.
- All of these developments are poised to reverse trend, heralding the acceleration in health spending projected for the period through 2001.

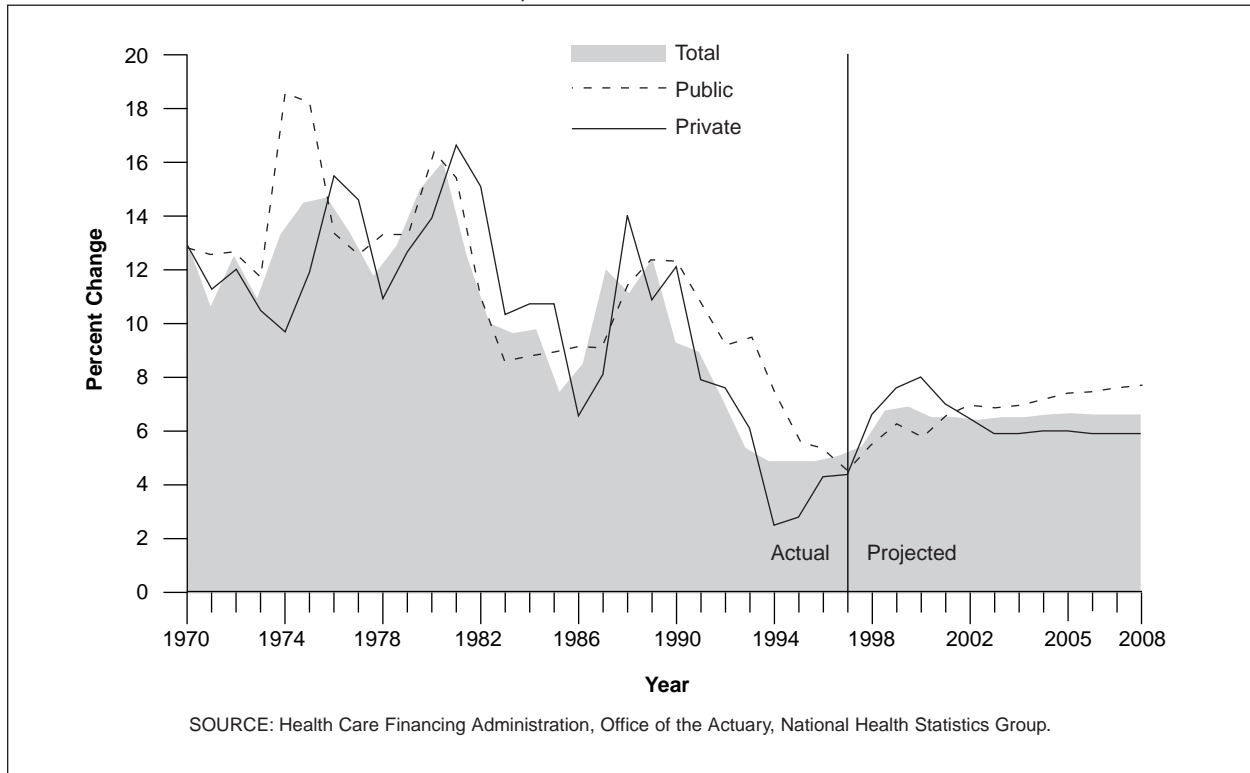
Figure 2
Percent Change in National Health Expenditures (Real per Capita Growth): 1960-2008



Patterns of Growth in Real per Capita Health Spending

- Despite the projected acceleration in health spending from recent lows, average growth in real per capita health spending over the coming decade is expected to remain well below the long-term historical average. Real per capita health spending is projected to grow 3.2 percent on average per year for 1997-2008, relative to the 4.9-percent annual average for 1960-1997. (Throughout this article, where we refer to “real per capita” terms, the deflator used is the GDP deflator. This implies that we exclude growth in health spending that is accounted for by economywide inflation and population growth but not that associated with medical inflation in excess of economywide inflation.)
- The projected slower growth in health spending for 1997-2008 relative to the 1960-1997 period reflects the estimated impact of slower projected growth in GDP, a rising uninsured population, the continued effects of managed care, and slower projected growth in Medicare spending. (We use the term “managed care” in the broadest sense, incorporating all models of health coverage that exercise significant limitations on the network of covered providers and/or covered services, including health maintenance organizations [HMOs], preferred provider organizations [PPOs], point-of-service [POS] plans, and provider sponsored organizations [PSOs].)
- The effect of slower growth in managed care is expected to result in increased growth in health spending in the short term. However, continued (slower) growth in managed care enrollment (among other effects) is expected to restrain growth on average over the decade relative to the entire historical period.

Figure 3
Percent Change in National Health Expenditures (Nominal Growth Rate) Total, Public, and Private: 1970-2008



Patterns of Growth in Private and Public Health Spending

- A rapid period of acceleration in NHE is expected to occur in the first 5 years of the forecast, driven primarily by faster growth in PHI spending. Private spending growth is expected to accelerate during 1997-2000, while Medicare spending will slow sharply from its recent pace.
- Slower growth in Medicare spending will act to restrain public and aggregate spending growth in 1998-2002, as the effects of the implementation of provisions of the BBA combine with the effects of fraud and abuse initiatives to reduce spending growth. The public sector share of health spending is expected to stabilize over the next 10 years. Following sharp increases for 1990-1997, the public share is projected to decline from 46.5 percent in 1997 to 44.8 percent by 2002 and then to rise back to 46.5 percent of total health spending by 2008.

Table 1
Track Record for National Health Expenditures Projections: 1995-1998

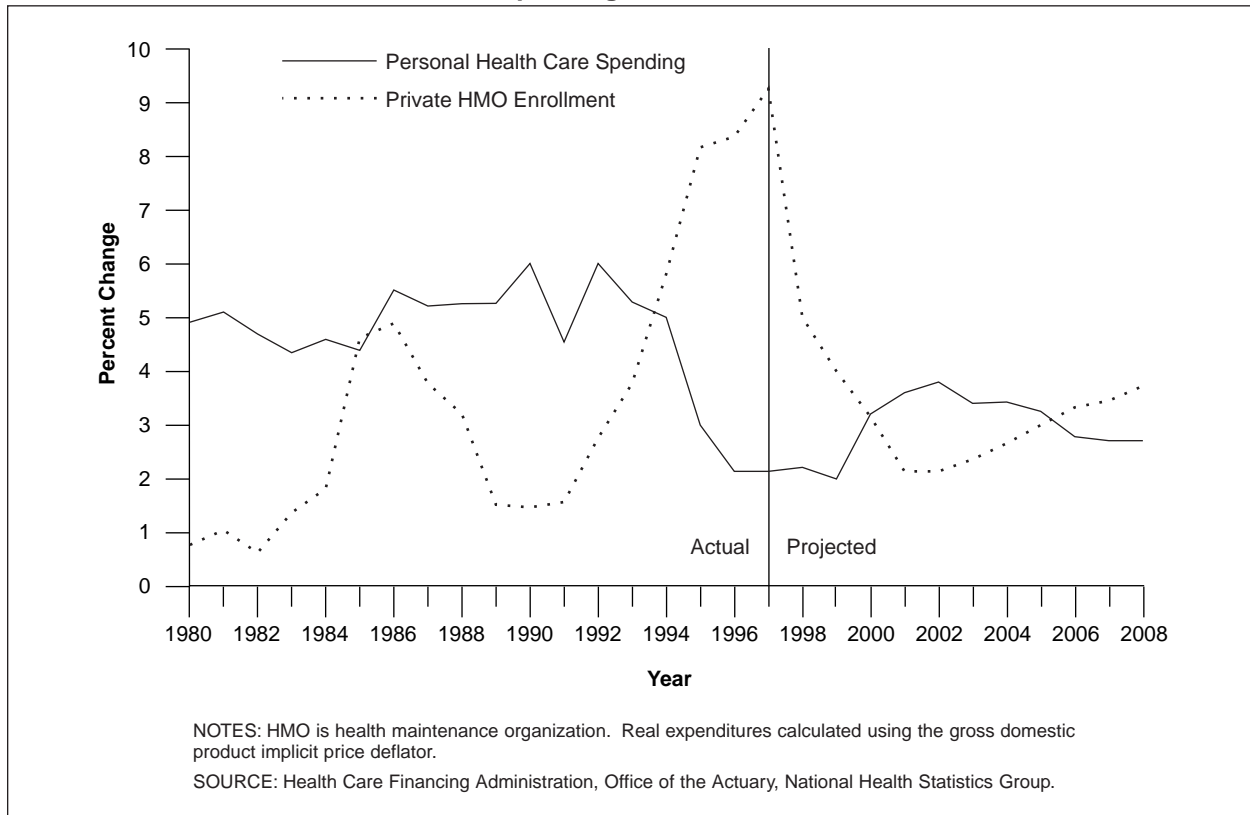
Item	1995	1996	1997	1998
National Health Expenditures				
Actual National Health Expenditures	4.8	4.6	4.7	5.6
1999 Projection	—	—	—	5.4
1998 Projection	—	—	4.8	5.8
Private Health Expenditures				
Actual National Health Expenditures	2.4	4.0	4.8	6.9
1999 Projection	—	—	—	6.3
1998 Projection	—	—	3.7	5.9
Public Health Expenditures				
Actual National Health Expenditures	7.8	5.4	4.5	4.1
1999 Projection	—	—	—	4.4
1998 Projection	—	—	6.0	5.6

SOURCES: (Cowan et al., 1999; Smith et al., 1998); Health Care Financing Administration, Office of the Actuary, National Health Statistics Group.

Projection Track Record

- Projected growth in the 1998 NHE projections proved close to the mark at the aggregate level.
- The projected reversal in patterns of growth for public and private spending was even more pronounced than anticipated, with private spending accelerating sharply and public spending slower than expected in our 1998 NHE projections.

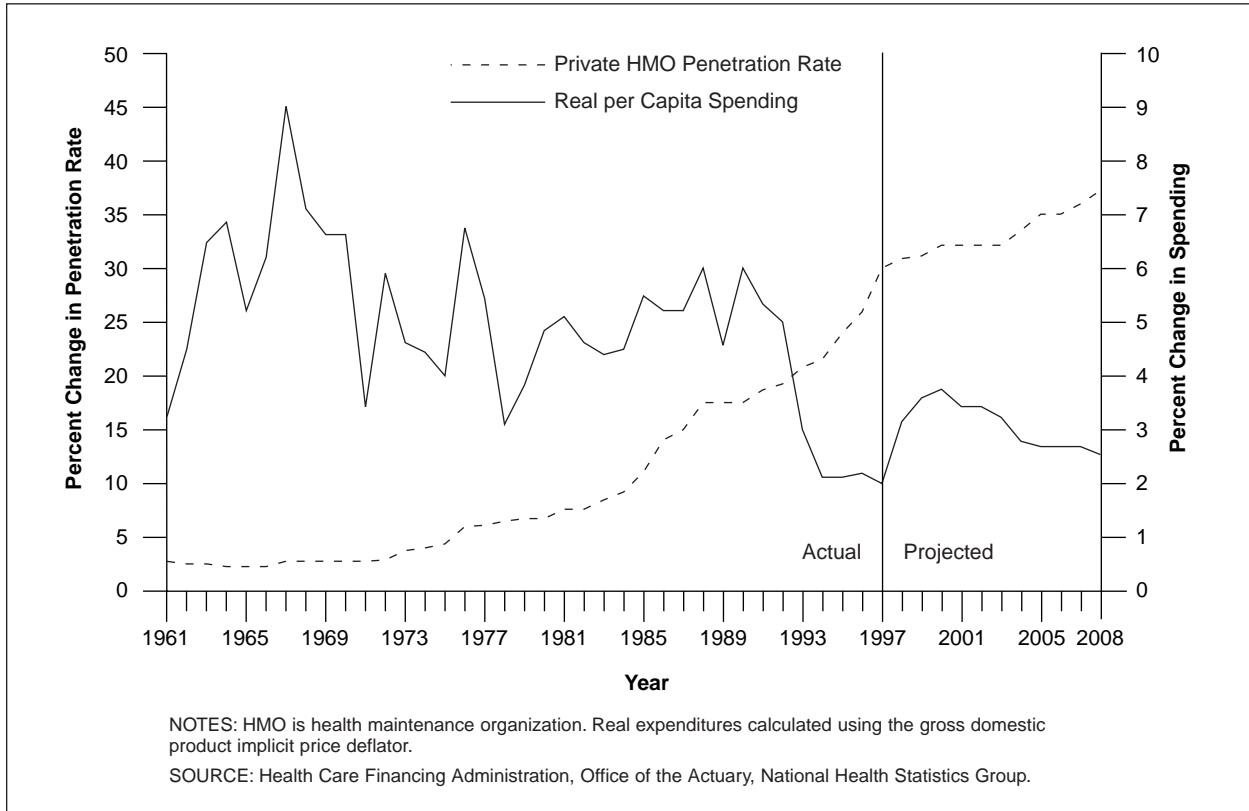
Figure 4
Percent Change in Private HMO Enrollment and Real per Capita Personal Health Care Spending: 1980-2008



Near-Term Managed Care Effects

- Slower growth in managed care enrollment is projected to boost health spending growth in the short term. In our models and in the charts presented in this article, we have used enrollment in HMOs as a proxy for enrollment in all forms of managed care because of the availability of a lengthy consistent time series on this variable. Enrollment gains in other forms of managed care tend to correlate with those for HMOs, however, this correspondence is not exact. To the extent that our proxy misses the effect of shifts across other models of managed care, we have attempted to adjust our forecast to reflect this phenomenon.
- From 1998-2002, we anticipate a continued slowdown in managed care enrollment and an accompanying movement toward less managed forms of care, such as POS plans, because managed care enrollment in employer-based plans is near the saturation point. We assume that the historical impact of rising managed care enrollment on growth in health care spending is primarily (although not wholly) a one-time effect. However, this one-time effect may extend over a period of time. The resulting reduction in growth in health spending results largely from a non-recurring decrease in the level of costs for enrollees moving from more expensive models of care to less expensive models. The projected slowdown in enrollment is expected to contribute to faster growth, with the effect concentrated in the private sector (Chernew et al., 1998).

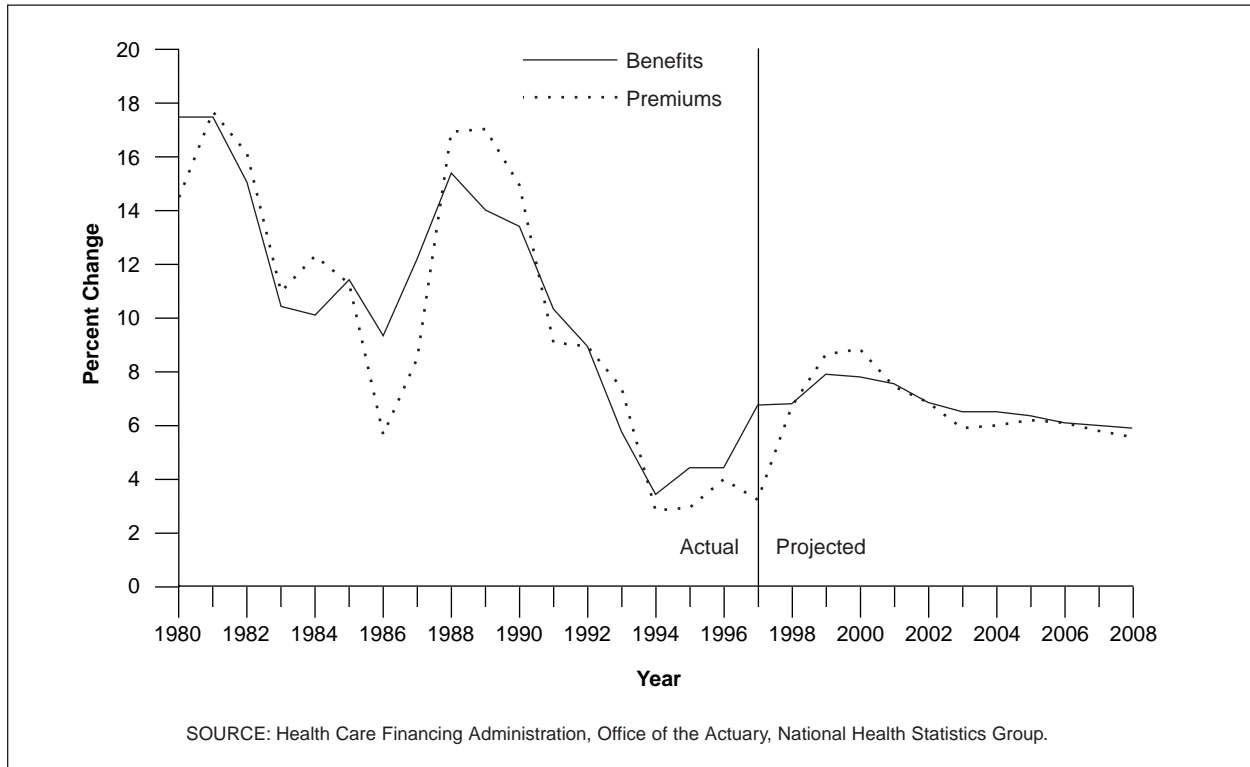
Figure 5
Private HMO Penetration Rate and Percent Change in Real per Capita Personal Health Care Spending: 1961-2008



Long-Term Managed Care Effects

- The net effect of managed care is an expected reduction in health spending growth for 1997-2008, compared with the entire historical period from 1960-1997.
- Although the reduction in growth attributable to managed care is expected to be small relative to that experienced over the past 5 years of rapid growth in enrollment, we expect managed care to continue to exercise some restraint on private sector spending. As health care costs once again accelerate relative to compensation, consumers are likely to find additional restraints on choice of provider and access to medical services an increasingly palatable tradeoff for cost restraint. Thus, the dampening effects on growth will be most pronounced in the second half of the forecast (2003-2008).
- We assume four key areas of change will be caused by the impact of managed care. First, we anticipate continued, albeit slower, growth in enrollment in managed care plans. Second, although slower growth in PHI premiums has encouraged an ongoing shift toward less restrictive models of managed care, we expect a shift in enrollment back into relatively restrictive forms of managed care in the latter half of the forecast in response to rapid growth in PHI premiums. Third, we anticipate the increasing use of financial incentives to foster cost-conscious behavior and other cost-saving innovations in the delivery of care, again concentrated in the latter half of the forecast interval. Finally, the new dominance of managed care is expected to result in slower diffusion of cost-increasing medical technologies.

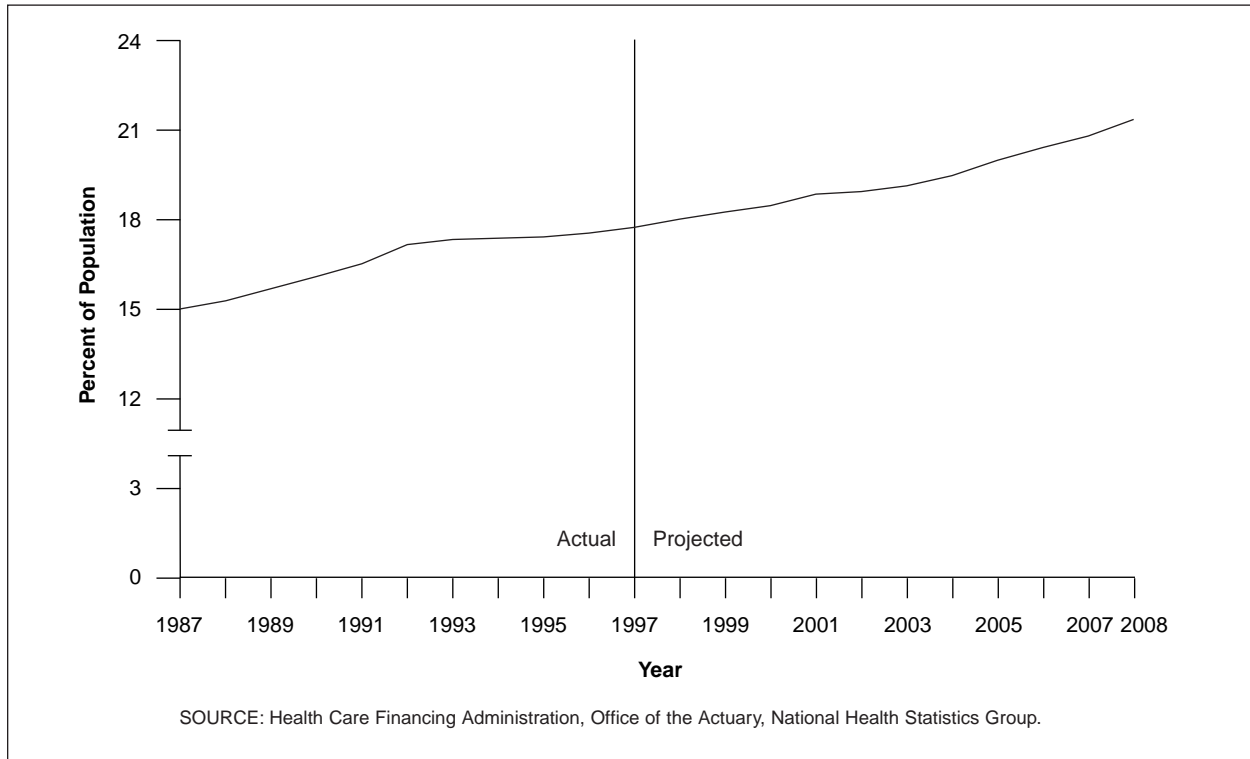
Figure 6
Percent Change in Private Health Insurance Benefits and Premiums: 1980-2008



Private Health Insurance

- An upturn in the PHI underwriting cycle through 2001 is expected to contribute to the acceleration in health spending, while a subsequent downturn is expected to reduce growth in health spending for the latter part of the projection.
- For 1998-2000, we anticipate a reversal of recent patterns of growth, with PHI premiums growing faster than covered benefits. This reflects two factors. First, PHI premiums tend to be subject to an underwriting cycle in which growth in premiums first exceeds then falls below growth in benefits. This is attributable to imperfect information on incurred medical costs relative to premiums, lags associated with premium negotiations, and the approval process of rates by State insurance commissions. Second, recent changes associated with the rise of managed care may have encouraged health plans to temporarily sacrifice profitability for market share.
- Survey results suggest that the underwriting cycle is on the upswing, as health plans hike premiums in the effort to improve profitability (The Controllers Report, 1999). This volatile component of spending is estimated to add 1.4 percentage points to growth in private health insurance spending over 1998-2000.

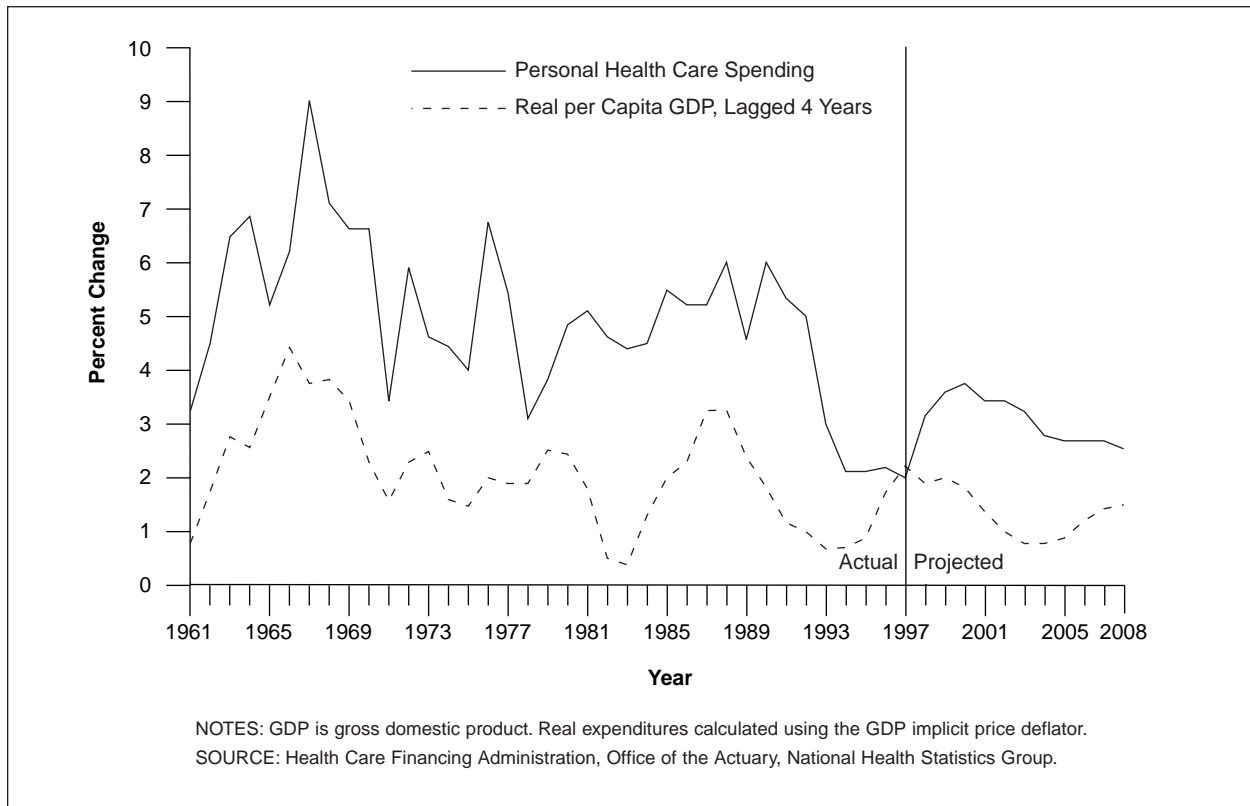
Figure 7
Percent of Population Without Medical Insurance Coverage: 1987-2008



Health Insurance Coverage

- A continued increase in the share of the population without health insurance coverage is expected to restrain growth in health spending through 2008. As economic growth is projected to slow, the rate of increase in the uninsured population is expected to rise.
- Recent research has shown that the downward trend in the share of the population with employer-provided coverage since 1987 can be almost wholly accounted for by declining rates of acceptance of coverage by employees; the share of employees with access to coverage through their employers has actually risen over this period (Cooper and Schone, 1997; Ginsburg, Gabel, and Hunt, 1998; Thorpe and Florence, 1999). (Note also that in 1995-1998, declining growth in the population insured under Medicaid contributed to the downward trend in the insured population, offsetting an incremental rise in the privately insured population.) The decline in private employer-provided coverage is concentrated among lower paid workers, who find rising employee contributions most onerous, and among younger workers.
- We expect the trend toward declining private coverage to become more pronounced over the next 10 years as economic growth slows and employers increasingly rely on employee contributions as a lever to restrain growth in insurance premium costs. The rising uninsured population is expected to act as a restraint on long-term growth in private health expenditures but at the cost of a growing population with reduced access to medical care.

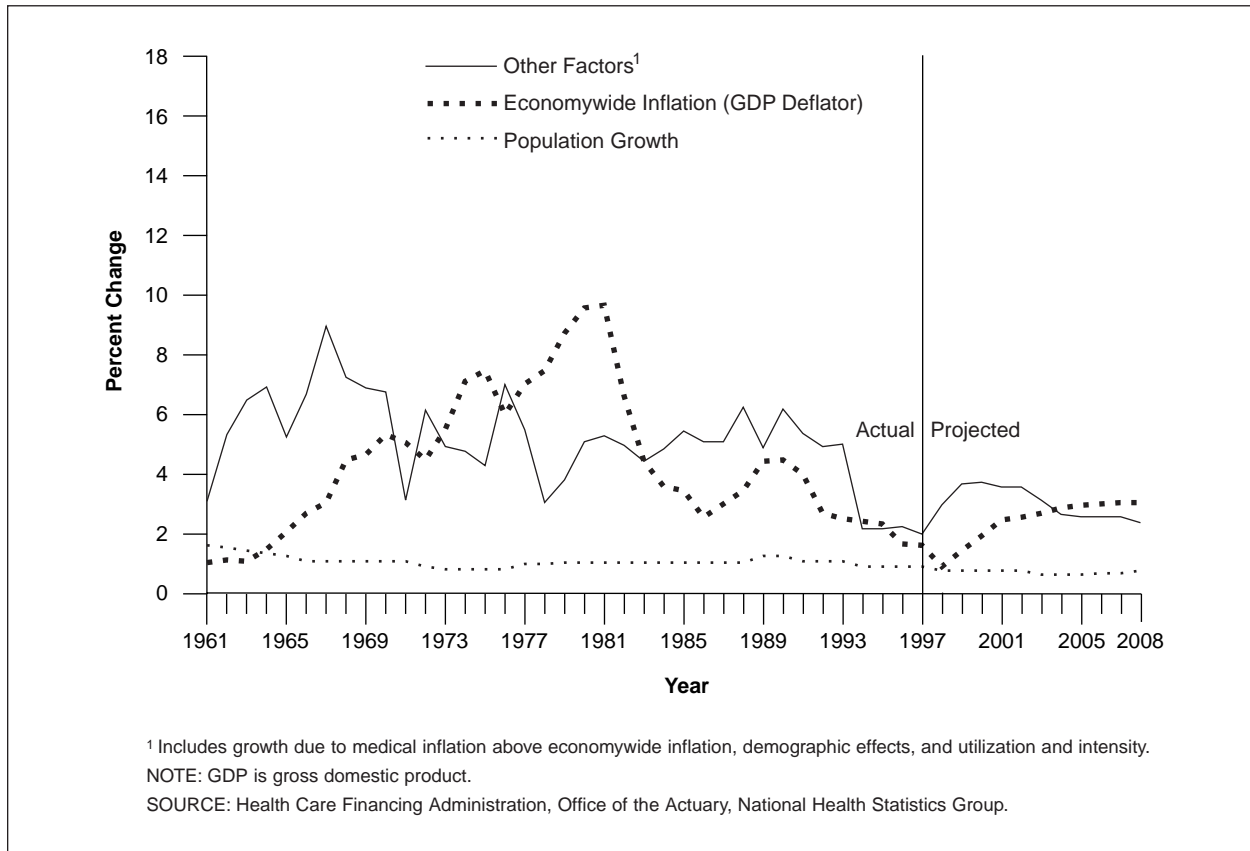
Figure 8
Percent Change in Real per Capita Personal Health Care Spending and Lagged Real per Capita GDP: 1961-2008



Income Effects

- Recent strong economic growth, with an accompanying rise in household incomes, is estimated to contribute to an acceleration in health spending growth for 1998-2000.
- Following the recent period of strong economic growth, real per capita GDP growth is expected to slow to more sustainable rates over the 1999-2008 period, resulting in a slow-down in estimated health spending growth in the latter part of the projection period (Board of Trustees, Old-Age and Survivors Disability and Insurance Trust Funds, 1999).
- As real per capita income increases, health spending increases more than proportionately, reflecting higher consumer demand for medical services. Rising real per capita income can be expected to have a small immediate effect on health spending, followed by a larger effect manifested over subsequent years (Getzen, 1990; Cookson and Reilly, 1994). The lag in the operation of this effect occurs primarily because consumers are largely insulated from the costs of the medical services they consume by the presence of insurance. These costs are felt only when they appear in the form of higher insurance premiums and taxes to cover the cost of public programs such as Medicare. In turn, changes in the nature of insurance coverage are mediated through employers and through the legislative process and thus may take a substantial period of time to respond to underlying shifts in consumer demand.

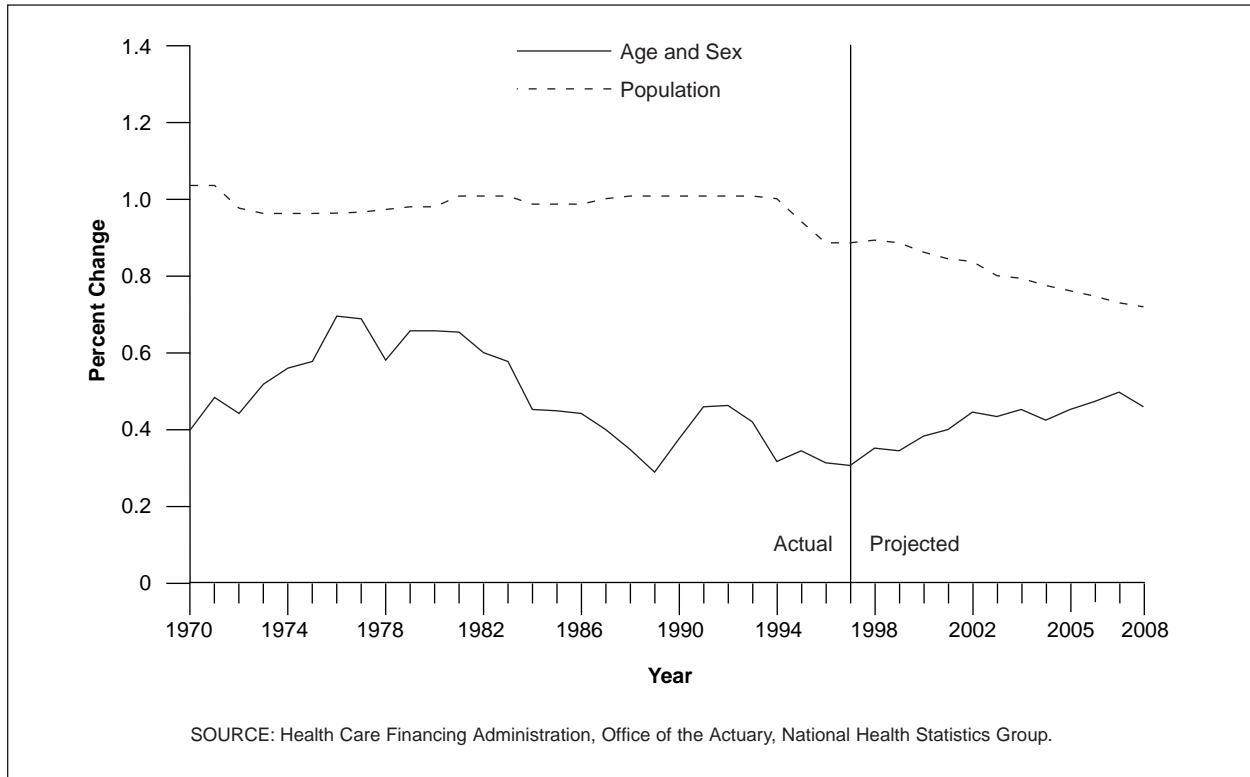
Figure 9
Contributions of Economywide Inflation, Population Growth, and Other Factors to Percent Change in Health Spending: 1961-2008



Economywide Inflation Effects

- Economywide inflation is expected to rise from its recent low of 1.0 percent in 1998 to 3.2 percent by 2008, contributing to faster growth in nominal health spending.
- Economywide inflation is expected to rise over the coming decade, accounting for about 40 percent of growth in nominal health spending. After excluding the high-inflation era of 1973-1982, when economywide inflation accounted for about 60 percent of growth in nominal health spending, this projected 40-percent contribution is approximately equal to the historical average.

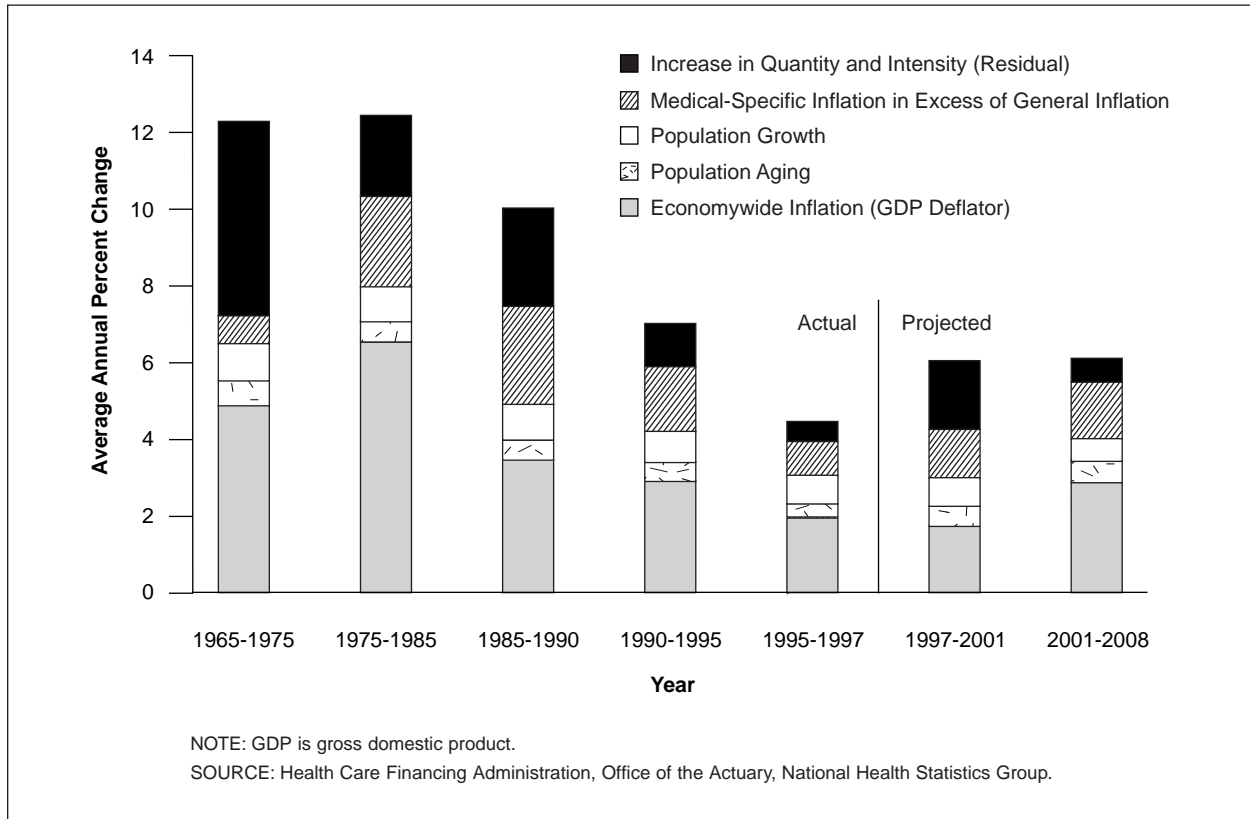
Figure 10
Contribution of Changes in Age and Sex Composition of the Population and Growth in Population to Percent Change in National Health Expenditures: 1970-2008



Demographic Effects

- Population aging will add increasingly to growth in health spending toward 2008 as the baby-boomers approach retirement age. However, the fraction of health spending growth accounted for by population aging during this period remains small.
- Population aging is projected to add just under 0.5 percent per year to growth in health spending, with this contribution rising as we approach 2008, reflecting the early effects of the aging of the baby-boom cohort.
- Population growth for 1997-2008 is projected to account for an average of 0.8-percent growth in health spending per year, slightly below the average of 1.0 percent for 1960-1997.

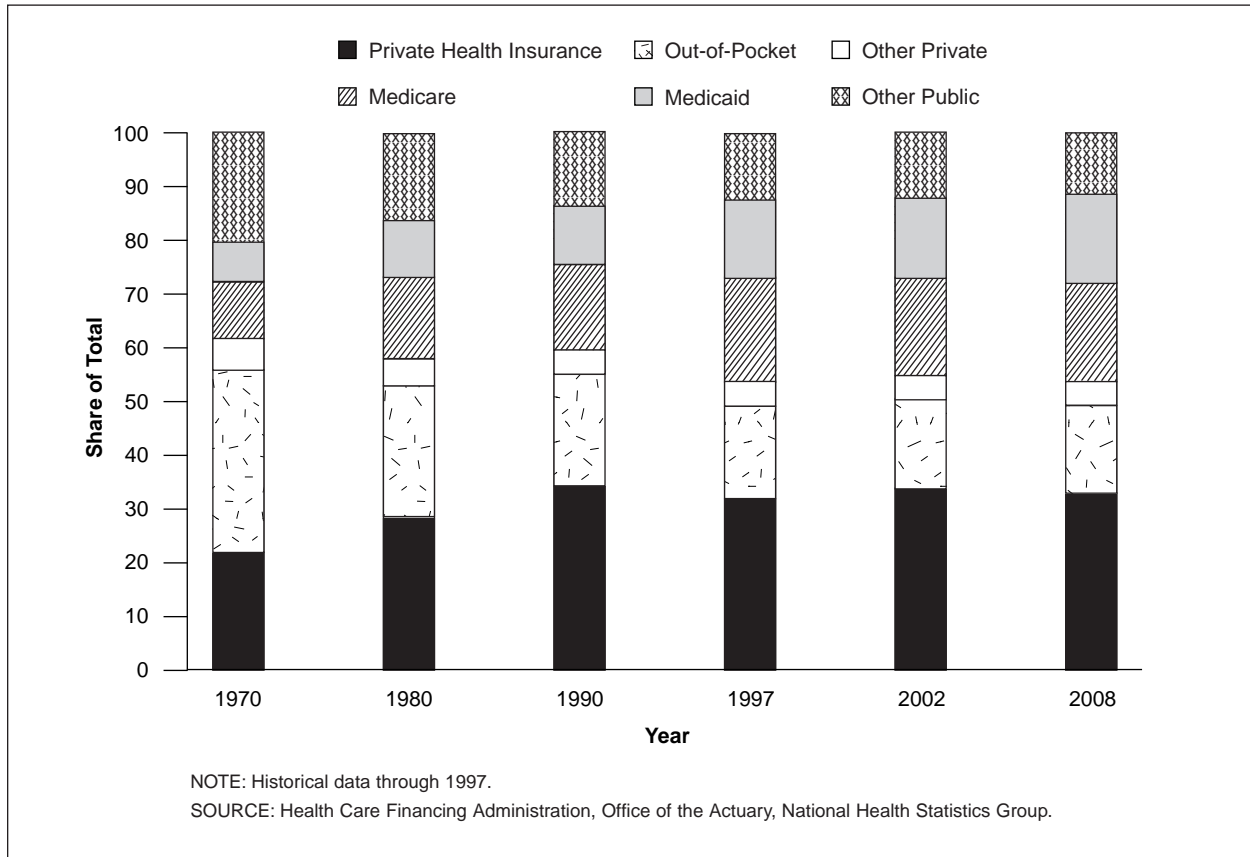
Figure 11
Factors Accounting for Growth in National Health Spending: Selected Periods 1965-2008



Composition of Growth in Health Spending

- Increased quantity and intensity of medical services are expected to contribute more to spending growth from 1997 to 2001 than in 1990-1997. Medical inflation in excess of economywide inflation is expected to accelerate as well but is projected to remain below the pace of the mid-1980s to early 1990s.
- Rising consumer demand for services, slower growth in managed care enrollment, a shift toward less restrictive models of managed care, and increased government regulation of health plans are expected to contribute to the rising growth in utilization and intensity over the next few years. We anticipate a reversal of this trend in the latter half of the projection interval, as declining real per capita incomes and rapidly rising PHI premiums prompt a decline in demand and a corresponding shift back into more restrictive forms of managed care.
- A continued focus on price discounting, combined with the presence of excess capacity among health providers (particularly hospitals), is expected to restrain medical inflation, although not to the degree experienced during the 1995-1997 period.

Figure 12
Composition of Health Spending, by Source of Funds: Selected Years 1970-2008

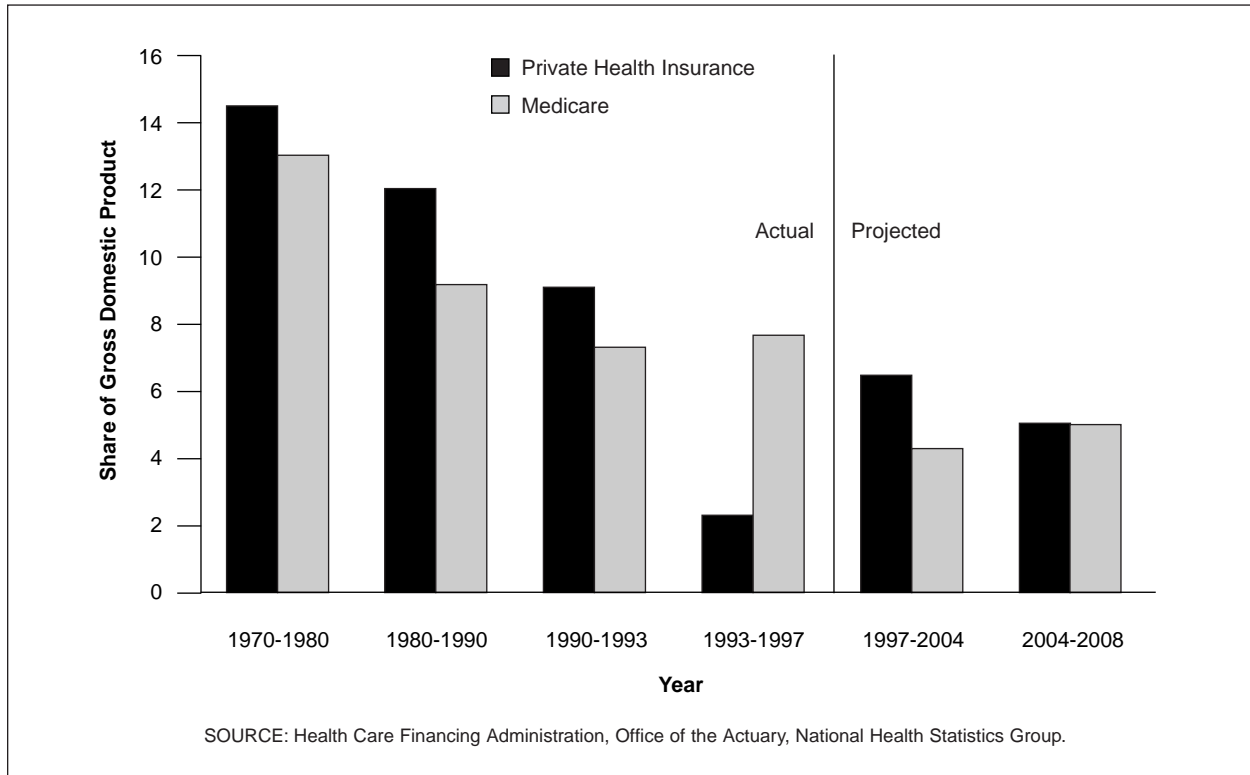


Projected Trends By Source of Funds

- PHI spending is expected to grow substantially faster than Medicare spending through 2002, a reversal of recent patterns of growth. This will push the private share of health spending upward for the first time since 1990.
- In the longer term from 2003 to 2008, nominal Medicare spending is projected to outpace PHI spending. Faster growth in the number of Medicare beneficiaries is the principal factor accounting for faster growth in Medicare spending in the long term.
- Medicaid spending is expected to rise as a share of total health spending.

Figure 13

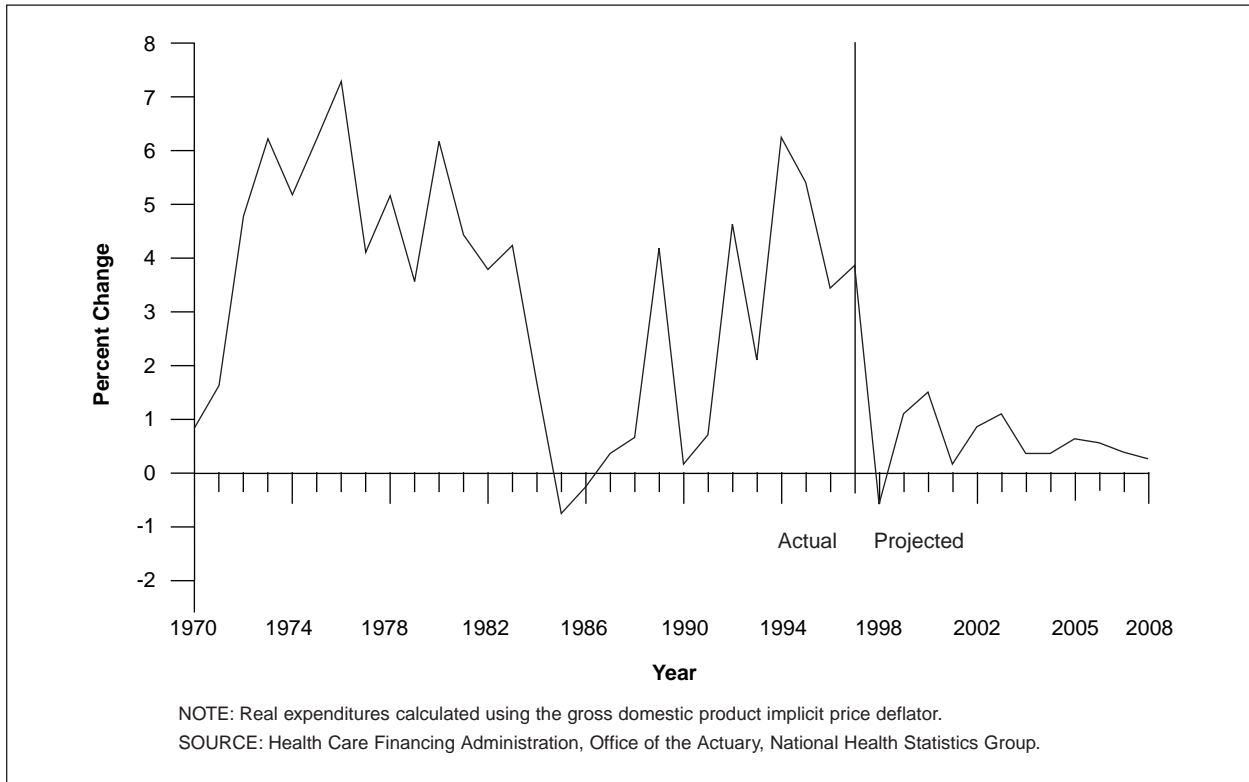
Percent Change in Private Health Insurance and Medicare Expenditures per Enrollee, Adjusted for Age and Sex Composition of Enrollment: Selected Periods 1970-2008



Private Health Insurance and Medicare

- After controlling for growth in enrollment and in the age-sex composition of enrollment, the long-term rate of growth in Medicare and PHI spending is expected to be similar.
- Shifts in the composition of the population by age and sex are expected to boost growth in private health spending and to depress growth in Medicare spending in the last 5 years of the projection. Growth in Medicare spending will be increasingly restrained as the Medicare population gets relatively younger.
- The aging of the baby-boom generation will tend to increase growth in PHI spending as the privately insured population becomes relatively older. This effect begins to be felt in about 2004 and increases in magnitude through 2008.

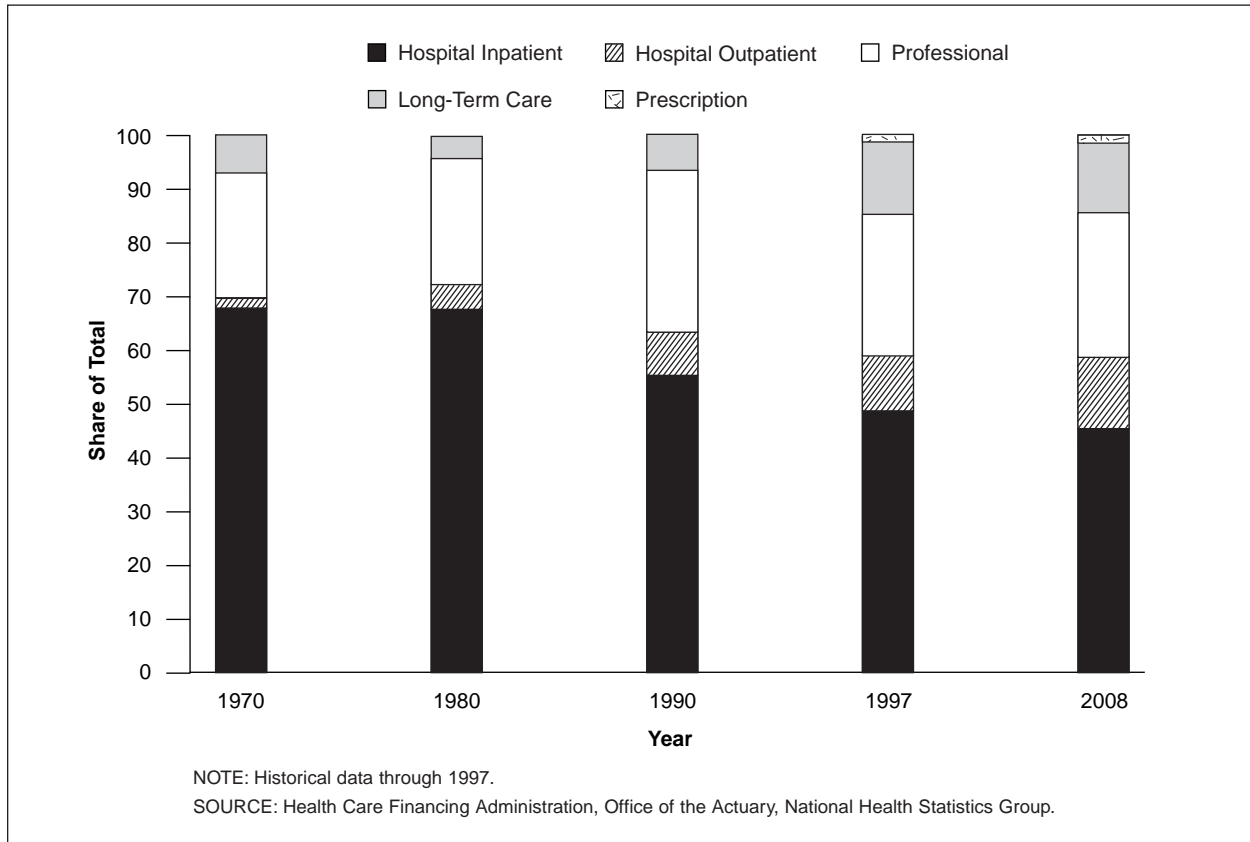
Figure 14
Percent Change in Real Medicare Spending per Enrollee: 1970-2008



Medicare

- The BBA is the dominant factor influencing patterns of growth in Medicare spending. Most of the impact of the BBA on Medicare spending growth will be felt in the short term, through 2002.
- The BBA incorporated three principal types of change to Medicare: (1) introduction of prospective payment systems (PPSs) across a wide range of services, (2) reductions in the growth in payment formulas where rates were perceived to be overly generous (primarily hospital inpatient, home health care, and durable medical equipment), and (3) the introduction of Medicare+Choice, incorporating changes in payments for capitated plans that were intended to reduce growth, diminish regional variation, and provide a floor for payment rates that could encourage growth in alternatives for Medicare beneficiaries in rural areas. The combination of reduced rates of increase in payments for capitated plans and the failure of plans to anticipate growth in the costs of the relatively more generous benefits packages offered to Medicare beneficiaries has led to the withdrawal of some of these plans from the Medicare+Choice program.
- Medicare managed care enrollment is projected to rise steeply, with 25 percent of beneficiaries enrolled in capitated plans by 2002.
- PPSs will be introduced for nursing homes, home health care, and hospital outpatient services, tempering growth in spending for these services.

Figure 15
Composition of Medicare Spending, by Type of Service: Selected Years 1970-2008

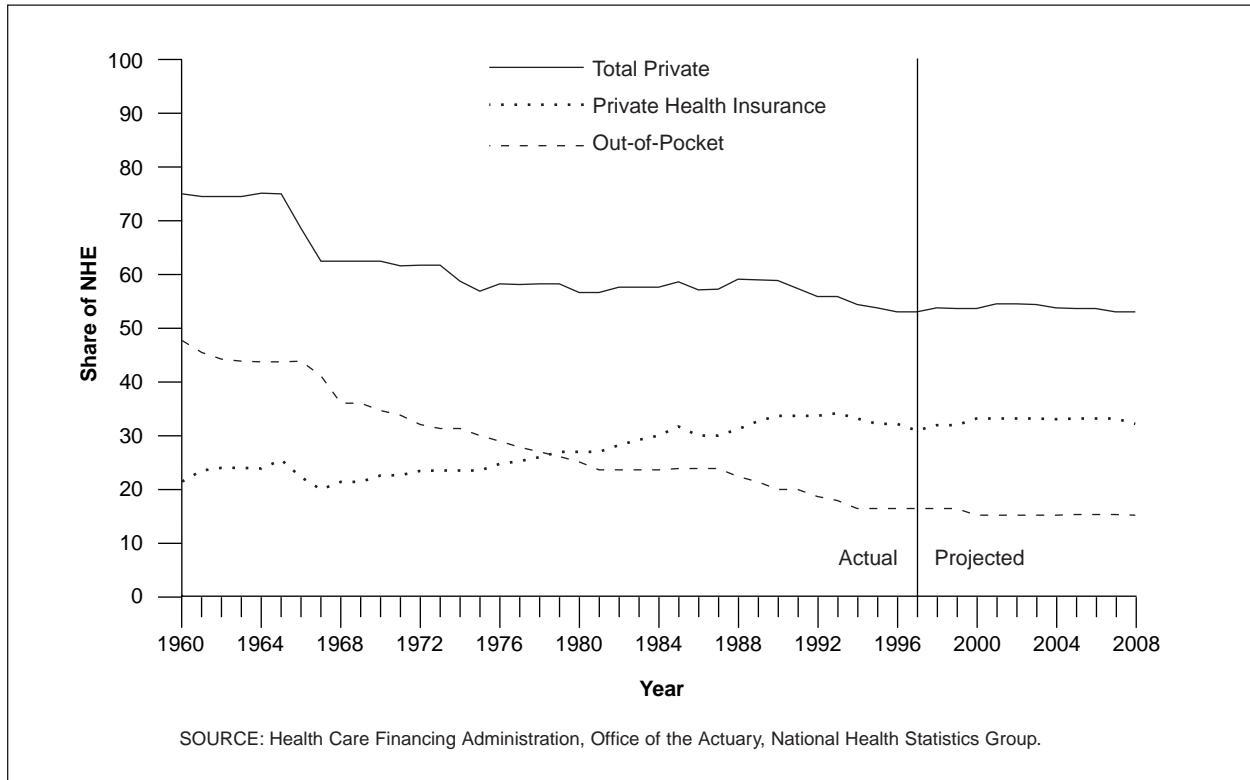


Medicare Spending by Type of Service

- We anticipate a substantial shift in Medicare spending for different types of medical services, in part due to the shift of a large fraction of beneficiaries to managed care. As a share of total Medicare spending, inpatient hospital services and home health care are projected to decline, while physician services, hospital outpatient care, drugs, and dental care are expected to increase.
- Medicare spending on drugs and dental services, which are mainly covered through Medicare+Choice plans, is projected to grow rapidly as beneficiaries shift into managed care plans but is still expected to remain a small fraction of total spending.
- Spending on nursing home and home health care, which have accounted for a sharply increasing share of Medicare spending over the past decade, is projected to slow decisively through 2008. This slowdown is unrelated to managed care, reflecting both legislative initiatives to restrain costs and demographic projections that suggest slower overall growth in demand for long-term care (LTC).

Figure 16

Private Health Expenditures as a Share of National Health Expenditures (NHE): 1960-2008

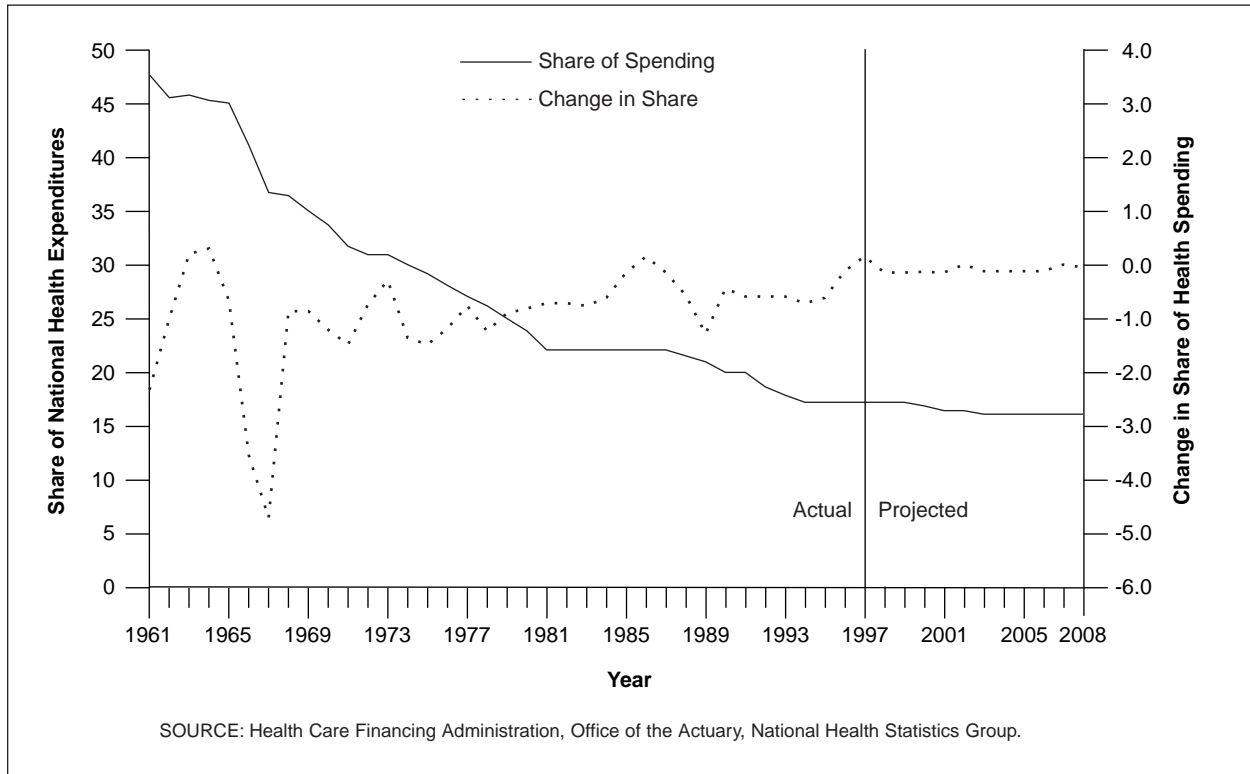


Private Health Insurance

- Total PHI spending is expected to accelerate in 1998 and to grow at an annual rate of 8.5 percent for 1998-2001. The acceleration, together with projected slower growth in public spending, is expected to temporarily increase the share of total health spending accounted for by PHI.
- A major factor contributing to the projected acceleration in total PHI growth for 1998-2000 is projected growth in PHI premiums in excess of growth in benefits. However, growth in spending on medical services is also projected to accelerate as enrollment in managed care organizations slows sharply. Over the next few years, a shift to less restrictive plans by current members is expected to add to growth, however, this trend is expected to reverse as premiums accelerate. Growth in PHI spending on personal health care services is expected to rise sharply in 1998 and to peak at 7.9 percent in 2000, following growth near 4.5 percent for 1995-1997.
- Growth in total PHI spending over the 1997-2008 period is expected to average 6.8 percent, significantly higher than the 3.4-percent average for 1994-1997 but well below the 11.5-percent average for 1988-1993.

Figure 17

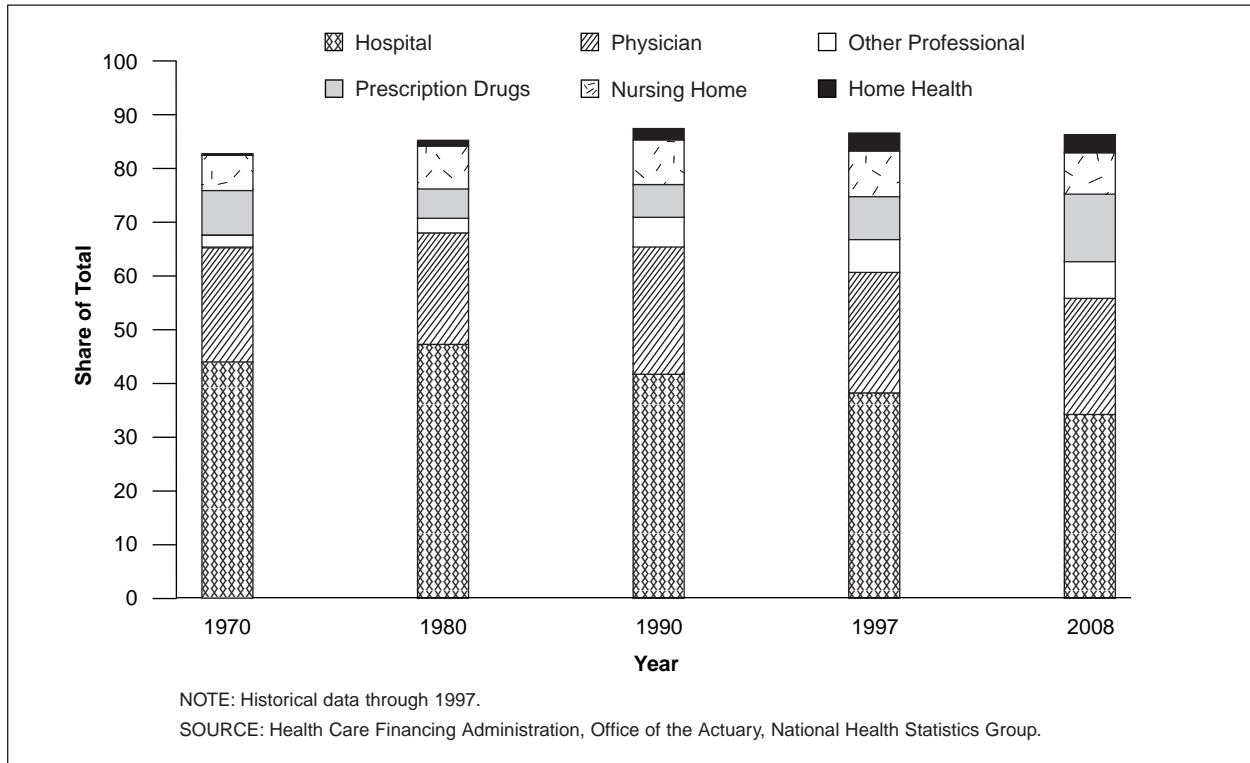
Consumer Out-of-Pocket Spending: Share and Change in Share of Health Spending: 1961-2008



Consumer Out-of-Pocket Spending

- We anticipate a leveling-off in the consumer out-of-pocket share of health spending, which would represent a significant change from the downward trend experienced over the past three decades. Based on recent survey data and widespread anecdotal reports, a trend is apparent toward the increasing use of consumer cost sharing as a tool to control utilization of health care in an environment where direct restrictions on choice are increasingly unpopular.
- We project a much slower rate of decline for the out-of-pocket share of health spending, as slower growth in private managed care combines with a rise in the uninsured population. This increase will offset the effects of the shift of Medicare beneficiaries into managed care, where their out-of-pocket costs are substantially smaller than in a fee-for-service environment, and the BBA-mandated gradual reductions in beneficiary coinsurance under a prospective payment system for hospital outpatients.

Figure 18
Composition of Health Spending, by Type of Service: Selected Years 1970-2008

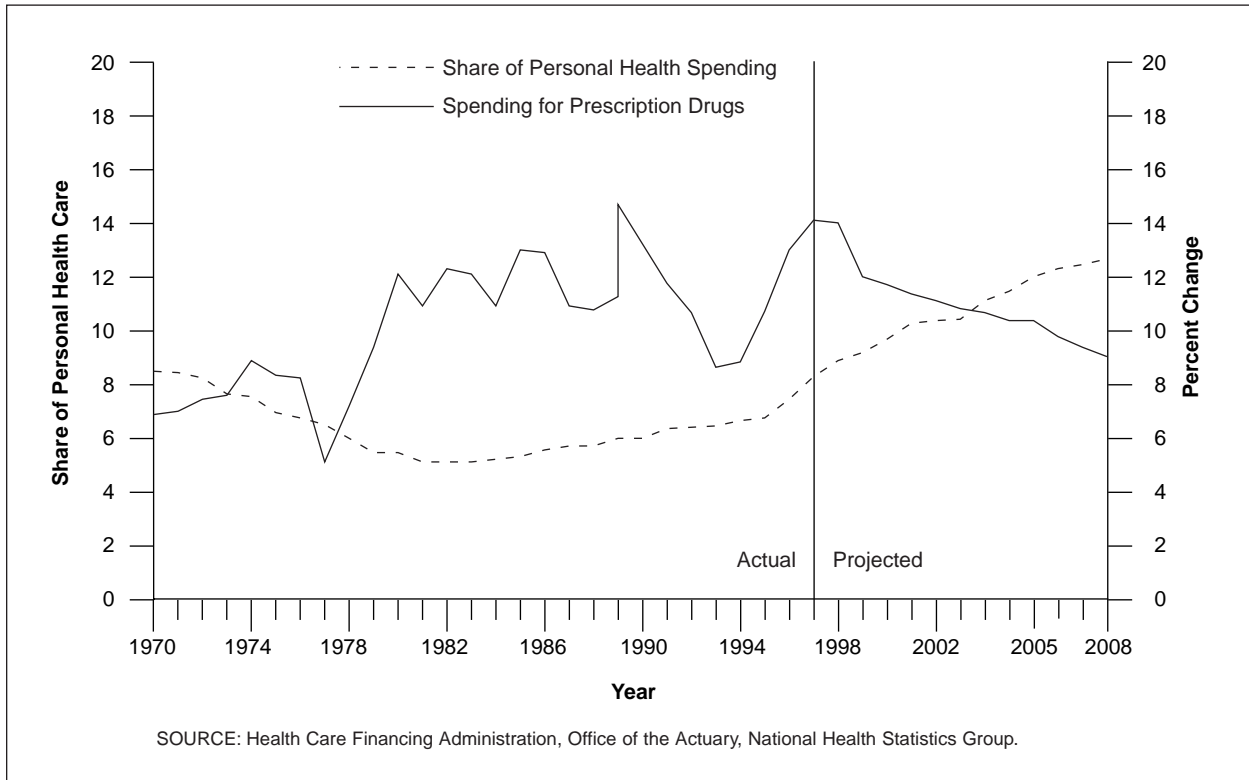


Projected Trends By Type of Service

- Spending on prescription drugs and other professional services is expected to account for an increasing share of health spending over the next decade, while hospital, physician, and LTC are expected to decline in share.
- Prescription drug spending is projected to grow rapidly, accounting for a rising share of total health spending. We project an eventual slowdown in growth for drug utilization as accelerating drug prices combine with a flattening in out-of-pocket share to increase the cost of drugs to consumers.
- Physician services are projected to continue to account for a declining share of the health care dollar over the next decade. The decline is due in part to the continued shift of care to other professional services and the expected slowdown in Medicare spending on physician services, as beneficiaries move into managed care plans with risk-adjusted payments.
- Other professional services, which include care performed by licensed practitioners other than physicians (such as chiropractors), are expected to continue to increase in share over the projection period as alternative forms of care continue to be substituted for physician services.
- Spending on hospital services is also expected to fall as a share of total health spending; however, we project a slower rate of decline than was experienced in the period after the introduction of prospective payment.
- Growth in spending for LTC services (nursing home and home health care) is projected to slow over the next 10 years, compared with historical trends.

Figure 19

Percent Change in Prescription Drug Spending and Percent of Personal Health Spending: 1970-2008

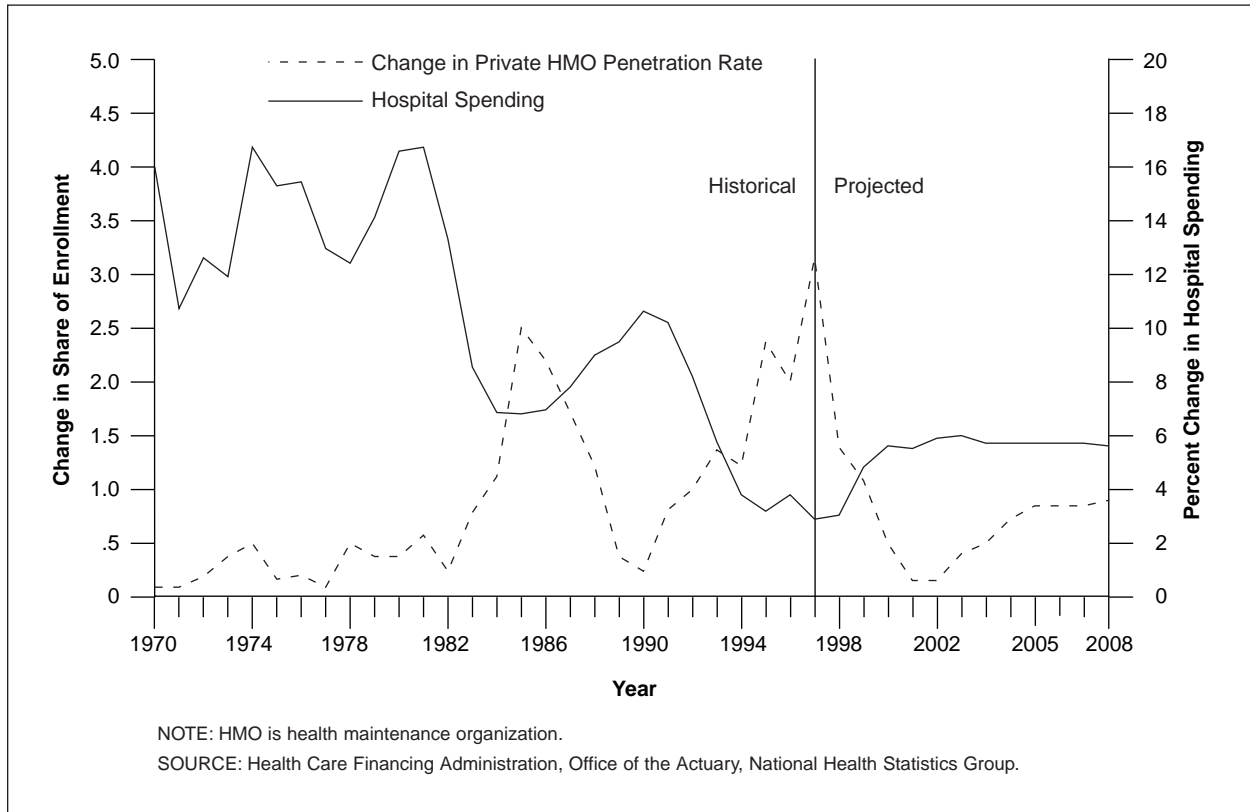


Prescription Drugs

- Prescription drug spending is projected to slow from the recent double-digit pace but continue to exceed growth in overall health spending by a wide margin.
- The recent rapid growth in prescription drug spending since 1995 reflects several special factors, not all of which will continue to apply over the next 10 years. In particular, the drop in out-of-pocket share of drug spending borne by consumers since 1990 has been largely a result of the shift to managed care. As managed care enrollment growth slows sharply, this downward trend can be expected to level out. The sharp deceleration in drug price inflation experienced from 1993 to 1997 has already begun to reverse, with drug price inflation up sharply through early 1999. The resulting increase in prices paid by consumers will discourage further rapid growth in utilization. But although the record-setting pace for new drug introductions is expected to decrease somewhat from its peak in 1996-1997, it is likely to remain high relative to the historical average and therefore to continue to boost projected growth in drug spending. In addition, increased direct-to-consumer advertising is expected to play an increasing and unpredictable role in driving demand upward.
- As a result, drug spending as a share of personal health care is projected to climb from 8.1 percent in 1997 to 12.6 percent in 2008, which would make it the third-largest service type.

Figure 20

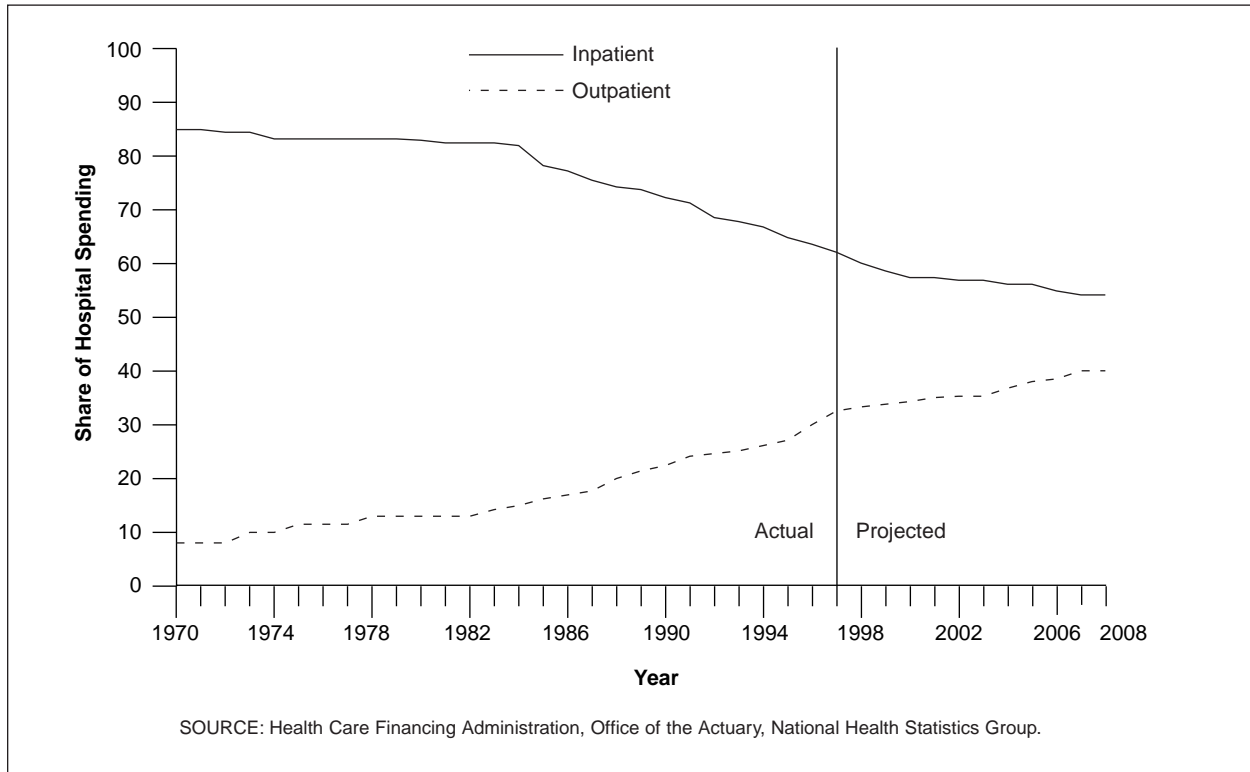
Change in Share of Private HMO Enrollment and Growth in Hospital Spending: 1970-2008



Hospital Services

- Hospital spending is expected to accelerate in 1998-2002. This reversal in trend reflects projected increases in spending on inpatient hospital services. Faster growth in inpatient hospital spending is entirely accounted for by projected increases in private sector spending—public spending is expected to decelerate in response to legislative changes to Medicare under the BBA.
- The projected acceleration in private spending reflects a slowdown in private sector managed care enrollment (inpatient care tends to account for a smaller share of spending for managed care enrollees than for those in traditional fee-for-service plans) and a projected modest increase in hospital price inflation.

Figure 21
Hospital Inpatient and Outpatient Spending Shares: 1970-2008

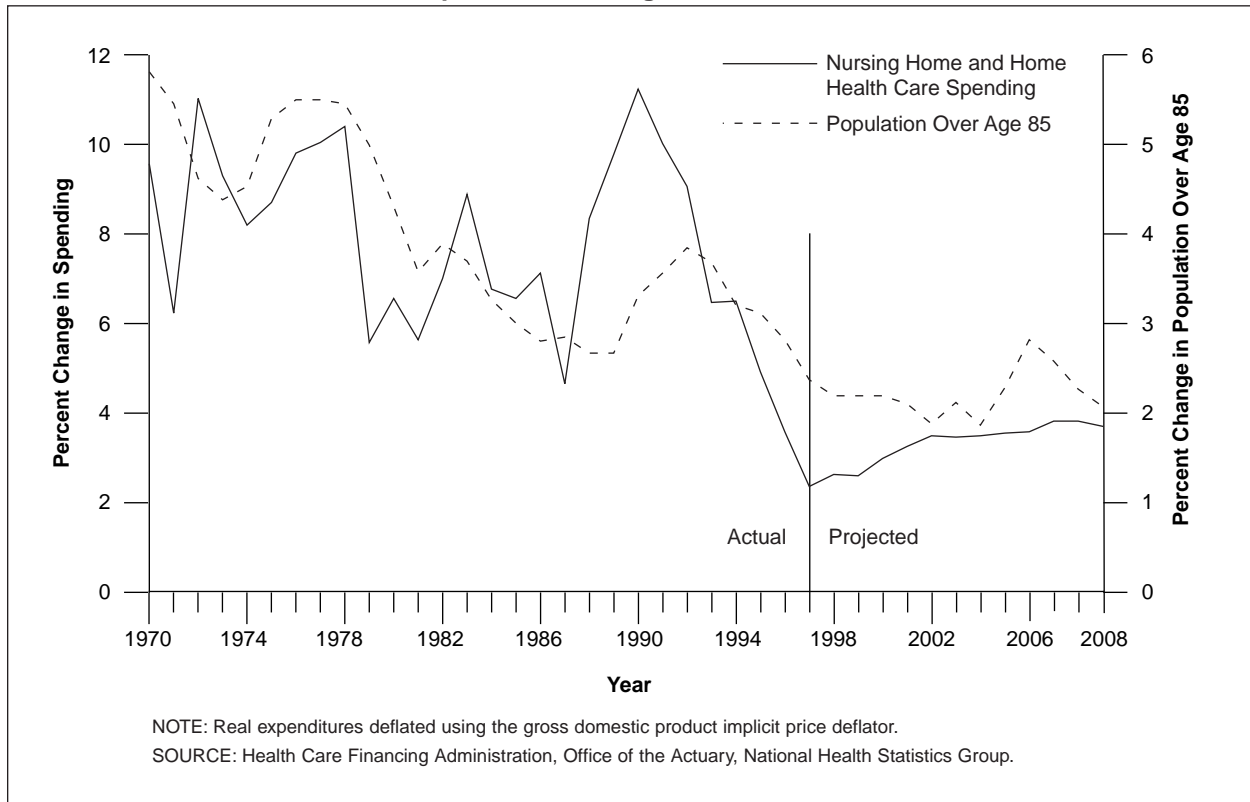


Hospital Inpatient and Outpatient Spending

- Although hospital outpatient care is expected to continue to grow as a share of health spending, its rate of increase is projected to slow. As outpatient spending accounts for an ever greater share of costs (roughly one-third of total hospital spending in 1997 [American Hospital Association, 1998]), constraining growth in this area of spending is expected to become an increasing priority for health plans.
- The downward trend in the inpatient hospital share of personal health care spending is expected to flatten somewhat over the coming decade, in comparison to the 1984-1997. The declining trend in inpatient hospital share of personal health care since 1984 results from two major factors. First, Medicare's prospective payment system, introduced in October 1983, provided a major incentive to reduce inpatient length of stay. Second, as managed care penetration increased sharply in the 1990s, inpatient care was increasingly the focus of utilization management. However, given that easy cuts and gains in efficiency are usually made first, further reductions in inpatient care spending are likely to become increasingly difficult.

Figure 22

Percent Change in Real Nursing Home and Home Health Care Spending and Percent Change in Population Over Age 85: 1970-2008



Nursing Home and Home Health Care Services

- Growth in expenditures for nursing home and home health services is expected to slow substantially over the next 10 years. Growth in the population over age 85 (the most intensive users of LTC services) is expected to be slower on average than has been the case over the past 30 years. This downward trend will act to retard growth in spending on LTC.
- In addition, BBA provisions that will subject nursing home and home health care spending to much tighter constraints, including implementation of PPSs, combined with increased emphasis on detecting fraud and abuse, are expected to continue to restrain growth in Medicare spending for both nursing home and home health care. Growth in alternative options, such as assisted-living facilities, which provide a more limited range of (largely non-medical) care for the frail elderly, will also tend to reduce growth in nursing home and home health care.
- Nursing home spending is expected to decline as a percentage of NHE from 7.6 in 1997 to 6.9 in 2008, and home health care spending is expected to remain a roughly constant 3.0 percent of NHE over the projection period.

CONCLUSION

Over the past 10 years, we have seen major changes in modes of payment and delivery for health care services, particularly in the private sector. The central focus of these changes was the strong growth in private managed care enrollment, which has proved successful in containing costs for health benefits in the private sector, at least in the short term. This period has also seen a divergence in growth between private and public sector health spending, with public spending exceeding private spending growth by a substantial margin.

An important question for health spending over the next 10 years is whether the recent changes in the financing and delivery of health services can be expected to result in a sustained reduction in health spending growth. Although we expect the expansion of managed care to have a continued negative effect on growth relative to the entire historical period since 1960, we project that this factor will have a much smaller impact than in recent years. This is attributable to both the anticipated slowdown in private enrollment and to changes in the nature of managed care in response to the consumer backlash against restricted access to care. Slower growth in managed care enrollment and the accompanying shift toward fewer restrictions on access will play a dominant role in pushing growth in private health spending over the next few years substantially above its recent pace. Eventually, these trends are expected to reverse as faster growth in premiums encourages a shift toward less costly coverage.

Another important factor for growth in health care costs will be the sharply slower growth anticipated for Medicare, largely in response to cost-containing provisions of the BBA. This slower growth will act to restrain aggregate growth in spending and

is expected to result in a reversal of recent patterns of growth, with Medicare spending growing more slowly than private spending.

Despite the acceleration in health spending projected for the next few years, our long-term projection is for a moderation in the trend rate of growth in real per capita health care expenditures compared with the long-term historical averages. This is due in part to an expected move to more restrictive managed care plans in the latter half of the projection period. However, this moderation is unlikely to be substantial enough to resolve long-term pressures on the system associated with growing demands on available economic resources, both for the public and private sectors.

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