American Economic Journal: Applied Economics 2019, 11(2): 302–332
https://doi.org/10.1257/app.20170295

Health Care Spending and Utilization in Public and Private Medicare[†]

By Vilsa Curto, Liran Einav, Amy Finkelstein, Jonathan Levin, and Jay Bhattacharya*

We compare health care spending in public and private Medicare using newly available claims data from Medicare Advantage (MA) insurers. MA insurer revenues are 30 percent higher than their health care spending. Adjusting for enrollee mix, health care spending per enrollee in MA is 9 to 30 percent lower than in Traditional Medicare (TM), depending on the way we define "comparable" enrollees. Spending differences primarily reflect differences in health care utilization, with similar reductions for "high-value" and "low-value" care, rather than health care prices. We present evidence consistent with MA plans encouraging substitution to less expensive care and engaging in utilization management. (*JEL* G22, H44, H51, I11, I13)

A long-standing question in economics concerns the appropriate roles of the public sector and private sector in providing services that society has decided are essential. This question comes up in many contexts, including education, utilities, transportation, and pensions. It is especially relevant in health care, where the United States is unusual among developed countries in its distinctive mix of public and private health insurance. Comparisons of public and private health insurance systems are difficult, however, since they typically do not operate at a similar scale, for the same population, in the same markets, or with the same health care providers.

The US Medicare program in recent years has been an exception because of the "side by side" operation of public and private insurance programs. While Traditional Medicare (TM) offers publicly administered insurance, a significant fraction of the

* Curto: Department of Health Policy and Management, T.H. Chan School of Public Health, Harvard University, 677 Huntington Avenue, Boston, MA 02115-6028 (email: vcurto@hsph.harvard.edu); Einav: Department of Economics, Stanford University, 579 Serra Mall, Stanford, CA 94305-6072 (email: leinav@stanford.edu) and NBER; Finkelstein: Department of Economics, MIT, 50 Memorial Drive, Cambridge, MA 02142-1347 (email: afink@mit.edu) and NBER; Levin: Graduate School of Business, Stanford University, 655 Knight Way, Stanford, CA 94305-7298 (email: jdlevin@stanford.edu) and NBER; Bhattacharya: School of Medicine, Stanford University, 616 Serra Street, Stanford, CA 94305-6019 (email: jay@stanford.edu). Ilyana Kuziemko was coeditor for this article. We are grateful to Diego Jimenez, Andelyn Russell, Daniel Salmon, and Martina Uccioli for excellent research assistance. We thank three anonymous referees and numerous seminar participants for helpful comments. We gratefully acknowledge support from the NSF (SES-1527942, Bhattacharya, Einav, and Levin), the NIA (R01 AG032449, Einav and Finkelstein; R37 AG036791, Bhattacharya), and the Sloan Foundation (Bhattacharya, Einav, Finkelstein, and Levin). The authors acknowledge the assistance of the Health Care Cost Institute (HCCI) and its data contributors, Aetna, Humana, and UnitedHealthcare, in providing the claims data analyzed in this study.

[†] Go to https://doi.org/10.1257/app.20170295 to visit the article page for additional materials and author disclosure statements or to comment in the online discussion forum.