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What Is Driving U.S. Health Care Spending?

America's Unsustainable Health Care Cost Growth

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ABOUT BPC

Founded in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole and George Mitchell, the Bipartisan Policy Center (BPC) is a non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation and respectful dialogue. With projects in multiple issue areas, BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.

HEALTH CARE COST CONTAINMENT INITIATIVE

BPC is embarking on an effort to address unsustainable health care cost growth in the United States. With the leadership of former Senate Majority Leaders Tom Daschle (D-SD) and Bill Frist (R-TN), former Senator Pete Domenici (R-NM) and former Congressional Budget Office Director Dr. Alice Rivlin, the BPC Health Care Cost Containment Initiative will explore and evaluate strategies to contain health care cost growth on a system-wide basis, while enhancing health care quality and value. This brief is the joint product of the Bipartisan Policy Center's Economic Policy Project, directed by Steve Bell, and Health Project, directed by Julie Barnes.

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Introduction

The Bipartisan Policy Center (BPC) is embarking on an effort to address unsustainable health care cost growth in the United States. With the leadership of former Senate Majority Leaders Tom Daschle (D-SD) and Bill Frist (R-TN), former Senator Pete Domenici (R-NM) and former Congressional Budget Office Director Dr. Alice Rivlin, the BPC Health Care Cost Containment Initiative will explore and evaluate strategies to contain health care cost growth on a system-wide basis, while enhancing health care quality and value. Our current health care system is rife with opportunities to reduce waste, deliver more effective, coordinated care, and improve the health and well-being of all Americans. BPC will prioritize effective cost-containment strategies with the greatest potential for bipartisan support and political success in 2013.

This background paper provides a basic overview of the drivers of health care cost growth, and serves as an analytical starting point for BPC's work on health care cost containment. At a basic level, health spending is a product of the *price* of health care services and the *utilization* of those services. The underlying drivers of price and utilization, which in turn are the key drivers of overall health care spending growth in the U.S., are described in this paper.

The analysis of these drivers will help inform BPC's selection and prioritization of proposals to improve the efficiency and quality of the health care system. As the paper demonstrates, however, drivers of health care cost growth are complex and overlapping. To some extent, experts disagree on how best to quantify their role in driving spending. For example, while most experts agree that advancing medical technology is a key driver of spending, there are differing views on the magnitude of its impact.[1] Thus, ranking cost drivers on the basis of their contribution to spending growth is beyond the scope of this paper.

Many of the cost drivers reviewed here can be confronted directly and curtailed through effective public policies, but others, such as aging of the population, cannot. In addition, some of the areas amenable to public policy solutions may involve areas that traditionally are the province of states, rather than the federal government. Another challenge is that none of the drivers of high and rising spending exists in isolation. Thus, solutions aimed at addressing a particular driver must account for any wide-ranging (and potentially unintended) impacts resulting from driver interactions, and policy interventions may need to address multiple drivers to reach a desired effect.

Finally, given the complexity, interconnectedness and magnitude of the problem, no single legislative initiative will be sufficient. The Patient Protection and Affordable Care Act (PPACA) calls for numerous regulatory and structural reforms to the health care insurance market, as well as demonstrations and pilot programs to encourage the development of

coordinated care delivery and payment systems. Many experts predict that these reforms will decrease the number of uninsured Americans and encourage higher quality care, as well as help control costs.[2-3] While the ultimate implications of these changes, especially in the face of mounting debt and strained state and federal resources, remains uncertain, the BPC believes that further action is needed to slow health care cost growth and ensure the sustainability of our nation's health care system. Multiple policy changes, developed with a broad bipartisan approach, will be necessary to address our health care cost growth challenges.

Background

In 2010, the United States spent over $2.6 trillion on health care, representing roughly 18 percent of gross domestic product (GDP).[4] Other advanced nations are able to provide health care services for significantly less – health spending in the U.S. is far higher than the United Kingdom (9.6 percent of GDP), Germany (11.6 percent) or Japan (9.5 percent).[5] Despite this high level of health care spending, the United States lags on many measures of health care outcomes and quality.[6-7] This discrepancy indicates opportunities to reduce spending while improving care, and the need to carefully examine the structural aspects of our health care system that contribute to inefficiency and wasteful spending.

Spending on health did not always comprise such a large fraction of U.S. economic activity. The percentage of our GDP devoted to spending on health care doubled over just the last 30 years.[8]

This rapid growth in health expenditures creates an unsustainable burden on America's economy, with far-reaching consequences. Because of this cost, businesses that provide health insurance to their workers are less competitive internationally and have fewer resources to invest in innovation and new technologies.[9] For employees, the increasing cost of employer-provided health insurance contributes to the stagnation of middle class wages, because salary increases are supplanted by an employer's subsidies toward health care benefits.[10-11]

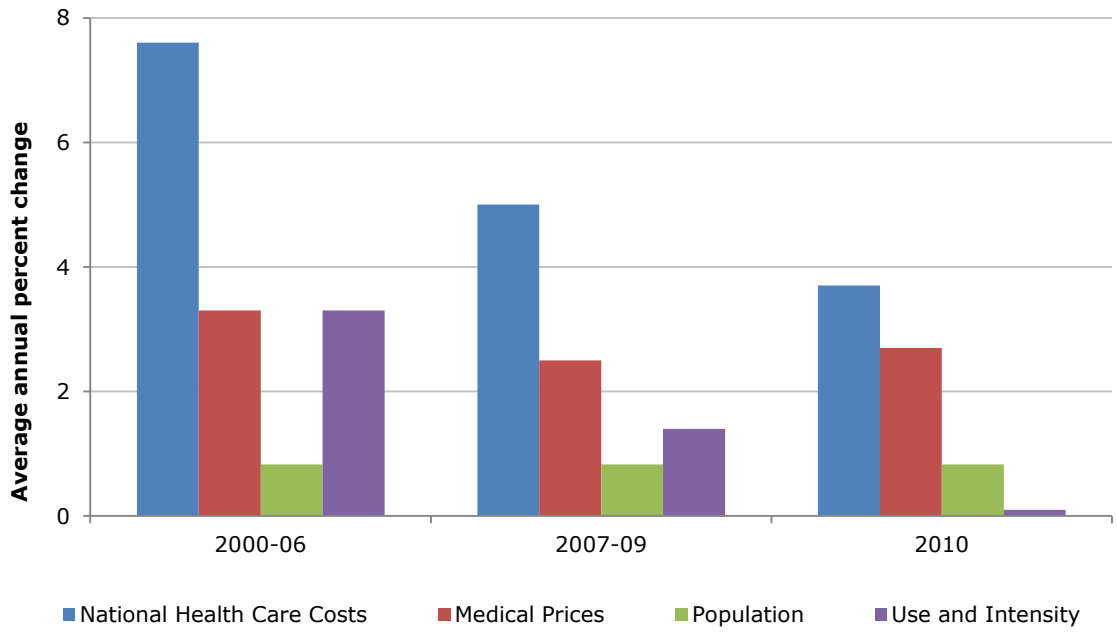
Additionally, the growing expense of private health insurance gradually redirects resources that consumers would ordinarily allocate to everything else, from food to housing to savings for their children's education. Increasing spending on government health care programs – primarily Medicare and Medicaid – consumes a growing portion of federal and state budgets, crowding out other priorities while also increasing public debt and reducing private investment in the economy.[12]

Recently, the growth rate of national health care spending slowed.[13] To understand this slowdown, note that total health spending is a direct consequence of how much care is consumed – which can be further broken down into the number of consumers (population)

and the amount of health services individuals use (use and intensity) – as well as the price of those services. Increases in any or all of these factors contribute to rising health care costs.

As Figure 1 (below) illustrates, the recent deceleration of cost growth stems almost entirely from a decline in the use and intensity of personal health services. In light of the recent economic downturn, this is not surprising. With less income, Americans cut back on spending for all goods and services, including health care.

Figure 1: Factors Accounting for Growth in Health Care Costs*, Selected Periods 2000-2010

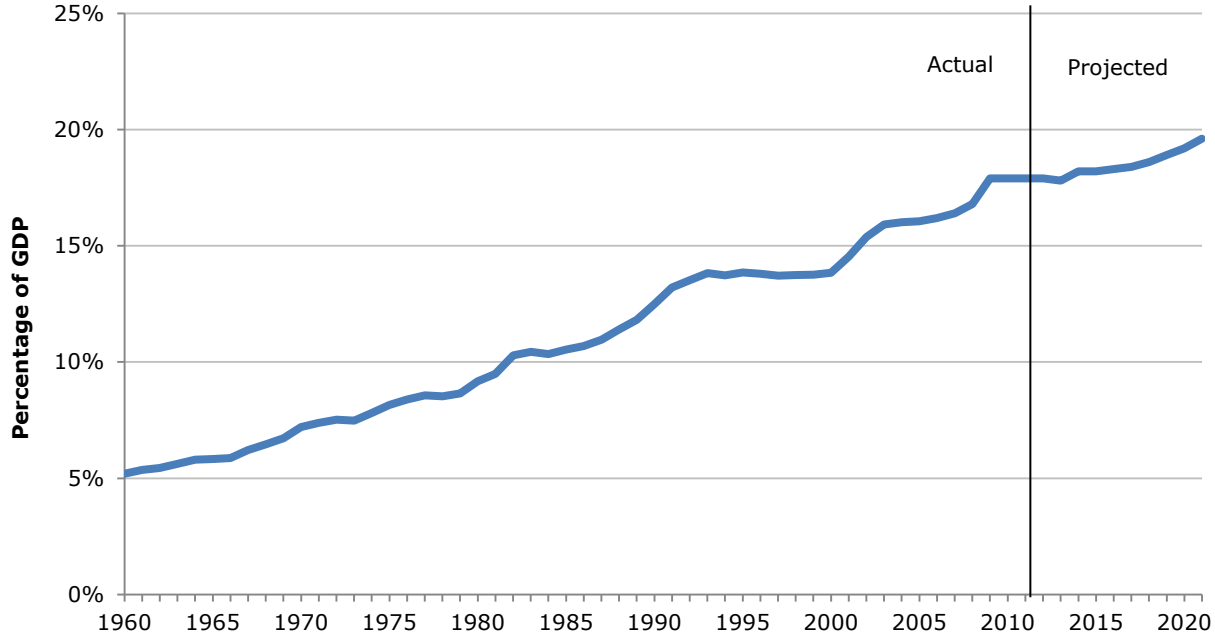


** For the calculations presented here, "health care costs" refers to national health expenditures minus the cost of health care investment, government administration of health programs, the difference between annual incurred premiums earned and benefits paid for private health insurance, and government public health activities. This categorization is referred to by CMS as "personal health care," and more details can be found on their website, www.CMS.gov.*

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group via Martin A B et al. Health Affairs 2013; 31:208-219.

Health care cost growth is currently projected to return to a rapid rate of increase in the near future, as illustrated by Figure 2. The Centers for Medicare and Medicaid Services (CMS) estimate that American health spending will reach nearly $5 trillion, or 20 percent of GDP, by 2021.[14]

Figure 2: U.S. National Health Expenditures as a Share of GDP, 1960-2021



Source: Centers for Medicare and Medicaid Services.

Moving forward, all three of the factors mentioned above – population, utilization rates and prices – are expected to continue (or resume) their upward paths. In this paper, we describe a range of complex "drivers" that are responsible for our high levels of health spending today. Some drivers will continue to push these factors (population, utilization rates, and prices), and thereby national health care costs, ever higher. The drivers listed below represent both structural barriers to the reduction of health care spending within the current system (such as the fee-for-service system of health care reimbursement) and more dynamic, changing aspects that will impact the overall growth rate of health care spending (such as the increasing prevalence of chronic disease). Broadly, these health care cost drivers include:

- Fee-for-service reimbursement;
- Fragmentation in care delivery;
- Administrative burden on providers, payers and patients;
- Population aging, rising rates of chronic disease and co-morbidities, as well as lifestyle factors and personal health choices;
- Advances in medical technology;
- Tax treatment of health insurance;

- Insurance benefit design;
- Lack of transparency about cost and quality, compounded by limited data, to inform consumer choice;
- Cultural biases that influence care utilization;
- Changing trends in health care market consolidation and competition for providers and insurers;
- High unit prices of medical services;
- The health care legal and regulatory environment, including current medical malpractice and fraud and abuse laws; and
- Structure and supply of the health professional workforce, including scope of practice restrictions, trends in clinical specialization, and patient access to providers.

This paper will provide an inventory and analysis of the key drivers of high and rising health care costs.

Health Care Financing and Delivery

Fee-for-Service

Reimbursement under the fee-for-service (FFS) model generates a strong incentive to perform a high volume of tests and services, regardless of whether those services improve quality or contribute to a broader effort to manage care.

Most health care services provided in the U.S. are paid for through a fee-for-service (FFS) system. A majority of public and private sector payers utilize FFS. In 2008, FFS plans comprised 78 percent of all employer-sponsored insurance plans in the United States.[15] As the term suggests, health care professionals and facilities are paid for each service they provide – the more services provided, the more fees will be paid. Accordingly, reimbursement under a FFS model generates a strong incentive for a high volume of tests, procedures, inpatient stays and outpatient visits, including those that have questionable potential to improve health.

The incentive to generate income by performing more tests and procedures is exacerbated by having the costs typically paid by third party insurance, masking the true cost to consumers. The economic incentives are particularly strong for services with high fixed costs, typically those making extensive use of medical equipment, such as imaging services. Moreover, FFS does not pay for many services perceived to be increasingly important for the management of serious illnesses, especially chronic disease, such as patient education and coordination of care with other providers. Lack of payment for emails, telephone calls or other services provided by professionals other than physicians makes it difficult to shift away from delivery models that rely heavily on in-person contact between patients and physicians. Across the nation, many alternative payment and delivery system pilot programs and demonstrations are underway – both in the public and private sector – with mixed results.[16-17] In CMS's recent Medicare Physician Group Payment Demonstration, the 10 participating physician groups were able to improve quality performance, however, most did not consistently earn the incentive payments available for care quality and cost savings.[18-19]

FFS may even exacerbate the magnitude of the cost impact of other drivers. For example, because FFS encourages the application of new medical technologies to all patients regardless of whether they are likely to benefit significantly or marginally from that

technology, the FFS environment increases the magnitude of cost increases from advancing medical technology.

Fragmentation of Care Delivery

Providers are paid for volume rather than patient outcomes, generating little financial incentive to coordinate with others to deliver more efficient care.

FFS payment contributes to fragmentation of the health care delivery system. When providers are paid on the basis of service volume rather than on the basis of taking responsibility for an episode of patient care, there is little incentive to coordinate with other providers to deliver care efficiently. Multi-specialty groups are widely considered to be better able to deliver high-quality and coordinated care; however, physician specialists tend to opt for single-specialty groups rather than multi-specialty groups because incomes in the former are potentially higher.[20-21]

Lack of care coordination often leads to overtreatment, costing the United States between $158 and $226 billion annually, experts estimate.[22] In a 2008 survey, 32 percent of adults reported experiencing duplicative or unnecessary care.[23] A more recent survey of primary care physicians found that 42 percent believed patients in their own practice were receiving too much care.[24]

Fragmentation may also contribute, at least in part, to preventable medical errors. Avoidable errors can stem from a failure to appropriately manage patient care or to deliver needed services, resulting in conditions such as pressure ulcers and surgical site infections.[25] In total, medical errors may have contributed to an estimated $17 billion in health spending in 2008.[26]

A good example of the need for more coordinated care delivery is the population that is dually eligible for Medicare and Medicaid, 60 percent of which suffer from multiple chronic conditions.[27] Representing only 15 percent of the Medicaid population and 16 percent of the Medicare population, these dual eligibles account for nearly 40 percent of Medicaid spending and 27 percent of Medicare spending.[28]

Administrative Burden

Our complex system of payment and delivery leads to increased paperwork and the need for greater administrative resources, raising provider and payer costs.

Fragmented payment and delivery leads to higher paperwork and other administrative burdens, raising provider and payer costs and consuming a significant amount of physician and patient time.[29] For example, most providers file claims with numerous health insurance plans, which typically utilize different processes for authorizing services, establishing patient eligibility and paying claims.[30] Navigating this complex system requires significant

administrative resources to complete necessary paperwork and contact payers about treatments, referrals and diagnoses.[31] Administrative costs in the U.S. are estimated to be somewhere between $156 and $183 billion annually – and growing.[32]

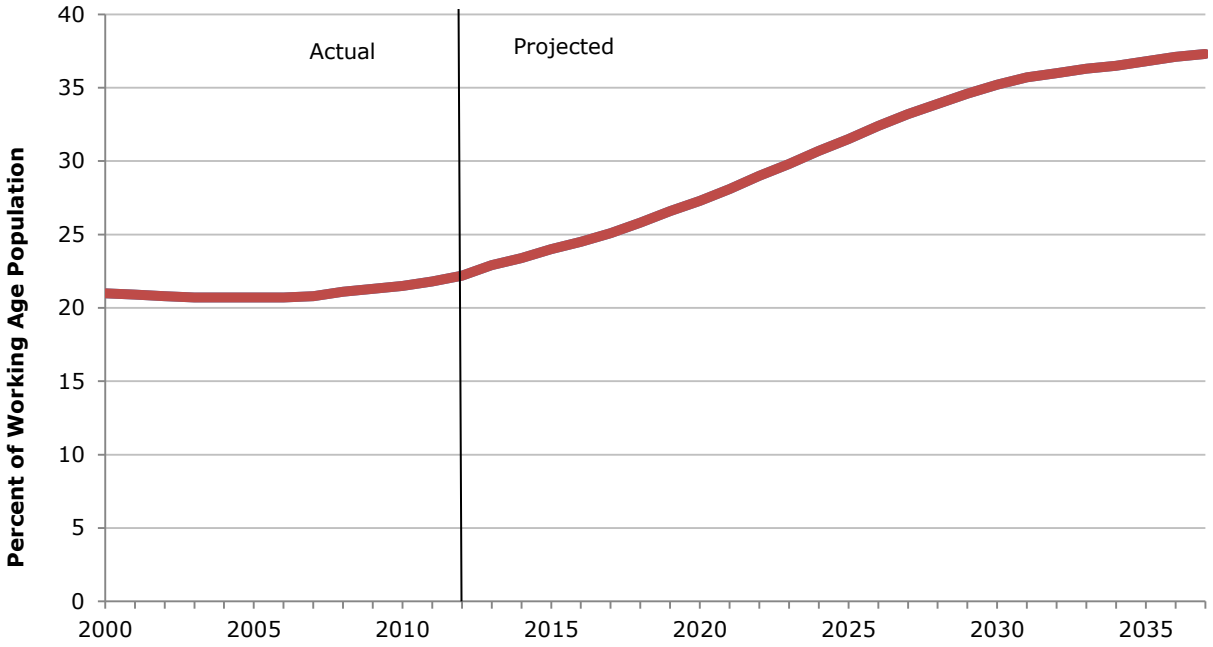
Population Needs for Care

Aging

The aging of the population will have a significant impact on health care spending growth.

Population aging will significantly impact the federal budget in coming years. When an individual turns 65, his or her total cost to the health care system does not suddenly increase. The cost to the federal government, however, will increase because Medicare will generally become the primary insurer. Congressional Budget Office (CBO) analysis indicates that, over the next 25 years (under their Alternative Fiscal Scenario), population aging will be responsible for 52 percent of the growth in spending on major federal health programs.[33] On average, Medicare enrollment is expected to increase by 1.6 million annually, leading to a total of nearly 81 million beneficiaries by 2030.[34-35] The percentage of people age 65 or older relative to those of working age will grow from roughly 22 percent in 2012 to almost 30 percent in 2022.[36]

Figure 3: Population Over 65 as Share of Working Age Population



Source: Congressional Budget Office.

Aging will impact both federal spending and system-wide health care spending. As the Baby Boom generation ages and leads to a population with a higher proportion of seniors, overall per capita spending will increase. Research examining demographic trends suggests that for the next 10-20 years, aging will increase spending growth by approximately 0.5 percentage points per year.[37] This spending growth increase reflects not only the aging of the Baby Boom generation, but increasing longevity due to factors such as advances in medicine and technology, particularly for the treatment of cardiac disease, and reduced rates of smoking.[38] Additionally, health care spending at the end of life accounts for a large portion of overall spending. In 2006, Medicare spent $38,975 per person on patients in the last year of life, roughly one quarter of the program's total spending.[39] Caring for patients at the end of life requires expensive services, such as inpatient hospital stays, hospice care, outpatient care, physician care, home health, and skilled nursing facility care.[40]

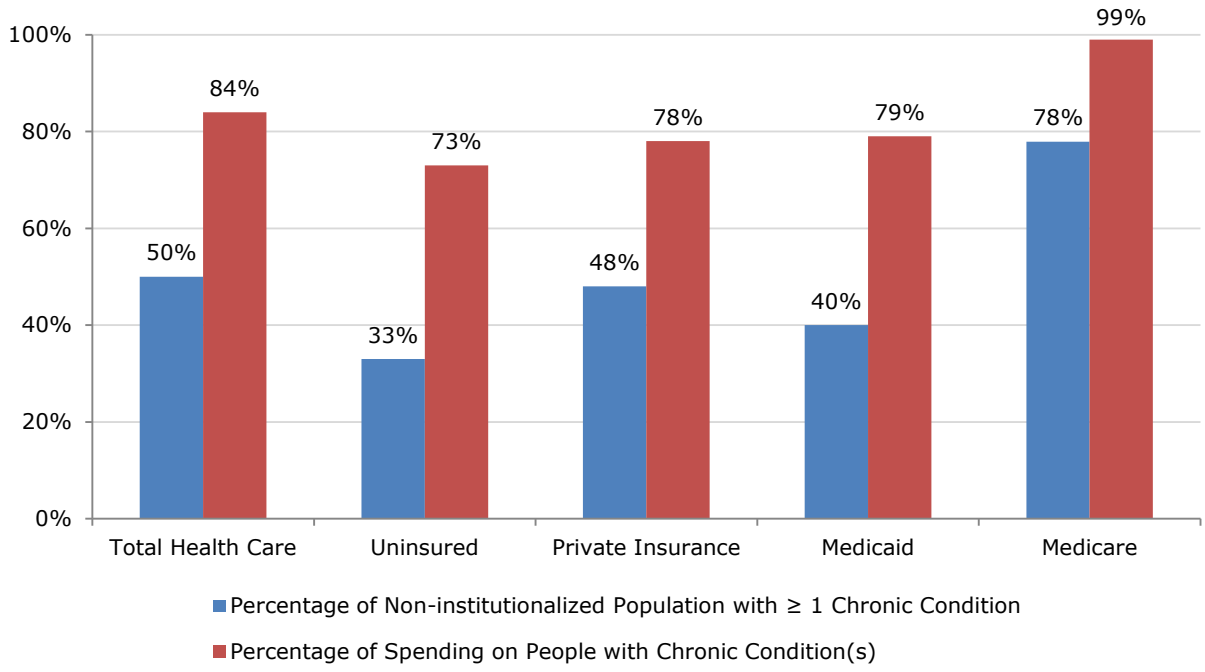
Over the coming decade, Medicare spending per beneficiary is expected to grow significantly slower, on average, than its historical trend and slower than the cost of private insurance. Due to a number of factors, however, such as the influx of younger (and thus healthier on average) Baby Boomers, it is unclear whether this trend will continue. In general, the relative growth rates of Medicare and private insurance costs vary over time, depending largely on the timing and intensity of various efforts to constrain costs in the public and private sectors. Therefore, it is important to address system-wide health care spending growth.

Chronic Disease

The rapidly increasing number of individuals with chronic disease account for a disproportionate percentage of overall health spending.

Individuals with chronic diseases utilize high volumes of complex health care services – roughly 84 percent of U.S. health care dollars and approximately 99 percent of Medicare spending are attributable to these individuals.[41] Figure 4 compares the percent of the population with chronic disease to total health care spending for these individuals. Chronic disease is also correlated with aging, as approximately 80 percent of American seniors have a chronic condition.[42] Nearly half of the U.S. population suffers from one or more chronic diseases, and by 2020, the number of Americans suffering from multiple chronic diseases is expected to reach 81 million, up from 63 million in 2005.[43]

Figure 4: People with Chronic Conditions Account for 84% of National Health Care Dollars and 99% of Medicare Spending



Sources: Medical Expenditure Panel Survey, 2006 and Robert Wood Johnson Foundation, Chronic Care: Making the Case for Ongoing Care, February 2010.

Research shows that rising rates of obesity, through its effects on the prevalence and severity of many chronic diseases, accounts for a significant portion of health spending growth.[44] In a 2012 study, CDC noted that many chronic conditions are preventable, and often accelerated by a personal choice to engage in unhealthy behaviors.[45]

The relationship between behavioral health issues and chronic disease is also important to consider. Behavioral health affects both mental and physical well-being, and includes health

problems such as major depression, bipolar disorder, or substance abuse, all of which can complicate the effective treatment of other chronic conditions.[46] Annually, approximately one in four American adults suffer from a diagnosable mental disorder.[47] Moreover, 17 percent of American adults experience a co-morbid mental and medical condition in a given year.[48] The presence of mental illness can worsen the prognosis for treatment of chronic conditions such as diabetes and heart disease, and lead to higher costs, worsened symptoms, and lower quality of life.[49-50] For example, depression associated with cardiac disease can lead to higher medical costs and increased risk that a patient will not comply with recommended treatments.[51] The burden of mental illness falls disproportionately on our poorest citizens. In 2005, behavioral health accounted for $135 billion, or 7.3 percent of total health care costs.[52] Medicaid paid a larger share of this total than other public and private sources in the United States, a total of 28 percent.[53-54] According to a recent inventory of state insurance mandates, coverage of general mental health benefits can result in a minimal (one to three percent) increase in premiums.[55]

Advancing Medical Technology

Advances in medical technology can both increase health system efficiency and encourage unnecessary utilization of expensive treatments in FFS.

Advances in medical technology are a major contributor to improving health and increasing longevity, but unnecessary utilization of new technology – especially where a less costly treatment would be equally effective – drives health care spending. The value of new technology largely depends on whether the increased spending on a new technology is justified by its ability to improve patient health outcomes. Though it is often an overall cost driver, advancing technology can positively or negatively impact cost growth. Previous studies distinguished between new technologies that substitute for older ones, which may either increase or decrease costs, and those that expand the range of treatments available, which almost always increase costs.[56]

A key challenge in employing advancing technology is assessing its effectiveness in improving patient outcomes. In the United States, many patients associate the use of more advanced technology, more tests, and more procedures with better care – even if clinical evidence demonstrates that these additional treatments do not improve patient health outcomes.[57]

Insurance Design

Tax Treatment of Health Insurance

The employer-sponsored health insurance tax exclusion encourages increasingly generous benefit designs and represents a significant loss in revenue for the federal government.

Under current law, employer contributions to employee health benefits are tax deductible as business expenses to the employer and are excluded from an employee's taxable income. Additionally, most employees – 54 percent of workers in firms with under 200 employees and over 90 percent of workers in larger firms – are permitted to use pre-tax income to pay for their employer-sponsored health insurance (ESI) premium contributions.[58]

The employer-sponsored health insurance tax exclusion allows employers to offer generous health plan benefits at a lower net cost. For example, consider a worker earning $50,000. She pays a marginal rate of 25 percent in federal income taxes, 6.3 percent (on average) in state income taxes if she lives in a state with an income tax, and, in effect, a combined (employee and employer) payroll tax of 12.4 percent for Social Security and 2.9 percent for Medicare. If her total ESI plan premium is $10,000, the exclusion saves her $4,660, or 46.6 percent of the total cost, in taxes.[59] Therefore, her after-tax cost of health insurance is only $5,340. This heavy subsidization of ESI can make additional health insurance benefits more valuable to many workers than additional cash compensation.

Moreover, the ESI tax exclusion is regressive in the sense that it generally subsidizes individuals at higher incomes more than individuals at lower incomes.[60] The ESI tax exclusion represents a total of about $250 billion in annual revenue loss to the U.S. Treasury.[61]

Utilization and Prevention

Access to health care services with little cost-sharing encourages higher care utilization and leads to increased spending.

Another consequence of the ESI tax exclusion is that it incentivizes employers to offer generous benefit designs and lower patient cost-sharing, which, in turn, encourage higher care utilization.[62] Similarly, in Medicare, 90 percent of beneficiaries have some source of supplemental coverage that limits their out-of-pocket responsibility.[63] Supplemental coverage comes from numerous sources, including Medicaid, employers and Medigap, with many of these payers providing protection against all or nearly all of Medicare's cost-sharing.[64] This practice leads to a higher utilization of services, increasing overall health spending. [65] Medicare outlays, in particular, rise because Medicare pays a large percentage of the spending from increased utilization. Many research studies suggest that increased

patient cost-sharing leads to lower utilization of both appropriate and inappropriate services.[66]

Coverage for preventive services, which typically feature no patient cost-sharing, has also increased over time. Some preventive services can lower spending by reducing the incidence of disease (e.g., through immunizations) or diagnosing it earlier (e.g., through routine cancer screenings) and precluding disease progression that would require more costly interventions. Many preventive services, however, increase total health system spending because of the large numbers that must be screened to find conditions where earlier intervention is effective.[67-68] Targeted application of preventive services, based on unique patient history and evidence-based practice, may be a more cost-effective way to utilize prevention.[69]

Lack of Transparency in Cost and Quality Information

Limited Consensus on Standards of Care

Without reliable information that enables a fair comparison of health care quality and outcomes, patients and clinicians are ill-equipped to utilize the best, most cost effective treatments.

The United States lacks a uniform, widely-accepted standard for evaluating the effectiveness of medical treatments and technologies. This lack of information is problematic for both patients and their caregivers. Health professionals are continually presented with a large volume of information on new treatments and interventions, but fair comparisons of the effectiveness of various interventions are not readily accessible.[70] Accordingly, health care professionals are frequently ill-equipped to communicate the relative costs and benefits of different treatments to patients.

Even widely accepted, evidence-based information on best practices and interventions is often implemented slowly. Procedures that are understood by many clinicians to be unnecessary are still commonly utilized.[71] The American Board of Internal Medicine Foundation, in conjunction with many specialty societies, published a list of common services for which research shows a lack of positive patient outcomes.[72] For example, imaging services generally increase costs without improving outcomes for patients with low

back pain.[73] Furthermore, unnecessary treatment can actually expose patients to risk, such as excess radiation from imaging scans.[74]

Consumers are rarely privy to information about the price of medical services. Additionally, insurance benefit designs typically do not encourage consumers to take price into account when choosing a provider. As benefit designs transform over time and create additional incentives to consider the prices of different providers, insurers will need to present these price differences to consumers in a clear and meaningful way.

Cultural and Institutional Influences

Cultural biases often favor more and prolonged care, regardless of its effectiveness.

In general, American culture tends to favor medical interventions that have the potential to prolong life or improve function, even when the chances for success are very low, the anticipated improvement is very limited, and the cost of treatment is very high. This cultural bias extends to both patients and providers. Our current reimbursement system, as well as our institutional and educational practices, do not adequately equip or encourage clinicians to have open discussions about the ultimate value of a particular intervention with their patients.[75] This leaves patients without the tools they need to become more responsible health care consumers and make informed decisions about appropriate care. Cultural and language barriers, among numerous other factors, can also contribute to the prevalence of racial and ethnic disparities in care quality and outcomes.[76]

Competition and Consolidation

Choice and Market Forces

Imbalances in market power due to regional variation as well as increasing provider and payer consolidation hinder market forces from limiting high prices.

Market competition can lower prices, improve productivity, and encourage innovation.[77] In a functioning market, individuals or entities evaluate competing suppliers and make informed choices about where to spend their money. In the health care system, however, numerous factors obstruct this basic dynamic.[78] As discussed above, consumers are often shielded from the direct cost of care, and information about the cost-effectiveness and potential adverse consequences of health care interventions is incomplete and difficult for patients to access in a meaningful way. The concentration of provider and payer market share varies

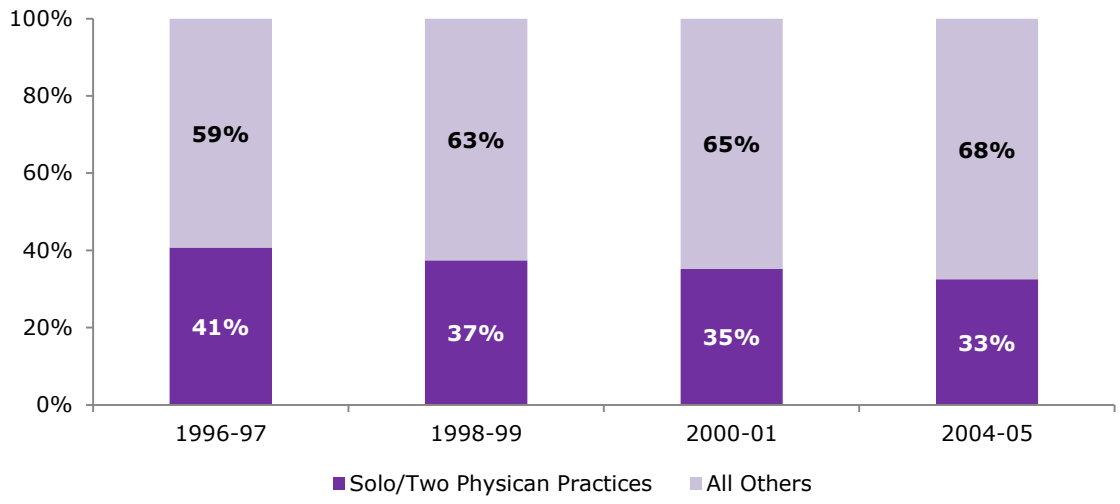
across the nation.[79-80] Excessive concentration of either providers or insurers in a single market can impact competitive price negotiation and potentially limit consumer choice.[81-82]

Provider Consolidation

Growing consolidation among providers can improve the delivery of care, but misuse of market power to increase the price of services is a risk.

Increasing provider consolidation, such as hospitals merging into larger systems or directly employing physicians, is one of the more prominent trends in America's current health care system.[83] Consolidation can encourage reduced waste and greater efficiency by facilitating clinical integration of services and coordination of care.

Figure 5: The Percentage of Physicians in Solo/Two-Physician Practices Dropped by One-fifth from 1996-97 to 2004-05



Source: Center for Studying Health System Change (HSC) Community Tracking Study Physician Survey.

Organizing fragmented providers will be a necessary part of the transition to a delivery system focused on better value. The risk of consolidation is increased prices and lack of incentives for dominant providers to innovate and increase efficiency.[84] A recent study found that hospitals in concentrated markets are able to charge considerably higher prices than hospitals in competitive markets for comparable patients.[85] For example, the price for a coronary angioplasty was 25 percent higher and total knee replacement was 19 percent higher in more concentrated markets.[86] In total, research suggests that hospital consolidation during the 1990s raised inpatient prices by at least five percent.[87]

Insurance Industry Consolidation

Larger insurers are gaining market share across the nation. Potentially, insurers could use this power to negotiate lower provider reimbursement.

The insurance industry is also experiencing market consolidation. Large national insurers and mid-size, multi-state plans are gaining market share at the expense of smaller regional insurers.[88] Part of this reflects the advantages rising from scale economies required to implement more advanced data systems and care management technologies. Large multi-location employers' shift toward favoring a single carrier for employees in all locations – as opposed to choosing plans in each location – has hurt regional insurers as well.[89]

More consolidated insurers could either increase or decrease health care spending. As intermediaries, larger insurers have more clout with both purchasers of insurance as well as providers. A dominant insurer can negotiate lower prices with providers through the threat of exclusion from local networks. Consolidated insurers can either translate these lower prices into lower premiums, or maintain premium levels and increase profit margins with minimal fear of losing beneficiaries.[90]

Some experts argue that current laws, which prevent consumers from buying insurance out-of-state, negatively impact competition and restrict consumer choice.[91] Others contend that selling insurance across state lines will have a limited impact on competition, and may encourage higher premiums while discouraging the inclusion of critical health benefits.[92] State-based health insurance exchanges (including, but not limited to those proposed by PPACA) might have larger effects on competition by lowering barriers for insurers to enter additional markets. Such proposals would not affect the majority of employer-based coverage, in which large and mid-sized employers are typically self insured and exempt from state regulation.

Unit Prices

The U.S. pays higher prices for health services, which leads to higher spending.

There is mounting evidence that the U.S. pays more for medical services and products than other nations. For example, U.S. commercial diagnostic imaging fees are, on average, far higher than other countries.[93] A recent evaluation of top-selling drugs showed that drugs in the U.S. are 2.3 times more expensive than in other nations.[94] Physicians in the United States – both primary care and specialists – are reimbursed at higher rates than their counterparts in other countries. Per capita spending on physician services in the U.S. reached $1,599 in 2008, compared to only $310 in other Organization for Economic Cooperation and Development (OECD) countries.[95]

There are a variety of factors that drive high prices, including the cost of new medical technology and equipment, administrative burdens, and greater fragmentation among the

purchasers of health services.[96] In some countries, the government sets prices or a consortium of insurers negotiating under a government-supervised framework is the only buyer. In the United States, buyers are numerous and their leverage is constrained by Americans' desire for broad provider choice.

Legal and Regulatory Environment

Legal Barriers

The current U.S. legal and regulatory environment drives up costs to our health care system by preventing transition to more cost-effective systems of care.

Our current regulatory system is structured to support the FFS model of health care delivery and payment. This legal environment indirectly encourages spending growth by making it more difficult for providers and payers to implement more cost-effective systems of care. Antitrust, anti-kickback and physician referral ethics laws – among others – are intended to prevent inappropriate activity within current payment and delivery systems. In many cases, the concerns that arise under FFS, such as physician self-referral, are reversed under alternative systems. For example, under a capitated system of health care payment, fear that providers will withhold necessary services to stay under budget may be a greater concern than overutilization of services.[97] Reforms to current law and regulations should complement the implementation of alternative models of health care delivery and payment. Simply eliminating or changing current laws within the context of a predominantly FFS payment system is unlikely to help control costs.

Medical Malpractice

Fearing malpractice lawsuits, many physicians significantly drive up costs to our health care system by ordering unnecessary tests and treatments.

Aside from the direct costs of medical lawsuits and high malpractice insurance premiums, our inefficient medical malpractice system also contributes to high health care costs through the practice of "defensive medicine" – tests and treatments that physicians prescribe largely in response to the threat of lawsuits. In a 2003 survey of physicians in high-risk specialties, 93 percent reported utilization of additional diagnostic procedures, tests and imaging technology services due to concern over growing malpractice costs.[98] Similarly, in a 2008 study, 83 percent of physicians surveyed in Massachusetts reported practicing defensive

medicine.[99] In total, these defensive medicine costs are estimated to be approximately $45.6 billion to over $650 billion per year.[100-101]

Fraud and Abuse

Fraud and abuse contributes to wasteful spending in both federal and private sector health programs.

Fraud, waste and abuse in Medicare and Medicaid cost approximately $50 to $100 billion or more annually.[102-103] Increased resources devoted to detecting, investigating and fighting fraud and abuse demonstrate a significant return on investment.[104] Between 2008 and 2010, the return on investment for the Health Care Fraud and Abuse Control (HCFAC) Program in CMS reached a high of 6.8 to one.[105] PPACA calls for a number of new provisions to combat fraud and abuse. In addition to increased funds for HCFAC, PPACA encourages new approaches to fighting fraud and abuse in Medicare, such as a shift toward pre-screening providers, increased disclosure requirements, and data sharing requirements that span multiple government agencies.[106] Numerous entities perform audits to detect fraud and abuse in Medicare. Recently, several congressional leaders called for a review of the administrative burden that these fraud and abuse detection efforts place on providers.[107] Though fraud in Medicare and Medicaid has greater public visibility, fraud and abuse also impact the private sector, accounting for an estimated three to 10 percent of annual, system-wide spending.[108]

Health Professional Workforce

Scope of Practice Restrictions

Utilizing a physician for a service that another professional is able to effectively and safely provide is a missed opportunity to utilize a lower cost provider.

Due to various regulations and restrictions, many professionals are not practicing at the "top of their license," meaning that they are not performing the work that reflects the fullest extent of their education and training. The time that a physician spends performing a task that a nurse practitioner (NP), physician assistant (PA), pharmacist or other health professional is qualified to perform drives up health care costs unnecessarily. Scope of practice restrictions vary across the nation, limiting the ability of certain professionals to provide cost-effective care. When an NP or PA can provide the same care to a patient safely and effectively, engaging a physician for this service is a missed opportunity to utilize a

lower cost provider. Differing state licensure and insurer payment policies interfere with greater substitution of other health professionals, such as NPs and PAs, for physicians. Furthermore, the required level of physician supervision of these professionals is inconsistent across the nation. Physician oversight of work that can be performed autonomously by other professionals can lead to unnecessary repetition of orders, office visits and services, thus increasing total costs without any additional benefit to patients.[109]

Health Professional Workforce Shortages

Shortages or maldistribution of health professionals can drive patients to seek care from higher cost providers.

Utilization of higher cost providers is a major driver of increased health care costs. Lack of accessible primary care professionals may drive patients to seek out specialists for the delivery of primary care services or drive patients to the emergency department. Though the utilization of specialists over primary care physicians may be driven, in part, by patient perceptions or preference, a recent study found that two in five American adults receive primary care services from specialists.[110]

More research is needed to understand and predict both the current and future supply of health professionals and demand for health care services. Experts disagree about whether the United States has an adequate supply of health professionals.[111-112] The total number and geographic distribution of health professionals are key factors in determining the United States' ability to meet the demand for health care services. Without a better strategy for more efficiently meeting the demand for health care services, we are unable to address this cost driver.

Clinical Specialization

The high ratio of specialty physicians in the U.S. can encourage utilization of higher cost services.

The United States has a much higher ratio of specialists to primary care physicians than other advanced countries.[113] Research suggests that more specialists lead to higher costs.[114] Studies show that health care spending is higher in regions with a larger proportion of physician specialists.[115] A 2010 study from the Archives of Internal Medicine found that primary care physicians are reimbursed at a significantly lower rate than specialists: wages are 48 percent higher for surgical specialties and 36 percent higher for internal medicine and pediatric subspecialties.[116] A career in specialty medicine, such as orthopedics or dermatology, requires more education but leads to greater financial rewards in the long term. The promise of substantially higher income, which also increases ability to pay off educational debt, encourages medical students to pursue specialty care. Between 1965 and 1992, the ratio of specialty physicians to U.S. population grew by 120 percent – compared to only 14 percent for primary care.[117] Without changing economic incentives, this trend

has the potential to slow movement towards delivery systems that expand the role of primary care physicians to encourage better care coordination and clinical integration.

Medicare and Medicaid Participation

Patients that cannot regularly access care via a physician office visit may seek treatment from higher cost providers, such as hospital emergency departments.

In addition to the differences in specialist and primary care physician reimbursement, Medicare traditionally reimburses at a rate that is below private payers, and Medicaid, on average, pays providers about 72 percent of what Medicare pays for care.[118-119] Some experts attribute physician reluctance to accept new Medicare and Medicaid patients to lower reimbursement from these programs, though the prevalence and severity of this problem is subject to debate.[120-121] In 2011, 31 percent of physicians refused to accept new Medicaid patients and 17 percent refused to accept new Medicare patients.[122] Like uninsured individuals, patients who are unable to access care via a physician office visit often seek care in hospital emergency departments and other outpatient settings, which come at a higher overall price.[123]

Conclusion and Next Steps

The drivers of health care cost growth are complex and multi-faceted. Just as no single driver is responsible for our high and rising health care costs, no single policy solution will be adequate to meet this challenge. For this reason, the BPC Health Care Cost Containment Initiative plans to produce a comprehensive, bipartisan package of health care cost containment options that, if implemented together, could reduce system-wide health care costs, slow cost growth and improve the efficiency and quality of care in the United States.

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