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Tracking Health Care Costs: Spending Growth Slowdown Stalls in First Half of 2004, *p. 2*

Executive Summary:

Tracking Health Care Costs: Spending Growth Slowdown Stalls in First Half of 2004

- The recent slowdown in health care spending growth stalled in the first half of 2004 as health care costs per privately insured American increased 7.5 percent during the first six months of 2004—virtually the same rate of increase as in 2003. Private-sector spending on health care constitutes more than half of all health care spending, and both the private and public sectors are subject to similar cost pressures.
- Growth in spending on hospital inpatient care slowed to 5.1 percent in the first half of 2004, while the trend for outpatient spending held steady at 11.4 percent. With hospital utilization continuing to grow at a slow rate for the second year in a row, hospital price increases—7.7 percent in the first half of 2004—accounted for much of the hospital spending increase.
- Spending on prescription drugs increased 8.8 percent in the first half of 2004, similar to the increases in the first and second halves of 2003 and substantially below the peak increase of 19.5 percent in the second half of 1999.
- Health care costs likely will continue to grow faster than workers' income for the foreseeable future, leading to greater numbers of uninsured Americans and raising the stakes for policymakers to initiate some type of effective cost-containment policies or accept the current trend of rapidly growing health costs and gradually shrinking health coverage.
- The main tool to control costs remains greater financial responsibility for patients. This could encourage consumers to use health care services more judiciously, particularly over time. However, the most common patient financial incentives are often too crude to allow distinctions between needed and more discretionary care, how efficient health care providers are, and how much of a financial burden some patients can afford. The result is a high potential of barriers to health care for people with low incomes or high medical needs.
- Little attention is being paid to the most important long-term driver of health care costs—new medical technology and its enthusiastic acceptance into mainstream medical practice. Measures that can be taken to control this relentless force, such as greater adherence to evidence-based medicine, increased research on medical effectiveness, and greater use of technology assessments generally have received short shrift from policymakers. When the limitations in the extent to which patient financial incentives can be used become more apparent, policymakers may increase their interest in measures designed to improve efficiency in the health care system.

Tracking Health Care Costs: Spending Growth Slowdown Stalls in First Half of 2004

by Bradley C. Strunk and Paul B. Ginsburg, Center for Studying Health System Change[1]

Introduction

The recent slowdown in health care spending growth stalled in the first half of 2004 as health care costs per privately insured American increased 7.5 percent during the first six months of 2004—virtually the same rate of increase as in 2003. Private-sector spending on health care constitutes more than one-half of all health care spending, and both the private and public sectors are subject to similar cost pressures.[2]

Growth in spending on hospital inpatient care slowed to 5.1 percent in the first half of 2004, while the trend for outpatient spending held steady at 11.4 percent. With hospital utilization continuing to grow at a slow rate for the second year in a row, hospital price increases—7.7 percent in the first half of 2004—accounted for much of the hospital spending increase.

Spending on prescription drugs increased 8.8 percent in the first half of 2004, similar to the increases in the first and second halves of 2003 and substantially below the peak increase of 19.5 percent in the second half of 1999.

Health care costs likely will continue to grow faster than workers' income for the foreseeable future, leading to greater numbers of uninsured Americans and raising the stakes for policymakers to initiate some type of effective cost-containment policies or accept the current trend of rapidly growing health costs and gradually shrinking health coverage.

Cost Trends Stabilize at High Rate of Growth

The cost of employer-sponsored health insurance continued to rise at double-digit rates in 2004, far exceeding growth in workers' incomes.[3] This state of affairs elevated health care affordability to near the top of the domestic policy debate in the recent presidential campaign. Employers have responded by shifting more health costs to workers, particularly through higher patient cost sharing, and U.S. Census Bureau data show that the number of uninsured people increased to 45 million Americans in 2003, or to almost 18 percent of the nonelderly (under age 65) population.[4] Employers and employees continue to wonder, as they have for several years now, whether and when they can expect relief from the rapid growth in health insurance premiums. The reality is that unless strong steps are taken to lower the high rate of health care spending growth, relief is unlikely.

The dominant driver of private health insurance premiums is the underlying spending trend for medical services typically covered by health insurance, such as hospital and physician care and prescription drugs. While spending growth for these services slowed in both 2002 and 2003 after peaking at 10 percent in 2001, spending continued to outpace growth in the U.S. economy by a considerable margin (see Data Sources).[5] Research has shown that if health care costs rise at a significantly faster rate than incomes, more people will become uninsured. In fact, the gap between trends in health care costs and incomes is the most important factor behind the long-term trend toward a smaller proportion of people having private health insurance.[6]

Early 2004 data on private health care spending suggest that the recent slowdown in spending growth may already be ending. Through the first six months of the year, total health care spending per privately insured person grew by 7.5 percent compared with the same months in 2003—virtually the same rate of growth as in both of the two previous half-year periods (see Figure 1). Health care cost growth in the first half of 2004 continued to outpace growth in the U.S. economy during the same period, although the difference between the two was considerably smaller than in the recent past because of a robust 5.9 percent per capita growth rate for the U.S. economy (unadjusted for inflation).

Figure 1
Per Capita Growth in Health Care Spending[a] and Gross Domestic Product (GDP), 1998–2004

	Spending on Type of Health Care Service					
	All Services	Hospital Inpatient	Hospital Outpatient	Physician	Prescription Drugs	GDP
Jan.–June '98	4.6%	–1.1%	7.9%	4.0%	13.1%	4.1%
July–Dec. '98	5.9	0.8	7.2	5.5	15.0	4.1
Jan.–June '99	7.6	1.9	10.4	6.4	17.2	4.6
July–Dec. '99	6.6	1.3	9.9	3.7	19.5	4.9
Jan.–June '00	7.1	3.1	8.1	6.0	15.3	5.4
July–Dec. '00	8.4	5.1	11.5	6.6	13.7	4.1
Jan.–June '01	9.9	7.9	15.1	6.2	15.3	2.5
July–Dec. '01	10.0	9.5	14.1	7.1	12.4	1.7
Jan.–June '02	9.3	9.3	12.6	5.9	13.0	2.1
July–Dec. '02	9.8	7.3	13.4	7.4	13.4	2.9
Jan.–June '03	7.6	6.0	11.7	5.7	8.5	3.0
July–Dec. '03	7.6	6.4	10.5	5.4	9.6	4.8
Jan.–June '04	7.5	5.1	11.4	5.7	8.8	5.9

Sources: Health care spending data are from the Milliman Health Cost Index ($0 deductible); GDP is from the U.S. Department of Commerce, Bureau of Economic Analysis.
[a] Each row indicates the percentage change for the period indicated compared with the corresponding months in the previous year.
Notes: GDP is in nominal dollars. Milliman HCI data reflect the September 2004 revision.

Hospital Spending Trends

In recent years, hospital spending trends have moved in the same direction as the overall health care spending trend. Moreover, growth in hospital spending has accounted for the largest portion of the overall increase in health care spending, which is not surprising given that hospital spending also makes up the largest portion of total spending. While the overall spending trend held steady in the first half of 2004, the hospital inpatient spending growth continued to slow. During the first six months of 2004, spending on inpatient care per privately insured person grew by 5.1 percent compared with the same months in 2003, which was about a percentage point lower than the growth rates in the first and second halves of 2003.

Like the overall spending trend, the trend for spending on hospital outpatient care held steady during the first half of 2004, increasing 11.4 percent—slightly faster than the increase in the second half of 2003 but virtually identical to the increase in the first half of 2003.

As it did in 2003, growth in hospital prices accounted for a much larger portion of the overall increase in hospital spending than growth in hospital utilization (see Figure 2). During the first six months of 2004, hospital prices grew 7.7 percent, roughly the same as the peak increase of 8 percent in both the first and second halves of 2003. The large increase in prices is due in part to strong growth in wage rates for hospital workers, which have been driven up by a persistent worker shortage, particularly for nurses. Nonetheless, the most recent rate of growth in wage rates for hospital workers—4.5 percent in the first half of 2004—was considerably smaller than recent hospital price increases and has declined significantly from the peak wage rate increase of 6.3 percent in the second half of 2001. This suggests that additional factors may be driving up hospital prices. One possibility is a sharp decline since 2001 in hospital profit margins for Medicare patients, which likely is prompting hospitals to shift costs to private payers.[7] At the same time, hospitals report total profit margins have increased in recent years to 4.8 percent in 2003.[8]

In contrast to hospital prices, hospital utilization barely grew during the first half of 2004, increasing 0.8 percent, virtually identical to the increases in both the first and second halves of 2003. The slowdown in hospital utilization growth may reflect an increase in health plans' utilization management activities. In the late 1990s and the early part of this decade, managed care plans retreated from using administrative tools to control utilization in response to widespread dissatisfaction among consumers and physicians. That retreat appeared to cause accelerating growth in utilization beginning in the late 1990s, with the hospital utilization trend peaking at 8.4 percent in

Figure 2
Hospital Spending Trend,[a] by Price and Hospital Utilization, 1998–2004
Change per Capita

	Spending on Hospital Services	Hospital Prices	Hospital Utilization[b]
Jan.–June '98	3.1%	2.0%	1.1%
July–Dec. '98	3.8	1.9	1.9
Jan.–June '99	6.0	2.4	3.5
July–Dec. '99	5.6	2.6	2.9
Jan.–June '00	5.6	2.8	2.8
July–Dec. '00	8.4	3.9	4.3
Jan.–June '01	11.6	4.0	7.3
July–Dec. '01	11.9	3.3	8.4
Jan.–June '02	11.1	4.3	6.5
July–Dec. '02	10.6	6.2	4.2
Jan.–June '03	9.1	8.0	1.0
July–Dec. '03	8.7	8.0	0.6
Jan.–June '04	8.6	7.7	0.8

Sources: Data on hospital spending are from the Milliman Health Cost Index ($0 deductible) and include both hospital inpatient and outpatient services. Data on hospital prices are from the Bureau of Labor Statistics' "Other payers" Producer Price Index (PPI) series for general and surgical hospitals.
[a] Each row indicates the annual percentage change for the time period indicated compared with the corresponding months in the previous year.
[b] Calculated as the residual of the hospital spending and hospital price trends.

the second half of 2001. More recently, health plans have selectively increased utilization management by reinstating tools such as prior authorization requirements for some hospital services and expanding disease and case management programs.[9]

The slow growth of utilization in 2004 also may reflect continuing increases in patient cost sharing. In recent years, cost sharing for hospital care—such as per-stay and per-day copayments for inpatient care—has become increasingly prevalent in health benefits, and general deductibles have been increasing rapidly.[10]

Prescription Drug Spending Trends

Prescription drugs continue to receive much of the blame for rising health care costs in the popular media, and the drug pricing debate was prominent during the recent presidential campaign. The reality, however, is that prescription drug spending trends have slowed considerably from the high rates of growth in the late 1990s and early part of this decade.

During the first half of 2004, spending on prescription drugs per privately insured person grew by 8.8 percent, slightly lower than the 9.6 percent increase in the second half of 2003 and virtually identical to the 8.5 percent increase in the first half of 2003. By comparison, spending on prescription drugs peaked at 19.5 percent in the second half of 1999—a time when drug spending accounted for a much larger share of the overall spending increase than it does today.

Prescription drug prices continue to increase at a rate well below what it was several years ago. During the first half of 2004, drug prices increased by 3.1 percent, which was largely unchanged from the 2.7 percent increase in the second half of 2003 (see Figure 3). In contrast, the increase in drug prices during the first half of 2004 was about half as large as the peak increase of 6.0 percent in the second half of 2001.

This relatively modest drug inflation may reflect the increased use of generic drugs, which tend to be priced considerably lower than brand-name equivalents. Another factor is the increased use of three-tiered pharmacy benefit structures. At the same time, there are indications that many employers are increasing copayments in these arrangements, and, in some cases, shifting to coinsurance, where patients pay a percentage of the total cost instead of a fixed-dollar amount. Greater use of three-tiered structures and increased cost sharing create incentives for patients to choose generics instead

Figure 3
Prescription Drug Spending Trend,[a] by Price and Utilization, 1998–2004
Change per Capita

	Spending on Prescription Drugs	Prescription Drug Prices	Prescription Drug Utilization[b]
Jan.–June '98	13.1%	2.7%	10.1%
July–Dec. '98	15.0	4.8	9.7
Jan.–June '99	17.2	5.5	11.1
July–Dec. '99	19.5	5.9	12.9
Jan.–June '00	15.3	5.0	9.8
July–Dec. '00	13.7	3.8	9.5
Jan.–June '01	15.3	4.8	9.9
July–Dec. '01	12.4	6.0	6.1
Jan.–June '02	13.0	5.6	7.0
July–Dec. '02	13.4	4.8	8.2
Jan.–June '03	8.5	3.5	4.8
July–Dec. '03	9.6	2.7	6.7
Jan.–June '04	8.8	3.1	5.5

Sources: Data on prescription drug spending are from the Milliman Health Cost Index ($0 deductible). Prescription drug prices are from the Bureau of Labor Statistics' Consumer Price Index (CPI) for prescription drugs and medical supplies. Data accessed on Oct. 7, 2004.
[a] Each row indicates the annual percentage change for the time period indicated compared with the corresponding months in the previous year.
[b] Calculated as the residual of the prescription drug spending and price trends.

of brand-name drugs and preferred over nonpreferred brand drugs and may pressure manufacturers to hold down prices.

The trend in prescription drug utilization also held fairly steady in early 2004, with drug utilization per person increasing 5.5 percent in the first half of the year. By comparison, drug utilization grew by as much as 12.9 percent in the late 1990s when drug spending accounted for a much larger portion of overall health care spending growth. In addition to its effects on drug prices, the increased use of three-tiered pharmacy benefits and the subsequently higher out-of-pocket costs for patients likely has slowed growth in prescription drug use. The relatively modest increases in drug utilization also may reflect a slowdown in the number of new drugs approved for sale and the reclassification of some major prescription drugs, such as Prilosec and Claritin, to over-the-counter status.

Physician Care Spending Trends

Spending on physician care per privately insured person held steady in early 2004. During the first six months of the year, spending on physician care grew by 5.7 percent—only slightly higher than the 5.4 percent increase in the second half of 2003 and identical to the increase in the first half of 2003 (Figure 1). In the recent past, physician care has been the slowest growing category of health care spending, but during the first half of this year it grew slightly faster than spending on hospital inpatient care, which, as described earlier, experienced a notable decline in its trend. Roughly equal growth in price and utilization accounted for the increase in spending on physician care. The trend of prices for physician care has not increased much in recent years—in stark contrast to the trend in hospital prices.

Implications

Early 2004 health care cost data suggest the decline in spending growth has stalled and may be ending long before reaching the lower trend for overall economic growth, let alone the very low rates of health cost growth seen in the mid-1990s. Moreover, given the sluggish recovery of the U.S. economy in recent months, it is unlikely workers' incomes will grow as rapidly in the second half of

2004 as they did in the first half, meaning the gap between income and health care cost growth may again be large.

Once again, this makes it more likely that the number of uninsured Americans—who receive fewer health care services and are in poorer health than those with health insurance—will continue to grow. Growth in health insurance premiums will likely slow somewhat in the coming years as a result of the recent slowdown in cost trends and an expected turn in the health insurance underwriting cycle, the insurance industry's interdependent pattern of profitability and pricing. However, the premium trend is unlikely to fall much below the underlying cost trend in the short run and is determined almost entirely by the cost trend in the long run. Clearly, there is a continuing strong need for a candid public discussion about how to control underlying health care cost growth—not just how to make health insurance more affordable.

At the moment, the main tool to control costs remains greater financial responsibility for patients, whether in the form of higher cost sharing in health maintenance organizations (HMOs) and preferred provider organizations (PPOs) or through so-called consumer-directed health plans, which typically include a high deductible and an account to draw on to pay medical bills. These tools could encourage consumers to use health care services more judiciously, particularly over time. However, the most common patient financial incentives, such as deductibles, copayments and coinsurance, are often too crude to allow distinctions between needed and more discretionary care, how efficient health care providers are, or how much of a financial burden some patients can afford. The result is a high potential of barriers to health care for people with low incomes or high medical needs. This will limit the extent to which these tools can be used without sacrificing to an unacceptable degree the basic reasons for health insurance—access to needed care and financial protection.

Meanwhile, little attention is being paid to the most important long-term driver of health care costs—new medical technology and its enthusiastic acceptance into mainstream medical practice. Measures that can be taken to control this relentless force, such as greater adherence to evidence-based medicine, increased research on medical effectiveness, and greater use of technology assessments, generally have received short shrift from policymakers. When the limitations in the extent to which patient financial incentives can be used become more apparent, policymakers may increase their interest in measures designed to improve efficiency in the health care system.

Endnotes

[1] The Center for Studying Health System Change (HSC) seeks to provide objective, incisive analyses that lead to sound policy and management decisions, with the ultimate goal of improving the health of the American public. Its Web site is www.hschange.org/. This report is being published concurrently as an *HSC Issue Brief.*

[2] See Katharine Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs,* Vol. 23, no. 1 (January/February 2004): 147–159.

[3] Jon Gabel et al., "Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll On Coverage," *Health Affairs,* Vol. 23, no. 5 (September/October 2004): 200–209.

[4] See Jon Gabel et al., ibid; Carmen DeNavas-Walt, Bernadette D. Proctor, and Robert J. Mills, "Income, Poverty, and Health Insurance Coverage in the United States: 2003," *Current Population Reports* P60–226 (Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration, August 2004); and Paul Fronstin, "Sources of Coverage and Characteristics of the Uninsured: An Analysis of the March 2004 Current Population Survey," *EBRI Issue Brief* no. 276 (Employee Benefit Research Institute, December 2004).

[5] Bradley C. Strunk and Paul B. Ginsburg, "Tracking Health Care Costs: Trends Turn Downward in 2003," *Health Affairs,* Web exclusive publication available on the Internet at http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.354/DC1 (June 9, 2004).

[6] Richard Kronick and Todd Gilmer, "Explaining the Decline in Health Insurance Coverage, 1979–1995," *Health Affairs*, Vol. 18, No. 2 (March/April 1999): 30–47.

[7] For information about hospital margins for Medicare patients, see Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, Washington, DC: MedPAC (March 2004). For information on cost shifting, see Paul B. Ginsburg, "Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payers?" *Health Affairs*, Web exclusive publication available on the Internet at http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.472v1/DC1 (Oct. 8, 2003).

[8] American Hospital Association, *AHA Hospital Statistics 2005* (Washington, DC: American Hospital Association, October 2004).

[9] Glen P. Mays, Gary Claxton, and Justin White, "Managed Care Rebound? Recent Changes in Health Plans' Cost Containment Strategies," *Health Affairs*, Web exclusive publication available on the Internet at http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.427/DC1 (Aug. 11, 2004).

[10] Claxton, Gary, et al., *Employer Health Benefits: 2004 Annual Survey*, The Henry J. Kaiser Family Foundation and Health Research and Educational Trust (September 2004).

Data Sources

The Milliman Health Cost Index (HCI) was used to examine recent trends in health care spending underlying private health insurance premiums. The HCI is designed to reflect the claims expenses experienced by private insurers for a typical insurance policy. As such, it measures spending on only health services that tend to be insured: inpatient and outpatient hospital services, physician services, and drugs. The HCI tracks the experience of a private policy with a $250 deductible, but the data in this report differ by reflecting a $0 deductible. Due to data limitations, the HCI includes spending for Medicaid and uninsured patients, which can cause HCI trends to differ from privately insured trends. Also, the HCI classifies spending on services performed in freestanding facilities in its hospital outpatient category, which is consistent with how insurers classify such services. As with most economic data, the HCI is subject to periodic retroactive revisions.

Data on hospital and prescription drug prices are from the U.S. Bureau of Labor Statistics' (BLS) Producer Price Index for general medical and surgical hospitals and the Consumer Price Index for prescription drugs and medical supplies, respectively. Both of these price indexes reflect actual transaction prices rather than billed charges. Changes in hospital and prescription drug utilization were calculated indirectly as the residual of the HCI for hospital and drug spending and the respective price index. The hospital residual measures changes in utilization, length-of-stay, and resource intensity, while the drug residual captures the change in the total number of prescriptions written per person, changes in the therapeutic mix of drugs prescribed and the introduction of new drugs. Finally, data on average hourly earnings for hospital workers come from the BLS's National Compensation Survey. Wage rate data from this survey are limited to production workers, so managers and executives are excluded.

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