Joint Economic Committee
CHAIRMAN ROBERT F. BENNETT
ECONOMIC POLICY RESEARCH
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HEALTH INSURANCE SPENDING GROWTH – HOW DOES MEDICARE COMPARE?

Policymakers are considering whether and how to reform Medicare. The "Baby Boom" generation is quickly approaching retirement, and there is a strong desire to add a prescription drug benefit to Medicare. Both these events put increasing pressure on the Medicare program to be as cost efficient as possible. As part of the Medicare reform debate, a question has arisen regarding Medicare's ability to control costs. Does Medicare have a competitive track record compared to other public and private insurers? How well has Medicare controlled the sometimes explosive growth in health care costs? This report compares the growth rate of Medicare spending with that of a number of other major public and private health insurers over the last two decades.[1]

PRINCIPAL FINDINGS

- *FEHBP and CalPERS, the two leading market-oriented government insurance programs, have delivered cost control comparable to Medicare's, while offering more comprehensive coverage.* FEHBP provides health insurance for federal workers and retirees. CalPERS provides health insurance for California state and municipal workers and retirees.

- *Despite being shielded from rising prescription drug costs, Medicare is no better at cost containment than other government insurance programs.* Over the last two decades the pattern of cost growth per enrollee has been:
  - Medicare costs grew 6.7 percent per year;
  - FEHBP costs grew 6.5 percent per year; and
  - CalPERS costs grew 6.9 percent per year.

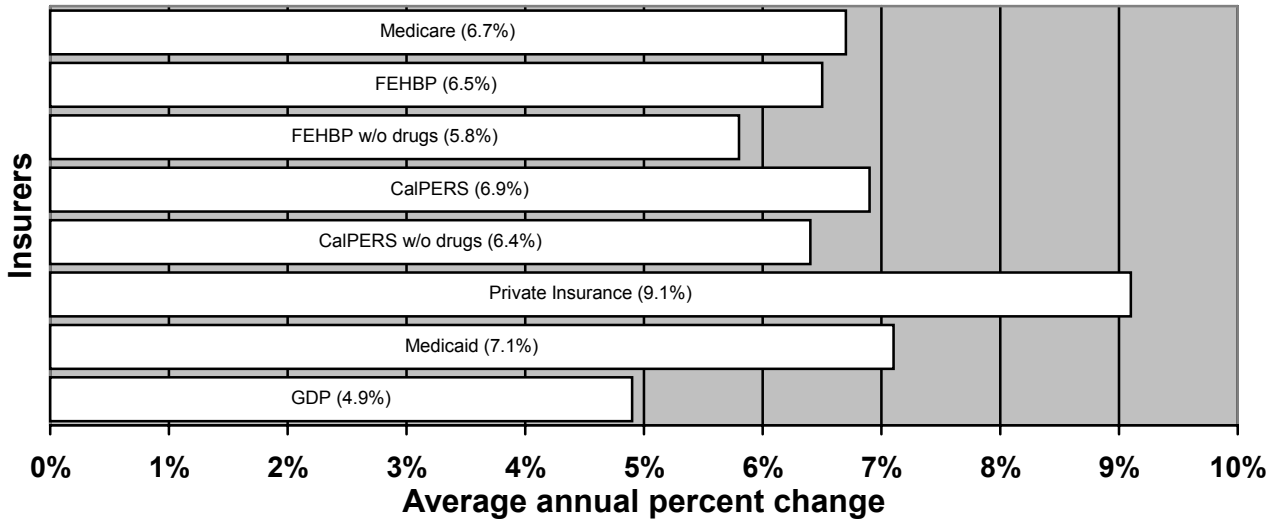
- *Medicare has the least generous benefits package among leading forms of insurance.* Medicare covers 56 percent of total health care expenses, while typical employment-based health insurance covers 70 percent.[2] Also, Medicare does not provide prescription drug coverage; FEHBP, Medicaid, CalPERS, and most private insurers do. Moreover, the Medicare benefits package has not grown significantly since the creation of the program in the mid 1960s; other insurers have consistently expanded the range of services that they cover.[3]

- *Medicare's cost growth has been competitive compared to that of other large insurers, but it has not faced the explosive cost of prescription drugs.* If FEHBP had not provided drug coverage, its costs would have grown by an estimated 5.8 percent per year over the last two decades; CalPERS' costs would similarly have grown by an estimated 6.4 percent per year. Medicare costs grew 6.7 percent per year over this period.

COST GROWTH OF MAJOR INSURERS OVER THE LAST TWO DECADES

Some recent research suggests that Medicare has done a better job of controlling costs than have private insurance plans.[4] While that may be true on the surface, this report reveals that comparing only Medicare and private insurance may be the wrong comparison.[5] Two of the most often cited market-based models for reforming Medicare are two other public insurers: the Federal Employees Health Benefits Program (FEHBP) and the health insurance program of the California Public Employees' Retirement System (CalPERS). This report compares the growth in Medicare spending to the growth in spending in FEHBP and CalPERS, as well as private health insurance and Medicaid. These comparisons adjust for a number of factors that might otherwise distort the comparison, including enrollment growth and benefit differences, for example drug coverage.[6] In order to take into account differences in population growth, the different insurers are compared on a per capita basis. In order to adjust for the most significant differences in benefits, the effects of prescription drugs are factored out for some insurers.

Chart 1. Per Capita Spending Growth for Major Health Insurers, 1983-2002[1]



Spending growth rates for the different insurers are presented in Chart 1 and Table 1. Many of the insurers show similar patterns in their per capita cost growth over time. Table 1 splits the time period into an earlier and later period of about a decade. All the insurers studied show higher growth rates in the earlier time period and lower in the more current time period.

The time period used was determined by the availability of data for the insurers analyzed, but different time periods could have been used. Focusing on too short a time period results in very misleading conclusions. For example, looking at only the last five or six years would incorporate Medicare's best performance since Medicare was created and the other insurers' worst, including two years of negative Medicare growth following the Balanced Budget Act of 1997 (BBA97).[7] Going farther back removes some of the volatility and any short-term advantage of one insurer over another.[8] However, the data from two or three decades ago may not tell us much about what to expect in the current market. The growth rates presented in this report are shown as nominal (non-inflation adjusted) annual rates of

change. Per capita Gross Domestic Product (GDP) is also displayed to show how these programs have grown compared to the rest of the economy.

The Market-Based Public Insurers

The California Public Employees' Retirement System (CalPERS) -- Over the past two decades, health insurance spending under CalPERS has grown at an average rate of 6.9 percent per year. CalPERS has covered outpatient prescription drugs, unlike Medicare, so some of this increase reflects the pressure of rising drug costs. When an adjustment is made to remove the estimated effects of prescription drug coverage, the CalPERS growth rate drops to 6.4 percent per year.[9]

CalPERS relies on two levels of competition to help control costs. On one level, health plans compete for access to the CalPERS market. Not all plans are necessarily allowed to offer coverage to the 1.3 million state and municipal employees, retirees and their families.[10] The state negotiates access to their employees and retirees. Plans with unacceptable premiums, quality, access, etc. are kept out. This provides a strong incentive for health plans to offer the best service at the most competitive price or risk not gaining access to the CalPERS market.

The second level of CalPERS competition occurs at the employee/retiree level, where participating health plans compete for market share. Again, this competition is based on a number of dimensions including premium price, quality, and access. In CalPERS, workers and retirees select their own plan from among the competing plans; this choice is not made by an employer or the government. This customer choice presents the health plans with a strong incentive to be responsive to the workers and retirees as their primary customers.

Federal Employees Health Benefits Program (FEHBP) -- FEHBP shows cost growth comparable to the Medicare program. Over the last twenty years, FEHBP premiums grew at an average annual rate of 6.5 percent, compared to Medicare's annual average rate of 6.7 percent. Removing the estimated effects of drug coverage from FEHBP to attempt a more "apples to apples" comparison reduces the FEHBP spending growth rate to 5.8 percent per year.[11]

FEHBP also relies on two levels of competition, but the intensity of the competition is quite different between FEHBP and CalPERS. CalPERS has a generous state contribution, so a number of the plans have no premiums for state workers and retirees. This lack of price competition at the worker/retiree level has provided a stronger incentive for the state's actuaries and administrators to negotiate even lower premiums at their level. In FEHBP the government never contributes more than 75 percent of any plan's premium. This ensures premium price competition at the worker/retiree level and therefore the FEHBP actuaries/negotiators are more likely to allow access, as long as the plan's premiums and benefits are sound in both their actuarial and fiduciary underpinnings.[12]

The main focus of competition in FEHBP is at the worker/retiree level. Health plans have a fixed percentage profit for each subscriber they enroll, therefore plans maximize their profit by maximizing their market share. This structure provides a strong incentive for the plans to treat the workers and retirees – not the employer – as their primary customers. Over the years this competition for market share and the premium price sensitivity of workers and retirees has helped slow the growth of costs. As workers and retirees shop between competing health plans, they slowed the growth in premiums by an average of 15 percent over the time period 1988 to 2002.[13]

Table 1 - Average Annual Growth in Spending of Major Health Insurers, 1983 - 2002

Two decades of data	Medicare	Federal Employees	Federal Employees (minus drug spending)[1]	California Public Employees	California Public Employees (minus drug spending)[1]	Private Health Insurance	Medicaid	GDP
First ten years 1983-1992	8.0%	7.3%	7.0%	11.0%	10.5%	11.3%	9.7%	5.8%
Next ten years 1993-2002	5.5%	5.7%	4.7%	3.1%	2.4%	6.9%	4.5%	4.0%
Total time period 1983-2002	6.7%	6.5%	5.8%	6.9%	6.4%	9.1%	7.1%	4.9%

[1] The effects of drug spending on per capita growth rates have been estimated using the Nation Health Account data on the per capita growth rates for private insurance, with and without drug spending. Sources: Medicare (CMS - nee HCFA - 2003 Trustees' Report pg. 118, Private Insurance (CMS - National Health Accounts), Federal Employees Health Benefits Program (U.S. Office of Personnel Management), California Public Employees (California Public Employees Retirement System, CalPERS) and U.S. Gross Domestic Product (Economic Intelligence Unit, International Monetary Fund).

The Public Insurers Where the Government Sets the Price

Medicare – Cost growth in Medicare averaged 6.7 percent over the two decades analyzed. This is very close to both CalPERS (6.9%) and FEHBP (6.5%). As the data in Chart 1 and Table 1 indicate, Medicare had somewhat of an advantage in not covering outpatient prescription drugs during the time period analyzed.

In addition, a recent study by the Congressional Research Service (CRS) found that Medicare benefits have not significantly expanded over the years, while other insurers have significantly expanded what they cover.[14] CRS found that between 1977 and 1999, Medicare increased the percentage of total health care expenses it covered from 53.2 percent to 56.0 percent, not a statistically significant increase. During the same time period the percentage of health care expenses paid by private insurers grew from 50.7 percent to 70.0 percent, a much larger, statistically significant increase.[15] This coverage growth may be the result of Medicare beneficiaries not enjoying the same out-of-pocket reductions that occurred when other insurers made greater use of managed care plans.

Medicaid – Cost growth in Medicaid averaged 7.1 percent per year over the time period analyzed. This is roughly comparable to the other major public insurers. In addition, unlike Medicare, Medicaid does cover outpatient prescription drugs and has done so since Medicaid was created in the late 1960s. Medicaid has a number of distinct characteristics that make it difficult to directly compare to other insurance programs. Medicaid covers mostly a low-income and disabled population and some of their

practices could be perceived as "government rationing." Presumably Medicaid spending would also be lower if the program did not cover drugs during this time period. However, the reimbursement mechanism is so unique that the technique used to remove the estimated effects of covering drugs in FEHBP and CalPERS was not attempted for Medicaid.

Private Insurance

Private insurance spending grew at a 9.1 percent rate over the two decades studied. The category "private insurance" includes most employment-based coverage, individual coverage, and other forms of commercial health insurance. Much of this coverage, especially the employment-based, does offer drug coverage, and the per capita costs of that drug coverage are measured directly. Without drug coverage, private insurance would have grown 8.3 percent, rather than 9.1 percent. Perhaps most importantly, this category captures a wide range of health insurance from the largest corporations to the self-employed. Although some large employers can take advantage of significant economies of scale, smaller employers and individuals cannot; as a result, cost-reducing economies of scale do not reduce costs for private insurance to the extent they do in the other categories. In addition, this category includes the supplemental policies Medicare beneficiaries purchase in order to obtain drug coverage. Therefore, direct comparisons between this category and the other categories can be difficult.

Gross Domestic Product (GDP)

Growth in per capita GDP is displayed in both Chart 1 and Table 1 as a proxy for growth in the income sources that pay for health insurance costs. Only a growing economy can provide the tax revenues needed to finance government insurance programs and the wages, salaries, and profits needed to finance private insurance. The message these data convey is that all these health insurance programs have grown at a faster rate than their funding sources. It is hard to see the long-term sustainability of any program, public or private, that spends faster than its income grows.

COST GROWTH AND WHETHER THE GOVERNMENT OR MARKET SETS PRICES

All health insurers struggle to control cost growth. Comparing the overall growth rates of the two types of public insurers shows all four programs performing fairly close to one another. Medicare did not have to contend with escalating drug costs, however. Medicare also did not expand its coverage to the extent other insurers did.

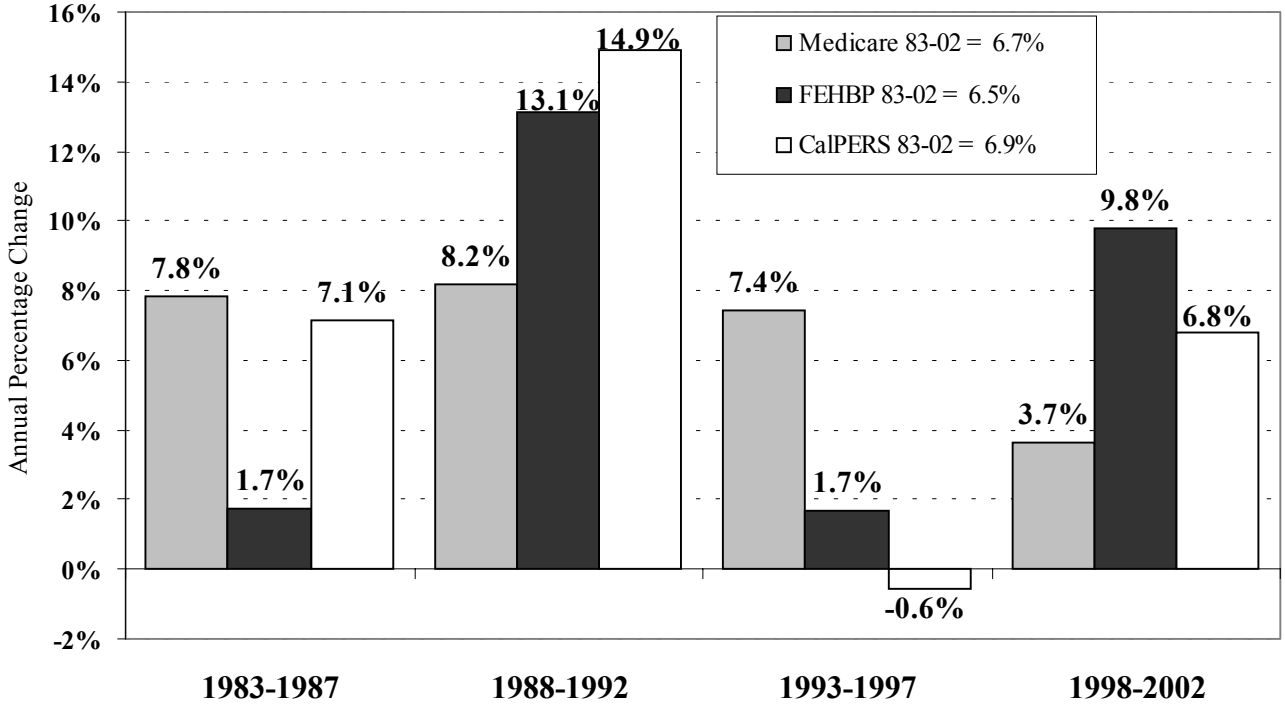
It is important to keep in mind that these systems do not operate in isolation. They are dealing with many of the same health care providers. If the administrators of one program see they are performing better or worse than other insurers they take action accordingly.

Chart 2 helps illustrate the variation different insurers have experienced over time. The twenty-year period under study has been broken into four five-year periods. In the first five-year period FEHBP had the best record. Medicare had the best record in the second and fourth periods and CalPERS in the third.

FEHBP and CalPERS tend to follow a cycle of the market, with premiums growing quickly for about three years, then growing more slowly for about three years. This pattern is typically referred to as the

"underwriting cycle". Medicare tends to follow a legislative cycle, with costs growing over a period of years, until there is pressure for a legislative action to control spending. These shocks to the system take the form of sharp payment cuts and slow or negative growth for a few years until there is legislative action to restore funding, or providers adjust to the cost controls and develop new strategies to increase Medicare payments. For example, Medicare spending slowed dramatically after Congress passed the Balanced Budget Act of 1997 (BBA97), but Congress soon increased spending in the Balanced Budget Refinement Act of 1999 (BBRA) and the Beneficiary Improvement and Protection Act of 2000 (BIPA),

Chart 2. Per Capita Health Insurance Spending Growth in Different Programs 1983-2002



Source: CMS-OACT (Medicare), OPM (FEHBP), and California Public Employees' Retirement System (CalPERS).

How prices are set and costs controlled may be a more germane comparison. In systems where the government sets prices it is clear what price will be paid, but it is unclear that it is the correct price. In markets with an over-supply of providers, the market-based approach generates lower prices as providers compete with one another. In markets with an under-supply of providers the opposite is true and prices will be higher. The market-based system may be less uniform than a system where the government sets the prices in the sense that there can be more variation in what providers receive for the same service. The market-based system will be more efficient in that providers will maximize their income by providing more efficient care, rather than gaming a government payment formula.

CONCLUSIONS

Medicare is no better at cost containment than other government insurance programs; FEHBP, CalPERS, and Medicaid have all experienced about the same spending growth as Medicare over the last twenty years. However, Medicare has not had to cover outpatient prescription drugs, while the others have. In addition, other insurers have expanded their coverage, while Medicare has not.

The different large insurers all struggle to control cost growth. Some have the government set prices like Medicare and Medicaid, while others allow the market to set prices like FEHBP and CalPERS. These two different approaches each have their strengths and weaknesses. Having the government set prices is a difficult task. Health care is a local, not a national, product. Getting thousands of different prices "right" in over 3,200 counties nationwide is a daunting task. While Medicare can control costs, it often requires "shocks to the system" such as the Balanced Budget Act of 1997.

Market-based approaches are better able to efficiently tailor prices to the local supply and demand for health care services; however, this does mean that prices may differ from market to market more than under a system where the government sets the prices. For example, in markets where there is an over-supply of providers, such as many larger cities, payments to providers would tend to be lower. In markets where there is an under-supply of providers, such as rural areas, payments to providers would tend to be higher.

Different policymakers and analysts will come to different judgments about the correct roles between the market and the government in setting health care prices and offering the best quality health care at the most competitive price. Looking to the future of both Medicare and health care in general, two significant factors come into play -- the looming retirement of the "Baby Boom" generation and the accelerating pace of technological innovation. Providing health coverage in the most flexible, innovative and efficient manner will be the challenge for the future.

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NOTES

[1] Twenty years, from 1983 to 2002, is the longest time period with reliable data for all the insurers. If CalPERS is excluded, the data go back to about 1970. Given the importance of the CalPERS data it was decided to use two decades of data and leave CalPERS in the analysis. The growth rates in this analysis are done on a nominal, per capita basis. Nominal means that inflation has not been factored out. Per capita means on a per person or per subscriber basis. For Medicare, private insurance, and Medicaid this was done as annual changes in per person spending plus administrative spending. For FEHBP and CalPERS this was done as annual changes in per subscriber premiums.

Sources of data: Medicare and Medicaid data are from the Office of the Actuary. CMS/HHS. Private Insurance is from the CMS - National Health Accounts (http://cms.hhs.gov/statistics/nhe/projections-2002/t11.asp). Data on the Federal Employees Health Benefits Program was obtained by the Office of Actuaries, U.S. Office of Personnel Management and represent premium changes after the end of the open season. California Public Employees data were obtained from the California Public Employees Retirement System, CalPERS, Health Administration.

[2] "Follow-Up Memorandum To The Distribution Of Total Expenses By Source Of Payments For Two Groups." Technical memorandum to the Joint Economic Committee, 5/22/03.

[3] Ibid.

[4] "Comparing Medicare And Private Insurers: Growth Rates In Spending Over Three Decades," *Health Affairs*, by Cristina Boccuti and Marilyn Moon. Volume 22 / Number 2.

[5] Cristina Boccuti and Marilyn Moon (see endnote 4) found that Medicare grew at an average annual per capita rate of 9.6 percent, while private insurance grew at 11.1 percent. This study found Medicare grew at 6.7 percent and private insurance grew at 9.1 percent. The results are consistent, but most probably different due to the time periods analyzed. Boccuti and Moon went back to 1970. This study stopped at 1983 to be able to have comparable CalPERS data.

[6] Growth rates are the primary measure used to compare different health insurance programs due to the significant differences in the populations covered by the different programs. Medicare covers the aged and disabled and may be three or four times as expensive as an insurer who covers a mostly non-aged and non-disabled population. Medicare clearly is not three or four times less efficient than other insurers. Growth rates provide a cleaner measure of the cost efficiency of different insurers, controlling for differences in populations covered.

[7] "The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform," Prepared by Mark Merlis, Kaiser Family Foundation, May 2003

[8] Op. cit. endnote 4.

[9] The effect of drugs on premium increases could not be directly measured. These estimates are derived by using National Health Accounts (CMS) data on private insurance per capita spending with and without drugs. The annual factors were then applied to the CalPERS premium growth rates. For example, in 2001 private health insurance per capita increased 9.6%, but not counting drugs the increase was 8.5%; this means that 89% (8.5/9.6 = .890) of the spending increases were due to costs other than prescription drugs. The 2001 CalPERS rate was multiplied by the same factor to remove the effect of drug coverage.

[10] http://www.calpers.ca.gov/

[11] Op. cit. endnote 9.

[12] FEHBP allows easy access and withdrawal of managed care plans, but the entry of FFS and PPO plans is more limited due to the peculiarities of the original 1959 law establishing the program.

[13] For the period 1988 to 2002 the enrollment weighted average premium growth at the beginning of the FEHBP "open season" was 9.49%. The movement of workers and retirees out of more expensive plans and into more affordable plans resulted in the average premium growth rate dropping to 8.09%, a 15 percent drop.

[14] "Follow-Up Memorandum To The Distribution Of Total Expenses By Source Of Payments For Two Groups." Technical memorandum to the Joint Economic Committee, 5/22/03.

[15] CRS used data from a number of large government surveys. These surveys treat FEHBP and CalPERS as if they were private insurance, although they are public programs.