Has the United States Bent the Health Care Cost Curve?

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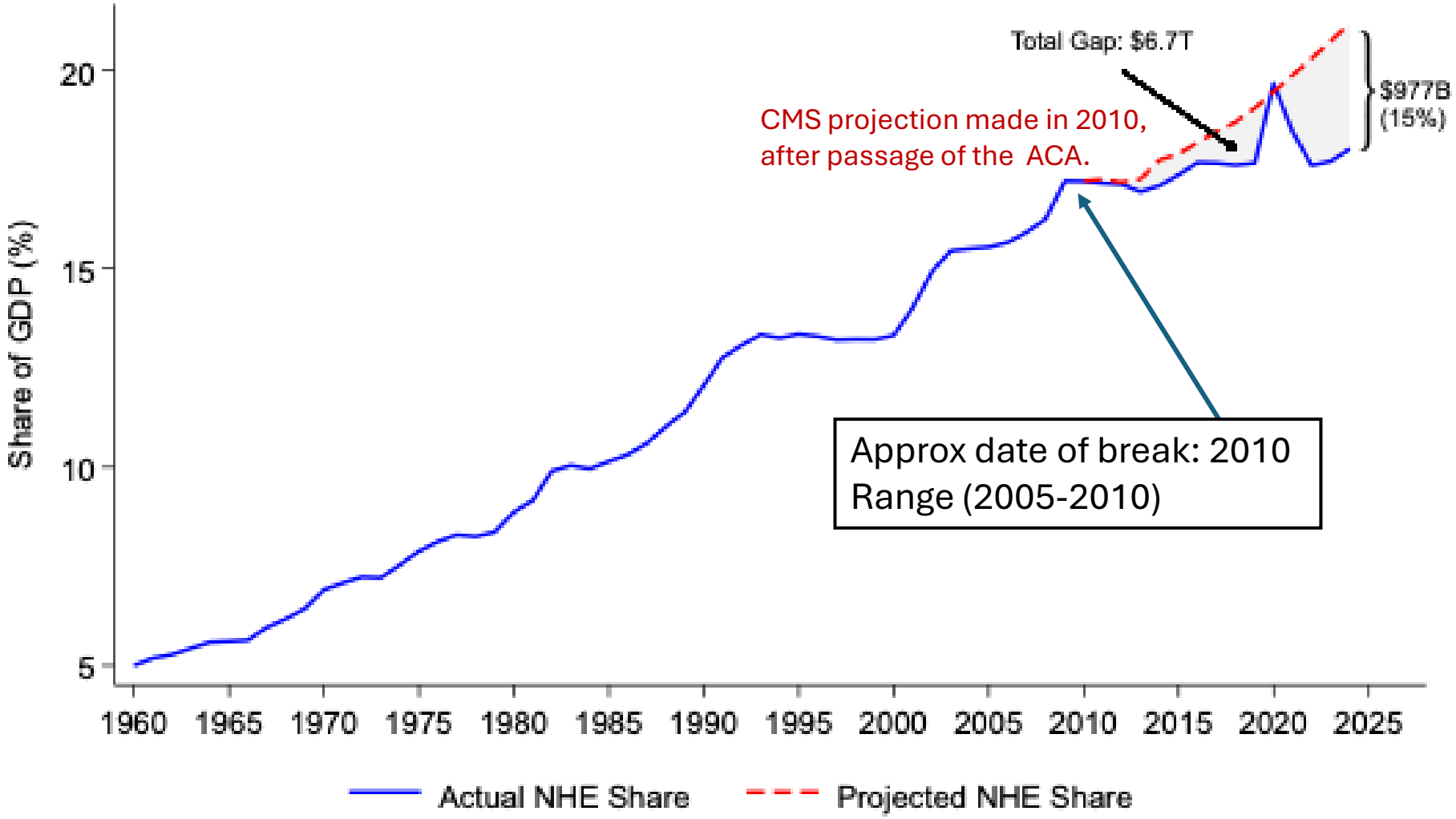
Medical Spending as Share of GDP is Far Below Projections



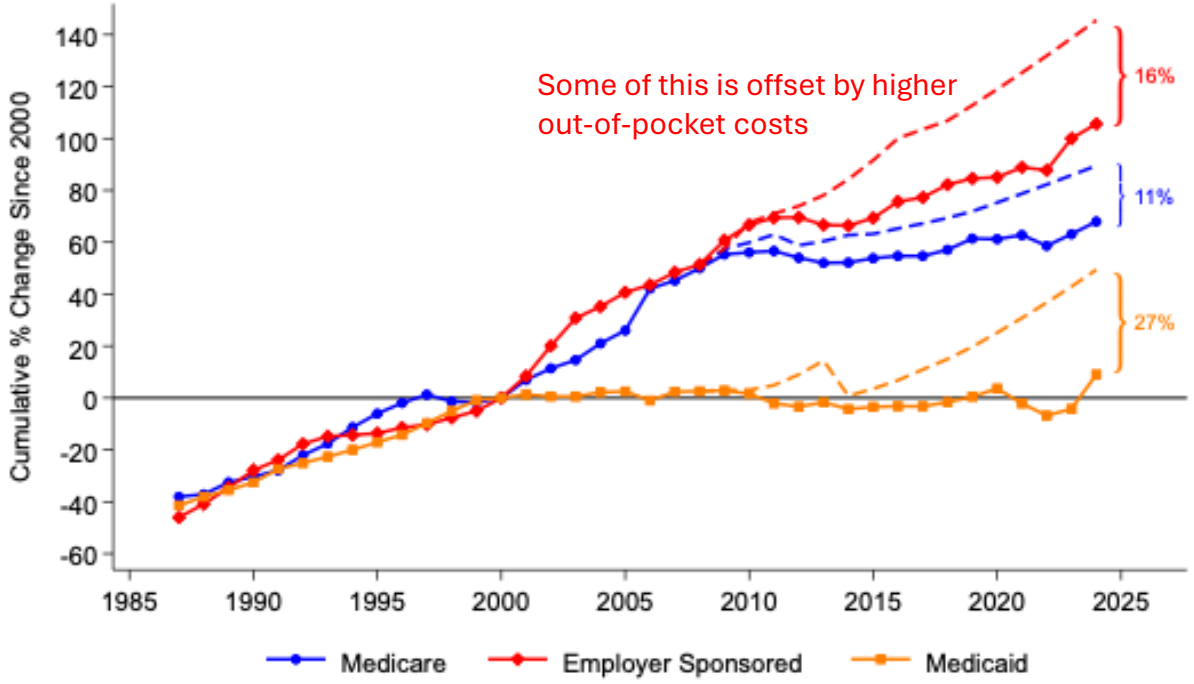
The slowdown is greater in the US than elsewhere

Standard theories predict that medical spending will increase over time.

Notes: Source CMS NHE Fact Sheet. The CMS projection is for 10 years. It is extrapolated through 2024 using the growth of medical spending relative to GDP growth in the final years of the forecast.

Spending growth slowed for all major payers; some services declined more

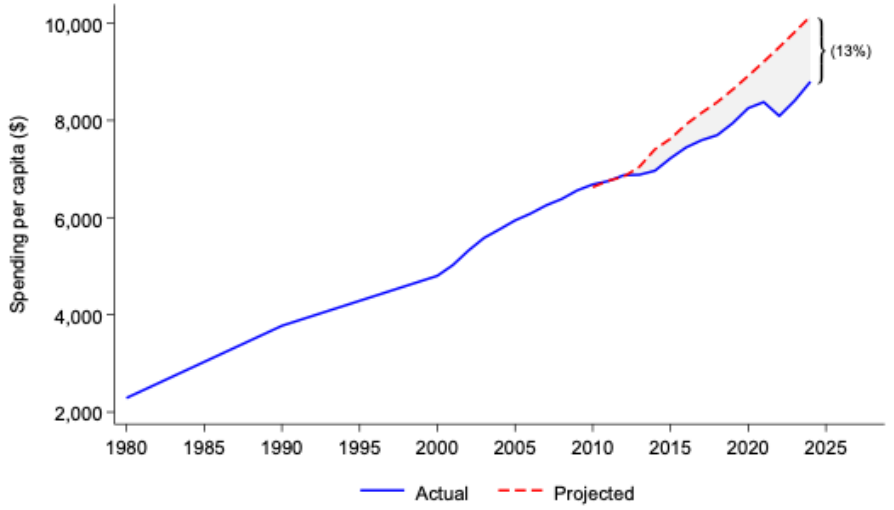
Spending by Payer



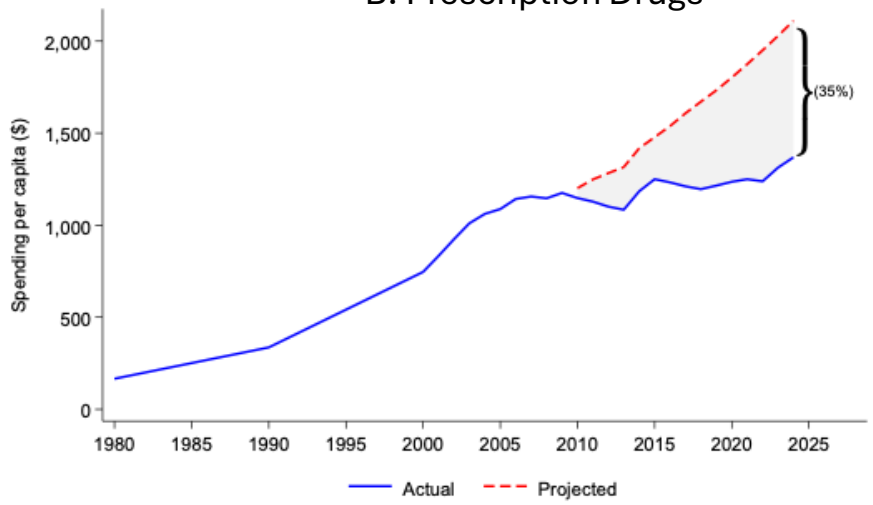
The **medical services market** is more important to understand that the **health insurance market**

Spending by Service

A: Acute Care



B: Prescription Drugs



Questions We Address

- Has the US bent the health care cost curve?
- How has it done so?
  - Medical care changes
  - Underlying economics

Static

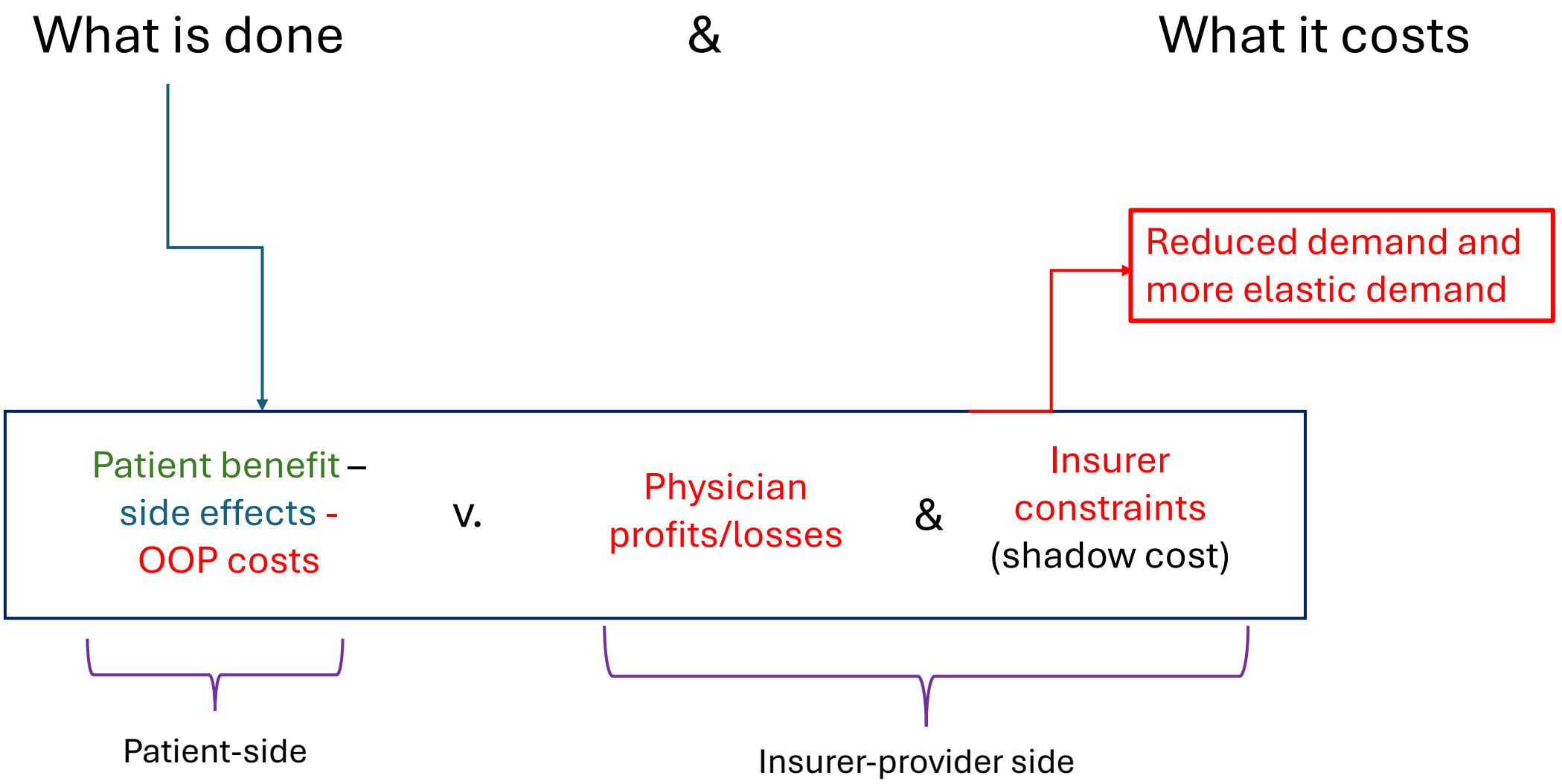
1. How much it is used?
2. How is it priced?

Dynamic

1. What is available?

- Modest attention given to
  - Is it ‘worth it’ to have reduced spending growth?
  - Can this be sustained?

Theoretical background: Static decision



Dynamics: What is available

Theory

T_0: No treatment

High disease burden, zero spending. Unmet need drives R&D.

T_1: Breakthrough

Works, expensive and with side effects. Big jump in spending — going from zero to $S_1 = P_1 \times Q_1$.

T_2: Follow-on innovation

Must beat T_1 on efficacy, side effects, price, or physician "profit." Often substitutes for T_1 rather than adding to it. Can have $S_2 < S_1$.

T_∞: Cure

Disease burden eliminated. If long-run supply is elastic, price falls. Spending declines.

Hip & Knee Replacement

T_0: 1890s

Theophilus Gluck experiments with ivory implants. Severe arthritis has no good option.

T_1: 1960s–1990s

Sir John Charnley develops modern implants. Open 10–12 inch incision, 5-day inpatient stay, SNF.

T_2: 2000s–present

Minimally invasive surgery: multiple small incisions, same-day discharge. By 2024, over 75% of replacements done outpatient at 40% lower cost.

T_∞: Cure

Nothing yet for arthritis, but many other examples like Hep C, HIV.

S_2 can be >< S_1, based on complementary / substitutability, unit costs differences, and utilization decisions

Empirical evidence on the spending slowdown

1. Cost-saving technological change

2. Long-run supply elasticity lowering prices (loss of patent expiration)
3. Improvements in population health (reduced smoking, pollution)

4. Demand changes (higher cost sharing, physician profits, insurer choices)
5. Price changes (administrative, or in response to demand)

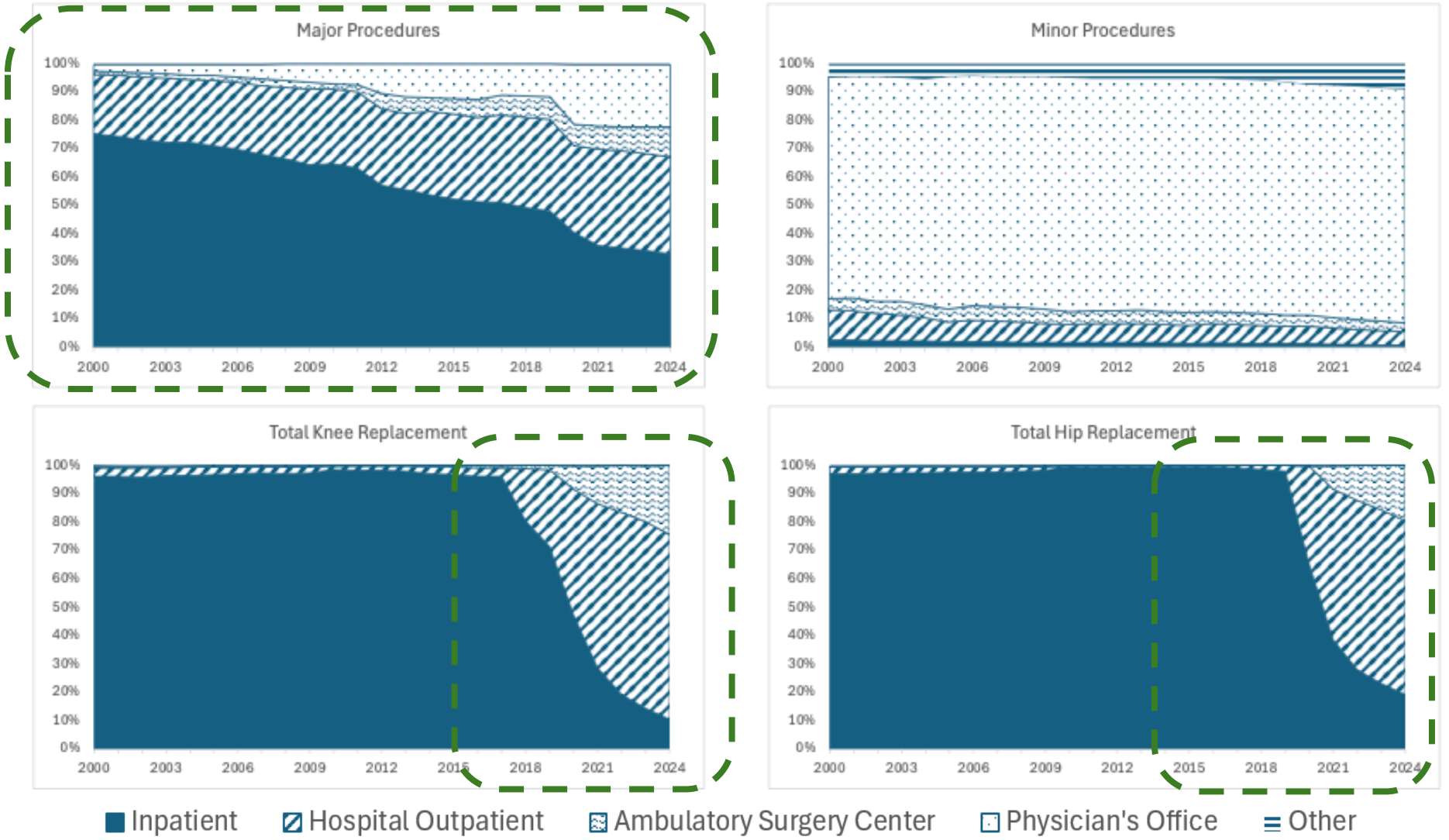
Empirically quantify how much each mechanism contributed to the slowdown

Cost saving technological change I: Minimally Invasive Surgery

Advances in surgical techniques lead major procedures to move from **inpatient → outpatient settings**

Outpatient procedures cost ~40% less than inpatient procedures

Shift to outpatient surgery explains **$92 billion (9%)** of the spending slowdown



Notes: Authors' tabulations from CMS claims data from 2010-2019 and extended through 2024 using the Physician/Supplier Procedure Summary public use files.

Cost Saving Technological Change II: Declining Urgent & Emergency Hospitalizations

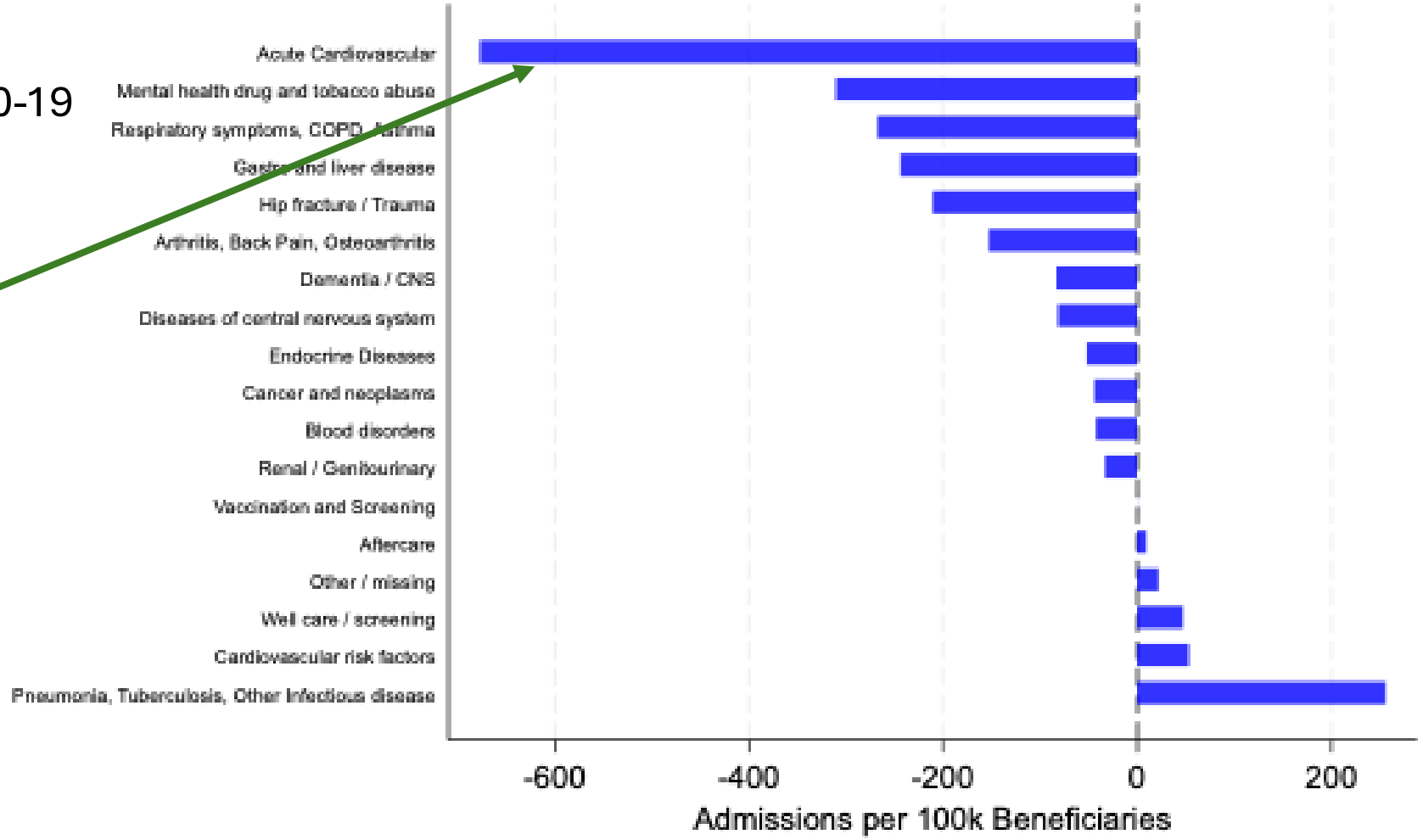
10% decline in age/sex adjusted hospitalizations for urgent and emergency conditions from 2010-19

Acute cardiovascular decline:

- Due to **preventive medical treatments**, anti-htn, statins (Cutler et al., 2019)
- Explains **$29 billion (3%)** of spending slowdown

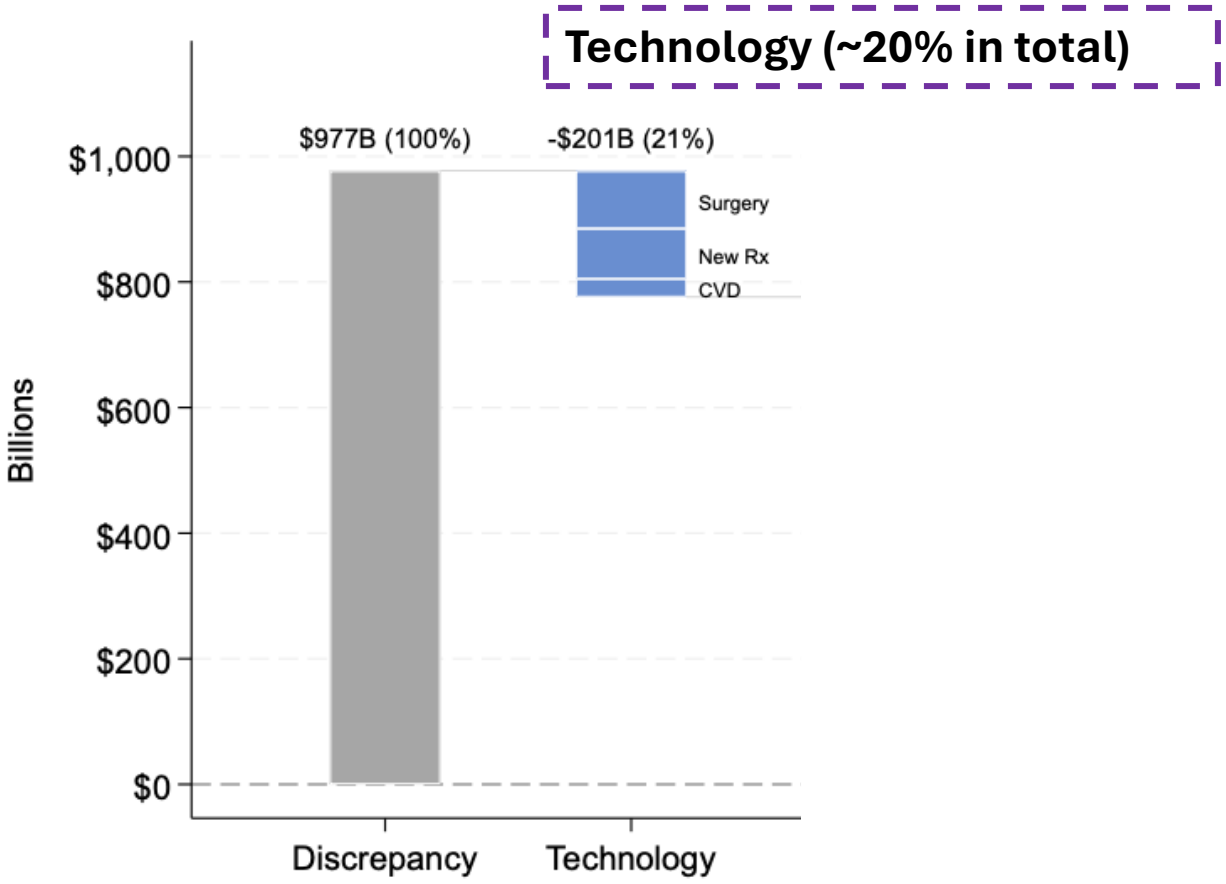
All other conditions decline:

- Explains $49 billion (5%) of spending slowdown



Notes: Source Medicare claims data. Admissions per 100k beneficiaries are age and sex adjusted within three-year age bins. Diagnosis categories are defined using ICD-CM codes as defined in Cutler et al. (2022).

Decomposition of the Spending Slowdown



Notes: This figure categorizes the $977B gap between projected and actual medical care spending into contributing factors. Analyses described in Cutler and Klarnet (2026).

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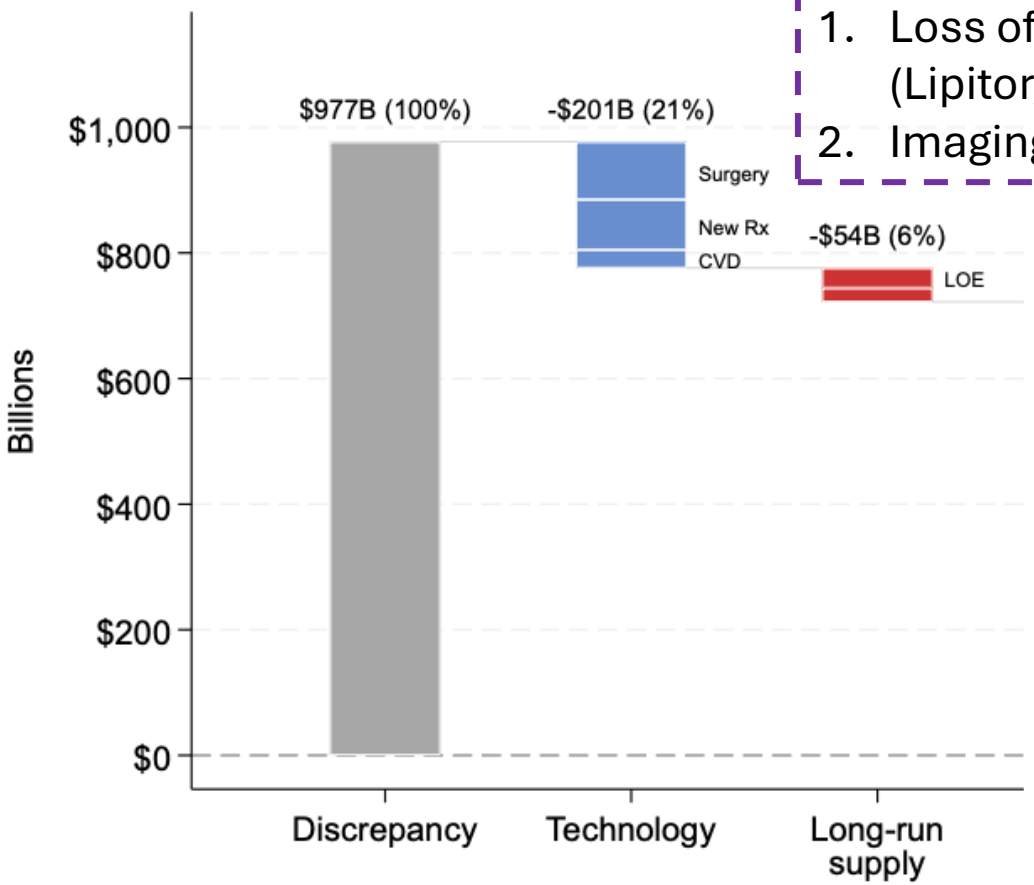

Long-run supply (6%):

1. Loss of patent exclusivity for several best-selling drugs, around 2011-12 (Lipitor, Plavix, Zyprexa)
2. Imaging price declines associated with reduced effort needed

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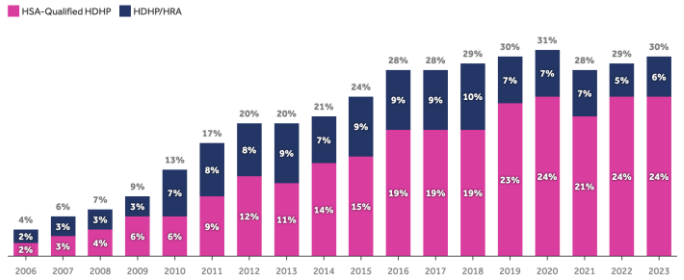
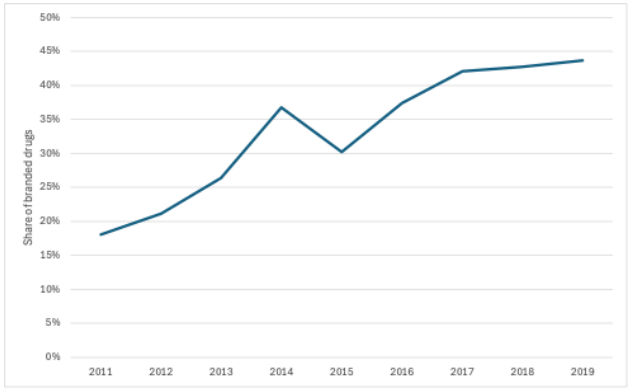
Demand reduction and efforts to increase elasticity

- Higher cost sharing
  - **5% spending slowdown**
- Physician payment moving from volume to value basis
  - **4% spending slowdown**
- Insurer restrictions on use
  - **8% spending slowdown**

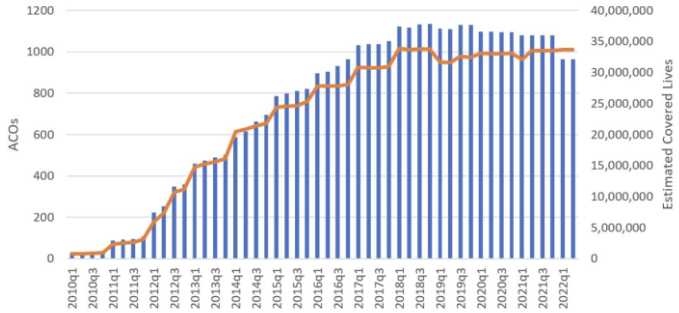
Share of Workers in High-Deductible Plans
Source: KFF (2023), Employer Health Benefits Survey



Prior Authorization on Branded Drugs
Source: Anne Kyle et al., 2026



ACOs and covered lives
Source: Muhlestein et al., 2022



Each of these may affect care for other patients, by changing the way that physicians approach practice.

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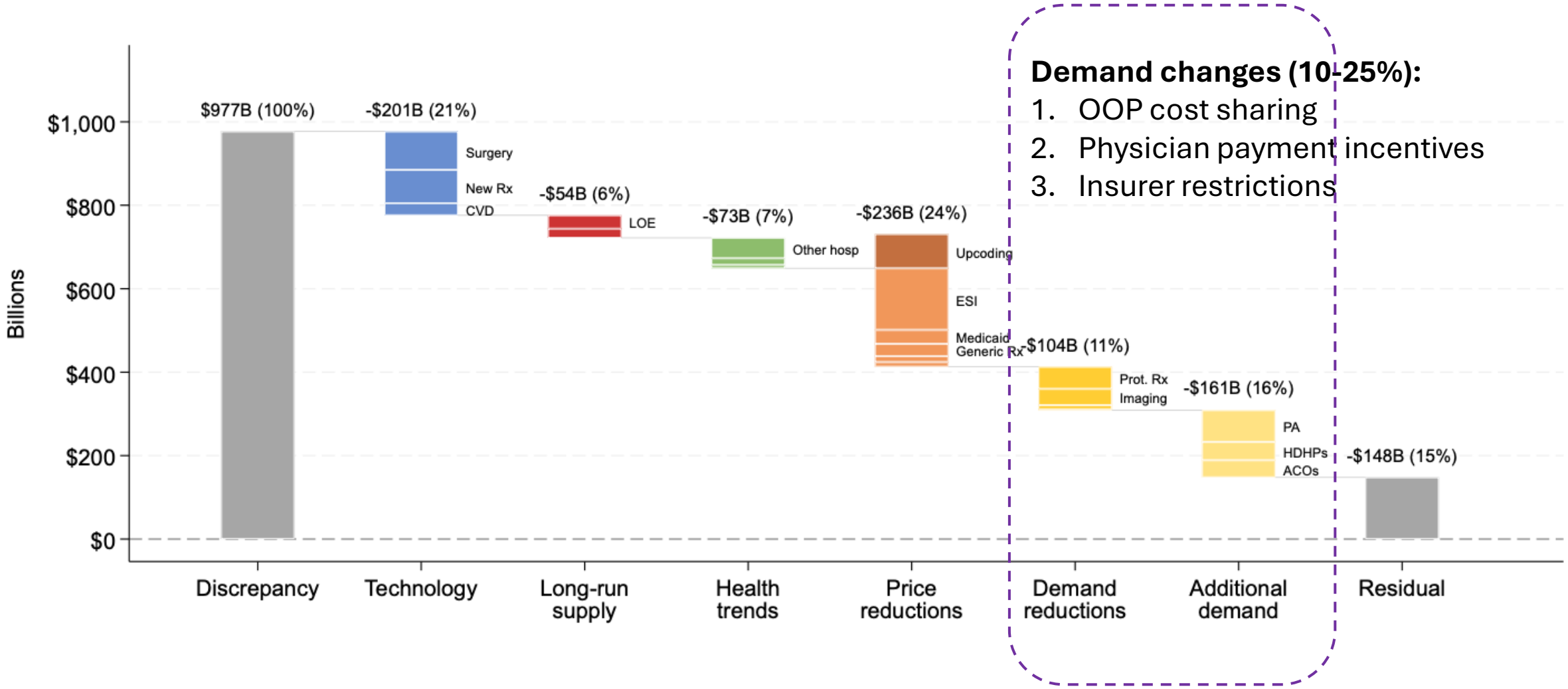

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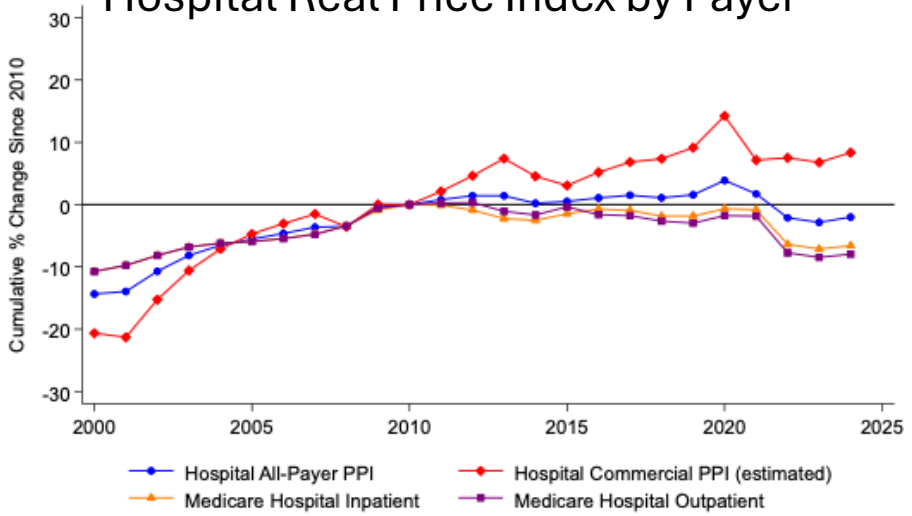
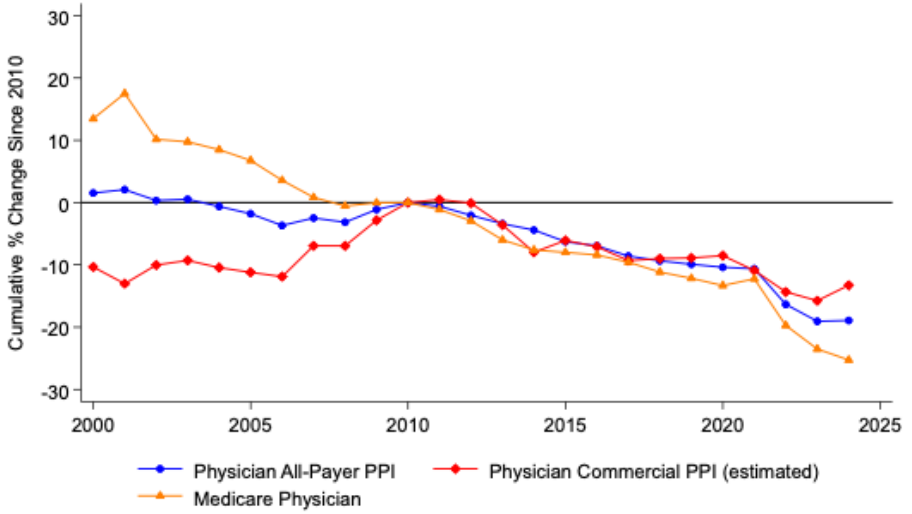
Slowdown of Price Growth

- Price growth fell from ~inflation + 1 or 2% to inflation
- Likely because of demand changes, though we do not know for sure
- Providers 'fought back' through upcoding, so total impact is difficult to determine.
- **24% spending slowdown**

Hospital Real Price Index by Payer

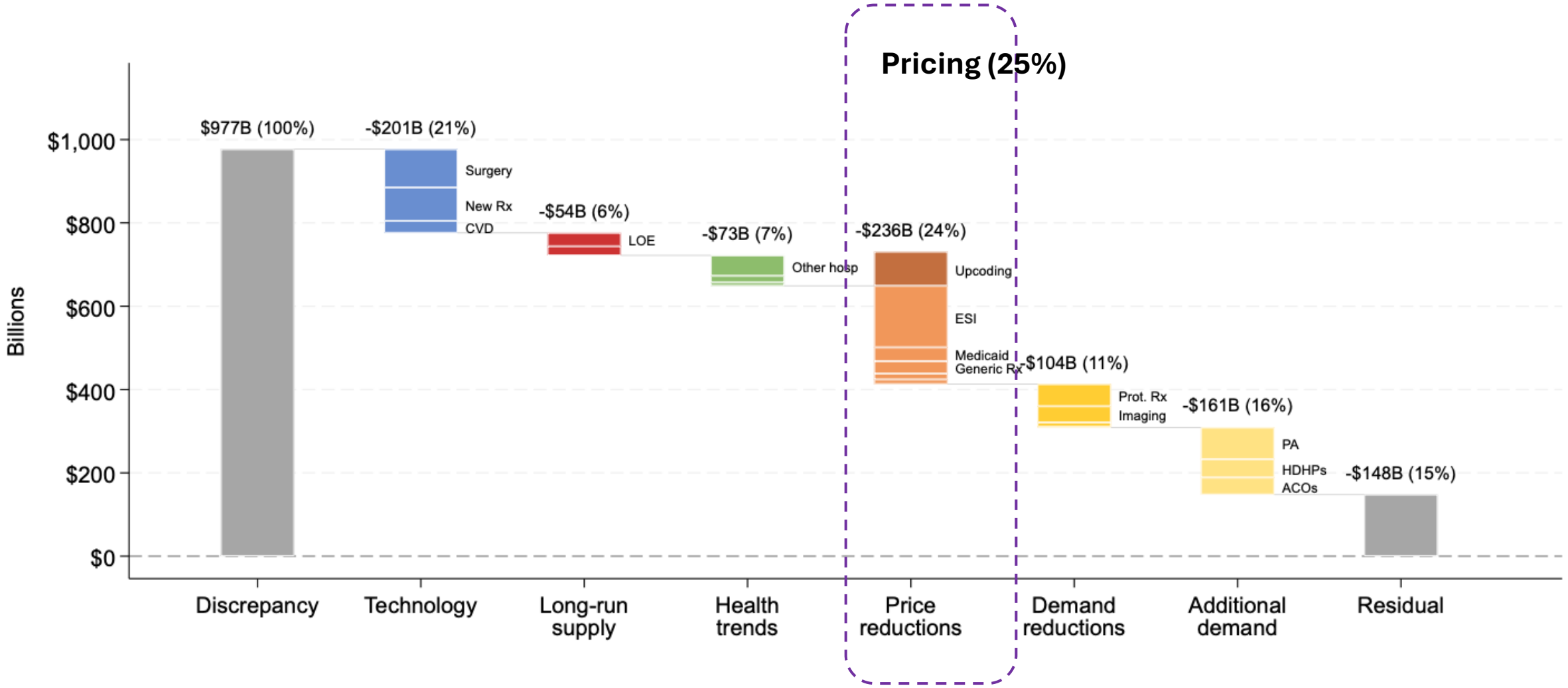


Physician Real Price Index by Payer



Source: authors calculations

Decomposition of the Spending Slowdown



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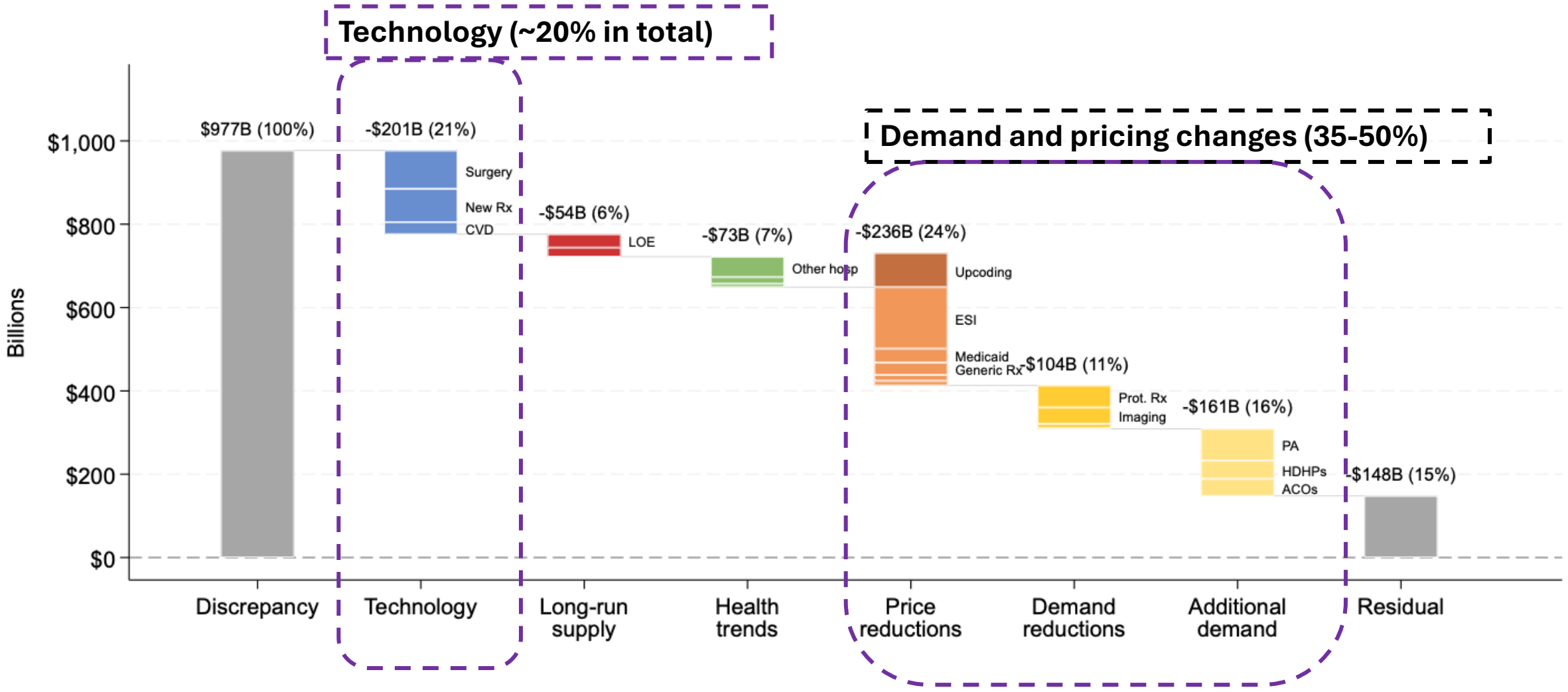

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Conclusion: Has the U.S. Bent the Cost Curve?

Yes.

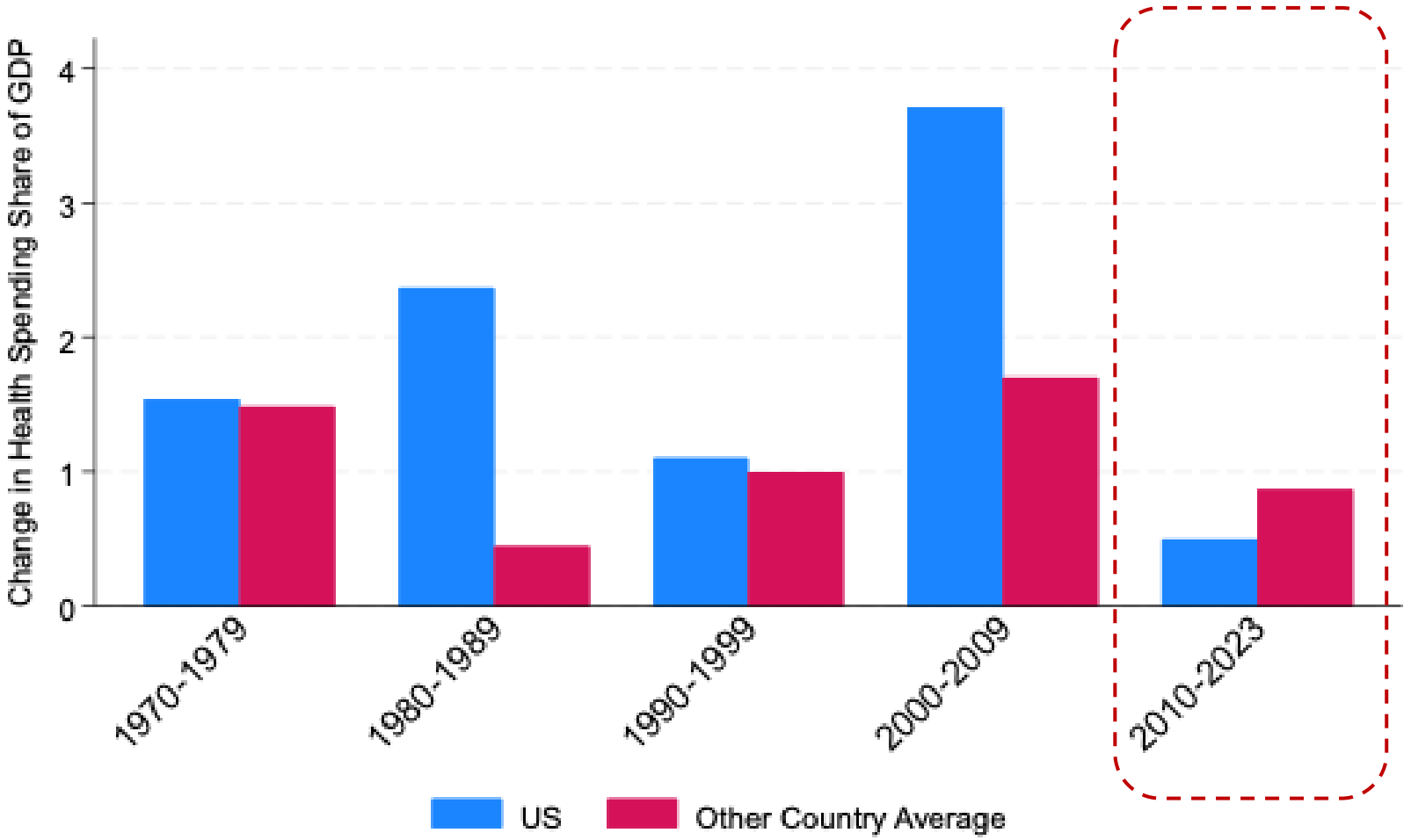
Some of this (but perhaps not all) has been associated with improved health.

Still the health care cost curve has not been bent as much as it could or likely needs to be.

Lessons

- Technology is no longer only a driver of increased spending.
- There are other potentials for money saving, including additional technological innovation and AI

The Slowdown is Large Relative to Other OECD Countries



2010-23 is the only 'decade' where spending growth relative to GDP was lower in the US than in comparable rich countries.

Notes: Source OECD. Medical spending excludes investment. Unique to this graph medical spending for the United States is measured from OECD data, not the NHEA. Other country average includes Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Iceland, Japan, Korea, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, and the UK.