Health Care Spending and Costs

by Steve Seninger

Health care spending continues to be a major national policy issue and a worry to providers, employers, and consumers. In 2001, U.S. health care spending hit $1.4 trillion, after several years of high growth rates.

The indicators include:

• The annual percentage change in health care spending per capita increased from 5.3 percent in 1998 to 7.8 percent in 2000, 10 percent in 2001, and is expected to increase by 8.8 percent in 2002.

• Increased health care spending is based on two factors: increased utilization of medical services and higher prices for the services. Increased utilization accounted for about half the average annual growth of 8.4 percent between 1999 and 2002; increased prices accounted for the remainder (Figure 1).

The biggest increases in health care spending have been in prescription drugs (13 percent in 2002), hospital outpatient services (13.6 percent), and inpatient services (6.2 percent) (Figure 2). Increased spending on inpatient and outpatient hospital services has been driven by increased utilization (60 percent of the growth) and increased prices (the remaining 40 percent).

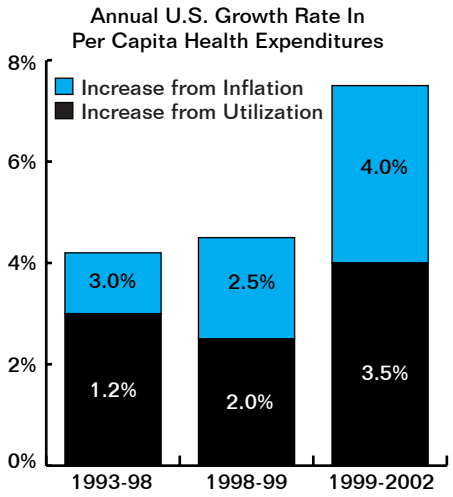
Montana's health care industry realized $3.3 billion in spending during 2002 and employed 40,800 workers. Wages paid exceeded $1.2 billion. Health care is the largest employer in the private business sector of the state's economy.

Hospitals are the largest sector in Montana's health care industry, accounting for about 50 percent of the revenues and employing 18,000 people, or 44 percent of the total health care workforce. Physician, dentist, and other health care professional offices account for 27 percent of health care industry revenues, while nursing homes and personal care account for 12 percent of total revenue.

Of course, the higher health care spending created by increased utilization and increased prices imposes costs on employers and consumers (Figure 3). In the United States, 68 percent of insured non-elderly health care spending is employment-based and was an increasing percentage up through 2001 because of a strong economy and low unemployment. Employers face higher health insurance costs when there is greater utilization by employees and when prices for health care services go up.

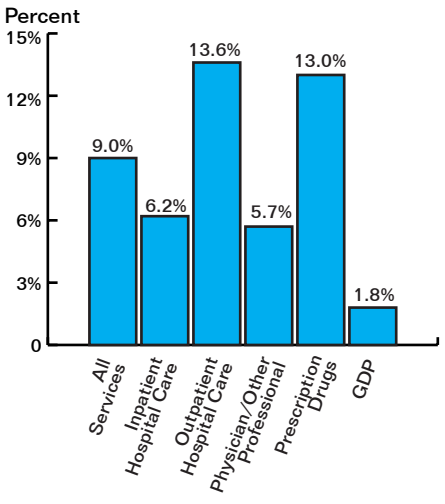
Employees and other consumers are impacted by higher prices when their health insurance premiums, co-pays, and deductibles increase. Higher health care costs and higher spending squeeze both employers and employees.

Figure 1
Health Inflation and Utilization Shares of Growth in Per Capita Health Care Expenditures



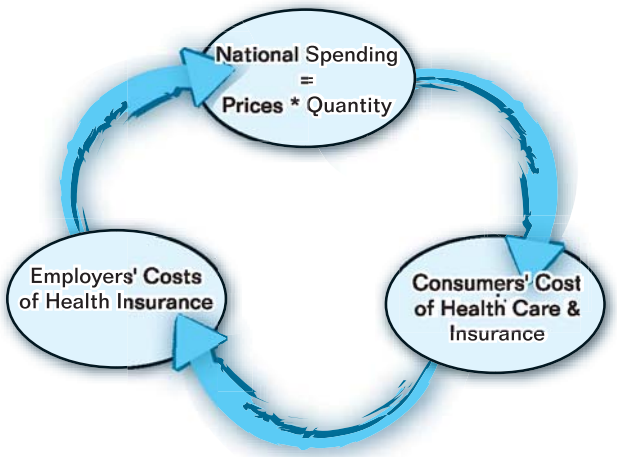
Source: Centers for Medicare and Medicaid.

Figure 2
U.S. Health Expenditure Per Capita Average Growth Rate, 2001 - 2002



Source: Milliman USA Health Cost Index & Center for Medicare and Medicaid Services.

Figure 3
Health Care Spending and Costs



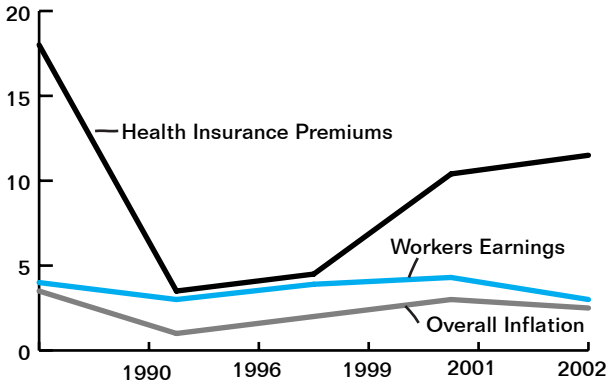
Source: Bureau of Business and Economic Rewsearch,
The University of Montana-Missoula.

Employer Costs

Health insurance premiums increased 13 percent between spring 2001 and spring 2002. Higher medical claims—again, because of higher utilization and prices—led to the premium increases. The overall inflation rate in health care is measured by the GDP personal health care price index or deflator, which increased by 3.6 percentage points in 2000, 4.3 in 2001, and is projected at 4.4 percentage points in 2002. These higher health care costs put employers in a bind, especially small employers where wages and benefits impact already small operating margins. Higher employee premium shares, higher co-pays, and higher deductibles shift some of the increased health insurance costs to workers.

There are two parts to employment-based health insurance: the employer offer rate and the worker take-up rate. Part-time work and small firms are two major factors that tend to reduce employers' offers of health insurance. Part-time workers are far less likely to be offered health insurance than full-time workers, especially in small firms. Low wages affect the take-up rate since the employee share of any offered coverage is less affordable. Workers' earnings have been lagging behind health insurance premium cost increases.

Figure 4
Health Insurance Premium Increases Compared with Other Indicators, 1990 - 2002



Source: Kaiser/Health Research and Educational Trust (HRET) Survey of Employer-Sponsored Health Benefits, 2001; KPMG Survey; and the Bureau of Labor Statistics.

Montana's economy is dominated by small firms of less than 10 employees. These small firms represent 72 percent of all companies and employ 30 percent of all workers in the state. About 40 percent of their workers are part-time. These economic demographics make for low offer rates. Only 30 percent of Montana firms with less than 10 employees offer health insurance, a percentage that increases with firm size. This compares to a national offer rate of 55 percent for small firms. Montana's offer rate is lower than the national, as shown in Figure 5.

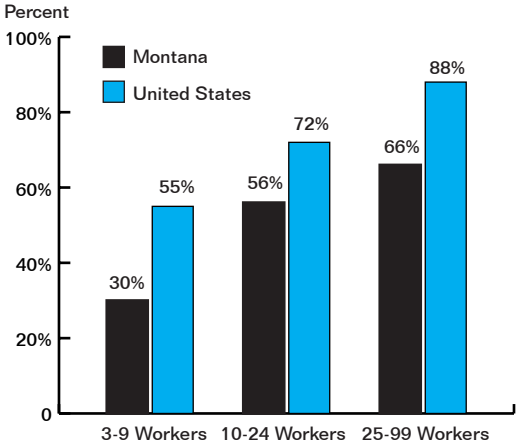
Consumer Costs

Increased health insurance premiums—in response to higher medical claims expenses—lead to higher costs for workers and consumers. The "buying-down" of rising health insurance premium expenses by reducing benefits and increasing worker cost-sharing reduces the affordability of health insurance to workers. Low-income and part-time employment in a small firm also reduce the likelihood of private health insurance coverage.

In Montana, employees with single coverage paid about 15 percent of the premium, or about $31 dollars per month in 1999. Montana workers with family coverage paid about 26 percent of the premium, compared to 32 percent nationally, or an average of $125 per month compared to $145 per month nationally (Figures 6 and 7).

The cost-share patterns, along with higher health insurance costs, put private health insurance coverage out of reach for many Montanans. One estimate shows that in 2000, more than 160,000 Montanans did not have any kind of health care insurance coverage, public or private. About 17 percent of

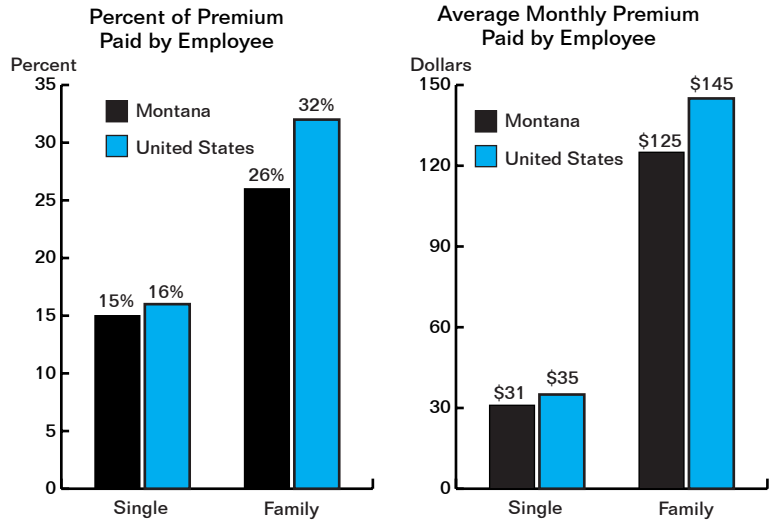
Figure 5
Montana and U.S. Firms Offering Health Insurance, by Firm Size, 1999



Source: Kaiser/Health Research and Educational Trust, Agency for Healthcare Research and Quality, U.S. Dept. of Health and Human Services.

Montanans receive health care from Medicare, the age entitlement federal health care program. About 110,000 Montanans have received some level of health services from Medicaid, the federal-state health coverage program for low-income people. And about 10,000 Montana children under 18 years of age are enrolled in the Children's Health Insurance

Figures 6 & 7
Employee Premiums, Single and Family Coverage, 1999



Source: Agency for Healthcare Research and Quality, U.S. Dept. of Health and Human Services.

Program (CHIP), a joint federal-state public health coverage program. Another 25,000 Montana kids are eligible, but are not enrolled in CHIP. Many of these uninsured kids have parents who work; 84 percent of Montana's uninsured children are in a family where at least one parent works full time.

The number of Montanans considered "at risk" of no health insurance coverage is based on the 160,000 uninsured, plus a fairly high proportion of the people enrolled in Medicaid and CHIP, both of which will be under extreme budgetary pressures during the 2003 state legislative session.

Outlook

Growth in health care spending is projected to level off at about 7 percent a year between 2003 and 2007 when national health care expenditures as a percent of GDP are projected to reach 16 percent, or about $2.2 trillion. Health care utilization will continue to increase, although some analysts expect price increases to moderate over the next couple of years, thereby reducing the pressure for higher health insurance premiums. In Montana, there will be more people without health care coverage as the economy continues to stumble and as budget pressures force reductions in public health coverage such as Medicaid and, perhaps, CHIP.❑

Steve Seninger is director of economic analysis at The University of Montana-Missoula Bureau of Business and Economic Research.