Back to the Future or Forward to the Past?

The Near-Term Outlook For Private Health Insurance Spending

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Introduction

The growth in private health insurance premiums has slowed dramatically since the end of our national debate over comprehensive health care reform. Several factors have contributed to this trend; including low growth in economy-wide inflation, and in particular the remarkable changes in the medical care marketplace. These changes have been spurred by purchasers eager to slow substantially the growth in private health care spending. Managed care has been the vehicle of choice; it has met the needs of purchasers willing to shift risk downstream and has been met enthusiastically by managed care plans seeking market share and financial gains. In just five years, traditional indemnity-based health insurance has been transformed from the mainstream to a near afterthought. In 1993, during the height of the debate over national health care reform, nearly half of all insured workers received coverage through a traditional indemnity plan (see Table 1). By 1997, only 15 percent of insured workers were covered through a traditional fee-for-service plan. Several analysts have attributed the attenuated growth in private health insurance spending to this dramatic shift.

A key issue concerns the sustainability of this slow growth in private health insurance payments. The issue of whether such spending continues its current trend, reverts to the experience during the early part of the decade, or assumes an alternative course has important ramifications. Higher or lower growth in private insurance premiums will impact the growth in cash wages. In addition, higher growth in private health insurance premiums, relative to the growth in income, would reduce the number of privately insured persons. This paper examines briefly the major forcing responsible for the attenuated growth in private health insurance premiums through 1997, and highlights some key

changes in the economy and health insurance marketplace that could reverse these trends. Section 2 examines the most recent data concerning private health insurance premiums, Section 3 examines underlying changes in the marketplace that could place upward pressure on premiums while the final section presents some observations concerning the next decade. Given the tremendous underlying uncertainty in medical technology and the economy, I limit my attention to prospective changes in the near term.

Table 1. Percent Distribution of Insured Workers By Plan Type, 1993-1997

% of Employees Enrolled In:	1997	1995	1993
Traditional Indemnity Plans	15%	29%	48%
Preferred Provider Organizations	35%	29%	27%
Point-of-Service Plans	20%	14%	7%
Health Maintenance Organizations	30%	27%	19%

SOURCE: Mercer/Foster Higgins

II. Recent Growth in Private Health Insurance Premiums

This section examines recent data from a variety of sources on health insurance premiums and underling health care expenditures. Between 1990 and 1993, private health insurance premiums increased sharply, rising faster than the growth in real gross domestic product (GDP), but similar to the growth in Medicare spending. Since 1993, however, the growth in private health insurance premiums has slowed substantially (see Table 2). As noted above, this reduction is associated with the shift away from traditional indemnity plans toward managed care. During the period of slowest spending growth, over a third of all insured workers shifted from higher cost indemnity plans to

lower cost managed care plans. At the same time, the growth in total private health insurance payments per insured increased by 0.3 percent. This contrasted sharply with the 5.6 percent real growth per Medicare beneficiary. During the same period, real GDP increased 2.7 percent. More recent data from 1997 highlights a continuation of these trends.

Table 2. Average Annual Growth in Real Per Capita Private Health Insurance Spending and Medicare Spending, 1990-97

Year	Nominal Private Insurance Premiums	Real Private Insurance Spending Per Privately Insured	Real Medicare Spending Per Beneficiary	Real GDP
1990-1993	8.3%	**5%**	5.5%	**1.4%**
1993-1996	**3.6%**	**0.3%**	**5.6%**	**2.7%**
1997	**4-5%**	**-1 to 1%**	**3.4%**	**3.8%**

SOURCE: Health Care Financing Administration, Mercer/Foster Higgins, Department of Commerce.

Much of the slower growth in private health insurance has been attributed to managed care. Managed care generates savings through reductions in inpatient utilization and provider payments. Inpatient hospital days of care delivered to patients under age 65 decreased nearly 9 percent between 1993 and 1998, despite a 2.5 percent rise in the under age 65 population (American Hospital Association, 1998). Payments to hospitals made by private health plans have also decreased, declining from 31 percent above costs in 1992 to “only” 21.5 percent above costs by 1996 (Prospective Payment Assessment Commission, 1994 and Medicare Payment Advisory Commission, 1998).

The data presented above focus on payments from health plans to providers, but do not comment directly on the growth in provider expenses. Health care expenses are also important to examine since higher expenditures eventually translate into higher premiums. At issue is the time lag between these events and the interrelationships between private and public insurance payments. Table 3 presents some data regarding recent growth in total hospital expenses, and domestic pharmaceutical sales.

Table 3. Annual Percent Growth in Hospital Expenses and Pharmaceutical Sales, 1990-1998

YEAR	Hospitals	Pharmaceuticals
1990	11.3%	**17.7%**
1991	9.3%	**15.1%**
1992	**11.7%**	**8.6%**
1993	**6.7%**	**1.0%**
1994	**4.3%**	**4.4%**
1995	**6.4%**	**12.6%**
1996	**5.4%**	**13.3%**
1997	**3.1%**	**10.8%**
1998	**3.7%**	**13.3%**

SOURCE: American Hospital Association, Panel Survey and Pharmaceutical Research and Manufacturers of America

At least two trends are noteworthy in these data. First, the growth in hospital expenditures decreased sharply between 1995 and 1997. This slower growth appears related largely to the slow growth in payroll expenses per full-time employees (which increased 3.3 percent during this period). The most

recent data from 1998 show a slight increase in expenditures. This increase appears related to a relatively high increase in payroll expense per FTE (4.7 percent). Moreover, in contrast to previous trends, both the number of hospital admissions and total days of care among the under age 65 population increased early in 1998 compared to earlier years.

II. Factors Influencing the Near-Term Trend in Health Insurance Premiums

Several changes in the medical marketplace are placing substantial upward pressure on private health insurance premiums. These changes include:

- The rise in pharmaceutical and hospital costs
- Slower overall growth in managed care enrollment
- Systems-related problems traced to rapid market consolidation

Each of these changes has reduced profitability among health plans. At issue is when these trends will translate into higher private health insurance premiums.

Since 1994, pharmacy-related sales and private plan costs have increased at least 10 percent per year. The most recent data indicate a 13 percent rise in pharmaceutical sales. Among private plans offering drug benefits, this spending growth would increase total health insurance premiums by 2 to 3 percent (this assumes that in such plans, drug benefits account for approximately 15 percent of total spending). This pricing pressure contrasts sharply with health plans' experience with drugs between 1993 and 1994. Given the lag between measured claims costs and premiums (approximately 18 months or so), the higher growth in pharmaceutical could add 2 percent to the growth in private premiums during 1999 or the year 2000.

Of course, higher drug expenses could be offset by slower growth in payments to hospitals or providers. However, there are preliminary indications that such expenses are rising, not falling. As noted above, early indicators reveal that hospital expenses have increased slightly during the first part of 1998.

A substantial portion of the slower growth in private health insurance premiums is traced to the migration from indemnity plans to managed care plans. To date, approximately 85 percent of insured workers receive care through a managed care plan. In contrast, only 52 percent of such workers were enrolled in managed care plans during 1993. The movement of over a third of the employed (and insured) workforce from higher cost indemnity plans to lower cost managed care plans was a central feature of the recent slowdown in private health insurance spending. In light of the high level of managed care enrollment, a similar shift will not occur again. However, there are substantial differences in the ability of different forms of managed care to control costs. HMOs, for example, appear more effective in reducing costs and use compared to point-of-service plans and other looser forms of managed care (Congressional Budget Office, 1995). Thus, shifts among various forms of managed care could continue to slow the growth in spending. Shifting enrollment to more restrictive panels and HMOs seems increasingly unlikely given growing concern about managed care, and the increased interest among the public for stricter regulation of managed care plans (Blendon, et al, 1998). As a result, future changes in health insurance premiums will hinge largely on the ability of managed care plans to generate recurring, rather than one-time savings. To date, there is little published empirical evidence of such savings.

The dramatic growth in managed care enrollment over the past five years has created substantial opportunities for plans to attract market share. Competition for these new lives has been vigorous within the managed care industry, particularly among for-profit plans. Managed care plans followed two common strategies in their quest for market share; consolidation and aggressive pricing. Many major mergers occurred within the managed care industry since 1995. Several for-profit plans experienced notable growth, including Aetna, United Healthcare, Oxford Health Plans and Humana, PacifiCare and FHP International. By 1997, the top 7 HMOs controlled approximately 40 percent of the national HMO marketplace (InterStudy, 1997 and Salomon Smith Barney 1998). Acquisition was coupled with aggressive market pricing to attract covered lives.

The rapid consolidation of the managed care marketplace created some well-publicized growing pains. Several health plans, notably Oxford Health, Aetna and PacifiCare experienced problems with their information technology systems. The inability to provide real time feedback and monitoring of underlying medical expenses was one result. Oxford's systems problems in particular have drawn widespread attention (particularly in the stock market) as they have requested substantial rate hikes to recoup operating losses. Though these operational problems are clearly fixable in the near term, rate hikes may eventually be required to cover (in some cases unknown) medical claims exposure.

Each of the factors noted above highlight the pricing pressures facing managed care plans. Two indications of the impact of the trends highlighted above are industry profits and trends in medical loss ratios (the percent of premiums paid in claims) among for-profit managed care plans provides some evidence that claim costs are rising faster than revenues (see, Robinson 1997 for caveats concerning these ratios). Different accounting conventions and differences in plan design make it

difficult to explain the variation in loss ratios across health plans. In contrast, tracking changes in medical loss ratios within firms provides some indication of changes in premium revenues and costs. Table 4 presents medical loss ratios and percent change in their fully insured managed care business for the major for-profit managed care firms. The data reveal two interesting trends. First, medical loss ratios have generally increased since 1994, approximately the same time the growth in private insurance premiums slowed. These data are consistent (though not conclusive) with the hypothesis that premium revenues are rising slower than underlying claims expenses. The second observation concerns the rapid growth in membership among these for-profit managed care plans. Between 1992 and 1997, the number of persons enrolled in HMOs increased by approximately 30 million. For-profit managed care plans accounted for two-thirds of this enrollment growth. A final observation concerns the number of managed care plans losing money. As of December 1997, three-quarters of all HMOs reported negative operating margins (InterStudy, 1997).

Of course, underwriting gains or losses are a natural part of the health insurance industry. Decisions concerning the change in health insurance premiums follow these cycles. When underwriting gains are realized, premium growth is low. When losses are reported, premiums eventually rise--when and how much of an increase is part of a broader strategic decision made by health plans. Prior to our most recent experience, the health insurance industry has followed a six year cycle--three years of gains followed by three years of losses (Gabel, et al, 1994). The most recent experience indicates these cycles have extended beyond three years. While recent underwriting losses have, in part, been offset by favorable investments buoyed by the expanding stock market, the extent of the losses is mounting. Major health plans in several states continue to report substantial underwriting losses, including some of the more innovative and successful plans. Two thirds of the health carriers in

Washington State recently reported losses during 1997, including Group Health Cooperative of Puget Sound (BNA, 1998). In light of the mounting industry losses, and rising loss ratios, the issue simply appears one of when and how much premiums will rise. The extent and timing of such increases will involve a delicate balancing act of satisfying purchaser demands with the reality plans face of higher claim costs.

Early indications from actual premium data show a rise in premiums during 1998. Premiums for the largest employer group--the Federal Employees Health Benefit Program (FEHB)--increased, on average, 8.5 percent during 1998. The largest single plan within the program, the Blue Cross Standard Option, recorded a 7.5 percent premium increase. Tracking the FEHB experience is important in two respects. First, the average increase in FEHB premiums have closely tracked the experience reported by other employers (Congressional Budget Office, 1998). Second, premiums in the FEHB cannot exceed the lowest rates health plans charge other similarly sized customers. Thus, there is a strong link between the FEHB and the commercial market.

IV. Factors Affecting Private Health Insurance Premiums During the Next Ten Years

Of course, projecting the future course of medical care spending is fraught with uncertainties and is inevitably wrong. However, several factors are likely to continue to place upward pressure on private health insurance spending over the next 10 years. These factors include changes in both the demand for and supply of medical care. Among the key determinants of health care spending in flux are:

- The relatively high recent growth in real GDP;
- Demographic changes in the workforce with health insurance coverage;
- Innovation in the treatment of medical disease;
- Implementation of the Balanced Budget Act of 1997;
- Legislative changes affecting the environment in which health plans operate;
- Changes in the relative bargaining strengths of purchasers and providers

Each of these trends will continue to place upward pressure on private insurance premiums. Though it is quite unlikely that, given the recent structural changes in the medical care delivery system, real per capita growth in spending will resume their pre-managed care levels, these forces will make it very difficult for purchasers and plans to sustain the most recent low rates of growth.

Table 4. Medical Loss Ratios and Enrollment Growth, Selected Publicly Traded Managed Care Plans, 1990-1997

Company	1990	1991	1992	1993	1994	1995	1996	1997
Aetna								
Loss Ratio	82.6%	77.1%	77.1%	72.7%	69.3%	78%	83.1%	84%
% Change Enrollment					11.2%	244%	-7.2%	-1.2%
Humana								
Loss Ratio			86.3%	83.8%	80.8%	81.5%	82.8%	82.5%
% Change Enrollment						168.8%	88.4%	47.9%
United Health Care								
Loss Ratio			81.2%	80.4%	79.1%	81.6%	84%	84.1%
% Change Enrollment							18.2%	-7.8%
PacifiCare								
Loss Ratio	86.9%	84.7%	83.4%	84%	83.5%	85%	85.1%	85.9%
% Change Enrollment					55.1%	15.9%	9.4%	-3.3%
Industry Average								
Loss Ratio	84.4%	83.9%	82.5%	81%	78.7%	83.7%	85.5%	85%
% Change Enrollment					28.4%	87.2%	24%	18.9%

SOURCE: Company Financial Records as tabulated by Solomon Smith Barney, 1998

A. Recent Growth in Real GDP

Several changes in the underlying demand for health care are in process. Of near-term note is the relatively high rate of growth in real GDP. Over the past three years, real GDP has increased 3.7 percent per year, and most recently it increased 3.8 percent. This is a full percent higher than the growth in real GDP measured during the 1993 to 1996 period. Higher growth in income will, with some lag, increase demand for medical care services over the next few years (i.e. 1999-2001). However, the CBO, among other forecasters, has projected slower growth in real GDP starting in

1999. This could dampen the outyear growth in demand for medical care spending past the year 2002.

B. Demographic Changes in the Workforce

Another factor affecting the demand for medical care services are the changing demographics of the workforce. While the pending retirement of the baby boomers has received substantial attention, relatively little attention has focused on the aging workforce. Just ten years ago, workers aged 45 and over comprised approximately 28 percent of the workforce. By the year 2006, such workers will account for nearly 40 percent of all workers (see Table 5).

Table 5. Actual and Projected Distribution of Workers By Age, 1986-2006

% Distribution	1986	1996	2006
Aged 16-19	6.7%	5.8%	6%
20-24	13.1%	10%	10.4%
25-34	29.4%	25.3%	20.7%
35-44	23.1%	27.3%	23.8%
45-54	15.1%	19.7%	23.6%
55-64	10.1%	9.1%	12.6%
65+	2.6%	2.9%	2.8%
Total	100%	100%	100%

SOURCE: Department of Labor, 1998

These relatively near term trends are notable. Health care spending increases sharply among both men and women after age 45. For instance, medical care expenditures are 45% higher among men

aged 45 to 54 compared to those aged 35 to 44. Even more striking, medical care spending is twice as high among men aged 55 to 64 compared to those aged 35 to 44. These demographics changes in the workforce will increase private health care spending by approximately 4 percent above underlying trends in per capita spending over time.

C. Changes in the Pace of Innovation

For years, many analysts have highlighted the innovative new medical technologies in the pipeline (Schwartz, 1994). Perhaps the most exciting wave of innovation has been sparked by the Human Genome Project. This project will identify and map each of the estimated 100,000 genes in the human body by the year 2005. Competition from private, commercial interests is seeking to complete the mapping and sequencing even earlier. This research has widespread implications for the prevention, cure and treatment of a broad range of diseases, many of which would represent substantial expansions of current approaches. Mapping the human genome facilitates the development of new pharmaceutical and treatment interventions. To date, we have enough information to identify approximately 500 targets for pharmaceutical intervention (Pharmaceutical Research and Manufacturers of America, 1998). Once completed, the human genome project will provide the opportunity for 3,000 to 10,000 new drug and diagnostic targets. Many of these discoveries will facilitate a welcome expansion in medical treatment. In the near term, many of these new innovations are likely to increase spending. New approaches for treating Alzheimer's, Parkinson's, spinal cord injuries, among others will bring new hope for many suffering these debilitating diseases and injuries and unprecedented improvements in the quality of life. They will

come at a cost, however. Whether these new treatment modalities increase or ultimately reduce costs over the long haul is very uncertain, however.

D. Implementation of the Balanced Budget Act of 1997

Medicare savings comprised the major component of the recent effort at balancing the federal budget. Over the next five years, the growth in Medicare spending will be approximately $100 lower than projected before the Balanced Budget Act. This significant reduction in the growth in Medicare spending may have implications for private health plans. As noted above, negotiating lower payments to providers, in particular hospitals, have been an important cost saving tool for managed care plans. Between 1992 and 1996, the ratio of private health plan payments to hospital costs has fallen from 131 percent to 121.5 percent (see Table 6).

Table 6. Total Hospital Margins and Payment to Cost Ratios, 1992-1996

YEAR	Total Margin	Medicare	Private Insurance	Medicaid	Uncompensated
1996	6%	102.4%	121.5%	94.8%	17.3%
1992	4.3%	89%	131%	91%	19%

SOURCE: ProPAC , 1994 and MEDPAC 1998.

However, during the period of declining private payment to cost ratios, hospital profitability actually increased. This increased profitability is traced both to the relatively high rates of growth in Medicare and Medicaid hospital payments between 1992 and 1996, and slower growth in costs. Note that the reduction in private sector payments transpired during a period of rising hospital profitability. In short, hospitals could "afford" to grant discounts to private health plans.

Over the next five years, however, Medicare payments to hospitals will rise at a substantially slower pace. For instance, payments to managed care plans will only rise by 2 to 3 percent during this period. While Medicare's fee-for-service spending on hospitals increased 5 percent during 1997, such payments could actually fall during 1998 and will increase by only 2 percent per year through the year 2001. These trends differ substantially from the revenue growth enjoyed by hospitals prior to the BBA. The slower growth in Medicare payments could make it more difficult for health plans to extract additional payment discounts from hospitals. However, excess bed capacity combined with on-going profits garnered by most hospitals could continue to give plans negotiating leverage. In the final analysis, however, the substantial slowdown in Medicare payments to hospitals could generate a different negotiation landscape.

E. Legislative Changes Affecting the Managed Care Industry

While most Americans appear generally satisfied with their health plans, there is growing sentiment to increase regulation of managed care plans. In particular, plan members are particularly concerned with their treatment options when they become ill (Blendon, et al 1998). Correspondingly, they are quite leery of several of the tools commonly used by managed care plans to control costs. Congressional interest in increasing regulation of managed care plans has surfaced recently. Several bills are currently pending in the Congress. One (H.R. 4250) bill has recently passed in the House. This bill would extent several new "patient protections" to those with group health insurance (the proposal does not cover those with individual health insurance), including emergency room protections, direct access to providers, uniform liability rules across the states, among others. The

leading Democratic proposal (S. 1890) in the Senate differs in several key respects from the House Republican bill. This proposal is generally more expansive with respect to loosening some of the "restrictive" practices used by managed care plans in defining network participation, and outlining when and how plan subscribers receive care. Moreover, the Senate bill changes substantially the scope of malpractice litigation, by allowing all plan members (including those in ERISA-covered plans) to sue their health plans. This proposal also changes fundamentally the process by which patients can adjudicate their grievances with plans. Depending on the approach (if any) selected by the Congress, such proposals could increase the cost of private health insurance. The more expansive approach suggested by the Democratic bill (S. 1890) would, according to the CBO, increase the cost of private health insurance by approximately 4 percent. The less ambitious approach proffered by the House Republicans would have a negligible impact on health insurance premiums.

F. Changes in the Relative Bargaining Strengths of Purchasers and Providers

The period between 1993 and 1998 will be remembered as the "managed care" era. However, equally important changes are currently underway in the health care delivery system. In short, the on-going battle is for market power. Health plans seeking to sustain the low rates of premium growth (and most directly claims costs) are consolidating rapidly. It is hoped that consolidation and merger will enhance their ability to negotiate contracts, and attract both local and national employers. At the same time, hospitals and physicians are also consolidating hoping to attract covered lives, attract and manage risk, all while enhancing their negotiating positions vis a vis health plans. Finally, there is also a rise in vertical integration as the number of hospitals managing or purchasing physician practices continues to rise.

These structural changes in the industry will important implications for the growth in costs, premiums, access to care and the quality of care. Whether the waves of horizontal mergers in the insurance industry, and among hospitals and physicians enhances or detracts efficiency remains at issue. As a result, these structural changes which will fundamentally change the relative bargaining strengths of purchasers and providers, both nationally and in local markets, would turn out to be as important as the managed care revolution. The following section summarizes briefly some of these on-going changes in the marketplace.

Based on their recent success, purchasers' expect slow, if any increases in health insurance premiums. Health plans seeking market share have largely been receptive. Several aspects of the health care marketplace have enhanced the ability of health plans to achieve savings roughly similar to premium expectations (though as noted above, claims costs are rising faster than premium revenue) expressed by purchasers:

Forces Contributing Toward Enhanced Purchaser Bargaining Power

- ***Excess capacity***. Average daily census continues to fall faster than the number of beds. As a result, many hospitals have low occupancy rates. Excess capacity enhances the ability of health plans to negotiate favorable rates with hospitals seeking to retain patients and volume.

- ***Horizontal Consolidation in the managed care industry.*** There were more than 60 HMO mergers and acquisitions in 19996 alone. Fewer plans in a locality increases enrollment, and with it the ability to negotiate rates by moving patients. Larger plans in a locality may also provide a more favorable setting for initiating and successfully implementing practice guidelines.

- ***Expanded use of health and productivity management and disease management interventions.*** Some larger employers and health plans have started to focus on lifestyle related interventions in order to reduce health care spending. These include smoking-cessation, stress reduction and weight and cholesterol interventions. Recent studies highlight the cost reducing success of these interventions (Curry, et al, 1998). Plans are also moving into disease

management programs, which generally identify a single provider responsible for a patient's health care. Such programs attempt to explicitly integrate practice guidelines into the process of care.

Forces Enhancing the Prospects for Enhanced Supplier Bargaining Power and Higher Cost Growth

- ***Few lives left to move to managed care***. Approximately 85 percent of the private insurance market are already enrolled in managed care. Thus, the ability for health plans to increase their bargaining power each year with more "moveable" managed care lives is decreasing.

- ***Supply side consolidation in the form of physician practice management, physician-hospital organizations, and provider-sponsored networks.*** The growth in managed care has spawned consolidation in both the physicians (in the form of physician practice management (PPM) companies) and hospital market. The number of physicians affiliated with the top three PPMs increased from under 3,800 in 1996 to over 25,000 by 1997 (Robinson, 1998). This consolidation could enhance the bargaining position of physician groups as they negotiate with health plans and hospitals. The growth in PSNs could provide a competitive check to the growing negotiating power of more traditional health plans.

- ***Rising Medical Loss Ratios***. At some point, health plans will have to recoup the on-going losses they continue to mount. While some of these losses have been offset by favorable investment income, recent downturns in the market may even make these returns less favorable.

- ***Rise in direct consumer marketing by pharmaceutical firms***. Drug companies spent nearly $4 Billion in promotionally expenses during 1996; much of it aimed directly at the consumer. The rise in direct television marketing of a range of new drugs is an important case in point. Such marketing is likely to continue the strong demand for pharmaceutical sales in the near future.

II. Projected Range of Growth in Private Health Insurance Premiums

Combining these observations into speculations regarding the growth in private health insurance is inherently risky. Point estimates of future trends generally have a common characteristic; they are all wrong. The projections presented in Table 7 represent an attempt to coalesce the several factors highlighted above into a range of projections. The projections rely on the estimated growth in real GDP, changes in the number of persons with private health insurance (and their demographics). The higher and lower ranges reflect uncertainty with respect to changes in health care sector. The point estimates are based largely on the historic relationship between the components of private health

insurance spending, real GDP, and covered lives. The higher and lower ranges are generally estimates within a standard deviation of these point estimates. A summary of the relationship between real GDP, real per capita private insurance spending and real per capita national health expenditures are presented in Table 7.

Table 7. Average Annual Growth in Real GDP, Real Private Health Insurance Per Insured, and Real Per Capita National Health Expenditures, 1970-1996

Year	Real GDP	Real Per Capita Private Health Insurance	Real Per Capita National Health Expenditures
1980-1990	2.9%	7.1%	5.1%
1990-1993	1.4%	5.0%	4.2%
1993-1996	2.7%	0.3%	1.5%
1990-1996	2.0%	2.6%	2.9%
1997-2002 *	2.3%	3.0%	3.3%

*Projected
SOURCE: Congressional Budget Office, HCFA, 1998, Department of Commerce

The projections estimate that real per capita spending on national health expenditures will 1 percentage point faster than the growth in real GDP, with private health insurance rising at 0.6 percentage points above GDP. Yet, as the discussion above suggests, if structural changes in the health sector marketplace are underway, these historic relationships may not prove a very accurate guide for future spending trends. Thus, to incorporate some of this uncertainty, Table 8 provides projections using these historic relationships, but also presenting a "higher" and "lower" estimate (essentially a standard deviation away from the point estimate). The lower estimates weight some of the more recent data regarding drug spending more heavily in the outyear projections. As a result,

the higher and lower estimates are not purely symmetric. This is based on the thought that the future growth in pharmaceutical spending will reflect the most recent experience.

Table 8. Projected Range of Private Health Insurance Spending, By Spending Type 1996-2007 (Billions of Dollars)

SOURCE OF PRIVATE HEALTH INSURANCE SPENDING	1996	2007	Average Annual Increase	
			Nominal	Real
Hospital Spending				
Higher		$215	6%	4%
Lower		$157	3%	1%
Actual	$113.4	?		
Physician Spending				
Higher		$214	7%	5%
Lower		$174	5%	3%
Actual	$101.8	?		
Drug Spending				
Higher		$176	12%	10%
Lower		$106	7%	5%
Actual	$50.3	?		
Other Spending				
Higher		$167	8%	6%
Lower		$123	5%	3%
Actual	$71.8	?		
Total Spending				
Higher		$772	7.8%	5.6%
Lower		$560	4.7%	2.5%
Actual	$337.3	?		

SOURCE: HCFA 1998 (for the 1996 data).

The projections presented in Table 8 present a wide range of potential rates of growth in private health insurance spending. By the year 2007, the (nominal) amount of such spending differs by $210

Billion in the projections. The average annual rates of (real) growth per insured ranges from 2.5 percent to 5.6 percent.

Conclusions

At least through 1997, private health insurance expenditures have grown at historically low rates. Several factors account for this slow growth, though the most important has been the explosive growth in managed care since 1993. Between 1993 and 1997, over a third of employees with employer-sponsored insurance have shifted from indemnity to managed care plans. Even a cursory examination of the aggregate data presented here indicates this movement has been associated with a substantial reduction in the growth in private health insurance spending.

A major issue facing employers is whether the slow rates of growth in premiums enjoyed during the past five years will continue. Such a question is, by its nature, speculative. This paper has identified several factors likely to increase the costs of health insurance over the next decade. Moreover, as 85 percent of those with private health insurance are already enrolled in managed care, the large savings achieved through migrating workers from high cost indemnity plans to lower cost managed care plans will be difficult to replicate. Indeed, the issue for managed care is whether such plans can generate long-term increases in claims costs and premiums similar to the past couple of years. This would require premiums to rise by 1 to 2 percent per year--negative real rates of growth.
Several on-going changes in the health care delivery system are working against the continuation of such slow rates of growth. While it appears very unlikely that the growth in private health insurance will resume the growth rates observed through 1993, it appears as unlikely that negative real rates of

growth are sustainable over the long term. The pace of innovation, crosscutting pressures facing health plans from cost containment efforts in the public sector, augmented supply side bargaining power and consolidation in the health insurance industry will increase pressures for premium increases. The rising medical loss ratios and negative operating margins facing what is now a predominantly for-profit health insurance industry are important markers. What only seems at issue here is when, and over what time period, premiums will increase. Early indications from 1998 reveal a mixed picture--substantial increases facing some employers (FEHB), more moderate ones reported in the popular press.

One of the more important wild cards in these projections is the form managed care will assume over the next decade. Managed care plans will have to develop new tools to keep the growth in health care claims costs and premiums low. They will have to develop these tools facing an environment of mounting public cynicism and legislative intervention and oversight into their operations. Several future models of managed care are currently evolving. These models are redefining and expanding the traditional focus of the industry from structuring financial risk, into broader visions of health and productivity management (HPM). The HPM model incorporates several interventions designed at reducing the demand for medical care and improving the process of care. Such interventions include managing workplace attendance and turnover, smoking cessation and other lifestyle related programs (i.e. stress reduction, weight management, alcohol) as well as the more formal integration of clinical practice guidelines into practice. Recent evaluations of these programs are very encouraging (Pelletier, 1996, Curry, 1998). This next frontier of managing care has much to offer. Failure to develop new interventions and models for enhancing health and health care, however, may improve the prospects for private health insurance to achieve the "higher" rates of growth displayed above.

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