The Factors Fueling Rising Healthcare Costs 2006

Prepared for America's Health Insurance Plans, January 2006

PricewaterhouseCoopers

PRICEWATERHOUSECOOPERS

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Executive Summary

The purpose of this report is to identify the underlying drivers of rising healthcare costs and to break down how current premium dollars are being spent.

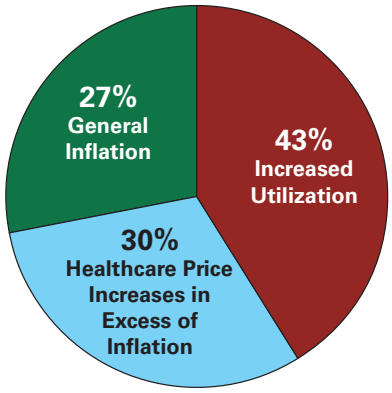
This PricewaterhouseCoopers (PwC) report was commissioned by America's Health Insurance Plans (AHIP) and revisits a subject examined in a 2002 PwC report entitled "The Factors Fueling Rising Healthcare Costs."

We based the estimate of overall increases on reviews of both government and private surveys that track employer costs of providing health coverage for their employees. In addition, we analyzed the drivers of healthcare cost increases based on discussions with actuaries as well as reviews of available research and literature.

Some of the key findings include:

- PwC estimates that the overall increase in premiums between 2004 and 2005 was 8.8 percent, which is 36 percent lower than the 13.7 percent increase reported in 2002. General inflation accounted for 27 percent of the 2005 increase in health insurance premiums. Increased utilization of services accounted for an estimated 43 percent of the increase. Price increases in excess of inflation for healthcare services accounted for the remaining 30 percent of the increase in health insurance premiums. The reasons for price increases in excess of inflation include movement among purchasers toward broader-access health plans, provider consolidation, increased costs of labor, and higher priced technologies.

Factors Contributing to the 8.8% Increase in Premiums



- PwC attributes utilization increases primarily to increased consumer demand, new medical treatments, and more intensive diagnostic testing due partially to the practice of defensive medicine. An aging population and increasingly unhealthy lifestyles were also contributors.

- While existing state and federal mandates continue to add to the cost of health benefits, the number of new mandates has decreased markedly in recent years and new mandates did not appear to be a major contributor to 2005 increases.

- A review of the cost increases by type of service indicates that the estimated increase in outpatient costs (13.6 percent) contributed to almost a quarter of overall premium increases in 2005. Other services such as physician, inpatient hospital, prescription drugs, and other medical services contributed to the balance of premium increases fairly evenly.

- A 2002 Juran Institute study estimated that the "cost of poor quality" in healthcare accounts for 30 percent of all direct healthcare spending as a result of overuse, misuse, and waste. Another study estimated that the direct costs of litigation and widespread practice of defensive medicine increase healthcare spending by 10 percent, disproportionately increasing outpatient and physician costs.

- In the other direction, widespread adoption of multi-tiered pharmaceutical benefits and generic drugs have helped slow the rate of increase in prescription drug spending.

- Approximately 86 cents out of every premium dollar go directly towards paying for medical services such as hospital care, physician care, medical devices and prescription drugs. Of the remaining costs, five cents go to other consumer services, provider support, and marketing (including prevention, disease management, care coordination, investments in health information technology and health support). Costs associated with government payments, regulation and other costs associated with administration (e.g., claims administration) comprise an estimated six cents. Health plan profits represent three cents of the premium dollar.

- Premium increases very closely follow healthcare spending increases over time. Over the most recent ten-year period (1993-2003) for which data are available, premiums grew at an annual rate of 7.3 percent, while the cost of healthcare services grew at an annual rate of 7.2 percent.

- A review of the history of medical cost increases shows that for the better part of the 1990s, healthcare costs rose at a slower rate than they had throughout the 1980s. Premium increases were the lowest in several decades from 1994-1998.

A number of current health plan initiatives have the potential to mitigate future cost increases and address several of the key cost drivers outlined in the report.

I. Introduction

Much has been written about the rising cost of healthcare costs and premiums. Less has been written about the underlying drivers of those rising costs. This report takes a fresh look at issues analyzed in a 2002 PricewaterhouseCoopers (PwC) report commissioned by America's Health Insurance Plans entitled "The Factors Fueling Rising Healthcare Costs." As with the 2002 report, the purpose of this report is to identify the underlying drivers of rising healthcare costs. This report takes the additional step of breaking down how current premium dollars are being spent. By detailing how premiums are being spent as well as identifying the drivers of premium increases, this report attempts to provide policymakers and other stakeholders with information that can help guide efforts to address rising healthcare costs and improve healthcare affordability.

II. Methodology

PwC estimates that the overall increase in premiums between 2004 and 2005 was 8.8 percent. We based the estimate on reviews of both government and private surveys tracking employer costs in providing health coverage for their employees. We examined data on 2005 premiums, when available, as well as 2004 data when data was not available for 2005. We also took into account the Center for Medicare and Medicaid Services (CMS) forecast for 2005. In addition to our review of these sources, we based our estimate on our own interviews with health insurance plan actuaries and examination of other unpublished sources.[1]

In this report, we segment the cost drivers that make up the 8.8 percent increase in healthcare premiums between 2004 and 2005. These drivers were initially identified from our discussions with actuaries from various health plans on premium increases and the factors underlying them as well as other literature on factors behind rising healthcare costs.

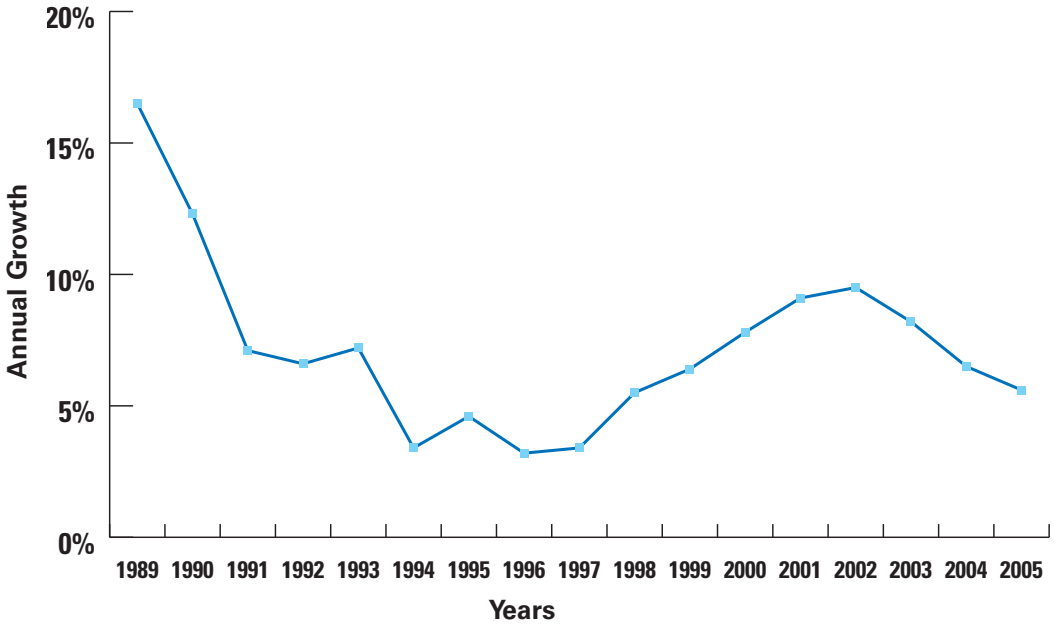
III. Recent Cost Trends

For the better part of the 1990s, healthcare costs rose at a slower rate than they had throughout the 1980s. Private health spending increases per capita were the lowest in several decades during the period 1994–1998. Industry observers generally attributed this slower growth in healthcare costs to the success managed care health plans had with network-based healthcare. Yet in the late 1990s, per capita healthcare spending costs began to increase again, peaking around 2002, when we estimated in our prior study that premiums were increasing 13.7 percent. (See Exhibit 1) The healthcare landscape has once again changed. In this latest report, we estimate that premiums rose by 8.8 percent from 2004 to 2005. This increase is 36 percent lower than our 13.7 percent increase estimate for 2002. (See Exhibit 2)

[1] We reviewed publicly available reports from firms that survey employers and their health plan costs. These sources include: Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits, 2004," September 2004; Mercer Human Resource Consulting, "US health benefit cost rises 7.5% in 2004, lowest increase in five years," November 2004; The Segal Group, Inc., "2005 Segal Health Plan Cost Trend Survey," August 2004; Towers Perrin HR Services, "2005 Health Care Cost Survey," December 2004.

EXHIBIT 1

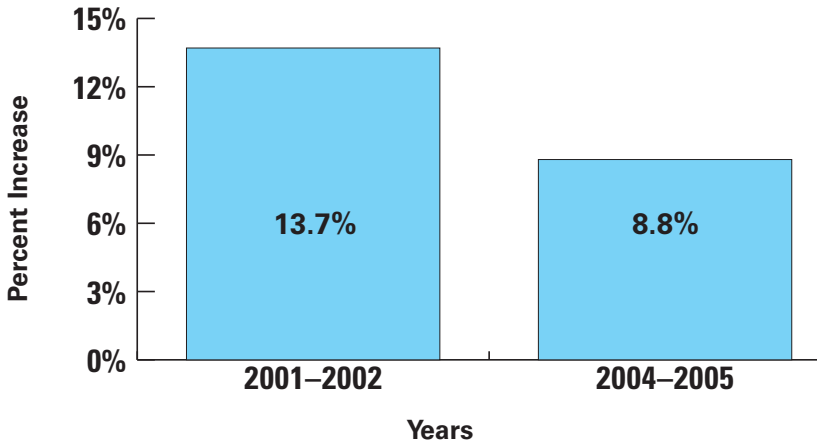
Annual Growth in Private Health Spending Per Capita ■ 1989-2005



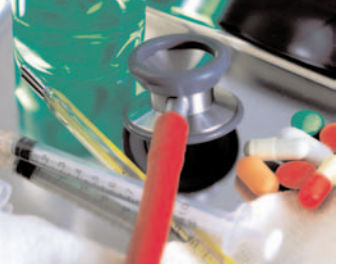
Source: Centers for Medicare & Medicaid Services, National Health Accounts, 2005.
Note: These are the payments made by third-party payers—mostly insurance companies and employers—toward the purchase of healthcare for their beneficiaries or employees. The payments include health benefits as well as administrative costs of insurers and third-party administrators. The payments include not only those made by group plans but also individual policies and Medicare supplemental (Medigap) plans. In recent years, the trend has been somewhat lower than many of the estimates that come from surveys of employer plans but the general pattern of the trend has been similar. The numbers after 2003 are official forecasts provided by CMS.

EXHIBIT 2

Increase in Health Insurance Premiums 2001-2002, 2004-2005



Sources: PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs." April 2002, PricewaterhouseCoopers' estimates 2005.



IV. Relationship Between Premium Dollars and the Cost of Health Benefits

The cost of health insurance premiums is primarily a reflection of the overall cost of healthcare services. Understanding the relationship between health insurance premiums and the cost of health benefits is the key to explaining increases in health insurance premiums.

The overwhelming share of health insurance premiums goes to pay for the cost of health benefits—actual services such as hospitals, doctors, drugs, and other services that directly benefit consumers. The remaining share of the premium is attributable to other consumer services, provider support, marketing, government payments, compliance, claims processing, other administration, and health plan profits.

As shown below, the bulk of the premium dollar goes towards paying for:

- Physician services (24%)
- Outpatient costs (22%) This includes free-standing facilities and outpatient departments of hospitals.
- Inpatient hospital costs (18%)
- Prescription drugs (16%)
- Other medical services (6%). This includes durable medical equipment, nondurable medical equipment, home health, other health professionals, and other personal care.
- Consumer services, provider support and marketing (5%). In addition to marketing and sales, this component includes communications with consumers regarding their existing and new benefits, disease management programs, care coordination, health promotion, wellness and prevention programs, and investments in health information technologies that benefit consumers.
- Government payments, compliance, claims processing and other administration (6%) Taxes on premiums, costs of complying with government laws and regulations such as filing and reporting requirements and the recent Health Insurance Portability and Accountability Act are included in this cost component as well as the costs associated with claims processing, premium and eligibility processing and other administrative activities that support health plan operations. Health plan claims processing procedures rely on a significant investment in technology and training to provide timely coverage determinations to consumers and timely payment to providers as well as guard against fraudulent billing practices.

- Health plan profits (3%). Health plan profits are available to meet risk-based capital needs, to support continued reinvestment into the system, and to provide a reasonable return to attract investors.

While the bulk of the premium dollar pays for medical services, those medical services include the cost of medical liability and defensive medicine. As malpractice premiums continue to rise, particularly in states that have not taken any action to contain the cost of the medical liability system, providers have responded in a number of ways, including the practice of defensive medicine (e.g., where doctors, in order to mitigate the threat of lawsuits, order tests and procedures they believe are not medically necessary). A recent survey of Pennsylvania providers in six specialties revealed that 93 percent reported practicing defensive medicine.[2] Defensive tests and treatment can pose unnecessary medical risks and add unnecessary costs to healthcare.[3]

Exhibit 3 illustrates the impact of the current medical liability system on the cost of the various medical services. Overall, approximately 10 percent of the costs of medical services are attributed to the cost of litigation and defensive medicine.[4] A reasonable breakout of the costs of liability and defensive medicine would include 3 percentage points of the 24 percent of the premium dollar being spent on physician services, and 4 percentage points of the 22 percent being spent on outpatient services. Of the money being spent on inpatient hospital services, prescription drugs, and other medical services, we estimate 1 percentage point is attributable to liability and defensive medicine.

EXHIBIT 3

Cost of Medical Liability and Defensive Medicine as a Share of the Premium Dollar, 2005

Component	Total Share of Premium	Medical Liability Share of the Premium Cost	Benefit Share of Premium Less Medical Liability
Physician	24%	3%	21%
Outpatient	22%	4%	18%
Hospital Inpatient	18%	1%	17%
Prescription Drugs	16%	1%	15%
Other Medical Services	6%	1%	5%
Total	**86%**	**10%**	**76%**

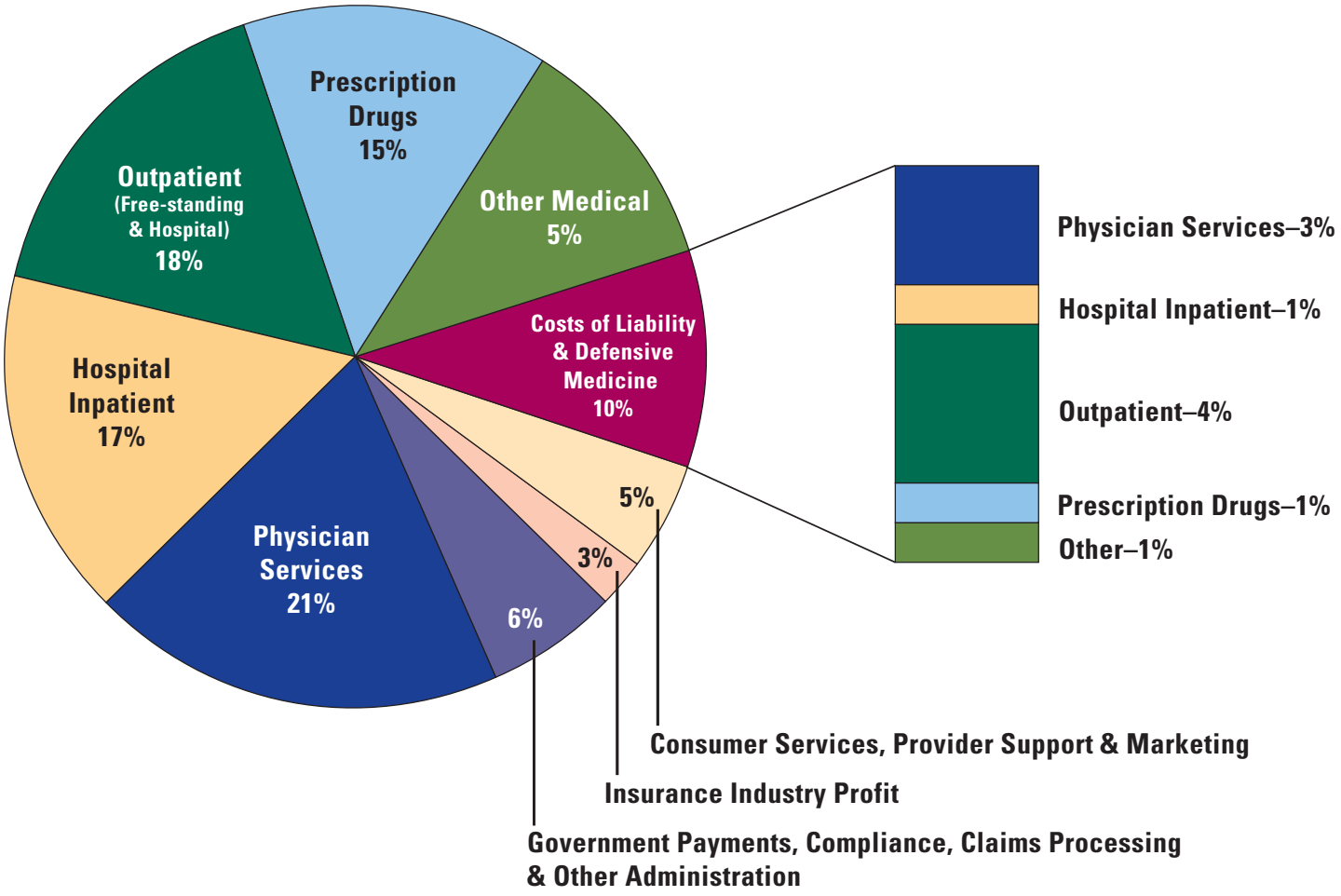
Source: PricewaterhouseCoopers' estimates, December 2005.

[2] Journal of the American Medical Association, June 2005.
[3] Midwest Business Group on Health, April 2003.
[4] The 10 percent was adapted from Kessler and McClellan as sourced in Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care," March 2003 and CMS' Medical Economic Indices. Kessler and McClellan estimate that the cost of defensive medicine was in the range of 5% to 9% of medical costs. The direct cost of medical liability insurance is roughly 2%. This suggests that total medical liability costs are in the 7% to 11% range.

Exhibit 4 shows how the various components discussed above contribute to overall premiums.

EXHIBIT 4

Estimated Breakdown of Insurance Premiums With Medical Liability and Defensive Medicine Extracted, 2005



Sources: Adapted from Centers for Medicare & Medicaid Services, National Health Accounts, 2005 and Midwest Business Group on Health, April 2003.

Exhibit 5				
Comparison of Premiums and Health Benefits, 1993-2003				
Type of Expenditure	**1993**	**2003**	**Change in Costs 1993–2003**	**Annual Growth Rate**
	(in millions)			
Premiums	298,078	600,594	302,516	7.3%
Benefits	259,865	518,737	258,872	7.2%

Sources: Centers for Medicare & Medicaid Services, National Health Acounts, 2005.

Since this section has shown that the predominant share of the premium dollar goes towards benefit costs exclusive of administrative expenses, it follows, then, that premium increases should track increases in the cost of healthcare benefits over the long run. As Exhibit 5 shows, during the past decade, premium increases have closely tracked increases in benefit costs. Over the same time period in which premiums have grown at an annual rate of 7.3 percent, the cost of healthcare benefits has grown at an annual rate of 7.2 percent.[5]

This section has established that the majority of the premium goes directly to the cost of healthcare benefits—actual medical services such as hospital care, physician care, and prescription drugs. The next section of our report will more closely examine the factors driving rising healthcare costs and the corresponding rises in health insurance premiums.

V. Factors Driving Cost and Premium Increases

PwC disaggregated the estimated 8.8 percent premium increase into three components: (1) general inflation; (2) healthcare price increases in excess of inflation; and (3) increases in utilization (as shown in Exhibit 6). This broad decomposition was based on forecasts from CMS, adjusted to reflect our estimate of the premium increase in 2005. We further disaggregated the three broad categories into specific drivers based on a wide range of studies and discussions with health plan actuaries.

HEALTHCARE PRICE INCREASES IN EXCESS OF INFLATION

Increases in healthcare prices beyond general inflation accounted for 2.6 percentage points of the 8.8 percent increase in premiums. The major factors that drive price increases are the movement to broader-access plans, higher-priced technologies, and cost-shifting from Medicaid and the uninsured to private payers. In fact, the cost of providing care to the uninsured was estimated to add as much as 8.5 percent to the cost of premiums according to a recent Families USA study.[6]

[5] Usually premiums track benefit costs over long periods of times but, in the short run, the two are not perfectly correlated due to "the underwriting cycle." Because premiums are set well before costs are known, insurance companies sometimes find that benefits grow faster than premiums and insurance industry profits are squeezed. At other times, the opposite pattern emerges and benefits increase slower than profits. The expectation that this happens in a single year is not realistic.

[6] Families USA. "Paying a Premium: The Added Cost of Care for the Uninsured." June 2005.

Exhibit 6

Increase in Premium Costs by Component, 2005

Components	Share	Total Share
Total Premium	**8.8%**	**8.8%**
General Inflation	2.4%	2.4%
Healthcare Price Increases in Excess of Inflation (Above CPI)		2.6%
Cost Shifting	0.5%	
Higher Priced Technologies	1.0%	
Broader-Access Plans/Provider Consolidation	1.1%	
Increased Utilization		3.8%
Aging	0.5%	
Lifestyle	0.3%	
New Treatments	1.0%	
More Intensive Diagnostic Testing/Defensive Medicine	0.8%	
Increased Consumer Demand	1.2%	

Source: PricewaterhouseCoopers' estimates based on review of various studies and analyses.

Cost Shifting: We estimate that cost shifting from public providers and the uninsured to private payers increased premiums by 0.5 percent in 2005. Data from the American Hospital Association shows that the ratio of Medicaid hospital payments to hospital costs fell from 96.1 percent in 2002 to 92.3 percent in 2003.[7] The number of uninsured as a percent of the population increased from 15.6 percent to 15.7 percent between 2003 and 2004.[8] The costs associated with these trends tend to be picked up by other payers, especially private health insurance plans.

[7] American Hospital Association. "TrendWatch Chartbook 2005." May 2005.
[8] US Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2004." August 2005.

Higher Priced Technologies: New technologies increase prices because they are frequently more expensive than existing technologies. Newer prescription drugs, in particular, tend to replace older drugs and generic drugs. New imaging technologies are being introduced into the market at a higher cost. We estimate that the cost of new technologies increased premiums by 1.0 percent in 2005.

Broader-Access Networks/Provider Consolidation: Market forces, and, in some cases, state laws, have prompted a movement towards plans with broader provider networks. Additionally, many plans have introduced open-access products that minimize the role of the primary care physician in facilitating consumer access to specialists. While many consumers have expressed a preference for broader provider networks, such networks tend to reduce the amount of competition in the system. In addition, there have been instances of provider consolidation that have similarly reduced levels of provider competition in some markets. For example, in one recent ruling, it was found that the enhanced post-merger market power of one health organization allowed it to obtain price increases that were one-third higher than the average increase obtained by other area hospitals. We estimate that these market directions contributed 1.1 percentage points to premium increases in 2005.

INCREASED UTILIZATION

Increased utilization was the most important factor in the 8.8 percent increase contributing 3.8 percentage points of the increase. As shown in Exhibit 6, the major factors that drive utilization are increased consumer demand, new treatments, and more intensive diagnostic testing. The aging population and lifestyle changes also contribute to increased utilization.

Aging: It is widely recognized that the population is aging as Baby Boomers approach retirement. We estimate that the aging of the population enrolled in health plans contributed a half a percentage point in 2005.

Lifestyle: Lifestyle challenges, including obesity, smoking, drug abuse, and physical inactivity have contributed to an increase in the utilization of health services. We estimate that continued deterioration in lifestyle contributed three tenths of a percentage point to premium increases in 2005.

New Treatments: New treatments come in the form of new imaging technologies, biologics, injectables for existing serious illnesses as well as "lifestyle" drugs for conditions that were once not considered illnesses, or at least were not commonly and effectively treated using prescription drugs. We estimate that increased utilization of new treatments contributed a percentage point to premium increases in 2005.

More Intensive Diagnostic Testing/Defensive Medicine: We estimate that more intensive diagnostic testing contributed eight tenths of a percentage point to premium increases in 2005. The practice of defensive medicine is one factor contributing to these increases in diagnostic testing.

Increased Consumer Demand: The increase in consumer demand is fueled by factors including the proliferation of information on medical treatments and demand pull strategies such as direct-to-consumer advertising. We estimate that increased consumer demand contributed 1.2 percentage points to premium increases in 2005.

VI. Cost Drivers by Type of Service

The previous section broke the 8.8 percent increase into three components—inflation, price increases in excess of inflation, and utilization. But as this section will show, the increases in inflation, price increases in excess of inflation, and utilization are not necessarily uniform across the different categories of healthcare services.[9]

The breakdown of the increase in premiums by major service categories from 2004-2005 is shown in Exhibit 7. The last column of numbers shows how each of the major components contributed to the 8.8 percent increase.

Physician Spending

As we saw in Exhibit 3, physician spending accounts for the largest share of health spending (24 percent), and it grew by 7.8 percent in 2005. The increase in physician spending accounted for 1.9 percentage points of the 8.8 percent increase in premiums. The 1.9 percentage points are derived from 0.7 percentage points from utilization, 0.6 percentage points from CPI, and 0.6 percentage points from price increases in excess of inflation. This results in about 22 percent (1.9 percentage points / 8.8 percent) of the total increase in premiums.

Outpatient Spending

Outpatient spending, including freestanding diagnostic centers and imaging centers, ambulatory surgical centers as well hospital outpatient departments, is the second largest component of current health spending (22 percent) and increased at the rate of 13.6 percent. Because of its high growth rate, outpatient spending accounted for 3.0 percentage points in which about 1.6 percentage points are from utilization, 0.9 percentage points are from price increases in excess of inflation, and CPI contributed about 0.5 percentage points. This results in about 34 percent (3.0 percentage points / 8.8 percent) of the total increase in premiums.

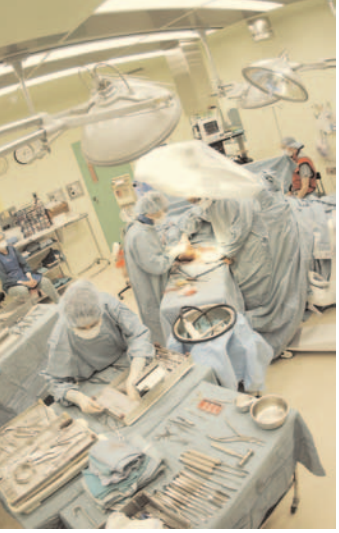
[9] PwC's breakdown of growth into price and utilization components is loosely based on a breakdown by CMS (unpublished data from CMS National Health Statistics Group). The CMS breakdown by these factors as well as population growth was a forecast for all of national health spending 2004–2005 and the overall increase did not match the 8.8 percent PwC estimate of the overall cost increase for private sector premiums. Moreover, the CMS components of spending did not match the components reported in this study. The estimates in Exhibit 7 are consistent with the overall CMS forecasts for 2004–2005 but adjusted to reflect the differences in components and estimated growth.

EXHIBIT 7

Growth in Health Insurance Premiums by Components, 2004-2005

Component	Share of Health Insurance Premium	Spending Growth Rate	Percentage Point Contribution to the 8.8% Increase in Health Insurance Premiums
PHYSICIAN	***24%***	***7.8%***	***1.9***
CPI		2.4%	0.6
Price Increase in Excess of Inflation		2.3%	0.6
Utilization		3.1%	0.7
OUTPATIENT	***22%***	***13.6%***	***3.0***
CPI		2.4%	0.5
Price Increase in Excess of Inflation		4.0%	0.9
Utilization		7.2%	1.6
HOSPITAL INPATIENT	***18%***	***7.5%***	***1.3***
CPI		2.4%	0.4
Price Increase in Excess of Inflation		4.0%	0.7
Utilization		1.1%	0.2
PRESCRIPTION DRUGS	***16%***	***8.6%***	***1.4***
CPI		2.4%	0.4
Price Increase in Excess of Inflation		1.1%	0.2
Utilization		5.1%	0.8
OTHER MEDICAL SERVICES	***6%***	***7.3%***	***0.4***
CPI		2.3%	0.1
Price Increase in Excess of Inflation		2.6%	0.2
Utilization		2.4%	0.1

Source: PricewaterhouseCoopers calculations, December 2005.
Contribution to the 8.8 percent increase is derived by multiplying the component's share of current spending by its growth rate.



The rapid growth in outpatient spending has often times in previous analyses been obscured by the increases in the traditional hospital and physician sectors. Services in outpatient hospitals and the other freestanding clinics, especially diagnostic and imaging centers, have been growing rapidly over the past several years. This rapid and steady growth in outpatient diagnostic testing is in part driven by the practice of defensive medicine.

Hospital Inpatient Spending

Hospital inpatient spending, which is the third largest component of health insurance premiums (18 percent), grew at 7.5 percent or about the same rate as physician spending and accounted for 1.3 percentage points of the overall premium increase. Hospital inpatient growth has been mitigated by shifts of services to outpatient settings, the renewed introduction of utilization controls and disease management programs, and increased cost sharing.

However, as evidenced in earlier studies by the Center for Studying Health System Change, a further breakdown of hospital costs reveals that price increases (about 54 percent) account for a much larger portion of the overall increase in hospital spending than growth in hospital utilization (about 15 percent). Unlike the other medical service categories, price increases in excess of inflation—not increased utilization—are disproportionately responsible for the increased spending on inpatient hospital services.

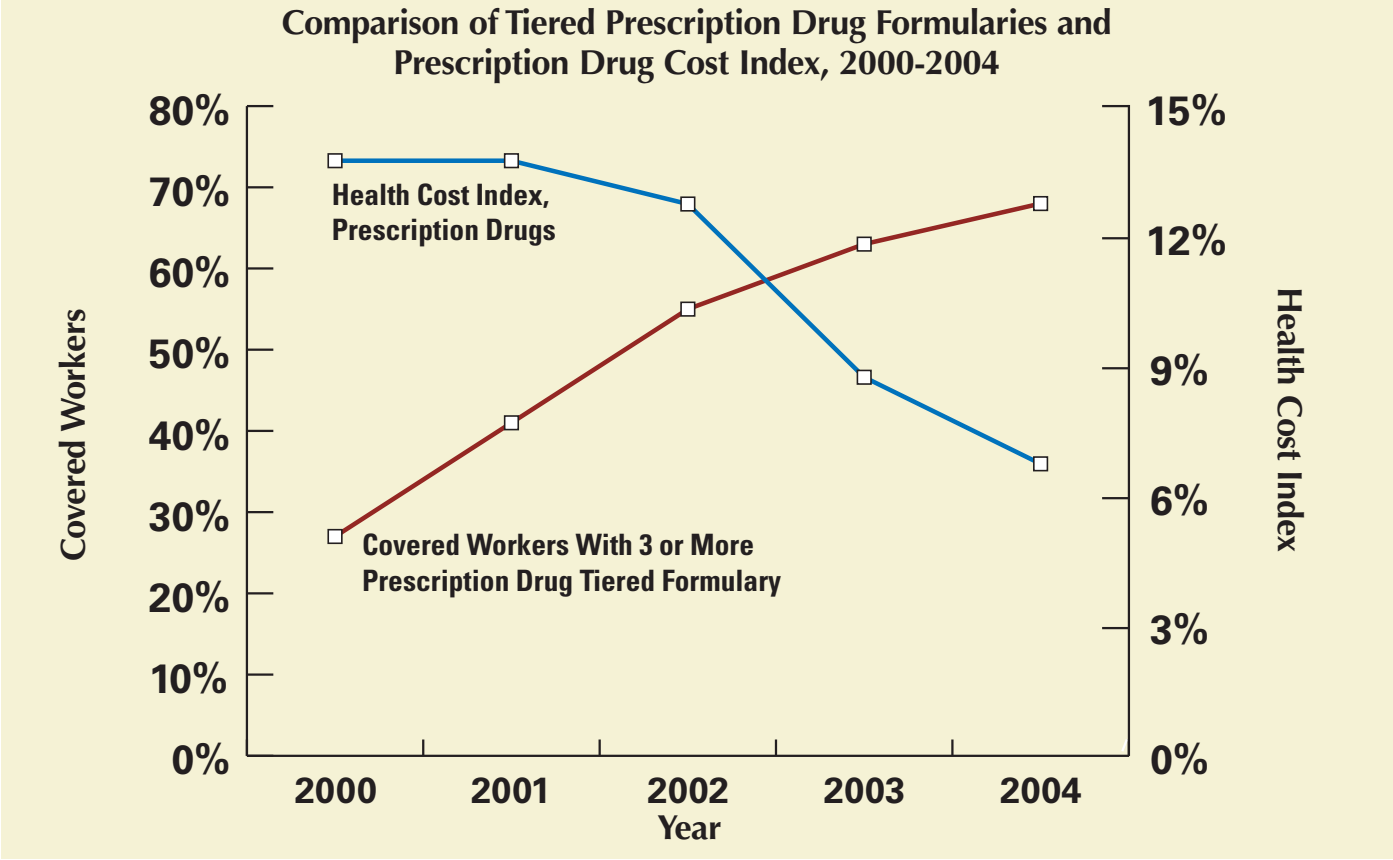
Part of the price increases in excess of inflation may be attributable to the effect of provider consolidation. In many major metropolitan markets, consolidation of hospital systems has led to market domination. Some hospital systems have, through consolidation, won the ability to negotiate higher payment rates from health insurance plans and demand higher prices. Other factors contributing to hospital price increases include cost pressures of labor arising from the competition for nurses and other clinicians as well as the impact of the growing uninsured segment.

Prescription Drugs

Prescription drugs had, in the past few years, been the fastest growing component of health insurance premiums, reaching well into double digits. However, prescription drug increases have recently slowed down to 8.6 percent in 2005, the same as the overall growth in premiums. Although prescription drug spending now accounts for a larger share of total spending than it did in the past, that share has stabilized at about 16 percent of the benefit dollar and accounted for 1.4 percentage points of the 8.8 percent premium increase. The 1.4 percent is composed of 0.8 percentage points from utilization, 0.4 percentage points from CPI, and 0.2 percentage points from price increases in excess of inflation.

The recent slower growth in prescription drugs is due to a number of converging factors—the higher base, introduction of fewer blockbuster drugs, some blockbusters going off patent, the transition of some drugs to over-the-counter status and a lower rate of price growth. One of the most striking reasons is that many health plans are shifting to two-, three-, and most recently four-tiered formularies that make beneficiaries more cost conscious when they choose preferred prescription drugs. The number of employers with at least three tiers of copayments has increased from 27 percent in 2000 to 68 percent in 2004.[10] (See Exhibit 8)

EXHIBIT 8



Sources: Kaiser Family Foundation, "Employer Health Benefits 2004 Annual Survey," September 2005; Strunk, B.C. et al., "Tracking Health Care Costs: Declining Growth Trend Pauses in 2004," Health Affairs Web Exclusive, June 21, 2005.

Other Medical Services

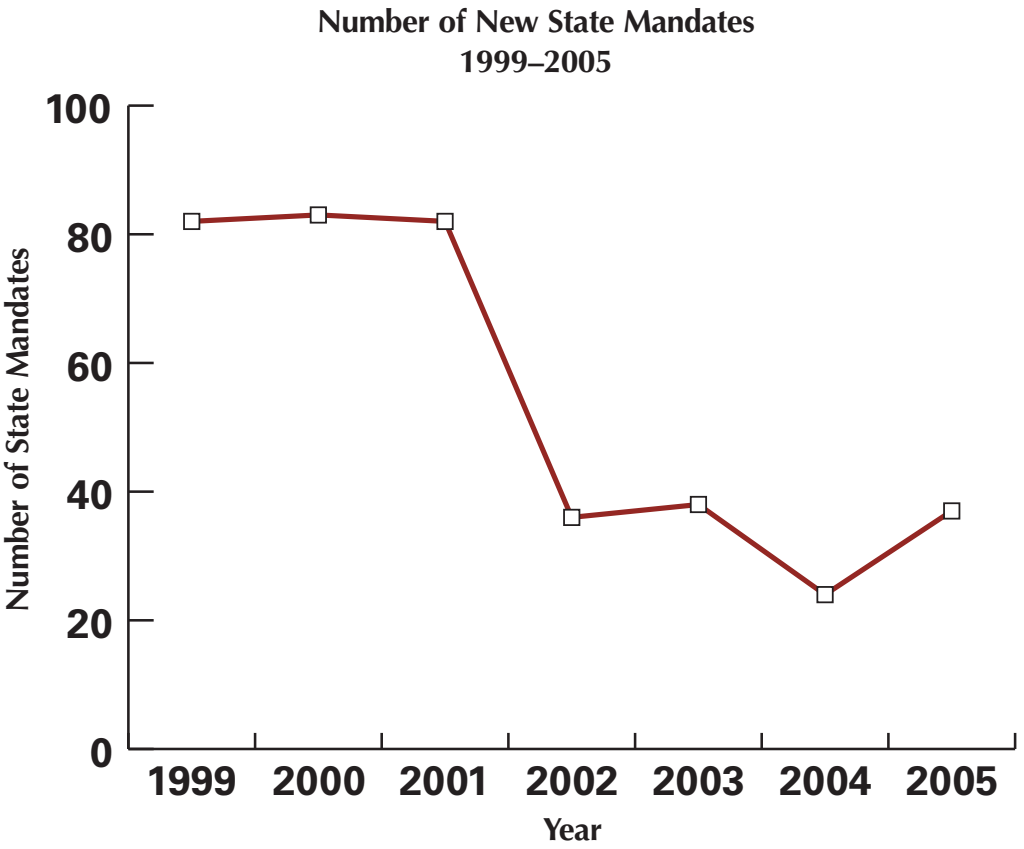
Finally, the remaining benefit costs accounting for 6 percent of health spending grew at 7.3 percent and accounted for 0.4 percentage points of the overall premium increase. Utilization contributed about 0.1 percentage points to the 0.4 percentage points, along with price increases in excess of inflation and CPI, at about 0.2 percentage points and 0.1 percentage points, respectively.

[10] Kaiser Family Foundation. "Prescription Drug Trends." October 2004.

VII. Conclusion and Outlook

Since our 2002 report, the growth in premiums has slowed down. As we indicate in this report, this easing of the rate of premium growth is largely due to reduction in the contribution of several key costs drivers. For example, in our 2002 report, government mandates were cited as contributor to rising health insurance premiums. And, while existing state mandates still contribute to the cost of health benefits, the latest data indicates that the number of new state mandates has abated. The decline in the passage of new mandates and the rise in the number of state mandate review commissions are indicative of the heightened attention being paid to the cost of mandates. (See Exhibit 9)

EXHIBIT 9



Sources: Blue Cross Blue Shield Association, "State Legislative Health Care and Insurance Issues: 2003 Survey of Plans," December 2003; The most recent data for mandates (2004 and 2005) was compiled by AHIP from an internal database that tracks healthcare legislation (including health insurance mandates) in each state.
Centers for Medicare & Medicaid Services, National Health Accounts, 2005.

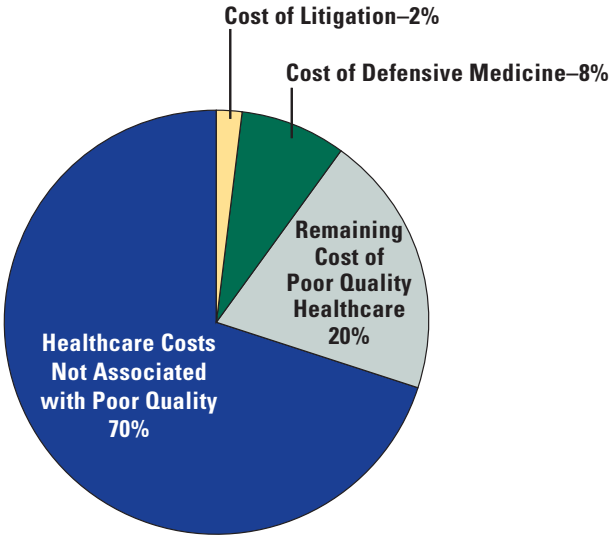
Additionally, the increase in prescription drug costs has slowed since 2000. A closer examination of the trends reveals that in 2000 a distinct minority of beneficiaries were in prescription drug benefit plans with three or more tiers. In 2005, however, seven out of ten beneficiaries were enrolled in a three- or four-tiered prescription drug plan. The smaller rate of increase in prescription drug spending is consistent with this trend.

Yet, increases in spending on healthcare services remain an unmet challenge. Prices growing in excess of overall inflation and increases in medical service utilization are sustaining pressures on health insurance premiums. And, consistent with our findings three years ago, the effects of litigation and provider consolidation continue to play a role in overall healthcare costs as does the variation from evidence-based practices.

The larger issue of variation in practice patterns, as well as compliance with evidence-based practices, of which defensive medicine is a part, has also drawn increased attention to the costs of poor quality. A 2002 study by the Juran Institute in conjunction with the Midwest Business Group on Health estimated that the cost of poor quality to be about 30 percent of healthcare costs including the result of overuse, misuse, and waste.[11] In Exhibit 10, PwC uses Juran's estimate that 30 percent of the healthcare dollar is related to poor quality, but we break it down further, using the conclusions reached earlier in this report, to suggest that of the 30 percent, 2 percent is the cost of direct litigation and 8 percent is the cost of defensive medicine.[12]

EXHIBIT 10

Estimated Breakout of Healthcare Costs of Poor Quality



Source: This graphic is based on the Juran Institute, Inc. and The Severyn Group Inc, "Reducing the Costs of Poor Quality Health Care Through Responsible Purchasing Leadership." April 2003.

[11] Midwest Business Group on Health in collaboration with the Juran Institute, Inc. and The Severyn Group Inc, "Reducing the Costs of Poor Quality Health Care Through Responsible Purchasing Leadership." April 2003.
[12] This breakdown is based on the assumption that the overall impact of medical liability and defensive medicine is 10 percent of total medical spending.

Looking forward, current health plan trends to promote provider pay-for-performance, transparency, consumer engagement, and healthy lifestyles have the potential to mitigate future cost increases and address some root cost drivers. Still other efforts to appropriately assess the emergence of new technologies and public reporting of quality measures across all members of the healthcare community would improve accountability throughout the healthcare system.

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