America's
Health
Insurance
Plans

A SHARED RESPONSIBILITY:

ADVANCING TOWARD A MORE ACCESSIBLE, SAFE, AND AFFORDABLE HEALTH CARE SYSTEM FOR AMERICA

TABLE OF CONTENTS

OUR COMMITMENT 1

INTRODUCTION: A STRATEGY TO MAKE HEALTH CARE MORE AFFORDABLE 2

I. HEALTH COST TRENDS — A TEN-YEAR LOOK 5

FIGURE 1. Growth of Hospital Benefit Costs, Private Insurance, 1995–2006 5

FIGURE 2. Growth of Prescription Drug Benefit Costs, Private Insurance, 1995–2006 6

FIGURE 3. Growth of Physician Benefit Costs, Private Insurance, 1995–2006 7

TABLE 1. Growth in Benefit Costs and Premiums for Private Health Insurance 7

II. WHAT'S DRIVING THE COST TREND? 8

FIGURE 4. Factors Contributing To The 8.8 Percent Increase in Health Insurance Premiums, 2004–2005 8

FIGURE 5. Growth in Supply and Utilization of Computed Tomography (CT) 11

TABLE 2. Cost of Medical Liability and Defensive Medicine as a Share of the Premium Dollar, 2005 12

FIGURE 6. Annual Medical Expenditures Attributed to Selected Chronic Conditions and Unhealthy Lifestyle Activities, 2005 13

FIGURE 7. Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1981 to 2005 14

FIGURE 8. Estimate of Increase in Private Health Insurance Premiums Due to Cost Shifting, 2005 15

FIGURE 9. Growth in Uninsured Rate by Income Level, 2005-2006 15

III. HEALTH PLAN LEADERSHIP TO IMPROVE HEALTH CARE AND REDUCE COSTS 16

TABLE 3. Selected Private-Sector Efforts 16

FIGURE 10. Prescription Drug Tiers Are An Effective Strategy in Controlling Health Care Costs 17

FIGURE 11. Percent of Total Health Care Expenses Incurred by Different Percentiles of U.S. Population, 2002 18

IV. REDUCING THE CURRENT COST TREND IS CRITICAL TO ENSURING THAT ALL AMERICANS HAVE ACCESS TO QUALITY HEALTH CARE 25

TABLE 4. Potential Savings: AHIP Affordability Proposals, Selected Years 25

V. CONCLUSION 32

FIGURE 12. Potential Savings from AHIP's Affordability Proposal 32

APPENDIX A A Review of AHIP Savings Estimates A1

APPENDIX B The Administrative Costs of Public and Private Health Insurance B1

A SHARED RESPONSIBILITY: ADVANCING TOWARD A MORE ACCESSIBLE, SAFE, AND AFFORDABLE HEALTH CARE SYSTEM FOR AMERICA

Our Commitment

America's health insurance plans are committed to three goals: getting all Americans covered, raising the bar on health care quality and safety, and making health care more affordable.

ACCESS: In November 2006, we announced a comprehensive proposal to provide universal access using a public-private, federal-state approach with the following key features:

- Repairing the safety net by strengthening SCHIP and improving Medicaid;
- Providing helping-hand tax credits for children and broader tax incentives on a sliding scale for adults and families with incomes up to 400 percent of the federal poverty level; and
- Establishing a grant program to encourage and sustain innovative, state-based coverage initiatives.

This affordable and achievable approach enables states to design solutions that best meet their needs within federal guidelines.

SAFETY AND QUALITY: In April 2007, our community proposed a set of recommendations that — if implemented — would lead to a safer, higher quality health care system. Our strategy includes:

- Improving value and safety by comparing the effectiveness of new and existing drugs, devices, and procedures, and strengthening reviews of their long-term safety and effectiveness;
- Improving clinical quality by incorporating breakthrough scientific research into practice more quickly and continuing the development of uniform quality and efficiency measures; and
- Improving the process of resolving patient disputes in a fast and fair manner that supports quality care.

AFFORDABILITY: The next stage in our health care reform effort is to present a public-private strategy for making health care more affordable. This paper presents the data on why health care costs are rising, where private sector strategies have succeeded in slowing rising costs, and what health insurance plans and all other members of the health care community need to do — together — to solve this problem.

Introduction: A Strategy to Make Health Care More Affordable

Key Drivers of Rising Health Costs

For much of the 1990s, health care costs rose at a slower rate than they had during the 1980s. Many experts attributed this slowdown to health insurance plans' use of network-based health care. Health costs began escalating more rapidly from 2000 to 2002, a period that coincided with new limitations on health plan tools to control costs. By continuing to innovate, health plans have restored the slowdown, and now health care costs — and the insurance premiums that reflect those costs — are rising at approximately half the rate of five years ago. However, health costs are still rising faster than many Americans can afford, and breaking this cycle requires confronting the five key factors driving health care costs:

1) Overuse, underuse, and misuse of health care services inconsistent with medical evidence;

2) Explosion of new technologies without a national entity to compare the clinical and cost-effectiveness of these new technologies to existing ones;

3) Prevalence of defensive medicine and poorly coordinated care;

4) Personal health habits — such as smoking, poor diet, and lack of exercise — that worsen health status; and

5) Cost-shifting to private payers to make up for insufficient payments from public programs and costs associated with providing uncompensated care for the uninsured.

This report presents data on these challenges, examines solutions that are showing promise, and outlines public and private sector approaches that need to be implemented together. Implementing these strategies could serve as a foundation for reforms that recognizes the intrinsic linkages among affordability, access and quality.

Health Plan Strategies that are Slowing the Growth in Health Costs

Health insurance plans have developed and put into practice specific strategies to address the key drivers of health costs. We are using a new generation of tools to help patients improve their well-being and promote value in health care. Premiums are increasing at the slowest rate in ten years; according to the national health expenditure data, private health insurance premiums grew 5.5 percent in 2006, the fourth consecutive year of a downward trend, and well below the 6.7 percent overall increase in health spending.[1] This report highlights the contributions of our community to slowing the growth of health costs in the following areas:

- Pharmacy innovations that promote both value and safety, such as the use of tiered formularies, e-prescribing, and increasing access to generic drugs;
- Disease management, prevention, and care coordination programs that bring evidence-based medicine into everyday practice;
- New benefit design and payment incentives that reward quality and value; and

- Health information technology advancements that enable practitioners to exchange information necessary to promoting optimal patient health.

Public and Private Initiatives That Need to Happen Together

Health plans have made progress in slowing down health care spending but a broader effort is needed to reverse spending trends. This report identifies and draws attention to selected areas where continued leadership from health plans and partnership with health care practitioners, employers, consumers, and the government are necessary if the country is to make health coverage affordable for more Americans.

A new entity to compare the clinical effectiveness and value of new treatments and services to existing ones would provide Americans with a trusted source from which to obtain up-to-date, objective, and credible information on which health care services are most effective and provide the best value. By establishing a process to expand the foundation of medical evidence, we can then work to strengthen the use of this information in everyday medical practice. A public-private partnership in this effort would enhance both the integrity of the evaluations and the integration of these results into medical practice.

Breakthrough and emerging drugs, devices, and technologies are products that all Americans want, but, in many cases, lack any scientific evidence regarding their use or value to specific populations. A focus on developing and strengthening scientific evidence for these emerging products will support innovation by determining what procedures and technologies are safe, effective and provide the highest value. This, in turn, will improve the quality and affordability of care. A new entity designed to compare the effectiveness and value of these experimental therapies with existing, approved treatments will be able to draw upon this larger body of evidence in its research. Similarly, government support of an expedited approval process for generic drugs and an approval pathway for generic biologics will speed up our nation's ability to offer consumers high-quality, lower cost alternatives.

Disease management, care coordination, and prevention programs initiated by health plans have made great strides in applying what we know about best practices to everyday medical practice. Yet, our significant national investment in research at the National Institutes of Health (NIH) and other federal agencies has lacked a parallel national commitment to integrating evidence-based practice into the delivery system. Existing programs rely on effective dissemination of information on best practices. The impact of these programs would be greatly enhanced if all stakeholders worked together to establish a national clearinghouse to disseminate information and foster the adoption of best practices for disease management, prevention, and care coordination programs among employers, government, and local communities.

Higher quality and value in health care is a goal sought by all — one that requires significant collaboration with practitioners. Partnerships with practitioners offer promising opportunities to test new models of care delivery and improve continuity and quality of care across a continuum of providers and specialized services. Models that emphasize a medical home for patients with chronic illnesses and fundamentally redesign payment systems to include care management and preventive care have demonstrated some early successes.

Health plans are seeking the appropriate use of high cost, advanced technology. For example, high-tech imaging services are being scrutinized as there is growing concern about costs and patient safety issues related to inaccurate readings and increased radiation exposure. For example, the annual growth rate in the number of computed tomography (CT) scans between 2000 and 2005 was 13 percent.[2] Plans are implementing new utilization management strategies to address the appropriate use of these services such as reminding physicians about current guidelines and providing peer-to-peer consultation.

Policymakers should establish an environment to encourage, not impede, these efforts to maximize the value of our health care dollars.

Health information technology advancements have the potential to significantly improve quality and affordability if they are integrated into broader reform strategies. The adoption of electronic health records with decision support provides the latest evidence to clinicians when prescribing needed care and offers reminders to avert medication errors and adverse interactions.

Consumers have become more engaged in taking responsibility for their own care with the advent of personal health records, which provide key information to manage chronic conditions and reminders for age-appropriate preventive screenings. Health plans have been at the forefront of developing personal health records (PHRs) that offer individuals the opportunity to become more engaged in their own care and provide a portable platform of key health information to improve the continuity of care. Broader collaboration is needed to expand the use of PHRs in public and private health care programs. Likewise, broad-based leadership is needed to encourage electronic data exchange utilizing electronic health records (EHRs) as a means of improving health outcomes, reducing medical errors, and enabling clinicians and consumers to communicate electronically across the health care system, with a marked improvement in efficiency and quality.

Medical liability reform is needed to improve health care affordability and quality by promoting evidence-based medicine instead of defensive medicine. The current system hinders efforts to transition to a health care system that recognizes and rewards best practices. We have a shared responsibility with other participants in the health care system to replace the current system with a new dispute resolution process that ensures fair compensation for consumers, promotes timely resolution of disputes, and improves the quality of care by relying on evidence-based medicine standards.

Transparency of information on the quality and cost of care provided by practitioners and hospitals should result in actionable information for consumers and patients. Key stakeholders across the spectrum of health care, including health insurance plans, physicians, hospitals, consumers, and employers — have convened broad-based, national alliances (AQA, formerly the Ambulatory Care Quality Alliance, and the Hospital Quality Alliance (HQA)) to determine a more effective strategy for measuring, reporting, and improving physician and hospital performance.

For information to be useful and consistent across the entire health care system, the federal government must initiate a parallel effort to measure and report on physician and hospital performance within public programs. This will provide the consistency and uniformity necessary to enable consumers to make treatment choices based on value, regardless of whether they have public or private health coverage.

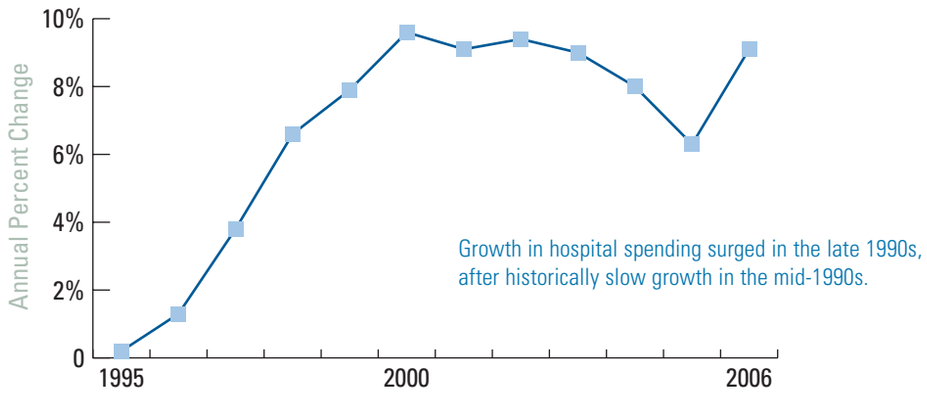
Our recommendations are based on the concept of shared responsibility: health insurance plans working with the public sector and other leaders in the private sector to build a more affordable, high-quality health care system.

I. Health Cost Trends — A Ten-Year Look

Over the last several years, hospital spending has risen, prescription drug spending has moderated, and spending for physician services has grown at a steady pace.

HOSPITAL SPENDING HAS RISEN SHARPLY. According to the national health expenditures (NHE) accounts compiled by the Centers for Medicare and Medicaid Services (CMS), in 2006, hospital spending comprised nearly one-third of NHE (31 percent). Hospital spending grew by 7.6 percent a year from 2001–2006, up sharply from nearly zero growth for several years in the mid-1990s (see Figure 1).[3] More specifically, spending on outpatient hospital services per privately-insured person grew 10.3 percent in 2006, and spending on inpatient care grew 5.1 percent.[4] The rapid expansion of specialty facilities (e.g., cardiovascular, orthopedics, and imaging centers), including hospital inpatient and outpatient facilities, freestanding centers, and provision of ancillary services in physician offices tend to drive hospital cost trends higher.

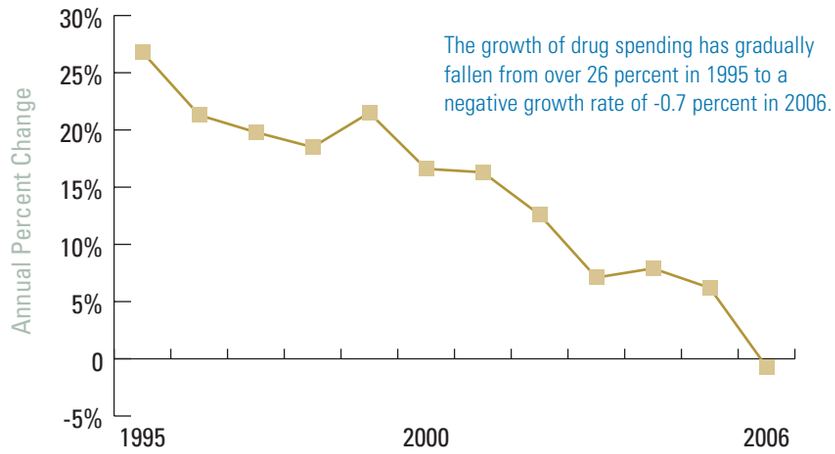
FIGURE 1.
Growth of Hospital Benefit Costs, Private Insurance 1995–2006



Source: National Health Expenditures, CMS Office of the Actuary

PRESCRIPTION DRUG SPENDING HAS MODERATED. Prescription drug spending comprises about 10 percent of national health expenditures. After slowing to a 5.8 percent growth rate in 2005, this figure increased to 8.5 percent in 2006[5] (due in large part to implementation of Part D of the Medicare Modernization Act (MMA) of 2003), but is still significantly below the 18.1 percent growth seen in 1999[6] (see Figure 2). According to the Center for Studying Health System Change (HSC), the slowdown in 2005 was largely due to decreased use of prescription drugs rather than changes in drug prices. CMS attributed the downward trend specifically to extensive use of multi-tiered benefit designs, increased use of certain generics, and a decline in the introduction and use of blockbuster drugs, including those that had been withdrawn from the market.

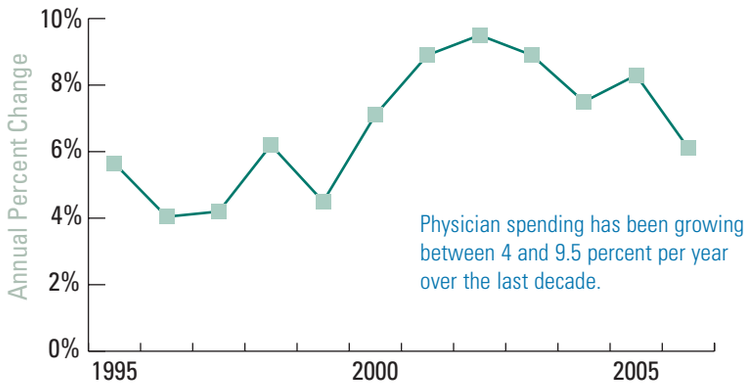
FIGURE 2.
Growth of Prescription Drug Benefit Costs, Private Insurance 1995–2006



Source: National Health Expenditures, CMS Office of the Actuary

PHYSICIAN SPENDING HAS BEEN STEADY. In 2006, physician and clinical services comprised approximately 21 percent of national health expenditures. Total spending growth for physician services increased by 5.9 percent in 2006 — more than a percentage point below the 7.8 percent average from 2000 to 2005 (see Figure 3).[7]

FIGURE 3.
Growth of Physician Benefit Costs, Private Insurance 1995–2006



Source: National Health Expenditures, CMS Office of the Actuary

Rising Health Costs Mean Rising Health Insurance Premiums

Higher trends in benefit costs translate into higher premium costs. When the cost of health services goes up, the cost of providing health benefits likewise rises, and premiums for health coverage must increase accordingly. For example, during the past 20 plus years in which NHE data have been collected, health benefit cost increases have averaged 8.7 percent per year, and premium increases likewise averaged 8.7 percent annually (see Table 1).

TABLE 1.
Growth in Benefit Costs and Premiums for Private Health Insurance

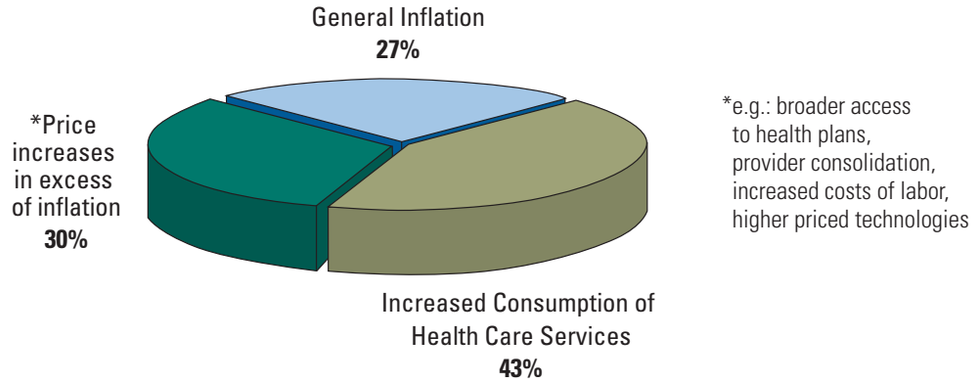
	Benefits (Millions)	Premiums (Millions)	Average Annual Growth Rate
1986	111,703	135,861	8.7%
2006	634,566	723,412	8.7%

Source: CMS, National Health Expenditures: Historical Tables

II. What's Driving the Cost Trend?

Utilization and prices underlie the growth in hospital, physician and drug costs. A 2006 study by PricewaterhouseCoopers (PwC) separated the growth of private health insurance premiums from 2005 into increased consumption of health care services (43 percent of the total increase), price increases in excess of inflation (30 percent) and general inflation (27 percent) (see Figure 4).

FIGURE 4.
Factors Contributing To The 8.8 Percent Increase in Health Insurance Premiums, 2004–2005



Source: PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs, 2006."

Rapid rates of growth in consumption and prices of health care services are caused, in turn by a number of forces, including:

- Overuse, underuse and misuse of medical services inconsistent with medical evidence;
- Proliferation of new technologies without a national entity to compare the clinical and cost-effectiveness of these new technologies to existing ones;
- Prevalence of defensive medicine and poorly coordinated care;
- Personal health habits that worsen health status; and
- Cost-shifting to private payers to make up for insufficient payments from public programs and costs associated with providing uncompensated care for the uninsured.

UNDERUSE, OVERUSE, AND MISUSE. Research consistently has shown that Americans receive health care services in sync with the latest scientific evidence only about half of the time.[8] There continue to be examples of treatments widely adopted in the absence of evidence only to later be found ineffective and, in some cases, harmful (e.g., autologous bone marrow transplants for metastatic breast cancer, drug-coated stents for blocked arteries, and arthroscopic knee surgery for arthritis). Research by Dr. John Wennberg and others has concluded that evidence-based medicine plays virtually no role in governing the frequency in use of supply-sensitive health services and that most of the services that are delivered are driven by other factors, such as the number of physicians and beds in a given market, and the widely-held assumption that more medical care means better care.[9]

Additionally, recent reports from the Center for Studying Health System Change (HSC)[10] and the Government Accountability Office (GAO)[11] suggest that the rise in spending for hospital and physician services in the past several years is due to increased use of services rather than price increases. Although the use of hospital and physician services and spending on such services have risen sharply, the overall quality of care has risen only about three percent on average over the past three years according to the Agency for Healthcare Research and Quality (AHRQ).[12]

Even among academic medical centers, similar results were reported. Wennberg and colleagues found that in high-spending areas, patients obtaining follow-up care after hip fracture surgery had 82 percent more physician visits, 26 percent more imaging exams, 90 percent more diagnostic tests, and 46 percent more minor surgical procedures, yet had higher mortality rates and poorer health outcomes than patients seeking the same care in low-spending areas.[13] Clearly, the type and number of treatments that individuals receive often depends more on where they live than on what medical evidence suggests.

Other research suggests that the rise in hospital spending may be related to mergers and consolidation among hospitals. According to a Robert Wood Johnson study that synthesized previous research on the topic, "consolidation in the 1990s raised prices by at least 5 percent and likely significantly more."[14] The Federal Trade Commission's *Evanston* opinion provides a more recent example of the impact of hospital consolidation on prices. In that opinion, the FTC held that a Chicago-area hospital merger had allowed the hospitals to raise average net prices to insurers "by a substantial amount."[15]

Though some analysts have suggested that the hospital consolidation trend was a response to changes in the health insurance market, the Robert Wood Johnson report concluded that "the preponderance of the evidence suggests that the rise in managed care did not cause the hospital merger wave." Moreover, in a 2004 report based on site visits to 12 nationally representative communities, HSC reported that "the balance of power stabilized [in 2002 and 2003], with providers, particularly hospitals, solidifying their dominant negotiating positions and securing concessions from plans in the form of significant payment rate increases and more favorable contract terms."[16]

Moving forward, the focus of national discussions about health care should be on strategies to promote the type and level of care consistent with medical evidence.

PROLIFERATION OF NEW TECHNOLOGIES WITHOUT COMPARING EFFECTIVENESS TO EXISTING TECHNOLOGIES. In January 2008, the CBO released a report,[17] based on review of the economic literature, which concluded that about half of all growth in health care spending in the past several decades was associated with changes in medical care made possible by advances in technology. The report also stated that, while technological advances are likely to yield new, desirable medical services in the future which will fuel further spending growth, if those services are used more selectively in the future, it is possible we could see smaller increases in health care spending.

Medical innovation is clearly one of the greatest strengths of the U.S. health care system. Yet many health economists and policy experts agree that the adoption of new technology — including new drugs, devices, procedures, and biologics — plays a major role in driving health care costs beyond sustainable levels.

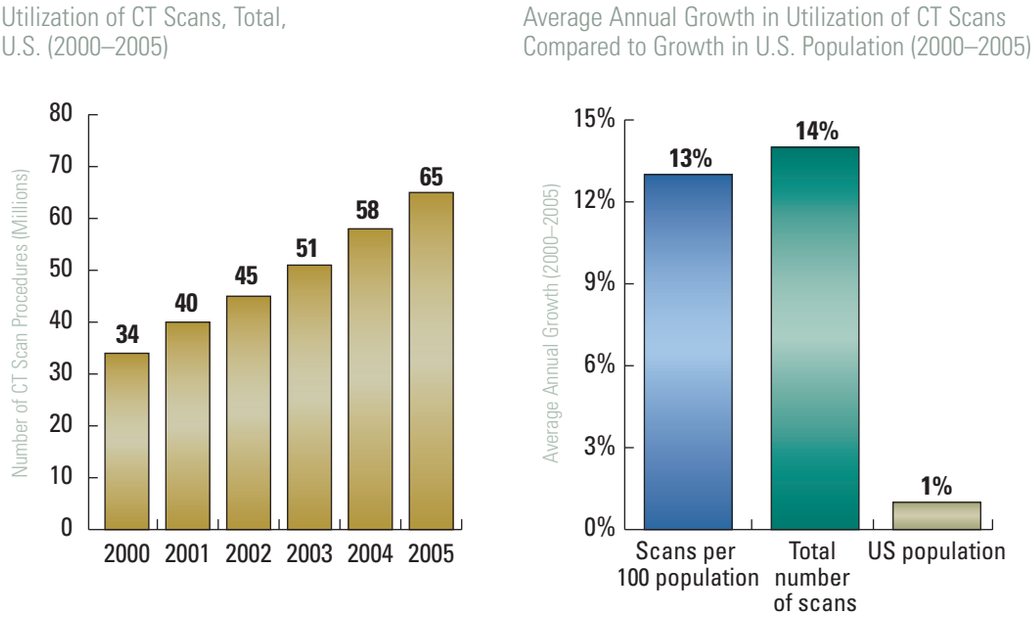
One proposed solution is the creation of a single, national entity to assess the clinical and cost-effectiveness of new and existing drugs, devices, procedures, and health care services to determine whether they provide superior patient benefit, or value, compared to existing alternatives. Such a system would provide a much needed venue to evaluate new treatments and technologies at least as quickly as they come to market. According to the CBO,[18] such comparative effectiveness analysis could ensure future technologies, as well as existing costly services, are only used when the clinical benefits will be superior to those of other, less expensive services. This would go a long way in preventing overuse of those technologies which offer little value at a higher cost, which CBO believes could substantially reduce spending below projected levels over the long run.[19]

For the emerging generation of specialty pharmaceuticals, comparative effectiveness is only part of the solution given the broad scope of indications and diseases that are sometimes being treated with these therapies. Biologics are one important example; researchers have noted that biologics are generally evaluated for specific conditions without regard to cost, and rarely compared to existing treatments.[20] Yet with an increasing number of new therapies being developed each year, integrating evidence-based decision making into the development process and prior to approval will be crucial when balancing access to these products with the cost of care. Otherwise, the use of these promising drugs will only serve to exacerbate the overuse, underuse, misuse problem discussed in the previous section.[21]

The lack of a system to assess new technologies further distorts the delivery of services in some markets where the supply of services can be the most important factor, as Dr. Wennberg and colleagues have suggested. The proliferation of certain technology and services in the outpatient hospital setting — particularly freestanding ambulatory surgery and imaging centers — is one important area where further assessment is warranted. According to a recent study by the McKinsey Global Institute, diagnostic imaging from CT and MRI scans contribute to $26.4 billion in unnecessary use of health services.[22] Moreover, the McKinsey report noted that the trend is particularly pronounced among physicians who refer to facilities in which they have an ownership interest (See Figure 5).

POORLY COORDINATED CARE AND DEFENSIVE MEDICINE. The consumption of health procedures and services is also pushed upward by poorly coordinated care and a less than predictable legal system. To the extent that services are unnecessary and duplicative, the entire system bears the burden of financing those costs, often with little, if any, parallel improvement in quality.

FIGURE 5.
Growth in Supply and Utilization of Computed Tomography (CT)



Source: McKinsey & Company: Accounting for the Cost of Health Care in the United States, January 2007 (OECD; Frost & Sullivan; MGI analysis)

In its landmark report, *Crossing the Quality Chasm*, the Institute of Medicine noted that despite the need for well-coordinated care among the more than 125 million Americans with chronic conditions, health care in the U.S. remains fragmented and poorly organized. The report pointed out that health care organizations, hospitals, and physician groups typically operate as separate "silos," without the benefit of sufficient information about the patient's current condition, medical history, or services and medications recently provided by other clinicians.

Poorly coordinated care can hurt patients, for example, when an individual suffers a serious or fatal drug reaction because he or she received prescriptions from two different physicians for medications that interact adversely. Poorly coordinated care also drives up costs when individuals seeing several health care practitioners receive the same diagnostic tests and procedures multiple times because one physician did not know that the other already had conducted them.

Defensive medicine is also a vivid example of unnecessary and costly care. A 2003 Harvard School of Public Health survey of 800 Pennsylvania physicians in six specialties considered to be at high risk of litigation found that nearly all (93 percent) reported practicing defensive medicine. Among the respondents, 59 percent said they ordered more diagnostic tests than were medically indicated.[23]

A more recent study in *Health Affairs* sought to quantify the association between medical malpractice costs and Medicare spending from 1993 to 2001.[24] The study found that a ten percent increase in average malpractice payments was associated with a one percent increase in Medicare

payments of total physician services and a two percent increase in the imaging component in these services. States in the top quartile of malpractice payments per physician had 70 percent more Medicare payments per physician than states in the bottom quartile. The 60 percent increase in average nationwide malpractice premiums between 2000 and 2003 was associated with a $16.5 billion increase in Medicare spending. The authors did not find that higher malpractice liability costs were associated with any reductions in total or disease-specific mortality.

For the health care system as a whole, the direct costs of medical liability were estimated to total $29.4 billion in 2005 according to a Towers Perrin-Tillinghast report.[25] These direct costs likely represent a fraction of the indirect costs. A 1996 article by Daniel Kessler and Mark McClellan estimated the system-wide costs of defensive medicine may be as much as 9 percent of NHE.[26] These costs in turn have an impact on health insurance premiums. A PWC analysis[27] of the composition of health insurance premiums concluded that a full ten cents of every premium dollar is spent on medical liability and defensive medicine (see Table 2).

TABLE 2.
Cost of Medical Liability and Defensive Medicine as a Share of the Premium Dollar, 2005

Component	Total Share of Premium	Medical Liability Share of the Premium Cost	Benefit Share of Premium Less Medical Liability
Physician	24%	3%	21%
Outpatient	22%	4%	18%
Hospital Inpatient	18%	1%	17%
Prescription Drugs	16%	1%	15%
Other Medical Services	6%	1%	5%
Total	**86%**	**10%**	**76%**

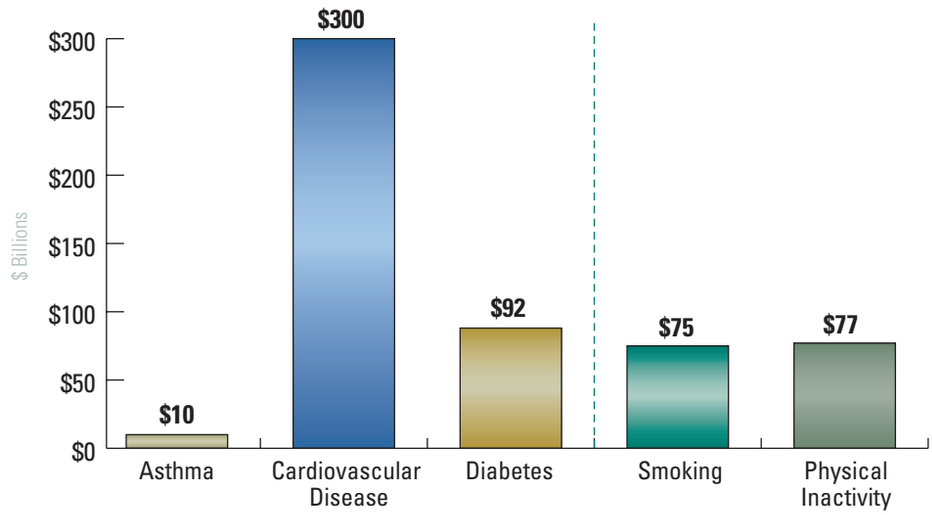
Source: PricewaterhouseCoopers' estimates, December 2005. *The Factors Fueling Rising Healthcare Costs 2006.*

PERSONAL HEALTH HABITS. Unhealthy lifestyles — characterized by smoking, poor diet and lack of exercise leading to obesity — are another key contributor to high health care costs in the U.S. Smoking and secondhand smoke cause an estimated 438,000 deaths each year in the U.S. and 8.6 million Americans experience serious illness due to smoking. Estimates suggest that the health consequences of smoking may lead to more than $75 billion per year in medical expenditures and $92 billion in lost productivity.[28]

Likewise, obesity and its complications — including cardiovascular disease, diabetes, and cancer — are estimated to cost $93 billion per year.[29] Thorpe and colleagues estimate that 27 percent of real per-capita growth in spending from 1987 to 2001 is attributable to increasing rates of obesity and increasing health care spending by individuals who are obese.[30]

FIGURE 6.

Annual Medical Expenditures Attributed to Selected Chronic Conditions and Unhealthy Lifestyle Activities, 2005



Source: Estimated expenditures on cardiovascular disease (2005 estimates), diabetes (2002), smoking (1997 - 2000), physical inactivity (1998 - 2000) are from the Centers for Disease Control and Prevention, Chronic Disease Overview; at http://www.cdc.gov/nccdphp/overview.htm, accessed on May 28, 2008. Estimated expenditures on asthma (current estimate) is from the Asthma and Allergy Foundation of America, "Cost of Asthma" report, at http://www.aafa.org/display.cfm?id=6&sub=63 <http://www.aafa.org/display.cfm?id=6&sub=63> , accessed on May 28, 2008.

Unhealthy lifestyles have led to tremendous growth in chronic disease in the U.S. According to the Department of Health and Human Services, in 2006 chronic diseases affected more than 90 million Americans, and accounted for more than 75 percent of the nation's total health spending.[31] Heart disease, cancer, and diabetes now account for 52.4 percent of all deaths and limit the activities of 25 million Americans.[32] The costs of treating diabetes alone add up to more than $9 2 billion annually (see Figure 6).[33] Reducing the incidence of preventable disease with a new national commitment to healthy behaviors could result in substantial cost savings while also improving the quality of life for millions of Americans.

Among children and young adults, the consequences of obesity and poor personal health represent a critical test toward controlling future health costs. A recent study in the journal *Pediatrics* concluded that childhood obesity significantly enhanced the risk of cardiovascular disease in adulthood.[34] Moreover, according to the U.S. Surgeon General, obesity among children has transformed type II diabetes as "previously considered an adult disease" into a condition increasingly affecting adolescents.[35]

The emergence of obesity as a precursor for heart disease, and the linkage to type II diabetes — a condition once believed to be mostly limited to the adult population — parallels increasing rates of obesity among children observed by researchers from the Centers for Disease Control and Prevention (CDC). According to this research, from 1980 to 2004, the number of overweight children aged 6 to 11 more than doubled from 7 percent to 18.8 percent, while the rate among adolescents (aged 12 to 19) rose from 5 percent to 17.1 percent.[36]

Fortunately, however, the recent *Pediatrics* study underscores the importance of early intervention in the presence of obesity (and related risk factors) and suggests that the consequences of excess weight in childhood can be limited by altering one's behavior. According to William Dietz, who leads the CDC's effort on nutrition and obesity, the *Pediatrics* study "...indicates it's not hard-wired. Some clearly are more susceptible, but susceptibility isn't the same as inevitability."[37]

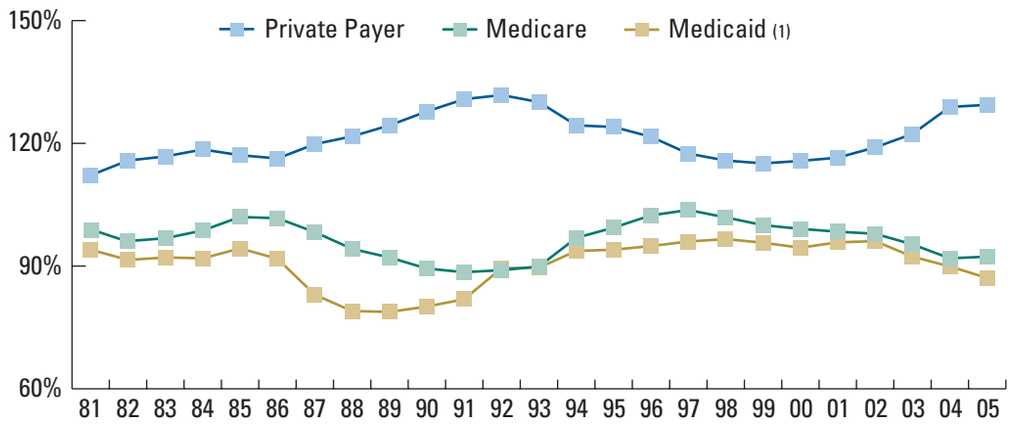
COST SHIFTING. Another trend that has become increasingly pronounced and problematic in recent years is cost-shifting: Facing inadequate payments from public programs and rising bills from uncompensated care of the uninsured, health care providers look for ways to recoup their losses. Medicare and Medicaid enrollment and spending rose dramatically during the economic slowdown of 2000-2001. At the same time, the percent of individuals with coverage from their employers declined from 63 percent in 2000 to 59 percent in 2006.[38]

With a growing share of their patient populations covered by public programs that provide reimbursements significantly lower than the cost of care, hospitals often look to private payers to make up the difference. The Lewin Group estimates that cost-shifting causes private payers to spend $1.22 for every dollar that public programs pay to hospitals.[39]

A similar analysis based on data from the American Hospital Association (AHA) also illustrates this trend and suggests that the gap between payment levels for public programs and private insurance is higher than any time in the last 15 years (see Figure 7).[40]

Furthermore, the cost of caring for uninsured individuals raises premiums of private health insurance significantly. According to Families USA, the cost-shift due to uncompensated care adds a "hidden tax" of $922 annually to family premiums and $341 each year to individual premiums (see Figure 8).[41]

FIGURE 7.
Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid,* 1981 to 2005

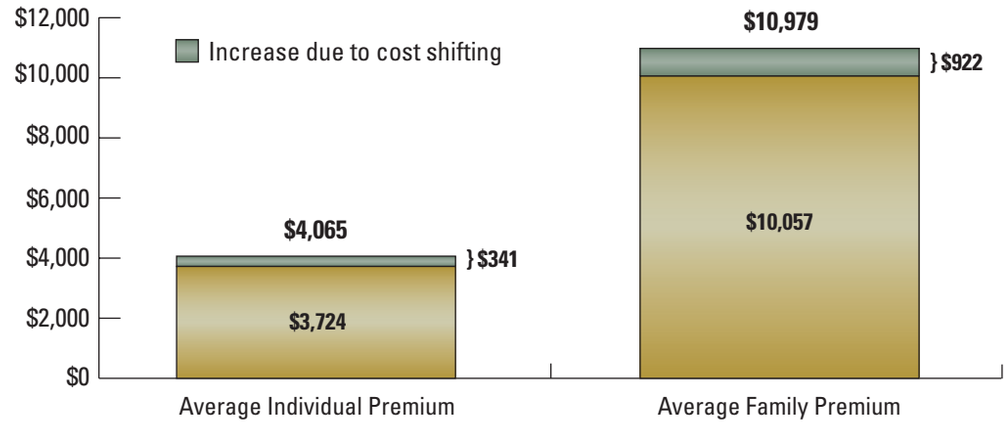


Source: 2007 Chartbook, Trends Affecting Hospitals and Health Systems, April 2007. American Hospital Association. Data by Avalere Health, analysis of AHA Annual Survey data, 2005, for community hospitals.

*Includes Medicaid Disproportionate Share payments.

FIGURE 8.

Estimate of Increase in Private Health Insurance Premiums Due to Cost Shifting, 2005



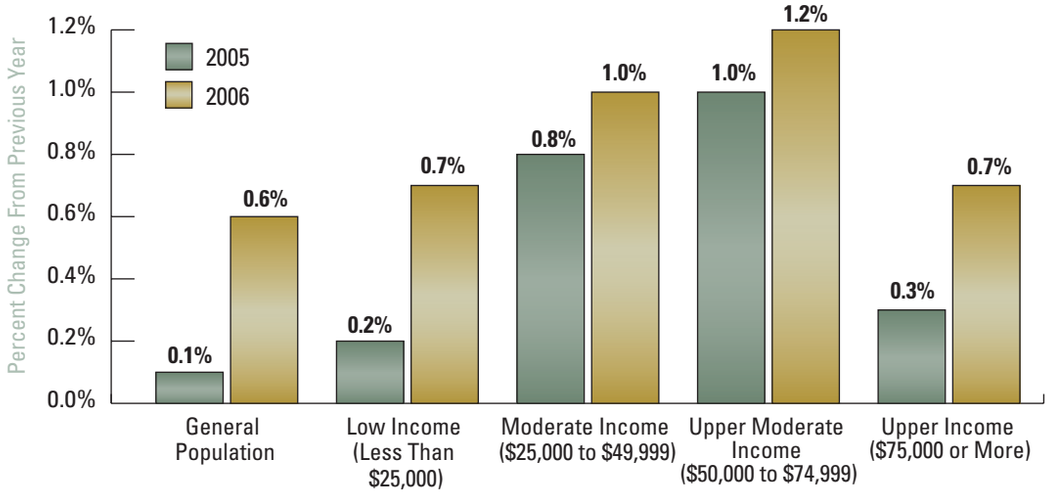
Source: K. Stoll, "Paying A Premium", Families USA, June 2005

As a result, during difficult economic times, middle-class families with private coverage face a double burden — the burden of inflation and a tight job market, plus the burden of health insurance premiums driven increasingly higher by cost-shifting.

RISING HEALTH CARE COSTS ARE CAUSING LOSS OF COVERAGE. The major system-wide factors described above have affected the prices we pay every day for hospital care, prescription drugs, and physician services. These cost pressures are causing many Americans to lose their health coverage. According to the Census Bureau, middle-income households ($50,000–$75,000 income) represent the fastest growing segment of the uninsured. From 2005 to 2006, the percentage of uninsured

FIGURE 9.

Growth in Uninsured Rate by Income Level, 2005-2006



Source: Income, Poverty, and Health Insurance Coverage in the United States: 2005 and 2006, Census Bureau

individuals with incomes between $50,000 and $75,000 rose by 1.2 percent to 14.4 percent (see Figure 9). Although the uninsured rate is still significantly higher among lower-income households, it is becoming clear that higher-income households are also at risk for losing coverage.

III. Health Plan Leadership to Improve Health Care and Reduce Costs

In this section, we describe the efforts that health insurance plans have led in partnership with health care practitioners to implement the tools described above.

Health plans' effective new tools for cost containment have been a key factor contributing to the slowdown in health spending.

In the past several years, health plans have been collaborating with health care practitioners on initiatives that support patients in improving their health and well-being, encourage excellence in medical practice, and promote value in health care. These initiatives feature tools such as: pharmacy innovation, prevention, disease management and care coordination, new payment incentives to promote evidence-based care, and health information technology, as well as innovative benefit designs and account-based products (see Table 3).

TABLE 3.
Selected Private-Sector Efforts

• PHARMACY INNOVATION
• DISEASE MANAGEMENT, CARE COORDINATION, AND PREVENTION
• BENEFIT INNOVATION AND INCENTIVES TO PROMOTE QUALITY & VALUE
• HEALTH INFORMATION TECHNOLOGY

PHARMACY INNOVATION. Health plans' pharmacy innovations are a major factor contributing to the downward trend in prescription drug spending. CMS has attributed the downward trend in spending to extensive use of tiered benefit designs, increased use of generics, and a decline in the introduction and use of blockbuster drugs, including those that had been withdrawn from the market.[42] Health plans' successful pharmacy management strategies include:

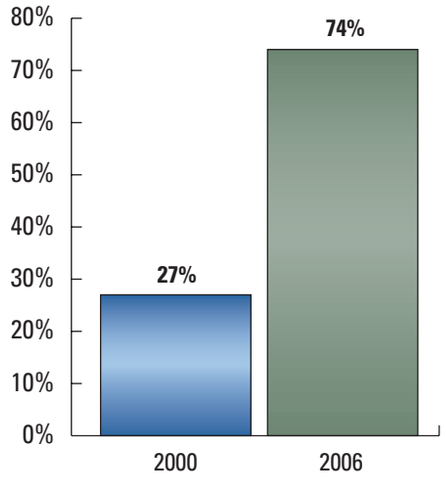
- Drug Tiering — Health plans have established several levels of copayments for generic and brand name drugs. For example, a health plan member may have a $10 copayment for a generic, a $20 copayment for a brand-name drug on the formulary, and a $35 copayment for a brand-name drug not on the formulary.

  By 2006, the number of workers whose health plans included prescription drug tiering nearly tripled to 74 percent from 27 percent in 2000 (see Figure 10).[43] Analysts widely agree that the

FIGURE 10.

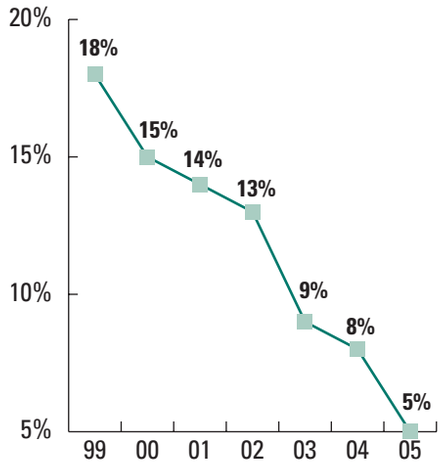
Prescription Drug Tiers Are An Effective Strategy in Controlling Health Care Costs

Percent of covered workers with three or more tiers of cost sharing for prescription drugs, 2000 to 2006



Source: Employer Health Benefits, 2006 Summary of Findings, The Kaiser Family Foundation and Health Research and Education Trust

Annual change in prescription drug spending, per privately-insured person, 1999 to 2005



Source: Ginsburg et al. (2006). Tracking Health Care Costs: Spending Growth Remains Stable at High Rate in 2005. Data Bulletin No. 33. Washington, DC. Center for Studying Health Systems Change.

resulting decline in the prescription drug cost trend is attributable to this now common strategy.

- e-Prescribing — Health plans are providing physicians with the tools and equipment needed to prescribe electronically. Using the personal computers and hand-held devices offered with e-prescribing systems, physicians can quickly consult health plan formularies for coverage information, check patient histories, and access information about effective generic alternatives to brand-name drugs. E-prescribing systems are helping protect patient safety and hold down prescription drug costs.

  The eRx Collaborative — an e-prescribing initiative involving **Blue Cross Blue Shield of Massachusetts (BCBSMA), Neighborhood Health Plan, and Tufts Health Plan** — reported that in 2006, approximately 88,000 electronic prescriptions were changed due to drug safety alerts generated by the e-prescribing system.[44] These alerts helped avoid potential adverse drug interactions and allergic reactions that have serious and/or life-threatening consequences. Overall, pharmacy costs associated with high-volume e-prescribers in BCBSMA's network fell by an estimated 3–3.5 percent in 2006 because they chose more affordable medications for their patients. Further, BCBSMA reported that its members saved an estimated $20–$25 for each electronic prescription changed in favor of a preferred brand or generic.

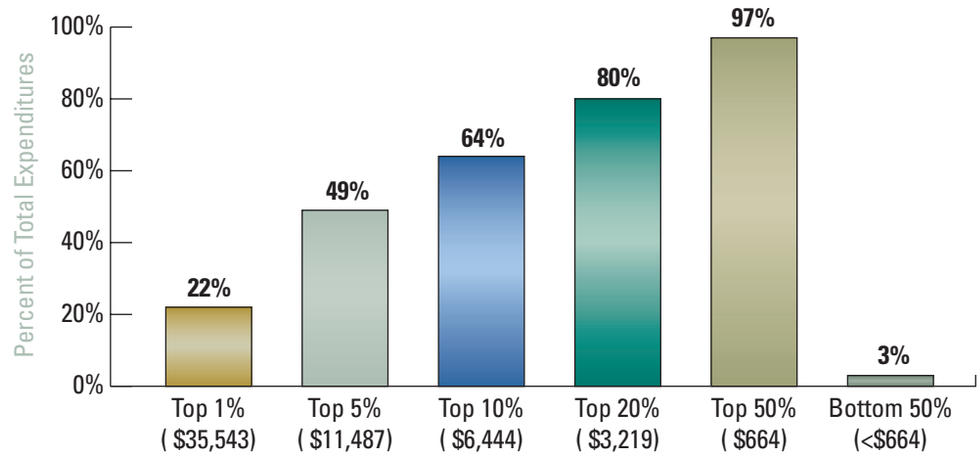
- Safety Alerts — Long before the risks of Cox-2 inhibitors were well known, the clinical team at **Kaiser Permanente** was assisting the Food and Drug Administration (FDA) in a landmark study

analyzing the experience of more than one million Kaiser members. Initiated in 2001, more than three years before the Vioxx recall, this study determined that serious cardiac problems were three times more likely among those being treated with Vioxx than those with a rival drug.[45]

DISEASE MANAGEMENT, CARE COORDINATION, AND PREVENTION. Health plans' efforts to improve the quality and coordination of care for individuals with complex and costly chronic conditions, in addition to efforts to prevent diseases before they occur, are critical to reversing current trends in health care costs. A small percentage of health conditions account for the vast majority of health care costs. According to AHRQ (which cited a 2002 *Health Affairs* study), the 5 percent of patients with the highest health costs accounted for 49 percent of total U.S. health care spending in 2002 (see Figure 11).[46]

Health insurance plans have implemented a wide variety of programs to improve the health and well-being of individuals with complex and costly conditions such as heart disease, diabetes, pulmonary conditions, chronic obstructive pulmonary disease, and cancer.[47]

FIGURE 11.
Percent of Total Health Care Expenses Incurred by Different Percentiles of U.S. Population, 2002



Note: Figures in parentheses are expenses per person.

Source: Conwell LJ, Cohen JW. Characteristics of people with high medical expenses in the U.S. civilian noninstitutionalized population, 2002. Statistical Brief #73. March 2005. Agency for Healthcare Research and Quality, Rockville, MD. Web site: http://www.meps.ahrq.gov/mepsweb/data_files/publications/st73/stat73.pdf.

BEGINNING IN 1997, **PACIFICARE**® (now a UnitedHealthcare company), developed a suite of wellness and chronic care programs for individuals with asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease, cancer, end-stage renal disease, depression, and/or coronary artery disease.

The programs address members' needs on a continuum, from wellness programs available to all members, to case management for individuals who are at high risk of hospital admissions or emergency room use within the upcoming 12 to 18 months. Results have been impressive. From 2001 to 2005:

- The percent of members with cardiovascular conditions whose LDL-cholesterol levels were below 130 mg/dL rose from 47 percent to 70 percent.
- The percent of individuals with diabetes whose HbA1c levels were above clinically recommended levels fell from 41 percent to 30 percent.
- The percent of members with asthma who took recommended controller medications increased from 62 percent to 71 percent among adults age 18 to 56.

In light of the medical evidence indicating that a multi-dimensional approach to chronic care is most effective, **CIGNA HealthCare** has used this strategy since it began offering disease management programs in the late 1990s. CIGNA's initiatives focus not only on chronic diseases such as asthma, diabetes, and congestive heart failure, but also on behavioral health issues that often accompany chronic conditions, and pharmacy issues — such as not wanting to take prescribed medications — that are common to individuals with multiple chronic conditions.

CIGNA's chronic care programs offer information and services to members with asthma, chronic obstructive pulmonary disease, diabetes, congestive heart failure, coronary artery disease, low-back pain, obesity, depression, and a group of ten other conditions that likewise have significant impact on members' quality of life and on health care costs. The programs offer health coaching to help members follow physicians' care plans and make healthy lifestyle changes.

- On average, CIGNA's chronic care programs reduced hospital admissions by 7.1 percent and lowered medical costs associated with the targeted conditions by an average of 11 percent in 2005.
- Overall, CIGNA's chronic care programs are saving an estimated $2 to $3 for every dollar spent.
- A study published in *Health Affairs* found that the health plan's diabetes care program for 43,000 members from 1998-2001 was associated with significant improvements in four key measures of diabetes care: increased use of dilated retinal exams, micro-albumin testing, cholesterol testing, and reduced use of tobacco.[48]

Similarly, recognizing that preventive health services — such as immunization, Pap testing, mammography, and blood pressure screening — go a long way toward reducing the risk of serious illness and disability, health plans have encouraged employers and individuals to adopt preventive strategies. For example, given the devastating health impact that tobacco use has had among all age groups in the United States, health plans have implemented evidence-based initiatives to reduce tobacco use,[49] including innovative smoking cessation programs that provide behavior and pharmacological therapy for members, clinical tools for physicians and value for employers and purchasers.

Health plans' collaborative work with health care practitioners has contributed to significant progress in the areas of child immunization,[50] cervical cancer screening,[51] blood pressure screening,[52] smoking cessation,[53] asthma care,[54] and diabetes treatment[55].

Because many of its elderly members have chronic conditions and face challenges maintaining healthy weight, **Humana** partnered with Healthways to provide the SilverSneakers® Fitness program to Medicare Advantage members beginning in 2004. The program combines exercise with social support to promote healthy living. Medicare beneficiaries enrolled in SilverSneakers® have free access to participating fitness centers, where they can use exercise equipment and swimming pools and take group classes such as yoga, water aerobics, and weight training.

Surveys of program participants in Central Florida found that from 2004 to 2005:

- The percent of respondents who said they exercised less than once a week fell from 19 percent to 8 percent.
- Among the 50 percent of respondents who reported losing weight, average weight loss was eight pounds.
- Self-perceived health status improved for 67 percent of respondents.

Recognizing that being overweight increases an individual's risk for developing a chronic condition, **Empire BlueCross BlueShield** created a work site wellness program called Healthy Weigh to Change in 2004. The program, which seeks to reduce the risks of chronic disease, provides classes led by registered dietitians, as well as Web- and phone-based resources to help members live healthy lifestyles. Employees enrolled in the program attend seven weekly, one-hour sessions taught by registered dietitians, along with a follow-up session several weeks later. Instructors provide coaching and discuss strategies for meal planning, portion control, eating out, and snacking. Besides attending classes, all Empire members can access a variety of Web- and phone-based resources with information on nutrition, exercise, and healthy lifestyles.

Among the 52 employees who participated in the first pilot of Healthy Weigh to Change in 2004:

- Eighty-five percent of program participants said they had made at least two behavioral changes to help them live healthier lifestyles.
- Eighty-nine percent of program participants with body mass index measurements of 25 or more had lost weight.

- Reduced Cost-Sharing for Maintenance Drugs — A growing number of health plans have reduced — and in some cases eliminated — cost-sharing for maintenance drugs that can prevent complications from chronic conditions and thus prevent unnecessary and costly medical emergencies.[56]

  For example, **Community Health Plan** has lowered cost-sharing for asthma controller medications. Whereas members previously paid 50 percent coinsurance (i.e., $25 to $30 per prescription), they now have a $10 copayment for all brands. From 2001 to 2005, use of controller medications among individuals with asthma who had private coverage grew from 60 percent to 81 percent. From 2000 to 2005, the percent of children who had emergency room visits for asthma fell from 32.3 percent to 12.8 percent.[57]

To bring the benefits of prevention to all Americans, community-based approaches involving multiple stakeholders in the health care system will be needed.

INNOVATIVE BENEFIT DESIGN AND PAYMENT INCENTIVES THAT REWARD QUALITY AND VALUE. Health plans and their partners in the employer community are increasingly structuring benefits to reflect more accurately the underlying value of the interventions provided. For example, by establishing varying levels of cost-sharing for different prescription drugs based on their safety, efficacy and cost-effectiveness, health insurance plans' use of tiered formularies has slowed the rise in prescription drug spending. Now many health plans are extending the scope and impact of this approach. By creating benefit plans in which clinically effective and cost-effective treatments, such as administering beta blockers following a heart attack, and waiving copayments for asthma treatment, are encouraged, patient outcomes will improve, while overall costs are reduced. In the future, increased data on comparative effectiveness for other services and technologies will enable an expansion of similar tiering techniques beyond prescription drugs.

Additionally, account-based products such as health savings accounts (HSAs) and health reimbursement arrangements (HRAs) offer premium savings, while also emphasizing the importance of preventive care and management of chronic conditions. According to the 2006 Kaiser Family Foundation annual employer survey, 82 percent of workers enrolled in HSAs and 74 percent of workers enrolled in HRAs are in products that cover preventive benefits before the deductible must be met. Moreover, a 2005 study by the consulting firm McKinsey & Company suggests that consumers with health reimbursement arrangements (HRAs) are more likely to take prescribed drugs and to engage in other behaviors designed to improve their health status.

ROCKY MOUNTAIN HEALTH PLANS OFFERS payment incentives to physicians to improve the health and health care of individuals with diabetes. Physician incentives are based on key health status indicators among patients with diabetes and physicians' use of quality improvement strategies such as scheduling planned visits for diabetes care. The health plan sends physicians reports comparing their performance in providing effective diabetes care to that of other physicians. During the program's pilot phase from September 2003 to September 2005:

- The percent of members with diabetes who had LDL-cholesterol levels below 100 mg/dL in the previous 14 months increased from 29 percent to 42 percent.
- Based largely on reductions in hospital admissions and lengths of stay attributable to the program, Rocky Mountain estimated that health care costs for members with diabetes in the pilot were approximately $73 per member per month below projections.

The health plan is conducting a formal evaluation of the program, and depending on the results, it will decide whether to implement the initiative throughout its network.

To increase use of recommended care for members with asthma, coronary artery disease, and diabetes, **Blue Cross and Blue Shield of Illinois** (BCBSIL) established a recognition and reward program for the 80 medical groups and independent practice associations in its HMO network. The program rewards physician groups that meet or exceed targets for providing care according to evidence-based clinical practice guidelines. BCBSIL lists blue stars in member newsletters, physician directories, employer materials, and on the health plan website next to physician groups who earn high performance awards for care associated with the three targeted conditions.

- The percentage of members with coronary artery disease whose cholesterol levels were below 130 mg/dL increased from 59 percent to 71 percent.
- The percent of members with diabetes whose LDL-cholesterol levels were below 130 mg/DL rose from 61 percent to 74 percent.

More work remains to be done to improve quality and promote evidence-based care throughout the health care system. Under the auspices of the AQA, health plans are collaborating with physician and hospital groups as part of a broad coalition involving more than 135 public- and private-sector organizations. The goal is to develop mutually agreed-upon strategies for: measuring performance at the physician and group level; collecting and aggregating data in the least burdensome way possible; and reporting meaningful information to consumers, physicians, and other stakeholders.

With Medicare and Medicaid's adoption of and influence on the development of physician incentive programs and the use of physician recognition and reward initiatives by private plans, these efforts may be extended beyond the ambulatory care setting to include the participation of hospitals, specialists, and surgeons, as well as primary care physicians.

HEALTH INFORMATION TECHNOLOGY. Health care has lagged behind virtually all other industries in adoption of information technology to promote quality and efficiency of operations. As a result, records containing personal health information often are fragmented and incomplete — leading to unnecessary and preventable medical errors, duplication of services, and ineffective care.

To address these problems, health plans have been at the forefront of efforts to advance an interconnected health care system in which health care practitioners can exchange health information electronically to promote optimal health. Health plans have made major commitments of time and resources to enable physicians and other health care providers to use both electronic health records (EHRs) and personal health records (PHRs).

IN A PROGRAM TO IMPROVE HEALTH STATUS and remove barriers to care for Medicare beneficiaries with chronic conditions, **Aetna** uses sophisticated information systems to track member needs and facilitate care coordination. Aetna's nurse case managers have operating systems on their desktops that allow them to monitor and coordinate activities with Lifemasters, Aetna's disease management partner for heart failure and diabetes. Based on the information that these systems provide about members' health, case managers develop global chronic care plans that account for all of their members' conditions and ensure that they receive services from social workers, behavioral health case managers, and other professionals as needed.

- Since 2002, rates of hospital admission for program participants have been 26 percent below rates for members formerly in disease management programs that did not integrate medical services with behavioral health and social services.
- In Aetna's 2003 member satisfaction survey, 98 percent of program participants rated its services for chronic heart failure as good to excellent, and 96 percent of participants rated the diabetes component of the program as good to excellent.

As part of a multi-faceted initiative to increase use of recommended care for individuals with chronic conditions, **Health Plan of Nevada** (HPN) and its physician group subsidiary, Southwest Medical Associates (SMA), use electronic registries to track members' use of effective treatments and procedures (such as controller medications for members with asthma and HbA1c and cholesterol tests for individuals with diabetes).

Based on data from the registry, HPN sends primary care physicians quarterly reports that document patients' use of recommended care, as well as the frequency of members' hospital stays, outpatient visits, and emergency room visits for congestive heart failure, diabetes, pediatric asthma, and/or chronic obstructive

pulmonary disease. In addition, these reports compare individual physicians' performance in providing effective services to that of all other primary care physicians within SMA and throughout HPN's network. Based on this information, physician office staff can contact patients to schedule appointments for recommended care.

Since the program was implemented, the number of people having recommended tests and treatments has increased significantly:

- Among HPN members with employer-sponsored coverage, the proportion of adults with diabetes who had HbA1c tests increased from 72.8 percent to 83.5 percent from 2003 to 2006.
- From 2005 to 2006, the proportion of Medicaid beneficiaries with asthma ages 5-9 using recommended controller medications increased from 63 percent to 86.4 percent.

To bring the benefits of these technologies to all Americans, ongoing public-private partnerships will need to be expanded, and additional incentives for health care practitioners should be provided.

Electronic Health Records (EHRs). Several years ago, a paper authored by researchers from the Rand Corporation made news when estimating that EHRs could result in a net savings of more than $500 billion over a 15-year period.[58] That estimate was premised on 90 percent of all providers adopting EHRs, but the actual adoption rate is approximately 25 percent.[59] Moreover, a 2006 Robert Wood Johnson Foundation Study found that while 25 percent of physicians use some form of EHR to provide care, only 11 percent of all doctors use an EHR that is "fully operational," to allow collection of patient information electronically, online ordering of lab tests, and electronic display of test results.

Personal Health Records (PHRs). Health plans have been at the forefront of developing PHRs, which are private, secure Web-based tools that are maintained by insurers and contain claims as well as administrative information. PHRs may also include information that is entered by consumers themselves, as well as data from other sources such as pharmacies, labs, and care providers.

PHRs enable individual patients and their designated caregivers to view and manage health information and play a greater role in their own health care. By providing a single and portable source of data on patients' medical histories and encounters with the health care system, PHRs have tremendous potential to prevent errors, adverse drug interactions, and allergic reactions.

To help realize this potential, AHIP and the BlueCross BlueShield Association have developed a model health plan-based PHR and the operating rules that would enable PHRs to be portable, so that consumers can take information with them if they change health plans. In addition, AHIP is partnering with the National Health Council on an initiative to help individuals with chronic conditions and disabilities understand and use PHRs to maximize the quality and coordination of their care.

As PHRs are used more widely, they will have a significant impact on health care costs and quality throughout the health care system.

IV. Reducing the Current Cost Trend is Critical to Ensuring that All Americans Have Access to Quality Health Care

The nation's challenge now is to go beyond slowing the growth of health care costs and put in place strategies that reduce costs, while at the same time bringing high-quality, affordable care not just to the 47 million uninsured,[60] but all Americans.

The national health expenditures data (NHE) and other recent reports have concluded that premiums are increasing at the slowest rate in ten years, suggesting that we are on the right track and that health plans innovations are demonstrating progress. At the same time, the nation is at a crossroads, and our ability to continue to slow the cost trend and provide coverage to all Americans will require a firm commitment to action by all stakeholders.

This section identifies key areas where leadership is necessary, what needs to be done, and provides data on the potential effectiveness of these strategies. A more detailed assessment of these strategies by the consulting firm PricewaterhouseCoopers is in the appendix.

Driving Down Expenditures for Hospital Care, Physician Services, Prescription Drugs and Other Health Services

The strategies outlined in this paper could yield substantial savings for the U.S. health system, provided that a coordinated set of public and private initiatives were launched in the coming years. Taken together, we estimate that the strategies in this report have the potential to reduce national health expenditures by as much as 3.7 percent annually (approximately $145 billion) in the year 2015 (see Table 4).

TABLE 4.
Potential Savings: AHIP Affordability Proposals, Selected Years

	Percent of National Health Expenditures		Potential Savings (Billions)	
	2010	2015	2010	2015
Comparative Effectiveness Research	-0.0%	-0.1%	$0	-$5
Health Information Technology	0.7%	-1.0%	$20*	-$37
Medical Liability Reform, Defensive Medicine	-0.3%	-1.2%	-$9	-$45
Value-Based Reimbursement	-0.0%	-0.3%	-$1	-$11
Disease Management, Chronic Care, Prevention	-0.2%	-1.2%	-$7	-$47
Total, National Health Spending	**0.1%**	**-3.7%**	**$3**	**-$145**

Source: America's Health Insurance Plans and PricewaterhouseCoopers.

Notes: The savings estimates are net of insurers' and health care providers' administrative costs, and include a small reduction to account for "overlap" in the savings estimates. In the area of health information technology, for example, the estimates include approximately $20 billion in costs in the short-term. The estimates do not include the costs of administering a comparative effectiveness program.

The estimated $145 billion in savings reflects a potential annual reduction in national health expenditures by 2015 from these strategies, rather than a budget savings or "score" as often done by the Congressional Budget Office (CBO) when analyzing legislation. Moreover, the estimate has been reduced by approximately $50 billion to reflect the costs of implementing and administering these programs. These costs are most prominent in the areas of health information technology, where initial investment costs are high, and disease management and chronic care programs, where the ongoing administrative expenses are often labor- and provider-intensive.

Two important strategies — comparative effectiveness analysis and medical liability reform — would have system-wide impact and could yield savings of approximately $50 billion annually by 2015. To achieve these savings, sufficient incentives would have to be in place so that health care providers, patients, and insurers (public and private) have a compelling reason to use and develop these tools. Likewise, additional legislation would be needed to realize all of the potential savings in Medicare and Medicaid.

Long a major force in the U.S. health care system, innovation has accelerated rapidly in recent years, and will be among the most important factors to address properly in order to reduce the upward cost trends. The challenge moving forward — as the CBO recently acknowledged in "Technological Change and the Growth of Health Care Spending" — is to ensure that new, more expensive, innovations yield greater value by producing better outcomes than existing, lower cost therapies.

Comparative Effectiveness Research

Americans need a trusted source where they can find up-to-date, objective, and credible information on which health care services are most effective and provide the best value. This new entity, which could be known as a Comparative Effectiveness Board (CEB) should be responsible for:

- Comparing the clinical and cost-effectiveness of new and existing drugs, devices, procedures, therapies, and other health care services;
- Assessing alternative uses of treatments currently in practice; and
- Distributing this information in a useful format so patients and clinicians can make more informed health care decisions.

In the short-term, the estimated savings from a CEB would be relatively modest compared to investment costs, perhaps $5 billion annually by 2015. However, over a long period of time, the establishment of a CEB has the potential to transform our health care system and vastly improve the value we obtain for our health care dollars, especially if payment incentives were modified to encourage value-based purchasing.

Rapid changes in drug development are among the most compelling examples of the growing cost

pressures from new technology. The latest generation of drug therapy, based on complex biologic mechanisms, or "biologics," heralds an era of "personalized" medicine in which treatments can be targeted more precisely for individual patients. The costs of these treatments far exceed those of most all medications currently used. Prices in the range of $50,000 to $100,000 for a course of treatment are not uncommon. Although the cost can be prohibitive, these unproven therapies often represent some hope for seriously ill patients. Recommended next steps include:

- Development of an expedited approval process for generic drugs and creation of an approval pathway for generic biologics to speed up our nation's ability to offer consumers high-quality, lower cost alternatives.
- A focus on developing and strengthening scientific evidence for emerging products that will support innovation by determining which procedures and technologies are safe and effective. This, in turn, will advance efforts to improve the quality and affordability of care.
- Strengthened capacity of the FDA to regularly assess the safety and effectiveness of drugs that have entered the market.

Reforming the Legal System

Medical practice driven by the fear of litigation is too often an unfortunate substitute for evidence-based medicine. The result is billions of dollars worth of medically unnecessary tests and procedures ordered in an effort to avert potential lawsuits. Research suggests that spending for these unnecessary services has been reduced in states that have adopted medical liability reforms. However, these measures also underscore the importance of a comprehensive and uniform national approach, which we estimate could generate savings of approximately $45 billion in 2015.

The current liability system, by increasing utilization without improving value, is at odds with efforts to transform the health care system to one that recognizes and rewards quality. There is a better way to resolve claims of medical negligence and to compensate patients who suffer injuries as a result of malicious or incompetent medical practice.

We believe that the current medical liability system should be replaced with a new dispute resolution process consisting of an independent third-party review process designed to provide fair compensation and quick resolution of disputes, while promoting health care quality nationwide through reliance on evidence-based medicine. This approach would offer a fresh strategy to solve a vital issue that has languished nationally for far too long.

Likewise, greater harmonization among states' statutory and regulatory requirements should be pursued — both by harmonizing state requirements with medical evidence and harmonizing requirements across multiple states. Health insurance plans often are mandated to provide specified benefits — some of which are inconsistent with medical evidence. Moreover, regulatory systems sometimes work at cross purposes with no assessment or coordination of regulatory oversight. Consistent regulation is crucial toward a predictable regulatory environment that fosters competition and encourages the development of novel ideas — that may ultimately evolve into "best practice" solutions.

Accelerating the Adoption of Health Information Technology

In the past five years, health plans have helped revolutionize the field of health information technology (HIT). Use of tools such as electronic health records (EHRs), personal health records (PHRs) e-prescribing, and secure e-visits with physicians have expanded rapidly. However, these tools have not yet become an integral part of health care for the majority of patients and physicians. Low rates of adoption have challenged leaders in the field to continue developing HIT tools so that they will become a valuable — and eventually essential — part of the health care delivery process. To this end, the focus of HIT development has shifted toward integration of electronic tools to create a seamless pathway for personalized, ongoing electronic communication among health plans, providers, and patients to improve patient care.

Despite the fact that health care has trailed other industries in the adoption of information technology, improvements in this area if they are integrated into broader reform strategies hold tremendous promise for advancing quality and efficiency. The ever-evolving initiatives and pilot programs being adopted in the private market highlight the importance of HIT to the U.S. health care system.

Accelerating strategies that promote the widespread adoption of HIT could produce savings of approximately $37 billion annually by 2015. However, that magnitude of savings will require substantial investment and administrative costs, perhaps $20 billion or more before realizing a return on the initial investment. Moreover, maximizing the financial and transformative impact of HIT requires a parallel commitment to producing actionable information at the consumer level and facilitating adoption by the provider community.

To further promote HIT adoption in the clinical setting, leaders in the public and private sectors should work together to:

- Develop and implement a national roadmap for HIT that ultimately would lead to adoption of uniform national standards that allow for interoperable electronic communication across the health care system.
- Expand the use of PHRs in public and private health care programs. Additionally, existing health plan PHR models and standards should be expanded to include lab test results as well as information provided by the consumer, such as family histories, emergency contacts, and over-the-counter medications. Inclusion of this information will facilitate physician access to vital patient information.

Improve the Quality and Safety of Health Services by Promoting Value

In most U.S. economic markets, entities compete based on price and quality, and consumers make decisions based on reliable, accurate information. For a variety of reasons, this has never been the case with health care. Instead, many consumers, having little information to rely on, tend to equate higher costs with better quality, although this often is not the case. In recognition of the issue, the Institute of Medicine (IOM) in its 2001 report, *Crossing the Quality Chasm*, stressed that transparency should be a key element of any strategy to improve clinical quality and achieve better value in the health care system.[61]

The combined impact of actionable consumer information and payment incentives to drive outcomes and competition could produce substantial savings to the health care system. We estimate that adoption of value-based reimbursement would reduce NHE by approximately $11 billion in 2015. This estimate is influenced by data from an existing Medicare demonstration, and could rise as additional evidence becomes available in both the public and private sectors. For example, if the impact of value-based reimbursement rippled more broadly throughout the health system — as has been the case with "tiering" of prescription drugs formularies — the impact could be much more significant.

Meaningful improvements in quality, safety and value depend on significant collaboration with practitioners. In addition to collaboration with the provider community, two factors are equally important to achieving both quality and safety improvements and enhanced value. First, stakeholders, including policymakers, need to ensure consumers are given actionable information, including support tools that help them better understand their options. Second, policymakers need to establish an environment that encourages innovation by promoting competition that will drive value-based decision making throughout the health community.

The private sector has led the way in developing a uniform approach for the disclosure of relevant, useful, understandable, and actionable information to facilitate consumer decision making. Key stakeholders across different disciplines — including health plans, hospitals, consumers, and employers — have convened broad-based, national alliances (AQA and HQA) to determine a uniform strategy for measuring, reporting, and improving physician and hospital performance. To foster the adoption of efficacious and cost-effective treatments and encourage quality improvement while making health coverage more affordable, recommended next steps include:

- An effort initiated by the federal government to measure and report on physician and hospital performance within public programs similar to initiative already undertaken in the private sector.
- Public-private collaboration to aggregate public and private performance data and production of national, regional and local benchmarks for quality that will provide consumers meaningful decision support tools.
- Encouraging payment incentives designed to drive quality improvement by halting overuse of wasteful, inappropriate services that do not produce improved outcomes, while increasing quality by encouraging patients and clinicians to examine both possible clinical outcomes and cost-effectiveness of alternative interventions.

As strategies designed to produce greater value continue to evolve, new models of care delivery that promote care coordination to help manage the overall health and health care needs of individual patients should be tested. Under these models, providers and payers would develop quality and outcomes measures to promote greater predictability of provider payments and cost increases. Demonstrations of these new models are already underway and health plans are committed to working with practitioners to test additional models as they are developed. Federal and state governments should work together to ensure appropriate levels of payment for medical services provided under public programs. Inadequate payment rates in public programs are contributing to the erosion of private coverage. Providers are recouping losses from Medicare, Medicaid, and SCHIP by looking to beneficiaries covered by private plans, thus adding to the cost of insurance and hampering the ability to develop innovative solutions.

Enhance Disease Management, Care Coordination and Prevention Programs

With estimates suggesting that as many as 150 million Americans have a chronic disease (many of whom have multiple conditions), we need a national commitment to improve the lives of individual patients while also adopting initiatives that make the best possible use of our nation's health care dollars. Health plans are developing a new generation of chronic care strategies that contemplate these compatible goals by helping tailor care to the individual patient and helping patients live longer and stay healthier.

We estimate that a sustained commitment to these strategies would produce significant savings for the entire health care system; by 2015 the nation could save an estimated $47 billion in NHE even after when accounting for the administrative costs of implementing these programs. Equally important to the estimated reduction in health expenditures, these savings could be achieved while improving the quality of life for millions of Americans.

Because the roots of most chronic disease lie in personal health habits and lifestyles, prevention, chronic care, and disease management strategies — more than the other recommendations in this paper — require a commitment from individual Americans. Health plans are working to realign incentives to encourage positive behavior, including for example, waiving co-payments and cost-sharing for maintenance drugs for asthma or other chronic conditions. This approach may seem obvious, but will falter without a national commitment, including a regulatory environment that permits health plans and employers to build on the success of earlier strategies.

With health plans, employers, and purchasers looking for solutions to reverse these trends, more must be done to realize the full potential of disease management, care coordination and prevention strategies. Recommended next steps include:

- Creation of a national clearinghouse for the collection of best practices and dissemination of information among employers, government and local communities to accelerate the adoption of evidence-based strategies for care coordination.
- Promotion of flexibility for employers using account-based products to contribute greater funds into the accounts of individuals with chronic illnesses, and government support for further incentives to build on the existing "corridor" for maintenance drugs under health savings accounts.
- Development of a national approach to consumer education and physical fitness, leading with a national discussion aiming to develop new strategies to promote early intervention of preventable disease. This campaign should focus particularly on obesity and related conditions among children and young adults, including highlighting the significance of reversing early indicators of obesity and related disease such as diabetes and cardiovascular disease.

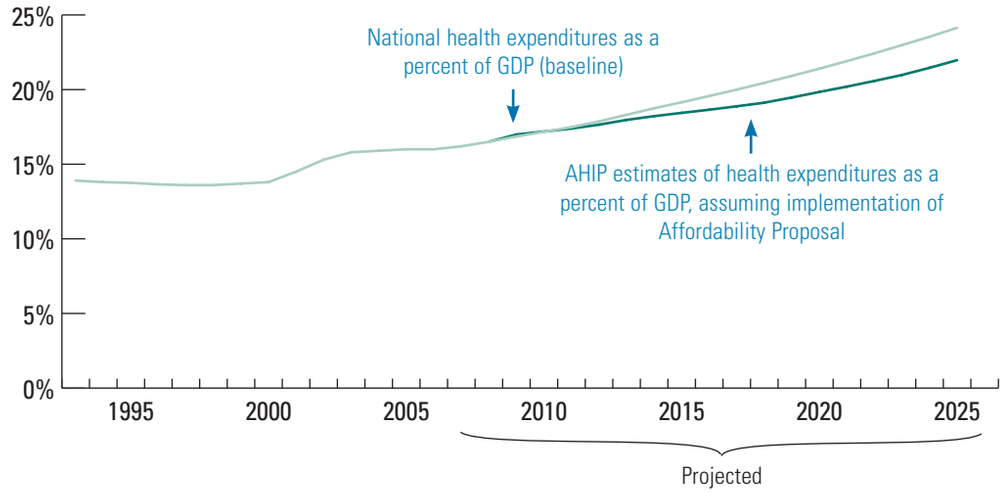
V. Conclusion

America's health insurance plans have played a pivotal role in helping the health care system advance beyond its traditional focus on acute care to provide access to a broad range of life-enhancing services, from wellness and fitness programs to ongoing chronic care and end-of-life services. These changes are improving the quality of care and the quality of life for millions of Americans, while slowing the growth of health costs.

We welcome the challenge of working with policy makers and our stakeholder partners to improve the health care system and extend coverage to all Americans. With this responsibility comes a recognition that lasting reforms will only succeed if they focus equally on improving affordability and quality, as well as expanding access to coverage.

AHIP and PwC estimate that these affordability proposals have the potential to reduce the growth of health spending significantly, from a baseline of 7 percent annually to an estimated 6.4 percent per year. Over time, this would make a big difference -- by 2025, the share of GDP devoted to health spending would be 2 full percentage points lower (see Figure 12).What's needed to actually

FIGURE 12.
Potential Savings from AHIP's Affordability Proposal



Source: America's Health Insurance Plans and PricewaterhouseCoopers.

reduce health costs and ensure that all Americans have access to high-quality, affordable care is a new level of commitment and partnership between government and private-sector leaders. Elected officials, the policy community, and the private sector have reached consensus that now is the time to enhance access to coverage. Because the price tag for inaction grows each day, there is a growing urgency for reform. The U.S. currently spends approximately $50 billion each year to provide health services to the uninsured. We believe that the time is now to eliminate the inefficiencies that occur when uninsured individuals use emergency rooms as a regular source of care and lack access to preventive care or care for chronic illnesses. Reform makes economic sense, will have a positive impact on the nation's productivity and global competitiveness, and is the right thing to do.

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A REVIEW OF AHIP SAVINGS ESTIMATES

Prepared for America's Health Insurance Plans, 2008

by PricewaterhouseCoopers

America's Health Insurance Plans (AHIP) asked PricewaterhouseCoopers (PWC) to assist in estimating the potential cost savings from the AHIP Board's recent set of proposals to improve the affordability of health care.[1] The new affordability proposals complete AHIP's three-pronged approach to health care reform; prior proposals focused on access to health insurance and health care quality.[2]

PricewaterhouseCoopers reviewed AHIP's initial estimates and made suggestions to refine the estimates in each of five areas:

- Comparative Effectiveness Research and Information
- Health Information Technology (HIT)
- Medical Liability Reform and Reductions in Defensive Medicine
- Value-Based Reimbursement
- Disease Management, Chronic Disease Prevention and Wellness

In general, the estimates are based on independent research and industry experience as appropriate. The savings estimated by AHIP for each of these areas in 2025 are shown in Chart 1 below. By 2025, the aggregate saving from all five initiatives would reduce total health spending by roughly 9 percent.

In the absence of any changes, national health expenditures (NHE) are projected to grow by an average annual rate of about 7 percent through 2025, or about 2 percent faster than annual GDP growth. At this rate of growth, the share of GDP devoted to health spending would increase from 16.0 percent in 2006 to an estimated 24.1 percent in 2025. If NHE were reduced by the savings estimated by AHIP, its average growth rate between 2008 and 2025 would fall to 6.4 percent per year (a reduction of 0.6 percentage points annually), and health spending would account for a lower share of GDP (22.0 percent) in 2025.[3]

CHART 1.
As a Percent of National Health Expenditures (NHE), 2025

	Percent
Comparative Effectiveness Research and Information	-0.6%
Health Information Technology	-3.6%
Medical Liability Reform and Defensive Medicine	-1.6%
Value-Based Reimbursement	-0.5%
Disease Management, Chronic Disease Prevention and Wellness	-2.7%
Total	**-9.0%**

Source: PricewaterhouseCoopers summary of calaculations by America's Health Insurance Plans.

Our review of these estimates indicates that the level of savings estimated by AHIP could be achieved if the broad changes proposed in this report were implemented. The savings estimates are small in initial years, because it would take several years to implement the new initiatives. The estimates generally assume long phase-in periods as the policies begin to take effect, and, in the early years, the investment costs may be larger than the savings.

In some cases, the savings appear to be estimated conservatively — that is, the actual savings could be higher if the healthcare industry vigorously adopted these new efforts. For example, initiatives such as comparative effectiveness research could potentially save the U.S. health system more than those estimated by AHIP if incentives were better aligned to use evidence-based care and select the most effective treatment options.

Our analysis of the level of potential savings considered the following criteria:

- How reasonable is the magnitude of the savings relative to the issue being addressed?
- How does the savings estimate compare to other published estimates and to the experience of PwC health industries advisors?
- Do the savings estimates appropriately consider the costs of implementing the changes proposed?
- What changes would be needed to achieve the estimated savings, and how difficult would it be to implement such changes?

AHIP, with input from PwC, adjusted for the potential overlap, or "interaction," between the savings estimates for the five areas of reform, so that the overall savings totals would not be overstated. In fact, some of the proposals could create complementary, or "synergistic," effects that would increase the overall savings, although no such effects were included in the estimates.

On balance, the available research and experience suggest that AHIP's affordability proposals would reduce U.S. health costs significantly over time. A more detailed discussion of the savings estimates follows below.

Comparative Effectiveness Research and Information

The lack of solid information about the effectiveness of many medical procedures and the large variation observed in medical practices are frequently cited as evidence that comparative effectiveness research could lead to major changes in the practice of medicine. According to the Institute of Medicine, "Quality assessment and improvement are knowledge-driven enterprises. We know far more today than in the past. Yet we still do not know enough about what works in medicine and health, for what conditions, under what circumstances, and at what cost to improve the quality of health care to the greatest extent possible. Effectively functioning markets require that patients, employers and other consumers have good information for decision making."[4]

The wide variation in medical treatments has been examined extensively and reported for years by Dartmouth researchers led by John Wennberg. Other studies show wide variation in both the cost and quality of care. For example, one study estimated that up to 30 percent of health care spending pays for ineffective, inappropriate, or redundant care.[5] Moreover, evidence suggests that higher costs are not only uncorrelated with better outcomes, but may, in some instances, be associated with poorer quality care.

"…we still do not know enough about what works in medicine and health, for what conditions, under what circumstances, and at what cost to improve the quality of health care to the greatest extent possible."

— Institute of Medicine, National Academy of the Sciences (1997)

AHIP estimates the savings from comparative effectiveness research and information studies at roughly 0.6 percent of NHE in 2025. This level of savings is within the range of recent independent estimates, which vary from less than 0.1 percent, estimated by the Congressional Budget Office, to more than 1.3 percent, estimated by the Commonwealth Fund.[6] These estimates appear to account for the costs of conducting comparative effectiveness research. Such costs are likely to be small relative to the total potential savings that can be achieved. PwC estimated that the costs of funding studies at a level comparable to the United Kingdom's National Institute for Health and Clinical Excellence (NICE) would be only about 0.03 percent of total premiums.[7]

Savings would be much greater if comparative effectiveness research and information were combined with changes in payment and coverage policies. The current system does not provide incentives to discourage the use of one treatment that is only slightly more effective than another but costs significantly more. If providers and patients were given incentives to use the information from comparative effectiveness research, the savings could be significantly larger than the AHIP estimate. For example, providers who adhere to comparative effectiveness research guidelines and information could be given safe harbors for non-economic and punitive damages when sued for malpractice. Information from comparative effectiveness research also could boost the savings in the other areas; for example, disease management could yield much higher savings if clearer evidence were available about what treatments and protocols work best to manage chronic disease. Incentives in value-based reimbursement could be designed better and made more effective if more were known about which treatments are most effective.

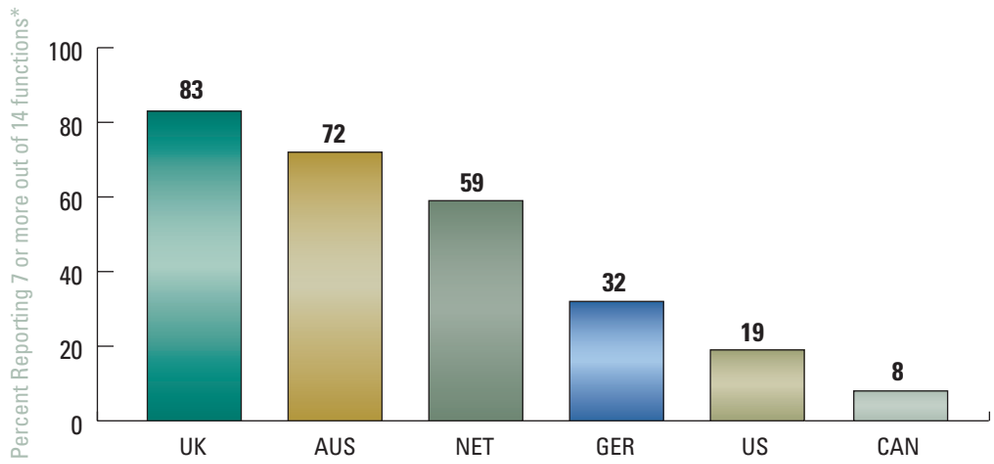
The savings from comparative effectiveness research and information, as a percent of health spending, could continue to increase for decades if it changed the direction of medical technology cost trends. In other words, savings would continue to grow if medical technology became a net cost saver instead of a net cost driver. Many policy analysts believe that technology has been increasing medical costs by as much as two percentage points each year. This growth contrasts with the experience in many other industries, where growth in the use of new technologies has significantly reduced costs. If the effect of technology were reversed from causing two percent growth in health care costs to merely being neutral, healthcare costs would be one-sixth lower than currently projected in ten years and one-third lower in two decades.

The AHIP estimates of potential saving from comparative effectiveness research and information are reasonable and may be conservative if payment policies change to reflect the results of comparative effectiveness studies.

Health Information Technology

The U.S. lags behind other advanced economies in the use of HIT. Whereas the majority of physicians in the U.K., Austria, and the Netherlands report using seven or more health IT tools in their offices, just 19 percent of U.S. doctors use these tools (see Chart 2).

CHART 2.
Primary Care Practices with Advanced Information Capacity, 2006



* Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, presriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt test reults; easy to list diagnosis, medications, patients due for care.

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicans

Adoption of new medical technologies has been slow in the past due to problems associated with cost. Physicians, who would have a central role in the implementation of the new health information technologies, do not always have an incentive to make the necessary investments. Furthermore, because most doctors in the U.S. work in independent group practices rather than in integrated health care systems, it is difficult to implement HIT solutions that are interoperable on a national or regional basis.

The following three changes are necessary to make HIT work effectively on a national level:

- Widespread adoption of HIT by health care providers;
- Interoperability, or use of consistent data standards across all stakeholders; and
- The adoption of strong, uniform privacy and security policies.

In the past five years, the health care sector has started to introduce a variety of new tools in the field of health information technology. Use of tools such as electronic health records (EHRs), personal health records (PHRs), secure e-visits with physicians, and e-prescribing are beginning to be applied and utilized more broadly. In order to realize the potential savings, additional HIT investments will be necessary in the provider community to better monitor and streamline the delivery of care and to enable improved transfer and retrieval of medical information. Adoption of these tools would enable patients to view key health information entered by health care providers and health plans, enter new information themselves, make appointments and order prescription refills online, and communicate with physicians on an ongoing basis about their health conditions. Likewise, new HIT tools in emergency rooms would allow doctors to access patients' medical and pharmacy records to help prevent errors, unnecessary duplication, and adverse reactions.

Widespread adoption of electronic pharmacy claims processing in the past 15 years shows how government can act as a catalyst in the diffusion of HIT. Following enactment (and subsequent repeal) of the Medicare Catastrophic Coverage Act of 1988, pharmacies were required to submit claims electronically as a condition of receiving Medicare payment. As a result, more than 50,000 retail pharmacies in the U.S. integrated their pharmacy management systems with those of pharmacy benefit managers (PBMs). Now virtually 100 percent of pharmacy benefit claims are processed electronically at the point of sale. If lessons learned from the experience in the pharmacy realm can be applied more broadly as part of a national HIT strategy, we will be well on our way to an interconnected, interoperable health care system.

These new integrated, interactive and personalized tools can help to enable both patients and health care providers to make health care decisions based on accurate, up-to-date information about patients' health status and effective treatments.

Assuming that AHIP's recommendations are implemented, HIT improvements will be able to reduce costs substantially, improve health care quality, and save lives. AHIP estimates that savings from widespread adoption of HIT systems will grow in 15 years to 10.3 percent of total spending on hospital services and 5 percent of spending on physician services. After accounting for an increase in administrative costs to pay for the new systems, net savings would represent a 3.6 percent reduction in NHE in 2025. The net savings estimate for HIT also includes a reduction of 0.3 percent of NHE to account for possible overlap with other savings estimates in this report (see "Timing, Interactive Effects, and Conclusion" below).

The AHIP savings estimates are derived from a recent study by RAND[8] and are much larger than a recent estimate by the Commonwealth Fund.[9] The latter estimate (0.5 percent of NHE) was based on legislation providing limited federal funding for HIT rather than on the broad-based HIT adoption as envisioned by RAND.

AHIP's estimates for potential savings from health information are consistent with the best available evidence. Achievement of these savings will require significant leadership from the federal government to overcome traditional barriers to adoption.

Medical Liability Reform and Reductions in Defensive Medicine

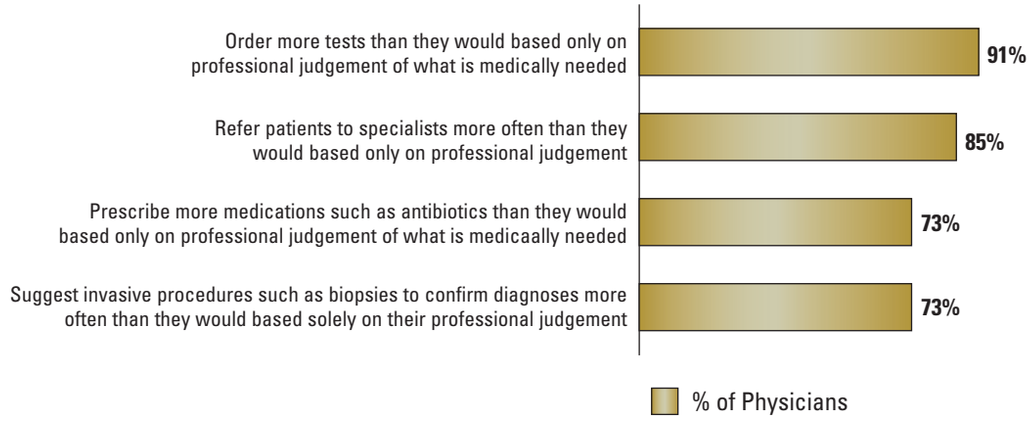
Large medical malpractice awards and high premiums for malpractice insurance receive considerable press attention. For example, medical liability costs in 2003 were $26 billion, a 2,000 percent increase over 1975. The high cost of settlements, however, is only a small part of the total cost of medical liability. To avoid lawsuits, physicians engage in what is known as "defensive medicine." In a recent Harris Interactive survey, a large majority of physicians said they were engaged in practices constituting defensive medicine, such as ordering unnecessary tests and prescribing more medications than they deemed medically appropriate (see Chart 3).

Medical liability reform that reduces the magnitude of awards would likely reduce not only the number of lawsuits but also the costs resulting from defensive medicine. AHIP estimates the savings from medical liability reform, when fully implemented, would reduce national health spending by about 1.6 percent. As a comparison, PwC estimated the combined costs of medical liability settlements and defensive medicine at 10 percent of total premiums in 2005.[10] The AHIP estimates are based on a study by Kessler and McClellan, which estimated that medical costs were 5 percent to 9 percent higher in states that had not enacted medical liability reform.[11] The AHIP estimate is consistent with the assumption that savings of 7.5 percent of medical costs are possible in states that have not instituted reforms.[12]

AHIP's estimate of potential savings from medical liability reform and reductions in defensive medicine are reasonable assuming a substantial reduction in the level of medical liability rewards, as well as a change in judicial processes.

CHART 3.

Physicians Opinions on the Impact of Malpractice Liability on their Behavior



* Physician Responses to the Question: "Based on your experience, have you noticed the fear of malpractice liability causing physicians to . . .?"

Source: Harris Interactive, Inc., Strategic Health Perspectives, July, 2003.

Value-Based Reimbursement

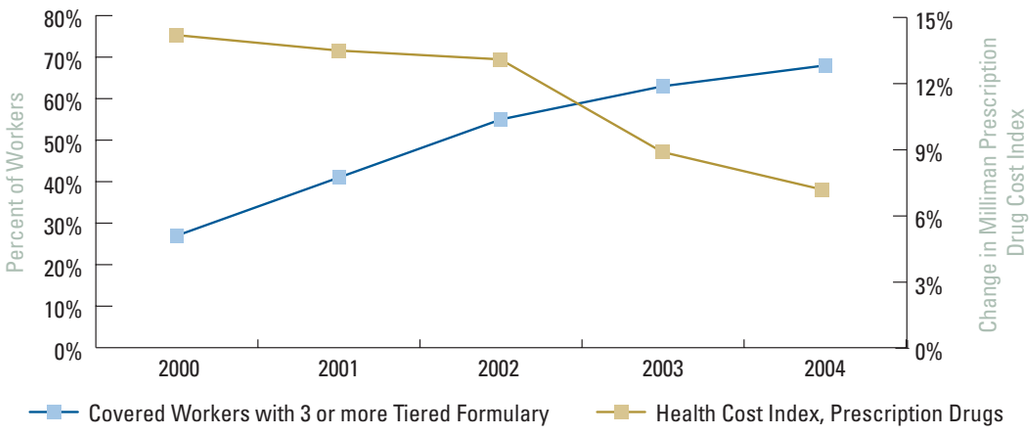
Payments and incentives in the healthcare system often fail to encourage high-quality or efficient delivery of services. For example, fee-for-service payments reward health care practitioners for providing more services rather than for the quality of services delivered. Consumers typically have the same cost-sharing for individual treatments, regardless of whether those treatments are based on medical evidence of effectiveness. The goal of value-based reimbursement is to change incentives by: (1) rewarding providers who deliver higher quality, more effective care according to the evidence; and (2) guiding consumers to more value-based providers and treatments.

AHIP estimates that a widespread expansion in value-based reimbursement programs over the next 10 years would reduce both hospital and physician spending by one percent, or approximately 0.5 percent of NHE. In one study, the Commonwealth Fund estimated that the savings from one specific type of value-based incentive limited to Medicare hospital payments would save as much as 1.1 percent of Medicare costs.[13]

Another example of value-based reimbursement is the use of tiered cost sharing for consumers, under which prescription drug copayments vary depending on whether a drug is generic or brand-name, and whether it is on the health plan's preferred list.[14] As indicated in Chart 4, the introduction of tiered copayments in the design of prescription drug plan designs coincided with the decline in the growth in prescription drug prices from 14.2 percent in 2000, when only about one-quarter of employers had multi-tier plans, to 7.2 percent in 2004 when more than two-thirds had them.[15] Growth in prescription drug costs appears to be inversely related to the number of employers with multi-tier plans. This example shows that significant change can take place in a few years.

CHART 4.

Comparison of Tiered Prescription Drug Formularies and Prescription Drug Cost Index, 2000–2004



Sources: Kaiser Family Foundation, "Employer Health Benefits 2004 Annual Survey," September 2005; Strunk, B.C. et al., "Tracking Health Care Costs: Declining Growth Trend Pauses in 2004," Health Affairs Web Exclusive, June 21, 2005.

Medicare is experimenting with value-based reimbursement to hospitals. For example, the Premier Hospital Alliance is conducting a project with Medicare that offers financial incentives to participating hospitals for meeting certain quality standards. Some payers are discussing the adoption of value-based reimbursements by directing contracting volume to providers that meet established quality goals. Those that do not meet the goals would be excluded from contracted networks. This approach could yield higher savings but faces crucial challenges, such as consumer acceptance, reliability of information, and physician supply.

Although the evidence is limited for value-based reimbursement systems for hospitals and physicians, the early reports seem promising. To maximize impact, value-based reimbursement would apply to both consumers and providers, and would apply not only to prescription drugs, but also to hospital and physician care.

The potential for value-based reimbursement to expand beyond the prescription drug area and to engage health care providers as well as consumers is vast, but mostly untested. PwC, in a recent report, found that value-based payments often were too low to significantly change provider behavior.[16] Specifically, the reported payment levels ranged from one percent to eight percent of total base physician reimbursement, whether in the form of bonus or fee schedule increase.[17] Furthermore, these payments generally are not coordinated across payers and thus have minimal impact on total provider reimbursement. To maximize impact, value-based reimbursement would apply to both consumers and providers, would be coordinated across the industry, and would take into account, not only prescription drugs, but also hospital and physician care.

AHIP's estimate of potential savings from value-based reimbursement appears to be conservative and could be much larger if efforts were coordinated and applied broadly across the system.

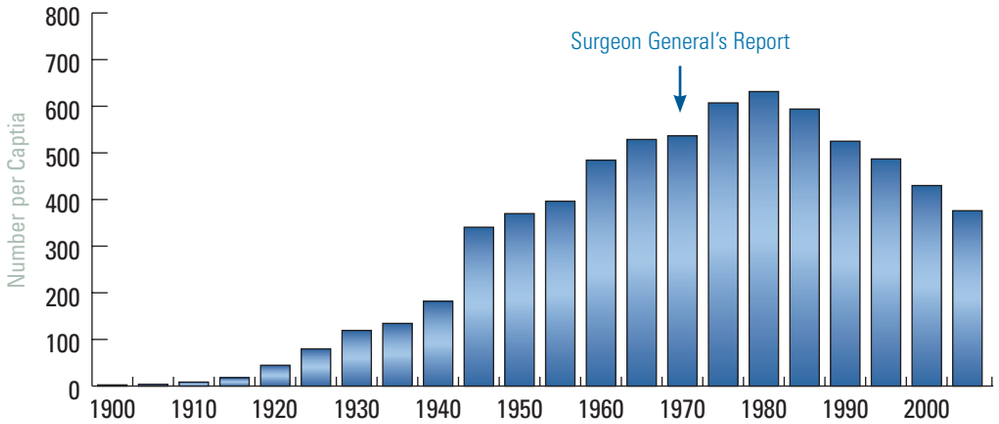
Disease Management, Chronic Disease Prevention and Wellness

Many chronic diseases, which increase medical costs and cause premature death, are preventable. For example, obesity increases the incidence of high blood pressure, heart disease and stroke, and is a major contributor to diabetes. Smoking increases the incidence of cancer and circulatory diseases. Changing Americans' behavior could lead to improved prevention and management of chronic diseases and save not only medical costs but years of life.

Based on the PwC analysis presented below, AHIP estimates that improvements in disease management, chronic disease prevention and wellness could save 2.7 percent of NHE by 2025. This amount represents the difference between estimated gross savings of 4.3 percent and estimated costs of 1.6 percent to implement the new programs. This estimate is based on actuarial estimates extrapolating from current research, and it incorporates savings from reversing the epidemic growth of obesity (70 percent of the 2.7 percent), enhancing smoking cessation initiatives (10 percent), and improving chronic care coordination and management (20 percent).

In considering this potential for changing the behavior of Americans, it is worthwhile to review the progress made on smoking cessation in past decades. The reduction in smoking rates following the Surgeon General's Report of 1964 is a good example of how unhealthy behavior can be slowed and then reversed as a result of strong leadership, public and private policy initiatives, and broad societal change. Chart 5 shows that the growth in cigarette consumption slowed in the initial years following the report's release, and, within 15 years, the absolute level of consumption declined. Additional savings from smoking cessation could be realized with additional interventions.[18]

CHART 5.
Per-Capita Annual Cigarette Consumption, United States, 1900–2007



Source: Tobacco Outlook Report, Economic Research Service, U.S. Dept. of Agriculture; downloaded on January 11, 2008 from: http://www.infoplease.com/ipa//A0908700.html

Were the path of the obesity epidemic to follow the same course as smoking rates in the 1960s and 1970s, for example, the percentage of obese individuals in the United States could be reduced over the next 10 years to approximately 23 percent of the population (the same level it was as recently as five years ago).[19] The Congressional Budget Office has estimated that obesity may have increased NHE by between 1.4 percent and 12 percent from 1987 to 2001.[20]

The final component of our estimate — improvements in chronic care coordination and management — is a factor that experts have long recognized. There is considerable potential value of reducing variations in medical practice and enhancing patient compliance with care plans associated with chronic disease.[21] While the quantitative research on the savings associated with chronic care management is still immature, there is anecdotal evidence that efforts to improve adherence to practice protocols and patient compliance offer significant savings opportunities.[22] Given that over 75 per cent of health care spending is for people with chronic conditions,[23] there is considerable opportunity to realize significant potential savings from chronic care management programs. Greater standardization and coordination of protocols, processes and provider interfaces in these efforts would likely enhance the effectiveness of these efforts.

Achieving major changes in health behaviors will likely require disciplined, collaborative and continuous efforts that include education, interventions, incentives and policy changes in both the private and public sectors. Strong values in our society led to fights about mandatory seat belt use, but eventually, the vast majority of Americans came to accept that the infringement on personal liberty was worth the lives saved by seat belts. Similarly, over decades, Americans came to know that smoking was harmful, not only to smokers, but also to those breathing secondhand smoke. Improving individuals' diet and exercise habits to mitigate the obesity epidemic takes place on the same battleground. New York City banned trans-fats in restaurants over fierce opposition. More and more local school districts are grappling with the tradeoff between unhealthy snacks and vending machine revenues used to support school programs.

AHIP's estimates of potential savings from disease management, chronic disease prevention and wellness are reasonable if concerted and complementary public and private efforts were enabled and implemented to improve health behaviors in the U.S.

Timing, Interactive Effects, and Conclusion

PwC examined timing for achieving savings from AHIP Section 1s recommendations, as well as the magnitude of projected savings. The types of health care system changes that AHIP recommends will take time to implement. Thus, AHIP Section 1s estimated savings are small in the early years but increase over time.

One final question that arises is whether the sum of the individual estimates overestimates the total savings because the recommended policies overlap. A careful review of the evidence suggests that only three of the areas are large enough for overlap to be an issue: (1) Health Information Technology; (2) Disease Management, Chronic Disease Prevention and Wellness; and (3) Medical Liability Reform and Defensive Medicine. Examination of the savings estimates in these major areas, however, revealed that they have very little overlap. Based on our analysis, AHIP reduced the initial savings estimate for only the largest savings area — health information technology — by 0.3 percent of NHE to account for possible overlap.

On the other hand, HIT improvements could lead to complementary or synergistic interactions with the other four areas discussed in this report. Better information makes it possible to develop metrics on which to base value-based reimbursement systems, and HIT makes it possible to compare treatment regimens to recommendations from comparative effectiveness studies. Finally, HIT is a major enabler of more effective monitoring of chronic conditions and improving outcomes. However, AHIP did not include estimates of potential savings from these possible interactive effects.

Overall, based on available research, PwC concluded that the level of savings estimated by AHIP is reasonable if the broad changes proposed in this report were implemented. In several cases, AHIP Section 1s estimates are conservative relative to the levels achievable if more aggressive industry actions followed from these efforts.

Endnotes

1 America's Health Insurance Plans, A Shared Responsibility: Advancing Toward a More Accessible, Safe, and Affordable Health Care System for America (May 2008)

2 For AHIP's access proposal, please see America's Health Insurance Plans, "A Vision for Reform," Federal Access Proposal (November 2006) available at http://www.ahipresearch.org/PDFs/vision_of_reform.pdf ; for AHIP's quality proposal, see America's Health Insurance Plans, "Setting a Higher Bar," (April 2007) available at http://www.ahip.org/content/fileviewer.aspx?docid=19476&linkid=167556 .

3 The GDP and health spending forecasts were derived from simple extrapolations of the NHE projections for 2006-2016 from the Centers for Medicare and Medicaid Services, available at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf .

4 Institute of Medicine, National Academy of Sciences, Preparing for the 21st Century: Focusing on Quality in a Changing Health Care System (1997), p.4.

5 Fischer, E. Wennberg, D., et al., The Implications of Regional Variations in Medicare Spending: Part 2, Health Outcomes and Satisfaction with Care, Annals of Internal Medicine 2003; 138: 288-98.

6 For the low-end estimate, see Congressional Budget Office, Research on Comparative Effectiveness of Medical Treatments (December 2007). The larger estimate comes from the Commonwealth Fund, Bending the Curve: Options for Achieving Savings and Improving Value in the U.S. Health Spending (December, 2007).

7 PricewaterhouseCoopers estimate reported in PwC Spotlight: "House-passed SCHIP bill contains new tax on health insurance" (August 17, 2007).

8 Girosi, Federico, Robin Meili, and Richard Scoville, Extrapolating Evidence of Health Information Technology Savings and Costs (RAND, 2005).

9 Commonwealth Fund, 2007, op. cit.

10 The Factors Fueling Rising Healthcare Costs 2006, PricewaterhouseCoopers (2006).

11 Kessler, Daniel P., and Mark B. McClellan, "Medical Liability, Managed Care, and Defensive Medicine," Stanford Law and Economics Olin Working Paper No. 191 , February 2000 (Revised: February 23, 2001).

12 The estimate that savings as a percent of NHE is 1.6 percent is based on half the 7.5 percent applied to only to physician, hospital, and prescription drug spending.

13 Commonwealth Fund, 2007, op. cit.

14 For example, the patient may pay a copayment of $10 for a generic drug, $20 for a preferred generic, and $40 for other branded drugs that are not on the preferred list.

15 Kaiser Family Foundation. "Prescription Drug Trends," October 2004.

16 PricewaterhouseCoopers, Keeping Score: A Comparison of Value-Based Purchasing Programs Among Commercial Insurers (2007).

17 Commonwealth Fund, 2007, op. cit.

18 The estimates were based on a number of studies including the following: Staff of the Joint Committee on Taxation, "Modeling the Federal Revenue Effects of Proposed Changes in Cigarette Excise Taxes," (October 19, 2007) JCX-101-07; De Vol, R. et al., "An Unhealthy America: The Economic Burden of Chronic Disease", Milken Institute, October, 2007; and Anderson, D. et al., op. cit.

19 The dollars associated with this projected variance from a "no-change" baseline scenario are based on estimates developed by the HERO study trended forward. See Anderson, D. et al., "The Relationship between Modifiable Health Risks and Group-level Health Care Expenditures," American Journal of Health Promotion, Vol. 15, No. 1, (September/October, 2000), pp. 45-52.

20 Statement of Peter R. Orszag before the Committee on the Budget, U.S. Senate, January 31, 2008.

21 For a discussion of the opportunities to improve outcomes and reduce costs by investing in wellness programs, see PricewaterhouseCoopers, Working Towards Wellness: Accelerating the prevention of chronic disease, World Economic Forum (2007).

22 See, for example: Congressional Budget Office, "An Analysis of the Literature on Disease Management Programs," (October, 2004).

23 National Center for Chronic Disease Prevention and Health Promotion, www.cdc.gov, 2005

THE ADMINISTRATIVE COSTS OF PUBLIC AND PRIVATE HEALTH INSURANCE

by PricewaterhouseCoopers

PricewaterhouseCoopers was asked by American's Health Insurance Plans to analyze the role of administrative costs in private plans, their contribution to healthcare services, their relationship to premiums, and their comparability to Medicare administrative costs.

Our findings, which are presented in more detail below, are as follows:

- Health insurance premiums are driven by growth in the underlying costs of health benefits, such as those for physician and hospital services and pharmaceuticals, not administrative expenses.
- Administrative expenses are incurred for basic functions of health insurance such as paying claims, but a significant portion of administrative costs go to services for consumers, purchasers and providers. These administrative costs, such as those devoted to improved information technology, help to hold down costs, and can lead to improved care.
- Comparisons of private administrative costs with those for Medicare should be viewed with caution because of differences in the populations served and services provided. Medicare lacks parallels to many of the value-added services provided value added services provided by the private sector.

Background

Administrative expenses, which are sometimes "net cost of private health insurance," comprise roughly 13 percent of total health insurance premiums. The nature of administrative expenses can be better explained by an estimated decomposition into the following components (as shown in Exhibit 1):

- **Consumer Services, Provider Support & Marketing (4%).** In addition to marketing and sales, this component includes communications with consumers regarding their existing and new benefits, disease management programs, care coordination, health promotion, wellness and prevention programs, and related investments in health information technologies that benefit consumers.
- **Government Payments & Compliance (2%).** Taxes on premiums, costs of complying with government laws and regulations such as filing and reporting requirements and the recent Health Insurance Portability and Accountability Act are included in this cost component.
- **Claims Processing (3%).** One of the major components is claims processing. Insurance plans have to process — collect, review, pay, and record — every claim that comes in from plan enrollees.
- **Other Administrative Costs (1%).** Other administrative activities that support health plan operations are included in this component including premium collection, actuarial and underwriting services.
- **Risk and Profit (3%).** Health plan profits are available to meet risk-based capital needs, to support continued reinvestment into the system, and to provide a reasonable return to attract investors (or, in the case of not-for-profit plans to pay interest on borrowed funds).

EXHIBIT 1.
Private Health Insurance Plan Administrative Costs as a Percentage of Premium (Estimates for 2006)

Premium	100%
Benefit Costs	87%
Administrative Costs	13%
Consumer Services, Provider Support & Marketing	4%
Government Payments & Compliance	2%
Claims Processing	3%
Other Administrative Costs	1%
Risk and Profit	3%

Source: PricewaterhouseCoopers calculations based on CMS National Health Expenditure Data, 1960–2006

Impact of Administrative Costs on Health Insurance Premiums

The cost of health benefits is the primary driver of premiums for two reasons. First, the underlying cost of benefits drives premiums because medical benefit costs account for the bulk of health insurance spending (87 percent of the premium). Second, medical benefit costs have grown at a faster rate than administrative costs over the long term. When both of these factors are considered, the cost of benefits has nine times the impact of administrative costs on the growth in health insurance premiums. As shown in Exhibit 2 below, over 40 years, the real costs of private health insurance have grown at an annual rate of 5.2%. Benefits, as measured by the cost of healthcare services to members, have grown at real rate of 5.3% over the same time period. Administrative costs have grown more slowly, at a real rate of about 4.9% since 1966.

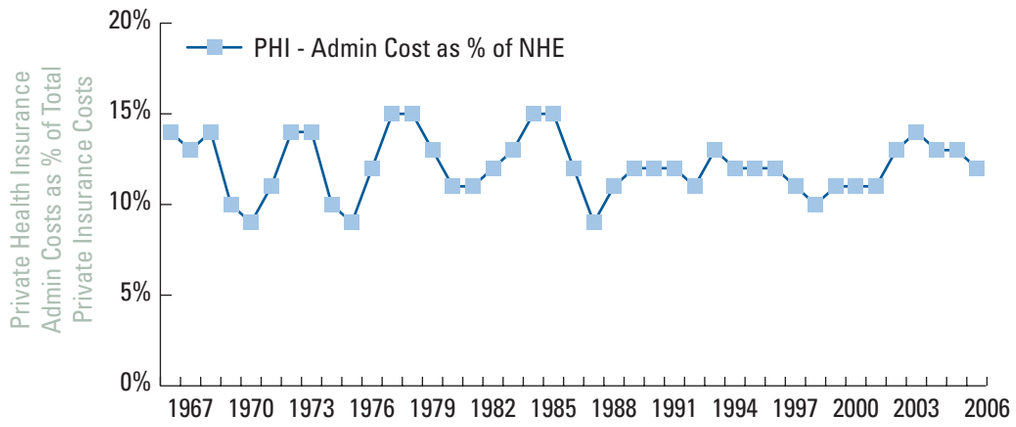
EXHIBIT 2.
Premiums, Benefits, and Administrative Costs Real Per Capita Growth, 1966–2006

	Per Capita Growth	Impact on Premium Growth	Share of Premium Growth
Premiums	5.2%	5.2 %	100.0%
Benefits	5.3%	4.7%	90.0%
Administrative Costs	4.9%	0.5%	10.0%

Source: *PricewaterhouseCoopers* calculations based of the CMS National Health Expenditure Data, 2008

As shown in Exhibit 3, administrative costs have been relatively stable as a component of total premiums. Administrative costs as a percentage of National Health Expenditures has hovered around 12 percent over the past 40 years. There has been a slight downward trend in administrative costs, which appear to have fluctuated much less in the most recent period. The impact on the overall trend in premium rates is small. Over the long haul, premiums grow at the rate of increase in underlying costs (such as those for physician and hospital services and pharmaceuticals) and administrative costs remain at roughly the same percentage of the total premium. Over the past few years, health insurance administrative costs have grown at a pace (approximately 2 percent) well below the overall growth in health spending (approximately 7 percent).

EXHIBIT 3.
Modeling Per Capita Private Health Insurance Administrative Costs (1966–2006)



Source: PricewaterhouseCoopers calculations based on CMS National Health Expenditure Data, 1960–2006

Apples and Oranges: Comparing Private Plan and Medicare Administrative Costs

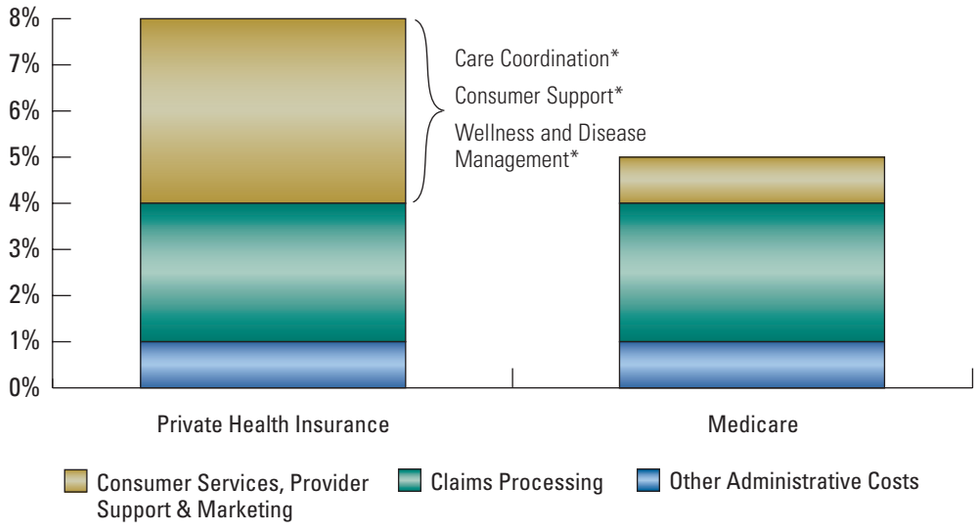
Private administrative costs are sometimes compared to Medicare's administrative costs without reference to the significant differences in the two programs and their target populations. Medicare administrative costs as a percent of total costs are estimated to be approximately 5 percent as compared to an estimated 13 percent for private plans. To start, they enroll very different populations with different costs per enrollee. On a per capita basis, Medicare monthly costs are about $750 per beneficiary compared to roughly $350 per member per month in private plans.

The differences go far beyond the underlying costs of the two programs. Private insurers develop a range of products, sell them to an under-65 population, develop and support provider networks, promote wellness and prevention, offer disease management services, access to health information, and offer consumer support services related to choice of providers and treatment plans. Traditional Medicare primarily provides basic coverage to a designated population, primarily seniors, without health management services, provider networks, or consumer choice of benefit packages. Private plans frequently pay state and local taxes from which Medicare is exempt. Similarly, private plans are required to meet "risk based capital requirements" as well as pay appropriate returns to investors. Medicare is financed not only through premiums, but through taxation and government borrowing. The comparison is complicated further because some of Medicare's cost of capital — for example, the interest cost of the share of national debt due to Medicare spending — is not included in the calculation of the program's administrative costs.

Exhibit 4 below provides a side-by-side comparison of some of the value-added administrative costs in a typical private plan and Medicare for a typical year.[2] The performance of Medicare and private plan is quite similar in the areas where they are most comparable — Claims Administration and Other Administrative Costs. In these areas, Medicare and private plans both have roughly 4% administrative costs. Medicare lacks many important benefits that are deemed administrative in nature including Consumer Services, Provider Support, and Marketing (as shown in the yellow-shaded area). Medicare has very little marketing expenses and provides minimal support related to consumer education, disease management, and network development. In addition, the Medicare program provides a floor of coverage, which is often complemented by enrollment in supplementary plans — all but about 10% of Medicare beneficiaries also enroll in other private insurance plans, such as Medigap, Medicare Advantage, Medicaid, and employer-based coverage.

EXHIBIT 4.

Comparison of "Value Added" Administrative Costs



Source: PricewaterhouseCoopers
Note: * Denotes services that Medicare does not provide

Conclusion

Based on our analysis, PricewaterhouseCoopers concludes:

- Health insurance premiums are driven by the costs of health benefits, not administrative expenses.
- A significant portion of administrative expenses go to value-added services for consumers, purchasers and providers.
- Comparisons of private administrative costs with those for Medicare should be viewed with caution because of differences in the populations served and services provided.

Endnotes

1 The U.S. Centers for Medicare and Medicaid Services provides data on the net cost of private health insurance. This data showed administrative expenses comprised 12.3 percent of total premiums in 2006. This data series includes the administrative costs of private health insurance and third-party administrators for employer plans, individually purchased health insurance, Medigap, and long-term care insurance. The 13% estimate shown here reflects an adjustment for non-medical coverages included in this data. See the National Health Expenditure Historical and Projections 1965-2016 at the website: http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp

2 Exhibit 4 compares the 'value-added' administrative costs and, therefore, excludes costs of capital, risk, profits, government payements & compliance..

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