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U.S. Health Care Costs: High and Rising

Are health care costs in the United States really out of control, and if so, what are the forces driving ever higher costs and what are the options available to exert control over this trend? These questions are addressed in a new report from the Robert Wood Johnson Foundation Synthesis Project.

At least since 1960, when the federal government began tracking U.S. health care spending, health care spending per capita in the U.S. has increased each year. In 2006, per person spending in the U.S. reached $7,026 annually, or $2.1 trillion. In the U.S., health care spending increased by an average of 7.7% per year during the period 1985-2006. During the same period gross domestic product (GDP) increased only 5.6% per year, which has contributed to an increasing percent of GDP devoted to health care and to a growing gap between the cost of health care and the ability of organizations and individuals to afford that care.

The two largest components of personal health spending in 2006, accounting for 31% and 21%, respectively, are hospital care and physician and clinical services. Although prescription drugs account for only 10% of spending, that level is a 40% increase over its share of health care spending in 1970. Each of these three factors has maintained higher rates of growth over the past several decades than the remaining categories of health spending. A dramatic drop in out-of-pocket spending from 33% in 1970 to 12% in 2006 may have come to an end with the advent of increased cost sharing that has occurred recently in employer-based coverage.

In the 10-year spending projection for 2007-2017 from the CMS Office of the Acturary, U.S. health care spending is projected to increase from approximately $2.2 trillion to $4.3 trillion, while the share of GDP will grow from 16.3% to 19.3%. A recent forecast from the Congressional Budget Office projected health spending would reach 49% of GDP in 2082. The forecast assumed an annual increase in health spending only 1 percentage point larger than the growth in GDP compared to the historical trend of 2.5 percentage points.

International Comparisons

By virtually all measures, U.S. spending exceeds that of any other developed country. Measuring health care spending as a percent of GDP spent on healthcare, it is 16% in the U.S., and averages only 8.9% in other developed countries as reflected in the Organization for Economic Co-operation and Development data for 2008. Among the OECD countries, the highest percentage of GDP following the U.S. is represented by France at 11%.

Recent data also suggests that the rate of increase has been greater in the U.S. since the mid-1980s. After 1985, growth in spending not accounted for by population aging or economic growth diverged—staying at 2% for the U.S. while dropping from 1.7% to 0.6% for OECD countries.

These differences remain after adjusting for national incomes and despite the fact that most of the OECD countries provide universal coverage. Studies suggest

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that they are driven by issues of pricing, efficiency, and administrative costs. Drug prices in the U.S. are some 70% higher than in OECD countries; physician compensation is higher (6.6 times per capita GDP for specialists and 4.2 times for primary care in the U.S. vs. 4 and 3.2 in OECD countries); and U.S. spending for the top 5 inpatient medical devices is 54% greater than in OECD countries. Duplication and poor coordination decrease U.S. efficiency, particularly evident in the amount of underutilized outpatient capacity in the U.S., which exists due to high prices that encourage and reward duplicative capacity. Administrative costs are estimated to be six times higher in the U.S.—before consideration of provider costs associated with interacting with multiple payors.

Identifying Cost Drivers

The obvious question in the face of these statistics is what forces lie behind the growth in U.S. health care spending? According to the Synthesis Report the large number of studies in this area have reached consistent conclusions about the importance of various cost drivers. Their conclusions about the primary forces leading to the growth in health care spending in the U.S.:

- **Medical technology is the driving force behind the growth in U.S. health care spending.** Estimates of the contribution of medical technology to health care spending growth range from 38% to more than 65%. Technology drives spending both through the substitution of higher cost services for lower cost services and the expansion of available treatments. Because technology is often measured as a residual, that is, what remains after all other factors are measured, its contribution to spending growth can be overstated if other factors are not accurately measured, however.
- **Obesity is a significant factor driving health spending, accounting for an estimated 12% of the growth in recent years.** Reducing obesity or improving overall health status can save money in the short and intermediate term, but some of the savings will be offset by increased longevity and the cost of diseases that are most prevalent during old age. Studies that do not take into account the increased longevity may exaggerate the contribution of health status to spending growth.
- **The increase in the percentage of people with health insurance accounted for approximately 10% to 13% of the historical growth in spending.** With increases in the uninsured over the last decade, however, insurance coverage has not contributed to the recent growth in health spending and will not be a driver in the future unless policies change to increase the number of people with insurance.
- **Demographics account for a very small percentage of the growth in spending.** Despite differences in methodologies, studies consistently conclude that aging has not been a major factor in driving health care spending and will not become one, despite aging baby boomers.
- **Productivity gains in the health care sector have probably been lower than in other industries.** This may be a result in part from little price competition among health care providers because of extensive third-party payment and payment policies that reward more units of service rather than efficient care for an episode of illness.
- **Medical malpractice is not a major driver of spending trends.** Premiums for liability coverage and defensive medicine do contribute to health spending at any moment in time, but they are not a large factor nor are they a significant factor in the overall growth of health care spending.

Concluding that advances in medical technology are the dominate driver of increased spending, the Synthesis Report puts forward three policy options that might reduce some of this pressure by decreasing spending for low-value applications of technologies

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***Denver Medical Bulletin**: Randall M. Clark, MD, DMS President and Publisher / Nora E. Morgenstern, MD, Chair of the Board / Michael B. Keller, MD, President Elect / Naomi M. Fieman, MD, Treasurer / Kathy Lindquist-Kleissler, Executive Director / Barbara Kamerling, Program Director. The **Bulletin** is the official publication of the Denver Medical Society, established April 11, 1871, as the first medical society in the Rocky Mountain West. Published articles represent the opinions of the authors and do not necessarily represent the official policy of the Denver Medical Society. All correspondence concerning editorial content, news items, advertising and subscriptions should be sent to: The Editor, **Denver Medical Bulletin**, 1850 Williams Street, Denver, CO 80218. Phone (303) 377-1850. Fax (303) 331-9839. Web www.denvermedsociety.org. Email: dms@denvermedsociety.org. Postmaster: Send address changes to 1850 Williams Street.*

CIGNA BEGINS PHYSICIAN NOTIFICATION OF 2009 "CIGNA CARE DESIGNATION" STATUS

There is no greater opportunity, and no greater threat, than how physician services are valued, rated, and tiered.

In mid-September, CIGNA began notifying physicians about their status as a CIGNA Care physician for 2009. This designation is based, according to CIGNA, on quality and cost-efficiency criteria and is extremely important because the data is made available to patients and ties directly into the CIGNA system for tiering of patient co-pays. If you have received a quality/cost-efficiency rating that does not qualify you for designation as a CIGNA Care physician, here is what you should do immediately:

a. Report this to Marilyn Rissmiller, Director of Health Care Financing, Colorado Medical Society, marilyn_rissmiller@cms.org, and
b. Go to the CMS website to obtain information on your rights under Colorado's newly-enacted Physician Designation Disclosure Act (SB-138).

CMS is taking the appropriate steps to determine if CIGNA's letters are in compliance with the new law and is working with CIGNA to address physician concerns.

IT'S NEVER TOO EARLY TO MAKE A NEW YEAR'S RESOLUTION!

RESOLVED: I promise to improve my ability to speak with my Spanish speaking patients.

HOW: By enrolling in **SPANISH FOR THE MEDICAL PROFESSION** with Joanna Rios, PhD

Look for registration materials soon.

WHEN: February 20 – 22, 2009. Now is the time to clear your calendar so you can attend!.

FEES: **$395** for DMS members; **$460** for all others

A maximum of 24 hours in category 1 credit towards the AMA Physician's Recognition Award awarded from the University of Arizona College of Medicine at the Arizona Health Sciences Center. For those interested in CME, an additional $35 processing fee applies.

New PhRMA Code Covers Interactions with Healthcare Professionals

The Pharmaceutical Research and Manufacturers of America (PhRMA) recently updated their Code on Interactions with Healthcare Professionals. Government scrutiny and billions of dollars paid in lawsuits involving illegal marketing practices have led to these changes. The updated Code—that will go into effect January 2009—has made a tough regulatory environment even tougher. As a result, many companies are scrambling to implement compliance plans. Here is a brief overview of some of the changes.

Meals

Under the code, companies are not permitted to directly pay for meals at CME events. However, they may give funding to a CME provider, who may, in turn, use the funding for meals for all participants. In addition, companies may fund meals at events—such as association meetings—where CME is only part of the event, with the understanding that the meal is separate from the CME activity and organizers' guidelines are followed. The Code specifically states, "When companies underwrite CME, responsibility for and control over the selection of content, faculty, educational methods, materials, and venue belongs to the organizers of the conferences or meetings in accordance with their guidelines. The company should not provide any advice or guidance to the CME provider, even if asked by the provider, regarding the content or faculty for a particular CME program funded by the company."

Travel

Reimbursement should not be offered for the costs of travel, lodging, or other personal expenses of non-faculty healthcare professionals attending continuing education events, either directly to the individuals participating in the event or indirectly to the event's sponsor. Similarly, funding should not be offered to compensate for the time spent by healthcare professionals participating in the CME event.

Giveaways

Certain items may occasionally be given to healthcare professionals if they are primarily used for the education of patients or healthcare professionals and are valued at $100 or less. Some examples may include medical textbooks, journals, anatomical models, etc. Practice-related items, such as pens or notepads with a company/product logo are NOT allowed.

Entertainment

Providing entertainment or recreational activities for healthcare professionals is now prohibited. The previous code did allow social/entertainment events under certain circumstances. Sales representatives are no longer allowed to treat healthcare professionals to meals, but a company can arrange for an expert physician to make a presentation to a group of providers in an appropriate venue "conducive to informational communication."

For more information and a full copy of the Revised Code, you may visit: http://www.phrma.org/code_on_interactions_with_healthcare_professionals/.

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The Denver Medical Society's 138th Annual Meeting

Friday, November 14, 2008
Cocktails—6:00 p.m.
Dinner—7:00 p.m.

Palettes
Denver Art Museum
100 West 14th Avenue Parkway

Featuring

The Installation of

Randall M. Clark, MD, as President

50 year Physician Recognition of

George E. Kandel, MD
Raymond J. Rademacher, MD
Robert B. Sawyer, MD

Rocky Mountain String Trio

Denver Medical Society Annual Meeting

November 14, 2008

I____ (we)___ plan to attend. $45 per person.

Full Name(s) Printed: _____

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Kindly return this form with your payment to 1850 Williams Street, Denver 80218.

$_____ enclosed Make your check payable to the Denver Medical Society.

Credit card payments and reservations may be faxed to (303) 331-9839.

___VISA ___ Master Card Name of card holder _____

Card address _____

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Signature _____ Phone _____

Reservations deadline: November 10, 2008 Phone inquiries: (303) 377-1850

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while still encouraging the development and use of high-value technologies. Their first recommendation is that funding be significantly increased for effectiveness research that can support differentiation between technologies and patient applications having high versus low value. Provider payment reform is the second policy option which should seek to address the distortions created by a payment system which offers incentives to provide services that are most profitable but not necessarily always most appropriate to the patient. Finally, the report suggests consumer incentives and decision making support that would encourage more thoughtful use of medical services, but must be carefully crafted to support appropriate use of health care services for preventive care and chronic disease management. The ability to effectively craft this option will be dependent upon increased effectiveness research to inform value-based purchasing and a reformed provider payment system such as one based on episodes of care.

The Report examines possible options for addressing the other cost-drivers of health care spending and concludes that we have a sufficient understanding of the problems. Future research and policy development in areas such as patient classification, risk adjustment and value-based benefit design, must focus on developing and testing solutions.

The Report may be accessed at www.rwjf.org/files/research/101508.policysynthesis.costdrivers.rpt.pdf.