

# Policy Research Perspectives

## National Health Expenditures, 2019: Steady Spending Growth Despite Increases in Personal Health Care Expenditures in Advance of the Pandemic

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### Introduction

This Policy Research Perspective (PRP) from the American Medical Association (AMA) examines the U.S. National Health Expenditures (NHE) data released by the Centers for Medicare & Medicaid Services (CMS) in December 2020. The data cover U.S. health care spending in 2019 and revised estimates for previous years (Martin et al., 2021). This PRP examines the breakdown of health care spending in 2019 and changes in its various subcomponents over the last decade. In brief, this report also examines 2020 health spending estimates provided by Altarum. A limited set of NHE estimates for 2020 is not expected to be released until later in the second quarter of this year with the more comprehensive data becoming available in (or after) December 2021.

NHE spending was \$3.8 trillion or \$11,582 per capita in 2019. This health spending was 17.7 percent of GDP in 2019, comparable with 17.6 percent in 2018. Likewise, the spending growth rate of 4.6 percent in 2019 was in line with that of 2018 (4.7 percent) and 2016 (4.6 percent), although a slight increase from 2017 (4.3 percent). Stability in 2019 spending growth can be attributed to an acceleration in personal health care expenditures (such as hospital care and prescription drug spending) being offset by a deceleration in the net cost of health insurance (e.g., insurers' administrative costs, taxes, fees, and net profits/losses) that resulted from the suspension of the health insurance tax. Altarum (2021) finds that 2020 national health spending was 2.0 percent lower than 2019 – this is the only time that spending has decreased from one year to the next since 1960 (the earliest year of data available). Data from Altarum suggest this is driven by declines in spending for most personal health expenditure categories during the pandemic.

### What are national health expenditures?

The NHE are the official estimates of U.S total health care spending and date back to 1960 (Centers for Medicare & Medicaid Services, 2020). One thing that differentiates the NHE from other data sources on spending is that it can be decomposed, or broken down, in the following three ways:

1. *Type of expenditure*: health care spending is divided into what was invested (e.g., research, structures and equipment) and what was spent on health consumption expenditures (HCE) (e.g., consumed today). The primary component of HCE is “personal health care spending,” which includes spending on hospital care, physician services, and prescription drugs. The remainder goes towards public health, government administration, and net costs for insurers (i.e., administration, taxes, fees, and profits of private health insurers). This breakdown answers the question, “where does the money go?”

2. *Source of funds*: health care spending is divided into what was invested and what was spent under different payers, including health insurance programs (private health insurance, Medicare, Medicaid, and other), out-of-pocket, and by other (non-insurance) third-party payers (i.e. workers compensation). This breakdown addresses the question, “who pays the bill?” for health consumption expenditures.
3. *Sponsor*: health care spending is divided by the financiers (i.e. “sponsors”) of health spending. This includes households, private businesses, other private revenues, the federal government, and state and local governments. While source of funds reflects the final payer of the spending, sponsors reflect the original financing source of the spending. For example, private health insurance is a source of funds but spending by insurers for patients covered by private health insurance comes from insurer premium revenue which, in turn, is funded by employees and employers. Thus, households and private businesses would be the sponsors of private health insurance spending since they are the original financing source for that spending. This breakdown addresses the question, “how is the spending financed?”

For each breakdown of the NHE (by type of expenditure, source of funds, or sponsor), the sum of the components will be \$3.8 trillion.<sup>1</sup> In addition to decomposing health spending using these three categorization schemes, another attribute that differentiates the NHE data from other sources is that it’s possible to examine the cross section between two breakout types, such as the source of funding for a particular type of expenditure (e.g., the amount of spending on physician services that was paid out-of-pocket).

### **Spending by type of expenditure: where does the money go?**

#### Spending shares

This section examines how 2019 spending breaks down by type of expenditure. Health care spending can be divided into investments and health consumption expenditures (HCE). In 2019, 5.3 percent of total health spending (or \$201.7 billion) went towards investment and 94.7 percent (or \$3,593.7 billion) went to the HCE category (see Exhibit 1). The HCE category consists of government public health activities (2.6 percent of total health spending or \$97.8 billion in 2019), government administration (1.3 percent or \$48.9 billion), net cost of health insurance (6.3 percent or \$239.9 billion), and personal health care spending (84.5 percent or \$3,207.0 billion).

Government administration includes the administrative cost of running government health care programs. The net cost of health insurance, the difference between what insurers incur in premiums and the amount paid in benefits, goes towards insurers’ administrative costs, taxes, fees, and net profits/losses.

Personal health care expenditures (84.5 percent of total health spending) include spending on hospital care (31.4 percent or \$1,192.0 billion), prescription drugs (9.7 percent or \$369.7 billion),

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<sup>1</sup> The NHE estimates provide a more complete picture of health spending because its structure is mutually exclusive and exhaustive (containing all the main components of the health care system), multi-dimensional (including both expenditures for medical goods and services as well as the financiers/origin of these expenditures), and consistent (using common definitions and methods that allow for comparisons over time and categories) (Centers for Medicare & Medicaid Services, 2020).

physician services (14.9 percent or \$565.5 billion), and clinical services (5.4 percent or \$206.6 billion). In the tables prepared by CMS, physician and clinical services are generally presented as a combined category; however, in this PRP they are shown separately because of notable differences between the two categories (such as in spending growth discussed later in Exhibit 2). Physician services consist of spending in establishments where physician services are the primary activity while clinical services include spending made in establishments classified as outpatient care centers.<sup>2</sup>

Personal health care expenditures also include spending on nursing care facilities (4.6 percent of total health spending or \$172.7 billion), home health care (3.0 percent or \$113.5 billion), and other personal health care services (15.5 percent or \$587.1 billion).<sup>3</sup>

Most of the 2019 spending shares presented in Exhibit 1 are within half a percentage point of those from 2018; the consistency of the health spending shares in recent years builds off an ongoing pattern over the last few decades (see Kane, 2017 for detailed discussion).<sup>4</sup>

### Spending growth

Although the spending shares have remained stable over the long and short terms, there is variation in spending growth for most of the type of expenditure categories. Exhibit 2 presents the annual spending growth rates over the 10-year period ending in 2019 for personal health care spending and its four major components (hospital care, physician services, clinical services, and prescription drugs). Personal health care spending growth was 5.2 percent in 2019, with subcomponents hospital care (6.2 percent), clinical services (5.8 percent), and prescription drugs (5.7 percent) having higher spending growth rates than physician services (4.2 percent).

The average annual growth rate for the 10-year period ending in 2019 was 4.3 percent for personal health care spending; clinical services (8.3 percent) and hospital care (4.5 percent) had the highest 10-year average rate while prescription drugs (3.8 percent) and physician services (3.4 percent) had the lowest. However, these averages mask important variation in the spending growth rate over the last decade. At the beginning of this period, personal health care spending growth remained low but spiked during ACA implementation (5.2 percent in 2014 and 6.0 percent in 2015) before dropping to 4.1 percent in 2017 and 2018. Similar patterns are present for the major subcomponents of personal health care spending albeit at different magnitudes; there was less fluctuation in physician services spending, which peaked at 4.9 percent in 2015 before dropping to 3.3 percent in 2018. In contrast,

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<sup>2</sup> NHE estimates for service categories are based on spending in establishments that fall under codes in The North American Industry Classification System (NAICS) that relate to the service category. Establishments are classified into NAICS based on the primary activity performed at the location and spending in the establishment consists of payments to the establishment, including payments to employees of the establishment. For example, payments to hospital-employed physicians will be classified as hospital services spending while payments to physicians employed in free-standing offices will be classified as physician services spending (even if that physician performed some of their services at a hospital).

<sup>3</sup>Other personal health care services include dental and other professional services, durable medical equipment, other non-durable medical products, and other health, residential, and personal care.

<sup>4</sup>The biggest percentage point change in spending shares over the past 25 years was for prescription drugs, which accounted for 5.6 percent of total health spending in 1990 but has remained at or above 9 percent since 2001 (Kane, 2017).

prescription drug spending growth peaked at 13.5 percent in 2014 before sharply declining to 1.7 percent in 2016. Although clinical services spending growth also spiked (reaching 12.4 percent in 2015 and 2016), the high growth rates in this category were sustained for a longer period (e.g., from 2013 to 2017 the growth rate remained above 9 percent); much of this was driven by high spending growth for clinical services made out-of-pocket (up to 13.5 percent growth in 2016), by private health insurance (up to 18.9 percent in 2017), and by the Medicaid program (up to 21.4 percent in 2014).

In 2019, there was another acceleration in personal health care expenditures as the spending growth of hospital care, physician services, and prescription drugs surpassed that of 2018. This was primarily due to growth in non-price factors (i.e., use and intensity of services) since growth in prices declined (for hospital care and prescription drugs) or remained stable (for physician services) (Martin et al., 2021).

The short-term fluctuations in spending growth (Exhibit 2) coexist with the stability of the spending shares discussed in the prior section because type-of-expenditure categories that have high or variable spending growth account for a relatively small share of total health spending (e.g., clinical services) while those with a large share have relatively low or stable growth rates (e.g., physician services). In 2020, a more substantial change in shares of spending is observed (discussed in the following section) because larger type-of-expenditure categories (e.g., hospital care and physician services) saw unprecedented, sharp declines in spending growth.

#### Where did the money go in 2020?

Although the 2020 NHE data is not expected to be released until December 2021, Altarum, a non-profit research organization, has released monthly briefs with 2020 health spending estimates.<sup>5</sup> The briefs only classify health spending by type of expenditure and not by source of funds or sponsor. That information will only be available later this year in the 2020 NHE data.

Altarum (2021) estimates that national health spending in 2020 was 2.0 percent *lower* than in 2019 – they note that this is the first decrease in annual spending (estimates go as far back as 1960). This was driven by declines in most personal health care expenditure categories; in particular, spending in hospital care services and dental services (included in other personal health care) decreased by, respectively, 7.0 percent and 20.2 percent (Altarum, 2021). Preliminary Altarum estimates (as of February 2021) also show a 4.2 percent decrease in physician and clinical services spending.<sup>6</sup> Physician and clinical services were presented as separate categories earlier in this PRP, but the Altarum estimates are only available in the combined category; this is the case for program administration and net cost of health insurance as well. The negative annual growth rates for these service categories stem from sharp declines in spending early in the pandemic (see discussion in Altarum, 2020); the preliminary Altarum estimates show monthly spending growth rates as low as -20.2 percent for hospital care (March 2020), -30.1 percent for physician and clinical services (April

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<sup>5</sup> The 2020 health spending estimates from Altarum are based on BEA monthly health spending data and CMS annual NHE estimates and projections. These preliminary estimates were developed by Altarum in February 2021. It is important to note that the underlying data are continually revised and official 2020 NHE estimates from CMS will be released later in 2021.

<sup>6</sup> Spending growth in 2020 from 2019 is calculated by comparing the 2020 health spending estimates provided by Altarum with the 2019 NHE.

2020), and -48.2 percent for dental services (April 2020).<sup>7</sup> The annual decrease in spending for most of these major spending categories is unsurprising as Altarum (2021) notes the pandemic disrupted the demand and delivery of health services, causing declines in both health spending and health care jobs that have yet to fully recover to pre-pandemic levels.

It is, however, important to note that there was positive spending growth in some categories, including the combined program administration and net cost of health insurance category (9.4 percent) and prescription drugs (6.1 percent). Throughout the pandemic there was mostly positive (and relatively stable) monthly spending growth for both these categories. Because most personal health expenditure categories had negative spending growth, the positive annual growth in program administration and net cost of health insurance is of particular interest as net cost reflects the difference between what insurers incur in premiums and the amount paid in benefits. A Kaiser Family Foundation analysis through the third quarter of 2020 (see McDermott et al., 2020) suggests that health insurers became more profitable during the pandemic as there were decreases in the medical loss ratio (i.e., the amount of premium revenue spent on medical services and improving care quality relative to profits, administrative costs, and other overhead expenses). Compared to the first three quarters of 2019, the first three quarters of 2020 saw a 3 to 7 percentage point drop in the medical loss ratio in the individual market, fully insured group market, Medicare Advantage, and Medicaid Managed Care. This would suggest a relative increase in premium revenue going towards profits and/or overhead expenses. This is consistent with reports of increasing annual profits for many for-profit insurers (see Humana, 2021, Cigna, 2021, and UnitedHealth Group, 2021 for 2020 earnings news release that also contains comparisons with 2019).

Using the preliminary Altarum estimates (as of February 2021), Exhibit 3 presents the estimated share of spending in 2020 by type of expenditure. In 2020, 5.7 percent of total health spending (or \$212.0 billion) went towards investment; the remaining went to HCE, which consists of government public health activities (2.7 percent of total health spending or \$100.3 billion), program administration and net cost of health insurance (8.5 percent or \$315.9 billion), and personal health care spending (83.1 percent or \$3,091.4 billion). Personal health care spending includes, among other things, spending on hospital care (29.8 percent of total health spending or \$1,108.3 billion), physician and clinical services (19.9 percent or \$739.3 billion), and prescription drugs (10.5 percent or \$392.4 billion).

The 2020 data provided by Altarum suggest that the relative spending shares are on par with past years, as hospital care remains the largest category of health spending followed by the combined physician and clinical services category and then prescription drugs. Nonetheless, some substantial shifts in the magnitude of the shares are apparent due to large differences across categories in 2020 spending growth. There was a 1.6 percentage point decrease in the share of hospital care spending between 2019 and 2020 while spending shares increased by 0.8 percentage points for prescription drugs and 0.9 percentage points for the combined program administration and net cost of private health insurance category.

### **Spending by source of funds: who pays the bill?**

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<sup>7</sup>Conclusions about the growth rates of type of expenditure categories during the pandemic are derived from examining monthly 2020 health spending estimates provided by Altarum.

### Spending shares

Returning to the National Health Expenditures (NHE) data, Exhibit 4 presents the share of spending in 2019 by source of funds. As with the type of expenditures breakdown, health care spending can be divided into investments or health consumption expenditures. However, for the source of funds breakdown, health consumption expenditures is decomposed based on who pays the bill: health insurance (72.5 percent of health spending or \$2,752.8 billion), other third party payers and programs and public health activities (11.4 percent or \$434.4 billion), and out-of-pocket spending (10.7 percent or \$406.5 billion).<sup>8</sup> Out-of-pocket spending consists of payments made directly by patients regardless of insurance status; this not only includes payments made by uninsured patients, but also pre-deductible spending as well as copayments and coinsurance payments of insured patients. Out-of-pocket spending share has been declining over the past 50 years (data not shown; see Kane, 2017).

Health insurance is further divided into four components: private health insurance (31.5 percent of health spending or \$1,195.1 billion), Medicare (21.1 percent or \$799.4 billion), Medicaid (16.2 percent or \$613.5 billion), and other health insurance programs (3.8 percent or \$144.8 billion). Kane (2017) notes that private health insurance has had the largest share for the past four decades. The 2019 spending shares are within half a percentage point of 2018 shares. In fact, year-to-year changes in spending shares over the past decade have remained within a percentage point, Medicaid being the only exception (although the greatest change was a 1.5 percentage point share increase in 2009).

### Spending growth

The spending shares show that private health insurance, Medicare, Medicaid, and out-of-pocket spending are the four main sources of health care funding; the spending growth for these four categories over the 10-year period ending in 2019 are presented in Exhibit 5.

During this period, spending patterns for most source of funds were influenced by the implementation of the ACA and the effecting health insurance tax (an expenditure under the net cost of health insurance category that includes costs/fees faced by insurers). Private health insurance spending growth spiked and remained between 5 to 6 percent (from 2014 to 2018) and Medicaid spending growth spiked to 11.9 percent (2014) and 8.9 percent (2015). Although Medicare spending growth mostly remained between 4 and 5 percent from 2010 to 2017, it spiked to 6.3 percent in 2018 due to the health insurance tax (see Rama 2020 for detailed discussion).

The ACA health insurance tax is an annual fee that is distributed among insurers based on their market share (Keith, 2019). Although the fee does not apply to government-run insurance programs, private insurers that contract with government organizations (e.g., entities offering Medicare Advantage Part C, Medicare prescription drug plans Part D, or Medicaid managed care plans) are

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<sup>8</sup>Other health insurance and third party payers and programs include Children's Health Insurance Program (CHIP), the Department of Defense (DOD) health care program (TRICARE), Department of Veterans Affairs health expenditures, worksite health care (i.e., expenditures for PHC directly provided by employers for their employees), other private revenues, Indian health services, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, substance abuse and mental health services administration, other state and local programs, and school health (Centers for Medicare & Medicaid Services, 2020).

subject to the fee (see Kirchhoff 2013 for details). Insurers did not have to pay this tax in 2019 like they did in 2018. As a result, private health insurance spending growth dropped to 3.7 percent in 2019 even though there was an acceleration in personal health care expenditures – this is the lowest spending growth rate since the ACA. In contrast, Medicare spending growth increased to 6.7 percent, as there was faster growth in personal health care expenditures in Medicare private plans (Martin et al., 2021).

Exhibit 5 shows that out-of-pocket spending growth fluctuated between a low of 1.6 percent in 2010 and a high of 4.6 percent in 2019. In fact, the 2019 growth rate is up from 3.8 percent in 2018 and is the highest seen since 2007 (5.5 percent); it is also only one of two years in the available data (the other being 2012) where out-of-pocket spending growth was greater than health insurance spending growth. Thus, the growth rate is deserving of closer examination.

Although the acceleration in out-of-pocket spending from 2019 may seem at odds with patterns observed with the other source of funds (namely the deceleration in private health insurance spending), it should be noted that the composition of out-of-pocket spending differs markedly from the composition of health insurance spending. While spending on other non-durable medical products and dental services make up a small portion of health insurance spending, they are large components of out-of-pocket spending; thus, changes in price and non-price factors (e.g., use and intensity) of these underlying products and services will affect out-of-pocket spending more than health insurance spending. In 2019, out-of-pocket spending growth accelerated for both other non-durable medical products and dental services as well as hospital care services and prescription drugs.<sup>9,10</sup> The latter was influenced by increases in average prescription drug costs for cash-paying patients which were only partially offset by decreases in these costs for the insured population (Martin et al., 2021). In general, most changes in out-of-pocket spending between 2009 and 2019 are related to expansionary policies (e.g., ACA) as well as enrollment growth in plans requiring higher cost-sharing or loss of health insurance coverage (Martin et al., 2012 and Hartman et al., 2018).

### **Spending by sponsor: how is all that financed?**

This section examines how health care spending is sponsored (i.e., the origin of the funding or the initial financing of the spending). There are five sponsors: private businesses, households, other private revenues, the federal government, and state and local governments. Exhibit 6 presents the shares of health care spending by sponsor (rightmost column) as well as the shares of private health insurance (leftmost column) and Medicare (middle column) spending by sponsor.<sup>11</sup>

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<sup>9</sup> Other non-durable medical products consist of non-prescription drugs and medical sundries.

<sup>10</sup> In addition, the acceleration in out-of-pocket spending in 2019 exceeded that of health insurance spending for hospital care services (3.3 percentage point increase in out-of-pocket spending growth compared to 1.4 percentage point increase in health insurance spending growth), dental services (2.1pp compared to -2.5pp), and other non-durable medical products (1.8pp compared to -1.9pp).

<sup>11</sup> Other private revenues are private sponsors of health care that are not included in private businesses and households (Centers for Medicare & Medicaid Services, 2020). This includes philanthropic support from individuals and organizations, income from operation of businesses in health care institutions (i.e., gift shops, cafeterias, educational programs, and investment income in hospitals, nursing homes, and other such institutions), as well as private investment in research, structures, and equipment.

In 2019, 29.0 percent of total health spending was financed by the federal government (\$1,102.3 billion), 28.4 percent by households (\$1,076.4 billion), 19.1 percent by private businesses (\$724.5 billion), 16.1 percent by state and local governments (\$609.3 billion), and 7.5 percent from other private revenues (\$282.9 billion). The federal government's share of spending has been slightly higher (within 0.6 percentage points) than that of households since 2015; prior to this, households were the largest financier of health spending. Over the long term, there have been significant shifts in the spending shares of these two sponsors as spending financed by households decreased from 36.8 percent in 1987 to 28.4 percent in 2019 while spending financed by the federal government increased from 16.8 percent in 1987 to 29.0 percent in 2019.<sup>12</sup>

Private health insurance spending was \$1,195.1 billion in 2019. Almost half of this spending (46.2 percent) was financed by private businesses, all of which came from employer contributions to employer sponsored health insurance premiums (\$551.6 billion). Nearly a third of private health insurance spending (30.2 percent) was financed by households through employee contributions to employer-sponsored health insurance premiums (\$288.2 billion) and household contributions to direct purchase insurance (\$73.3 billion). As employers, state and local governments financed 15.7 percent of private health insurance spending through the employer contribution to employer-sponsored health insurance premiums (\$187.8 billion). The federal government financed 7.9 percent through employer contributions to health insurance premiums (\$38.6 billion), marketplace tax credits and subsidies (\$49.8 billion), and other federal (\$5.9 billion).

The breakdown of Medicare spending by sponsor is in the middle column of Exhibit 6. In Medicare financing, sponsors contribute to the hospital insurance (HI) trust fund for Medicare Part A (to cover, for example, inpatient care in hospitals and skilled nursing facilities) and the supplemental medical insurance (SMI) trust fund for Medicare Part B and Part D (to cover, respectively, physician services and outpatient care, and prescription drugs) (Centers for Medicare & Medicaid Services, 2021a and Tax Policy Center, 2020). In 2019, Medicare spending was \$799.4 billion. Nearly half of this spending (46.7 percent) was financed by the federal government. Since the implementation of Medicare Part D, the federal government has been the largest sponsor of Medicare. \$357.2 billion comes from federal general revenue and Medicare net trust fund expenditures; this includes funding from the general pool of funds that were not initially appropriated for Medicare and surpluses in the Medicare HI trust fund that allow for reductions in current federal general funding obligations for Medicare (Centers for Medicare & Medicaid Services, 2021a).<sup>13</sup> Federal government financing also includes an additional \$4.6 billion from employer Medicare HI trust fund payroll taxes (from the federal government's role as an employer) and \$11.8 billion from the federal portion of Medicare buy-in premiums that contributes to both the HI and SMI trust funds.<sup>14</sup>

Households were the next largest sponsor, financing 34.0 percent of Medicare spending. This includes \$176.1 billion that came from employee and self-employment payroll taxes and voluntary premiums paid to Medicare HI trust fund. It also includes \$95.5 billion in premiums paid by

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<sup>12</sup> Data on sponsors' shares of health care spending are available from 1987 onwards.

<sup>13</sup> The HI trust fund ran a deficit of 5.8 billion and estimates through 2029 suggest the deficit is expected to grow (The Board of Trustees, 2020).

<sup>14</sup> The Medicare buy-in program allows states to "buy-in" (i.e., pay for) the premiums of eligible low-income individuals so that these individuals can afford to enroll in Medicare (Centers for Medicare & Medicaid Services, 2021b). In 2019, states paid the Medicare Part B premiums for over 10 million individuals and Medicare Part A premiums for over 700,000 individuals.



individuals to Medicare SMI trust fund and the pre-existing condition insurance plan. Private businesses financed 14.8 percent of Medicare spending, all of which was from employer Medicare HI trust fund payroll taxes (\$118.6 billion). The remaining 4.4 percent of Medicare spending was financed by state and local governments. This includes \$15.3 billion from employer Medicare HI trust fund payroll taxes as well as \$12.3 billion in state phase down payments (Part D) that flow into the SMI trust fund. Also included is \$7.9 billion from the state portion of Medicare buy-in premiums; these are payments made by state Medicaid programs for Medicare Part A (HI trust fund) and Part B (SMI trust fund) premiums (Centers for Medicare & Medicaid Services, 2020).

## Conclusion

U.S. health care spending increased by 4.6 percent in 2019 to \$3,795.4 billion or \$11,582 per capita. In comparison, spending grew 4.7 percent in 2018, 4.3 percent in 2017, and 4.6 percent in 2016. This recent stability in spending growth comes after higher growth rates previously seen during the implementation of the Affordable Care Act. Health spending was 17.7 percent of GDP in 2019, similar to 17.6 percent in 2018.

Personal health care spending made up 84.5 percent of total health spending (or \$3,207.0 billion). Included in this is spending on hospital care (31.4 percent of total health spending or \$1,192.0 billion), physician services (14.9 percent or \$565.5 billion), clinical services (5.4 percent or \$206.6 billion), and prescription drugs (9.7 percent or \$369.7 billion). These shares have remained stable, within half a percentage point of those from 2018. Personal health care spending growth was 5.2 percent in 2019, with subcomponents hospital care (6.2 percent), clinical services (5.8 percent), and prescription drugs (5.7 percent) having higher spending growth rates than physician services (4.2 percent).

Although NHE data are only available through 2019, Altarum has developed estimates of 2020 national health spending. Their data suggest that national health spending decreased by 2.0 percent in 2020 due to spending decreases in hospital care (-7.0 percent spending growth), physician and clinical services (-4.2 percent), and dental services (-20.2 percent). These negative annual growth rates stem from sharp declines in spending early in the pandemic that were not fully recovered by the end of 2020. Nonetheless, during the pandemic, there was positive spending growth in prescription drugs (6.1 percent) and program administration and net cost of health insurance (9.4 percent). Because most personal health expenditure categories had negative spending growth, the positive annual growth in program administration and net cost of health insurance is of particular interest as the latter in the combined category reflects the difference between what insurers incur in premiums and the amount paid in benefits. Research that shows the medical loss ratio decreased during the pandemic (e.g., McDermott et al., 2020) suggests a relative increase in premium revenue going towards profits and/or overhead expenses. A better understanding of the net cost of health insurance can be developed when the NHE data for 2020 are released later in the year with information about this category by source of funds (payer).

Decomposing national health spending by source of funds show that the largest share of spending came from, as it has in the last four decades, private health insurance (31.5 percent of health spending or \$1,195.1 billion). This is followed by Medicare (21.1 percent or \$799.4 billion), Medicaid (16.2 percent or \$613.5 billion), and then out-of-pocket spending (10.7 percent or \$406.5 billion).

There have been differences across payers in spending growth patterns over the last decade, with spending growth in Medicare (6.7 percent) and out-of-pocket payments (4.6 percent) reaching their highest rates in 2019 while private health insurance (3.7 percent) and Medicaid (2.9 percent) were on a downswing.

Lastly, national health spending can also be broken down by sponsors (i.e., original financier). The federal government finances the largest share of health spending (29.0 percent of total health spending or \$1,102.3 billion); this has been the case since 2015, although prior to this, households were the largest financiers of health spending. In 2019, the second largest share of financing came from households (28.4 percent or \$1,076.4 billion) followed by private business (19.1 percent or \$724.5 billion), state and local governments (16.1 percent or \$609.3 billion), and other private revenues (7.5 percent or \$282.9 billion). Although the shares of spending by sponsor have been stable over the last few years, there have been significant shifts over the long term (i.e., the share of spending sponsored by households decreased from 38.1 percent in 1987 to 28.4 percent in 2019 while the share sponsored by the federal government increased from 16.5 percent in 1987 to 29.0 percent in 2019).

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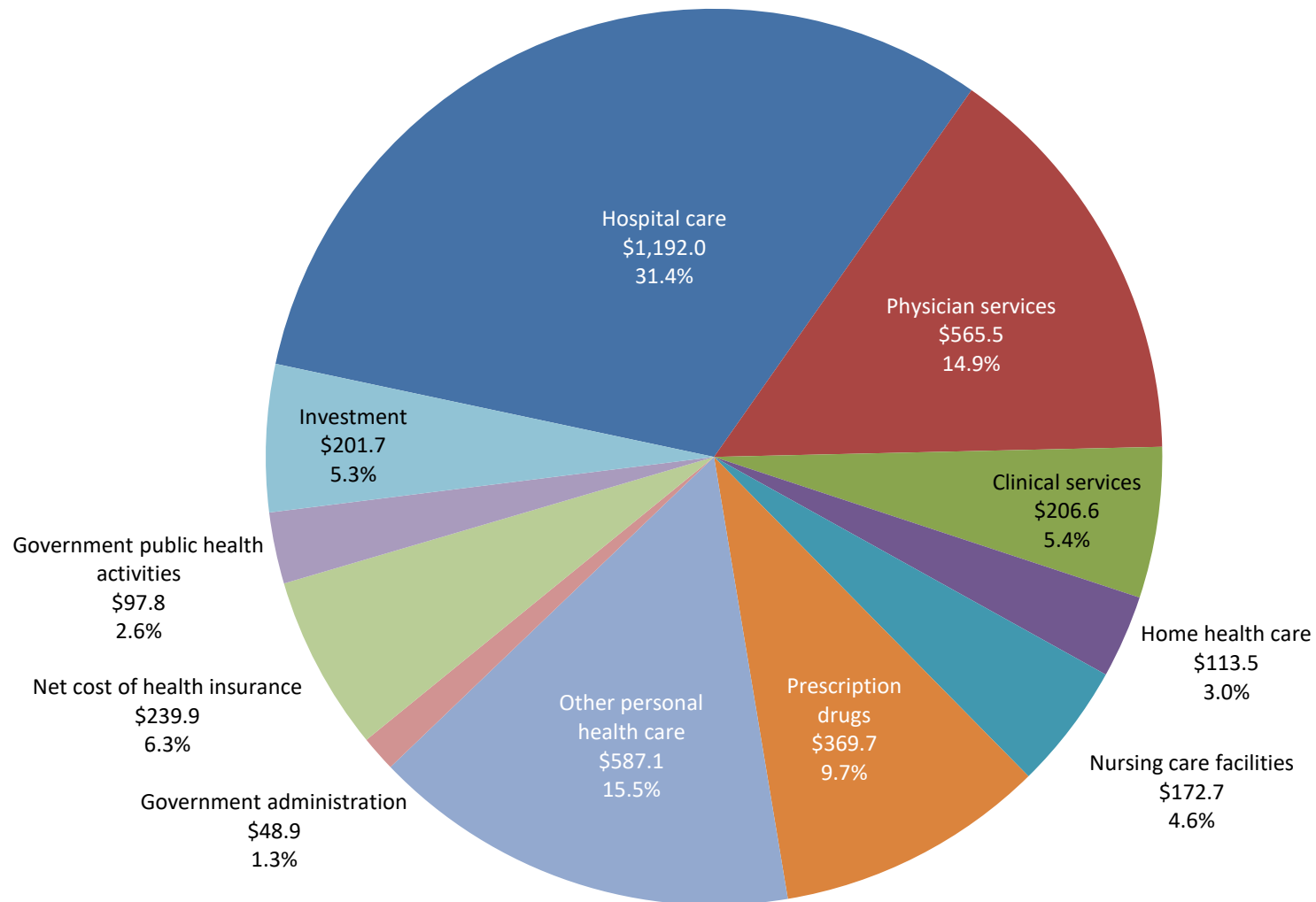
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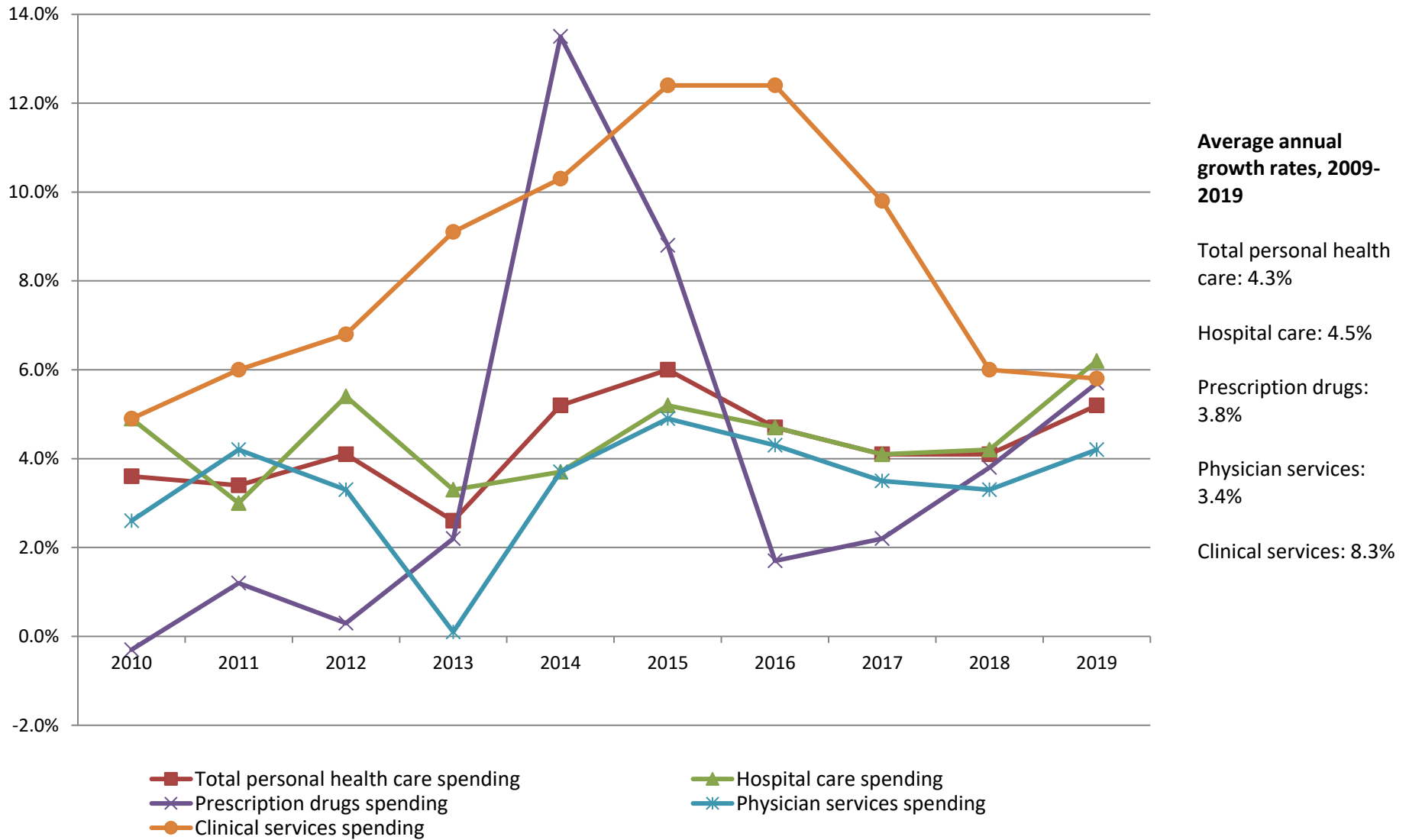
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**Exhibit 1. The U.S. spent \$3,795.4 billion on health care in 2019  
where did it go?**



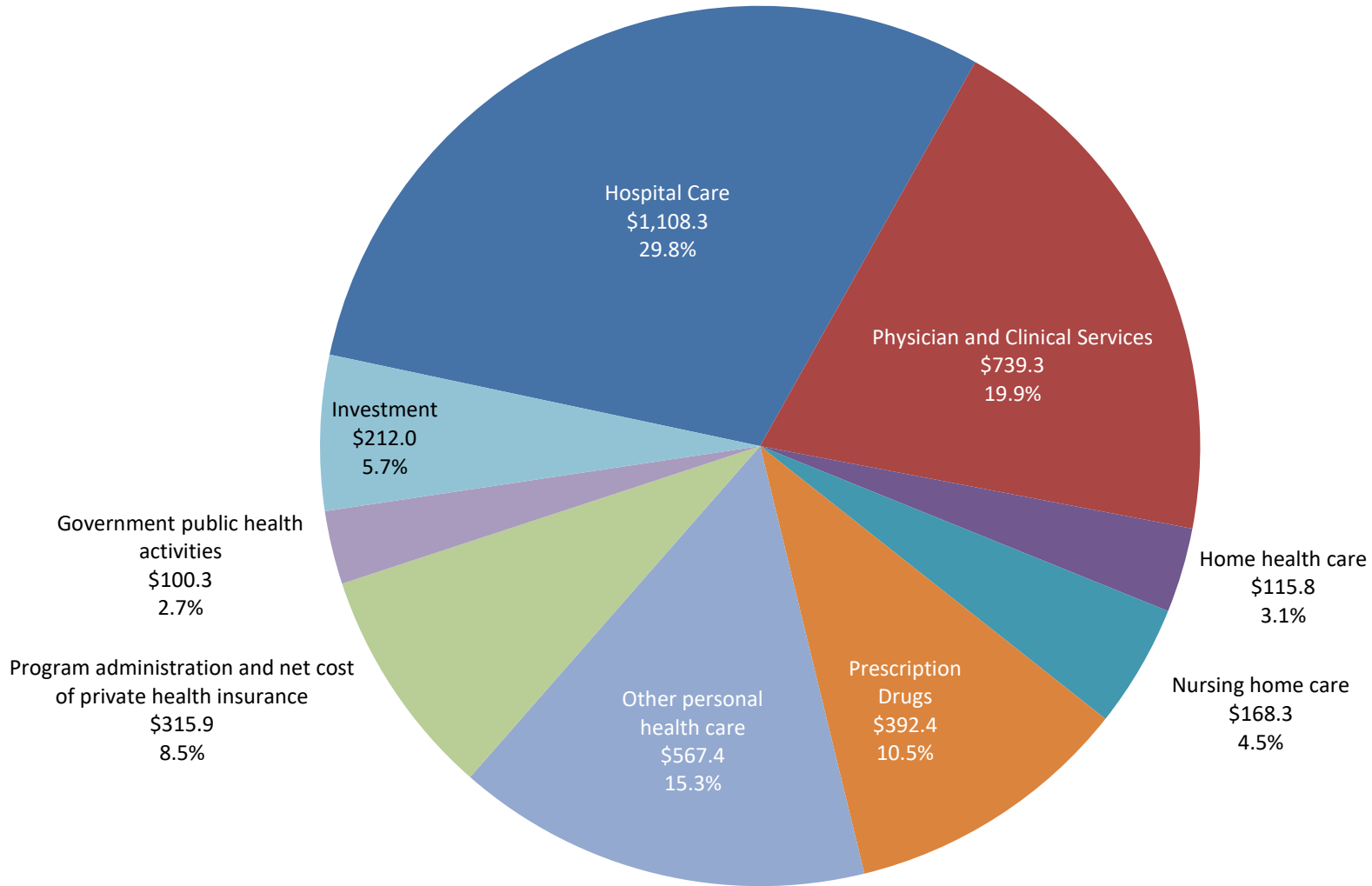
Source: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>. Tables 6, 7, 9, 10, and 16 in NHE Tables [ZIP].

**Exhibit 2. Spending growth rates by type of expenditure**



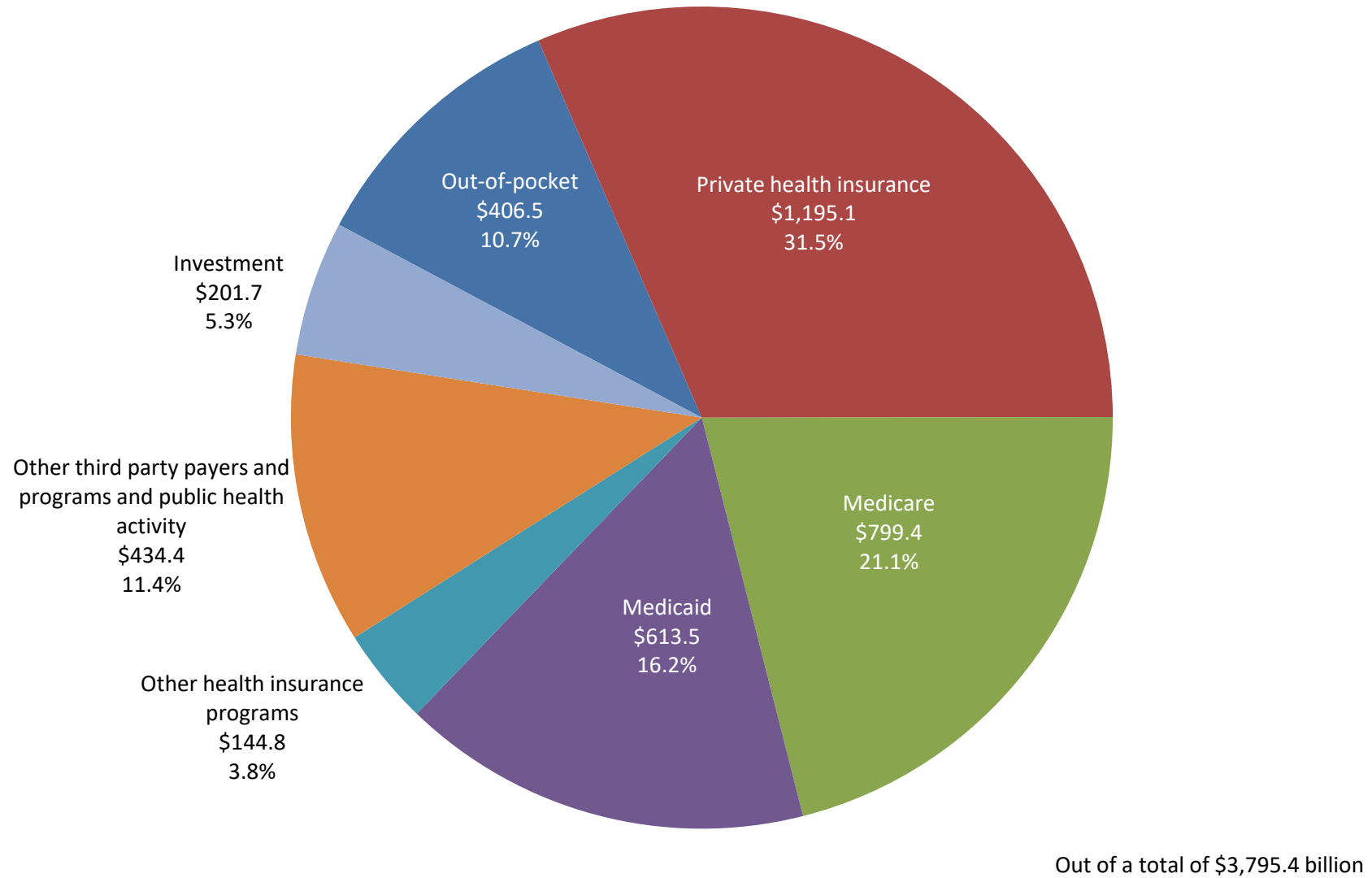
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### Exhibit 3. The U.S. spent \$3,719.5 billion on health care in 2020 where did it go?



Source: preliminary Altarum estimates as of February 2021. Data was obtained through direct correspondence with Altarum and analysis of data is printed with permission. For details about Altarum 2020 health spending data see <https://altarum.org/publications/february-2021-health-sector-economic-indicators-briefs>

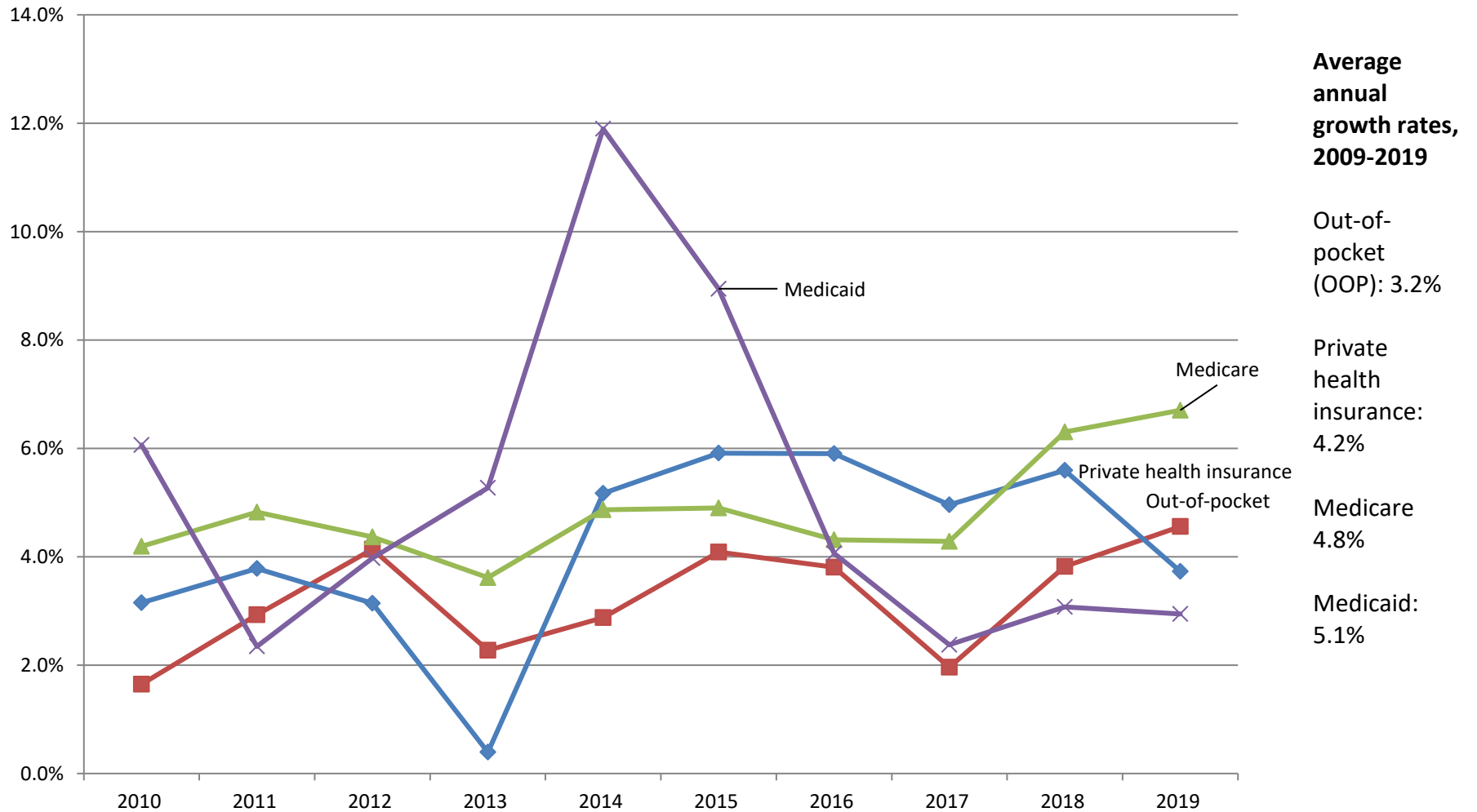
### Exhibit 4. 2019 Health care spending by source of funds



Source: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>. Table 2 in NHE Tables [ZIP].



**Exhibit 5. Spending growth rates by source of funds**



Source: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>. Tables 6, 7, 9, 6 and NHE2019 in NHE Tables [ZIP].

**Exhibit 6. The financing of private health insurance spending, Medicare spending, and NHE in 2019 (billions of dollars)**

SPONSOR	Private health insurance spending		Medicare spending		NHE	
	Level	Percentage	Level	Percentage	Level	Percentage
<b>Private business</b>						
Employer contribution to employer sponsored health insurance premiums	\$551.6	46.2%			\$551.6	14.5%
Employer Medicare Hospital Insurance Trust Fund payroll taxes			\$118.6	14.8%	\$118.6	3.1%
Workers' compensation, temporary disability insurance, worksite healthcare					\$54.3	1.4%
<b>Total private business</b>	<b>\$551.6</b>	<b>46.2%</b>	<b>\$118.6</b>	<b>14.8%</b>	<b>\$724.5</b>	<b>19.1%</b>
<b>Household</b>						
Employee contribution to employer-sponsored health insurance premiums	\$288.2	24.1%			\$288.2	7.6%
Household contribution to direct purchase insurance	\$73.3	6.1%			\$73.3	1.9%
Medical portion of property and casualty insurance					\$36.8	1.0%
Employee and self-employment payroll taxes and voluntary premiums paid to Medicare Hospital Insurance Trust Fund			\$176.1	22.0%	\$176.1	4.6%
Premiums paid by individuals to Medicare Supplementary Medical Insurance Trust Fund and the Pre-existing Condition Insurance Plan			\$95.5	11.9%	\$95.5	2.5%
Out-of-pocket health spending					\$406.5	10.7%
<b>Total household</b>	<b>\$361.5</b>	<b>30.2%</b>	<b>\$271.6</b>	<b>34.0%</b>	<b>\$1,076.4</b>	<b>28.4%</b>
<b>Other private revenues</b>					<b>\$282.9</b>	<b>7.5%</b>

## Exhibit 6. continued

SPONSOR	Private health insurance spending		Medicare spending		NHE	
	Level	Percentage	Level	Percentage	Level	Percentage
<b>Federal government</b>						
Employer contribution to employer-sponsored health insurance premiums	\$38.6	3.2%			\$38.6	1.0%
Employer Medicare Hospital Insurance Trust Fund payroll taxes			\$4.6	0.6%	\$4.6	0.1%
Federal general revenue and Medicare Net Trust Fund expenditures			\$357.2	44.7%	\$357.2	9.4%
Federal portion of Medicaid payments					\$387.5	10.2%
Federal portion of Medicare buy-in premiums			\$11.8	1.5%	\$11.8	0.3%
Retiree Drug Subsidy payments to employer-sponsored health insurance plans	\$0.7	0.1%			\$0.7	0.0%
Other federal health insurance and programs	\$5.2	0.4%			\$252.2	6.6%
Marketplace tax credits and subsidies	\$49.8	4.2%			\$49.8	1.3%
<b>Total federal government</b>	<b>\$94.2</b>	<b>7.9%</b>	<b>\$373.6</b>	<b>46.7%</b>	<b>\$1,102.3</b>	<b>29.0%</b>
<b>State and local government</b>						
Employer contribution to employer-sponsored health insurance premiums	\$187.8	15.7%			\$187.8	4.9%
Employer Medicare Hospital Insurance Trust Fund payroll taxes			\$15.3	1.9%	\$15.3	0.4%
State portion of Medicaid payments					\$226.0	6.0%
State portion of Medicare buy-in premiums			\$7.9	1.0%	\$7.9	0.2%
State phase down payments (Part D)			\$12.3	1.5%	\$12.3	0.3%
Other programs					\$160.0	4.2%
<b>Total state and local government</b>	<b>\$187.8</b>	<b>15.7%</b>	<b>\$35.5</b>	<b>4.4%</b>	<b>\$609.3</b>	<b>16.1%</b>
<b>TOTAL</b>	<b>\$1,195.1</b>	<b>100%</b>	<b>\$799.4</b>	<b>100%</b>	<b>\$3,795.4</b>	<b>100%</b>

Source: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>. Tables 5, 5-1-5-2, 5-3, 5-4, 5-5, and 5-6 in NHE Tables [ZIP].