

National Health Expenditures, 1998

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In 1998, national health care expenditures reached \$1.1 trillion, an increase of 5.6 percent from the previous year. This marked the fifth consecutive year of spending growth under 6 percent. Underlying the stability of the overall growth, major changes began taking place within the Nation's health care system. Public payers felt the initial effects of the Balanced Budget Act of 1997 (BBA), and private payers experienced increased health care costs and increased premium growth.

INTRODUCTION

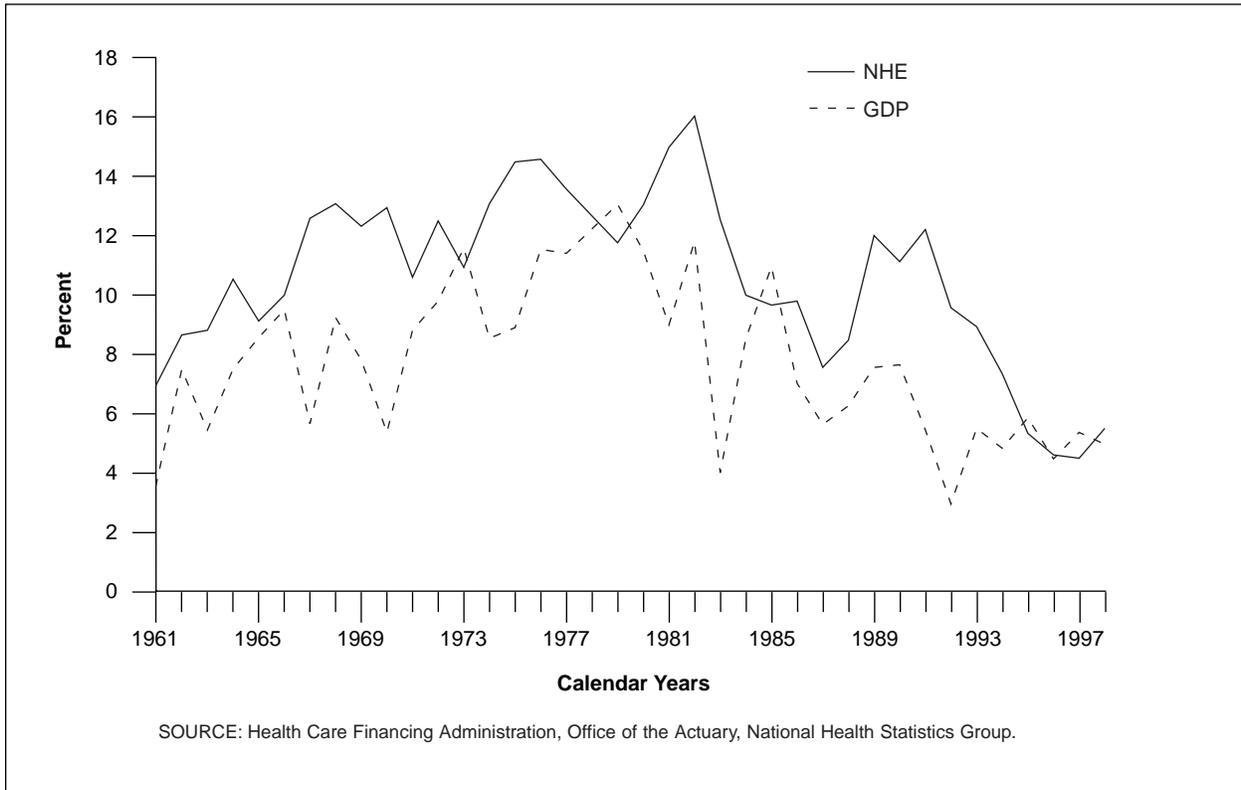
In this article, we present historical health spending in the United States for the period 1960-1998. The statistics are shown in a matrix structure that describes trends in the size, growth, and distribution of health care expenditures. This matrix rep-

resents spending by type of service, such as hospital care and physician services, matched against the sources that pay for the health care bill, including private health insurance (PHI) and government programs such as Medicare and Medicaid. These statistics provide an historical basis for policymakers, researchers, and the public to understand the trends in spending for the health industry and lay a foundation for projections of health care spending (Smith et al., 1999; Smith et al., 1999).

In the figures that follow, we present information on health care spending, focusing on calendar year 1998. A Technical Note includes a brief summary of the provisions of the BBA that affected national health expenditures (NHE) in 1998. Tables 3-12 following the figures provide detailed NHE information for selected calendar years by type of service and source of funds. More complete time series estimates can be found online at <http://www.hcfa.gov/stats/stats.htm>.

The authors are with the Office of the Actuary, Health Care Financing Administration (HCFA). The views expressed in this article are those of the authors and do not necessarily reflect the views of HCFA.

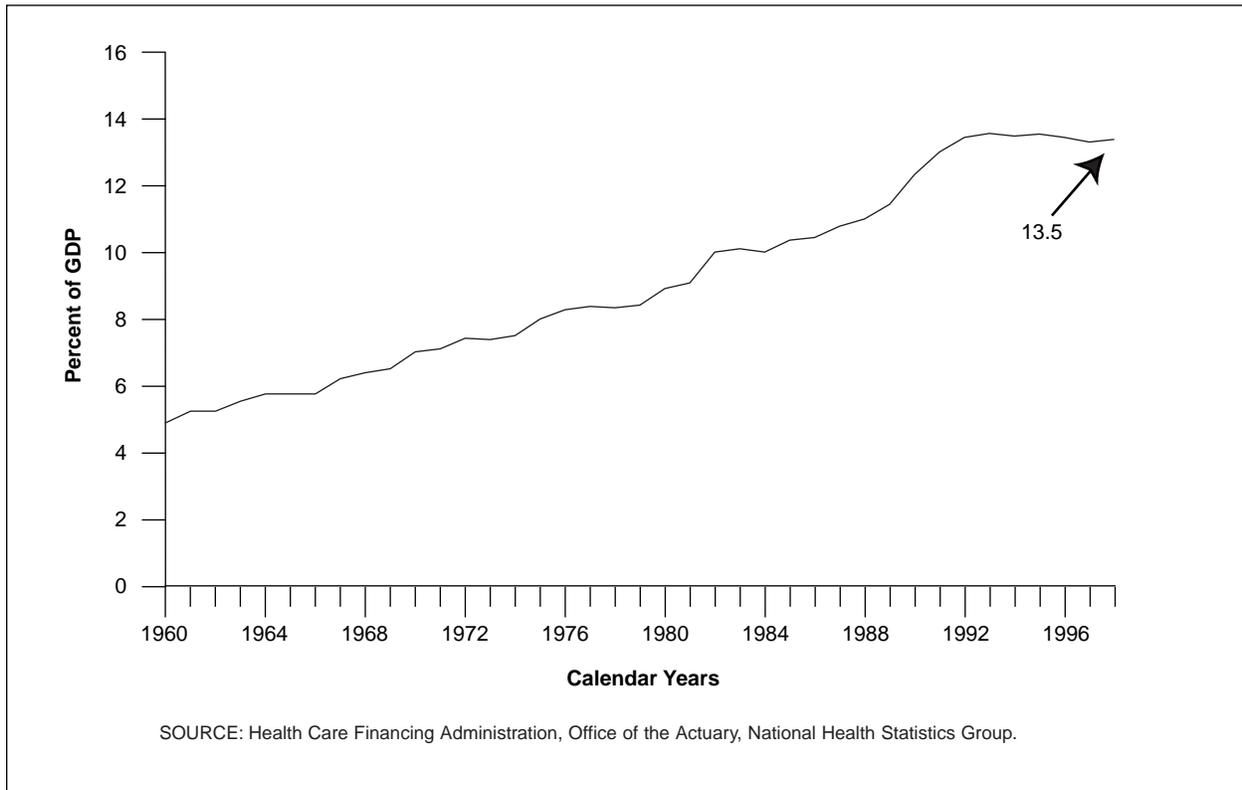
Figure 1
Growth in National Health Expenditures (NHE) and Gross Domestic Product (GDP):
Calendar Years 1961-1998



Slow nominal growth in health care spending continued, but accelerating growth in 1998 signals possible future change.

- NHE reached \$1.1 trillion in 1998, up 5.6 percent from 1997, and continued the trend of growth below 6 percent that began in 1994. However, the re-acceleration in NHE growth during 1998 signals a change toward stronger NHE growth in the future (Smith et al., 1999).
- On a per person basis, health spending in 1998 increased \$182 from 1997 to \$4,094.

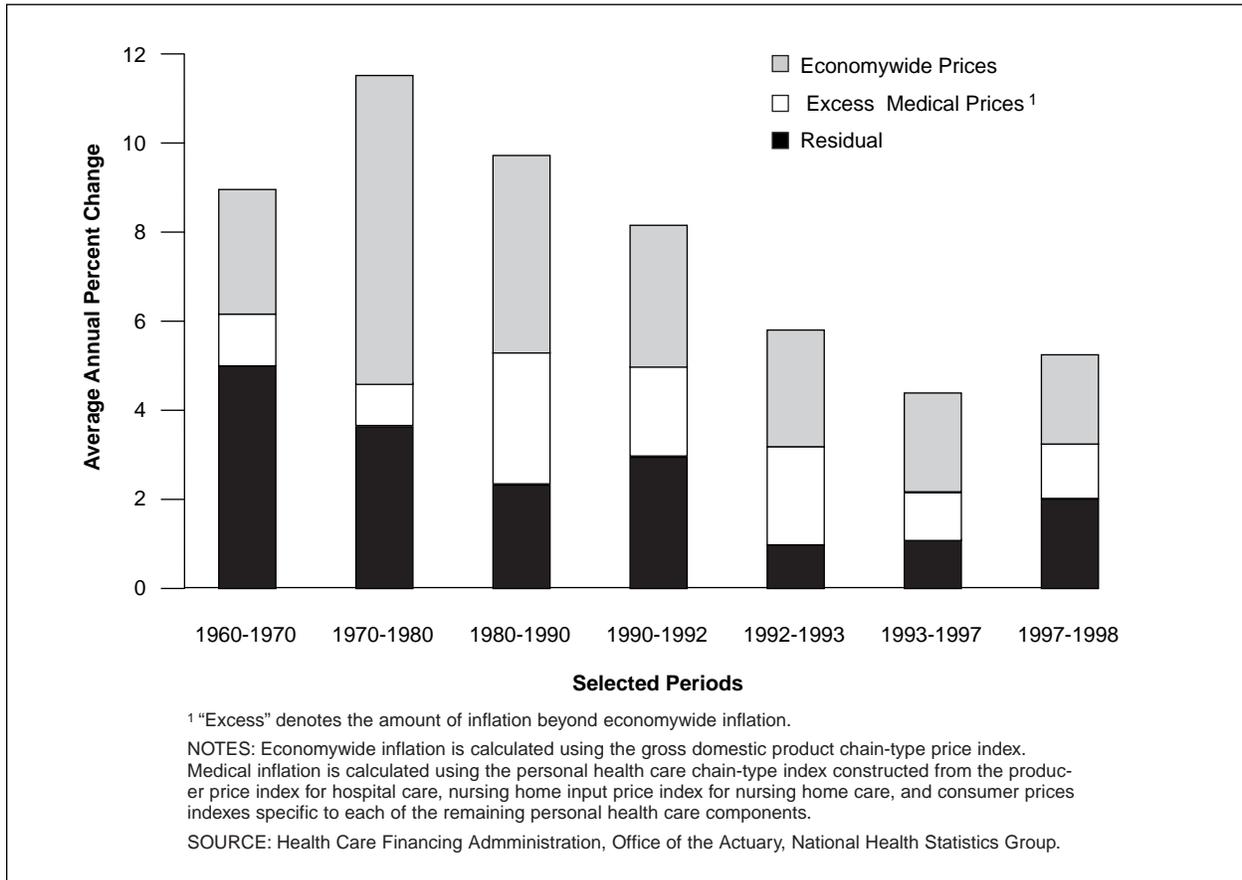
Figure 2
National Health Expenditures as a Share of Gross Domestic Product (GDP):
Calendar Years 1960-1998



NHE's share of gross domestic product (GDP) remained stable for an unprecedented 6 years.

- The share of GDP dedicated to health expenditures has ranged between 13.4 percent and 13.7 percent over the last 6 years. Strong overall economic growth and relatively slow growth in health care costs contributed to this stability. Slow growth in health care costs was driven by low medical inflation that resulted in part from strong growth in managed care enrollment. Managed care organizations (MCOs) negotiated strong discounts, which kept prices low, and more individuals enrolled in these MCOs meant a larger negotiated low-price pool.

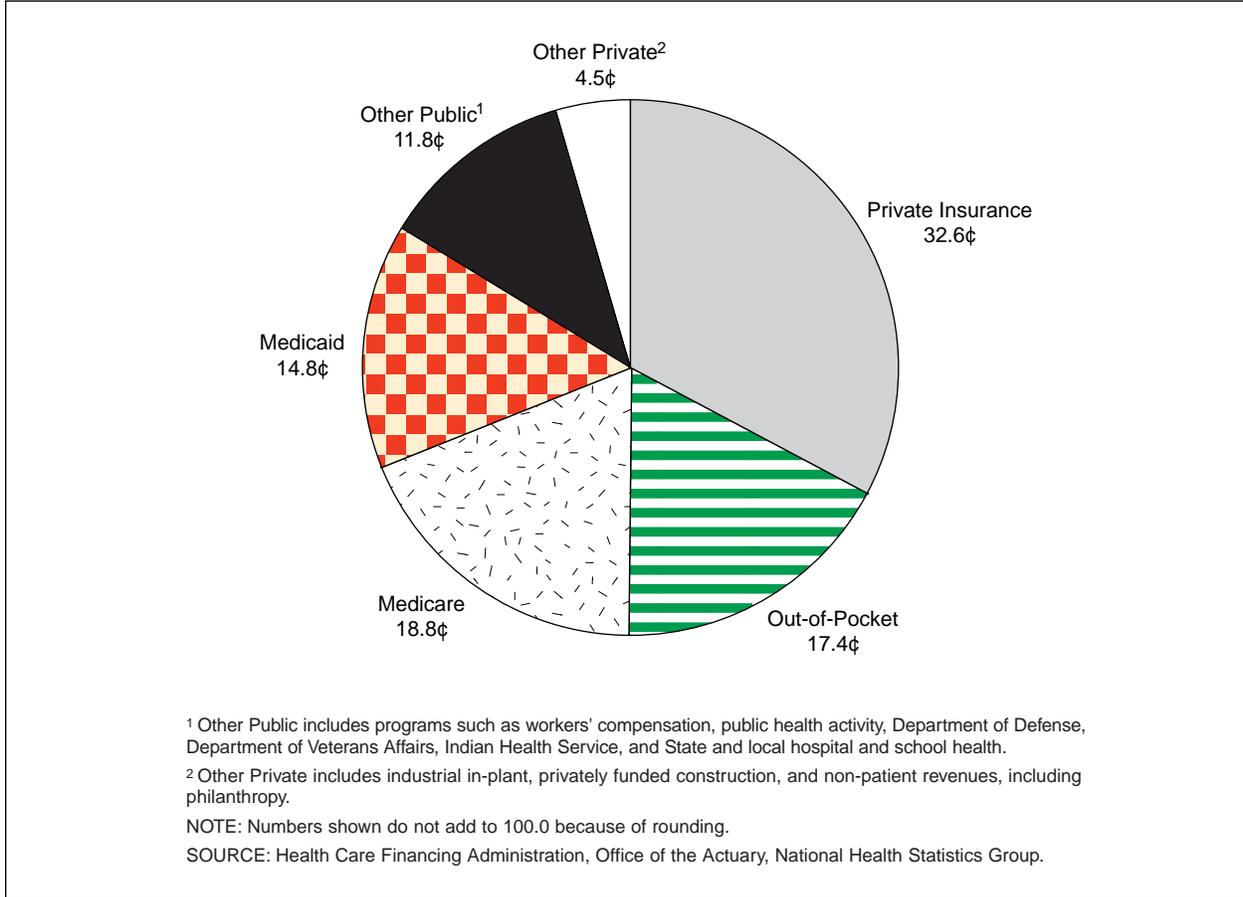
Figure 3
Factors Accounting for Growth in per Capita Personal Health Care Expenditures:
Selected Periods 1960-1998



Inflation plays a smaller role in personal health care (PHC) spending per capita in 1998.

- Before adjusting for inflation, growth in nominal PHC expenditures per capita increased 4.3 percent in 1998. Growth in per capita PHC spending can be broken down into three factors: economywide inflation, “excess” medical inflation (above and beyond economywide inflation), and a residual, which includes the use and intensity of services, including the use of new technology.
- Of the 4.3-percent annual growth, economywide inflation accounted for only 24 percent, a very low share even by recent historical standards. Excess medical inflation accounted for 28 percent, and the residual accounted for the remaining 48 percent.
- General inflation, a significant factor of the 1970s, has gradually assumed a smaller role in health care expenditure growth. Excess medical-specific inflation, which played a small part in the high overall growth periods of the 1970s, accounted for a larger portion in the 1980s and has since subsided. The residual, responsible for a large part of health spending growth in the 1960s when Medicare and Medicaid were introduced, continued to play an important role in health spending growth up to the early 1990s. In the mid-1990s, the residual declined to very low levels, corresponding to the period of rapid managed care enrollment growth. In 1998, the residual rebounded significantly.

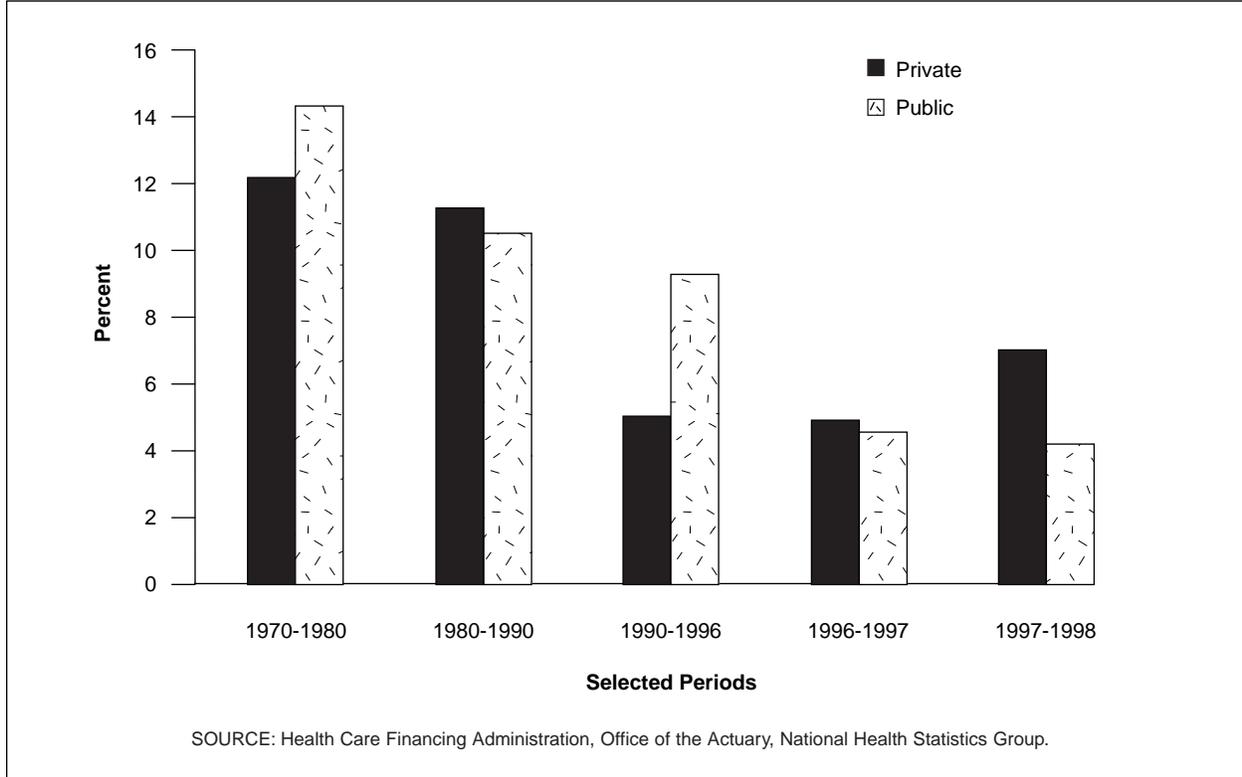
Figure 4
The Nation's Health Dollar in Calendar Year 1998: Where It Came From



About one-third of the Nation's health care bill was paid for by private health insurance (PHI), and another one-third was funded by Medicare and Medicaid.

- Private sources funded \$626.4 billion, or 54.5 percent, of health care in 1998, up from 53.8 percent in 1997. Public sources funded \$522.7 billion, or 45.5 percent, down from the 1997 share of 46.2 percent.
- PHI, obtained mostly through employer-sponsored health plans for the population under age 65, paid for 32.6 percent of the Nation's health bill; HCFA-run programs, Medicare and Medicaid, accounted for another one-third.
- The remaining third of the Nation's health dollar was funded by individuals' out-of-pocket payments, and by other public and other private payments. Out-of-pocket payments (direct consumer payments for services not covered by public and PHI, and copayments and deductibles) accounted for 17.4 percent of NHE.

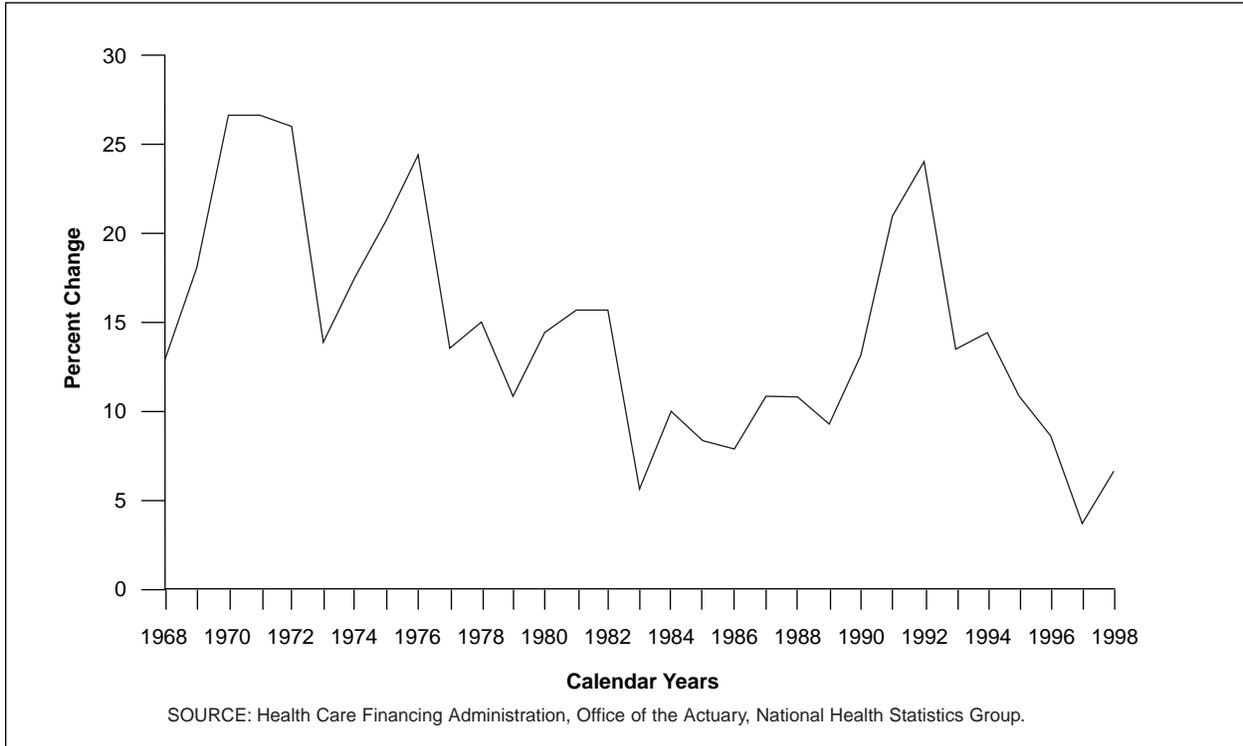
Figure 5
Growth in Private and Public Sources of Funding: Selected Periods 1970-1998



Beginning in 1997 and continuing in 1998, public health expenditures grew less rapidly than private health expenditures.

- In 1997 and 1998, public spending for health care grew less rapidly than private spending. Medicare was primarily responsible for the deceleration in 1998. Implementation of the BBA, as well as falling hospital case-mix and continuing Federal Government efforts to detect and reduce fraud and abuse, were the major factors causing this deceleration.
- In 1998, the increase in growth of private expenditures was driven by PHI. Private health insurers increased premiums in order to restore deteriorating profit margins and reserves. Aggregate premiums also increased as consumers chose plans that were more expensive (KPMG Peat Marwick, 1998).
- Changes affecting the PHI industry, combined with the effects of the BBA, produced a reversal in the recent trends of public and private spending growth starting in 1997. From 1990 to 1996, public funding grew faster than private funding (annual average growth of 9.2 percent and 5.0 percent, respectively). In 1997, public and private funding grew at similar rates (4.5 percent and 4.8 percent), and by 1998, private funding grew 2.8 percentage points faster than the public sources.

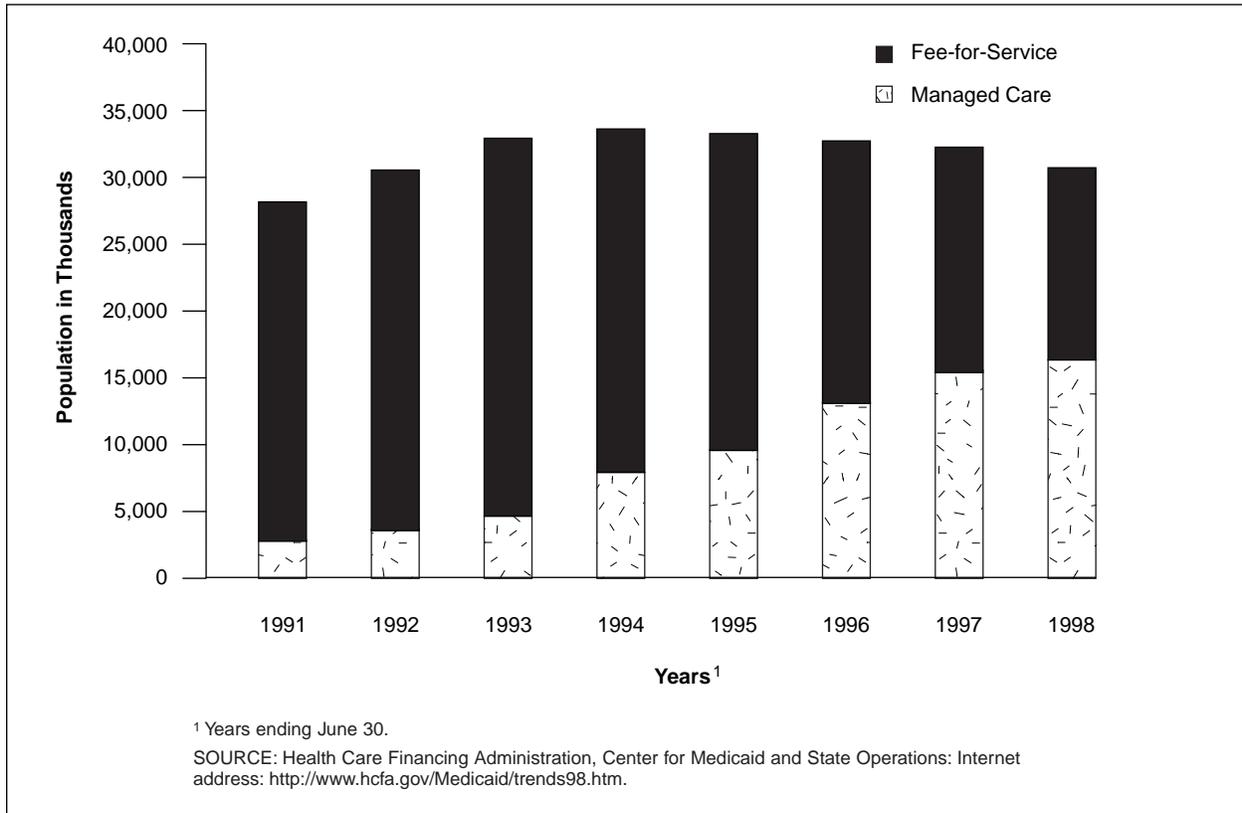
Figure 6
Growth in Total Medicaid Spending: Calendar Years 1968-1998



Growth in Medicaid spending rebounded slightly in 1998 but remained low by historical standards.

- Total Medicaid spending was \$170.6 billion in calendar year 1998, accounting for 14.8 percent of total NHE. The increase of 6.6 percent over the 1997 level represents an acceleration in Medicaid spending growth compared with 1996 and 1997, when annual increases averaged 4.6 percent per year.
- The 1998 increase in Medicaid expenditures was still low compared with most past years. Medicaid spending had grown 12.5 percent on average from 1992 to 1994 and 19.6 percent on average from 1989 to 1992.

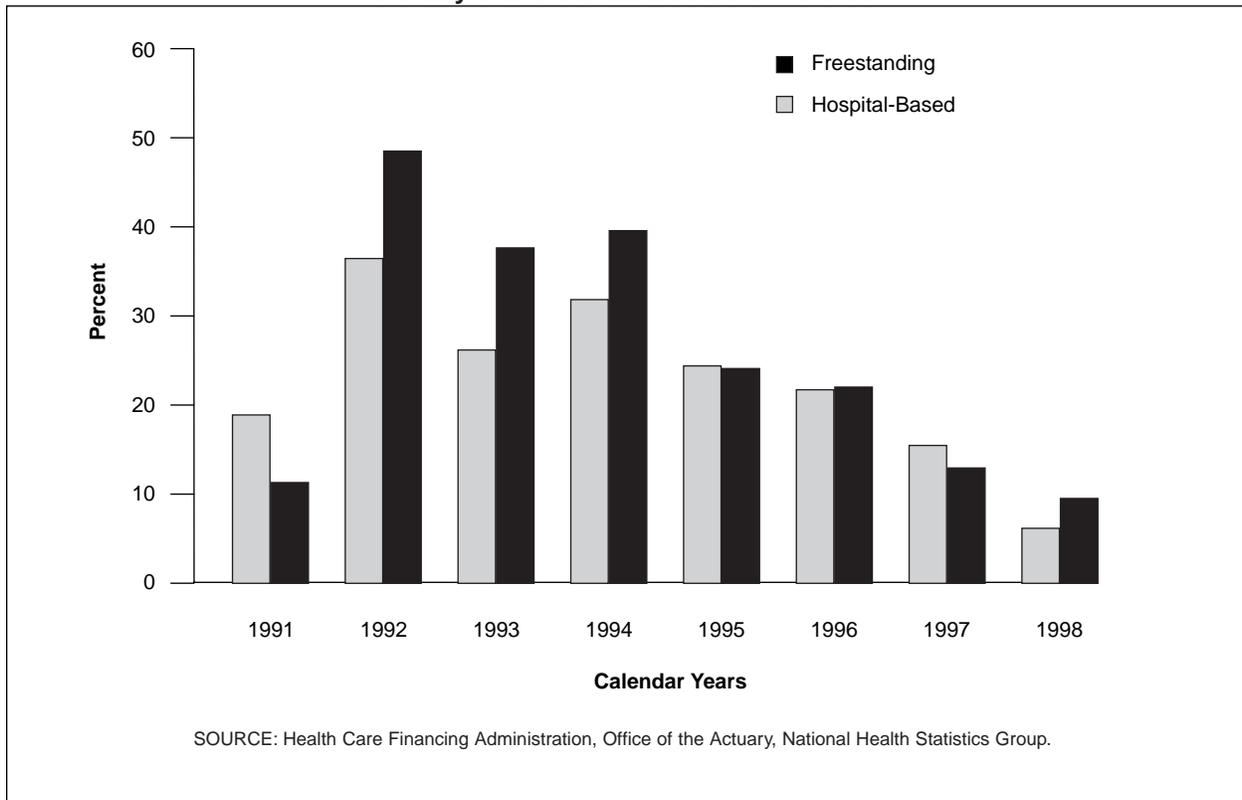
Figure 7
Type of Enrollment of Medicaid Population: 1991-1998



The number of Medicaid enrollees decreased in 1997 and 1998.

- After 4 years of relative stability in the number of Medicaid enrollees from 1993 to 1996, the total Medicaid enrollment declined somewhat in 1997, and preliminary data suggest that the decline continued in 1998. A strong economy and the welfare-to-work incentives provided by the Temporary Assistance to Needy Families statute contributed to this decline.
- As of June 30, 1998, for the first time, more than one-half of the Medicaid enrollees were in some form of managed care or a case management program.
- The BBA gave States the authority to mandate enrollment of Medicaid recipients in MCOs without obtaining a Federal waiver (certain exceptions apply). The BBA also permitted the establishment of Medicaid-dominated plans by eliminating the “75/25” rule that required that at least 25 percent of a plan’s enrollment be privately insured. Recent studies suggest Medicaid-dominated MCO’s have become an increasingly dominant force in the Medicaid market (The Henry J. Kaiser Family Foundation, 1999).

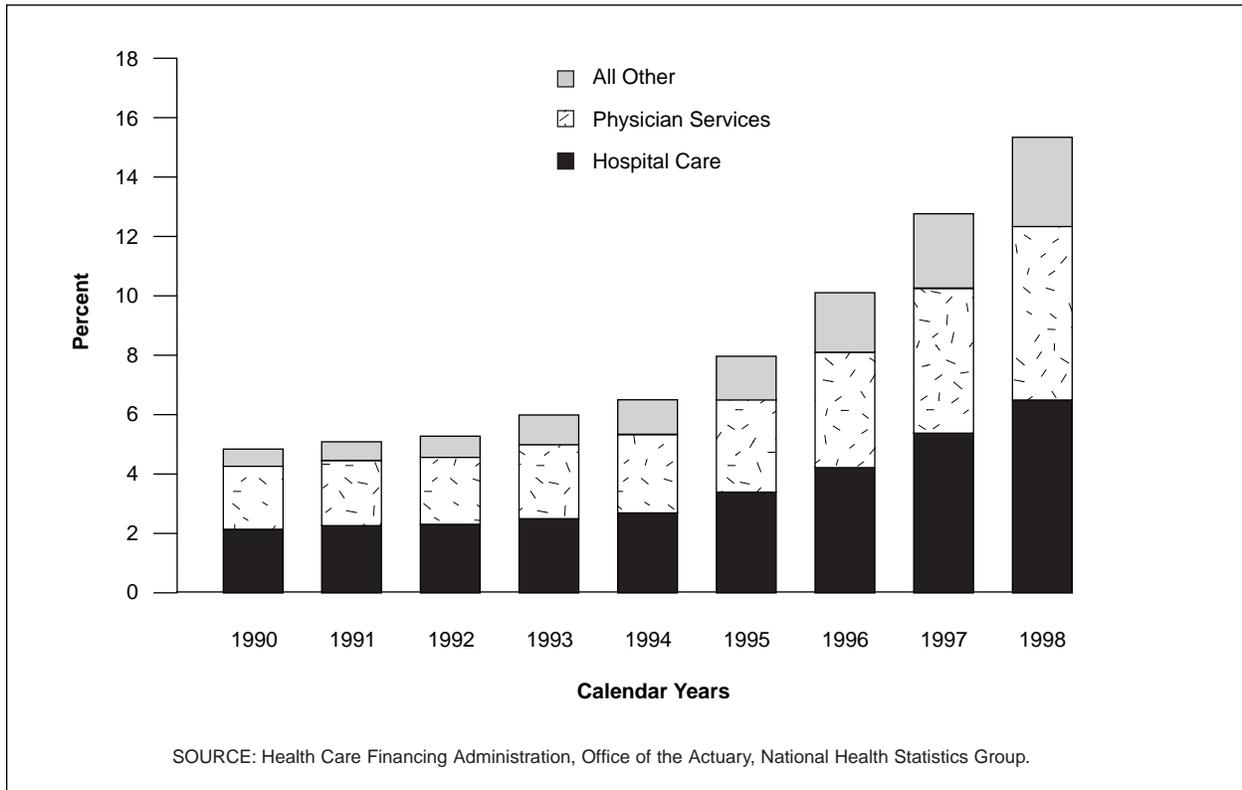
Figure 8
Growth in Medicare Expenditures for Freestanding and Hospital-Based Skilled Nursing Facility Care: Calendar Years 1991-1998



Medicare tightened controls on spending growth for freestanding and hospital-based SNF care since 1994.

- Annual growth in Medicare spending for freestanding and hospital-based SNF care slowed to single digits in 1998 for the first time since 1990. In 1998, Medicare paid \$10.4 billion for care in freestanding SNFs and another \$4.1 billion to hospital-based facilities.
- Growth in spending for freestanding SNF care considerably exceeded growth in spending for hospital-based SNF care from 1992 to 1994. Continuing government efforts to detect and curb fraud and abuse gradually slowed the growth in both components since 1995 (U.S. Government Accounting Office, 1997).
- The conversion of payments to SNFs from cost-based reimbursement to a prospective payment system (PPS) started in July 1998 and contributed to the 1998 deceleration in growth. The PPS is designed to limit the growth in Medicare spending for SNF services and requires that all services provided in the SNF be bundled into the SNF PPS payment.

Figure 9
Capitated Payment Share of Total Medicare Expenditures and Service Distribution of Capitated Payments: Calendar Years 1990-1998

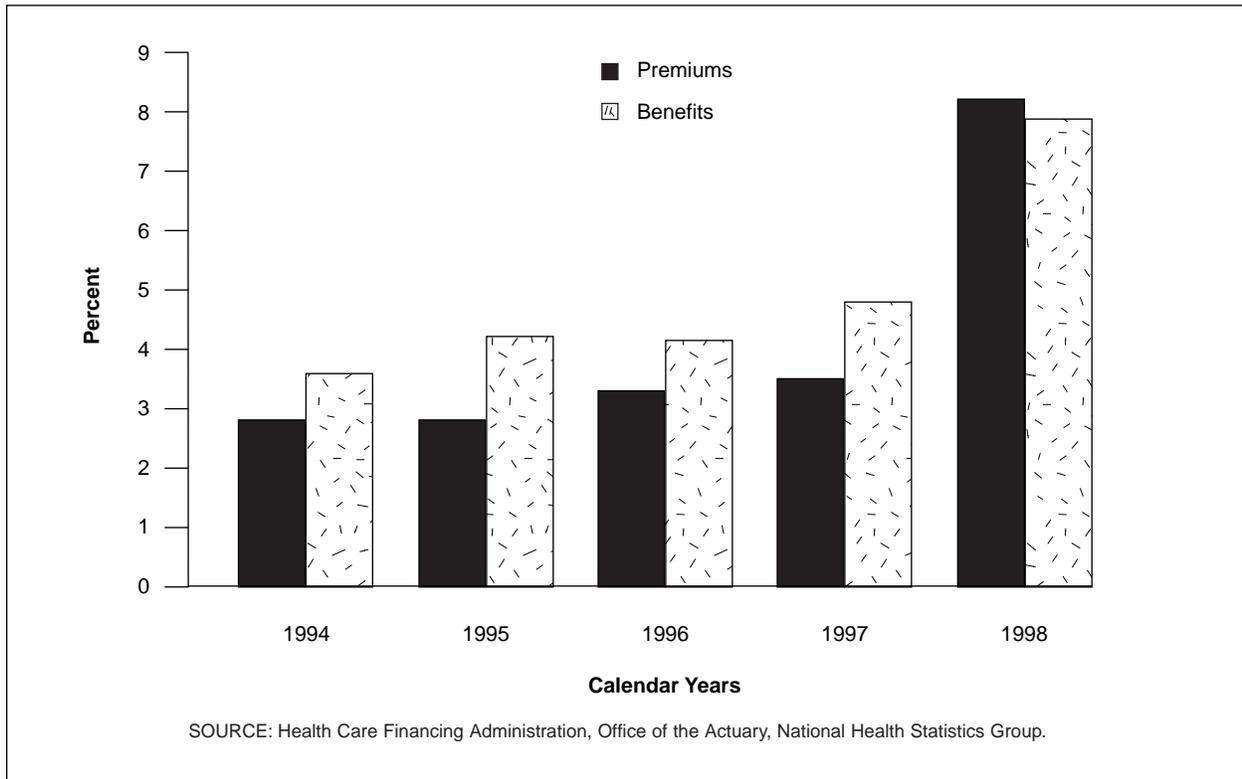


Managed care consumed an increasing share of total Medicare spending throughout the 1990s.

- Medicare payments to managed care plans increased from 10.3 percent of total Medicare expenditures in 1996 to 15.6 percent in 1998 as a result of rapid increases in Medicare managed care enrollment. Although still increasing at a rapid pace, growth in managed care payments has slowed from a high of 36.1 percent annual rate in 1996 to 24.0 percent in 1998, as enrollment growth eased somewhat.
- Changes in Medicare payments to some managed care plans (refer to Technical Note) may have had a dampening effect on their willingness to participate in the Medicare program in 1998, and/or to serve the same geographic areas served before the change. As of the fall of 1998, 45 plans chose not to renew their contracts with Medicare, and 54 other plans announced they would reduce the geographic areas in which they provided services. A portion of the withdrawals and service-area reductions could be related to these managed care plans' inability to compete effectively in some geographic areas. Meanwhile, 40 new plans applied to enter the Medicare managed care program, some of which were existing plans looking to expand the areas they serve (U.S. General Accounting Office, 1999).
- Under Medicare's capitated payments, hospital care (combined inpatient and outpatient) and physician services each accounted for approximately 40-percent shares. Under fee-for-service (FFS) payments, hospital care and physician services account for 60- and 20-percent shares, respectively.

Figure 10

Private Health Insurance Premium and Benefit Growth: Calendar Years 1994-1998

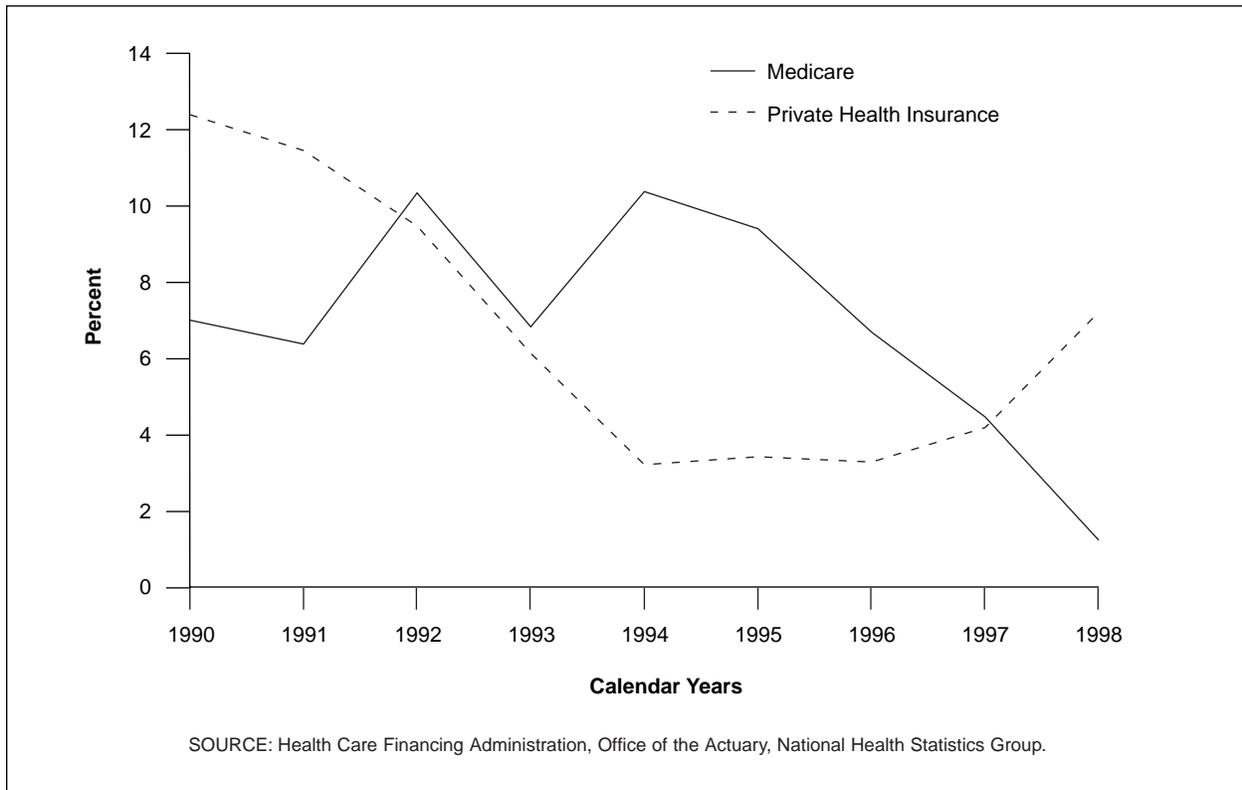


For the first time in 5 years, PHI premiums grew faster than benefits in 1998.

- In 1998, Americans spent \$375.0 billion for PHI premiums, an increase of 8.2 percent over the previous year. Benefits paid accounted for \$337.0 billion, a growth of 7.9 percent from the previous year. This was the first time since 1993 that premiums grew faster than benefits. Managed care plans had generally kept premiums low to attract new customers and increase their market share in the mid-1990s (Meyer, 1998). In 1998, insurance companies, in an attempt to increase sagging profitability and to cover benefit costs, raised premiums (KPMG Peat Marwick, 1998; Mercer/Foster Higgins, 1998). This resulted in an increase of 10.8 percent in the net cost of insurance over the previous year. The net cost of insurance, the difference between premiums and benefits, amounted to \$38 billion in 1998. The net cost of health insurance includes the administrative costs of insurers, net additions to reserves, rate credits and dividends, premium taxes, and profits or losses of insurance companies.
- Consumer demand for greater choice in health care plans resulted in a growth in enrollment in less restrictive managed care plans (point-of-service plans and preferred provider organizations), which tend to be more expensive than the more restrictive plans (primarily health maintenance organizations [HMOs]). This change in enrollment into less restrictive plans, as well as soaring costs for newer and costlier drugs, contributed to the increase in both premiums and benefits in 1998 (Mercer/Foster Higgins, 1998; KPMG Peat Marwick, 1998).

Figure 11

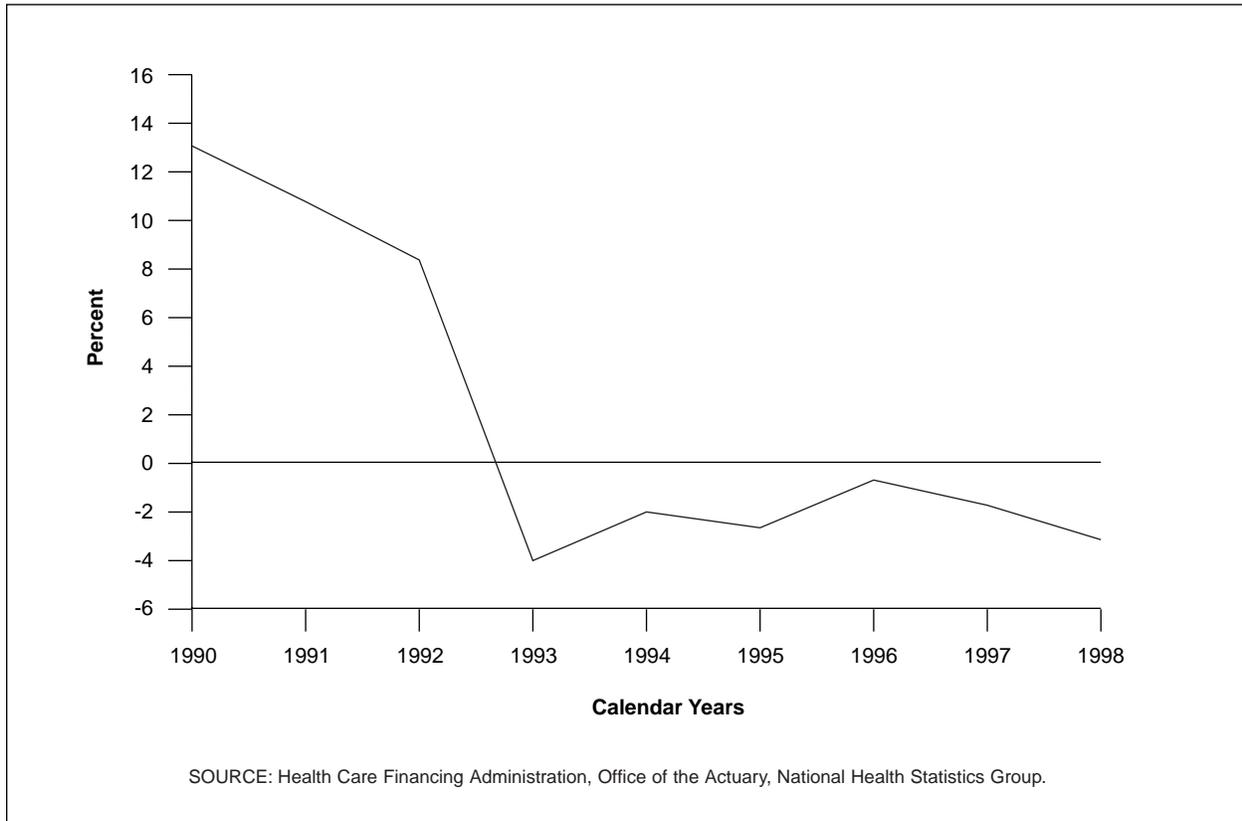
Comparison of Average Growth in per Enrollee Medicare and Private Health Insurance Benefits:
Calendar Years 1990-1998



Medicare and PHI per enrollee benefit growth rates diverged in 1998.

- During the 1990s, the predominant form of PHI was transformed from largely FFS indemnity plans to managed care plans. This change helped produce a major deceleration in growth in PHI costs, as plans negotiated steep discounts with providers and more tightly controlled utilization of services (Smith, 1997). By 1998, however, growth in benefits paid out by insurance plans accelerated, as most of the one-time savings that resulted from the initial migration into managed care plans were realized.
- Medicare spending growth remained rapid during the first half of the 1990s. In 1997 and 1998, growth decelerated as the results of efforts to fight fraud and abuse and the early effects of BBA became apparent.
- The interaction of these trends in PHI and Medicare benefit growth led to wide and reversing gaps in benefit growth rates for these two major health payers during the 1990s. In 1990 and 1991, per enrollee benefit growth in PHI exceeded Medicare by a wide margin. In the 1994-1996 period, the trend reversed, with Medicare growth per enrollee exceeding PHI growth by a wide margin. In 1998, we again saw a sizable reversal, as growth in PHI benefits accelerated while Medicare decelerated.
- Despite diverging substantially over shorter periods, Medicare and PHI per enrollee benefits grew at comparable average annual rates over longer periods: 6.8 and 6.0 percent, respectively, from 1990 to 1998, and 10.0 and 11.2 percent, respectively, from 1969 to 1998.

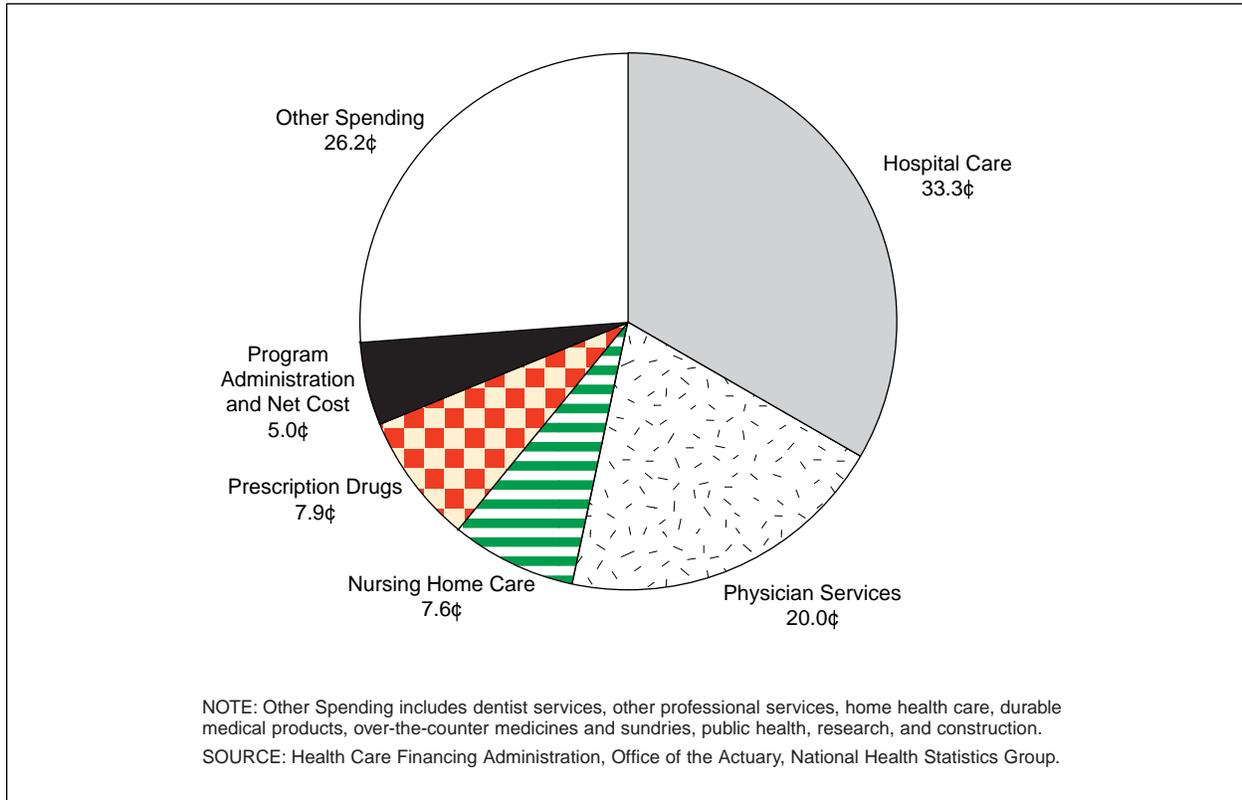
Figure 12
Growth in Workers' Compensation Medical Benefits: Calendar Years 1990-1998



Expenditures for workers' compensation medical benefits continued to fall since 1993.

- Workers' compensation is a major form of social insurance that covers medical and rehabilitative expenses and lost wages for workers sustaining occupational injuries or diseases. Medical benefits have consistently accounted for approximately 40 percent of total benefits throughout the 1990s.
- Expenditures for workers' compensation medical benefits experienced high growth in the late 1980s and early 1990s but have actually fallen since 1992. This turnaround was due to State legislation and privately developed initiatives aimed at alleviating costs. These initiatives have led to a trend of implementing certain cost-reducing policies: safety and return-to-work programs, regulation of program procedures, reduction of plan generosity, and increased use of managed care programs (National Academy of Social Insurance, 1999).

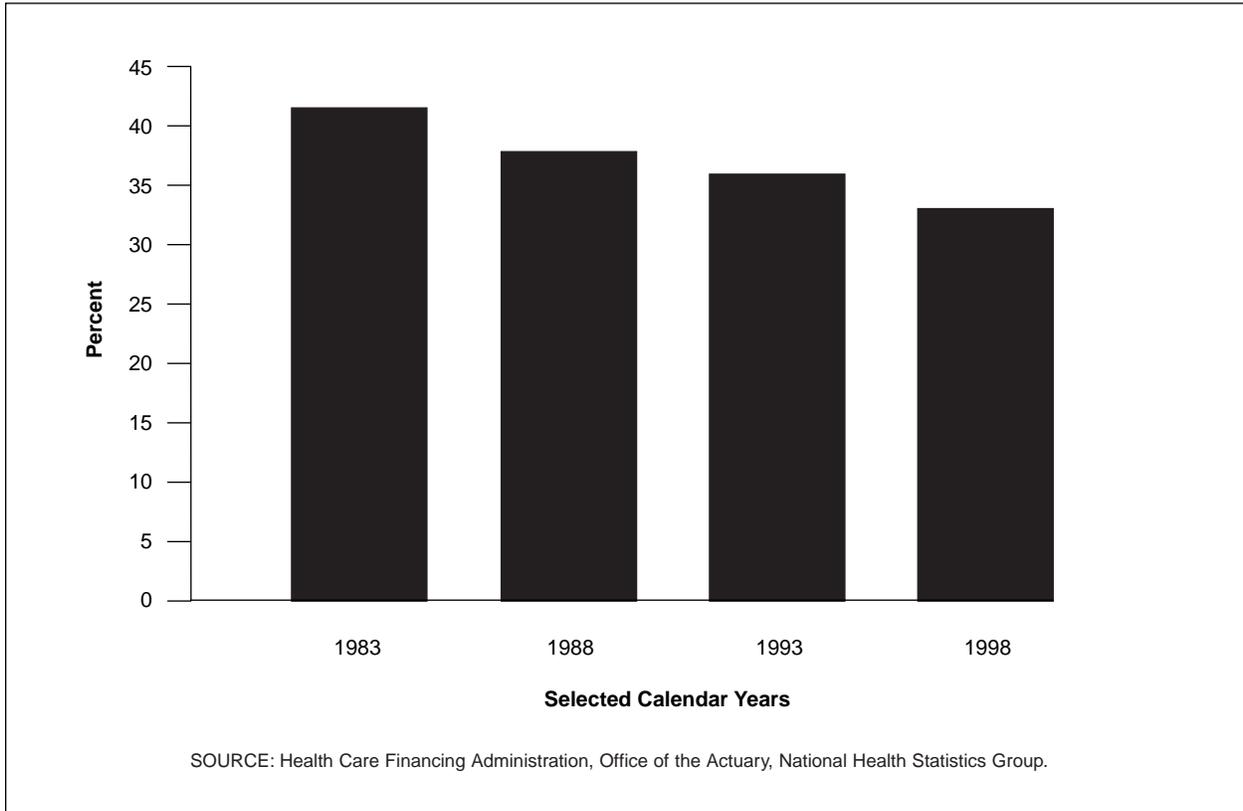
Figure 13
The Nation's Health Dollar in Calendar Year 1998: Where It Went



Hospital care and physician services account for more than one-half of the Nation's health care dollar.

- In 1998, spending for outpatient and inpatient services provided in a hospital was one-third of the NHE. Expenditures for physician services, including independently billing labs, accounted for one-fifth of all health care spending.
- Retail spending for prescription drugs, although less than 10 percent of all health care spending, had the largest increase in share among all the services, rising from 7.2 percent in 1997 to 7.9 percent in 1998.

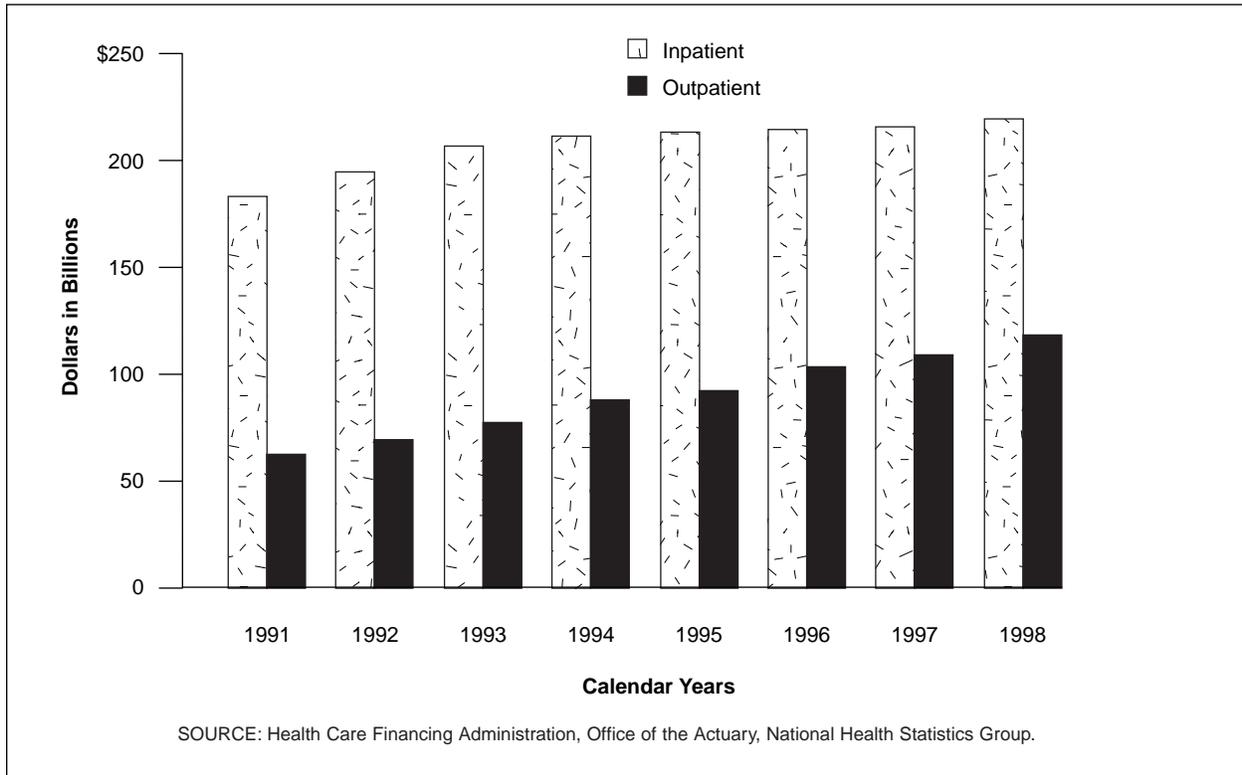
Figure 14
Hospital Expenditures as a Share of Total National Health Expenditures: Selected Calendar Years 1983-1998



Long-term slow growth in hospital spending has caused a continuing fall in the hospital share of total NHE since 1983.

- The hospital share of NHE has fallen almost every year since 1983, when Medicare's PPS for inpatient services was implemented. The PPS, as well as the growth in managed care, provided incentives for hospitals to become more efficient in the delivery of inpatient services (Casey, 1998).

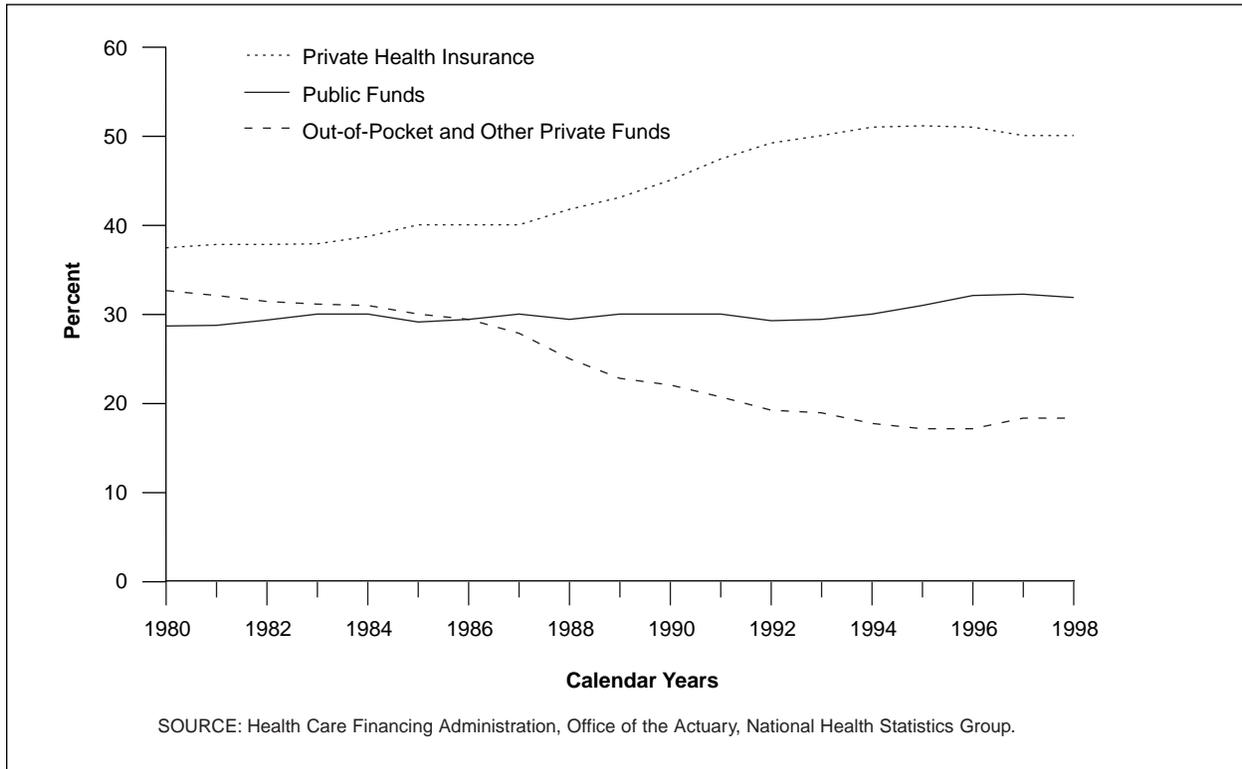
Figure 15
Community Hospital Inpatient and Outpatient Revenue: Calendar Years 1991-1998



Strong growth in outpatient revenue continued to dominate community hospital revenue growth.

- Outpatient revenue increased at a strong 8.0-percent rate in 1998, down somewhat from the 8.8-18.3-percent range in growth rates that occurred from 1991 to 1997 (Table 2). As services provided in community hospitals continued to shift to outpatient departments, outpatient revenue shares of total revenue grew to 35.8 percent of total community hospital revenue in 1998, up from 25.2 percent in 1991. Outpatient revenues include revenues from services provided in outpatient departments and clinics, hospital-based home health agencies, and emergency departments.
- Inpatient revenue growth increased a slight 1.1 percent in 1998, continuing 3 years of growth of less than 2 percent each year. Inpatient revenue growth has been slow in 1998 because of a 1-year freeze of Medicare PPS rates for inpatient services and a first-time reduction in the average complexity of Medicare inpatient admissions (Health Care Financing Administration, 1998). Inpatient revenues include revenues for services provided in acute care departments and hospital-based nursing homes.
- Because efficiencies in inpatient care are becoming increasingly difficult to achieve, the trend of slow inpatient revenue growth is expected to change (Smith et al., 1999). During the first 9 months of 1998, inpatient days, which had declined at an average rate of 2.7 percent from 1983 to 1997, increased slightly. Inpatient admissions also experienced a slight increase during the first 9 months of 1998.

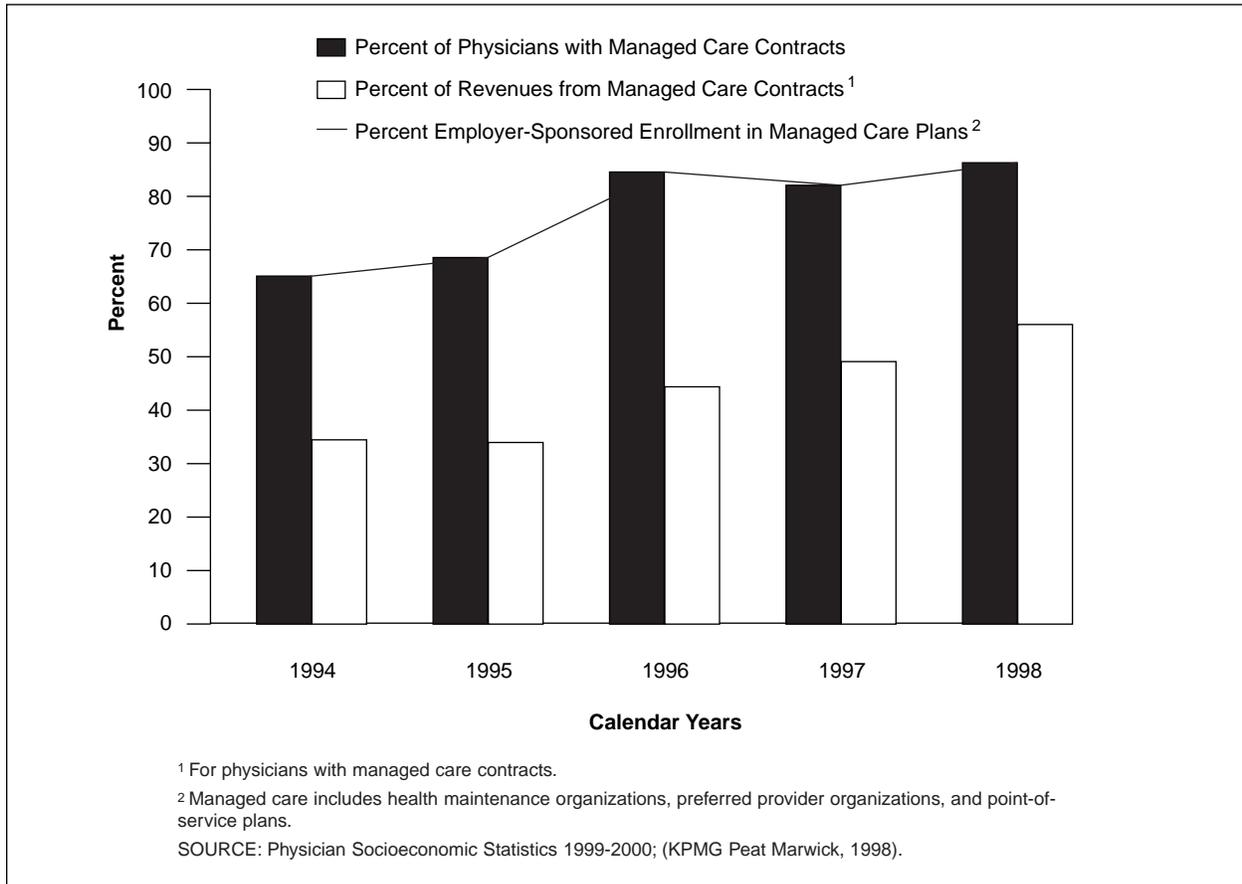
Figure 16
Expenditures for Physician Services, by Source of Funds: Calendar Years 1980-1998



Spending by PHI for physician services remained a stable share of physician expenditures since 1993.

- Physician expenditures reached \$229.5 billion in 1998, one-fifth of all health expenditures. Growth in physician expenditures has been accelerating over the last 2 years, reaching 5.4 percent by 1998.
- In 1998, public funds paid for 31.9 percent of physician services, and direct-from-consumer out-of-pocket payments and other private funds paid for 15.6 percent and 2.0 percent, respectively. The rest (50.5 percent) was financed by PHI.
- From 1980 to 1993, the share of physician expenditures paid by PHI grew from 37.9 percent to 50.6 percent. From 1993 to 1998, this rapid growth ceased. This stabilization occurred as enrollment grew in managed care (KPMG Peat Marwick, 1998). The phase-in of the Medicare physician fee schedule and volume performance standards helped the public share of physician services to remain steady.
- The out-of-pocket share of physician expenditures fell between 1964 and 1996, as more individuals were covered by health insurance. This trend was more pronounced in the early 1990s as a result of increased enrollment in managed care plans that typically have lower copayments and deductibles than traditional indemnity plans. The slight upswing in share in 1997 and 1998 was due in part to managed care plans increasing copayments and deductibles or requiring them for the first time (KPMG Peat Marwick, 1998).

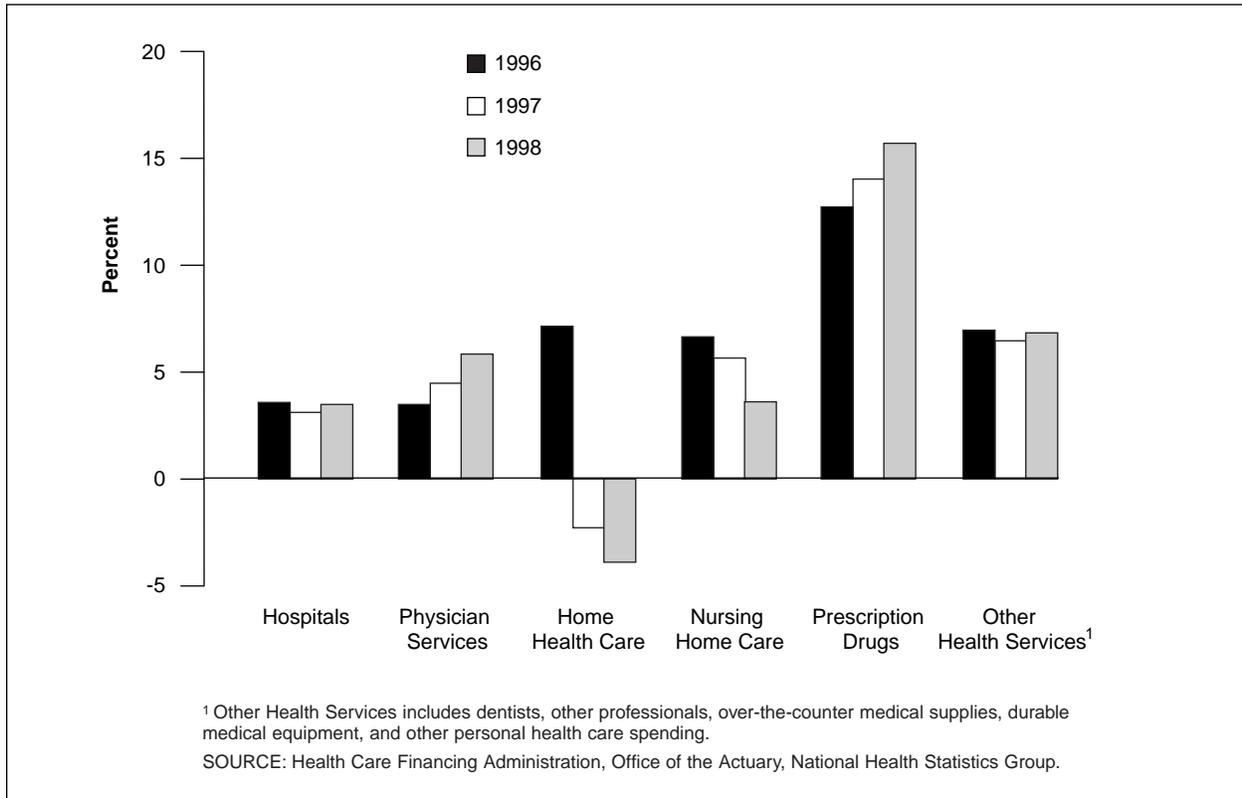
Figure 17
Physician Involvement with Managed Care: Calendar Years 1994-1998



Physicians' involvement with managed care continued to grow.

- As managed care enrollment in employer-sponsored health insurance increased, so has physician involvement with managed care plans. In 1998, 94 percent of physicians had at least one managed care contract; for physicians with such contracts, managed care accounted for 56 percent of their revenues.
- Increased reliance on managed care plans along with the introduction of the Medicare payment system and volume performance standards put some pressure on physicians' income. These changes contributed to no change in the physician inflation-adjusted mean net income between 1993 and 1997, after many years of steady increases (American Medical Association, 1999a; Moser, 1999).
- Currently, physicians are attempting to strengthen their bargaining position with insurers. Physicians are turning to the American Medical Association to form a national negotiating organization and to lobby for the relaxation of antitrust laws for physicians (American Medical Association, 1999b).

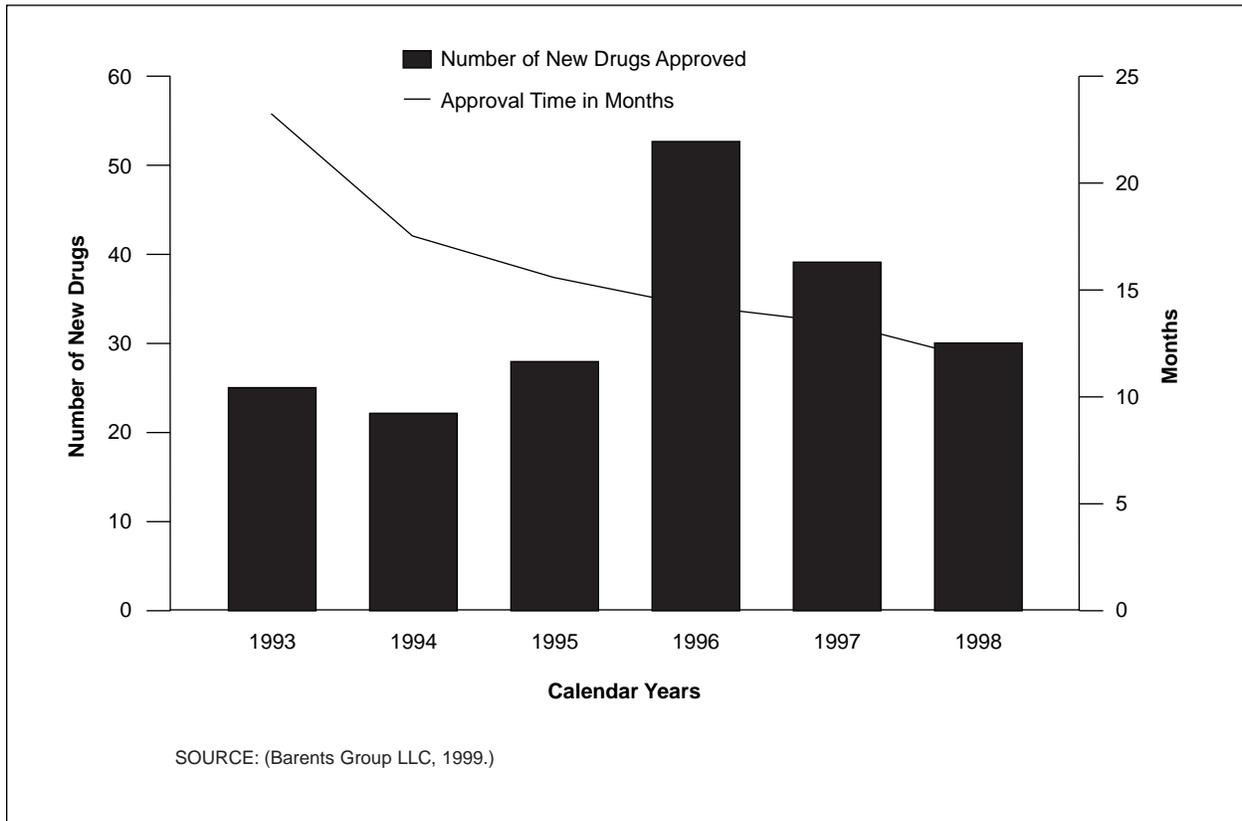
Figure 18
Growth in Personal Health Care Service Components: Calendar Years 1996-1998



Prescription drug expenditures were the fastest growing PHC component in 1998.

- In 1998, \$90.6 billion was spent on prescription drugs purchased in retail settings, 15.4 percent higher than in 1997. This high growth rate in spending for prescription drugs was faster than any other personal health category in 1998, as it also was in the preceding 2 years (1996 and 1997).
- From an increase of 8.7 percent in 1993, growth in prescription drug spending steadily accelerated to 15.4 percent in 1998.
- There are many causes for the rapid increase in prescription drug spending. Changes in the Food and Drug Administration's (FDA) approval process sped the introduction of new prescription medicines, which are often priced higher than existing products. Consumer demand rose as manufacturers of these new products increased spending for advertising, as PHI picked up a larger share of total prescription drug spending, and as increased access to physician services under managed care increased prescription drug utilization (Scott, 1999; Barents Group LLC, 1999).

Figure 19
Food and Drug Administration New Drug Approval Time and Number of New Drugs Approved:
Calendar Years 1993-1998

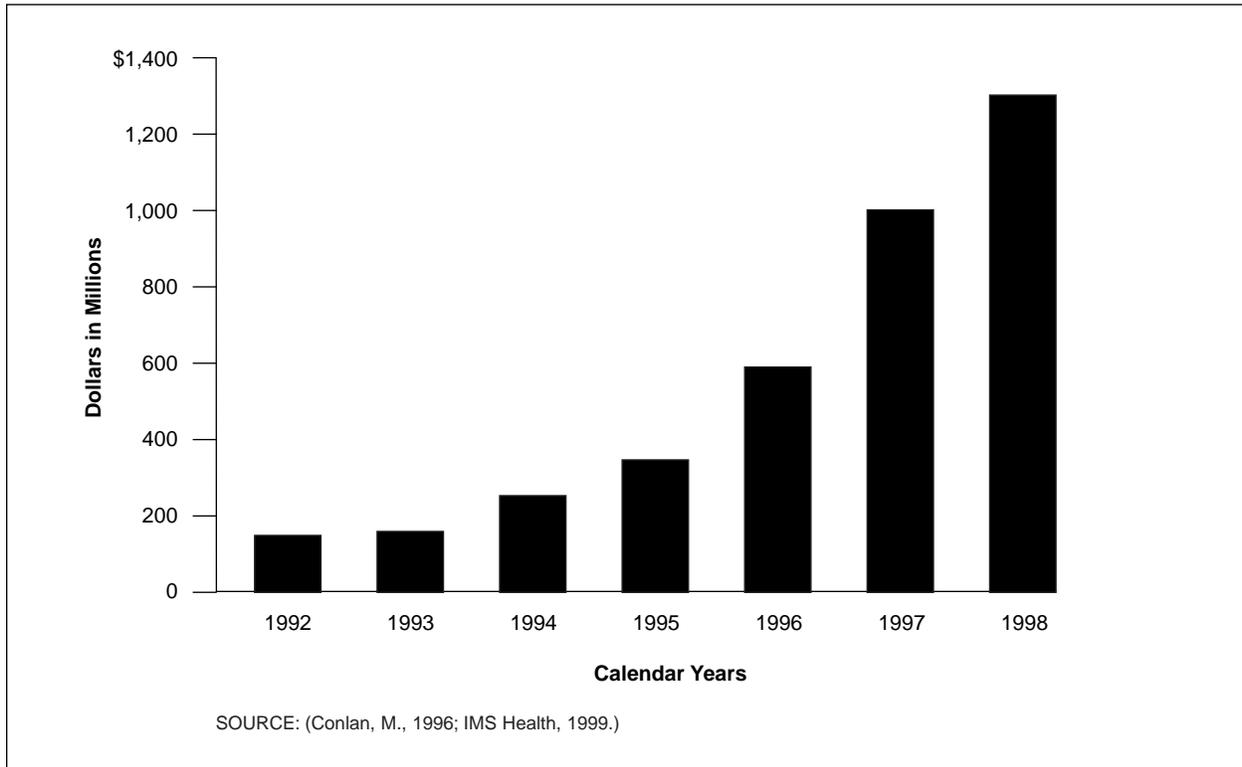


Changes in the FDA’s approval process sped the introduction of new, higher priced prescription medicines.

- Two pieces of legislation introduced in recent years dramatically shortened the length of time required to bring a drug to market.
- The Prescription Drug User Fee Act of 1992 allowed the FDA to hire additional personnel to review new drug applications and financed this effort by collecting user fees from pharmaceutical companies.
- The FDA Modernization Act of 1997 further reduced the drug introduction time by establishing strict performance targets that limited the amount of time a drug is in the clinical development phase.
- These legislative changes reduced average FDA total review time from 23 months in 1993 to 12 months in 1998. This acceleration produced a spike in the number of new drugs approved in 1996 and 1997 as the approval time for drugs in the pipeline shortened.

Figure 20

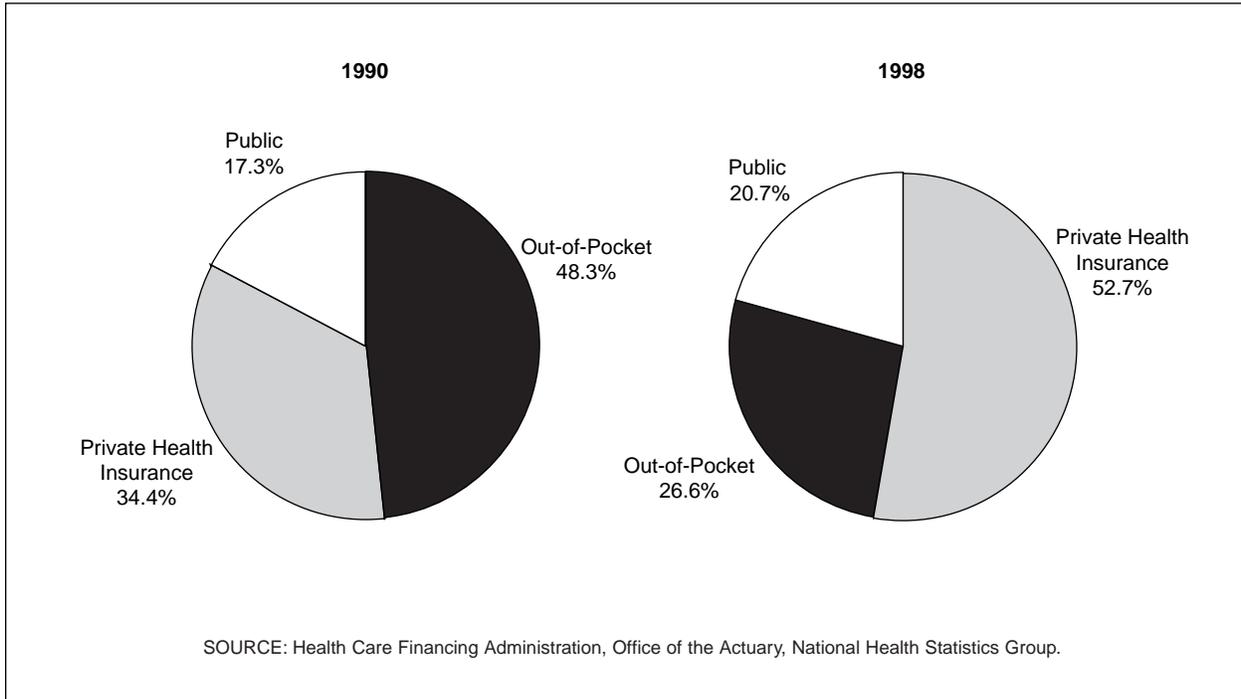
Spending for Direct-to-Consumer Prescription Drug Advertisements: Calendar Years 1992-1998



Drug manufacturers increased their spending for advertising of new and existing products to \$1.3 billion in 1998, boosting consumer demand.

- Pharmaceutical manufacturers spent record amounts for direct-to-consumer advertising to promote the sale of new drugs approved (on top of already hefty budgets used to publicize to the medical professions). Out of total U.S. promotional budgets of \$8.3 billion, drug manufacturers spent \$1.3 billion in 1998 for direct-to-consumer advertising, up 55 percent from 1997 (Barents Group LLC, 1999).
- Advertising had a big effect on increasing consumer spending, with spending for the top 10 most heavily advertised drugs accounting for more than one-fifth of the overall increase in prescription drug spending between 1993 and 1998 (Barents Group LLC, 1999).

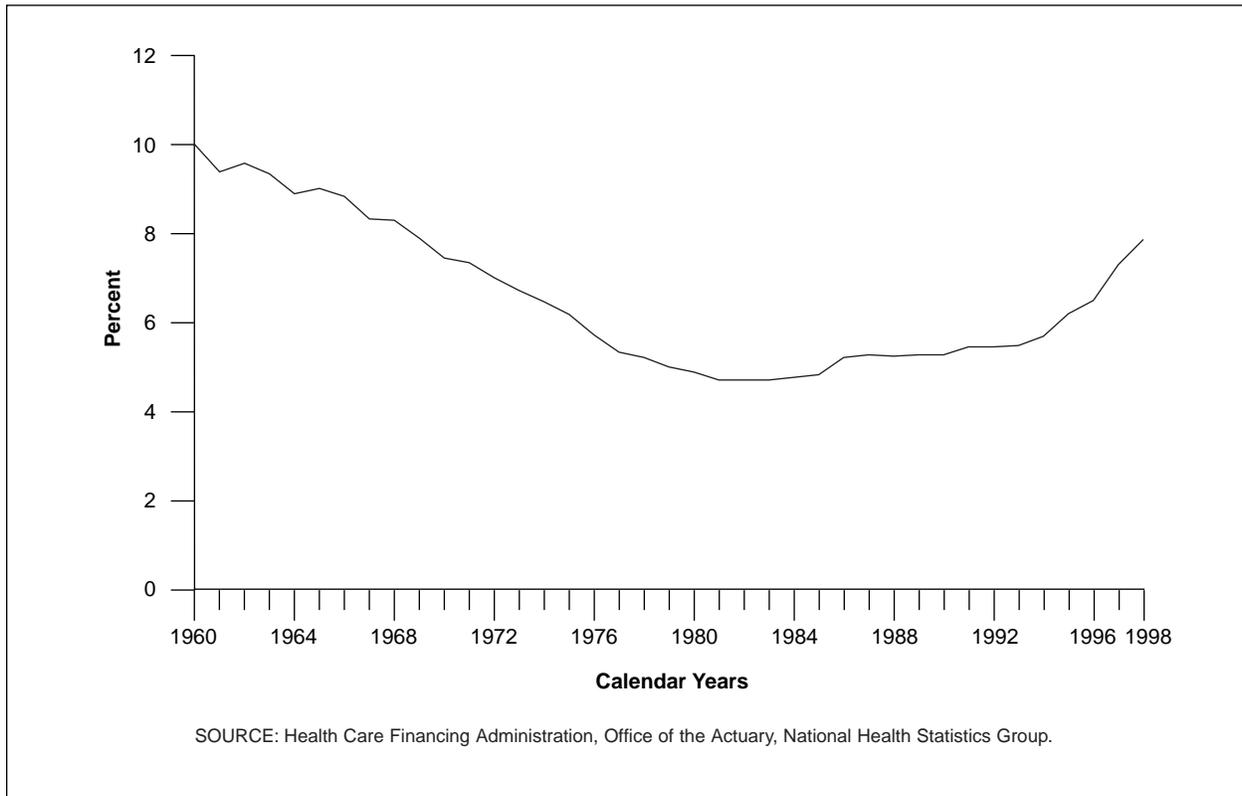
Figure 21
Expenditures for Prescription Drugs, by Source of Funds: Calendar Years 1990 and 1998



Consumer demand for prescription drugs increased in part because of falling out-of-pocket expenditure requirements.

- The share of prescription drugs purchased with direct-from-consumer out-of-pocket payments has fallen steadily, from 96.0 percent of total drug expenditures in 1960 to 26.6 percent in 1998. Since 1990, the out-of-pocket share has fallen from 48.3 percent, primarily as a result of growth in PHI payments.
- Since 1990, managed care enrollment has grown significantly. Managed care plans typically require lower copayments for physician visits than are required under traditional indemnity plans. This allows patients easier access to physicians for written prescriptions and for diagnosis of conditions that frequently require treatment with prescription drugs. In addition, managed care plans (especially HMOs) usually require smaller out-of-pocket payments in the form of copayments and deductibles for the purchase of drugs than FFS plans, further inducing demand (U.S. Bureau of Labor Statistics, 1998; Barents Group LLC, 1999). Finally, some analysts believe that prescription drugs are a more cost-effective way for managed care plans to treat plan members for certain conditions that would otherwise require more involved treatment (e.g., hospitalization [Strongin, 1999]).

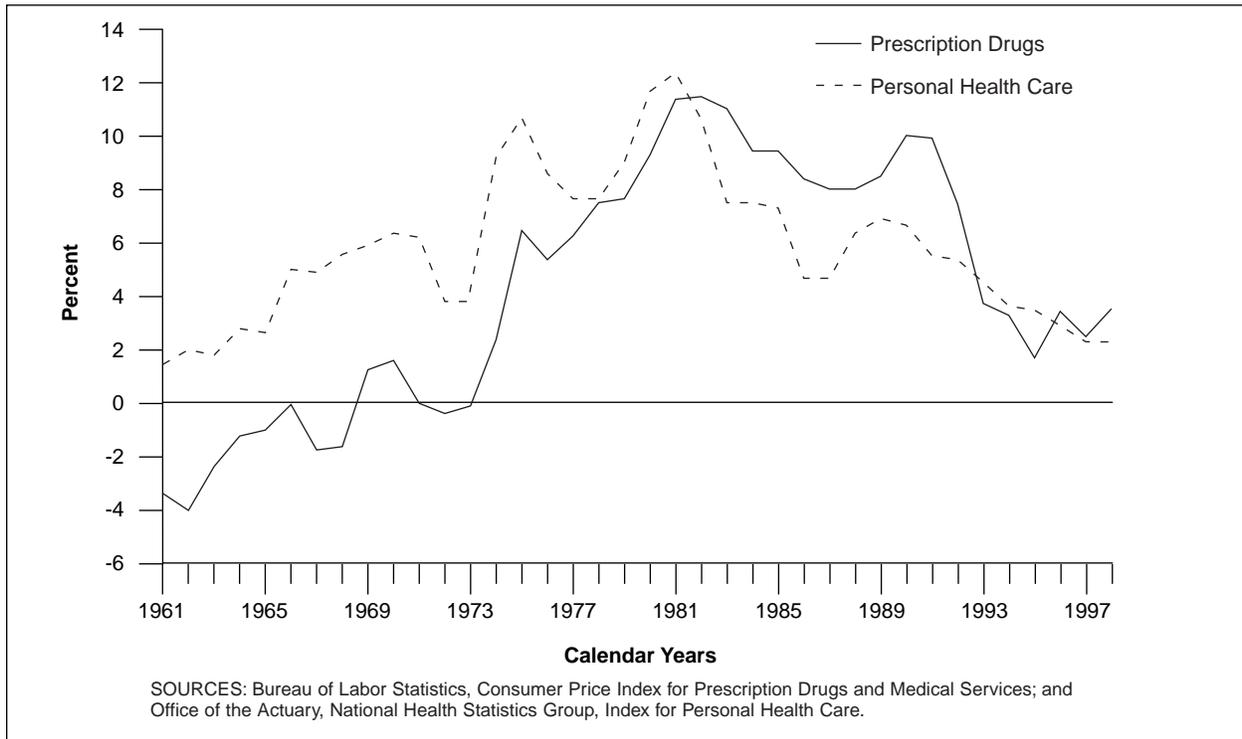
Figure 22
Prescription Drug Spending as a Share of National Health Expenditures:
Calendar Years 1960-1998



Prescription drug spending has rapidly increased as a share of total health spending in recent years.

- The rapid increase in prescription drug spending in recent years, combined with relatively slow growth in overall health spending, resulted in a steep rise in the share of total health spending for prescription drugs. This share rose from 5.6 percent of total health spending in 1993 to 7.9 percent in 1998.
- This increase contrasts significantly with the gradual increase in the drug share of total spending that occurred during 1983-1992 and the steadily declining share from 1960-1982.

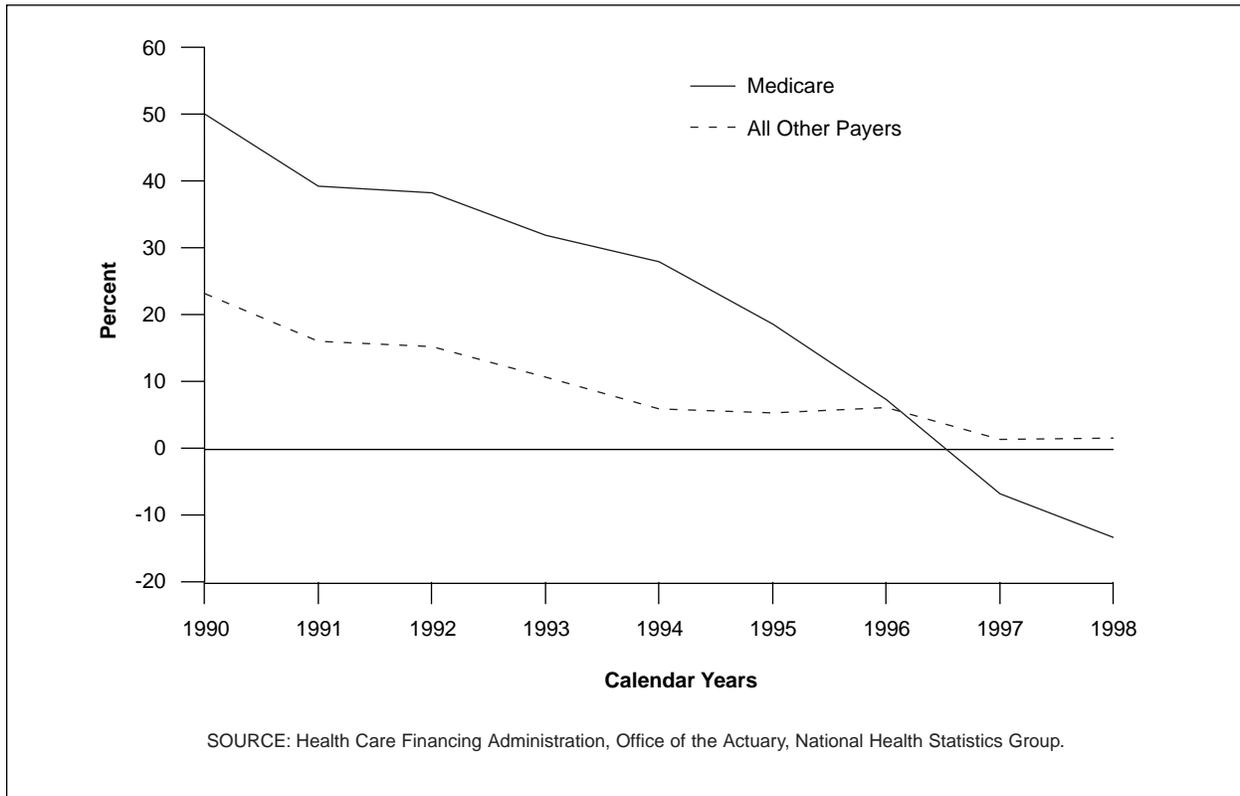
Figure 23
Growth in Health Care Price Indexes for Personal Health Care and Prescription Drugs:
Calendar Years 1961-1998



The decline and subsequent resurgence in prescription drug spending as a share of total health spending over the past four decades is attributable to a combination of price growth differentials, relative utilization changes, and third-party insurance enrollment and coverage expansions.

- From 1960 to 1982, prescription drug expenditures as a share of total health spending declined from 10.0 to 4.7 percent. Rapid expansions in public and private third-party insurance enrollment caused overall health care spending to grow rapidly, surpassing drug-spending growth.
- From 1982 to 1993, the prescription drug expenditure share of total health spending increased only slightly, from 4.7 to 5.6 percent. Aggregate expenditures for prescription drugs grew at roughly the same rate as total health spending, due partially to higher relative drug price growth. Higher drug prices precipitated a congressional call for industry curbs on price increases as an alternative to price controls.
- From 1993 to 1998, the prescription drug expenditure share of total health spending grew from 5.6 to 7.9 percent. Responding to congressional threat, drug manufacturers publicly committed to holding drug price increases to no more than overall Consumer Price Index increases, leading to low and stable price inflation for prescription drugs from 1994 to 1997. By 1998, drug prices had accelerated somewhat, exceeding overall health price inflation. In addition, increases in the number of prescriptions dispensed (up 5 percent in 1996 and 7 percent in 1998 [IMS America, 1999]) and the record-setting low rate of growth in overall health spending contributed further to the increased drug expenditure share of health spending.

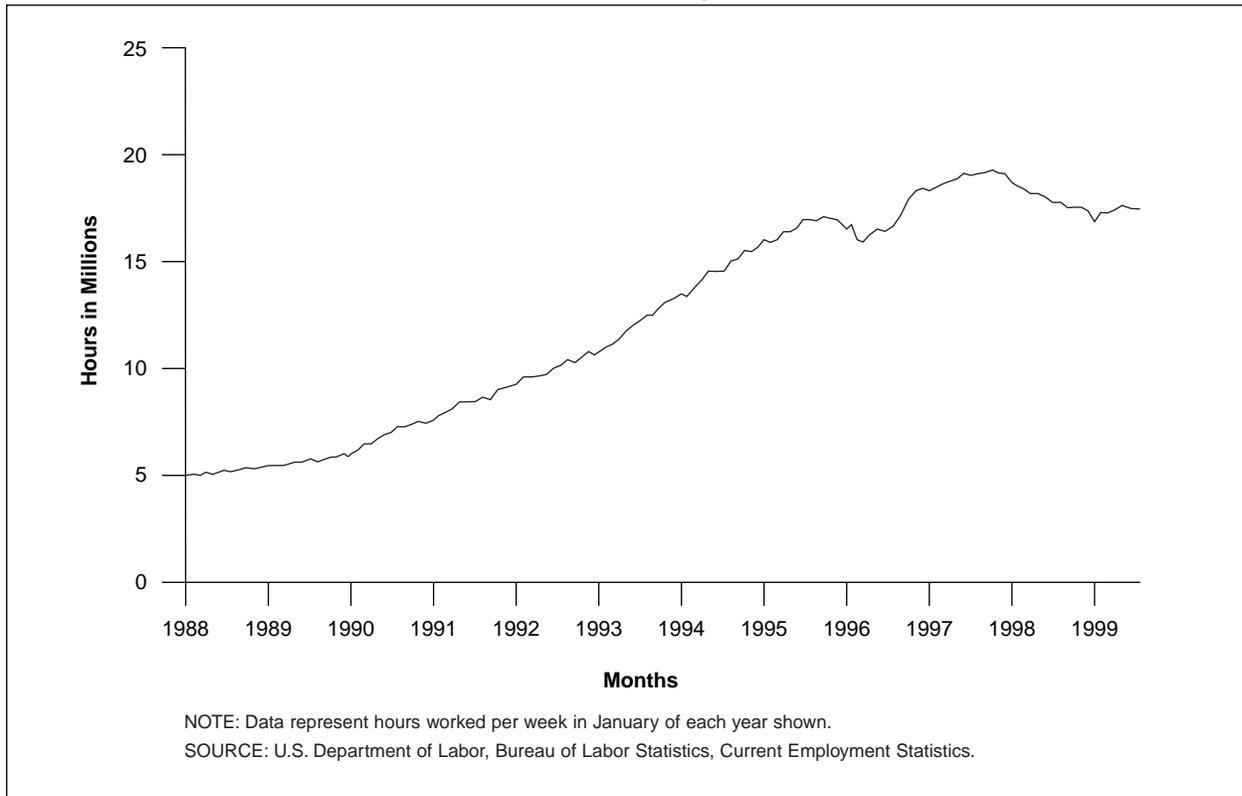
Figure 24
Growth in Expenditures for Home Health Care Funded by Medicare and All Other Payers:
Calendar Years 1990-1998



Government efforts to combat fraud and abuse coupled with the implementation of BBA have led to a steady deceleration in Medicare home health care spending.

- Expenditures for total home health care provided by freestanding facilities fell by 4.0 percent in 1998, to \$29.3 billion. Medicare, the largest single payer for home health care, drove the decrease, with payments falling 12.9 percent in 1998, the second consecutive year of negative growth.
- The steady deceleration of home health care expenditure growth has been brought about by many changes affecting the industry in the last decade. In the late 1980s and early 1990s, the home health care industry experienced rapid growth, occurring in response to court-mandated changes in Medicare coverage criteria. The home health care industry expanded its capacity, anticipating demand primarily from the Medicare population. Growth in Medicare home health care spending peaked at 50.1 percent in 1990. As demand eased, home health care industry revenue growth slowly decelerated. By 1995, Operation Restore Trust began to tighten payments as part of the government's widespread efforts to combat fraud and abuse, continuing the trend of a deceleration in growth. The BBA sought to tighten payment restrictions even further, resulting in negative growth in Medicare home health care payments in 1997 and 1998 (refer to Technical Note).
- All other payers, including Medicaid and PHI, experienced 1.8-percent growth in home health care expenditures in 1998. Medicaid home health care expenditures increased 8.8 percent in 1998, helping to offset the drop in Medicare expenditures.

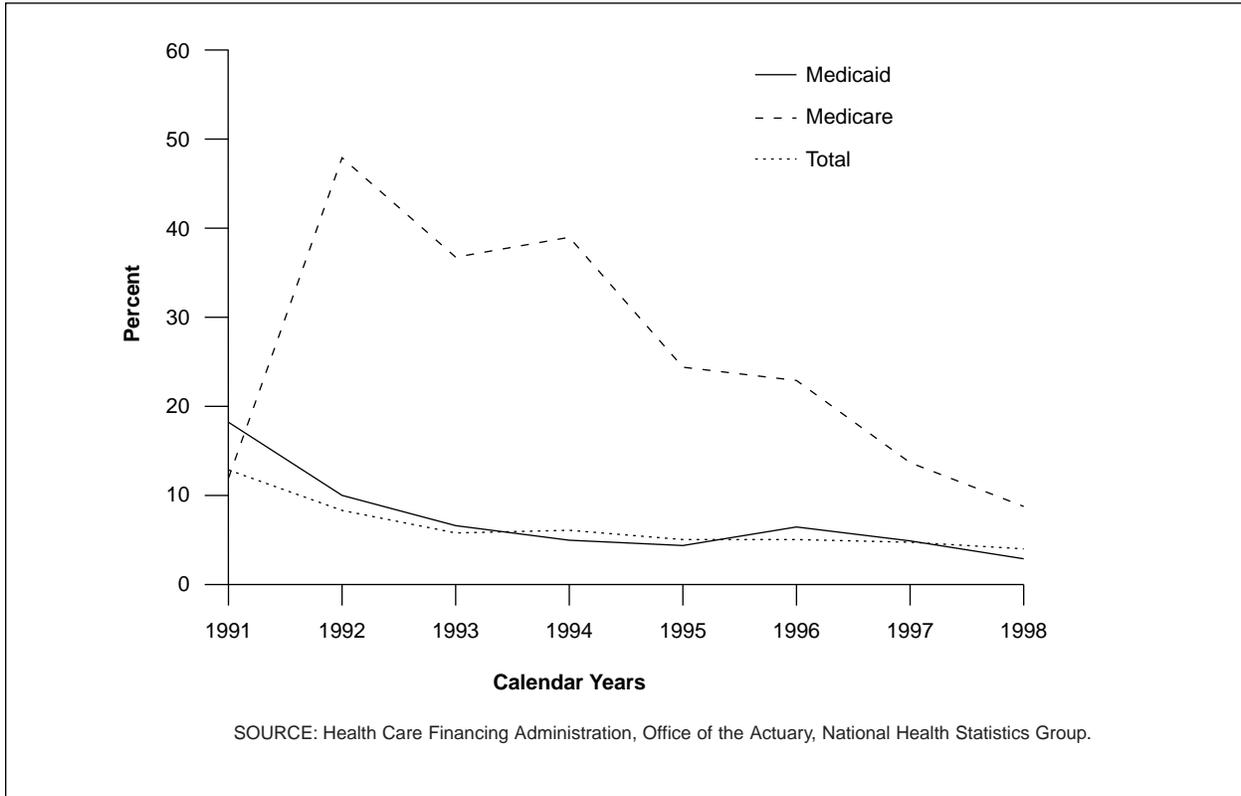
Figure 25
Aggregate Non-Supervisory Hours Worked per Week in Freestanding Home Health Care Establishments: January 1988-1999



The drop in home health care hours worked per week is reflective of the impacts of BBA.

- Between January 1988 and January 1998, aggregate weekly hours worked, as measured by the U.S. Bureau of Labor Statistics, grew 269 percent or 14 percent on average each year, before beginning to fall in 1998.
- Aggregate weekly hours worked represent a measure of capacity to deliver home health services. From January 1998 to December 1998, aggregate weekly hours fell by 7.7 percent, during the time in which the BBA was implemented.
- Despite the pronounced decline in 1998, aggregate hours worked per week are gradually beginning to increase in 1999. After reaching a low in January 1999, aggregate hours worked per week have returned to mid-1996 levels. This suggests that by 1999, home health care facilities are demonstrating comparable capacity to deliver services as in 1996, and that home health agencies' adjustment to the interim payment system may be almost over.

Figure 26
Growth in Total, Medicare, and Medicaid Expenditures for Freestanding Nursing Home Care:
Calendar Years 1991-1998



Nursing home spending growth was the slowest on record in 1998. Medicare, although a small share of nursing home spending, experienced the slowest growth since 1991.

- Annual expenditures for nursing home care provided by freestanding nursing homes increased 3.7 percent in 1998 to \$87.8 billion. Growth in spending for nursing home care decelerated almost steadily from 13.3 percent in 1990 to 3.7 percent in 1998, the slowest growth recorded in 1961.
- Public programs, primarily Medicaid, funded more than 60 percent of expenditures for nursing home care in 1998. Almost all private spending for nursing home care is paid out-of-pocket by patients or their families. Growth in Medicaid funding for nursing home care grew 7.3 percent annually from 1990 to 1998; growth in Medicare spending averaged 25.2 percent, although it has been decelerating rapidly since 1992.
- Deceleration in freestanding nursing home expenditure growth is affected by slower growth in the population age 85 or over, and growth in alternative treatment settings, such as home health care, hospital-based nursing homes, assisted-living facilities, and community-based day care, and more recently, this deceleration has been affected by the implementation of Medicare's PPS for SNFs (Saphir, 1999).