

What is Driving Health Care Cost Increases?

In recent years, the cost of health care has been increasing. According to the Centers for Medicare and Medicaid Services (CMS), national health expenditures increased almost 33 percent from 1995 to 2000 (\$990 billion to \$1.3 trillion). CMS estimates spending to have increased another 19 percent through 2002 - to \$1.55 trillion. The change in the consumer price index (CPI) for medical care has exceeded the change in the CPI for all products each year for the past 10 years. Let's look at some contributing factors to the increasing costs.

Hospital services - The Center for Studying Health System Change (HSC), a Washington D.C. based nonprofit research and policy organization, recently published a study in the journal *Health Affairs*. The annual study examines the drivers of health care cost increases in the employer-sponsored health insurance population. Last year, overall health care spending increased by 10 percent - the first double-digit increase in more than a decade. The authors found that hospital services, including both inpatient and outpatient, were the largest driver of health care cost increases.

The Center reports that "spending on outpatient hospital care grew 16.3 percent in 2001, accounting for 37 percent of the overall spending increase. Outpatient care surpassed prescription drugs as the fastest-growing component of overall health spending." <http://www.hschange.com/CONTENT/472/>>). The Center further reports that hospital inpatient care accounts for 14 percent of overall healthcare spending growth in 2001.

The authors report that an increase in utilization accounted for about two-thirds of the spending increase

on hospital services, while higher prices made up the other third. They say that one factor in the increased utilization is the loosening of restrictions imposed by managed care companies. Outpatient services such as surgeries, diagnostic tests, and emergency visits have been increasing. People are presumably drawn to the convenience of same-day surgery, and insurers encourage the use of these services over inpatient care as the less expensive alternative.

One factor in the increased price of services is the gain in the leveraging power of hospitals over health plans due to consolidations and the emergence of large hospital alliances. As reported by B.C. Strunk, K. Devers, and R.H. Hurley, *Health Plan-Provider Showdowns on the Rise*, Issue Brief no. 40 (Washington: Center for Studying Health System Change, June 2001), "Over the past few years hospitals have regained a sizable amount of negotiating leverage over health plans and have used it to demand large payment rate increases." Another factor: Some staff wages are increasing to combat severe staffing shortages and to compensate for longer hours needed to treat more patients.

Prescription drugs - In recent years, increases in costs, at least in part, have been attributed to prescription drugs, which accounted for 21 percent of total health care spending in 2001. Studies indicate that although prescription drug costs have increased, the real driver behind drug spending growth has been increased utilization, particularly during the latter half of the 1990s. This is due to the introduction of newer, more efficient drugs with fewer side effects; the availability of drugs as a cheaper alternative to inpatient care; and HMOs paying

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for a larger percentage of drugs than before. Research indicates direct-to-consumer marketing strategies have increased utilization. The HSC study found that the spending increase for prescription drugs in 2001 was 13.8 percent, dropping from 14.5 percent in 2000 and 18.4 percent in 1999. In 2001 prescription drugs were not the largest factor in the overall increase – for the first time since 1995.

Insurance industry – Increases in private health insurance premiums during the past decade are as follows: 1991: +12%, 1993: +8%, 1995: +2%, 1997: 0, 1999: +7%, and 2001: +15%. The nation’s HMOs and health insurers reported a 25 percent increase in profits for 2001, earning \$4.1 billion for the year, compared to \$3.3 billion in 2000, according to research by Weiss ratings Inc., an independent provider of ratings and analysis of financial service companies, mutual funds and stocks. And yet in Pennsylvania, PHC4 hospital data shows an improvement in hospital income levels during FY01 – which resulted partly from better reimbursement contracts with commercial insurers.

Aging population – It is assumed the aging population is responsible for some of the increase in health care spending. However, the HSC study estimated that the increase in spending on health care due to the aging population in 2001 was only 0.7 percent. But the authors report that per capita health spending increases by about \$74 each year between the ages of 18 through 50, and then increases to about \$152 each year from age 50 through 65. PHC4 data indicates that persons older than 80 represented more than \$5.3 billion in hospital charges for 281,000 admissions in 2001 – up from \$2.3 billion for 191,000 cases in 1991.

Once the Baby Boomers reach age 65, the sheer volume of people eligible for Medicare will increase spending in the publicly funded program. The HSC authors recognize that the aging population may increase health spending and have a more profound impact on specific hospital services, such as cardiac and oncological services in the coming years. Heroic attempts at end-of-life care also increase costs.

Complications and readmissions - In CY2000, PHC4 data shows there were about 5,000 “misadventures in

surgical care” in Pennsylvania hospitals, accounting for more than \$35 million in additional hospital charges. While misadventures during care may add to costs, the costs associated with readmissions are also worth examining - high quality care may lessen the need for subsequent hospitalizations. For example, PHC4’s recent report on Coronary Artery Bypass Graft surgery showed that in Pennsylvania total charges for readmissions within 30 days of CABG surgery were \$53 million in 2000, and about 20 percent of these readmissions were related to infections. Additionally, readmission rates for CABG appear to have increased from 10.3 percent in 1995 to 14.3 percent in 2000. Preliminary analyses of data from the December 2002 PHC4 *Hospital Performance Report* indicates that more than \$100 million of hospital charges might have been avoided if all hospitals that had higher than expected readmission rates related to complications and infections had performed at their expected levels of effectiveness.

Government regulations and mandates - The health care industry is heavily regulated, often for patient protection. For both providers and insurers, regulatory requirements make business increasingly complex. Two examples of areas where regulatory oversight impacts health care costs are HIPAA and government mandates. An April 2002 report by PriceWaterhouseCoopers estimated that mandates and government regulation add about 15 percent (\$10 billion) of the overall increase in health premiums.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal law that makes hundreds of changes in procedures. Among other things, the law requires health plans and providers to institute “administrative simplification” for a variety of new data systems to insure privacy and standardize electronic transactions. The administrative simplification requirement was enacted to “reduce the costs and administrative burdens of health care by making possible the standardized, electronic transmission of many administrative and financial transactions that are currently carried out manually on paper.”

It is estimated that the cost to comply with the HIPAA privacy regulation alone could range from \$3.8 billion (U.S. Department of Health and Human Services esti-

mate) to \$43 billion (BlueCross/BlueShield Association estimate). While it appears that the initial costs to comply with HIPAA are quite extensive, proponents claim there may be cost savings in the long run. An HIMSS-Phoenix survey noted the overall benefit to the administrative simplification rules would be the use of one electronic claim form versus the 400 forms currently in use.

A mandated benefit enacted by the state or federal government requires health insurers and managed care plans to provide coverage for a specific service, treatment or provider. Insurance benefits are utilized when they exist, and mandates typically increase the cost for coverage because insurers – and therefore purchasers – must pay for the increased utilization. A 1997 study conducted by Milliman and Robertson for the National Center for Policy Analysis estimates that 12 of the most common mandates can increase the cost of health insurance by as much as 30 percent. Currently Pennsylvania has more than 25 benefit and provider mandates.

Loosened managed care restrictions – As a result of mounting pressure from consumers, purchasers, providers and legislators, managed care plans are changing their policies and procedures. Some would argue that managed care is decreasing. Data from the Kaiser/HRET employer survey shows that the percentage of employees in indemnity, PPO, and point-of-service (POS) plans who are subject to concurrent review of hospital stays has fallen from 79 percent in 1996 to 62 percent in 2002. Health plans are experiencing reduced ability to negotiate discounts with providers. The use of risk contracting is decreasing. Risk contracting was used by managed care plans as an incentive for providers to control utilization. With fewer restraints in place, the impact will continue to be higher utilization and increased costs. In light of the above trends, a number of managed care plans are expanding their case management and disease management programs.

Increase in litigation – Governor-elect Rendell has called medical malpractice reform a priority. Malprac-

tice insurers are leaving the market, and malpractice insurance premiums are skyrocketing as access becomes more and more limited. The Pennsylvania General Assembly recently approved and the Governor signed a measure to address one issue: “venue shopping.” The new law will require patients to file medical-malpractice lawsuits in the county where the incident occurred. The law attempts to respond to plaintiffs seeking to file lawsuits in counties where juries historically hand out large awards.

Capital cost increases – The termination of the Commonwealth’s Certificate of Need program has meant that new construction is less constricted. For example, there has been a 40 percent increase in the number of surgical heart units since the Certificate of Need program went out of existence. Major capital acquisitions by a hospital can be in the form of an expansion of a hospital’s facilities and equipment or a merger with another hospital. Over the long run, will increased revenues from the hospital’s expanded services offset the incremental costs from the expansion? Will mergers lead to reduced costs and/or diminished care? PHC4 data has not been extensively evaluated on these questions.

In summary – Just as it is nationally, the cost of health care in Pennsylvania is increasing for many reasons. Here however, PHC4 data and analysis can and has helped restrain the overall costs of health care. Hospitals, the medical community, health plans and purchasers are using PHC4 data to pinpoint cost drivers and opportunities for quality enhancements. As demonstrated by PHC4 data on complications and readmissions, and by other public data, improvements in the *quality of care* can help contain costs. What is needed is ongoing analysis of data, acceptance of the results, and system-wide responsiveness to proposed quality improvements. Without outcomes data in the marketplace, the factors driving health care cost increases will only become worse.

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