

# Inflation Spurs Health Spending In 2000

*Drug costs once again constitute the fastest-growing component of health spending, although hospital spending accounts for the largest share.*

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HEALTH SPENDING totaled \$1.3 trillion in 2000, with spending averaging \$4,637 per person (Exhibit 1). Nominal health care expenditures increased 6.9 percent in 2000, the third year of accelerating growth (Exhibit 2). The 1.2-percentage-point gain in the rate of spending growth in 2000 primarily reflects an increase in economywide inflation and a gain of only 0.3 percentage points in real spending.<sup>1</sup>

Spending growth in 1999 and 2000 slightly outpaced growth in gross domestic product (GDP), the first sign that the nine-year stability in health spending's share of GDP may be coming to an end. The health spending share of GDP increased slightly, from 13.1 percent in 1999 to 13.2 percent in 2000. Available data for 2001 indicate that GDP growth decelerated as health care employment (Exhibit 3), medical inflation, and premium growth escalated. This suggests a stronger increase in the health spending share of GDP in the near future.<sup>2</sup>

Strong economic growth between 1997 and 2000 and the accompanying tight labor market caused those who are insured through employer-sponsored plans to choose less restrictive, more costly options. This resulted in faster growth in private health care spending than existed between 1993 and 1997, when cost containment strategies and increasing enrollment in managed care plans helped to dampen spending growth.

Expanding budget surpluses supported federal policy initiatives that increased funding for Medicare. Congress passed two major pieces of legislation that added to Medicare funding in 2000: the Balanced Budget Refinement Act (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA). After the Balanced Budget Act (BBA) slowed Medicare spending growth to 0.6 percent in 1998 and 1.5 percent in 1999, the effects of the BBRA boosted Medicare spending to 5.6 percent in 2000. The full effects of BIPA will not be felt until 2002.

Because spending for services in both the private and public sectors increased at similar rates in 2000 (6.9 and 7.0 percent, respectively), there was little change in the public share of health spending (Exhibit 4). Public spending in 2000 accounted for 45 percent of all national health expenditures, and private spending, the remainder.

## Systemic Changes In The Public Sector

Public policymakers have two conflicting goals: providing greater access to services, and limiting cost growth. A series of adjustments introduced by the BBA along with more-intensive fraud-and-abuse investigation strengthened the solvency of Medicare, causing an abrupt slowdown of payments in 1998 and into 1999. State and federal policymakers

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**EXHIBIT 1**

**National Health Expenditures (NHE), Aggregate And Per Capita Amounts, And Share Of Gross Domestic Product (GDP), Selected Calendar Years 1970–2000**

Spending category	1970	1980	1988	1993	1997	1998	1999	2000
NHE, billions	\$73.1	\$245.8	\$558.1	\$888.1	\$1,091.2	\$1,149.8	\$1,215.6	\$1,299.5
Health services and supplies	67.3	233.5	535.4	856.3	1,053.9	1,111.5	1,175.0	1,255.5
Personal health care	63.2	214.6	493.3	775.8	959.2	1,009.9	1,062.6	1,130.4
Hospital care	27.6	101.5	209.4	320.0	367.5	379.2	392.2	412.1
Professional services	20.7	67.3	176.3	280.7	352.3	375.7	397.0	422.1
Physician and clinical services	14.0	47.1	127.4	201.2	241.0	256.8	270.2	286.4
Other professional services	0.7	3.6	14.3	24.5	33.4	35.5	36.7	39.0
Dental services	4.7	13.3	27.3	38.9	50.2	53.2	56.4	60.0
Other personal health care	1.3	3.3	7.3	16.1	27.8	30.2	33.7	36.7
Nursing home and home health	4.4	20.1	48.9	87.6	119.6	122.7	121.6	124.7
Home health care <sup>a</sup>	0.2	2.4	8.4	21.9	34.5	33.6	32.3	32.4
Nursing home care <sup>a</sup>	4.2	17.7	40.5	65.7	85.1	89.1	89.3	92.2
Retail outlet sales of medical products	10.5	25.7	58.7	87.5	119.8	132.3	151.8	171.5
Prescription drugs	5.5	12.0	30.6	51.3	75.7	87.2	103.9	121.8
Durable medical equipment	1.6	3.9	8.7	12.8	16.2	16.5	17.6	18.5
Other nondurable medical equipment	3.3	9.8	19.4	23.4	27.9	28.6	30.4	31.2
Program administration and net cost of private health insurance	2.8	12.1	26.6	53.3	59.2	63.7	71.5	80.9
Government public health activities	1.4	6.7	15.5	27.2	35.5	37.9	40.9	44.2
Investment	5.7	12.3	22.7	31.8	37.2	38.3	40.5	43.9
Research <sup>b</sup>	2.0	5.5	10.8	15.6	18.7	20.6	23.1	25.3
Construction	3.8	6.8	11.9	16.2	18.5	17.7	17.5	18.6
NHE per capita	\$ 347.6	\$1,067	\$2,243	\$3,381	\$4,001	\$4,177	\$4,377	\$4,637
Population (millions)	210.2	230.4	248.9	262.6	272.7	275.2	277.7	280.2
GDP, billions of dollars	\$1,039.7	\$2,795.6	\$5,108.3	\$6,642.3	\$8,318.4	\$8,781.5	\$9,268.6	\$9,872.9
Real NHE <sup>c</sup>	\$251.5	\$430.8	\$695.7	\$944.2	\$1,070.3	\$1,114.1	\$1,161.4	\$1,214.0
Chain-weighted GDP index	29.1	57.1	80.2	94.1	102.0	103.2	104.7	107.0
Personal health care deflator <sup>d</sup>	17.7	37.7	68.0	90.3	102.1	104.4	107.3	110.9
NHE as percent of GDP	7.0%	8.8%	10.9%	13.4%	13.1%	13.1%	13.1%	13.2%

**SOURCES:** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.

<sup>a</sup> Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

<sup>b</sup> Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

<sup>c</sup> Deflated using GDP chain-type price index (1996 = 100.0).

<sup>d</sup> Personal health care (PHC) chain-type index is constructed from the Producer Price Index for hospital care, Nursing Home Input Price Index for nursing home care, and Consumer Price Indices specific to each of the remaining PHC components.

also attempted to improve insurance coverage in the midst of the longest economic expansion in U.S. history. New policies primarily benefited uninsured children and teens.

■ **SCHIP.** The State Children's Health Insurance Program (SCHIP) was created in the BBA to provide additional health care coverage for low-income children. SCHIP is a joint state-federal program under which states may cover eligible children, either through state-

specific programs or through Medicaid expansions. SCHIP enrollment grew approximately 70 percent in fiscal year 2000, from 1.9 million to 3.3 million.<sup>3</sup> Total SCHIP spending (\$1.8 billion in 1999) increased to \$2.8 billion in 2000. Outreach efforts related to SCHIP campaigns boosted Medicaid enrollment in 1999 and 2000, providing increased coverage for the low-income population.<sup>4</sup>

■ **Medicaid.** While rising Medicaid en-

**EXHIBIT 2**

**National Health Expenditures (NHE), Average Annual Percentage Growth From Prior Year Shown, Selected Calendar Years 1970–2000**

Spending category	1970 <sup>a</sup>	1980	1988	1993	1997	1998	1999	2000
NHE	10.6%	12.9%	10.8%	9.7%	5.3%	5.4%	5.7%	6.9%
Health services and supplies	10.4	13.2	10.9	9.8	5.3	5.5	5.7	6.9
Personal health care	10.5	13.0	11.0	9.5	5.5	5.3	5.2	6.4
Hospital care	11.7	13.9	9.5	8.8	3.5	3.2	3.4	5.1
Professional services	9.5	12.5	12.8	9.8	5.8	6.7	5.7	6.3
Physician and clinical services	10.1	12.9	13.2	9.6	4.6	6.6	5.2	6.0
Other professional services	6.6	17.1	18.8	11.4	8.1	6.4	3.3	6.3
Dental services	9.1	11.1	9.4	7.3	6.6	6.0	6.1	6.3
Other personal health care	7.2	10.0	10.5	17.2	14.5	8.8	11.7	8.9
Nursing home and home health	17.2	16.3	11.8	12.4	8.1	2.6	-0.9	2.5
Home health care <sup>b</sup>	14.5	26.9	17.1	21.0	12.1	-2.8	-3.7	0.3
Nursing home care <sup>b</sup>	17.4	15.4	10.9	10.2	6.7	4.7	0.2	3.3
Retail outlet sales of medical products	7.8	9.4	10.9	8.3	8.2	10.4	14.8	13.0
Prescription drugs	7.5	8.2	12.4	10.8	10.3	15.1	19.2	17.3
Durable medical equipment	9.7	8.9	10.7	8.0	6.0	2.3	6.3	5.4
Other nondurable medical equipment	7.4	11.4	8.9	3.9	4.4	2.6	6.3	2.7
Program administration and net cost of private health insurance	8.6	15.9	10.3	15.0	2.7	7.5	12.3	13.1
Government public health activities	13.2	17.4	11.0	11.9	6.9	6.8	7.8	8.3
Investment	12.9	7.9	8.0	7.0	4.0	2.9	5.8	8.4
Research <sup>c</sup>	10.9	10.8	8.9	7.6	4.7	10.1	11.9	10.0
Construction	14.1	6.1	7.2	6.4	3.4	-4.4	-1.3	6.4
NHE per capita	9.3	11.9	9.7	8.6	4.3	4.4	4.8	6.0
Population	1.2	0.9	1.0	1.1	0.9	0.9	0.9	0.9
Gross domestic product (GDP)	7.0	10.4	7.8	5.4	5.8	5.6	5.5	6.5
Real NHE <sup>d</sup>	7.7	5.5	6.2	6.3	3.2	4.1	4.2	4.5
Chain-weighted GDP index	2.7	7.0	4.4	3.2	2.0	1.2	1.4	2.3
Personal health care deflator <sup>e</sup>	3.9	7.9	7.6	5.8	3.1	2.2	2.8	3.4

**SOURCES:** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.

<sup>a</sup> Average annual growth in 1960–1970.

<sup>b</sup> Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

<sup>c</sup> Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from “research expenditures” but are included in the expenditure class in which the product falls.

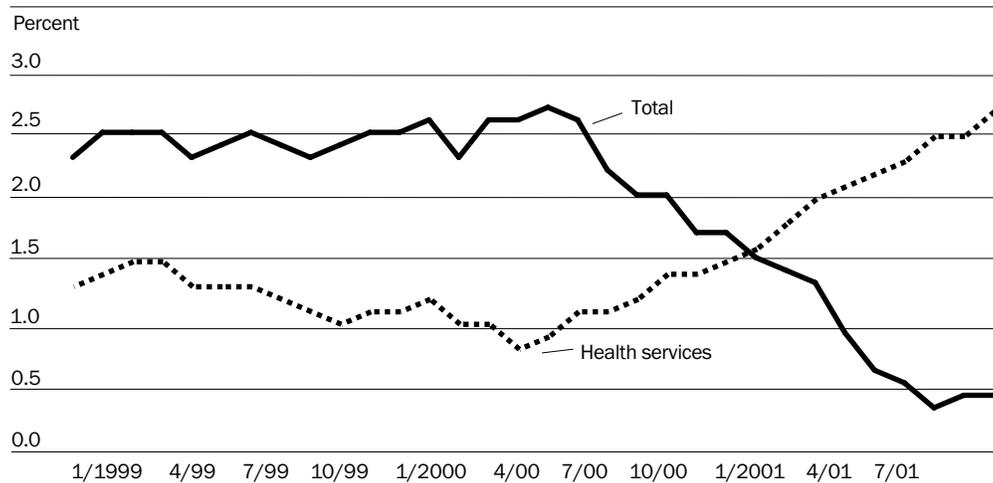
<sup>d</sup> Deflated using GDP chain-type price index (1996 = 100.0).

<sup>e</sup> Personal health care (PHC) chain-type index is constructed from the Producer Price Index for hospital care, Nursing Home Input Price Index for nursing home care, and Consumer Price Indices specific to each of the remaining PHC components.

rollment has contributed to rising expenditures, public spending would have been even greater had state Medicaid expenditures not been adjusted for states’ use of creative and controversial financing arrangements, including disproportionate-share hospital (DSH) payments and upper payment limit (UPL) enhanced payments for both hospitals and nursing homes. States used a large portion of these increased payments for nursing homes for other purposes, whereas hospitals generally retained UPL funds.<sup>5</sup> UPL and DSH provide

loopholes that some states have used to boost revenues. Medicaid DSH payments were curbed in the late 1990s, causing a drop in Medicaid hospital spending growth, but UPL payment controls are only now being phased in. State Medicaid hospital and nursing home spending was adjusted to remove estimated amounts retained by the states. After adjustments, total Medicaid spending increased 8.3 percent in 2000.

■ **Legislative changes.** Other systemic changes are related to new Medicare payment

**EXHIBIT 3****Growth In Total And Health Services Employment, January 1999–August 2001**

**SOURCE:** U.S. Department of Labor, Bureau of Labor Statistics.

**NOTE:** Growth is measured as the percentage change from the same period of the previous year.

policies introduced in 1997–1998 and eased in 1999–2000. Rapid growth in Medicare spending for certain services in the mid-1990s prompted additional scrutiny of public payments. After adjusting for enrollment increases, high rates of Medicare spending growth in 1993–1997 stood in contrast against the deceleration in spending that occurred as managed care enrollment surged and cost growth was constrained in the private sector. Growth in public expenditures prompted renewed fraud-and-abuse investigation of Medicare and led to enactment of the BBA, which slowed growth in hospital, home health, and nursing home payments. As the brunt of the BBA adjustments and fraud-and-abuse enforcement was felt in 1998, average per enrollee Medicare benefit spending fell 0.4 percent and in 1999 increased by a mere 0.1 percent. Concerned about the impact of the BBA, Congress enacted the BBRA in November 1999 to increase payments or delay payment reductions. This caused Medicare per enrollee spending to grow in 2000 (4.7 percent) at a rate slightly slower than per enrollee private health insurance (5.2 percent). Part of the reason for private health insurance's slightly faster growth is its coverage of

outpatient prescription drugs, which are not covered by Medicare.

■ **Effects on nursing homes.** Spending growth for freestanding nursing homes decelerated from 9.1 percent in 1995 to 0.2 percent in 1999 and then rebounded to 3.3 percent in 2000, with spending of \$92.2 billion. This industry, facing increased quality-of-care scrutiny, remains heavily dependent on public funding to pay for services.<sup>6</sup> Public spending accounts for 61 percent of all spending, mostly from Medicaid (Exhibit 5). Despite Medicare's small 10 percent share of all nursing home spending, wide swings in Medicare spending growth have affected overall trends in nursing home spending growth. From a high of 45.3 percent in 1994, growth in Medicare spending for skilled nursing facilities plummeted to -18.6 percent in 1999, before rebounding in 2000 with a 13.3 percent increase. This turnaround is attributable to BBRA provisions that raised Medicare payments for some complex patient conditions and for facilities specializing in care for AIDS.

■ **Effects on home health.** Medicare spending for freestanding home health services declined by 36.8 percent from 1996 to 1999 after years of double-digit growth. This

**EXHIBIT 4**

**National Health Expenditures (NHE), Amounts And Average Annual Percentage Growth, By Source Of Funds, Selected Calendar Years 1970–2000**

Source of funds	1970 <sup>a</sup>	1980	1988	1993	1997	1998	1999	2000
NHE, billions	\$73.1	\$245.8	\$558.1	\$888.1	\$1,091.2	\$1,149.8	\$1,215.6	\$1,299.5
Private funds	45.4	140.9	331.7	497.7	588.8	628.8	666.5	712.3
Consumer payments	40.6	126.4	293.8	445.0	521.8	557.7	593.8	638.4
Out-of-pocket payments	25.1	58.2	118.9	146.9	162.3	174.5	184.4	194.5
Private health insurance	15.5	68.2	174.9	298.1	359.4	383.2	409.4	443.9
Other private funds	4.8	14.5	37.9	52.7	67.0	71.1	72.7	73.8
Public funds	27.6	104.8	226.4	390.4	502.4	520.9	549.0	587.2
Federal	17.6	71.3	154.1	274.4	358.8	367.7	384.8	411.5
Medicare	7.7	37.4	89.0	148.3	208.2	209.5	212.6	224.4
Medicaid <sup>b</sup>	2.8	14.5	31.0	76.8	94.9	99.6	108.4	118.4
Other federal <sup>c</sup>	7.1	19.4	34.1	49.3	55.8	58.6	63.8	68.7
State and local	10.0	33.5	72.3	116.0	143.6	153.3	164.2	175.7
Medicaid <sup>b</sup>	2.4	11.5	24.1	44.8	64.8	71.8	78.3	84.3
Other state and local <sup>c</sup>	7.6	22.0	48.2	71.1	78.8	81.5	85.9	91.4
Average annual growth in NHE from prior year shown	10.6%	12.9%	10.8%	9.7%	5.3%	5.4%	5.7%	6.9%
Private funds	8.5	12.0	11.3	8.5	4.3	6.8	6.0	6.9
Consumer payments	8.0	12.0	11.1	8.7	4.1	6.9	6.5	7.5
Out-of-pocket payments	6.9	8.8	9.3	4.3	2.5	7.5	5.7	5.5
Private health insurance	10.2	15.9	12.5	11.3	4.8	6.6	6.8	8.4
Other private funds	14.0	11.6	12.8	6.8	6.2	6.1	2.3	1.5
Public funds	15.4	14.3	10.1	11.5	6.5	3.7	5.4	7.0
Federal	20.1	15.0	10.1	12.2	6.9	2.5	4.7	6.9
Medicare	– <sup>d</sup>	17.2	11.4	10.8	8.8	0.6	1.5	5.6
Medicaid <sup>b</sup>	– <sup>d</sup>	17.7	10.0	19.9	5.4	5.0	8.8	9.2
Other federal <sup>c</sup>	9.6	10.6	7.3	7.7	3.1	5.0	8.9	7.7
State and local	10.2	12.8	10.1	9.9	5.5	6.8	7.1	7.0
Medicaid <sup>b</sup>	– <sup>d</sup>	16.8	9.6	13.3	9.6	10.9	9.1	7.7
Other state and local <sup>c</sup>	7.2	11.2	10.3	8.1	2.6	3.4	5.4	6.4

**SOURCE:** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

**NOTE:** Numbers may not add to totals because of rounding.

<sup>a</sup> Average annual growth in 1960–1970.

<sup>b</sup> Includes State Children’s Health Insurance Program (SCHIP) expansion (Title XIX).

<sup>c</sup> Includes SCHIP (Title XXI).

<sup>d</sup> Not applicable; Medicare and Medicaid became effective in July 1966.

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decline resulted from intensified government efforts to detect fraud and abuse, the industry’s reaction to increased oversight, greater financial constraints imposed by the BBA, and providers’ behavioral responses to the limitations imposed by the BBA provisions.<sup>7</sup>

In November 1999 the BBRA called for a delay in previously mandated BBA Medicare payment reductions to providers and for increased Medicare per beneficiary payment limits for some home health agencies. The Medicare home health agency prospective payment system (PPS), based on per episode payment rates, became effective in October

2000, replacing the interim payment system. Medicare spending rose 0.8 percent in 2000, the first positive growth in four years.

Because it finances a large share of home health services (28 percent in 2000), Medicare influences trends in overall home health spending. The industry had five years of decelerating growth from 1992 through 1997 and actual declines in spending in 1998 and 1999. In 2000 all-payer spending for home health services increased by 0.3 percent. Growth in industry work hours and employment confirmed this turnaround.

A modification in the definition of “home-

**EXHIBIT 5**  
**Expenditures For Health Services And Supplies, By Type Of Service And Source Of Funds, Calendar Year 2000**

Spending category	Private funds				Public funds			
	Total	Total <sup>a</sup>	Out-of-pocket	Private health insurance	Total	Medicare	Federal and state Medicaid <sup>b</sup>	Other public
Health services and supplies (billions)	\$1,255.5	\$695.6	\$194.5	\$443.9	\$559.9	\$224.4	\$202.7	\$132.9
Personal health care	1,130.4	641.4	194.5	390.7	489.0	217.0	188.5	83.4
Hospital care	412.1	168.9	13.0	133.9	243.2	125.7	70.1	47.4
Professional services	422.1	282.3	71.8	181.8	139.8	64.4	47.1	28.4
Physician and clinical services	286.4	191.3	33.2	136.7	95.2	59.6	19.1	16.5
Other professional services	39.0	29.6	11.7	15.0	9.4	4.7	1.5	3.1
Dental services	60.0	57.2	26.9	30.1	2.8	0.1	2.5	0.2
Other personal health care	36.7	4.2	- <sup>d</sup>	- <sup>d</sup>	32.5	- <sup>d</sup>	23.9	8.6
Nursing home and home health	124.7	51.8	31.2	15.1	72.8	18.7	50.4	3.7
Home health care <sup>c</sup>	32.4	15.5	6.4	7.6	16.9	9.2	6.0	1.7
Nursing home care <sup>c</sup>	92.2	36.3	24.9	7.4	55.9	9.5	44.4	2.0
Retail outlet sales of medical products	171.5	138.4	78.5	59.9	33.1	8.2	21.0	3.9
Prescription drugs	121.8	95.3	39.0	56.3	26.5	2.3	21.0	3.2
Durable medical equipment	18.5	13.3	9.6	3.6	5.3	4.6	- <sup>d</sup>	0.7
Other nondurable medical products	31.2	29.8	29.8	- <sup>d</sup>	1.3	1.3	- <sup>d</sup>	- <sup>d</sup>
Program administration and net cost of private health insurance	80.9	54.2	- <sup>d</sup>	53.1	26.7	7.3	14.2	5.2
Government public health activities	44.2	- <sup>d</sup>	- <sup>d</sup>	- <sup>d</sup>	44.2	- <sup>d</sup>	- <sup>d</sup>	44.2

**SOURCE:** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

**NOTE:** Numbers may not add to totals because of rounding.

<sup>a</sup> Includes other private funds.

<sup>b</sup> Includes Medicaid State Children's Health Insurance Program (SCHIP) expansion (Title XIX).

<sup>c</sup> Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

<sup>d</sup> Not applicable.

bound" for Medicare home health coverage in BIPA is expected to increase the number of beneficiaries qualified to receive Medicare home health services in 2001.<sup>8</sup> This will likely contribute to rising spending in the future.

■ **Effects on hospitals.** A deceleration in Medicare hospital spending resulting from the BBA produced a decline of 1.2 percent in 1998 and an increase of only 0.4 percent in 1999. This was partly accomplished by the BBA's slowing of the rate of fee-for-service (FFS) inpatient payment growth for hospitals paid under inpatient PPS. Medicare hospital

spending further slowed in 1999 as payments to hospital-based home health agencies (included in these estimates of hospital spending) were reduced.

Medicare hospital spending made a comeback in 2000, similar to that in nursing homes and home health agencies. Its 4.5 percent increase in 2000 was the highest rate of growth since 1997, as the BBRA reduced BBA-mandated Medicare cuts for graduate medical education and lessened reductions in DSH payments for hospitals with a large share of indigent patients. The BBRA also provided for

a one-year payment increase to hospitals that are sole providers in their communities, to be implemented in FY 2001.

Two changes in Medicare affect payments for outpatient services. First, changes in Medicare outpatient rules gradually reduced average beneficiary copayments for hospital outpatient services, shifting some spending from beneficiaries to Medicare. Second, starting in July 2000, hospitals receive a prospectively determined fee according to the ambulatory payment classification of services. These two changes contributed to a 10 percent increase in Medicare FFS outpatient spending in 2000. Medicare funds a relatively small share (15 percent) of outpatient services.

■ **Other changes.** Apart from legislative changes, declines in the average complexity of Medicare inpatient services continued for the third consecutive year. Some of these declines in case-mix were associated with changes in hospitals' coding of admissions that may be related to investigations of fraud and abuse by the U.S. Department of Justice. Overall, Medicare inpatient spending increased slightly (2.1 percent) in 2000.

### Private-Sector Spending

■ **Private health insurance.** As did public spending, the pace of private spending quickened slightly in 2000 to 6.9 percent, up from 6.0 percent in 1999. This uptick is partly the result of accelerating private health insurance premium growth. Premiums (\$443.9 billion) rose 8.4 percent in 2000, making this one of the fastest-growing health care payer sectors. Premiums increased primarily because benefit costs rose (especially for prescription drugs), insurers sought to restore profitability, enrollment increased, and the mix of plan types shifted to higher-cost options. A generally tight labor market also made employers more willing to pay a large share of health premiums, further encouraging plan enrollment.<sup>9</sup> The recent rise in health insurance premium growth may signal the gradual end of what researchers call managed care's one-time impact on slowing spending growth.<sup>10</sup>

For the past two years private insurers

have raised premiums more than they have increased the benefits provided. Premiums increased 8.4 percent in 2000, compared with benefit growth of 7.4 percent; in 1999 premiums were up 6.8 percent, compared with benefit increases of 6.2 percent. This produced an upward movement in the net cost ratio (the difference between premiums and benefits divided by premiums)—from 10.6 percent in 1998 to 11.1 percent in 1999 and 12.0 percent in 2000—the second year of an upswing in the underwriting cycle.<sup>11</sup>

■ **Managed care backlash.** Rising insurance benefit expenses also result from health care providers' taking a stronger stance in negotiating with managed care plans. Physicians' acceptance of health maintenance organization (HMO) capitation is down, with providers citing inability to meet expenses and displeasure with strict management of medical costs by the health plan itself.<sup>12</sup> As a result, some HMOs are abandoning capitation in selected markets for FFS arrangements with physicians and hospitals.<sup>13</sup> The consolidation of hospitals into networks and systems also has increased providers' bargaining power for higher payment from insurers.

Consumers increasingly choose less restrictive forms of managed care, boosting benefit growth per enrollee. The share of workers covered by more-restrictive HMOs has remained relatively constant since 1998, while the share covered by preferred provider organizations (PPOs) has risen from 35 percent in 1998 to 41 percent in 2000 at the expense of conventional (FFS) and point-of-service (POS) plans.<sup>14</sup>

■ **Out-of-pocket spending.** Out-of-pocket expenditures account for 15 percent of national health spending. This share has remained relatively unchanged since 1994, even as managed care plans increased in popularity. Low copayments and smaller deductibles allowed managed care plans to attract enrollees from the previously dominant FFS plans. Consumer spending for prescription drugs in 2000 represented the largest single component—20 percent—of out-of-pocket spending. (Physician and clinical services ac-

counted for 17 percent, and over-the-counter medicines and other medical sundries accounted for another 15 percent.) The large percentage spent by consumers on drugs comes disproportionately from persons age sixty-five and older, many of whom have no third-party coverage for these products.<sup>15</sup>

### Specific Health Services

Growth in spending accelerated for most health care services except for retail sales of medical products and other personal health care services. While growth in prescription drug spending slowed from 1999 to 2000, it was still the fastest-growing service in 2000.

■ **Drugs: key driver of cost trends.** Growth of prescription drug spending at retail outlets once again exceeded that of other health services by a wide margin, increasing 17.3 percent in 2000, the sixth consecutive year of double-digit growth. Rapidly increasing drug spending accounted for more than a quarter of the total growth in personal health care spending between 1999 and 2000 and raised pharmaceuticals' share of personal health care spending to 10.8 percent in 2000. Rapid growth can be attributed to increased direct-to-consumer advertising, a shift in payment of drugs from consumers to private health insurance companies, and newer therapies and consequent shifts in consumption toward these newer, higher-price drugs.

*Factors driving growth.* The impact of new therapies on spending is related to the number of new drugs, especially blockbusters, entering the market. In 1999 two top-selling drugs, Celebrex and Vioxx, helped to drive spending growth to 19.2 percent. While sales of drugs introduced in 1999 continued to grow rapidly, none entering the market in 2000 were considered blockbusters, and spending growth slowed to 17.3 percent.

Together with the aging of the population,

the introduction of new therapies for chronic conditions gradually adds to the average number of prescriptions purchased. These factors contribute to the rising number of retail prescriptions per capita: 10.5 per person in 2000, from 8.3 in 1995.<sup>16</sup>

*Managing the drug benefit.* Faced with increasing drug benefit spending, insurers established incentives for more efficient drug purchasing using tiered copayment structures that vary copayments depending on the drug purchased.<sup>17</sup> According to the Scott-Levin Managed Care Formulary Drug Audit, the percentage of managed care plans using three-tier benefit structures rose rapidly—from 36 percent in 1998 to 80 percent in spring 2000.<sup>18</sup> Increasing copayments helped to narrow the growth gap between out-of-pocket and total drug spending in recent years.

Some studies show that tiered plans lower health plans' prescription drug spending, as a greater portion of costs is shifted to consumers.<sup>19</sup> Conversely, some researchers believe that the consumption of newer drugs may lower overall health spending by reducing use of more costly services.<sup>20</sup>

Pharmacy benefit managers (PBMs) in 1999 administered 71 percent of third-party payments for drugs, affecting drug selection and prices. On behalf of their clients, PBMs process drug claims, administer benefit plans, and deliver other cost-saving services. One such service is the negotiation of rebates with manufacturers. The rebates are typically shared with insurers, reducing insurers' expenditures. (For this reason, retail sales figures often cited in the trade press are somewhat higher than expenditures included in the National Health Accounts.) Because rebates are negotiated for brand-name products only, PBMs are motivated to boost sales of these drugs by including them in the plan's formulary or preferred status. This preference for brand-name products, along with steady

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increases in the number of new drugs, contributed to the fact that brand-name drugs' share of retail prescription sales grew to approximately 91 percent of sales in 1999.<sup>21</sup>

■ **Hospitals.** Hospital expenditures contributed more to increased spending in 2000 than did prescription drugs, primarily because hospital spending comprises a larger share of total health spending and because hospital spending growth jumped above 4 percent for the first time since 1993. Expenditures rose to \$412 billion, an increase of 5.1 percent from 1999. Growth in spending for inpatient services in community hospitals continued to increase at a slow but somewhat accelerated rate—3.4 percent in 2000, up from a 1.9 percent average annual rate in 1993–1999. This corresponds with faster growth in hospital discharges in recent years.<sup>22</sup> The average annual rate of growth in outpatient hospital revenue of 8.3 percent between 1993 and 1999 rose to 8.7 percent in 2000. Faster growth in outpatient revenues than inpatient reflects use of less-invasive technologies.

Hospital revenues grew 1.6 percentage points faster in 2000 than in 1999 but were partly offset by rising expenses.<sup>23</sup> As nonprofit networks and corporate systems consolidated, they were able to negotiate increased payments from private payers.<sup>24</sup> But these gains were tempered by rapidly rising nurses' wages and energy costs. Weekly wages paid to workers in private hospitals increased 4.1 percent in 2000, up from 2.3 percent in 1999.<sup>25</sup> Costs also increased as hospitals hired more-costly temporary staff, provided flexible work arrangements, and offered signing bonuses to meet staffing needs. While nursing shortages wax and wane, pressures to increase nurses' wages are expected to continue.

**H**ISTORICAL SPENDING TRENDS through 2000 along with historical medical inflation and employment reports for the first half of 2001 indicate that the acceleration in health care costs will likely continue. This stands in stark contrast to recent reports of an increasingly sluggish U.S. economy. Pressure will mount on both public

and private payers to finance accelerating health care costs out of decelerating incomes and revenues. Increased job layoffs in the slowing economy will lead to a less competitive job market, reducing private employers' incentive to shoulder rising health care costs, potentially increasing the number of uninsured persons. Competition may force employers to shift a larger share of rising costs to workers, who may no longer be able to afford accelerating out-of-pocket costs. Fewer employers may offer health insurance, and the recently unemployed are often left without coverage. Shrinking tax revenues will likely force government to evaluate health care priorities at a time when the need for coverage is rising. These national health spending estimates may well mark the end of an era of reasonably affordable health care cost growth.

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#### NOTES

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