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The 1990s Blueprint: Controlling Healthcare Costs to Boost the Economy

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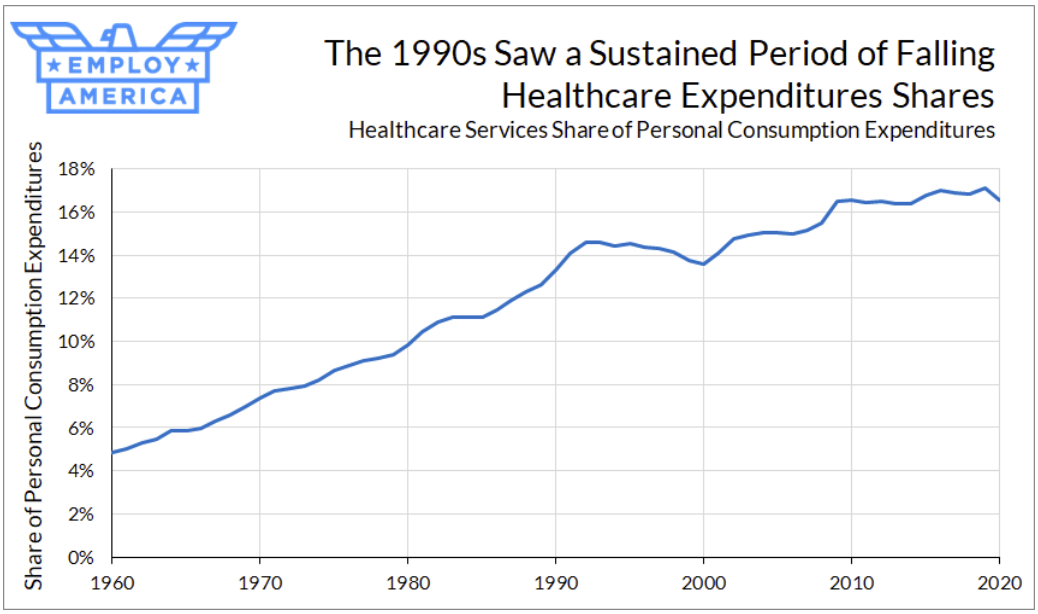
The mid-to-late 1990s is widely regarded as a time of macroeconomic prosperity. During the expansion of the 1990s—the longest expansion of the 20th century—unemployment fell to historical lows, productivity growth was high, and inflation remained under control. In this piece, we take a closer look at one reason for the success of the 1990s: the slowdown in the growth of healthcare costs. Why was healthcare inflation so low during the 1990s, and how did that play into the larger macroeconomic success of the era?

Introduction

The rising cost of healthcare in the United States is a longstanding economic concern. Compared to other advanced economies, healthcare expenditures make up a disproportionate share of GDP in the United States. Healthcare spending's share of the economy has risen from a mere 5.0% of GDP in 1960 to 17.3% in 2022. This growth is in part due to an increase in utilization that is related to rising incomes and an aging population, but it is also partly attributable to the relatively rapid growth of healthcare prices (Chen and Goldman, 2016). For most of the 20th century, the prices of healthcare services in the personal consumption expenditures (PCE) price index grew faster than the prices of overall PCE.

However, the rise in healthcare spending has not been completely steady. In particular, there was one extended period where healthcare spending slowed substantially: the 1990s. Between 1993 and 2000, healthcare's share of PCE fell from 14.6% to 13.6%. In the post-war era, this is the only period of a sustained decline in healthcare's share of PCE.



Source: Bureau of Economic Analysis, Author's Calculations

The 1990s, particularly the latter half, were also known for its broader economic success. Once dubbed the "Fabulous Decade" by Alan Blinder and Janet Yellen, the 1990s were known for its robust GDP growth, innovation in computing technology, and full employment. Inflation, a persistent headache of the 1970s and 1980s, was finally tamed in the mid-1990s as core PCE inflation gradually fell and remained below 2% during the latter half of the decade. All this occurred while the prime-age employment rate peaked above 81% between 1998 and 2000, its highest level ever in the postwar period.

The macroeconomic success of the 1990s resulted from many factors, and the relatively slow growth of healthcare prices and expenditures was one of them. The fall in healthcare inflation played an important role in the overall disinflation of the 1990s, both through its direct effect on the overall inflation rate as well as its role in limiting the growth of labor compensation costs. The slowdown in healthcare costs reduced the cost of providing employer-sponsored health insurance to workers, likely allowing for faster wage growth and higher employment. Healthcare's role in disinflation allowed the Federal Reserve to keep monetary policy and financial conditions loose, supporting investment.

The 1990s Slowdown in Healthcare Inflation and Spending

In the decades before the 1990s, healthcare expenditures were growing rapidly. Large increases in the share of the population covered by health insurance, technological improvements leading to new medical procedures, and a general rise in incomes all contributed to the rapid growth in healthcare expenditures relative to the overall economy (Chen and Goldman, 2016). During the late

1980s, healthcare services inflation was more than double that of the overall PCE price index. By the late 1990s, the gap between healthcare services and overall inflation had mostly converged.

PCE Price Index, Annualized Growth Rate			
Years	Health Services	Overall PCE	Difference
1961 - 1965	2.5%	1.2%	1.3%
1966 - 1970	6.6%	3.9%	2.7%
1971 - 1975	6.8%	6.2%	0.5%
1976 - 1980	9.8%	7.9%	1.8%
1981 - 1985	8.7%	4.7%	4.0%
1986 - 1990	7.8%	3.7%	4.0%
1991 - 1995	5.1%	2.3%	2.8%
1996 - 2000	2.3%	1.8%	0.5%

Source: Bureau of Economic Analysis, Author's Calculations

The primary reason why healthcare inflation fell to such low levels during the 1990s was the rise of cost containment measures in both the private and public sectors. One of the driving forces in containing healthcare costs was the rise and prevalence of managed care. Managed care is a broad term that refers to various health insurance plans, including health maintenance organizations (HMOs) and preferred provider organizations (PPOs). These plans engage in practices such as selectively contracting with providers, integration of insurance and health services, and other mechanisms aimed at reducing excess healthcare utilization and spending.

Managed care was not always such a prevalent feature of health insurance. Prior to the 1970s, 17 states prevented insurers from restricting physician choice. However, rapid healthcare spending growth in the 1970s and 1980s encouraged the federal government and state governments to ease restrictions on managed care. The Health Maintenance Organization Act in 1973 provided start-up funds for HMOs and even required employers to offer HMO plans. Medicare and Medicaid also adopted managed care plans in the 1980s (Chen and Goldman, 2016). The result of these reforms was a rapid growth in the prevalence of managed care plans. In 1985, just over 20% of the American insured population was enrolled in a managed care plan; by 1993, that figure grew to over 70%

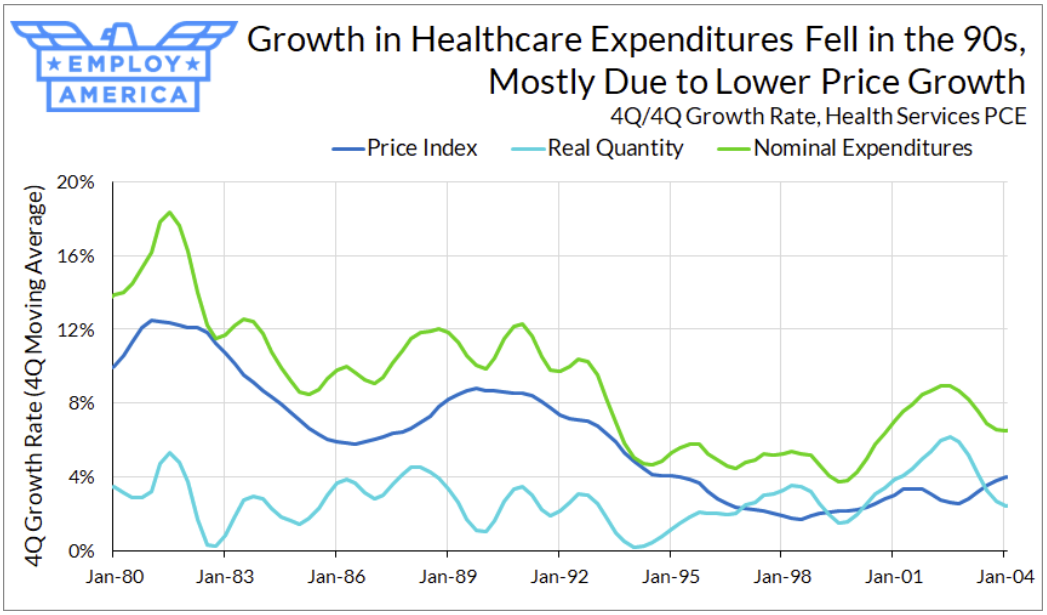
(Glied, 2000).

The rise of managed care also altered the relationship between Medicare reimbursement rates and spending elsewhere in the healthcare sector. Throughout the 1980s and 1990s, various budget acts[1] slowed or even outright reduced Medicare's reimbursement rates for medical services as a way of reducing budget deficits. Cutler (1998) finds that the effect of these reductions in Medicare reimbursement rates differed between the 1980s and 1990s. In the 1980s, when managed care was relatively less common, reductions in Medicare spending were largely offset by higher private-sector spending. However, when managed care became dominant in the 1990s, reductions in Medicare spending were associated with reductions in private spending, rather than offset by increases in private sector costs.

Private insurance reimbursements are often expressed as a percentage of the Medicare reimbursement rate (Gesme and Wiseman, 2010), so reductions in Medicare rates greatly influence private prices. Using claim-level data from 1995 to 2002, Clemens and Gottlieb (2016) find that a $1.00 increase in Medicare reimbursement rates was associated with a corresponding increase in private prices by $1.16. Medicare reimbursement adjustments did not cause providers to 'shift' payments onto private payers; rather, private prices moved in the same direction as Medicare prices, multiplying the effect of changes in Medicare reimbursement rates on healthcare services inflation.

As a result of the rise in managed care and cost reduction efforts in government insurance programs, the growth rate in both expenditures and prices in physician and hospital services fell dramatically by the latter half of the 1990s. While part of the reduction in nominal expenditure growth was due to a slower growth rate of real quantities of healthcare services, the lion's share came from lower growth rates in prices.

1 Including: The Omnibus Budget Reconciliation Acts of 1985, '87, '89, ' 90, '93, and the Balanced Budget Act of 1997.

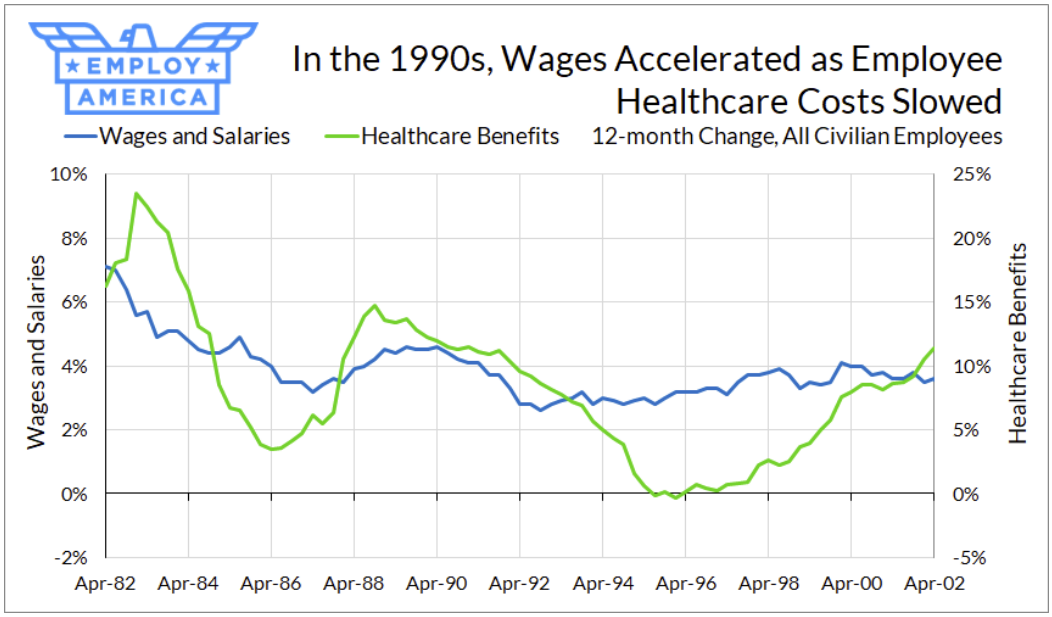


Source: Bureau of Economic Analysis

The Macroeconomic Benefits of Lower Healthcare Cost Growth

The reduction in the cost of healthcare services played a profound role in the macroeconomic achievements of the 1990s. Lower healthcare inflation and expenditure growth reduced overall inflation and labor costs. This allowed the Federal Reserve, which was aiming for a soft landing in the mid-1990s, to refrain from tightening monetary policy even as the unemployment rate fell below levels that Federal Reserve officials believed were possible to sustain without triggering excess inflation.

The reduction in employees' healthcare expenses allowed for more room for wages to accelerate and lower unemployment, as a key feature of labor market dynamics is the role of employer-sponsored insurance. During the 1990s, over 70% of workers, including over 85% of full-time workers, had access to employer-sponsored health insurance. The importance of employer-sponsored health insurance increased throughout the decade as employment growth came disproportionately from larger firms, which were more likely to offer health insurance benefits. The cost of healthcare benefits grew at a slower rate than wages and salaries between 1993 and 2000.



Source: Bureau of Labor Statistics

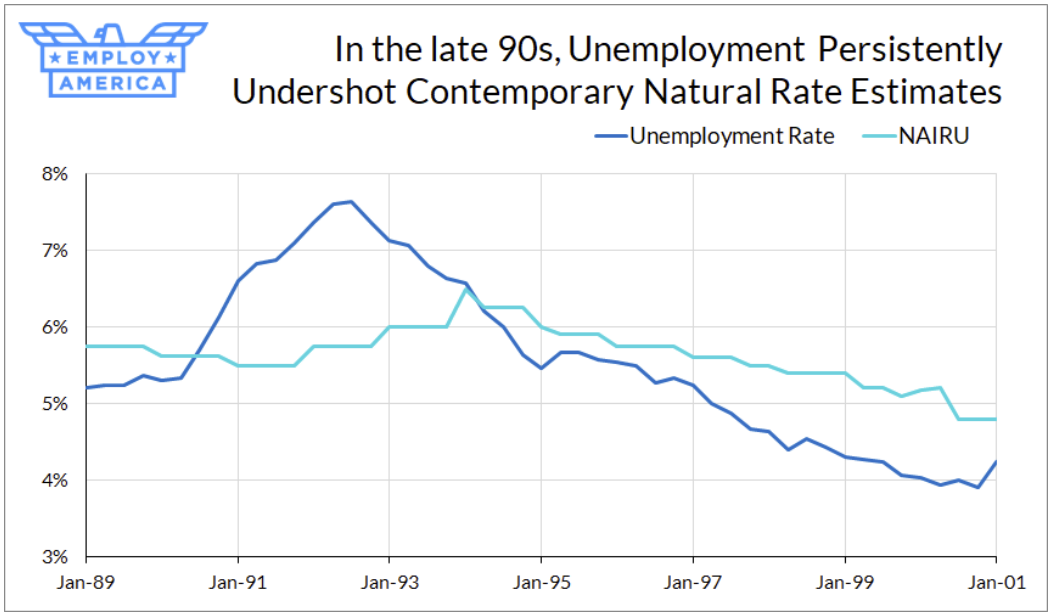
As Katz and Krueger (1999) note, the exact relationship between total compensation costs, wages, salaries, and healthcare benefits is unclear. Because wages and benefits are at least somewhat fungible, some of the acceleration in wage growth during this time was likely contingent on the slowdown in the cost of health insurance benefits. However, if the decline in healthcare benefit cost growth was not completely offset by wage growth, the overall decline in compensation cost growth would boost labor demand and employment levels.

There is evidence that healthcare prices do affect labor demand. Brot-Goldbert, et. al (2024) estimate the effect of healthcare prices on employment. The authors study variations in employers' exposure to rising healthcare prices from hospital mergers. By combining W-2 data with health insurance claim data, they show that a 1% increase in healthcare prices causes a 0.4% fall in employment. The loss in employment is concentrated in middle-income workers, those workers for whom health insurance comprises a relatively large portion of compensation, rather than low-income workers (who are less likely to receive health care from their employer) and high-income workers (who receive a lower fraction of their compensation through health insurance).

One possibility raised by the authors is that benefits and wages are not completely fungible if employees do not place a value on health insurance benefits equal to the cost that employers pay for them. Another possibility is that short-term wage rigidity prevents wages from completely offsetting changes in the costs of health benefits. The effect of health insurance costs on employment and wages may lie somewhere in the middle, with the slowdown in the costs of health benefits partly offset by wage increases and partly acting to slow overall compensation cost growth.

In any case, both effects would have been a boon for the 1990s macroeconomy. Higher wages and salary growth would have boosted labor income that was not diverted to health insurance benefits and could be spent on discretionary consumption. The rise in incomes served to justify and support fixed investment and research into new technologies, a key part of the 1990s growth story. Lower compensation cost growth would have increased the demand for labor and allowed for lower unemployment than would otherwise be possible. Gordon (1998) estimates time-varying non-accelerating inflation rates of unemployment (NAIRU) using different labor cost series. He finds that in the mid-1990s the implied NAIRU was about 0.5pp lower when using the total compensation Employment Cost Index (ECI) instead of the wages and salaries ECI.[2] Showing that lower healthcare costs from employers could have been a contributing factor in reducing labor compensation, keeping inflation stable, and maintaining high employment.

The 1990s fall in the unemployment rate without a surge in inflation certainly puzzled policymakers at the time. The unemployment rate, which gradually fell from a peak of 7.8% in 1992 to below 4.0% in 2000, persistently undershot the Fed's own contemporary estimates of the NAIRU.

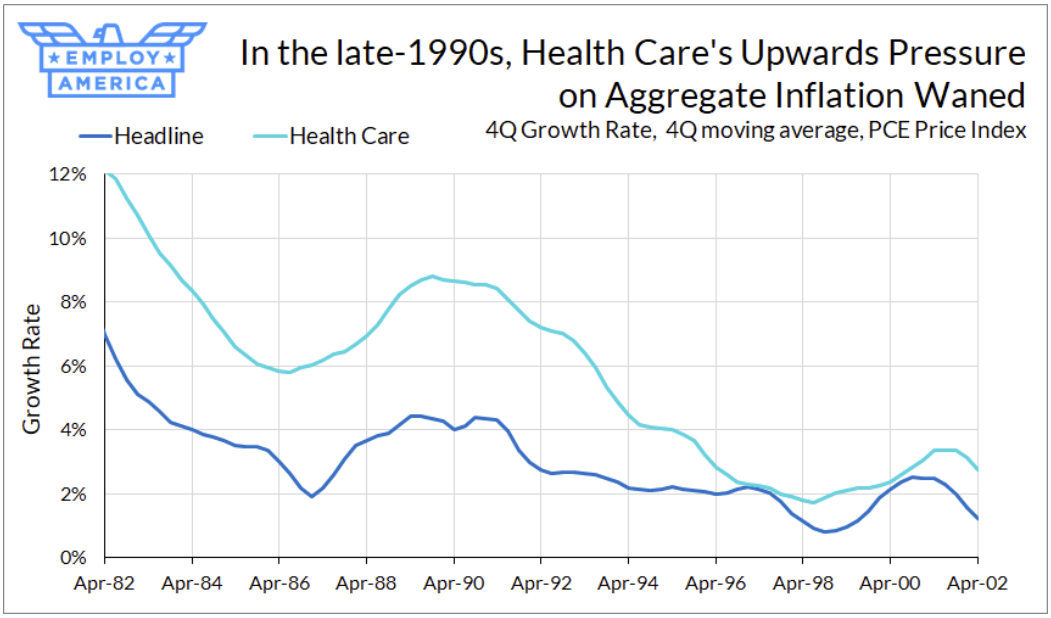


Source: Source: Bureau of Labor Statistics, Bureau of Labor Statistics

The low inflation of the 1990s was the result of a myriad of factors. Favorable commodity prices, a lack of supply shocks, technological improvements in computing technology, and even changes in price measurement methods all helped lower measured inflation. Falling healthcare inflation also played an important role here. Outside of a short period in the 1970s, when overall inflation was high due to spiking food and energy prices, healthcare inflation was

2 The total compensation ECI also includes the cost of retirement benefits, which were also slowing due to rapid growth in stock prices.

persistently higher than overall inflation. By the mid-1990s, healthcare inflation had fallen to levels closer to overall consumption inflation.



Source: Bureau of Economic Analysis, Author's Calculations

Federal Reserve officials saw the coexistence of low unemployment and low inflation as a puzzle, but one that they welcomed. Because inflation remained relatively low and stable, the Federal Reserve felt comfortable refraining from tightening monetary policy—even as they were concerned about the potential inflationary effect of low unemployment rates. They essentially adopted a strategy that Yellen and Blinder (2001) would name "forbearance," where they would wait for inflation to show itself rather than act to preempt it when they saw low unemployment rates.

> *"For a number of meetings now, the economy has seemed to be déjà vu. For some time, we have felt that we were looking at a fully utilized economy, one with tight and tightening labor markets that seemed likely to begin to show escalating labor costs and from there, escalating inflation—in short, an overheating economy. But that has not happened so far. In fact, inflation is flat to down according to many statistical series."*
>
> *Edward W. Kelley Jr (member of the Board of Governors of the Federal Reserve, 1987 - 2001), during March 25th, 1997 FOMC Meeting*

As we discussed in *The Dream of the 90's*, the decision to allow monetary policy to accommodate lower unemployment rates turned out to be a boon for the 1990s economy. The tight labor market allowed workers to move up the skill ladder to higher productivity jobs, and the higher wage growth and strong employment rates formed the foundation for solid aggregate demand growth,

supported by labor income growth. Strong demand and supportive financial conditions combined to create an era of rapid growth in business fixed investment and productivity-enhancing investments in research.

Bringing the Healthcare Lessons of the 90s to Today

The 1990s saw an extended period of full employment, high growth, and low inflation. Part of this achievement was attributable to healthcare cost control efforts undertaken by both public- and private-sector actors. By lowering the growth rate of healthcare expenditures and prices, managed care and Medicare rate cuts bolstered full employment and helped keep inflation low. Those two macroeconomic forces helped support accommodative monetary policy, business investment, and productivity growth.

Lowering costs through broad reimbursement rate reductions and managed care came with drawbacks. Consumers generally disliked managed care, and there is some evidence that managed care resulted in worse health outcomes for those with low incomes or serious health conditions (Glied, 1999). Throughout the late 1990s and early 2000s, the influence of managed care practices waned due to consumer and employee backlash against managed care, increasing regulation of HMO practices, and hospital mergers that led to an increase in provider bargaining power (Lesser, Ginsburg and Devers, 2003).

Nevertheless, the success of healthcare cost control in the 1990s in its contribution to the larger macroeconomic landscape provides lessons for the current day. There are echoes of the mid-1990s today; like then, monetary policy is aiming for a soft landing, and we may be looking at another era of high productivity growth. To replicate the benefits of healthcare services disinflation we saw in the 90s, policymakers should consider pragmatic, equitable cost-control measures that reduce cost and price growth in the healthcare sector, without negatively impacting patient outcomes.

The rest of this series will focus on specific healthcare policy proposals and how they might impact today's macroeconomic environment. One example of a high-leverage policy option is to implement policies that encourage site-neutral payment structures. Currently, patients, private insurers, and public insurance programs pay significantly higher prices for many healthcare services that are provided in hospital settings compared to the same services provided at standalone physicians offices or other settings. This price differential often exists even if patient outcomes are not affected by the setting in which the services are performed. Policymakers can use the outsized influence of the government in the healthcare sector to reduce the growth rate of healthcare expenditures and prices, and deliver some of the macroeconomic boons of the 1990s to today's labor market.