Why does health insurance cost so much?
What’s the cost for having it all?

As Americans, we believe we should have access to the best of everything, and health care is no exception. We have world-renowned hospitals, top-notch medical schools, and our expected life spans exceed those in most of the world. In the Philadelphia area alone, we have a world renowned children’s hospital, more than 10 teaching hospitals, top-rated doctors and access to cutting-edge technology. But what is the price for having it all?

A recent report showed that the United States spent $2.1 trillion on health care, or about 16 percent of the gross domestic product in one year. Spread over the population, this equates to about $7,000 spent per person annually and is more than seven percentage points higher than the average for other developed countries. It is estimated that costs will continue to increase rapidly with $4.4 trillion being spent on health care annually by 2018 — or one fifth of the gross domestic product. Unless we slow the rise in the cost of health care, premiums will continue to rise at a pace far faster than inflation.

What is driving these escalating costs?

- advances in medical technology and the corresponding increase in utilization;
- lifestyle choices (an unhealthy and overweight population);
- historical drivers such as our aging population, prescription drugs, fraud and abuse, the uninsured, and cost-shifting from Medicare and Medicaid.

U.S. health care costs exceed those of other world leaders

<table>
<thead>
<tr>
<th>Country</th>
<th>Cost as a Share of GDP</th>
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<tbody>
<tr>
<td>United States</td>
<td>16%</td>
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<tr>
<td>France</td>
<td>11%</td>
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<tr>
<td>Germany</td>
<td>10.4%</td>
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<tr>
<td>Canada</td>
<td>10.1%</td>
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<tr>
<td>OECD AVG</td>
<td>8.9%</td>
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<tr>
<td>Australia</td>
<td>8.7%</td>
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<tr>
<td>United Kingdom</td>
<td>8.4%</td>
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<tr>
<td>Japan</td>
<td>8.1%</td>
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Health expenditures as a share of GDP, 2007 or most recent year available

Source: Organisation for Economic Co-operation and Development OECD, Health Data 2009, June 2009
Outpatient imaging utilization
CT / MRI / PET radiology services
per 1000 commercial members


Many studies are now pointing to technology as the leading driver of health care costs, accounting for an estimated half to two-thirds of the spending growth.¹ This isn’t hard to believe considering all of the ads on TV, radio, and billboards promoting the latest advances in radiology and imaging, fertility services, and advanced heart surgeries. We’ve all heard about gamma knife technology, open MRIs, and the use of proton beam therapy. If you build it, they will come. People are using these services, especially in the Philadelphia area. For instance, take outpatient imaging services such as CAT scans, MRIs, and PET scans. Philadelphia ranks third in utilization of these radiology services, more than 29 percent above the national average.²

There has been discussion that one reason for the increased utilization of diagnostic testing is the practice of defensive medicine. The Massachusetts Medical Society and University of Connecticut researcher Robert Aseltine Jr. recently completed a study based on survey responses from 900 physicians about their use of certain services including X-rays, CT scans, MRIs, ultrasounds, laboratory testing, and hospital admissions. According to the study, roughly 83 percent of the physicians surveyed reported practicing defensive medicine. On average, 13 percent of hospital admissions and 18 to 23 percent of tests, procedures, referrals, and consultations were ordered for defensive reasons.³

Advances in other aspects of health care are also having an equally profound effect on costs. Implantable cardiac defibrillators, which regulate the heartbeat of patients who have suffered heart damage, can reduce the risk of death from a heart attack by 30 percent. Roughly 50 percent of heart attack survivors now receive one of these devices and implementation of the device can cost between $68,000 and $102,000. Another advancement in the treatment of heart disease is the use of robots to perform heart bypass surgery. On the positive side, the da Vinci robot is less invasive for the patient and can reduce recovery time by a third. But, the da Vinci robot comes with a $1.5 million price tag, requires the replacement of $2,000 worth of supplies each time it is used, and typically takes longer than an actual surgeon. A recent study estimates that the robot increases the cost of bypass surgery by $8,000.⁴
There are also examples where new technology is not always better in terms of improving a patient’s quality or length of life. For instance, a gender specific knee device is now being manufactured for women, unlike the “old knee” which was used for both men and women. This gender-specific device is $10,000 more expensive than the traditional knee, and has been quickly adopted, even though it has not been proven to make a difference for the patient. Another more highly debated example is the use of proton beam therapy for the treatment of prostate cancer. Proton beam therapy allows for more precise targeting of tumor cells with higher doses of radiation without harming non-targeted tissues only millimeters away. However, a proton beam machine can cost as much as $200 million and studies have not shown that it produces any better outcomes than traditional treatments for prostate cancer. A recent cost benefit analysis by Konski et al. concluded that proton beam therapy would not be cost-effective for most prostate cancer patients. Results of the study showed that at 15 years proton beam therapy had only a 49 percent chance of being cost effective for a 70-year old patient and only a 54 percent chance of being cost effective for a 60-year-old patient.

**TECHNOLOGY comes at a price:**

- use of a **robot** adds **$8,000** to the price of bypass surgery;
- new **gender-specific knee replacement joint** is **$10,000** more expensive than a traditional device;
- a **proton beam** can cost as much as **$200 million** to purchase and install.

**So, how do you determine the most appropriate use of medical technologies?**

Many call for standardization of best practices to help practitioners look more strictly at which device or treatment is really most appropriate for each patient based on their medical issue. Studies have shown that practice patterns, or the tests and treatments prescribed by physicians, vary based on geography, medical school training, and physician experience. A recent New England Healthcare Institute study listed two primary areas of opportunity for controlling costs related to variation in practice patterns:

- unexplained variation in the intensity of medical and surgical services, including but not limited to: end-of-life care, overuse of coronary artery bypass, and overuse of angioplasties;
- misuse of drugs and treatments, resulting in avoidable adverse effects of medical treatment.
While technology is a key driver of costs, the lifestyle we choose — smoking, poor nutrition, not exercising — also plays a major role. Obesity alone results in $117 billion in United States health care costs each year, tobacco use costs America $180 billion annually, and 78 percent of health care spending in Pennsylvania pays for treating largely avoidable chronic conditions.

If we take a closer look at the increase in obesity and related health concerns, it is easy to see the effect on health care costs. The Centers for Disease Control and Prevention reported in 2007 that more than a third of U.S. adults (more than 72 million people) were obese. This is a significant increase from 20 years earlier when adult obesity in the United States was only 14 percent on average. If obesity rates had remained at the 1987 levels, health care spending in the U.S. today would be 10 percent lower per person, or about $200 billion less each year. Obese people are at risk for a multitude of chronic conditions and diseases, including diabetes, cardiovascular disease, stroke, cancers, back problems, kidney disease, and more.

In fact, a recent study shows that the occurrence of weight-related chronic conditions grew by over 180 percent from 1997-2005. The prevalence of diabetes and heart disease grew by more than 70 percent as a result of increased obesity rates while hypertension rates grew by 60 percent and arthritis by nearly 50 percent. A major pain point for employers is the sharp increase in back problems associated with being overweight, which increased 578 percent from 1997. This is concerning because lower back pain is the most common work-related disability in people under age 45 and is extremely costly for employers, in terms of workers’ compensation and medical expenses. Overall, obesity in working-age adults

The prevalence of chronic conditions associated with overweight and obesity has grown by more than 180%

Overweight- and obesity-associated changes in chronic condition prevalence, working-age adults, 1997-2005

Source: Tabulations from the 1997 and 2005 household component to the Medical Expenditure Panel Survey. Sample sizes were: 19,961 (1997) and 20,486 (2005). Data restricted to adults 19 to 64, excluding pregnant women and those who gave birth in the survey year.
accounts for 27 percent of the rise in inflation-adjusted health care costs. 10

To put it in perspective, let’s look at some specific examples. According to the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, the number of gastric bypass surgeries in the United States grew from roughly 13,000 in 1998 to more than 121,000 in 2004. While this surgery can vastly improve health outcomes, as many as 14 percent of patients may be readmitted to the hospital as a result of complications, placing a further burden on the health care system.11 In addition to the cost of treating obesity, we also have to look at the cost to treat its complications. As the prevalence of obesity increases, so do the cases of arthritis and the need for joint replacements. In the last seven years, the incidence of primary hip replacements increased by 48 percent and first-time knee replacements grew by 63 percent. If we continue to perform joint replacements at this rate, an estimated 600,000 hip replacements and 1.4 million knee replacements will be performed in 2015.12

Controlling health care costs related to lifestyle choices is a challenge but one that can be met by helping members become effective health care consumers.

Consumerism is transforming health care in the United States and is about empowering individuals with information, tools, resources, and incentives so they can choose healthier ways of living and make wise health care decisions.

- Incenting consumers to make healthy choices. Rewards encourage lifestyle changes by incenting consumers to lose weight, quit smoking, exercise, get preventive screenings, and engage in other healthy activities that focus on the long-term benefits of wellness.

- Providing evidence-based worksite wellness programs. Reinforcing wellness and prevention in the workplace by sponsoring biometric screenings, conducting health seminars, and promoting wellness in employee communications provides another opportunity to engage consumers in the health care experience — and it works. Data shows that employer wellness programs offer a $3 return for each $1 spent.

- Utilizing technology to engage consumers. Sometimes members need additional encouragement and support to make lifestyle changes. Online tools to track blood pressure, food consumption, and test results can make a difference. Targeted messaging to those at risk for health issues can give them the push they need to make a healthy behavior change.
Still playing a role in rising health care costs are the historical drivers such as an aging population, cost-shifting associated with certain government sponsored programs such as Medicaid and the uninsured; prescription drug costs; and fraud and abuse in the health care system. By 2030, the number of Americans 65 or older will more than double to 71 million. Philadelphia ranks first among America’s top ten cities, with 13 percent of our population 65 or older. In southeastern Pennsylvania, there are more than 262,000 uninsured adults and almost 49,000 uninsured children. Nationally, 10 percent of all health care costs are attributed to the use of prescription drugs and almost three percent, or $68 billion, is lost to health care fraud each year.

The question of how an aging population contributes to increased health care spending is an easy one to answer. As Americans age, we use more medical resources. Older Americans account for 50 percent of physician visits and 50 percent of all hospital stays. In the coming years, this will be further exacerbated as baby boomers, whose health care spending is more than double that of younger adults, get older. In fact, some scholars theorize that as baby boomers age, they think they are still young — a mentality that leads to increased use of new medical technologies, and a demand for all of the latest bells and whistles. In addition, the longer we live, the more likely it is that something we had treated in our 40s or 50s will require more care as we age. If we look at joint replacement surgery again, we see that the longer a person lives the higher the probability that he or she will outlive the artificial joint. In 2004, revision surgeries were done on 40,000 knees and 46,000 hips in the United States. This is concerning because revision surgeries have a longer recovery time, are costlier, and have a higher incidence of complications.

Here are the facts:

- 13% of Philadelphia’s population is 65 or older
- more than 262,000 adults and 49,000 children are underinsured in southeastern Pennsylvania
- 10% of health care costs nationally are attributed to prescription drugs
- $68 billion is lost to health care fraud annually
When we look at prescription drug spending, we now see a more favorable story. Over the last 10 years the biggest change in health care spending has been the significant reduction in prescription drug costs. Prescription drug premiums are increasing at a much slower rate, growing only 5.7 percent in 2007.21

The widespread adoption of multi-tiered drug plans that encourage value-based decision-making are positively influencing the use of generic medications. This trend has been accelerated in recent years as several highly utilized blockbuster drugs have gone off-patent. We’ve seen this trend in our generic utilization rates as well. Our generic dispensing rates have increased nearly 10 percent in the past two years and, when available, our members are currently substituting generic medications for their brand counterpart nearly 95 percent of the time.

While the growth in prescription drug spending has stabilized over the years, we still have opportunities to better control these costs. One area of concern is the increase of “off-label” use of prescription drugs. This is the practice of prescribing a drug or medical device outside of the scope of the drug’s/device’s FDA approval. An April 2009 article in “Psychiatric Times” indicated that approximately 40 to 60 percent of prescriptions written are for off-label use. A recent review of 160 common drugs revealed that 21 percent of all prescriptions were for off-label uses and 73 percent of the off-label uses had little or no scientific evidence.22 Actiq, for example, is commonly prescribed for off-label use even though it is a Schedule II controlled substance. Approved for use in treating cancer breakthrough pain, Actiq is about 80 times stronger than morphine and is now often prescribed for off-label uses such as bone injuries, migraines, severe back pain, cluster headaches, neuropathy, arthritis, and other situations of moderate to severe chronic, non-malignant pain. At more than $1,300 for 30 lozenges, this practice has significant cost implications when there are other effective pain management prescriptions available.
While we’ve made progress in managing prescription drug spending, the effect of the uninsured and cuts in reimbursement for government-sponsored plans has created a greater burden on the health care system. As reimbursement to doctors and hospitals for some government programs drop below what the care actually costs, doctors and hospitals seek higher payments from health insurers to make up the difference. A 2008 Milliman study estimates that the total annual shift of costs from Medicare and Medicaid to health insurance companies was almost $89 billion. Simply put, this cost-shifting increased the 2008 health insurance premium for a family of four by $1,512, or 10.6 percent annually. Adding to the problem is the cost of the uninsured. In Pennsylvania, about 6.5 cents of every insurance premium dollar goes to cover the cost of providing care to the uninsured.23

Finally, the effect of fraud and abuse on America’s health care system is widespread. In 2008, IBC’s Corporate & Financial Investigations Department (CFID), which oversees this work, recovered nearly $52 million resulting from fraud, waste, or abuse. Since 2004, CFID has recovered more than $192 million, and referred 325 cases to law enforcement and regulatory authorities, resulting in 86 fraud charges and 65 convictions. Nationally, Blue Cross and Blue Shield companies’ anti-fraud investigations resulted in savings and recoveries of nearly $350 million in 2008, an increase of 43 percent from 2007.

While these historical drivers of health care costs may never be eliminated, there are things that we can do to limit their effects.

- Initiate programs like IBC’s No Pay Copay and Rx For Better Health to promote market awareness and acceptance and continued use of generic medications.
- Practice utilization management in prescription drug benefit administration, such as prior authorization and utilization reviews, to ensure that drugs are used safely, effectively, and cost-efficiently.
- Utilize sophisticated data-mining tools to detect fraudulent claims and actively pursue compensation and legal resolution.
- Provide information on the many special programs for the uninsured, helping them obtain no- or low-cost coverage.
There isn’t an easy answer to solving the health care crisis. The issues facing health care are complex, and we alone cannot address the forces that drive up costs, drive down quality, and limit access. We and the 38 other independent Blue Cross and Blue Shield plans in the Blue Cross and Blue Shield Association acknowledge that the health care system must change and we are focused on initiatives to reduce the cost of health care services. We will continue to work collaboratively with physicians, hospitals, employers, brokers, and other key health care stakeholders to develop a delivery system that can provide more affordable, high-quality coverage for all Americans.

Our dedication to strengthening the health of our members and our customers’ bottom line continues. We doubled the number of hospitals in our pay-for-performance program, which rewards hospitals for providing top-notch care. We launched Healthy LifestylesSM Rewards, an incentive program that rewards members for engaging in healthy activities and getting preventive care. We introduced electronic Clinical Alerts to provide physicians with real-time information on their patients who have not received recommended care, and we are proud to offer our customers our award-winning Connections Health Management Program, which provided more than 2.6 million educational and reminder cards, letters, and telephone calls to members in 2008.

We continue our commitment to improving the health of the communities that we serve. Participation in Health eTools for Schools, our award-winning program that helps local students get more exercise, adopt healthy eating habits, and control their weight, now reaches more than 375,000 children in the region. Our ongoing commitment to the Partnership for Patient Care, a quality and patient safety effort led by local hospitals, has helped reduce the number of surgical site infections, improved the prevention of patient falls, and enhanced monitoring of medications to prevent harmful drug interactions and dosing errors. We are a participant in the Pennsylvania Medical Home Project, a pilot program that is transforming care for patients with diabetes and asthma. In just the first year of the program, IBC members with diabetes made improvements in several key areas. Diabetic patients were more engaged in preventive care – 71 percent more got eye exams and 142 percent more got an annual foot exam. The number of patients that got their cholesterol below 130 increased by 43 percent and the number of patients that got their blood pressure below 140/90 jumped by 25 percent. Results also showed that diabetic patients were able to better manage their blood sugar levels. The number of diabetic patients that got their hemoglobin A1c score below nine grew by 23 percent and those that got their score below seven grew by 33 percent.

In our 70-year history, we have negotiated through challenging times, while always keeping a steady eye on improving the health of our members and our community. That distinguishes us from many health insurers, whose focus is on satisfying the demands of Wall Street. For seven decades, Independence Blue Cross has remained true to its mission: building the health of our members and strengthening the well-being of our community by improving access to affordable, quality health care. We look forward to working with you as we develop unique solutions to address the crisis facing our industry, and welcome your comments and ideas.
Achieving measurable results

- Our Connections™ Health Management Program has produced a 1.5% reduction in medical cost trends annually since we introduced the program in 2004.

- The Pennsylvania Medical Home Program’s first-year results show a 71% increase in diabetic patients getting eye exams and a 142% increase in those getting their annual foot exams.

- Health eTools for Schools helps more than 390,000 children stay fit.
FOOTNOTES


