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The American health system isn't perfect. It delivers some of the best care possible in the world for certain conditions and certain patients, but millions are uninsured, and will remain so even in the event of full enactment of the Affordable Care Act. Millions more lack adequate access to the medical services they need. Chronic disease is a widespread problem. The health system consumes a tremendous amount of both public and private resources each year, and frequently fails to deliver good value for the dollar. High health costs, without consistently high health outcomes, may be the largest problem facing the American health system today. Considering the significant health and medical needs of the United States' population and the current pressure on the federal budget, as well as the budgets of states, businesses, and families, a high-cost, wasteful system is one we cannot afford.

## Background

When compared to other economically advanced nations, the United States spends significantly more on health care, though American health outcomes are not significantly better than those of other OECD countries. In 2009, the United States spent \$2.5 trillion on health care, 17.4 percent of its gross domestic product. In comparison, the next closest nation in terms of spending was the Netherlands, at 12 percent of GDP.<sup>1</sup> Per capita spending on health in the U.S. is \$7,960, nearly 50 percent more than per capita spending in Norway, the next highest per capita spender.<sup>2</sup> In contrast, life expectancy in the United States comes in below the OECD average, ranked twenty-seventh among 34 developed nations.<sup>3</sup> The United States does face a unique set of challenges when compared to

many of its OECD companions, including large racial and income diversity and an expansive and varied geography, factors that could contribute to some of this disparity, but are unlikely to account for all of it.

This is not a temporary problem. National health spending grew at its slowest rate in decades in 2009 and 2010, 3.9 percent, largely due to the economic recession.<sup>4</sup> However, total national health expenditures, public and private, are still expected to constitute 20% of gross national product by 2020. Worse, in future decades, the problem will continue, with health expenditures expected to consume 37 percent of the GDP by 2035 on current trends.<sup>5</sup>

There is widespread consensus that the U.S. spends too much on health, but little agreement about how to fix it. Many policymakers support proposals that focus on federal health spending, specifically Medicare and Medicaid, and either reduce benefits or reduce payments to providers in order to reduce overall spending. However, these kinds of cuts threaten access to and quality of care for beneficiaries of these programs. There is another way to think about the problem. The Institute of Medicine has estimated that roughly one third of health spending is waste, grouped into the categories of unnecessary services, services delivered inefficiently, prices that are too high, excessive administrative costs, missed prevention opportunities, and fraud.<sup>6</sup> Roughly 33 cents out of every dollar spent in

health care does nothing to improve patient health, directly or indirectly. Focusing on waste in both the public and private sectors allows policymakers to reduce overall health spending, while also improving care for all Americans. However, in order to understand how to reduce this waste, one must first understand why the U.S. health system spends so much money in the first place.

## History

The contemporary American health system evolved in a unique historical context. For many developed countries, the infrastructure devastation of World War II necessitated government intervention in the development of a new health system. In some cases this new system was public, in others private, and in some instances a hybrid model emerged. However, all of these new postwar systems required the consideration of how to build a complete system and the generation of a blueprint to structure it. The United States was able to continue relying upon its existing health care capacity after the war, because of the lack of physical damage in World War II, and has continued to build on it in a piecemeal fashion ever since, never developing a true system.

That existing prewar health capacity developed over the country's history; this section will focus on the health system as it has evolved since the early twentieth century, when advancements in medical technology and the movement of treatment out of the patient's home signal the precursor to the modern system.

## Why does health spending grow?

Growth in health spending is the result of a number of different factors. Some amount of growth in spending is to be expected and can be attributed to a measurable set of factors. First, the demographic make-up of the U.S. has a clear and measurable impact on health spending. Most lifetime

1 OECD Health Data 2011 – Frequently Requested Data. Total expenditure, % GDP

2 OECD Health Data 2011 – Frequently Requested Data. Total exp., per capital US\$ PP

3 OECD at 50 – Health at a Glance 2011: OECD Indicators. <http://www.oecd.org/dataoecd/6/28/49105858.pdf>

4 Martin, A. B., Lassman, D., Washington, B., Catlin, A., & National Health Expenditure Accounts Team (2012). Growth In US Health Spending Remained Slow In 2010; Health Share Of Gross Domestic Product Was Unchanged From 2009. *Health Affairs* 31(1), 208-219.

5 Congressional Budget Office (2009) The Long Term Budget Outlook. Chapter 2: The Long-Term Outlook for Medicare, Medicaid, and Total Health Care Spending. <http://www.cbo.gov/ftpdocs/102xx/doc10297/chapter2.5.1.shtml>

6 Institute of Medicine (2010) The Healthcare Imperative: Lowering Costs and Improving Outcomes, Workshop Series Summary. National Academies Press

health spending occurs in the later part of a person's life; therefore, health spending will increase as a result of an aging population. Over the past 30 years, this has not been a significant contributor to health cost growth, but it is expected that this will change with the aging of the Baby Boom generation over the next few decades.<sup>7</sup> The impact of an aging population is estimated to contribute to less than 0.7 percent of cost growth per year.<sup>8</sup> The overall growth of the population and the rate of inflation in the economy are also contributors to normal cost growth.

The growth of health spending attributed to inflation, the overall growth of the population, and the aging of the population can be measured and compared to the overall rate of health cost growth in order to determine the rate of excessive cost growth. The Congressional Budget Office determined that the rate of excess cost growth between 1975 and 2007 was 1.9 percent annually.

The factors that drive excess cost growth are more difficult to pin down. Though most experts acknowledge a similar set of drivers, they may not agree on the relative impact of each, ways to address them, or the other implications of each factor. This section will discuss some of the possible drivers of health costs.

## Technology

Technology is frequently named as the major source of growth in health care costs. Unfortunately, the precise impact of advances in medical technology can be difficult to quantify, as technology advances are intertwined with changes in health status and influenced by the likelihood that the

7 Congressional Budget Office (2009) The Long Term Budget Outlook. Chapter 2: The Long-Term Outlook for Medicare, Medicaid, and Total Health Care Spending. <http://www.cbo.gov/ftpdocs/102xx/doc10297/chapter2.5.1.shtml>

8 Ginsburg, PB. (2008) High and rising health care costs: demystifying U.S. health care spending. Robert Wood Johnson Foundation. <http://www.rwjf.org/files/research/35368.highrisingcosts.rpt.pdf>.

## Major Milestones in U.S. Health System

- 1929 The first modern group health insurance is formed. A group of teachers in Dallas, TX, contracted with Baylor Hospital for hospital-based care in exchange for a monthly fee. This was the prototype for later Blue Cross plans.
- 1935 Social Security Act passes. It does not include health insurance.
- 1939 Kaiser Permanente and first Blue Shield plan develop in California to provide prepaid medical care for workers.
- 1940s Wage freezes during WWII incentivize employers to offer health benefits to attract employees, solidifying the employer based health insurance system.
- 1955 Nearly 70 percent of the population has acquired health insurance coverage.
- 1965 Creation of Medicare and Medicaid to provide health coverage to the elderly and some poor.
- 1983 Medicare implements the diagnostic-related group (DRG) prospective payment system, establishing hospital payments based on distinct diagnoses.
- 1996 Health Insurance Portability and Accountability Act (HIPAA) passes, establishing health insurance protections for workers who lose their jobs, requiring national standards for electronic health information, and addressing the privacy and security of health data.
- 1997 Balanced Budget Act passes, creating the Children's Health Insurance Program (CHIP) to help states insure children who do not qualify for Medicaid but cannot afford private insurance. It also creates Medicare+Choice, a privately administered Medicare option and establishes the sustainable growth rate (SGR) mechanism to control the growth rate of Medicare provider payments.
- 2003 Medicare Modernization Act creates Medicare Part D, the federal program to offer prescription drug coverage to the elderly.
- 2010 Affordable Care Act passes, expanding Medicaid, imposing new insurance regulation, and establishing health insurance exchange system with accompanying subsidies.

*Throughout the course of the health system's evolution, rates of health spending growth have varied, and efforts to rein in spending have accompanied that variation. The managed care boom in the late 1980s and early 1990s was one such attempt, as was the establishment of the sustainable growth rate (SGR) and the creation of the Center for Medicare and Medicaid Innovation in the Affordable Care Act. However, health spending continues to grow.*

use of such technology will be paid for by insurers. Some advances in technology may reduce the growth of health spending immediately or over time. For example, administrative improvement through the use of electronic medical records could, after the initial investment, result in lower overall costs, both on the administrative side and through the better coordination of care and reduction in medical errors. Highly effective pharmaceuticals are generally quite expensive during their early years because of patent protection, but once generic versions become available, this advancement in technology can in fact result in lower costs.<sup>9</sup>

While some technological innovations are likely to reduce spending, other emergent technologies cause increases in health costs.<sup>10</sup> This can occur because a new technology replaces an older treatment for a particular condition or because a new technology expands the treatment of a condition, usually because there was no effective or low-side effect treatment in existence for that condition. This is not to say that the higher cost of the more advanced technology is unwarranted. Many new technologies greatly increase life expectancy or quality of life for those with a certain disease. However, some new technologies that are covered by insurers, public and private, show no significant improvement over existing treatments, despite the much higher price tag. In these instances, the development and use of such technologies unquestionably increase health costs. Other scenarios are more nuanced: a treatment might provide a marginal benefit or reduced side effects at a much greater cost than an existing treatment. In these situations, continued research can inform treatment and coverage decisions.

9 Ginsburg, P. B. (2008). High and rising health care costs: demystifying U.S. health care spending. Robert Wood Johnson Foundation. <http://www.rwjf.org/files/research/35368.highrisingcosts.rpt.pdf>.

10 Ginsburg, P. B. (2004). Controlling health care costs. *N Engl J Med*, 351(16), 1591-1593.

## Lack of True Market Forces

Over 80 percent of Americans are covered by some form of health insurance.<sup>11</sup> By the very nature of health insurance, most patients do not bear the full cost of their health care and most are not even aware of the full cost, which can lead them to spend more on health care than they could be expected to if they did bear the cost. This distortion has led many stakeholders to argue in support of a “market-based solution” to health system problems. This kind of approach could work, if the health system were in fact a true market. However, this is not the case. The person receiving medical services is rarely paying the bill. The amount of copay or coinsurance they may be paying often does not reflect the value of the service the patient receives. In a pure market situation the efficacy of a course of treatment would be weighed against its cost and appropriate prices would emerge. However, in a situation with much insulation between payer and receiver, this is an unlikely situation.

### *Lack of Adequate Information and Transparency*

Knowledge and information are key to a functioning market. However, there are dramatic imbalances in knowledge and information in the health care market. In order for the market to function effectively, the patient, when ill or otherwise in need of medical services, would need to know the cost of all possible providers and treatment options, the expected outcomes of all treatment options, and the quality of care offered by all providers. Both the insurer and the provider may be aware of the charges associated with a patient’s care, but the patient is unlikely to receive this information until weeks after care is delivered, if at all. The provider may know the expected outcomes of all possible treatment options, but he/she has the benefit of years of medical training; an ill patient is hardly in the position to receive and understand all

11 DeNavas-Walt, C., Proctor, B. D., & Smith, J.C. (2011). U.S. Census Bureau, Current Population Reports, Income, Poverty, and Health Insurance Coverage in the United States: 2010, P60-239, U.S. Government Printing Office, Washington, DC, 2011.

of that information in the time needed to make the decision. Even with all possible information about treatment outcomes, it is an imperfect calculation at best. The quality of care offered by providers can vary greatly. Some degree of clarity about an individual provider’s quality may be available to the patient and, to a greater degree, the insurer; but this information is generally not available in a uniform, widespread manner.

The relative wealth of information available to providers and insurers does not necessarily mean that those two forces alone can create a functioning health care market. The reimbursement and benefits offered by health insurers have evolved in a piecemeal way. Providers and facilities may be able to demand greater than appropriate reimbursement because they may operate as a monopoly in their geographic area or because their name recognition or reputation provides them with disproportionate market power. Alternatively, insurers may be able to underpay small, high-performing provider practices because they lack bargaining power. Additionally, benefits may reflect currently popular treatment options that lack a solid evidence base. Scenarios in which a highly touted and well covered therapy is proven ineffective or even detrimental to the patient over the course of years of study are not uncommon.

### *Provider Incentives and Practice*

Physician practice patterns, and the treatment recommended to an individual patient, vary greatly and are determined by a number of different factors. Physician age, practice size, practice setting, physician training, patient population, and other factors all help to determine these patterns.<sup>12</sup> Patient preference can also play a role. The Dartmouth Atlas Project has detailed this variation extensively, noting that choices of individual procedures, courses of treatment, and overall spending per capita varies greatly from region to region, city to city, and even

12 O’Neill L., Kuder J. Explaining variation in physician practice patterns and their propensities to recommend services. (2005) *Medical Care Research and Review*, 62 (3), pp. 339-357.

hospital to hospital.<sup>13</sup> This is not to suggest that providers in some regions willfully offer substandard care to their patients. Rather, the artful nature of medicine, the lack of comprehensive information on the relative value of treatments, and variation in the patients and conditions providers regularly encounter have led to a system in which two identical patients seeing two different providers can receive very different care.

The degree of variation in provider practice indicates that perhaps consistent, rational forces are not what is informing care patterns. Besides the clear influence of training and exposure to the practice patterns of colleagues, other factors are at work in determining physician behavior. The physician frequently does not have incentives to consider the cost of care in treatment decisions. In fact, the fee-for-service system that predominates in Medicare and other payers may encourage the exact opposite response. Physicians are rewarded for the volume of care provided, rather than for keeping patients healthy or returning them to health. This does not mean that physicians consciously choose to over treat patients in order to earn more money. Rather, providers are not encouraged to be good stewards of the resources in demand by all patients. If there is no reason not to perform a multitude of tests on a patient, the provider may see this decision as beneficial to the patient, even if there was no indication that the patient was suffering from the ailment for which the test was designed. If enough tests are performed, the provider is bound to find something out of the ordinary, and, once they find it, to treat it, even if the patient may never have become aware of the issue otherwise and never needed treatment. Fee-for-service reimbursement encourages an excess of care and caution, rather than the prudent use of limited health resources.

#### *Prices Don't Reflect Value*

The lack of effectively functioning market forces in health care means that prices for services and products do not necessarily reflect their value. Typically,

13 The Dartmouth Institute for Health Policy and Clinical Practice. The Dartmouth Atlas of Health Care. (2012) [www.dartmouthatlas.org](http://www.dartmouthatlas.org)

the more technologically advanced the product of service, the greater its reimbursement. If advanced imaging is well-reimbursed, but extensive time spent talking to the patient is not, the provider will have an incentive to spend more time on the former. The difference in cost between these two services may not be monumental, but in the aggregate, these choices cost the health system quite a bit. Patients, payers, and even providers, often lack clear information on the relative cost and effectiveness of a particular course of treatment, which prevents them from making rational decisions. Not only does this encourage the use of more expensive treatments, it means that the prices of those treatments have no downward pressure, leading to the excessively high prices that make up part of the system-wide waste.

The market has failed the health system in other ways as well. High levels of consolidation, particularly in the hospital arena, in certain areas of the country give providers undue leverage in reimbursement negotiations with insurers. Patients frequently expect access to the most well-known facilities in their region, giving further advantage to hospitals with high name recognition, like those affiliated with universities. If patients were exposed to the actual costs at these health care facilities, they might choose to receive care elsewhere. This absent rational consumer behavior, were it to emerge, could be expected to drive reimbursement down at the highest cost hospitals.

#### Fragmentation of Care

Good coordination of care is especially important for a population facing a plethora of chronic diseases. A single patient with multiple chronic diseases may see several providers. In the current system, it is very likely that those providers do not talk to one another; in fact they may not even realize that they share a patient. This situation can lead to contradictory treatment plans and even the use of medications and therapies that counteract one another. The patient may fill his or her prescriptions at one or more pharmacies. If the patient only sees one pharmacist, it is possible that the

pharmacist will recognize the contradictory medications and attempt to coordinate, or at least streamline, the patient's regimen. However, if there are multiple pharmacies involved, the insurer may be the only one with all the relevant information and that insurer may or may not take an active role in identifying these kinds of high cost, high need patients and coordinating their care.

The fragmentation of the delivery system almost guarantees that patient care will be less effective than it could be. All the providers involved are likely doing their best to serve patient needs, but without a coordinating lead, something is bound to fall through the cracks. If a patient's care is less effective than it could be, it is therefore of lower value. Adverse drug events, poor follow up care, contradictory courses of treatment, and poor communication can all land a patient in the hospital - and they can all be prevented in a well-integrated health system.

There have been experiments in reducing fragmentation. Some insurers have developed care coordination programs. The medical home model and accountable care organizations are both intended to address this problem. Integrated payment and delivery systems, like Kaiser Permanente in some parts of the country, have brought all aspects of a patient's care under one roof. Some of these initiatives have been more successful than others, but none are sufficiently widespread to adequately reduce fragmentation of care.

#### Medical Malpractice

Although official estimates of the cost of defensive medicine (the practice of providing excess care in order to ameliorate the potential for liability) are not particularly large,<sup>14</sup> medical malpractice is still worth mentioning in a conversation about health costs. Fear of lawsuits is widely assumed to cause providers to offer unnecessary services and testing in order to protect themselves from lawsuits. This care is often provided

14 Leonhardt, D. (2009 September 22). Medical Malpractice System Breeds More Waste. New York Times. Retrieved from <http://www.nytimes.com/2009/09/23/business/economy/23leonhardt.html>.

with the goal of ensuring that the provider can say that everything possible has been done for a patient. Defensive medicine clearly contributes to health costs on the whole, but it also clearly has a profound impact on the individual provider.

The cost to providers of malpractice insurance premiums, particularly in certain specialties, can drive a provider out of the field or at least out of private practice. The cost of a single lawsuit, in terms of time, money, and loss of reputation, can be devastating for a provider and his or her practice. The resulting shortage of adequate providers, particularly in primary care and in rural areas is a significant problem. For example, many rural areas are without an obstetrician-gynecologist because malpractice insurance is too expensive. This situation can lead to women receiving less prenatal care, which lead to increased health costs. The cost of medical malpractice, both in terms of defensive medicine and the workforce cost, is too great to ignore.

## Health Status and Lifestyle Changes

Changes in the American diet and activity levels over the past several decades have created a noticeable change in American health status. Most notably, increased rates of obesity in all demographic subgroups have contributed to an increased burden of disease, and, therefore, health costs, throughout the entire health system. As of 2008 in the U.S., 33.8 percent of the adult population was obese, with a BMI greater than 30.<sup>15</sup> For American women, the rate was even higher. In the U.S., as in most developed countries, diet-related chronic diseases affect 50 to 65 percent of the adult population.<sup>16</sup> Annual per capita sugar consumption in the U.S. has increased from 55.5 kilograms in 1970 to 69.1 kilograms in 2000. Over the same time period, American jobs have become more sedentary; in 1960, about half of all jobs in the U.S. required at least a moderate amount of physical activity

and today, only about 20 percent do.<sup>17</sup>

Several reasons contribute to the unfortunate changes in the American diet. The past norm of home cooked meals became less powerful as greater numbers of American women entered the workforce and single parent homes and homes with two working parents increased. The food industry developed the capacity to produce food in massive quantities. Processed and ready-to-eat foods proliferated, both because of the capacity and because changes in the American lifestyle demanded them. Identifying the root cause behind this change is a research project in itself, but it is enough to acknowledge that the most readily available and affordable calories today often fall short nutritionally, encouraging poor eating habits.

The increase in sedentary jobs is not the only way in which inactivity has pervaded American life. Physical activity in leisure time has decreased at all ages. Among school-age children, watching television is now the most common leisure activity.<sup>18</sup> Most adults and children fail to achieve the recommended amount of daily or weekly physical exercise.<sup>19</sup>

The combination of poor diet and low levels of physical activity reflect an environment in which the default choice is not a healthy one and this fact has a profound impact on health, namely the epidemic of chronic disease currently facing the population. Obesity is associated with a variety of diseases, including diabetes, cardiovascular disease, and some cancers. In 2008, the estimated cost of obesity

and related diseases was \$147 billion.<sup>20</sup> Twenty-seven percent of the increase in inflation adjusted health spending between 1987 and 2001 has been attributed to the increase in obesity and changes in the patterns of treating obesity and its related diseases.<sup>21</sup> Chronic conditions, many of which are attributable to lifestyle changes, are now understood to be the major driver of cost increases in Medicare.

Other lifestyle changes have been positive. Adult smoking rates have declined significantly from their 1956 peak of 45 percent, though there is still room for improvement.<sup>22</sup> This change is accompanied by a decrease in lung and other cancers, though the lag time between smoking and the development of cancer means that former smokers will continue to become ill for some time. Recognition of the importance of folic acid and fluoride and the dangers of asbestos, have led to public health initiatives that have reduced the impact of birth defects, dental caries, and some cancers. However, in the aggregate the environment in the United States is less conducive to a healthy lifestyle than in previous decades.

## Excessive growth in health costs is a problem

Unmitigated growth in health costs is a problem for all sectors of American society. In a world of limited resources, excessive health spending and unlimited growth in that spending rate is simply unsustainable. Not only does spending on public programs squeeze the federal budget, but private health spending and out-of-pocket costs are having a profound effect on families, businesses, and state and local governments.

### A problem for families

Between 1999 and 2009, the average

15 OECD Health Data 2011 – Frequently Requested Data. Obesity, total.

16 Cordain, L; Boyd Eaton, S; et al. Origins and evolution of the Western diet: health implications for the 21st century. *Am J Clin Nutr* 2005 81: 2 341-354

17 Church, T. S., Thomas, D. M., Tudor-Locke, C., Katzmarzyk, P. T., Earnest, C. P., et al. (2011) Trends over 5 Decades in U.S. Occupation-Related Physical Activity and Their Associations with Obesity. *PLoS ONE* 6(5): e19657. doi:10.1371/journal.pone.0019657

18 Andersen, R. E., Crespo, C. J., Bartlett, S. J., Cheskin, L. J., Pratt, M. Relationship of physical activity and television watching with body weight and level of fatness among children. *JAMA* 1998;279:938-942,959-960.

19 CDC. National Center for Chronic Disease Prevention and Health Promotion. Behavioral Risk Factor Surveillance System prevalence data 2000. Online. 26 June 2002.<<http://apps.nccd.cdc.gov/brfss>>.

20 Finkelstein, E. A., Trogon, J. G., Cohen, J. W., and Dietz, W. Annual medical spending attributable to obesity: Payer- and service-specific estimates. *Health Affairs* 2009; 28(5): w822-w831.

21 Thorpe, K. E., Florence C. S. , Howard, D. H., Joski, P. "Trends: The Impact of Obesity on Rising Medical Spending." *Health Affairs*, Web Exclusive, October 20, 2004.

22 Mukherjee, S. (2010), *The emperor of all maladies*. New York, NY: Scribner.

family of four saw its overall income gains wiped out by increased health spending. According to a Sept 2011 RAND study, “the typical median-income family of four with employer-based health insurance would have had \$545 more in disposable income to spend per month in 2009 than in 1999, if medical inflation had not exceeded general inflation. But after factoring in actual increases in health insurance premiums, out-of-pocket health spending, and taxes for health care, that same family instead had only \$95 more per month in available income.”<sup>23</sup>

### A problem for businesses

According to the U.S. Chamber of Commerce, health care is the most expensive benefit offered by U.S. employers. This cost is passed on to consumers as well. The Council on Foreign Relations found that General Motors spent about \$5 billion a year to cover its 1.1 million employees and retirees, adding \$1,500 to \$2,000 to the cost of each car. Employer-sponsored premiums have more than doubled over the last ten years.<sup>24</sup> Health care costs are even more daunting for small businesses, which pay as much as 18 percent more than large businesses for employee health coverage.<sup>25</sup>

23 Auerbach, D. I. and Kellermann, A. L., “A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average U.S. Family,” *Health Affairs*, Vol. 30, No. 9, September 2011.

24 Small Business Majority. Healthcare Policy. <http://smallbusinessmajority.org/policy/healthcare-policy.php>.

25 Small Business Majority. Statement for the Record – Before House Ways and Means Committee. January 26, 2011. [http://smallbusinessmajority.org/policy/docs/House\\_Ways\\_and\\_Means\\_HCR\\_Testimony.pdf](http://smallbusinessmajority.org/policy/docs/House_Ways_and_Means_HCR_Testimony.pdf)

### A problem for governments

Aside from the obvious fact that continued aggressive spending growth in Medicare and Medicaid is a strain on the federal budget, the federal government is also impacted by health spending growth in the private sector. Because employer based health insurance is excluded from taxable income, increased spending on health insurance by employers increases the amount of tax revenue lost to the federal government. Money that employees could have received in salary, on which they would have paid taxes, is redirected to pay for increasing health insurance premiums.

Growth in health costs has been recognized by the independent, non-partisan Congressional Budget Office as the greatest threat to the federal budget in the coming years and is acknowledged to be a major contributor to the federal deficit. Without significant intervention, this problem will continue to compound.

State and local governments also suffer under rising health costs, generally in a more immediate fashion than the federal government, since they must balance their budgets. First, as employers that provide health benefits to their employees, governments face nearly the same problem that businesses do: growth in health costs decreases the funds available for compensation increases, investment in the infrastructure of the government (or business), and other projects. States also share in financing the Medicaid program with the federal government. Unfortunately, Medicaid cost growth frequently results in cuts to benefits or

provider payments as states struggle to meet their obligations. Maintenance of effort requirements, the obligation of states to continue to provide Medicaid benefits at current levels, will necessitate that states bear additional cost growth, while finding savings elsewhere. Local governments often provide a health care safety net for those who cannot receive health care elsewhere. As the cost of health care grows, so could the population that cannot afford it, relying on safety net services provided by federal, state, and local governments.

### Conclusion

As shown here, high health spending and rapid growth in that spending are the result of a variety of causes and structural deficiencies in the health system and will require a number of different approaches to address them. It is clear from the problems facing all sectors of American society as a result of health costs that this is an issue that must be addressed, and soon. It is also clear that costs are inextricably tied to quality and minimizing costs while maximizing quality will result in the highest overall value for the system. Solving the problem of health costs will be difficult, but it will go a long way toward making the system a little more perfect.



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