

Trends in Health Care Costs

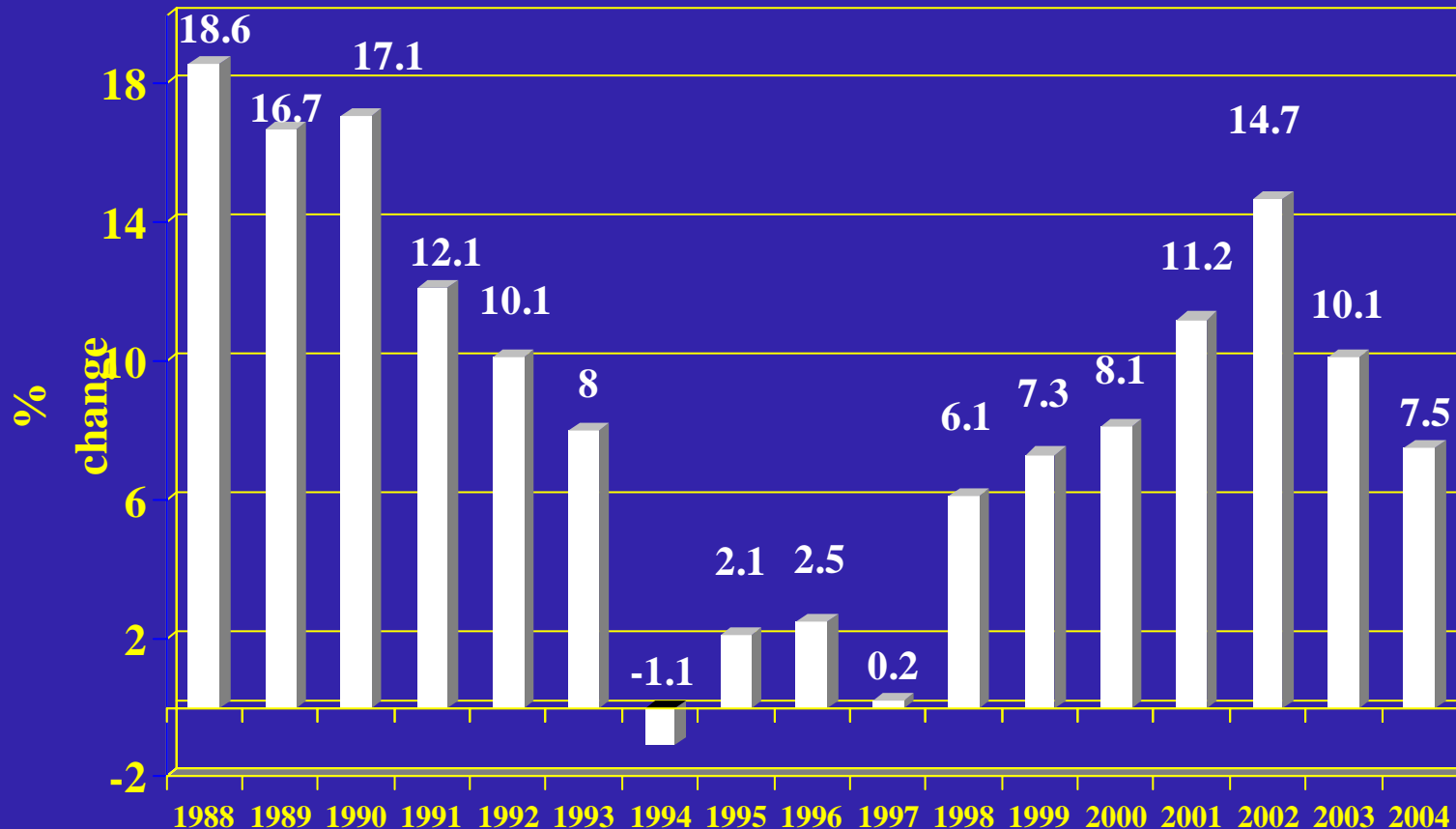
IOM Taskforce on Covering the Uninsured
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Presentation Outline

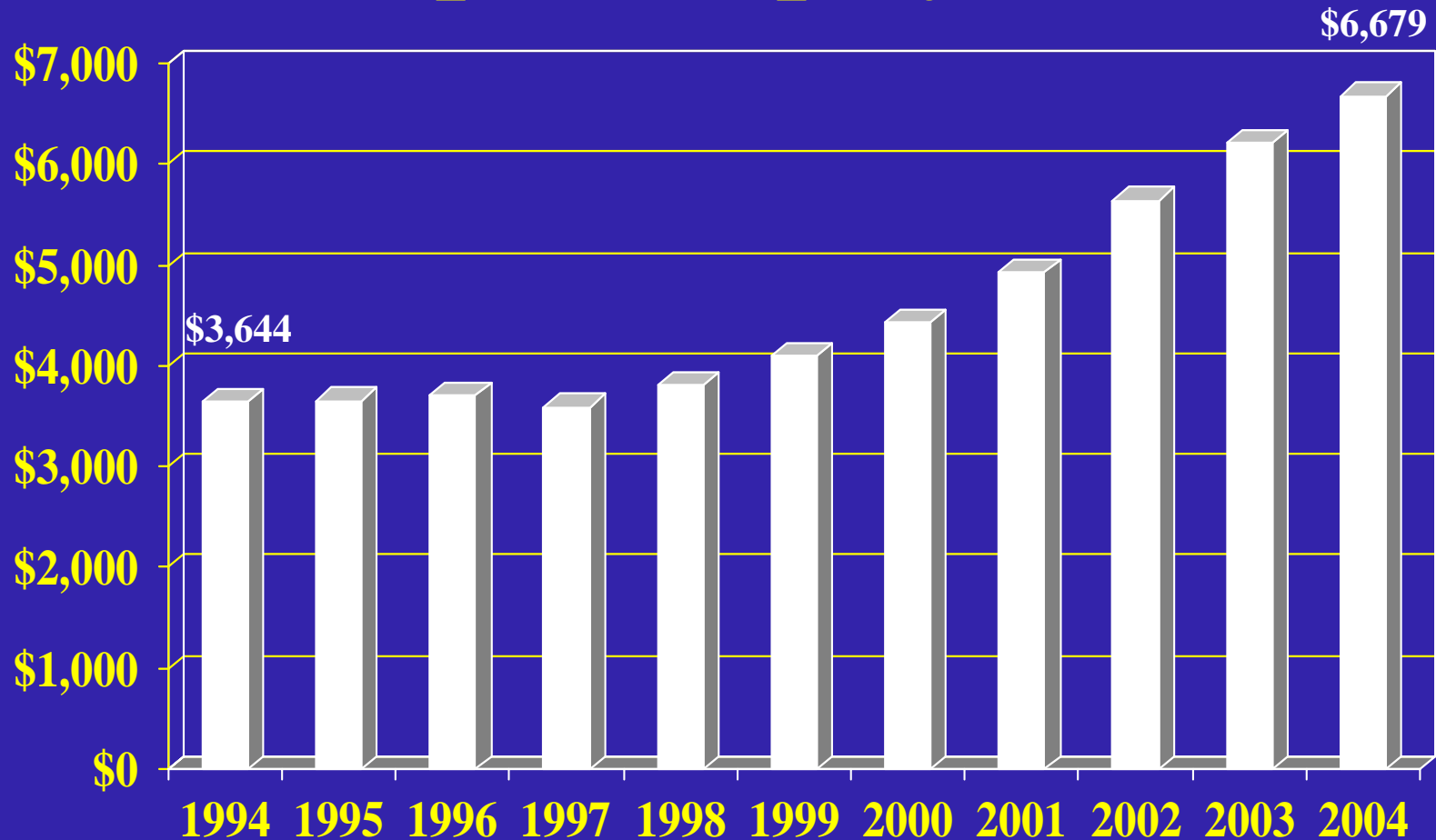
- Framing the health care trends
- Understanding cost drivers
- Employer reactions to recent increases

Trends in Health Care Costs



Source: Mercer/Foster Higgins Nat. Survey

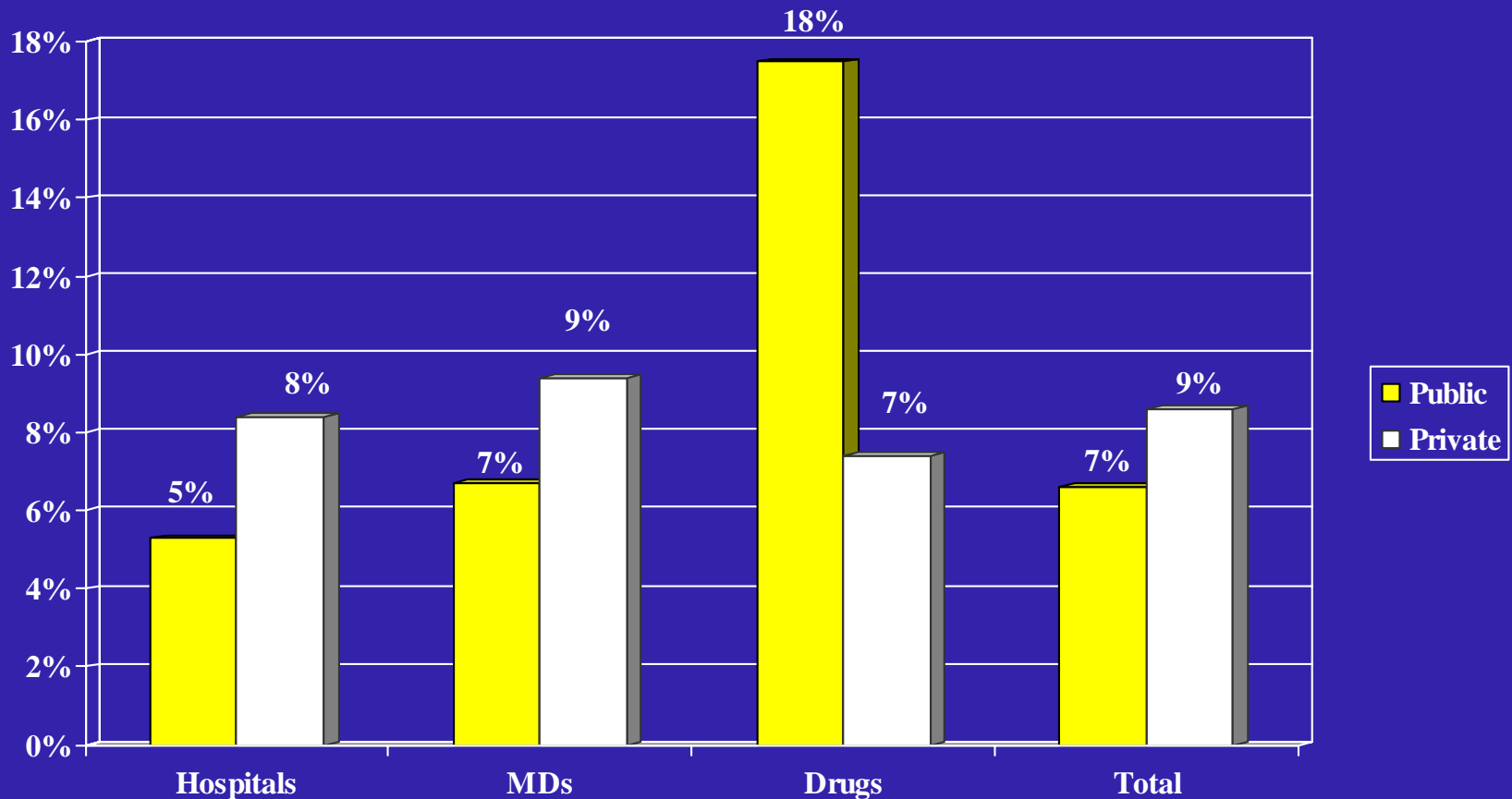
Total Health Benefit Cost per Employee



Source: Mercer's National Survey of Employer-Sponsored Health Plans

National Health Expenditures

2003 Increases



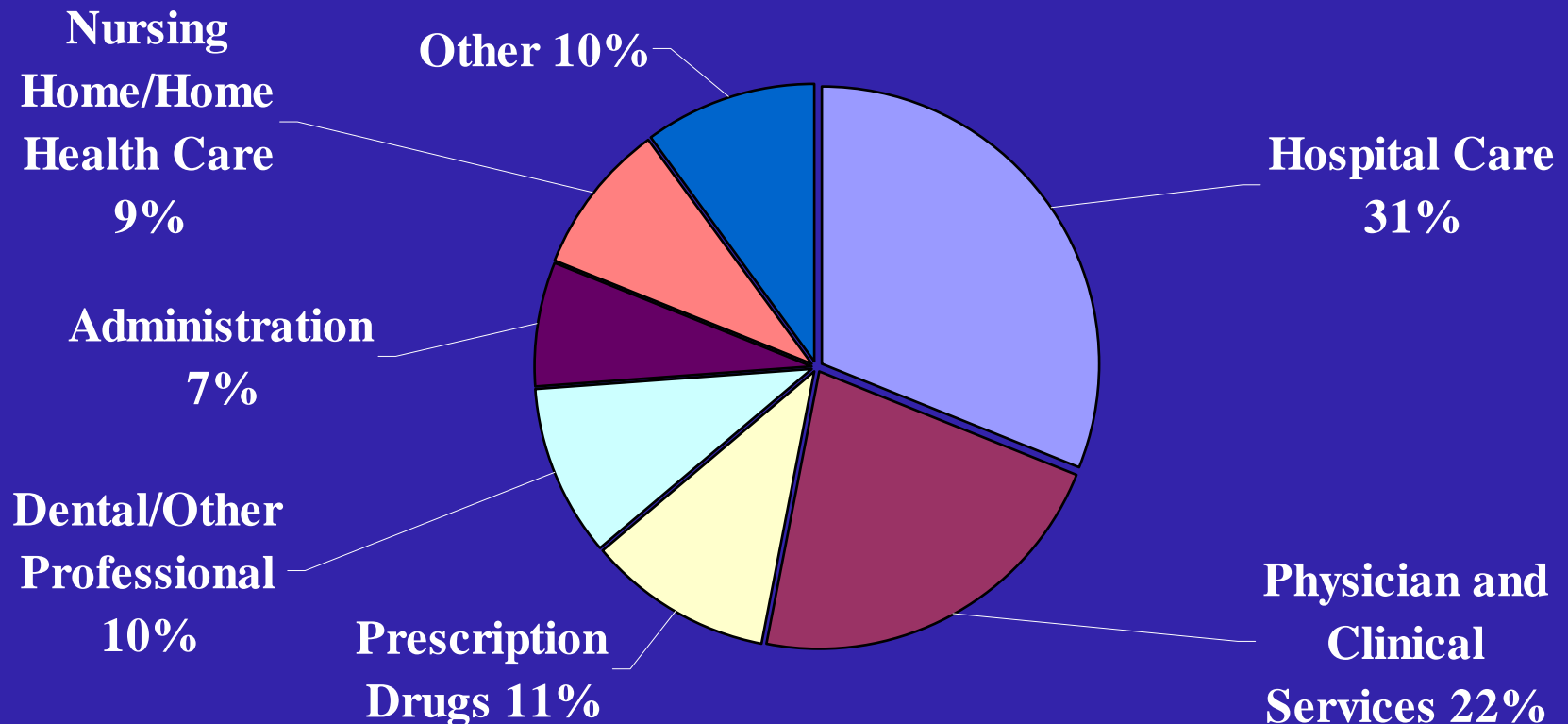
Source: NHE data as presented in Smith, et al, *Health Affairs*, Jan-Feb 2005.

Distribution of Health Expenditures U.S., 1996

Population	Share of Health Care Spending
Top 1%	27%
Top 2%	38%
Top 5%	55%
Top 10%	69%
Top 30%	90%

Source: 1996 Medical Expenditure Panel Survey

Distribution of Health Care Expenses, 2003



Source: California HealthCare Foundation

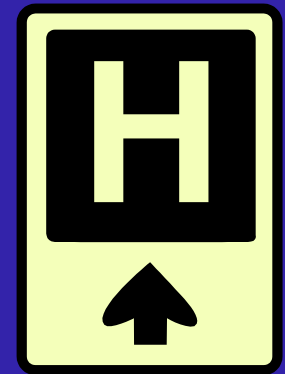
$$\text{Cost} = \frac{\text{Price}}{\text{Per Unit}} \times \text{Number of Units}$$

Understanding cost drivers

- What categories of care are increasing?
- What are the underlying factors driving the increases?
- How do the drivers change over time?
- What drivers lend themselves to control?
- Are there positive trade-offs for increases in some areas of health care?

What is increasing?

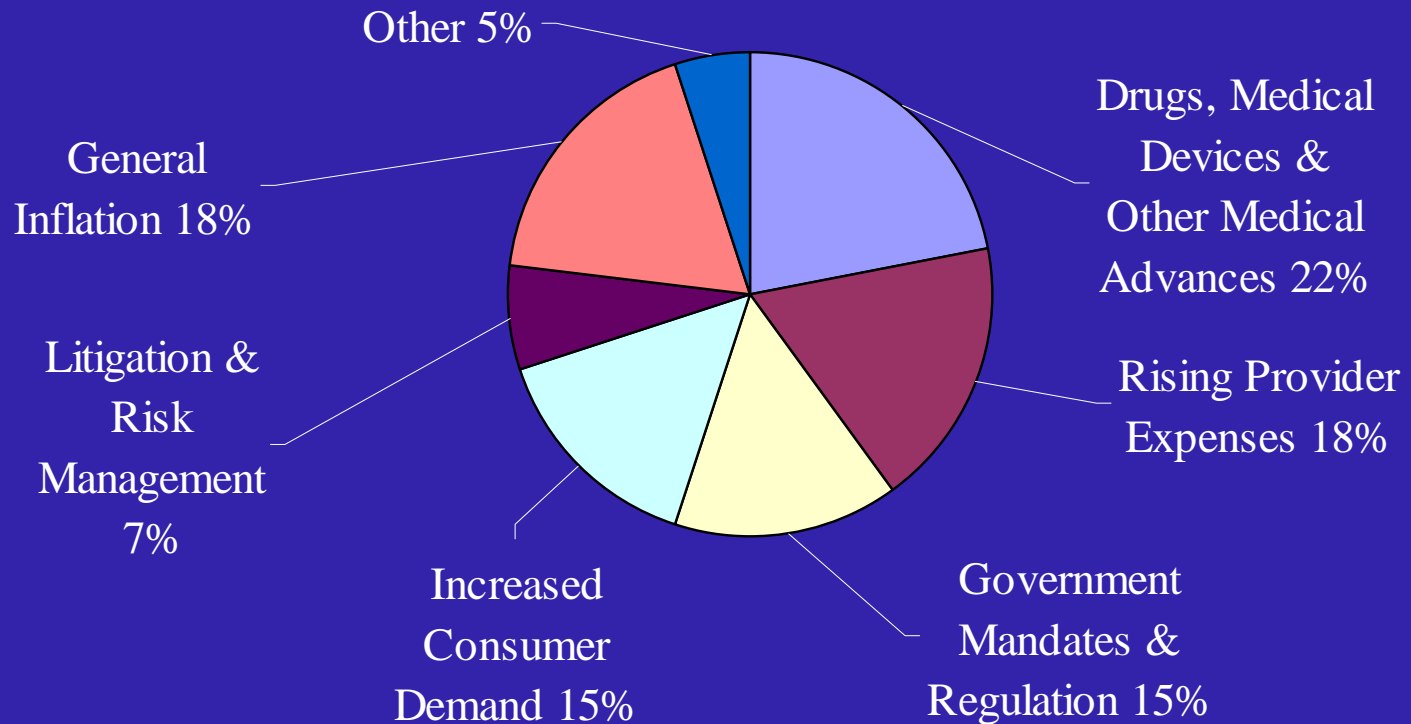
- Hospital inpatient costs
- Hospital outpatient utilization, and to some extent costs
- Use of technology – particularly imaging
- Prescription drug costs and utilization



Cost Drivers

- Major
 - Technological advances
 - New drug development
 - Dismantling of managed care
 - Provider consolidation
 - Consumer demand and expectations
- Minor
 - Malpractice
 - Aging of the population

Factors Driving Rising Costs in Healthcare, 2001-2002



Source: The Factors Fueling Rising Healthcare Costs. Prepared for the American Association of Health Plans by PricewaterhouseCoopers, April 2002.

Impact of Aging

- Avg. per capita spending for age 65+ is 3 times spending for age 34-44
- The aging of the overall population is modest from one year to the next
- Factors other than aging explain far more of the increases in spending from year to year

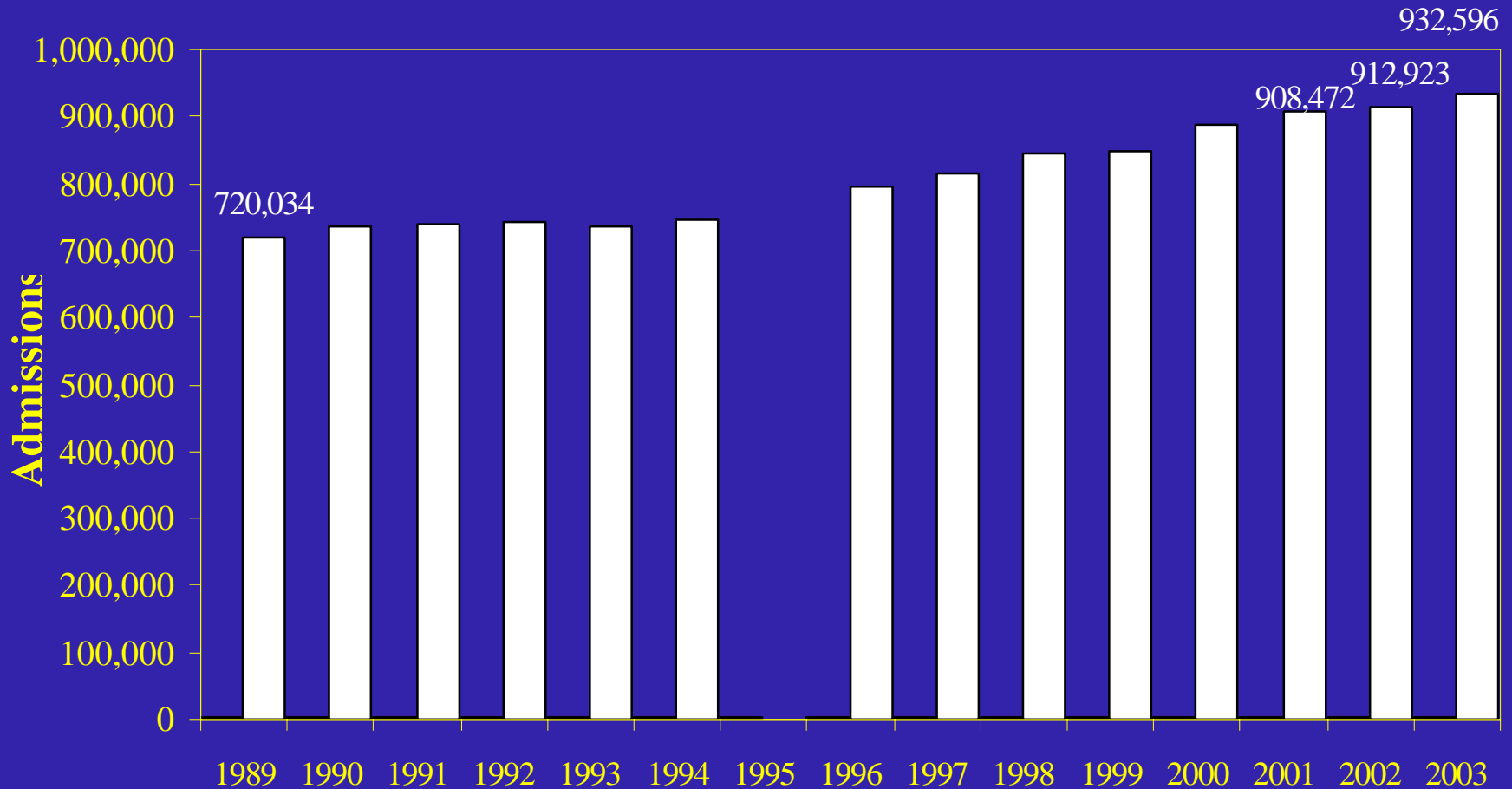


Source: Reinhardt, Uwe E. Does the Aging of the Population Really Drive The Demand for Health Care? *Health Affairs*, Nov/Dec 2003.

Hospital Inpatient

- Admission rates have stopped their decline, due to loosening of managed care controls
- Complexity of day in hospital increasing due to technology
- Unit prices also on the rise due to provider consolidation and new bargaining clout

Acute Care Admissions 1989-2003

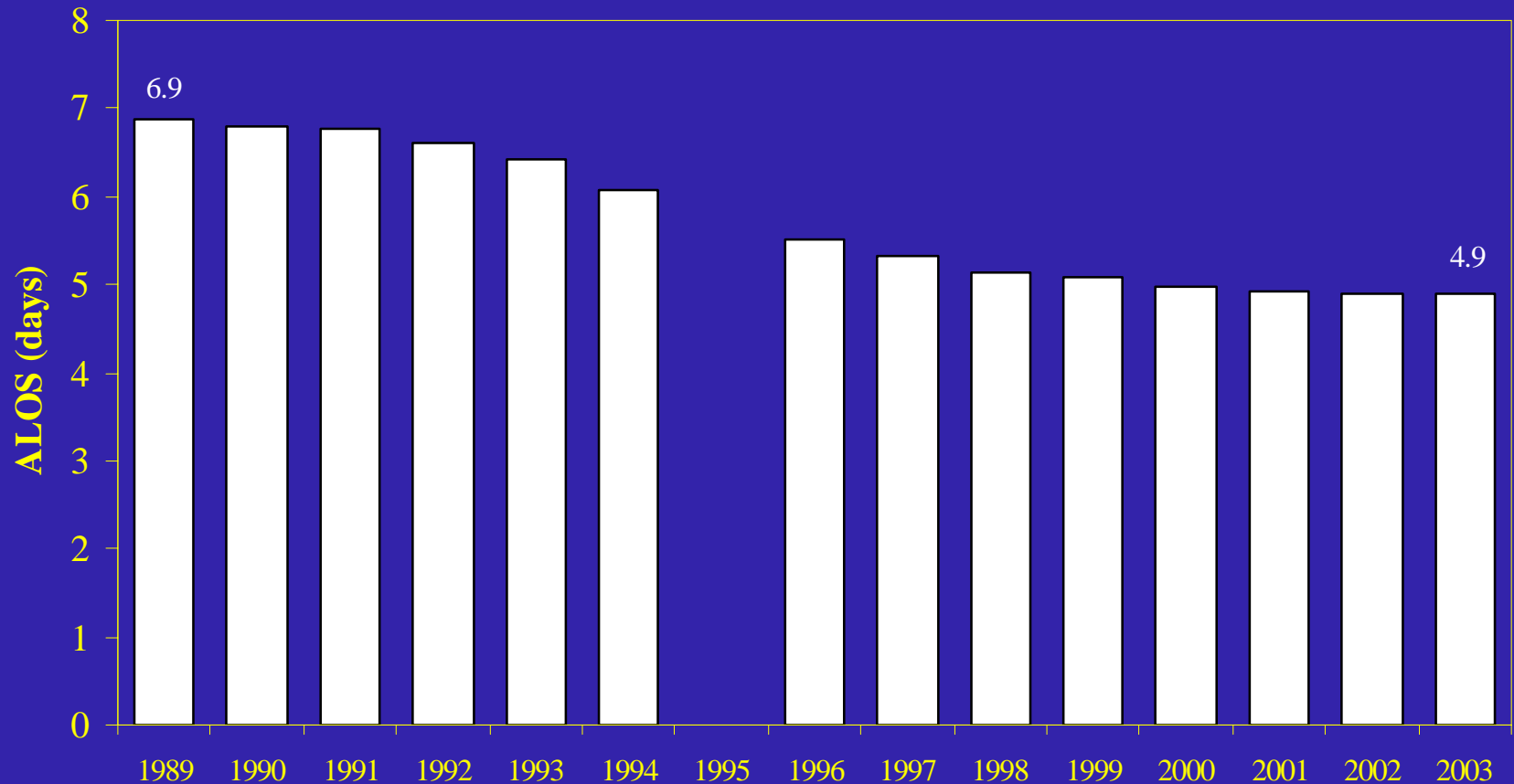


Sources: Admission data from Solucient, FY 1996-2001; Medical Database Commission FY 1989-1994.

Notes: No hospital data available for 1995. Total admissions to psychiatric, rehabilitation and substance abuse facilities have been removed. Normal newborn admissions (DRG 391) have also been removed.

Acute Care Average Length of Stay

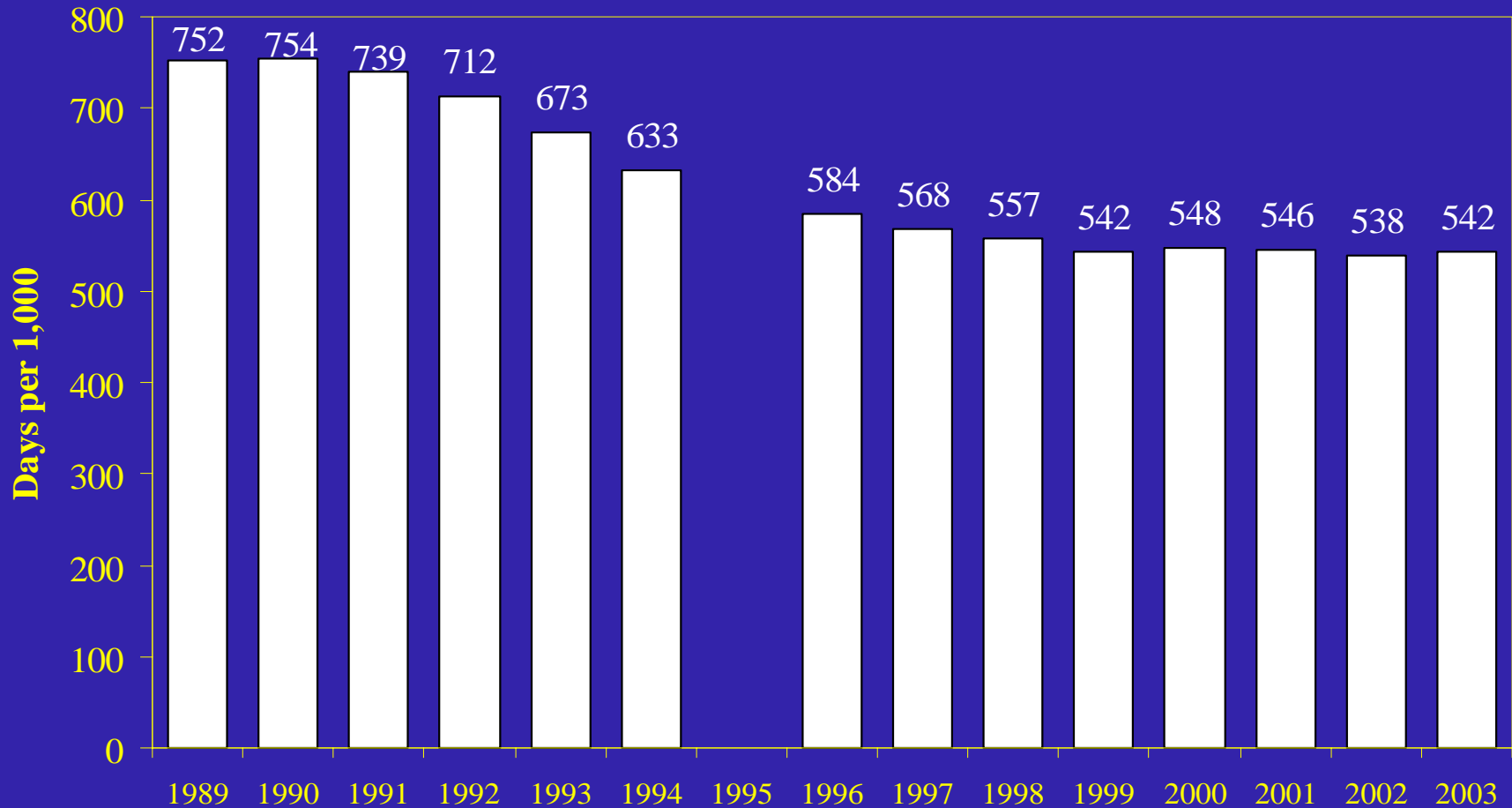
All Ages, 1989-2003



Sources: Admission data from Solucient, FY 1996-2001; Medical Database Commission FY 1989-1994.

Notes: No hospital data available for 1995. Total admissions to psychiatric, rehabilitation and substance abuse facilities (and beds) have been removed. Normal newborn admissions (DRG 391) have also been removed.

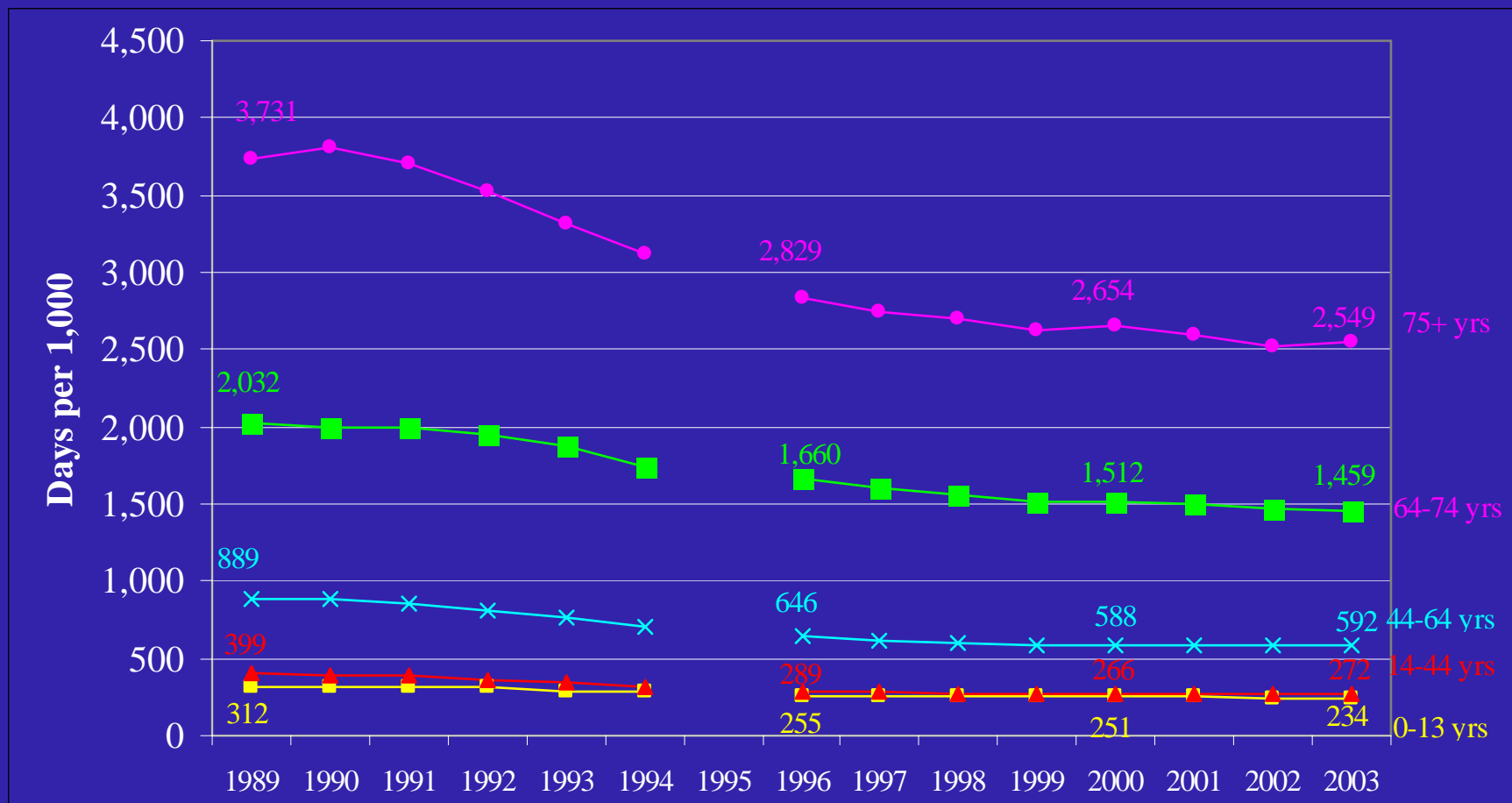
Days per 1000 Persons



Sources: Admission data from Solucient, FY 1996-2001; Medical Database Commission FY 1989-1994.

Notes: No hospital data available for 1995. Total admissions to psychiatric, rehabilitation and substance abuse facilities (and beds) have been removed. Normal newborn admissions (DRG 391) have also been removed.

Acute Care Hospital Days per 1,000 Population by Age Group, 1989-2001



Sources: Admission data from Solucient, FY 1996-2001; Medical Database Commission FY 1989-1994. Population data from NC Office of State Planning.

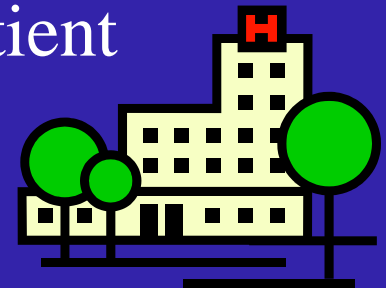
Notes: No hospital data available for 1995. Total admissions to psychiatric, rehabilitation and substance abuse facilities have been removed. Normal newborn admissions (DRG 391) have also been removed.

*“Managed care has been defanged,
and the leverage providers have
gained will not be easily reversed.
This should send a chill down the
backs of employers, public
purchasers and consumers
because we can expect our
premiums to surge.”*

Stuart Altman
Brandeis University

Hospital Outpatient

- Combination of increasing **use** and **price**
- Double digit rates of increase for number of years
- Reflection of more services and procedures safe and acceptable on outpatient basis – biopsies, surgeries, chemotherapy
- Unit prices not as well controlled as inpatient



What is increasing?

- Hospital inpatient utilization and costs
- Hospital outpatient utilization, and to some extent costs
- **Use of technology – particularly imaging**
- Prescription drug prices and utilization

Imaging as a cost driver



PET Scanners in NC

- Introduced in 1985
- For 15 years there were 3 in NC: Duke, NC Baptist, and Carolinas Medical Center
- 18 approved in last few years
- Recent petitions to State for more

3 → 21

Technology Innovations – Cost Savings or Cost Additions?

- Imaging is often performed as a progression, rather than substitution of technologies
- Are better treatment choices made as a result?
- Does the patient have a better outcome?
- Research in this field is difficult, and often lacking

Technology Availability and Health Care Spending

- Analyzed relationship between supply of new technology and health care utilization and spending
- Diagnostic imaging, cardiac, cancer and newborn technologies
- Increases in supply of technology are related to higher utilization and spending
- For diagnostic imaging, increases in availability are associated with incremental utilization rather than substitution

Source: Baker et al. The relationship between technology availability and health care spending. *Health Affairs*, Nov 2003.

Cost/Benefit of 4 Medical Innovations

- **Heart attack** - (1984 - 1998) - caths, angioplasty, CABG
- **Low-birth weight infants** - (1950-1990) - ventilators, monitoring, drugs
- **Depression** (1991-1996) - new drugs such as SSRIs
- **Cataracts** - (1969-1998) - significant improvements in surgical procedure
- **Breast cancer** - (1985-1996) - changes in surgery and chemo regimens

What is Increasing?

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New Drug Innovation

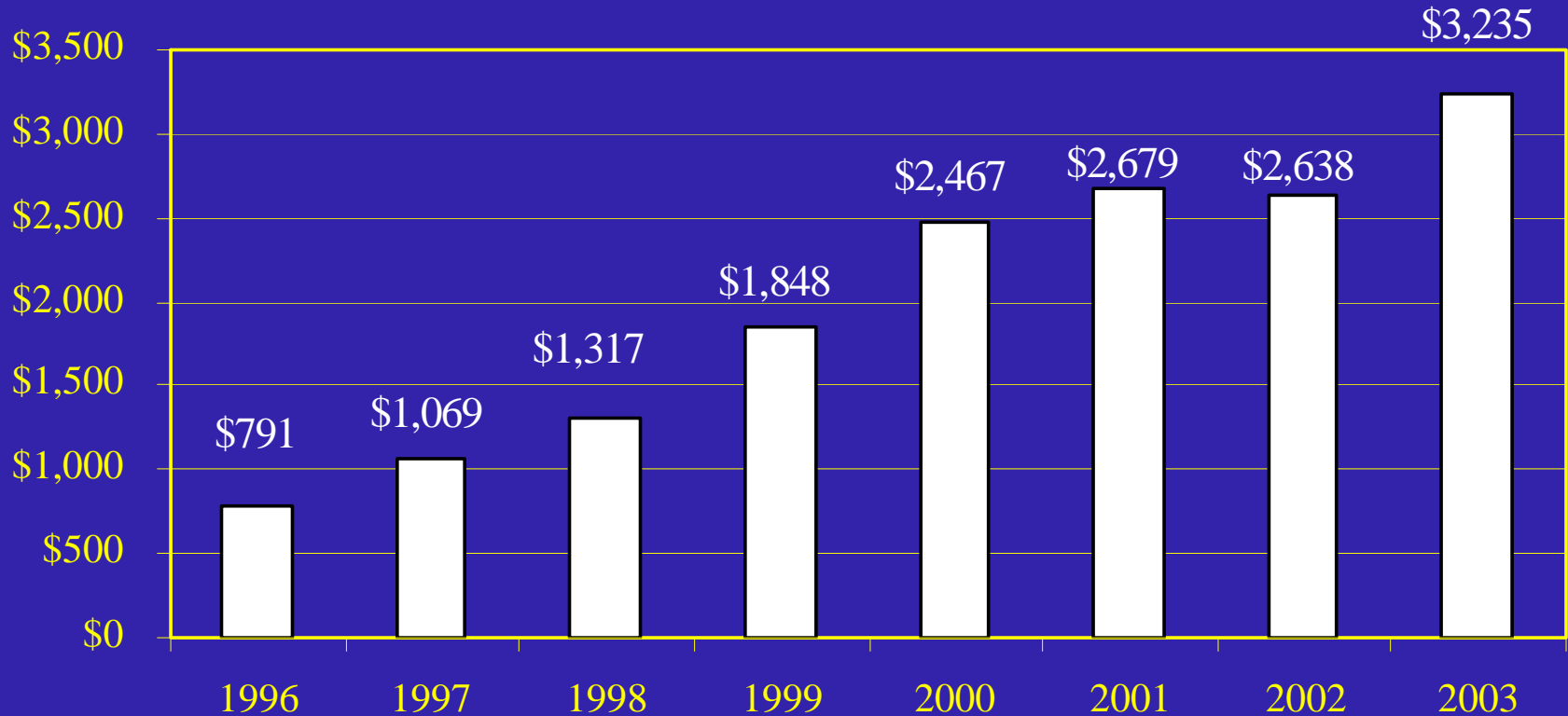
- 1035 New Drug Applications (NDAs) to FDA between 1989 and 2000
- NDAs were reviewed on two dimensions:
- **New Active Ingredients (NMEs)** vs **Existing Active Ingredients (IMDs)**
- Provides significant clinical improvement over an existing drug, or does not



Findings

- Only 35% are NMEs – 65% are IMDs
- Only 24% offer clinical improvement, while 76% do not
- Only 15% of drugs are highly innovative, that is have new active ingredients and provide significant clinical improvement – Lipitor, Viagra, Fosamax, Avandia, Actos, Plavix

DTC Spending, 1996-2003 (in millions)



Source: IMS Health, 2005.

Concerns about DTC influence

- Ads contain insufficient information concerning side effects
- Patients exert undue pressure on MDs to prescribe
- Consumer pressure may lead to inappropriate clinical use
- Ads promote expensive brand drugs over generics

Reaction of Employers

to recent insurance premium increases

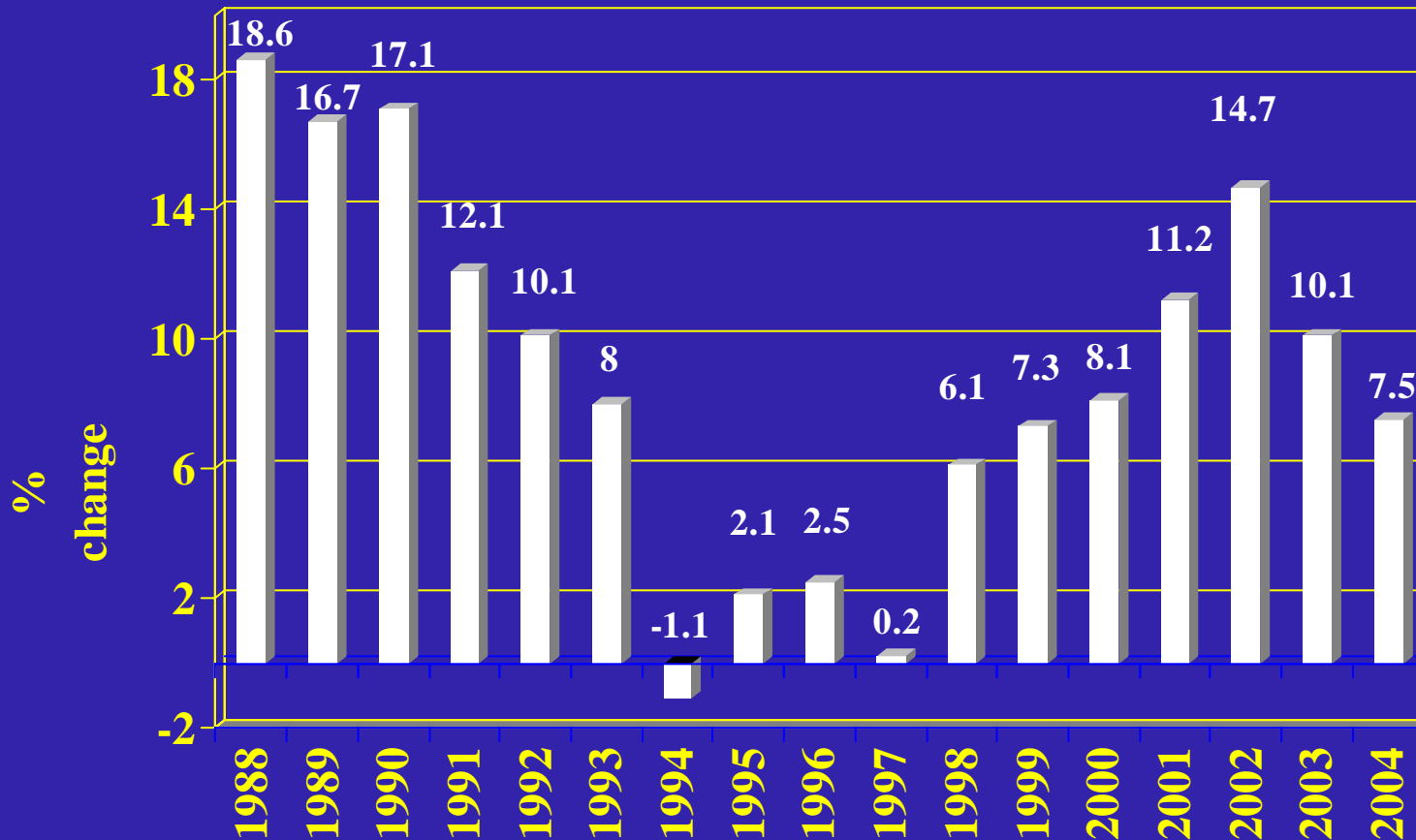
- Reducing employer contribution to premium
- Increasing deductibles and copays
- Changing drug benefits
- Moving from HMOs, POS to PPOs with less admin cost
- Empowerment of employees to choose less costly providers and plans
- Defined contribution benefit plans

Employers' Views of Future

- No confidence in market forces to slow premium growth
- Limited ideas on effective strategies other than cost shifting and reducing benefits
- 21% employers believe disease management will save money, though little scientific evidence to support this

Source: Gabel, et al, Health Benefits in 2003. *Health Affairs*, Sep/Oct. 2003.

Trends in Health Care Costs



Source: Mercer/Foster Higgins Nat. Survey

What is likely...

- Significant cost increases will continue
- Some employers who now provide health insurance will be priced out of the market, increasing the number of **uninsured**
- There will be more **under insured** due to heavier cost sharing and defined contribution benefit plans
- There will be heavier reliance on public programs

What is uncertain...

- How will employers react to current round of cost increases?
- In the early 1990s they responded by promoting managed care
- Will employers embrace defined contribution benefit plans?
- Or will they simply increase deductibles and copays to the employees?