

provider in a timely fashion, because schedules are often full, after-hours service is unavailable, and many acute problems are not well suited to office practices lacking basic laboratory and imaging capabilities.⁴ As hospitals strive for administrative efficiency by maximizing occupancy rates, it becomes more difficult for outpatient providers to admit patients directly to the hospital. Yet since such hospitals' practices have largely been reactive, it is unclear whether this trend reflects high-value use of limited emergency care resources and whether it has resulted in more or less appropriate use of scarce inpatient beds.

This increasing use of EDs for inpatient admissions has important implications for the redesign of delivery systems. The need for more efficient use of inpatient resources is a clear focus of the Affordable Care Act (ACA), and the increased role of EDs in inpatient admissions will affect the implementation of central ACA principles, such as quality measurement, care coordination, and payment reform. Yet policymakers seem to view EDs as little more than a locus of inefficient or unnecessary care — the place where patients without access or insurance seek care at great expense to taxpayers. This popular view fails to address the ED's increasingly important role in hospital admissions, and it is not supported by the data.⁵

EDs' growing role in hospital admissions is a clue to their critical role in the health care system. Rigorous research to identify drivers of this trend and determine the value or cost of emergency care is needed to inform health policy. For example, comparative effectiveness studies on admission from the ED versus direct admission can evaluate whether early access to diagnostic and therapeutic services improves outcomes while shortening lengths of stay. Similarly, studies of conditions that are ideally evaluated in the ED, such as chest pain, must demonstrate the ability of evidence-based rapid diagnostic pathways to safely stratify patients according to risk level and reduce admissions rates.

Should we return to having primary care providers initiate and direct hospital admissions? Because of the increasingly specialized nature of patient care, our systems have evolved into separate arenas of hospital-based and ambulatory care provided by clinicians with different types of training. As reimbursement models shift from providing incentives for admissions as a hospital's revenue source to providing incentives for reducing admissions, EDs will probably reduce their use of hospital admission. Yet the ACA's expansion of insurance coverage, the reality of an aging population with complex conditions, and the expectation of timely, specialized, and coordinated

care mean that the trend toward increasing percentages of ED admissions is unlikely to be reversed. New models of acute care delivery aiming to improve the use of scarce intensive, hospital-based services should take into account this change in patient and provider expectations.

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Medicare and Medicaid Spending Trends and the Deficit Debate

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Historically, U.S. health care spending has grown at rates exceeding the economy's growth rate, often by at least 2 percent-

age points per year. It has therefore grown as a share of the gross domestic product (GDP), and proposals for reducing spend-

ing growth in Medicare and Medicaid have become prominent parts of the debate over the federal deficit. A commonly cited

goal of such proposals is to reduce the spending growth rate to roughly the GDP growth rate.

The National Commission on Fiscal Responsibility and Reform (the Bowles–Simpson Commission), House Budget Committee chair Paul Ryan (R-WI), and others have outlined proposals that would substantially cut spending in both programs. Some advocate making modest changes to the existing programs, whereas others, arguing that the programs are fundamentally flawed, call for major restructuring. Are these structural changes, such as premium support in Medicare or block grants in Medicaid, really necessary to create sustainable spending growth?

Evidence from the past decade shows that increases in enrollment have contributed greatly to spending growth, and forecasts for the next decade suggest that this trend will continue. Over the past decade, spending growth per enrollee slowed in Medicare and Medicaid, and per-enrollee growth rates in the next decade are projected to be very close to the expected growth in GDP per capita. These data do not support the need for major restructuring of either program.¹

In the past decade, health care expenditures grew about 3 percentage points faster than the GDP. Expenditure growth was quite high early in the decade but slowed considerably by the end. Because GDP growth also slowed during the Great Recession, health care spending growth remained well above GDP growth, but that doesn't diminish the importance of the marked slowdown in spending growth. Between 2000 and 2005, Medicare spending per enrollee grew about 7.2% annually, as compared with 9.1% growth

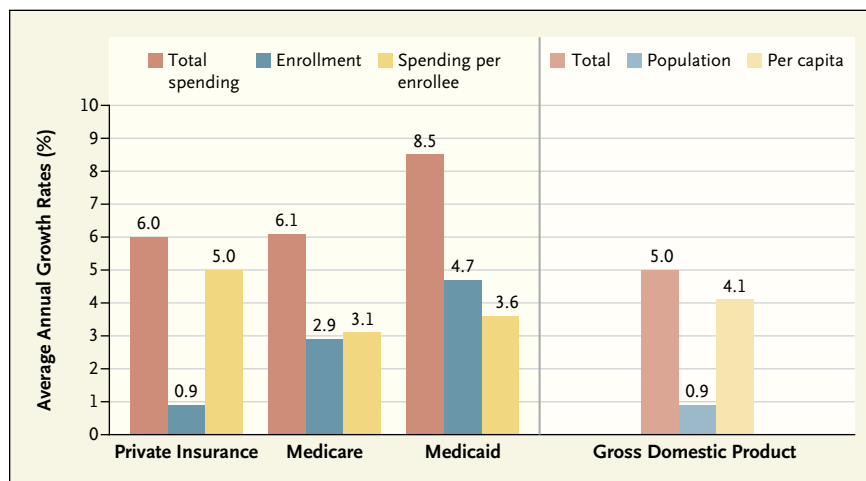
among private payers. Between 2006 and 2010, however, growth in Medicare spending per enrollee slowed to 4.2% annually, as compared with 4.5% among private payers. After large increases in enrollment due to two recessions and the increasing numbers of Americans with disabilities are accounted for, growth of Medicaid spending per enrollee was relatively slow (less than 3% per year) throughout the past decade, owing to both enrollment of a less-expensive population because of the recession and, more important, the fact that states with decreasing revenues and competing priorities were aggressively containing costs.

The reasons for the more general slowdown in health care spending, however, are poorly understood. The recession beginning in 2007 contributed, with job losses and income reductions leading to losses of insurance coverage. But spending growth began to slow as early as 2004, so the recession alone cannot explain the trend. A shift toward plans with higher deductibles might explain some of the slowdown in private spending, but Medicare spending also slowed, with no changes to its cost-sharing structure. Thus, other structural changes probably contributed. These may include lower growth rates for prescription-drug spending given the development of fewer blockbuster drugs, the adoption of tiered formularies, the increased substitution of generics for brand-name drugs, and measures taken to reduce hospital spending. We may also be seeing early effects of changes in the delivery system such as tiered-network insurance products and increases in clinical integration and the number of salaried physicians.

Despite the incomplete understanding of the slowdown's causes, the Centers for Medicare and Medicaid Services (CMS) projects that health care expenditures will continue to grow relatively slowly over the next decade — about 1 percentage point faster than the GDP.² This forecast seems to reflect the aforementioned factors plus cost-containment provisions in the Affordable Care Act (ACA).

CMS projections for growth in private and public spending between 2012 and 2021 are shown in the graph. (Congressional Budget Office [CBO] projections are similar.) Private health insurance expenditures and Medicare expenditures are projected to grow at similar rates, about 6.0% per year — but for different reasons. Medicare enrollment will grow much faster than enrollment in private coverage, as Baby Boomers age into Medicare. Private health insurance spending per enrollee is projected to increase by 5.0% per year, about 1 percentage point faster than the GDP per capita. In contrast, Medicare expenditures per enrollee are expected to increase by 3.1% per year, largely because of ACA-mandated cuts in provider payments. This growth rate will be slightly higher if scheduled physician-fee cuts are eliminated as usual. If fees are increased with inflation, the per-enrollee growth rate could reach 3.8% per year, whereas freezing fees or including spending offsets would result in smaller increases.

Simultaneously, overall Medicaid expenditures are projected to grow at 8.5% per year, driven largely by growth in enrollment because of increasing numbers of low-income people and the ACA coverage expansion. If many states opt out of the Medicaid expansion, as permitted by the recent Supreme Court ruling, total



Health Care Spending and Economic Growth, 2012–2021.

Data are from the Centers for Medicare and Medicaid Services, Office of the Actuary. Medicare spending projections will be slightly higher without the physician-fee cut included in current law.

Medicaid spending growth will be lower. On a per-enrollee basis, the increase in Medicaid is expected to be 3.6% per year — somewhat lower than the projected increase in GDP per capita.

With the per-enrollee spending growth in Medicare and Medicaid less than that in private insurance and close to the growth in GDP per capita, it's hard to argue that spending on either program, on a per-enrollee basis, is "out of control." Rather, per-enrollee growth in both programs is near the target often advocated in debt-reduction proposals. Total spending growth, which also includes growth in enrollment, is faster than the economy's growth. But policies that are appropriate when the problem is per-capita spending growth differ from those that make sense when enrollment growth is such an important cost driver. Policy options such as premium support and block grants that entail indexing growth rates to some measure of economic growth will have a hard time achieving lower per-enrollee spending growth than is currently projected. CBO estimates suggest that both approaches may

achieve savings for the federal government, but such savings shift Medicare costs onto existing enrollees and, in the case of Medicaid, onto the states as well.³

Some argue that the low growth rate of Medicare spending is unsustainable, particularly for hospitals. Medicare spending on hospital care per enrollee is projected to increase by 3.2% per year. The concern, however, is that hospital costs will grow faster than Medicare payments, and the hospitals will have to increase private charges to compensate. But mounting evidence suggests that such cost shifting is possible only for hospitals with substantial market power; others face constraints on private revenue growth and respond by containing costs.⁴

None of this means that we cannot do better in controlling health care costs. There have been many proposals for restraining Medicare spending within the current structure, including increasing Part B and Part D premiums, reforming the Medigap benefit, increasing the Medicare eligibility age, expanding efforts to reduce fraud, reducing payments for pre-

scription drugs for Americans eligible for both Medicare and Medicaid, and increasing the emphasis on managing the care of the chronically ill.⁵

Achieving savings in Medicaid is harder because states have already adopted aggressive cost-containment policies. States currently have all the major tools that would be available with a block grant — such as control over provider-payment rates, managed-care contracting, and drug-pricing and utilization policies — as well as strong financial incentives to control costs, largely because they face competing priorities that are more politically popular. A block grant is therefore likely to stick states with higher costs, forcing them to reduce coverage.

Rather than pursuing major restructuring of either program, then, we should continue adopting available strategies to contain costs within the programs' current structure, especially since many of those implemented in the past decade seem to be working, and many on the horizon appear promising.

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