
Health Care Cost Growth, Drivers, and Implications for States

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Many factors are driving health care costs including technological advances, the decline in the prevalence of managed care, inappropriate use of health care services, and consumer incentives and lifestyle behaviors. For example, advances in technology are thought to account for a majority of increases in health care spending. According to recent studies, the overuse of health care services has also driven up costs, without improving health outcomes. Lifestyle behaviors like tobacco smoking account for 7% to 14% of annual medical spending and obesity-related expenditures account for an estimated 9%. States play three critical roles in the health policy arena, each that shape the strategies they can use to address health care costs: (1) purchaser of health care for low-income populations through Medicaid and other programs, (2) employers that provide health benefits to states employees, and (3) policymaker and marketplace regulator that affects the rules of pricing and competition. Leitz uses this framework to discuss Consumer Health Savings Accounts, one type of consumer-driven plan that aims to promote efficient, effective spending by consumers. Overall, Leitz concludes that long-term solutions will require more than shifting costs to other services or payers. Opportunities exist to place a greater emphasis on high-quality care, cost-efficient services, and evidence-based medicine.

Rising health care costs have captured the attention of citizens and policymakers alike. Although some of the factors that are driving increased costs are outside the control of policymakers, states can play a variety of roles and use a number of strategies to help control health costs. In the short run, strategies that shift costs may result in some temporary relief from rising health costs. However, strategies that reduce costs in the mid- to longer-term may require different approaches.

This chapter begins by examining how rapidly health care costs are rising, and how increased health care costs are affecting state budgets, employers, and workers. Next, the chapter examines the drivers of rising health care costs and what roles states can play in containing costs. Finally, Health Savings Accounts, a policy option that has gained attention in Wisconsin, is discussed from a state perspective.

How Important is Health Care to the Overall Economy?

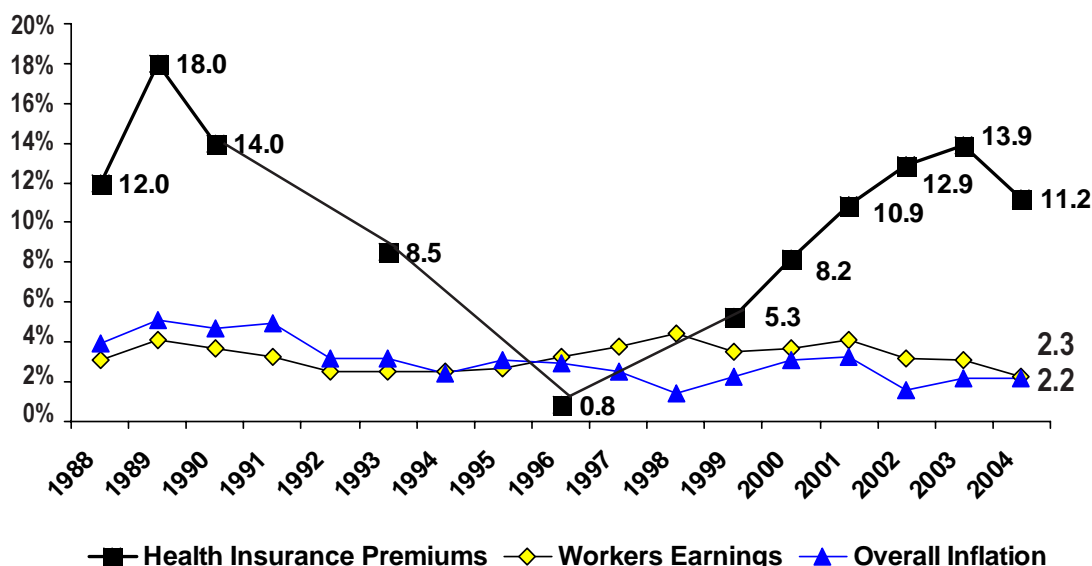
To place health care premiums and spending increases in context, it is important to know how health care fits into our economy. Overall, the United States spent \$1.6 trillion on health care in 2002. This figure reflects nearly 15% of the U.S. economic output. The portion of our economy that is devoted to health care services has grown rapidly over the past 40 years, as health care expenditure growth has exceeded growth in the overall economy.

How Much Have Health Care Premiums and Costs Increased for Employers and Workers?

Businesses have seen the cost of health insurance provided to their employees increase dramatically since the late 1990s. As private sector health care costs have grown, pressure has been placed on both the ability of private employers to offer coverage, and on employees to continue to buy into that coverage.

Employers have faced double-digit increases in their health insurance premiums over the last four years. These increases have risen more rapidly than wages or inflation (see Figure 1). In fact, premiums increased nearly five times faster than the increase in workers' wages between 2003 and 2004. These increases have placed pressure on employees as well. For example, as increases in health insurance premiums continue to outpace the growth in workers' wages, workers are paying a larger percentage of their wages on health insurance, potentially making that coverage increasingly unaffordable.

Figure 1: Increases in Health Insurance Premiums Compared to Workers' Earnings and Overall Inflation, 1988 to 2004 (In Percentages)



Source: Kaiser Family Foundation/Health Research & Educational Trust Survey of Employer-Sponsored Health Benefits: 1999-2004; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996.

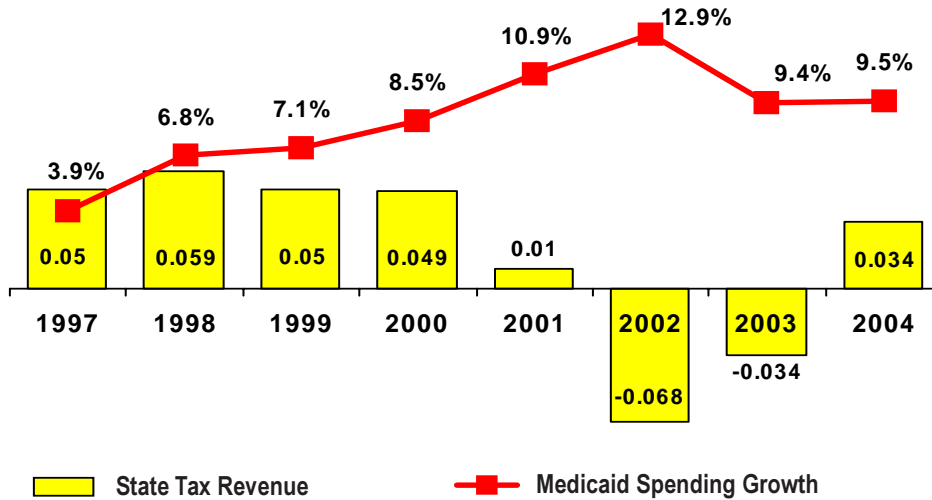
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

In addition to the increase in health insurance premiums for employers, the increase in health care costs—that is, the amount actually paid in claims for health care services—has also outpaced growth in the economy. Since 1998, the growth in underlying health care costs for privately insured consumers has outpaced overall economic growth, reversing the trend of the mid-1990s.¹

What Portion of State Budgets is Spent on Health Care?

Rising health care costs have also taken on an increasingly important role in state budgetary discussions. One reason is that state spending on health care has grown faster than the increase in revenue (see Figure 2).

Figure 2: Underlying Growth in State Tax Revenue Compared with Average Medicaid Spending Growth, 1997-2004



Note: State Tax Revenue data is adjusted for inflation and legislative changes. 2004 is a preliminary estimate.

Source: Analysis by the Rockefeller Institute of Government of data from the Bureau of the Census, Bureau of Economic Analysis and the National Association of State Budget Officers.

States spend over one-fourth of their budget on health care. In fiscal year 2001, states spent an average of 30% of their total budgets on health care expenditures.² This increased from 29% in 2000 and 27% in 1999. As shown in Table 1, the largest share of states' health care expenditures in 2001 was allocated to Medicaid (69%); the second largest category was employee health benefits (8%).

Wisconsin is below average in the percentage of its budget spent on health care. In fiscal year 2001, Wisconsin spent 16% of its budget on health care expenditures (see Table 1).³ However, Wisconsin distributed its health expenditures similar to the average state. In 2001, Wisconsin allocated about two-thirds (66%) of its health expenditures to Medicaid and 10% to employee health benefits.

On average states spent 30% of their budgets on health care expenditures in 2001, compared to 16% in Wisconsin.

Table 1: State Expenditures on Health Care in 2001

	Health Care Budget as Percent of Total Budget	Percent of Health Care Budget Spent on Medicaid	Percent of Health Care Budget Spent on Employee Benefits
Wisconsin	15.9%	66.3%	9.8%
U.S. Average	29.9%	69.2%	8.3%

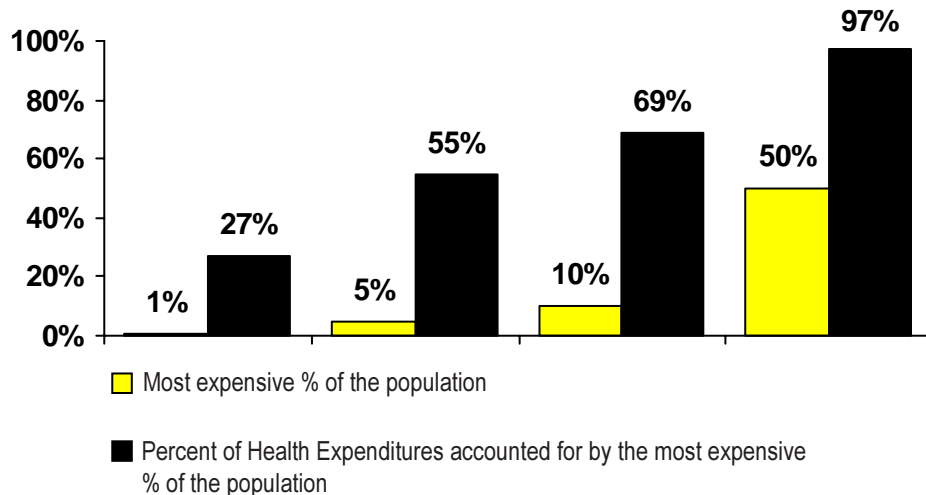
What is Driving the Increase in Health Care Costs?

Most factors acting to increase health care costs are ones that affect both private insurance costs and publicly-sponsored health care services.

One important factor to keep in mind when examining health care cost increases or strategies that address these increases is the context within which health spending occurs at the population level. In particular, it is important to note that a relatively small percentage of the population spends the most on health care.

High health care spending is limited to a small percentage of the population (see Figure 3). Specifically, 1% of the population accounts for 27% of all health care expenditures in the United States, and 5% of the population accounts for 55% of expenditures.

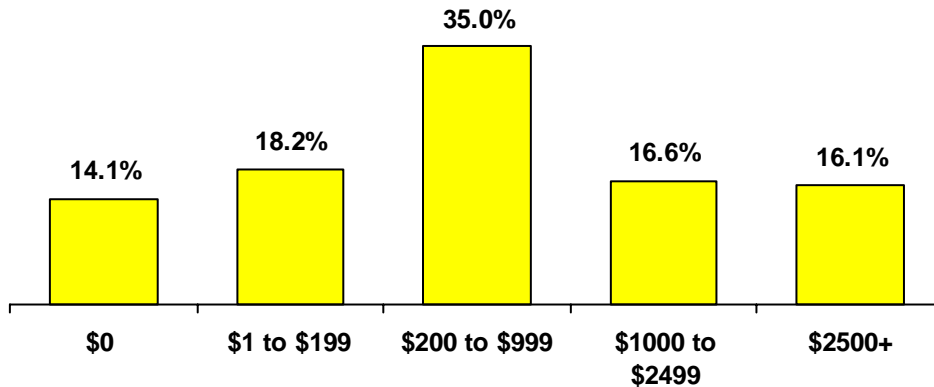
Figure 3: Concentration of Health Care Spending in the Most Expensive Portion of the Population



Source: Berk and Monheit, "The Concentration of Health Care Expenditures, Revisited," Health Affairs, March/April 2001. Expenditure estimates are for the civilian non-institutionalized population.

How does this translate into dollar amounts? About two-thirds (67%) of people with private health insurance spend less than \$1,000 for out-of-pocket health care expenses. The most expensive 16% of the population spends over \$2,500 each year (see Figure 4). These numbers have important implications for strategies that states can use to control costs; any strategy will have to take into account how it will affect high-cost consumers.

Figure 4: Distribution of Health Spending Among People with Private Health Insurance



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey.

A number of drivers affect health care cost growth, five of which are mentioned here:

Technology. Most economists believe that technological advances account for a majority of increases in health care spending over the longer term. Economists estimate that at least half of health care cost increases are due to advances in medical technology.⁴ This means that health conditions can now be treated more effectively, but often at a higher cost. A widely-cited study examined whether the benefits of this increased spending on medical technology outweighed the costs. In four of five conditions (i.e., heart attacks, low birthweight infants, depression, and cataracts), the estimated benefit of specific technological advancements far exceeded the costs. In the fifth condition (i.e., breast cancer), the benefits and costs were roughly equal.⁵

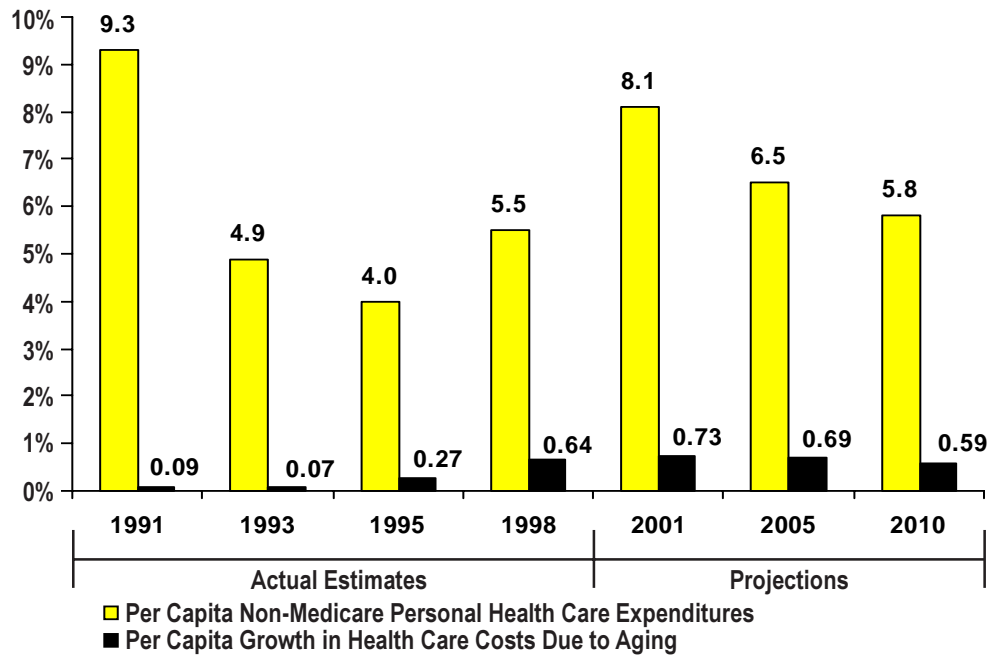
Some health care experts have recently raised concerns about a renewed “medical arms race.” If expensive technologies are available at too many regional hospitals and clinics, this duplicates services and drives up costs. Recently, hospitals’ strategic emphasis has changed significantly. In the mid-1990s, hospitals primarily competed on price through “wholesale” strategies (i.e., providing services attractive to *managed care plans*). By the early 2000s, nonprice competition was becoming increasingly important and hospitals were reviving “retail” strategies (i.e., providing services attractive to *individual physicians and the patients they serve*).⁶

Aging Population. Surprisingly, most analyses show that aging has not yet become a major factor in health care cost growth.⁷ That is, the cost of covering and treating individuals over age 65 has not resulted in dramatic increases in health care costs for the rest of the population. In 1998, for example, consumers spent 5.5% more on health care than in 1997. Population aging accounted for about 9% of this increase. Projections for 2005 and 2010 suggest that increases due to the aging population will stay around 9% to 10% (see Figure 5).

Technological advances are estimated to account for at least half of health care cost increases.

However, aging is expected to become increasingly important in the future. Use of hospitals, physician services, and pharmaceuticals increases with age. As the baby boomers grow older, it is likely that their use of services will increase, potentially straining current health care resources.⁸

**Figure 5. Effect of U.S. Population Aging on Health Care Costs
(Annual Percentage Change)**



Source: Strunk, B.C., & Ginsburg, P.B. (2002). *Aging plays limited role in health care cost trends*, (Data Bulletin No. 23). Washington DC: Center for Studying Health System Change.

The Decline in the Use of Managed Care. Most analysts believe that the decline in the prevalence of managed care has contributed, at least in the short- to mid-term, to the increase in health care costs. The percentage of private health plan enrollees in HMOs rose substantially in the mid-1990s, doubling between 1988 and 1996, as employers turned to managed care to help control health care cost increases.⁹ These plans used restricted networks to negotiate lower costs with providers. Also, tools such as utilization review and gatekeeper physicians controlled usage by plan members.

During the latter part of the 1990s, a tight labor market along with provider and media backlash against managed care led many employers and managed care health plans to loosen many of the “heavier” aspects of managed care. Managed care plans established broader provider networks and loosened restrictions on access to providers by, for example, providing more direct access to specialty care. As a result, many analysts believe this resulted in providers being able to leverage higher rates, and consumers being able to utilize more services. While these changes in the use of managed care may have brought positive results from a consumer-access perspective, they also contributed to the growth in overall health costs.

Overuse, Underuse, and Misuse of Health Care Services. Based on growing evidence, the U.S. health care system has high levels of overuse, underuse, and misuse of health services. In fact, many of the pay-for-performance purchasing initiatives currently under consideration are a direct response to this.

Overuse of services, in the form of unnecessary services, tests, and procedures, can drive up health care costs, while not producing any noticeable gains in health outcomes. Researchers at Dartmouth Medical School concluded that Medicare beneficiaries in higher-spending regions of the United States received approximately 60% more care than those in lower-spending regions. However, they did not have better quality of care, better access to care, higher survival rates, or better health outcomes.^{10, 11}

Misuse of the system is evident in medical errors and preventable mistakes. These errors and mistakes not only lead to serious injuries and death, but also add to costs. The Institute of Medicine estimates that between 44,000 and 98,000 persons in the U.S. die annually in hospitals from preventable medical errors, resulting in \$17 to \$29 billion annually in increased health care costs, lost income, and lost productivity.¹²

Finally, underuse of the system is also prevalent and well-documented. For instance, recent studies have shown that only approximately half of adults in the United States receive recommended levels of preventive, acute, and chronic care.¹³

Consumer Incentives and Lifestyle Behavior. Because of the widespread use of third-party payment in our current health care system and the complexity of the health care services delivered, consumers are frequently removed from knowing either the cost of the services they consume or the quality of care they receive. As a result, there is little incentive for consumers to utilize care in a cost-effective manner. Some analysts believe that an increased awareness of the cost and quality of health care consumed by patients would contribute to a more efficient and effective health care system. In fact, much of the recent interest in consumer-driven health plans, including Health Savings Accounts, is based on this premise.

The lifestyles led by consumers also contributes to health care cost growth. For example, tobacco smoking is estimated to account for between 7% and 14% of annual medical spending in the U.S, and obesity for an estimated 9% of annual medical spending.^{14, 15}

Not all factors driving health care cost increases can be directly influenced by policymakers, such as the emergence of new technology, the aging of the population, and an individual's genetic factors. Acknowledging all of these factors, however, can paint a more accurate picture of the complexity of health care costs and which aspects state policymakers can affect.

Tobacco smoking accounts for 7% to 14% of annual medical spending and obesity for an estimated 9%.

What Role Can States Play in Addressing Health Care Costs?

States play three critical roles in the health policy arena.

As a large employer and purchaser, state employee groups are often in a position to be a leader for other purchasers.

States are **purchasers** of health care services for low-income populations through Medicaid and other programs. In recent years, Wisconsin and other states have expanded their public health insurance programs. These expansions have increased access for many people, with a corresponding increase in the state's health care budget. These budgetary pressures are even more pronounced in tight economic times. Enrollment in publicly-sponsored health programs tends to be counter-cyclical. As the economy softens and incomes stagnate, more persons become eligible for public programs; at the same time, less tax revenue is generated to operate them.

States face several challenges as purchasers of health care services for low-income populations. Budgetary constraints make it difficult to maintain or enhance payment levels to health plans and providers, or to finance future expansions.

States are **employers** that provide health benefits to their employees. Because they are among the state's largest employers and purchasing groups, state employee groups are often in a position to be a leader for other purchasers.

States face special challenges as employers, three of which will be mentioned here. First, state workforces are aging, which may increase costs because older workers are, on average, higher health care users. Second, benefits such as health care have traditionally been a tool that states, as employers, have used to recruit and retain employees. Therefore, changes to the benefit structure may affect their ability to attract a competent workforce. Finally, many benefits within state governments are collectively bargained. As a result, states face a unique challenge in innovating or reorganizing their health benefits compared to many private-sector employers.

Finally, states are **policymakers** that regulate the insurance marketplace, have responsibility for health care access issues, and affect the rules of pricing and competition. States are often prompted by businesses, consumers, and providers to act on a given issue. For example, states have been pressured to respond to increases in pharmaceutical prices, with some states making arrangements with Canadian pharmacies for reduced-cost drugs.

As policymakers, states must address consumers who are concerned about both costs and access to services. In addition, states face pressure from employers about rising costs. In the past, states have tried a variety of approaches to address these concerns, such as certificate of need programs, health planning, hospital rate setting, and, more recently, widespread use of managed care. At present, there appears to be little consensus over what the next best strategy is for curbing rising health care costs.

The state's role as purchaser, provider, and policymaker/marketplace regulator, each with their unique challenges, shape the strategies that states can use to address rising health care costs. Several strategies are described below.

What Strategies Can States Use to Address Rising Health Care Costs?

State as Purchaser on behalf of low-income populations. As purchaser of health care services, states should first seek to understand the drivers of Medicaid and other health program expenditures. Medicaid programs have a wealth of data that can be analyzed and examined to identify areas of high growth. Many states have developed an increasingly sophisticated means of doing this.

Given that much of state Medicaid budgets are driven by the needs of chronically-ill populations and those in need of long term care, states have begun to invest in disease management programs (although the long-range cost savings from these programs is unclear at present). States are also continuing to examine how best to integrate support services with delivery of health care services. Finally, on the acute care side, states are increasingly using creative strategies to reexamine benefits covered under Medicaid. States are experimenting with premium subsidies and a variety of other methods that attempt to leverage existing private sector contributions to maintain or expand coverage for low-income populations.

State as Employer. As employers, it is important that states analyze and understand the cost drivers for their employee populations.

States are exploring a variety of strategies to control health care costs for their state employee populations. Many of these strategies are similar to those being used by large private sector employers. These include the introduction of consumer-directed health plans, examination of various pay for performance or value-based purchasing initiatives, and selective contracting with cost-effective or high-quality providers.

State as Policymaker. In the current political environment, it seems unlikely that most states will move toward a highly regulatory approach toward containing health care costs. Many states are likely to examine strategies which balance a competitive approach to cost containment with some level of regulation. As strategies are implemented, it is important for states to collect and analyze data to determine the drivers of health care cost increases, and monitor the impact of policy interventions.

States as policymakers are considering a variety of approaches. Some include trying to place limits on the supply side of the health care market. This might include reexamination of existing strategies such as certificate of need. On the demand side, states are examining strategies that encourage consumers to become more involved in health care decisionmaking. In the short run, consumer engagement may simply take the form of higher cost sharing by consumers. However, states may also want to examine insurance innovations such as consumer-directed health plans and Health Savings Accounts.

In addition, it is possible that states may feel pressured to decrease mandates and taxes in the system. The extent to which reducing mandates will lower overall health costs is unclear. In fact, studies indicate that mandated benefits account for only 5% to 8% of total spending. In addition, repealing mandates may produce only a one-time savings and may not address underlying cost trends. However, this cost reduction would likely be real and may produce at least some short-term cost relief.

In the health policy arena, states are purchasers, employers, and policymakers/marketplace regulators that affect the rules of pricing and competition.

What Questions Should Policymakers Ask About Health Savings Accounts?

Consumer Health Savings Accounts (HSAs) are one type of “consumer-driven” health plan. These plans aim to promote wise spending habits by making consumers aware of the costs of their health care. HSAs must be combined with high-deductible health insurance plans. Consumers face some level of out-of-pocket payments for their health care before the deductible kicks in. Advocates of these accounts argue that the account encourages consumers to use their health care services wisely and cost-effectively. HSAs raise a number of issues in each of the roles that states play in the health policy arena.

State as Employer/Purchaser. On average, state workforces tend to be older and more heavily unionized. States may be concerned that low users of health services, who tend to be healthier, will select HSAs. Higher users of health care are more likely to remain in traditional health plans, which could end up raising the premiums of these plans.

Another issue is the contribution requirements which could be higher under HSAs than traditional plans. In states where state employee groups are self-insured, states pay enrollee claims as they are incurred. Therefore, non-users, who account for approximately 15% of a given large group, do not contribute to the overall cost of the group. Under HSAs, however, the state would make contributions to the HSAs of both health care users and non-users. As presented in Figure 4, most consumers spend less than \$1,000 each year on health expenses. The state would, in effect, be making contributions to a low-users’ health plan, which does not occur in the current system.

State policymakers must determine whether any cost savings in the whole pool’s health insurance premiums outweigh the additional contributions that will be made to low health care users’ HSAs.

State as Policymaker and Regulator. Because HSAs are a new option in the marketplace, states will have to monitor their effect and ask the following questions:

- ❖ Will there be any cost savings in the system? Early studies on HSAs are mixed regarding cost savings; more research is needed.
- ❖ How will risk segmentation issues play out over time? Will the healthy and wealthy be more apt to join HSAs? We will not know the extent of market segmentation for a few years.
- ❖ How will the high deductibles under HSAs affect affordability of health insurance, especially for low-income workers? Will low-income workers be unable to afford employer-sponsored coverage and spill over into the public insurance market?
- ❖ As consumers pay more out-of-pocket costs for their care, will there be an increase in uncompensated care? Providers often find that it is more difficult to collect payment from individual consumers than from insur-

Will low-income workers be unable to afford the high deductibles and spill over into public insurance programs?

ance companies. Because consumers will be responsible for the first dollars spent on health care each year, providers may have more uncompensated care if they are unable to get payment for their services.

- ❖ Will consumers be more likely to use less care or delay needed care because they must pay for the complete cost of services before their deductible is met? Or will exempting preventive care from the required deductible offset this risk?
- ❖ Do consumers have the information they need to make decisions about cost-efficient and high-quality health care? If this information is not available, who is responsible for providing it?
- ❖ Finally, because HSAs lower a consumer's taxable income, will there be a noticeable reduction in the income tax states collect? The reduction is probably not large, but it may be an issue for the legislature to consider.

Will consumers have the information they need to make decisions about efficient, high-quality care?

Conclusion

Many factors are driving the increase in health care costs. Some of these factors are not in state policymakers' control, yet policymakers do have opportunities to reduce cost growth. As policymakers debate their options, long-term solutions will require more than shifting costs to other services or payers. Real solutions will address the underlying reason for increased costs and take steps to contain them. Consumers have a role to play in containing costs as well, but they need more information in order to make better decisions. Opportunities exist in the current system to place a greater emphasis on high-quality health care, cost-efficient services, and evidence-based medicine.

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