What are the leading factors contributing to the increased cost of health care?

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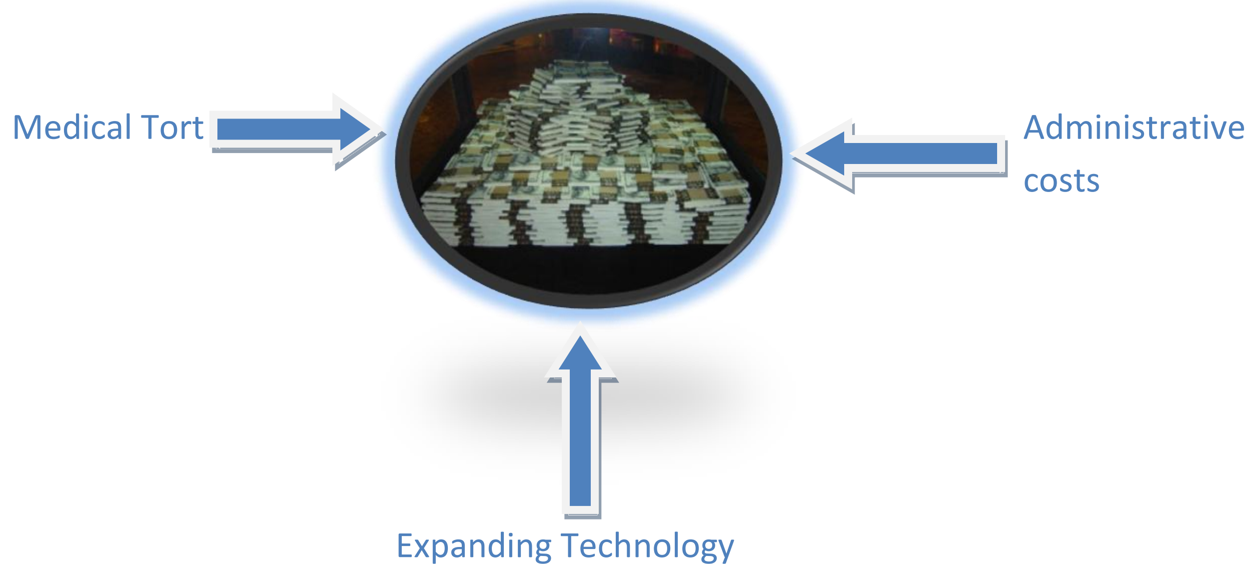
Annual spending on health care increased from $75 billion in 1970 to $2.0 trillion in 2005, and is estimated to reach $4 trillion in 2015. As a share of the economy, health care has more than doubled over the past 35 years, rising from 7.2% of GDP in 1970 to 16.0% of GDP in 2005, and is projected to be 20% of GDP in 2015. Health care spending per capita increased from $356 in 1970 to $6,697 in 2005, and is projected to rise to $12,320 in 2015. One would expect that this spending involves payments to doctors and hospitals. In fact, while costs continue to rise, payments to physicians and hospitals has been falling for the past several years. This decline in income is expected to accelerate in 2010 as CMS, the Centers for Medicare & Medicaid Services has proposed a 21.5 percent rate reduction for the 2010 calendar year to more than one million physicians and non-physician practitioners who are paid under the Medicare Physician Fee Schedule (MPFS). The MPFS sets payment rates for more than 7,000 types of services in physician offices, hospitals and other settings. Private insurance companies have been steadily cutting payments to physicians and hospitals as well; all the while raising premiums at a pace well above inflation rates.

So where has the money gone? If physicians and hospitals are not receiving the funds, who is laying claim the ever rising health care dollar? The answer lies in three separate areas that have increased significantly in cost over the past 10 years. The first is medical technology. This category includes advances in diagnostic testing, imaging, lifesaving surgical procedures, and pharmaceuticals. By themselves, one can say that these advances represent the price we must pay for the best medical care in the world. Unfortunately, these technologies are frequently over utilized in the practice of “defensive medicine”. The second category includes medical tort. The costs of frivolous law suits affects the premiums physicians must pay for malpractice insurance, costs of defending the same suits, and the cost of increased testing and overtreatment that doctors engage in to fend off potential claims of negligence. Finally, the costs of medical administration continues to increase at alarming rates. This category includes the ever increasing government bureaucracy with its inefficiencies, susceptibility to fraud and over bloated union negotiated benefits. In addition, the private insurance industry has capitalized on this by paying excessive senior executive salaries and expanded layers of bureaucracy with the preauthorization process that has been proven time and again to not save money but delay care. Each of these categories are discussed in detail below.



1. Advances in technology and therapeutic regimens: Broadly speaking, the term “medical technology” can be used to refer to the procedures, equipment, and processes by which medical care is delivered. Overall, the advances in technology that have occurred in the past 20 years have served to significantly improve quality of life for the average citizen. In the 2000s, better tests became available to diagnose heart attack, drug-eluting stents were used, and new drug strategies were developed (aspirin, ACE inhibitors, beta-blockers, statins) for long-term management of heart attack and potential heart attack patients. From 1980-2000, the overall mortality rate from heart attack fell by almost half, from 345.2 to 186.0 per 100,000 persons. It is not possible to directly measure the impact of new medical technology on total health care spending; innovation in the health care sector occurs continuously, and the impacts of different changes interrelate. The size of the health sector (16% of gross domestic product in 2005) and its diversity (thousands of procedures, products, and interventions) also render direct measurement impractical. Economists have used indirect approaches to try to estimate the impact of new technology on the cost of health care. In an often-cited article, Newhouse estimates the impact of medical technology on health care spending by first estimating the impact of factors that can reasonably be accounted for (e.g., spread of insurance, increasing per capita income, aging of the population, supplier-induced demand, low medical sector productivity gains). He concludes that the factors listed

above account for well under half of the growth in real medical spending, and that the bulk of the unexplained residual increase should be attributed to technological change – what he calls “the enhanced capabilities of medicine.” (Joseph P. Newhouse, “Medical Care Costs: How Much Welfare Loss?” *Journal of Economic Perspectives* 6(3) (Summer 1992): 3-21.) As mentioned above, this is not necessarily a negative as it has resulted in improved quality of life and greater longevity.

Overutilization of the technologies becomes an expensive problem when doctors are faced with the threat of a medical malpractice law suit. The physician’s greatest concern is that a lawsuit will be filed for an “act of omission”. That is a lawsuit filed because the physician failed to order a particular test. One jury awarded $1.5 million to a 57-year-old man who had sued his internist for not ordering a prostate-specific antigen (PSA) test in a timely fashion, resulting in a delayed diagnosis of prostate cancer. Another jury awarded $1.3 million to a man who also had sued his internist for failing to order a PSA test. In Illinois, a jury awarded $30 million to the parents of a neonatal boy who died at the age of 16 days of sequelae of kernicterus. After delivering the baby at the mother's home, the obstetrician as a routine measure had drawn a blood sample from the baby but he never submitted the sample to a laboratory to determine the bilirubin level. That jury verdicts such as these have caused physicians in all specialties to increase their ordering of both radiologic and nonradiologic diagnostic tests seems self-evident. Clearly, the experience of having been sued in the past, or the fear of being sued in the future, for these types of errors of omission is a strong motivation to order more tests.

Without effective tort reform, the only option available for limiting spending on technology is to ration its use. As evidenced in other countries, limiting the application of technology is a strategy that governments use to limit the cost of providing care under a nationalized system. In Canada for example, colonoscopy services are limited and, as a consequence, the incidence of colon cancer is 16% higher than in the United States. Compounding the effect, by limiting the availability of the newer chemotherapies available for treatment of colon cancer, mortality from this condition is significantly higher in Canada relative to the United States. MRI, an expensive but precise diagnostic imaging technology is severely limited in Canada. According to Forbes magazine, there are more MRI scanners in Pittsburg, PA than in all of Canada. In a recent report by the Canadian Institute for Health Information, Canada's supply of the machines per capita ranks below many Organization for Economic Co-operation and Development countries and is even below the median ranking. A broad range of other countries -- from Spain to Korea to Finland -- has more MRI and CT scanners per million people than does Canada. As a result, waiting times for MRI scans are long and many experience life threatening delays in the management of various cancers. Similar examples of limiting

the application of technology exist in England where a government rationing panel recently concluded that chemotherapy for the treatment of breast cancer was too expensive. Patients presenting with advanced stages of breast cancer are now denied medical treatment. In June of this year, new guidelines for management of advanced breast cancer were published. “Breast Cancer Care’s new Standards of Care highlights 10 key areas where patients should expect to receive appropriate care to enable them to live with their diagnosis, including access to emotional and psychological support and receive expert palliative care.” In other words, affected women will be able to better live with, and die from their disease.

2. Medical Tort: **No significant health care reform can take place without bringing the trial lawyers to that table and enacting real tort reform**. As a physician in Virginia, I see thousands of dollars spent every day in pursuit of "defensive medicine." So much could be saved if doctors were allowed to practice medicine as they were trained in medical school, and not in fear of losing their livelihood with each narcotic prescription they write or mammogram they order. Think about countries where the malpractice risk is less; this is a big reason why their health care costs are less. Some analysts argue that new tort limits would reduce overall spending for health care in two ways. First, they would reduce the size of the average award paid by malpractice insurers to claimants and, thus, reduce premiums for malpractice insurance (the “malpractice premium” effect). A reduction in malpractice premiums would tend to reduce the prices that insurers and individuals pay for health care services. Second, those analysts argue that the proposed changes in tort law would reduce health care spending by reducing the intensity and volume of health care services provided (the “utilization” effect). The argument for a utilization effect is built on two premises: first, that fear of litigation drives medical providers to deliver additional medical services (“defensive medicine”), and second, that the proposed tort limits would reduce that perceived threat among physicians and thereby reduce utilization and spending. In recent years, the Congress has considered a number of legislative proposals that would modify the tort litigation system in the United States by imposing limits on medical malpractice claims, as many states have done. Most recently, the “Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003” was proposed (HR50). This legislation passed in the House of Representatives but was filibustered by the then House Minority Leader Tom Daschle (D-SD). The Congressional Budget Office, a non-partisan arm of Congress estimated that this legislation would reduce federal direct spending on Medicare, Medicaid, and the Federal Employees Health Benefits program by about ***$15 billion over 10 years***. That reduction in federal spending reflected the estimated reduction in malpractice premiums, which CBO concluded would reduce both private health insurance premiums and payment rates in the Medicare and Medicaid programs. CBO

did not, however, assign savings to effects on utilization. By contrast, the Assistant Secretary for Planning and Evaluation (ASPE) of the Department of Health and Human Services, for example, has estimated that a cap on noneconomic damages alone would reduce costs to the federal government by between ***$25 billion and $44 billion*** per year, an effect approximately ***20 times as large as CBO's estimate*** of the impact of the HEALTH Act of 2003 (which included a cap on noneconomic damages as well as other tort limits).5 The vast bulk of ASPE's estimated savings was attributable to its estimate of the effects of the proposed rule on ***utilization***. Effective tort reform would then, provide a savings of up to 50% of that needed to effectively reform the health care system based on current estimates.

3. Administrative costs: In their annual report, the Medicare Trustees recently announced that both the Medicare Hospital Trust Fund and the Supplementary Medical Insurance Trust Fund expenditures are growing faster than the rest of the economy. The Trustees report expenditures were $432 billion in 2007, or 3.2 percent of gross domestic product (GDP), and are projected to increase to nearly 11 percent of GDP in 75 years. The Trustees report that Medicare's Hospital Insurance Trust Fund will become insolvent earlier in 2019 than reported last year. Hospital insurance expenditure growth is estimated to average 7.4 percent each year over the next 10 years, a higher rate than either Gross Domestic Product (GDP) or Consumer Price Index (CPI) growth. This year the Hospital insurance Trust Fund will spend more than its income, and from 2009 through 2017, about $342 billion will need to be transferred from the Federal treasury to cover beneficiaries' hospital insurance costs. If the government cannot keep Medicare expenditures in line with budget, who is to believe they can keep a larger single payer system under budget. Meanwhile, payments to doctors and hospitals by Medicare are so low that they fall "below overhead" and the net result is a loss to those physicians and hospitals that accept Medicare payments. Consider the cost to the health care system if all payments to doctors and hospitals were at Medicare rates. Surely, if it were not for the more expensive private insurance plans effectively subsidizing the government insurance, the entire health care delivery system would collapse in financial ruin. The gap between the ever increasing costs and the constantly falling reimbursements lies in the government's inefficiency. Layers upon layers of bureaucracy filled with union federal employees are responsible for a large proportion of the costs. Even with the high cost of government employees, the fraud in the Medicare system is enormous. Historically, the government has never been able to operate with anything near the efficiency of the private sector. For this reason alone it is counterintuitive to expect government run health care will do anything but run costs up while cutting services back.

The private insurance sector has done its share of abusing the system. When you buy insurance, you enter into a complex relationship with a company that promises to pay for services you haven't yet used. You start paying it substantial amounts of money right away, but you don't actually use its service until some time in the future. You're also required to sign lengthy, intricate documents full of conditions and exclusions and legalese that few people are equipped to understand. You are at the company's mercy, which makes its incentives and inclinations so important. The private health insurance market is dominated by four gigantic insurers: UnitedHealth, WellPoint, Aetna, and Cigna. In the last five years, these companies have combined to earn over $44 billion in profits; UnitedHealth alone has made over $17 billion in profits over that period. These profits are not reinvested in the health care system but are actually removed from the system by way of payments to shareholders. "On Wall Street," the *Los Angeles Times* has noted, these companies "showcase their efforts to hold down expenses and maximize shareholder returns by excluding customers likely to need expensive care, including those with chronic diseases such as asthma and diabetes. The companies lobby governments to take over responsibility for their sickest customers so they can reserve the healthiest (and most profitable) for themselves." Indeed, insurance companies collectively spent $74 million on lobbyists in 2008 alone. Below is a list of the senior executive salaries paid in 1996.

Oxford Health Plans, Inc.	$57,374,098	
Aetna, Inc	$28,268,875	
CIGNA Corporation	$25,382,230	
WellPoint Health Networks, Inc.	$12,848,023	
Foundation Health Corporation	$8,189,220	
Mid-Atlantic Medical Services, Inc.	$6,526,065	
PacifiCare Health Systems, Inc.	$7,325,466	
Humana, Inc.	$5,166,575	
United HealthCare Corporation	$2,697,751	
Cumulative Total		**$153,778,303**

Below are the compensation packages for the CEO's only in 2008.

* Ron Williams – Aetna:	$24,300,112.
* H. Edward Hanway – CIGNA:	$12,236,740.
* Angela Braly – WellPoint:	$9,844,212.
* Dale Wolf – Coventry Health Care:	$9,047,469.
* Michael Neidorff – Centene:	$8,774,483.
* James Carlson – AMERIGROUP:	$5,292,546.
* Michael McCallister – Humana:	$4,764,309.

* Jay Gellert – Health Net: $4,425,355.
* Richard Barasch – Universal American: $3,503,702.
* Stephen Hemsley – UnitedHealth Group: $3,241,042.

To summarize, the bulk of the 2 trillion dollar health care system in this country is seen in the form of medical legal expense, inefficiencies in administration along with enormous waste and inefficiencies in the government side. Legislation currently being evaluated in Washington fails to account for any of the major contributors to increased costs. It is time to tell Washington to scrap the plan and start over with a bipartisan plan approach that addresses the major problems outlined above without the influence of special interests including the Trial Lawyers Association, Health Insurance, or labor union Lobby.