Slowdown in Health Care Spending Growth: What, Where, Why?

Amy Finkelstein

Massachusetts Institute of Technology

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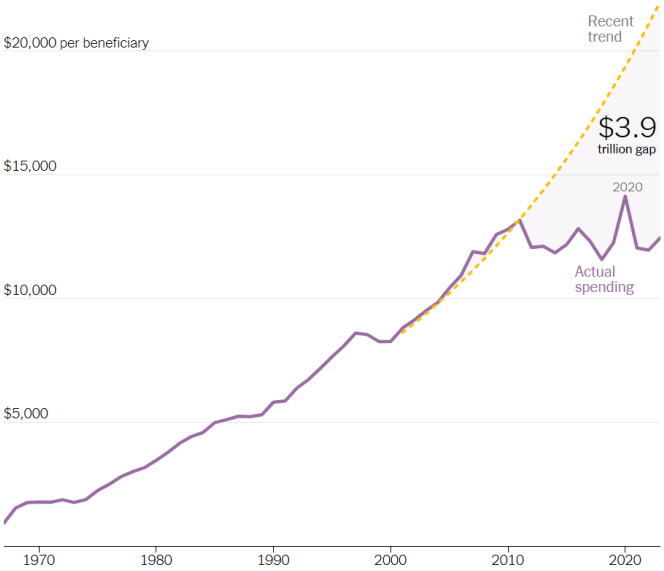
Slowdown in Medicare Spending



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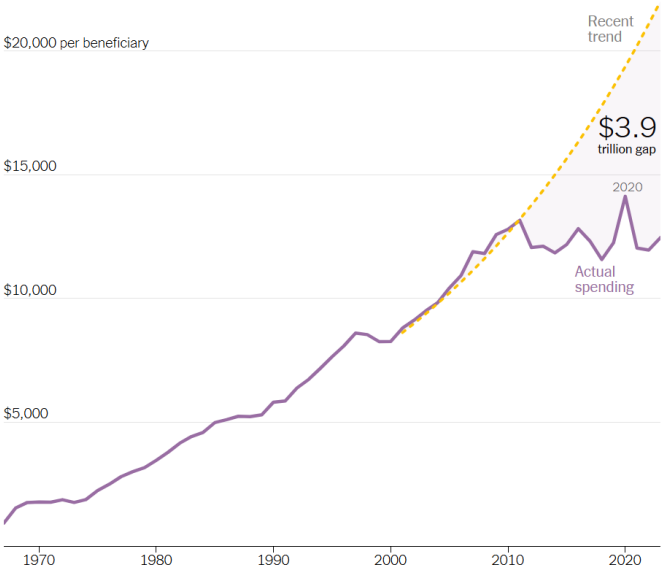

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$3.9 trillion is ...

85%	All federal pandemic relief
1.8x	Wars in Iraq and Afghanistan (military spending)
2.4x	All federal student loan debt
3.5x	War in Iraq (military spending)
5x	All military spending in one year
6x	Walmart revenue FY23
14x	Veterans spending in one year
18x	Salaries of all public school teachers in one year
27x	Food stamps (SNAP) in one year

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- It's happening in all countries, although more pronounced in US (Figure 2)
  - Suggests looking beyond direct effects of US health care policy (e.g. 2010 Affordable Care Act)
- It's happening across all types of medical care (Figure 4)
  - Acute spending, prescription drugs, long term services and support,...

Cutler and Klarnet: Decomposition of the Slowdown

- Decomposition of the slowdown (both for Medicare where data are richer, and overall)
- Identify several key drivers
  - Development of cost-saving technologies (20%)
  - Changes in demand (10-25%)
    - These include both shifts in site of care and reduced demand for certain types of care (e.g. imaging)
    - These in turn may reflect policy or insurer changes
  - Healthier population (10%)
    - Prior work suggests large role for technological progress in preventive, cardiovascular medicine (Cutler et al. 2019)
  - Reductions in rate of price growth (25%)

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3. Changing the narrative about technological change in medicine
4. (How) does this all relate to health?

How The Cost Curve Was Supposed To Bend (At Least for Medicare)

Atul Gawande, *The New Yorker* (2009)

"Most Americans would be delighted to have the quality of care found in places like Rochester, Minnesota, or Seattle, Washington, or Durham, North Carolina—all of which have world-class hospitals and costs that fall below the national average. If we brought the cost curve in the expensive places down to their level, Medicare's problems (indeed, almost all the federal government's budget problems for the next fifty years) would be solved. The difficulty is how to go about it."

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Peter Orszag, OMB Director (2009 Congressional Testimony)

"Some researchers believe health care costs could be reduced by a stunning 30 percent—or about $700 billion a year—without harming quality if we moved as a nation toward the proven and successful practices adopted by lower-cost areas and hospitals."

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  - Get providers in high-spending Miami to behave more like their low spending counterparts in Minneapolis
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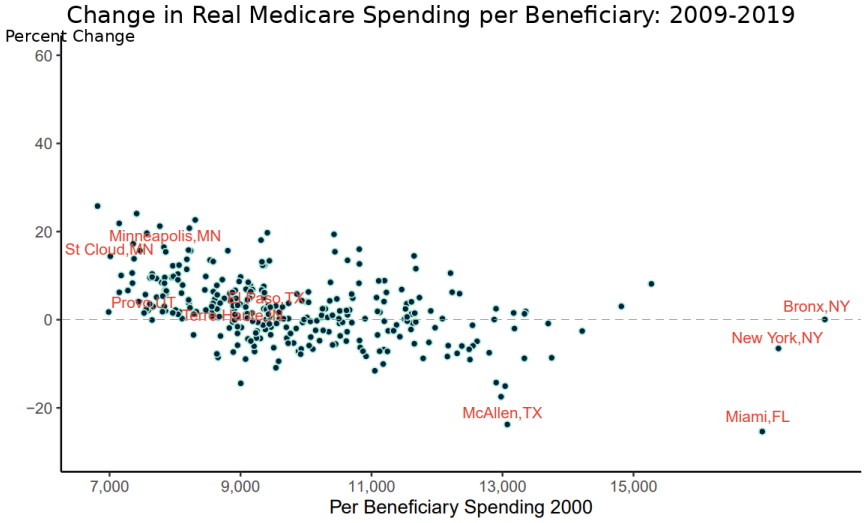
- So Did that Happen?
  - Did the slowdown in Medicare spending growth occur more in the higher-spending parts of the country?

Slowdown in Spending Growth Is More Pronounced in Higher Spending Regions



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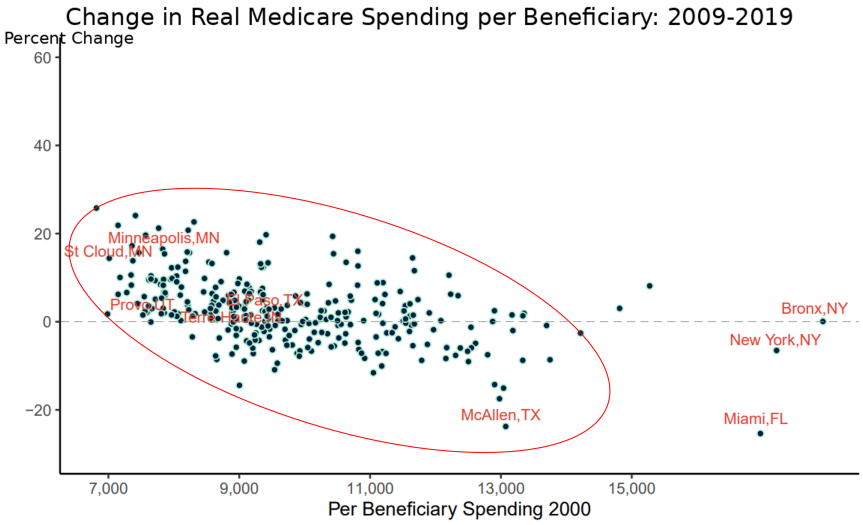
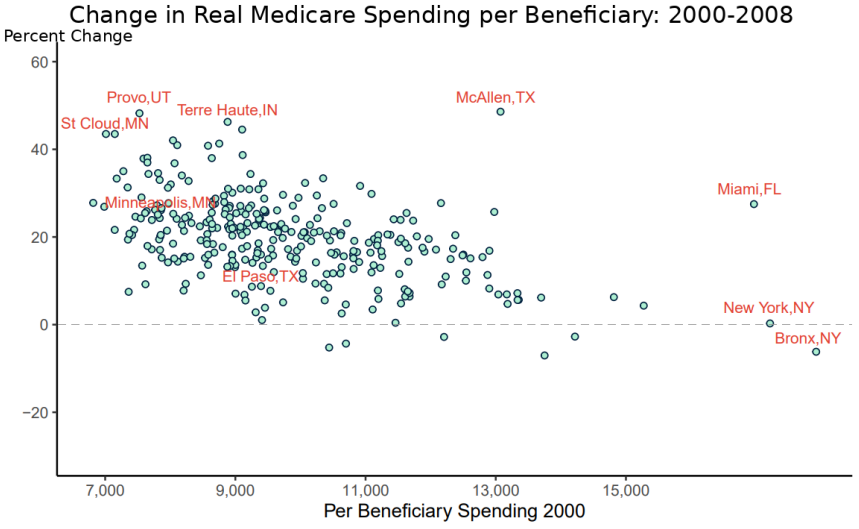


But This Was Also True Before the Slowdown Began



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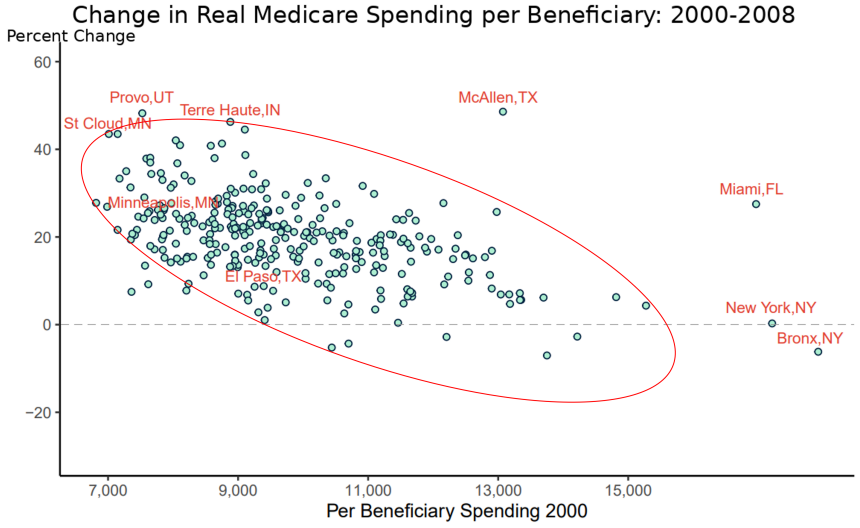

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- Or at least there's no compelling evidence that it did
- Consistent with Cutler and Klarnet's view that that 'the cost curve has not bent as much as it could, or as much as it needs to'

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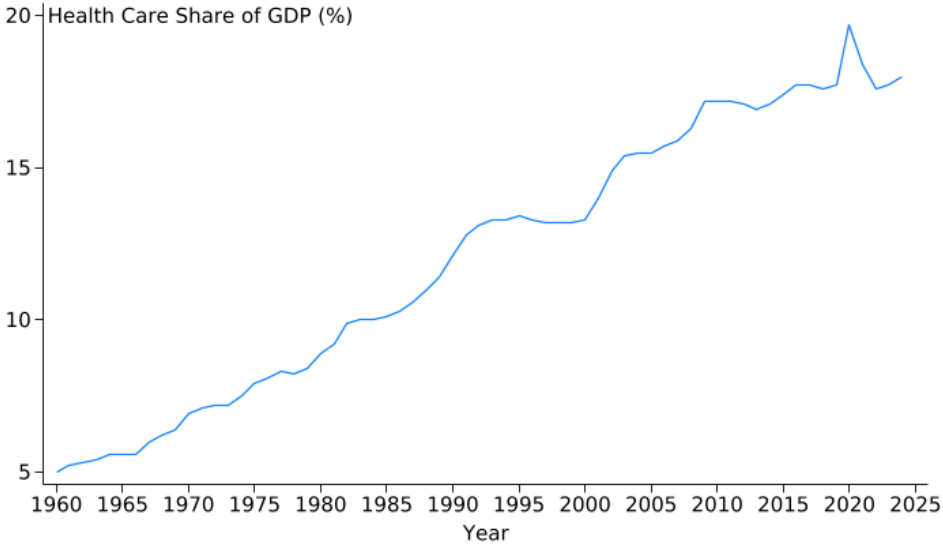

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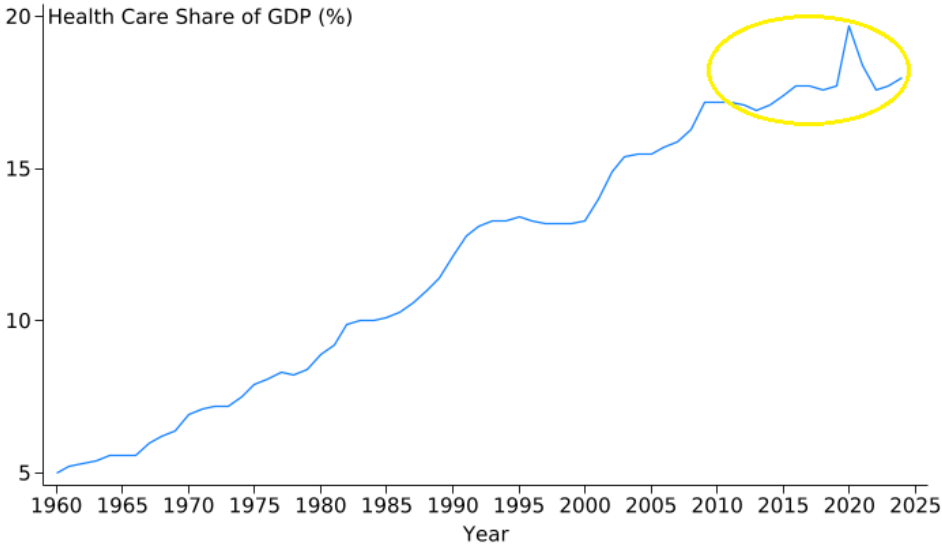

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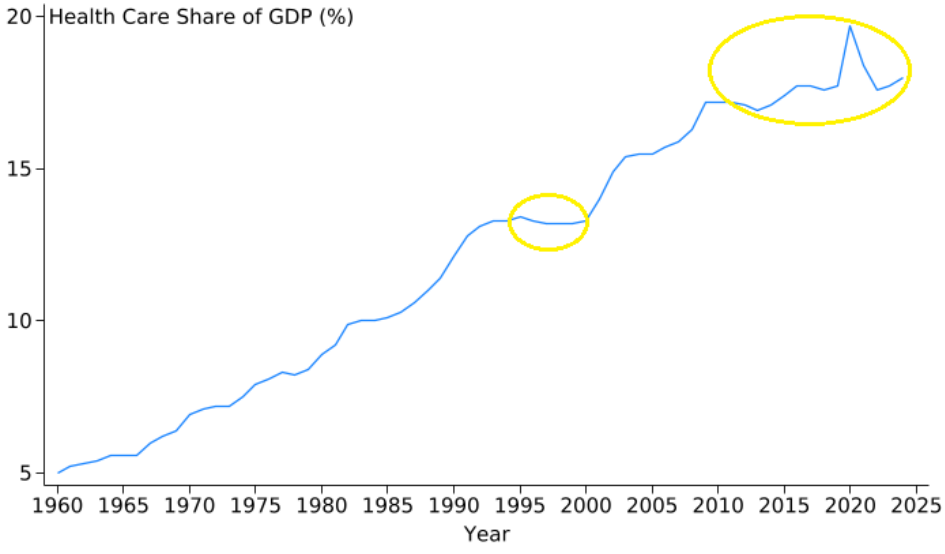

Technological Change: The Changing Narrative

- What I learned in graduate school
- What I learned between graduate school and this paper
- The narrative going forward

The Existing Narrative in late 1990s: Technological Change Drives Health Care Spending Growth

- Health care spending is rising at an "unsustainable" rate
- This creates enormous fiscal strain (half of health care spending is publicly financed)
- But spending growth has been 'worth it' in terms of the health benefits it has brought (Cutler 2004 'Your Money or Your Life")
- The major driver of health care spending growth is technological change (Newhouse 1992 JEP)
  - "The march of science" explains over half and maybe over three-quarters of health care spending growth since WWII

The Subsequent Narrative:
Endogenous Technological Change Drives Spending Growth

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  - Introduction of Medicare (Finkelstein 2007)
  - Introduction of Medicare Part D (Blume-Kohout and Sood 2013)

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- Evidence of Insurance-Induced Adoption and Innovation
  - Introduction of Medicare (Finkelstein 2007)
  - Introduction of Medicare Part D (Blume-Kohout and Sood 2013)
- Evidence that increases in demand for particular treatments increases medical innovation for them (e.g. Acemoglu and Linn 2004; Finkelstein 2004; Costinot et al. 2019)
- Key point of theory and empirics: Expected profitability affects not only the *rate* but also the *direction* of technological change in medicine

New Narrative (Cutler and Klarnet 2026): Health Care Innovation May No Longer Be Spending Increasing

- Idea: Changes in health policy and insurance design may be changing innovation incentives
- Alternative payment models, value-based care design, prior authorization etc
- Can create incentives for creating less expensive technologies
  - e.g. Innovations in surgery that allow for outpatient procedures (e.g. minimally invasive joint replacement)

Existing Evidence Consistent with This New Narrative

- Agha, Kim and Li (2022) " Insurance Design and Pharmaceutical Innovation":
  - Closed formularies (starting in 2012): PBM's start excluding new drugs in therapeutic classes which have more existing therapies and high prescription volume
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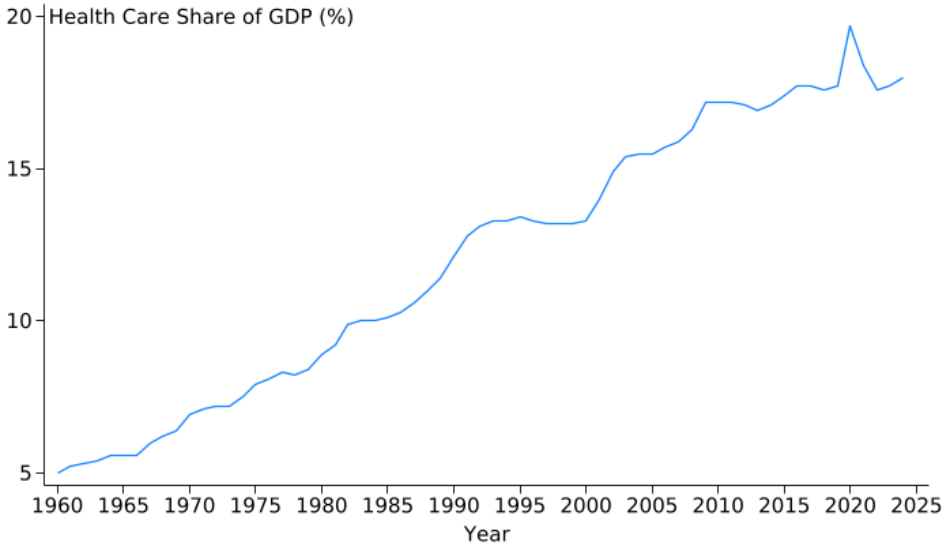
- Is US policy also creating spillovers to other countries?

Final thought: (How) Does This All Relate To Health?



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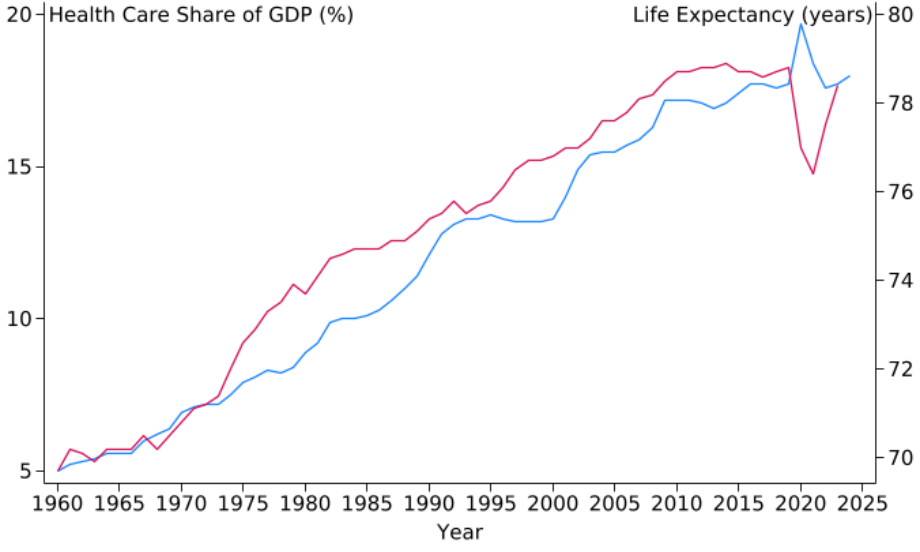

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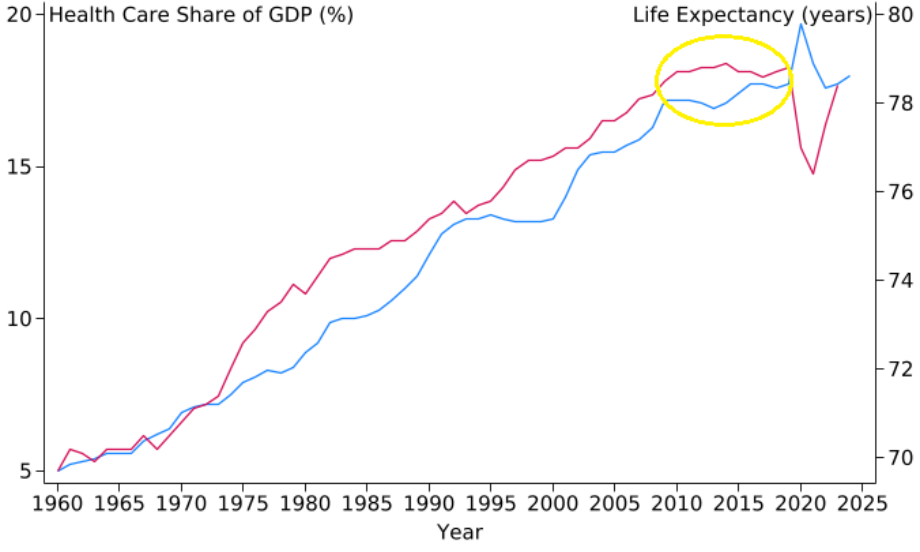

Conclusion

- Valuable new evidence on the nature of the spending slowdown
- Intriguing hypothesis about the changing nature of technological change in medicine: may no longer be / need not always be spending increasing
- Highlights important directions for future work:
  - Scope for further cost curve bending
  - Impacts of spending reduction on health
  - How much of the spending growth reduction is policy-induced (e.g. changes in demand; (some of) technological change?) and relatedly what might make spending growth take off again?