THE HENRY J. KAISER FAMILY FOUNDATION

# Health Care and the 2008 ELECTIONS

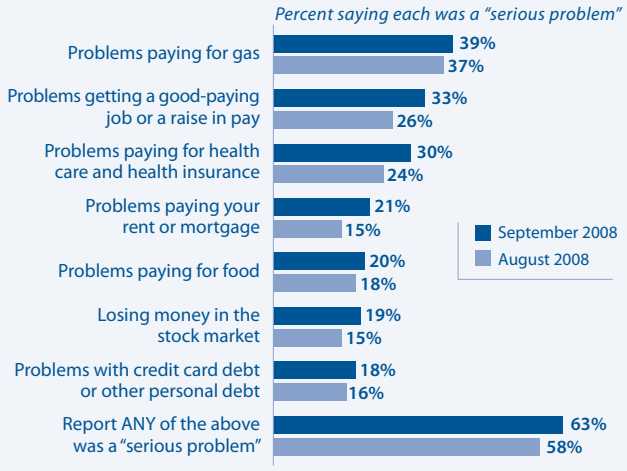
OCTOBER 2008

## Health Care Costs

The high and rapidly rising cost of health care affects the financial security of families and the economic health of the nation. Thirty percent of respondents in a recent Kaiser Poll reported that they had experienced a serious problem paying for health care and health insurance as a result of recent changes in the economy, and a recent study found that 10% of people with problems paying medical bills were denied care because of medical bills.[1] In 2004, 18% of the nonelderly population had out-of-pocket health costs that exceeded 10% of their disposable income.

### Problems Paying for Health Care Compared to Other Problems

**As a result of recent changes in the economy, have you and your family experienced any of the following problems, or not? Was this a serious problem, or not?**




SOURCE: *Kaiser Health Tracking Poll: Election 2008 (conducted July 29 – August 6, 2008 and September 8 – 13, 2008)*

### KEY FACTS ON HEALTH CARE COSTS

- Health spending in the United States is an estimated $2.4 trillion in 2008, an average of $7,868 per person
- The share of the economy (GDP) devoted to national health spending has increased from 7.2% in 1970 to an estimated 16.6% in 2008
- Eighteen percent of the nonelderly were in families that spent over 10% of their disposable on out-of-pocket health care premiums and cost sharing in 2004
- Almost one-in-four respondents in a recent Kaiser Poll reported experiencing a serious problem paying for health care and health insurance as a result of the recent economic turndown

At a national level, health care accounts for a large and growing slice of the overall U.S. economic pie. The growth in health expenditures routinely outpaces growth in income, making health insurance less affordable for all Americans and making it more costly to extend coverage to the over 45 million Americans who are uninsured. These rising health costs also make public health programs more difficult to sustain, straining federal and state budgets.

Finding a way to address high costs and cost growth without unreasonably reducing access to new and needed services is a significant challenge. How the candidates for the upcoming election propose to address the challenges posed by the increasing costs of health care is a critical component of the current political debates.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The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible information, research and analysis on health issues.

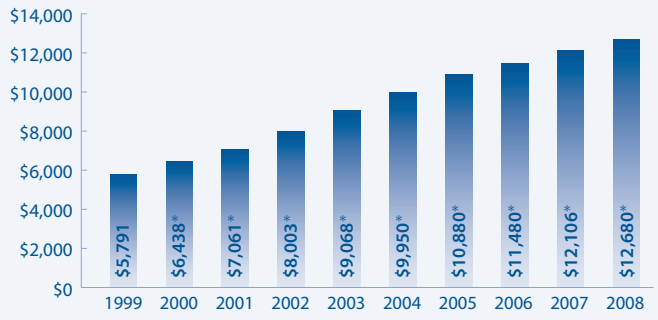
## BACKGROUND

Expenditures on health care have outpaced the growth in national income over each of the recent decades. Between 1970 and 2008, the share of the economy going to health care rose from 7.2% to an estimated 16.6%, or from about $356 per person in 1970 to an estimated $7,868 per person in 2008. Total health spending in the United States in 2008 is an estimated $2.4 trillion.

### Impact on Health Insurance Costs

Although Americans benefit from this increasing investment in health care, its high cost and persistent cost growth are placing great strains on the systems we use to finance health care, including private employer-sponsored health insurance coverage and public insurance programs such as Medicare and Medicaid. Employer-sponsored health coverage premiums for family coverage have increased by 97% since 2000, from $6,438 to $12,680 in 2008. Medicare and Medicaid spending have also been increasing. Medicare per enrollee expenditures for 2008 are estimated to be about $11,093, an increase of 96% over 2000 expenditures.[2] Part of the reason for the increase in the Medicare spending was the implementation of the Medicare prescription drug benefit in 2005. Medicaid per enrollee expenditures increased from $5,763 in 2000 to an estimated $6,610 in 2006 (the latest year available), about a 15% increase.[3] The rate of increase for Medicaid is relatively low because a portion of Medicaid drug spending for beneficiaries eligible for both Medicare and Medicaid was transferred to Medicare when the Medicare prescription drug benefit was enacted.

**Average Annual Premiums for Family Coverage, 1999 – 2008**




*Estimate is statistically different from estimate for the previous year shown (p<.05).

SOURCE: *Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008.*

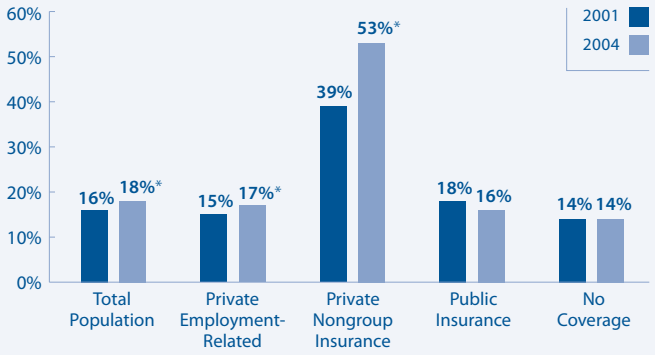
### Impact on Families and Affordability of Coverage

Families have seen significant increases in out-of-pocket costs in recent years. Since 2000, the average worker contribution for a family health insurance policy has increased 107%, from $1,619 to $3,354. In addition to premium contributions, families may face significant out-of-pocket costs when they seek services. Over the last three years (2006 to 2008), the percentage of workers with coverage in plans with a deductible of at least $1,000 for single coverage has risen from 10% to 18%; for covered workers in small firms the percentage has increased from 16% to 35%.

For families purchasing coverage directly from insurers (sometimes referred to as non-group or individual health insurance), a recent survey by America's Health Insurance Plans (AHIP) found that the average costs for family coverage in 2006/2007 were $4,309 for a family headed by a person age 30-34 and $7,881 for a family headed by a person age 55 to 59.[4] Deductibles for family policies in the individual health insurance market averaged $2,753 for preferred provider and point-of-service plans and $5,329 for plans that permit purchasers to have a health savings account or medical savings account.[5]

Premiums and point-of-service cost sharing can result in families paying a considerable share of their resources for health care. In 2004, 18% of the nonelderly population overall and one-half of the nonelderly with non-group health insurance had out-of-pocket health costs that exceeded 10% of their disposable income. In a recent Kaiser Poll, 30% of respondents (including the elderly) reported that they had experienced a serious problem paying for health care or health insurance as a result of recent changes in the economy.[6] Another recent study found that people with problems paying medical bill are much more likely to report having unmet health care needs, and 10% reported being denied care due their medical bill problems.[7]

**Prevalence of High Out-of-Pocket Burdens Among the Nonelderly, by Insurance Status, 2001 vs. 2004**




*Statistically significant change between 2001 and 2004 (p<.01).

Note: All amounts are in 2004 U.S. dollars. Total financial burden includes all out-of-pocket payments for health care, including premiums. Insurance status is based on monthly indicators and reflects coverage for the whole year. People with multiple coverage are assigned the coverage with the longest duration.

SOURCE: *Banthin, J., Cunningham, P., and Bernard, D., "Financial Burden of Health Care, 2001-2004," Health Affairs, vol. 27, no. 1, January/February 2008, pp. 188-195.*

## WHY HEALTH CARE IS COSTLY

A variety of factors help explain why health care costs are so high and why they grow so rapidly. One factor is expanding wealth. Studies looking at the United States and other economies have found a strong correlation between wealth and health care spending as nations become wealthier they choose to spend more of that wealth on health care.[8]

The availability of new treatment options is another important factor. Nations can spend more because the health care community continues to learn more every day about human health and health care conditions and is able to expand the inventory of health care products, techniques and services. Health experts point to the development and diffusion of medical technology as primary factors in explaining the persistent difference between health spending and overall economic growth, with some arguing that new medical technology may account for about one-half or more of real long-term spending growth.[9] Some also suggest that the high prevalence of health insurance encourages technology development because those who develop new technologies know that insurance (and the government through public programs and health insurance tax subsidies) will bear a substantial share of any new costs.[10]

The prevalence of chronic diseases such as diabetes, asthma, and heart disease, coupled with growing ability of the health system to treat the chronically ill, also contributes to the high and growing levels of health spending. About 45% of Americans suffer from one or more chronic illnesses, which account for 70% of deaths and about 75% of all health care spending.[11] Rising obesity levels have been identified as a factor in growing prevalence of some chronic diseases such as hypertension and diabetes. Other population trends however, such as lower levels of smoking and alcohol consumption, may be having a favorable impact on health and costs.[12]

Tax incentives that encourage workers to demand comprehensive health benefits also have been identified as a factor that increases health costs.[13] People use more health care when insurance pays a high percentage of the cost.[14] Generally across the whole population, the share of personal health expenditures paid directly out-of-pocket has fallen from about 40% in 1970 to about 15% in 2006.[15] Although recently we have seen increases in out-of-pocket liability through higher deductibles and other cost-sharing, over the longer-term the share of total benefits paid by insurance has been increasing.

Inefficiencies in medical care delivery and financing also contribute to the high cost of medical care. Studies by the Dartmouth Atlas Working Group and others have shown wide variation across providers in the treatment and cost of patients with similar health care needs without comparable differences in outcomes.[16] The lack of integrated, efficient systems for electronically storing and transmitting health data results in service duplication, misdiagnosis, and high transaction costs, and also limits the data available to study the effectiveness of treatments.[17]

## ADDRESSING THE COST OF HEALTH CARE

A number of strategies have been offered to affect the high and growing cost of health care and its impacts on people and on private and public institutions. Some aim at reducing the need or demand for health care in order to reduce the amount of care that people use. Other strategies focus on making the delivery and financing of the care that people get more efficient and cost effective. All involve important tradeoffs and/or significant changes to the health care system.

### Changing How Much Health Care People Use

An important theme in health policy and in the marketplace has been increasing consumer responsibility in health care. New health care plans, often called "consumer-directed" health plans, are a combination of tax-favored savings accounts and catastrophic insurance for expenses beyond a high annual deductible. Proponents of these arrangements argue that providing consumers with more information about their health care choices, coupled with strong financial incentives to be prudent purchasers of services, will result in lower costs. Research shows that increasing consumer cost sharing reduces the amount of health care that people use,[18] although higher out-of-pocket burdens also may increase consumer insecurity and place difficult burdens on low- and moderate-income families who may have difficulty meeting high out-of-pocket requirements if they become seriously or chronically ill.[19]

Another approach to reducing consumer demand for health care is to reduce the government tax subsidy (referred to as a tax exclusion) for employer-sponsored health insurance. Currently, workers do not pay income or payroll taxes on the value of the contributions that their employers make toward the cost of their employer-sponsored coverage. Critics argue that the open-ended nature of the current tax exclusion, which is estimated to cost more than $200 billion annually, encourages workers to demand very comprehensive benefits which lead to high levels of health spending.[20] The current approach also has been criticized because it provides greater tax benefits to higher income workers than to lower income workers. Proposals have been offered by President Bush and others to cap or modify the current tax exclusion in ways that encourage workers to purchase less comprehensive coverage, leading to lower health care use. Changing the tax exclusion has potentially far-reaching implications for the large share of families that currently have employer-sponsored coverage, and could lead employers and employees to reassess whether health insurance is best provided through the workplace. Current alternatives to employer-sponsored coverage suffer from high administrative costs and are not necessarily accessible for people with health problems, issues that may need to be addressed if this is to be a viable option.

Finding ways to improve the health and health behaviors of Americans has received growing attention as important ways to reduce future health spending. As discussed above, chronic diseases account for a large share of health spending, and the growth in the prevalence of risk factors such as obesity and of chronic illnesses such as diabetes and asthma raises concerns about the health of Americans and the influence these trends will have on the future cost of health care. Strategies to address these issues include workplace and public health programs that: encourage people to adopt healthy behaviors and modify unhealthy ones; identify people with or at risk to develop chronic diseases and provide resources, incentives, and assistance to help them manage their health; provide case management and other services to people with chronic diseases when they use health care to help achieve better and more cost effective outcomes.

### Improving Efficiency and Effectiveness of Delivery and Financing

Reducing practice disparities and encouraging evidence-based medical practice are other potential strategies that proponents believe affect health care costs. As discussed above, research shows significant variation across providers and regions in health care spending for people with similar conditions with no resulting differences in quality. Strategies that give providers better information about appropriate practice and that better align provider payments with the provision of high quality cost-effective health care have the potential to reduce these variations and reduce unnecessary costs.[21]

Developing programs to comprehensively evaluate the effectiveness and costs of different medical treatments is an approach that proponents believe would reduce health spending by targeting practice and reimbursement to cost-effective interventions. New medical technologies and procedures are often developed and used without good information about whether they are better than existing interventions or, if they are better, whether the additional benefit is worth any additional cost. Comparative effectiveness studies also can be used to identify the types of patients who would most benefit from a procedure or practice. As discussed above, the development and dissemination of new medical technologies is a significant contributor to health care cost growth, and comparative effectiveness offers an opportunity to evaluate their benefits and costs in a systematic way.

Promoting the greater use of health information technology is another strategy that has been proposed to reduce longer-term costs, although a significant up-front investment may be required.[22] Widespread adoption of electronic medical records could, among other things, reduce the provision of duplicate services, improve opportunities to coordinate care and disseminate information to providers, and provide information for research on provider quality and the cost effectiveness of clinical interventions.

Another option for affecting health costs is more government involvement in setting reimbursement rates or implementing new payment policies. For example, Medicare could serve as a model for payment reforms such as pay-for-performance or coordinated care. The government also could extend the prices it receives to other payers or take more direct actions to try to regulate costs. Less government regulation also is an option that could affect costs. Reducing requirements for providers or insurers could reduce the cost of supplying health care or health insurance generally, but less regulation also could leave some families exposed to higher out-of-pocket costs.

### Reducing the Level of Spending or the Rate of Spending Growth

Many of the policies under discussion in health policy circles to address costs — such as increasing the use of electronic medical records and other information technology, promoting evidence-based medicine, provider pay-for-performance, consumer-directed health care, or disease management are aimed at improving the efficiency with which care is delivered. Successfully implementing these policies, which are not easy tasks, could reduce the amount that we pay on average for care, but may not slow how quickly the costs grow once lower, more efficient levels of spending have been reached. Over the long run, bringing health spending growth closer to the rate of overall economic growth may require finding ways to slow the development and diffusion of new health care technologies and practices. One approach, comparative effectiveness research, directly addresses one of the fundamental drivers of high cost growth, although its implementation presents serious practical and philosophical challenges. Practically, the sheer volume and pace of medical advance would make it difficult to actually assess many important changes before they were incorporated into medical practice. Philosophically, medical assessment requires people to make difficult decisions about whether a medical benefit for some is worth the cost to the broader system. Other ways of potentially reducing the development and diffusion of new health care technologies, such as much higher cost sharing that could reduce the ability of many to afford expensive treatments (which in turn would dissuade their development), are no less controversial.

There are a number of different strategies for influencing the cost of health care and its growth. Some are more focused on how care is delivered and others are more focused on how care is financed. Each of these involves meaningful change for consumers, providers, and payers. In some cases, the goal of reducing system cost growth may conflict with the goal of increasing family financial security. For example, increasing cost sharing in health insurance policies would likely reduce overall spending because people use less health care when faced with higher out-of-pocket liability. At the same time, this higher out-of-pocket exposure may make families feel less secure and less confident that they will be able to afford the health care that they need. Other approaches to reducing costs, such as implementing comparative effectiveness research to inform treatment and payment decisions, involve very difficult political and ethical decisions about the care that patients are eligible to receive.

## ASSESSING THE CANDIDATES' POSITIONS

Senators McCain and Obama have each produced health care proposals that have a number of elements that would affect the cost of health care. Senator McCain's approach emphasizes the role of consumers by eliminating the income tax exclusion for employer-sponsored coverage and introducing new flat tax credits that provide incentives for consumers to select less comprehensive coverage. He also stresses reducing regulation of the insurance markets as a way to lower the cost of health insurance by reducing state insurance requirements. Senator Obama largely builds on the current financing system, but suggests new regulations that would change how insurance is offered to people who buy coverage on their own. He also proposes a reinsurance system to lower premiums and a new public program that would compete with and offer an alternative to plans offered by private insurers. Both candidates stress the need for promoting health information technology, preventing and managing chronic disease, and improving the health delivery system.

***Included below are a series of questions to help evaluate the candidates' proposals:***

- ★ How can health care be made more affordable without limiting access to necessary care?
- ★ How would each candidate's proposal affect the premiums and other out-of-pocket costs that people face? How would people with different incomes be affected?
- ★ What role should government play in controlling increases in the cost of care and the cost of health coverage?
- ★ What is the responsibility of individuals in the cost of their care? Are health savings accounts and high deductible insurance policies an approach that should be expanded?
- ★ What is the best approach to protect low-income Americans from unaffordable out-of-pocket costs for health care while containing health costs overall?
- ★ How would each candidate's proposal change the health care delivery system?

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[1] Kaiser Family Foundation, Health Tracking Poll: Election 2008 (conducted September 8-September 13, 2008); Peter J. Cunningham, *Trade-Offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families, 2003-2007*, Tracking Report No. 21, Center for Studying Health System Change, September 2008, http://hschange.org/CONTENT/1017/, accessed October 3, 2008.

[2] The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," March 25, 2008, p. 173, Washington, DC., accessed October 10, 2008, http://www.cms.hhs.gov/reportstrustfunds/downloads/tr2008.pdf.

[3] John Holahan et al., *Why Did Medicaid Spending Decline in 2006? A Detailed Look at Program Spending and Enrollment, 2000-2006,* Kaiser Commission on Medicaid and the Uninsured, October 2007, http://www.kff.org/medicaid/7697.cfm.

[4] America's Health Insurance Plans, *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits*, December 2007, http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf, accessed Sept. 16, 2008.

[5] Ibid. Preferred provider/point-of-service plans and HSA/MSA plans had the highest market shares for family coverage at 65.7% and 23.3%, respectively. Health maintenance organizations and exclusive provider organization plans (with 5.5% of the market) had a lower average deductible of $1,234, largely because a substantial percentage (30%) of plans had no deductible.

[6] Kaiser Family Foundation, Health Tracking Poll: Election 2008 (conducted September 8-September 13, 2008).

[7] Peter J. Cunningham, *Trade-Offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families*, op. cit.

[8] Joseph P. Newhouse, Medical Care Costs: How Much Welfare Loss? *The Journal of Economic Perspectives*, vol. 6, no. 3, 1992, pp. 3-21.

[9] Ibid.; Richard A. Rettig, Medical Innovation Duels Cost Containment, *Health Affairs*, vol. 13, no. 3, pp. 7-27.

[10] See, e.g., Joseph P. Newhouse, Medical Care Costs: How Much Welfare Loss? , op. cit.; and Burton A. Weisbrod, The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment, *Journal of Economic Literature*, vol. 29, no. 2, 1991, pp. 523-552.

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[12] Kenneth E. Thorpe, Curtis S. Florence, David H. Howard, and Peter Joski, The Rising Prevalence Of Treated Disease: Effects On Private Health Insurance Spending, *Health Affairs*, web exclusive, pp. w5-317 - w5-325. On trends in mortality rates, see, e.g., David M. Cutler, Edward L. Glaeser, and Allison B. Rosen, Is the U.S. Population Behaving Healthier? National Bureau of Economic Research, NBER Working Paper No. 13013, April 2007, http://www.nber.org/papers/w13013.

[13] See, e.g., John F. Cogan, R. Glenn Hubbard, and Daniel P. Kessler, Evaluating Effects of Tax Preferences on Health Care Spending and Federal Revenues, National Bureau of Economic Research, NBER Working Paper No. 12733, December 2006, http://www.nber.org/papers/w12733.

[14] Joseph Newhouse and the Insurance Experiment Group (1993). *Free For All? Lessons from the RAND Health Insurance Experiment*. Cambridge, MA: Harvard University Press; see discussion and cited studies in Jonathon Gruber, *The Role of Consumer Copayments for Health Care: Lessons From the RAND Health Insurance Experiment and Beyond*, Kaiser Family Foundation, October 2006, http://www.kff.org/insurance/7566.cfm.

[15] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, Table 13, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.

[16] The Dartmouth Atlas of Health Care, http://www.dartmouthatlas.org/, accessed September 17, 2008; *Health Affairs*, Web Exclusive, series of papers on Perspective: Practice Variations And Health Care Reform: Connecting The Dots, October 7, 2004, http://content.healthaffairs.org/cgi/content/abstract/hlthaff.var.140, accessed September 18, 2007; Congressional Budget Office, Testimony of Director Peter Orszag before the Senate Finance Committee, The Overuse, Underuse, and Misuse of Health Care, July 17, 2008, http://www.cbo.gov/ftpdocs/95xx/doc9567/07-17-HealthCare_Testimony.pdf.

[17] Congressional Budget Office, Testimony of Director Peter Orszag before the House Committee on Ways and Means, Evidence on the Costs and Benefits of Health Information Technology, July 24, 2008, http://www.cbo.gov/ftpdocs/95xx/doc9572/07-24-HealthIT.pdf

[18] See references at Footnote xiv.

[19] See, for example, Paul D. Jacobs and Gary Claxton, Comparing The Assets Of Uninsured Households To Cost Sharing Under High-Deductible Health Plans, *Health Affairs*, May/June 2008; 27(3): w214-w221.

[20] John F. Cogan et al., op. cit.

[21] See, e.g., Elliott S. Fisher, David E. Wennberg, Therese A. Stukel et al., The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care, *Annals of Internal Medicine*, 138(4): 273 288, 2003, http://www.annals.org/cgi/reprint/138/4/273.pdf.

[22] See Federico Girosi, Robin Meili, and Richard Scoville (2005), Extrapolating Evidence of Health Information Technology Savings and Costs, RAND, p.36; Peter Orszag, Presentation to The Alliance for Health Reform, June 2008, http://cbo.gov/ftpdocs/94xx/doc9495/06-20-2008-Presentation.pdf; and Congressional Budget Office, Evidence on the Costs and Benefits of Health Information Technology, May 2008, op. cit.

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