Understanding Healthcare Spending Trends: A Guide to Finding the Next B Opportunity

JAN 26, 2026

Table of Contents

Abstract

Between 2009 and 2019, US healthcare spending growth slowed to 1.7 percent annually in real per capita terms, less than half the historical rate of 3.7 percent 1970-2008. A recent Health Affairs study by Glied and Lui decomposes this slowdown, revealing four main patterns:

- Declining utilization with substitution toward lower-cost alternatives across hospitals, physicians, and pharmaceuticals

- Slower private hospital and physician price growth despite accelerating consolidation

- Unexpected decline in home health utilization among oldest Medicaid benefici

- Greater-than-projected compression in private insurance administrative costs

Key market opportunities emerge from these trends:

- $167.8B private physician spending residual suggests massive market for care substitution platforms

- $78.9B hospital spending reduction points to ambulatory and virtual care plays

- $58.6B pharmaceutical underspend indicates generic acceleration and specialty competition opportunities

- $34.1B Medicaid home health reduction reveals aging-in-place and family care support gaps

- $66.6B insurance administrative savings shows potential for continued automa

The data suggests regulatory tailwinds, large TAMs, and clear ROI cases exist fo non-physician workforce enablement platforms, hospital-to-home transition too specialty pharmacy cost management solutions, and administrative automation a claims processing, prior authorization, and care coordination.

Introduction: The Slowdown Nobody Sa Coming

Healthcare spending has been the bogeyman of American fiscal policy for decad Every projection showed costs marching inexorably upward, consuming an ever- share of GDP until the entire economy would theoretically consist of nurses and administrators shuffling papers about other nurses and administrators. Except t not what happened.

The 2009-2019 period saw inflation-adjusted per capita health spending grow ju percent annually, compared to the 3.7 percent historical rate. More remarkably, slowdown persisted even as 20 million people gained insurance coverage throug ACA. The healthcare share of GDP basically flatlined around 17-18 percent. An kicker - this moderation appears to have continued post-COVID, with 2019-202 showing the same 1.7 percent growth rate.

The Glied and Lui paper does something clever. They took CMS's 2009 projectic what 2019 spending would look like (pre-ACA), subtracted out all the forecasted effects of actual policies that got implemented (ACA, sequestration, various Mec payment changes, etc), and were left with a $783 billion residual. That's $783 bil less spending than expected even after accounting for known policy changes. Th

question is why, and more importantly for our purposes, what does this tell us al where to build businesses.

The answer matters because the conventional wisdom about healthcare cost driv has been wrong. The assumed iron laws - that reducing public payment rates wo just shift costs to private payers, that price controls would be offset by volume increases, that slowing one sector would just balloon another - turned out not to laws at all. This creates opportunity. When the fundamental assumptions change business models become viable that previously would have been dismissed as economically impossible.

The Four Patterns That Defined 2009-2019

Pattern One: Utilization Decline and Care Substitution

The first major pattern was straightforward utilization decline across major categories. Medicare and Medicaid inpatient stays per beneficiary both fell by ro 10-30 percent depending on the program. Private insurance saw a smaller but st meaningful 11 percent drop in inpatient utilization. This wasn't just fewer hosp admissions - prescription fills dropped significantly for Medicare (from 30.8 to 2 per beneficiary) and private insurance (from 7.2 to 6.0 per beneficiary), though Medicaid held steady.

At the same time, care was actively substituting to lower-cost alternatives. Outp visits increased across all payers even as inpatient declined. More strikingly, offi visits shifted from physicians to non-physician practitioners. Medicare saw non- office visits jump from 3.5 to 5.7 per beneficiary, Medicaid from 1.0 to 2.8, and p insurance from 1.9 to 3.0. Meanwhile physician visits declined across all three p

The pharmaceutical story followed similar dynamics. Generic prescribing rates jumped from 75 percent in 2009 to 90 percent in 2019. Several high-volume cate went over-the-counter (antihistamines, PPIs, nasal sprays), which likely accounts some of the prescription decline. And expensive specialty drugs like hepatitis C

treatments saw rapid generic competition after initial launches, preventing the c
explosion many forecasters expected.

This utilization pattern reveals something important - the healthcare system can
actually reduce consumption without apocalyptic consequences. Fewer hospital
fewer physician visits, fewer prescriptions. And patients seem to be doing fine o
better, given that we saw no corresponding spike in mortality or morbidity. The
substitution toward lower-cost alternatives suggests the previous level of high-
intensity, high-cost care delivery was producing diminishing returns.

Pattern Two: Price Growth Deceleration Despi Consolidation

The second pattern is genuinely surprising. Real (inflation-adjusted) costs per
inpatient hospital stay grew 2.1 percent annually from 2010-2019, down from 2.9
percent in 2000-2009. This deceleration happened during a period of acceleratin
hospital consolidation. About a third of hospitals were involved in mergers betw
2010-2019, and conventional wisdom said this would give them pricing power ov
private insurers.

But the price effects of mergers actually declined during this period. Mergers be
2010-2015 averaged just 1.6 percent price increases, lower than historical patter
Why? Because more of the consolidation involved combinations of small and lar
systems, which produce smaller price effects than mergers between already-larg
systems. Do the math: one-third of hospitals involved in mergers with 1.6 percen
average price effect translates to maybe 0.5 percent total impact on 2019 spendi
around $2 billion on a $430 billion private insurance hospital spending base. Ba
a rounding error.

The physician price story is even more dramatic. Real wages for high-earning
physician specialties fell between 1.8 and 8.2 percent from 2009 to 2019. Across
specialties, real wage and salary earnings declined 0.4 percent during 2012-2019
Some of this reflects shifting compensation from salary to business income, but t
overall moderation is clear. Meanwhile nurse practitioners saw real earnings gro

of 9.8 percent during 2012-2019, though they still earn about half what physicia
make.

This creates an obvious arbitrage opportunity. If you can deliver care with nurse
practitioners, PAs, and other non-physician providers instead of physicians, you
capturing real wage cost savings plus the substitution gap. The data shows patie
are already voting with their feet - non-MD visits are growing rapidly across all
payers. The market is saying it's okay to see an NP for a sinus infection or diabe
follow-up.

Pattern Three: The Medicaid Long-Term Care Puzzle

Here's something basically nobody predicted. Home health utilization among th
oldest Medicaid beneficiaries fell dramatically. The share of beneficiaries 85+ wi
home health use dropped from 46 percent in 2008 to 32 percent in 2018. This
contributed to Medicaid home health spending coming in 27 percent ($34.1 billi
below 2009 projections.

CMS actuaries correctly predicted a shift from institutional to home-based long
care, but completely missed that home-based utilization rates would decline. Th
paper identifies several potential explanations: declining smoking rates across b
cohorts (7.8 percent among 75-84 year-olds in 1998 down to 6.3 percent in 2008)
fewer elderly living alone (49 percent in 2009 down to 47 percent in 2019), and r
real average family incomes (from $44,909 in 2008 to $50,451 in 2018).

Translation: older Americans are healthier, wealthier, and more likely to have fa
support than forecasters assumed. The cohort aging into their 80s and 90s durin
period had lower lifetime smoking exposure, more financial resources, and bette
family structures than previous generations. This reduced their need for paid hc
health services.

The business implication is subtle but important. The long-term care crisis ever
predicted hasn't materialized in the form expected. Yes, the population is aging,
they're aging better. The opportunity isn't necessarily building massive instituti
or home health capacity - it might be tools that help healthy, financially stable el

people age in place with minimal formal healthcare intervention. Think less "bu more nursing homes" and more "help families coordinate care for aging parents.

Pattern Four: Administrative Cost Compression

Private insurance administrative costs came in 26 percent ($66.6 billion) below C post-ACA projection. The ACA's medical loss ratio requirements mandate that insurers spend at least 80-85 percent of premiums on actual medical care, with t remainder available for administration and profit. By 2016, 90+ percent of enroll across individual, small group, and large group markets were covered by plans meeting these standards.

Now, there's some gaming happening here. Insurers have incentives to shift cost related businesses or manipulate administrative cost definitions to meet MLR requirements. But even accounting for that, the compression is real. Administra spending as a percentage of premiums has declined meaningfully.

This matters for two reasons. First, it suggests the ACA's regulatory approach w better than expected at constraining administrative costs. Second, it means there continued pressure on insurers to find genuine efficiency gains. You can only ga the MLR requirements so much before you need actual administrative productiv improvements.

The opportunity is in building tools that deliver legitimate administrative saving claims processing automation, prior authorization streamlining, care coordinatic platforms, member communication systems. Insurers face regulatory pressure tc reduce admin costs and can't just shift everything to related entities. They need solutions.

Market Sizing Implications for New Ventures

Hospital Services: The Shift to Lower Acuity Settings

Private insurance hospital spending came in $78.9 billion below projections, Me
$54.3 billion below, Medicaid $54.3 billion below. Across all payers, that's about
billion in hospital spending that didn't materialize. Some of this reflects lower
utilization, some reflects price moderation, but the core message is that traditio
inpatient hospital care is a shrinking market in real terms.

The growing market is everything else. Outpatient visits grew across all payers.
Ambulatory surgical centers, urgent care centers, telehealth, hospital-at-home
programs - these are all capturing volume that historically went to inpatient sett
The data suggests we're still in early innings of this transition.

Market size estimates for hospital substitution plays should be based on the por
of that $187 billion residual that's addressable by lower-cost alternatives. Not al
inpatient care can move - you can't do major trauma or complex surgery outside
hospital. But a lot of observation stays, short-term acute care for manageable
conditions, post-surgical monitoring, etc can shift to other settings.

If you assume 30-40 percent of the hospital spending reduction is addressable by
care models (probably conservative), that's a $55-75 billion TAM. And it's a TAM
regulatory tailwinds, clear ROI cases (lower cost per episode with similar or bett
outcomes), and stubborn underlying trends (patients prefer convenience, payers
lower costs, providers need margin improvement).

Physician Services: The Rise of Non-Physician Practition

Private insurance physician spending shows a $167.8 billion residual, by far the
largest single category. This represents 43 percent of the total private insurance
residual and 21 percent of the overall spending slowdown. Medicare and Medica
physician spending also came in below projections, though not as dramatically.

The substitution pattern is clear - physician visits declining, non-physician visits
rising sharply. This isn't just cost shifting, it's a fundamental change in care deli
Scope of practice regulations for NPs, PAs, and other advanced practice provide
expanded during this period. More states granted independent practice authorit
Professional identity and patient acceptance both increased.

The market opportunity is in platforms that enable this transition. Workforce optimization tools that match patient acuity to provider type. Supervision and collaboration software for states that still require physician oversight. Training a credentialing systems to scale non-physician provider supply. Care protocols and clinical decision support designed for NP/PA workflows rather than just adapted physician patterns.

Size this market by thinking about the wage differential and visit differential. N earn roughly 50 percent of physician wages while handling visit volumes that gr from 1.9 to 3.0 per private insurance enrollee (a 58 percent increase). The efficie gains from optimal deployment of non-physician workforce are massive. Even capturing a small percentage of the $167.8 billion physician spending residual represents a multi-billion dollar TAM.

Pharmaceutical Spending: Generic Acceleration and New Drug Dynamics

Pharmaceutical spending came in $18.1 billion below projections for Medicare, billion below for Medicaid, $58.6 billion below for private insurance. Total pharmaceutical residual around $115 billion. The generic substitution story (75 percent to 90 percent of prescriptions) explains a lot of this, as does the rapid ge competition for expensive specialty drugs like hepatitis C treatments.

But there's another dynamic worth noting. New drug introductions slowed betw 2016-2019, and new drugs never exceeded 5 percent of retail specialty prescripti The pharmaceutical innovation pipeline didn't deliver the constant stream of expensive new therapies that forecasters assumed. This creates a lumpy opportu landscape.

When blockbuster new drugs do launch (think GLP-1s for weight loss currently) create massive short-term spending increases but also trigger rapid competitive responses. Ozempic and Wegovy dominated early, but now there are multiple competitors and biosimilars in development. The pattern seems to be: expensive drug category emerges, prices spike, competition intensifies, prices moderate.

The business opportunity is in tools that accelerate this cycle. Specialty pharmac platforms that create price transparency and drive competition. Biosimilar manufacturing and distribution. Patient access programs that reduce out-of-poc costs while maintaining volume. Pharmaceutical benefit management that's actu aligned with cost reduction rather than rebate maximization.

The TAM is significant because brand to generic conversion and specialty drug competition apply across all payers. The $115 billion pharmaceutical residual su there's massive value in solutions that accelerate competitive dynamics and gene substitution.

Long-Term Care: Demographics vs Reality

The Medicaid long-term care story deserves its own analysis. The $34.1 billion h health residual (27 percent below projections) runs counter to every demographi forecast. Population aging is real - the 65+ cohort is growing rapidly and will co to do so. But the relationship between age and healthcare utilization is more cor than simple headcount projections.

The data shows three factors driving lower than expected utilization: better heal status (lower smoking rates), more financial resources (higher real incomes), and stronger family structures (lower rates of living alone). Each of these reduces the for paid home health services among the oldest cohorts.

This suggests the market opportunity is not in replicating traditional home heal models at larger scale. Instead, look for adjacent plays. Technology that helps fa caregivers coordinate with professional services. Financial products that help m income elderly pay for care without qualifying for Medicaid. Home modification safety solutions that extend independent living. Remote monitoring that catches problems before they require intensive intervention.

The TAM might actually be larger than the $34 billion residual suggests, becaus you're serving a population that's staying healthier longer and has more resource They won't qualify for Medicaid home health, but they'll pay out-of-pocket or through insurance for solutions that maintain independence. Think of it as capt

the delta between “needs institutional care” and “could use some support” - a m bigger cohort with purchasing power.

Where the Money Is: Identifying High-Potential Markets

Care Delivery Transformation Plays

The hospital and physician utilization data points to massive opportunity in care delivery transformation. We’re talking about $187 billion in hospital spending a $167 billion in physician spending that came in below projections. Some of this better outcomes, some is deferred care, but a lot represents structural changes i and where care gets delivered.

High-potential areas include hospital-at-home programs (acute care delivered at patient homes with remote monitoring and periodic visits), ambulatory surgical centers for procedures that historically required inpatient stays, specialty telehe for conditions that don’t require physical exam, and hybrid models that combine person and virtual care.

The key is understanding the regulatory landscape and reimbursement dynamic Hospital-at-home gained permanent Medicare coverage in 2023, creating huge tailwind for these models. ASCs have strong Medicare and commercial reimbursement in many categories. Telehealth reimbursement remains uncertai is stabilizing around hybrid care rather than pure virtual.

Build businesses that have clear cost savings vs traditional care delivery (minimu 30 percent), equal or better outcomes, and positive patient experience. If you hit three, payers will pay and patients will choose you. The TAM is whatever percen of hospital and physician spending is addressable by your model - even a few pe of $350+ billion combined residual is a big market.

Workforce Optimization Solutions

The non-physician provider trend is one of the most durable patterns in the data Every payer, every year, more NP/PA visits and fewer MD visits. This reflects regulatory changes (scope of practice expansion), economic incentives (wage differentials), and patient acceptance (people are fine seeing NPs for most things

The opportunity is in platforms that help healthcare organizations optimize workforce mix and deployment. Think scheduling software that routes patients t appropriate provider types based on acuity. Clinical protocols designed for non-physician workflows. Supervision and collaboration tools for states requiring physician oversight. Credentialing and training systems to scale NP/PA supply.

Size the market by thinking about the productivity gains from optimal deployme a healthcare system can handle 30 percent of its patient volume with NPs instead MDs, and NPs cost 50 percent as much, that's a 15 percent direct labor cost savi a huge denominator. US physician services spending was around $800 billion in Fifteen percent is $120 billion in potential savings, of which tools enabling this transition could capture meaningful share.

The regulatory tailwinds are strong. More states are granting independent pract authority to NPs. Federal rules increasingly allow non-physician billing for servi that previously required physician involvement. Professional organizations are supporting scope expansion. Build tools that ride these trends rather than fighti them.

Administrative Efficiency Tools

The $66.6 billion insurance administrative cost residual suggests continued opportunity in automation and efficiency. MLR requirements create sustained pressure on insurers to reduce admin costs without sacrificing service quality. T means investments in technology that genuinely reduces work rather than just shifting it around.

High-potential areas include prior authorization automation (using clinical logic approve straightforward cases without manual review), claims processing straigh through processing (no human touch for clean claims), member communication

automation (chatbots and self-service for routine inquiries), and care coordinatio platforms (managing complex patients across providers and settings).

The key is demonstrating real cost reduction with maintained or improved outco Insurers are sophisticated buyers who will measure whether your tool actually re FTEs or just moves work from one department to another. Show clear before/aft metrics on manual work required, processing time, error rates, and member satisfaction.

TAM sizing is tricky because you're selling to a concentrated buyer base (a few hundred health plans and TPAs), but the spending base is enormous. Private hea insurance administrative costs were around $250 billion in 2019. If your tool can credibly claim to reduce admin costs by 5-10 percent for a specific function, and function represents 10-20 percent of admin spending, you're looking at a $1-5 bi addressable market. That supports meaningful venture-scale businesses.

Chronic Disease Management Platforms

The utilization data shows fewer physician visits but more non-physician visits a stable to declining inpatient stays. This suggests chronic disease management is shifting to lower-intensity, more distributed models. Fewer quarterly physician checks, more frequent NP or care manager touchpoints, remote monitoring, pati self-management with periodic clinical oversight.

The business opportunity is in platforms that enable this model. Remote patient monitoring for diabetes, hypertension, heart failure, COPD - conditions that are prevalence, high-cost, and manageable with proper monitoring and intervention management platforms that help nurses and community health workers coordina across multiple patients and providers. Patient engagement tools that drive beha change and medication adherence.

The TAM is based on chronic disease prevalence and cost. Diabetes affects 37 m Americans and costs around $400 billion annually in direct and indirect costs. Hypertension affects 120 million and contributes to cardiovascular disease costs Heart failure affects 6 million and costs $30+ billion. Even modest improvement

management (reducing hospitalizations by 10-20 percent, improving medication adherence, catching deteriorations earlier) represent billions in savings.

The regulatory environment is increasingly supportive. CMS has created dedicat payment codes for remote patient monitoring and chronic care management. Commercial payers are following suit. Value-based care arrangements reward population health management. Build tools that integrate with existing clinical workflows, produce measurable outcomes, and have clear ROI for payers and providers.

Regulatory Tailwinds Worth Riding

Several regulatory trends from the 2009-2019 period create persistent tailwinds building businesses around. The ACA's MLR requirements aren't going anywhe regardless of political changes - they've become embedded in how health insura works. This creates sustained pressure for administrative efficiency.

Medicare payment reforms (bundled payments, value-based purchasing, hospital readmission penalties) have proven stickier than expected. Despite initial skepti these programs have driven real changes in provider behavior and created infrastructure for continued quality/cost measurement. New businesses that hel providers succeed under value-based payment have clear value proposition and buyers.

Scope of practice expansion for non-physician providers continues across states. states that haven't granted full independent practice are expanding supervision requirements and billing rules. The long-term trend is clear - NPs and PAs will increasing autonomy. Tools that assume this future rather than fighting it will a better.

Telehealth reimbursement reached an inflection point during COVID but has stabilized around hybrid care models rather than pure virtual. This is actually b for businesses - pure virtual has limited use cases, but hybrid models (combinin

virtual and in-person based on patient needs) can address much broader populat
Build assuming hybrid is the steady state.

Hospital price transparency requirements are creating new data availability. Kn
what hospitals actually charge different payers for specific services enables all s
price shopping, reference-based pricing, and competitive dynamics. Businesses b
on transparent pricing data have regulatory wind at their backs.

Building Businesses Around Stubborn Trends

The most valuable businesses get built on trends that persist regardless of polic
changes or economic cycles. The 2009-2019 period included major policy upheav
(ACA), economic crisis (Great Recession), and significant market changes (accele
consolidation), yet certain patterns held throughout. These are the trends to bet

Care delivery shifting from high-intensity to lower-intensity settings and provid
appears structural. Patients prefer convenience, payers prefer lower costs, new
technology enables remote and asynchronous care. This trend survived policy ch
economic fluctuations, and pandemic disruption. Build businesses assuming inp
stays, traditional physician offices, and brick-and-mortar delivery continue decli

The shift from brand to generic pharmaceuticals accelerated throughout the per
despite new expensive specialty drugs. Generic substitution reached 90 percent
shows no signs of reversing. Every new branded drug faces faster generic compe
than the previous generation. Build businesses assuming continued generic
dominance and rapid erosion of specialty drug pricing power.

Administrative cost pressure on health insurers intensified and stayed intense. M
requirements, competitive pressure, employer demands, political scrutiny - all p
toward leaner administration. This survived changes in administration, market
concentration, and business model evolution. Build businesses assuming insurer
sustained pressure to reduce administrative costs.

Non-physician provider utilization grew across all payers, all settings, all condit
This reflects scope of practice changes, wage differentials, professional identity
evolution, and patient acceptance. It survived physician opposition, quality conc
and regulatory uncertainty. Build businesses assuming continued growth in
NP/PA/other advanced practice provider utilization.

The absence of cost shifting from public to private payers represents a major cha
from historical patterns. Private prices didn't spike when Medicare reduced pay
rates. Hospital consolidation didn't produce the price increases expected. This
suggests market dynamics have changed in ways that make regulation more effec
Build businesses assuming price discipline persists rather than reverting to hist
cost escalation.

Conclusion: Forecasting the Future of Health Spending

The 2009-2019 healthcare spending slowdown happened because fundamental
assumptions about cost drivers turned out to be wrong. Cost shifting between pa
was minimal. Volume didn't offset price controls. One sector's savings didn't bal
other sectors. The iron laws weren't laws, they were just lazy assumptions.

For entrepreneurs and investors, this creates opportunity. When the fundamenta
model changes, new businesses become viable that previously would have been
dismissed as economically impossible. You can build on substitution because vo
offsets aren't eating all the savings. You can build on price moderation because c
shifting isn't inevitable. You can build on one sector's efficiency without worryi
about balloon effects elsewhere.

The highest-value opportunities combine large TAM, stubborn trends, regulator
tailwinds, and clear customer ROI. Care delivery transformation plays (hospital-
home, ASCs, hybrid virtual care) hit all four. Workforce optimization (enabling l
substitution) hits all four. Administrative automation (prior auth, claims process
care coordination) hits all four. Chronic disease management platforms hit all fo

Market sizing should be aggressive but grounded in the data. The $783 billion t
residual represents real spending that didn't happen. Not all is addressable by n
business models, but meaningful percentages are. A business that can credibly
capture even one percent of an addressable market in the tens of billions is vent
scale and then some.

The regulatory environment matters more than founders sometimes acknowledg
MLR requirements, scope of practice rules, reimbursement policy, price transpa
mandates - these shape what's possible and profitable. The best businesses ride
regulatory tailwinds rather than fighting them. Understand the policy landscape
build with it rather than against it.

The most important insight from the data is that health spending growth can
moderate without catastrophe. Fewer hospital stays, fewer physician visits, fewe
prescriptions, less intensive care delivery - and outcomes stayed stable or impro
This proves the system was operating with significant slack and waste. The
opportunity is in capturing that slack through better models.

One final thought on forecasting. The paper notes that simple transparent algori
(like five-year moving averages) predict better than complex expert-driven foreca
This should humble entrepreneurs who think they can precisely predict market
evolution. Build for multiple scenarios. Stay flexible. Focus on solving real probl
with clear ROI rather than betting on specific future states.

The healthcare system is changing in ways that create genuine opportunity for n
business models. The 2009-2019 data shows which changes are durable vs transi
which assumptions are broken vs still valid, and where the money is vs where pe
think it is. Pay attention to what actually happened rather than what people pre
would happen. That's where the next generation of successful healthcare compa
will find their openings.

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