Health Care Costs

Issue

Health cost increases threaten to make health insurance less affordable for all Americans, and make it harder to extend coverage to the 45 million Americans who are uninsured. Rising health costs are also taking a larger share of government spending at a time of high and continuing budget deficits. Strategies for moderating growing health costs may include a strong role for government negotiation or market-based models relying on competitive forces. How the candidates for the upcoming election propose to address these challenges is a critical component of the current political debates.

Background

Since the 1960s, the nation's efforts to control health care costs through either government regulation or market forces have not had much long-term effect.[1] After a brief respite in the mid-1990's, expenditures on health care are again growing at rapid rates, significantly outpacing inflation and the growth in national income. Total health care expenditures grew at an annual rate of 9.3 percent between 2001 and 2002, pushing health spending from 14.1 to nearly 15 percent of the U.S. economy over the period. Health spending in the U.S. totaled $1.6 trillion in 2002 (the last year for which there is complete information), or about $5,400 per person, by far the highest per capita spending on health care in the world.[2]

Although Americans benefit from this increasing investment in health care, recent rapid cost growth, coupled with an overall economic slowdown, is placing great strains on the systems we use to finance health care, including private employer-sponsored health insurance coverage and public insurance programs such as Medicare and Medicaid. Since 2000, employer-sponsored health coverage premiums have increased by nearly 60 percent for family coverage, with family premiums increasing 11.2 percent between 2003 and 2004.[3] Medicare and Medicaid program spending have also been increasing, but at lower rates than employer plan premiums.

In the shorter term, policymakers and private payers for care are seeking ways to reduce cost growth and improve efficiency. Absent aggressive efforts at cost control, however, advances in medicine and the growing elderly population will almost inevitably cause health care spending to grow faster than the economy overall. In the longer term, the nation faces the question of how to finance health care's growing share of national resources.

The challenges facing policymakers are made more difficult by unprecedented federal deficits, which are projected to continue over at least the next 10 years – totaling some $2.3 trillion.[4] These fiscal pressures are likely to intensify efforts to slow growth in health spending for programs like Medicare and Medicaid. Further, nearly 45 million Americans, many with low incomes, are without any health coverage, and providing them with access to coverage – either by expanding government programs or providing subsidies through tax credits – will increase rather than decrease total spending.[5]

And, despite the fact that the U.S. devotes significantly more of its national income to health than other countries, performance on a number of important health status indicators lags that of a number of other industrialized countries. Specifically, 2001 data from the Organization for Economic Cooperation and Development (OECD) on 26 nations shows 23 countries with lower infant mortality rates, and 17 nations with longer life expectancy than in the U.S.[6] While the level of investment in health care is only one factor affecting health status, U.S. rankings suggest that the benefits of spending on health are not evenly distributed.

Sources of Cost Increases

Costs for each of the major components of health care spending have risen faster than inflation in recent years. Between 2001 and 2002, the last year for which we have complete information, nearly one-third of the growth in health spending was due to increases in spending on hospital care. Increased consolidation and mergers have given hospitals more negotiating clout, allowing them to charge higher prices for their services. Of the 9.5 percent increase in hospital spending in 2002, higher prices accounted for 5 percent of the growth.[7] Much of the rest of the increased spending is attributable to more hospital admissions and increases in the amount of services given to hospital patients.

Prescription drugs costs are widely assumed to be responsible for much of the increase in overall health spending. While drug spending increased 15.3 percent in 2002, it represents only 11 percent of total health spending and about 16 percent of the increase in all health care spending for the year.[8] In fact, spending for drugs has been declining over the past three years probably as a result of higher co-pays, more use of generic drugs, and tighter controls on drug coverage by private insurers and Medicaid.

Physician spending growth declined in 2002 to 7.7 percent compared to the 8.6 percent increase recorded in 2001.[9] Limitations on Medicare physician payments are assumed to account for the slower growth in overall spending. One factor that is often cited for contributing an increase in health care costs is the practice of defensive medicine by doctors due to a fear of malpractice claims. While physicians often cite the high cost of professional liability insurance, according to the Congressional Budget Office (CBO), spending on malpractice insurance accounts for less than 2 percent of total health spending. Although malpractice premiums continue to escalate at about 15 percent a year, CBO states that significant reductions in this rate of growth would only modestly affect overall health spending growth.[10]

The remaining one-third of health spending increases is attributable to spending for nursing homes, home health care, and other items of medical equipment and supplies. Spending for home health care rose by 7.2 percent in 2002, primarily as a result of higher Medicare payments and an expansion in Medicare coverage of home care.[11]

While more recent data record a slow down in the rate of increase in health spending, most observers predict that future increases will continue to outstrip growth in the overall economy and wages. These trends will make health insurance less affordable, increase out-of-pocket spending, and require larger public outlays at a time of rising budget deficits.

Cost Control Strategies

Cost containment strategies are likely to be pursued by government and private purchasers of health care – insurance plans and employers. Government policies intended to reduce the increase in spending for Medicare and Medicaid will be on the public policy agenda regardless of the election outcome. Meanwhile, employers and insurance plans will continue to search for ways to slow spending increases by using their leverage in the market to hold the line on price increases, by shifting costs to workers in the form of higher premiums, deductibles, and co-payments, and by attempting to use innovations such as disease management to head off more expensive health care interventions with tailored guidance and care for commonplace, chronic diseases.

At the political level, much of the discussion about health care costs has centered on the greater burden of costs to employers and individuals. Some think introducing more consumer involvement into health care spending decisions is an answer. Supporters of new “consumer-driven” health plans – consisting of tax-favored savings accounts and catastrophic insurance for expenses beyond a high annual deductible – believe that providing consumers with more information about their health care choices, coupled with strong financial incentives to be prudent

purchasers of services, will result in lower cost growth. Advocates of this approach favor greater price transparency so that consumers can make more informed choices and more reliance on personal savings accounts for health care that allow patients to control routine health spending. Critics of this approach raise concerns about the potential impacts that the higher cost-sharing would have on lower income people, about the potential for these new arrangements to be disproportionately used by healthy people, and about the risk that important health care services will be forgone.

Others have called for a more direct role for government in containing health costs. They cite the success of Medicare policies in reducing the increase in per capita spending over the history of the program. The adoption of prospective payment systems in Medicare that shift financial risk for benefit costs to providers, and increased reliance on fee schedules and competitive bidding as the basis for other provider payments have been, in their view, effective in moderating Medicare spending growth. These payment policies have been widely adopted by private insurers as well. Direct government negotiation of prescription drug prices by the veterans health system is also cited as an example of government cost controls that have significantly lowered costs. Critics of this government role argue that such regulation imposes its own costs by stifling innovation, and preserving inefficient ways of delivering health care.

In sum, advocates of a stronger direct government role in health cost containment cite the Medicare and veterans health system experience, and point out that market-based approaches combined with greater individual financial responsibility can disadvantage those with limited financial resources and create barriers to needed care. Proponents of market-based approaches argue that consumers will benefit from a wider range of choices for their health coverage and that competition for enrollees will result in more effective cost containment benefiting consumers and all other purchasers of health care services.

Other political debates about health care costs have been focused on specific issues or parts of the market. Rapidly increasing costs for prescription drugs have generated several different cost containment proposals. One approach that receives substantial bipartisan support would permit people to purchase drugs that have been imported from Canada or other countries. These proposals would take advantage of price limits negotiated by other countries to lower the costs of drugs in the U.S. Opponents of this approach argue that it is merely importing government price controls. Moreover, lowering drug prices below market levels would reduce manufacturers' financial incentives to develop new therapies. Supporters of this approach argue that Americans are subsidizing the citizens of other countries by paying higher prices for drugs, and that permitting drugs to be imported from other countries would result in a more fair allocation of drug costs across countries. The Congressional Budget Office has noted that this approach would have little long-run impact because both manufacturers and the governments in exporting countries would have strong incentives to end the practice.[12]

Another focus of the health care cost debate has been medical malpractice; in particular the recent rapid increases in medical malpractice premiums and the overall impact of medical malpractice claims on health care costs. Proposals split largely but not entirely across partisan lines, with Republicans generally supporting caps on non-economic (pain and suffering) and punitive damages, and other changes to the legal system for resolving medical malpractice claims. Proposals often made by Democrats include: excluding amounts awarded in binding arbitration from taxable income (e.g., encouraging the use of alternative dispute resolution rather than the courts), elimination of the Federal antitrust exemption for insurers, establishment of a Federal reinsurance program to cover damage awards above a specified threshold, and tougher penalties for frivolous malpractice lawsuits.

There is substantial disagreement over the potential impacts of any of these different approaches, both on compensation for victims and on overall costs. However, a recent Congressional Budget Office report concluded that even large reductions in malpractice premiums would have only a "small direct impact on health spending." The report also observes that the evidence for lower

health costs as a result of reducing the amount of 'defensive medicine' is "weak or inconclusive."[13]

Impact of the Election

While the two major candidates for president have not released a specific set of proposals to slow the growth in health spending, both candidates talk about making health care more affordable – at least in some targeted way – by cutting the cost of drugs, reducing malpractice premiums, using information technology to make the system more efficient, or helping both employers and individuals reduce their insurance costs. Neither candidate has put forward a comprehensive plan for slowing increases in health costs in the aggregate.

Assessing Candidate Positions

- How can health care be made more affordable without limiting access to necessary care?
- What role should government play in controlling increases in the cost of care and the cost of health coverage?
- What is the responsibility of individuals in the cost of their care? Are health savings accounts and high deductible insurance policies an approach that should be expanded?
- What is the best approach to protect low-income Americans from unaffordable out-of-pocket costs for health care while containing health costs overall?
- Should the government negotiate prices for prescription drugs? Should Americans be permitted to import drugs from foreign countries?
- How could the cost of malpractice insurance be reduced while assuring patients timely and appropriate compensation for medical injuries?

Prepared by Health Policy Alternatives, Inc.

[1] Drew Altman and Larry Levitt, "The Sad History of Health Care Cost Containment As Told in One Chart," *Health Affairs,* January 23, 2002.
[2] Katharine Levit, et. al., "Health Spending Rebound Continues in 2002," *Health Affairs, v. 23, no.1*, January/February 2004.
[3] Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2004 Annual Survey*, September 2004, www.kff.org/insurance/ehbs/7148 (date accessed).
[4] "The Budget and Economic Outlook: An Update," Congressional Budget Office, September 2004.
[5] *Current Population Surveys,* Census Bureau, U.S. Department of Commerce, August 2004.
[6] "OECD Health Data 2004-Frequently Requested Data," Organization for Economic Co-operation and Development, June 3, 2004.
[7] Katharine Levit, et. al., "Health Spending Rebound Continues in 2002," *Health Affairs, v. 23, no.1*, January/February 2004.
[8] Katharine Levit, et. al., *Health Affairs, v. 23, no.1*, January/February 2004.
[9] Katharine Levit, et. al., *Health Affairs, v. 23, no.1*, January/February 2004.
[10] "Limiting Tort Liability for Medical Malpractice," Congressional Budget Office, January 8, 2004.
[11] Katharine Levit, et. al., *Health Affairs, v. 23, no.1*, January/February 2004.
[12] "Limiting Tort Liability for Medical Malpractice," Congressional Budget Office, January 8, 2004.
[13] "Limiting Tort Liability for Medical Malpractice," Congressional Budget Office, January 8, 2004.

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