Health Policy Brief

October 2012 • No. 4

NATIONAL ACADEMY OF SOCIAL INSURANCE

Health Care Spending Trends: Medicare and Private Health Insurance

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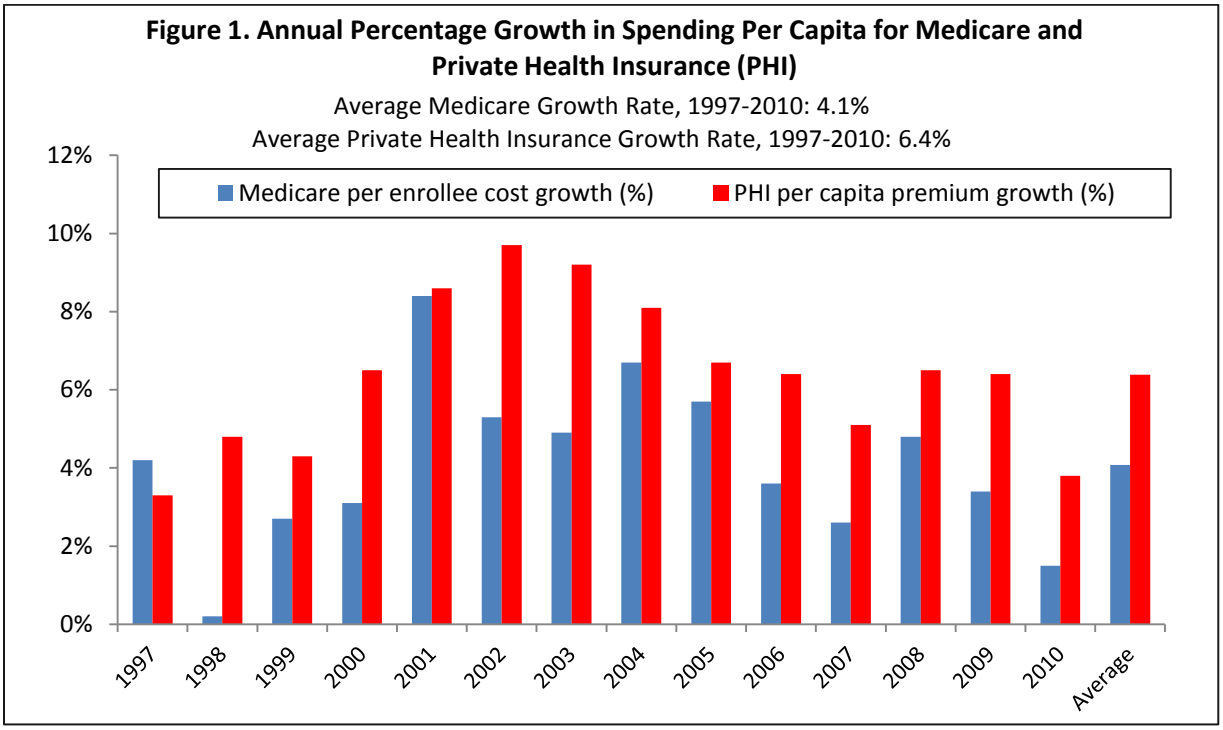
Slowing the growth of health care spending continues to be a major domestic policy challenge. In 2010, total U.S. health expenditures reached $2.6 trillion – 18 percent of gross domestic product (GDP).[1] Although health care spending has slowed in recent years, it is projected to grow faster than GDP over the next decade.[2] Medicare, the nation's largest health insurance program, accounts for one in five health care dollars, and in 2010 accounted for 15.1 percent of the federal budget – a figure that is expected to reach 17.4 percent by 2020.[3,4]

There are many drivers of national health care spending, ranging from rising prices for medical services and increasing reliance on new and more expensive medical technologies to our growing elderly population and imperfections in the market for medical goods and services. While per capita spending for both Medicare and private health insurance has increased in recent years, Medicare's costs appear to have grown more slowly, according to national health expenditure data compiled by the Centers for Medicare & Medicaid Services' (CMS) (Figure 1).[5] The data indicate that Medicare expenditures since the enactment of the Balanced Budget Act of 1997[6] have grown by an annual average of 4.1 percent, compared to 6.4 percent for private health insurance.

Figure 1. Annual Percentage Growth in Spending Per Capita for Medicare and Private Health Insurance (PHI)



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

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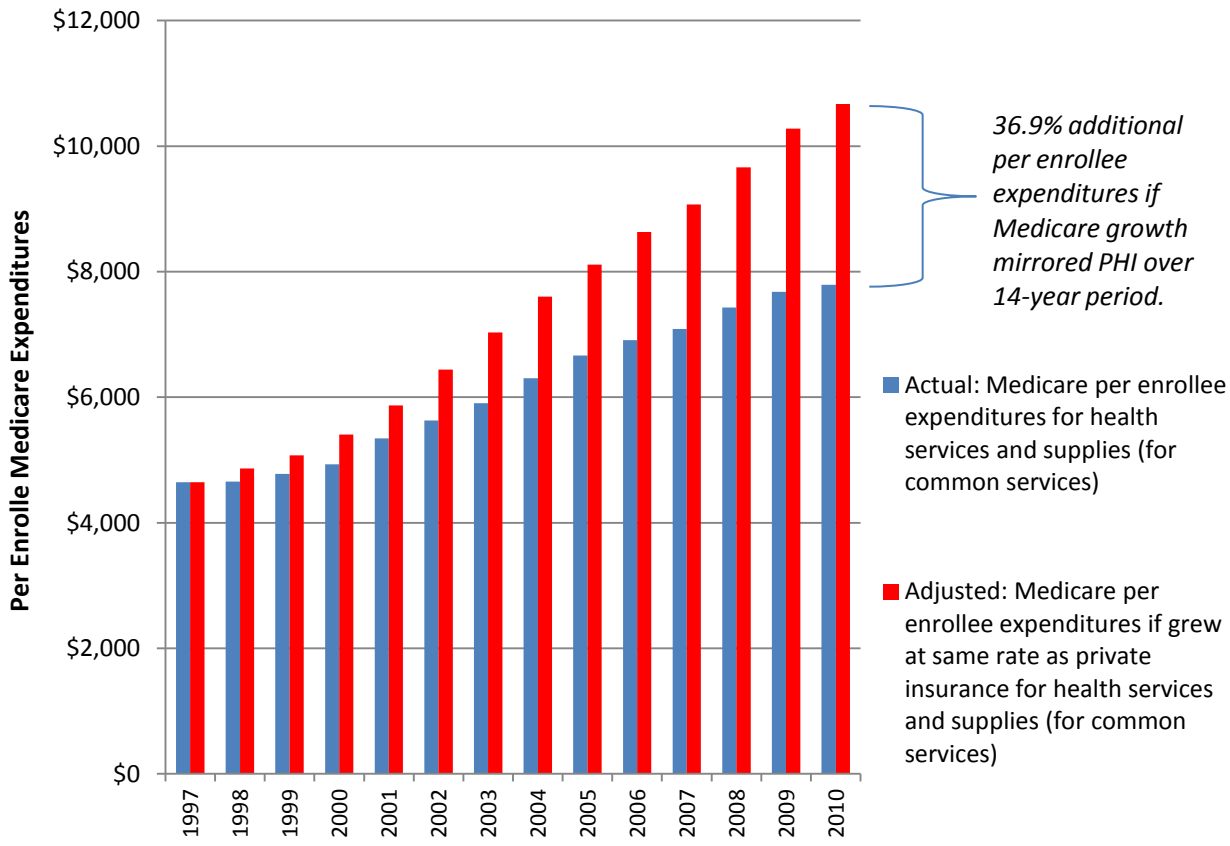
It is important to note that this data is not age-adjusted, although it is not clear what the impact of doing so would be on the difference between private insurance and Medicare growth rates. The aging of the baby boom generation has increased the average age of the population covered by private health insurance and therefore increased health care utilization. In the near term, the reverse will be true for Medicare: the initial waves of Medicare-eligible boomers will lower the average age and improve the average of health status of the Medicare population and therefore slow the growth of Medicare per capita spending. Since there is a significant correlation between age and health care utilization, demographic factors account for some unknown portion of projected health care cost growth rates, now and in the future.

Regardless of the age-effect, the apparently lower rate of growth of the Medicare program compared to plans in the commercial market raises concerns among some about proposals to move from the current system to one that would increasingly rely on competing private plans to provide Medicare coverage.

Figure 2. Private Health Insurance Growth Exceeds Medicare (1997 - 2010)



Source: National Academy of Social Insurance Analysis of CMS National Health Expenditures and CMS Enrollment Reports.

- If Medicare expenditures had grown at the same rate as private health insurance, Medicare expenditures in 2010 would have been 37 percent higher, or an additional $2,876 per enrollee per year by 2010, as shown in Figure 2.[7]
- In 2010 alone, Medicare spending would have been $136 billion greater if the program had grown at the same rate as private health insurance.

Reasons that Medicare Spending Grew More Slowly than Private Health Insurance
Comparing the spending of Medicare and private health insurance is difficult given the different populations served by each. Nevertheless, two factors are particularly worth noting:

- **Provider Payments.** Medicare's payments in 2010 for physician services averaged 81 percent of private payments, according to the Medicare Payment Advisory Commission (MedPAC).[8] Private insurers pay doctors and hospitals higher rates than Medicare because the insurer lacks the government's regulatory power to limit price increases.[9] Throughout Medicare's history, the federal government has developed varying reimbursement methodologies based on actual input prices. For example, the Inpatient Prospective Payment System implemented in 1983 limited spending by moving from a fee-for-service cost reimbursement system to a system that pays a fixed rate per hospital discharge.[10]

- **Administrative Costs.** Administrative costs for Medicare include costs incurred directly by government agencies that collect revenue for Medicare (including for participating private plans such as Medicare Advantage plans, Medicare prescription drug plans and Medicaid health maintenance organizations) or contribute to its administration. For private health insurers, administrative costs also include taxes, profits and marketing expenses. Most estimates of Medicare administrative expenses range from two to five percent of program expenditures, while private health insurance administrative expenses range from 12 to 30 percent.[11]

Implications for Future Health Care Spending
Projections of future Medicare spending are highly uncertain due to the likelihood of legislative changes in the near term and concerns about the effectiveness of existing policy. According to the Congressional Budget Office (CBO), Medicare spending is projected to increase an average of 5.7 percent annually between 2012 and 2021.[12] However, CBO projections are based on current law, which would reduce physician reimbursement by 27 percent starting on January 1, 2013 as part of a policy known as the sustainable growth rate (SGR). When Medicare reimbursement to physicians has exceeded spending targets in the past, Congress has enacted last-minute legislation to avoid cuts called for by the SGR. Few experts believe that the physician reimbursement cuts scheduled for January 2013 will actually be implemented.

Another concern with current CBO spending projections involves the Patient Protection and Affordable Care Act (ACA) provisions that reduce Medicare market basket productivity adjustments for most providers other than physicians. The ACA reduces the annual reimbursement increases for most providers by an amount equal to the expected increase in productivity. Although projected productivity increases may indeed occur, many experts are doubtful, or are skeptical that Congress will fully implement reductions in market basket updates if payment rates fail to keep up with providers' input costs.[13]

Medicare is of course not the only area of health care for which it is difficult to forecast future costs. Private sector health expenditures for the next decade are equally difficult to project, because of uncertainty over the impact of coverage expansion under the ACA, the consolidation of providers currently taking place in the hospital sector, the development of private-sector equivalents to Accountable Care Organizations and any spillover effect from repeal of the SGR. All of these will have significant but difficult-to-predict effects both on public and private insurance payments and on negotiating between health insurers and providers.

Endnotes

[1] CMS, Office of the Actuary, National Health Statistics Group. Accessed September 11, 2012, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

[2] For 2011 through 2021, national health spending is projected to grow at an average rate of 5.7 percent annually, which would be 0.9 percentage point faster than the expected annual increase in the GDP. The health share of GDP is projected to rise from 17.9 percent in 2010 to 19.6 percent by 2021. See Keehan, Sean P., Cuckler, Gigi A., Sisko, Andrea M., Madison, Andrew J., Smith, Sheila D., Lizonitz, Joseph M., Poisal, John A. and Christian J. Wolfe, "National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands And Economic Growth Accelerates," *Health Affairs* 31, no. 7 (2012): 1-13, http://content.healthaffairs.org/content/early/2012/06/11/hlthaff.2012.0404.

[3] See *supra*, note 1.

[4] Kaiser Family Foundation, *Medicare Spending and Financing: A Primer*, February 2011, http://www.kff.org/medicare/7731.cfm.

[5] This comparison is made looking at common benefits for Medicare and private health insurance, including hospital services, physician and clinical services, other professional services and durable medical products. Per enrollee expenditures for Medicare includes the fee-for-service Medicare program and Medicare Advantage.

[6] The Balanced Budget Act of 1997 included changes in provider payments to slow the growth in Medicare spending to balance the federal budget. It established the Medicare+Choice program, a new structure for Medicare HMOs and other private health plans offered to beneficiaries. The BBA also called for the development and implementation of five new Medicare payment systems.

[7] The findings are based on analysis of CMS National Health Expenditures per enrollee Medicare expenditures and per enrollee private health insurance premiums, as well as the average annual growth rates. Private health insurance per enrollee growth rates were applied to Medicare per enrollee expenditures. The difference between the adjusted and the actual Medicare per enrollee expenditures was then multiplied by the number of enrollees in the Medicare program from CMS' Medicare Enrollment Reports. Note that this data is not age-adjusted, thus making it unclear to what extent the changing age distribution explains per capita cost growth over time.

[8] Medicare Payment Advisory Commission, "Report to Congress: Medicare Payment Policy", March 2012, http://www.medpac.gov/documents/Mar12_EntireReport.pdf, 88.

[9] Robert A. Berenson, Paul B. Ginsburg, Jon B. Christianson, and Tracy Yee, "The Growing Power Of Some Providers To Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed," *Health Affairs*, vol. 31 no. 5 973-981 (2012). Available online at http://content.healthaffairs.org/content/31/5/973.full.pdf+html.

[10] White, Chapin, "Why Did Medicare Spending Growth Slow Down?", *Health Affairs* 27, no. 3 (2008):793-802, http://content.healthaffairs.org/content/27/3/793.abstract.

[11] National Academy of Public Administration and National Academy of Social Insurance. 2009. *Administrative Solutions in Health Reform*. Washington, DC. Available online at http://www.nasi.org/research/2009/administrative-solutions-health-reform.

[12] Congressional Budget Office, *March 2012 Medicare Baseline*, Accessed September 11, 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43060_Medicare.pdf.

[13] CMS, Office of the Actuary, "Projected Medicare Expenditures Under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers", May 18, 2012, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2012TRAlternativeScenario.pdf.

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