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LEGISLATURE  
COMMITTEE HEARING  
RECORDS

**2005-06**

(session year)

**Assembly**

(Assembly, Senate or Joint)

**Task Force on  
Medical  
Malpractice  
(ATF-MM)**

Sample:

Record of Comm. Proceedings ... RCP

- 05hr\_AC-Ed\_RCP\_pt01a
- 05hr\_AC-Ed\_RCP\_pt01b
- 05hr\_AC-Ed\_RCP\_pt02

➤ Appointments ... Appt

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➤ Clearinghouse Rules ... CRule

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➤ Committee Hearings ... CH

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Health Insurance Association of America

## Issue Brief:

# Why Do Health Insurance Premiums Rise

September 2002

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202/824-1600 — <http://www.hiaa.org>

## Why Do Health Insurance Premiums Rise?

### Overview

Health insurance is a vital form of financial protection – it is also a significant expenditure. The average annual cost of family coverage, when provided through an employer, was \$7,954 in 2002.<sup>1</sup> Currently, premiums are rising at double-digit rates. This has come as an unexpected shock to many consumers. Any increase in the cost of health insurance is significant, since it is already unaffordable for far too many Americans. Two trends are coming together to cause the current increase in costs.

First, the transition to managed care has largely been completed. After rising rapidly for many years, increases in health insurance premiums slowed dramatically during the 1990s as Americans moved into managed care programs (enrollment in managed care plans surged from 40 percent in 1990 to over 90 percent in 1999). These large, one-time savings have all been taken now; in fact, the market is shifting away from the more restrictive forms of managed care.

Second, health care inflation is on the rise again. In turn, health insurance premiums are also rising. It is too early to know if the country is entering another lengthy period of sustained inflation in health care costs and health insurance premiums, like that seen in the 1970s and 1980s. However any increase in the cost of health insurance is significant, since each 1 percent increase in premiums leads to several hundred thousand Americans losing their health insurance coverage.

Why do premiums rise year after year? The primary factor is the growing cost of health care itself. Benefit payments are the single largest component of health insurance premiums; on average almost 90 cents of every premium dollar are paid back in benefit payments for health care services. America's spending on health care continues to grow faster than the rest of the economy, accounting for an ever-larger share of the country's gross domestic product. Prices for health care goods and services are rising faster than those for other goods and services, and we're using more health care than ever before. As health care spending rises, so do health insurance premiums.

Much of the growth in health care spending may be attributed to factors such as rising prices, growing expectations, an aging population, increasing reliance on new medical technologies, and rising malpractice awards. In particular, spending on certain categories of benefits has risen dramatically. Prescription drug costs, for example, have grown more rapidly over the past few years than all other major categories of health spending. According to recent surveys, prescription drug prices have fueled much of the rise in employer-sponsored health plan costs. Even in managed care programs, prescription drug costs are increasing by more than 16 percent a year and, on average, now account for 11 to 14 percent of total medical expenses.

At the same time, technology is advancing at an explosive pace. Medical science now offers care for conditions considered untreatable just a few years ago. These are positive breakthroughs. However, these advances also mean increased health spending.

Demographics and consumer attitudes also affect health care spending. As the nation ages and baby boomers reach their retirement years, there will be greater demand for health care resources. As the aged population grows there will likely be increases in chronic conditions. This will put more pressure on resources such as prescription drugs and home health services. As new treatments are developed, consumer expectations change, and our society becomes accustomed to an increased reliance on the use of health care services. The nation's collective notion of what constitutes "health care" is likely to continue to evolve, further driving up spending.

Government regulation of the health insurance industry, including new coverage mandates, also contributes to premium growth. State benefit mandates now total almost 1,400 in number, a 40-fold increase over the last several decades. Not only do these mandates increase the cost of health insurance, they make health insurance disproportionately more expensive for small companies. Employers may then be faced with a decision to shift more of the cost to their employees or drop coverage completely. As a result, as many as one of every four Americans who are uninsured lacks coverage due to these costly mandates.

Finally, government Medicare and Medicaid policies have contributed to the increase in private sector insurance premiums. As the government has used its administrative pricing authority to drive down payments to hospitals and physicians, these groups have looked to the private sector to try to make up losses and to subsidize care furnished to the uninsured.

While we are able to identify the factors contributing to rising premiums and, to some extent, predict the future pace of spending on health care items and services, there is a great deal that we do not know about the forces that drive health care spending. For example, why have pharmaceutical costs suddenly begun to skyrocket? Why have hospital and physician costs resumed their increase in recent years despite advances in medical technology and the introduction of medications that may reduce hospitalization? What impact will demographic changes, shifting consumer expectations, and evolving technologies have on health costs?

We also do not know how legislators and regulators – who have become more aggressive in regulating health insurers and employer-sponsored health plans during the past few years – will respond to the expected growth in health care spending and health insurance premiums.

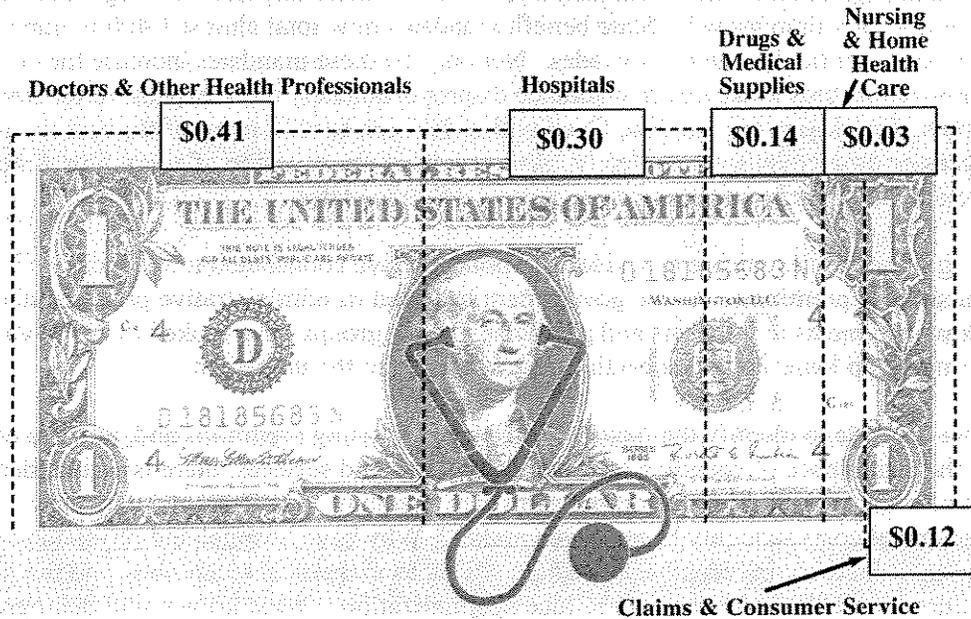
Over the years, Americans have made it clear that they value access to health care. We all want the newest, most advanced medical technology and highest quality care available for our families and ourselves; often, this also is the most expensive care. It seems likely that overall health care spending will grow in response to the public's demands and desires and so, in turn, will the cost of health insurance coverage.

This updated issue brief provides a conceptual framework for analyzing the primary components of health insurance premiums and health benefit costs, and briefly summarizes what is known about cost growth for these goods and services. Historical trends are identified, and some of the factors that may have contributed to those trends are discussed.

**Introduction**

While several factors influence health insurance premium rates, the cost of health care itself is by far the most important.<sup>2</sup> Almost ninety cents out of every premium dollar paid by employers and consumers goes to cover the cost of health care goods and services. Consequently, increasing health care costs have a significant impact on premiums.<sup>3</sup>

## The Premium “Health Care” Dollar



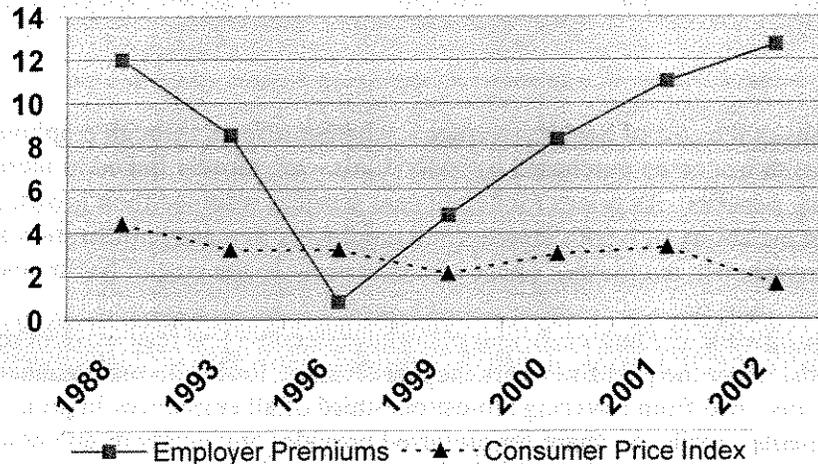
Consumers frequently misinterpret the relationship between health care costs and insurance premiums. Indeed, even the best journalists sometimes get it wrong. During a 1999 broadcast of ABC’s “World News Tonight,” anchor Peter Jennings said that “Health care costs have been going up every year, but this is the first major jump since the beginning of the decade. And it is being driven by rising premiums charged by health maintenance organizations.” In fact, the opposite is true: Instead of raising health care costs, premiums actually are driven up by the higher costs of health care goods and services.

Four primary factors affect the cost of health benefits: (1) the number of covered services delivered (utilization), (2) the unit cost of each service (price), (3) the relative proportions of services delivered (mix of services), and (4) the benefit program’s coverage and cost-sharing provisions (benefit level). Unfortunately, reliable data about each these four elements separately is not readily available, making it difficult to break down an overall increase in benefit costs into each of its component factors.

In addition, there is a significant time lag for reporting health care cost data. While premium level and claim payment information can be obtained relatively quickly, national data on health care utilization, price levels, and mix of services usually does not become available for two or more years after the fact. As a result, the relationship between costs for insured and self-insured health benefit programs and health care prices and utilization can be tracked historically, but it is hard to paint a clear picture about the relationship between current health care costs and health coverage costs. It is also important to remember that aggregate or per capita national data illustrate broad national trends. Cost trends for a particular health benefit plan may vary significantly from that average, depending on the particular benefits provided and the demographics of the covered individuals.

### Premium Trends

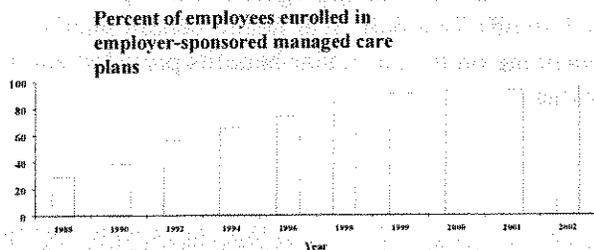
**Health Insurance Premiums Spike Despite Constant Rate of Inflation**



Source: Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2002 Annual Survey*.

In recent years, much of the media attention to the price paid by consumers for health care has focused on trends in insurance premiums. (The other primary focus of media attention has been on rising drug prices – particularly for seniors.) This heightened interest may be due to expectations shaped by the remarkably low rate of increase in health insurance premiums experienced during the mid-1990s. Between 1992 and 1996, the average annual increase in employer health insurance costs per covered worker dropped from over 10 percent to about .5 percent. Much of this reduction can be attributed to the adoption of managed care, which in 1996 saved purchasers of private health insurance between \$23.8 and \$37.4 billion.<sup>4</sup> These savings came from health insurers' and employers' efforts to moderate price increases in hospital, physician, and other services through market competition, and to eliminate some unnecessary and inappropriate care. At the same time, health insurers and employers were able to expand wellness screening and preventive efforts to help save lives, as well as to reduce costs.

## Today, 9 in 10 Americans Are Enrolled in Managed Care



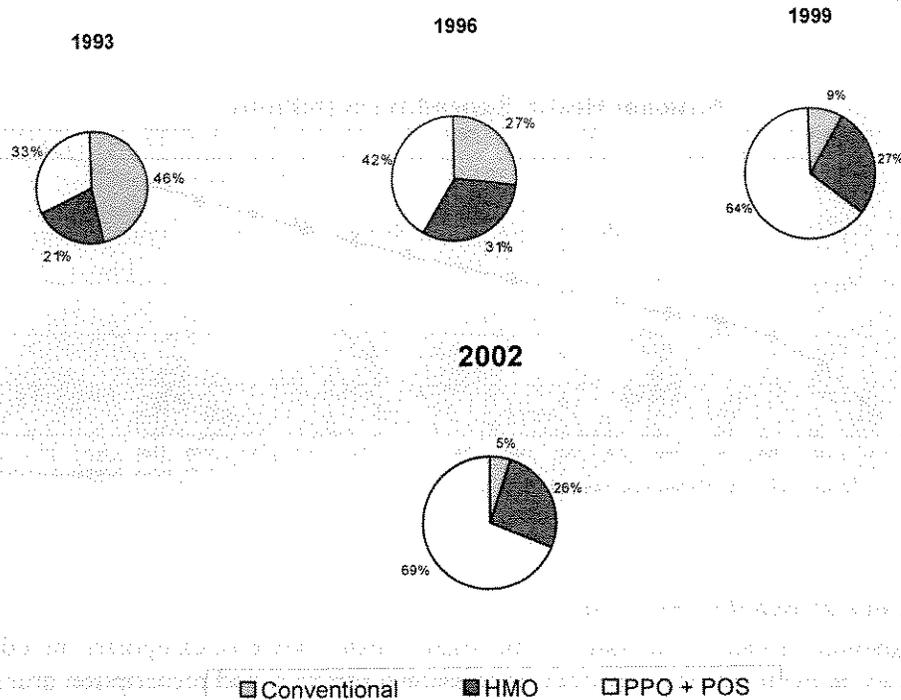
Source: Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits Survey, 2002*.

However, increases in the cost of health coverage – whether offered through employers or by the government or health insurance purchased by individuals – are closely linked to increases in the costs of underlying benefits. As prices for health care services resumed their growth, regulators imposed limits on the ability of health insurers and employers to manage utilization and enacted more and more government mandates. These also contribute to the cost of health insurance.

In addition to legislative interventions, health plans have become less restrictive in response to consumer demands. Over the past five years the market share for health maintenance organizations has declined from covering almost one-third of all employees in group health plans to less than one-quarter, while the share for preferred provider organizations and point of service plans has increased from 40 percent to 70 percent.

With the desire for greater access to health services, health plans have dropped authorization requirements for hospital admissions, referrals to specialists, and the use of expensive diagnostic procedures. Other less restrictive provisions have been the expansion of provider networks, movement away from capitation arrangements, and the availability of external review mechanisms.

## Market Shift in Managed Care from HMO to PPO + POS



Source: "Employer Health Benefits," Kaiser Family Foundation and Health Research and Educational Trust, 2002.

### Overall Health Care Spending Trends

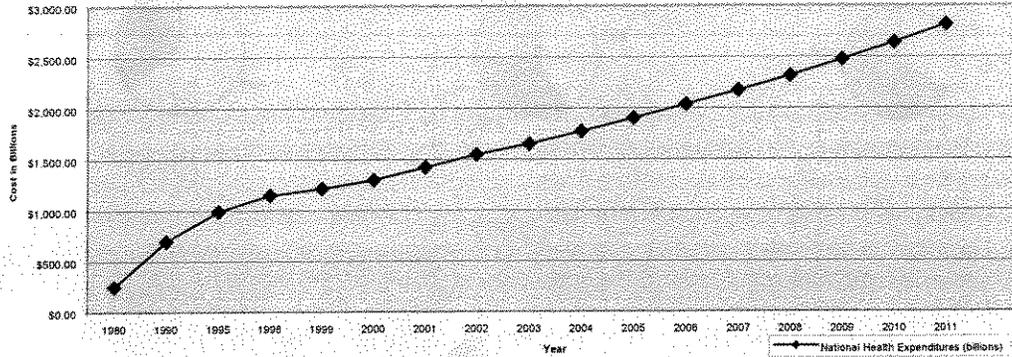
America's spending on health care continues to grow faster than the rest of the economy, accounting for an ever-larger share of the country's gross domestic product. Additionally, prices for health care goods and services are rising faster than those for other goods and services. Health care spending<sup>5</sup> is affected by a variety of factors. These include the number of people receiving health care, the kind and amount of care they receive, the prices paid for that care,<sup>6</sup> increased government mandates, and a rise in litigation.

For covered goods and services,<sup>7</sup> both price and use are significant; in many cases, both are rising. New technologies and drugs, the aging of the population, and rising incomes and public expectations are at least partially responsible for the increased use of health care. But greater utilization of health care and the adoption of new technologies are not reflected in measures of health care price inflation. When, in addition to rising prices, consumers purchase more health care and a wider mix of services, health benefit costs, total health spending, and premiums will rise more rapidly than price inflation alone would suggest.

The increase in per capita health care spending has slowed over the past 20 years from annual average increases of 10 percent or more during the 1970s and 1980s to between 5 and 6 percent in the mid-to-late 1990s. Recent data suggests that spending growth is beginning to accelerate

again. While projected growth rates in per capita spending are still relatively modest, total expenditures are expected to grow more rapidly than the economy as a whole, reaching \$2.8 trillion by 2011.<sup>8</sup>

**National Health Expenditures (billions)**

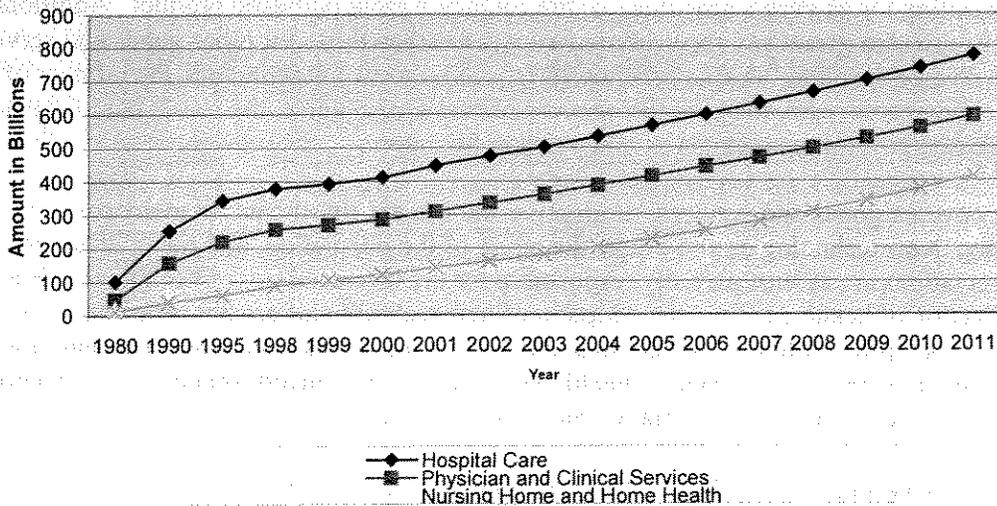


Source: Centers for Medicare and Medicaid Services.

**I. A Closer Look at Benefit Categories**

A number of spending trends are apparent in the major health care cost categories including hospital services, home health care services, professional services, and prescription drugs. Some of the growth may be attributed to factors such as rising prices, growing expectations, an aging population, and an increasing reliance on new medical technologies.

**National Health Expenditure Amounts, by Type of Expenditure:  
Selected Calendar Years 1980-2011**



Source: Centers for Medicare and Medicaid Services.

### **Hospital Services**

Hospital expenditures continue to make up the largest share of the nation's health care spending on average. In 2000, spending for outpatient care increased 11.2 percent and inpatient care increased 2.8 percent.<sup>9</sup> While the rate of increase in hospital spending has declined in the last 20 years, it is projected to remain somewhat higher than the growth in the general economy, rising at rates of between 5 and 6 percent during the next 10 years.<sup>10</sup> These trends will vary for individual benefit programs depending on demographics, local trends in health delivery and variations in the adoption and development of managed care.

Data on community hospitals show that the use of inpatient hospital care declined during the 1990s. Both the average daily number of patients and the average length of stay dropped. At the same time, the cost for a patient to stay in a hospital (on both a per-stay and per-day basis) has been rising. It is not clear to what extent this is due to rising unit prices, a changing case mix caused by less severe cases moving to other settings, or "front-loading" services with treatment concentrated in the first days of shorter hospital stays.

Consolidation of the hospital market over the past few years has resulted in less competition and concentrated the negotiating power of hospitals to bargain for higher reimbursement rates. Additionally, the cost of new technology and increased labor costs due to shortages of medical personnel has added to increased hospital expenses.<sup>11</sup>

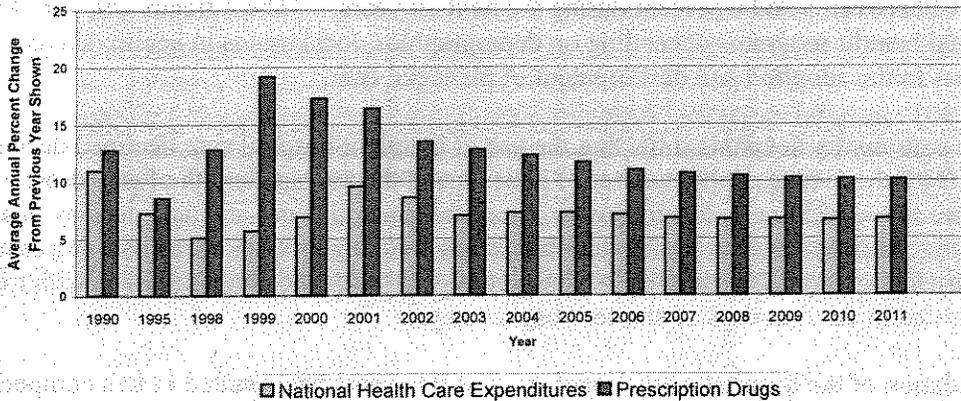
Regardless of the reason, the overall result has been rising hospital revenues and expenses during the past decade. Revenues have kept pace with expenses, leading to relatively stable hospital profit margins.

With shorter hospital inpatient stays, care has continued in other settings, increasing that share of the nation's spending on personal health care. For example, over the five years from 1994 through 1998 spending for nursing home care grew more rapidly than hospital spending, averaging 6 percent a year compared to 4 percent for hospitals.

### **Prescription Drugs**

Prescription drug spending has grown more rapidly than all other major categories of health spending over the past few years. This area is an increasingly significant portion of national spending on health care.<sup>12</sup> Projections show spending on prescription drugs growing an average of 11 percent per year through 2008.<sup>13</sup>

## Prescription Drug Expenditures Are Expected to Increase More Each Year Than Any Other Health Care Expenditure



Source: Centers for Medicare and Medicaid Services.

A number of factors have contributed to the rise in prescription drug spending. An aging population requires more frequent and often more expensive drugs. With a shift in focus from treatment of acute conditions to management of chronic conditions, the use of drug therapy-intensive disease management programs may also have resulted in increased prescription drug use.

Drug advertising directly to consumers also puts new pressure on providers to prescribe medications requested by their patients. Employer coverage of prescription drug costs – with limited employee cost-sharing – provides an added incentive for increased use. Consequently, there has been both an increase in the use of pharmaceuticals and a shift towards newer, higher-priced drugs.<sup>14</sup>

According to recent surveys, prescription drug prices have fueled much of the rise in employer-sponsored health plan costs. Even in managed care programs, prescription drug costs are increasing by more than 16 percent a year and, on average, now account for 11 to 14 percent of total medical expenses. Depending on the particular benefits provided, enrollee demographics, and enrollee use of other services, prescription drug costs may be even more significant for specific benefit plans. Plan sponsors are reacting with changes in their benefit programs, such as increased employee cost-sharing or modified lists of covered drugs.<sup>15</sup>

### Rising Costs in Chronic Illness and Aging<sup>16</sup>

#### Chronic Medical Conditions and Costs for Care on the Rise

	1995	2000	2005*	2010*	2020*	2030*	2040*
Persons (millions)	99	105	112	120	135	148	158
Cost of Chronic Care (billions)	\$470	\$503	\$539	\$582	\$685	\$798	\$864

\* Projections

Chronic illness in the United States has increased among the young (e.g., asthma) and old. Nearly 70 percent of Medicare recipients have two or more chronic illnesses. By 2020, 157 million Americans are anticipated to be suffering from one chronic condition, up from the current 125 million.<sup>17</sup> Drugs for chronic conditions, including those related to obesity and diabetes, cardiac and circulatory system conditions, joints and muscles, and mental health, increase the volume of prescriptions. In addition, these conditions may rely more heavily on health professions to administer these services efficiently outside of an institutional setting.

### **Home Health Services**

Shorter hospital stays combined with an increased aging population also have led to greater reliance on home health care services. As a result, home health care has been one of the fastest growing categories of health expenditures. Though spending in this area is expected to rise more slowly over the next decade, growth in home health care will still exceed increases for most other categories of health care expenditures. The greatest users of home-health services are older people, two-thirds of whom have at least one chronic disease that may require daily home-monitoring devices.<sup>18</sup>

No reliable data show the utilization and price components of private spending on home health care services. However, substantial growth in the number of home health agencies and personnel employed in the field suggest a significant increase in home health care use during the past decade.<sup>19</sup> More recently, it appears that growth in the home health care industry has moderated, perhaps due to cost saving and other measures instituted by the federal government in the Medicare program. However, given the continuing efforts of insurers and employers to shift away from more costly inpatient services toward outpatient care, it seems likely that use of home health care services will continue to grow over the long term.

### **New Technologies**

Medical technology encompasses all aspects of medicine: devices, pharmaceuticals, surgical procedures, and the organization of medical practice itself, and has sometimes been called the "culprit" behind the rise in health spending in the U.S.<sup>20</sup> The prevalence of costly medical technology necessarily increases the cost of health care. Technology often saves and extends lives. However, the true effect depends on the specific technological advance. Some developments represent less expensive or more efficient methods of treatment. Other technologies have the potential to significantly increase costs per patient.

Some new technologies are simply more expensive in and of themselves. Costs also can rise because sophisticated new techniques that reduce unit costs may result in greater use of services and increased overall costs. In addition, while some technologies offer more efficient, less costly replacement services, the general pattern is to provide new capabilities rather than substitutions for existing technology.

One example of a new, more effective technology that is substantially more expensive is the latest type of test to detect early signs of cervical cancer. While this new test costs about three times as much as the conventional screening, it increases the chances of early detection and, consequently, early treatment.

On the other hand, laparoscopic procedures (a small incision using fiber optics rather than more invasive surgery) were thought to reduce costs. They may, in fact, not save money because of the need for increased physician training and skills, higher associated professional fees, and increased postsurgical complications. Recent studies of cholecystectomies have shown that total hospital and physician costs are only about 9 percent lower when done laparoscopically than through an open approach.<sup>21</sup> A similar study of appendectomies indicated total charges for the laparoscopic approach were 17 percent higher than for the open approach.<sup>22</sup>

An analysis of the effect of new medical advances using case studies of new and emerging technologies conducted by Project HOPE for HIAA and the BlueCross BlueShield Association in 2001 shed light on several important points: "cost-saving" technologies often spread in cost-increasing ways, technologies exert their influence through both volume and price effects, and technologies cannot be separated from the systems in which they are used. It concluded the upward pressure on health care costs exerted by new medical advances would continue in the coming five years, at perhaps a slightly higher pace than the average trend for the 1990s.<sup>23</sup>

Additionally, unlike other industries, new technologies in health care tend to drive up labor costs. Unskilled workers simply cannot operate complex equipment and must have additional training. As in any other industry, these added labor costs are passed on to consumers.

### **Professional Services**

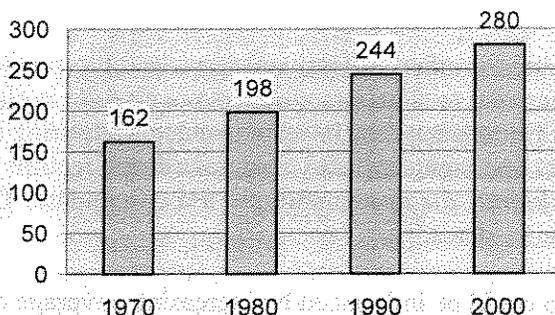
Professional services include those provided by physicians, nurses, dentists, podiatrists, chiropractors, optometrists, and other medical practitioners. Physicians represent the largest portion of professional services, accounting for almost two-thirds (65.6 percent) of spending in this area. The primary components of practitioner expenses are costs for professional services and support, including office staff compensation, and overhead costs. An increasing part of professionals' expense is the cost of malpractice insurance.

Health spending on physician services is second only to that of hospital care. While the annual growth rate of spending for physician services remains higher than the general inflation rate, it has moderated somewhat since 1990. Nevertheless, spending growth in this area is expected to continue to rise at about 6 percent annually, above the growth rate for the economy as a whole.

The number of active physicians grew more rapidly during the 1990s than the general population. In other industries, a relative increase in the supply of a product over demand for the product may lead to more competition and lower prices. However, in its *2001-2002 Occupational Outlook Handbook*, the Bureau of Labor Statistics (BLS) reports that, the number of physicians will grow at about the same rate as the rest of the population and continue to "have among the highest earnings of any occupation." According to the BLS report, "Physicians can do more tests, perform more procedures, and treat conditions previously regarded as untreatable."<sup>24</sup> Moreover, physician offices and clinics experienced employment increases of 4 to 5 percent from 1995 to 1998 with payroll increases of between 7 and 11 percent (compared to overall industry payroll increases averaging 7 percent).

Some discrepancy surrounds the future of the profession. In 1996, six leading medical groups including the AAMC and AMA signed a document warning that the number of physicians being trained was “excessive.” Many articles have been written warning of a physician oversupply.<sup>25</sup> Yet a recent study published in *Health Affairs* (January 2002) warns of a shortage of physicians due to inaccurate census predictions and variations in work efforts.<sup>26</sup> In any event, it appears unlikely that public demand for physicians’ services, or the prices charged for those services, will stop rising in the near future.

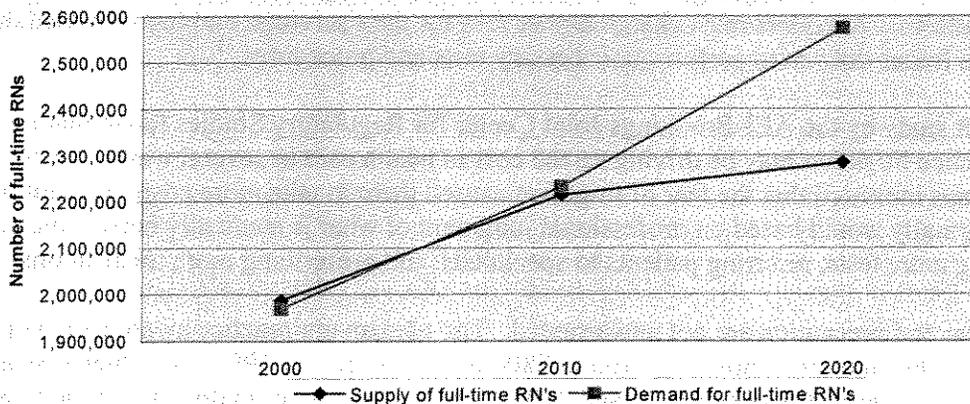
**Physicians per 100,000**



Source: *MS JAMA*; Council on Graduate Medical Education, 2000.

An undisputed concern, however, is the impending shortage of registered nurses. The health care industry will be particularly affected by the aging nurse population: nearly 40 percent of all registered nurses will be at or near retirement age by 2008. By 2010 a shortage of almost 20,000 RN positions is projected. By 2020 the shortage is projected to reach almost 300,000.<sup>27</sup> This will lead to a workforce shortage and lack of medical expertise as more nursing duties are taken over by less-trained technicians. Already, this shortage is being partly blamed for a number of unanticipated problems that result in death or injury to hospital patients.

**Projected Supply and Demand in the RN Labor Market**



Source: “A Shortage of Registered Nurses,” CRS Report, May 2001.

Of course, even with a growing number of practitioners, utilization could remain relatively constant and physicians would compete for the same market share. However, data on physician income levels suggests that this is not the case.<sup>28</sup> Other factors, such as those discussed under the section on demographic and social trends, are complicating market trends. More research is needed to determine whether the number of services per physician is remaining relatively constant, the unit price per service is increasing, or the mix of services is changing.

In contrast to physicians, spending for dental services has increased only moderately and is expected to continue rising at relatively modest levels. As a result, these expenditures are expected to represent a slightly declining share of national health care spending over the next decade.

On the other hand, expenses for other professional services (chiropractors, podiatrists, optometrists, and other licensed medical practitioners not elsewhere classified) have been increasing more rapidly. One reason may be state mandates requiring increased coverage of nonphysician practitioners and their services. Forty-one states require some type of coverage for chiropractors and psychologists, the most common form of mandate. Coverage for optometrists and dentists is required in 35 states.<sup>29</sup>

Spending in this area also could be influenced by increasing coverage of complementary and alternative medical treatments by health benefit programs, and by consumers taking advantage of that benefit. Recent surveys indicate that as many as one in five employers currently offer one or more alternative health benefits other than chiropractic.<sup>30</sup> Such benefits include acupuncture/acupressure, biofeedback, homeopathy, and massage therapy. As coverage levels increase and as consumer expectations and society's conception of what constitutes health care change over time, it is reasonable to expect consumers to make more use of these practitioners and their services. It also illustrates how these changing demands and expectations can affect health care spending in ways that are difficult to predict using historical data.

#### **Increased Malpractice Awards**

Medical malpractice insurance rates are adding to the mix of factors affecting both the cost and utilization of health care services. Litigation involving health care has grown dramatically over the last 20 years, resulting in greatly increased costs. Soaring malpractice insurance rates mean that health care providers must charge higher fees for their services, and the increased threat of lawsuits forces doctors to perform unnecessary tests and procedures.<sup>31</sup>

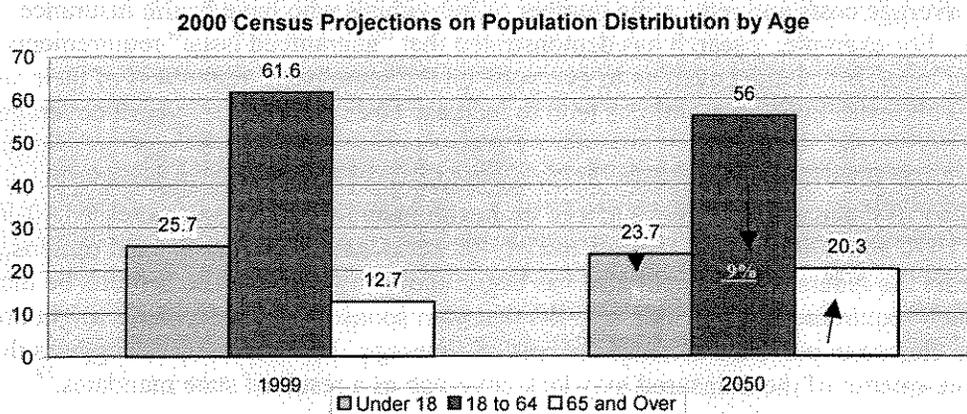
A recent study by the AEI-Brookings Joint Center for Regulatory Studies found that the fear of malpractice litigation may be driving up the cost of health care in several ways. Nearly all physicians indicated that the fear of litigation caused them to take more costly precautions than they normally would based on professional judgment of what is medically needed including: ordering more tests, referring patients to specialists, and prescribing more medications.<sup>32</sup>

Such fear and precaution are not unwarranted. The median malpractice award rose 63 percent between 1993 and 1999, hovering around \$800,000 at the end of 1999<sup>33</sup> and then rose an additional 43 percent between 1999 and 2000. The growth rate of malpractice awards was seven times the rate of inflation, and today the average jury award is over \$3 million.

## II. Demographic and Social Trends

Demographics are a major factor behind health care cost increases. As the population increases and ages, more people consume greater amounts of health care services, thus creating pressure that raises costs and expenditures.

The median age of the U.S. population continues to rise. In 1980 the median age was exactly 30 years. By 1990, it had risen to 32.8, and increased further to 35.9 by 2000. By 2050, the median age is expected to reach 38.8.<sup>34</sup> According to the 2000 census, the elderly population is expected to increase from 12.7 percent in 1999 to 20.3 percent in 2050.



Source: "Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin: 1999 to 2100," Department of Commerce, U.S. Census Bureau, Population Projections Program, January 2000.

A major demographic trend is the declining proportion of people under age 35 and an increasing proportion over age 65, with the sharpest gains in the 85 and over range. As the population ages, per capita costs for health expenditures will almost certainly increase.

A review of Centers for Medicare & Medicaid Services (CMS) figures for health care expenditures reveals the disparity in per capita spending levels between Medicare beneficiaries and Americans in general.<sup>35</sup> Total personal health care spending of \$1.1 trillion in 2000 for the U.S. population averaged just over \$4,000 per person. Medicare spending of \$203 billion on personal health services and supplies resulted in a per capita figure of over \$6,000 for each Medicare enrollee, over 50 percent higher than the general population. Another example of health care spending rising sharply with age is the case of prescription drugs; Medicare recipients account for 43 percent of the nation's spending on drugs, but represent only 14 percent of the U.S. population.<sup>36</sup>

Along with demographic changes have come changes in attitude that influence costs. Rising incomes and expectations regarding medical advances are driving the increased use of health services. New standards for cholesterol and blood pressure levels, awareness of health problems associated with excess weight and general health awareness may now send individuals previously considered "well" into doctors' offices for checkups, tests, and prescriptions. New medications, such as cholesterol-lowering drugs, as well as early or periodic interventions to

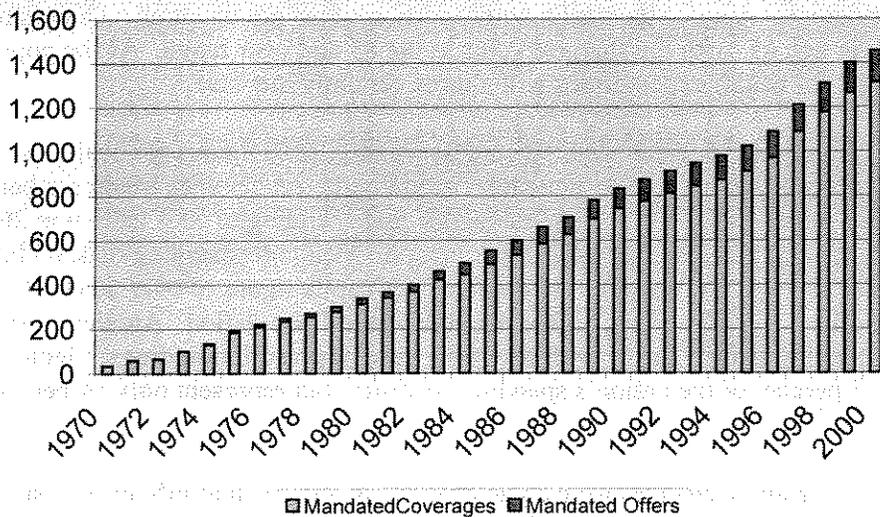
enhance well-being, may very well result in longer, disease-free lives; but these innovations increase health care spending as well. For example, more than 50 percent of Medicare beneficiaries undergo an angiogram following a heart attack, a 42 percent increase since the early 1980s. At large teaching hospitals, each angiogram costs between \$3,000 and \$4,000.

### III. Legislative and Regulatory Trends

Legislative and regulatory requirements placed on insurers and health benefit plans are another factor pushing costs higher. Within the small group and individual health insurance markets in particular, attempts at market reform intended to improve access to coverage may actually increase average costs and reduce the number of individuals who have health insurance coverage. For example, research has demonstrated that “guaranteed issue” requirements (requiring insurers to issue coverage to everyone on the same basis, regardless of their health) coupled with restrictions on premiums tend to increase costs and reduce overall coverage levels.<sup>37</sup>

The number of mandates states have placed on health insurance plans has increased 40-fold between 1970 and 2000. There are now over 1,400 state-mandated benefits and options.<sup>38</sup> In recent years the federal government also has begun requiring that specific benefits be included in plans. Such requirements to include benefits that plan sponsors and individuals might not otherwise choose to purchase increase the cost of coverage. Indeed, research suggests that one-fifth to one-quarter of the uninsured may lack coverage as a result of state mandates.<sup>39</sup>

**The Number of State Mandates Increased More Than 40-fold Over the Last Three Decades**



Source: HIAA analysis of S. Laudicina, B. Loseban, and N. Walker, “State Legislative Health Care and Insurance Issues: 2001,” State Services Department, Office of Policy and Representation, BlueCross BlueShield Association, Dec. 2001.

In recent years, there also has been growing political pressure for regulation of managed care programs. For example, nearly 30 states now require some type of independent review mechanism for health plan coverage decisions, and more than 100 bills to expand liability have been introduced in legislative sessions in 30 states and the District of Columbia. Managed care has been the primary mechanism health benefit sponsors use to help control the rising cost of coverage. To the extent that the legislative and judicial backlash restricts the use of managed care techniques, the cost of coverage is likely to rise.<sup>40</sup> This would have significant societal drawbacks. Research suggests that without the cost savings attributable to the growing influence of managed care, the number of uninsured Americans would probably be 3.1 to 5 million higher than it is today.<sup>41</sup>

In addition, overly restrictive regulations placed on certain market segments, such as the small group market, hinder the industry's ability to adjust premium rates to reflect higher risks making small employer insurance more expensive and less attractive to healthier individuals and groups. As healthier small groups and individuals drop coverage, premiums for those who are left must go up. The U.S. General Accounting Office reports that small employer premiums in states with the most stringent restrictions are 6 to 7 percent higher than in other states.<sup>42</sup>

#### **IV. Consumer Services, Benefits Administration and Other Expenses**

Little information has been published on health benefit administrative and other "non-benefit" costs. The primary components include claims administration, general program administration (for example, enrollment, billing, legal, actuarial, and other management expenses), marketing expenses, state taxes (premium taxes, licenses, and fees), federal income taxes, and risk and surplus charges ("profit"). Due to economies of scale and the fixed nature of certain costs, the percentage of health insurance premiums represented by these expenses is generally lower for employer-sponsored group health plans than for individually purchased health insurance. For group plans, expenses tend to decrease as the size of the group increases. Administrative costs also vary by health delivery system.

Survey data collected in 1991 by HIAA indicate that for mid-size employer groups (100 to 499 employees), claims administration expenses represented 3 percent of premiums.<sup>31</sup> General program administration was 5 percent of premiums, marketing and distribution expenses were 2 percent, and state taxes another 2 percent. Federal taxes represented 1 percent of premiums, and risk and surplus charges accounted for an additional 1 percent. Overall, administrative and other expenses accounted for 14 percent of premiums for these employers.

For small groups (fewer than 25 employees), expenses represented a somewhat higher percentage of premiums. Claims administration was 4 percent, program administration 6 percent, and marketing and distribution were 6 percent of premiums. State taxes were 3 percent, federal taxes 2 percent, and risk and surplus charges made up 4 percent of premiums. A June 2002 HIAA survey of small group carriers produced almost identical results for small groups.

On a national basis, recent data from the Centers for Medicare and Medicaid Services (CMS) indicate that the percent of total expenditures for all private insurers represented by administrative costs has changed little. Data for 2000 indicate that the net cost of administration represented 12 percent of all insurance spending.<sup>43</sup> The administrative costs incurred by private insurers represent approximately 6 percent of total personal health expenditures. These costs are, in aggregate, lower than administrative costs incurred by hospitals or by physicians.<sup>44</sup>

The profit margins of commercial health insurers have historically represented a small percent of overall premiums. For the period between 1976 through 1995, claims and administrative expenses for the top 20 commercial group insurers exceeded premiums, producing an average underwriting loss of 1.7 percent of premiums.<sup>45</sup> Net operating earnings, which primarily reflect the addition of investment earnings and federal income taxes, showed an average gain equal to 1.87 percent of premiums.<sup>46</sup> Results were similar for the individual health insurance policies issued by those same companies. Claims and administrative expenses exceeded premiums by 4.7 percent. Net operating gain for the period averaged 3.8 percent of premiums.<sup>47</sup> The net after tax profit for commercial insurers was 0.4 percent in 1998.<sup>48</sup> Recent data on profitability indicate continued small profit margins for the insurance industry. *Fortune* magazine's 2001 report on profitability by industry<sup>49</sup> indicates a 3 percent profit margin for both the insurance and health care sectors, while medical products and equipment have a 10 percent profit margin, and pharmaceutical manufacturers have a 17 percent profit margin.

Low margins for commercial health insurers mean that increases in the underlying benefit costs have a direct and significant impact on premiums paid by employers and individual consumers.

Despite evidence to the contrary, public opinion surveys show that Americans believe the health insurance industry in general, and in particular those insurers using managed care, are highly profitable. One recent survey found that 95 percent of Americans believe that insurance industry profit margins exceed 10 percent and over 40 percent believed profits exceeded 25 percent.

Managed care techniques complicate the analysis of administrative costs. In general, utilization review, antifraud activities, and other cost management programs represent new administrative expenses that reduce overall spending. For instance, HIAA data show that health insurers' antifraud activities in 1998 saved more than \$11 for every dollar spent.<sup>50</sup> As a result of these important and cost-effective activities, the percent of premiums attributed to administrative expenses tends to rise.

In addition, the way a network-based health plan contracts with providers may affect the accounting for administrative expenses. Amounts paid to providers or provider groups, in general, are treated as benefit costs. In a managed care environment, provider groups may be responsible for administrative functions that would otherwise be performed by the health plan administrator. If the reimbursement for those services is included in the overall capitation, then it will be treated on the insurer's books as a benefit cost rather than an administrative cost. This makes comparisons of administrative cost levels between different types of health benefit programs very difficult.

It is particularly difficult to compare voluntary private programs and mandatory social insurance programs. Private programs have many types of expenses, for instance, marketing and taxes, which have no direct parallel in a social insurance program. Billing, product development, and regulatory compliance also are typically much more significant in a private insurance program. In addition, it may be difficult to capture fully all of the expenses associated with a social insurance program. Billing may be replaced by tax collection, as in the Medicaid program, or may be integrated into another social insurance program, as with Medicare. In either case, revenue collection is not directly associated with the health insurance program itself. Certain legal and audit services may be provided by other government entities. Much of the cost of product development becomes part of the political process rather than an administrative function of the insurance program.

In the Medicare program, administrative expenses are partially placed on the private entities that assist in program administration. These entities must perform all the required program administration, including eligibility verifications, coverage determinations, coordination of benefits between sources of coverage, and benefit payments. In addition, they must conduct other services such as fraud detection.

In addition, while the dollars spent per claim for program administration may be relatively equal between Medicare and private programs, the average claim amount may be significantly higher for Medicare than for private programs. This causes the percentage spent on administration to be much smaller. Private programs cover frequently used services such as prescription drugs, which have relatively lower average claim costs, compared to hospital services with higher average costs.

Overall, mandatory social insurance programs appear to have somewhat lower administrative expenses than private insurance programs. However, economic theory suggests that private markets are superior to centrally planned systems in allocating resources efficiently. Further, government-run health care systems have not been without their own problems. Private health insurance systems can provide an array of coverage options to consumers. Without the discipline of market competition, social insurance systems can become unresponsive. In addition, these programs may not allocate sufficient resources to effectively combat fraud and abuse.

### **Summary**

Benefit payments are the single largest component of health insurance premiums. Thus, increases in health care prices and consumer use of health care services are the primary factors that cause premiums to rise over time. While both historical spending data and predictive cost trend information are available, more research is needed to uncover the factors influencing health care cost drivers and their precise relationship to health insurance costs.

### **Growth in Future Health Care Spending**

A number of factors have been suggested as contributing to current increases in health coverage costs. Among the prominent reasons are increased spending on prescription drugs due to direct-to-consumer advertising and accelerating development and approval of new drugs. Mandates and other regulations also have contributed to increased costs. Other factors include an aging

population, rising consumer expectations, and premiums that were artificially low as a result of competition for market share in the 1990s. Each factor has its own implications for the likely course of future spending levels.

#### Impact of the Cost of Health Coverage on Access to Coverage

The cost of health coverage has become a significant national issue. The most recent available data show that almost 40 million Americans lacked health insurance coverage in 2000.<sup>51</sup> The cost of health benefits has a direct impact on the number of uninsured in this country. As a matter of fact, rising health care spending relative to personal income can account for almost all of the increase in the number of uninsured Americans between 1979 and 1995.<sup>52</sup> More recent data confirm that increasing health care costs relative to family income remains the single most significant factor driving the rising number of Americans without health insurance coverage.<sup>53</sup> Similarly, cost is the primary reason some uninsured workers decline employer-sponsored coverage even when they have access to this benefit.<sup>54</sup>

#### Funding Rising Expectations and an Aging Population

Modern medicine can do many things that were impossible only a few years ago. With advancing technology have come greater expectations. At the same time, our society is aging. Improved care of all Americans, young and old, is a desirable public policy goal. However, achieving this objective will require significant resources. Whether this funding comes from private or public sources, the level of spending dedicated to health care will have an impact on the resources available for other uses.

#### Adjusting to Changing Patterns of Use and Spending

The level of health care spending is changing, as is the way in which we use our health care dollars. Use of hospital care is down while use of prescription drugs is becoming increasingly important. In addition, more Americans are turning to nursing home and home health care. As these shifts occur, excess capacity may develop in some sectors of the health care market while shortages develop in others. These market dislocations will present challenges to providers, patients, and health benefit sponsors.

#### **Additional Data Are Needed**

While data on aggregate spending levels are important for projecting short-term funding requirements, more data on utilization, price, service mix and outcomes will be necessary to effectively analyze the forces driving health care spending. Until more current data are available on these underlying factors, data-driven discussions of health care spending will have to be limited to explaining the past rather than the present.

#### **Notes**

1. *Employer Health Benefits: 2002*: 29 (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, September 2002).

2. The cost of health coverage also reflects claims administration, general program administration, reserve increases, and taxes, profits for commercial insurers or contributions to capital, and surplus for nonprofit organizations.

3. "2002 National Healthcare Expenditures," Centers for Medicare and Medicaid Services, 2002.

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4. John F. Shiels and Randall A. Haught, "Managed Care Savings for Employers and Households: Impact on the Uninsured," The Lewin Group, June 1997.
  5. The National Health Accounts provide estimates of this spending level. National health expenditures include all types of health care spending, including amounts directly related to the personal consumption of health care services, as well as on other items such as health research, facilities construction, and the administration of health plans. Personal Health Care Expenditures (PHCE) represent only those expenditures that are directly related to the personal consumption of health services. For purposes of this report, we will use the term "health care spending" to refer to PHCE.
  6. The CPI-M is not a good indicator of either the benefit costs faced by health plans or the premiums that they charge. It also is not a good indication of the overall growth in national health spending. The mix of services included in the CPI-M is very different from that of a typical health benefits plan. This index reflects direct consumer expenditures and does not include the value of employer or government contributions toward the cost of health care coverage. Thus, expenses covered by health plans are given less weight while expenses typically excluded from coverage, such as over-the-counter drugs, are included in the CPI-M.
  7. Health plans cover a wide array of goods and services. The costs of these goods and services dramatically influence the costs of benefits. Major categories of health care that are significant for a typical health benefit plan include inpatient hospital care, outpatient hospital care, care provided at other facilities (for example, skilled nursing facilities and freestanding surgical centers), physician and other professional care, and prescription drugs.
  8. The annual growth in health spending is projected to exceed the growth rate of the Gross Domestic Product (GDP) by an average of 2.5 percentage points over the period 2001–2011. "National Health Expenditures Projections: 2001–2011," Centers for Medicare and Medicaid Services, Office of the Actuary, March 2002.
  9. "Hospital Spending Drives Largest Health Care Cost Increase in a Decade," Center for Studying Health System Change, September 26, 2001.
  10. "National health expenditures are projected to reach \$2.8 trillion in 2011, growing at a mean annual rate of 7.3 percent during the forecast period 2001–2011. During this period, we expect health spending to grow 2.5 percent per year faster than nominal gross domestic product (GDP), so that by 2011 it will constitute approximately 17.0 percent of GDP compared to its 2000 level of 13.2 percent. This projection represents a 0.9 percentage point increase in GDP share by 2010 compared with last year's forecast." "National Health Expenditures Projections," Centers for Medicare and Medicaid Services, 2002.
  11. "Tracking Health Care Costs," Data Bulletin, no. 21, Center for Studying Health System Change, September 2001.
  12. For a more detailed discussion of prescription drug costs, see Thomas Musco, *Prescription Drugs: Cost and Coverage Trends* (Washington, D.C.: Health Insurance Association of America, September 1999).
  13. "National Health Expenditures: Projections," table 2, Centers for Medicare and Medicaid Services @ <http://www.hcfa.gov/stats and data/>.
  14. *Factors Affecting the Growth of Prescription Drug Expenditures*, National Institute for Health Care Management Research and Educational Foundation, July 1999.
  15. "Enrollment in Employer-Sponsored HMO/PPO Plans Drops, While Health Plan Costs Jump 6.1%," William M. Mercer, Inc., news release, January 26, 1999.
  16. Robert Wood Johnson Foundation, "Chronic Conditions: A Challenge for the 21<sup>st</sup> Century," 1996; Institute for Health and Aging, University of California at San Francisco, 2000.
  17. Michael L. Millenson, "America's Health Care Challenge: Rising Costs," Institute for Health Services Research and Policy Studies, Northwestern University, January 22, 2002.

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18. Kaiser Permanente's Medical Care Program; Carol Lewis, "Emerging Trends in Medical Device Technology: Home Is Where the Heart Monitor Is," *Consumer Magazine*, U.S. Food and Drug Administration, May-June 2001.
  19. The early to mid-1990s saw a rapid expansion in both the number of home health care establishments and the number of people employed in the industry. *Statistical Abstract of the United States, 1998: 779* (Washington, D.C.: Bureau of Census, 1998).
  20. "The Impact of Medical Technology on Future Health Care Costs," Project HOPE, Center for Health Affairs, February 28, 2001.
  21. "Average Charges for Cholecystectomies in the United States, 1996," *Statistical Bulletin, October-December 1998* (New York, NY: Metropolitan Life Insurance Company, 1998).
  22. "Laparoscopic and Open Appendectomies, Average Charges, 1997," *Statistical Bulletin, January-March 1999* (New York, NY: Metropolitan Life Insurance Company, 1998).
  23. "The Impact of Medical Technology," Project HOPE, 2001.
  24. Bureau of Labor Statistics @ <http://www.bls.gov/ocohome.htm>.
  25. Peter A. Setness, "Doctor Glut Revisited," *Postgraduate Medicine*, February 2001.
  26. Jay Greene, "Now forecast is for shortage of physicians," *AMNews*, January 21, 2002.
  27. "Report to the Secretary of the Department of Health and Human Services on the Basic Registered Nurse Workforce," National Advisory Council on Nurse Education and Practice, HRSA, Bureau of Health Professions, Division of Nursing, 1996.
  28. In September 1999, the Medical Group Management Association reported "annual compensation levels for all primary care physicians rose to \$139,244 in 1998, a 2.54 percent increase. . . . Compensation for all specialists increased by 5.22 percent."
  29. Data from the Blue Cross and Blue Shield Association (1997), as reported by Gail A. Jensen and Michael A. Morrissey, *Mandated Benefit Laws and Employer-Sponsored Health Insurance* (Washington, D.C.: Health Insurance Association of America, January 1999).
  30. Daniel B. Moskowitz, "Employers' Alternative Medicine Dilemma: Pleasing Believers While Limiting Costs," *Medicine & Health*, October 4, 1999.
  31. "Doctors across the board and around the country are facing double-digit hikes in malpractice premiums," *USA Today*, December 4, 2001. "In 2001, physicians in eight states saw two or more medical liability insurers raise rates by 30% or more: Arkansas, Connecticut, Illinois, Nevada, North Carolina, Ohio, Pennsylvania & Texas. A dozen states saw rate increases of 25% or more," *American Medical News*, January 7, 2002.
  32. "Fear of Litigation Study: The Impact on Medicine," conducted by Harris Interactive for Common Good, April 2002.
  33. Tanya Albert, "Malpractice awards pushing insurance premiums higher," *American Medical News*, March 5, 2001.
  34. National Population Projections, U.S. Census 2000.
  35. "Personal Health Care Expenditures Aggregate and Per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1980-2000," table 4, Centers for Medicare and Medicaid Services, CMS website.

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36. "The Medicare Program," Kaiser Family Foundation, 2001.
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38. "State Legislative Health Care and Insurance Issues: 2000 Survey of Plans," BlueCross BlueShield Association, December 2000.
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40. *Medical Necessity and Health Plan Contracts* (Washington, D.C.: Health Insurance Association of America, March 1999); Sheila Smith et al., "The Next Decade of Health Spending: A New Outlook," *Health Affairs*, no. 4: 18 (July/August 1999).
41. Shiels and Haight, "Managed Care Savings," The Lewin Group, 1997.
42. "Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage," GAO-02-8 U.S. General Accounting Office, October 2001.
43. Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group @ [www.cms.hhs.gov/statistics/nhe/historical/t3.asp](http://www.cms.hhs.gov/statistics/nhe/historical/t3.asp).
44. William D. Marder, *Administrative Costs and the Debate about U.S. Health System Reform: a Review of the Literature* (Cambridge, MA: Abt Associates Inc., February 1993).
45. The *underwriting result* (gain or loss) for an insurance program is the amount left over when claims and administrative expenses are subtracted from premiums.
46. The *net operating result* (gain or loss) for an insurance program is the sum of the underwriting results, net investment income, reserve adjustments, dividend accumulations, expense allowances, and miscellaneous income minus federal income taxes.
47. "Operating Results from the Leading Writers of Group and Individual Health Insurance: 1995," Health Insurance Association of America, June 1996.
48. Unpublished HIAA analysis based on 1998 data from *Best's Aggregates and Averages: Life-Health*, 1999 edition.
49. "The Fortune 500," *Fortune*, April 15, 2002.
50. Thomas D. Musco and Kathleen H. Fyffe, *Health Insurers' Anti-Fraud Programs* (Washington, D.C.: Health Insurance Association of America, 1999).
51. Robert J. Mills, "Health Insurance Coverage: 2000," *Current Population Reports* (Washington, D.C.: U.S. Census Bureau, Economics and Statistics Administration, U.S. Department of Commerce, September 2002).
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54. Kenneth E. Thorpe and Curtis S. Florence, "Why Are Workers Uninsured? Employer-Sponsored Health Insurance in 1997," *Health Affairs*, no. 2:18(March/April 1999). Peter Cunningham et al., "Who Declines Employer-Sponsored Health Insurance Coverage and Is Uninsured?" *Issue Brief No. 2*, (Washington, DC: Center for Studying Health System Change, October 1999).