

# CONTROLLING HEALTHCARE COSTS

## PART ONE: UNDERSTANDING THE FACTORS DRIVING HEALTHCARE INFLATION

### HIGHLIGHTS

- Despite a history of being better than the nation, Utah now exceeds the national average in uninsured rates.
- Employers have been reducing or eliminating health insurance coverage for employees as costs rise, leading to greater uninsured rates.
- As the costs of uncompensated care are shifted to the insured, employer costs rise, leading to more reductions in employee health benefits.
- Utah firms are less likely than those in other states to provide health insurance to employees.
- Drivers of rising healthcare costs include increased consumer demand, broader-access health plans, hospital consolidation, new treatments and technologies, defensive medicine, cost shifting from uncompensated care, the aging population, and unhealthy lifestyles.
- Increases in health costs also impact public budgets; nationally, state Medicaid costs recently began to exceed state K-12 education spending.
- According to focus groups with Utah business people, insurers, hospital managers, and physicians, reforms should focus on limiting defensive medicine and overutilization, promoting healthier lifestyles, making better information available on quality and costs, and incentives for greater quality.

The mission of Utah Foundation is to promote a thriving economy, a well-prepared workforce, and a high quality of life for Utahns by performing thorough, well-supported research that helps policymakers, business and community leaders, and citizens better understand complex issues and providing practical, well-reasoned recommendations for policy change.

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A group of business leaders asked Utah Foundation to examine national research on the drivers of healthcare inflation, review data on Utah's healthcare situation, and conduct focus groups with healthcare stakeholders to better understand healthcare cost issues facing Utah. This report provides the findings of that process. A second report will examine specific reform ideas on which the group requested analysis.

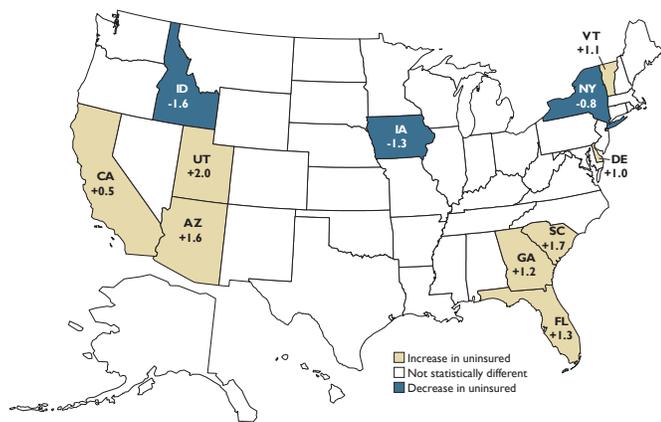
Healthcare costs have risen rapidly over the last decade. As costs rise, fewer employers can afford to offer health insurance, and fewer employees can afford to pay their share of the premium when coverage is offered. Although Utah enjoys a relatively healthy and young population, it has not escaped the national trend of escalating health costs, rising premiums, and growing numbers of uninsured adults and children. Earlier this year, Utah Foundation, at the request of the Employers Healthcare Coalition, began investigating the issue of escalating health costs. Utah Foundation spoke with various sectors of the healthcare community to understand how Utah's situation compares with the nation and to explore their ideas for making health coverage more affordable for employers and employees. This report explains state and national trends in healthcare costs and summarizes the findings of focus groups with healthcare experts and stakeholders. A second report will introduce five possible areas of reform on which the Employers Healthcare Coalition requested analysis.

### HEALTHCARE IN UTAH

**Number of Uninsured.** According to Census data, the number of uninsured in Utah has been steadily rising over the last several years. Census identifies individuals as uninsured if they have lacked health insurance coverage (public or private) for the entire previous calendar year. In 2003, 12.7 percent of all Utahns were uninsured. In 2004, 14.3 percent of all Utahns were uninsured. By 2005, 16.6 percent of all people, or 420,000 persons were uninsured in Utah.<sup>1</sup> Based on two-year moving averages (2003-2004 and 2004-2005) Utah is one of only seven states that experienced an increase in the percentage of uninsured persons (see Figure 1).<sup>2</sup>

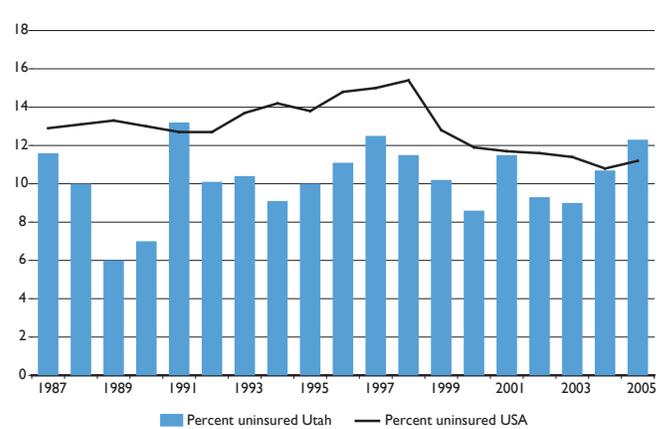
Historically, Utah's uninsured rate has been below the national average (see Figure 2). In 2005, however, Utah's percentage of uninsured persons surpassed the national average for

**Figure 1: Differences in Uninsured Rates by State, 2004-2005\***



\*The map represents differences between the two-year moving averages from 2003-04 and 2004-05. Source: U.S. Census Bureau.

**Figure 3: Uninsured Rates for Children**



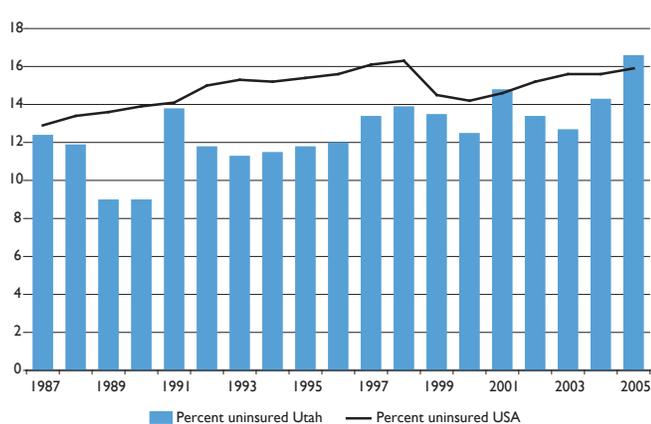
Source: Census.

only the second time in almost twenty years. From 1995 to 2005, the uninsured rate increased by only one-half percentage point for the nation overall (15.4 to 15.9 percent) but by almost 5 percentage points for Utah (11.8 to 16.6 percent).<sup>3</sup>

While several other national surveys (such as MEPS, SIPP, and NHIS) and state surveys of health insurance coverage report different absolute numbers of uninsured, all the surveys confirm the trend of rising numbers of uninsured. For example, the Utah Department of Health reports that 11.6 percent of Utahns lacked health insurance at any time during 2005, which represents a 13.5 percent increase over 2004. Census estimates of the uninsured tend to be higher than other surveys, but only Census provides both national estimates and reliable state-level estimates, thus allowing a comparison of Utah trends to national trends.<sup>4</sup>

The situation has been worsening for children under 18 in Utah as well. In 2005, 94,000 or 12.3 percent of children under 18 in Utah were uninsured. That represents a 1.6 percent increase over 2004, and a 3.3 percent increase over 2003. Utah's uninsured rates for children have now surpassed the national average for the first time since 1991 (see Figure 3).<sup>5</sup>

**Figure 2: Uninsured Rates for All People**

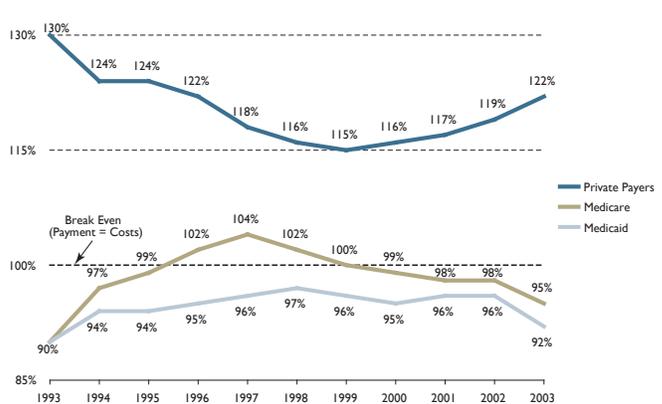


Source: Census.

Federal law requires that all people have access to emergency care, even if they do not have the means to pay for it. Hospitals and physicians frequently receive no compensation for emergency care provided to the uninsured. In addition, hospitals and physicians are not fully compensated for publicly funded programs, such as Medicaid and Medicare (see Figure 4).<sup>6</sup> The number of uninsured or publicly insured people affects the price of private health insurance as the healthcare costs from uncompensated care are shifted to private payers. Healthcare costs for the insured increase partly as a result of growth in the rate of uninsured. But as premium amounts rise, fewer employers are able to afford to provide health benefits to their employees, which can then lead to even higher numbers of uninsured individuals.

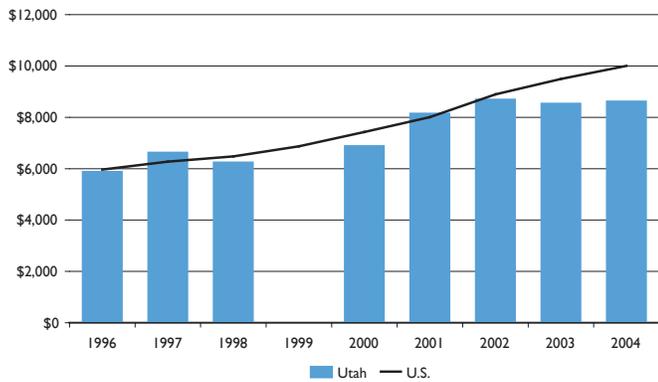
**Growth in Health Insurance Premiums.** As in the rest of the United States, the cost of health insurance in Utah has experienced significant increases. From 1996 to 2004, the average health insurance premium for a family of four in Utah increased from \$5,916 to \$8,654 (adjusted for inflation to 2004 dollars). This represents a 46 percent increase in the premium amount over eight years. Premium amounts appear to have flattened out some from 2002 to 2004. Nationally, the family premium for health insurance increased 68 percent between 1996

**Figure 4: Hospital Payment-to-Cost Ratios for Medicare, Medicaid, and Private Payers**



Source: BlueCross BlueShield.

**Figure 5: Average Health Insurance Premium for a Family of Four, 2004 Dollars**



Note: Utah data is not as consistent as the national sample due to small sample sizes. For 1999, AHRQ did not report individual estimates for several small states, including Utah.  
Source: AHRQ, MEPS.

and 2004 (after adjusting for inflation). In Utah, the employee's contribution to the family premium increased from \$1,415 in 1996 to \$2,417 in 2004 (adjusted for inflation to 2004 dollars), a 71 percent increase. Nationally, the employee's contribution to the family premium increased by 59 percent.<sup>7</sup>

**Employer-Sponsored Health Insurance Coverage.** Most Americans with health insurance obtain it through their jobs. Employers offer insurance through the workplace in order to promote worker productivity, to obtain tax advantages, to attract high-quality workers, and because it is a convenient way to pool risks.<sup>8</sup> In 2005, 59.5 percent of all people (workers and non-workers) in the U.S. had job-related coverage, down from 59.8 percent in 2004. This figure includes both employees and their family members who receive coverage through the employee's job with a private or public entity. According to Census, the decline in employment-based coverage from 2004 to 2005 "essentially explains the decrease in total private health insurance coverage." Utah has likewise experienced a decrease in employment-based coverage, down from 64.8 percent in 2004 to 62.2 percent in 2005. A decade earlier, 71.2 percent of Utahns and

61.1 percent of all Americans had job-related coverage. The percent of persons with job-related coverage has steadily fallen since 2000 for both Utah and the nation.<sup>9</sup>

Coverage by employer-sponsored health insurance varies greatly by size of private firm as shown in Figure 6.<sup>10</sup> The share of employees in firms that offer health insurance in Utah is similar to the national average for larger firms (50 or more employees), but significantly lower for smaller firms (less than 50 employees). For larger firms, both in Utah and the U.S., 97 percent of workers are in firms that offer health insurance. For smaller firms, just 55 percent of Utah workers are in firms that offer health insurance, compared to 61 percent of workers nationally. This ranks Utah 33<sup>rd</sup> among the states for this category.

Only some of the employees who work for a firm that offers health insurance coverage will actually be covered by their employer. Within a firm that offers coverage, only some of the employees are eligible for health insurance, and some of those who are eligible decline the coverage that is offered to them. Some may decline coverage because they have coverage through another source (through a spouse's employer, for example), but some decline coverage because they cannot afford to pay the employee's portion of the premium. In a recent publication of the Federal Reserve Bank of San Francisco (FRBSF), economists attribute most of the decline in employer-sponsored coverage to a decreasing share of workers who are eligible for coverage and declining participation by those who are eligible within firms that offer coverage. They suggest that the decline in participation by employees who are eligible for coverage is related to rising costs, particularly for employees at low-wage firms, who typically have more constrained budgets and pay a larger share of health insurance premiums.<sup>11</sup>

Compared to the national average, Utah employees are much less likely to be eligible for employer-sponsored insurance. For example, for firms with less than 10 employees, only 67.2 percent of Utah employees working for firms that offer insurance are eligible to enroll compared to 82.5 percent of employees nationally. In fact, for all firm size categories reported in Figure 6, the proportion of employees eligible for coverage in Utah is below the national average. However,

**Figure 6: Employees and Employer-Sponsored Health Insurance by Size of Firm, 2004**

		Less than 10	10-24	25-99	100-999	1000 or more	Less than 50	50 or more	All firms	Total number of employees
		employees	employees	employees	employees	employees	employees	employees		
Employees by firm size	Utah	15.2%	9.0%	11.8%	17.9%	46.1%	30.7%	69.3%	100.0%	932,564
	U.S.	13.2%	8.8%	13.8%	17.7%	46.5%	29.1%	70.9%	100.0%	112,087,067
Employees in firms that offer health insurance	Utah	39.5%	57.4%	87.2%	97.3%	97.9%	54.6%	97.0%	84.0%	783,354
	U.S.	45.5%	68.4%	84.2%	94.8%	99.5%	61.0%	97.2%	86.7%	97,179,487
Employees eligible for health insurance at firms that offer health insurance	Utah	67.2%	62.2%	70.9%	64.7%	73.3%	67.2%	70.8%	70.1%	549,131
	U.S.	82.5%	77.9%	75.0%	75.3%	79.9%	78.8%	78.3%	78.4%	76,188,718
Employees who are eligible for health insurance that are enrolled in health insurance	Utah	87.0%	72.0%	77.7%	78.2%	80.4%	78.8%	79.8%	79.7%	437,657
	U.S.	81.5%	76.1%	78.1%	78.4%	81.0%	78.5%	80.2%	79.8%	60,798,597
Employees enrolled in health insurance as percent of all employees	Utah	23.1%	25.7%	48.0%	49.2%	57.7%	28.9%	54.8%	46.9%	437,657
	U.S.	30.6%	40.5%	49.3%	56.0%	64.4%	37.7%	61.0%	54.2%	60,798,597

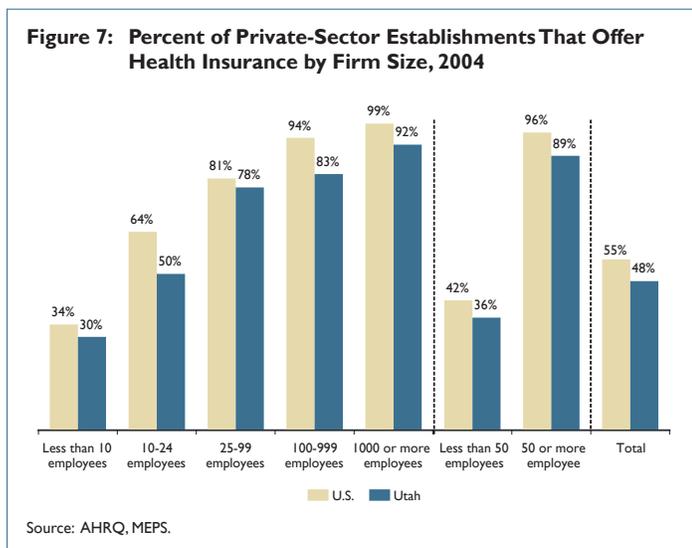
Source: AHRQ, MEPS.

when Utahns are eligible for health insurance coverage, they enroll in employer health plans at about the same rate as workers nationally. For all firms, about 80 percent of Utah and U.S. workers who are eligible for health insurance actually enroll.

Given the large proportion of people who depend on job-related coverage, employer decisions about whether or not to offer health insurance coverage to employees significantly impact the number of uninsured persons. In fact, according to the FRBSF publication, the decline in employer-based coverage has been the “driving force” for overall coverage trends in recent years. The publication reports that a pronounced decline in employer-based coverage from 2000 to 2005 has not been fully offset by increased coverage through other sources, such as individual plans and government programs.<sup>12</sup>

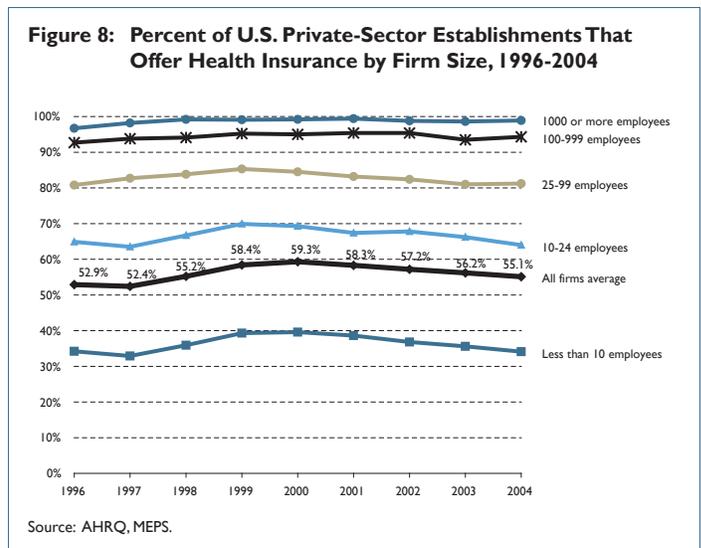
Another way to examine trends in employer-based coverage is to look at the proportion of firms that offer health insurance coverage (rather than the percent of individuals who have coverage through their employers). Based on the Medical Expenditure Panel Survey – Insurance Component (MEPS-IC), 55 percent of the nation’s firms offered health insurance coverage to their employees in 2004 (see Figure 7). In Utah, 48 percent of firms covered their employees. Utah ranks 37th in the nation with respect to the percent of private-sector establishments offering coverage. In all of the other mountain states except Wyoming, a higher percentage of firms offer employees coverage compared to firms in Utah.<sup>13</sup>

Once again, the data show that coverage varies greatly by size of firm. Figure 7 shows the proportion of firms offering health insurance coverage to employees declines as firm size decreases. Nationally, 96 percent of large firms with 50 or more employees offered health insurance to their employees in 2004, while 42 percent of firms with less than 50 employees offered coverage. For all categories of firm size, the percent of Utah firms offering coverage lags behind the national average. For firms with fewer than 50 employees, Utah ranked 31<sup>st</sup> of the states, with 36 percent of smaller firms offering coverage. For firms with 50 or more employees, Utah ranked last nationally, with less than 89 percent of larger firms offering coverage.<sup>14</sup>



Nationally, the proportion of private-sector establishments offering health coverage has declined since 2000 (see Figure 8). For all firms combined, the percent of firms offering health benefits has decreased from 59 percent in 2000 to 55 percent in 2004. This downward trend is driven by firms with less than 100 employees. When firms are examined by size, it is evident that for firms with either 100-999 employees or 1000 or more employees the percent of firms offering coverage has been relatively stable since 2000. On the other hand, since 2000 the percent of firms offering coverage has steadily declined for firms with 25-99 employees, firms with 10-24 employees, and firms with less than 10 employees.<sup>15</sup>

Data from the Kaiser Family Foundation, based on a survey of over 3,100 firms regarding employer-sponsored health benefits, show a higher level of overall firm offering compared to MEPS data, but confirm that the percent of firms offering health benefits varies by firm size. For example, Kaiser reports that in 2006, 98 percent of

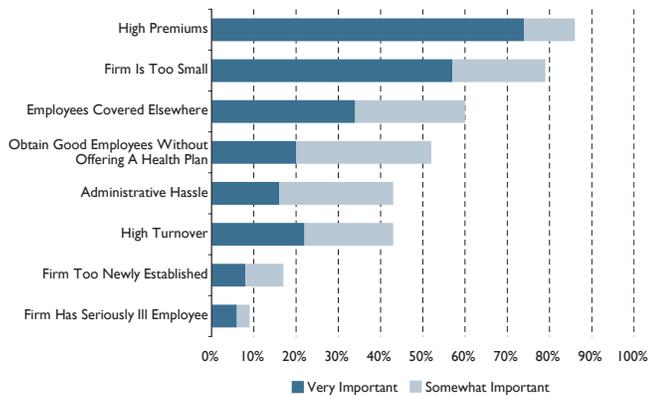


firms with 200 or more workers offered health insurance, compared to 92 percent of firms with 50-199 workers, 87 percent of firms with 25-49 workers, 73 percent of firms with 10-24 workers, and just 48 percent of firms with 3-9 workers.<sup>16</sup>

In its survey of firms, Kaiser also collected information on the reasons why firms were not offering coverage. The reasons most often reported as “very important,” included “high premiums” and “firm is too small.” Eighty-six percent of firms not offering coverage reported that high premiums were a very or somewhat important reason for not offering coverage, and 79 percent reported that “firm is too small” was a very or somewhat important reason for not offering coverage. Firm size significantly affects the firm’s decision about whether or not to offer health benefits.<sup>17</sup>

The fact that many small businesses do not offer their employees health insurance coverage is an important factor in the rate of uninsured in both Utah and the nation. Legislation that facilitates the offering of health benefits by small employers has the potential to decrease

**Figure 9: Among Firms Not Offering Health Benefits, Somewhat and Very Important Reasons for Not Offering**



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006.

both the number of uninsured and the costs of uncompensated care that are shifted to private payers.

In an environment of escalating healthcare costs, firms must make decisions about how to handle annual growth in health insurance premiums. Most firms offering coverage report that they are very or somewhat likely to increase the amount employees pay for health insurance during the next year. Only a small percentage plan to drop coverage, with a higher percentage of small firms (defined as employers with 3-199 workers in the Kaiser survey) than large firms (defined as employers with 200 or more workers) reporting that they are likely to drop coverage.<sup>18</sup>

### NATIONAL TRENDS IN HEALTHCARE INFLATION

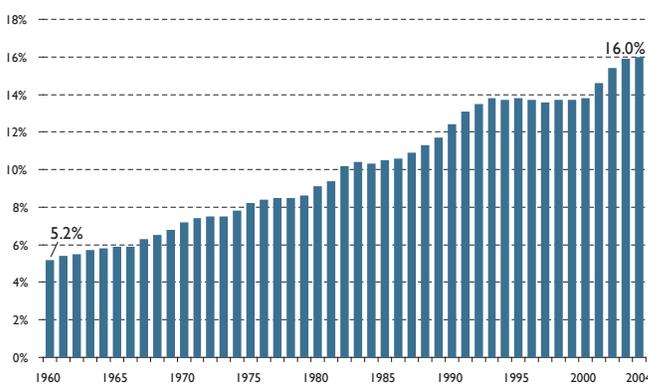
**Overall Healthcare Expenditures.** Healthcare is the largest sector of the U.S. economy. Our nation spends more on healthcare per capita than any other country. Healthcare expenditures per person increased from \$944.50 in 1960 to \$6,280 in 2004 (both in 2004 dollars). National spending on healthcare as a percentage of GDP

has been steadily increasing since 1960, when healthcare spending accounted for just 5.2 percent of GDP (see Figure 11). By 2004, healthcare spending represented 16 percent of GDP, and researchers estimate that by 2015 it will account for 20 percent of GDP.<sup>19</sup> The rapid growth rate in healthcare expenditures is not unique to the U.S. Although other industrialized nations currently have lower healthcare costs, most also face similar challenges in accelerating healthcare costs.<sup>20</sup>

Generally, premium increases closely follow growth in healthcare expenditures. From 1993 to 2003, health insurance premiums increased 7.3 percent annually. During that same time, health expenditures grew 7.2 percent annually.<sup>21</sup>

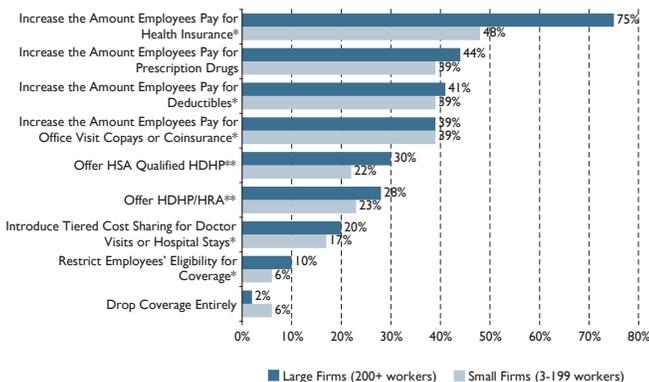
**State Spending.** Although K-12 education has historically represented the largest share of state spending, in 2003 Medicaid surpassed K-12 education and became the largest category of state spending nationally. In Utah, K-12 education continues to be the largest spending category, but while education spending as a percent of

**Figure 11: U.S. Health Expenditures as Percent of GDP**



Source: Centers for Medicare & Medicaid Services (CMS).

**Figure 10: Among Firms Not Offering Health Benefits, Percent Very or Somewhat Likely to Make Specified Changes In The Next Year**



\*Distributions are statistically different between All Small Firms and All Large Firms within category at p<.05.

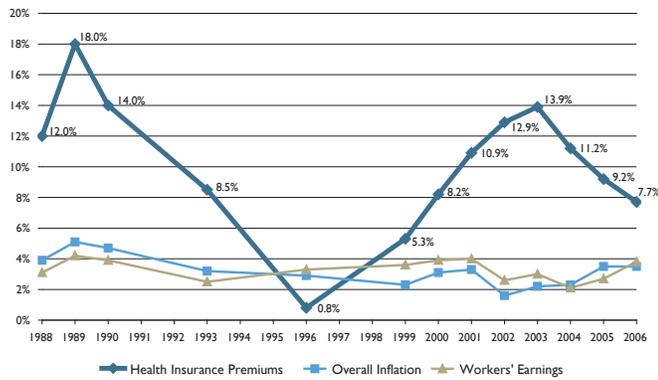
\*\*Among firms not currently offering this type of HDHP/SO.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006.

total expenditures has remained relatively flat during the last several years, the share of Utah's state budget spent on Medicaid has steadily increased. K-12 education represented 25.7 percent of state spending in 2003 and 25.5 percent in 2005. Medicaid spending as a percent of total state spending increased from 14.5 percent in 2003 to 17 percent in 2005.<sup>22</sup>

**Health Insurance Premiums.** Premium growth for employer-sponsored health insurance has moderated in recent years. From the spring of 2005 to the spring of 2006, premiums rose by 7.7 percent, down from a 9.2 percent increase in premiums in 2005 and an 11.2 percent increase in 2004 (see Figure 12). Nonetheless, premium growth continues to outpace both the rate of inflation and the growth in workers' earnings. From 2005 to 2006, the rate of overall inflation was 3.5 percent and wages grew by 3.8 percent. Average annual premiums for work-based health insurance coverage are currently \$4,242 for single coverage and \$11,480 for coverage for a family of four. Premiums for family coverage have increased by 87 percent since the year 2000.<sup>23</sup>

**Figure 12: Percent Increase in Employer-Sponsored Health Insurance Premiums Compared to Other Indicators**



Source: Kaiser Family Foundation.

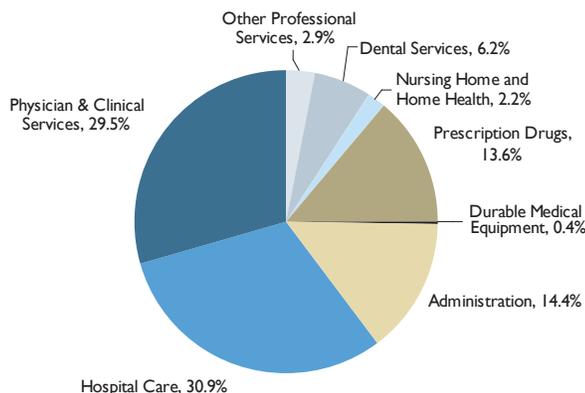
Most covered workers contribute to the total premium for their coverage, an average of \$627 annually for single coverage and \$2,973 annually for family coverage. Covered workers in firms with 3-199 workers on average make a significantly higher contribution towards single and family coverage compared to covered workers in firms with 200 or more workers (\$515 vs. \$689 for single coverage; \$3,550 vs. \$2,658 for family coverage). The average percentage of premiums paid by covered workers has remained steady from 1999 to 2006 (16 percent for single coverage; 27 percent for family coverage).<sup>24</sup>

### FACTORS DRIVING RISING COSTS

**Health insurance expenditures by category.** Hospital care represents the largest category of private insurance expenditures, accounting for over 30 percent of all expenditures in 2004 (see Figure 13). A close second is physician and clinical services at nearly 30 percent, which means that hospital care and physician and clinical services together accounted for well over half of all spending. Administration and prescription drugs each represent approximately 14 percent of all expenditures.<sup>25</sup>

**Hospital Costs.** In the last decade, inpatient admissions have remained relatively stable (from 119.3 admissions per 1,000 persons in 1993 to 119.5 admissions per 1,000 persons in 2003). The average length of

**Figure 13: Private Insurance Expenditures, 2004**

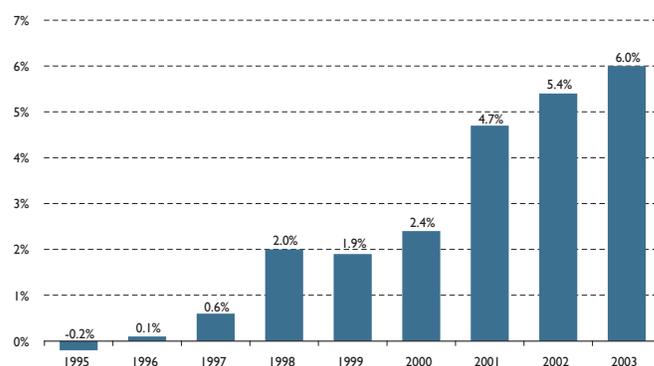


Source: Centers for Medicare and Medicaid Services (CMS), Calculations by Utah Foundation.

stay has decreased in the last decade, from 6.5 days in 1995 to 5.6 days in 2004, though it has remained relatively stable since 2001.<sup>26</sup> However, while the rate of inpatient admissions has remained stable and the length of each stay has decreased, the actual expense of each inpatient stay has accelerated each year since 1995. From 2002 to 2003, hospital expenses per inpatient stay increased by 6.0 percent, compared to 5.4 percent the year before (see Figure 14).<sup>27</sup> A 2005 RAND report on U.S. healthcare states that the real cost per hospital day (in 2002 dollars) increased from about \$128 in 1965 to \$1,289 in 2002. According to RAND researchers, “much of this increase reflects that we are delivering more technologically advanced care in the hospital.”<sup>28</sup>

A report by PricewaterhouseCoopers (PwC) estimates that broader-access plans and provider consolidation were responsible for 13 percent of premium growth from 2004 to 2005.<sup>29</sup> In a review of the relevant studies, researchers with the Robert Wood Johnson Foundation (RWJF) concluded in a 2006 report that “the great weight of the literature shows that hospital consolidation leads to

**Figure 14: Annual Change in Hospital Expenses Per Inpatient Stay**

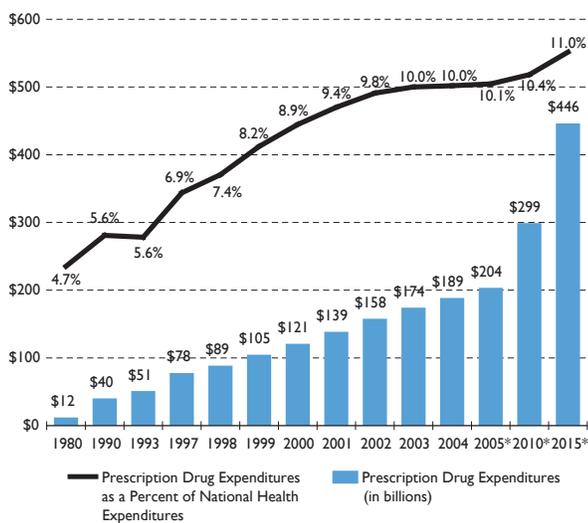


Source: BlueCross BlueShield Association.

price increases,” especially among hospitals that are geographically close to one another.<sup>30</sup> As a result of hospital consolidation and looser managed care, the bargaining power of hospitals and physicians has increased relative to insurance plans. In addition, the considerable nursing shortage in the U.S. may have increased the employment costs of hospitals.<sup>31</sup>

Although hospital care and physician and clinical services are the largest components of healthcare and the largest contributors to total growth in private health insurance expenditure growth, other categories of spending actually have exhibited a faster growth rate during the last several years. From 1999 to 2004, hospital care costs and physician and clinical services increased by 55 percent and 52 percent respectively. In contrast, during the same period, administration costs increased 107 percent and prescription drugs increased by 75 percent.<sup>32</sup> Administration costs are partly a result of the overwhelming number of insurance and hospital plans that are available. In Seattle, it is estimated that a single hospital may have to deal with up to 755 different health plans.<sup>33</sup> In California,

**Figure 15: Prescription Drug Expenditure Growth**



\*Projected by CMS.  
Source: Centers for Medicare & Medicaid Services (CMS).

billing and insurance-related costs account for 31 to 51 percent of total hospital administrative costs.<sup>34</sup>

The total amount spent on prescription drugs in 2005 is more than 2.5 times the amount spent in 1997 (see Figure 15). The amount is expected to double again by 2015. In addition, prescription drugs represent a rising share of healthcare expenditures, from less than 5 percent in 1980 to more than 10 percent in 2005.<sup>35</sup> According to RAND researchers, about 80 percent of the increase in prescription drug expenditures over the last decade is a result of higher drug use per capita (rather than higher prices).<sup>36</sup> Promotional spending by pharmaceutical companies doubled between 1998 and 2003, from \$12.5 to \$25.3 billion. The category of direct-to-consumer advertising more than doubled, from \$1.3 to \$3.2 billion over the same time period.<sup>37</sup>

**Factors Driving Growth in Health Insurance Premiums.** In 2006, PwC published “The Factors Fueling Rising Healthcare Costs.” This report attempts to attribute the 8.8 percent growth in premiums between 2004 and 2005 to particular factors. PwC concluded that increased utilization accounted for 3.8 percentage points of the total 8.8 percent growth in premiums between 2004 and 2005 (or 43 percent of the overall increase in health insurance premiums) (see Figure 16). PwC attributes increased utilization mainly to increased consumer demand, new treatments, defensive medicine, the aging of the population, and lifestyle choices such as smoking and poor nutrition. That leaves 5 percent premium growth to account for. PwC attributed 2.4 percentage points (or 27 percent of total growth) to general inflation and 2.6 percentage points (or 30 percent of total growth in premiums) to increases in healthcare prices beyond general inflation. Movement to broader-access plans, higher-priced technologies, and cost-shifting from Medicaid and the uninsured to private payers all contribute to higher healthcare prices.

It is important to keep in mind that the report addresses what proportion of premium *growth* from 2004 to 2005 can be attributed to particular factors, and not what proportion of the total premium *amount* for a given year can be attributed to particular factors.<sup>38</sup> Thus, PwC attributes three percent of premium *growth* to lifestyle, but research shows that lifestyle accounts for a much larger proportion of healthcare spending. For example, one researcher estimated that 12 percent of all healthcare spending in 2002 was due to obesity alone.<sup>39</sup>

BlueCross BlueShield estimates that advances in medical technology contribute about 20 percent of growth in inpatient costs and 18 percent of outpatient costs. New technologies are often more expensive than previous technologies and also tend to increase consumer demand and, thus, utilization. According to PwC, increases in consumer demand are “fueled by factors including the proliferation of information on medical treatments and demand pull strategies such as direct-to-consumer advertising.” The number of diagnostic imaging centers and imaging procedures, as well as the use of expensive specialty pharmaceuticals have all increased significantly over the last several years.<sup>40</sup>

**Poor Quality.** Rising healthcare costs have also focused attention on variation in providers’ use of evidence-based practices and the cost of poor quality. A 2002 study by the Juran Institute and the Midwest Business Group on Health estimated that the cost of poor quality, as a result of overuse, misuse, and waste, accounted for about 30 percent of healthcare costs. The report attributed 10 of the 30 percent to litigation and defensive medicine.<sup>41</sup> RAND researchers report that about one-third of common surgical procedures performed in the 1980s and early 1990s were provided “for reasons that were not supported by clinical research and may have been harmful to patients.” Using a comprehensive method for assessing quality (with 439 measures of effectiveness for 30 acute and chronic health problems as well as leading preventive interventions), the RAND report estimated that American adults received about one-half of recommended medical services. Recommended medical services were defined as services “shown in the scientific literature to be effective in specific circumstances and agreed upon by medical experts.” Consistent with other studies, the report concluded that patients

**Figure 16: Increase in Health Insurance Premiums by Component 2004 to 2005**

Component	Premium Growth Due to Component	Share of Premium Growth
<b>General Inflation</b>	<b>2.4%</b>	<b>27%</b>
<b>Healthcare Price</b>	<b>2.6%</b>	<b>30%</b>
Cost Shifting		6%
Higher Priced Technologies		11%
Broader-Access Plans/Provider Consolidation		13%
<b>Increased Utilization</b>	<b>3.8%</b>	<b>43%</b>
Aging		6%
Lifestyle		3%
New Treatments		11%
More Intensive Diagnostic Testing/Defensive Medicine		9%
Increased Consumer Demand		14%
<b>TOTALS</b>	<b>8.8%</b>	<b>100%</b>

Source: PricewaterhouseCoopers.

received unnecessary services (overuse) about 11 percent of the time and failed to receive necessary services (underuse) about 46 percent of the time. Adherence to standards of care was even worse for geriatric conditions, where recommended care was provided only 31 percent of the time.<sup>42</sup>

**Aging of the population.** A major factor in our country's rate of growth for health expenditures is the aging of the population. In general, healthcare costs rise exponentially with age. Consumption of healthcare by persons 65 and older is nearly four times larger than consumption for individuals under 65. Clearly, demographics, including the aging of the baby boom generation, have a significant impact on healthcare spending. From 1900 to 2000, the percent of the U.S. population who was 65 and older increased from 4 percent to more than 12 percent.<sup>43</sup> Figure 17 shows how the elderly share of the population is expected to nearly double (from 12 percent in 2005 to 23 percent in 2080) over the next 75 years.<sup>44</sup>

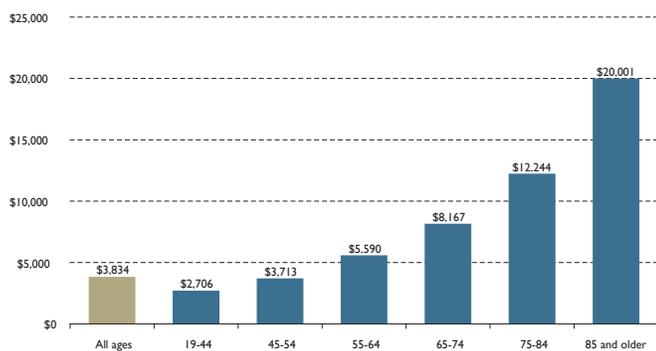
**Figure 17: Projected Rise in Aged Population**

	2005	2025	2045	2065	2080
Number of aged (in millions)	37	62	79	89	96
Share of total population	12%	18%	21%	22%	23%

Source: U.S. Department of Health and Human Services.

As the population of the United States continues to age, it will consume growing amounts of healthcare, since older people suffer from medical problems to a greater extent than younger people. In addition, public programs such as Medicare finance a large share of the elderly's healthcare. Even within the population of elderly, spending diverges significantly by age. In 1999, Medicare enrollees (87 percent of whom were age 65 or older) accounted for 37 percent of national personal healthcare expenditures, although they comprised only 14.5 percent of the total population. In 1999, persons age 85 and older comprised just 1.6 percent of the population, but accounted for more than 8 percent of the nation's personal healthcare spending. Figure 18 shows differences in per-capita healthcare spending across various age groups.<sup>45</sup>

**Figure 18: Per-Capita Health Spending by Age Group, 1999**



Source: U.S. Department of Health and Human Services.

## FOCUS GROUPS WITH HEALTHCARE STAKEHOLDERS

In June and July 2006, Utah Foundation conducted four focus groups with stakeholders in the healthcare system. We began with business human resource officials who must manage and budget for health insurance for employees. The next three groups comprised health insurers, hospitals, and physicians. The purpose of these focus groups was to gather insight into how healthcare costs are growing in Utah, the primary reasons for rapid cost growth, problems that hinder better management of healthcare costs, and ideas for reform.

**Focus Group with Human Resource Managers.** This group was fairly evenly divided among those from large, mid-sized, and small companies. Most said that their health insurance premiums had risen between 10 and 20 percent annually in recent years, and one participant had increases higher than 20 percent. As a consequence of those rising costs, most of the participants said their employees were trying to reduce costs by choosing more limited insurance plans, dropping double coverage if a spouse has insurance, and even dropping out of coverage altogether. A manufacturing industry leader stated that many small manufacturers have eliminated health insurance benefits for employees in recent years. Almost all participants said healthcare was in their top five cost concerns, many ranking it very near the top. All agreed that healthcare inflation is a serious problem in Utah's economy.

Company representatives focused much of their attention on markets, competition, and information issues. When asked for ideas for solutions, their answers focused mostly on how to improve markets for health insurance by providing clearer more in-depth information to healthcare consumers and the companies that purchase insurance for their employees. Many also expressed positive hopes for high-deductible health plans coupled with a health savings account or health reimbursement arrangement as a means of reducing employer costs. Desires for incentives to reduce over-utilization and excessive litigation were also prominent. Significant highlights from this group include the following ideas and comments.

Companies described problems they face in providing health insurance to employees:

- Limited insurance options for small firms. For example, small firms have limited access to lower-cost Preferred Provider Organizations (PPOs).
- Inability for small employers to pool together for better rates. Pooling together would allow companies to both spread risks among a wider pool and achieve greater bargaining power with insurers.
- Inability of small firms to self-insure. Self-insuring would provide firms with greater information about their groups' utilization and more control over benefits offered.
- Poor incentives for prevention. Many would like to reduce employees' health insurance premiums for those who participate in wellness programs or live healthy lifestyles.

- The Health Insurance Portability and Accountability Act (HIPAA). HIPAA prevents some of the transparency on company costs and utilization that they want from their insurers. They also felt this law limits accountability and adds unnecessary bureaucratic paperwork.
- The presence of one or two major insurers in Utah. Some in the group felt that competition is lacking in Utah's market, allowing higher annual price increases.

Participants also expanded the conversation to include a discussion of what they think are the drivers of overall healthcare inflation in America:

- Increased utilization of prescription drugs and consumer demand for a range of healthcare services.
- Unlimited malpractice litigation leading to the practice of defensive medicine and consequent over-utilization of medical services.
- Lack of information and cost transparency. A true market would have greater information about the costs and quality of healthcare services, allowing employees or other consumers to better judge how to appropriately spend healthcare dollars.
- Declining health and poor lifestyles of Americans leading to more chronic illness.
- Aging populations.
- Cost shifting from the uninsured and from those covered by Medicaid and Medicare in the form of higher prices to all others, including insured employees.

Utah Foundation asked the participants to offer potential solutions to the problem of rising health insurance costs. Their responses included:

- Providing greater insurance options to small employer groups.
- Greater information on quality of care.
- Reform of the medical malpractice system to reduce over-utilization caused by defensive medicine.
- Transparency in pricing, including clearer justification by insurers for annual premium rate increases.
- Health insurers joining employers in financially sponsoring and promoting wellness programs.
- Better information for consumers to reduce over-utilization of services and non-generic drugs.
- Broader choices for high-deductible health plans.

Companies also described actions they are considering or implementing to control costs:

- Switching employees to High-Deductible Health Plans (HDHPs) with Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs).
- Increasing employee contributions for insurance.
- Implementing tiered pharmacy benefits (a price preference for generics).

- Implementing wellness programs.
- Dropping coverage (particularly by small firms).
- Tiering employer contributions by salary. Higher-paid employees would pay a greater share of premiums so the lower-paid can better afford coverage.

*Focus Group with Insurers.* This group included representatives of the large and small Utah insurers, the director of the Utah Health Insurance Association, and an actuary. Much of the discussion pointed to large-scale market failure on a nationwide level, including forces that can't be controlled, such as the aging population, or forces that are difficult to control, such as individual lifestyle choices. This group was less hopeful than the business focus group about the potential success of consumer-driven healthcare, including HDHPs, citing several problems with moving away from group coverage toward individual plans. One of the most interesting ideas discussed in this meeting was the possibility of promoting wider use of treatment protocols or best practices, combined with limited liability for physicians adhering to the protocols.

Participants described their understanding of the reasons for rapid healthcare cost growth as follows:

- Declining health of the population, due to poor lifestyles, less exercise, and worse diets. These behaviors lead to more diabetes, heart disease, etc.
- Lack of incentives to reward those who improve their lifestyle. Current group insurance rates do not allow for lower premiums for such people.
- Aging population (baby boomers). Older persons need more healthcare.
- The high concentration of healthcare spending. Most health costs are incurred by a small portion of the population, making it more difficult for broad reforms to affect overall healthcare costs.
- Adverse selection, where persons with the most expensive health problems are those most likely to purchase insurance, while many young people often go uninsured because they are healthy and have few assets to worry about losing. Adverse selection results in higher insurance costs.
- Mandates for specific benefits, which make insurance more expensive. Mandates mostly affect smaller employers, because larger employers are more likely to self-insure, and the Employee Retirement Income Security Act (ERISA) exempts them from state mandates.
- Increased utilization of medical services and prescription drugs (enhanced by direct-to-consumer marketing) and demand for new technologies.
- High concentration of spending on the very old and very young. We spend a great deal of money keeping the very fragile (both very elderly persons and premature babies) alive longer, prolonging death. For many patients, the outcome is the same but the process is much more expensive than it used to be.

- Cost shifting. Medicaid and Medicare underpay severely, so hospitals shift expenses to those who can pay through private insurance.

Participants were asked to describe the most important reforms that would reduce cost growth in the healthcare system:

- Better quality of care information, including more definition of best practices for various diseases and conditions.
- A return to some of the principals of managed care to control over-utilization. Although there was a backlash against managed care in the 1990s, the group stated that managed care has proven to have no adverse effect on health outcomes.
- Indemnification from malpractice liability for physicians who practice according to protocols or best practices. This would reduce the practice of defensive medicine (over-utilization) and lower liability insurance costs.
- Stronger incentives for employees to participate in employer-sponsored wellness programs.
- Health risk assessments, with entire families, not just employees, which would facilitate improvements in the lifestyles and health of the insured population.
- Greater promotion of wellness by society, including restoring more physical education in schools and teaching children more about nutrition.

This group also offered some criticism of other reform ideas, including the drive for more consumer-directed healthcare with high-deductible health plans and greater reliance on the individual insurance market rather than employer sponsored insurance. They stated that HDHP enrollees tend to be more healthy, educated, wealthy, and savvy consumers. Removing them from traditional insurance pools may drive up costs for the remaining consumers by concentrating the less healthy in those pools.

Similarly, they criticized the suggestion by some advocates that employers stop providing group insurance and instead provide a contribution employees can use in purchasing their own insurance. They agreed that individual plans can be cheaper than group plans, as long as the enrollee and family are healthy. But premiums skyrocket when someone gets very ill, because the risks are not spread among a group. More individual plans would also greatly increase administrative costs, as insurers would need to bill each individual customer and make contracts one-on-one with each enrollee. They warned that greater reliance on individual plans would eventually impose severe costs on state government, because more of those who become seriously ill would need to shift to the state's high risk pool.

**Focus Group with Hospitals.** This was a small group, but attendees represented the two largest hospital chains in Utah. Overall, a theme of this focus group was that cost shifting, both from uncompensated and under-compensated care, is a major driver of healthcare cost increases. They suggest that more complete healthcare coverage would

solve a lot of problems, such as government programs that chronically underpay for services. More complete healthcare would also include the expansion of programs to cover the uninsured and other ways to compensate hospitals for uncompensated care.

They are interested in ways to control the push for more expensive technology that is driven by patient and physician demand and competitive pressures from other hospitals and clinics. The group also had much to say about the high costs of operating a full-service hospital and how niche providers of specialty services are disrupting the market because they do not have to cover less profitable or mandated services that hospitals do.

Participants described their understanding of the reasons for rapid healthcare cost growth as follows:

- Cost shifting from inadequate payments from Medicare and Medicaid. Government programs' annual payment increases are only 1-3 percent, which is less than inflation, and about 50 percent of a hospital's service volume is paid for by government programs.
- Cost shifting from uncompensated care (care for the uninsured).
- Free standing surgical centers and ambulatory services, which are driving up costs for hospitals by taking away from hospitals the profitable services that subsidize uncompensated emergency care.
- Emergency Medical Treatment and Active Labor Act, which requires hospitals and ambulance services to provide care to anyone needing emergency treatment regardless of citizenship, legal status, or ability to pay.
- Defensive medicine and malpractice litigation, which cause over-utilization and high malpractice insurance premiums.
- The distance between payers (insurers) and the providers with respect to decisions about pharmaceuticals. Consumers are detached from the true costs of providing expensive new medicines, but are susceptible to direct-to-consumer marketing.
- Patient and physician demand for new technology. Competitive pressures require hospitals to keep up with new technology even if it is sometimes unnecessary. Some new technologies are only needed for very specific diagnoses, but due to patient and physician demand, hospitals invest to avoid losing business to other hospitals.
- Increasing wages and salaries of nurses due to the nursing shortage. Although the nursing shortage here has increased costs, the shortage in Utah is not as severe as in the rest of the country. The shortage is caused largely because of a lack of faculty for nursing education and training, due to lower wages for teaching than for practicing.
- The movement away from tightly managed care, which has led to increased administrative costs. Further, the push for increased transparency will increase administrative costs to comply with new requirements.

When asked to rank the causes of increasing healthcare costs, this group came up with the following rough ranking. Understand that it is subjective but provides insight on the relative importance of the factors described above:

1. Cost shifting from federal programs that underpay
2. Cost shifting from uncompensated/uninsured care
3. Technology investments
4. Consumer demand for services and procedures
5. Niche provider competition
6. Labor shortages, such as nurses
7. Government regulation, including HIPAA

Participants were asked to describe the most important reforms that would reduce cost growth in the healthcare system:

- Reevaluation of reimbursement for medical services by the federal government. If government programs paid the market rate for healthcare, then we would truly know the cost of care and avoid constant shifting to other payers.
- Cut optional programs from Medicaid, which draw funds away from more broadly needed services, and increase Medicaid reimbursement rates for basic services.
- Adequate funding of the Children's Health Insurance Program (CHIP) and the Health Insurance Pool (HIPUtah). Otherwise people in these programs will become uninsured and will end up in emergency rooms for more expensive care.
- Examination of mental health programs. Many hospitals are eliminating mental health beds to avoid complying with expensive legal mandates on services to these patients.
- Enact a "play or pay" law requiring individuals or employers to purchase insurance or pay into a pool to help the uninsured.
- Enact a moratorium on new niche providers and free standing facilities and/or require them to take on uncompensated care like hospitals.
- Consider the burden of data reporting required by the state and whether federal standards for data collection are sufficient.
- Reduce defensive medicine through tort reform, such as mandatory arbitration in malpractice cases, strengthening caps on liability awards or settlements, or requiring a stronger burden of proof for malpractice (such as gross negligence).
- Create a fund to compensate patients for adverse medical outcomes, replacing the traditional remedy of medical malpractice litigation.
- Provide incentives for wider adoption of best practices in medical care.

Similar to the insurer focus group, this group offered criticism of other reform ideas, including proposed "any willing provider" laws. They felt that removing insurers' ability to contract with exclusive providers would remove the ability to negotiate reduced price arrangements and would lead to higher medical costs. They also did not look favorably on the trend toward HDHPs, feeling that patients are not prepared to pay the large deductibles for treatments. Even in the common area

of maternity care, patients are not aware of all the costs and have difficulty in planning their expenses

*Focus Group with Physicians.* This group included independent physicians, those working for large health systems, and representatives of the Utah Medical Association. In describing reasons for rising healthcare costs, these physicians placed a high level of emphasis on the costs of serving the uninsured, similar to the views of hospitals. However, their views differ from hospitals in several ways, including the value of physician-owned freestanding facilities (like imaging centers). These physicians also felt that medical liability was a large factor in rising costs and hoped that the business community could work with them to reduce the burdens of legal liability on the system. Doctors were less hopeful about high-deductible health plans and health savings accounts than any of the other groups, feeling that they will lead to less preventive care. They want universal coverage but also felt strongly that it should not come through a government operated single-payer system.

Participants described their understanding of the reasons for rapid healthcare cost growth as follows:

- General factors which are difficult or impossible to control: population growth, the aging population, new diseases, longevity, and technological change.
- Controllable factors: unhealthy lifestyles, obesity, sexually transmitted diseases, teen pregnancy, violence, suicide, accidents, and alcohol and tobacco abuse.
- Prescription drugs. Many new drugs are merely equivalent or incrementally improved versions of already available drugs. Direct-to-consumer advertising drives demand for newer, more expensive drugs that are often unnecessary or unproven to be more effective than current drugs.
- Detachment of patients from how medical expenses are paid, which drives increased utilization of medical services. The current healthcare system pushes utilization.
- Cost shifting from the underinsured and uninsured, including those on government health programs that underpay. These doctors stated that they are unable to shift costs themselves because their rates are determined by insurers. They cite hospitals as the primary cost shifters.
- Lack of preventive care received by underinsured and uninsured patients. Consequently, these patients often wait until diseases progress and conditions worsen to the point that they must access the emergency room, leading to expensive care.
- Administrative costs, which are largely driven by the costs of complying with government regulations, as well as inefficiencies and long delays in receiving payment from government programs and private insurance. Receiving payments can require months of effort and staff time.

Because of the frequent mention of defensive medicine in earlier focus groups, Utah Foundation asked these physicians how liability concerns affect the way they practice medicine. The doctors were

emphatic that liability concerns are a huge driver of defensive medicine. One stated that medical liability costs are estimated to be two percent of the entire U.S. GDP. They agreed that it is impossible to practice medicine without keeping liability in mind. However, they also expressed concern that the American tort system is random in awarding compensation to those who need it, citing estimates that many who are victims of negligence receive no compensation and of those who do receive compensation, many did not experience any medical negligence.

Utah Foundation asked these physicians to comment on the complaints from hospital officials about niche providers of specialty services, including freestanding physician-owned facilities such as imaging centers or specialty surgery centers. Members of the group cited research showing that niche providers offer better care with more positive outcomes and lower costs. However, they did acknowledge that the poor do not have adequate access to these centers and that certain services provided at these centers may actually cost more without a definitive quality advantage. They also acknowledged that hospitals generally see less healthy patients, which could affect comparisons between hospitals and other providers. They disputed the notion that doctors make more money at these centers, saying that a primary motivation for working in the centers was frustration with hospital work and to benefit from greater coordination with colleagues. With regard to the concern about specialty centers harming a hospital's ability to subsidize emergency care and other less profitable (or unprofitable) activities, these doctors suggested that insurers and government programs should pay appropriately for all services, removing the need to subsidize the less profitable activities. They also urged reforms aimed at covering the uninsured to negate many of the subsidy needs at hospitals.

When asked to rank the causes of healthcare inflation, this group produced the following rough ranking. Understand that it is subjective but provides insight on the relative importance of the factors described above.

1. Costs of serving the uninsured
2. Unhealthy lifestyles
3. Liability and defensive medicine
4. Aging populations
5. Technology spending
6. Drugs
7. Administrative costs
8. Government regulations

This list is similar to the ranking given by hospital officials, with cost shifting at the top, technology in the middle, and government regulations near the bottom but still significant.

Participants were asked to describe the most important reforms that would reduce cost growth in the healthcare system:

- Comprehensively reform the entire system.

- Mandate healthcare coverage for all. Universal coverage would reduce cost shifting, increase preventive care, and reduce emergency room visits and lead to more preventive care. Universal coverage may even reduce litigation because many liability cases are spurred by concerns about the cost of dealing with the patient's adverse outcome in the future.
- Improve information on care quality and reducing variation in medical practices by encouraging the use of best practices or standards of care.
- Identify quality centers and increase transparency for consumers on quality. However, the system is currently not ready for a great deal of transparency because it may lead to adverse selection of patients (physicians refusing care for risky patients because they will make the doctor's statistics look bad). Transparency should not be punitive.
- Reform the tort system. Require mandatory arbitration in malpractice cases or stronger evidence of negligence before a trial may proceed.
- Identify alternative ways to compensate patients with adverse medical outcomes rather than through malpractice lawsuits.
- Encourage use of electronic records and clinical data exchange, which will ultimately save money and reduce redundancy in the healthcare system. However, the initial overhead and time required to implement electronic records is daunting.

Because of the interest among group members in universal coverage, Utah Foundation asked them to describe how best to achieve such coverage. They suggested tax credits as an incentive for employers or individual to buy insurance. They also suggested finding a way to make ethical choices on rationing care. The group did not like a government-funded single-payer system; they felt it would be too bureaucratic and continue underpaying for services. But a mandate on individuals and employers to obtain or provide coverage was more appealing to them. Additionally, they were not impressed with HDHPs, especially those that do not provide "first dollar coverage" for preventive care. They felt that patients with HDHPs will avoid preventive care to preserve their HSA cash balances, and one cited an article in the *Journal of the American Medical Association* showing that even those with a good ability to pay will avoid preventive care.

Finally, these physicians emphasized that, despite all the increases in healthcare costs in recent years, physicians are not generally increasing their incomes. Payment rates are constantly under downward pressure and many doctors are seeing larger loads of patients for the same or less income than in earlier years. One surgeon in the group said his income is down 40 percent since the late 1990s. They also mentioned that many doctors work on call in emergency rooms and when doing so, each provides an average of \$2,000 per week in uncompensated care.

*Summary of focus groups.* Each of the four focus groups agreed on some common observations, especially that rising healthcare costs are having a significant impact on Utah's economy. Business

managers told of employees canceling insurance coverage because of rising costs, while hospital leaders described how uncompensated care for the uninsured is passed on in higher prices for the insured. Insurers and doctors emphasized unhealthy lifestyles as a driver of medical cost increases. Hospitals, insurers, and doctors agreed that fear of medical malpractice liability is driving significant amounts of overutilization through defensive medicine. Hospitals, doctors, and insurers also agreed that government healthcare programs do not pay their proportionate share of costs, causing more costs to be shifted to those with health insurance.

Regarding potential reforms, each of the groups was interested in ways to broaden healthcare coverage in Utah. However, especially among doctors, they were leery of proposals to significantly expand government's presence in the healthcare market, feeling that such expansion would exacerbate chronic underpayment problems with federal health programs. Hospitals also suggested scaling back on optional Medicaid services so government programs could more adequately fund basic medical services for the needy. Business people and insurers asked for stronger incentives for promoting healthy living through wellness programs or other means.

Although the business managers were very interested in consumer-directed healthcare through instruments like high-deductible health plans and health savings accounts, the hospitals and doctors were hesitant to endorse this trend. These medical professionals felt that such strategies discourage utilization too much and cause patients to avoid preventive care and necessary procedures. They also felt that moving away from protections inherent in the group insurance market would be harmful to consumers.

Each group agreed that important reforms should limit defensive medicine and overutilization, promote healthier lifestyles, make better information available on quality and costs, create incentives for greater quality, and make coverage more affordable to reduce the uninsured population.

## ENDNOTES

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<sup>36</sup> Goldman and McGlynn.

<sup>37</sup> BlueCross BlueShield Association.

<sup>38</sup> PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2006."

<sup>39</sup> BlueCross BlueShield Association.

<sup>40</sup> BlueCross BlueShield Association; PricewaterhouseCoopers, “The Factors Fueling Rising Healthcare Costs 2006.”

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<sup>43</sup> Goldman and McGlynn.

<sup>44</sup> Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, “Long-Term Growth of Medical Expenditures — Public and Private,” May 2005, <<http://aspe.hhs.gov/health/MedicalExpenditures/index.shtml>> (13 October 2006).

<sup>45</sup> Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

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