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Tracking Health Care Costs: What’s New In 1998?

The much-feared upswing in costs still is not as imminent as media reports suggest.

by Paul B. Ginsburg and Jon R. Gabel

At a time when the nation’s leading newspapers are proclaiming that health care costs are rising again, this review of trends in health care costs tells a different story. The media report that insurers are raising premiums to restore their profit margins and that underlying costs are rising as a result of growing use of expensive pharmaceuticals and diminished abilities of health plans to obtain discounts from providers. Although there is truth to these observations, the most recent systematic data on cost trends—1998 private insurance premiums, 1997 provider revenues, and 1997 and 1998 payrolls in health services establishments—show only a small upswing in the rate of increase of costs. Perhaps a more substantial increase is just around the corner, but recall that in early 1997 the media were trumpeting that health care costs were rising. The data described in this paper show that their predictions have not come to pass.

We begin with a discussion of trends in the rate of growth of health care costs, which are proxied by data on providers’ revenues and on payrolls in health services establishments. We then turn to premiums for employment-based health insurance. Finally, to gauge the impact of these trends on consumers, we look at employees’ share of health insurance premiums and their out-of-pocket spending for medical services and prescription drugs.

Recent Data on Health Care Spending

Data on revenues reported by health care providers show that the rate of increase in health care expenditures rose modestly in 1997 (Exhibit 1). Our expanded version of the Milliman and Robertson Health Cost Index shows that after adjustment for general inflation, revenues per capita increased 1.8 percent in 1997, compared with 0.9 percent in 1996. This rate of increase is less than the rate of growth in real per capita gross domestic product (GDP), which was 2.8 percent in 1997.

Data from the Bureau of Labor Statistics on payroll costs in health services establishments provide another vantage point on expenses incurred by health care providers. Although payroll is only one component of provider costs, it is an important one, and these data are available with the shortest lag. Real payroll per capita increased 3.6 percent in 1997, compared with 2.4 percent in 1996. This increase is comparable with that of provider revenues. In nominal terms, payroll data for the first five months of 1998 are similar to those for 1997 (see Exhibit 3).

Rates of growth in both provider revenues and payrolls have declined sharply in the 1990s, reaching lows in 1994 and 1995. Although growth rates have increased since then, the increases have been modest, well below those of the 1980s.
EXHIBIT 1
Annual Change In Per Capita Health Care Expenditures, 1990–1997

<table>
<thead>
<tr>
<th>Year</th>
<th>National health expenditures&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Expanded health cost index&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Payroll, health services establishments&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>6.4%</td>
<td>5.5%</td>
<td>5.4%</td>
</tr>
<tr>
<td>1991</td>
<td>4.2</td>
<td>3.1</td>
<td>4.9</td>
</tr>
<tr>
<td>1992</td>
<td>5.0</td>
<td>4.4</td>
<td>4.4</td>
</tr>
<tr>
<td>1993</td>
<td>3.2</td>
<td>3.1</td>
<td>2.8</td>
</tr>
<tr>
<td>1994</td>
<td>2.2</td>
<td>0.7</td>
<td>1.9</td>
</tr>
<tr>
<td>1995</td>
<td>1.3</td>
<td>1.2</td>
<td>1.9</td>
</tr>
<tr>
<td>1996</td>
<td>1.2</td>
<td>0.9</td>
<td>2.4</td>
</tr>
<tr>
<td>1997</td>
<td>–&lt;sup&gt;d&lt;/sup&gt;</td>
<td>1.8</td>
<td>3.6</td>
</tr>
</tbody>
</table>

**SOURCES:** See below.

**NOTES:** Data presented here are adjusted for general inflation. Adjustment is based on the chain-type gross domestic product (GDP) price index developed by the U.S. Department of Commerce, Bureau of Economic Analysis.

<sup>a</sup> From the National Health Accounts database at the Health Care Financing Administration, National Cost Estimates Unit.

<sup>b</sup> Calculations by the authors using data from Milliman and Robertson’s Health Cost Index database, expanded to include Medicare.

<sup>c</sup> From U.S. Department of Labor Bureau of Labor Statistics, Employment, Hours, and Earnings database. Payroll calculated as the product of production workers, average hours per week, and average hourly wage.

<sup>d</sup> Not available.

Among the major components of provider revenues, the contrast between the high rates of increase for drugs and the low rates for hospital and physician spending is striking (Exhibit 2). Increases in drug revenues have been in double digits for three years now. Most of this increase reflects growth in units rather than in price. For example, in 1997 expenditures increased 11.5 percent, while the drug component of the Consumer Price Index (CPI) increased only 2.5 percent. The trends in revenues for hospitals and physicians are similar to each other, but one should note that hospital revenues consist of a decrease in revenues for inpatient services (from declining rates of admissions and lengths-of-stay) and a relatively high rate of increase for outpatient services (not shown).

Among the components of payroll costs, the higher growth rate in 1997 than in 1996 is accounted for entirely by more hours worked (Exhibit 3). The increase in the average hourly wage—3.2 percent—was the same as that for 1996. In contrast, increases in average hourly wages in all industries rose to 3.8 percent. The historical context is important. For many

EXHIBIT 2
Annual Change Per Capita In Health Care Expenditures, By Component, 1990–1997

<table>
<thead>
<tr>
<th>Year</th>
<th>Total health</th>
<th>Hospital</th>
<th>Physician</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>10.1%</td>
<td>9.4%</td>
<td>9.6%</td>
<td>14.7%</td>
</tr>
<tr>
<td>1991</td>
<td>7.1</td>
<td>7.1</td>
<td>5.7</td>
<td>12.4</td>
</tr>
<tr>
<td>1992</td>
<td>7.3</td>
<td>7.8</td>
<td>5.0</td>
<td>11.7</td>
</tr>
<tr>
<td>1993</td>
<td>5.8</td>
<td>6.5</td>
<td>3.7</td>
<td>7.1</td>
</tr>
<tr>
<td>1994</td>
<td>3.2</td>
<td>3.0</td>
<td>2.5</td>
<td>4.7</td>
</tr>
<tr>
<td>1995</td>
<td>3.8</td>
<td>3.1</td>
<td>3.2</td>
<td>10.9</td>
</tr>
<tr>
<td>1996</td>
<td>3.2</td>
<td>2.9</td>
<td>1.4</td>
<td>11.3</td>
</tr>
<tr>
<td>1997</td>
<td>3.9</td>
<td>2.4</td>
<td>2.0</td>
<td>11.5</td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ calculations using data from Milliman and Robertson’s Health Cost Index database, expanded to include Medicare.

**NOTE:** Data presented here are not adjusted for inflation.
years wage rates rose much more rapidly in health care than in other industries, but that disparity ended in 1994. Does the 1997 result portend slower wage growth for health care workers in relation to workers in other industries?

Data for the first five months of 1998 do not answer this question. They show roughly unchanged rates of growth for hours but an increase in the rate of growth of wages in health services establishments—roughly in line with the increase for workers in all industries.

**Insurance Premiums**

In sharp contrast to anecdotes in the media, premiums for employment-based health insurance actually increased only 3.3 percent in 1998 (Exhibit 4). Most predictions were for increases in the 5–7 percent range. Although the increase for 1998 is higher than the 2.1 percent increase in 1997, it continues to be below the rate of growth of hourly earnings (Exhibit 3). The premium increase was relatively uniform among health plan types, ranging from 2.9 percent for both health maintenance organizations (HMOs) and point-of-service (POS) plans to 3.8 percent for preferred provider organizations (PPOs).

Some analysts have questioned whether low premium increases could reflect changes in plan mix or reduced benefits, but neither explanation appears to be correct. The KPMG Peat Marwick data that we use here are based on responses to a question on the premium change from the previous year for the most popular plan of each type. So if one type of plan had a higher level of premium than another type, changes in mix would not affect the data used here to describe trends. The KPMG survey indicates that deductibles for conventional and in-network PPO and POS services today are lower than they were in 1994. Only 2 percent of employers reported a decline in the overall level of covered benefits from 1997 to 1998.

Exhibit 4 combines data on premium trends with data on provider revenue for the non-Medicare population. From 1992 through 1994 premium increases exceeded underlying cost increases by a substantial margin, and health plans were very profitable. However, this reversed in 1995. In 1996 and 1997 premium increases lagged behind expenditure increases, and profit margins in health plans fell considerably. For 1998 analysts have been expecting that premium trends will be above trends in provider revenues. However, the KPMG estimate of premium increases re-
ported here suggests that this may not turn out to be the case. The 1998 increase in premiums is no higher than the 1997 rate of increase in the corresponding Milliman and Robertson index.

This pattern traces an underwriting cycle. When insurance is profitable, firms keep premiums low to enter new markets and expand market share in existing markets. However, these activities tend to be cut back when profits are down.

IMPLICATIONS FOR CONSUMERS

Consumers appear to be receiving substantial benefits from the low rates of growth in costs. This was not the case a few years ago, when at the same time that growth rates of premiums for employment-based insurance were dropping rapidly, the proportion of the premium paid by employees was rising (Exhibit 5). This trend appears to have reversed (or at least leveled off) in 1995 or 1996. Since then, employee contributions to coverage have grown more slowly than premiums. Indeed, when we combine the data in Exhibits 4 and 5, we find that employee contributions have been declining over the past three years. A delayed reaction to the slowdown in premium growth and tightening labor markets may have been factors in ending the trend of requiring employees to contribute a higher proportion of the premium.

Consumers also have had very good news on their out-of-pocket spending for medical care. For example, data from the U.S. Department of Labor's Consumer Expenditure Survey show that out-of-pocket spending for medical services was 9 percent lower in 1995 than it was in 1990. Consumers' spending for drugs increased only 11 percent—compared with a 56 percent increase in drug expenditures per capita (Exhibit 2). Similar declines in the proportion of medical services financed through consumer out-of-pocket payments are reflected in the Health Care Financing Administration's (HCFA's) National Health Accounts. These low trends in out-of-pocket spending may be attributable to the rapid shifts from conventional coverage to managed care. Switching to an HMO reduces consumers' out-of-pocket responsibility from a deduct-
ible of perhaps $250 and coinsurance of 20 percent to payments of $10 per physician visit and $5 per prescription filled. For those switching to PPO or POS products, similar savings are available to the extent that patients use network providers. However, some of consumers’ financial gains are accompanied by restrictions in choice and other constraints of managed care.

**CONCLUSION**

When Health System Change began this annual synthesis of data on cost trends two years ago, our major challenge was to demonstrate to readers that the decline in the rate of increase in costs was broad and sustained. Many were skeptical that data they had seen reflected only the employer share of premiums or that it reflected only the routine underwriting cycle in insurance and not the costs experienced by insurers. Now that the trends are better understood, many want to look beyond the present year to 1999 or 2000.

When looking to the future, we must distinguish between trends in premiums and trends in the costs that underlie insurance. Much of the media discussion has focused on premiums. In the short run, low profit margins for insurers will affect the rate of growth of premiums as insurers become less aggressive in keeping prices low to expand market share. Consequently, premium increases could well be higher in 1999, about two years after originally predicted by the media. But over a slightly longer period, the dominant influence on premiums is underlying costs. An acceleration of costs could be brought on by the rapid introduction of new drugs and other new technologies and by the increasing difficulty that health plans have in obtaining provider discounts. However, the expansion of information on effectiveness, growing use of secondary prevention, continuing excess capacity among health care providers, and continued aggressiveness on the part of purchasers will work to hold costs down.

The authors acknowledge the superb research assistance of Peter Swanljung, access to data provided by Jay Thayakaran of Milliman and Robertson, and the financial support of the Robert Wood Johnson Foundation.
NOTES
3. HCFA’s National Health Accounts obtain a two-way matrix of data from both providers and insurers. These data are generally recognized as the “gold standard” for studying cost trends and are used extensively by researchers and policy analysts. Readers of Health Affairs are familiar with these data from the regularly published work of Katharine Levit and colleagues at the HCFA Office of the Actuary.

The Milliman and Robertson Health Cost Index (HCI) is obtained from various surveys of providers, some widely known and some proprietary. It is designed to serve as a leading indicator of private health insurers’ claims experience. Thus, it is limited to health services that tend to be insured: inpatient and outpatient hospital services, physician services, and prescription drugs. Because provider revenue data tend to cover all patients, the HCI analysts subtract data on Medicare reimbursements. Revenues for Medicaid and uninsured patients are not removed. The HCI contains more current data than the National Health Accounts. Because the HCI is designed to track the experience of a private policy with a $250 deductible, but we are interested in tracking total expenditures, we have obtained data adjusted to reflect a $0 deductible and expanded it to include Medicare spending.

For 1996 and earlier years, some of the estimates from the National Health Accounts and the Milliman and Robertson index have been revised from those published in previous syntheses on health care cost trends. These series are routinely revised as more complete data become available. The implication for users of the series is that estimates for the most recent years are subject to more error than are those for earlier years. This is a price we willingly pay for more timely tracking of trends.

4. These data include all nonsupervisory workers in health services establishments. Nonsalaried health professionals are not included.

5. We use nominal rates of growth because the GDP price index is not yet available for the second quarter.

6. Note that these data and the data presented in the remainder of the paper are in nominal terms (not adjusted for inflation).

7. However, May and June 1998 data on producer prices have reflected sharp increases in drug prices. If this proves to be more than an aberration, it would portend an acceleration in growth of spending for drugs.

8. See, for example, Findlay, “Study: Health Costs Held in Check.”


11. The Consumer Expenditure Survey asks a sample of approximately 5,000 households about their spending by category of goods and services over the past quarter. For health services, there are separate questions for health insurance premiums, medical services, drugs, and medical supplies. The results that we report for medical services refer to the second category only and do not include insurance premiums. These questions have not changed over the period reported, so comparisons over time are expected to be valid.