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U.S. HEALTH CARE COSTS

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- Background
- How is the U.S. health care dollar spent?
- What is driving health care costs?
- What are the major proposals to contain costs?
- Discussion Questions

Background

Health care costs have been rising for several years. Expenditures in the United States on health care surpassed $2.3 trillion in 2008, more than three times the $714 billion spent in 1990, and over eight times the $253 billion spent in 1980. Stemming this growth has become a major policy priority, as the government, employers, and consumers increasingly struggle to keep up with health care costs. [1]

In 2008, U.S. health care spending was about $7,681 per resident and accounted for 16.2% of the nation's Gross Domestic Product (GDP); this is among the highest of all industrialized countries. Total health care expenditures grew at an annual rate of 4.4 percent in 2008, a slower rate than recent years, yet still outpacing inflation and the growth in national income. Absent reform, there is general agreement that health costs are likely to continue to rise in the foreseeable future. Many analysts have cited controlling health care costs as a key tenet for broader economic stability and growth, and President Obama has made cost control a focus of health reform efforts under way.

Although Americans benefit from many of the investments in health care, the recent rapid cost growth, coupled with an overall economic slowdown and rising federal deficit, is placing great strains on the systems used to finance health care, including private employer-sponsored health insurance coverage and public insurance programs such as Medicare and Medicaid. Since 1999, family premiums for employer-sponsored health coverage have increased by 131 percent, placing increasing cost burdens on employers and workers. [2] With workers' wages growing at a much slower pace than health care costs, many face difficulty in affording out-of-pocket spending.

Government programs, such as Medicare and Medicaid, account for a significant share of health care spending, but they have increased at a slower rate than private insurance. Medicare per capita spending has grown at a slightly lower rate, on average, than private health insurance spending, at about 6.8 vs. 7.1% annually respectively between 1998 and 2008. [3] Medicaid expenditures, similarly, have grown at slower rate than private spending, though enrollment in the program has increased during the current economic recession, which may result in increased Medicaid spending figures soon. [4]

How is the U.S. health care dollar spent?

As shown in the figure below, hospital care and physician/clinical services combined account for half (51%) of the nation's health expenditures.

National Health Expenditures, 2008

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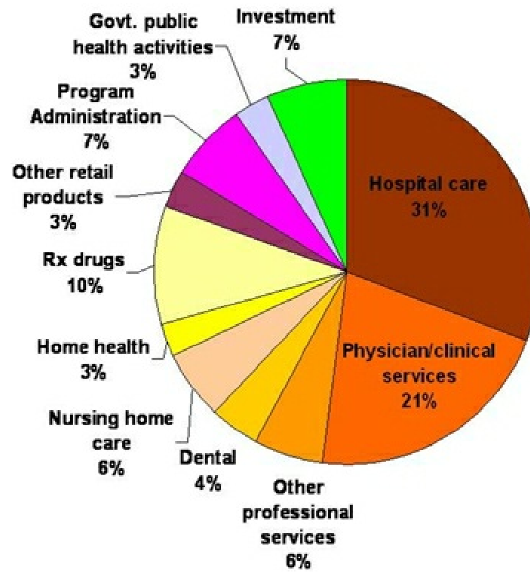

Total = $2.3 Trillion
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

What is driving health care costs?

Controlling health care expenditures requires a solid understanding of the factors that are driving the growth in spending. While there is disagreement on exactly what those are, some of the major factors to consider are:

- Technology and Prescription drugs – For several years, spending on new medical technology and prescription drugs has been cited as a leading contributor to the increase in overall health spending; however, in recent years, the rate of spending on prescription drugs has decelerated. Some analysts state that the availability of more expensive, state-of-the-art technological services and new drugs fuel health care spending not only because the development costs of these products must be recouped by industry but also because they generate consumer demand for more intense, costly services even if they are not necessarily cost-effective. [5]
- Chronic disease – The nature of health care in the U.S. has changed dramatically over the past century with longer life spans and greater prevalence of chronic illnesses. This has placed tremendous demands on the health care system, particularly an increased need for treatment of ongoing illnesses and long-term care services such as nursing homes; it is estimated that health care costs for chronic disease treatment account for over 75% of national health expenditures. [6]
- Aging of the population – Health expenses rise with age and as the baby boomers are now in their middle years, some say that caring for this growing population has raised costs. This trend will continue as the baby boomers will begin qualifying for Medicare in 2011 and many of the costs are shifted to the public sector. However, experts agree that aging of the population contributes minimally to the high growth rate of health care spending. [7]
- Administrative costs – It is estimated that at least 7% of health care expenditures are for administrative costs (e.g., marketing, billing) and this portion is much lower in the Medicare program (<2%), which is operated by the federal government. [8] Some argue that the mixed public-private system creates overhead costs and large profits that are fueling health care spending.

What are the major proposals to contain costs?

The start of a new administration and the economic recession present a new window of opportunity for health care reform and for controlling health costs. However, since the 1960s, the nation's efforts to control health care costs have not had much long-term effect, prompting a debate over what proposals are actually able to sustainably reduce costs. [9] One effort, the advent of "managed care," which represented a shift towards greater control over utilization of services, did initially seem to generate savings as managed care practices became widespread throughout the late 1980s and 1990s. However, spending has since rebounded sharply as the health sector seems to have exhausted one-time savings and a backlash loosened many managed care policies, particularly restrictions on consumer choice. The different proposals currently in the policy arena are divided broadly by debate over a stronger role for government negotiation or market-based models relying on competitive forces.

- Investment in information technology (IT) – Greater use of technology, such as electronic medical records (EMR), has been promoted and researched for its potential to more efficiently share information and reduce overhead costs. $19 billion in federal funding has already been allocated to uniformly upgrade health IT, a major component of the Obama administration's health reform plan, indicating that the movement to invest in IT has gained significant traction.
- Improving quality and efficiency – There are a number of initiatives in play that aim to help make the health care system more efficient and higher quality, and consequently more cost-effective. Overall, decreasing unwarranted variation in medical practice and unnecessary care is seen as a priority, particularly geographic variation, since higher spending on health care in certain geographical areas does not correspond to better health outcomes. Some experts estimate that up to 30% of health care is unnecessary, emphasizing the need to streamline the health system and eliminate this needless spending.
- Adjusting provider compensation – The current system of provider compensation pays physicians a given fee per procedure or test, for example as dictated by the Medicare Physician Fee Schedule guidelines for the value of over 10,000 physician services. Currently, there are proposals to revamp some provider payments to ensure that fees paid to physicians reward value and health outcomes, rather than volume of care. This is meant to eliminate unnecessary care and thereby decrease costs. Comparative effectiveness research (CER) is being increasingly emphasized as a means to determine which treatments are most effective for given conditions, in order to provide doctors with the necessary information to make the best choices for patients' care.
- Government regulation – Citing the success of the Medicare program in controlling per capita spending over its history and warning that market-based approaches combined with greater individual financial responsibility can disadvantage those with limited financial resources and create barriers to needed care, some policymakers favor

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more government involvement in the health care sector. Critics argue that such regulation stifles innovation and that market-based approaches are more cost-effective and will provide consumers with a wider range of choices.

- Prevention - The burden of chronic diseases, such as diabetes and cardiovascular disease, has risen dramatically; both of these chronic conditions are known to be correlated with obesity, smoking, and diet, and are very expensive to treat over long periods of time. Proposals have been put forward to emphasize prevention by providing financial incentives to workers to engage in wellness and prevention, in order to decrease the prevalence of these conditions and avoid incurring the long-term costs of treatment. However, it is unclear how much prevention programs will decrease costs, since paradoxically healthier people will likely live—and use the health system—longer. For those already suffering from chronic diseases, disease management strives to improve and streamline the treatment regimen for common, chronic health conditions.
- Increasing consumer involvement in purchasing – Supporters of "consumer-driven" health care believe that greater price transparency would make consumers more price sensitive and more prudent purchasers and thus save consumers and employers money. One of the major forms currently is tax-favored "health reimbursement accounts (HRA)," to which employers contribute funds that are managed by the employee to spend on primary health care as she directs. Critics of the consumer-directed approach raise concerns about the potential impacts that the higher cost-sharing would have on lower income people and about the potential for these new arrangements to be disproportionately used by healthy people, shifting sicker groups to more expensive forms of insurance.
- Altering the tax preference for employer-sponsored insurance – Currently, employees do not pay income or payroll tax on money employers spend on their health insurance, regardless of the cost of those benefits. Some current health reform proposals suggest eliminating or changing the tax exclusion for employer-sponsored health care to help finance the costs of expanding coverage as well as reducing incentives for the most generous and therefore expensive health plans. One possibility is that the tax exclusion would be capped at the value of benefits received by Members of Congress, and employees opting for more expensive health plans would be taxed on the difference. Those against eliminating the tax exclusion worry doing so could drive up the cost of health insurance to workers and disproportionately affect smaller companies and those with an older workforce, who tend to pay higher premiums.

Costs have emerged as a central element of any national health reform effort. As policymakers move forward with plans to enact comprehensive health reform, costs will surely continue to be at the forefront of the surrounding policy debates.

Discussion Questions

- What are the major drivers of the rise in health care spending?
- 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 different choices do state and federal policymakers have in containing costs?
- What is the responsibility of individuals for the cost of their care? Are health savings accounts and high deductible insurance policies an approach that should be expanded? What are the concerns for low-income individuals?
- How does the rise in costs affect efforts to expand coverage to the nation's 47 million uninsured?

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