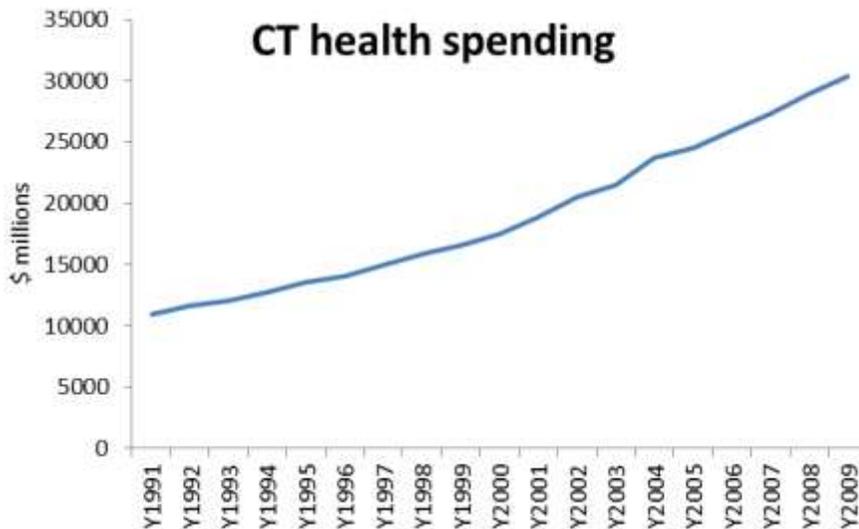


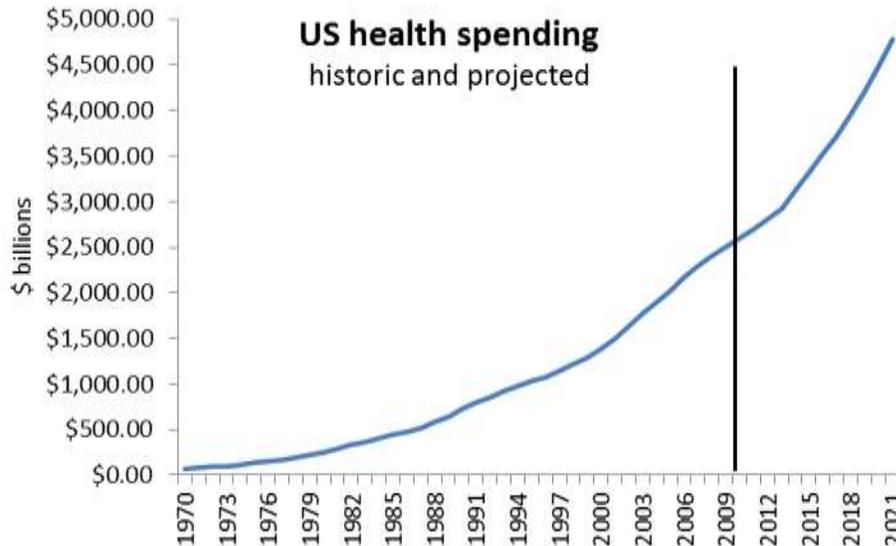
Connecticut Health Care Costs

How much does Connecticut spend on health care?

In 2009 Connecticut spent \$30.4 billion dollars on health care. That is \$8,653.57 for every state resident. And those costs are rising quickly.ⁱ



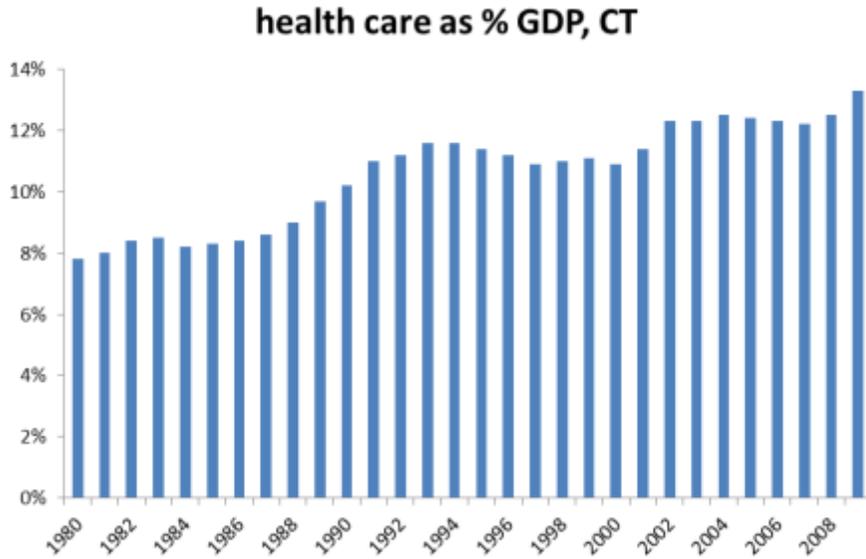
Projections for US health spending predict that, without intervention, that trend will accelerate.ⁱⁱ



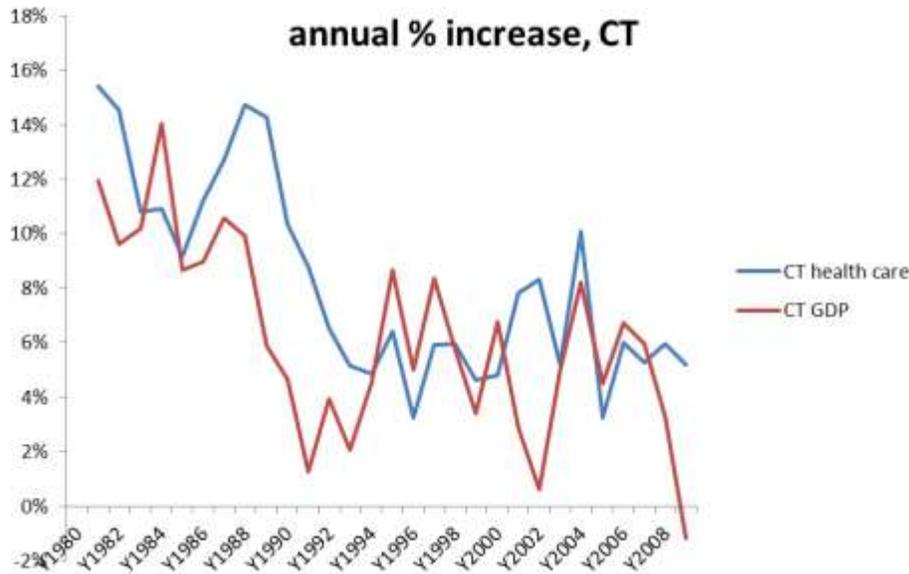
But there is potential good news. US health care cost growth moderated significantly as the overall economy slowed in 2008. However the slowdown in health costs pre-dated the 2008 recession, suggesting that structural changes to the system, such as generic drugs, encouraging preventive care and reforming payment to reward quality, may be working to bring costs in line.ⁱⁱⁱ

CT Health Policy Project 2012 Candidate Briefing Book – CT Health Care Costs

In 2009, health care consumed 13 cents of every dollar spent in Connecticut’s economy and that proportion is rising as well.^{iv}

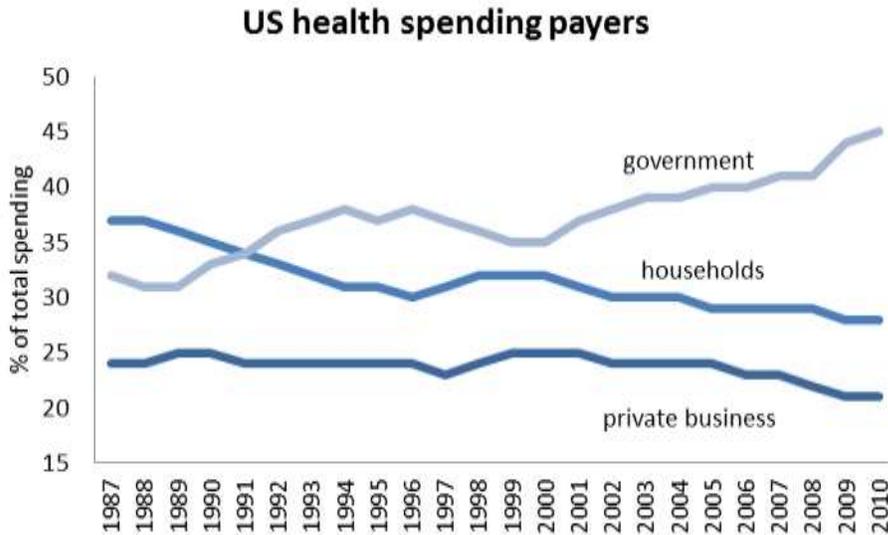


Health care costs largely track the rest of Connecticut’s economy –It is true that total health spending in Connecticut averaged 7.9% annual increases from 1980 to 2009, higher than the 6% growth rate for our overall state economy (Gross State Product, GDP). However when overall economic growth slows, health care spending growth does as well.^v



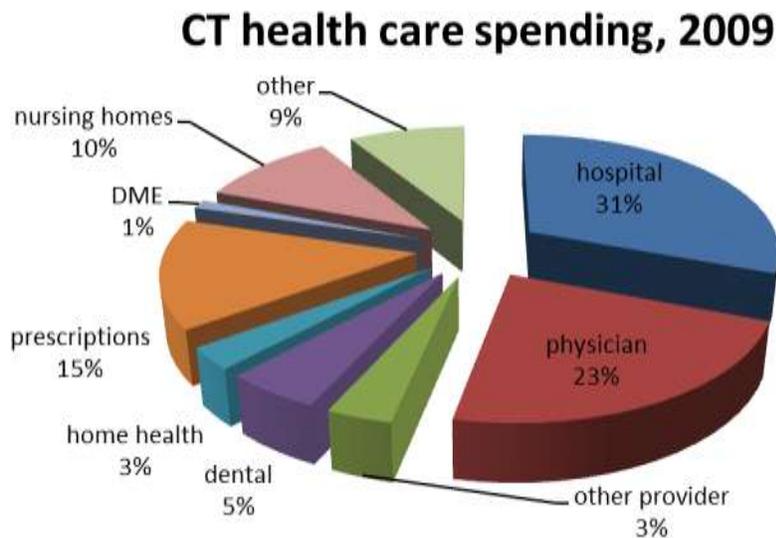
Who pays for health care?

The share of health bills paid by government has risen significantly over the last two decade. Surprisingly, although the total costs of health care for households have risen, the proportion of total costs paid by households has declined. The share paid by private businesses has remained largely steady.^{vi}

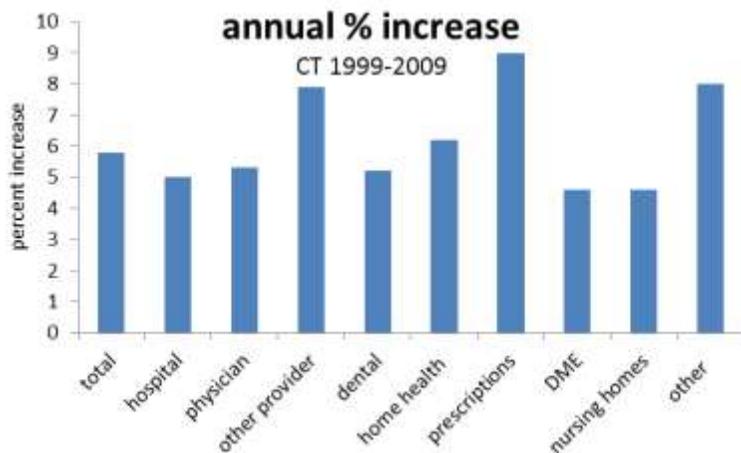


Where do we spend our health care dollar?

Almost half of Connecticut health care spending goes to hospitals and physicians. Prescriptions make up 15% of spending and nursing homes 10%.^{vii}



Mirroring national trends, the proportion of Connecticut health spending devoted to prescriptions is growing faster than the rest of health care^{viii}, but that may not be a bad thing. Appropriate use of prescriptions for many conditions can keep patients out of hospitals and more expensive care.



What is driving rising health costs?

- **Market consolidation** – Competition keeps prices down and Connecticut’s health care market is very concentrated. One Connecticut insurer controls more than half the individual health plan market.^{ix} Hospital mergers and the trend toward larger physician practices are creating fewer, larger providers increasing negotiating power and eventual costs.
- **Prices** – Prices for health services are rising faster than for other parts of the economy. Between 2009 and 2010, prices for outpatient care rose 10% while prices in the general economy grew 1.6%.^x Prices for health care services can vary by five fold in the same community, with no clear link to quality. Higher US health care spending is driven mainly by higher prices for care than other industrialized countries, far more than utilization, supply or quality of care.^{xi}
- **Expensive medical technology** – New technologies, drugs and devices in health care are estimated to account for up to 65% of the growth in health care spending, far more than any other factor including the aging of our population, prices or administrative costs.^{xii}
- **Obesity** – Obesity is associated with 36% higher inpatient and outpatient spending on health care and 77% higher prescription spending. These increases are more than the increased costs of smoking or drinking.^{xiii} It is estimated that increasing levels of obesity drove about 4% of the increase in health spending from 1987 to 2001.^{xiv}
- **Our historic fee-for-service payment system** – The vast majority of US health care providers are paid based on the number and intensity of services they deliver to patients, generally in-person. Providers are paid more to provide more care to more people, not to prevent or reduce the need for care. Payments are not linked to the quality or effectiveness of the care delivered – good and poor quality care pay the same. Recently there have been significant efforts to align payment incentives to shift from volume-based funding to a system that rewards providers for quality, efficient care.^{xv}

- **Administrative inefficiencies** – It is estimated that 31 cents of every US health dollar is spent on administration, almost twice the rate of other countries with better health outcomes.^{xvi} Fragmentation of our health system has significant costs. Physician offices spend 3 hours/week or three weeks/year just getting paid by insurers.^{xvii} Connecticut insurers spent between 8 and 37% of revenues on administration last year.^{xviii} It is estimated that the US health system could save \$130 billion/year if services were delivered efficiently and that excessive administrative costs, including profit, cost the system another \$190 billion/year.^{xix}
- **Overtreatment and inappropriate care** – There is wide variability between health care settings and communities in the costs of care for identical conditions. It is estimated that across just hospital care for three conditions (hip replacement, colon cancer and heart attacks), bringing high cost, high treatment hospitals up to the performance of high quality providers could reduce spending by 8%, saving the US health system over \$1 billion each year and giving an extra year of life to 11,500 people. Eliminating preventable medical errors could save the US as much as \$16 billion/year and eliminating redundant tests would save \$8 billion.^{xx} Many new drugs and treatments are widely adopted because they are new, before their effectiveness has been tested. The federal government has begun a large investment in Comparative Effectiveness Research to study new treatments and learn whether they are any better than what they replaced and whether they are worth the extra cost. It is critical that health care payers, such as the state, incorporate that new research into payment and prevention policies.^{xxi}
- **Missed prevention** – Missed opportunities to prevent disease are a significant driver of health costs. It is estimated that increasing the use of clinical preventive services could save the US over \$55 billion/year.^{xxii}

What isn't driving health costs (or not as much as we think)?

- **Medical malpractice** – While it may be a cost driver for some individual providers, estimates place medical malpractice, and resulting defensive medicine, costs at only 2.4% of all health care. Reducing medical malpractice premiums by 10% is estimated to result in savings of less than 1 percent of total medical care.^{xxiii}
- **Prescription drugs** – While spending on prescription drugs has increased faster than the rest of health care over the last 30 years, that growth has moderated recently. It is also likely that drug costs will continue to slow as several popular medications come off patent protection and fewer blockbuster new medications are in the pipeline. There is also some evidence that increased prescription spending may be more than compensated for by reductions in hospital and physician costs by preventing or managing disease.^{xxiv}
- **Aging** – About 8,000 baby boomers turn 65 every day, qualifying for Medicare. As we age, health needs and costs rise. So it is understandable that many believe that our aging American population is driving rising health costs. However, economists estimate that the increasing age of the population accounts for only 2% of the increase in health costs, far less than other factors.^{xxv}

- Consumers do not bear the full cost of increases** – Since consumers in traditional health plans pay the same copayments whether they seek treatment from a high or low price provider, they have no incentive to price-shop. It has often been suggested that reversing this incentive, or giving consumers some “skin in the game”, will bring competitive market forces to bear and reduce prices. Unfortunately, that hasn’t happened. Consumer-directed health plans, that force consumers to use their own funds to self-pay many health costs, have not been demonstrated to reduce overall costs. While costs for consumers enrolled in the plans are lower, members reduce the use of both unnecessary and necessary preventive and maintenance care. There is also evidence that consumer-directed health plans attract healthier members, leaving consumers with more costly health problems in traditional coverage, raising those costs. It is very difficult to price-shop as an individual consumer, and most do not have the sophistication or the information to know what they need and judge the quality of providers to get the best value^{xxvi}.

Ellen Andrews

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September 2012

ⁱ National Health Accounts, CMS, HHS, accessed August 2012

ⁱⁱ *ibid*

ⁱⁱⁱ C Roehrig, et. al., When the Cost Curve Bent — Pre-Recession Moderation in Health Care Spending, *New England J Med*, 367: 590-593, August 16, 2012

^{iv} *ibid*

^v *ibid*

^{vi} *ibid*

^{vii} *ibid*

^{viii} *ibid*

^{ix} How Competitive are State Insurance Markets?, Kaiser Family Foundation, October 2011

^x Health Care Cost and Utilization Report: 2010, Health Care Cost Institute, May 2012

^{xi} Explaining High Health Care Spending in the United States, Commonwealth Fund, May 2012

^{xii} Technological Change and the Growth of Health Care Spending, Congressional Budget Office, 2008

^{xiii} R. Sturm, The Effects Of Obesity, Smoking, And Drinking On Medical Problems and Costs, *Health Affairs* 21:245-253, 2002

^{xiv} Technological Change and the Growth of Health Care Spending, Congressional Budget Office, 2008

^{xv} Value over Volume, CSG/ ERC, 2010

^{xvi} S Woolhandler, et. al., Costs of Health Care Administration in the US and Canada, *New England J Med*, 349:768, 2010

^{xvii} The Health Care Imperative: Lowering Costs and Improving Outcomes, Institute of Medicine, 2010

^{xviii} Consumer Report Card on Health Insurance Carriers in Connecticut, CT Insurance Dept., October 2011

^{xix} The Health Care Imperative: Lowering Costs and Improving Outcomes, Institute of Medicine, 2010

^{xx} The Health Care Imperative: Lowering Costs and Improving Outcomes, Institute of Medicine, 2010

^{xxi} CEPAC

^{xxii} The Health Care Imperative: Lowering Costs and Improving Outcomes, Institute of Medicine, 2010

^{xxiii} JW Thomas, et. al., *Health Affairs*, 29: 1578-1584, 2010; M Mello, *Health Affairs*, 29: 1569-1577, 2010

^{xxiv} US Health Care Costs, Kaiseredu.org, Kaiser Family Foundation

^{xxv} AARP; Technological Change and the Growth of Health Care Spending, Congressional Budget Office, 2008

^{xxvi} A Haviland, et al, Health Affairs 31: 1009-1015, 2012; R Cohen and M Martinez, NCHS Data Brief No. 15, CDC, March 2009