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*Analysis of 1994 Commerce Department
Health Expenditure Data*

Sidney M. Wolfe, M.D., Director

Public Citizen's Health Research Group

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For Further Information: Sid Wolfe 202/833-3000*

**PUBLIC CITIZEN'S HEALTH RESEARCH GROUP
ANALYSIS OF 1994 COMMERCE DEPARTMENT
HEALTH EXPENDITURE DATA
Sidney M. Wolfe, M.D.**

**U.S. Commerce Department: \$1.0605 Trillion Health Costs for
1994; \$1.2037 Trillion by 1995: \$1.9975 Trillion by 1999**

In a Commerce Department report, U.S. Industrial Outlook 1994, embargoed until 10 a.m. Tuesday December 28th, 1993, the government estimates that **national health expenditures will increase to \$1.0605 trillion in 1994**, a 12.5% jump from the 942.5 billion spent in 1993 for yet another year of double digit increases in this, the largest industry in the United States.

A RECORD TOTAL EXPENDITURE, ONE-YEAR INCREASE and % GDP

The estimate of \$1.0605 trillion for 1994 health expenditures is, to our knowledge, the largest estimate yet made by any governmental agency for 1994 health expenditures. **The increase from 1993 to 1994 of \$118 billion dollars is also the largest one-year increase ever in health expenditures and is greater than the total U.S. health expenditures just 20 years ago, in 1974.** (the 1974 U.S. health expenditures were, according to Commerce Dept. data not included in this report, \$116.1 billion). The current report also estimates that outlays for hospital care will increase 12.5% to \$408.8 billion in 1994. Expenditures for physicians services will amount to an estimated \$194.9 billion, an 11.2% increase over 1993, while spending for nursing homes and home care will approach \$85.5 billion, a 12.5% increase.

In addition, because of the still weakened U.S. economy, **the percent of the gross domestic product (GDP) which went for health expenditures was an all-time record in 1993 and "surpassed 14 percent of the GDP". For 1994, the Commerce Department is again projecting that health expenditures will amount to a new record, 15% of the GDP.** In other words, more than one out of every seven dollars in our economy will be spent for health, despite the fact--based on data from mid-1992--that more than 38 million Americans were without health insurance. By now, late 1993, the number is probably 40 million or greater. As more and more people are unemployed, the ranks of the uninsured will grow even more rapidly.

CONTINUING DOUBLE DIGIT INFLATION PROJECTED

Another extremely troubling aspect of the Commerce Department report is the projection for increasingly uncontrolled health expenditures for the next five years. It states that **"Without reform, health care expenditures are projected to rise by an average annual rate of growth of 13.5% during the next five years."**

Assuming increases of 13.5% each year for the next five years, we have calculated that this would result in 1995 national health expenditures of \$1.2037 trillion, with projected expenditures of \$1.997 trillion by 1999. This would mean that in just six years, 1993-1999, there will be more than a doubling of expenditures with an increase of more than \$1.05 trillion, an increase which exceeds the projected total U.S. health expenditures in 1993 of \$942.5 billion.

Having stated that "The health care system will likely be reformed based on managed competition..", the Commerce Department pessimistically but, we believe, realistically states that "...even with [this] reform, if one were to apply the theory of rational expectation, then health care revenues would not be dampened, but continue to rise. Providers would find alternative means to increase health care prices, shift prices, hoard inventories, and incur capital costs to be passed on to consumers."

WHY HEALTH CARE EXPENDITURES ARE OUT OF CONTROL

Among the causes for these year-after-year unaffordable increases in health expenditures and the fact that the U.S. spends twice as much [per capita] on health care as the average for the 24 industrialized countries in Europe and North America, according to the Commerce Dept. report, "the greater [than other countries] amount of spending for health care in the United States goes to support: Regulation and administration---estimates of insurance [induced] overhead account for nearly 25% of total spending . By contrast, administrative costs in other industrialized countries total 11% or less." Elsewhere in the report, the Commerce Department states that the health industry "supports 1100 health insurance companies."

WHY SHOVING MOST PEOPLE INTO HMO'S IS NOT THE ANSWER

Not surprisingly, a managed competition strategy based on marketplace competition between HMO's will work less well as the HMO industry becomes concentrated. According to the Commerce Dept. report, there was a sharp decrease in the number of HMO's between 1987 and 1992, from 662 in 1987 to 544 in 1992 although the total number of enrollees increased from 29.3 million to 41.4 million. (by 1993, the estimate is 45 million). Not only are there 41% more people in 18% fewer HMO,s but, according to a September, 1993 Marion Merrell Dow study, 45% of the HMO's in the country are now owned by Aetna, Cigna, Humana, MetLife, Prudential, Travelers, United Health Care or Blue Cross.

One reason why HMO's do not save as much money as they are touted to, aside from the often-documented evidence that they skim off healthier patients, is their extraordinary profitability. According to the Commerce Dept. report, "HMO's had the highest overall profit gain of the 50 largest public traded U.S. health care companies...The average [profit] gain [from first quarter 1992 to first quarter 1993] was 40%." Little wonder that HCFA (HHS's

Health Care Finance Administration) Director Bruce Vladeck has recently been quoted as saying that he "would not aggressively promote HMO's for [Medicare] recipients" because "the Government loses money on people enrolled in such plans".

But aside from the economic reasons against managed competition based on HMO's for almost everyone, there are other persuasive arguments.

A recent (March 27, 1993) article in the Lancet, by William Glazer, one of the world's authorities on international health comparisons, stated that: HMO's were invented not by Americans but by Europeans; they are not new but were the most common way of organizing health insurance a century ago. At that time, workers joined a sickness fund, the fund hired its own doctors on capitation fees or salaries, the fund had agreements with certain hospitals, and a patient consulted out-of-plan providers only by paying out-of-pocket. Because the public opposes lock-ins, subsequent national health insurance laws have guaranteed that every insured person can consult any doctor and hospital..... HMO's can not survive under national health insurance laws. They endure only in the United States, which alone lacks the national health insurance laws that guarantee free choices by patients and doctors."

Glazer's article, entitled "The Competition Vogue and its Outcomes", ends by stating that " America's destiny is supposed to lie in economic markets, and the market must be made to work successfully in health. If facts deviate, they must be forced to conform; if the facts prove recalcitrant, they must be imagined away, since only the theory is true. Perhaps some day the facts will prove inescapable."

WHY NOT A SINGLE PAYER SYSTEM?

As we have stated previously, there would be enormous annual administrative savings from going to an improved American version of Canada's single payer system--which eliminates the wasteful role of the private insurance industry and all of the paperwork it foists on hospitals, doctors, nursing homes and the rest of the health care system. Current estimates of these savings are over \$100 billion a year and, unlike the Clinton plan--and all other plans--universal coverage for all Americans could occur now, not in 1998, by the millennium, or never. In addition, Americans would not be increasingly forced to switch doctors to save money since the Canadian system allows patients the choice of all doctors.

Health and Medical Services

Expenditures on health care (SIC 80) in the United States are expected to rise by more than 12 percent in 1994 to exceed \$1 trillion for the first time. Continued growth is envisioned for home health care as well as managed care organizations for the balance of the decade. The reduction of consistent double-digit rates of increase in health care expenditures will require a sustained national commitment and accommodation by health care providers and consumers.

Before reading this chapter please see "Getting the Most Out of Outlook '94," on Page 1. That section will answer questions you may have concerning data collection procedures, forecasting methodology, and sources and references. For other topics related to the health care industry, see chapters 5 (Construction), 43 (Drugs), 44 (Medical and Dental Instruments and Supplies), and 52 (Insurance).

The health care industry consists of public, private, and non-profit institutions. These institutions are hospitals; offices and clinics of medical doctors; nursing homes; other specialized health care facilities; managed care consisting of pre-paid plans such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and independent practice associations (IPAs).

The health care industry generated more than \$942.5 billion in expenditures in 1993, and employed more than 10 million people including 2 million nurses, more than 650,000 doctors, and 150,000 dentists. The industry supports 126 medical schools and approximately 6,600 hospitals; 1,100 health insurance companies; and 25,600 nursing care facilities.

The nation's health care services industry includes thousands of independent medical practices and partnerships, as well as public and non-profit institutions, and major private corporations. America's complex health care system is a leader in the use of sophisticated and expensive technology.

Dynamics of the Health Care Industry

The dynamism of this industry is reflected in part by its contribution to the national output as well as the social well being of the population. Since Federally sponsored health care began in 1965, the nation's health care expenditures have risen from \$41.6 billion, or about 6 percent of the gross domestic product (GDP), to an estimated \$942.5 billion in 1993, representing more than 14 percent of GDP.

Modern technologies have contributed significantly to the worldwide delivery of high-quality health care. Besides developing new medical technologies, the United States probes the mysteries of disease through basic and clinical research.

Trends and Forecasts: Health and Medical Services

(in billions of dollars except as noted)

Item	1987	1988	1989	1990	1991 ¹	1992 ²	1993 ²	1994 ³	Percent Change (1987-1994)						
									87-88	88-89	89-90	90-91	91-92	92-93	93-94
National health expenditures . . .	495.2	547.2	605.4	676.3	753.1	840.4	942.5	1,060.5	10.5	10.6	11.7	11.4	11.6	12.1	12.5
Health services and supplies . . .	476.9	526.2	583.6	652.4	728.6	813.9	914.0	1,029.6	10.3	10.9	11.8	11.7	11.7	12.3	12.6
Personal healthcare	439.3	482.8	530.9	591.5	660.2	739.0	830.2	934.8	9.9	10.0	11.4	11.6	11.9	12.3	12.6
Hospital	194.2	212.0	232.4	258.1	288.6	323.2	363.4	406.8	9.2	9.6	11.1	11.8	12.0	12.4	12.5
Physicians' services	93.0	105.1	116.1	128.8	142.0	157.1	175.2	194.9	13.0	10.5	10.9	10.2	10.6	11.5	11.2
Dentists services	27.1	29.4	31.6	34.1	37.1	40.4	44.2	47.5	8.5	7.5	7.9	8.8	8.9	9.4	7.5
Other professional services . .	21.1	23.8	27.1	30.7	35.8	41.7	47.4	54.0	12.8	13.9	13.3	16.6	16.5	13.7	13.9
Home health	4.1	4.5	5.6	7.6	9.8	12.7	16.5	22.2	9.8	24.4	35.7	28.9	29.6	29.9	34.5
Nondurable medical products .	43.2	46.3	50.5	55.6	60.7	66.4	72.6	80.2	7.2	9.1	10.1	9.2	9.4	9.3	10.5
Durable medical equipment . .	9.1	10.1	10.4	11.7	12.4	13.2	14.2	15.5	11.0	3.0	12.5	6.0	6.5	7.6	9.2
Nursing home care	39.7	42.8	47.7	53.3	59.8	67.3	76.0	85.5	7.8	11.4	11.7	12.2	12.5	12.9	12.5
Other personal health care . . .	7.8	8.7	9.8	11.5	14.0	17.0	20.7	25.2	11.5	12.6	17.3	21.7	21.4	21.8	21.7
Administration	23.0	26.9	33.8	38.9	43.9	48.6	54.3	61.9	17.0	25.7	15.1	12.9	10.7	11.7	14.0
Government public health activity .	14.6	16.6	18.9	22.0	24.5	26.3	29.4	32.9	13.7	13.9	16.4	11.4	7.3	11.8	11.9
Research and construction	18.2	21.0	21.8	23.9	24.5	26.5	28.5	30.8	15.4	3.8	9.6	2.5	8.2	7.5	8.1
Research ⁴	9.0	10.3	11.0	11.9	12.6	13.3	14.1	15.0	14.4	6.8	8.2	5.9	5.6	6.0	6.4
Construction ⁵	9.2	10.7	10.8	12.0	11.9	13.2	14.4	15.8	16.3	0.9	11.1	-0.8	10.9	9.1	9.7

¹Preliminary.

²Estimate.

³Forecast.

⁴Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures," but they are included in the expenditure class in which the product falls.

⁵Benchmark data by HCFA.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: U.S. Department of Health and Human Services: Health Care Financing Administration (HCFA), Office of the Actuary; U.S. Department of Commerce: International Trade Administration (ITA). Estimates and forecasts by ITA.

Through the development of new diagnostic tools and treatments, the United States increases the effectiveness of medical care worldwide. In 1991, total health research and development spending amounted to an estimated \$25.6 billion with the Federal Government contributing more than half.

Many foreign students come to the United States to pursue their medical education. Upon completion, they return home to apply their knowledge and skills. In addition, many affluent foreign patients come to the United States for health care treatment. Education of foreign students and treatment of foreign patients contributes to a services surplus in the U.S. balance of payments.

Some aspects of the health care industry contribute to rising costs for consumers, businesses, states, and the Federal Government. There are also areas that most observers agree receive too few resources, such as immunizations against disease and other preventive procedures.

In regard to costs, the health care market is unique among industries. For most products and services, the purchaser knows the price, quantity, and quality of the goods before consumption. However, in the health care market price information is not generally available. To further complicate the cost issue, the health care industry is dominated by third-party providers in the form of private insurers and publicly funded Medicare and Medicaid that insulate patients from assessing price. The persistent rise in health care costs has absorbed much of the growth of employees' real compensation in the past two decades. Increasing health care costs discourage worker mobility, particularly among older workers who are concerned about losing insurance coverage. Approximately half the estimated 37 million uninsured Americans are in the 16-to-34 age group that is entering the workforce or generally undergoing the most frequent job changing. In the 1980's and 1990's, increasing health care costs have put pressures on budgets of Federal, state, and local governments. Both workers and governments have less to spend on other priorities.

Health Care Expenditures

The cost of the nation's health care (SIC 80) rose about 12 percent in 1993 to reach an estimated \$942.5 billion, or about \$3,900 per capita. By 1993, the U.S. health and medical care

sector outlays amounted to 14 percent of the nation's economy. As health care expenditures have risen, there has been an accompanying shift from the private to the public sector. Private sector health care expenditures represented about 54 percent of total health care spending in 1992, down from 58 percent in 1980. Medicaid programs accounted for most of the 4 percent increase from 1980 to 1992.

International Comparisons

In 1990, on a per capita basis, health care expenditures among nations ranged from a low of \$2 to more than \$2,700. Low-income countries, such as Bangladesh, India, Pakistan, Egypt, and most sub-Saharan African countries with per capita income of \$100 to \$600 spend between \$2 to \$40 per individual on health care. Another set of countries called middle-income, whose per capita income ranges between \$600 and \$7,900, spend about \$20 to \$400 per capita on health care services. Among them are South Africa, Zimbabwe, Costa Rica, South Korea, Turkey, Poland, and the republics of the former Soviet Union. Established-market economies whose per capita income ranges between \$5,000 and \$34,000 consume per capita health care expenditures of \$400 to \$2,500. However, the United States, with a per capita income of \$22,000, spent more than \$2,700 on health care services in 1990 (Table 1).

With the exceptions of the United States and Egypt at the high and low extremes, per-capita expenditures fall in a general range for most countries, which suggests there are potential growth markets for health care in many countries. As countries become more developed, they spend a greater share of their income on health care services.

Health Care Services Revenue

Despite the 1.2 percent decline in the U.S. economy from 1990 to 1991, the Census Bureau estimated health care services revenue rose 9.5 percent from an estimated \$521.7 billion to \$571.3 billion. The highest revenue growth areas occurred in home health care services (19.2 percent), kidney dialysis centers (18 percent), specialty outpatient facilities (17.4 percent), and nursing and personal care facilities (15.7 percent). Hospitals realized a 10.8 percent increase, while offices and clinics of doctors of medicine grew 7.2 percent during that

Table 1: International Health Care Spending

(in dollars except as noted)

Country	Income per capita ¹	Spending per capita ²	Health care expenditures as a percent of 1990 GDP		
			Public	Private	Total
Mozambique	80	5	4.4	1.5	5.9
Bangladesh	220	7	1.8	1.9	3.7
Egypt	610	18	1.0	1.6	2.6
India	330	21	1.3	4.7	6.0
Bolivia	650	25	2.4	1.6	4.0
Poland	1,790	83	4.1	1.0	5.1
Mexico	3,030	89	1.6	1.6	3.2
Brazil	2,940	132	2.8	1.4	4.2
South Africa	2,560	158	3.2	2.4	5.6
South Korea	6,340	377	2.7	3.9	6.6
United Kingdom	16,550	1,039	5.2	0.9	6.1
France	20,380	1,869	6.6	2.3	8.9
Canada	20,440	1,945	6.8	2.4	9.2
Sweden	25,110	2,343	7.9	0.9	8.8
United States	22,240	2,763	5.6	7.0	12.6

¹Gross domestic product per capita in 1991.

²Health care expenditures per capita in 1990.

SOURCE: World Bank, *World Development Report 1993*.

period. Hospitals accounted for 53 percent of all revenues for the health services industries in 1991. Hospital revenues rose by \$29.7 billion to reach an estimated \$305.9 billion in 1991, the Census Bureau reported.

According to the Census Bureau, these estimates are obtained from a sample of health care businesses and do not include income that self-employed individuals received for delivering health care services. From the estimated \$521.7 billion in revenues, annual receipts for taxable firms in health services amounted to \$245.7 billion. In 1990, hospital taxable receipts were estimated at \$25.2 billion out of their \$276.2 billion in revenue representing about 9.1 percent of total revenue.

Health Care Industry Employment

Health care is a leading employment sector in the economy. Employment rose steadily from 9.1 million in June 1990 to 10.2 million in June 1993, an average annual increase of 3.8 percent despite the 1990-91 recession and the weak economic recovery. Health care employment surpasses that of transportation and public utilities (5.7 million); wholesale trade (6.1 million); and finance, insurance, and real estate (6.6 million).

Employment has grown in all health care sectors, especially in home care, nursing, and personal care facilities, offices and clinics of medical doctors and dentists, and hospitals (Table 2). The highest growth rate occurred in home health care services where employment rose an average annual pace of 17.6 percent from 290,900 in June 1990 to 473,100 in June 1993. Hospitals have the lowest rate of growth, but accounted for more than half of the total employment in the industry.

Medicare and Medicaid

Medicare and Medicaid programs are subject to statutory and regulatory charges; administrative rulings, interpretations, and determinations; and governmental restrictions. All such charges may materially increase or decrease payments to hospitals, physicians, and other medical providers. During the 1980's, as Medicare and Medicaid programs became costlier, their financing was

reduced. Consequently, Federal and state governments tightened regulations on publicly financed medical programs.

Medicare and Medicaid pay hospitals, physicians, and other medical providers for services to qualified patients. In 1992, Medicare payments under its Hospital Insurance provision increased an estimated 8.5 percent to approximately \$84 billion. Of the payouts, nearly \$82 million was collected in the form of payroll taxes on employers and their workers. Medicare payments under the Supplementary Medicare Insurance program for physicians, outpatient hospital care, and other health services totaled nearly \$51 billion in 1992. SMI enrollees paid premiums that covered less than 30 percent of the outlays. Government subsidies made up the difference.

Medicaid program expenditures grew by 33.2 percent to \$100 billion in 1991, surpassing its 21.3 percent increase in 1990. This growth in expenditures was the result of 3 million additional people who qualified under the program due to the recession, Federal mandates to expand the program, and an increase in Federal payments to hospitals and nursing homes. In addition to the growth in the number of recipients, the growth in payment per recipient accelerated from \$2,516 in 1989 to \$3,412 in 1991 (Table 3).

Many states that administer the Medicaid program opted for donated funds and imposed provider-specific taxes to finance it. As states received more taxes and donations (T&D), the Federal matching fund share for T&D automatically increased. These T&D programs increased both the Federal share to be paid for Medicaid and the Federal matching rate.

Home Health Care

Home-delivered health and medical services are being increasingly recognized as vital components of comprehensive health care and local health-planning activities. High hospital and nursing home care costs have underlined the need for alternative, less expensive ways to deliver care to the elderly sick who do not require continuous institutional care.

Many people with chronic illnesses can be adequately cared for in a home setting if some type of nursing care and supportive

Table 2: Health Care Services Employment 1990-1993*

Item	1990	1991	1992 ¹	1993 ²	Percent Change 1990-93		
					90-91	91-92	92-93
Health Services	9,147.2	9,500.9	9,856.3	10,239.4	3.9	3.7	3.9
Offices and clinics of medical doctors	1,342.1	1,407.1	1,470.0	1,547.9	4.8	4.5	5.3
Office and clinics of dentists	516.5	528.9	535.8	562.0	2.4	1.3	4.9
Nursing and personal care facilities	1,415.6	1,494.8	1,539.9	1,614.5	5.6	3.0	4.8
Home health care services	290.9	345.7	401.0	473.1	18.8	16.0	18.0
Hospitals	4,869.2	4,963.9	5,098.0	5,184.6	1.9	2.7	1.7

*Fiscal years ending June 30.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics.

Table 3: Medicaid Recipients and Health Care Expenditures, 1988-1991

Item	1988	1989	1990	1991	Percent Change 1988-91		
					88-89	89-90	90-91
Number of recipients ¹ (millions)	22.9	23.5	25.3	28.3	2.6	7.7	11.9
Expenditures per recipient ²	2,274	2,516	2,837	3,412	10.6	12.8	20.3

¹Fiscal year ending Sept. 30 as reported on Health Care Financing Administration Form 2082.

²Calendar year expenditures in dollars.

SOURCE: U.S. Department of Health and Human Services: Health Care Financing Administration, Office of the Actuary; Office of National Health Statistics.

services are available. Home care agencies are filling this void. There were an estimated 12,500 home care agencies in the United States in 1992, including 6,129 Medicare certificate home health agencies, and 1,100 certified hospices. The remaining 5,258 were home health agencies, home care aid organizations, and hospices that do not participate in the Medicare program.

The number of Medicare-certified home health agencies increased nearly 6 percent from 5,785 in 1987 to 6,129 in 1992. During the same period, the number of proprietary home health agencies also increased nearly 6 percent from 1,846 to 1,953.

The latest National Medical Expenditure Survey indicates that a variety of health care providers administered home care services to 5.9 million Americans in 1987.

Demographics, technology, cost-effectiveness, and consumer choice should provide added momentum for the expansion of the home care sector. President Clinton's proposal for health care reform includes a significant initiative to expand home and community care for elderly and disabled Americans. Under health care reform, the nationally guaranteed benefit package also covers home-based care following an acute illness.

Continuing Care Retirement Communities

An estimated 900 continuing care retirement communities (CCRCs) in the United States provide continuing care for more than 270,000 residents who are still ambulatory. CCRCs provide coordinated housing and health-related services to older individuals under an agreement which may last as little as 1 year or as long as the life of the individual. CCRCs provide campus-style living with convenient services such as house-keeping, meals, and health care. The most significant of these is long-term nursing, which is often very expensive and usually not covered by Medicare.

Typically, a healthy, active elderly person moves into residential accommodations (apartment, townhouse, single-family home). Many activities and levels of care are available, such as assisted living and skilled nursing care. There is usually a resident health clinic that coordinates preventive health care and medical services.

Health care services are at the heart of the continuing care concept. These services include emergency response system, resident health clinic, wellness programs, health education, hospice services, nursing advice, physician services (primary and specialty), podiatry services, dental services, pharmacy services, therapies, assisted living, and nursing care.

Managed Health Care

Managed health care, a system of prepaid plans providing comprehensive coverage to voluntarily enrolled members, continues as the growth leader in the health care industry.

Providers of managed care include health maintenance organizations (HMOs) and preferred provider organizations (PPOs), as well as traditional indemnity insurance companies.

Prepaid managed care is designed to control the use of health care services so that these services are provided cost effectively. Because traditional indemnity plans or programs do not control health care costs effectively, employers, including the U.S. Government, are offering their employees the opportunity to join HMOs and PPOs. Currently, HMOs and PPOs service more than 25 percent of the U.S. population, up from 3 percent in the 1970's.

The number of HMO plans decreased from 662 in 1987 to 544 in 1992, but the number of enrollees increased from 29.3 million to 41.4 million due to greater efforts by employers who prefer these plans. In 1993, HMO enrollment reached an estimated 45 million. The decline in the number of HMO plans is due to mergers and acquisitions and consolidations and terminations (Table 4).

Every measure of HMO median rates of return was positive for 1990. Rates of return are measures of the ability of an HMO to generate funds. HMOs reported a median net rate of return on assets of 8.8 percent, a median net rate return on revenues of 2.5 percent, and a median net return on equity of 33 percent. Industry earnings in 1990 were \$1.39 billion before taxes on revenue of \$45.61 billion. Eighty percent of HMOs reported positive gross income in 1990.

For the first quarter of 1993, industry data indicated HMOs had the highest overall profit gains for the 50 largest public traded U.S. health care companies. According to the *Jenks Health Care Business Report*, first-quarter earnings showed that seven HMOs listed among the Jenks Top 50 posted higher profits in the first quarter of 1993 than in the first quarter of 1992. The average gain was more than 40 percent.

PPOs, a modified version of HMOs, increased from 692 in 1987 to 978 in 1991. The number of eligible family members of those employees has increased from 28.0 million in 1987 to 85.0 million in 1991, a threefold increase.

PPOs have a weaker incentive to control utilization than do HMOs. PPOs permit enrollees to use non-plan providers (hospital and physicians), but cover less of non-plan provider costs. PPOs use various management programs such as recertification, concurrent review, and discharge planning to reduce patient use of unnecessary services.

The rapid growth of HMOs and other managed care organizations has somewhat restrained the expansion in hospital services, including the number of inpatient admissions. Some health care critics have expressed concern about the quality of care provided by managed health care organizations, although there is no real evidence that the trend toward managed care has had a negative effect on quality. Others maintain that managed care may have more of a positive effect on quality care than the traditional fee-for-service indemnity insurance system. Moreover, managed care plans offer more coverage than indemnity plans, especially in the area of

Table 4: HMO Plans and Enrollment, 1987-1993

Item	1987	1988	1989	1990	1991	1992	1993 ¹	Percent Change (1987-93)					
								87-88	88-89	89-90	90-91	91-92	92-93
Number of Plans	662	614	591	569	550	544	—	-7.3	-3.7	-3.7	-3.3	-1.1	—
Enrollment ²	29.3	32.7	34.7	36.5	38.6	41.4	45.0	11.6	6.1	5.2	5.8	7.3	8.7

¹Estimate by U.S. Department of Commerce, International Trade Association.

²In millions of enrollees.

SOURCE: Group Health Association of America, Inc.

preventive medical expenses where HMOs have ongoing wellness programs including programs for smoking cessation, prenatal care, and, diet and nutrition counseling.

Industry experts, health care administrators, legislators and various health care interest groups, realizing that managed care is rapidly expanding, are beginning to ask whether managed care companies can assure patients that the quality of care they receive will be protected. As a result, Congress has mandated peer review of HMOs and other competitive medical plans by professional review organizations. The indications are that with a few adjustments these managed care organizations will continue to play a leading role in providing health care to the nation.

Managed competition lies at the heart of the President's proposal to reduce health care costs, and to provide care for the uninsured. Reform or not, managed care through HMOs and PPOs is already dominating the market.

Licensure of Health Care Market

Licensure of medical facilities in the United States involves a variety of regulators with no one agency or level of government responsible for maintaining the integrity of all providers. State and local government, the Federal Government, the National Governors Association, and private trade associations such as the American Medical Association and the American Hospital Care Association all play a part in ensuring that health care facilities are safe.

The Federal Government has provided a licensure process, a survey and certification process, for those who wish to participate in the public financing programs of Medicare and Medicaid.

Survey and certification state agencies, usually the state Health Departments, with which the Department of Health and Human Services enters into agreements, are responsible for conducting various survey and certification activities on the part of the Federal Government. These activities ensure that facilities receiving payment under Medicare and Medicaid meet certain conditions of participation established by regulation. The state agency of the Health Care Financing Administration (HCFA) regional office "certifies" the conditions of participation, thus allowing providers to participate in the Medicare and Medicaid programs. The Secretary of Health and Human Services agrees to provide funds to the states for a portion of the costs of performing these functions.

Facilities subject to survey and certification requirements are hospitals, nursing homes, home health agencies, ambulatory surgical centers, intermediate care facilities for the mentally retarded, rehabilitation facilities, hospices, rural health clinics, end-stage renal disease facilities, and screening mammography facilities. In addition, the Clinical Laboratory Improvement Act of 1988 requires HCFA to survey clinical laboratories, not just those participating in Federal or state programs.

When an initial on-site survey of a provider seeking entry into Medicare or Medicaid demonstrates that the provider meets the necessary conditions of participation, that entity is permitted to participate. If the periodic recertification of an existing provider identifies serious deficiencies, HCFA may impose sanctions or terminate the providers participation. However, the provider is generally given a reasonable amount of time to correct deficiencies before adverse action is taken. If a deficiency poses an immediate and serious threat to patient health and safety, the entity's participation may be terminated immediately.

The Secretary of Health and Human Services has, pursuant to the Social Security Act, recognized certain national accreditation organizations, such as the Joint Commission of the Accreditation of Health Care Organizations, as having standards that are equivalent to the Medicare requirements. Providers and suppliers accredited by these organizations have "deemed status" therefore, are deemed to meet Medicare requirements, and need not undergo routine surveys in order to participate. Currently, about 5,300 of the 6,700 Medicare hospitals have deemed status.

Health Care Reform

The President's Task Force on Health Care Reform completed its work in late summer 1993. The President's proposal for national health care reform initiated a major national debate that is playing a commanding role on the agenda of the current session of Congress.

The inclusion of the uninsured (while various interest groups scramble to maintain, increase or gain their market share of the industry), probably will increase health care expenditures, but not at the rate that occurred during the 26 years since the 1965 enactment of Medicare and Medicaid. The focus of the reform is to provide cost-effective health care for all Americans. Currently there are 37 million Americans who are uninsured or underinsured and more than 14 percent of the GDP is spent on health care services, the highest among all nations.

The concept of managed competition is focused on market establishment of a health services purchasing strategy. It is designed to promote competition and reward providers and insurers for efficient health care delivery in terms of cost, access, quality, and consumer satisfaction. This system would establish health purchasing alliances to organize purchasers of health care within a region or state. Within a national framework and to implement a nationally guaranteed, comprehensive health benefit package, states would set standards for competing health plans offered through alliances.

Consumers would have information on health care prices and quality and would be able to make choices on an annual basis as to which plan to purchase. This system would be non-discriminatory so that high-risk clients would obtain health care coverage at a reasonable price. The plan provides a safeguard called "budget target" in case competitive-market forces fail to control rising costs.

This plan is proposed to be affordable for small businesses that would provide coverage for employees who otherwise would have been uninsured. Major national corporations may organize their own corporate health alliances and continue covering their employees through them, although they must comply with national guarantees related to providing the comprehensive benefit package, quality, and other critical factors.

INTERNATIONAL COMPETITIVENESS

Without reform, the annual cost of health care for a family in the United States may reach \$14,000 by the end of the decade. In 1992, average per capita spending for health care in United States totaled \$3,160 a year, up from \$1,000 in 1980. The United States spends twice as much on health care as the average for the 24 industrialized countries in Europe and North America. The economic drain on U.S. society represented by higher and rising health care costs threatens to jeopardize the United State's competitive position in international trade.

Glossary

Medicaid—Medicaid is a federally supported and state-administered assistance program providing medical care for certain low-income individuals and families. Medicaid covered more than 31.2 million people at a cost of \$91.5 billion in 1992.

Medicare—A U.S. government program that pays hospitals, physicians, and other medical providers for serving patients aged 65 years and older, certain disabled people, and most persons with end-stage renal disease (ESRD).

Medicare enrolls approximately 34 million people, including 3.5 million disabled. An estimated 97 percent of Medicare enrollees are elderly. Medicare consists of two basic programs: Part A, or Hospital Insurance (HI) and Part B, or Supplementary Medical Insurance (SMI).

Hospital Insurance (HI)—HI is the Medicare program that pays for inpatient hospital care, skilled nursing facility care, home healthcare, and hospice care. Payments under the HI Program are made from a trust fund which is financed primarily from payroll taxes. In 1993, employees and employers each paid a payroll tax of 1.45 percent on income up to \$135,000. Self-employed persons paid 2.9 percent in 1992 and 1993.

Supplementary Medicare Insurance (SMI)—The SMI program pays for services from physicians, outpatient hospital services, home health agencies, independent laboratories, and group practice prepayments. SMI funding comes primarily from government contributions, plus premiums paid by eligible people, those over 65 years old and disabled people under 65.

Continuing Care Retirement Communities (CCRCs)—CCRCs in the United States provide continuing care for more than 270,000 Americans aged 75 to 78. CCRCs provide coordinated housing and health-related services to older individuals under an agreement which may last as little as one year or as long as the life of the individual.

CCRCs services include emergency response system, resident health clinic, wellness programs, health education, hospice services, nursing advice, physician services (primary and specialty), podiatry services, dental services, pharmacy services, therapies, assisted living, and nursing care.

Continuing care has three different healthcare coverages based upon the agreement one has with the CCRC: extensive, fee-for-service, and modified.

Extensive Agreement—The extensive agreement covers most health-related services including long-term care. The services are provided without additional costs.

Fee-for-Service Agreement—The fee-for-service agreement requires payment for health-related services, including long-term care, as they are delivered.

Modified Agreement—The modified agreement covers some health-related services, including some long-term care. The agreement is expressed as a number of days per year or as a lifetime of long-term care.

Health Maintenance Organization (HMO)—HMOs provide "managed healthcare" services, usually in their own facilities.

Preferred Provider Organizations (PPO)—PPOs provide "managed healthcare" services. PPOs are a modified version of HMOs. PPO enrollees are offered incentives to limit their provider selection to preferred providers.

Home Health Care—Home healthcare is a method of providing services to disabled people in their homes rather than in medical facilities.

During 1992, general government contributions amounted to \$38.7 billion or 72.7 percent of all SMI income. The remaining \$14.5 billion or 27.3 percent came from premiums paid by SMI enrollees, interest, and other income. About 33.8 million persons were enrolled under SMI in 1992.

Home Care Agencies—Home health agencies, home care aid organizations, and hospices are known as home care agencies.

Managed Health Care—Managed healthcare is a system of prepaid plans providing comprehensive coverage to voluntarily enrolled members. Managed healthcare typically covers professional fees, hospital services, diagnostic services, emergency healthcare services, limited mental services, medical treatment for drug or alcohol abuse, home health services, and preventive healthcare.

Although the United States spends more on health care than any other industrialized nation, a lower proportion of U.S. citizens have health insurance coverage and a typical insurance policy provides less coverage than in any other industrialized nation.

According to industry studies, the greater amount of spending for health care in the United States goes to support:

- Inappropriate care and inefficient systems—some estimates put the level of unnecessary tests and procedures at \$130 billion per year.
- Regulation and administration—estimates of insurance overhead account for nearly 25 percent of total spending. By contrast, administrative costs in other industrialized countries total 11 percent or less.

Over the past 20 years, the wages of U.S. workers have fallen in real terms while health care costs have climbed 10 to 15 percent each year. For small businesses, premiums have risen by as much as 50 percent annually. Skyrocketing health care costs make it harder for U.S. companies to compete in the global marketplace. Health care costs add more than \$1,100 dollars to the price of every car manufactured in the United States—Japan spends half of this amount. In 1990, General Motors spent \$3.2 billion in medical coverage for its 1.9 million employees and retirees. That is more than the company spent on steel.

Without health care reform, it is projected that the cost of health care will rise from 14 percent of GDP today to 18 percent in the year 2000. In other words, without reform, in less than 10 years, almost one dollar out of every five dollars earned by people living in the United States will go to cover the cost of health care.

If the United States were able through health reform to achieve a level of spending comparable to other countries, the United States could save about 4 percent of GDP. Those savings could be reallocated to investments in other areas such as training and production, thus enhancing the U.S. competitive position.

The International Health Care Market

Internationally, health care spending amounted to an estimated \$1,700 billion in 1990, 8 percent of the world's income. The share of the public and private sectors was 40 and 60 percent respectively. In the developing countries of Africa, Asia, and Latin America, health care expenditures totaled \$170 billion, 10 percent of the world's health care market. By contrast, the United States accounted for approximately 40 percent of global spending on health care.

The business climate in many of countries appears favorable for U.S. health care companies to expand. The prospects in Western Europe, Mexico, and in Japan are viewed as particularly

promising. In some foreign markets, U.S. firms face trade and regulatory barriers. This is very visible in Japan where foreign ownership of health care firms is prohibited. The best opportunities for U.S. health care providers are in the areas of primary care, home care, and nursing home care services. In addition, opportunities exist in hospital management, ancillary services, private health insurance, and drug rehabilitation programs.

Governments of many nations have made health care a centerpiece of their social policy, and are providing steady annual budget increases for health care. The World Bank annual *World Development Report* calls for \$2 billion of increased official development assistance for health care to the developing countries. The World Bank, in particular, will be the largest single source of external funding for health care by 1995; with \$1 billion to be disbursed annually. Other development banks are expected to follow the World Bank's lead, and increase their expenditures. Rising health care budgets could present significant commercial opportunities to U.S. health care firms.

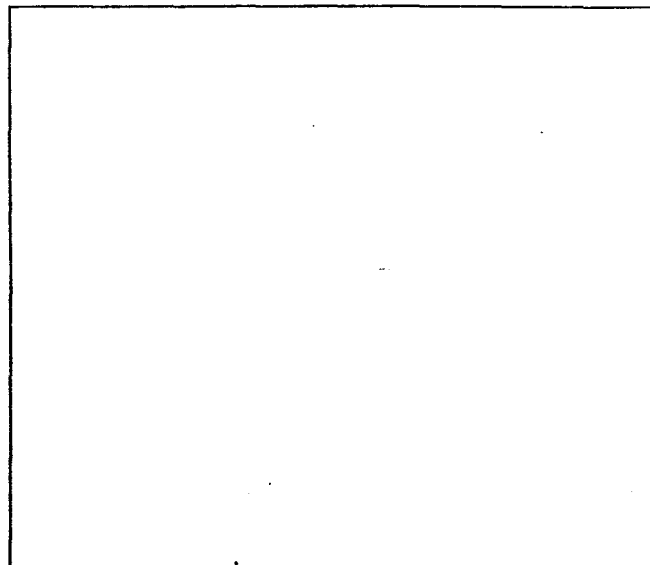
Russia and Eastern Europe

In Eastern Europe, Russia, and other successor states to the former Soviet Union, the painful macroeconomic adjustments accompanying transition to more market-oriented economies have not prevented the establishment of medical service operations by foreign providers. This development has been encouraged by the generally poor quality of treatment provided, the breakdown of state-run distribution and supply channels, and worsening environmental conditions in these states. Hungary, Poland, and the Czech Republic have offered the most numerous opportunities thus far in Eastern Europe in line with these countries' earlier steps to attract foreign investment and, particularly in the Polish case, to decentralize budgetary allocations for health care. Foreign and U.S. health care providers have capitalized primarily on small-scale undertakings such as medical clinics and Health Maintenance Organizations. Private and supplementary health insurance

Reasons for Rising Health Care Expenditures

Factors contributing to the rising costs of health care are numerous and well-known. They include the following:

- Use of sophisticated, expensive technologies.
- Duplication of tests and sometimes duplication of technologies which yield similar results.
- Increases in variety and frequency of treatments including arguably unnecessary tests.
- Increasing number and longevity of the elderly.
- Regulations that result in cost shifting rather than cost reduction.
- Increasing number of accidents and crimes that require emergency medical services.
- Limited competition and restrictive work rules in the health care delivery system.
- Labor intensiveness and rapid average earnings growth for health care professionals and executives.
- Built-in inflation in the health care delivery system.
- Other major factors, which cost billions of dollars each year, are fraud, administrative waste, malpractice insurance, excessive surgical procedures, a wide range of prices for similar services, and double health coverage including medigap.



Kaiser Permanente

Health care expenditures are expected to increase by more than 12 percent in 1994 to exceed \$1 trillion for the first time

represents another area of opportunity because of a greater stabilization of the inflation rate in the above three countries compared with the former Soviet Union.

As the most populous of the Soviet successor states, Russia and Ukraine present the most promising long-term markets there for U.S. health care providers, despite the present shortage of hard currency and persisting inflationary pressures. Immediate prospects are proving most favorable in regions rich in oil or other marketable raw materials, such as Russia's Ural Mountain region or Tatarstan, where health care facilities are being constructed for workers and some hard currency exists. The reduction of central government authority in Russia and increasing regional access to financial resources have resulted in opportunities for service firms seeking to open and manage diagnostic clinics, private physician practices, and mini-hospitals. Maternity care and home health care represent two secondary areas for health care providers' activity in these states.

Outlook for 1994

The probability is good that health care reform in the United States will be enacted into law following intensive discussion and debate. More small businesses and uninsured individuals will begin to gain greater access to health care services. However, even with reform, if one were to apply the theory of rational expectation, then health care revenues would not be dampened, but continue to rise. Providers would find alternative means to increase health care prices, shift prices, hoard inventories, and incur capital costs to be passed on to consumers.

Health care expenditures in 1994 are expected to increase 12.5 percent to \$1,060 billion, or 15 percent of GDP. Outlays for hospital care are expected to increase 12.5 percent to \$409 billion. Expenditures for physicians' services are expected to increase 11 percent to an estimated \$195 billion while those for nursing home care will rise 12.5 percent to \$85.5 billion. Home care, the fastest growing health care sector, is expected to top 35 percent to reach \$22 billion.

Long-Term Prospects

The health care system will likely be reformed based on managed competition to provide health care access to the uninsured and accomplish cost efficiency. Comprehensive health care reform will take many years and its success will depend on controlling costs and maintaining quality. Increases in funding will most likely be directed at home nursing to accommodate long-term care needs. Consequently, home care will continue to gain market share. More medical technology will be developed to be used in the home care sector.

The implementation and success of health care reform will require the cooperation of providers, investors, and consumers. Strong measures will have to be introduced so as to eliminate billions of dollars of wasted resources in providing health care to the nation. The nation's schools and colleges may introduce health care consciousness into the curriculum as a way to help reduce costs.

It is difficult to accurately project health care costs for the next 5 years without knowing the outcome of health care reform. However, without reform, health care expenditures are projected to rise by an average annual rate of growth of 13.5 percent during the next 5 years.—*Simon Francis, Office of Service Industries (202) 482-2697, September 1993.*

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Public Citizen's Health Research Group Table Showing How Consumer Price Index Changes Always Significantly Understate Actual Health Spending Changes. December 28, 1993

Gap Between Consumer Price Index (CPI) ¹ for Health and National Health Expenditures ²			
Years	Incr in CPI	Incr Hlth Exp	$\frac{\% \text{ Incr Hlth exp} - \% \text{ incr CPI}}{\% \text{ incr CPI}}$
1986-1987	6.6%	8.6%	30%
1987-1988	6.5%	10.5%	62%
1988-1989	7.7%	10.6%	38%
1989-1990	9.0%	11.7%	30%
1990-1991	8.7%	11.4%	31%
1991-1992	7.4%	11.6%	57%
1992-1993	Not available	12.1%	---
1993-1994	Not available	12.5%	---

1. Bureau of Labor Statistics, Dept. of Labor

2. HHS and Commerce Dept. Data