

HEALTH COST PRIMER: EXPLAINING THE MEDICAL COST TREND

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HEALTH COVERAGE



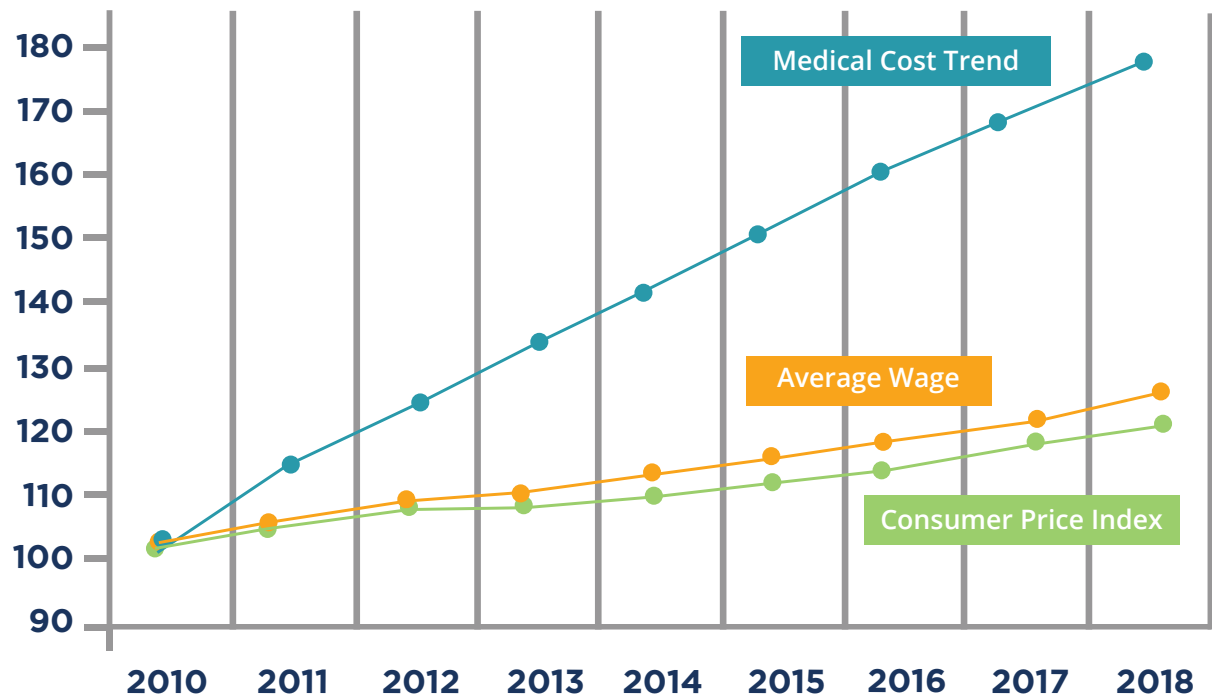
HEALTH COST PRIMER: EXPLAINING THE MEDICAL COST TREND

CAHC is concerned health costs are too high and rising too fast.

Health costs for working families, who receive coverage through employers, have grown dramatically faster than pay. The two trends are connected: rising premiums soak up raises that otherwise would boost living standards.¹

Since 2010, the medical cost trend has grown by 73 percent, about four times faster than the average wage and five times faster than the Consumer Price Index. Because costs (total, out-of-pocket, premiums, etc.) are rising faster than wages, health coverage is becoming less and less affordable. If current trends persist, the typical family will spend more than 50 percent of their income on health care by 2030.

FIGURE 1
 MEDICAL COST GROWTH RELATIVE TO WAGES



Source: PricewaterhouseCoopers; Census; BLS, CAHC Calculations

In 2019, this medical cost trend once again is expected to rise 6 percent.²

Behind the rise in health costs has been relentless inflation at the point of care. America spends about seventy percent more, as a share of GDP, on health care than the rich country average, yet has some of the lowest life expectancies across practically every socioeconomic group at practically every age.³ This unhealthiness stems in part from an epidemic of chronic diseases, including opioid abuse. Compounding these costs is widespread waste.⁴ In addition, the price of health services are significantly higher in the U.S. than in peer countries.⁵ Prices are highest in private insurance markets, where employer-sponsored health plans pay roughly twice as much as Medicare and Medicaid for common tests and procedures.⁶ In 2019, health costs for a working family of four will average almost \$30,000.⁷

This primer summarizes the magnitude of and composition of U.S. health spending, the drivers of medical costs and the interactions between them. We conclude with several recommendations for reform that directly address the problems confounding affordability.

THE MEDICAL INDUSTRY

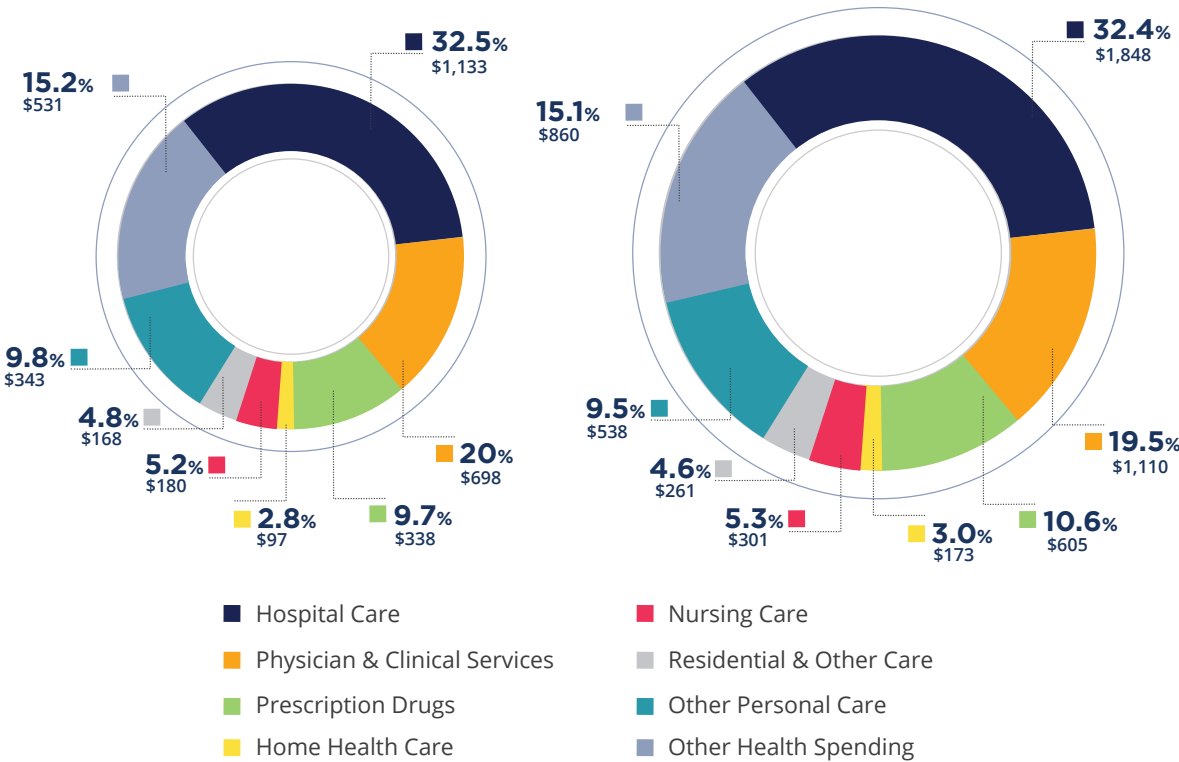
In 2019, health care spending will total \$3.8 trillion—equal to 18.3 percent of the economy (38 percent more than the output of California). Over the next 10 years, national health expenditures (NHE) are on track to top \$50 trillion. The Center for Medicare and Medicaid Services (CMS) projects that health spending will grow 71 percent during 2016 to 2026, compared to GDP growth of 55 percent. In this projection, NHE's share of the economy will expand from 17.9 percent of GDP to 19.7 percent of GDP.⁹

The health sector's largest component is hospital care, at 32.5 percent of NHE in 2017. Figure 1 breaks health spending into its main components for 2017 and 2026. At 20.0 percent of NHE in 2017, Physician and Clinical Services is the largest non-hospital component.

FIGURE 2
COMPONENTS OF NHE, BY INDUSTRY, 2017 AND 2026

2017 - \$3.4 TRILLION

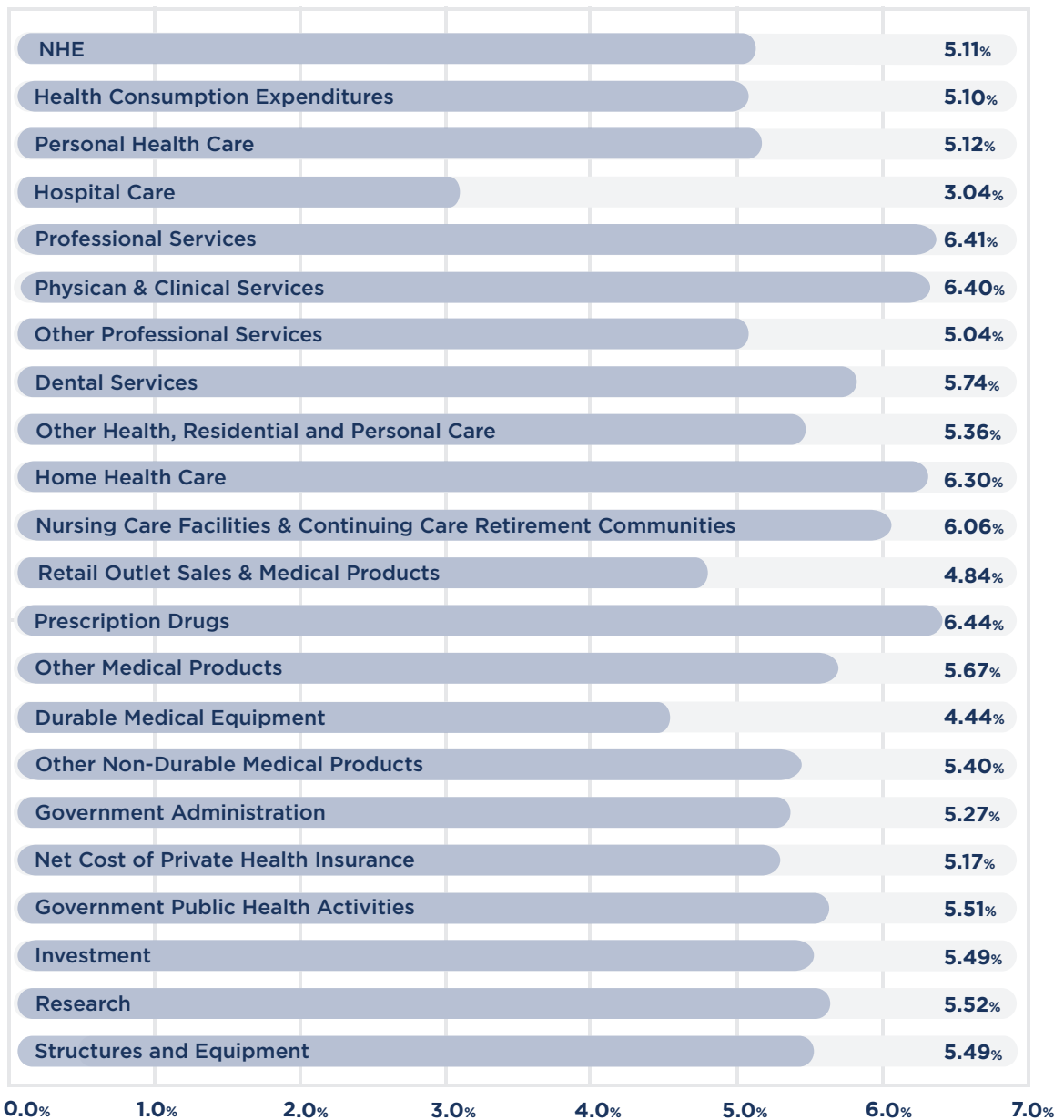
2026 - \$5.6 TRILLION



Source: CMS

All major components of the medical industry are expected to grow faster than GDP—with their shares remaining relatively stable. Some components, however, are growing at an especially rapid clip. Figure 2 shows the average annual growth rate (both projected and actual) of key industry components during 2017 to 2026. Among the major components, prescription drug costs are growing fastest, but remain stable as a share of the health dollar over the ten year period and may also be lowering other costs. Administrative costs, both government and private, are also expanding as a share of NHE.¹⁰

FIGURE 3
AVERAGE ANNUAL CHANGE IN HEALTH SPENDING,
BY INDUSTRY, 2017-2026



Source: CMS

COST DRIVERS

Several trends, individually and in interaction with each other, are driving up medical costs as a share of household incomes. In the broadest sense, every year, medicine becomes a bigger driver of job growth and economic output. Yet this growth constrains economic activity in non-health sectors (a dollar spent on insurance cannot be spent on restaurants or automobiles), thus contributing to their relative shrinkage. In this section, we look at key industry components and the interactions among them.

1. Price Inflation

Much of the growth in health costs reflects simple inflation—higher prices for the same good or service, such as a medication or blood test. Non-inflationary factors, such as the use of more sophisticated drugs and testing equipment, also can drive up prices. Medical inflation varies from year to year and component to component. One comprehensive study found that rising unit costs account for about three-quarters of the rise in premiums.¹¹ Other studies have found that in some years, for some components, inflation accounted for more than 100 percent of cost growth, overwhelming the effect of lower volume.¹²

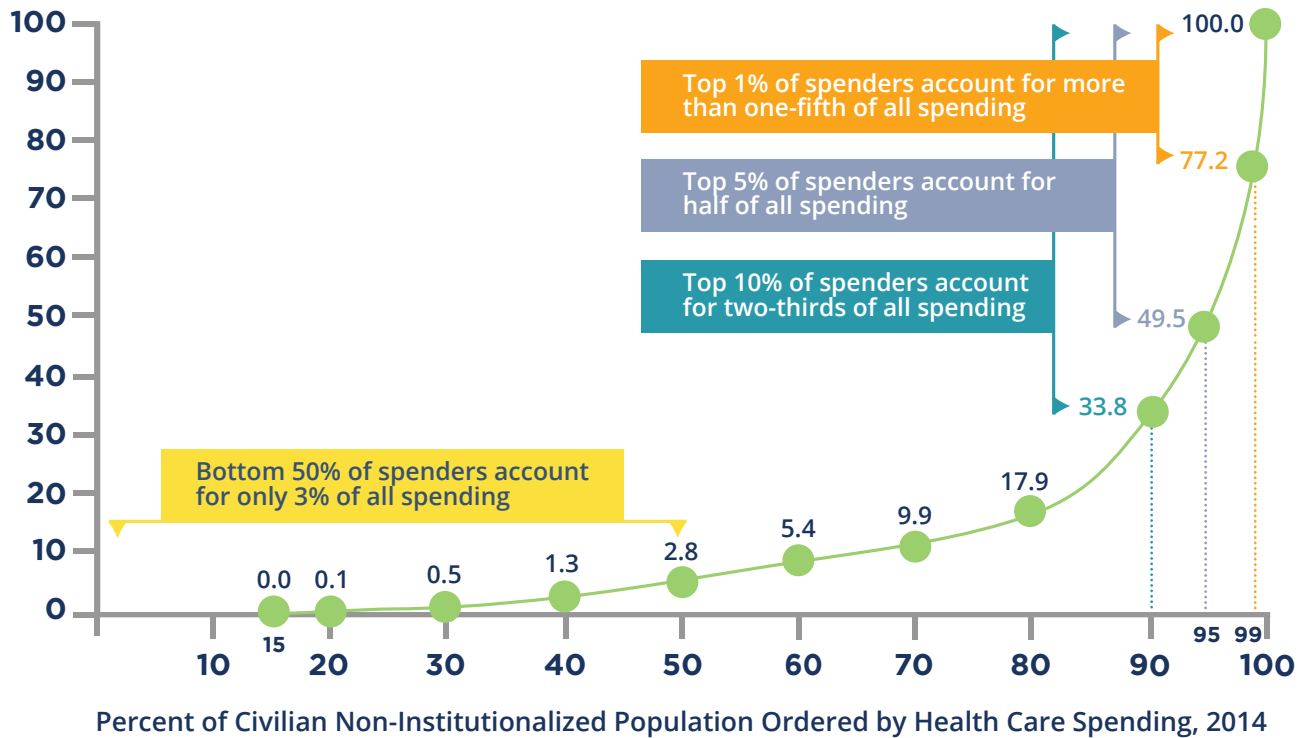
2. Volume and Intensity

Aggressive prescribing can drive up health costs by increasing both the volume of services (e.g., more blood tests) and the intensity of treatments (e.g. surgery instead of physical therapy). One study found that among major medical centers, the average cost of treatment for chronically ill Medicare patients varied by 250 percent. Medical outcomes were more or less the same, as were the prices paid for services; the differences mainly reflected patterns of prescribing. An estimated 60% of health services prescribed to Medicare patients are “supply sensitive,” meaning their prescription is driven more by the availability of resources than patient need. Another 24% of care is “preference sensitive,” reflecting the decision to treat patients more intensively.¹³ Higher volume and intensity also can reflect poor medical quality. One study found that hospital profits more than doubled when private patients were the victims of surgical mistakes.¹⁴ The Institute of Medicine estimates that 30 percent of the care Americans receive is wasteful, meaning it has no beneficial impact on patients.¹⁵

3. Chronic Disease

In any given year, the healthiest half of the population accounts for less than 3 percent of health care spending.¹⁶ Most spending goes toward the treatment of chronic conditions, such as heart failure or drug addiction, that are long in duration and have no definite cure. Patients with two or more chronic diseases account for 84 percent of health spending.¹⁷ Left untreated, chronic conditions multiply. For example, diabetes carries high risks of heart disease and hypertension, which in turn carry high risks of heart attacks and strokes. For this reason, self-neglect is a major driver of medical spending. Many patients under care for chronic conditions fail to take their medicines—a problem that could cost as much as \$6 trillion over the next decade.¹⁸ Obesity, a precursor to diabetes, is among the most expensive behavioral cost drivers. The percentage of overweight Americans has ballooned from 17 percent in 1980 to 40 percent in 2016—more than two times higher than in France and ten times higher than in Japan.¹⁹

FIGURE 4
 CONCENTRATION OF HEALTH CARE SPENDING IN
 THE U.S. POPULATION, 2014



Source: NIHCM Foundation analysis of data from the 2014 Medical Expenditure Panel Survey

4. Opaque Health Markets

Recent research has found that consumers with deductibles greater than \$2,501 (much less than the average second lowest cost silver plan deductible) were more likely to shop for coverage or switch doctors than consumers with a lower or no deductible.²⁰ But consumers have less information on the price and quality of health care providers than they do on televisions or smart phones. Most providers do not provide prices publicly, and if they do, the prices typically reflect “charges”—list prices—that often exceed actual amounts collected by several fold. In addition, prices within local markets can vary by as much as 700 percent. For example, MRIs are largely a commodity, but their price varies greatly.

5. Provider Concentration

Even if data were available, and consumers could choose, they might lack options. The relaxation of antitrust guidelines in 1992, 1994, 1996 and 2011—and several subsequent court rulings—has facilitated the breakneck consolidation in local health services markets.²¹ In 2019, 93 percent of Metropolitan Statistical Areas have highly concentrated hospital markets, with weak or nonexistent price competition.²² More recently, hospitals have bid up physician wages to corner the market in outpatient services. Today less than a third of physicians are independent.²³ As in other industries, a central motive for consolidation is pricing power. The prices charged to private patients are determined through annual negotiations between insurers and myriad providers in thousands of local markets. Insurers' ability to hold down prices depends on their ability to exclude high cost providers. Concentration turns the tables, giving high-cost providers the ability to exclude low paying insurers. This gives hospitals and dominant physician groups financial stability and the ability to attract specialists, who in turn drive revenues. In 2016, 67 percent of hospitals were in "systems" (chains), allowing them to leverage their monopoly power in one market to demand higher prices in others.²³

6. Cost Shifting

Medicare and the state-administered Medicaid programs pay for nearly half of health services at a combined cost of about \$1.3 trillion in 2017.²⁴ This purchasing power gives Congress and the Administration the ability to, in effect, set prices. Since the mid-2000s Congress has held the prices the public pays for health services roughly to the rate of inflation—producing a widening gap between public and private reimbursement. The gap in 2015, as documented by CBO, suggests that were the government to pay private prices, the budget deficit this year would increase by several hundred billion dollars.²⁵ Monopoly power has allowed providers to continue providing care inefficiently to Medicare beneficiaries by raising private prices.^{26, 27} This cost-shifting is unsustainable.²⁸

7. Medical Workers

From 2000-2017, the health sector accounted for 33 percent of economy-wide job growth, two-thirds of it in the ranks of nonprofessional support personnel. During this time, medicine's share of the workforce expanded 30 percent.²⁹ In 2014, the Labor Department projected that health care would account for 41 percent of new jobs going forward.³⁰ Yet other indicators suggest that the medical industry has negative or stagnant productivity growth.³¹ The post-2000 trend toward aggressive prescription has helped to drive this hiring. This trend, in turn, is driven by physician specialists, who prescribe more complex care—and hence earn more. In 2015 specialist incomes averaged \$425,000, versus \$251,000 for primary care physicians.³² In response to these incentives, the share of physicians in the specialties grew 48 percent during 2005-2015.³³ The Association of American Medical Colleges (AAMC) predicted that by 2025 there would be a shortage of up to 90,400 physicians—one-tenth of the current physician workforce. Two-thirds of the projected shortage is in the specialties.³⁴

8. Taxes and Regulation

Health insurance redistributes premium dollars from the healthy to the sick, and between other groups as well. Inefficient regulatory policies can transfer income from taxpayers and consumers to providers. Much of the industry's wastefulness is rooted in a tangle of federal and state rules—from the ACA's insurance rules, to the Emergency Medical Treatment and Labor Act (EMTALA), to licensure to privacy—that promote cost shifting, hardwire labor practices, compartmentalize care and drive up costs. These rules, in effect, turn insurers, employers and many hospitals into tax-collectors for a regulatory welfare state that redistributes trillions of consumer dollars with little accountability for efficiency or effectiveness. Many of today's rules were adopted as part of the ACA, to implement a regulatory agenda designed, among other things, to protect some consumers at the expense of others. One result was a deterioration of the exchange risk pool that increased premiums by 44 to 68 percent and may have priced some consumers out of the market.^{35, 36} Taxes imposed by the ACA also directly raise the cost of coverage for consumers, such as the health insurance tax, device and drug taxes and the so-called Cadillac tax.

ADDRESSING RISING COST GROWTH

The ACA provides a cautionary tale about relying on changes in insurance design to address what are essentially medical cost drivers. Coverage rules are a tempting way to redistribute income without raising taxes. But if the underlying medical costs are allowed to grow uninterrupted, even those favored under by new coverage rules eventually will find their costs unaffordable. To address this challenge, CAHC has identified several options, including:

- Reduce spending on health services by implementing payment benchmarks in the 93 percent of provider markets that are uncompetitive
- Expand incentives for value-based payment arrangements for drugs by allowing coordination across payers, manufacturers and providers, and by suspending laws that prevent aggressive price discounts
- Improve medication adherence, a \$300 billion annual problem
- End anti-market practices, surprise billing, and payments for medical errors
- Empower consumers and make health care more transparent by disclosing prices, and provider quality and safety performance
- Expand the availability and use of data (claims and clinical) for consumers, employers, and plans
- Expand provider access to clinical and cost data for outcomes improvement and efficiency (interoperability; Real Time Benefit Check)
- Expand consumer health coverage choices and end public insurance exchange monopolies by transitioning to support of private enrollment tools

While there are no politically easy ways to curb medical inflation, the alternative is even less palatable. Policymakers must shift their focus from fiddling at the margins of health care reform to addressing head on the factors leading to unsustainable cost growth. If they are unable to do so, costs will continue to rise much faster than wages, making coverage less and less affordable for working Americans and cultivating greater economic turmoil and political instability.

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