projected spending growth make them likely targets for plans to reduce the federal deficit. The question is whether health care providers or Medicare and Medicaid beneficiaries will bear the brunt of spending cuts. Tax policy will also have a vital impact, since both programs will require additional revenues to absorb growing populations and finance rising medical costs. Meanwhile, the search for stronger cost control and improved quality will continue.

The most crucial issue, though, is what happens to the ACA after the 2012 elections. Barack Obama's reelection would ensure that the ACA moves forward, albeit with continued conflicts over its implementation at both the state and federal levels. If Mitt Romney wins the presidency, however, and Republicans secure majorities in the House and Senate, major provisions of the law could be overturned.

The ACA will not remedy all that ails U.S. medical care. Much can be done to strengthen its coverage and cost-containment foundations. But the ACA will dramatically improve the health care circumstances of tens of millions of Americans, making coverage more accessible and affordable for uninsured Americans and more secure for those who are insured. After a century of struggle, the ACA's enactment provides strong grounds for optimism about the future of the American health care system. Yet with implementation of the ACA uncertain, U.S. health policy stands at a crossroads: will we continue down the path of reform or move backward?

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the University of North Carolina at Chapel Hill.

1. Starr P. The social transformation of American medicine. New York: Basic Books, 1982.
2. Blumenthal D, Morone JA. The heart of power: health and politics in the Oval Office. Berkeley: University of California Press, 2009.
3. Committee on Energy and Commerce, Subcommittee on Oversights and Investigations, U.S. House of Representatives. Terminations of individual health insurance policies by insurance companies. June 16, 2009 (http://democrats.energycommerce.house.gov/index.php?q=hearing/terminations-of-individual-health-policies-by-insurance-companies).
4. McDonough JE. Inside national health reform. Berkeley: University of California Press, 2011.
5. Altman S, Shactman D. Power, politics, and universal health care: the inside story of a century-long battle. Amherst, NY: Prometheus Books, 2011.
6. Marmor T, Oberlander J. From HMOs to ACOs: the quest for the holy grail in U.S. health policy. J Gen Intern Med 2012 March 13 (Epub ahead of print).

DOI: 10.1056/NEJMp1202111

When the Cost Curve Bent — Pre-Recession Moderation in Health Care Spending

Charles Roehrig, Ph.D., Ani Turner, B.A., Paul Hughes-Cromwick, M.A., and George Miller, Ph.D.

Commentators have noted recent moderation in the rate of growth of U.S. health care spending — a bend in the cost curve.[1] A critical question is whether the low growth rate is likely to continue — an issue with enormous implications for the country's fiscal future. If the slowdown resulted from the recession, the rate is likely to increase as we return to full employment; if not, it may provide a respite from the problems created by spending inflation.

Our analysis of monthly data on health care spending shows that the moderation in growth began well before the recession and has continued through May 2012. Spending estimates are based on monthly data from the Bureau of Economic Analysis (BEA), transformed for consistency with the official annual figures from the National Health Expenditure Accounts (NHEA). Since the NHEA runs through 2010, our monthly estimates for 2011 and 2012 are based on BEA data, adjusted according to the historical relationship between BEA and NHEA figures (see the Supplementary Appendix, available with the full text of this article at NEJM.org).[2]

Economists and policymakers often compare the growth of health care spending to that of the overall economy, as measured by the gross domestic product (GDP). However, this comparison can give a false sense of "excess" health care spending growth during economic recessions and recoveries. Although this growth-rate differential surges during recessions, the surge signals abnormally low GDP growth rather

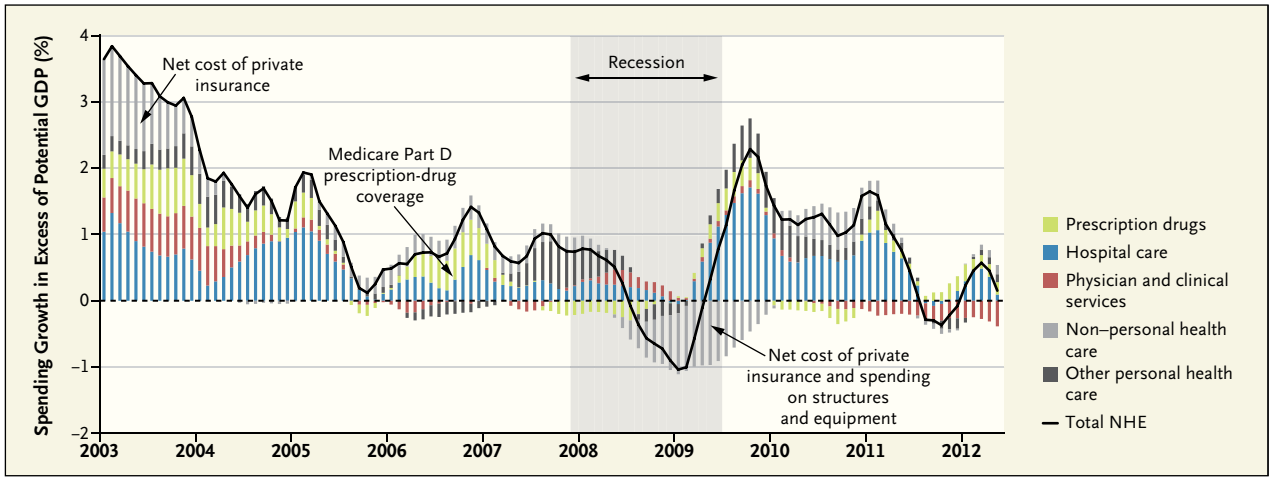

Figure 1. Growth of National Health Expenditure (NHE) in Excess of Potential Gross Domestic Product (GDP), with Component Effects.

The net cost of private insurance (a major contributor to increased excess spending in 2003 and reduced excess spending in 2008 and 2009) is premium revenues minus health care payments, whereas spending on structures and equipment represents investments in health care delivery systems. Medicare Part D, implemented in 2006, introduced prescription-drug coverage for the first time to Medicare beneficiaries and was a major cause of increased excess spending. Spending estimates are from Altarum Health Sector Economic Indicators. Estimates of potential GDP are from the Congressional Budget Office. Growth rates for each month are computed relative to the same month a year earlier, smoothed by means of a 3-month moving average.

than high health care spending growth. During recoveries, when the GDP accelerates as we advance toward full employment, excess health care spending may appear to fall. To smooth these misleading cyclical effects, we define "excess" health care spending growth as the gap between the growth in such spending and that of potential GDP, or full-employment GDP.[3] The growth in potential GDP, calculated by the Congressional Budget Office, captures the long-term trend in GDP driven by labor-force growth and trends in labor productivity.

The solid line in Figure 1 shows excess health care spending growth from January 2003 through May 2012. The bars show the contribution of each of five comprehensive categories of health care spending: hospital care, physician and clinical services, prescription drugs, other personal health care, and non–personal health care (which includes the cost of administering government health insurance programs; the net cost of private insurance; and spending on public health, noncommercial research, and structures and equipment).

Excess growth decreased from more than 3% during 2003 to less than 1% starting in July 2005 and continuing, for the most part, until near the end of the recession in June 2009. Excess growth exceeded 1% during the post-recession period, until May 2011, when it again dropped below 1%, going negative during the latter part of that year. If we use 1% as a threshold to denote moderation in excess health care spending, these data show that July 2005 marked the onset of moderation. Although the level of excess spending was above 1% for a few months in 2006, that was the year in which Medicare Part D prescription-drug coverage began and prescription-drug spending was a major driver of excess spending. Without Part D spending, excess growth would have been 1% or less throughout the pre-recession period starting in July 2005.

"Non–personal health care" contributed greatly to increased excess spending in 2003 and to reduced excess spending in 2008 and 2009. Although each component of this category represents a relatively small share of overall spending, some of these components are quite volatile and therefore capable of noticeably affecting excess-growth estimates. The most important factor in 2003 was the net cost of private insurance (roughly the difference between premium revenues and payments to health care providers), which rose sharply. In 2008 and 2009, that net cost dropped sharply, which, combined with reduced spending on structures and equipment, drove down overall excess spending.

In a further analysis (see Fig. 2), we eliminated the volatility associated with these factors by focusing strictly on personal health

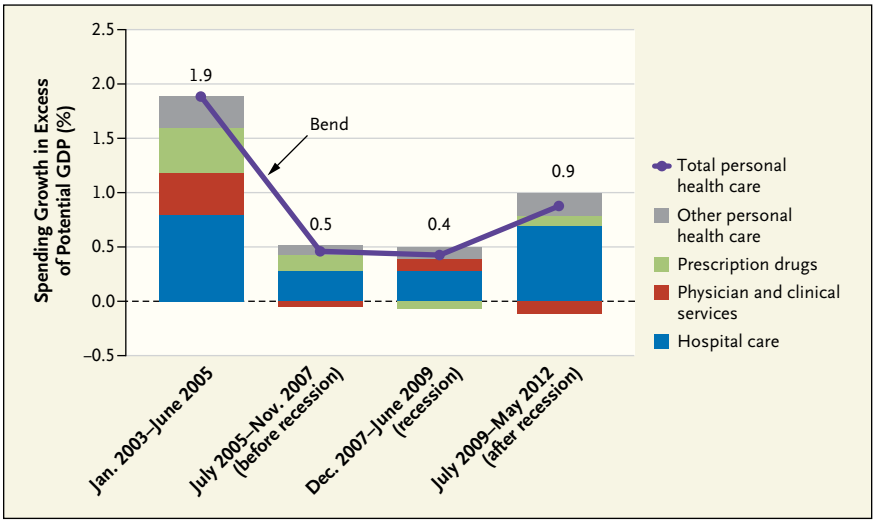

Figure 2. Average Growth of Personal Health Care Spending in Excess of Potential GDP, with Component Effects for Selected Periods.

care spending. We grouped the data into four periods according to the timing of the recession and our conclusion that spending moderation began in July 2005. From January 2003 through June 2005, all categories grew faster than potential GDP, and excess growth in health care spending averaged 1.9%. From July 2005 through November 2007, excess growth averaged 0.5%, with spending on physician services actually growing more slowly than potential GDP. During the recession, there was 0.4% excess growth, with prescription-drug spending growing more slowly than potential GDP. In the post-recession period, excess growth has averaged 0.9%, but it accelerated initially, driven primarily by hospital spending, and then sharply declined, bringing current levels close to zero. Spending for physician services has grown more slowly than potential GDP since mid-2010, contributing to the slowdown.

Our analysis shows that cost moderation predated the recession by about 2.5 years, so the bend in the curve cannot be attributed solely to the economy. In fact, there was lower excess spending before the recession than after it (though this pattern emerges only when the low economy-wide inflation rates — and hence lower potential-GDP growth rates — in 2009 and 2010 are taken into account). The post-recession uptick doesn't change our conclusion, because excess growth has dropped below 1% during the most recent 10 months. Thus, the bend in the spending-growth curve began in mid-2005, continued through the recession, and seems to be holding.

Analysts have begun to speculate about the slowdown's causes, but more research is needed to disentangle cyclical factors (e.g., elevated unemployment rates and increases in the uninsured population) from structural factors (e.g., changing physician practice and employment patterns; payment-rate pressure; increases in consumer-driven health care and patient cost sharing; new care models; and slowing drug spending due to patent expiration, use of generics, and a reduced number of new blockbuster agents).[4] Given the data presented above, one could argue that the poor economy had nothing to do with slower growth in excess personal health care spending. We do not adhere to that extreme view but do put more weight on structural factors.

Spending for physician and clinical services has grown particularly slowly since the curve bent in 2005. In the pre-recession period, we trace this slowdown to slow growth in physician-payment rates relative to overall prices in the economy. In the post-recession period, payment-rate increases have remained low and the growth in the utilization of physician services has diminished. Although many observers expect utilization to bounce back once the recovery becomes more robust, new payment methods discouraging high levels of utilization are also spreading. Of course, utilization will increase in 2014, when millions of uninsured Americans gain coverage under the Affordable Care Act (ACA).

Will the low spending-growth rates continue, or will spending accelerate, as it did after the managed-care era? Some increase in growth over the next few years is possible, but we expect that excess growth will remain, on average, significantly below 1% (excluding a one-time jump associated with the ACA coverage expansion). A repeat of the rapid growth seen at the end of the 1990s seems unlikely, thanks to ongoing structural changes in the health care system and our vastly

different fiscal situation: the federal budget surplus in the late 1990s reduced the pressure on the government to constrain health care spending; no such surplus is on the horizon today. Moreover, in an era of increased price transparency, the private sector is not likely to ratify substantial cost shifting.

If lower growth rates continue, are they low enough? Since much health care is publicly funded, the answer depends on what we're willing to pay in taxes and what we spend on items not related to health care.[5] It must also proceed from a clear notion of what Americans consider acceptable levels of access to and quality of care.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Center for Sustainable Health Spending, Altarum Institute, Ann Arbor, MI.

This article was published on August 8, 2012, at NEJM.org.

1. Lowrey A. In hopeful sign, health spending is flattening out. New York Times. April 29, 2012:A1.
2. Altarum Institute. Health sector economic indicators spending brief. June 7, 2012 (#12-06) (http://www.altarum.org/files/imce/CSHS-Spending-Brief_June%202012_060612.pdf).
3. Roehrig C. The case for tracking health spending as a share of "potential" GDP. Altarum Institute Health Policy Forum Blog. May 11, 2011 (http://healthpolicyforum.org/post/case-tracking-health-spending-share-potential-gdp).
4. Kaufman K. Bending the health care cost curve: more than meets the eye? Health Affairs Blog. April 13, 2012 (http://healthaffairs.org/blog/2012/04/13/bending-the-health-care-cost-curve-more-than-meets-the-eye/?goback=.gde_1878748_member_107737725).
5. Roehrig C. Is health spending growth of "GDP+0" sustainable? Altarum Health Policy Forum Blog. June 7, 2012 (http://healthpolicyforum.org/post/health-spending-growth-gdp0-sustainable).

DOI: 10.1056/NEJMp1205958