How to Reduce Health Care Costs: Understanding the Cost of Health Care in America

Statement of

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Chairman Alexander, Ranking Member Murray, and Members of the Senate HELP Committee, it is an honor and a privilege to have been invited to offer my thoughts on understanding the cost of health care in America. My name is Niall Brennan. I am the President and CEO of the Health Care Cost Institute (HCCI). HCCI is an independent, nonpartisan, not-for-profit organization founded in 2011 to foster greater understanding of health care spending trends and the drivers of health care cost growth among Americans with employer-sponsored insurance (ESI) – who account for nearly half of the national population in the United States. HCCI's data covers about one-fourth of all ESI enrollees under age 65, or roughly 40 million people each year over a 10-year period. In addition to conducting our own research using this data we also provide it to leading researchers and research organizations to conduct their own analyses, and use the data to build price transparency tools for consumers.

On the basis of HCCI's analysis of those data, I would like to make the following key points regarding spending trends in the ESI population:

- After several years of relatively slow growth following the recession, per person spending growth on health care services under ESI plans has been rising again toward pre-recession rates – both tracking with and contributing to the unsustainable health care spending trend for the country.

- The main driver of these increases in ESI spending has not been growth in the number of services used but rather growth in the cost per unit of service – a measure which combines increases in the prices of specific services and shifts toward the use of higher-priced services.

- Although spending growth rates differ across types of health services, those rates are increasing largely in tandem– suggesting that systemic factors are at work and that a combination of solutions will be needed to address the factors driving cost growth with all stakeholders contributing.

In the remainder of my testimony, I will provide an overview of recent health care spending trends in the ESI population, examine specific spending trends by type of service and discuss changes in consumer out-of-pocket spending.

Background on HCCI and its Data and Analyses

HCCI possesses detailed claims data from four leading US health care organizations: United Health Group, Aetna, Humana, and Kaiser Permanente. HCCI receives data from these four organizations, and after a rigorous deidentification process to ensure patient privacy, we engage in a number of activities.

First, HCCI's in-house team of researchers and data scientists produce their own research and analyses on a range of issues. Our flagship publication is our annual Health Care Cost and Utilization Report which provides year-on-year and cumulative trends in health care spending for the ESI population – and this work will form the basis for much of my remarks.[1] Beyond this report, however, we engage in a range of research examining issues such as geographic variation in health spending, the impact of high-deductible

[1] Health Care Cost Institute. "2016 Health Care Cost and Utilization Report." HealthCostInstitute.org, published January 23, 2018. http://www.healthcostinstitute.org/report/2016-health-care-cost-utilization-report.

health plans on health spending, shoppable versus not shoppable health care services, and spending for populations with specific chronic conditions such as diabetes, hypertension and multiple sclerosis.

Second, we license our data to researchers to enable even more insights into the drivers of US health care spending. Researchers access HCCI data remotely via a secure data enclave. We're proud that the finest researchers and health policy analysts have chosen to use our data including the Congressional Budget Office, the Medicare Payment Advisory Commission, the CMS Office of the Actuary, the Federal Trade Commission, the Society of Actuaries, the American Academy of Actuaries and academics from a host of universities including Harvard, MIT, the University of Michigan, Dartmouth, Stanford, and others.

Third, we leverage our data assets to provide health care price transparency tools to consumers at the national, state, and local levels. In 2015, HCCI launched Guroo.com, an easy-to-navigate, consumer-friendly website that aggregated billions of claims from our partners at United Health Group, Aetna, and Humana into "care bundles" that allowed consumers shopping for care to understand the average costs associated with common services such as knee replacement and childbirth.[2] Recently, HCCI was selected through a competitive procurement by the State of Florida to help launch a facility-level, consumer-facing website to provide health care price transparency to all Floridians. This site, known as the FloridaHealthPriceFinder will launch in the near future.[3]

Finally, HCCI was the first organization – and remains one of a select group –to have been designated by CMS as a National Qualified Entity. Under this designation, HCCI receives 100 percent of Medicare fee-for-service data that it combines with its commercial data assets to advance public reporting on the quality and cost of care in the United States.

HCCI is governed by an independent board comprised of leading academics and health care experts.

Health Care Spending in the ESI population

Concerns about health care spending are not new, interventions are many and varied – and yet the one constant seems to be that spending on health care goes up every year, often significantly faster than inflation. According to the National Health Expenditures (NHE) estimates, the country spent a grand total of $3.3 trillion dollars on health care in 2016, or about 18 percent of gross domestic product – that is twice the share in 1980.[4] Focusing just on payments for health care goods and services (including hospital admissions, physician visits, prescription drugs, and nursing home care, etc.), spending nationwide totaled about $2.8 trillion or approximately $8,800 per person that year.[4]

Health care spending growth challenges the budgets of governments, businesses, and families. The rapid growth in health care spending leaves less room for other investments, and this pressure will only increase over time if these expenditures continue to grow as projected.

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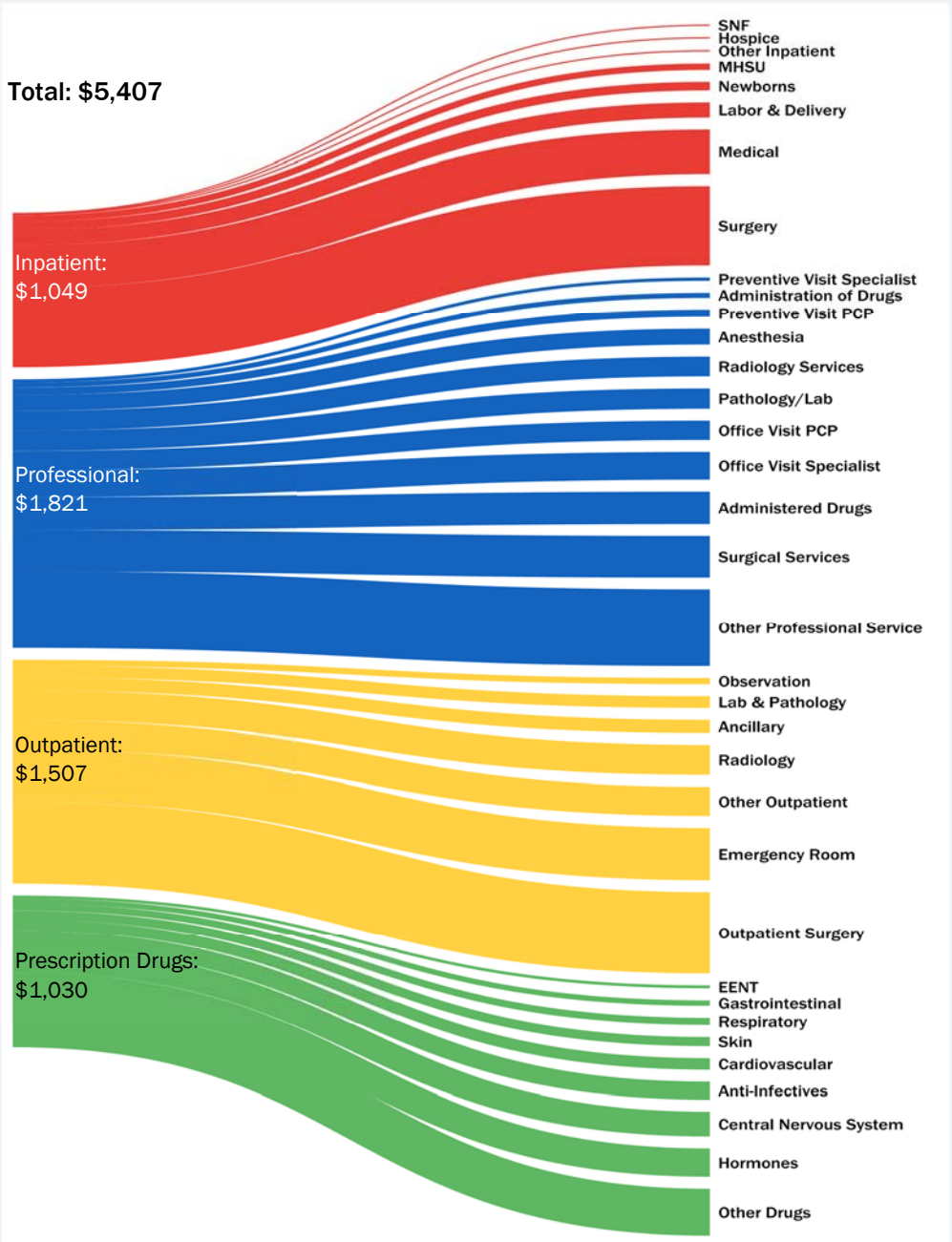
[2] Health Care Constitute. Guroo.com, accessed June 21, 2018. https://www.guroo.com.

[3] Agency for Health Care Administration. FloridaHealthPriceFinder.gov, accessed June 21, 2018. https://pricing.floridahealthfinder.gov.

[4] Centers for Medicare & Medicaid Services. "NHE Fact Sheet." CMS.gov, last modified April 27, 2018. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

At HCCI, our analysis focused primarily on the ESI population, including workers, spouses, and dependents, which is somewhat younger and healthier than the US population overall. Using the most recent HCCI data, we found that total spending per person in ESI plans averaged $5,407 in 2016 – which was a new high for this population (see Figure 1). That amount captures payments by payers (employers and insurers) for health care goods and services and out-of-pocket costs paid by enrollees through deductibles, coinsurance, and co-payments; it does not include insurance premiums or insurers' administrative costs.

Figure 1: Spending per Person in 2016



In our analysis, we divided that spending into four broad categories:

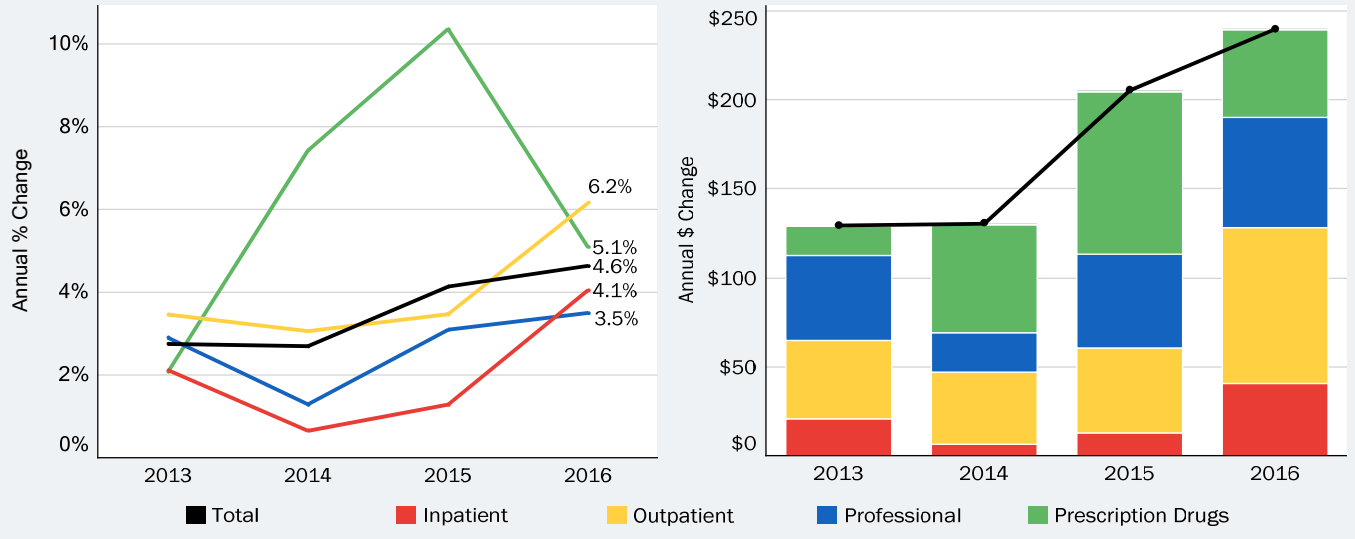
- Inpatient spending, which consists primarily of spending on hospital admissions but includes some spending on skilled nursing facilities and other inpatient care, averaged $1,049 per enrollee (19 percent of total spending).
- Spending on professional services – including physician visits, vaccines, physician-administered drugs, imaging services, and lab tests – averaged $1,821 per enrollee (34 percent).
- Spending on services provided by outpatient facilities, including emergency room (ER) visits and outpatient surgery, averaged $1,507 per enrollee (28 percent).
- Spending on prescription drugs – brand and generic – averaged $1,030 (19 percent).[5]

ESI Spending Trends, 2012-2016

Next, we turned to the question of how health care spending is changing. Examining trends in spending growth, we found that after several years of slowing spending growth, rates of growth are again increasing. Our analysis of more than 40 million people with ESI coverage found that per capita spending increased by 4.6 percent between 2015 and 2016 and 4.1 percent between 2014 and 2015 – these were the highest rates of growth since 2009 when spending per capita rose by 6.4 percent. By contrast, spending growth per capita from 2009 to 2014 averaged 3.3 percent per year.[6]

Between 2012 and 2016, total health care spending increased 15 percent. In 2016, the annual health care bill for working Americans and their families in our sample was more than $700 higher than 2012, not counting the cost of increased premiums.

Figure 2: Annual Change in Spending per Person, 2012-2016

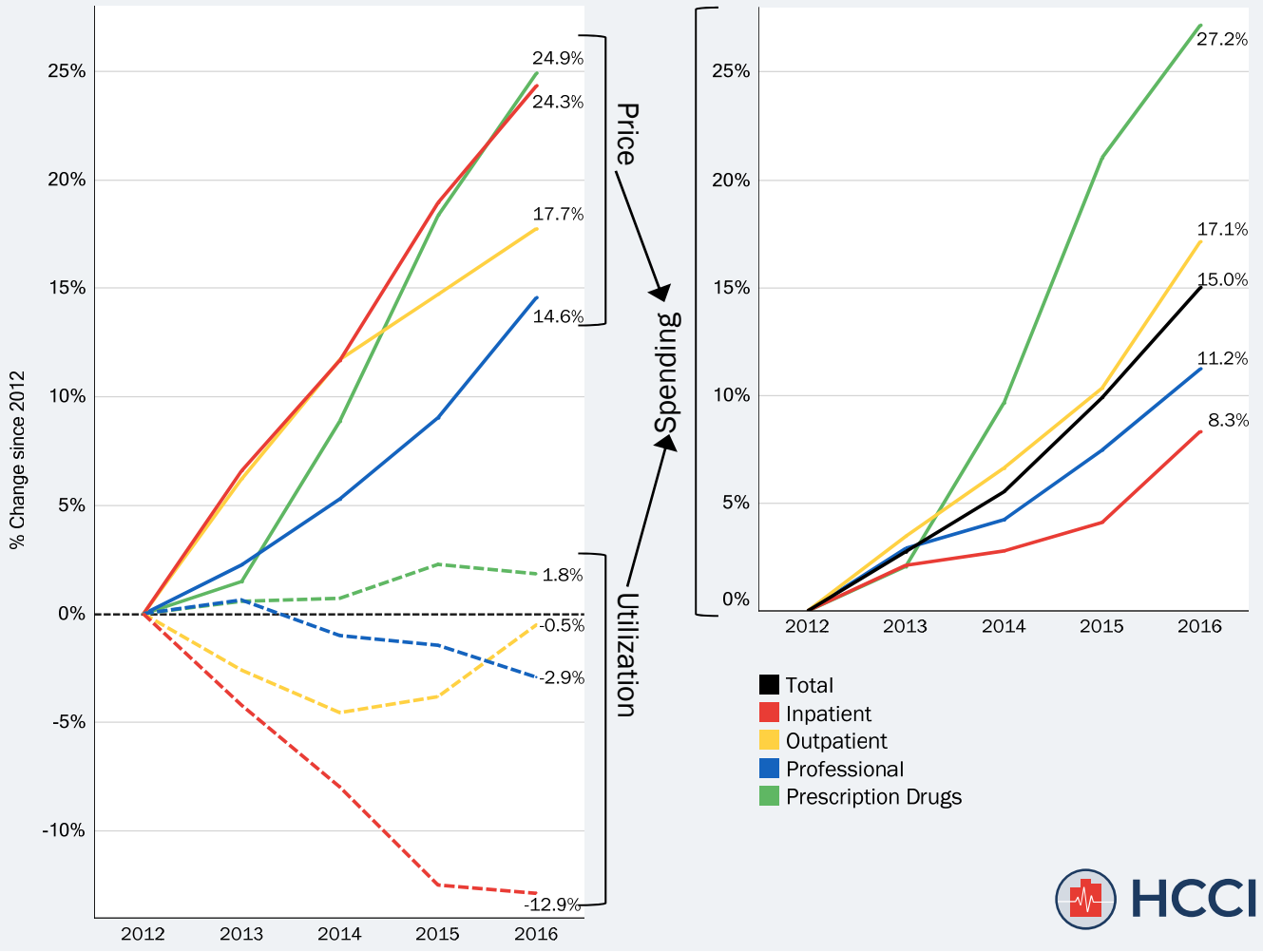


[5] Health Care Cost Institute. "2016 Health Care Cost and Utilization Report."
[6] Herrera, Carolina-Nicole, Martin Gaynor, David Newman, Robert J. Town, and Stephen T. Parente. "Trends underlying employer-sponsored health insurance growth for Americans younger than age sixty-five." *Health Affairs* 32, no. 10 (2013): 1715-1722.

Utilization is Not Driving Spending Growth

Why is spending rising? We found that working Americans are using the same or lower quantities of health care but are paying more for it every year. Based on our data, utilization rates – that is, in the number of services used – declined between 2012 and 2016 for hospital inpatient, outpatient, and professional services, while increasing a modest 1.8 percent for prescription drugs (see Figure 3). Despite a cumulative 12.9 percent reduction in hospital admissions per 1,000 people, hospital spending rose by 8.3 percent – meaning that price increases and service intensity played an important role in increasing hospital spending during a period of declining hospital utilization. Therefore, we conclude that spending increases are largely due to increases in the spending-per-unit of health care (which, for simplicity, we refer to as "price" per unit).

Figure 3: Cumulative Change in Price, Utilization and Spending, 2012-2016



We acknowledge that differences in service mix, quality, and the introduction of new technologies and therapies – which are often very expensive but only sometimes represent significant clinical advances – play a role in driving overall health care spending and distort the overall price effect we calculate. That being said, this should not distract us from the larger issue at hand – that health care spending continues to rise at a rate that will ultimately be unsustainable for the US economy.

Moreover, we are able in the HCCI data to account for growth in the intensity of care within service categories (using measures developed in Medicare such as relative value units for physician services and Diagnosis Related Group weightings for inpatient admissions). When we do that we find, for example, that while the average price of an inpatient admission rose by 24.3 percent between 2012 and 2016, the average intensity-adjusted price rose by 16.7 percent. Although overall trends in spending are also affected by shifts in the mix of services used across categories (for example, from care moving from inpatient to outpatient settings) we believe our findings point strongly to the important role of price growth in spending trends for the ESI population.

Growth in Spending by Type of Service

A great advantage of the HCCI dataset is that we can use it to examine spending trends within service categories and subcategories to gain additional insights. In our most recent annual report, our analysis yielded the following findings.[7]

Inpatient Admissions. Inpatient utilization declined steadily from 2012 to 2016, continuing a long-established trend of declining inpatient utilization. The cumulative decline in inpatient utilization from 2012 to 2016 was 12.9 percent, while spending increased by 8.3 percent – meaning that the price of the average inpatient admission increased by 24.3 percent over this period. Surgical admissions were the largest contributor to the spending and price trends within the inpatient category. The price of a surgical admission, measured as the average facility fee for the average surgical admission, increased by nearly $10,000 from 2012 to 2016 (from $32,088 to $41,702) leading to a 9.2 percent increase in spending despite a 16.0 percent decrease in utilization.

Outpatient Services. The use of outpatient services declined from 2012 to 2014 but increased between 2014 and 2016, resulting in a small net decline in outpatient utilization between 2012 and 2016. However, outpatient spending rose every year, with a cumulative increase of 17.7 percent – which appears to be largely attributable to increases in price per unit. For example, ER visits comprised 23.4 percent of outpatient spending and saw a cumulative price increase of 31.5 percent from 2012 to 2016.

Professional Services. Declines in the use of professional services represent a comparatively recent trend, as use of these services decreased every year since 2013. Despite declines in use, spending on professional services increased a cumulative 11.2 percent from 2012 to 2016, while the average price per service increased a cumulative 14.6 percent. The professional service subcategory with the greatest increase in average price per service was administered drugs. The average price of administered drugs increased dramatically since 2012, a cumulative 41.9 percent to an average of $581 per service in 2016.

Prescription Drugs. Although the utilization of prescription drugs remained relatively constant over the study period, spending on all prescription drugs grew a cumulative 27.2 percent. A large component of this growth was increased spending on brand name prescription drugs. While annual spending growth on generic drugs has been driven largely by increased use, increased spending on brand prescription drugs was due to increases in average price per filled day (a standardized measure of prescription prices).

[7] Health Care Cost Institute. “2016 Health Care Cost and Utilization Report.”

The average price – measured through allowed amounts, not including any coupons, discounts, or rebates – for a filled day of a brand prescription drug increased more than 20 percent per year from 2012 to 2015, and grew 15.0 percent from 2015 to 2016, for a cumulative growth of 111 percent from 2012 to 2016. Part of the substantial price growth of brand prescription drugs is in part explained by the introduction of new drugs that feature both high prices and breakthrough clinical improvements and outcomes (e.g., hepatitis C antivirals that first became available in 2013) and the decline in use of lower cost brand drugs after patent expirations (e.g., Singulair and Lexapro in 2012, Nexium in 2014).[8,9] However, the change in the mix of prescription drugs due to innovative new therapies and patent expirations does not fully explain why spending on brand prescriptions continues to increase each year as use continues to fall.

Spending Variation Across States

HCCI's dataset covers enrollees in every state so we are able to examine differences in spending per capita across states (with adjustments to make the data representative of the national under-65 population with ESI). Alaska and Hawaii have unique issues regarding health care and can be difficult to compare to other states, but even within the continental U.S. average spending per capita varied widely around the national average of $5,407 in 2016 (see Figure 4). Eight of those 48 states had average spending of over $6,000 per capita led by Wyoming at $6,916, while nine states had average spending below $5,000 per enrollee, with Utah the lowest at $4,415.

Geographic differences in spending for working individuals can stem from a number of factors from differences in the cost of services across locations, to differences in the age, health and socioeconomic influences of enrollees, to differences in how providers treat patients. One recent study showed that in the ESI population about half of the variation in spending may be due to differences in prices across locations.[10] However, there is an ongoing debate among healthcare researchers on this issue, with some drawing important inferences from spending differences in Medicare and others raising questions about those findings and their implications. [11,12] Further analysis about the geographic differences in spending among the ESI could yield important insights.

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[8] Chhatwal, Jagpreet, Fasiha Kanwal, Mark S. Roberts, and Michael A. Dunn. "Cost-effectiveness and budget impact of hepatitis C virus treatment with sofosbuvir and ledipasvir in the United States." *Annals of internal medicine* 162, no. 6 (2015): 397-406.

[9] Deruiter, Jack, and Pamela Holston. "Drug Patent Expirations and the 'Patent Cliff'." U.S. Pharmacist, published June 20, 2012. http://stage.uspharmacist.com/article/drug-patent-expirations-and-the-patent-cliff

[10] Cooper, Zack, Stuart V. Craig, Martin Gaynor, and John Van Reenen. *The price ain't right? hospital prices and health spending on the privately insured*. No. w21815. National Bureau of Economic Research, 2015.

[11] Song, Yunjie, Jonathan Skinner, Julie Bynum, Jason Sutherland, John E. Wennberg, and Elliott S. Fisher. "Regional variations in diagnostic practices." *New England Journal of Medicine* 363, no. 1 (2010): 45-53.

[12] Reschovsky, James D., Jack Hadley, and Patrick S. Romano. "Geographic variation in fee-for-service medicare beneficiaries' medical costs is largely explained by disease burden." *Medical Care Research and Review* 70.5 (2013): 542-563.

Effects on Consumers and Budgets

HCCI also focuses on the effect that these trends are having on consumers through out-of-pocket (OOP) payments. Over time, people with ESI are generally using fewer inpatient, outpatient, and professional services, but the amount of OOP payment continues to increase. OOP spending, while displaying a slightly lower overall cumulative growth rate than total spending between 2012 and 2016 (12 percent versus 15 percent). However, for most services OOP spending is actually rising faster than total spending, the exception being prescription drug spending where average OOP declined significantly, although this decline was primarily driven by steep declines in OOP spending for a small number of people with very high prescription drug spending.

More importantly, the cost of insurance coverage in the form of premiums is a significant and growing burden for working individuals and families. For example, the Kaiser Family Foundation and Health Research & Educational Trust (HRET)'s annual survey of employers found that the average contribution of workers towards their premiums increased 22.3 percent between 2012 and 2016.[13]

Individual Spending is Often Unpredictable

In addition to the rising burden of OOP costs, it is important to remember that most health care spending is concentrated among a small group of people. Indeed, in a recent analysis we found that from 2009 to 2015, the top 5 percent of people – so called "top spenders" - accounted for over half of all health care spending, consistent with many previous studies.[14] However, we also found that each year most top spenders – more than 60 percent - were different from the year before.[15]

In other words, high health care spending annually affects new people. In 2015, for example, the median new top spender faced an over $3,000 increase in their OOP spending from the previous year.[15] To put this spending increase in context, the Federal Reserve Board's 2017 Survey of Household Economics and Decision reported that 41 percent of respondents could not afford even a $400 emergency expense.[16] The jarring impact of unpredictable health care spending on individuals' will only become worse as the cost of health care continues to rise.

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[13] The Henry J. Kaiser Family Foundation. "2017 Employer Health Benefits Survey." KFF.org, published September 19, 2017. www.kff.org/health-costs/report/2017-employer-health-benefits-survey.

[14] Johnson, William, Niall Brennan, Sally Rodriguez, and John Hargraves. "Consistently High Turnover in the Group of Top Health Care Spenders. NEJM Catalyst, published February 1, 2018. https://catalyst.nejm.org/high-turnover-top-health-care-spenders/

[15] Johnson, William and Sally Rodriguez. "Top Spenders Among the Commercially-Insured: Increased Spending Concentration and Consistent Turnover from 2013 to 2015." HealthCostInstitute.org, published February 2018. http://www.healthcostinstitute.org/wp-content/uploads/2018/04/Issue-Brief-Top-Spenders.pdf

[16] Board of Governors of the Federal Reserve System. "Report on the Economic Well-Being of U.S. Households in 2017." FederalReserve.gov, published May 2018. https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf

Conclusions

Individuals and families with ESI coverage represent nearly half of the U.S. population, and our report suggests that health care spending growth for this population is trending in the wrong direction. Despite the recent attention around value-based care approaches as a means to reducing health care costs and improving quality, the reality is that across the health care system as a whole, spending is projected to increase from 17.9 percent of GDP in 2016 to 19.7 percent in 2026.[17] Put another way, U.S. health care spending in 2025 will be $2.3 trillion dollars higher than it was in 2016.

Yes, there will be innovative new drugs and technologies, and yes, some of them may be expensive, but that alone does not explain the rapid price and spending growth in U.S. health care nor does it guarantee higher value care. We believe there needs to be a meaningful conversation among all stakeholders across the U.S. health care system to better understand the causes and drivers of increased health care spending. Bringing these groups together can lead to meaningful policy decisions that continue to respect and reward innovation in health care within the parameters of a sustainable health care system.

[17] Centers for Medicare & Medicaid Services. “NHE Fact Sheet.”