

# Chapter 8: Health Care Costs

**W**hen Americans speak of "health care reform," they often mean "reducing the cost of health care." This is particularly true for employers, through whom the majority of Americans receive their health coverage.

Governments too, at all levels, are concerned about their growing expenditures for health care and the trade-offs this imposes on other, equally important programs, such as education. And of course, health care can be a significant part of individual and family spending, particularly for those without health coverage or with limited coverage. Thus, tracking and attempting to rein in health care costs occurs constantly in the U.S.

At the same time, some health economists say we shouldn't be obsessed with the rising cost of care, particularly cost increases resulting from new treatments and technologies. These analysts have written that the benefits of these technologies as a whole more than outweigh their cost, as will be discussed later. (See box, "Are We Spending Too Much for Health Care?")

## HEALTH SPENDING TRENDS

In calendar year 2004, total health spending in the nation rose to \$1.88 trillion<sup>1</sup>, which equaled \$6,280 for

each person in the U.S.<sup>2</sup> This total was 7.9 percent higher than in 2003, well above the growth in gross domestic product.

Total health care spending was 16 percent of GDP in 2004, slightly higher than the 15.9 percent a year earlier.<sup>3</sup> By 2015, the federal Centers for Medicare and Medicaid Services estimates that the nation will spend \$4 trillion on health care – 20 percent of GDP.<sup>4</sup> (See chart, "National Health Spending as a Share of Gross Domestic Product, Selected Years.")

Spending is rising by all who pay for health care, including government insurance programs, primarily Medicare and Medicaid. Medicare spending grew by nearly 9 percent in 2004, to \$309 billion – all federal dollars.<sup>5</sup> Virtually everyone over 65 is eligible for Medicare, along with certain younger individuals who have permanent disabilities and those with end-stage renal disease.<sup>6</sup>

Medicaid, 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 on Medicaid in 2004 was \$293 billion, 7.9 percent higher than 2003, which was the smallest percentage increase in

## KEY FACTS

- Total health spending in the U.S. was \$1.88 trillion in 2004,<sup>a</sup> or an estimated \$6,280 for each person in the U.S.
- Total health spending increased 7.9 percent in 2004 compared to 2003.<sup>b</sup>
- Total health spending totaled 16 percent of GDP in 2004, up from 15.9 percent in 2003.<sup>c</sup>
- Of the increase in health spending in 2004, 33 percent went to spending on hospitals, 24 percent for physicians, 11 percent for prescription drugs, and 32 percent for all other spending categories.<sup>d</sup>
- Between 2005 and 2006, premiums for health coverage offered by employers increased 7.7 percent, the third straight year of declines in premium growth. Even so, this was more than twice the growth in the Consumer Price Index.<sup>e</sup>
- Of every dollar spent on health services in the U.S. in 2004, 45 cents came directly from government sources.<sup>f</sup>
- Costs for program administration and the net cost of private health insurance were about 7 percent of total health spending in the U.S. in 2004, and grew 9.4 percent, a rate higher than the 7.9 percent increase in total health spending.<sup>g</sup>

For story ideas on health care costs, see page 116. A list of experts and websites begins on page 117.

## Are We Spending Too Much for Health Care?

Although health care spending continues increasing faster than the GDP, some health economists believe this growth may not be a looming crisis for the country. Those holding this view argue that health spending growth may exceed GDP growth, yet still be affordable.

A recent Medicare Technical Review Panel defined growing health spending as “affordable” if it did not result in a downward trend in non-health spending, i.e., if the country as a whole could still purchase at least what it has been able to, outside of health care. Using this perspective, researchers found that the country could afford health care spending increases one percentage point greater than the growth in real per capita GDP until 2075 and growth that was two percentage points higher (closer to the historical norm) until 2039.<sup>1</sup> (It is worth noting, however, that in 2004, the gap was 4.4 percentage points – 7.9 percent growth in health spending vs. 3.5 percent growth in GDP.)<sup>2</sup>

There is no target share of GDP that should necessarily be devoted to health care.<sup>3</sup> In the past, when people believed that the opportunity cost of allowing health spending to grow was too high, then approaches to rein in costs were developed (e.g., cost sharing and managed care). These approaches have produced some short-term success. But there was little support for strengthening these controls, raising some doubt about their ability to control spending over the long term.<sup>4</sup>

<sup>1</sup> Chernew, Michael. (2003). “Increased Spending on Health Care: How Much Can the United States Afford?” *Health Affairs*, July/August, p. 15 - 25. ([www.healthaffairs.org](http://www.healthaffairs.org)).

<sup>2</sup> Smith, Cynthia et al. (2006). “National Health Spending in 2004: Recent Slowdown By Prescription Drug Spending.” *Health Affairs*, January/February, p. 186. ([www.healthaffairs.org](http://www.healthaffairs.org))

<sup>3</sup> Pauly, Mark (2003). “Should We Be Worried About High Real Medical Spending Growth In The United States?” *Health Affairs Web Exclusive* ([www.healthaffairs.org](http://www.healthaffairs.org))

<sup>4</sup> Pauly, Mark (2003). “Should We Be Worried About High Real Medical Spending Growth In The United States?” *Health Affairs Web Exclusive* ([www.healthaffairs.org](http://www.healthaffairs.org))

Medicaid spending in six years. The federal government paid \$173 billion for Medicaid in 2004 and the states paid most of the rest (in some states, local governments contribute a small amount).<sup>7</sup>

Premiums paid by employers also have been going up, much faster than overall inflation. (See chart, “Cost of Health Insurance Premiums Continues Rising Faster Than Earnings, Inflation or GDP.”)

Between 2005 and 2006, premiums for employer coverage increased by 7.7 percent. That was more than twice the growth in the Consumer Price Index (3.5 percent), but was the smallest percentage increase in premiums since 1999.<sup>8</sup> Small employers, those with less than 200 workers, saw their premiums increase by 8.8 percent, while firms above that size had their premiums increase by 7 percent.<sup>9</sup>

The percentage of the premium paid by workers has remained stable since 2000 at 16 percent. But in dollar terms, workers' contributions to their health coverage have increased considerably - from \$28 a month for single coverage in 2000 to \$52 in 2006, and from \$135 for family coverage to \$248.<sup>10</sup>

In addition, worker out-of-pocket spending is on the upswing for other types of cost sharing, such as copayments for office visits, and deductibles before coverage kicks in. (A copayment is the portion of a medical bill not covered by the patient's health insurance, and which must thus be paid out of pocket by the patient. A deductible is the amount a beneficiary must pay to directly to a health care provider before the person's health insurance begins paying anything.)

For the most common kind of coverage, a preferred provider organization (PPO), the average deductible an individual worker paid for a preferred or in-network provider grew 58 percent between 2001 and 2005, from \$204 to \$323.<sup>11</sup> If this amount had simply kept pace with inflation, workers would have paid only 10 percent more, or \$225, according to the U.S. Bureau of Labor Statistics' inflation calculator.<sup>12</sup>

Out-of-pocket expenses paid by individuals, whether insured or not, increased to \$236 billion in 2004 – up 5.5 percent over 2003.<sup>13</sup> (This doesn't include amounts paid for health insurance premiums.)

## WHAT DOES A HEALTH CARE DOLLAR BUY?

In 2004, nearly \$2 trillion was spent on health care and related services. What did all that money buy?

The most common way to answer that question comes from 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 2004, the latest year for which figures were available at press time. These expenditures include all money for health purposes, as defined in the NHA, paid by everyone – governments, businesses, non-business entities and individuals. (See chart, “National Health Expenditures, 2004.”)

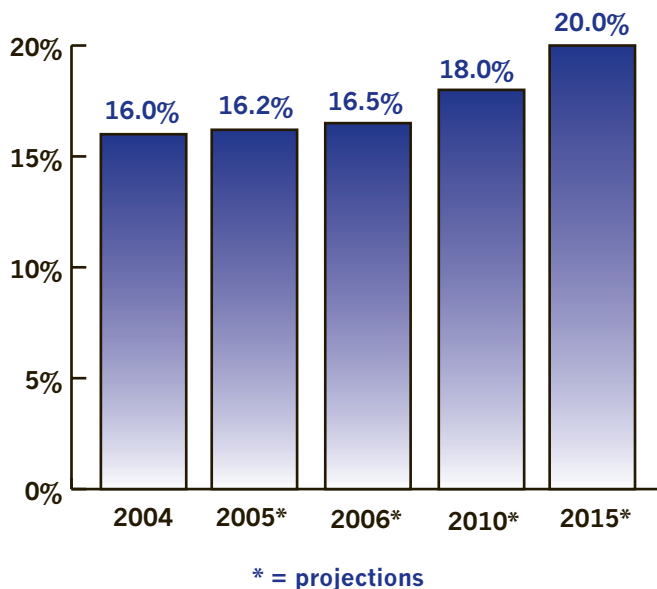
According to the National Health Statistics Group:<sup>14</sup>

- 30 cents went for hospital care, including spending for drugs dispensed in hospitals, plus hospital-based nursing homes and home-health care services
- 21 cents paid for physician services and other clinical services
- 10 cents paid for prescription drugs purchased at retail
- 7 cents paid for what’s termed “program administration and net cost of private health insurance,” i.e., administrative costs
- 6 cents paid for nursing home care in free-standing facilities
- 5 cents went for purchasing or constructing buildings and obtaining equipment such as x-ray machines, examination tables, MRI machines, etc.

Other categories, including dental services and public health, each accounted for less than 5 cents of the national health care dollar.

Of the overall 7.9 percent increase in health spending in 2004, 33 percent went to spending on hospitals, 29 percent for physicians, 11 percent for prescription drugs, and 27 percent for all other spending categories.<sup>15</sup>

## NATIONAL HEALTH SPENDING AS A SHARE OF GROSS DOMESTIC PRODUCT, SELECTED YEARS



Source: Christine Berger et al. (2006). "Health Spending Projections Through 2015: Changes on the Horizon." Health Affairs. ([www.healthaffairs.org](http://www.healthaffairs.org))

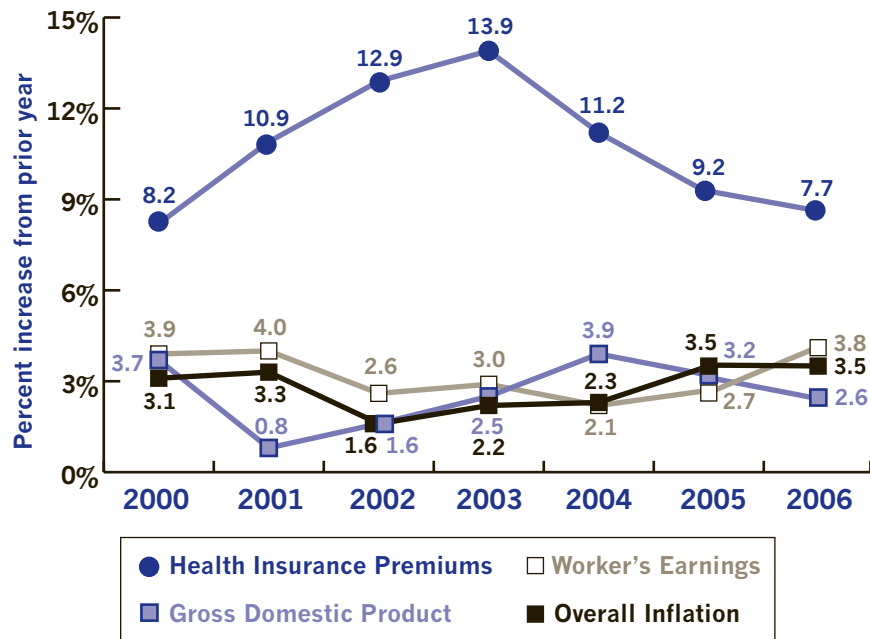
## WHO PAYS FOR HEALTH CARE?

In the end, the individual consumer pays for health care. Sometimes we pay out of our own pocket to health care providers. We pay premiums to health insurers who in turn pay health care providers, and we pay taxes to governments who use some of those funds to purchase health care. Portions of our wages are withheld, indirectly, to pay for the employer portion of the premium. Finally, some of the money we spend for the goods and services we purchase from companies is used to provide health care for their employees and retirees.

The National Health Accounts data provide a breakdown on the different payers for health care. Four sources accounted for 80.5 cents of every dollar of national health spending in 2004:<sup>16</sup>

- 35 cents came from private health insurance
- 16.5 cents came from federal government Medicare payments
- 16 cents came from federal and state payments for Medicaid

## COST OF HEALTH INSURANCE PREMIUMS CONTINUES RISING FASTER THAN EARNINGS, INFLATION, OR GDP



Note: GDP figure for 2006 is as of the second quarter, annually adjusted (2000 dollars).

Source: Kaiser Family Foundation and Health Research and Educational Trust (2006). "Employer Health Benefits: 2006 Annual Survey." Exhibit 1.1 ([www.kff.org/insurance/7527/upload/7527.pdf](http://www.kff.org/insurance/7527/upload/7527.pdf)) and U.S. Department of Commerce, Bureau of Economic Analysis (2006). "Gross Domestic Product: Percent Change from Preceding Period." ([www.bea.gov/bea/dn/gdpchg.xls](http://www.bea.gov/bea/dn/gdpchg.xls))

- 13 cents came from consumer out-of-pocket payments

The remaining sources are "other federal," "other state and local" and "other private" funds." (See chart, "Sources of Health Care Funds, 2004.")

## WHAT IS THE KEY DRIVER OF HEALTH CARE SPENDING?

Research shows that, above all other potential drivers of health care spending, advances in medical technology contribute the most to rising costs.<sup>17,18,19</sup> This includes the introduction of new equipment, new procedures and new treatments. These technological changes can increase health spending by introducing a new, more expensive treatment that becomes the standard therapy for a particular disease, or by lowering the cost of a treatment, thus increasing its use.<sup>20,21</sup>

An example of a technology that increased the unit cost of standard treatment is cardiac catheterization,

which has become a common addition to drug therapy in treatment of heart attacks. Laparoscopic gall bladder surgery is a technological advance that lowered the unit cost of a treatment (including reduced recovery time) and led more patients to have the procedure than would have occurred with the more invasive open gall bladder surgery.<sup>22</sup>

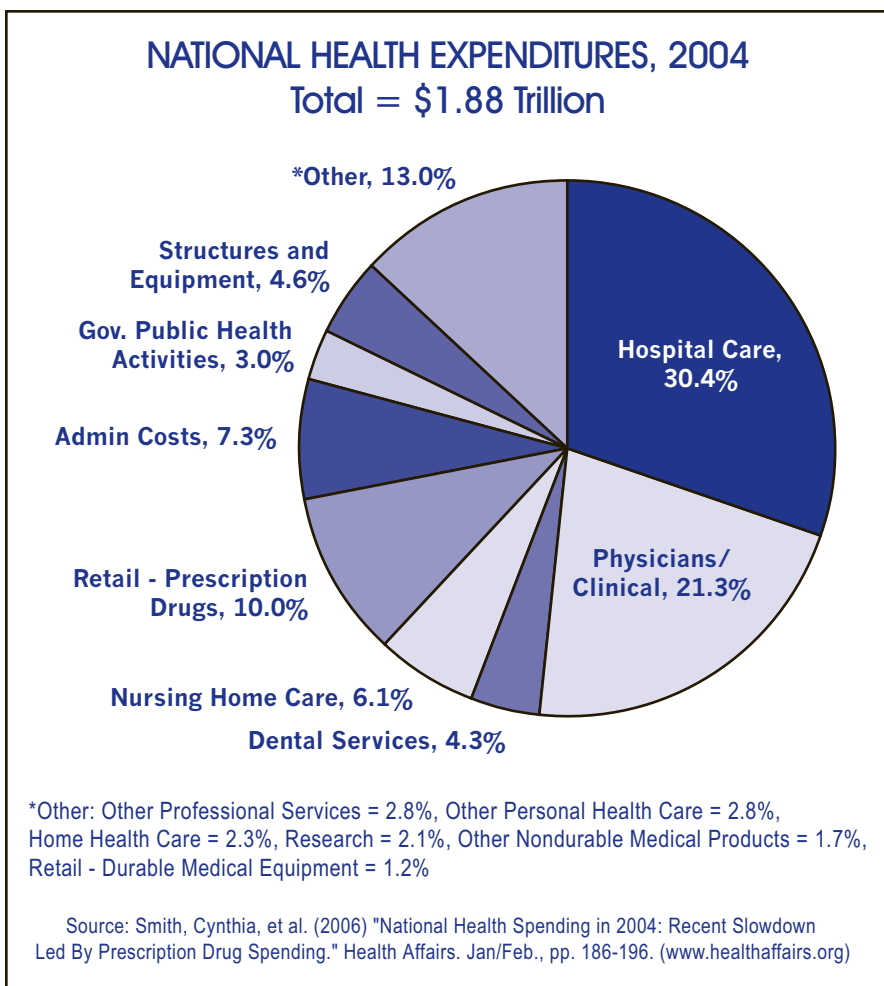
The additional costs of technological change have been clearly shown to improve health outcomes in many cases.<sup>23,24</sup> On the other hand, agreeing to pay for new technologies just because they are new can lead to inefficient health spending.<sup>25</sup>

## OTHER CONTRIBUTORS TO RISING COSTS

A number of factors other than technology also have been thought to influence the growth in health spending. Included among these are:

*Third-Party Payment* – Physicians and insured patients who make health care decisions are not directly responsible for the financial consequences of those decisions because health insurance shields patients from the true costs of treatment. As a result, neither the patient nor the physician has a strong financial reason not to use high-cost health services that could have a positive effect, even if cheaper alternatives may be just as effective.

*Managed Care "Pushback"* – Evidence suggests that some providers resisted contracting with managed care plans to put themselves in better bargaining positions and that, in some markets, this increased the fees paid by preferred provider organizations.<sup>26,27</sup> These high prices could be a problem for insurers, but it also appears that insurers have been able to continue to increase premiums and maintain operating margins, in part by consolidating to reduce competition.<sup>28</sup>



*Growing Prevalence of High-Cost Diseases* – Evidence suggests that the underlying prevalence of certain conditions and the occurrence of multiple chronic conditions is increasing, particularly among the Medicare population.<sup>29</sup> Changes in the costs and prevalence of specific high-cost diseases may be having an effect on the overall growth in health spending. A 2004 study found that five conditions – heart disease, pulmonary conditions such as asthma, mental disorders, cancer, and hypertension – accounted for 31 percent of the growth in health spending between 1987 and 2000.<sup>30</sup> An earlier study showed that obesity adds to health care costs for adults and is a more costly condition than smoking.<sup>31</sup>

*Lack of Information Technology* – Lack of an adequate system of information technology may be adding to overall health spending by contributing to poorly organized care (and adversely affecting quality of care).<sup>32</sup> For example, it is estimated that if 90 percent of all hospitals and doctors' offices were to adopt electronic medical record systems by 2018, \$77 billion could be saved annually. Most of the

savings would come from reduced hospital lengths-of-stay, nurses' administrative time, drug usage in hospitals, and drug and radiology use in the outpatient setting.<sup>33</sup> Still, this amount is less than 2 percent of projected future health spending by then.<sup>34</sup>

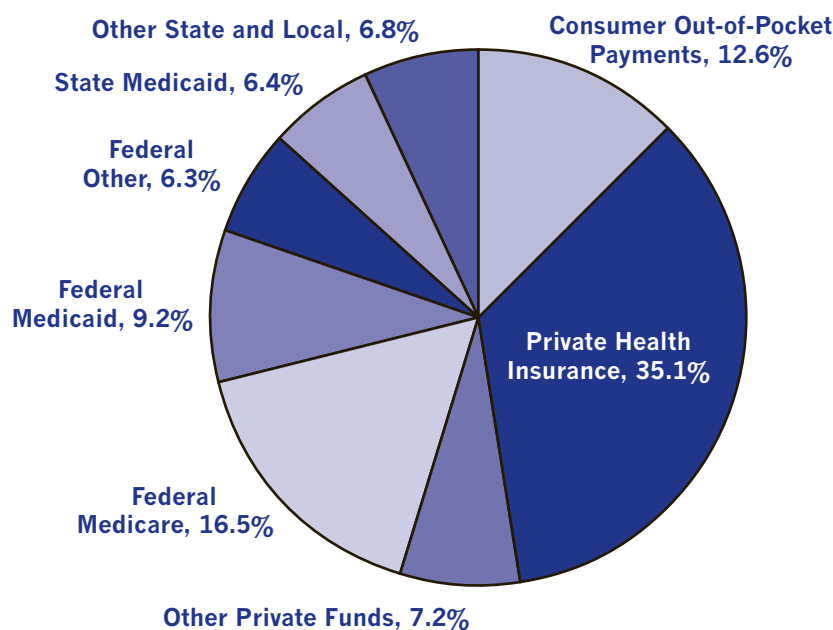
*Administrative Costs* – CMS actuaries concluded that administrative expenses do not have much of a role in explaining spending growth, since they comprised just 7 percent of overall health spending and contributed only 9 percent of 2004's growth in spending over 2003. However, in 2004, costs for program administration and the net cost of private health insurance grew faster than almost every other spending category,<sup>35</sup> suggesting that this type of spending warrants close attention.

*Malpractice Claims* – A recent study found that malpractice payments grew an average of 4 percent a year between 1991 and 2003. Malpractice payments comprised about the same share of total health care spending across this period, and were not an important factor in driving health care cost growth.<sup>36</sup> However, if doctors perform excessive or unnecessary tests to protect themselves in the event of a malpractice suit, a practice known as "defensive medicine," this could contribute to higher health spending.<sup>37,38</sup>

## APPROACHES TO CONTROLLING SPENDING GROWTH

Some approaches to controlling health spending rely on market forces, such as making patients more aware of the comparative costs and quality of health care providers in their area. Others lean on public sector controls on payment rates. In some other countries, such as Canada and Great Britain, costs are controlled by limiting the supply of medical technology in a region or by restricting patients' access to certain technologies, such as kidney

## SOURCES OF HEALTH CARE FUNDS, 2004



Source: Smith, Cynthia, et al. (2006) "National Health Spending in 2004: Recent Slowdown Led By Prescription Drug Spending." *Health Affairs*. Jan/Feb., pp. 186-196. ([www.healthaffairs.org](http://www.healthaffairs.org))

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dialysis for the elderly. Some may combine elements of all three strategies.

Spending controls that ultimately work will either lower the growth in the prices paid for health care services or the volume and intensity of the services patients receive.

Public payers set provider payment rates and, when budgets get tight, they will freeze, cut or slow the growth in those rates. The Balanced Budget Act of 1997 is an example of this approach applied to Medicare. Likewise, state Medicaid programs adopted controls on payments rates as part of their efforts to close budget shortfalls in recent years.<sup>39</sup>

Pricing strategies are not a long-run solution because provider fees cannot be cut indefinitely in either the public or private sectors. Nonetheless, fee cuts, freezes or slowdowns can produce short-run savings.

Strategies that address the growth in the volume and intensity of health services also have a long history. Cost-sharing through deductibles, copayments and coinsurance is well-established and is supposed to encourage people to use health care more

judiciously. However, the most comprehensive study of cost-sharing indicates that people do cut back use when cost-sharing amounts are raised, but they reduce necessary as well as unnecessary health care.<sup>40</sup>

In recent years, the cost-sharing strategy has spawned "consumer-directed health plans" in which high-deductible health plans are combined with health reimbursement accounts (HRAs) or health savings accounts (HSAs). President Bush based a large part of his health policy agenda in 2006 on expanding the use of HSAs (see box, "President Bush's Plan to Control Health Spending").

These approaches increase the patient's financial stake by having the consumer pay for covered services from his or her account until the high deductible is met, as well as pay for uncovered services (in the case of HSAs). At this point, there is little research to suggest what impact consumer-directed health plans will have on health spending. However, patients' incentives to seek less care will diminish if they have a chronic condition or if they get seriously ill, because spending will quickly exceed the deductible each year.

Managed care is another volume-oriented strategy that has evolved greatly over the years. Originally, managed care simply encouraged or required patients to use providers connected with a particular network of providers, with whom a health plan had negotiated rates. The idea of "managing" care to reduce unnecessary costs and improve quality now encompasses other approaches such as: disease management and case management to reduce waste among providers and patients; pay-for-performance to reward high quality care and efficiency; and preferred provider networks built on information about provider quality and price. (For explanations of these terms, please see the glossary.)

Government programs are also looking at traditional managed care as well as these newer strategies.

## President Bush's Plan to Control Health Spending

President Bush in early 2006 put forward a health care plan that would expand high-deductible insurance combined with HSAs and eliminate all taxes on out-of-pocket spending through HSAs. The President's vision is to empower the consumer to make decisions about purchasing health care based on the price and quality of services. In addition, providers and insurance companies would be urged to make information about prices and quality available so that consumers would be better able to make informed choices. Spending growth would be kept in check as consumers voluntarily limit overuse of medical care and spur development of more cost-effective technology.<sup>1,2</sup>

Opponents contend the President's plans will do little to control the growth in health spending. First, by giving out-of-pocket spending more favorable tax treatment, the plan could create incentives for spending to increase in much the same way that the current tax exclusion for employer contributions has led to the purchase of employer plans with relatively generous benefits. Second, since approximately 90 percent of health care spending is for patients spending at least \$1,000 for their health care, roughly the deductible for high-deductible plans,<sup>3</sup> high-cost patients may quickly exceed their deductibles and lose the incentive to limit their use of care. Third, with complex and hidden pricing for medical procedures and the need to often get urgent medical care before having an opportunity to compare prices, consumers may not be able to participate in the prudent decision making needed to control health care spending.<sup>4</sup>

<sup>1</sup> National Economic Council. (2006). "Reforming Health Care for the 21st Century." The White House. ([http://www.whitehouse.gov/stateoftheunion/2006/healthcare/healthcare\\_booklet.pdf](http://www.whitehouse.gov/stateoftheunion/2006/healthcare/healthcare_booklet.pdf)). Retrieved on March 31.

<sup>2</sup> Council of Economic Advisors. (2006). Economic Report of the President. (Washington: United States Government Printing Office).

<sup>3</sup> Thorpe, Kenneth. (2005). "The Rise in Health Care Spending And What To Do About It." Health Affairs, November/December, p. 1436 – 1445. ([www.healthaffairs.org](http://www.healthaffairs.org)). Retrieved on March 31.

<sup>4</sup> Ginsburg, Paul. (2006). Testimony before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health. "Consumer Price Shopping in Health Care." March 15. (<http://www.hschange.org/CONTENT/823/823.pdf>). Retrieved on March 31.

During the 1990s, many state Medicaid programs required enrollment in managed care plans for certain types of beneficiaries. Medicare has also tried to increase enrollment in managed care, via a program known as Medicare Advantage, but a relatively small share of beneficiaries enrolled when given this voluntary option. (For more on Medicare managed care, see Chapter 4, Medicare.) Currently, the Medicare Payment Advisory Commission and a series of legislative proposals are exploring options such as pay-for-performance, disease management and new payment system incentives to yield more cost-effective patterns of care.<sup>41,42</sup>

The rate of annual growth in health care spending typically varies across types of services, but the growth in spending on prescription drugs has led the way since the early 1990s. Between 1993 and 2003, prescription drug spending grew at an average annual rate of 13.3 percent, well in excess of the average annual growth in spending for hospitals (4.9 percent) or physicians (6.3 percent) spending.<sup>43</sup> The growth in prescription drug spending did not fall to a rate below that of hospital or physician services until the 2003–2004 period, when drug spending increased 8.2 percent.

In order to get drug spending under control, many employers implemented tiered cost-sharing and increased copayments. Under tiered cost-sharing, an individual may have a very low copayment for a generic drug, a somewhat higher copayment for a brand name drug included in a health plan's formulary or one for which there is no generic equivalent, and a large copayment for a name brand drug not on the formulary. (A formulary is a list of selected pharmaceuticals developed by a health plan or other coverage provider to guide physician prescribing.)

In 2006, 90 percent of covered workers had tiered cost-sharing for prescription drugs. The average copayment for "nonpreferred" drugs was almost four times as high as for generic drugs (\$38 vs. \$11).<sup>44</sup> In addition, people are using more over-the-counter versions of commonly used drugs like anti-ulcerants and antihistamines, and obtaining prescription drugs by mail order (sometimes from Canada or other countries).<sup>45</sup>

However, the mail-order importation of drugs has led to conflict between people's interest in obtaining drugs at low costs on the one hand, and concerns about drug safety and availability of drugs in the

exporting countries, on the other. And with the implementation of the Medicare drug benefit, questions have been raised about whether mail-order importation from other countries actually saves a Medicare beneficiary money.

## CONCLUSION

It is likely that attempts to constrain health spending growth will be pursued with increasing intensity over the next few years and that these attempts will continue to combine government price setting with consumer-directed health plans and evolving managed care approaches.

The search for cost containment strategies has been going on for decades. Researchers Drew Altman and Larry Levitt of the Kaiser Family Foundation concluded that Americans continually look for ways to control spending, but resist “tough decisions.”<sup>46</sup> Success may ultimately be found in a series of constantly evolving short-term strategies that draw on many different approaches as opposed to a single sweeping reform.

## STORY IDEAS

- Contact the large employers in your community and find out how many are offering employees high-deductible health plans (HDHPs) and health savings accounts (HSAs). How many employees are signing up and how is this influencing employer and employees costs? If some large employers have not chosen to offer the HDHP/HSA option yet, why not?
- Explore the impact that health plans with high cost-sharing may be having on providers' economic situations. Speak to hospitals, physician associations and community health centers to determine if a growing number of patients are having difficulties paying their share of the bill. Is there any evidence that patients with high deductibles are refusing tests or treatments that they would have to pay for out of pocket? Are community health centers seeing more patients with private insurance who want to avoid potentially larger out-of-pocket costs at higher priced providers?
- Speak to providers and their representatives about the impacts that consumer-directed health care may be having on patient behavior. Are patients seeking more information about the costs and quality of care before they agree to undergo tests or receive treatments? What types of questions do patients seem most interested in getting answered? Has this changed in recent years?
- Interview officials at major hospitals, representatives of physicians and health plan managers in your community to find out what new technologies (equipment, procedures, or drugs) are coming online. Ask if insurers decided to cover this service and what factors they took into account in making this decision. Try to determine if this new technology has replaced some previous medical service or if it is being provided in addition to existing technologies (e.g., a new diagnostic test).
- Interview officials at local health plans to determine how they perceive high costs may be influencing the type of care patients receive. Are patients more likely to use in-plan providers? Is there any evidence that elective surgery is becoming less prevalent? Are there fewer non-urgent emergency room visits? Have the frequency of visits for chronic conditions, such as diabetes, gone down? Or is expanding service use still a major reason for the growth in health care costs?
- Talk to a sample of small and large employers to determine how high health care costs are affecting the benefits they offer or the way they run their businesses. Are there plans to drop health insurance as a fringe benefit for their regular employees? Is there an effort to use more contract or part-time employees who would not be eligible to enroll in the company-sponsored health plan?
- Are state and local officials and managers of publicly subsidized health care facilities finding it increasingly difficult to meet the community's health care needs with available tax revenues? Is there a concern that public health problems could develop or spread more quickly than they otherwise would because the costs of maintaining an adequate health care safety net is too high?

## EXPERTS AND WEBSITES

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Kanof, Marjorie, *Managing Director*, Health Care, Government Accountability Office, 202/512-7114

Miller, Mark, *Executive Director*, Medicare Payment Advisory Commission, 202/220-3700

Rimkunas, Richard, *Head*, Health Insurance and Financing, Congressional Research Service, 202/707-7334

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Craine, Brenda, *Director*, Washington Media Relations, American Medical Association, 202/789-7447

Grealy, Mary, *President*, Healthcare Leadership Council, 202/452-8700

Halvorson, George, *Chairman and CEO*, Kaiser Permanente, 510/271-5660

Ignagni, Karen, *President and CEO*, America's Health Insurance Plans, 202/778-3200

Kahn, Charles, *President*, Federation of American Hospitals, 202/624-1500

Lehnhard, Mary Nell, *Senior Vice President*, Blue Cross Blue Shield Association, 202/626-4781

McArdle, Frank, *Principal*, Hewitt Associates LLC, 202/331-1155

Mongan, James, *President and Chief Executive Officer*, Partners Healthcare, 617/278-1004

Rogers, Edwina, *Vice President*, Health Policy, The ERISA Industry Committee, 202/789-1400

Shea, Gerry, *Assistant to the President of Government Affairs*, AFL-CIO, 202/637-5237

Stern, Andrew, *President*, Service Employees International Union, 202/898-3200

Tuckson, Reed, *Senior Vice President*, UnitedHealth Group, 952/936-1253

### **Websites**

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

Academy Health  
[www.academyhealth.com](http://www.academyhealth.com)

AFL- CIO  
[www.afl-cio.org](http://www.afl-cio.org)

Alliance for Health Reform  
[www.allhealth.org](http://www.allhealth.org)

Alliance of Community Health Plans  
[www.achp.org](http://www.achp.org)

American Enterprise Institute  
[www.aei.org](http://www.aei.org)

American Institutes for Research  
[www.air.org](http://www.air.org)

American Medical Association  
[www.ama-assn.org](http://www.ama-assn.org)

- America's Health Insurance Plans  
www.ahip.org
- Blue Cross Blue Shield Association  
www.bcbs.com
- Boston University School of Management  
http://management.bu.edu/index.html
- The Brookings Institution  
www.brook.edu
- Cato Institute  
www.cato.org
- Center for Studying Health System Change  
www.hschange.org
- Center on an Aging Society  
Georgetown University  
http://ihcrp.georgetown.edu/agingsociety/
- Center on Budget and Policy Priorities  
www.cbpp.org
- Centers for Medicare and Medicaid Services  
www.cms.hhs.gov
- Columbia University, Mailman School of Public Health  
www.mailman.hs.columbia.edu/
- The Commonwealth Fund  
www.cmwf.org
- Congressional Budget Office  
www.cbo.gov
- Consumers for Health Care Choice  
www.chcchoices.org
- Consumers Union  
www.consumersunion.org
- Council of Economic Advisors  
www.whitehouse.gov/cea
- Economic & Social Research Institute  
www.esresearch.org
- Employee Benefit Research Institute  
www.ebri.org
- The ERISA Industry Committee  
www.eric.org
- Families USA  
www.families.org
- Federation of American Hospitals  
www.fah.org
- Galen Institute  
www.galen.org
- George Washington University Department of Health Policy  
www.gwhealthpolicy.org
- Government Accountability Office  
www.gao.gov
- Health Affairs  
www.healthaffairs.org
- Healthcare Leadership Council  
www.hlc.org
- IMS Health  
www.imshealth.com
- Kaiser Family Foundation  
www.kff.org
- Kaiser Foundation Health Plan Inc.  
www.kaiserpermanente.org
- The Lewin Group  
www.lewin.com
- Massachusetts General Hospital  
www.mgh.harvard.edu
- Medicare Payment Advisory Commission  
www.medpac.gov
- National Academy of Social Insurance  
www.nasi.org
- National Coalition on Health Care  
www.nchc.org
- New America Foundation  
www.newamerica.net
- Partners Healthcare  
www.partners.org
- Private Enterprise Research Center  
www.tamu.edu/perc/
- Robert Wood Johnson Foundation  
www.rwjf.org
- Rollins School of Public Health  
Emory University  
www.sph.emory.edu
- Service Employees International Union  
www.seiu.org
- United Hospital Fund  
www.uhfnyc.org

UnitedHealth Group  
www.unitedhealthgroup.com

Univ. of Minnesota-Prime Institute  
www.pharmacy.umn.edu/centers/prime/

University of Pennsylvania  
www.wharton.upenn.edu

Urban Institute  
www.urban.org

## ENDNOTES

- <sup>a</sup> Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." Health Affairs, January/February, p. 186-196. (www.healthaffairs.org).
- <sup>b</sup> Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." Health Affairs, January/February, p. 186-196. (www.healthaffairs.org).
- <sup>c</sup> Borger, Christine, et al. (2006). "Health Spending Projections Through 2015: Changes on the Horizon." Health Affairs Web Exclusive, February 22, 2006, p. W61-W73. (www.healthaffairs.org). Retrieved on March 31
- <sup>d</sup> Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." Health Affairs, January/February, p. 186-196. (www.healthaffairs.org).
- <sup>e</sup> Kaiser Family Foundation and Health Research and Educational Trust (2006). "Employer Health Benefits: 2006 Annual Survey." Exhibit 1.1 (www.kff.org/insurance/7527/upload/7527.pdf)
- <sup>f</sup> Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." Health Affairs, January/February, p. 186-196. (www.healthaffairs.org).
- <sup>g</sup> Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." Health Affairs, January/February, p. 186-196. (www.healthaffairs.org).
- <sup>1</sup> Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." Health Affairs, January/February, p. 186-196. (www.healthaffairs.org).
- <sup>2</sup> Unless otherwise noted, all dollar amounts cited in this chapter are in current dollars (not adjusted for inflation).
- <sup>3</sup> Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." Health Affairs, January/February, p. 186-196. (www.healthaffairs.org).
- <sup>4</sup> Borger, Christine, et al. (2006). "Health Spending Projections Through 2015: Changes on the Horizon." Health Affairs Web Exclusive, February 22, 2006, p. W61-W73. (www.healthaffairs.org). Retrieved on March 31.
- <sup>5</sup> Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." Health Affairs, January/February, p. 186-196. (www.healthaffairs.org).
- <sup>6</sup> Kaiser Family Foundation (2006). Medicare at a Glance. April 21. (www.kff.org/medicare/7067/ataglance.cfm)
- <sup>7</sup> Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." Health Affairs, January/February, p. 186-196. (www.healthaffairs.org).
- <sup>8</sup> Kaiser Family Foundation and Health Research and Educational Trust (2006). "Employer Health Benefits: 2006 Annual Survey." Exhibit 1.1 (www.kff.org/insurance/7527/upload/7527.pdf)
- <sup>9</sup> Kaiser Family Foundation and Health Research and Educational Trust (2005). "Employer Health Benefits: 2005 Annual Survey." Chart 3. (www.kff.org/insurance/7315/sections/upload/7375.pdf)
- <sup>10</sup> Kaiser Family Foundation and Health Research and Educational Trust (2005). "Employer Health Benefits: 2005 Annual Survey." Chart 5. (www.kff.org/insurance/7315/sections/upload/7375.pdf)
- <sup>11</sup> Kaiser Family Foundation and Health Research and Educational Trust (2005). "Employer Health Benefits: 2005 Annual Survey." Chart 21. (www.kff.org/insurance/7315/sections/upload/7375.pdf)
- <sup>12</sup> This calculator can be found at <http://data.bls.gov/cgi-bin/cpicalc.pl>.
- <sup>13</sup> Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." Health Affairs, January/February, p. 188. (www.healthaffairs.org).
- <sup>14</sup> Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." Health Affairs, January/February, p. 187. (www.healthaffairs.org).

- 15 Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." *Health Affairs*, January/February, p. 186-196. ([www.healthaffairs.org](http://www.healthaffairs.org)).
- 16 Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." *Health Affairs*, January/February, p. 186-196. ([www.healthaffairs.org](http://www.healthaffairs.org)).
- 17 Newhouse, Joseph. (1992). "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives*, Summer p. 3–21.
- 18 Technical Review Panel for the Medicare Trustees Reports. (2000). "Review of Assumptions and Methods of the Medicare Trustees' Financial Projections." (<http://www.cms.hhs.gov/ReportsTrustFunds/downloads/TechnicalPanelReport2000.pdf>).
- 19 Nichols, Len. (2002). "Can Defined Contribution Health Insurance Reduce Cost Growth?" *Employee Benefit Research Institute Issue Brief No. 246* (<http://www.ebri.org/pdf/briefspdf/0602ib.pdf>).
- 20 Cutler, David & Mark McClellan. (2001). "Is Technological Change in Medicine Worth It?" *Health Affairs*, September/October, p. 11–29. ([www.healthaffairs.org](http://www.healthaffairs.org)).
- 21 Cutler, David & Robert Huckman. (2003). "Technological Development and Medical Productivity: The Diffusion of Angioplasty in New York State." *Journal of Health Economics*, March p. 187–217.
- 22 Legorreta, Antonio et al. (1993). "Increased Cholecystectomy Rate After the Introduction of Laparoscopic Cholecystectomy." *Journal of the American Medical Association*, September 22, p. 1429 – 1432.
- 23 Cutler, David. (2004). *Your Money or Your Life: Strong Medicine for America's Health Care System*. (New York: Oxford University Press).
- 24 Cutler, David & Mark McClellan. (2001). "Is Technological Change in Medicine Worth It?" *Health Affairs*, September/October, p. 11–29. ([www.healthaffairs.org](http://www.healthaffairs.org)).
- 25 Strunk, Bradley C. and Paul Ginsburg (2004). "Tracking Health Care Costs: Trends Turn Downward in 2003." *Health Affairs*, June 9. ([www.healthaffairs.org](http://www.healthaffairs.org))
- 26 Strunk, Bradley et al. (2001). "Health Plan–Provider Showdowns on the Rise." *Center for Studying Health System Change, Issue Brief No. 40*. (<http://www.hschange.com/CONTENT/326/>). Retrieved on March 31.
- 27 Capps, Cory & David Dranove. (2004). "Hospital Consolidation and Negotiated PPO Prices." *Health Affairs*, March/April, p. 175–81. ([www.healthaffairs.org](http://www.healthaffairs.org)).
- 28 Robinson, James. (2004). "Consolidation and the Transformation of Competition in Health Insurance." *Health Affairs*, November/December, p. 11–24. ([www.healthaffairs.org](http://www.healthaffairs.org)).
- 29 Anderson, Gerard et al. (2004). "Chronic Conditions: Making the Case for Ongoing Care." *Partnership for Solutions, Robert Wood Johnson Foundation*. (<http://www.rwjf.org/files/research/Chronic%20Conditions%20Chartbook%209-2004.ppt>). Retrieved on March 31.
- 30 Thorpe, Kenneth et al. (2004). "Which Medical Conditions Account for the Rise in Health Care Spending?" *Health Affairs Web Exclusive*, August 25, p. W4-437 – W4-445. ([www.healthaffairs.org](http://www.healthaffairs.org)). Retrieved April 4.
- 31 Sturm, Roland. (2002). "The Effects of Obesity, Smoking, and Drinking on Medical Problems and Costs." *Health Affairs*, March/April, p. 245 – 253. ([www.healthaffairs.org](http://www.healthaffairs.org)).
- 32 Goldsmith, Jeff et al. (2003). "Federal Health Information Policy: A Case Of Arrested Development." *Health Affairs*, July/August, p. 44 – 54. ([www.healthaffairs.org](http://www.healthaffairs.org)).
- 33 Hillestad, Richard et al. (2005). "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, And Costs." *Health Affairs*, Sept./Oct., p. 1107. ([www.healthaffairs.org](http://www.healthaffairs.org))
- 34 Borger, Christine, et al. (2006). "Health Spending Projections Through 2015: Changes on the Horizon." *Health Affairs Web Exclusive*, February 22, 2006, p. W61-W73. ([www.healthaffairs.org](http://www.healthaffairs.org)). Retrieved on March 31.
- 35 Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." *Health Affairs*, January/February, p. 186-196. ([www.healthaffairs.org](http://www.healthaffairs.org)).
- 36 Chandra, Amitabh et al. (2005). "The Growth Of Physician Medical Malpractice Payments: Evidence From The National Practitioner Data Bank." *Health Affairs Web Exclusive*, May 31, 2005, p. W5-240 – W5-249. ([www.healthaffairs.org](http://www.healthaffairs.org)). Retrieved on March 31.

- <sup>37</sup> Kessler, Daniel and Mark McClellan (1996). "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*, Vol. 111, No. 2, (May).
- <sup>38</sup> FactCheck.org. "President Uses Dubious Statistics on Cost of Malpractice Lawsuits." Annenberg Public Policy Center, Univ. of Pennsylvania. ([www.factcheck.org/article133.html](http://www.factcheck.org/article133.html))
- <sup>39</sup> Coughlin, Teresa & Zuckerman, Stephen (2005). "Three Years of State Fiscal Struggles: How Did Medicaid and SCHIP Fare?" *Health Affairs Web Exclusive*, August 16, p. W5-385 – W5-398. ([www.healthaffairs.org](http://www.healthaffairs.org)). Retrieved April 4.
- <sup>40</sup> Newhouse, Joseph. (1995). *Free for All? Lessons from the RAND Health Insurance Experiment*. (Cambridge, MA.: Harvard University Press).
- <sup>41</sup> Medicare Payment Advisory Commission. (2005). "Report to the Congress: Medicare Payment Policy." ([www.aafp.org/online/en/home/publications/news/news-now/archive/080505healthit.html](http://www.aafp.org/online/en/home/publications/news/news-now/archive/080505healthit.html)). Retrieved April 4.
- <sup>42</sup> American Academy of Family Physicians. (2005). "Compare Medicare Physician Payment, Health IT Bills." August. (<http://www.aafp.org/x36696.xml>). Retrieved April 4.
- <sup>43</sup> Zuckerman, Stephen & Joshua McFeeters. (2006). "Recent Growth in Health Expenditures" *The Commonwealth Fund, Commission on a High Performance Health System*. ([http://www.cmwf.org/publications/publications\\_show.htm?doc\\_id=362803&#doc362803](http://www.cmwf.org/publications/publications_show.htm?doc_id=362803&#doc362803)). Retrieved April 4.
- <sup>44</sup> Kaiser Family Foundation. (2005). "Prescription Drug Trends." November. (<http://www.kff.org/rxdrugs/3057-04.cfm>). Retrieved April 3, 2006.
- <sup>45</sup> Smith, Cynthia et al. (2006). "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." *Health Affairs*, January/February, p. 186-196. ([www.healthaffairs.org](http://www.healthaffairs.org)).
- <sup>46</sup> Altman, Drew & Larry Levitt. (2002). "The Sad History of Health Care Cost Containment as Told in One Chart." *Health Affairs Web Exclusive*, January 23, p. W83 – W84. ([www.healthaffairs.org](http://www.healthaffairs.org)). Retrieved on April 4.