

**By almost any measure, health care cost increases are worrisome. Employers have cited rising costs as a reason to have employees pay a higher percentage of their health coverage premiums. State governments say rising costs, and lower-than-expected revenues, have forced them to cut back on Medicaid eligibility or benefits, or both.**

Individuals are concerned as well. An ABC News/Washington Post poll released in October 2003 found that 59 percent of respondents said they were worried that they won't be able to afford health insurance in the future.<sup>1</sup> The percentage of worried individuals rose to seven in 10 among those over age 50.<sup>2</sup>

More recent polls show similar anxieties. A survey released in April 2004 by America's Health Insurance Plans found that "controlling costs" was cited by voters in 17 "battleground" states as the most important health care issue in evaluating candidates in the 2004 election.<sup>3</sup> In Texas, a poll by Scripps-Howard Newspapers found a majority of respondents listed the cost of health care and health insurance as the most urgent health problem facing the nation.<sup>4</sup>

### TRENDS IN HEALTH CARE COSTS

In 2002, total health spending in the U.S. rose to \$1.55 trillion.<sup>5</sup> That comes to an estimated \$5,440 for each person in the U.S. This total amount was a 9.3 percent increase over 2001, more than two and a half times as much as the 3.6 percent increase in gross domestic product (GDP).

Total health care spending totaled 14.9 percent of GDP in 2002. By 2013, the federal Centers for Medicare and Medicaid Services estimates that the nation will spend \$3.34 trillion on health care — 18.4 percent of GDP.<sup>6</sup> (See chart, "National Health Spending as Share of Gross Domestic Product, Selected Years, 1993-2013.")

Part of the increase in health care spending comes from increasing outlays by government insurance programs, especially Medicare and Medicaid. Medicare spending grew by eight percent in 2003, to \$274 billion — all federal dollars.<sup>7</sup> Virtually everyone over 65 is eligible for Medicare, along with certain individuals who have permanent disabilities and those with end-stage renal disease.

### KEYFACTS

- Total health spending in the U.S. was \$1.55 trillion in 2002.<sup>a</sup> That comes to an estimated \$5,440 for each person in the U.S.
- Total health spending in the U.S. increased 9.3 percent in 2002 compared to 2001, more than twice as much as the 3.6 percent increase in gross domestic product (GDP).<sup>b</sup>
- Total health care spending in the U.S. totaled 14.9 percent of GDP in 2002.<sup>c</sup>
- Between spring of 2002 and spring of 2003, premiums for health coverage offered by employers increased 13.9 percent -- more than six times faster than the 2.2 percent growth in the Consumer Price Index.<sup>d</sup>
- Of every dollar spent on health service in the U.S. in 2002, 46 cents came directly from government sources.<sup>e</sup>
- Spending on prescription drugs, as a percent of total health care spending, has more than doubled in the past two decades, from 4.9 percent in 1980 to 10.5 percent in 2002. This does not include the cost of drugs administered in hospitals.<sup>f</sup>
- Between 2001 and 2002, average malpractice insurance premiums for the physician specialties of general surgery, internal medicine and obstetrics/gynecology increased by 15 percent nationally, but by more than 100 percent for certain of these specialties in some states.<sup>g</sup>
- Of the increase in health spending in 2002, 32 percent went to spending for hospitals, 18 percent for physicians, 16 percent for prescription drugs, and 34 percent for all other spending categories.<sup>h</sup>

For key fact sources, see endnotes.

The Medicaid program, which should not be confused with Medicare, covers three main groups of low-income Americans: parents and children, the elderly, and the disabled. In addition to paying for medical care, Medicaid is the primary payer for long-term care in this country. Total spending for Medicaid was expected to reach \$284 billion in 2003, 9.2 percent higher than a year earlier but significantly less of a percentage jump than the previous four years. The federal government paid \$162 billion for Medicaid in 2003 and the states paid the rest.<sup>8</sup> Providers often assert that Medicare and Medicaid pay them less than the actual cost of providing care, meaning they must charge private parties, like insurance companies, more to make up the difference.

Premiums paid by employers have been going up as well — much faster than overall inflation. (See chart, "Cost of Health Insurance Premiums Rising Faster Than Earnings or Inflation.")

Between spring of 2002 and spring of 2003, premiums for coverage offered by employers increased 13.9 percent — more than six times faster than the growth in the Consumer Price Index (2.2 percent). The average cost for individual coverage for health plans of all types

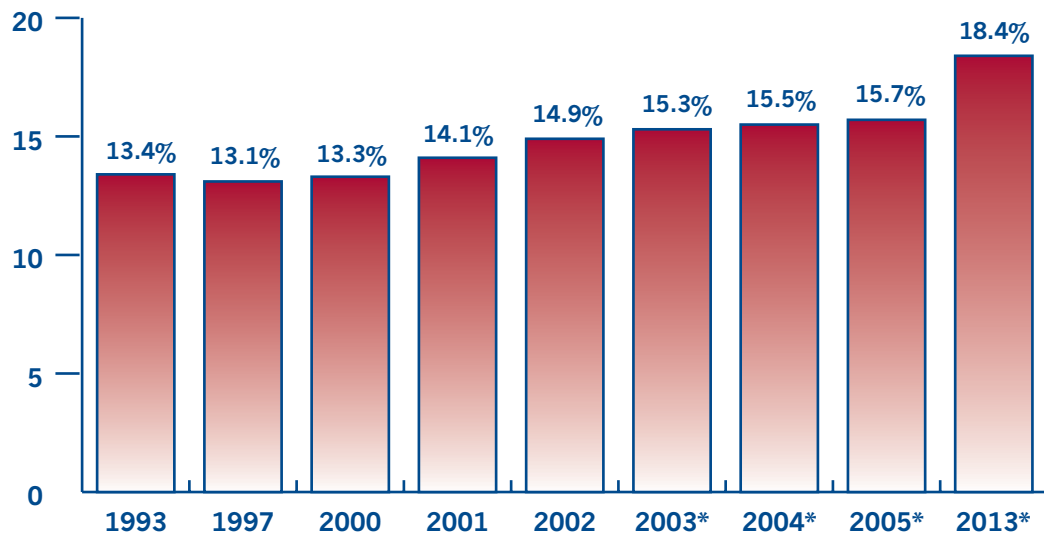
in 2003 was \$3,383, and for family coverage, \$9,068.<sup>9</sup>

The cost for the part of the premium paid by workers has gone up as well, about 40 percent for individual coverage between 2001 and 2003, to \$42 a month, and 35 percent for family coverage, to \$201 a month. Despite this steep rise in the amount paid by workers, their share of the premium, on average, is lower than in 1993.<sup>10</sup> That's because overall premium costs have increased even faster than the amounts paid by workers.

Workers also face other cost-sharing, such as copayments for office visits (96 percent of workers), and deductibles (79 percent) before coverage kicks in. For the most common kind of coverage, a preferred provider organization (PPO), the average deductible for a preferred or in-network provider grew 57 percent between 2000 and 2003 to \$275. For out-of-network providers, the increase was 65 percent, to \$561.<sup>11</sup>

Nonetheless, only 19 percent of insured adults polled in February 2004 said they found it "very difficult" or "somewhat difficult" to pay their monthly health insurance premium. Similar percentages of respondents said they found it very or somewhat difficult to pay for

### NATIONAL HEALTH SPENDING AS SHARE OF GROSS DOMESTIC PRODUCT, SELECTED YEARS, 1993 - 2013



\* = Projected

Source: Heffler, Stephen, et al. "Health Affairs (2004) "Health Spending Projections Through 2013." (www.healthaffairs.org)

doctors' visits (16 percent) and for prescription drugs (25 percent).<sup>12</sup>

## WHAT DOES A HEALTH CARE DOLLAR BUY?

We know that we as a nation spend more than \$1.5 trillion dollars annually on health care and related services. What does all that money buy?

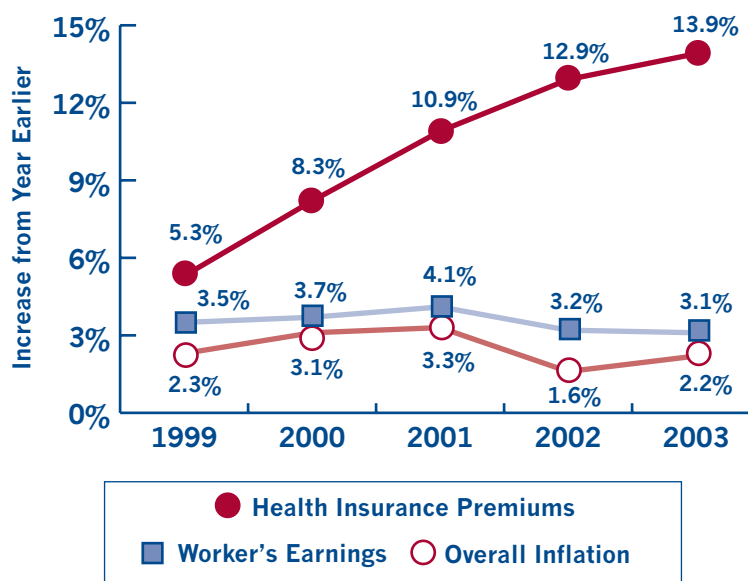
The most common approach to answering that question is that used by the National Health Statistics Group, a unit of the federal Centers for Medicare and Medicaid Services. This is the group that monitors the National Health Accounts (NHA) in the U.S. — historical trends on health care spending at the national and state level, and projections for national spending.

Here is a look at national health expenditures for 2002, the latest year for which figures are available. These expenditures include all money for health purposes, as defined in the NHA, paid by everyone — governments, businesses, non-business entities and individuals. This amount totaled \$1.55 trillion in 2002.<sup>13</sup> (See chart, "National Health Expenditures, 2002.")

### According to the National Health Statistics Group:

- 31 cents of the national health care dollar goes for hospital care, including spending for drugs dispensed in hospitals, plus hospital-based nursing homes and home-health care services
- 22 cents pays for physician services and other clinical services
- 11 cents pays for prescription drugs purchased at retail
- 7 cents goes for nursing home care in free-standing facilities
- 7 cents pays for what's termed "program administration and net cost of private health insurance," i.e., administrative costs
- 5 cents pays for dental services

## COST OF HEALTH INSURANCE PREMIUMS IS RISING FASTER THAN EARNINGS OR INFLATION



Source: Kaiser Family Foundation and Health Research and Educational Trust (2003). "Employer Health Benefits: 2003." Chart pack, p.2. (<http://www.kff.org/insurance/ehbs2003-abstract.cfm>)

Other categories, including public health, each account for less than 5 cents of the health care dollar.

Overall, health care spending rose 9.3 percent. Of the overall increase in health spending in 2002, 32 percent went to spending for hospitals, 18 percent for physicians, 16 percent for prescription drugs, and 34 percent for all other spending categories.<sup>14</sup>

## WHO PAYS FOR HEALTH CARE?

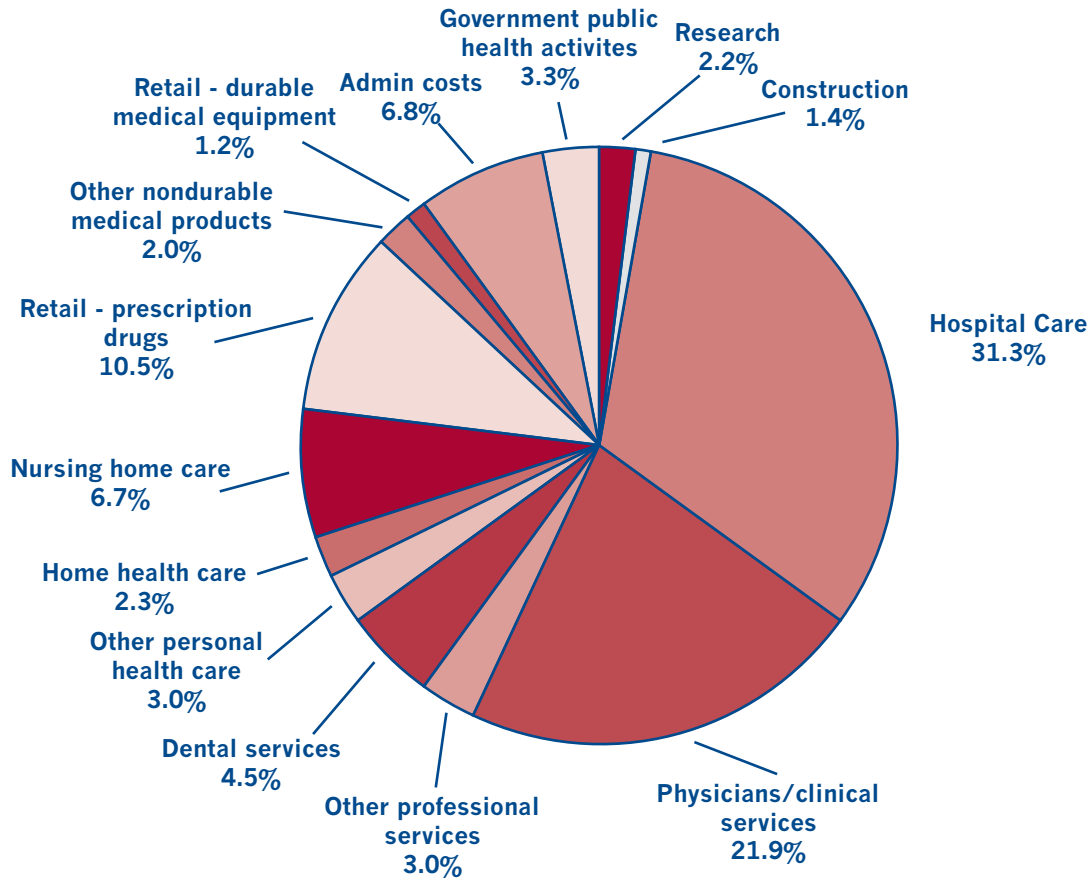
Where does the money for health care come from?

Ultimately, of course, most of it comes from us as individuals. We make out-of-pocket payments to health care providers. We pay premiums to health insurers, who in turn pay providers. We pay taxes to governments, which then use a portion of those taxes to fund health services. And, we buy products and services from companies, many of which use a portion of those revenues to buy health coverage for their employees and retirees.

Again using the analogy of the health care dollar, the

## NATIONAL HEALTH EXPENDITURES, 2002

TOTAL = \$1.553 TRILLION



Source: Levit, Katharine, et al. (2004). "Health Spending Rebound Continues in 2002." *Health Affairs*, Jan./Feb., pp. 147-159. ([www.healthaffairs.org](http://www.healthaffairs.org))

National Health Accounts show that four sources accounted for more than 80 cents of every dollar of national health spending in 2002:

- 35 cents came from private health insurance
- 14 cents came from consumer out-of-pocket payments
- 17 cents came from federal government Medicare payments
- 16 cents came from federal and state payments for Medicaid<sup>15</sup>

(See chart, "Sources of Health Care Funds, 2002.")

## TECHNOLOGY AND COSTS

Many analysts believe that advances in medical technology drive health care costs up more than any other single factor, accounting for perhaps as much as half to two-thirds of cost increases above general inflation.<sup>16</sup> Yet new surgical and diagnostic techniques, medical devices and pharmaceuticals — as well as new applications for existing technologies — offer many benefits to patients. Mark McClellan, then commissioner of the Food and Drug Administration, told a Senate committee in 2003 that "technological change in medicine brings benefits in addition to direct economic gains, including increased longevity, improved quality of life, and less time absent from work."<sup>17</sup>

New clinical technologies may sometimes result in savings, replacing more costly treatments. But there is no clear evidence that technological advances in health care save money in the aggregate. These new technologies often flow from basic scientific advances like those developed through research supported by the National Institutes of Health. Considering that Congress doubled the NIH budget between 1998 and 2003, it seems unlikely that upward pressure on health costs from this factor will diminish in the near future.

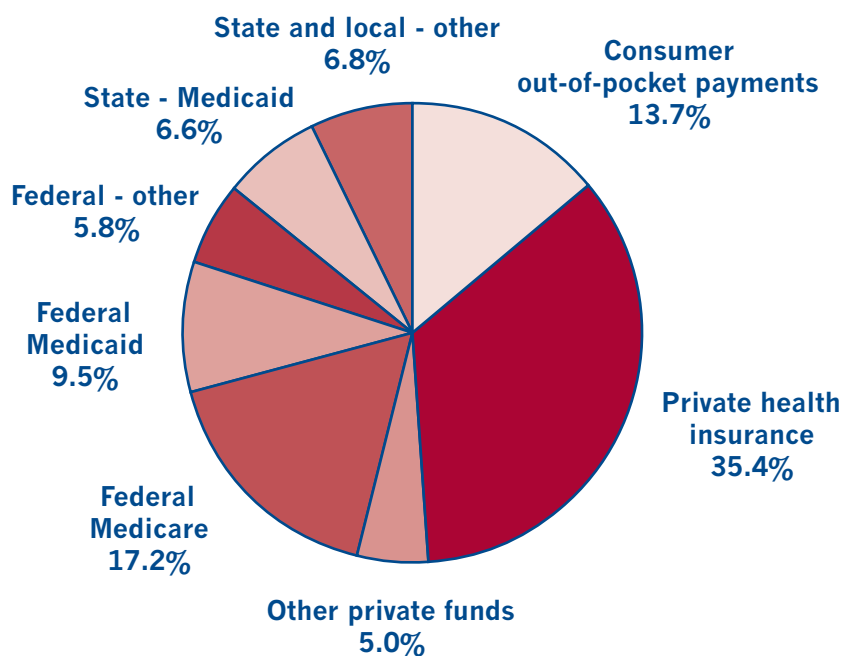
## PRESCRIPTION DRUGS AND COSTS

Spending on prescription drugs has soared over the past two decades. In 1980, the nation spent \$12 billion on drugs, amounting to 4.9 percent of total health care spending. By 2002, that amount had risen to \$162.4 billion, or 10.5 percent of total health spending, excluding the costs of drugs administered in hospitals.<sup>18</sup> The \$162.4 billion in spending represented a 15.3 percent increase over 2001.

Costs are rising not only because people are using more drugs, but also because they are using newer drugs, which tend to cost more than the ones they replace. Average per-capita outpatient drug spending for people age 65 and older increased from \$819 in 1997 to \$1,102 in 2000 — a 35 percent increase. For those under age 65, average outpatient drug expenditures rose from \$347 in 1997 to \$485 in 2000 — up 40 percent.<sup>19</sup>

Six out of 10 employers surveyed in 2003 said "higher spending for prescription drugs" contributed "a lot" to increases in health care premiums — the factor cited most often among six possibilities.<sup>20</sup> Companies are seeking to temper their pharmaceutical costs by imposing requirements on providers, such as obtaining prior authorization before prescribing expensive medications. They are also increasingly passing costs through to their workers in the form of higher

## SOURCES OF HEALTH CARE FUNDS, 2002



Source: Levit, Katharine, et al. (2004). "Health Spending Rebound Continues in 2002." *Health Affairs*, Jan./Feb., pp. 147-159. ([www.healthaffairs.org](http://www.healthaffairs.org))

copayments for drugs — out-of-pocket payments not covered by insurance.

A popular cost containment mechanism is the so-called "three tiered" system of charging for drugs. If the patient is willing to accept a generic drug, he or she pays a low copayment, maybe \$5. If the patient wants a brand name drug on the plan's formulary (approved list), the copayment could be \$10. For a brand name drug not on the formulary, the patient would have to pay a larger copayment, possibly \$25.

Rising drug costs are also affecting state-funded pharmaceutical assistance programs. According to the National Conference of State Legislatures (NCSL), 39 states have established or authorized some type of pharmaceutical assistance program.<sup>21</sup> (See chart, "State Pharmacy Assistance Programs," Chapter 6, Prescription Drugs.) Some of these states are likely to revise their coverage to complement the Medicare drug discount card program in 2004-2005, and to subsequently supplement or "wrap around" the

Medicare drug benefit that takes effect in January 2006.

Medicaid drug costs are a much larger concern for states: In 2003, Medicaid spent an estimated \$27.5 billion on outpatient prescription drugs.<sup>22</sup> State initiatives to curb costs include a variety of strategies, including restrictions on the number and type of medications that beneficiaries may receive each month. While states are entitled under federal law to get the lowest prevailing, or best, price in the market for prescription drugs, they are clamoring for additional purchasing authority to control costs. Toward this end, a growing number of both state and local governments are looking to reimportation as a mechanism that could bring fiscal relief.

Typically, reimportation refers to pharmaceutical products that are first made in the U.S. and exported to other countries, then "reimported" back to the U.S. Since many foreign governments, including Canada, control pharmaceutical prices, such reimported drugs can often be sold well below their prices in the United States. Current U.S. law prohibits reimportation except by the original U.S. manufacturer.

Nonetheless, several state and local governments are encouraging their employees and others to reimport drugs from Canada, as a way to lower drug spending. (For more information on reimportation, including state efforts to encourage reimportation by their employees and citizens, see Chapter 6, Prescription Drugs.)

In addition to reimportation strategies, some states are looking for ways to increase their bargaining clout with the pharmaceutical industry. For example, five states — Michigan, Vermont, New Hampshire, Alaska and Nevada — have formed a collective buying pool for prescription drugs in Medicaid. Approved by HHS in April 2004, the arrangement is expected to generate collective savings of more than \$12 million in 2004.<sup>23</sup>

## OTHER COST DRIVERS

Some analysts believe that at least part of the reason for rising insurance premiums is the insurance cycle. This is a pattern in which insurers try to keep premium increases down in some years to build market share, then increase them substantially in subsequent years to boost profits. A combination of other factors is also thought to be contributing to the increase. Here are

some of them:

**Malpractice awards** — Medical malpractice insurance premiums have increased sharply in some states for some specialties in the past several years, triggering national and state-level efforts to cap certain damage awards. Advocates of these actions say that these awards affect not only insurance premiums, but also the underlying cost of care. Physicians may try to protect themselves by practicing "defensive medicine," ordering unneeded tests and procedures.<sup>24</sup>

**Managed care "pushback"** — In a response to tough bargaining by managed care in the late 1990's, hospital mergers in many markets have given newly enlarged hospital firms the clout to insist on larger payments from insurers. More than half (51 percent) of the spending growth per privately insured person in 2002 came from higher hospital spending.<sup>25</sup>

**Population aging** — The aging of the population also contributed to health care spending. Health expenses rise with age, and 77 million baby boomers are now middle aged. Compared with people ages 18 to 44, people ages 55 to 64 are nearly three times more likely to have a disability, six times more likely to have high blood pressure, and 15 times more likely to die of cancer.<sup>26</sup> Yet the aging of baby boomers was found by one study to have contributed only about one-tenth of the increase in under-65 health spending in 2001.<sup>27</sup>

**Lack of disease management** — Since most health care dollars are spent on patients with chronic conditions, many stakeholders believe that making sure that this population gets coordinated, timely, evidence-based, appropriate care can help control costs.<sup>28</sup>

**Lack of information technology/poor quality** — Many analysts have concluded that much of the care that is delivered is inappropriate,<sup>29</sup> and that the system is subject to underuse, overuse and misuse.<sup>30</sup> In addition, some providers forego information technology that could save money over time. The often-cited reason for not adopting the technology: up front costs.<sup>31</sup>

**Administrative costs** — The cost of administering the mixed public-private health care system in the U.S. has been identified by some as a largely unnecessary expense, especially in contrast to the low administrative costs in countries like Canada, with its government-

sponsored "single payer" health coverage. Administrative expenses for private insurance include such items as advertising, marketing, billing and sales expenses. Overall, administrative costs made up 6.8 percent of total health spending in 2002, or \$105 billion. These costs grew 16.2 percent from 2001, a greater rate than almost any other component of health expenditures.<sup>32</sup>

**Third-party payment** — Those who favor market-oriented approaches to our health care system believe that, by insulating consumers from the true cost of care, the health care system gives them no incentive to choose more cost-efficient providers or plans.<sup>33</sup> This has in turn spawned several efforts to put in place consumer-driven health plans, which are designed to make individuals more sensitive to the costs of the care they are using. (See below for more information.)

## WILL CONSUMER-DIRECTED HEALTH PLANS KEEP COSTS DOWN?

Employers and governments have made many attempts to control health care costs over the years, but none has had a lasting effect. But the search for new ideas that can help save money continues. The latest of these innovations has been termed consumer-driven or consumer-directed health plans. Some of them could also be described as defined contribution or employer capped plans.

A typical consumer-directed health plan attempts to hold down costs by getting individuals more involved in decisions about how to spend health care dollars. Here is the way Whole Foods Market operates a consumer-directed plan for its 30,000 workers:

The company contributes an amount every year into an account for each employee, to be used for routine medical care or prescription drugs. The amount varies from \$300 to \$1,800, depending on how long the employee has worked for the company. Amounts unused at the end of the year get rolled over to the next year.

The employee must pay out of pocket for any expenses that exceed the amount in his or her account, up to \$1,500 per year — \$500 for prescription drugs and \$1,000 for all other medical costs. At this point, a health insurance policy kicks in, with the employee paying 20

percent of covered expenses and the insurance the other 80 percent.

The insurance is free for individual full-time workers who have been employed by Whole Foods for a couple of months. Workers wanting to cover a spouse or children must at first pay a share of the insurance premiums for them, but the share is reduced over time until, after about five years, the employee pays nothing for this coverage.

Whole Foods management has been pleased with the results of the program. In 2003, the first year the plan was in effect, overall medical claim costs fell 13 percent from the year before. Hospital admissions per 1,000 employees fell 22 percent. About 90 percent of employees had money left over in their accounts at the end of the year, amounts that rolled over for use in 2004. The company's costs for employee health care stayed flat for the year, when health insurance premiums nationally went up by double digits.<sup>34</sup>

Consumer-directed plans come in at least two versions. Health reimbursement arrangements (HRA), like the Whole Foods plan, involve only employer money in the up-front account. Employees may not contribute. The employer's contributions generally are excluded from the employee's taxable income, and claims payments from the account are a tax-deductible business expense for the employer. Also, the employer actually owns the account, although the employee can draw money from it. The employee loses access to the money if he or she leaves the company.

A health savings account (HSA) is somewhat different. In this case, both the employer and the employee can contribute money to the account. Contributions by either are tax deductible, and employer contributions don't count as taxable income for the employee. With HSAs, the employee truly owns the account, which is portable. The money goes with the employee if he or she leaves the company.

Both HRAs and HSAs are usually paired with a health insurance plan covering expenses that exceed the relatively high deductible.

Proponents of consumer-directed plans point to actual savings, in their early experience. For instance, in addition to Whole Foods' story, a group of employers

offering such a plan from Humana said their health costs rose 5.9 percent in 2003, compared to cost increases of 14 to 15 percent for employers nationally.<sup>35</sup>

A key to making consumer-directed plans work as intended is the assistance provided by the employer or health plan in making wise choices among providers. This may be in the form of a report card rating providers on several quality measures, as well as a list of providers with prices charged for the same service. But critics say that information actually being made available to consumers is inadequate, as to both quality and price. Making informed, prudent choices under those circumstances is impossible, they argue.<sup>36</sup>

Detractors also say consumer-directed plans discourage employees from seeking care. If employees feel that they are spending their own money, they may be reluctant to seek care for a problem that could later turn into a more serious and much more expensive situation. These incentives may work against those with chronic illnesses, who must choose between meeting regular medical expenses and spending the money in their accounts, exposing them to the risk of lacking funds to meet other, unforeseen care needs.

Also, enrolling large numbers of people in consumer-directed plans could create an adverse selection problem for those with other types of coverage. Critics say this is because if they have a choice, people expecting to need little care will opt for the consumer-directed plan, leaving less healthy, more expensive people in other plans. This could increase the average expense per enrollee for those other plans, and would add to pressure to increase premiums and copayments.

## CURRENT POLICY DEBATES AND PROPOSALS

### Health Savings Accounts

President Bush supports growth in health savings accounts, as provided for in the Medicare drug law which he signed in December 2003, and greater use of consumer-directed health plans.<sup>37</sup> The new provisions allow individuals with high-deductible health plans, and their employers, to make tax exempt contributions — up to the value of the deductible — to health savings accounts (HSAs) for routine medical expenses, as described earlier. Plans must have deductibles of at least \$1,000 for an individual and \$2,000 for a family and the

annual contribution is capped at \$2,600 a year for an individual or \$5,150 for a family. Money not spent from the account belongs to the individual and rolls over from year to year.

The president says that since individuals are spending their "own money" when they draw from their HSA, they will be more cost-conscious in selecting providers and treatments. He has proposed that individuals with HSAs be allowed to deduct from their taxable income the premiums they pay for their accompanying catastrophic health plans.<sup>38</sup>

### Reducing Spending For Prescription Drugs

Senator John Kerry says he would help all states provide drug discounts to their citizens along the lines of those Maine has tried to extend to its citizens. Those discounts, based on prices for drugs used in the Medicaid program, have been blocked by courts from going into effect.

Senator Kerry targets pharmacy benefit managers (PBMs) as a potential source of savings. PBMs are companies that contract with insurers and employers to manage the prescription drug benefits of enrollees. If a PBM does any business with the federal government, Senator Kerry would require the company to make public the discounts they get from drug manufacturers, and how much of those discounts is being passed along to beneficiaries.<sup>39</sup>

The Bush administration has shown no interest in regulating PBMs.<sup>40</sup>

Senator Kerry supports drug reimportation. President Bush has suggested that reimportation of drugs from Canada and other countries poses significant safety concerns, but has also stated that, if those concerns can be addressed, allowing limited reimportation, "makes sense."<sup>41</sup>

President Bush supported the inclusion of a prescription drug benefit in Medicare, and signed such a benefit into law in December 2003. Senator Kerry also supported a Medicare drug benefit, though he has criticized the one enacted by Congress and signed by the president.

### Helping Employers

President Bush proposes allowing small employers to

pool together to buy health insurance for their workers, in groupings known as association health plans. He believes this will lower costs by increasing small firms' buying power, and by allowing them to avoid some state requirements that increase costs needlessly.<sup>42</sup>

Senator Kerry would create a premium rebate pool to help employers deal with catastrophic health care costs. Under this arrangement, the pool would reimburse employer-sponsored health plans for 75 percent of the costs they incur above \$50,000, as long as they would guarantee the resulting savings would be used to reduce the cost of workers' health premiums.<sup>43</sup>

To be eligible for reimbursement from the pool, an employer would have to provide health coverage to all workers and would have to offer disease management programs for employees with chronic diseases such as asthma, cancer, cardiovascular disease and diabetes.<sup>44</sup> Disease management attempts to involve the patient as an active participant in his or her treatment, and in preventing disease in the first place. It places special emphasis on identifying those at highest risk for certain medical problems, so that intervention can begin as early as possible.

The president opposes this sort of reinsurance as a cost shift from those paying health insurance premiums to taxpayers, which he says would cost \$290 billion over nine years.<sup>45</sup>

### **Consumer Education**

President Bush notes that the Administration has taken steps to make more information available to the public about medical treatments and the quality of health care providers, including nursing homes. Surgeon General Richard Carmona has spoken out for several years on the need to deal with obesity in the U.S. The Department of Health and Human Services has opened the door to reimbursing Medicare beneficiaries for weight reduction treatments and programs.<sup>46</sup>

Senator Kerry would attempt to curb some health spending by disseminating information widely on the best ways to promote health and prevent diseases.

### **Medical Malpractice Reforms**

President Bush has called for changes aimed at slowing

the growth of medical malpractice premiums and reducing payments to plaintiffs who win malpractice suits. The president favors "national adoption of proven standards to make the medical liability system more fair, predictable and timely." These standards would include a \$250,000 cap on non-economic damages awarded to plaintiffs, payments over time of amounts awarded to plaintiffs rather than lump-sum payments, and a provision that losing defendants would pay judgments in proportion to their degree of fault.<sup>47</sup> The president estimates that defensive medicine — tests and treatments prescribed to guard against lawsuits — costs the federal government \$28 billion yearly.<sup>48</sup>

Senator Kerry would work to reduce "meritless claims and defenses." He would prohibit individuals from bringing a medical malpractice suit unless a "qualified specialist determines that a reasonable claims exists." He would require states to make available nonbinding mediation before permitting plaintiffs to proceed to trial. He would oppose punitive damages in such cases unless it can be proven that the defendant engaged in "intentional misconduct, gross negligence or reckless indifference to life."<sup>49</sup>

### **Information Technology**

Both President Bush and Senator Kerry advocate the greater use of information technology to improve quality and lower costs. In May 2004, for example, President Bush appointed David Brailer, M.D., as the National Health Information Technology Coordinator, a new position. The coordinator's office provides national leadership to encourage the government and the private sector to develop the standards and infrastructure to support more effective use of information technology. The president's Consolidated Health Information initiative is underway, with the goal of setting uniform standards for the exchange of clinical health information within the Federal Government. In 2003, standards in 5 of 24 health data domains were endorsed, addressing areas such as laboratory test results and retail pharmacy transactions.

In FY 2004, the Agency for Healthcare Research and Quality (AHRQ) will spend \$50 million on research and demonstration projects to highlight how health information technology can improve the quality of care and patient safety. Senator Kerry's healthcare proposal would require private insurers in the Federal Employee

### **COSTS AND PREMIUMS BOTH GO UP, BUT NOT ALWAYS BY THE SAME AMOUNT**

Health care costs grew by 9.3 percent in 2002, while private insurance premiums paid by employers increased an average of almost 13 percent. These figures differ because they don't measure the same things. Consider:

- Costs include a great deal of spending not covered by private insurance, notably government programs like Medicare and Medicaid, funds for community health centers and free clinics.
- The underwriting cycle (also known as the insurance cycle) includes alternate periods when premiums grow faster or slower than underlying health care costs. Recent rapid growth in premiums reflects, in part, attempts by health insurers to recapture profits lost in the 1990s when they tried to under-price their competitors to gain market share.
- Premium increases measure unit price. When the price goes up, volume may be reduced, as some decide not to buy coverage. Thus total spending would rise more slowly than premium rates.

Health Benefit Plan and other federal programs to use electronic information technologies.

The president's FY 2005 budget includes more support for health care information technology improvements. For example, the budget proposes \$50 million in new funding to support state or regional demonstration grants to test ways to exchange information among different health care settings, and other information technology projects.

In addition, the budget proposes \$84 million for AHRQ to improve the quality of care and patient safety in all health care settings. Within this total, \$50 million will fund grants to continue efforts to promote, accelerate, and demonstrate the development and adoption of information technology, including in small and rural communities where health information technology penetration has been low.<sup>50</sup>

Senator Kerry would help reduce administrative costs by ensuring that all Americans have a secure, private electronic medical record by 2008. He notes that the Veterans Health Administration now allows its physicians to access electronic medical records without the \$9 per record costs previously required with paper

records. Senator Kerry would assure that all agencies of the federal government use electronic means to deal with medical transactions, such as requesting a medical record or scheduling an appointment.<sup>51</sup>

### **STORY IDEAS**

- Check with local hospitals about their rising costs, especially labor costs, which is their largest expense. How much of a price increase will they be charging health plans during the next year? How large an expense item is administrative costs? How much are they rising from year to year? How much do expenses for unused beds count toward total expenses?
- Interview local health plan officials about the pattern of health service usage. Are hospital admissions increasing? Are people visiting the doctor more often? How about pharmaceutical usage? What sorts of premium increases appear likely for next year?
- Check with local community health centers, the federally subsidized clinics that serve the uninsured. Are they seeing an increase in visits this year because of the rising number of uninsured people? Is their funding adequate?
- Contact the county medical society and arrange to interview a sampling of local doctors. Find out if their costs of operating a medical practice are rising this year, and how much they expect to increase their charges next year. Are managed care arrangements, especially the fees they receive, changing the way they practice medicine? Are they seeing more patients to make up for low payments?
- Talk with both small and large businesses to compare their strategies for dealing with large health insurance premium increases.
- What do state and local government officials believe is important for consumers to know about purchasing drugs reimported from abroad? What do physicians in your area think of reimporting prescription drugs? What are the relative advantages and disadvantages of reimporting drugs from Canada only, as compared to the European Union

and other industrialized nations? How does reimportation affect the prices and safety of consumer products other than pharmaceuticals?

## SOURCES AND WEBSITES

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## CANDIDATES' VIEWS

President Bush supports greater use of health savings accounts and consumer-directed health plans to make consumers more cost conscious in their health care choices.

The president initially opposed reimportation of cheaper drugs from Canada, but has shown more openness as of late summer 2004. Senator Kerry is in favor of allowing reimportation of drugs from Canada.

The president supports medical malpractice reforms that would cap non-economic damages and, he says, reduce malpractice insurance premiums. Senator Kerry claims he would reduce malpractice premiums by restricting "meritless" lawsuits.

Both candidates favor expanded use of information technology as a cost reducer. Additional cost containment measures proposed by Senator Kerry include requiring the federal government to negotiate drug prices on behalf of Medicare beneficiaries, and reimbursing employer-sponsored health plans for 75 percent of catastrophic medical expenses incurred by enrolled members. Senator Kerry claims that this should translate into lower premiums, allowing more individuals and small businesses to keep or begin purchasing health insurance.

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**Websites**

AARP

[www.aarp.org](http://www.aarp.org)

Alliance for Health Reform

[www.allhealth.org](http://www.allhealth.org)

America's Health Insurance Plans

[www.ahip.org](http://www.ahip.org)

Center for Studying Health System Change

[www.hschange.org](http://www.hschange.org)

Center on Budget and Policy Priorities

[www.cbpp.org](http://www.cbpp.org)

Centers for Medicare and Medicaid Services

[www.medicare.gov](http://www.medicare.gov)

The Commonwealth Fund

[www.cmwf.org](http://www.cmwf.org)

Covering Kids, The Robert Wood Johnson Foundation

[www.coveringkids.org](http://www.coveringkids.org)

Covering the Uninsured

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Families USA

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Government Accountability Office

[www.gao.gov](http://www.gao.gov)

Health Affairs

[www.healthaffairs.org](http://www.healthaffairs.org)

Health Care Leadership Council

[www.hlc.org](http://www.hlc.org)

Health Research and Educational Trust

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Insure Kids Now

[www.insurekidsnow.org](http://www.insurekidsnow.org)

The Kaiser Family Foundation

[www.kff.org](http://www.kff.org)

Medicare Payment Advisory Commission

[www.medpac.gov](http://www.medpac.gov)

National Academy of Social Insurance

[www.nasi.org](http://www.nasi.org)

National Coalition on Health Care

[www.nchc.org](http://www.nchc.org)

The Robert Wood Johnson Foundation

[www.rwjf.org](http://www.rwjf.org)

Southern Institute on Children and Families

[www.kidsouth.org](http://www.kidsouth.org)

State Coverage Initiatives

[www.statecoverage.net](http://www.statecoverage.net)

Urban Institute

[www.urban.org](http://www.urban.org)**ENDNOTES**

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