The Factors Fueling Rising Health Care Costs 2008

Prepared for America's Health Insurance Plans, December 2008

PRICEWATERHOUSECOOPERS

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Executive Summary

Despite slower growth in recent years, the rising costs of health care services and premiums continue to be a major source of concern for employers, workers, and patients and attracts strong interest in the media. This report updates the findings of two previous PricewaterhouseCoopers (PwC) reports commissioned by America's Health Insurance Plans (AHIP) entitled, "The Factors Fueling Rising Health Care Costs," and "The Factors Fueling Rising Health Care Costs 2006." The purpose of this report is to identify the underlying drivers of health care costs, and to disaggregate those costs by source of spending in the past year.

Health insurance premiums generally track the underlying growth of the cost of health services. This relationship held in 2007; the cost of health services increased at an annual rate of 6.4 percent, while health insurance premiums increased by 6.1 percent. Economists generally disaggregate these costs into general inflation (as measured by the Consumer Price Index [CPI]), price increases in excess of CPI, and increases in utilization. General inflation accounted for 2.8 percentage points (46 percent of the increase), price increases in excess of CPI accounted for 2.0 percentage points (estimated 30 percent of the increase) and increases in utilization accounted for the remaining 1.5 percentage points (25 percent of the increase).

Factors Contributing to the 6.1 Percent Increase in Health Insurance Premiums

In recent years, the annual growth in premiums has been decelerating, with the 6.1 percent increase in 2007 down from a rate of 13.9 percent in 2002. While short term medical trend increases tend to be cyclical, there is evidence that the long-term trend rate is also decelerating slowly. The underlying trend in real per capita costs (i.e., when adjusted for the general inflation rate) appears to have fallen from about 7 percent to about 5 percent over the past four decades. While some progress has been made, 5 percent real growth is still significantly higher than the growth in real incomes and real output per capita.

PricewaterhouseCoopers looked at the components of health care costs. About 87 percent of the costs of health insurance are benefits paid out. Administrative costs and profits account for the other 13 percent. Administrative costs grew slower than benefit costs, with real annual growth of 4.9 percent over the period 1966-2006 compared to 5.3 percent real annual growth in benefits during the same period, demonstrating that administrative costs were not a significant driver of underlying cost growth.

Underlying Drivers of Premium Growth

PricewaterhouseCoopers further delineated the 6.1 percent growth in premiums into the following underlying drivers as follows:

- **General Inflation:** 2.8 percentage points, or about 46 percent, of the increase was driven by the general economy-wide inflation as measured by the Consumer Price Index (CPI).
- **Health Care Price Increases in Excess of Inflation:** Prices for health care services, as measured by the Medical CPI, contributed 1.8 percentage points, or about 30 percent,

of the increase to the growth in premiums. The major factors that drive price increases are reduced provider competition (0.8%), cost shifting from Medicaid and the uninsured to private payers (0.5%), and higher-priced technologies (0.5%).

- **Increased Utilization of Services:** The remaining increase of 1.5 percentage points, or 25 percent of the increase in premiums, is attributed to increased utilization of services. This increase is driven by new treatments (0.5%), aging (0.5%), changes in lifestyle (0.3%), and more intensive diagnostic testing/defensive medicine (0.3%).

Breakdown of Growth by Type of Service

PricewaterhouseCoopers further decomposed the growth in benefit costs into the various health care services as follows:

- **Physician & Clinic:** Physician and clinical services, which grew by 5.5 percent in 2007 account for 33 percent, the largest share of health spending, and 1.8 percentage points of the 6.1 percent increase in private premiums.
- **Hospital Inpatient:** Hospital inpatient spending makes up the second largest component of health insurance premiums, growing at 7.5 percent, about 1.5 percentage points of the 6.1 percent increase in premiums.
- **Hospital Outpatient:** Hospital outpatient spending accounts for about 15 percent of private health care costs and increased at the annual rate of 8.2 percent, the highest growth rate among the major components. Outpatient spending accounted for 1.2 percentage points of the 6.1 percent growth in premiums.
- **Prescription Drugs:** Prescription drugs had, in the past few years, been the fastest growing component of health insurance premiums, reaching well into double digits. However, prescription drug increases have recently slowed significantly and grew at only 5.7 percent in 2007, less than the overall growth in premiums. Prescription drugs accounted for 0.8 percentage points of the 6.1 percent increase in premiums.
- **Other Medical Services:** The remaining benefit costs, which accounts for only 5 percent of health spending, grew at only 3.8 percent and accounted for only 0.2 percentage points of the 6.1 percent increase in premiums.

Breakdown of Growth by Type of Service

While premium increases have slowed, there are still major concerns about underlying health care cost increases continuing to outpace inflation (averaging 5% real growth in recent years). Both utilization and price increases in excess of inflation continue to contribute to health care spending increases. Some of the contributors to this real growth are systemic and difficult to influence (e.g., aging, technology), but many factors can be influenced with concerted and coordinated efforts by the stakeholders in the system. This is particularly critical when considering the significant amount of health spending that does not improve outcomes and promote value.

Looking forward, many stakeholder organizations are expanding efforts to collaborate with policymakers and others to combat the underlying sources of waste in the system. While progress has been made, much more can be done through enhanced collaboration and execution to reduce waste and improve the effectiveness and performance of the health system.

Despite slower growth in recent years, the rising cost of health care services and premiums continues to be a major source of concern for employers, workers, and patients and attracts strong interest in the media. This report updates the findings of two previous PricewaterhouseCoopers (PwC) reports commissioned by America's Health Insurance Plans entitled, "The Factors Fueling Rising Health Care Costs," and "The Factors Fueling Rising Health Care Costs 2006." The purpose of this report is to identify the underlying drivers of the increase in health care costs in the past year. By detailing the underlying health care cost drivers of premium increases, this report attempts to provide policymakers and other stakeholders with information that can help guide efforts to address rising health care costs and improve health care affordability.

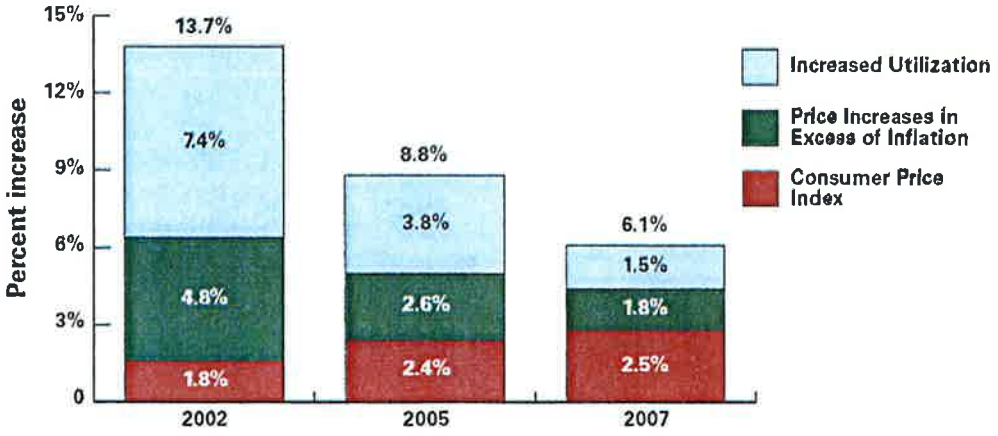
Increase in Health Care Costs 2007

Private health insurance premiums grew by 6.1 percent in 2007. This was the fourth year in a row that the trend fell from the peak growth rate of 13.9 percent in 2003. However, the 2007 growth rate in private health insurance costs continues to be higher than the growth in the Consumer Price Index or per capita GDP and, for that reason, health spending continues to account for more and more of both private and government spending.

PricewaterhouseCoopers has been tracking the factors driving rising health care costs for AHIP since 2002. In 2002, as shown in Exhibit 1, PwC estimated that premiums rose by 13.7 percent. General inflation, or CPI growth, was only 1.6 percentage points of the 13.7 percent growth in 2002, but medical prices rose by another 4.8 percent beyond general inflation. Since then, premium growth has declined to 8.8 percent in 2005, and 6.1 percent in 2007. By 2007, most of the growth was due to general inflation, which accounted for 2.8 percentage points of the total growth. In 2007, medical prices beyond inflation and utilization accounted for 1.8 percentage points and 1.5 percentage points, respectively.

EXHIBIT 1

Increases in Health Insurance Costs—2002, 2005, 2007

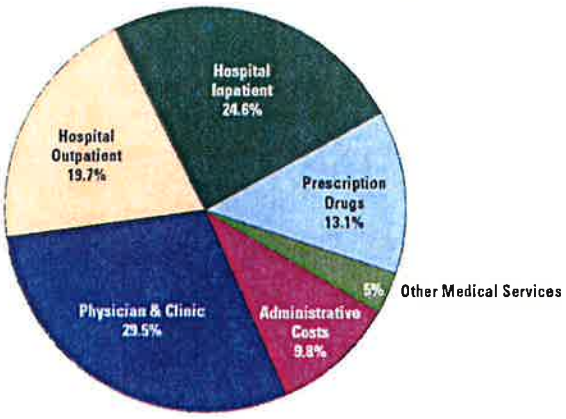


Source: PricewaterhouseCoopers calculations. The overall increase in premiums in 2002 is from *The Factors Fueling Rising Health Care Costs*. The 2005 increase is from *The Factors Fueling Rising Health Care Costs 2006*.

More than three-quarters of the increase in health care costs in 2007 was driven by rising provider costs. As shown in Exhibit 2, physician & clinic costs accounted for 30 percent of the total increase; inpatient hospital costs accounted for another 25 percent, and outpatient hospital costs accounted for 20 percent. Prescription drugs accounted for about 13 percent and other providers only about 3 percent. Administrative costs—claims processing, consumer and provider support, taxes, and profits—accounted for less than one-tenth of the increase. As discussed in more detail below, the relative contributions of a component is related to its share of health spending as well as how fast it is growing.

EXHIBIT 2

Growth in Health Insurance Premiums—2006–2007



PricewaterhouseCoopers also analyzed the long-term trends in health insurance costs and found that the per capita trend is also down. As shown in Exhibit 3, the trend in health insurance costs rises and falls over time, but over the past 40 years, a downward trend is observable. The higher line shows per capita trend in nominal health insurance costs and the lower one shows the trend in real per capita health insurance costs per capita after adjusting for inflation. The underlying trend in real per capita costs appear to have fallen from about 7 percent to about 5 percent over the four decades. Efforts to slow the real growth in health expenditures over time have included efforts to ensure that medical services are clinically appropriate, implementation of network negotiated fees, increased coordination of care, improved health status and enhanced prevention, and tools and coaching to help consumers make value-based decisions. While some progress has been made, 5 percent real growth is still significantly higher than the growth in real incomes and real output per capita.

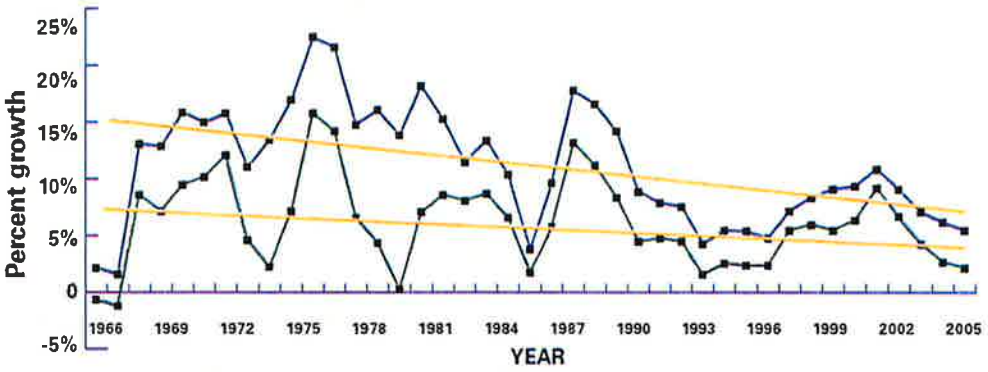
Annual trend continues to exhibit a cyclical pattern of periods with trend above the long-term trendline followed by periods below the trendline. Although the trend growth in real costs may fall to 4 percent over the next decade, the year to year trend rate may accelerate over the next few years. Given the deceleration in trend that we have seen for the past four years and in 2007, a continuing concern is the potential for the health care cost trend to accelerate to a level comparable to 5 percent real growth, or higher, in the near future.

The Role of Administrative Costs

Administrative expenses comprise roughly 13 percent of total health insurance premiums.[1] The nature of administrative expenses can be better explained by an estimated decomposition into the following components:

EXHIBIT 3

Per Capita Growth in Private Health Insurance (1933–2006)



Source: PricewaterhouseCoopers' calculations of the CMS, National Health Expenditure Accounts, 2008

- **Consumer Services, Provider Support & Marketing (4%).** 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. This also includes marketing and sales.
- **Government Payments & Compliance (2%).** Taxes on premiums, costs of complying with government laws and regulations such as filing and reporting requirements and the 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.

[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

- **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.

Although administrative costs are a component of premiums, they are not a key driver of health insurance premiums. As shown in Exhibit 4 below, over 40 years, the real costs of private health insurance have grown at an annual rate of 5.2 percent. Benefits, as measured by the cost of health care services to members, have grown at real rate of 5.3 percent over the same time period. Administrative costs have grown more slowly, at a real rate of about 4.9 percent since 1966. Compared to real benefit costs, administrative costs have tended to reduce the growth in premiums.

EXHIBIT 4

Growth in Real Health Insurance Costs Per Capita (1966–2006)

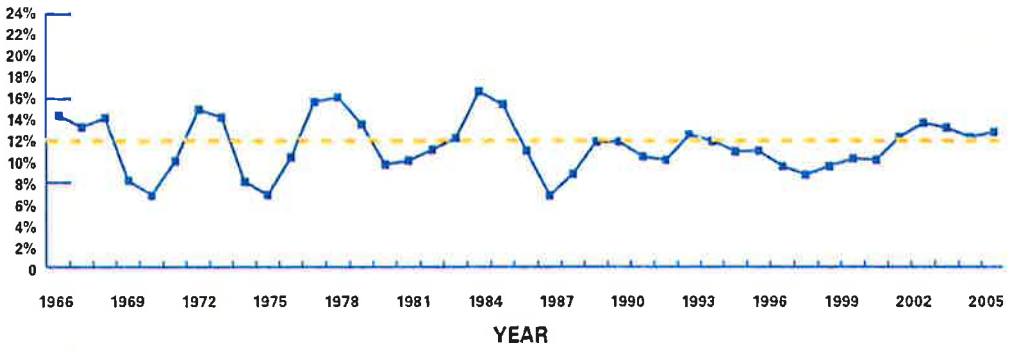
Real Health Insurance Per Capita Cost	5.2%
• Real Benefit Costs Per Capita	5.3%
• Real Administrative Per Capita	4.9%

Source: PricewaterhouseCoopers' calculations of the CMS, National Health Expenditure Accounts, 2008

The very stable contribution of administrative costs over time is illustrated in Exhibit 5 on the following page. Not only has the long-term trend been slightly downward, but the volatility and nature of administrative costs have changed over time, due to the role of managed care and information technology. In 1966, claims were submitted on paper and many functions that health plans perform today did not exist. Today, pharmacies have to process claims electronically on the spot, all providers have computer systems, and patients get information on the internet. Plans now manage networks, negotiate contracts and provide a spectrum of patient care management and consumer support services that did not exist in 1966. Interestingly, while these value-added services have continuously evolved and increased over time, the administrative share of health care costs continues to cycle at about roughly the same average level.

EXHIBIT 5

Administrative Costs as Percent of Private Health Insurance Costs (1966–2006)



Source: National Health Expenditure Historical and Projections 1965-2016 at the website: http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp

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, treatment plans and value. Traditional Medicare primarily provides basic coverage to designated populations, seniors and persons with disabilities, 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 meet state imposed "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.

Factors Behind Rising Costs

PricewaterhouseCoopers has analyzed the increase in private health insurance costs in recent years and explained the changes in terms of underlying factors as shown in Exhibit 6. In our previous study of the 2004-2005 health insurance cost increases, nearly three-quarters of the 8.8 percent increase was attributed to price increases greater than inflation and increased utilization of services. In this year's analysis, almost half of the 6.1 percent increase in health care premiums between 2006 and 2007 was due to the 2.8 percentage points in underlying economic inflation rate. As was done in the previous studies, PwC estimated the portion of the rest which can be attributed to price increases greater than inflation and increased utilization of services.

Health Care Price Increases in Excess of Inflation

Increases in health care prices beyond general inflation accounted for 1.8 percentage points of the 6.1 percent increase in premiums. The major factors that drive price increases are the movement to broader-access plans and less provider competition, higher-priced technologies, and cost-shifting from Medicaid and the uninsured to private payers.

- **Reduced Provider Competition:** Over the past decade, there has been a movement towards plans with broader provider networks. While many consumers have expressed a preference for broader provider networks, such networks tend to reduce the amount of competition in the system. In addition, there have been instances of provider consolidation that have similarly reduced levels of provider competition in some markets. While health care consumerism is intended to provide information and incentives related to provider performance and value, the system is still in its infancy in the availability of and incentives to use such data. We estimate that this reduced level of provider contribution has continued to contribute to provider price increases in excess of inflation and is estimated as 0.8 percentage points of the health care cost increases in 2007.
- **Cost Shifting:** We estimate that cost shifting from public providers and the uninsured to private payers increased premiums by 0.5 percent in 2007, the same as we found in 2005. Data from the American Hospital Association shows that the ratio of Medicaid hospital payments to hospital costs fell from 96.1 percent in 2002 to 87.1 percent in 2005.[2] The number of uninsured as a percent of the population increased from 16.6 percent to 18.3 percent between 2002 and 2007. This increasing amount of unreimbursed costs associated with public programs and the uninsured tends to be shifted by providers to other payers, particularly self-insured employers and private health insurance plans.

[2]American Hospital Association, TrendWatch Chartbook 2007, April 2007.

- **Higher Priced Technologies:** New technologies increase prices because they are frequently more expensive than existing technologies. Newer prescription drugs, in particular, tend to replace older drugs and generic drugs. New imaging technologies are being introduced into the market at a higher cost. We estimate that the cost of new technologies increased premiums by 0.5 percent in 2007 as compared to 1.0 percent in 2005. The difference is largely due to the rising number of prescription drugs going off patent, combined with the lack of major new drugs coming into the market.

Increased Utilization of Services

The remaining 1.5 percentage point increase in premiums is attributed to increased utilization of services. This increase is driven by new treatments, aging, changes in lifestyle, more intensive diagnostic testing, and defensive medicine.

- **New Treatments:** New treatments come in the form of new imaging technologies, biologics, and injectables for existing serious illnesses as well as "lifestyle" drugs for conditions that were once not considered illnesses, or at least were not commonly treated effectively using prescription drugs. We estimate that increased utilization of new treatments contributed 0.5 percent in 2007 as compared to 1.0 percent in 2005. The difference, like the reduction in the trend in higher priced technologies, is largely due to the decreased number of major new drugs coming into the market.
- **Aging:** It is widely recognized that the population is aging as Baby Boomers approach retirement. We estimate that the aging of the population enrolled in health plans contributed 0.5 percent in 2007, the same as in 2005.
- **Lifestyle:** Lifestyle challenges, including obesity, smoking, drug abuse, poor nutrition and physical inactivity have contributed to an increase in the utilization of health services. We estimate that continued deterioration in lifestyle contributed 0.3 percent in 2007, the same as in 2005.
- **More Intensive Diagnostic Testing/Defensive Medicine:** We estimate that more intensive diagnostic testing contributed 0.2 percent to the increase in 2007 as compared to 0.8 percent in 2005. The change is attributed to the slowdown in the trend growth we are seeing in outpatient spending.

[2] American Hospital Association. "TrendWatch Chartbook 2005." May 2005.
[3] US Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2004." August 2005.

EXHIBIT 6

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

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

Source: PricewaterhouseCoopers estimates

We have also broken down the increases in premium costs by health services category into price and utilization components.[3] Exhibit 7 shows the contribution to the 6.1 percent premium increase for each component and, within that increase, how much due to general inflation, excess price, and utilization[4].

- **Physician & Clinic:** Physician services, which account for the largest share of health spending (33 percent), grew by 5.5 percent in 2005 and accounted for 1.8 percentage points of the 6.1 percent increase in private health care costs. The 1.8 percent is derived from 0.9 percent from CPI, 0.4 percent from price increase in excess of utilization, and 0.5 percent increased utilization. This results in about 30 percent (1.8 percent divided by 6.1 percent) of the total increase in premiums.
- **Hospital Outpatient:** Hospital outpatient spending accounts for about 15 percent of private health care costs and increased at the annual rate of 8.2 percent, the highest growth rate among major components. Outpatient spending accounted for 1.2 percent of total growth, or about 20 percent of the 6.1 percent increase. Of the 1.2 percent contribution, 0.4 percent came from CPI, 0.6 percent from price increases in excess of inflation, and 0.2 percent from increased utilization.

[3] Note that the components in Exhibit 7 differ from those in Exhibit 7 in our previous report, "The Factors Fueling Rising Health Care Costs 2006." See Footnote 1 above. In 2006, we combined hospital outpatient and the ambulatory clinics into a single category called "Outpatient Hospital and Clinic." We were unable to find good data for this breakdown in more recent years. For that reason, the services in ambulatory clinics were combined with other physician services into a component called, "Physician & Clinic."

[4] Note that the growth rates in Exhibit 7 average 6.4 percent rather than 6.1 percent. This is because the growth in administrative costs is 4.4 percent in 2007. The weighted average of the growth in benefit and administrative costs is 6.1 percent.

- **Hospital Inpatient:** Hospital inpatient spending, the second largest component of health insurance premiums, accounts for 20 percent of total private health care costs, grew at 7.5 percent. Hospital inpatient spending accounted for 1.5 percent of total growth, or about 25 percent of the 6.1 percent increase. Of the 1.5 percent contribution, 0.6 percent came from CPI, 0.7 percent from price increases in excess of inflation, and 0.2 percent from increased utilization. The higher share for hospital inpatient compared to hospital outpatient, despite its lower growth, is because hospital inpatient has a one-third larger share of total spending.

EXHIBIT 7

Growth in Health Insurance Costs by Components, 2006–2007

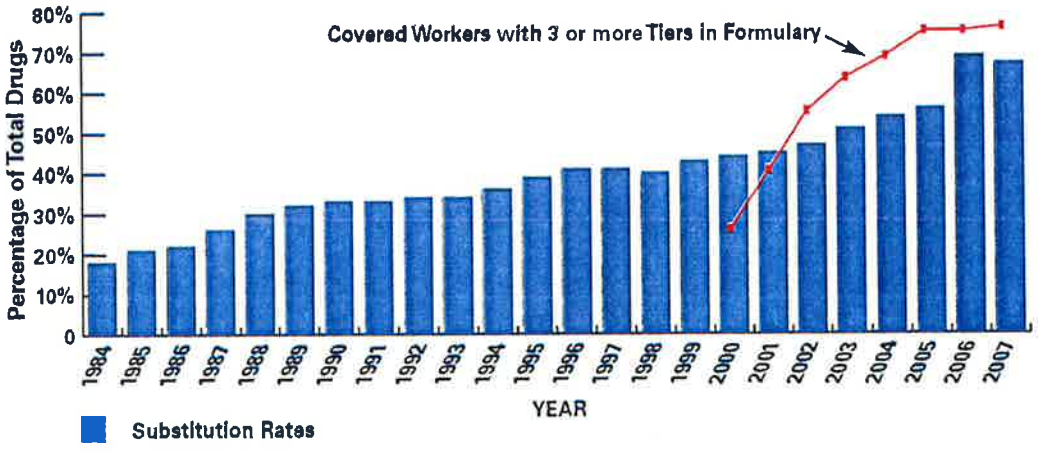
	Share of Health Insurance Premium	Spending Growth Rate	Shared Growth in Health Insurance Premium	% Point Contribution to 6.1 Increase in Health Insurance Premium
PHYSICIAN	***33%***	***5.5%***	***30%***	***1.8%***
CPI		2.8%		0.9%
Price Increase in Excess of Inflation		1.1%		0.4%
Utilization		1.6%		0.5%
OUTPATIENT	***15%***	***8.2%***	***20%***	***1.2%***
CPI		2.8%		0.4%
Price Increase in Excess of Inflation		3.8%		0.6%
Utilization		1.5%		1.2%
HOSPITAL INPATIENT	***20%***	***7.5%***	***25%***	***1.5%***
CPI		2.8%		0.6%
Price Increase in Excess of Inflation		3.5%		0.7%
Utilization		1.2%		0.2%
PRESCRIPTION DRUGS	***14%***	***5.7%***	***13%***	***0.8%***
CPI		2.8%		0.4%
Price Increase in Excess of Inflation		0.3%		0.0%
Utilization		2.6%		0.4%
OTHER MEDICAL SERVICES	***5%***	***3.8%***	***3%***	***0.2%***
CPI		2.8%		0.1%
Price Increase in Excess of Inflation		-0.1%		0.0%
Utilization		1.1%		0.1%
	87%		***90%***	

- **Prescription Drugs:** The biggest shift over the last decade has been the sharp reduction in drug spending growth. The reduction in prescription drug spending offers lessons about strategies to restrain cost growth without harming quality. Prescription drug increases have recently slowed down and grew at only 5.7 percent in 2007, less than the overall growth in premiums. Prescription drugs accounted for only 0.8 percent of total growth, or about 13 percent of the 6.1 percent increase. Of the 0.8 percent contribution, 0.4 percent came from CPI and 0.4 percent from increased utilization. We estimate that none of the increase came from price increases in excess of inflation due to the growth in generic prescribing which has kept the average costs per script constant.

PricewaterhouseCoopers analyzed the underlying changes in prescription usage including the relationship to health insurance plans' designs, formularies, and other therapeutic strategies. In general, the evidence suggests that multi-tiered drug plans and other coordination of pharmacy care have increased the use of generics and value based decision making and consequently mitigated prescription drug cost increases. Exhibit 8 shows the rising share of generics in overall prescription drug use. This trend has accelerated over the past few years as more well-known blockbusters have gone off patent.

EXHIBIT 8

Tiered Formularies Affecting Generic Substitution Rates, 1984-2007

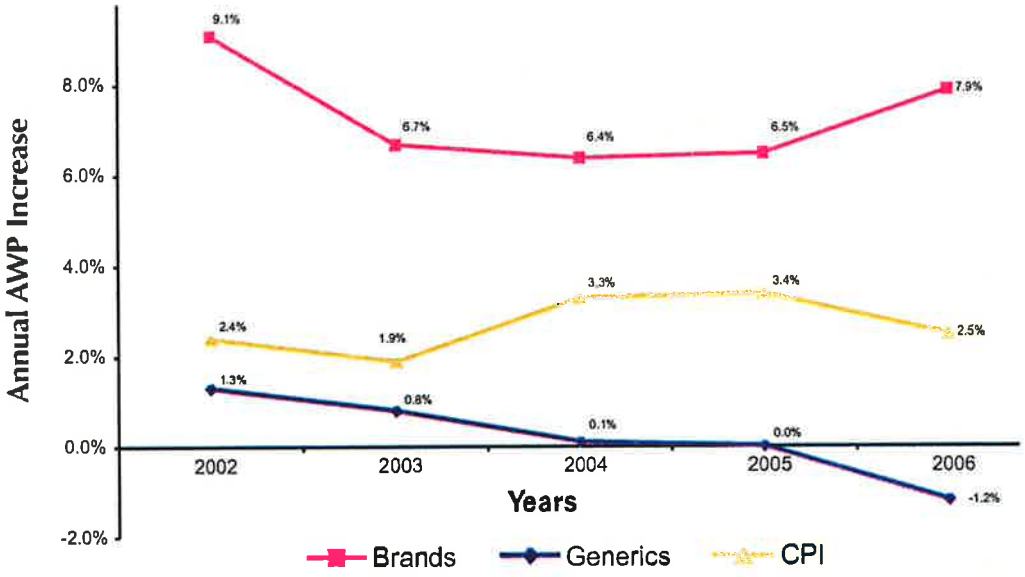


Source: IMS Health; Henry J. Kaiser Foundation, Employer Health Benefits: 2007 Annual Survey

The average cost of generic drugs is about 70 percent lower than brand drugs.[5] Furthermore, Exhibit 9 shows the dramatic difference in the growth in the price of generics compared to branded drugs. Specifically, the price of branded drugs rose by 7.9 percent in 2006 compared to a 1.2 percent decline in the price of generics.

EXHIBIT 9

AWP Inflation: Brands Outpace CPI, but Generics Price Decrease



Source: AWP data from First Data Bank and Medispan ("Caremark 2007 Trends Rx Report", https://www.caremark.com/portal/asset/TrendsRxReport_07.pdf).
Consumer price index from Bureau of Labor Statistics, "Consumer Price Index: December 2007", http://www.bls.gov/news.release/archives/cpi_01162008.pdf

- **Other Medical Services:** Finally, the remaining benefit costs, which account for only 5 percent of health spending, grew at only 3.8 percent and accounted for only 0.2 percent of the overall premium increase.

[5] According to the National Association of Chain Drug Stores, the average price of a generic prescription is $32.23 which is 71% lower than the $111.02 price of the average branded drug prescription. (http://www.nacds.org/wmspage.cfm?parm1=507)

Reexamining the Impact of Waste on Health Care Costs

While increases in health care costs have declined, it is important to note that a significant share of spending does not add value or improve health, or what is frequently called, "waste." The Institute of Medicine describes waste as activities, or resources, that do not benefit patients. The PwC Health Research Institute in its publication, "The Price of Excess—Identifying Waste in the Health Care Spending," calculated waste at 34-50 percent of the $2.2 trillion dollars spent nationally. That paper defines "wasteful spending" as costs that could have been avoided without a negative impact on quality and categorizes waste into three main categories—clinical, operational and behavioral (as illustrated in Exhibit 10):

- **Clinical:** The impact of defensive medicine, uneven adoption of evidence based medical practices and, in general, the variation in medical care itself contributing to overuse, misuse and under-use of interventions, missed opportunities for earlier interventions and overt errors leading to cost, rework and quality issues for the patient.
- **Operational:** The impact of administrative processes across the system includes under-use of information technology and lack of process coordination across the health system stakeholders.
- **Behavioral:** The impact of individual behaviors that have been shown to lead to health problems and have potential opportunities for earlier, non-medical interventions. This includes the costs associated with preventable risk factors such as obesity, smoking, poor adherence to prescription drug regimens and alcohol abuse.

EXHIBIT 10

Total Health Care Expenditures and Wasteful Spending

Source: Based on mid-point of estimates provided in "The Price of Excess: Identifying Waste in Health Care Spending", PricewaterhouseCoopers Health Research Institute, 2008

Conclusion and Outlook

There is clear evidence that health care increases have abated over the past several years continuing a long term trend of declining health care trends. However, concerns remain that health care cost increases continue to outpace inflation (averaging 5 percent real growth in recent years). Both utilization and price increases in excess of inflation continue to contribute to health care cost increases. Some contributors to this real growth are systemic and difficult to influence (e.g., aging, technology) but many factors can be influenced with concerted and coordinated efforts by the stakeholders in the system. This is particularly critical when considering the degree of waste present in our current health care costs.

Looking forward, the industry is expending efforts to collaborate with policymakers and others to combat the underlying sources of waste in the system through:

- Coordinated efforts to improve health promotion, chronic disease management and prevention;
- Increased standardization and transparency to help consumers make value based decisions related to health plans, providers and treatment options;
- Improved research on comparative effectiveness of treatments and clinical programs;
- Reform of legal liability to decrease the prevalence of defensive medicine and refocus on a quality based system;
- Promotion of value based reimbursement to engage consumers more actively in their health care decisions and reward providers for effective clinical practice;
- Enhanced health information technologies to support improved quality management, and streamline administrative processes.

While progress has been made, much more can be done through enhanced collaboration and execution to reduce waste and improve the effectiveness and performance of the health system.

Appendix

METHODOLOGY BEHIND THE ESTIMATES

Private health insurance costs grew by 6.1 percent in 2007.[6] The decomposition of this increase into price and utilization components, shown in Exhibit 1, was based on the growth in the Consumer Price Index and Medical Consumer Price Index from the U.S. Bureau of Labor Statistics. The decompositions in earlier years were based on unpublished factors obtained from the Centers for Medicare and Medicaid Services.

In this report, in Exhibit 6, we segment the cost drivers that make up the 6.1 percent increase in health care premiums in 2007. This decomposition of premium increase is our best estimate based on a combination of interviews, literature review, analysis of data, and professional judgment. The drivers were initially identified from lists of factors that appeared in our earlier studies of the factors fueling rising health care costs.[7] This list was used in discussions with actuaries from various health plans on premium increases and the factors underlying them. We also interviewed PricewaterhouseCoopers partners and staff to find out what their clients in the insurance companies were experiencing. We reviewed the literature on factors driving health care costs to inform areas such as percent growth due to technology. Also, to assure internal consistency, we looked at the relationship between the growth rates in each of the spending components and compared those to our estimates of the factors. For example, the high growth rate in prescription drugs in the late 1990s was in large part due to new drugs coming on the market and presumably led to a larger technology factor those years.

The decomposition of the spending into components—physician & clinic, hospital, prescription drugs, other medical services, and administrative costs was based on the corresponding components of the CMS forecasts of the "Net Cost of Private Health Insurance" from the CMS website.[8] The hospital category was broken into outpatient and inpatient components based on American Hospital Association data on the volume of outpatient and inpatient services, adjusted to account for the differences in use of outpatient and inpatient services between those who are in private plans and those in Medicare. Growth rates in the individual components of health care spending, as shown in Exhibit 7, were also based on the CMS projections, and adjusted to the overall estimate of 6.1 percent growth.

Other sources of data and methodology behind the estimates are described in the relevant sections of this report.

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[6] Based on the estimate from the Kaiser Family Foundation, Employer Health Benefits, 2007

[7] *The Factors Driving Rising Health Care Costs*, America's Health Insurance Plans, 2000 and The Factors Driving Rising Health Care Costs 2006, America's Health Insurance Plans, 2006.

[8] The Centers for Medicare and Medicaid Services, projections of National Health Expenditures at http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage.

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