



## NAHU'S HEALTHY ACCESS BRIEFING REPORT: CONSTRAINING MEDICAL COSTS

Comprehensive health reform plans need to address the true underlying problem with our existing system: the cost of medical care. The reality is that consumers pay for all health care costs through one of three ways: taxes, premiums or out-of-pocket expenses. If the cost of health care becomes too great, the method of payment no longer matters – the country and its people are bankrupt or unable to access care.

Constraining skyrocketing medical costs is the most critical – and vexing – aspect of health care reform. It is the key driver in rising health insurance premiums and it is putting the cost of health care coverage beyond the reach of many Americans.

There is no one magic answer to health care cost containment and there are many reasons health care costs are skyrocketing. Addressing this massive societal problem requires a multitude of comprehensive actions by both individual citizens and elected officials. Many of the topics that need to be addressed to truly lower health care costs in the country, like physical education for children or nutritional choices, are not ones in which NAHU members as a whole have any particular expertise. However, as health insurance producers and employee benefit specialists, we do have extensive knowledge of health insurance markets and factors that are directly driving up health insurance claims costs and consequently health insurance premiums. We feel that the following recommendations would make important improvements to the U.S. health care system to lower costs, improve quality and create greater efficiency.

### **1. Behavior and Lifestyles**

Unhealthy behavior and lifestyle choices are two key factors in the increased cost of health care. Research shows that behavior is the most significant determinant of health status<sup>1</sup>, with as much as 50 percent of health care costs attributable to individual behaviors such as smoking, alcohol abuse and obesity. According to the National Center for Health Statistics, 30 percent of adults (more than 60 million Americans) are obese, and the problem is worsening. Obesity has risen by 10 percent in the past decade and the trend can now be observed among American children<sup>2</sup>. Other sources show that smoking costs our country \$157.7 billion each year, with \$75 billion of that representing direct medical costs for adults<sup>3</sup>. These behaviors lead to many serious chronic health conditions, and consumers are seeking medical solutions for these lifestyle issues rather than correcting unhealthy behavior. Consequently, reducing overall health care costs through promoting and achieving a healthier lifestyle for all Americans should be a top priority.

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<sup>1</sup> Mercer Management Journal 18; Centers for Disease Control and Prevention.

<sup>2</sup> Employee Benefit News, "Employers tackle obesity." Centers for Disease Control and Prevention; January 2006, <http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/>

<sup>3</sup> U.S. Department of Health and Human Services. "The Health Consequences of Smoking: What it Means to You" 2004.

### ***Behavior and Lifestyles Recommendations:***

- Require federal and state governments incorporate wellness and disease-management programs into medical programs for employees and government-subsidized health coverage programs such as Medicaid, Medicare, SCHIP and the Veteran Health system. Such programs could be modeled after the highly successful Healthy Arkansas Initiative, which targets the state's 50,000 employees, Medicaid recipients and other residents by encouraging them to stop smoking, lose weight and exercise more. Arkansas state employees now receive nutrition counseling, "walking breaks" instead of smoking breaks, paid leave as a reward for healthy behaviors, and discounted health insurance premiums if they agree to undergo a voluntary personal health risk assessment. The state's nearly 600,000 Medicaid recipients have similar incentives and Medicaid program now pays for nicotine patches and similar smoking-cessation tools. According to a recent national study, 26% of all adult Medicaid recipients in Arkansas used tobacco products in 2002, costing the state an estimated \$540 million. The state Medicaid program is also implementing a highly successful disease-management program to help curb costs and improve treatment of diabetes.
- Provide employers with legal protection, tax incentives and premium incentives for implementing smoking, drug, alcohol and other wellness programs to encourage their employees and their families to adopt healthier lifestyles. This includes establishing a safe harbor for those employers promoting wellness and health activities among their employees from non-intentional discrimination charges by adopting regulatory changes that adopt bone fide wellness plans under recent federal Department of Labor regulations.

## **2. System Inefficiencies**

Duplication of procedures and overuse of high-end procedures in situations where they add little value increase medical spending unnecessarily. Both patients and the provider community should focus on identifying less expensive but equally efficacious alternatives. The inconsistent focus on quality outcomes when providing treatment impacts costs too. According to a report by the National Committee for Quality Assurance, "The U.S. health care system is saddled with an anachronistic payment systems that rewards quantity, not quality, of care. This contributes to widespread variations in the way health care is delivered – from failure to deliver needed care, to huge numbers of unnecessary procedures that drive up costs and endanger patients."<sup>4</sup>

Preventable mistakes caused by providers of medical care also drive up health care costs. The November 1999 report of the national Institute of Medicine (IOM) indicated that 44,000 to 98,000 people die in hospitals each year as the result of medical errors.<sup>5</sup> Those numbers do not even take into account medical errors that occur in other clinical settings. These medical errors are not only tragic, they also carry a strong financial consequence. IOM estimates that medical errors cost Americans approximately \$37.6 billion each year, and about \$17 billion of those costs are attributable to preventable medical errors. About \$8.5 billion is spent annually for direct payments for preventable errors.<sup>6</sup> Unnecessary medical treatments and prescriptions are also

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<sup>4</sup> National Committee for Quality Assurance. "The State of Health Care Quality 2005."

<sup>5</sup> Institute of Medicine. *To Err Is Human: Building a Safer Health System*. 2000.

<sup>6</sup> Ibid.

costing the U.S. health care system billions of dollars each year. For example, 25 percent of physician visits (costing \$11.4 billion annually) and 55 percent of emergency-room visits (costing \$14.7 billion annually) are unnecessary, according to American Institute for Preventive Medicine.<sup>7</sup>

***System Inefficiencies Recommendations:***

- Provide incentives for doctors and medical facilities to improve system inefficiencies and eliminate errors through pay for performance, best practice guidelines and support for evidence-based medicine.
- Create federal standards for interoperable electronic medical record technology to help unify the health care system, reduce errors and improve patient satisfaction. Advances in health IT will enable true collaboration between doctors and patients as consumers make more informed choices and doctors become more involved in their care. In the long run, improved technology will also provide better information to track public health problems and advance clinical research.

**3. Medical Malpractice**

The amount health care providers must pay for medical liability insurance coverage is on the rise, directly affecting health care costs in this country. But an even more costly side-effect of rising medical malpractice insurance rates is when doctors order more tests, medications and referrals than are medically necessary to protect against accusations of negligence. Since 1975, when medical malpractice insurance data were first separated from other types of liability insurance, increases have outpaced other tort areas, rising at an average of 11.7 percent a year. This compares with 90 percent for all other tort costs. In 2004, medical malpractice costs totaled over \$28.7 billion, up from about \$26.5 billion the previous year.<sup>8</sup> Medical liability costs and defensive medicine, combined, currently account for 10 percent of medical care costs.<sup>9</sup>

***Medical Malpractice Recommendation:***

- Enact comprehensive medical malpractice reform that limits non-economic damage awards, allocates damages in proportion to degree of fault, places reasonable limits on punitive damages and attorney fees, and imposes reasonable statute of limitations on claims.
- Encourage state authorities to increase the effectiveness of disciplining imposed on incompetent doctors.

**4. Cost Shifting**

Cost-shifting is a “hidden tax” imposed when providers of medical care adjust the prices they charge to private insurance companies in order to offset losses from partial or non-payers. These

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<sup>7</sup> *Employee Benefits Journal*. “The High Cost of Health Care.” Volume 27, Number 1, March, 2002.

<sup>8</sup> Towers Perrin. *U.S. Tort Costs: 2005 Update*. March 2006.

<sup>9</sup> PricewaterhouseCoopers for America’s Health Insurance Plans. *The Factors Fueling Rising Healthcare Costs 2006*. February 2006.

losses are primarily attributable to uncompensated care costs and declining reimbursements from Medicare and Medicaid, and have a significant impact on private health insurance premiums.

Blue Shield of California and Premera Blue Cross in Mountlake Terrace, Washington, have worked with Milliman, the actuarial and consulting firm, to evaluate how much more private health plans have to pay in their states because of government underpayments. In Washington, where Medicare pays about 25 percent less than private insurers, hospitals in 2004 charged private payers \$738 million to make up for underpayments and physicians charged private payers \$620 million to make up for shortfalls—almost \$1.4 billion. That translates to \$902 per family insurance policy, or 13 percent of all commercial hospital and physician payments. Milliman found similar results in California, where employers and employees paid about \$951 per family insurance policy to cover losses from Medicare and Medi-Cal.

The study also found that cost-shifting constituted 3.6 percent of private health insurance premiums in 2000 and 9.5 percent of premiums by 2004.<sup>10</sup> In addition, in 2001, the uninsured received about \$35 billion in uncompensated health care treatment, with federal, state and local governments covering as much as 85 percent of the costs. Hospitals deliver two-thirds of uncompensated care and private-practice physicians account for more than half of the private subsidies that underwrite the cost of uncompensated care.<sup>11</sup>

#### ***Cost-Shifting Recommendations:***

- Reimburse providers participating in all federal health care coverage programs, including Medicaid, Medicare and SCHIP, set at the same level paid to providers serving federal employees through the Federal Employees Health Benefit Plan. This will not only eliminate much of the Hidden Tax, but will have the added benefit of drawing more providers into these programs. More participating providers will not only increase access to care for all public program participants, but the increased competition will also have a positive impact on overall reimbursement rates.
- Incent states to streamline the application processes for public health insurance programs like Medicaid and SCHIP and allow for presumptive eligibility in these programs, so that all eligible participants are enrolled and their providers are paid instead of incurring uncompensated care expenses.

#### **5. Increased Utilization**

Utilization of health care services is increasing. In a report prepared by PricewaterhouseCoopers on behalf of America's Health Insurance Plans titled *The Factors Fueling Rising Healthcare Costs 2006*, “Higher utilization of services accounted for 43 percent of the increase, fueled by factors such as increased consumer demand, new and more intensive medical treatments and defensive medicine, as well as aging and unhealthy lifestyles.” Americans need to become more engaged as consumers. Informed shoppers are more efficient consumers and efficient consumers spend less money.

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<sup>10</sup> Margaretann Cross. *Managed Care December 2006*. “Confronting the Medicare Cost Shift.”

<sup>11</sup> 2003 Health Affairs. Report for the Kaiser Commission on Medicaid and the Uninsured.

As noted above, increased use of a more consumer-directed approach to health insurance coverage has great potential to reduce overall health care costs. However, to be fully successful, American consumers must be fully aware of the cost of the health care that they are purchasing.

***Increased Utilization Recommendations:***

- Encourage expansion of consumer-directed health insurance products, like Health Savings Accounts, Health Reimbursement Arrangements and Flexible Spending Accounts. Recent changes to HSAs made as part of the Tax Relief and Health Care Act of 2006 will help make this consumer-directed health care option much easier for employers and insurers to administer, thereby making HSAs more accessible to all Americans. However, additional improvements should be implemented, including:
  - Permitting employees to contribute to a HSA even if their spouses have an FSA.
  - Increasing more deductible flexibility in HSAs by allowing prescription drug coverage to be offered without a high deductible.
  - Clarifying that individuals with a family HSA policy simply need to meet the individual deductible requirements, rather than the whole family deductible.
  - Permitting employers to reserve their contributions for disbursements to pay for qualified medical expenses only, to increase employer willingness to contribute.
  - Permitting early retirees to use accumulated HSA funds to pay for health plan premiums, expanding the current rules which limit this privilege to those ages 65 and older.
  - Eliminating restrictions on the use of HSA funds for Medigap coverage to help those beneficiaries, particularly in rural and urban areas, who only have this option available to them to supplement basic Medicare coverage.
  - Allowing individuals over age 65 to contribute to an HSA as long as they are not yet retired, even though they may automatically be enrolled in Medicare Part A.
  
- American consumers must be fully aware of the cost of the health care that they are purchasing. To create transparency in health care, we should:
  - Enable and encourage health plans and providers to overcome policy concerns (e.g. prohibiting gag provisions in provider contractors) and bring complete price information to the public as soon as possible.