# Health Care Costs:
# Trends and Relationship to Insurance Premiums

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After a period of relatively low health care inflation during the 1990s, health care costs increased sharply in 1999 and 2000, and similarly high increases are estimated for 2001. The news for employers providing health insurance and their employees is worse: data indicate that increases in insurance premiums exceed the increases in the cost of care. Finally, whereas employers might have absorbed most or all of the increase in the tight labor environment of recent years, the current economic downturn has made it more likely that increases will be passed on to employees—or employers will move to benefit designs that impose more cost sharing in the form of deductibles and co-pays. This brief reviews the literature on recent health care cost trends and examines some of the underlying factors driving costs. We then review the relationship between costs and health insurance premiums, and the recent experience of employers in firms of varying size.

The Washington-based Center for Studying Health System Change (HSC) estimates that health care costs for the privately insured population increased by 7.2 percent in 2000, the largest annual increase since 1990 (Strunk et al., 2001). Using somewhat different data sources and including Medicare expenditures, the Centers for Medicare and Medicaid Services (CMS) estimate total growth in expenditures at 7.0%, and the increase in private expenditures at 6.9% ( Levit et al., 2002). The 2000 increase continues a trend of accelerating costs that began three years ago and HSC estimates growth of 7.7% in 2001. Table 1 summarizes growth figures from HSC, and includes nominal growth in GDP. The percentage of GDP devoted to health care is a figure closely watched by health care analysts; after a four-year period of relatively slow growth from 1994-1997, health-care costs resumed their traditional trajectory of outstripping GDP growth in 1998. According to CMS figures, health care expenditures constituted 13.2% of GDP in 2000. By comparison, they comprised only 8.8% of GDP in 1980, and Switzerland, which has the world's second most expensive health care system, devoted 10.4% of its GDP to health care in 1998 (OECD, 2001).

| Year | Percent Change | GDP Growth |
|---|---|---|
| 1991 | 6.9 | 2.1 |
| 1992 | 6.6 | 4.4 |
| 1993 | 5.0 | 4.0 |
| 1994 | 2.1 | 5.2 |
| 1995 | 2.2 | 3.9 |
| 1996 | 2.0 | 4.6 |
| 1997 | 3.3 | 5.4 |
| 1998 | 5.3 | 4.6 |
| 1999 | 7.1 | 4.6 |
| 2000 | 7.2 | 5.6 |
| 2001 | 7.7 | 3.7 |

HA September 2001. Percent change is annual change per capita.

As Table 1 suggests, the increases in health care costs in recent years are not anomalous, but represent a resumption of a decades-long trend of relatively high health care inflation after a brief respite during the mid-1990s (for an elaboration of this argument, see Altman and Levitt 2002, "The Sad History of Health Care Cost Containment as Told in One Chart"). Thus these data prompt two lines of inquiry: what accounts for the secular trend of increasing health care costs, and what accounts for the deviation from that trend during the 1990s?

The two factors widely regarded as major drivers of health care expenditure increases are the aging of the population and the "march of science"—biomedical advances. As people age, they consume more health care resources; for example, about 12 percent of the population is elderly, but the elderly comprise nearly half of the top five percent of health care users (Berk and Monheit 2001). The debut of blockbuster drugs—and their prices—have been commanding headlines, but the development of new drugs is only part of the story of advances in medical technology. More broadly defined, technological advances encompass sophisticated diagnostic imaging devices as well as more sensitive laboratory tests, and new techniques using new technologies such as laparoscopic surgery. Sometimes new technology replaces old, as H2 blockers made most surgery for gastric ulcers obsolete—and greatly reduced the costs of treating most ulcers. But advances in technology frequently make treatments more palatable to a broader population of potential users: as anyone who watches commercial TV or reads magazines surely knows, stomach meds aren't just for ulcers anymore. Thus even in cases where technology reduces the cost of treating a condition, it frequently results in much greater demand for treatment (Aaron, 2002).

In his response to the Altman and Levitt commentary, Henry Aaron outlines the confluence of events that led to the lull in health care inflation during the period 1994-1997 (Aaron, 2002): managed care organizations exercised considerable leverage in holding down expenditures, while at the same time sacrificing profits to market share in the "soft" phase of the underwriting cycle. Furthermore, the credible threat of reform at the beginning of the Clinton administration may have also had some effect, just as it did during the Carter years (Altman and Levitt, 2002).

In recent years, however, managed care has been in retreat on several fronts, and analysts have been competing to write its obituary and perform the post mortem. In his essay "The End of Managed Care," Jamie Robinson summarizes the nature of the consumer backlash against managed care:

> The fundamental flaw of managed care, in retrospect, was that it sought to navigate the tensions between limited resources and unlimited expectations without explaining exactly how it was so doing. Enrollees were offered comprehensive benefit coverage with only minimal co-payments, which they interpreted as a promise of unrestrained access to all relevant services….Consumers experienced managed care's cost-control strategy in the form of barriers to access, administrative complexity, and the well-articulated frustration of their caregivers. (Robinson, 2001.)

Evidence from survey data suggests that in a tight labor market, employers responded to their employees' dissatisfaction by moving away from tightly managed HMO products towards less restrictive point-of-service (POS) and PPO products. An annual survey of employers found a sharp drop in HMO enrollment between 2000 and 20001 from 29 to 23 percent of enrollment, while enrollment in PPOs increased from 41 to 48 percent of total enrollment (Kaiser Family Foundation, 2001).

In a related development, managed care organizations have found themselves losing leverage vis a vis providers. In previous years, MCOs were able to exploit overcapacity in hospitals and the threat of network exclusion to extract favorable prices from providers. But the Center for Studying Health System Change, which uses extensive interviews in twelve cities to track developing trends, reports that now hospitals have the upper hand in negotiations—a change brought about by reduction in capacity, reinforced by new pressures on MCOs to have larger, more inclusive provider networks. (Strunk et al., 2001.) Cost data provide intriguing additional evidence for diminished control over provider costs by MCOs: both inpatient and outpatient spending accelerated in 2000 (after a period of actual decline in spending on inpatient care in the mid-90s), and together accounted for 43 percent of the total growth in overall spending in 2000.

Another important source of information about changes in health care costs comes from employer survey data on health insurance premiums, and here, too, the news is not good. While insurers incurred underwriting losses during the mid-1990s, evidence suggests that we are now in the "hard" phase of the underwriting cycle, when insurers focus more on rebuilding profits and less on building (or maintaining) market share. Thus insurers are now passing on to their policyholders cost increases they might have absorbed in past years—and are adding to them in the process of improving their bottom lines. The Kaiser Family Foundation and the Health Research and Educational Trust, which conduct a longstanding annual survey of employers, report that monthly premiums for employer-sponsored health insurance increased by 11 percent between the spring of 2000 and the spring of 2001. This represents significant acceleration in premium costs; premiums increased by 8.3 percent on average between 1999 and 2000.

According to data from the Kaiser/HRET survey, small employers (3-199 employees) faced larger increases than large firms—premiums for small firms increased 12.5 percent, compared to 10.2 percent for large firms (Kaiser Family Foundation, 2001). Although in the past very large employers have exercised some negotiating power with insurers, the nation's two largest purchasers of health insurance, FEHBP, the benefit plan for federal employees, and CalPERS, the plan for California public employees, have recently faced sharp increases. CalPERS agreed to a 9.7 percent increase in 2000 and a 9.2 percent increase in 2001. In negotiations over 2002 rates, CalPERS rejected initial bids that increased rates by 13 percent, and eventually negotiated rates that increased premiums by only 6 percent—but doubled out-of-pocket costs for doctor visits and prescription drugs. (Gellene, 2001). Premiums for FEHBP enrollees increased 10.5 percent on average for 2001, and premiums for the most popular plan increased 21.2 percent (Barr, 2001).

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