The Factors Driving Rising Health Care Costs

Our crisis in health care costs is deepening.
Consider the evidence:

- For the fifth consecutive year, America’s health care spending grew at a faster rate than the year before. At this pace, health care spending by 2010 will reach $2.6 trillion—twice the amount spent in 2000.¹

- The average total cost of health care benefits for active employees (which includes all medical and dental plans offered) rose 14.7% in 2002, the second consecutive year of double-digit premium increases—and the largest increase since 1990.²

- In its annual survey, the Kaiser Family Foundation reported that 53% of businesses named health insurance as the “greatest cost concern for the company.” Some are shifting more of the cost to workers, some are buying fewer benefits and some are dropping coverage for employees altogether.³

- Premiums for medical malpractice insurance continued to skyrocket, causing physicians in a number of specialty areas to leave the state or simply stop practicing.

- Most disturbingly, an estimated 40 million people⁴ now have no health insurance at all. And the number is growing.
The Situation

While the situation is serious everywhere, it is even more concerning in New Jersey. Utilization of medical services and the length of hospital stays in New Jersey continue to rise. Increasing numbers of experienced physicians, faced with the mounting medical malpractice insurance crisis, are threatening to retire, leave the state or stop performing surgeries in their specialty areas.

The crisis created by these and other factors requires AmeriHealth to play a challenging role—attempting to balance competing interests. Physicians and providers want higher reimbursements, while employers and customers want lower insurance premiums. No one is happy.

And no one can point to a solution. Instead, for more than a decade, all of the parties in our health care system—hospitals, physicians, insurers, patients, lawyers, legislators and media—have pointed fingers at each other, assigning blame for the crisis.

In truth, all of us played a role in creating this crisis. And if anything is to change, all of us must play a role in finding a solution.

We hope this brochure, which describes many of the factors that are driving this cost crisis, helps to promote a much broader—and more collaborative—search for answers.

First, A Look In the Mirror

At the heart of the health care cost crisis is an assumption that we must question:

Are we as Americans entitled to anything the health care system has to offer—new technology, breakthrough drug or the latest diagnostic test—no matter how much it costs?

We act as if we are. And that assumption is driving up health insurance premiums.

Consider this recent study by PricewaterhouseCoopers, which identified these factors as drivers of increased premiums:

<table>
<thead>
<tr>
<th>Factor</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs, Medical Devices &amp; Other Medical Advances</td>
<td>22%</td>
</tr>
<tr>
<td>Rising Provider Expenses</td>
<td>18%</td>
</tr>
<tr>
<td>General Inflation</td>
<td>18%</td>
</tr>
<tr>
<td>Government Mandates &amp; Regulation</td>
<td>15%</td>
</tr>
<tr>
<td>Increased Consumer Demand</td>
<td>15%</td>
</tr>
<tr>
<td>Litigation &amp; Risk Management</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
</tr>
</tbody>
</table>

Obviously, “Medical Advances” and “Consumer Demand” (which account for 37% of the increase) reflect a health care marketplace that demands the latest, and is using more and more of it. But so do “Government Mandates and Regulation.” Legislators, responding to public
frustration with managed care, have enacted mandates aimed at insurance companies. But the fact is, insurers do not pay for mandates—employers and employees foot the bills. And the bills are getting higher every year.

**Utilization**

Health care costs can be broken down into this simple formula:

\[
\text{“Price”} = \text{Cost Per Service} \times \text{Number of Services Performed}
\]

We know that the “price” of health care is rising. That’s partly because the costs for individual medical services in New Jersey are rising, as are the number of services performed in the state.

Physician visits per thousand members throughout the state have increased each year since 1999. New Jersey residents also spend more time in the hospital than the rest of the country. In 2001, New Jersey recorded 726.6 inpatient days per 1,000 population, compared to the U.S. figure of 681.6.

AmeriHealth’s Commercial HMO and Point-of-Service medical costs rose 16% from 2001 to 2002. Costs for AmeriHealth’s PPO plans rose 14.7% during the same time period.

Let’s examine some of the factors behind those increased costs.

**Aging Population**

As Americans age, they consume more medical resources. By the end of this decade, nearly one in four Americans will be 65 and older.

In New Jersey, the percentage of residents aged 65 and older (13.2%) is higher than the national average of 12.4%.

An older population translates to increased costs. On average, a U.S. male’s health care spending doubles in the 45-54 age group, as compared to the 35-44 age group, and rises another 50% in the 55-64 age group. Baby Boomers who used few health care services for two decades are turning to physicians, hospitals and other providers with increasing regularity—and demanding the best medical care no matter how high the costs.

**New Technology**

Medical advances often involve new technology, and usually have inflationary effects. For example, one of the fastest growing areas among hospitals and outpatient centers is radiology—our use of expensive imaging procedures such as MRI and PET is growing at 8-9% a year. Such tests routinely cost thousands of dollars.
And more advances are arriving. Whole body imaging and virtual colonoscopies will allow asymptomatic individuals to address their fears of cancer and heart attacks. But the demand for new technologies often leads consumers to demand that health insurers pay for these previously uncovered services. And that often leads to government mandates—and higher insurance costs for the employers and employees.

State Mandates

Compared to its neighbors, New Jersey is a heavily mandated state. In the past few years alone, the state legislature has enacted laws relating to fertility procedures, mental health/alcohol/substance abuse, colorectal screenings, infant hearing tests, infant formula and contraceptive benefits.

Currently, more than 25 health-related mandates are pending in the New Jersey Legislature. These proposals call for full or partial coverage of children’s hearing aids, hairpieces for people receiving chemotherapy, counseling for compulsive gambling, ovarian cancer screenings, Lyme disease and hepatitis B vaccinations, the AIDS vaccine and treatment for post-traumatic stress, drug and alcohol addiction, joint disorders, autism and cystic fibrosis.

As insurers add mandated benefits to their standard benefits, premiums are affected. According to the National Center for Policy Analysis, six states determined that mandates account for between 7-21% of the cost of all insurance claims. The study also found that one of every four uninsured persons lost their coverage because of premium increases that resulted from the enactment of state mandates.\(^1\)

In 2002, New Jersey became the third state to allow independent physicians to bargain collectively with managed care plans over the terms of their contracts. The law allows New Jersey doctors to negotiate with health plans on the definition of medical necessity, utilization management procedures, quality assurance programs, clinical practice guidelines, dispute resolution and credentialing. Doctors also can negotiate payment issues if the attorney general determines that an insurer had substantial market power and that terms or conditions of the plan could pose a threat to quality and availability of care.

Federal Legislation

Federal Legislation also has had an effect on health insurance cost. Recent amendments to the federal Health Insurance Portability and Accountability Act (HIPAA) include an Administrative Simplification phase to ensure standardization in communication between parties using electronic transactions, as well as requirements to ensure the privacy and security of member-specific information. By the time these regulations are fully implemented, the industry will have spent $43 billion to comply with the law.\(^1\)
Another piece of federal legislation, born of frustration over rising health care costs, would allow small employers to form multi-state Association Health Plans (AHPs). Under this proposal, independent businesses could form AHPs for the purpose of purchasing group health benefits. AmeriHealth and others who oppose the bill are concerned that because these groups could be exempt in varying degrees from state oversight and regulation, AHPs could choose to operate from states with the least amount of oversight.

While AmeriHealth understands the cost pressures facing employers, we believe that AHPs are an ill-advised—and short-term—source of relief from the health care cost crisis. By exempting out-of-state plans from state oversight, these plans pose an unacceptable risk to members, providers, small businesses and others who depend upon health insurers to meet all of their financial obligations.

Prescription Drug Costs

For several years now, prescription drug spending in America has risen 15% or more annually. Total retail spending on prescription drugs in the U.S. for 2001 was $154.5 billion, a 17.1% increase from 2000.15 Half of the increase occurred in the following categories—depression, high cholesterol, arthritis, high blood pressure, allergies and ulcers. What is behind the spending?

Because of an increase in chronic conditions such as asthma, diabetes, elevated cholesterol and arthritis, Americans are using more prescription drugs than ever.

The drugs cost more than ever.

And despite the availability, in many cases, of less expensive generic prescription drugs, more and more Americans are responding to pharmaceutical marketing campaigns and requesting higher-priced, brand name drugs. One report, by Families USA, said nine U.S. pharmaceutical companies spent 27% of their revenue on marketing and advertising and 11% on research and development.

Malpractice Insurance

How serious is the malpractice insurance crisis?

Serious enough for the American Medical Association (AMA) to list New Jersey as a state in “full-blown medical liability crisis.”16

The AMA blames the crisis on skyrocketing jury awards that “are part of a legal system that in many states is simply out of control.” AMA data shows that increasing lawsuit awards and litigation expenses are the primary factors for increasing medical liability premiums.17

And, as malpractice insurance premiums continue to rise, physicians have taken action.
The AMA estimates that at least 15% of all OB-GYNs in New Jersey have stopped offering obstetrical care.\(^{18}\) And the Medical Society of New Jersey (MSNJ) reports that 25% of New Jersey obstetricians have simply left the state because of escalating liability premiums.\(^{19}\) This rapid exodus may be attributable to the MSNJ’s projection that more than 70% of all obstetricians will be sued at some point.\(^{20}\)

Other states have responded to the malpractice issue by setting a cap on jury awards for “non-economic” damages. Since setting its cap at $250,000 in 1976, California’s medical liability insurance premiums have risen 167%. This compares to a 505% increase in the rest of the country.\(^{21}\)

New Jersey legislators are discussing solutions to this issue, but have not yet made a significant impact on the malpractice insurance crisis. Additional work needs to be done to address this issue.

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**Fraud/Abuse**

Between 3-5% of health care dollars—an estimated $50-80 billion—are lost each year to fraud and abuse.\(^{22}\) Through aggressive health care fraud investigations and increased cooperation with law enforcement officials, AmeriHealth works to prevent fraudulent activities.

AmeriHealth’s Corporate and Financial Investigations Department, during a recent 24-month period, referred 22 cases of suspected fraud or abusive practices to law enforcement or New Jersey state regulatory authorities, resulting in health care fraud indictments and convictions.

AmeriHealth also received 18 tip allegations of fraud or abusive practices, resulting in 5 fraud cases initiated, 13 under evaluation.

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**“Do concerns about malpractice liability ever cause you to...?”**  
*Base: All practicing physicians*

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Order more tests than you would based only on professional judgement of what is medically needed</td>
<td>79%</td>
<td>21%</td>
</tr>
<tr>
<td>Prescribe more medications such as antibiotics than you would need based only on professional judgement of what is medically needed</td>
<td>41%</td>
<td>59%</td>
</tr>
<tr>
<td>Refer patients to specialists more often than you would based only on professional judgement</td>
<td>74%</td>
<td>26%</td>
</tr>
<tr>
<td>Suggest invasive procedures such as biopsies to confirm diagnoses more often than you would based solely on professional judgement</td>
<td>51%</td>
<td>49%</td>
</tr>
</tbody>
</table>

Source: Dept. of Health and Human Services, July 2002.
When premiums rise significantly, hundreds of thousands of Americans lose their health insurance.

The People Left Behind

When premiums rise significantly, more Americans lose their health insurance. History shows that about 300,000 individuals lose health insurance coverage with each one-percent inflation-adjusted increase in premiums. In 2002, only 61% of small businesses offered health coverage to their workers, as compared to 67% in 2000.

The Congressional Budget Office (CBO) reports that about 40 million people are uninsured at some point each year, as they lose coverage when switching jobs or through other life changes. The CBO estimates that since 1998, 21-31 million people remained uninsured for an entire year or more.

The Insurer’s Role

It would be easy to simply point fingers at others who need to address this cost crisis. But like all insurers, AmeriHealth contributes to the overall cost of health care with its administrative costs—the only factor in the health care equation that AmeriHealth directly controls.

Over the last year, AmeriHealth handled over 3 million customer transactions—more than 11,500 every day. We processed 2.5 million claims and had over a half-million phone conversations with members. Such a volume of transactions generates significant costs.

Reducing these costs is one of our highest priorities. Since 1999, AmeriHealth has made investments in technology, process engineering and education that have contributed to more than $40 million in annualized savings. But additional savings need to be realized in 2003 and beyond.

In addition, AmeriHealth has taken other initiatives to help contain health care costs:

- AmeriHealth introduced NaviNet™, an application that electronically links providers with AmeriHealth via the Internet. NaviNet simplifies daily administrative transactions, allowing both parties to conduct business more quickly, accurately and efficiently.

- AmeriHealth introduced amerihealthexpress.com—a web site that allows plan administrators and members to view account information, check eligibility, find a network physician, print forms, request an ID card and check on claims.

- AmeriHealth introduced new PPO products that add several lower-cost options to our portfolio for both small- and large-group customers, offering health insurance that is both affordable and accessible. AmeriHealth HMO and Point-of-Service options provide employers with alternatives for increased employee cost-sharing.
The Challenge Ahead

It is difficult to imagine that current trends in health care costs can continue for much longer without causing the entire system to implode. Increasing numbers of people cannot afford insurance at all, and those who pay for insurance cannot absorb double-digit increases in premiums indefinitely.

Ultimately, we must return to that opening assumption and ask: Do we have the right to any health care that is available, no matter what it costs? If the answer is yes, then we must decide how we will pay—because the current model is breaking down.

In the meantime, we invite you to share this brochure with others so that they, too, might better understand this crisis and, ultimately, join all of us in the health care system in the search for solutions.

We have the best health care in the world. But the system that gives us access to that care is very ill.

It needs our help—all of us.
Sources

7. Ibid.
12. Ibid.
20. Ibid.