A BRIEF EXPLORATION OF RISING HEALTH CARE COSTS

By Dimitris Karapiperis, CIPR Research Analyst

♦ INTRODUCTION
The U.S. has the most expensive health care system in the world, with expenditures growing at a faster rate than the economy and well above the rate of inflation. The financial burden for the average American family is increasing every year. Consumers are experiencing rising prices for most health treatments, doctor visits and prescription drugs, while their use of all services has remained mostly flat.

The federal Centers for Medicare & Medicaid Services (CMS) indicated total health care expenditures in 2016 amounted to $3.3 trillion or $10,348 for every man, woman and child. This accounted for an astounding 17.9% of the country’s gross domestic product (GDP). It is projected national health spending will grow at an average rate of 5.5% per year for 2017–2026, reaching $5.7 trillion by 2026. With health care spending growing one percentage point faster than GDP, the health share of GDP will balloon to an estimated 19.7% by 2026.1

This article will explore some of the factors driving U.S. health care costs at unsustainable levels, at least in the long term. While there is no one right level of health spending or rate of increase, the U.S. is spending twice what other wealthy countries spend on health care, delivering on average poorer health outcomes.2 It is important to clarify the main factors driving rising health care costs and how health care is delivered and paid for in rethinking health care for all Americans.

One of the key initiatives NAIC President and Tennessee Insurance Commissioner Julie Mix McPeak has proposed is for state insurance regulators to examine health care cost drivers and help implement or strongly support solutions to mitigate these costs. She has tasked the NAIC Health Insurance and Managed Care (B) Committee and the NAIC Center for Insurance Policy and Research (CIPR) with studying these cost drivers and reporting findings and recommendations.

♦ UTILIZATION VERSUS UNIT PRICES
The two components of overall health care spending are utilization of services and unit prices. Understanding which component has the greatest impact on the cost of health care is critical for developing the most effective reforms. Interventions aimed at reducing costs by targeting the right component will likely provide more impactful and lasting solutions.

A recent study in the Journal of the American Medical Association (JAMA) found prices have been consistently the most important cost driver of rising health care costs, with utilization of health services and disease prevalence playing still important but less dominant roles.3 Utilization rates in the U.S. have been found to be largely similar to those in other comparable developed countries. Thus, reform efforts focusing primarily on containing the rise in prices should produce more positive results.

♦ COST DRIVERS

Demand Side
An examination of aggregate, demand driving factors for both rising overall health care spending and prices reveals increasing national income per capita, aging population and disease prevalence play a significant role in rising health care costs.

Higher incomes are generally associated with higher spending for health care. However, for high-income countries like the U.S., the marginal increase may be less significant than in developing countries. For most wealthy countries, increasing longevity is the driver of overall per capita health care spending. Rising rates of chronic disease and co-morbidities are more common among the elderly, driving demand for costly health services, such as inpatient hospital stays, hospice care, home health and skilled nursing facility care.

However, disease prevalence is not exclusively the product of an aging population. Higher rates of obesity can lead to diseases and poor health conditions. Obesity is often associated with more developed countries’ tendencies toward unhealthy diets, lack of exercise and poor lifestyle choices. Unhealthy behaviors—such as the use of cigarettes, alcohol and drugs—can increase risk for heart disease, stroke, cancer, type 2 diabetes, obesity and arthritis—which are the most common, costly and preventable of health problems.

According to the Centers for Disease Control and Prevention (CDC), about half of all U.S. adults suffer from one or more chronic health conditions, and 25% have two or more chronic conditions. The CDC reported seven of the top 10 causes of death in 2014 were preventable chronic diseases. Furthermore, the CDC pointed to poor behavioral and lifestyle choices as major causes for much of the illness, suffering and early death related to chronic diseases and conditions. CDC studies have shown 50% of all Americans do not meet

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minimum recommendations for aerobic physical activity, 30% or about 92 million people have at least one type of cardiovascular disease, and about 37 million adults smoke. Cigarette smoking accounts for about 480,000 avoidable deaths every single year.4

In terms of costs, total annual cardiovascular disease costs averaged $316.1 billion in 2012–2013. The total estimated cost of diagnosed diabetes in 2012 was $245 billion, and health care costs linked to obesity were estimated to be $147 billion in 2008. Also, annual costs related to smoking and alcohol abuse are thought to be approximately $300 billion and $249 billion, respectively.5

Demand for health care is also influenced by information shortfalls affecting both patients and health care providers. Lack of relevant data can seriously hamper the complete and effective clinical evaluation and the delivery of proper and timely treatment. This makes not only the diagnostic process more costly, but also delays appropriate treatment. The resulting compromise in patient recovery and long-term health prospects add to the already increasing costs. The absence of usable quality information and pricing transparency is another important cost driver. Without this information, patients cannot make fully informed decisions on their choice of medical provider and health services.

Supply Side
From the supply side of the equation, factors such as medical technological advances, provider compensation levels, pharmaceutical prices, administrative costs and health care delivery systems contribute to rising costs.

Medical technological innovations can be important contributors to both improving health and rising costs. Advances in medical technology can help treat previously incurable diseases and extend life. This leads to improved health and helps contain future cost growth. Conversely, new technologies may increase the number of treatable health conditions, but at a higher cost.

The duplication of services as many practices invest heavily in new technologies in order to be competitive can also drive up costs without necessarily improving health outcomes. The overuse and misuse of technology can increase costs as patients typically demand the use of the latest technologies for more tests and procedures as they generally equate it with better quality care. Providers often accommodate their patients even when clinical evidence suggests improvements in patients’ health may be unlikely.

The incentives to over-test, overuse specialists and perform excess procedures tend to be much stronger in large hospital-owned practices. In these settings, employee physicians are encouraged to maximize downstream health system services. The displacement of independent primary care practices has adversely affected the total costs of care.

The traditional fee-for-service payment system with its primary focus on the quantity of services has overburdened independent primary care practices—increasing administrative costs and making it hard to compete with larger hospital-owned health systems. However, the consolidation of the health care marketplace has generally not resulted in lower health care costs as expected. This is mostly due to overuse of services and higher prices.

The decline of independent primary care has endangered the integrity of the primary doctor-patient relationship, which has historically helped contain costs and improve outcomes. A strong doctor-patient relationship built on trust traditionally placed the focus of health care on well-informed, thoughtful and effective preventive care. The current trend tends to favor volume and intensity of services.

As primary private doctor practices disappear, many people turn to impersonal urgent care centers or even costly emergency rooms for their health care needs. From 2012 to 2016, visits to primary care doctors actually dropped 18%, even as visits to more expensive specialists increased, according to the Health Care Cost Institute.6

The over-reliance on specialist care instead of primary care has also contributed to higher compensation levels for physicians, which has helped to increase overall health care costs. Compensation for all medical professionals in the U.S.—including general practitioners, specialists and nurses—are often twice or three times higher than their counterparts in most countries in Europe.7

The U.S. has been an outlier in terms of administrative costs in health care as compared with 10 other comparable developed countries. Administrative and government expenditures account for about 8% of the GDP for the U.S compared to a mean of 3% of GDP for all 11 countries.8 Physicians in the U.S. reported having to perform more administrative tasks than the mean of the other 10 comparable countries. Approximately 54% of surveyed physicians in the U.S. noted time spent on administrative tasks for insurance or claims represented a significant cost. About 33% also said time spent on administrative tasks for clinical or quality data reporting to the government or other agencies was a major

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problem, and 16% stated they spent too much valuable time on paperwork or disputes related to medical bills.9

A study using 2011 data compared administrative costs across eight of the wealthiest nations, including the U.S. It found administrative costs accounted for 25% of hospital spending in the U.S., or more than twice the proportion seen in Canada and Scotland, which spent the least on administration in the group.10 A new study in the Journal of the American Medical Association (JAMA) noted the impact of administrative costs on health care costs. Specifically, the study found billing costs represented 14.5% of professional revenue for primary care visits, 25.2% for emergency room visits, 8% for general medicine inpatient stays, 13.4% for ambulatory surgical procedures and 3.1% for inpatient surgical procedures.11

Researchers also found prescription drug prices were significantly higher in the U.S. A study published earlier this year in the JAMA reported the U.S. spends more per capita on prescription drugs than any other country, even other developed wealthy countries. Using data primarily from 2013 to 2016, the study found Americans spent an average of $1,443 on prescription drugs compared with a mean per capita spend of $749 for all 11 developed countries in the study.12 For four common pharmaceuticals ( Crestor, Lantus,Advair and Humira), the U.S. was reported to have higher prices than the other developed countries. Furthermore, the prices were over double the next highest price for three of the four drugs analyzed.13

Pharmaceutical prices are expected to continue rising in the foreseeable future. The increase is largely attributable to increasing use, delays in the introduction of less expensive generic drugs, expensive research and development, and the multilayered and complex supply chain. For pharmaceutical purchases made from July 1, 2018, to June 30, 2019, Vizient, a health care performance improvement company, has estimated health systems can expect a 7.35% increase. Although the increase is slightly moderated when compared to past increases, it still represents a substantial impact on overall health care costs.14

♦ Value-Based Care

The still dominant fee-for-service payment system has long been considered as an important factor for the rising health care costs. Disease management programs focused on improving efficiency, increasing quality and improving access to care could be the key to controlling costs while providing a better overall patient experience. However, an alternative payment method for health care centering on patient outcomes could advance the goal of improving quality of care based on specific measures and help reduce costs.

As opposed to fee-for-service where providers are compensated for the number and type of services they perform, a value-based reimbursement system is based on quality measures. Value-based care is driven by data health care providers report on a variety of measures to demonstrate concrete improvements in their patients’ health. Under a value-based reimbursement system, health care providers are incentivized to use evidence-based medicine fully engaging and empowering patients to manage their health. The end result is that when patients receive more coordinated, appropriate, better quality and effective care, as evidenced by specific health measures, providers are accordingly rewarded. Transitioning to such a patient-centered system is expected to not only improve outcomes, but also reduce costs as providers are held fully accountable for both cost control and quality gains.

Given evidence suggests about 80% of what drives health outcomes is technically outside the strictly defined clinical realm and includes social health determinants (economic, behavioral, environmental, etc.), an approach focusing on a patient as a whole person— from a physiological, psychological, spiritual, and social perspective— can improve preventative care and reduce the number of unnecessary tests and hospital readmissions. Engaging patients in managing their own health helps embed critical healthful behaviors improving outcomes.15

The U.S. Department of Health and Human Services (HHS) is at the forefront of the advance towards value-based care. The HHS has committed to tie 90% of Medicare payments to value, and it has set a goal of converting 50% of fee-for-service Medicare payments to alternative payment models by the end of 2018.16 Significant efforts are also underway at the state level, with several states having already implemented value-based strategies and more than 40 states having state-initiated plans to move toward value-based reimbursement systems.17

States also play a key role in health care transformation as major buyers of health care, as regulators and administrators. Five state governors (Alaska, Colorado, Nevada, Ohio and Pennsylvania) developed a bipartisan plan to reform the U.S. health care system by using value-based care strategies. This includes quality reporting, insurance stabilization policies and encouraging consumers to have a more proactive role in their health care.18

The governors recommended a series of reform strategies based on four value-based care principles. These principles include: 1) improving health care affordability; 2) restabiliz-

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ing insurance markets through competition; 3) allowing states the ability to create innovative health solutions; and 4) improving the regulatory environment.19

**Conclusion**

A number of factors are driving the rise in health care costs. What is even more problematic is the rise in prices and overall expenditures does not deliver commensurate results. It is important to not only try to address the underlying cost drivers, but also to engage patients to take ownership of their own health.

A transformation promoting real and lasting solutions is required to contain costs and improve outcomes. A data-driven, patient-centered system with a payment system based on value rather than a menu of services could potentially help deliver high-quality and cost-efficient health care.

The CIPR is currently working on a study to explore how health care is provided and analyze the main factors driving the increase in health care costs. The study will discuss different approaches advancing the goals of better quality care and reduced costs and will present initiatives by different states to address cost drivers. It engages notable health care experts from academia, the medical community and industry. Health insurance plays a central role in the delivery of health care. As such, the study will also highlight how state insurance regulators can serve as informed truth-tellers with respect to multi-stakeholder initiatives to address health care costs and performance.

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**ENDNOTES**


3 Ibid.


5 Ibid.


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**ABOUT THE AUTHOR**

Dimitris Karapiperis joined the NAIC in 2001 and he is a researcher with the NAIC Center for Insurance Policy and Research. He has worked for more than 20 years as an economist and analyst in the financial services industry, focusing on economic, financial market and insurance industry trends and developments. Karapiperis studied economics and finance at Rutgers University and the New School for Social Research, and he developed an extensive research background while working in the public and private sector.

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8 Ibid.

9 Ibid.


13 Ibid.


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