

TRENDS

Comparing Medicare And Private Insurers: Growth Rates In Spending Over Three Decades

Medicare can be counted on to control per enrollee spending growth over time, more than private insurers can.

by **Cristina Boccuti and Marilyn Moon**

ABSTRACT: Over the past three decades both Medicare and private insurers have initiated cost containment mechanisms to control the growth of spending on personal health care. To compare spending growth between these two payers, we present four measurement principles that should be implemented when drawing such comparisons, and we apply them to the National Health Accounts data files. We attribute Medicare's ability to equal—and using our measures, actually exceed—the private sector in controlling the rate of health spending growth to Medicare's ability to price aggressively for the services it covers.

FROM ACADEMIC JOURNALS to the popular press to the House and Senate floors, comparisons are frequently drawn between Medicare and private health insurers regarding their rates of spending growth. Assertions that the private sector is better able to constrain spending are common.¹ On the other hand, we are learning that private insurers, including participants in the Federal Employees Health Benefits Program (FEHBP), are raising their premiums by double digits to compensate for their tremendous cost increases.²

Varying conclusions on spending growth rates often reflect differences in data sets, analytical techniques, and selected variables. In this paper we first present four measurement principles that are useful when comparing rates of growth for personal health care spending. Then we apply these approaches to health spending data produced annually by the Centers for Medicare and Medicaid Services (CMS), finding that, on average, Medicare has

enjoyed a lower annual growth rate than private insurance has. Moreover, cumulative analysis shows that Medicare's spending growth from 1970 through 2000 was lower than that of the private sector.

Methods For Comparing Rates Of Spending Growth

To compare Medicare and private insurance spending growth accurately, four measurement principles should be observed.

■ **Examine an extended span of time.** Short-term comparisons present an unreliable picture because short-lived regulatory changes or management techniques, or both, can alter findings considerably from year to year. Moreover, growth in insurance and health care costs does not remain constant over time. It is important, therefore, to assess annual spending fluctuations over a period of years, the longer the better. Our research tracks average annual and cumulative spending growth between 1970 and 2000.

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■ **Base comparisons on per enrollee spending.** When analyzing Medicare and private health insurance spending growth, one should use calculations that show per enrollee spending as the unit of comparison. Conclusions based simply on total spending reflect a covered population's growth or decline as well as costs of health care. That is, while an increase in the number of covered lives will inevitably raise total annual spending, per enrollee spending does not necessarily rise.³ This distinction is particularly pertinent when comparing expenditures between Medicare and private insurance because the number of Medicare beneficiaries is growing more rapidly than the number of persons covered by private insurance.

■ **Calculate the cumulative impact of spending growth.** Cumulative analyses provide a more accurate picture than simply comparing annual growth rates because they smooth out annual fluctuations and recognize that some of those fluctuations even out over time. Further, cumulative analyses recognize that slow growth in spending in early years for one payer may influence future prospects for holding down growth by that payer relative to others. That is, over a period of time, differences across payers may smooth out. To calculate cumulative growth rates, we established an initial index value of 100 for both Medicare and private insurance in 1970 and then cumulated the annual per enrollee growth rates for each sector to create an index of cost growth.

■ **Compare like services.** It can be misleading to compare Medicare and private insurance expenditures across the full range of personal health care expenditures because covered benefits and use of services in the two sectors vary considerably. Differences in the rates of growth of a given service can alter average annual spending for each sector according to its enrollees' relative use of that service. Consequently, we offer an alternative spending growth index that focuses on those services for which both Medicare and private insurance play a substantial role, particularly hospital and physician services.

Spending Growth Comparisons: Medicare And Private Insurers

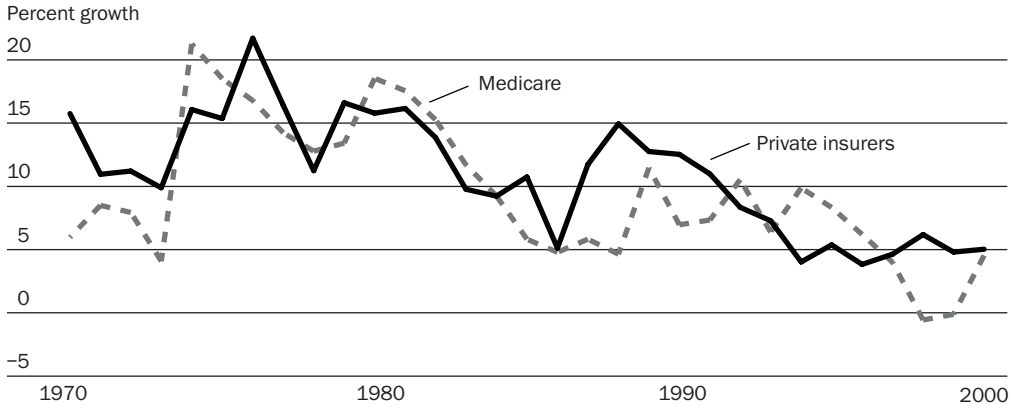
To make our spending growth comparisons, we examined National Health Accounts data produced annually by the CMS. This data set includes detailed health care spending estimates by service type and payment source, based on actual public spending and a variety of surveys of the private sector's health care providers. We used unpublished private insurance enrollment numbers from the CMS and Medicare enrollment numbers, also from the CMS, to create per capita estimates. Following are analyses that track spending over three decades (1970–2000), looking at annual per enrollee growth rates, the cumulative impact of the annual growth rates, and then payer comparisons of like services.

■ **Annual per enrollee growth rates.** We begin with the standard set of overall personal health care expenditures (with no services excluded). Since 1970 Medicare's average annual per enrollee growth rate of 9.6 percent is lower than the growth rate of 11.1 percent for private health insurers.⁴ On an annual basis this would not be a very great difference, but over thirty years this finding is important. In general, as seen in Exhibit 1, short-run trends in growth rates tend to be similar between the two, after accounting for lags. Nonetheless, in the long run, Medicare has enjoyed an advantage in slowing per enrollee health care spending growth, relative to private insurance.⁵

Exhibit 1 also reinforces the importance of studying extended periods of time to generate a meaningful analysis of spending growth. There are many periods in which per enrollee spending growth differs dramatically between Medicare and private insurance in one year, only to reach similar rates of growth in the following year or two. For example, between 1986 and 1988 spending per enrollee by private insurers rose twice as fast as Medicare spending. But by 1989 both sectors' rates hovered near each other, only to diverge again over the next three years.

■ **Cumulative per enrollee growth.** Cumulative spending per enrollee helps illustrate the impact of cost containment performance

EXHIBIT 1
Annual Growth Rates In Per Enrollee Payments For Personal Health Care, Medicare
And Private Insurers, 1970-2000



SOURCE: Urban Institute analysis of National Health Accounts data from the Centers for Medicare and Medicaid Services.

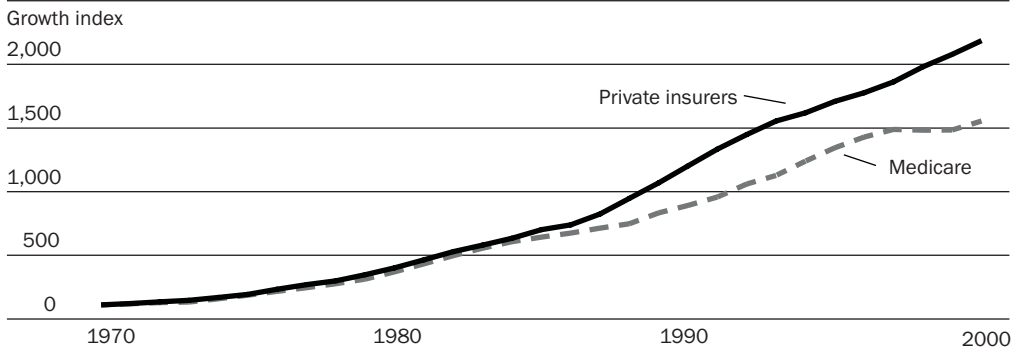
over time. Cumulative measures also account for differences in payers’ spending relative to previous spending trends, allowing for a more comprehensive look at trends over time.

Relying on the same data that we used to compare annual per enrollee growth rates, we calculated cumulative per enrollee growth by first establishing a 1970 index value of 100 for both Medicare and private insurance. To this index we added the annual per enrollee growth rate for each sector. An index number of 200, for example, indicates that spending

per enrollee has doubled since 1970 (Exhibit 2). Since a cumulative index is based intrinsically on the starting point, we were careful to choose an initial measure for which the private sector and Medicare were growing at similar rates. Also, we chose a starting point that would provide us with the longest time period for analysis, while avoiding Medicare’s earliest years, in which enrollment and spending are more difficult to interpret.

Exhibit 2 also illustrates that over the past three decades Medicare has been more suc-

EXHIBIT 2
Cumulative Growth In Per Enrollee Payments For Personal Health Care, Medicare And
Private Insurers, 1970-2000



SOURCE: Urban Institute analysis of National Health Accounts data from the Centers for Medicare and Medicaid Services.

cessful than the private insurance industry has in constraining its per enrollee cost growth for personal health care. By 2000 Medicare's index number for per enrollee costs was 1,544, compared with 2,176 for private insurance. In other words, by 2000 the index for the private market was 44 percent higher than the index for Medicare.

Initially, Medicare and private insurance spending per enrollee rose very much in tandem, showing few discernible differences. Both public and private insurers essentially passed through costs to taxpayers or their clients. And while health care costs were rising rapidly in the 1970s, so were costs of other goods and services. By the end of the 1970s, health costs became an issue for debate.

By the 1980s per enrollee health care spending had more than doubled for both Medicare and private insurance. During this time Medicare became more proactive in constraining spending growth, in part as an effort to fend off mounting criticism against "big government." Although still on a similar growth path with per enrollee private health spending, Medicare expenditures were rising more rapidly than those of other federal programs. Therefore, in the 1980s Medicare instituted cost containment efforts—namely, hospital payment reforms—resulting in a slower per enrollee growth rate than in the private sector. At first, in the early part of the decade, ad hoc adjustments were used to try to slow growth. From about 1984 through 1988, the slope of Medicare's cost growth line flattens out, indicating that it was much more successful than the private sector was in restricting growth (Exhibit 2).

In the mid-1990s private insurers turned to cost containment strategies but did not necessarily follow Medicare's example, since private insurers do not share Medicare's market clout. Instead, this slowdown occurred during a period of rapid rise in managed care. During this time the slope of private per enrollee spending rates is similar to Medicare's in the 1980s, thus

narrowing the overall gap between the two spending growth paths. However, with the introduction of the Balanced Budget Act (BBA) in the late 1990s, Medicare's cumulative per enrollee growth rate again declined, while the private sector's rate steadily rose. Finally, between 1999 and 2000 the gap in overall growth remained in Medicare's favor, with private industry's cumulative growth rising faster than that of Medicare.

■ Comparison of like services. Medicare

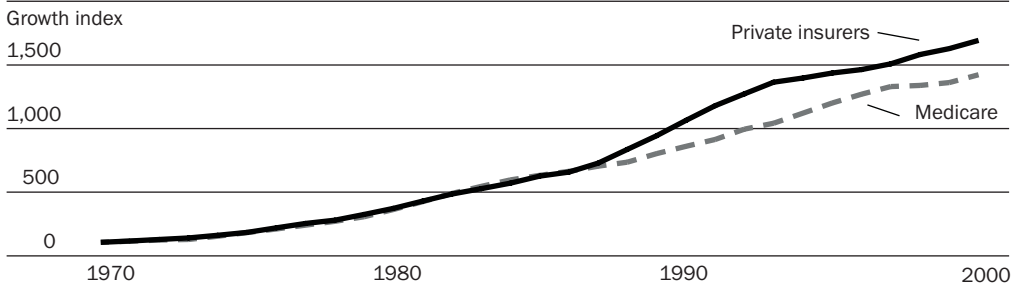
and private insurance spend money on health care services differently. In addition to variations in benefit packages, Medicare and private insurance enrollees use a different mix of services. Thus far, our growth comparisons have relied on the broad range

“The differential impacts of hospital care growth over time between Medicare and private insurers are quite low.”

of personal health care services, as defined by the CMS, when calculating national health spending data. While helpful for evaluating fluctuating and aggregate growth rates, these analyses can be misleading, in light of the differences in service use between Medicare beneficiaries and private insurance enrollees. Therefore, we also offer alternative spending growth comparisons that focus on those services for which both Medicare and private insurance play a substantial role.

Exhibit 3 presents cumulative rates of growth, but in contrast to Exhibit 2, Exhibit 3's calculations are limited to services that both Medicare and the private sector routinely cover: hospital care, physician and clinical services, durable medical equipment (DME), and other professional services.⁶ This analysis excludes home health care and skilled nursing facility services—two parts of Medicare that have grown rapidly in some years—because of their relatively small rates of use by younger families covered by private insurance.⁷ We also exclude prescription drug spending—a component of health care spending that has grown at an extremely rapid pace, showing double-digit growth for six consecutive years through 2000.⁸ Medicare's spending, however, is much

EXHIBIT 3
Cumulative Growth In Per Enrollee Payments For Comparable Services, Medicare And Private Insurers, 1970-2000



SOURCE: Urban Institute analysis of National Health Accounts data from the Centers for Medicare and Medicaid Services.
NOTE: Comparable services include hospital care, physician and clinical services, durable medical equipment, and other professional services.

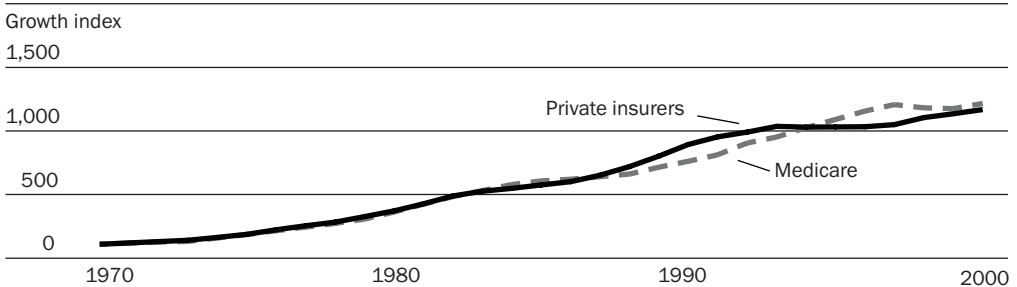
less affected by this component because it does not offer an outpatient drug benefit. Thus, exclusion of prescription drugs in spending growth comparisons improves the expenditure trends for private insurance.

When spending comparisons are limited to like services, private insurance still experiences a higher cumulative rate of growth per enrollee than Medicare does over the three decades. However, some interesting differences appear when noncomparable services are excluded from the measure. For instance, beginning in 1993 private industry's cumulative rate is relatively flatter in Exhibit 3 than in Exhibit 2, because of the elimination of prescription drugs from the comparison. Removal of home health and nursing home services reduces

Medicare's cumulative rate of growth from 1992 to 2000. For both sectors, overall cumulative growth rates are less when non-comparable services are excluded from the analysis, and by 2000 the gap between the two is narrower.

■ **Comparison of specific services: hospital and physician/clinical services.** Given that hospital and physician/clinical services are often considered main drivers of health care spending, it is useful to compare these services separately. With respect to hospital care, we found that by 2000 Medicare's hospital spending index was just 4 percent above that of the private sector (Exhibit 4). Thus, the differential impacts of hospital care growth over time between Medicare and private in-

EXHIBIT 4
Cumulative Growth In Per Enrollee Payments For Hospital Care, Medicare And Private Insurers, 1970-2000



SOURCE: Urban Institute analysis of National Health Accounts data from the Centers for Medicare and Medicaid Services.

surers are quite low.

In analyzing annual growth, our research finds that Medicare and the private sector's per enrollee growth rates track each other closely for the first two decades. The early 1980s saw dramatic declines in growth for both payers, coinciding with Medicare's implementation of the hospital prospective payment system. Annual per enrollee growth charts, if presented, would show that Medicare and the private sector began to run divergent patterns in the 1990s, when managed care influences decreased hospital costs for private insurers, while Medicare spending began to rise. Then, in the latter part of the 1990s, Medicare hospital growth slowed substantially, subsequent to the BBA and Medicare's fraud-and-abuse crackdown. Private insurers, however, experienced increased growth in per enrollee hospital spending during that same time.⁹

When examining the impact of Medicare's physician and clinical services payment policies, Exhibit 5 shows that the gap between Medicare and the private sector has remained quite large. Private insurers were essentially playing "catch-up" to Medicare's lower growth in the 1980s and early 1990s. If shown on a year-to-year basis, physician and clinical services would display a highly erratic annual per

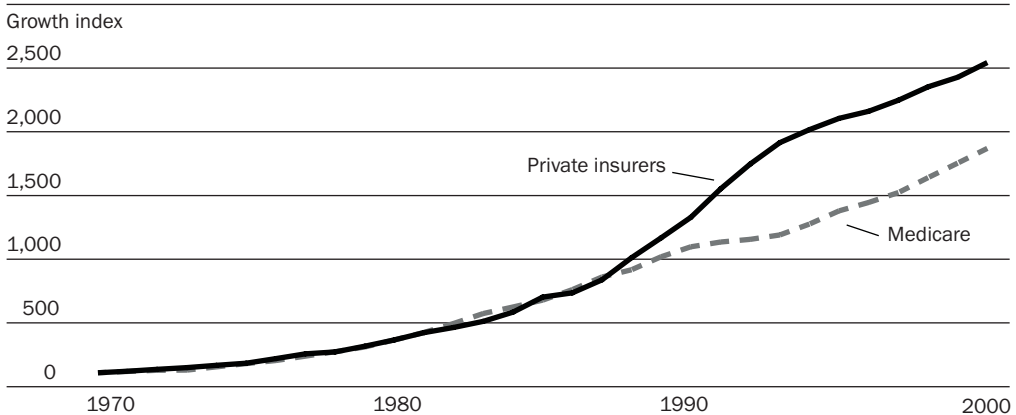
enrollee growth pattern that is likely due to legislative reform.¹⁰ In general, though, the private sector's annual growth in physician spending was higher in the late 1980s and early 1990s but fell below that of Medicare in 1994 and remained so through 2000, as evidenced by Medicare's slightly steeper incline in the latter years shown in Exhibit 5.

Conclusions

In 2000 Medicare spent about \$217 billion on personal health care, and private insurers spent about \$391 billion. Given these large sums of money, it is not surprising that both sectors are concerned with spending growth. Drew Altman and Larry Levitt note that thus far both the private and public sectors have made several attempts to constrain national health care costs, but all have been short-lived.¹¹

■ **Medicare's success.** While in many ways private insurers and Medicare track similarly in per enrollee growth rate trends over time, Medicare has proved to be more successful than private insurance has been in controlling the growth rate of health care spending per enrollee. Moreover, recent survey research has found that Medicare beneficiaries are generally more satisfied with their health care than are privately insured people under age sixty-five.¹²

EXHIBIT 5 Cumulative Growth In Per Enrollee Payments For Physician And Clinical Services, Medicare And Private Insurers, 1970–2000



SOURCE: Urban Institute analysis of National Health Accounts data from the Centers for Medicare and Medicaid Services.

■ **Impact of drug spending.** When we exclude services that are not comparably covered by Medicare and the private sector, we find that the private sector's per enrollee cumulative growth fell to a greater extent than Medicare's did in the 1990s (Exhibits 2 and 3). Clearly, removing outpatient prescription drug spending from these calculations is the major driver in the private sector's downward shift. Medicare has been shielded from the rapid growth of prescription drug spending because it has never offered an outpatient drug benefit.

■ **Home health and SNF spending.** Also noteworthy is that the elimination of home health and skilled nursing facility (SNF) expenditures (costs not typically covered by private insurance) is associated with a relatively small drop in Medicare's per enrollee cumulative growth rate. Over a thirty-year period these two services have not been a major factor in Medicare's per enrollee growth rate—certainly not to the extent that outpatient prescription drugs affect the private sector's growth rate.¹³ Because Medicare's spending growth rates on home health and SNF services have fluctuated over time, opposing swings in spending per enrollee on these services balance out Medicare's cumulative growth in personal health care spending when left in the calculation.

■ **Provider payments.** While Medicare must be a savvy payer for health care services, it cannot be an inadequate payer, without risking patients' access to care, particularly to physician services. A cumulative gap in physician payment growth has remained between Medicare and private insurance since the end of the 1980s. Physicians' complaints of low reimbursements for Medicare services have accelerated in 2002 when payments were cut, but it is important to keep in mind that between 1994 and 2000 Medicare's spending on physician and clinical services grew at a faster pace than did that of private industry.

■ **A Medicare drug benefit.** This analysis emphasizes the need for policymakers to recognize and prepare for the sizable impact that a Medicare drug benefit could have on federal

expenditures. Also, to the extent that Medicare can be involved in purchasing outpatient prescription drugs, its track record as a purchaser is better than the private industry's over time in controlling overall growth in health care costs. Moreover, in a number of instances, private insurers have adopted Medicare payment practices. Proposals for a Medicare drug benefit that do not take advantage of Medicare's regulatory tools miss the opportunity to save the government money, assuming that Medicare's effectiveness elsewhere can be applied to drugs.

WHILE SUPPORTERS of the private sector often claim that greater efficiency results from reliance on market forces rather than on government-administered pricing mechanisms, Medicare's long-term success in constraining spending growth per enrollee cannot be ignored. Its ability to accomplish this feat is in part a result of its structured payment systems and regulatory controls, which have affected both price and use of services. And because the private sector often tracks closely with Medicare's annual growth rates, we can say that although specific payment disparities do exist, Medicare's overall per enrollee spending growth does not stray tremendously from that seen in the private market. Thus, future reform proposals could justifiably rely on Medicare to control per enrollee spending growth over time, as long as it continues to play a meaningful role in purchasing benefits and services.

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NOTES

1. See, for example, K. Hammonds, "Medicare Gets an Umbrella for an Avalanche," *Business Week* (2 June 1997): 44; and S. Butler, "The FEHBP as a Model for Reforming Medicare" (Testimony before the United States House of Representatives, Committee on Energy and Commerce, 20 March 2002).
2. See, for example, Hewitt Associates, "Double-Digit Health Care Cost Increases Expected to Continue in 2002," Press Release, 29 October 2001; and S. Barr, "In Face of Premium Increases, Health Plan Seeks New Ways to Cut Costs," *Washington Post*, 22 April 2002.
3. If the composition of the covered population changes, there can be impacts on per enrollee numbers as well. For example, when Medicare added disabled and end-stage renal disease patients, per enrollee costs rose.
4. Without per enrollee adjustments, Medicare and private insurers each average 12 percent annual growth between 1970 and 2000.
5. This also includes spending growth in the mid-1970s when people with disabilities were added to Medicare. Payments to such persons averaged 25 percent above those to the aged in 1975, and for the period 1974–1976 per enrollee reimbursement for the aged rose about 40 percent but 55 percent for the disabled, as calculated from data published in B. Hirsch, H. Silverman, and A. Dobson, "Medicare Summary: Use and Reimbursement by Person, 1976–1978," *Health Care Financing Program Statistics* (Baltimore: Centers for Medicare and Medicaid Services, August 1982), 1–30.
6. The national health spending data set does not separate vision care from the category of DME. Although vision care is not well covered in Medicare, we decided to retain the DME category in the set of comparable services. Much of the growth in nonvision DME spending is borne by Medicare.
7. If these two benefits were truly postacute care services and hence served as substitutions for hospital care, it might still be important to include them with other acute care coverage. But much of the growth of these benefits in the early 1990s reflected an expansion of Medicare home health into long-term care types of services. Medicare Payment Advisory Commission, "Home Health Utilization," in *Report to the Congress: Context for a Changing Medicare Program* (Washington: MedPAC, June 1998), 107–113.
8. K. Levit et al., "Inflation Spurs Health Spending in 2000," *Health Affairs* (Jan/Feb 2002): 172–181.
9. After 1997 researchers have linked higher hospital spending with easing of managed care restrictions by private insurers. See B.C. Strunk, P.B. Ginsburg, and J.R. Gabel, "Tracking Health Care Costs: Growth Accelerates Again in 2002," 25 September 2002, www.healthaffairs.org/WebExclusives/Strunk_Web_Excl_092502.htm (13 December 2002).
10. For example, in 1987 and 1989 Congress imposed reductions in Medicare payment ceilings for procedures (mostly surgical or diagnostic) that were identified as being overvalued or overpaid. Annual growth rates for physician and clinical services dropped following each of these payment decreases. And with the implementation of the Medicare physician fee schedule in 1992, per enrollee growth has since remained below 9 percent (through 2000).
11. D.E. Altman and L. Levitt, "The Sad History of Health Care Cost Containment as Told in One Chart," 23 January 2002, www.healthaffairs.org/WebExclusives/Altman_Web_Excl_012302.htm (13 December 2002).
12. K. Davis et al., "Medicare versus Private Insurance: Rhetoric and Reality," 9 October 2002, www.healthaffairs.org/WebExclusives/Davis_Web_Excl_100902.htm (13 December 2002).
13. An earlier analysis done by Marilyn Moon and Stephen Zuckerman, however, did find more of an impact since this preceded the dramatic growth in drugs and decline in postacute care at the end of the 1990s. M. Moon and S. Zuckerman, *Are Private Insurers Really Controlling Spending Better than Medicare?* (Menlo Park, Calif: Henry J. Kaiser Family Foundation, July 1995).