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# Issue Brief

## What's Driving Health Care Costs?

PATRICIA SELIGER KEENAN  
JOHN F. KENNEDY SCHOOL OF GOVERNMENT

For more information,  
please contact:

Mary Mahon  
Public Information Officer  
The Commonwealth Fund  
One East 75th Street  
New York, NY 10021-2692

Tel 212.606.3853

Fax 212.606.3500

E-mail [mm@cmwf.org](mailto:mm@cmwf.org)

### Introduction

National health care spending reached \$1.6 trillion in 2002, accounting for one-seventh of the U.S. economy, or 14.9 percent of gross domestic product (GDP).<sup>1</sup> Federal Medicare and Medicaid spending accounted for one-fifth of total federal outlays in fiscal year 2002, with Medicare at 12.7 percent and Medicaid at 7.4 percent of outlays.<sup>2</sup> Health care costs are a longstanding concern to policymakers. For years, health care spending has been rising faster than the rate of economic growth, raising the question of whether we are getting good value for the spending.

### Does Spending Improve Health?

In part because of the financial pressure that rising spending creates, policy debates often focus on restraining spending growth. A common rationale for reducing spending growth is that high spending is wasteful—that it does not lead to improved health status or longevity. Yet, research suggests that over the long term, medical advances are a main driver of spending growth, and such growth does result in improved health.

### *Long-Term Spending Growth*

Economists agree that the main reason for higher spending over several decades is the advance in medical capabilities. A key study concluded that technological change accounts for at least 50 percent of the increase in health care spending between 1940 and 1990, while population aging, increases in health insurance coverage, rising income, increases in physician supply and physician-induced demand, growth of defensive medicine, rising administrative costs or costs for care of the terminally ill, and lower productivity explain less than 25 to 50 percent of the rise in medical care spending over this period.<sup>3</sup> Some economists suggest that the relative similarity in rates of spending growth across countries with vastly different health care systems, shown in Figure 1, provides further support that technological change, common across countries, drives spending increases.<sup>4</sup>

Medical technological change and associated spending over time is shown to result in improved health outcomes for specific conditions.<sup>5</sup> Figure 2 shows that the benefits due to additional life expectancy resulting from treatments for heart attacks,

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cardiovascular disease, and low birth weight infants is greater than the increase in costs, and that the benefits of increased life expectancy for women with breast cancer are equal to the increase in treatment costs. Research also shows that improved treatments for cataracts and for depression have improved quality of treatment at no additional cost, and have resulted in expansion of treatment to additional people, with benefits greater than costs.<sup>6</sup> The benefits from increases in life expectancy from improved medical treatment for two conditions—low birth weight infants and ischemic heart disease—are

about equal to the costs of the entire increase in medical care spending per person between 1950 and 1990.<sup>7</sup> Although further research is needed to learn whether these results hold across additional medical conditions, this research suggests that the benefits from the entire increase in medical care spending are greater than the increased costs.

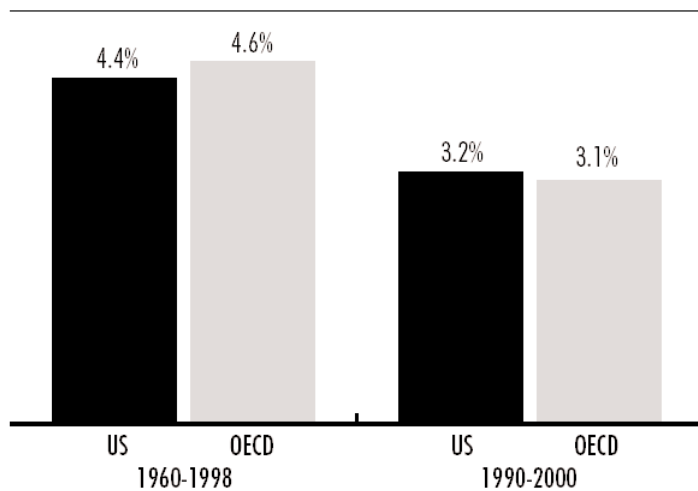
### Health Care Spending Levels

Although spending increases result in overall improvements to health, there is some amount of waste within the system. Two types of research point to inefficiency in health care spending levels: U.S.–international comparisons and geographic variations in spending within the United States.

The United States spends over twice as much per person on health care as the median Organization for Economic Cooperation and Development (OECD) country. Figure 3 shows that U.S. spending levels were higher as long ago as 1960, and remain higher today. Studies have consistently shown that higher income countries spend more on health care. Differences in gross domestic product explain a substantial amount of the variation in per capita health spending across nations.<sup>8</sup> One cause of higher U.S. spending is higher prices paid in the United States, for example for prescription drugs and physician fees.<sup>9</sup> While international comparisons of health outcomes are difficult, studies suggest that despite spending per capita that is nearly double that of the median OECD country, U.S. performance falls below the median OECD country on measures such as infant mortality rates and life expectancy at birth.<sup>10</sup>

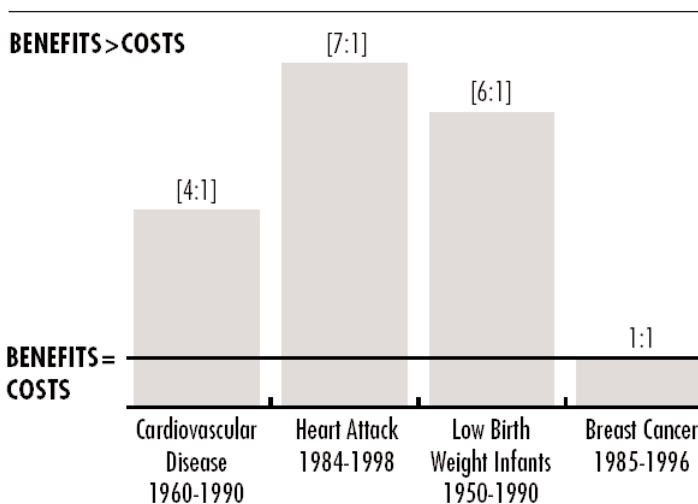
Within the United States, some geographic areas spend more per person on health care than other areas. Research suggests that more intensive physician practice patterns, such as greater use of lab tests and hospitalizations, are a main explanation for differences. Such studies also find that characteristics such as the number of physicians and specialists per capita, hospital beds and teaching hospital beds per capita, health insurance levels, and area differences in medical care prices are important determinants in spending variations.<sup>11</sup> Areas with higher spending levels do not have better health outcomes, rates of delivering appropriate or effective care, or satisfaction with care, compared with lower spending areas.<sup>12</sup> Some have suggested that since areas with higher average spending levels do not have improved health outcomes or quality of care, the Medicare program could cut spending by 15 to 20 percent if spending levels in high areas were reduced to levels in low areas.<sup>13</sup> Yet it is unclear how to put into place policies that will reduce only services of low medical benefit, rather than all

Figure 1  
US and OECD Average Annual Spending Growth



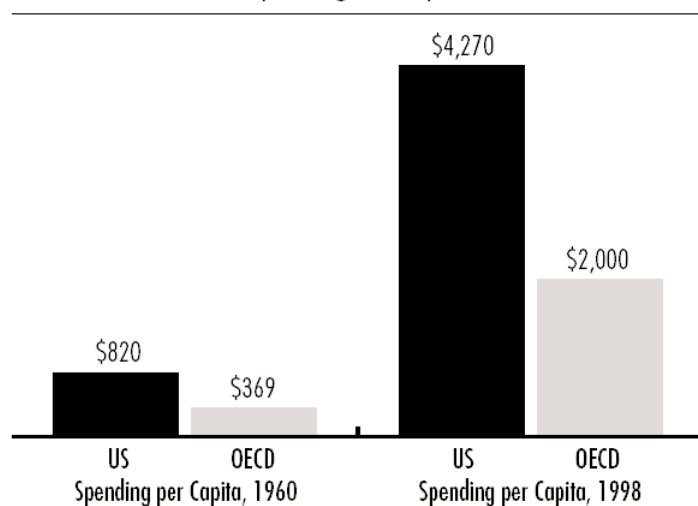
Source: Anderson GF et al., 2001, 2003.

Figure 2  
The Value of Technological Change: Benefits of Increased Life Expectancy vs Increased Treatment Costs



Source: Cutler and McClellan, 2001; Cutler, 2004. An additional year of life is valued at \$100,000.

Figure 3  
US and OECD Health Spending Per Capita, 1960 and 1998



Source: Anderson GF et al., 2000.

services. Studies find similar rates of inappropriate care across low-spending and high-spending areas, suggesting problems with underuse as well as overuse of services.<sup>14</sup> In addition, one study shows that regional variation in angiography rates occurred mostly in categories of patients where the treatment was “appropriate but not necessary” or “uncertain.”<sup>15</sup>

### Recent Trends

Between 1994 and 2000, annual rates of growth in national health expenditures slowed from historic rates of 6.3 percent to 3.8 percent, but returned to historic rates beginning in 2001.<sup>16</sup> A combination of factors explain the slowdown in spending growth in the ‘90s, and its return.<sup>17</sup>

Private health insurance spending slowed as increasing numbers of employees shifted from conventional insurance to lower-cost managed care plans. By 2000, however, enrollment shifted away from tightly managed care plans toward higher-cost plans. In addition, in the 1990s, private insurers held premium increases to artificially low levels to compete for additional enrollees. More recently, insurers have increased premiums at rates higher than the underlying growth in costs to recoup past losses, increase profits, and more accurately cover costs.<sup>18</sup> Private premiums for employers increased by over 10 percent each year in 2001 through 2003, and by 13.9 percent in 2003.<sup>19</sup> Average increases were even higher, 15.6 percent, for employers with fewer than 200 workers.

Medicare spending growth slowed following enactment of the Balanced Budget Act of 1997 (BBA, P.L.105-33), which reduced growth in provider payments.

Congress subsequently enacted two bills that increased Medicare spending, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113) and the Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554). Even including changes enacted in BBRA and BIPA, Medicare spending increased at only 4 percent between 1998 and 2002. This growth rate was substantially less than the 5.9 percent that the Congressional Budget Office had projected shortly after BBA was enacted.<sup>20</sup> The lower growth is attributed to a combination of the BBA legislation, and increased efforts by the Centers for Medicare and Medicaid Services to reduce fraud and abuse.<sup>21</sup> Medicare spending grew at a slower rate than private health insurance between 1970 and 2002, accounting for differences in benefits (such as removing prescription drug costs from private spending).<sup>22</sup>

Medicaid spending slowed in the mid 1990s, reflecting declines in enrollment, low health care inflation, growth in Medicaid managed care enrollment, and declines in disproportionate share payments to hospitals.<sup>23</sup> Federal and State Medicaid spending increased by 25 percent between 2000 and 2002, from \$206 billion to \$258 billion. Two-thirds of the increase is attributable to increased spending for elderly and disabled enrollees, due to a combination of enrollment growth and increases in per-person spending for these groups.<sup>24</sup>

### Responses to Spending Growth

#### *Increased Premium Contributions*

As far back as the late 1980s, employers have responded to rising premiums by increasing the amount that employees contribute toward health insurance premiums.<sup>25</sup> Rising health care costs and increases in employee contributions are associated with declines in coverage rates.<sup>26</sup> Since 2000, the amount that employees pay monthly to contribute toward employment-based coverage has increased 50 percent on average for single and family coverage.<sup>27</sup>

#### *Increased Cost Sharing and Consumer-Driven Health Plans*

In 2000, employers began to increase deductibles that must be paid out of pocket before insurance coverage begins. Employers also have added out-of-pocket payments for hospital care.<sup>28</sup> Insurers and employers also are experimenting with “consumer driven” health plans that combine very high deductibles or medical savings accounts with catastrophic insurance coverage.<sup>29</sup> Because insurance shields patients from the true costs of care, these plans have the potential to make consumers more price-sensitive, which can be beneficial if patients overuse services. Yet they also create the potential to further segment health insurance according to health status. If healthier individuals are more likely to choose high-

deductible plans, this would result in lower average premiums for these plans and higher average premiums for traditional insurance products, such as preferred provider organization plans. In 2003, 17 percent of large employers with over 5,000 employees reported offering a plan with a deductible of \$1,000 or more.<sup>30</sup>

Cost sharing has almost always been a component of health insurance. The RAND Health Insurance Experiment, conducted in the 1970s, showed that the typical consumer did use less care when faced with increasing cost sharing. The study results also raise questions about whether cost sharing creates incentives to use care more effectively. The study found that people reduced consumption of appropriate as well as inappropriate care, and that cost-sharing primarily affected initiation of care rather than the total amount of care used once an individual seeks medical treatment.<sup>31</sup> No such studies have been conducted more recently, although health care services and delivery systems have changed substantially since the 1970s. Cost sharing also places greater financial burdens on individuals with an ongoing need for medical care. A recent study shows that among both the elderly and the nonelderly, individuals pay more out of pocket for health care as their number of chronic conditions increases.<sup>32</sup>

#### *Declining Offer of Future Retiree Coverage*

While employers continued to offer health insurance to workers during the 1990s, several studies have identified a decreasing trend in offering retiree coverage to current employees, beginning in the late 1980s and continuing into the 21st century.<sup>33</sup> These declines will primarily affect the next generation of retirees. Some evidence suggests, however, that employment-based retiree coverage has declined for 65- to 69-year-olds, who are likely to be new or recent retirees.<sup>34</sup>

#### *Managed Care*

Employers and state Medicaid programs responded to higher spending in the 1990s by increasing enrollment in managed care. Experts generally agree that the growth of managed care in the 1990s led to a one-time reduction in spending growth. Some evidence suggests that managed care affects the rate of technological diffusion, which would have long-term effects on spending growth.<sup>35</sup> Research comparing different types of health insurance within a market area suggests that managed care has resulted in cost savings by negotiating lower prices, rather than by reducing the intensity of care. This would indicate one-time effects.<sup>36</sup> Other research finds a “spillover” effect in which areas with higher overall managed care penetration have lower spending for fee-for-service Medicare beneficiaries.<sup>37</sup> This suggests that

managed care may affect provider practice patterns throughout a market area.

#### *Prospective Provider Payment Systems*

Since the 1980s, the Medicare program has increasingly relied on prospectively set payments and updates for hospitals, physicians, and other providers. Proponents point out that more bundled prospective payment systems have resulted in Medicare program savings with little evidence of adverse effects on beneficiaries’ health. Detractors point out that such prospective payment systems face difficulty keeping pace with ongoing technological changes and create incentives to shift sites of care to places where providers receive most favorable payment rates.<sup>38</sup> These critics tend to favor a mix of such systems such that there is some payment for additional utilization.<sup>39</sup>

#### *Medicaid Responses*

In recent years, states have instituted a variety of cost-containment strategies in response to increases in Medicaid spending.<sup>40</sup> The strategies are most heavily focused on reducing or freezing provider payments and controlling prescription drug expenditures.<sup>41</sup> In response to state budgetary pressure from rising Medicaid spending, Congress allocated \$10 billion for a temporary increase in the federal matching rate for state Medicaid spending in the Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27).

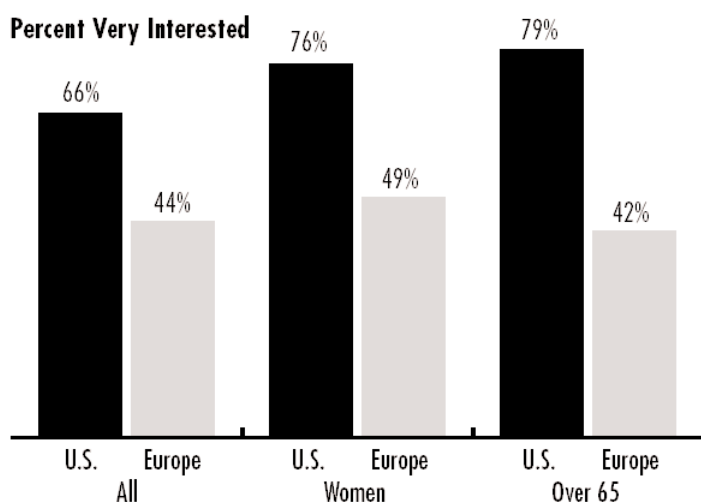
### **Public Attitudes**

Public opinion surveys suggest that people are concerned about high prices of health care, but also value medical technology. As of August 2003, four in ten respondents cite health care costs as the most important problem for government to address.<sup>42</sup> Yet, surveys also show that the public favors increased spending to improve the nation’s health and favors increased government spending on medical research.<sup>43</sup> National opinion surveys suggest that the U.S. public has a greater interest in new medical technologies than people in 12 European countries, with 66 percent of the U.S. indicating they are “very interested” in new medical technologies compared with an average of 44 percent across 12 European nations, with similar patterns across demographic subgroups (Figure 4).<sup>44</sup>

In addition, people view a main approach to contain costs, managed care, with skepticism, although literature reviews find no consistent differences in quality of care in managed care and fee-for-service insurance plans.<sup>45</sup> The public sees managed care plans as holding back on treatment such as cancer care for children and hospital care for newborn babies. Individuals in managed



Figure 4  
Interest in New Medical Technologies, U.S. and Europe, 1992



Source: Kim M. et al., 2001. Europe average is for 12 nations: Belgium, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, United Kingdom.

care plans are more likely to express concern that, if they were to become sick, their plan would be more focused on saving money than on providing the best treatment.<sup>46</sup> A greater share of the public views cost savings from managed care as helping insurance companies earn higher profits (72 percent) than as allowing employers to pay less for insurance (56 percent) or making health care more affordable for individuals (49 percent).<sup>47</sup>

## Conclusion

National health care spending as a share of gross domestic product is projected to reach 17.7 percent in 2012.<sup>48</sup> Responses such as managed care and increased cost-sharing are unlikely to affect the technological change that drives long-term spending growth, nor lead to improvements in quality of care. Since the 1940s, per-capita growth in national health expenditures has increased at a faster rate than GDP growth, resulting in an ongoing increase in the share of GDP devoted to health care.<sup>49</sup> Some have argued that continued increases in health spending as a share of GDP are not inherently a problem if the increased spending finances medically beneficial treatments that people value.<sup>50</sup> Nonetheless, the growth in medical spending creates pressure on policymakers to provide additional financing to maintain or expand access to increasingly expensive medical care services and to create incentives to improve quality of care so that resources are used more effectively.

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