

## HEALTH CARE COSTS: GOING DOWN FIGHTING

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The dust is settling after the passage of health care reform legislation. Controversy continues to rage, but on one point there is agreement: we need to take steps to stem rising health care costs. Employer family health insurance premiums rose 119% from 1999 to 2008 versus a rise of less than 30% in the median family income.<sup>1</sup> The costs of Medicare and Medicaid have also been rising fast -- faster than the growth rate of national income. More and more of every dollar spent is going to health care.

The shrinking percentage of our workforce with health care coverage is tied to the high cost of health insurance. In Mississippi, 52% of private employers do not offer health insurance; nationally, the figure is somewhat lower, at 44%, but is still high.<sup>2</sup> Since health care is basic to well-being, this lack of access to appropriate care is hurting the U.S. quality of life. It also harms worker productivity and firm competitiveness.

There are effective ways to slow the rapid rise of health care costs. These fall into two categories: changes that increase efficiency on the supply side and changes that reduce demand. Reducing demand through prevention of health problems holds promise. Consider, for example, that the Centers for



Disease Control estimate that health care costs for chronic disease treatment account for over 75% of national health expenditures.<sup>3</sup> Programs and incentives to promote healthy lifestyles can reduce obesity and other problems that contribute to chronic disease. Increased efficiency in the delivery of health care can be promoted by changes that link payments to the quality of outcomes, and not only to the quantity of services supplied. Improved use of information technologies in administration and medical malpractice reforms also hold

promise. The Patient Protection and Affordable Care Act (PPAC) contains several programs and initiatives that hold promise of being effective in reining in rising costs.

### **The Scope of the Problem**

Health care will continue to absorb an increasing proportion of output and income even if the costs of PPAC are fully financed as estimated by the Congressional Budget Office. Health plans have been raising premiums at rates that greatly exceed the growth rate of income; as a result, average family premiums for group policies rose from 11 percent to 18 percent of median family income between 1999 and 2008.<sup>4</sup>

It is simply not feasible for health care to continue absorbing an ever-increasing percentage of national income indefinitely.

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**Most private sector employers in Mississippi do not offer health care coverage.**

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### **What are the cost-reducing proposals in PPAC? How promising are they?**

There are several pilot projects in the health care reform bill aimed at lowering costs. Consider medical malpractice. "The medical tort system does not deter medical errors, compensates a small percentage of patients affected by negligent care, and is driving shortages in specialty care through rapidly rising insurance rates. New approaches, including an administrative system of health courts, may address these issues and improve patient safety", according to the Robert Wood Johnson Foundation.<sup>5</sup> One suggestion by experts involves setting up medical courts where judges or other trained professional would handle malpractice suits.<sup>6</sup>

The PPAC, in response to such suggestions, awards five-year grants to the states to develop, implement and evaluate alternatives to current tort litigations while maintaining incentives to enhance patient safety.



Reduced threat of inappropriate court outcomes could reduce the cost of malpractice insurance for most doctors and could also cut back the number of unnecessary medical procedures, while protecting patient rights.

The insurance Exchanges are intended to lower the cost of insurance to individuals and firms through increasing competition and spreading costs over a larger insured population. The experience of Massachusetts, which has had programs in place since 2006 targeting a similar population, has been that initially manageable costs have increased and accelerated over time. Broadening the insurance base and increasing competition, in short, have not been sufficient to control the cost problem.

The Independent (Medicare) Payment Advisory Board established under the bill is considered likely to be effective. Under this provision of PPAC, by 2018, if Medicare per capita spending exceeds the growth rate of GDP per capita by more than 1%, the Board will submit proposals to Congress for immediate consideration. Congress cannot modify or filibuster these proposals, and if it wants to reject them, it must find another way to save the same amount of money.<sup>7</sup>



To cut back administrative costs, health care plans are required to report the proportion of premiums spent on items other than medical care starting this year and by 2011, health plans are required to refund enrollees for non-claims costs that exceed 15% of costs in the large-group market. Since administrative costs (including provider overhead as well as that of insurance companies) in the U.S. are

about \$1,000 higher per capita than in Canada, potential savings from reducing administrative costs are great.<sup>8</sup> Improved electronic record-keeping in PPAC can help with this.

### **Pilot and Prevention Programs**

One of the more promising pilot programs involves “bundling” of payments to health care providers. Instead of getting paid on a per service basis, a hospital would get paid once for all the services provided over a certain period of time related to, say, a heart attack or diabetes. There would be no reward, then, for unnecessary services.

There is a Prevention and Public Health Fund charged with expanding and sustaining funding for prevention and public health programs, as well as grants for prevention, wellness, and public health activities (\$7 billion is allocated for FY2010 through FY2015 and \$2 billion per year thereafter.) Employers can offer employees rewards of up to 30% of the cost of coverage to employees who participate in wellness programs and meet health-related standards. Insurance companies can consider participation in a health promotion program in determining an individual’s rating (age, tobacco use, family composition, and geography are other factors that can be considered).



Funds are provided for developing a national quality improvement strategy by examining patient outcomes, and for conducting research that compares the clinical effectiveness of alternative medical treatments.

### **Problematic Provisions: Some Examples**

Productivity improvements can make possible a slower growth of health care costs per capita. PPAC has a provision that reduces the growth rate of Medicare provider payments, in the expectation of productivity and efficiency increases.<sup>9</sup> However, if providers cannot or do not institute improvements in

productivity at a sufficiently rapid rate, the lower payments to providers will be a burden that could force them to reduce the quantity and/or quality of their services.

For some providers, such as hospice care providers, the rate of increase in efficiency is likely to be below the nationwide average and unless these caregivers also provide services enjoying rapid technological advance, hospice patients would have to supplement Medicare payments to ensure quality is maintained.



Another problematic provision is one that limits the ratio of the most expensive to the least expensive premium, based on age differences alone, to 3:1 on the insurance Exchanges. This may cause financial losses for insurers, who are required to provide certain basic services. The viability of this cap on premiums depends on productivity advances that reduce costs and/or on the health of the population that is insured through the Exchanges.

States have a major role to play in implementing reforms, including the creation and supervision of insurance exchanges. Medicaid matching funds must also be found. The expense will be considerable by 2020 and is a source of concern across the nation.



Several studies have long stressed the need to revamp the budgeting process in the states to avoid looming deficits.<sup>10</sup> Revenue sources need to be more aligned with the sources of economic growth in state economies, and improved oversight and performance measures are also needed. Until this happens, the increased obligations under health reform are likely to contribute to fiscal stress in the states, as well as at the federal level.

### **In Summary**

In sum, the initiatives directed at cost containment are broad-ranging. Two of the most significant are the insurance Exchanges and the Payment Advisory Board in Medicare. But in the long-run, changes tested under pilot programs and incentives promoting and rewarding healthy lifestyle choices may be just as important in reducing costs. Some experts believe that a decade from now, the system actually in place will differ greatly from that laid out under PPAC. Amendments and supplemental legislation are inevitable. But we learn from experience and improvements in coverage and cost control depend on taking first steps.

An accompanying article provides details about who will be covered and who will pay for the expanded services that will be available under health care reform legislation.

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## **Commentary: Doing nothing to address soaring health care costs and falling coverage is not an option.**

High and growing health care costs are absorbing more and more of our national income, of our federal and state budgets, and of family incomes.<sup>11</sup> These spiraling costs contribute to a rising percentage of workers without adequate access to health care.

The growing cost of health care affects both those without and those with coverage. Those who do have coverage often find that when they most need health services, their coverage is inadequate. In fact, most personal bankruptcies are due to medical expenses and most individuals filing for bankruptcy due to health-related reasons had health insurance coverage.<sup>12</sup>

Individuals without coverage can find their life savings depleted by a serious accident and once their resources are exhausted, their ability to get the care they need to maintain their health is in jeopardy. It is no surprise to physicians that excess mortality rates have been documented for the uninsured.<sup>13</sup>

Treatable conditions are often left untreated among the uninsured until a crisis stage is reached. This not only harms the individual; it is an inefficient approach to health services delivery.

It is not only the uninsured individual who suffers; their families and employers are adversely affected as well. Employers who rely on employees without health insurance find that their businesses suffer when employees do not have the resources required to deal with adverse health events in their families. Firms unable to offer coverage are at a competitive disadvantage in recruiting and in relation to competitors abroad, where health care may be provided to all at heavily subsidized rates.



PPAC may prove to be only the first in a series of steps on the long road to the restructuring of our health care system; it is a step with both perils and opportunity. What we learn in the coming years about how to reduce costs while improving outcomes can stand us in good stead. The response of private health care providers and insurers to the challenge of improving efficiency and expanding coverage will be critical to the success or failure of PPAC. There are models within the U.S. and around the world showing that lowering costs while improving outcomes is possible. (See “Mississippi and Health Care Reform” in the January issue of this *Review*.)



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**We could all go down the tubes together, but at least we're going somewhere! *Jack Lewin, CEO, College of Cardiology***

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Only time will tell if the incentive to cure our health care ills is strong enough. Jack Lewin, CEO of the College of Cardiology offers a perspective that seems to resonate among health care providers:

“The keys to keep the (PPAC) law’s good intentions from becoming a nightmare are basically two: 1. Devising cost containment strategies that do not undermine the patient physician relationship and also improve quality – only we know how to do this – Congress has no idea. 2. Creating payment reforms that incentivize quality improvement and protect the viability of physician practices, hospitals, and ongoing clinical innovation...Are these not interesting times to be involved in health care? We could all go down the tubes together, but at least we’re going somewhere!”<sup>14</sup> He exhorts cardiologists to assume leadership in pointing out how to improve quality and reduce unnecessary spending in the most expensive ailment covered by Medicare – cardiovascular care. If such efforts are undertaken across the private sector by health care providers, substantial progress in cost containment and in the quality of care becomes likely.

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## Notes

1. Employer family health insurance premiums rose 119% from 1999 to 2008 versus a rise of less than 30% in the median family income (see Davis, Karen. "Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums", at [www.commonwealthfund.org](http://www.commonwealthfund.org).)

2. See [www.statehealthfacts.org](http://www.statehealthfacts.org) on health coverage. A Kaiser Family Foundation website.

3. See Koot, A. et al. "2009 Almanac of Chronic Disease" at the following site: [www.fightchronicdisease.org/pdfs/2009PFCCDAlmanac.pdf](http://www.fightchronicdisease.org/pdfs/2009PFCCDAlmanac.pdf).

4. Davis, *ibid*.

5. Robert Wood Johnson Foundation ([www.rwjf.org](http://www.rwjf.org) – search on medical malpractice).

6. Betsy McCaughey, "Medical Courts Would health Infirmities of Legal System", in *Investor's Business Daily*, July 17, 2003. At <http://commongood.org>.

7. See Ezra Klein, "How Health Care Reform Reduces the Deficit in 5 Not-So-Easy Steps", *Newsweek*, 3/21/10.

8. According to a 2003 study by Woolhandler et al., "The gap between U.S. and Canadian spending on health care administration has grown to \$752 per capita", indicating large potential savings through reducing administrative costs. In 2010 dollars, this \$752 would be about \$955. Per capita, U.S. administrative costs were \$1,059 in 1999 versus \$307 in Canada. Between 1969 and 1999, the share of the U.S. health care labor force accounted for by administrative workers grew from 18.2% to 27.3%. In Canada, this percentage was 19% in 1996. This excludes insurance-industry personnel. After exclu-

sions, administration accounted for 31% of U.S. health care expenditures, versus 16.7% in Canada in 1999. Private insurers had overhead costs of 13.2% in the U.S. Providers also accounted for administrative costs.

As to U.S. versus Canadian health care outcomes, an Urban Institute article reviews several studies of U.S. health care. The article by E. Docteur and R. Berenson, "How Does the Quality of U.S. Health Care Compare Internationally?" (8/20/09), concludes that U.S. health care outcomes are uneven across categories in comparison to other countries. For example, Canada is a country whose health care system has been extensively researched in comparison to that of the U.S. One of the works cited, Guyatt et al., identified 38 studies comparing populations of patients in Canada and the United States. Studies addressed diverse problems, including cancer, coronary artery disease, chronic illnesses and surgical procedures. Of 10 studies that included extensive statistical adjustment and enrolled broad populations, five favored Canada, two favored the United States, and three showed equivalent or mixed results. Note: The high rate of obesity in the U.S. may contribute to the more unfavorable ranking of the U.S. in relation to Canada and other countries in studies.

9. The rate of increase would be adjusted by a ten-year moving average multifactor productivity index of the total nonfarm economy, and would apply to payments for dialysis, prosthetics, hospice and other services individually, regardless of actual advances in those specific areas. The White House proposal was slightly different: see [www.whitehouse.gov/medicarefactsheetfinal/](http://www.whitehouse.gov/medicarefactsheetfinal/) Recently, productivity has been growing at about a 3% annual rate, but that rate is expected to drop substantially as job creation picks up.

## Sources

10. GAO document GAO-07-1080SP. See also GAO-09-210T on rising health care expenditures by states and GAO-08-957.
  11. Between 1991 and 2004, health care expenditures per person in the U.S. increased at an average annual rate of 5.5% and, in Mississippi, at 6.7%. This was faster than the growth rates of per capita incomes for both the U.S. and Mississippi. The Government Accountability Office estimates that the growth rate of health expenditures by the states will outpace the growth of GDP over the coming decade as well (see footnote 9).
  12. Harvard Medical School news release 2/2/05 on *Health Affairs* article “Illness and Injury as Contributors to Bankruptcy” by David Himmelstein et al.
  13. Reuters News Service, “Study links 45,000 U.S. deaths to lack of insurance”, 9/18/09, by Susan Heavey.
  14. Lewin, Jack, Chief Executive Officer, American College of Cardiology. 4/5/10. “How to Keep Health Reform from Becoming a Nightmare.” <http://lewinreport.acc.org>.
- Commonwealth Fund, “Congressional Health Reform Bills, Comparison of Senate and Reconciliation Bills.” [www.commonwealthfund.org](http://www.commonwealthfund.org).
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- Henry J. Kaiser Family Foundation. April 2010. “Summary of New Health Reform Law”, (#8061). [www.kff.org](http://www.kff.org).
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- U.S. House of Representatives, <http://edlabor.house.gov/newsroom/2010/03/chairman-miller-today-americas.shtml> On the Health Care and Education Affordability Reconciliation Act of 2010.
- Woolhandler, S., M.D., et al. 8/21/03. “Costs of Health Care Administration in the U.S. and Canada”, *New England Journal of Medicine*.