

Healthcare Cost Drivers

White Paper

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The National Association of Benefits and Insurance Professionals (NABIP), a professional trade association representing more than 100,000 health insurance agents, brokers and employee benefit specialists nationally, is concerned about how rising health care costs are impacting health insurance coverage in this country. NABIP serves millions of Americans by working to help both individuals and employers purchase and maintain health insurance coverage. As such, we see on a daily basis, how much the cost of health insurance coverage is impacting our nation's employers and economic growth, and we know the cost of financing health care will continue to rise if the driving medical care cost factors remain unchecked.

Statistical evidence supports what NABIP has observed relative to the economic impact of health care spending. In 2013, health care spending in the United States reached \$2.9 trillion and accounted for 17.4 percent of the gross domestic product (GDP). This is an increase from \$2 trillion and 15.9 percent of GDP in 2006, and spending is only continuing to rise with costs projected to exceed \$5.1 trillion and 19.3 percent of GDP by 2023¹. Furthermore, the annual increases in national health care spending historically outpace both the rate of general price inflation. Between 2000 and 2010, healthcare spending grew by 5.6 percent per year, while overall inflation grew at 2.4 percent per year and GDP grew at 2.9 percent per year. By 2020, healthcare spending is projected to grow at 5.8 percent per year on average, exceeding the growth rate of GDP by one percentage point each year on average. The result of the high cost of care has been Americans delaying treatment, with 33% of Americans putting off healthcare in 2014 according to Gallop, which generally result in costlier medical bills later.²

Like the problem of the uninsured, there is neither one cause nor one solution to containing the rising cost of health insurance. In order to develop effective private and public policy solutions to contain the cost of health care, we need to thoroughly examine the factors causing dramatic increases in health care spending. NABIP has identified the following factors as the major contributors to this national crisis:

Aging Population

Americans are living longer and better than ever, but unfortunately such longevity comes with great health care costs. The number of people over the age of 60 is projected to grow to as many as 110 million, or 27.4% of its total population by 2050. By 2025, public healthcare spending (including Medicare, Medicaid, CHIP, and marketplace subsidies) will total nearly \$1.9 trillion, roughly half of the federal mandated spending of \$3.89 trillion, according to Congressional Budget Office (CBO) projections.³ That is up from 29 percent of federal spending in 1990 and 35 percent in 2000. The bulk of that growth is spending on the federal government's two largest health care programs, Medicare and Medicaid. Their combined costs are projected to nearly double, to a combined total of \$1.76 trillion in 2025 from \$901 billion in 2014, after having already doubled over the previous decade.

¹ U.S. Centers for Medicare and Medicaid Services

² <http://www.gallup.com/poll/179774/cost-barrier-americans-medical-care.aspx>

³ www.cbo.gov/sites/default/files/cbofiles/attachments/49973-UpdatedBudgetProjections.pdf

Pharmaceutical Costs

The rising cost of pharmaceutical products in this country also clearly impacts the rising rate of medical spending. In 2014, prescription drug spending totaled \$373.9 billion, a 13.1 percent increase over the previous year, and accounted for 12.2 percent of total healthcare spending.⁴ Last year, the average cost of a prescription was \$58.99 and prescription drug costs are expected to increase 6.4 percent in 2015.⁵ On average, Americans use 12.2 prescriptions per year.⁶ Factors driving the increases include: increasing utilization of prescription drugs; newer, higher-priced drugs replacing older, less-expensive drugs; fewer manufacturers and less competition, and manufacturer price increases for existing drugs.

Biologics and New Technologies

There are many types of new technologies coming into the forefront in health care that promise to both prolong and improve the quality of life. Many are proclaiming that the future of health care belongs to biotechnology.⁷ The drugs are expensive for patients, and expensive to create and develop, but the handful of biotech home runs, such as synthetic insulin and new anti-cancer drugs, have vastly improved lives. New advances in Hepatitis C treatment can cure a patient in 12 weeks, instead of as long as a year under previous treatments. However the cost of these drugs run upwards of \$1,000 a day and are resulting in significant expenses for payers, including Medicare which paid more than \$4.5 billion for the drug in 2014, as well as private insurers where the costs are ultimately shifted onto individuals. Biosimilars are also advancing on the progress made on biologics, and could result in \$250 billion in savings between 2014 and 2024 with just a handful of the most promising biosimilar candidates.⁸ However, it is important to examine how much spending on medical technologies is actually necessary, and whether the costs are justified by the benefit provided to the patient. Spending on medical technology implementation accounts for between 38 and 65 percent of healthcare spending increases, according to the Robert Wood Johnson Foundation.⁹

Behavioral and Lifestyle Choices

Key drivers in the increased cost of health care are unhealthy behavioral and lifestyle choices. Research shows that behavior is the most significant determinant of health status, with as much as 70 percent of health care costs attributable to individual behaviors such as smoking, alcohol abuse, and obesity.¹⁰ While obesity trend lines have stabilized in recent years, nearly 80 million Americans (34.9 percent) are obese, according to the National Center for

⁴ National trends in prescription drug expenditures and projections for 2015. <http://www.ajhp.org/content/72/9/717>.

⁵ <http://blog.primetherapeutics.com/blog/prime-therapeutics-microsites/introducing%3A-2014-report-on-prescription-drug-costs>

⁶ <http://www.imshealth.com/portal/site/imshealth/>

⁷ <http://content.healthaffairs.org/content/34/2/210.abstract>

⁸ <http://lab.express-scripts.com/insights/specialty-medications/specialty-drug-spending-to-jump-67-percent-by-2015#sthash.fwZbV2uA.dpuf>

⁹ http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71331

¹⁰ http://www.theihcc.com/en/communities/employee_communication_education/focusing-on-what-matters-most-%E2%80%93-healthy-behavior-a_gqk6ur59.html

Health Statistics. Childhood obesity continues to be an issue, with one out of every six children age 2 to 19 are overweight or obese, more than doubling for children and quadrupling for adolescents over the past 30 years.¹¹

As of 2014, more than 42 million Americans smoked. Each smoker costs an employer an additional \$5,128 a year in health care costs and lost productivity.¹² Other sources show that smoking is responsible for approximately 8.7 percent of total U.S. health care costs.¹³ Hepatitis C is often contracted through lifestyle behaviors such as injection drug use and contact with bodily fluids of an infected person, and the disease becomes a chronic condition in 75-85% of all infected. Treating Hepatitis C includes expensive drug therapies and is the leading cause of liver transplant in the U.S.¹⁴ These and other lifestyle behaviors lead to many serious chronic health conditions such as cancer, diabetes, heart and cardiovascular disease, and consumers are seeking medical solutions for these lifestyle issues rather than practicing wellness behavior.

System Inefficiencies

Duplication of procedures and overuse of high-end procedures, in situations where they add little value, have driven up medical spending unnecessarily. Both patients and the provider community should focus on looking for less expensive but equally efficacious alternatives. It is estimated that hospitals waste as much as \$11 billion annually on inefficiencies.¹⁵

Preventable mistakes caused by providers of medical care also help account for rising costs. As many as 400,000 people die each year as the result of medical errors.¹⁶ These medical errors are not only tragic; they also carry a strong financial consequence. A 2012 study estimates that medical errors cost Americans approximately \$1 trillion each year.¹⁷

Unnecessary medical treatments and prescriptions are also costing the U.S. health-care system billions of dollars each year. For example, 25 percent of physician visits (227 million annually) and 55 percent of emergency room visits (65.5 million annually) are unnecessary according to American Institute for Preventive Medicine. Defensive medicine practices, including ordering unnecessary tests is estimated at over \$200 billion annually.¹⁸

Technological Inefficiencies particularly from the adoption of electronic health records and the lack of interoperability within the systems. More than \$6 billion was spent between 2010-15 for providers to update their records technology, but so far there has been little to show with interoperability between systems still hampering progress.¹⁹ Forced upgrades of other technologies also add cost to the system, such as adoption to the ICD-10 coding.

¹¹ <http://www.cdc.gov/healthyouth/obesity/facts.htm>

¹² Centers for Disease Control and Prevention~ Morbidity and Mortality Weekly Report Note: Study updated using National Health Expenditures Trend.

¹³ <http://www.ajpmonline.org/article/S0749-3797%2814%2900616-3/fulltext>

¹⁴ <http://www.cdc.gov/hepatitis/HCV/HCVfaq.htm>

¹⁵ <http://www.ponemon.org/local/upload/file/2014%20Imprivata%20Report%20FINAL%203.pdf>

¹⁶ http://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A_New_Evidence_based_Estimate_of_Patient_Harms.2.aspx

¹⁷ <http://www.wolterskluwerlib.com/health/resource-center/articles/2012/10/economics-health-care-quality-and-medical-errors>

¹⁸ <http://www.nap.edu/catalog/13444/best-care-at-lower-cost-the-path-to-continuously-learning>

¹⁹ <http://healthinformatics.uic.edu/resources/articles/emrehr-spending-to-hit-6-billion-by-2015/>

The inconsistent focus on quality outcomes, when providing treatment, is another inefficiency impacting medical costs. Stakeholders in both public and private healthcare delivery have expressed intentions to moving towards quality and value based models. Innovations in care coordination, case management, and technology are directed at improving patient care and reducing system utilization through delivery and payment reform. These include accountable care organizations (ACOs), patient-centered medical homes (PCMH), and payment reforms including pay for performance, full capitation with quality and/or global payment, bundled payment, and the shared savings and shared risk models. As of 2014, roughly two in six commercial in-network payments were value-oriented, while one in ten outpatient specialists were value-oriented.²⁰ Medicare's "Better, Smarter, Healthier" initiative will move that program to 90 percent value-oriented by 2018, with half of all payments in Accountable Care Organization models. More will need to be done to move both public and private payers toward quality, but quality improvements must be meaningful to achieve real value.

Medical Malpractice

The amount health care providers must pay for medical liability insurance coverage continues to rise, which has directly impacted health care costs in this country. But an even more costly side-effect of rising medical malpractice insurance rates is the cost of defensive medicine (when doctors order more tests, prescribe more medication and make more referrals than they believe are necessary to protect themselves from being accused of negligence). It is estimated that medical malpractice adds between \$55-200 billion annually, and that medical liability costs and defensive medicine combined account for 7.2 to 12.7 percent of the increase of health care costs.²¹ A CBO study found that capping the award for punitive damages, changing liabilities laws, and shortening the statutes of limitations could save \$11 billion annually.²² Another proposal which has been proposed in Congress is the creation of "medical courts" that would turn medical malpractice cases over to specialized courts overseen by medical experts, similarly to workers compensation claims.

Cost-Shifting

Cost-shifting occurs when providers of medical care adjust the prices they charge to private payers in order to offset losses in other areas. Recent changes in contract rates, reimbursements, and network rates have further pushed costs onto individuals to cover more of their expenses. Providers are also offsetting losses from declining reimbursements from Medicare, Medicaid and uncompensated care, where federal, state, and local governments cover 85 percent of the costs, and pushing those costs onto non-government plan consumers.²³ PPACA reforms attempt to stem cost-shifting from uncompensated care by pushing uninsured individuals to Medicaid or to coverage with Advanced Premium Tax Credits through the exchanges; however as public reimbursements fall short of covering the full costs of care, providers will continue to shift those costs onto insured individuals to make up the difference.

²⁰ <http://www.catalyzepaymentreform.org/how-we-catalyze/national-scorecard>

²¹ www.physiciansfoundation.org/uploads/default/Drivers_of_Health_Care_Costs_-_November_2012.pdf

²² <https://www.cbo.gov/publication/24975>

²³ <https://www.iom.edu/Reports/2003/Hidden-Costs-Value-Lost-Uninsurance-in-America.aspx>

Increased Utilization

The Great Recession resulted in a temporary decrease in the overall trend-line of increasing utilization, but recent data suggests that utilization will resume its upward pre-recession trend in the coming years. In 2014, utilization increased in virtually every metric, with more physician visits, hospitalizations, and prescriptions filled than in 2013. Prior to the recession, “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.” As American consumers return to increasing use of healthcare services, including many newly insured individuals, utilization is expected to increase.²⁴

Changes in the rate of utilization could also be attributed to plan design and the use of technologies in place of traditional medicine. To help offset the impact of increasing premiums, insurers and plan administrators have increasingly turned to higher deductibles. From 2009 to 2014, premiums increased by 26% in employer-sponsored plans while deductibles increased by 47%. In 2006, only 10% of employers offered plans with deductibles over \$1,000 and 3% had deductibles over \$2,000, compared to 40% and 18% in 2014, respectively. This increased out-of-pocket expense before coverage kicks-in may be deterring individuals from seeking care.²⁵ Delaying necessary care may exacerbate medical conditions, requiring more expensive care later on. Telemedicine is a way that some patients are seeking care without receiving more expensive care in person, as these services can be available at a significantly reduced first-dollar cost to the patient.²⁶ Other plan design changes include value-based insurance design, which encourage chronic disease management while reducing the need for more expensive care.

Government Regulation

The PPACA has only exacerbated the compliance burden on employers, employees, individuals, and governments. Many of these compliance burdens discourage employer-sponsored coverage by adding onerous requirements and responsibilities that must be performed on behalf of employees. For small employers, many of PPACA’s arbitrary provisions, such as narrow rating bands, limits on composite rating and new levels of minimum coverage, have resulted in higher rather than lower costs. Larger employers are overwhelmed by the compliance burden of counting employees and documenting and reporting coverage options caused by the health reform law’s employer shared responsibility provisions. They are also now subject to new fines, in some cases, even when they do provide coverage to employees. However, the compliance burden does not end with just employers, as individuals, providers, state and local governments, and all other elements of the healthcare delivery and financing system must meet the requirements of the law.

The cost to implement the PPACA at the state level can be exorbitant in a time where state budgets are already stretched. States that opt for the Medicaid expansion will be required to come up with their share of funding to cover

²⁴ <http://www.pwc.com/us/en/health-industries/behind-the-numbers/index.jhtml>

²⁵ <http://kff.org/health-costs/report/2014-employer-health-benefits-survey/>

²⁶ <http://www.corpsyn.com/knowledgecenter/articles/telemedicine.html#.VVTq0pLeVA>

the additional enrollees, with federal matching funds gradually reducing to 90% of each state's cost by 2022. States are responsible for the standard federal match (roughly 57%) for covering all other additional individuals below their current eligibility level who otherwise may not have been covered, plus 10% of all newly eligible beneficiaries. For states with low eligibility levels, such as Texas and Louisiana which only provide Medicaid coverage to those earning 12 and 11 percent of poverty, respectively, expanding Medicaid would result in considerable expense to the state. To receive the benefits of Medicaid expansion, Texas estimates that it would first need to come up with an additional \$15-16 billion over the next decade to cover the newly eligible.²⁷ States operating their own health insurance marketplaces are also required to finance tens of millions of dollars in operational expenses as federal rules require them to be self sufficient. States already dealing with regular structural budget deficits may be unable to afford to add any additional expenses to implement the health reform law.

Other Market Factors

Other changes in the healthcare system have resulted in changes in the cost of care. Hospital consolidations have the potential to significantly increase the cost of care, particularly in already concentrated markets where prices can increase more than 20 percent.²⁸ Throughout the 1990s there were more than 1,000 consolidations and the trend-line of consolidations is expected to increase under the PPACA.²⁹ Physicians' offices being consolidated into hospital systems is also causing a significant increase in reimbursement rates, because they are billed through the hospitals instead of a stand-alone practice. The reduction in provider availability is also causing a similar supply and demand effect on consumers. An Institute of Medicine report found that there will be a deficit of 3.5 million health care providers by 2030 as current providers retire, with a projected shortage of 91,500 doctors by 2020 and half of all current nurses having reached retirement age by that time.^{30,31} The move towards concierge medicine is also impacting provider availability as some providers move to a charging patients a monthly or annual fee for direct access instead of being reimbursed through insurers. The move from the traditional insurance-based system will only exacerbate the demand from patients who will compete for time from a dwindling list of available providers.

Recommended Solutions

Health insurance is expensive because of the high cost of health care. The driving factors impacting the cost of health care would require comprehensive solutions in order to benefit consumers, employers, providers and insurance carriers. NABIP believes competitive market forces will have the greatest positive impact on the cost of health care. Health care reforms need to build on the best aspects of the American health care system and unleash the creative power of a competitively driven marketplace. The following recommendations are important in making improvements in the U.S. health care system to lower costs, improve quality, create greater efficiency and provide better access to care.

²⁷ <http://kff.org/health-reform/report/the-cost-and-coverage-implications-of-the/>

²⁸ <http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html>

²⁹ <http://www.hfma.org/Content.aspx?id=23307>

³⁰ www.dol.gov/odep/pdf/NTAR-AgingWorkforceHealthCare.pdf

³¹ https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf

Transparency

Medical cost transparency is particularly important, because medical care is perhaps the only service American consumers regularly purchase without having any upfront knowledge of the actual price. Americans are very accustomed to “shopping” for the best price on goods and services. Consumers need to become educated consumers on how to shop for good medical care on the basis of price and quality of service. According to the Catalyst for Payment Reform, 29 of the 50 States scored an F in transparency.³² NABIP believes the best practices for transparency include: current, accurate, unbiased and relevant data sources; ease of access with a format and process that is user-friendly; cost differentiations based on outcomes and clinical performance; quality measures, including outcomes, quality designations and any disciplinary actions; personal touch, with the ability to talk to a live person; and consumer ratings and user experiences.

Payment Reform

As stakeholders move increasingly towards value-based design models, these delivery and performance measures must be integrated into consumer directed health plans to help achieve real value and savings for all payers. The Robert Wood Johnson Foundation estimates that CDHPs have reduced health care spending an average of 5-14 percent, which is largely attributed to reductions in pharmaceutical and outpatient expenditures and that consumers reduce their use of less appropriate care.³³

Value-Based Insurance Design

As costs continue to rise for individuals, the use of value-based insurance design (VBID) is growing to help offset these costs. The premise of VBID is to reward good behavior in maintaining health by incentivizing low-cost treatments, such as preventive care, wellness, and medications that control chronic conditions at little or no cost to the consumer. The VBID plans may also dis-incentivize care that is unnecessary, repetitive, or more costly than an alternative. As of 2008, an estimated 20-30 percent of large employers used VBID principles in their plan design.³⁴

Consumer-Directed Health Care

Expansion of access to consumer-directed health insurance products, like Health Savings Accounts and Health Reimbursement Arrangements, will do much to help curb the problems and costs associated with over-utilization of health care services. High-deductible health plans (HDHPs) paired with savings accounts savings options were first introduced in 2006. As of 2014, 26 percent of all covered employees were enrolled in high deductible plans, an increase

³² <http://www.hci3.org/content/report-card-state-price-transparency-laws-2014>

³³ <http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf402405>

³⁴ http://www.ajmc.com/journals/supplement/2009/A264_09dec_HlthPolicyCvrOne/A264_09dec_FendrickS277to283

from just 8 percent of employees in 2009.³⁵ However, these new products will not reach their full cost-savings potential unless American consumers are fully aware of what various medical services cost when doing their health care spending.

High Value Health Plans

Another layer to CDHPs is the use of High Value Health Plans (HVHPs) that combine the principles of HDHPs and consumer directed health plans with VBID. HVHPs provide evidenced-based services that manage chronic conditions to be exempt from deductibles. This includes allowing first-dollar coverage to incentivize high value treatments, especially for chronic conditions. Data indicates that their premiums are lower than traditional PPOs and HMOs, and slightly higher than other HDHPs. On the aggregate population level there could be substantially lower expenditures on healthcare as consumers are incentivized to utilize low-cost preventive services to manage conditions.

Choice and Flexibility

Any effort to reduce the cost of healthcare must include choice and flexibility for consumers. A virtuous cycle can be reached with increased competition within the marketplace to lead to greater consumer choice, which in turn will lead to more competition to help drive down costs. Consumers also need to have adequate choice in numerous aspects of their healthcare delivery, including full choice and flexibility in selecting the appropriate health insurance plan that best meets their individual needs, choosing which providers that they will have access to, and choice in the delivery of their care to include specialty providers, treatments, and pharmaceuticals. Consumers should be incentivized to receive the highest value care and have access to the full range of options in their healthcare decision making process. Greater transparency of these choices will further this end by empowering consumers with the information necessary for making these decisions.

Wellness

We also need to explore public-policy initiatives regarding wellness promotion. Health insurance costs are driven by health insurance claims. Promoting and achieving a healthier America is one way that we can reduce health insurance claims and overall health care costs. Employer requirements regarding smoking, means to prevent and better manage chronic diseases, wellness incentives in health plan offerings, and other means to encourage healthy lifestyles are all under debate. An estimated 18.4% of all employers offer wellness incentives, including 58.8% of large businesses with 1,000 or more employees,³⁶ and efforts should be made to improve wellness programs that will help Americans achieve a greater level of health, in addition to reduce medical care utilization, reduce the use of sick time, reduce injuries, and reduce insurance claims and overall healthcare costs. NABIP strongly supports group wellness programs and encourage policy makers to support any effort that will encourage more employers to offer wellness programs.

³⁵ http://www.pwc.com/en_US/us/health-industries/behind-the-numbers/assets/hri-behind-the-numbers-2014-chart-pack.pdf

³⁶ <https://www.ubabenefits.com/Wisdom/UBASurveys>

Medical Liability Reform

NABIP has taken a strong position on medical liability costs and believes federal legislation is needed to limit medical liability. Medical liability reforms that limit non-economic damage awards, allocate damages in proportion to degree of fault; place reasonable limits on punitive damages and attorney fees and a statute of limitations on claims would all have a positive impact on medical liability insurance premium rates. If medical liability insurance costs were lower it would likely reduce the health care costs associated with the practice of defensive medicine. In addition, state authorities should do a better job disciplining incompetent doctors, thereby reducing costs associated with their liability rates and medical errors.

Other Policy Ideas Being Monitored by NABIP feels the implementation of these policy solutions would go a long way toward raising American awareness of the true health care cost drivers, which will help pave the way for true systemic change.

- Reinsurance programs to better manage high-dollar health care claims.
- Electronic medical records to help unify the health care system.
- Pay-for-performance initiatives to positively impact care outcomes and reduce the number of medical errors.
- New health plan options that will reduce over-utilization of health care services.
- Creating a more level playing field across the states in terms of regulation of health insurance.
- Changes to benefit design and payment reforms

NABIP members work with individuals and employers on a daily basis to determine the best coverage options for their needs. In doing so, we also educate Americans about the drivers of the cost of medical care and ways to contain spending through various insurance products and programs. Individuals and employers are increasingly looking for solutions on reducing the cost of their health insurance; as uniquely qualified professionals in the sale and service of health insurance, NABIP members seek to be part of the solution in offering these proposals. Through consumer engagement and education we can help empower consumers to make the best choices which will help to contain their costs without reducing the quality of care.