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TRENDS IN HEALTH SPENDING BY THE PRIVATE SECTOR AND MEDICARE

INTRODUCTION

Recent evidence from a variety of sources--the national health accounts (NHA), surveys of private employers, and the experience of large groups of employees--suggests that the growth in private health expenditures has slowed considerably in recent years, continuing at least through 1995. That decline has given rise to questions about the likely future growth of private health spending. It has also raised concerns about the comparative performance of the Medicare program, in which spending continues to increase rapidly. This memorandum explores those issues.

CBO'S PROJECTIONS OF NATIONAL HEALTH EXPENDITURES

The Congressional Budget Office's (CBO's) most recent projections of national health spending were distributed to the Congress in early 1995 and subsequently published as an appendix to *The Economic and Budget Outlook: An Update* (August 1995). Those projections assumed that total private spending for health insurance (including employment-based plans, individually purchased insurance, and medigap coverage) would grow by about 5 percent in 1994, 6 percent in 1995, and 7 percent in 1996. The projected growth rate for private health insurance premiums and benefits averaged about 7 percent a year over the 1995-2005 period.

The latest indicators of trends in private-sector premiums, however, suggest that CBO's projections of 6 percent growth in 1995 and 7 percent growth in 1996 may have been too high. Information from surveys of employers, as well as the experience of several major groups of public employees, suggests that premiums actually grew more slowly in 1995 than in 1994, not more rapidly as CBO's earlier projections assumed (see Table 1). Although they are not without their limitations, those indicators suggest a continuing decline in employers' health insurance costs (see Appendix A).

CBO plans to update its projections of national health expenditures later this year and, in the light of the 1995 data, is likely to lower its private-sector estimates for 1995 and 1996. At present, however, it is too early to conclude that the longer-term growth rates should be lowered. CBO's projections of private health expenditures are based on the assumption that continuing competitiveness in health insurance

TABLE 1. GROWTH IN EMPLOYMENT-BASED HEALTH INSURANCE PREMIUMS OR COSTS, BASED ON SELECTED SURVEYS AND GROUPS
(Annual percentage change, by calendar year)

	1990	1991	1992	1993	1994	1995
Surveys of Employers						
Hay Huggins	17	13	12	8	3	1
Foster Higgins	17	12	10	8	-1	2
KPMG Peat Marwick	n.a.	12	11	8	5	2
Bureau of Labor Statistics[a]	12	12	10	8	6	2
Major Public Employee Groups						
Federal Employees Health Benefits Program	9	6	7	10	2	-3
CalPERS[b]	17	11	6	1	-1	-4[c]
Minnesota State Employees Insurance Plan	14	10	6	6	3	-5

SOURCE: Congressional Budget Office based on Hay Huggins Benefits Reports; Foster Higgins National Surveys of Employer-Sponsored Health Plans; KPMG Peat Marwick, *Health Benefits in 1995, Executive Summary*; U.S. Department of Labor, Bureau of Health Statistics, Employment Cost Indexes.

NOTE: n.a. = not available.

a. Employers' share of premiums (or costs) only.

b. California Public Employees' Retirement System. CalPERS generally uses a July-to-June contract year.

c. August 1995 through December 1996.

markets will determine future growth in private health insurance spending. In the first half of the 1990s, that growth was slowed through a combination of aggressive private purchasers seeking better deals for their health care dollars and the growth of managed care plans that could compete effectively on price. CBO assumes that the resulting price competition among health plans and providers will continue in the future. Although premiums are likely to grow somewhat more rapidly than in the past two years, growth rates are unlikely to return to the high levels of the 1980s, when private health insurance spending increased at an average rate of almost 13 percent a year.

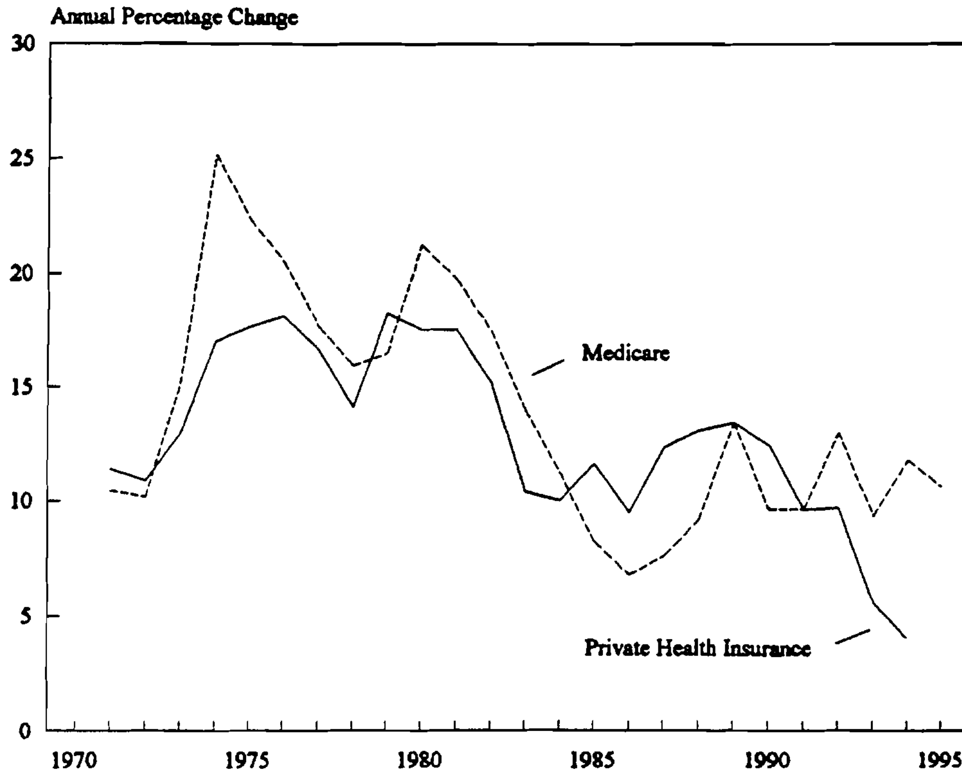
COMPARING THE PRIVATE SECTOR AND MEDICARE

Unlike private health expenditures, Medicare spending has continued to grow rapidly in the 1990s. That difference represents a marked change from the 1980s, when private and Medicare expenditures grew at similar average annual rates (see Figure 1, which shows growth in total payments for benefits). According to the NHA, while the annual growth in private health insurance expenditures fell from about 14 percent in 1990 to less than 6 percent in 1994, Medicare spending continued to grow at double-digit rates.

It is hardly surprising that the growth in private-sector health spending appears to have slowed significantly but the growth in Medicare spending has not. In the 1980s, Medicare and most private health plans generally paid claims based on providers' costs or charges, creating no incentives to control costs. Recent changes in private health insurance markets, however, have resulted in aggressive competition among private plans and corresponding efforts to constrain premium increases as plans compete for shares of the health insurance market. By contrast, competition still plays only a minor role in the Medicare market, and approximately 90 percent of Medicare beneficiaries are still enrolled in the traditional fee-for-service program. Moreover, Medicare payments on behalf of beneficiaries enrolled in managed care plans are directly tied to fee-for-service payments. Those differences in spending growth and market structure inevitably raise questions about whether Medicare could improve its performance by adopting private-sector innovations.

Precise comparisons of spending growth rates between Medicare and the private sector are difficult to make, however, and erroneous inferences are hard to avoid. Comparisons of the growth in total expenditures, for example, are problematic because of differing trends in the number and type of people covered by private insurance and Medicare. While the Medicare population increased steadily

FIGURE 1. GROWTH IN TOTAL BENEFIT PAYMENTS FOR MEDICARE AND PRIVATE HEALTH INSURANCE
(By calendar year)



SOURCE: Congressional Budget Office based on 1996 data from the Health Care Financing Administration, Office of the Actuary.

during the 1990-1994 period, the privately insured population probably declined.[1] So one would expect Medicare spending to grow faster simply because its covered population was growing faster than the privately insured population. Comparisons based on the rate of growth of spending per covered person would avoid that problem, but data limitations constrain such comparisons (see Appendix B), and other concerns about comparability would remain.

Drawing policy inferences from comparisons between the growth in employment-based premiums and the growth in Medicare spending per beneficiary is difficult because of the uncertainty about what the changes in private insurance premiums actually reflect (see Appendix A). Moreover, Medicare expenditures per beneficiary provide only a partial picture of the insured spending of the Medicare population, a significant proportion of which is financed by private medigap coverage and employment-based retiree coverage. Unless the costs of those plans are growing at the same rate as Medicare's costs, the growth rate of Medicare spending per capita presents a potentially biased picture of the growth in the insured health spending of the Medicare population.

Recently, researchers from both the Health Care Financing Administration and the Urban Institute have used data from the national health accounts, which are broken out by type of service, to make comparisons of spending growth in Medicare and private insurance using a common group of services.[2] The researchers based their comparisons on what they termed comparable benefit packages by excluding expenditures for some services that are covered under Medicare but not covered (or covered considerably less generously) under private plans, or the converse. Thus, for example, both studies excluded spending on home health and skilled nursing facility (SNF) services, because those services are covered generously by Medicare and used extensively by Medicare beneficiaries. Both also dropped prescription drugs and dental services, because those services are not covered by Medicare but are generally covered by private plans. By limiting the benefits included in the comparison, the studies produced results that place Medicare's relative performance in a much more favorable light than comparisons based on overall spending would.

Analysts who base Medicare/private-sector comparisons on the per capita costs of a common set of benefits argue that it is the only way to compare "apples to apples"--that is, it would be unfair to include services that were covered in one sector

1. Because of recent changes and other problems in the Current Population Survey, which is the primary source of information on trends in insurance coverage, it is difficult to produce a consistent annual series of the privately insured population for the 1990-1994 period.

2. Katherine R. Levit, Helen C. Lazenby, and Lekha Sivarajan, "Health Care Spending in 1994: Slowest in Decades," *Health Affairs* (Summer 1996), pp. 130-144; Marilyn Moon and Stephen Zuckerman, "Are Private Insurers Really Controlling Spending Better Than Medicare?" (monograph prepared for the Henry J. Kaiser Family Foundation, Washington, D.C., July 1995).

and not the other (if spending on those services grew at different rates than average spending). In fact, however, basing comparisons on a subset of covered benefits is potentially just as misleading, because the resulting comparisons reflect incomplete health insurance packages.

Variations in the package of services included in any comparison will produce different conclusions about Medicare's relative performance. Private health plans and Medicare vary in the benefits they cover, in the characteristics of their enrollees, in the cost sharing they require for different benefits, and in the ways in which they reimburse providers for different services. Consequently, each type of plan establishes different incentives for both providers and beneficiaries to use certain services more extensively than others, and different patterns of service substitution arise. Dropping some services from consideration may therefore bias comparisons of spending growth between different types of plans. The exclusion of home health and SNF services is a particular concern because those services may serve as substitutes for inpatient care for the elderly, and they are certainly important adjuncts to the acute care services that the elderly receive. Similarly, excluding prescription drugs drops an important private insurance benefit that may lower the use of other acute care services.

Because of the difficulties in comparing the growth of health expenditures in Medicare with that in the private sector, estimates of differences between the growth rates should be viewed with caution. Nonetheless, the striking difference in the recent experiences of the private and public sectors clearly suggests that private health plans have achieved more effective control over spending than has Medicare.

The policy implications of that finding are complex, however. In exchange for slower spending growth, employers and employees in the private sector have accepted more management of their use of health services and restrictions on their choice of providers. Most Medicare beneficiaries, by contrast, are still enrolled in the traditional fee-for-service Medicare program, which represents a type of unmanaged health plan that is fast disappearing in the employment-based health insurance market. For Medicare to adopt private-sector strategies would require a similar acceptance by Medicare beneficiaries of greater controls on their use of health services.

APPENDIX A
MEASURING TRENDS IN PRIVATE HEALTH EXPENDITURES

Several data sources describe trends in private health insurance spending. They use different measures of spending and provide limited information on why those trends might be changing. Understanding the reasons for slower growth in private health expenditures is particularly important when comparing the performance of the private sector and Medicare.

Two broad approaches to measuring the growth in private sector health spending exist: estimates based on the national health accounts, and surveys of employers to obtain data on the costs of health insurance for their employees. (The experience of large groups of public employees, such as the California Public Employees' Retirement System and the Federal Employees Health Benefits Program, also provide helpful information on the experience of powerful and aggressive purchasers of health insurance. Those groups, however, are not the focus of this discussion.)

The National Health Accounts

The Health Care Financing Administration produces the national health accounts, which track national health expenditures by type of spending and source of funds. Because the accounts provide estimates only of total health expenditures, they include the effects of growth or decline in covered populations as well as changes in average spending per capita.

The most recent NHA data provide strong evidence that the growth of private health expenditures slowed significantly in the first half of the 1990s. The estimates indicate that the annual rate of growth of private insurance spending fell from about 14 percent in 1990 to less than 6 percent in 1994 (the most recent year for which data are available). Although the size of the privately insured population probably declined slightly during the period, the rate of growth of per capita spending--measured as private health insurance spending per covered person--almost certainly fell. But, for reasons discussed in Appendix B, it is difficult to draw precise inferences from the NHA about trends in private health expenditures per capita.

Surveys of Employers

Several employee benefits consulting firms conduct annual surveys to obtain data on employers' health insurance costs, which may be reported in the form of average premiums per covered employee or average health insurance costs per employee. The Bureau of Labor Statistics (BLS) also conducts quarterly surveys of establishments to estimate changes in employers' labor costs, including health care benefits.

The Congressional Budget Office has studied four such surveys--by KPMG Peat Marwick, Hay Huggins, Foster Higgins, and BLS. The Peat Marwick, Hay Huggins, and Foster Higgins surveys produce estimates of average premiums (or average costs in the case of self-insured firms) per covered employee, whereas the BLS survey produces estimates of average costs per employee, measuring the employer's share of premiums only. (The other three surveys measure the combined shares of both the employer and the employee.) That is, the BLS measure takes into account changes in the number of covered employees as well as changes in the employer's cost of insurance.

All four surveys demonstrate remarkably similar declines in the rate of growth of employers' average health insurance costs over the 1991-1995 period (albeit with some variation in 1994). Average growth rates were about 12 to 13 percent in 1991 and fell to about 1 to 2 percent in 1995 (see Table 1). The generally consistent pattern among the surveys, in spite of differences in methodology and sample design, justifies the conclusion that employers' health insurance costs have fallen significantly in the 1990s. The broader implications of that conclusion, however, are less clear cut.

Employers' premiums represent only a portion of private health expenditures, and their rates of growth are not necessarily indicative of trends in the other components: premiums paid by people purchasing in the individual market (including medigap premiums), out-of-pocket spending, and other private spending. The findings from surveys of employers usually cannot even be generalized to all employers, because small employers are typically underrepresented and some surveys are not based on random samples.

Moreover, although the evidence indicates that employers' health insurance costs are growing more slowly than in the past, the reasons for that slowdown are not entirely clear. Slower growth undoubtedly reflects greater competition in the health care marketplace, but several other factors may also come into play. In the current dynamic health care market, for example, the types of plans offered by employers are changing. Part of the slowdown in premium growth reflects shifts--potentially of a one-time nature--into lower-cost types of plans. Data from the surveys of employers also indicate, however, that spending is growing more slowly within each of the

major plan types (indemnity insurance, preferred provider organizations, point-of-service plans, and health maintenance organizations). That finding suggests that slower spending growth reflects both competitive effects and shift effects.

Other factors--such as changes in covered benefits or cost sharing, changes in the mix of individual and family policies, or restrictions on retiree benefits--may also be contributing to the slower growth of employers' health care costs. But any conclusions about the effects of those factors would be more speculative because the available data are so limited.

APPENDIX B
ANALYTICAL ISSUES IN USING THE NATIONAL HEALTH ACCOUNTS

For several reasons, using the national health accounts to estimate private health expenditures per capita is difficult. Problems also arise in attempting to use the NHA to make spending comparisons between the private sector and Medicare.

Estimating Private Health Expenditures per Capita

Private health expenditures in the NHA include premiums for group and individual health plans, medigap premiums, out-of-pocket spending, and other private spending. The corresponding population consists of people who are covered by group, individual, or medigap insurance, and people whose care is financed through charity or their own out-of-pocket spending. To estimate per capita spending, that population count would have to be adjusted to avoid duplication (for people having more than one kind of health spending) and to account for partial-year coverage (for people who do not have insurance coverage for a full year). That information is not available either from the NHA or from other data sources.

Even if the relevant population could be estimated, conceptual problems would arise in interpreting the resulting per capita expenditure figure. Most people covered by group and individual insurance depend on private spending sources for their entire care. Those covered by medigap insurance, and many of those who pay for some of their services out of pocket, rely on government financing programs--Medicare and Medicaid--for the bulk of their health expenses. Combining such diverse populations into one measure of per capita spending would be problematic.

Similar problems arise when only expenditures financed by private insurance are considered. The available NHA data do not enable analysts to match spending with covered populations. The Office of the Actuary at the Health Care Financing Administration is developing new methods to produce health expenditure data, which will permit more disaggregation by source of payment than has been possible to date. Those data should be released later this year and may allow analysts to produce more meaningful per capita spending estimates from the NHA.

Comparing Medicare and Private-Sector Health Spending per Capita

Some analysts have turned to the NHA to aid comparisons of the growth in per capita spending between Medicare and the private sector--on the grounds that at least the

spending data on the two sectors are compiled in a consistent fashion. But, although the spending data may be compiled consistently, they are not broken down in a way that allows a direct Medicare/private-sector comparison. Because private insurance spending in the NHA includes medigap and retiree premiums, part of the expenditures of the Medicare population are included in private insurance spending. In addition, all the problems of developing the appropriate counts of people covered by insurance arise.