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National Health Care Spending In 2018: Growth Driven By Accelerations In Medicare And Private Insurance Spending

ABSTRACT US health care spending increased 4.6 percent to reach $3.6 trillion in 2018, a faster growth rate than the rate of 4.2 percent in 2017 but the same rate as in 2016. The share of the economy devoted to health care spending declined to 17.7 percent in 2018, compared to 17.9 percent in 2017. The 0.4-percentage-point acceleration in overall growth in 2018 was driven by faster growth in both private health insurance and Medicare, which were influenced by the reinstatement of the health insurance tax. For personal health care spending (which accounted for 84 percent of national health care spending), growth in 2018 remained unchanged from 2017 at 4.1 percent. The total number of uninsured people increased by 1.0 million for the second year in a row, to reach 30.7 million in 2018.

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Total health care spending in the United States increased 4.6 percent to reach $3.6 trillion in 2018, or $11,172 per person—a faster growth rate than the rate of 4.2 percent in 2017 and equal to the rate in 2016 (exhibit 1).[1] Just as growth was relatively stable over this period, so too was the share of the economy devoted to health care as measured by gross domestic product (GDP), which was 17.9 percent in 2016–17 and 17.7 percent in 2018.

Much of the faster spending growth in 2018 was associated not with expenditures for goods and services but instead with the net cost of health insurance (the amount of insurance spending attributed to nonmedical expenses, including administration, taxes, and underwriting gains or losses). The net cost of health insurance grew more rapidly in 2018, increasing 13.2 percent after growing 4.3 percent in 2017.[2] The faster growth in 2018 was driven primarily by the health insurance tax, a fee that was reinstated in 2018 following a one-year moratorium in 2017.[3,4] This fee was imposed on all health insurance providers beginning in 2014 as part of the funding for the Affordable Care Act (ACA). The Consolidated Appropriations Act of 2016 instituted a one-year moratorium on it for 2017.

The growth rate for total personal health care spending (expenditures for health care goods and services) was the same in 2017 and 2018 (4.1 percent) (exhibit 2). That spending accounted for 84 percent of total national health expenditures in 2018. Its stable growth of 4.1 percent in 2018 reflected mixed trends in the three largest goods and services categories: hospital care, physician and clinical services, and retail prescription drugs. Together, spending for these categories accounted for 73 percent of total personal health care expenditures. Hospital spending growth was similar in 2017 and 2018, at 4.7 percent and 4.5 percent, respectively. For physician and clinical services, spending growth slowed from 4.7 percent in 2017 to 4.1 percent in 2018, while growth in retail prescription drug spending increased from 1.4 percent in 2017 to 2.5 percent in 2018.

EXHIBIT 1

National health expenditures (NHE), aggregate and per capita amounts, share of gross domestic product (GDP), and annual growth, by source of funds, calendar years 2012–18

Source of funds	2012[a]	2013	2014	2015	2016	2017	2018
EXPENDITURE AMOUNT							
NHE, billions	$2,791.1	$2,875.0	$3,025.4	$3,199.6	$3,347.4	$3,487.3	$3,649.4
Health consumption expenditures	2,637.7	2,720.9	2,875.6	3,045.5	3,190.7	3,319.0	3,475.0
Out of pocket	319.2	326.9	331.8	341.7	357.2	365.2	375.6
Health insurance	2,015.8	2,079.2	2,223.0	2,373.4	2,487.5	2,592.3	2,729.0
Private health insurance	922.0	939.1	994.1	1,060.9	1,119.9	1,175.0	1,243.0
Medicare	568.5	588.9	618.5	648.8	676.8	705.1	750.2
Medicaid	422.9	445.2	497.8	542.6	565.4	580.1	597.4
Federal	243.4	256.9	305.7	342.6	358.1	359.3	370.9
State and local	179.5	188.4	192.1	200.1	207.2	220.8	226.5
Other health insurance programs[b]	102.4	105.9	112.6	121.1	125.4	132.1	138.3
Other third-party payers and programs and public health activity	302.7	314.9	320.8	330.4	346.0	361.5	370.5
Investment	153.3	154.1	149.8	154.1	156.7	168.3	174.4
Population (millions)[c]	313.3	315.5	317.9	320.1	322.5	324.6	326.6
GDP, billions of dollars	$16,197.0	$16,784.9	$17,527.3	$18,224.8	$18,715.0	$19,519.4	$20,580.2
NHE per capita	$8,908	$9,113	$9,518	$9,995	$10,379	$10,742	$11,172
GDP per capita	$51,695	$53,200	$55,143	$56,932	$58,025	$60,128	$63,004
Prices (2012 = 100.0)							
Chain-weighted NHE deflator	100.0	101.3	103.0	103.9	105.2	106.6	108.8
GDP price index	100.0	101.8	103.6	104.7	105.8	107.8	110.4
Real spending							
NHE, billions of chained dollars	$2,791	$2,839	$2,937	$3,081	$3,182	$3,272	$3,354
GDP, billions of chained dollars	$16,197	$16,495	$16,912	$17,404	$17,689	$18,108	$18,638
NHE as percent of GDP	17.2	17.1	17.3	17.6	17.9	17.9	17.7
ANNUAL GROWTH							
NHE	4.0%	3.0%	5.2%	5.8%	4.6%	4.2%	4.6%
Health consumption expenditures	4.1	3.2	5.7	5.9	4.8	4.0	4.7
Out of pocket	2.8	2.4	1.5	3.0	4.5	2.2	2.8
Health insurance	3.8	3.1	6.9	6.8	4.8	4.2	5.3
Private health insurance	3.5	1.9	5.9	6.7	5.6	4.9	5.8
Medicare	4.3	3.6	5.0	4.9	4.3	4.2	6.4
Medicaid	4.0	5.3	11.8	9.0	4.2	2.6	3.0
Federal	–1.6	5.5	19.0	12.1	4.5	0.3	3.2
State and local	12.6	4.9	2.0	4.2	3.6	6.5	2.6
Other health insurance programs[b]	2.3	3.5	6.3	7.5	3.6	5.3	4.7
Other third-party payers and programs and public health activity	7.8	4.0	1.9	3.0	4.7	4.5	2.5
Investment	2.8	0.5	–2.8	2.9	1.7	7.4	3.6
Population[c]	0.7	0.7	0.7	0.7	0.8	0.7	0.6
GDP, billions of dollars	4.2	3.6	4.4	4.0	2.7	4.3	5.4
NHE per capita	3.3	2.3	4.5	5.0	3.8	3.5	4.0
GDP per capita	3.4	2.9	3.7	3.2	1.9	3.6	4.8
Prices (2012 = 100.0)							
Chain-weighted NHE deflator	1.7	1.3	1.7	0.8	1.3	1.3	2.1
GDP price index	1.9	1.8	1.8	1.0	1.0	1.9	2.4
Real spending							
NHE, billions of chained dollars	2.3	1.7	3.5	4.9	3.3	2.8	2.5
GDP, billions of chained dollars	2.2	1.8	2.5	2.9	1.6	2.4	2.9

SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and Census Bureau. **NOTES** Definitions, sources, and methods for NHE categories can be found in Centers for Medicare and Medicaid Services. National Health Expenditure Accounts: methodology paper (see note 20 in text). Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2011–12. [b]Includes health-related spending for Children's Health Insurance Program (CHIP) Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs. [c]Estimates reflect the Census Bureau's definition of resident-based population, which includes all people who usually reside in the fifty states or the District of Columbia but excludes residents living in Puerto Rico and areas under US sovereignty, members of the US Armed Forces overseas, and US citizens whose usual place of residence is outside of the US. Estimates also include a small (typically less than 0.2 percent of the population) adjustment to reflect census undercounts.

EXHIBIT 2

National health expenditures (NHE) amounts and annual growth, by spending category, calendar years 2012–18

Spending category	2012[a]	2013	2014	2015	2016	2017	2018
EXPENDITURE AMOUNT							
NHE, billions	$2,791.1	$2,875.0	$3,025.4	$3,199.6	$3,347.4	$3,487.3	$3,649.4
Health consumption expenditures	2,637.7	2,720.9	2,875.6	3,045.5	3,190.7	3,319.0	3,475.0
Personal health care	2,361.1	2,431.2	2,556.0	2,710.2	2,838.3	2,954.5	3,075.5
Hospital care	902.5	937.6	978.2	1,034.6	1,089.5	1,140.6	1,191.8
Professional services	743.2	759.6	792.5	837.9	883.2	924.0	965.1
Physician and clinical services	557.1	569.6	595.7	631.2	665.6	696.9	725.6
Other professional services	76.4	78.7	83.0	87.8	92.7	97.5	103.9
Dental services	109.7	111.2	113.8	118.8	124.9	129.6	135.6
Other health, residential, and personal care	139.1	144.3	151.5	164.5	173.6	183.2	191.6
Home health care	78.3	81.4	84.8	89.2	93.0	97.1	102.2
Nursing care facilities and continuing care retirement communities	147.4	149.0	152.4	158.1	163.0	166.2	168.5
Retail outlet sales of medical products	350.6	359.3	396.6	425.9	436.0	443.2	456.3
Prescription drugs	253.0	258.2	292.4	317.1	322.3	326.8	335.0
Durable medical equipment	43.7	45.1	46.7	48.6	51.0	52.4	54.9
Other nondurable medical products	53.9	56.0	57.5	60.2	62.7	64.1	66.4
Government administration	34.2	37.5	42.3	42.8	44.9	44.8	47.5
Net cost of health insurance	165.2	173.3	195.3	206.7	218.8	228.3	258.5
Government public health activities	77.2	79.0	82.0	85.8	88.7	91.4	93.5
Investment	153.3	154.1	149.8	154.1	156.7	168.3	174.4
Noncommercial research	48.4	46.7	46.0	46.4	47.4	50.1	52.6
Structures and equipment	105.0	107.5	103.7	107.7	109.3	118.2	121.8
ANNUAL GROWTH							
NHE	4.0%	3.0%	5.2%	5.8%	4.6%	4.2%	4.6%
Health consumption expenditures	4.1	3.2	5.7	5.9	4.8	4.0	4.7
Personal health care	4.1	3.0	5.1	6.0	4.7	4.1	4.1
Hospital care	6.0	3.9	4.3	5.8	5.3	4.7	4.5
Professional services	3.7	2.2	4.3	5.7	5.4	4.6	4.4
Physician and clinical services	4.0	2.2	4.6	6.0	5.4	4.7	4.1
Other professional services	5.0	3.0	5.4	5.9	5.5	5.2	6.5
Dental services	1.6	1.4	2.3	4.4	5.1	3.8	4.6
Other health, residential, and personal care	5.6	3.7	5.0	8.6	5.5	5.5	4.6
Home health care	4.9	3.9	4.2	5.3	4.2	4.5	5.2
Nursing care facilities and continuing care retirement communities	1.4	1.1	2.3	3.8	3.1	2.0	1.4
Retail outlet sales of medical products	1.0	2.5	10.4	7.4	2.4	1.7	2.9
Prescription drugs	0.4	2.1	13.3	8.4	1.7	1.4	2.5
Durable medical equipment	3.4	3.2	3.6	4.1	4.9	2.9	4.7
Other nondurable medical products	2.0	3.9	2.7	4.7	4.1	2.2	3.6
Government administration	3.9	9.6	12.8	1.2	5.0	–0.2	6.0
Net cost of health insurance	4.0	4.9	12.7	5.8	5.9	4.3	13.2
Government public health activities	3.7	2.3	3.8	4.6	3.4	3.0	2.4
Investment	2.8	0.5	–2.8	2.9	1.7	7.4	3.6
Noncommercial research	–2.4	–3.5	–1.4	0.8	2.1	5.7	5.0
Structures and equipment	5.4	2.4	–3.5	3.8	1.5	8.1	3.0

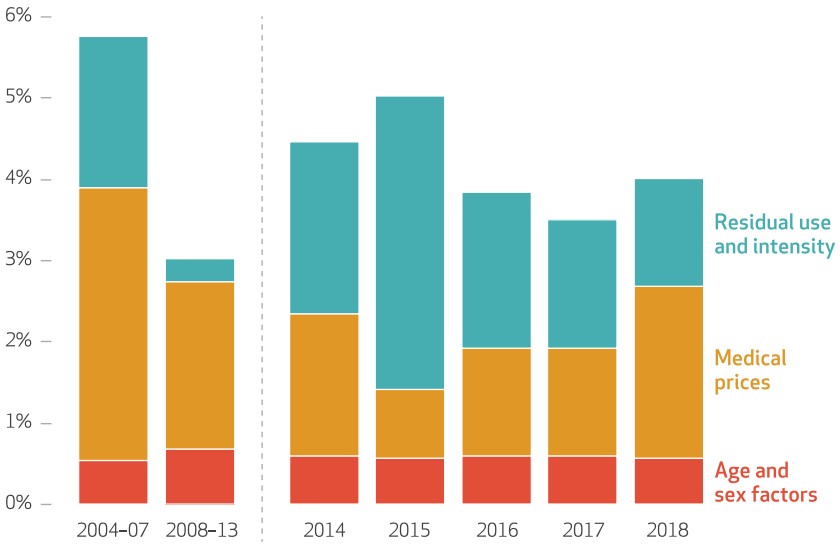
SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in Centers for Medicare and Medicaid Services. National Health Expenditure Accounts: methodology paper (see note 20 in text). Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2011–12.

Factors Accounting For Growth

Exhibit 3 breaks down growth in per capita national health care spending into the factors that account for such growth: the use and intensity of services, medical prices (which reflect both economywide and excess medical-specific inflation), and the changing age and sex composition of the population. Growth in per capita spending accelerated in 2018 to 4.0 percent, following a rate of 3.5 percent in 2017, as faster growth in medical prices more than offset slower growth in the use and intensity of health care goods and services. In 2018 medical price growth accounted for 2.1 percentage points of the 4.0 percent growth in per capita spending (a 53 percent share), while growth in the residual use and intensity of health

EXHIBIT 3

Factors accounting for growth in per capita national health expenditures (NHE), selected calendar years 2004–18



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Medical price growth, which includes economywide and excess medical-specific price growth (or changes in medical-specific prices in excess of economywide inflation), is calculated using the chain-weighted NHE price deflator. "Residual use and intensity" is calculated by removing the effects of population, age and sex factors, and price growth from the nominal expenditure level.

care goods and services accounted for 1.3 percentage points (a 33 percent share), and the changing age and sex mix of the population accounted for 0.6 percentage points (a 14 percent share).

Medical price growth of 2.1 percent in 2018 was faster than the rate of 1.3 percent in 2017, in part because of faster growth in economywide inflation (as measured by the GDP price index)—which increased 2.4 percent in 2018 compared to 1.9 percent in 2017 (exhibit 1). Additionally, excess medical-specific price inflation beyond economywide price inflation declined less in 2018 (−0.3 percent) than in 2017 (−0.6 percent), as faster growth in the net cost of insurance offset some of the negative excess price inflation associated with retail prescription drugs and physician and clinical services (data not shown). Although overall medical price growth in 2018 was the most rapid since 2011, the 2018 growth rate of 2.1 percent was below the average annual rate of 3.4 percent during 2004–07, but the same as the average rate of growth during 2008–13 (exhibit 3).

Residual use and intensity, which reflects changes in the use and mix of health care goods and services, grew 1.3 percent in 2018, slower than the rate of 1.6 percent in 2017.[5] The services that experienced slower growth in the use and intensity of services in 2018 included hospital care, physician and clinical services, dental services, home health care, and nursing care facilities and continuing care retirement communities. In 2018 the number of uninsured people grew by 1.0 million for the second year in a row to reach 30.7 million (exhibit 4). The increase in the number of uninsured people may have contributed to the slowdown in growth in the residual use and intensity of services, as people without health insurance may use fewer services.[6]

Sponsors Of Health Care

In 2018 the federal government and households accounted for the largest shares of health care spending (28 percent each), followed by private businesses (20 percent), state and local governments (17 percent), and other private revenues (7 percent) (exhibit 5). Faster overall spending growth was due to spending from the federal government and private businesses, which experienced faster growth in 2018—more than offsetting slower spending growth for state and local governments and other private revenues.

For the federal government, spending growth on health care accelerated in 2018 to 5.6 percent, compared to a rate of 2.8 percent in 2017. The acceleration in 2018 was driven mainly by faster growth in the federally sponsored portion of expenditures for the Medicare program (a 32 percent share), which increased 6.5 percent in 2018 compared to 1.3 percent in 2017 (data not shown). Furthermore, growth in spending on the federal portion of Medicaid payments (a 36 percent share) accelerated to 3.2 percent in 2018 after growth of 0.3 percent in 2017—the first year that states were required to fund 5 percent of the spending for the Medicaid expansion population (exhibit 1). In the years before 2017, these costs were funded entirely by the federal government.

For state and local governments, spending on health care grew more slowly in 2018, increasing 2.5 percent after a rate of 3.6 percent in 2017 (exhibit 5). The deceleration in 2018 was driven by slower growth in state and local Medicaid spending (which represented 38 percent of total health spending for state and local governments). State and local Medicaid spending grew 2.6 percent in 2018 after growing 6.5 percent in 2017—again reflecting the increased state funding responsibility for the expansion population discussed above (exhibit 1).

Household health care spending includes out-of-pocket spending, contributions to private health insurance premiums, and contributions to Medicare through payroll taxes and the payment of premiums. In 2018 health care spending by households grew 4.4 percent—the same rate

EXHIBIT 4

National health expenditures (NHE) and health insurance enrollment, aggregate and per enrollee amounts, and annual growth, by source of funds, calendar years 2012–18

	2012[a]	2013	2014	2015	2016	2017	2018
PRIVATE HEALTH INSURANCE							
Expenditure (billions)	$922.0	$939.1	$994.1	$1,060.9	$1,119.9	$1,175.0	$1,243.0
Expenditure growth	3.5%	1.9%	5.9%	6.7%	5.6%	4.9%	5.8%
Per enrollee expenditure	$4,825	$4,916	$5,106	$5,296	$5,550	$5,813	$6,199
Per enrollee expenditure growth	1.9%	1.9%	3.9%	3.7%	4.8%	4.7%	6.7%
Enrollment (millions)	191.1	191.0	194.7	200.3	201.8	202.1	200.5
Enrollment growth	1.7%	0.0%	1.9%	2.9%	0.7%	0.2%	–0.8%
MEDICARE							
Expenditure (billions)	$568.5	$588.9	$618.5	$648.8	$676.8	$705.1	$750.2
Expenditure growth	4.3%	3.6%	5.0%	4.9%	4.3%	4.2%	6.4%
Per enrollee expenditure	$11,441	$11,485	$11,704	$11,951	$12,137	$12,334	$12,784
Per enrollee expenditure growth	0.3%	0.4%	1.9%	2.1%	1.6%	1.6%	3.7%
Enrollment (millions)	49.7	51.3	52.8	54.3	55.8	57.2	58.7
Enrollment growth	4.1%	3.2%	3.1%	2.7%	2.7%	2.5%	2.6%
MEDICAID							
Expenditure (billions)	$422.9	$445.2	$497.8	$542.6	$565.4	$580.1	$597.4
Expenditure growth	4.0%	5.3%	11.8%	9.0%	4.2%	2.6%	3.0%
Per enrollee expenditure	$7,278	$7,536	$7,592	$7,835	$7,948	$8,041	$8,201
Per enrollee expenditure growth	0.6%	3.5%	0.7%	3.2%	1.4%	1.2%	2.0%
Enrollment (millions)	58.1	59.1	65.6	69.3	71.1	72.1	72.8
Enrollment growth	3.3%	1.7%	11.0%	5.6%	2.7%	1.4%	1.0%
UNINSURED AND POPULATION							
Uninsured (millions)	44.7	44.1	35.5	29.5	28.7	29.7	30.7
Uninsured growth	–1.9%	–1.4%	–19.5%	–17.0%	–2.8%	3.7%	3.1%
Population (millions)[b]	313.3	315.5	317.9	320.1	322.5	324.6	326.6
Population growth	0.7%	0.7%	0.7%	0.7%	0.8%	0.7%	0.6%
Insured share of total population	85.7%	86.0%	88.8%	90.8%	91.1%	90.8%	90.6%

SOURCES Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group; and Department of Commerce, Census Bureau. **NOTES** Definitions, sources, and methods for NHE categories can be found in Centers for Medicare and Medicaid Services. National Health Expenditure Accounts: methodology paper (see note 20 in text). Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2011–12. [b]Estimates are explained in exhibit 1 notes.

experienced in 2017 (exhibit 5). Out-of-pocket health spending (a 36 percent share) increased 2.8 percent in 2018, faster than the growth rate of 2.2 percent in 2017 (exhibit 1), whereas growth in contributions to employer-sponsored private health insurance premiums (a 27 percent share) slowed from 6.8 percent in 2017 to 3.4 percent in 2018 (data not shown).

Health care spending by private businesses increased at a faster rate in 2018 (6.2 percent) than in 2017 (4.8 percent) (exhibit 5), and the 2018 growth rate was the fastest since 2003 (data not shown) in spite of a slight drop in the number of people covered by employer-sponsored insurance (exhibit 5). Contributions by private businesses to employer-sponsored private health insurance premiums accounted for the largest share of private businesses' health spending in 2018 (77 percent), with such contributions increasing 7.2 percent in 2018, up from a rate of 5.5 percent in 2017.

Private Health Insurance

Private health insurance expenditures accounted for 34 percent of total national health care spending in 2018 and reached $1.2 trillion (exhibit 1). Spending in this category increased 5.8 percent in 2018, which was a faster rate than the 4.9 percent growth experienced in 2017. Private health insurance spending for medical goods and services grew 4.5 percent in 2018, similar to the growth rate of 4.3 percent in 2017, while the net cost of private health insurance (which represents 64 percent of the total net cost of health insurance) increased rapidly in both years—9.5 percent in 2017 and 15.3 percent in 2018 (data not shown).

The 4.5 percent growth in medical goods and services paid for by private health insurance reflected mixed trends in underlying goods and services, as spending for hospital care, retail prescription drugs, dental services, and other professional services grew more rapidly in 2018

EXHIBIT 5

National health expenditures (NHE) amounts, annual growth, and percent distribution, by type of sponsor, calendar years 2012–18

Type of sponsor	2012[a]	2013	2014	2015	2016	2017	2018
EXPENDITURE AMOUNT							
NHE, billions	$2,791.1	$2,875.0	$3,025.4	$3,199.6	$3,347.4	$3,487.3	$3,649.4
Businesses, household, and other private revenues	1,572.2	1,615.3	1,666.1	1,742.6	1,828.0	1,921.0	2,013.1
Private businesses	564.9	573.6	599.0	622.7	652.8	684.2	726.8
Household	807.7	834.4	862.5	908.1	950.5	992.5	1,035.7
Other private revenues	199.5	207.3	204.6	211.7	224.7	244.3	250.7
Governments	1,218.9	1,259.8	1,359.2	1,457.0	1,519.4	1,566.3	1,636.3
Federal government	731.3	751.9	835.1	908.1	951.9	978.5	1,033.8
State and local governments	487.6	507.9	524.2	548.9	567.5	587.8	602.5
ANNUAL GROWTH							
NHE	4.0%	3.0%	5.2%	5.8%	4.6%	4.2%	4.6%
Businesses, household, and other private revenues	5.3	2.7	3.1	4.6	4.9	5.1	4.8
Private businesses	4.5	1.5	4.4	4.0	4.8	4.8	6.2
Household	4.4	3.3	3.4	5.3	4.7	4.4	4.4
Other private revenues	11.5	3.9	–1.3	3.5	6.1	8.7	2.6
Governments	2.5	3.4	7.9	7.2	4.3	3.1	4.5
Federal government	0.2	2.8	11.1	8.7	4.8	2.8	5.6
State and local governments	6.1	4.2	3.2	4.7	3.4	3.6	2.5
PERCENT DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, household, and other private revenues	56	56	55	54	55	55	55
Private businesses	20	20	20	19	20	20	20
Household	29	29	29	28	28	28	28
Other private revenues	7	7	7	7	7	7	7
Governments	44	44	45	46	45	45	45
Federal government	26	26	28	28	28	28	28
State and local governments	17	18	17	17	17	17	17

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in Centers for Medicare and Medicaid Services. National Health Expenditure Accounts: methodology paper (see note 20 in text). Numbers might not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2011–12.

while spending growth for physician and clinical services, nursing home care, home health care, and durable medical equipment decelerated.

The net cost of private health insurance reached $164.3 billion and grew 15.3 percent in 2018, its fastest rate of increase since the 2003 increase of 20.7 percent (data not shown).[7] The faster growth in the net cost was driven in large part by the reinstatement of the health insurance tax in 2018, following a one-year moratorium in 2017.[8]

Private health insurance enrollment declined slightly (–0.8 percent) in 2018, primarily because of declines in enrollment in other directly purchased plans (non-Marketplace plans) and employer-sponsored insurance plans (exhibit 4). Enrollment in other directly purchased plans declined by 1.4 million people, as average premiums increased.[9,10] For employer-sponsored private health insurance coverage, enrollment declined 0.2 percent, as data indicate that employees took up offers of insurance at a slightly lower rate in 2018.[11] Per enrollee, spending for private health insurance was $6,199, an increase of 6.7 percent over 2017. This is the highest per enrollee spending growth rate since the 2004 growth rate of 7.5 percent but similar to the growth rate of 6.6 percent in 2009, when personal health care spending was the main driver. In 2018 the net cost of private health insurance was the significant factor behind the rapid growth (data not shown).

Medicare

Medicare spending represented 21 percent of all national health care spending in 2018 and reached $750.2 billion (exhibit 1). Total Medicare spending growth accelerated in 2018 to 6.4 percent, compared to a rate of 4.2 percent in 2017. Medicare enrollment growth was fairly steady, accelerating 0.1 percentage point to 2.6 percent (exhibit 4). Accordingly, per enrollee Medicare expenditures grew more rapidly in

2018, increasing 3.7 percent from a growth rate of 1.6 percent in 2017. The low per enrollee expenditures in 2017 reflected slow growth in Medicare private plan spending resulting from the suspension of the health insurance tax.

Medicare spending on non–personal health care, which includes government administration and the net cost of insurance for Medicare private health plans, was one of the drivers of faster growth in the program in 2018.[12] Growth in non–personal health care spending rose from a decline of 2.4 percent in 2017 to an increase of 16.0 percent in 2018, largely as a result of faster growth in the net cost of insurance as private Part C and Part D plans adjusted their premiums to reflect the expiration of the moratorium on the health insurance tax (data not shown). In addition, growth in Medicare government administrative expenditures rebounded from a decline in 2017 to positive growth in 2018, contributing to the acceleration in Medicare non–personal health care spending in 2018. The decline in Medicare administrative expenditures in 2017 was largely attributable to the impact of recoveries for excess Medicare administrative expenses that had been paid by the federal government prospectively in prior years. These recoveries more than offset government administrative costs that had been disbursed during 2017. In contrast, Medicare personal health care spending accelerated just one percentage point, from a rate of 4.7 percent in 2017 to 5.7 percent in 2018, as spending growth for most goods and services accelerated in 2018.

Fee-for-service Medicare spending accounted for 64 percent of overall Medicare spending in 2018, down slightly from a 66 percent share in 2017 as a result of slower growth in fee-for-service enrollment compared to Medicare Advantage enrollment. In 2018 spending in fee-for-service Medicare grew 3.5 percent, after a smaller increase of 1.4 percent in 2017. In both 2017 and 2018 fee-for-service Medicare enrollment remained steady at thirty-eight million people, accounting for 65 percent of total Medicare enrollment in 2018. Growth in per enrollee fee-for-service Medicare expenditures accelerated from 1.5 percent in 2017 to 3.6 percent in 2018. This faster growth was influenced by faster per enrollee expenditure growth for physician and clinical services—which was attributable, in turn, to an increase in the volume and intensity of services and an acceleration in spending growth for physician-administered drugs. Additionally, faster growth in Medicare spending for durable medical equipment resulted from an increase in the volume and mix of products consumed, following numerous years of declines associated with the implementation of competitive bidding for these products.

Medicare private health plan spending (the majority of which is associated with Medicare Advantage plans) increased 11.8 percent in 2018, faster than the rate of 9.9 percent in 2017. Enrollment in Medicare private health plans increased 7.9 percent in 2018, about the same rate as in 2017. Continued faster enrollment growth in these plans, compared to fee-for-service Medicare, increased the share of enrollment in private plans to 35 percent of total Medicare enrollment in 2018. At the same time, Medicare private health plans also continued to account for a larger portion of total Medicare spending, at 36 percent in 2018—a 6-percentage-point increase since 2014. Per enrollee spending for Medicare private health plans grew 3.6 percent, which was faster than per enrollee growth of 1.7 percent in 2017 mostly because of faster growth in the net cost of insurance for private plans that resulted from the reinstatement of the collection of the health insurance tax.

Medicaid

Medicaid spending by federal and state and local governments accounted for 16 percent of national health care spending and reached $597.4 billion in 2018 (exhibit 1). Medicaid spending increased 3.0 percent in 2018 after growing 2.6 percent in 2017. The faster growth in 2018, which was influenced by the net cost of insurance, was partly offset by a deceleration in enrollment growth and slower spending growth for Medicaid managed care goods and services.

Medicaid enrollment growth most recently peaked in 2014, when numerous states expanded eligibility to certain adults, but growth slowed each year thereafter (exhibit 4). Medicaid enrollment is estimated to have increased 1.4 percent in 2017 and 1.0 percent in 2018. The slower growth in Medicaid enrollment in 2018 was largely the result of stronger economic growth.[13] Medicaid per enrollee spending growth accelerated to 2.0 percent in 2018 from 1.2 percent in 2017, primarily because of the increased growth in the net cost of insurance—which was driven both by the decrease in recovery payments from Medicaid managed care plans to the federal government and by the health insurance tax.[14]

Medicaid hospital spending, which accounted for a third of total Medicaid spending, increased 2.0 percent in 2018 compared to 1.9 percent in 2017 (data not shown), as a slowdown in growth in Medicaid managed care payments was more than offset by faster growth in Medicaid supplemental payments to hospitals.[15] The second- and third-largest Medicaid services—other health, residential, and personal health care services

and physician and clinical services—both experienced slower spending growth in 2018, at rates of 4.9 percent (down from 6.0 percent in 2017) and 2.9 percent (down from 4.2 percent in 2017), respectively. For Medicaid other health, residential, and personal care services, the slower growth in spending in 2018 resulted partly from slower growth in nonwaiver services, such as school-based and rehabilitative services. For Medicaid physician and clinical services, the deceleration in spending growth reflected slower growth in Medicaid managed care payments for physician and clinical services as well as slower growth in fee-for-service payments to clinics.

Medicaid state and local spending grew 2.6 percent in 2018, a slower rate than the rate of 6.5 percent in 2017 (exhibit 1). The faster growth in 2017 was largely attributable to the initial requirement that states fund 5 percent of the costs for the expansion population. Federal spending grew slightly faster than state and local spending, increasing 3.2 percent in 2018 after growing only 0.3 percent in 2017. States that expanded Medicaid to eligible adults were required to fund 6 percent of the costs for this population in 2018, up one percentage point from the 5 percent rate in 2017.

Hospital Care

Hospital care spending increased at about the same rate in both 2017 and 2018 (4.7 percent and 4.5 percent, respectively) to reach $1.2 trillion in 2018, or 33 percent of total health care spending (exhibit 2). Hospital prices increased 2.4 percent in 2018 compared to 1.7 percent in 2017, while nonprice factors (such as the use and intensity of services) grew more slowly in 2018.[16] Growth in total inpatient days was slower in 2018 at 0.7 percent, after 1.7 percent growth in 2017.[17]

Hospital care was paid for largely by private health insurance, Medicare, and Medicaid, which together accounted for over three-quarters of all hospital expenditures in 2018. Spending for hospital care by private health insurance (a 40 percent share) increased at 5.9 percent, and such spending by Medicare (a 25 percent share) increased at 4.6 percent—faster than in 2017—while Medicaid hospital spending growth remained around 2 percent (data not shown). Slower growth in other private hospital revenue and out-of-pocket spending for hospital services, combined with a decline in spending from the Department of Defense, more than offset the faster growth in private health insurance and Medicare spending for hospital services in 2018.

Physician And Clinical Services

Spending for physician and clinical services increased 4.1 percent in 2018, reaching $725.6 billion or 20 percent of total health care expenditures (exhibit 2). This increase followed faster growth of 4.7 percent in 2017, and spending growth slowed for the third consecutive year. Nonprice factors such as the use and intensity of services contributed to the slowdown, while prices for physician and clinical services increased 0.7 percent after growing 0.4 percent in 2017.[18] While growth in spending for clinical services (6.0 percent) continued to outpace such growth for physician services (3.6 percent) in 2018, each experienced slower growth than in 2017.

Spending growth for physician and clinical services was driven by slower growth in spending by private health insurance, Medicaid, and other private revenues. For private health insurance spending, which accounted for 43 percent of total physician and clinical expenditures, growth slowed in 2018 to a rate of 3.9 percent, compared to an increase of 4.6 percent in 2017 (data not shown). For Medicaid (an 11 percent share), expenditure growth also slowed in 2018, increasing 2.9 percent compared to 4.2 percent in 2017. Furthermore, other private revenues (which includes philanthropy and other non–patient care income) declined 3.2 percent in 2018, following much larger average annual growth of 11.4 percent during 2015–17. Medicare spending (a 23 percent share) partially offset the overall slowdown in spending growth for physician and clinical services. It accelerated to 7.8 percent in 2018 from 5.9 percent in 2017, primarily because of an increase in the volume and intensity of services and an acceleration in spending growth for physician-administered drugs.[19]

Retail Prescription Drugs

Spending on retail prescription drugs increased 2.5 percent in 2018 to $335.0 billion, and the share of national health spending for this category of goods and services remained unchanged at 9 percent (exhibit 2).[20] The 2.5 percent increase in prescription drug spending in 2018 was faster than the 1.4 percent increase in 2017, as increased spending on new oncology and autoimmune drugs was partially offset by a decline in price growth and the continued increase in the use of generic drugs.[21]

In 2018 faster growth in nonprice factors helped drive the increase in total retail prescription drug spending growth, while price growth for both generic and brand-name drugs slowed. The number of prescriptions dispensed (based on thirty days' supply) increased 2.7 percent,

which was faster than the 2017 growth rate of 1.8 percent.[21] Recently, the average days' supply has increased, as studies have shown that this leads to better adherence by patients.[21]

Retail prescription drug prices declined by 1.0 percent in 2018, reflecting a decline in generic drug prices and slower and relatively low growth in prices for brand-name drugs.[21,22] Additionally, greater use of generic drugs in 2018 put downward pressure on prices, even though the change in the generic dispensing rate was the smallest since 2000—an increase of just 0.3 percentage points to 85.6 percent.[23] Despite the increase in the generic share of the total number of drugs dispensed, brand-name medications increased their share of spending by 2 percentage points in 2018 (from 76.7 percent to 78.7 percent).[21]

The four largest payers—private health insurance (a 40 percent share), Medicare (32 percent), out-of-pocket expenditures (14 percent), and Medicaid (10 percent)—account for more than 96 percent of retail prescription drug spending. The three largest payers of prescription drugs all experienced accelerating growth in 2018, with private health insurance and out-of-pocket spending growing 0.8 percent and 0.6 percent, respectively, after declines in spending in 2017 of 0.4 percent and 2.2 percent, respectively (data not shown). Medicare prescription drug spending increased 5.9 percent in 2018 after 4.8 percent growth in 2017, while Medicaid spending growth slowed from 2.7 percent in 2017 to 1.4 percent in 2018.

Conclusion

Health care spending increased 4.6 percent in 2018, a faster rate than in 2017 but a lower growth rate than that of the overall economy, which increased 5.4 percent in 2018. For health care, the relative stability in spending growth since the insurance expansions in 2014 and 2015 reflects continued low growth in medical prices, which is influenced by both low economy-wide price growth and negative excess medical price inflation, as well as relative stability in health insurance enrollment.

The slight acceleration in health care spending growth in 2018 reflected faster growth in non–personal health care spending, particularly in the net cost of health insurance. Price growth was faster for health insurance because of the impact of the reinstated health insurance tax, which had been suspended in 2017. Personal health care spending grew at the same rate in 2018 as in 2017, as slower growth in the use and intensity of services was offset by faster growth in prices for most health care services.

Except for the slight uptick that was driven primarily by the one-time impact of the reinstated health insurance tax, growth in 2018 was relatively stable. Still, changes may be on the horizon. In 2019 that tax was suspended and Medicaid coverage was expanded in five additional states, while at the same time the individual mandate penalty was effectively repealed.[24] In addition, the results of the upcoming comprehensive revision of the National Health Expenditure Accounts will be reflected in the release of next year's health spending report detailing trends through 2019.[25] ■

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NOTES

1 All data from the National Health Expenditure Accounts discussed in this article can be accessed at CMS.gov. Historical: downloads [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [last updated 2019 Dec 5; cited 2019 Dec 5]. Available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

2 The types of private health insurance for which net cost of insurance is estimated include fully insured group/commercial insurance, direct purchase or nongroup insurance, self-insured insurance, and the health portion of property and casualty insurance. Also included in the net cost of insurance are Medicare Advantage and stand-alone Medicare Part D plans, Medicaid managed care plans, Children's Health Insurance Program (CHIP) managed care plans, and the majority of workers' compensation insurance.

3 Internal Revenue Service. Affordable Care Act provision 9010—health insurance providers fee [Internet]. Washington (DC): IRS; [last updated 2019 Sep 6; cited 2019 Nov 7]. Available from: https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010

4 American Academy of Actuaries. Drivers of 2018 health insurance premium changes [Internet]. Washington (DC): The Academy; 2017 Jul [cited 2019 Nov 7]. (Issue Brief). Available from: https://www.actuary.org/content/drivers-2018-health-insurance-premium-changes

5 Growth in the use and intensity of health care goods and services includes changes in both the use and the mix (or intensity) of the goods and services consumed. It is calculated as a residual and reflects

growth in nominal health care spending less growth in the population, changes in the age and sex mix of the population, and medical price growth. As a residual, use and intensity cannot be estimated separately. The sum of the factors might not equal the total because of rounding.

6 Meer J, Rosen HS. Insurance and the utilization of medical services. Soc Sci Med. 2004;58(9):1623–32.

7 The net cost of private health insurance does not include the net cost of insurance for Medicare Advantage and stand-alone Medicare Part D plans, Medicaid managed care plans, CHIP managed care plans, and the majority of workers' compensation insurance.

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9 Cox C, Fehr R, Levitt L. Individual insurance market performance in 2018 [Internet]. San Francisco (CA): Henry J. Kaiser Family Foundation; 2019 May 7 [cited 2019 Nov 7]. Available from: https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-2018/

10 Fehr R, Cox C, Levitt L. Data note: changes in enrollment in the individual health insurance market through early 2019 [Internet]. San Francisco (CA): Henry J. Kaiser Family Foundation; 2019 Aug 21 [cited 2019 Nov 7]. Available from: https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/

11 Henry J. Kaiser Family Foundation. Employer health benefits: 2018 annual survey [Internet]. San Francisco (CA): KFF; 2018 Oct 3 [cited 2019 Nov 7]. Available from: https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-3-employee-coverage-eligibility-and-participation/

12 Non–personal health care includes all government costs associated with the administration of Medicare Parts A (Hospital Insurance), B (Supplementary Medical Insurance), and D (prescription drug coverage), as well as the net cost of private health insurance associated with Medicare Advantage and Part D prescription drug private health plans.

13 Rudowitz R, Hinton E, Antonisse L. Medicaid enrollment and spending growth: FY 2018 and 2019 [Internet]. San Francisco (CA): Henry J. Kaiser Family Foundation; 2018 Oct 25 [cited 2019 Nov 7]. Available from: https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2018-2019/

14 Recovery payments reflect money recovered by the federal government from managed care organizations as a result of favorable prior-period experience.

15 Supplemental payments are additional payments beyond the amount paid under the standard fee schedule. These payments are intended to account for the difference between what Medicaid paid and what Medicare would have paid for the same service. See Medicaid and CHIP Payment and Access Commission. Supplemental payments [Internet]. Washington (DC): MacPAC; [cited 2019 Nov 7]. Available from: https://www.macpac.gov/subtopic/supplemental-payments/

16 Bureau of Labor Statistics. Producer Price Index industry data, series report: series ID PCU622---622--- [Internet]. Washington (DC): BLS; [cited 2019 Nov 7. Available for download from: https://data.bls.gov/cgi-bin/srgate

17 Census Bureau. Business and industry: time series/trend charts: hospitals: U.S. total—not seasonally adjusted total inpatient days [Internet]. Washington (DC): Census Bureau; 2019 Sep 6 [cited 2019 Nov 7]. Available from: https://www.census.gov/econ/currentdata/dbsearch?program=QSS&startYear=2003&endYear=2019&categories=622A&dataType=INPAT&geoLevel=US&notAdjusted=1&submit=GET+DATA&releaseScheduleId=

18 Authors' analysis of Producer Price Index data for North American Industry Classification Codes 6211 and 6215 as of September 2019. See Bureau of Labor Statistics. Producer Price Indexes [Internet]. Washington (DC): BLS; [cited 2019 Nov 7]. Available from: http://www.bls.gov/ppi/

19 Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2019 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2019 Apr 22 [cited 2019 Nov 7]. Available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf

20 A new methodology for estimating prescription drug rebates for private health insurance was incorporated into the National Health Expenditure Accounts for 2018. For more information on the updated methodology, see Centers for Medicare and Medicaid Services. National Health Expenditure Accounts: methodology paper, 2018 definitions, sources, and methods [Internet]. Baltimore (MD): CMS; 2019 [cited 2019 Dec 5]. Available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/DSM-18.pdf

21 IQVIA Institute for Human Data Science. Medicine use and spending in the U.S.: a review of 2018 and outlook to 2023. Parsippany (NJ): The Institute; 2019 May 9.

22 Based on unpublished data from the Bureau of Labor Statistics, Consumer Price Index.

23 Authors' analysis of unpublished data purchased from IQVIA.

24 Sisko AM, Keehan SP, Poisal JA, Cuckler GA, Smith SD, Madison AJ, et al. National health expenditure projections, 2018–27: economic and demographic trends drive spending and enrollment growth. Health Aff (Millwood). 2019;38(3):491–501.

25 Every five years the National Health Expenditure Accounts undergo a comprehensive revision that includes the incorporation of newly available source data, methodological and definitional changes, and benchmark estimates from the Census Bureau's quinquennial economic census. During these comprehensive revisions, the entire National Health Expenditure Accounts time series is opened for revision.