



What Drives Rising Health-Care Costs?

BY MARK MACK

Government leaders across the United States are concerned with rising health-care costs — but what are the root causes of those large and persistent annual increases that we all have learned to take for granted? Understanding those forces could help you better understand the strategies you need to contain the cost of your employer-provided health benefit. Research conducted by the Commonwealth Fund found that family plan premiums for private employer-based health insurance (the type typically found in most local government organizations) grew an average of 7.3 percent a year between 2003 and 2013. Employee premium contributions grew an average of 9.3 percent a year in the same period.¹ The study also found that deductibles for firms of all sizes more than doubled over this timeframe, causing premiums and deductibles to combine for a greater share of an average family’s income than ever before. These facts clearly illustrate the challenges posed by rising health-care cost.

This kind of cost growth is not inevitable; clear and striking differences exist in the U.S. rate and that of other industrialized nations. Observers might assume that the high costs in the United States are related to higher capacity (an ability to do more for patients) or greater utilization (patients electing to purchase more health care than their peers in other countries). They might also assume the higher spending totals produce a superior level of care. But some findings contradict this belief. Research conducted by the Organization for Economic Co-operation and Development (OECD) Health Division (2006) found that the United States fared poorly when compared against 30 other industrialized

nations with market economies. Take the number of physicians per capita for instance. The OECD found that the United States had 5.8 physicians per capita, while the OECD median was 5.9, suggesting a roughly equivalent doctor to population ratio.² The OECD median for average hospital stay is almost two days longer than that of the United States, suggesting a higher utilization of hospital beds. Taken together, these findings seem to suggest that the United States simply has higher prices for similar goods. (See Exhibit 1.)

SPENDING MORE AND BUYING LESS?

If we conclude that the U.S. spends more than other industrialized nations for comparable utilization rates, the next logical question is why. Why is the United States willing to pay more than other countries for what appears to

be similar health-care utilization? The answer to this question may be found not in what we purchase but rather in the way we purchase health care — namely, the separation of payment and consumption. Economists believe this separation of payment and consumption affects purchasing decisions by introducing an element of irrationality into the buying process — the true value of consumers’ purchases are not determined in the same way

they would be if consumers experienced the full cost at the time of consumption. Some researchers in the fields of behavioral and health economics think high-deductible health-care plans (HDHPs) offer a solution to this challenge.

Unfortunately, the “spend-more-buy-less” situation is not the only catalyst for rising health-care costs in the United States. Other, more traditional challenges — waste-

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Exhibit I: Per Capita Spending for the U.S. Canada, and OECD Median

Time Period	United States	Canada	OECD Median
1 Year	\$6,393.68	\$3,292.23	\$2,710.22
5 Years	\$35,187.06	\$17,838.92	\$14,797.25
10 Years	\$79,630.21	\$39,563.57	\$33,149.26

Data Provided By Organization for Economic Co-operation and Development

ful spending, prescription drug cost, advances in medical technology — also play a role, exacerbated by an aging workforce, unhealthy lifestyles, high administrative costs, and service provider consolidation that creates an apparently insurmountable climate of cost growth. Public-sector public-finance professionals need a robust understanding of this dynamic before they can begin addressing these challenges.

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WASTEFUL SPENDING

Wasteful health-care spending generally takes the form of redundant, inappropriate, or unnecessary tests and procedures that are recommended by physicians (and also frequently requested by patients). Some believe physicians “over-prescribe” in an effort to avoid litigation or to appease demanding patients, while others believe the goal is simply to increase profitability. The reasons believed to be driving patient’s demands for high-priced care also vary. Value-based insurance design, which steeply reduces or eliminates the cost of preventive care, might help combat this challenge. The approach seeks to decrease the frequency of expensive procedures, thereby reducing overall cost. Activities such as wellness visits and some treatments such as blood pressure medication would be provided at no charge or a drastically reduced rate.

Technology Creep

The use of CT and MRI scans grew more than 15 percent annually between 2000 and 2004. CT angiograms, typically used to detect heart disease in patients with chest pain, are now commonly used to screen people with no symptoms. There is also no solid evidence that the additional treatment improves or prolongs life. At more than \$1,000 per image, the costs add up. (Randy Dotinga, “Huge Rise in CT, MRI, Ultrasound Scan Use: Study,” *U.S. News and World Report*, June 12, 2012.)

PRESCRIPTION DRUGS

U.S. prescription drug spending doubled between 1995 and 2000, reaching \$122 billion, according to a 2003 report by the National Institute for Health Policy.³ Despite significant efforts to control cost (e.g., encouraging employees to purchase generic drugs), prescription drugs remain among the top three cost growth categories, along with hospital usage and physician services. The causes for rising prescription drug cost are twofold:

1) purchasing habits, or the propensity of patients to select brand-name drugs; and 2) the type of drugs being consumed. What’s striking about the first cause is that the cost difference between brand-name-drugs and their less expensive generic counterparts is so well known that some studies categorized the cost difference between the two as “waste” because this cost difference should be avoidable. Programs aimed at changing purchasing behavior help by educating employees about the similarities and differences between brand-name and generic drugs. According to the AARP’s Public Policy Institute, plan participants who “viewed generic and brand name price comparisons were 60 percent more likely to select a generic drug than those who did not conduct price comparison exercises.” The study also cited a 22 percent increase in plan participants switching to generic drugs because of direct-mail educational efforts.⁴ Web-based shopping tools have also increased the likelihood of selecting less expensive drugs by making that option simpler and more user-friendly. Tools such as tiered prescription drug benefits, which charge plan participants different co-pay amounts depending on the tier their drug is in, may offer a viable cost control option as well.

ADVANCES IN MEDICAL TECHNOLOGY

Congressional Budget Office (CBO) testimony pointed to advances in medical technologies as a primary driver of increasing health-care costs.⁵ Advances in medical technology are obviously important, but there is no requirement that effectiveness be demonstrated before a technology is adopted in the U.S. health-care market. This may be due in

part to a large appetite for innovation among U.S. health-care consumers. Eagerness for innovation, however, seems to have created a culture where medical technologies are adopted prematurely and new medical technology is employed for additional uses beyond the original intent. In some instances, technologies that offer only marginal improvements over existing treatments — but with dramatically higher price tags — are adopted broadly and rapidly.

The average patient wants the most modern care available, often regardless of price.⁶ This creates an inherent problem from a cost-control perspective because people usually view their health as their most valuable asset. Complicating the matter further is that the consumers setting the fair market value for such advances in medical technology — by being willing to pay for them — often aren't willing to bear the full cost burden. Purchasers do not typically pay for the services they consume at the time of consumption. Payment for care is almost exclusively a function of insurance companies, with the consumers paying a fraction of the actual cost in the form of a co-payment. This would distort the value assignment in a buying transaction under any circumstances, but when a patient's health is in jeopardy, he or she is more motivated than usual to make the purchase (i.e., procure treatment), leading patients to seek advanced treatments or technology. An approach that could help here is evidence-based medicine, which was pioneered by Oxford University with the goal of going beyond empirical "support" to encourage the use of only the strongest types of empirical "evidence" such as meta-analyses, systematic reviews, and randomized control trials for medical treatment recommendations.

AGING WORKFORCE

Workers who are 55 or older will likely make up approximately 26 percent of the labor force by 2022, compared to 21 percent in 2012 and just 14 percent in 2002, according to the Bureau of Labor Statistics. This aging population is expected to play a large role in the increased cost of Medicare,

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Medicaid, and health care generally over the next 25 years. As this generation ages, more people will require increased levels of care, creating more demand. When demand increases, suppliers can usually charge more, further driving up costs. In this case, wellness clinics may be able to reduce the likelihood of catastrophic medical events through early detection and increased preventative care.

UNHEALTHY LIFE STYLES

Increases in addictions, obesity rates, and inactivity are all linked to chronic health conditions that cause some of the heaviest use of medical services. Chronic diseases are the most common and costly of all health problems, but they are also the most preventable. People who have three or more chronic diseases fall into the top 1



percent of patients who account for 20 percent of all health care spending in the United States. The extent to which an employer endorses health improvement initiatives can play a significant role in an employee's lifestyle choices.⁷ Employers can make a difference here by supporting healthy lifestyles among employees; one strategy is implementing a formal wellness program.

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offering incentives or passing costs along to employees is not sufficient. Studies on monetary incentives for smoking cessation demonstrate that a one-dimensional approach can fall short. This is because without multidimensional and sustained involvement from the employer, employees typically relapse shortly after the incentive ends. On the other hand, multidimensional approaches such as wellness

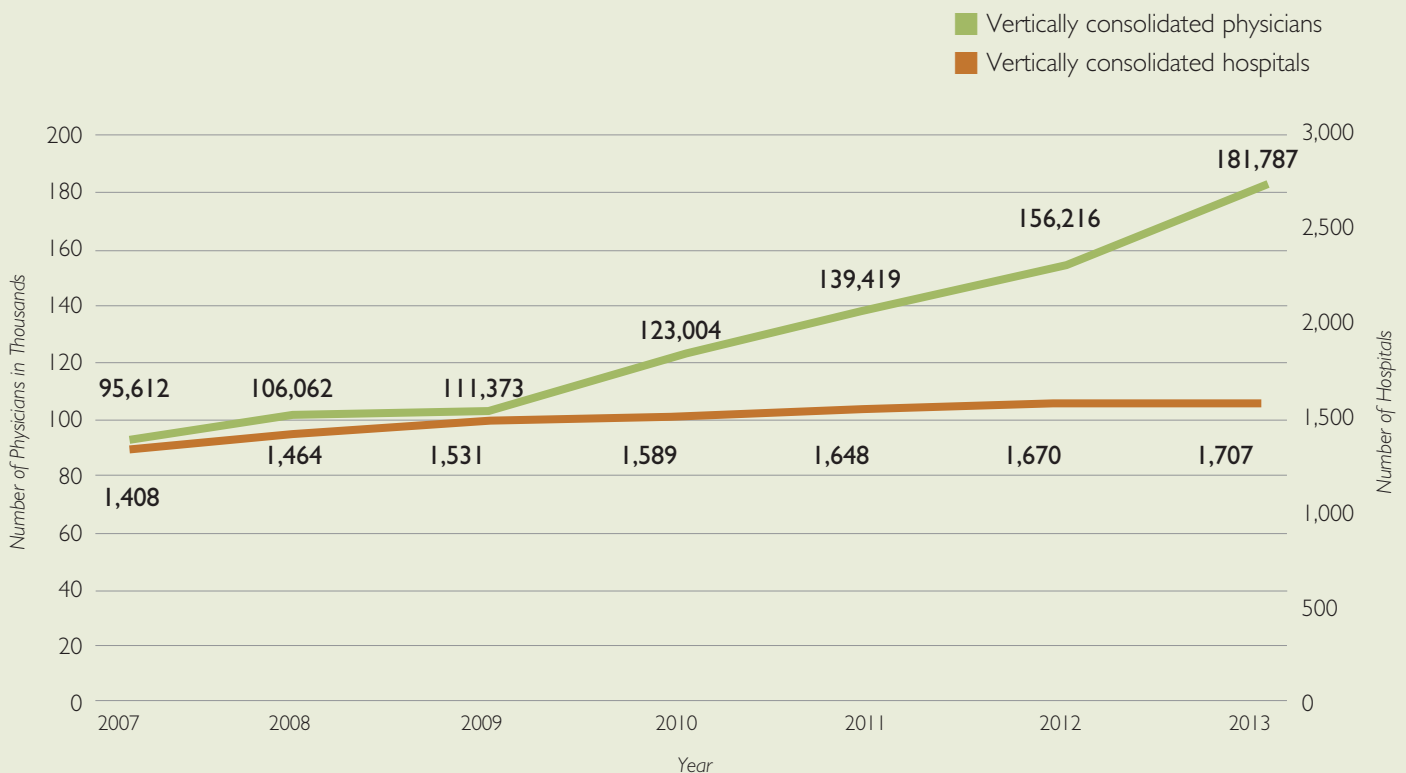
If employer support can truly reduce addiction, obesity, or inactivity, then it would seem reasonable to assume that doing so might lead to a reduction in the medical costs associated with these conditions. One approach to curbing unhealthy behavior is an addiction (e.g. tobacco) cessation program, coupled with cost-sharing programs like HDHPs. Still, simply

programs and onsite clinics, coupled with incentives or cost-sharing, yield sustained results.⁸

HIGH ADMINISTRATIVE COSTS

Administrative costs include spending by public and private health insurers that are not actual payments to

Exhibit 2: Number of Vertically Consolidated Hospitals and Physicians, 2007 to 2013



Source: GAO analysis of American Hospital Association data. | GAO-16-189

health-care providers, including costs incurred by other system participants such as providers, employees, and consumers working with insurers. High administrative costs have often been cited as a contributor to health-care cost inflation; in a 2014 University of Tennessee survey, nearly 30 percent of local governments cited administrative cost as a major driver.⁹ This is due, at least in part, to the highly complex nature of private health insurance in the United States (e.g., state-by-state limitations on where health insurance can be purchased).

The 2010 Patient Protection and Affordable Care Act made significant strides in containing administrative costs, primarily by limiting insurance company profit margins. Still, self-insurance — whereby the employer assumes the financial risk for providing the health-care plan, basically paying for each claim instead of paying a fixed premium to an insurer — can further increase savings in this area by completely eliminating the profit margin component. In self-insured plans, any payments employees make toward their coverage go through the employer's payroll department. According to the Employee Benefits Research Institute, the percentage of private-sector workers in self-insured plans jumped from 40.9 percent in 1998 to 58.5 percent in 2011.¹⁰ While most self-insured employers have more than 50 workers (largely because of the cash flow required to meet this obligation) the practice seems to offer promise for larger government jurisdictions.

SERVICE PROVIDER CONSOLIDATION

Consolidation of service providers also increases health-care costs. Hospitals are acquiring physician practices and consolidating with other hospitals under a single network with increased regularity. According to a 2015 report by the Government Accountability Office (GAO), the number of physician practices owned directly by hospitals nearly doubled between 2007 and 2013, growing from 96,000 to 182,000 in just six years.¹¹ (See Exhibit 2.)

Hospitals are also combining with other hospitals in some geographical areas to create monopoly hospital networks, a

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change that is being found to increase health-care costs for consumers. Prices for health services in markets with fewer than four hospitals were found to be 15 percent greater than services in areas with four or more competitors.¹² Similar, although less extreme, price impacts were seen in areas with only two or three options.

This effect should not come as a surprise; as hospitals gain market power over a given geographical area, the ability of that hospital network to dictate prices grows — as it would with any service. The Health Care Cost Institute conducted research with 88 million Americans covered by three of the five largest U.S. insurance companies and found that hospitals consistently negotiate higher prices when they face less competition.¹³



The impact of decreased competition on price was further illustrated by the Federal Trade Commission's November 2015 intervention blocking what they called anticompetitive hospital mergers in Ohio, Pennsylvania, Illinois, and West Virginia.¹⁴ The director of the FTC's Bureau of Competition didn't mince words when she said that one proposed merger would "eliminate competition...resulting in higher prices and diminished quality."¹⁵

Many U.S. health-care consumers pay just a fraction of the true cost of their health care. Even less of that true cost is actually rendered at the point of purchase, usually in the form of a co-payment.

The larger the service provider network, the stronger its negotiating position with health insurance companies, and the increased insurer costs are being passed along to patients. One lesson that can likely be drawn from this challenge is that volume matters, particularly in price negotiations. One way to address this issue, then, might be for local governments to purchase health care cooperatively to increase relative buying power. Many governments are already self-insured; perhaps growing the size of these insurance pools could offer additional leverage with monopoly hospital networks. More aggressive price negotiations with insurance companies and hospitals could also be considered.

CONCLUSIONS

Despite reductions in percentage by which health-care costs have grown in recent years, health care in the United States is expensive and will likely remain so for the foreseeable future. This makes any steps a local government can take to mitigate cost critical to the long-term financial sustainability of the organization. The good news is that solutions to create significant and sustainable cost reductions exist, and local governments are likely to be able to find an approach suited to their individual needs. ■

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