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CENTER FOR HEALTH POLICY
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The Rising Tide of Healthcare Costs in Indiana

High healthcare costs are a perennial policy concern in Indiana and across the nation. While it is relatively easy to measure these costs, it is much more challenging to estimate with confidence just how much we should spend as a society. This is particularly true in recent years, both because the growing life science sector is a major source of economic development and because there is increasing concern that our high healthcare expenditures are not resulting in better overall health. Even when consensus exists that costs should be curtailed, before we can implement effective containment strategies, we must first understand why costs are as high as they are and what factors are driving them higher.

In this issue brief, we first summarize the cost situation in Indiana, using national and international benchmarks to assess to what extent healthcare costs are a problem in the state. We then discuss possible causes of increasingly high costs that have been identified in the health services literature, again using empirical evidence to evaluate the validity of these claims when possible. Finally, given the most likely drivers of high healthcare costs, we identify some cost containment strategies that are now being discussed in policy circles.

In 2004, Indiana spent a total of $33 billion dollars on health care.[1] This represents 14.4% of gross state product, or roughly $1 of every $7 of income generated in the state. These numbers translate to $5,295 spent, on average, on every man, woman, and child in Indiana.

Assessing the Problem

In 2004, Indiana spent a total of $33 billion dollars on health care.[1] This represents 14.4% of gross state product, or roughly $1 of every $7 of income generated in the state. These numbers translate to $5,295 spent, on average, on every man, woman, and child in Indiana. In contrast, nationwide, 13.3% of income (or about 93 cents of every $7 dollars earned) is spent on health care.[1] Spending in Indiana is particularly high for expensive institutional care, including both acute hospital and long-term care facilities (see Table I).

High spending on health care is not, in itself, a problem. It becomes a problem if the value of the care obtained does not merit the expenditures, or if the level of expenditures is so high that it impairs the functioning of other important sectors of the economy. In an international context, it is well established that the investment the U.S. makes in health care generates much lower health outcomes than those achieved in countries that spend considerably less.[2] This seems to be especially true in Indiana, where, despite spending more per capita than the rest of the country, Hoosiers suffer from an age-adjusted mortality rate that is 6.2% higher than the national average, with excess mortality particularly notable in diabetes- and cancer-related deaths.[3]

A second concern is costs becoming so high that they are no longer economically sustainable. Between 1995 and 2004, personal healthcare expenditures in Indiana rose 83% while gross state product grew only 55%. This discrepancy in growth rates was twice the national average.[1] If the trends of the early years of this decade continue, healthcare spending will absorb half the state's income

Table I: Per Capita Health Expenditure, by Type, U.S. and Indiana, 2004

	Type of Expenditure				
	Hospital	Nursing Home	Drugs	Physician	Other
Indiana	$2,051	$461	$796	$1,264	$723
U.S.	$1,931	$392	$757	$1,341	$861

Source: Centers for Medicare and Medicaid Services, Health Expenditure Data, Health Expenditures by State of Residence, 2007

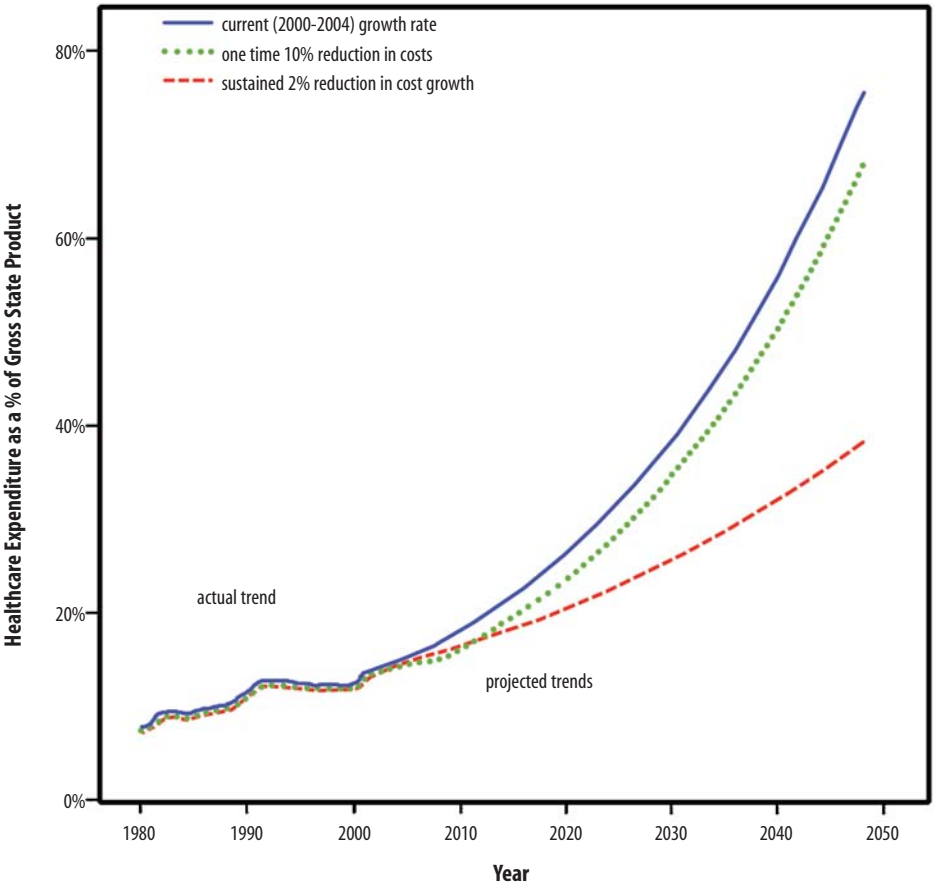
within 35 years (see Figure 1). High healthcare costs can have several economic impacts. Government might be able to support other essential functions without raising taxes to onerous levels. Businesses might be unable to stay competitive while still supporting the employer-based health insurance system on which the nonelderly population relies. Individuals, particularly those who most need health care and could benefit most from it, would likely no longer afford to access these services.

While public spending is a lower *portion* of total healthcare expenditure in the U.S. than in other developed countries, it is at a comparable *level*.[4] In Indiana, state spending on health care is second only to spending on education. Medicaid alone now consumes 12% of the state budget,[5] even though the federal government covers roughly 60% of the state's Medicaid costs. However, the federal government's ability to continue to support state spending on Medicaid is uncertain because of the challenges it will face to continue funding Medicare under the dual pressures of rising healthcare costs and an aging population. The Office of Management and Budget has predicted that if current trends continue for another 10 to 20 years, the tax increases that will be required to support Medicare spending will be so high that they will "threaten the Nation's future prosperity."[6] Under such conditions, it is likely that all levels of government will face increasing fiscal strain, and that healthcare costs, if not constrained, will crowd out other essential public functions such as education and public safety.

Rising healthcare costs have already led to erosion in the employer-based health insurance system. Although Indiana has historically enjoyed relatively high levels of employer-based coverage between 2001 and 2005, Indiana has experienced an 8.8% drop in such coverage.[7] This effect can be attributed to the loss of manufacturing jobs in the state, possibly because high insurance costs make large manufacturers less competitive in a global economy, and because the small firms that remain are less able or willing to offer coverage for employees. In 2006, only 34% of Indiana firms with fewer than 50 employees offered health insurance to their workers, notably lower than the 43% who did so nationally.[3] The firms that continue to offer insurance are shifting an increasing portion of costs to their employees.[8]

Hoosiers are increasingly confronting significant financial barriers to appropriate health care, not just because of the direct effect of rising healthcare costs, but also because of the actions of government (limiting eligibility for public programs) and employers (dropping coverage) in response to these increasing costs. Even by 2001, average personal spending on healthcare exceeded that spent on food, housing, or transportation.[9] In the absence of complete insurance coverage, the burden of healthcare costs is not evenly distributed across the population. Nearly a quarter of nonelderly families in Indiana spend at least 10% of their pretax income on

Figure 1: Actual and Projected Growth in Healthcare Expenditures as a Percentage of GSP, Indiana, 1980-2050



Source: Centers for Medicare and Medicaid Services, Health Expenditure Data, Health Expenditures by State of Residence, 2007; author's calculations

health care,[10] and as many as half of all personal bankruptcies may be due to medical expenses.[11] While these burdens are particularly acute for Hoosiers with lower incomes and serious health issues, they are increasingly affecting the middle class.[12] As healthcare costs continue to rise, an increasingly large share of the population may find that it is simply priced out of the healthcare market.

Identifying Causes

A number of possible causes have been identified as contributing to high costs, including "prices, technology, aging, waste, inefficiency, the legal system, new disease patterns, corporate consolidation, or profligate providers and consumers."[13] This brief summarizes the three most likely culprits.

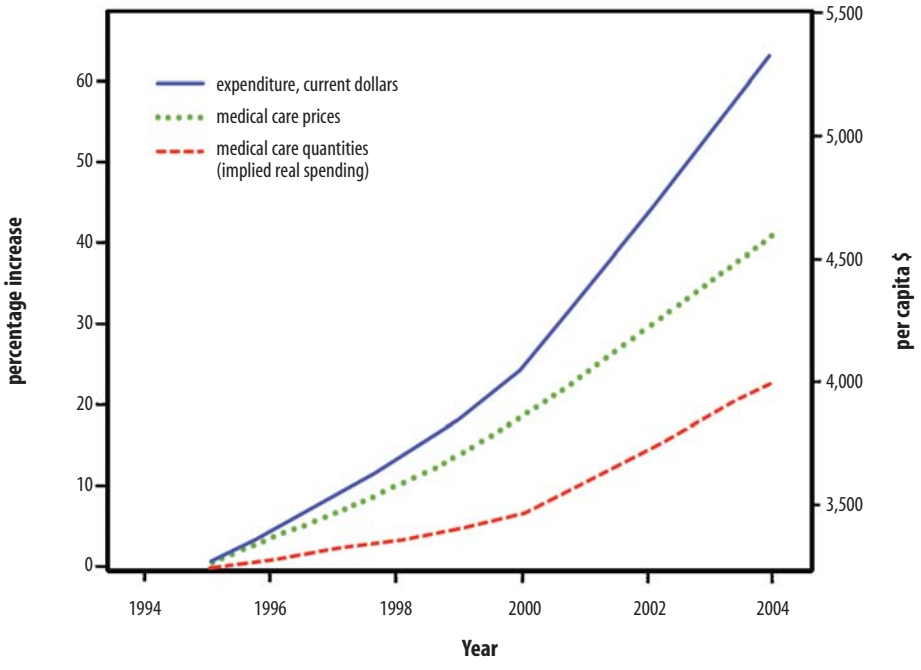
1. *Administrative Inefficiencies*
   A number of researchers have pointed to the high costs of administering the U.S. healthcare system as a potential explanation for high costs. For instance, researchers have estimated that per capita administrative costs in the U.S. in 1999 were $1,059, compared to only $307 in Canada.[14] Most of this cost difference has been attributed to the highly fragmented insurance system in the U.S., resulting in much more complex billing-related activities, a lower rate of information technology uptake,[15,16] and higher levels of spending on marketing and underwriting associated with competitive insurance markets.[14] It has been estimated that Indiana spends $5.5 billion annually on such excess administrative expenses.[17]

2. *High Healthcare Prices*
   International observers have noted that the higher expenditures on health care in the U.S. have not resulted in higher levels of service use or availability.[2] One possible explanation is that the U.S. pays higher prices for care. Increasing prices for individual services appear to be a major driver of healthcare costs. From 1995-2004, when the Centers for Medicare and Medicaid Services (CMS) reported that U.S. per capita healthcare spending increased by 63%, the Bureau of Labor Statistics reported healthcare prices increased 41%.[1,18] Thus it appears that price increases drove most of the increase in overall healthcare costs during this 10-year period (see Figure 2). Thomas Bodenheimer, after assessing the leading causes of healthcare cost increases, concluded that the most important causes are market conditions in the U.S. that allow providers to negotiate ever-increasing prices for their services.[19]

3. *High Healthcare Utilization*
   Both supply- and demand-side factors have been blamed for the high use of health care. For instance, problems with care coordination and concerns with malpractice are thought to lead to unnecessary duplication and overuse of services by providers. Similarly, several factors, including age, disease prevalence, and risky behaviors (e.g., smoking), are thought to increase patients' need for services. These effects should result in higher quantities of care being provided, but, as noted before, international evidence does not support this quantity hypothesis.

   Instead, it is likely that the U.S. uses different types of health care than elsewhere, health care that is more expensive and may yield a lower return on investment. Reimbursement rates have long rewarded expensive spe-

Figure 2: Changes in Medical Expenditures and Prices, US, 1995-2004



Source: Centers for Medicare and Services, Health Expenditure Data, Health Expenditures by State of Residence, 2007; BLS, Consumer Price Index, 2008

cialty care more liberally than primary care.[20] This encourages an abundance of both speciality care providers and hospitals in Indiana, where a disproportionate share of medical students enter surgical specialities[21] and specialities have proliferated.[22] Not surprisingly, these providers perform surgery at a higher rate in Indiana compared with rates in other states,[23] resulting in a disproportionate share of healthcare spending on hospital care (see Table I, page 1). Compounding this problem are perverse incentives stemming from competitive insurance markets that foster large financial barriers for the people who are most likely to benefit from health care. This inequitable price rationing results in overinvestment in services related to the choice and comfort of the well-insured, and under-investment in effective basic care.[24]

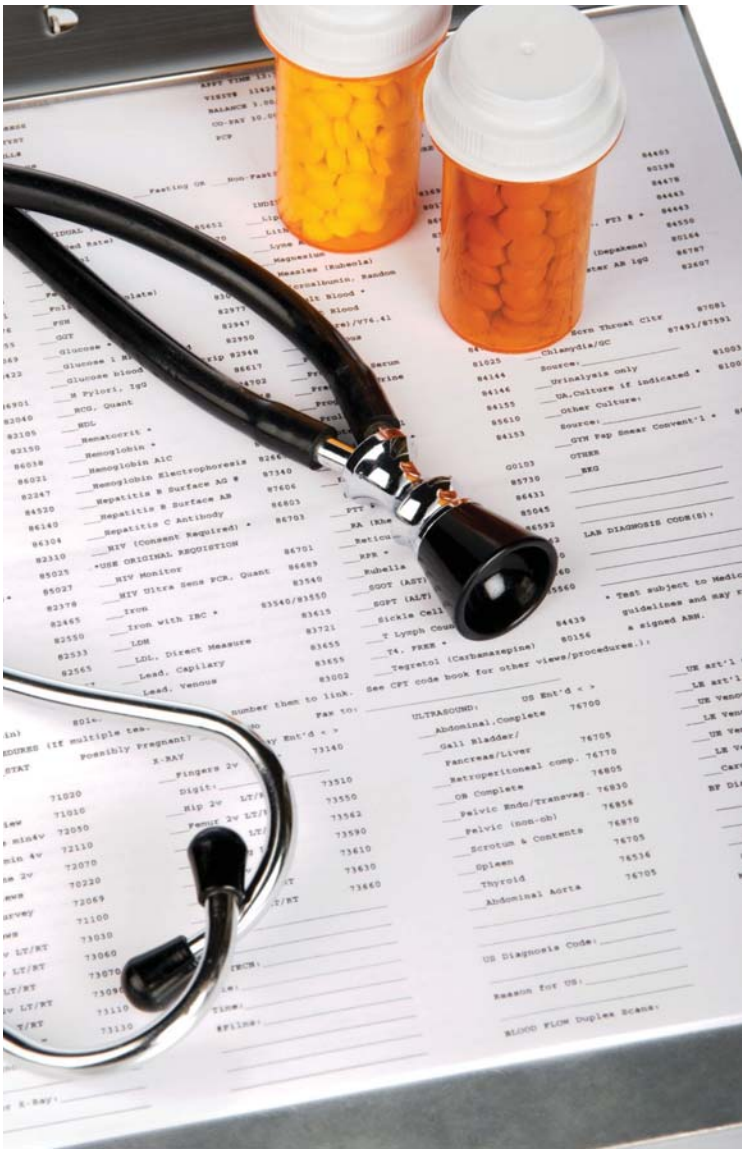
Thoughts for Policymakers

A number of proposals to reduce healthcare spending are currently under public discussion. When evaluating these proposals, it is important to distinguish between those that cause once-and-for-all reductions in costs, and those that constrain cost growth. As depicted in Figure 1 (page 2), the restraining influence of cost containment strategies that do not address cost growth are short-lived and merely delay the time when healthcare spending will become unsustainable.

1. *Policies Targeting Administrative Costs*

   Because administrative costs in the private insurance market are much higher than those incurred in public insurance programs, either domestically or abroad, policymakers often see constraining administrative costs as a way to control healthcare spending without adversely impacting patient care.

   One proposal is to require insurance companies to maintain a minimum loss ratio. For example, a minimum loss ratio of 80% would require that at least 80% of all revenues be spent on direct patient care.[25,26] While this may reduce resources devoted to marketing and overhead, it may also limit spending on initiatives that may improve insurees' health, including some disease management programs. It may also further discourage insurers from participating in individual and small-group markets where overhead rates tend to be highest.



A second proposal is to regulate insurance markets to reduce resources devoted to market segmentation. The strategy would encourage competition on costs rather than risk. Some states have adopted a policy of guaranteed issue that compels insurance companies to charge the same premiums to all purchasers.[27,28] However, such initiatives, without accompanying protection for insurers against adverse selection by high risk insurees, could serve to further destabilize the private insurance market. Recently, Massachusetts pioneered the use of healthcare exchanges in a program, called the Commonwealth Connector, in which individuals purchasing health insurance can join with others and spread risk over larger numbers of people.[29]

A third proposal is to facilitate the use of information technology to streamline the billing process.[16] Such strategies require not only the dissemination of an interconnected technology infrastructure, but also standardized billing protocols across insurance plans and consumers.

2. *Policies Targeting Price Levels and Relative Prices*

Because of empirical evidence that prices for health care, especially specialty care, are unusually high in the U.S., some policymakers see controlling provider prices as a logical policy initiative. Unlike improving efficiency in administration, which would result in a one-time cost reduction, constraining price increases offers a mechanism to constrain cost growth.

One proposal is to foster countervailing payer-side market power by large purchasers of health care.[30] Such countervailing power may be particularly effective when negotiating with large, well-organized specialty practices, as they will generally seek to preserve their pay differentials over less well-compensated primary care providers.[20] Past attempts to exercise such payer-side market power have shown limited success because they are often countered by mergers that further consolidate the market power of providers. There are also economic risks associated with a highly concentrated payer (i.e., insurance) market.

A second proposal is to differentially limit prices to affect the mix of care. In particular, compensation can be structured to correct Indiana's apparent overuse of institutional care and shortages in the primary care workforce. The state, however, has a limited ability to effect this change via reimbursement rates offered through its own programs (e.g., Medicaid).[36] An alternative that may achieve a more global impact is to impose differential taxes on certain types of providers (e.g., ambulatory surgery centers).[31]

Many observers believe that true cost containment will require control not only over prices, but also quantities.[14, 35] This requires negotiating global cost constraints with providers (e.g., Medicare's Volume Performance Standards).[32] The success of such initiatives in Indiana could be limited by the extent to which many Hoosiers living along the state's periphery seek care from out-of-state providers.

3. *Policies Targeting Patterns of Utilization*

Empirical evidence also suggests that certain types of health care are over-utilized while others are under-utilized. In other countries, new technologies are prioritized according to their economic and health impact, a strategy that improves the efficiency of their healthcare systems. In the U.S., utilization is driven by financial incentives that are sometimes perverse, often resulting in the wrong people receiving the wrong type of care. Many policymakers see potential in realigning financial incentives to reduce healthcare costs and improve system performance.

One proposal is to change provider reimbursement to encourage the provision of high-value care. For instance, pay-for-performance schemes may help improve the return on investment in health care.[33] These schemes reward the provision of care that adheres to best practice guidelines, improves care coordination, and reduces medical errors. However, the successful implementation of this strategy might require significant investments in information, including the identification and development of best practices, the construction of information systems capable of tracking the provision of such care, and development of risk-adjustment algorithms to discourage providers from choosing patients who are most likely to adhere to care recommendations.

A second class of proposals is to adjust the financial incentives directed to patients to improve their health-related and care-seeking behaviors. For instance, Florida's Medicaid program has been experimenting with financial incentives to promote healthy behaviors among their Medicaid enrollees.[34] More commonly, such approaches have focused on increasing patient cost-sharing for health care. The potential success of such strategies will again depend on providing the information that patients need to make efficient choices about their health care. Not only must price information be provided, but also accurate information on the potential risks and benefits associated with each treatment option.[35] In some situations, the costs of providing such information may well exceed the potential savings from increased cost-sharing. In addition, the potential benefits of more efficient care provision must be weighed against the shift of financial burden to vulnerable populations.

Summary

The seemingly never-ending rise in healthcare costs will continue to be a significant challenge for policymakers over the next several decades, as the rate of increase in healthcare costs is expected to outpace inflation and growth in other sectors of our economy. The many factors contributing to rising healthcare costs suggest it is highly unlikely that any single policy proposal alone will have a sufficiently significant impact. True healthcare cost containment will require a comprehensive policy strategy that addresses multiple cost drivers.

References

1. Centers for Medicare and Medicaid Services. (2007, September). *Health expenditure data, health expenditures by state of residence.* Washington, DC: Office of the Actuary, National Health Statistics Group. Available at http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp#TopOfPage

2. Anderson, G.F., Reinhardt, U.E., Hussey, P.S., & Petrosyan, V. (2003). It's the prices, stupid: why the United States is so different from other countries. *Health Affairs*, 22(3), 89-105.

3. Kaiser Family Foundation (n.d.). *50 state comparisons*. Retrieved June 18, 2007, from http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare

4. Organisation for Economic Cooperation and Development. (2007). OECD *Health Data 2007*. Paris: OECD. Available at http://www.oecd.org/dataoecd/46/36/38979632.xls

5. Indiana Local Government Information Website. (2008). *An overview of the Indiana State Budget*. West Lafayette, IN: Dept. of Agricultural Economics, Purdue University. Available at http://www.agecon.purdue.edu/crd/localgov/Topics/Essays/State_Budget.htm#Revenues,%20Expenditures%20and%20Balances

6. Office of Management and Budget. (2007). *The nation's fiscal outlook*. Washington, DC: Executive Office of the President. Available at http://www.whitehouse.gov/omb/budget/fy2007/outlook.html

7. State Health Access Data Assistance Center. (2008). Squeezed: How costs for families are outpacing incomes. RWJF 2008. Available at http://www.rwjf.org/files/research/042508ctuwfinalembargoed.pdf

8. Families USA. (2008). *Premiums versus paychecks: A growing burden for Indiana's workers*. Washington, DC: Families USA. Available from http://familiesusa.org/assets/pdfs/premiums-vs-paychecks/indiana.pdf

9. Reinhardt, U.E., Hussey, P.S., & Anderson, G.F. (2004). U.S. health care spending in an international context. *Health Affairs*, 23(3), 10-25.

10. Families USA. (2007). *Too great a burden: America's families at risk.* (Publications No. 07-113). Washington, DC: Families USA. Available from http://www.familiesusa.org/assets/pdfs/too-great-a-burden.pdf

11. Himmelstein, D.U., Warren, E., Thorne, D., & Woolhandler, S. (2005, February 2). Illness and injury as contributors to bankruptcy. *Health Affairs*. (Web exclusive W5-63-W5-73).

12. Banthin, J.S., Cunningham, P., & Bernard, D.M. (2008). Financial burden of health care, 2001-2004. *Health Affairs*, 27(1), 188-195.

13. Anderson, G.F., Hussey, P.S., Frogner, B.K., & Waters, H.R. (2005). Health spending in the United States and the rest of the industrialized world. *Health Affairs*, 24(4), 903-14.

14. Woolhandler, S., Campbell, T., & Himmelstein, D.U. (2003). Costs of health care administration in the United States and Canada. *New England Journal of Medicine*, 349(8), 768-75.

15. Kahn, J.G., Kronick, R., Kreger, M., & Gans, D.N. (2005). The cost of insurance administration in California: Estimates for insurers, physicians, and hospitals. *Health Affairs*, 24(6), 1629-39.

16. Anderson, G.F., Frogner, B.K., Johns, R.A., & Reinhardt, U.E. (2006). Health care spending and use of information technology in OECD countries. *Health Affairs*, 25(3), 819-31.

17. Himmelstein, D.U, Woolhandler, S., & Wolfe, S.M. (2004). Administrative waste in the U.S. health care system in 2003: The cost to the nation, the states, and the District of Columbia, with state-specific estimates of potential savings. *International Journal of Health Services*, 34(1), 79-86.

18. Bureau of Labor Statistics. (2008). *Consumer Price Index*. Washington, DC: US Department of Labor. Available at http://www.bls.gov/cpi/home.htm

19. Bodenheimer, T. & Fernandez, A. (2005). High and rising health care costs. Part 4: can costs be controlled while preserving quality? *Annals of Internal Medicine*, 143(1), 26-31.

20. Ginsburg, P.B. & Berenson, R.A. (2007). Revising Medicare's physician fee schedule – Much activity, little change. *NEJM*, 356(12), 1201-1203.

21. Hardin, M. (2006, March 16). *Soon-to-be Docs from Indiana University set sights on residencies nationwide.* Indianapolis, IN: Indiana University School of Medicine News. Available from www.medicine.indiana.edu/news_releases/view Release.php4?art=477

22. Berenson, R.A., & Bazzoli, G.J. (2006). *Specialty hospitals promote price competition?* (Brief No. 103). Washington, DC: Health Systems Change Issue. Available at http://www.hschange.com/CONTENT/816/

23. Chollet, D., Nyman, R., & Smeiliauskas, F. (2004). *Factors that drive health care costs in Indiana.* Washington, DC: Mathematica Policy Research Inc.

24. WHO. (2000). *World Health Report 2000—Health systems: Improving performance*. Geneva: World Health Organization.

25. New York. (2003). *Public Insurance Law*, §4308. Available from http://www.ins.state.ny.us/acrobat/4308.pdf

26. Wieske, J.P. (2007). *How high loss ratios undermine affordable health insurance* (Issues and Answers No. 141). Alexandria, VA: Council for Affordable Health Insurance. Available at http://www.cahi.org/cahi_contents/resources/pdf/n141 lossratio.pdf

27. Wachenheim, L., & Leida, H. (2007). *The impact of guaranteed issue and community rating reforms on individual insurance markets.* Washington, DC: America's Health Insurance Plans.

28. Davidoff, A., Blumberg, L., & Nichols, L. (2005). State health insurance market reforms and access to insurance for high-risk employees. *Journal of Health Economics,* 24(4), 725-50.

29. Raymond, A.G. (2007). The *2006 Massachusetts Health Care Reform Law: Progress and challenges after one year of implementation.* Boston, MA: BCBSMA Foundation.

30. Cauchi, R. (2008). Pharmaceutical bulk purchasing: Multi-state and inter-agency plans (2008 edition). Denver, CO: Pharmaceuticals Project, NCSL Health Program. Available from http://www.ncsl.org/programs/health/bulkrx.htm

31. New Jersey. (2004). *An Act Concerning Assessments on Certain Health Care Facilities and Amending P.L. 1992, c. 160 and P.L. 1971, c. 136, c. 54.* Available from http://www.njleg.state.nj.us/2004/Bills/PL04/54_.HTM

32. Marquis, M.S. & Kominski, G.F. (1994). Alternative volume performance standards for Medicare physicians' services. *Milbank Quarterly*, 72(2), 329-57.

33. Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs. (2007). *Rewarding provider performance aligning incentives in Medicare*. Washington, DC: The National Academies Press.

34. Greene, J. (2007). *Medicaid efforts to incentivize health behaviors* (Pub. 299). Hamilton, NJ: Center for Health Care Strategies.

35. Beeuwkes Buntin, M., Damberg, C., Haviland, A., Kapur, K., Lurie, N., McDevitt, R., & Marquis, S. (2006). Consumer-directed health care: Early evidence about the effects on cost and quality. *Health Affairs,* 25(6), w516-w530.

36. Buchanan, R.J., . Cappelleri, J.D., & Ohsfeldt, R.L. (1991). The social environment and Medicaid expenditures: Factors influencing the level of state Medicaid spending. *Public Administration Review,* 51(1), 67-73.

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About This Report

This report is the first of a series on the health care system in Indiana. It was created as a result of the work of the Indiana University Heath Care Reform Faculty Study Group, a group of faculty members and analysts from the following Indiana University organizations:

- IU Center for Health Policy
- IUPUI Consortium for Health Policy, Law, and Bioethics
- William S. and Christine S. Hall Center for Law and Health
- IU School of Medicine

The Indiana University Center for Health Policy is an independent, nonpartisan applied research unit within the Indiana University School of Public and Environmental Affairs at Indiana University–Purdue University Indianapolis (IUPUI). CHP researchers work on critical policy issues related to the health of Hoosiers and the quality and accessibility of health care in Indiana. The CHP is part of the Indiana University Public Policy Institute and the Consortium for Health Policy, Law, and Bioethics, a Signature Center at IUPUI. For more information, visit the CHP Web site at http://www.healthpolicy.iupui.edu.

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Authors: Ann Holmes, PhD, Associate Professor, School of Public and Environmental Affairs, and Adjunct Associate Professor of Public Health, School of Medicine, and **Eric R. Wright,** PhD, Director, Center for Health Policy, Professor, School of Public and Environmental Affairs, Co-chair, Indiana University Healthcare Reform Faculty Study Group, Indiana University–Purdue University Indianapolis.

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