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# WHAT'S REALLY DRIVING THE INCREASE IN HEALTH CARE PREMIUMS?

**SUMMARY**

Although the rate of increase has slowed in recent years, the cost of health care services and premiums continues to rise and is a major concern to individuals, employers and the government. The escalation of costs accounts for the overwhelming impetus behind calls for health care reform. Yet most people don't understand what drives health care premiums. For meaningful health care reform to occur, policymakers will need a clear and accurate understanding of the real (vs. perceived) factors that are actually driving the cost increases.

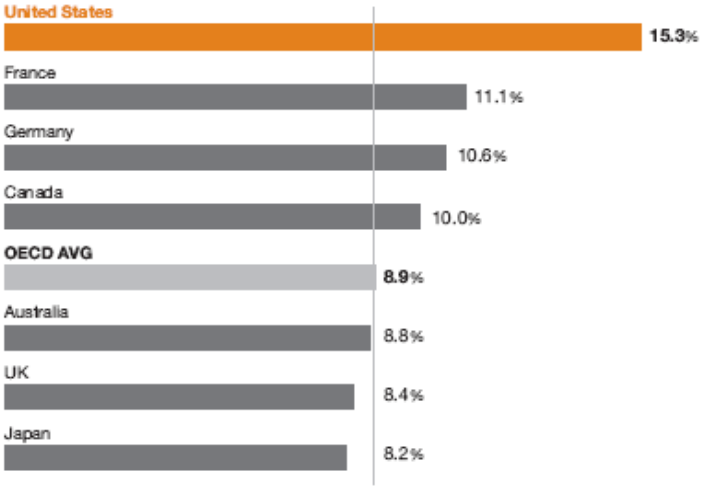
Despite the common belief that costs increase due to excess insurer profits, the aging of America and the high cost of medical malpractice, these factors have little if any impact on health care premiums. The key drivers of health care premium increases are advances in medical technology and subsequent increases in utilization, excess price inflation for medical services, cost-shifting, the high cost of regulatory compliance and patient lifestyles (e.g., physical inactivity and increases in obesity). Though still a factor, prescription drugs contribute less significantly to rising health care costs due to the increased use of generic medications.

## HEALTH CARE EXPENDITURES: A HIGH AND RISING TIDE

The high and rising cost of health care in the United States is a pervasive and growing concern. In 2006, the U.S. spent $2.1 *trillion* on health care, more than any other developed country in the world. This expenditure represents over 15% of U.S. GDP and equates to more than $7,000 spent *per person*.[1]

**Figure 1**

**Health Expenditures as a Share of GDP, 2006**

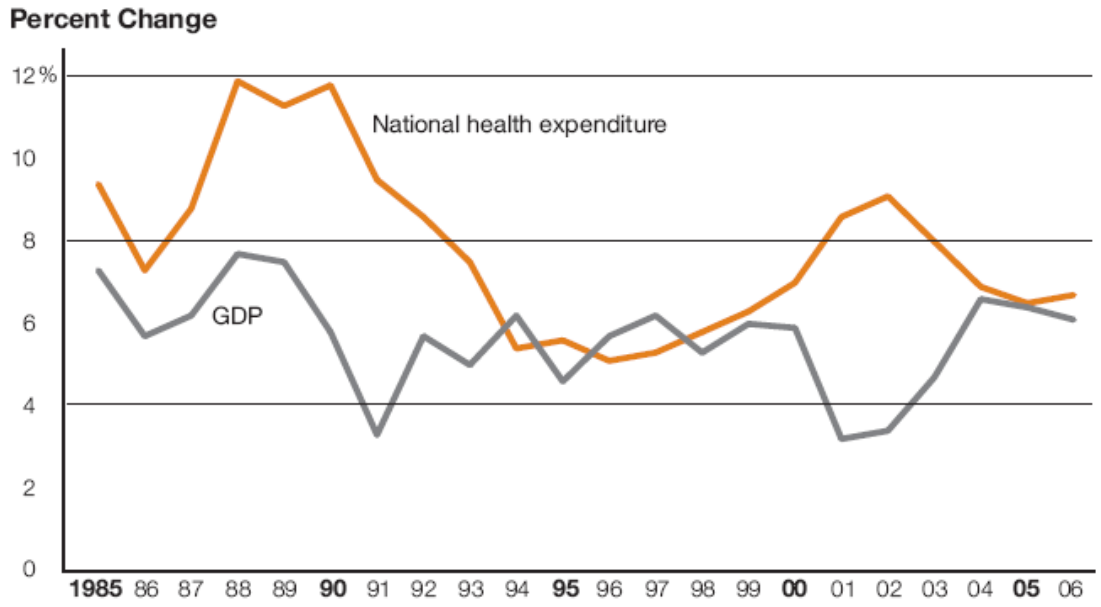



*Source: Organization for Economic Co-operation and Development, 2008 (Reference 5)*

*Note: While the OECD data for the United States is based on NHEA data, adjustments are made to be comparable to data on other nations resulting in lower figures.*

Health care costs are rising faster than the overall economy, wages and general consumer prices. During the two decades from 1985 to 2006, health care spending in the U.S. grew at 7.7 percent, while spending on GDP grew at the slower rate of 5.6 percent.[2]

**Figure 2**

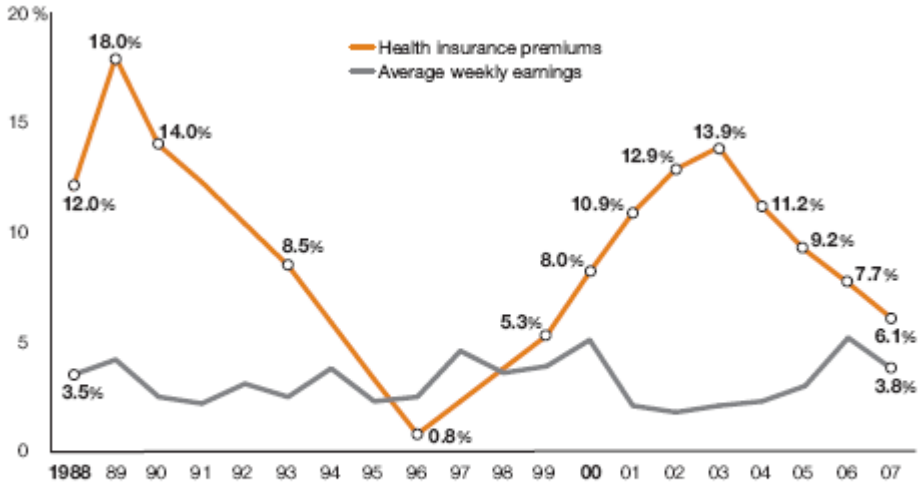



*Source: Centers for Medicare and Medicaid Services (Reference 3)*

Similarly, when growth in health care costs is compared to growth in workers' earnings over the past two decades (from 1988 to 2007), the differential is sobering, as shown in Figure 3 below.[3]

**Figure 3**

**Average Percentage Increase in Health Insurance Premiums Compared to Workers' Earnings, 1988 – 2007**




Sources: Kaiser Family Foundation and Health Research and Educational Trust (46); Bureau of Labor Statistics, Non-Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988–2007 (April to April).

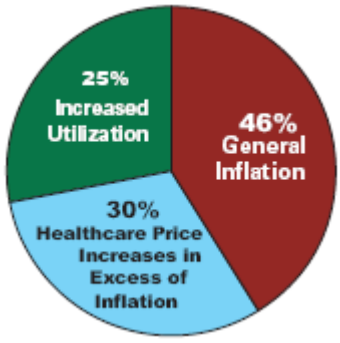
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. The average premium increase is weighted by covered workers. Data on premiums not available for 1991, 1992, 1994, 1995, 1997, 1998.

Rising health care costs translate directly into rising health insurance premiums, as health insurance premiums generally parallel the underlying cost of the services they cover. For example, health care costs increased at an annual rate of 6.4 percent in 2007, while health insurance premiums increased 6.1 percent over that same period.[4]

While health insurance premium growth decreased in recent years, from 13.2 percent in 2002 to 6.1 percent in 2007, the *rate* of growth is still faster than general inflation. In fact, general inflation, as reflected in the Consumer Price Index (CPI) accounts for a little less than half of the increase in premiums during this period, while increased utilization and price increases for health care services in excess of the inflation rate account for the remainder, as shown in Figure 4.[4]

**Figure 4**

**Factors Contributing to the 6.1 Percent Increase in Health Insurance Premiums**




Together, these rising costs place tremendous stress on limited budgets, making it difficult for individuals and employers – as well as various government entities – to afford health insurance coverage.

Popular explanations for the upward spiral of health care and health insurance costs include the impact of an aging U.S. population, the high cost of medical malpractice insurance and "excess" insurer profits. None of these, however, is a primary driver of health care costs and the resulting rise in health insurance premiums.

## HEALTH INSURANCE PREMIUMS: WHERE DOES THE MONEY GO?

Before addressing which factors are driving health insurance premiums skyward, it's helpful to understand how health insurance premium dollars are spent. As shown in Figure 5, 87 cents of every premium dollar received is spent on providing medical services to members: physician services, hospital costs (inpatient and outpatient costs), drugs and other medical services. Another 10 percent goes to compliance, claims processing and other administrative costs. Only three percent represents insurers' profits.[4]


**Figure 5**

**How Health Insurance Premiums are Spent**

Perceptions are quite another matter: Sixty percent of consumers surveyed think that insurers' profit margins are in excess of 20 percent and 25 percent of consumers think that insurer's margins are more than 40 percent.[5]

When examining health premium price increases, it's important to keep *relative* costs in perspective: if the price for two components of the health care premium both increase by 10 percent, but one component represents 80 percent of the premium and the other component represents only five percent of the premium, each component's impact on the overall premium increase will be dramatically different. For example, it would take a 145 percent increase in insurer profits to match the impact of a five percent increase in medical costs.

With 87 percent of health care premiums spent on the actual delivery of medical care, one must look behind the curtain to find the primary drivers of rising health insurance premiums.

## TECHNOLOGY'S ROLE IN HEALTH CARE: GOOD NEWS AND BAD NEWS

With medical care costs accounting for the bulk of health insurance premiums, it's critical to understand the factors that drive the cost increases in care.

As noted earlier, medical price increases *in excess* of the CPI are a primary driver of health care cost increases. According to a study of rising health care costs conducted by PriceWaterhouseCoopers (PWC) in 2008, there are three major factors driving the increase in underlying medical prices as shown in Figure 6:[4]

**Figure 6**

**Growth in Health Insurance Costs: 2004-2005 and 2006-2007**

| | 2004-2005 Components | 2006-2007 Components |
|---|---|---|
| **Growth in Premiums** | **8.8%** | **6.1%** |
| **General Inflation** | **2.4%** | **2.8%** |
| **Health Care Price Increases Above Inflation** | **2.6%** | **1.6%** |
| Cost Shifting | 19.2% | 31.3% |
| Higher Priced Technologies | 38.5% | 25.0% |
| Reduced Provider Competition | 42.3% | 43.8% |
| **Increased Utilization** | **3.8%** | **1.7%** |
| Aging | 13.2% | 29.4% |
| Lifestyle | 7.9% | 17.6% |
| New Treatments | 26.3% | 35.3% |
| More Intensive Diagnostic Testing/Defensive Medicine | 21.1% | 17.6% |
| Increased Consumer Demand | 31.6% | 0.0% |

Source: PricewaterhouseCoopers estimates

Details of these and other primary cost drivers identified in other research studies are summarized below.

**Higher priced technologies, used more often:** Two papers referenced in a recent Robert Wood Johnson Foundation paper confirm that medical technology appears to be a major driving force behind the growth in U.S. health care spending. Estimates of how much medical technology contributes to health care spending growth range from 38 percent to more than 65 percent in these studies, as shown in Figure 7 below.[6,7]

**Figure 7**

**Estimated Contributions of Selected Factors to Growth in Real Health Care Spending Per Capita, 1940-1990**

*Table 1. Estimated Contributions of Selected Factors to Growth in Real Health Care Spending Per Capita, 1940–1990*

| | Studies Estimating Contributions of Selected Drivers | | |
|---|---|---|---|
| **Drivers of Cost Trend** | **Smith, Heffler and Freeland (2000)** | **Cutler (1995)** | **Newhouse (1992)** |
| Aging of the Population | 2% | 2% | 2%[a] |
| Changes in Third-Party Payment | 10 | 13 | 10[b] |
| Personal Income Growth | 11–18 | 5 | <23 |
| Prices in the Health Care Sector | 11–22 | 19 | * |
| Administrative Costs | 3–10 | 13 | * |
| Defensive Medicine and Supplier-Induced Demand | 0 | * | 0 |
| Technology-Related Changes in Medical Practice | 38–62 | 49 | >65 |

Notes: Amounts in the table represent the estimated percentage share of long-term growth that each factor accounts for.

* = not estimated.

[a] Represents data for 1950–1987

[b] Represents data for 1950–1980.

Source: Congressional Budget Office, 2008 (17) based on Smith (79), Cutler (19) and Newhouse (59)

Technology drives costs higher in two ways. First, newer technologies tend to increase prices because they are generally more expensive than the older technologies they replace. While the availability of more advanced, superior technologies can yield better results for some portion of the patient population, these technologies and diagnostic tests can also be used inappropriately.

Both the PWC analysis and the research referenced in the Robert Wood Johnson brief recognize the proliferation of new technologies and new treatments and their effect on costs.[4, 7] These new treatments, in the form of new imaging technologies, biologics and injectables, can increase costs in two ways: by expanding treatment options and by increasing the per unit cost of the treatment (e.g., as for new drug therapies).

In some cases, treatment expansion may actually *reduce* the "per unit" cost of treatment; however, it almost always increases *overall* spending. This dichotomy exists because lower costs are often accompanied by less pain, less disability and/or better outcomes that, in turn, increases demand for the treatment and results in an overall absolute increase in cost.

Examples of treatment "expansion" include cataract surgery, which has become a simple outpatient procedure, or treating depression with selective serotonin reuptake inhibitors (SSRI), which results in the reduction or elimination of psychotherapy.

In addition, certain "lifestyle" drugs such as prescription sleeping pills have been developed for conditions that were once not even considered illnesses – or at least were not commonly treated with prescription drugs – thereby increasing overall health treatment costs.

**Prescription drugs:** According to the PWC analysis, the biggest shift over the last decade has been the sharp reduction in drug spending growth. PWC's analysis indicates that the reduction in prescription drug spending actually offers lessons regarding how costs can be contained without harming quality. Their analysis shows that prescription drug cost increases have slowed recently and grew at only 5.7 percent in 2007, less than the overall percent growth in premiums.

Prescription drugs accounted for approximately 13 percent of the increase in health insurance premiums. Half of this growth was due to normal CPI inflation and half came from growth in utilization. Increases above the rate of inflation have been kept at bay by the growth in generics, which has kept the average cost per prescription constant.[4]

**Reduced provider competition**: Ironically, while consumers place great emphasis on choosing insurers with the broadest provider networks, the proliferation of broad networks has actually reduced the level of competition in the system. In some markets, providers have consolidated their practices, further reducing competitive forces.[4]

**High cost of regulation**: In his analysis of health care regulation, research professor Christopher Conover concluded that the total cost of health services regulation exceeds $339.2 billion. Conover defines health care regulation as regulation of health facilities, health professionals, health insurance, drugs and medical devices and the medical tort system, and includes the costs of defensive medicine.

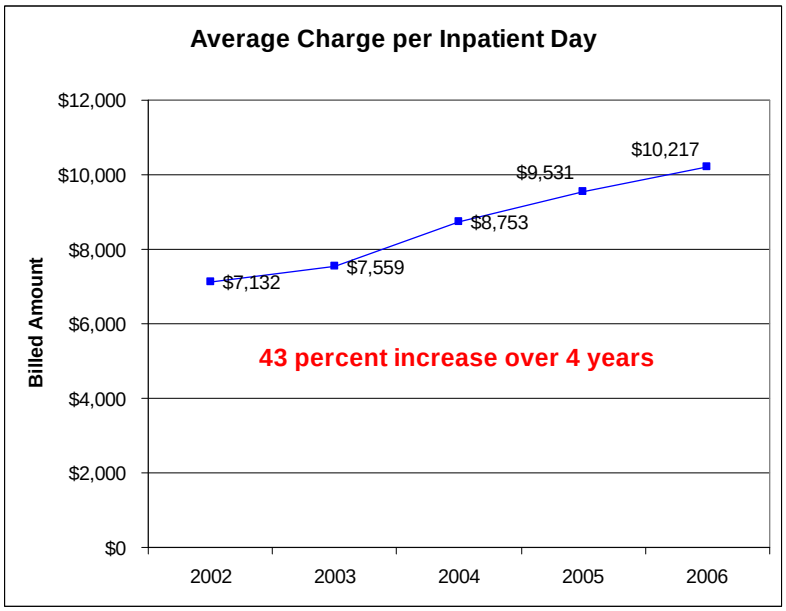
Even after subtracting $170.1 billion in benefits that result from this regulation, the net cost of health services regulation still amounts to $169.1 billion annually and costs the average household over $1,500 per year. In short, the cost of health services regulation outweighs the benefits by a two-to-one margin.

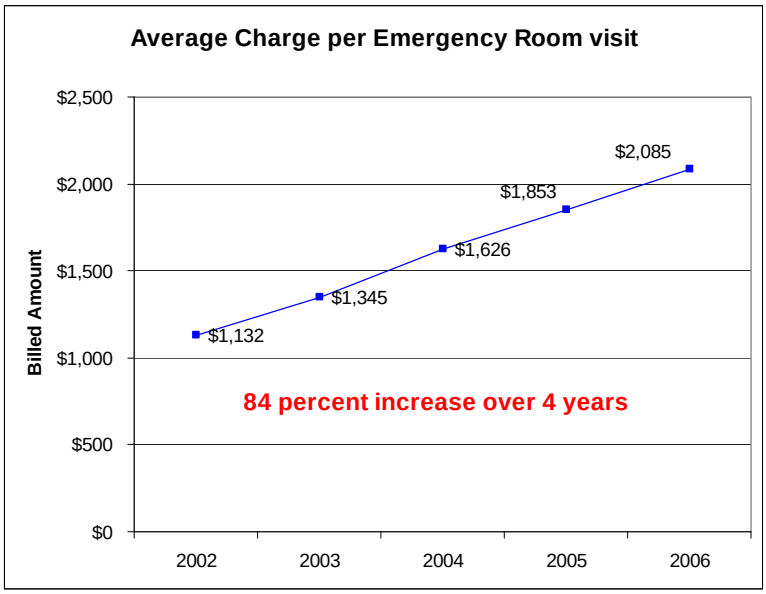
Conover estimates that the high cost of health services regulation is responsible for more than seven million Americans lacking health insurance. He asserts that 4,000 more Americans die every year from costs associated with health services regulation (22,000) than from the lack of health insurance (18,000). The annual net cost of this regulation exceeds annual consumer expenditures on gasoline and oil in the United States and is twice the size of the annual output of the motion picture and sound recording industries.[9]

**Cost-shifting from Medicaid, Medicare and the uninsured to private payers**: A recent study by Milliman concluded that significant underpayments in Medicaid and Medicare result in a shift of $88 billion (15% of provider costs) to private coverage, which increases private premiums by over 10%.[10] Additionally, according to the American Hospital Association, Medicaid hospital payments declined to 87.1 percent in 2005 from 96.1 percent in 2002.[4] During a similar period, (from 2002 to 2007), the ranks of the uninsured swelled from 16.6 percent of the population to 18.3 percent of the population. Together, these factors shift non-reimbursed costs onto self-insured employers and private health insurance plans.

This dynamic is exemplified by the increases in hospital prices in recent years – particularly for inpatient, emergency department and neonatal intensive care services. The illustrations on this page show the price increases that a WellPoint affiliated health plan has experienced in California.

Average hospital charges per inpatient day increased by 43 percent from 2002 to 2006.[8]




Increases in emergency room costs increased even more dramatically, rising 84 percent from 2002 to 2006.[8]

## OTHER DRIVERS OF HEALTH CARE PREMIUM INCREASES: NOT THE USUAL SUSPECTS

Different approaches to the research yield somewhat different perspectives when it comes to other potential drivers of health care cost increases. Yet, in most cases, there appears to be general agreement in the literature regarding the factors that drive price increases, as summarized below.

**Lifestyle:** Lifestyle and patient health status play a significant role in driving up health care costs. Increasing numbers of patients who are challenged by obesity, smoking, drug abuse, poor nutrition and physical inactivity contribute to an increase in utilization and therefore the cost health care services.[4]

In the Robert Wood Johnson research synopsis, obesity accounted for an estimated 12 percent of the growth in premium costs in recent years.[11] The study noted that reducing obesity or improving overall health status can save money in the short and intermediate term, but cautioned that some of the savings will be offset by increased longevity and the cost of diseases that are most prevalent during old age.

Based on government survey data, 44 percent of Americans in 2005 had at least one chronic medical condition, up from 41 percent in 1996. “Chronic conditions” include diabetes, high blood pressure, high cholesterol levels, cancer, arthritis, heart failure and others. Obesity and sedentary lifestyles are believed to contribute to many chronic ailments, including diabetes. U.S. health officials say the rate of new cases of diabetes has soared by about 90 percent in the past decade.

The percentage of Americans with three or more chronic illnesses rose even more sharply over the past decade, as shown below:

| Percentage of Americans with Three or More Chronic Conditions | | |
|---|---|---|
| **Age bracket** | **1996** | **2005** |
| 45 – 64 | 13% | 22% |
| 65 – 79 | n/a | 45% |
| 80 and older | 38% | 54% |
| All ages | 7% | 13% |

Chronic disease accounts for three-fourths of the more than $2 trillion spent on health care yearly in the United States.[12]

**Health insurance**: The segment of the population with health insurance has historically accounted for approximately 10 percent to 13 percent of the growth in health care spending.[13] People with insurance naturally tend to be less price-sensitive than those without insurance. However, as the number of people without insurance has increased over the last decade, insurance coverage has not contributed to the recent growth in health spending and is not likely to be a driver in the future – unless policies change to increase the number of people with insurance.

**Lower productivity gains**: Productivity gains in the health care sector have been lower than in other industries because of limited price competition among providers, pervasive third-party payment and payment policies that reward providers for delivering more units of service as opposed to the delivery of *efficient* treatment for a given illness.[14]

## FACTORS THAT HAVE A SMALLER IMPACT ON COSTS

**Intensive diagnostic testing and defensive medicine:** Intensive diagnostic testing contributed only 0.2 percent to the increase in health care costs in 2007 as compared to 0.8 percent in 2005. This change is attributed to a slowdown in outpatient spending.[4]

**Medical malpractice:** Medical malpractice is not a major driver of spending trends. Premiums for liability coverage and defensive medicine contribute to health spending at any moment in time but are not considered a recent significant factor in the overall growth of health care spending.[15] Put another way, tort reform would lower health insurance premiums but medical malpractice is not currently driving the rate of increase.

**Aging:** The effect of an aging population on health care costs is less clear. The PWC study considers the aging of baby boomers to be a reasonably important contributor to premium cost increases (see Exhibit 6); however, several studies referenced in the Robert Wood Johnson study conclude that "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."[15]

## CONCLUSION

Popular theories suggest that health insurance premiums are driven by an aging population, excessive insurer profits or medical malpractice. Objective research, however, clearly indicates that these factors have a minimal impact on the high price of health insurance premiums.

If meaningful health care reform, including health care cost containment, is to occur, emphasis must be placed on the real drivers of increased health care costs and concomitantly, health care premiums. These include the following key factors:

- **Advances in medical technology** and subsequent increases in utilization
- **Price inflation for medical services** that exceeds inflation in other sectors of the economy
- **Cost-shifting** from people who are uninsured and those receiving Medicaid to the private sector
- **High cost of regulatory compliance**
- **Patient lifestyles**, such as physical inactivity and increases in obesity.

To learn more about WellPoint's health care reform activities, see Building a Sustainable Health Care System.

## ABOUT THE WELLPOINT INSTITUTE OF HEALTH CARE KNOWLEDGE

The WellPoint Institute of Health Care Knowledge is a web-based publishing clearinghouse for health related research conducted by WellPoint and its subsidiary companies. The Institute regularly releases educational information in the form of reports, white papers and research summaries, with the goal of enhancing health care quality and value by providing facts and information to support informed health care decision-making. For more information, visit WellPoint Institute of Health Care Knowledge at www.wellpoint.com/institute.

[1] Organization for Economic Cooperation and Development, "OECD Health Data 2008: Statistics and Indicators for 30 Countries." June 2008, as quoted in The Robert Wood Johnson Foundation Policy Brief No. 16, October 2008.

2 Centers for Medicare and Medicaid Services. “NHE Summary Including Share of GDP, CY 1960 – 2006.” 2008 as quoted in The Robert Wood Johnson Foundation Policy Brief No. 16, October 2008.

3 Kaiser Family Foundation and Health Research and Educational Trust (46); Bureau of Labor Statistics, Non-Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988 – 2007 (April to April). Data on premium increases reflect the cost of health insurance premiums for a family of four. The average premium increase is weighted by covered workers. Data on premiums not available for 1991, 1992, 1994, 1995, 1997, 1998. As quoted in The Robert Wood Johnson Foundation Research Synthesis Report No. 16, October 2008.

[4] PriceWaterhouseCoopers, “The Factors Fueling Rising Health Care Costs 2008” December 2008.

[5] Data based on quantitative and qualitative research conducted by an independent, third party marketing research firm for WellPoint’s Customer Viewpoint Program. Insights derived from approximately 100,000 responses from consumers, employers and industry thought leaders across 16 states between 2005 and 2008. Data are weighted to be representative of demographic census information.

[6] Newhouse JP. “Medical Care Costs: How Much Welfare Loss?” Journal of Economic Perspectives, vol. 6, no. 3, Summer 1992; Peden EA, Freeland MS. “A Historical Analysis of Medical Spending Growth, 1960-1993.” Health Affairs, vol. 14, no.2 , Summer 1995; Cutler DM. “Technology, Health Costs, and the NIH.” Paper prepared for the National Institute of Health Economics Roundtable on Biomedical Research, September 1995 as quoted in The Robert Wood Johnson Foundation Policy Brief No. 16, October 2008.

[7] Cutler DM. McClellan M. “Is Technological Change in Medicine Worth It?” Health Affairs, vol. 20, no. 5, September/October 2001 as quoted in The Robert Wood Johnson Foundation Policy Brief No. 16, October 2008.

[8] WellPoint Internal Data (2008).

[9] Christopher J. Conover, “Health Care Regulation – A $169 Billion Hidden Tax” Policy Analysis No. 527, Cato Institute 2004.

[10] Strunk BC, Ginsburg PB. :Aging Plays Limited Role in Health Care Cost Trends.” Center for Studying Health System Change Data Bulletin No. 23, 2002; Seshamani M, Gray A. “Time to Death and Health Expenditure: An Improved Model for the Impact of Demographic Change on Health Care Costs.” Age and Ageing, vol. 33, no. 6, November 2004; Cutler DM, Sheiner L. “Demographics and Medical Care Spending: Standard and Nonstandard Effects.” National Bureau of Economics Research Working Paper No. 6886, 1998 as referenced in The Robert Wood Johnson Foundation Policy Brief No. 16, October 2008.

[11] Thorpe KE, Florence CS, Howard DH, Joski P, “Trends: The Impact of Obesity on Rising Medical Spending.” Health Affairs, Web Exclusive, October 20,2004; Congressional Budget Office. Technological Change and the Growth of Health Care Spending (No. 2764). Washington, DC: Congressional Budget Office, January 2008 as referenced in The Robert Wood Johnson Foundation Policy Brief No. 16, October 2008

[12] Will Dunham, More Americans getting multiple chronic illnesses, Thomson Reuters, January 2009.

[13] Congressional Budget Office. Technological Change and the Growth of Health Care Spending (No. 2764). Washington, DC: Congressional Budget Office, January 2008 as referenced in The Robert Wood Johnson Foundation Policy Brief No. 16, October 2008.

[14] The Robert Wood Johnson Foundation Policy Brief No. 16, October 2008.

[15] Sloan FA, and Chepke L. “From Medical Malpractice to Quality Assurance.” Issues in Science and Technology, Spring 2008, as referenced in The Robert Wood Johnson Foundation Policy Brief No. 16, October 2008.