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Data Concerns in Out-of-Pocket Spending Comparisons between Medicare and Private Insurance

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As Medicare beneficiaries double over the next 30 years, controlling per enrollee spending growth becomes increasingly more important. Cost containment, therefore, is a major feature of most Medicare reform discussions. When assessing private and public approaches, a careful comparison of spending growth between Medicare and private insurers can shed light on which sector is better able to control per enrollee spending in the long run. This research note discusses some recent relevant studies and the important data limitations of this type of analysis.

Recent Findings

Using the National Health Accounts dataset from The Centers for Medicare and Medicaid Services (CMS), we compared Medicare and private insurer spending from 1970 to 2000. We did not include out-of-pocket spending in our analysis because the data do not attribute out-of-pocket spending by insurance status. Looking only at Medicare and private insurance payments, therefore, we found that Medicare has contained per enrollee costs for health care more successfully than private insurance. Cumulatively, when comparing similar sets of services, we found that private insurance spending per enrollee grew 20 percent more than Medicare over these three decades, as shown in Figure 1.

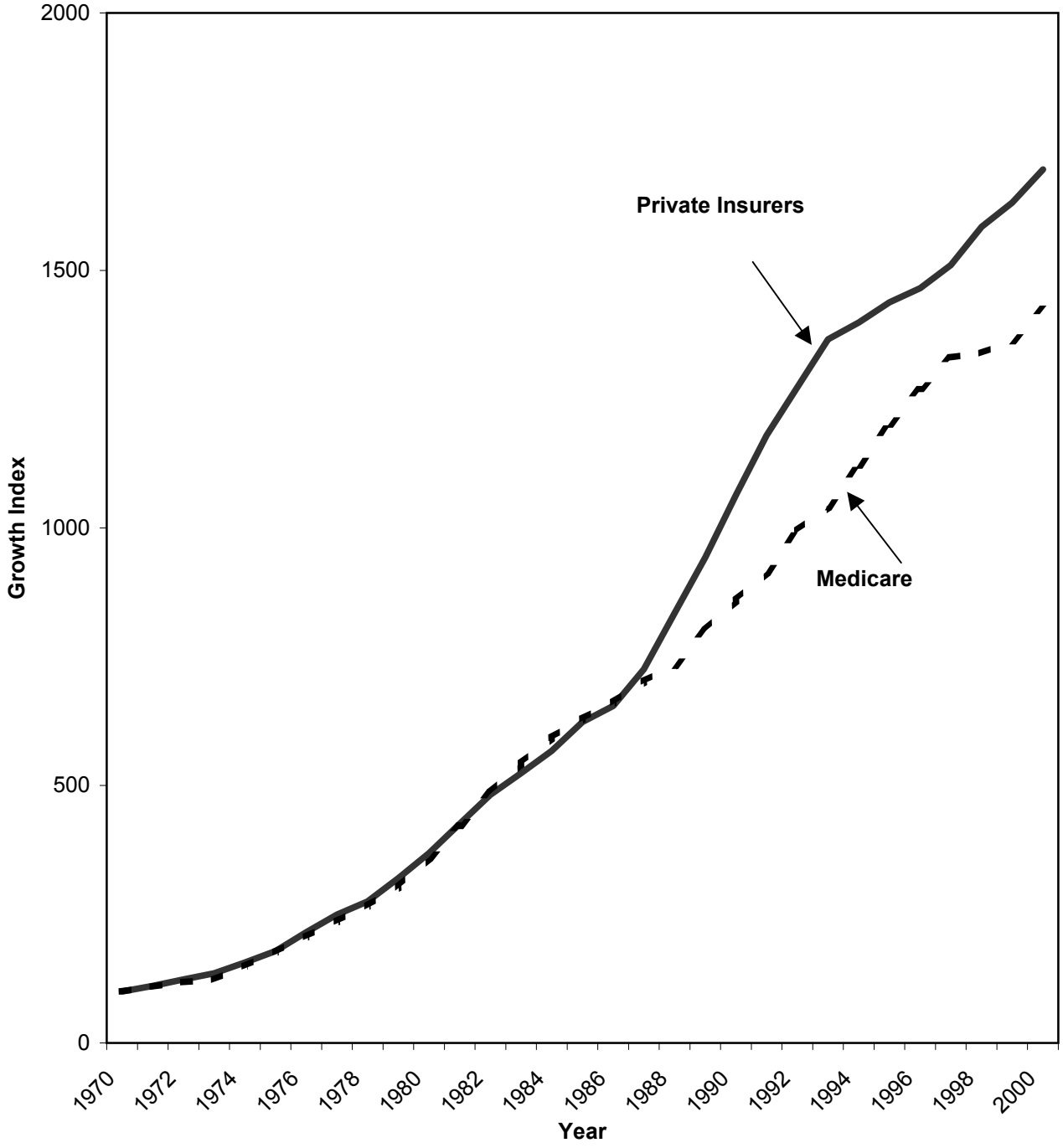
Since our analysis was published, Joseph Antos and Alfredo Goyburu have undertaken additional work on this topic, but have not controlled for some of the data limitations with the National Health Accounts and other available data. These authors have recently published a WebMemo that attempts to show that faster growth in private insurer spending has resulted in lower national out-of-pocket costs. Unfortunately, the authors do not describe their methodology. It appears, however, that their calculations misrepresent out-of-pocket spending because the dataset does not allow attribution of out-of-pocket spending by insurance status. Thus it is unclear how the authors "adjusted" for private insurance generosity using these data. Antos and Goyburu also turn to additional data to back up their claim that private insurance has become more generous than Medicare—covering more health care costs. Since this additional comparison keeps prescription drugs in the spending analysis, their finding is likely true, but it does *not* address the point of relative cost containment between Medicare and private insurance.

Increased Public Coverage

Because the National Health Accounts data do not attribute out-of-pocket spending by insurance status, researchers cannot use them to determine the insurer most responsible for the decrease in out-of-pocket spending seen over the past three decades. A

Figure 1

Cumulative Growth in Per Enrollee Payments for Comparable Services, Medicare and Private Insurers, 1970-2000



Source: Boccuti and Moon, Urban Institute (2003). Analysis of National Health Expenditures data from CMS.
Note: Includes hospital care, physician and clinical services, durable medical equipment, and other professional services. Does *not* include outpatient prescription drugs, home health, and skilled nursing facility services.

look at health insurance coverage trends over time provides some insight into another factor that likely contributed to this welcome decline in Americans' overall out-of-pocket spending—growth in the publicly insured population. Medicaid enrollment grew substantially between 1977 and 1998, from 23 million to 40 million—a 74 percent increase. (In comparison, private insurance enrollment grew only 17 percent and Medicare grew 47 percent.) Because Medicaid's cost-sharing requirements are almost negligible for its recipients, it can be assumed that by 1998, Medicaid absorbed a considerable portion of the national out-of-pocket spending, particularly for those who previously would have been uninsured.[1] Figure 2 shows that from 1970 to 2000 the public sector share of health spending increased, while the share from out-of-pocket spending declined.

Thus, to get a reliable estimate of how much "private spending" is covered by private insurance, it is important to net out fluctuations in public coverage sources and their effect on enrollees' out-of-pocket spending. Further, since Medicare and Medicaid enrollment have grown faster than private insurance enrollment, any spending comparisons should be made on a *per enrollee* basis. Increases in aggregated spending can reflect growth in program size as well as higher per person spending on health care services. For instance, while total private health insurance payments for personal health care grew 788 percent between 1977 and 1998, Medicaid and Medicare payments grew 870 percent and 819 percent, respectively, over the same period because of the greater share of the population covered. The greater increase in *aggregate* public spending over time reinforces the probability that a substantial share of the reduction in Americans' out-of-pocket spending is related to increased public coverage.

Out-of-Pocket Spending Liability over Time

To track Medicare beneficiaries' liability for payment of deductibles and co-insurance between 1977 and 1998, we turn to a different data source, the Statistical Supplement of *The Health Care Financing Review*, also published by CMS. We calculate that beneficiaries' share of spending for hospital and physician services has slightly *decreased* over this time period, per person. Specifically, beneficiaries were liable for 17 percent of the costs of hospital and physician services in 1977 and 15 percent in 1998.

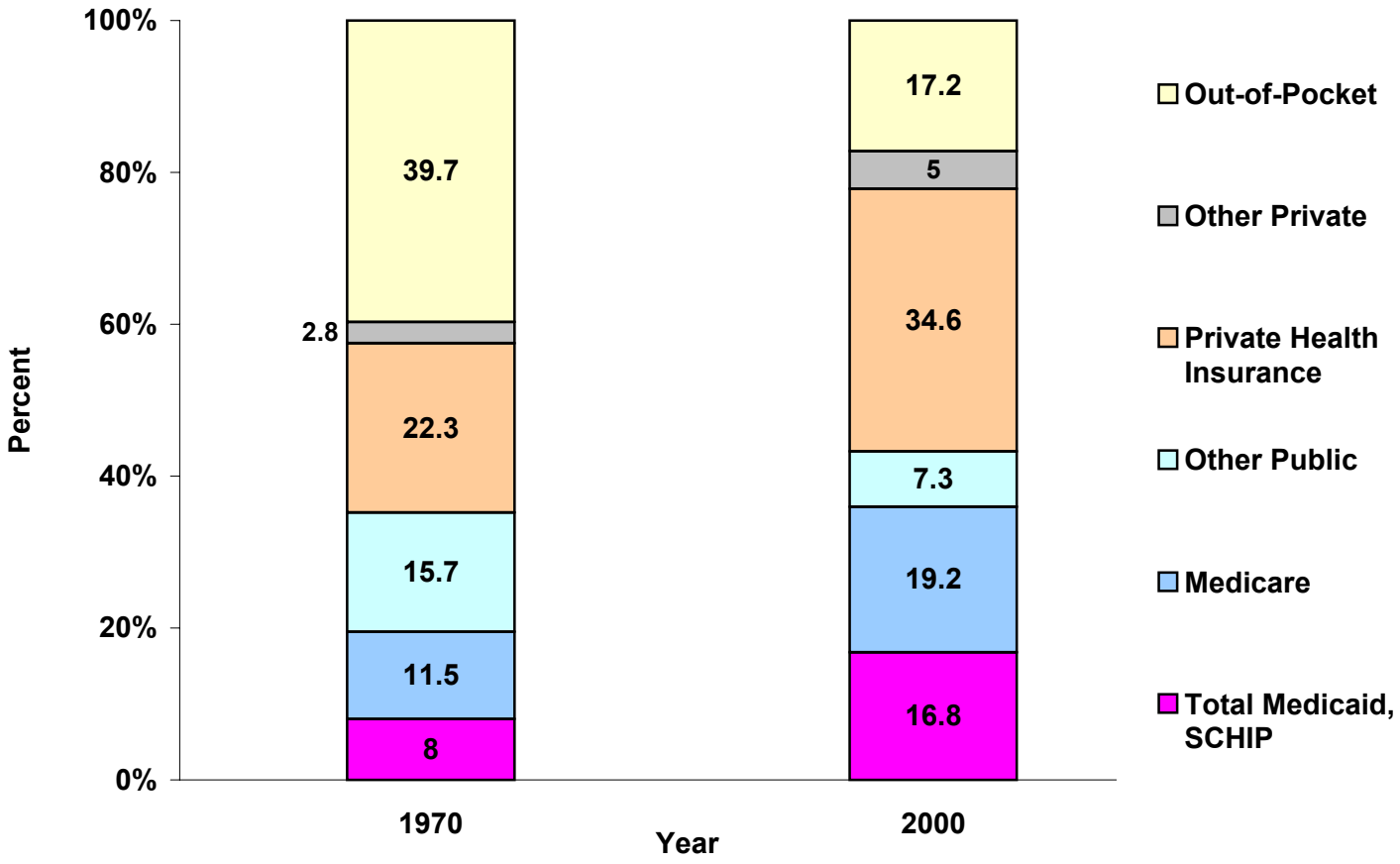
Medicare's benefit package also has not changed substantially since 1970, although some adjustments have served to *hold down* out-of-pocket spending for Medicare covered services. For example, Medicare limits the amount physicians may charge beneficiaries over and above the approved amount, as a result almost eradicating balance billing. Also, most beneficiaries who need hospitalization and/or require home health services pay little to no co-insurance for these services.

At this time, we do not have comparable out-of-pocket spending figures for privately insured people from 1977 to 2000. More recent data suggest that private insurance shifts in the 1990s to managed care likely contributed to some decrease in out-of-pocket spending, particularly for people enrolled in staff model HMOs. But enrollment in this type of HMO declined considerably in later years—by 45 percent from 1997 to 1998 alone (InterStudy Publications 1999). Furthermore, a recent report by KFF and

[1] This trend is seen in recent years where the growth in Medicaid and the State Children's Health Insurance Program (SCHIP) roughly offset the decline in employer-sponsored insurance, particularly for children (Holahan and Wang 2003).

Figure 2

Personal Health Care Expenditures by Source of Funds, 1970-2000



Source: CMS, Office of the Actuary, National Health Statistics Group (from *The CMS Chart Series: An Overview of the U.S. Healthcare System*).

HRET shows considerable increases in employee cost-sharing in the past decade. Between 1988 and 2002, employee deductibles have increased 66 percent for conventional single coverage, and 160 percent for PPO coverage. In addition, employee premiums have risen rapidly in recent years—including a 12.7 percent increase from 2001 to 2002. On top of these increases, employees report reductions in their health plan benefits, according to this study (Kaiser 2002).

Controlling for Medicare's Lack of Drug Coverage

Medicare coverage continues to lag behind private insurance because it does not cover outpatient prescription drugs. A final analysis by Antos and Goyburu uses other datasets, and does not control for this discrepancy. Thus, when the authors indicate that private insurance "generosity" has grown more for private insurers than for Medicare, an undeniable driving factor in their finding is that Medicare beneficiaries are responsible for their outpatient prescription drug payments. Therefore, a comparison of insurance generosity and expenditure growth over time should logically examine comparable sets of services.

Indeed, when we eliminated prescription drug spending from our analysis, using the National Health Accounts dataset, the rate of private insurance spending per enrollee slowed, dropping closer to Medicare's rate of growth. However, Medicare remained more successful in containing spending growth, as shown in Figure 1.

Conclusion

When comparing similar sets of services, Medicare has been able to control spending better than private health insurance, while maintaining greater beneficiary satisfaction. Further, Medicare has made efforts to reign in out-of-pocket costs for the services it covers. Medicare's success at holding down spending exists, despite its beneficiaries' increasing use of expensive medical technologies and surgeries, which have become safer for elderly and disabled patients. In combination with an aging population, this may lead to greater upper pressures on Medicare's per enrollee spending than the pressures on private insurance.

We welcome more study and reaction to our work. It would be desirable to take more factors into account when examining the question of whether Medicare or private health insurance is more successful at cost containment over extended time periods. At this point, however, the data in the National Health Accounts are insufficient to permit adjustments for the generosity of benefits.

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