

The Facts About Rising Health Care Premiums

**Underlying Health
Costs Drive Growth**

April 2010



The Familiar Problem

Annual health care spending in the United States is estimated to surpass \$4.2 trillion in 2018, up from \$2.5 trillion in 2009 and \$75 billion in 1970. Such spending accounts for 17% of GDP currently and is expected to reach 19% in 2018.¹

Many consumers and small employers are struggling to afford their health insurance premiums. High costs have fueled an uninsured rate of 15.4% with 46.3 million uninsured.² About 56% of the uninsured are ineligible for public programs and cannot afford coverage, while another 25% are eligible for public programs but not enrolled.³

For many employees, the growth in health care premiums is displacing wage increases. For other employees, high health care costs mean their employers cannot offer coverage at all. For firms with less than ten employees, only 46% offer coverage to their workers.⁴

What's Causing Rising Premiums?

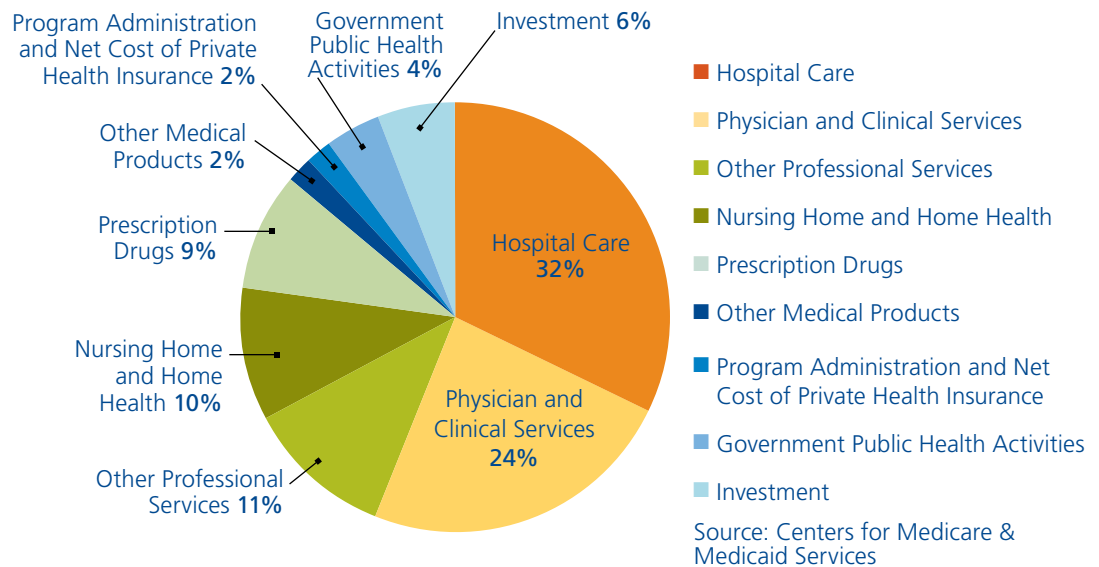
There are several important components that drive rising health insurance premiums. These include medical costs charged by providers — hospitals, doctors and pharmaceuticals — cost-shifting by the government, taxes, unhealthy lifestyles and adverse selection.

Provider Pricing and Activity:

Overall, the United States spent about \$7,290 per capita on health care services in 2007 — or almost two and a half times the average Organization for Economic Cooperation and Development (OECD) country.⁵ This is about 50% more than Norway, the second highest OECD country.⁵ Part of the reason for higher U.S. total expenditures is that the U.S. pays 50% to 60% more per unit of health care than any other industrialized country.⁶

A recent investigation by the Massachusetts Attorney General found that medical price increases in Massachusetts accounted for 80% of the growth in total medical expenses for one major payer. Further, they found that provider prices vary significantly with the disparity between lowest and highest paid providers as much as 200%. Price variations were correlated to market leverage — not quality of care, or the sickness or complexity of the population being served.⁷

Projected Percentage of Healthcare Spending Growth, 2008-2009



Another reason for high U.S. expenditures is waste. Peter Orszag, Director of the Office of Management and Budget, has stated that the U.S. spends approximately \$700 billion on unnecessary tests and services.⁸ Some experts, such as Elliot Fisher and John Wennberg, estimate that up to 30% of health care is unnecessary.⁹ Researchers at the Dartmouth Institute for Health Policy and Clinical Practice found that Medicare could save up to 30% by reducing unnecessary or unwanted surgeries.¹⁰

Perhaps most troubling of all, many consumers still face quality issues when seeking healthcare. A 2008 study for the Agency for Healthcare Research and Quality found that the median level of receipt of needed care was only 59%.¹¹

Health insurance premium rates are so closely tied to medical costs that premium growth closely tracked the growth of overall health care

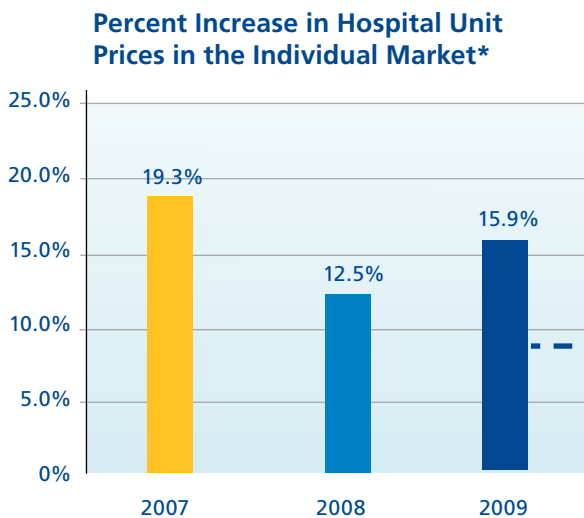
costs in the past decade. Health care costs increased about seven percent per year and premiums increased about seven percent per year as well.¹²

The main specific components of health cost growth include:

- **Hospitals:** Hospitals accounted for 32% of health care spending growth in 2009.¹³ According to a recent international comparison, the U.S. pays more than Western counterparts for many procedures. Even Germany, a country with many private doctors and hospitals, still has costs significantly below the U.S. For instance, the U.S. pays between \$7,473 and \$12,226 for a normal delivery versus \$3,400 in Germany. An appendectomy costs between \$624 and \$1,803 in the U.S. versus \$376 in the UK.¹⁴

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Hospital Prices Increasing



- In 2009, over 50 hospitals requested increases of over 20% in their inpatient facility prices
- A community in California had a 39% medical trend increase in the first three quarters of 2009
- One California hospital generated charges at 490% of Medicare. Another hospital system's rates ranged from 198% to 316% of Medicare.

*Based on national averages in the individual market

Source: Internal Aetna analysis

In *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, researchers say "evidence from two decades of hospital mergers and acquisitions nationally demonstrates that consolidating hospital markets drives up prices...." and they note "a definite shift in negotiating strength toward providers, resulting in higher payment rates and premiums."¹⁵

Several items have contributed to this market leverage. There are new provider consolidation and integration strategies where "must have" hospitals and facilities combine with lesser known facilities and then negotiate rates for the entire system in "all or none" contracts. Hospitals also are collaborating with doctors and negotiating for the entire system.¹⁵

An overall physician shortage and reduction in hospital beds as well as consumer demand for broader provider networks also has heightened provider leverage. The enhanced provider market power is demonstrated through the near doubling of California hospital prices from 1999-2005 even though national Medicare hospital inpatient costs per admission increased only 5.5% during the same time period.¹⁵

Aetna individual market subscribers are facing higher inpatient facility prices as well. On average, inpatient facility unit prices increased 19.3% (2007), 12.5% (2008) and 15.9% (2009). Just in the last year, over 50 hospitals nationwide requested increases of over 20% from Aetna. This masks even higher localized trends.

One California community faced a medical trend increase of almost 39% for the three quarters of 2009 data available.¹⁶

One hospital in California is generating charges of 490% of Medicare. Another hospital system has negotiated rates that range from 198% to 316% of Medicare.¹⁶

Another problematic issue is hospital up-coding — where a hospital uses a billing code for a patient’s services that reflects more intense and more expensive services. For instance, one hospital began up-coding for emergency room services. In less than two quarters, there was a pattern change where level three intensity visits increased by 25% and level four and five intensity visits increased by over 30%. At the same time, low intensity — and lower cost — ER visits (levels one and two) dropped by 85%. A level five intensity visit is reimbursed at almost seven times the rate of a level one visit. These coding changes would have cost \$30 million if Aetna had not identified and challenged the changes.¹⁶

■ **Physician services:** Physician services accounted for 24% of health care spending growth in 2009.¹⁷ The Centers for Disease Control and Prevention (CDC) reports that in the most recent decade for data available, hip replacements have increased by one-third, knee replacements are up by 70% and MRI/CT/PET scans have tripled.¹⁸

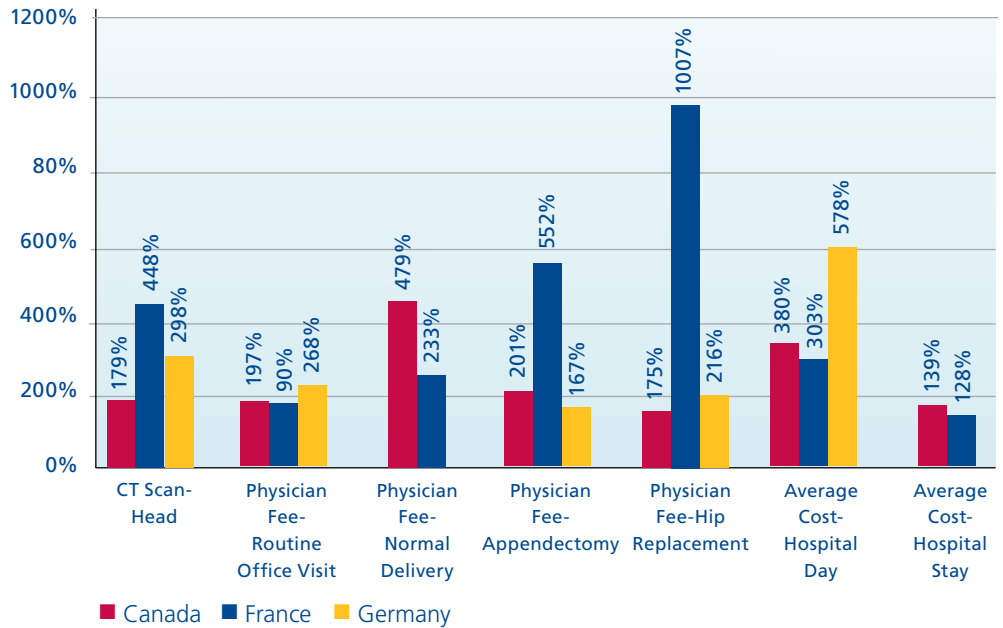
An international comparison of prices indicates that the U.S. also tends to pay more for physician services. For instance, the U.S. pays almost three times as much for CT scans (of the head) than Germany (\$950-\$1,800 versus \$319).²⁹ Americans also pay higher fees for typical office visits: \$50-\$151 versus \$22 (Germany) and \$31 (France).²⁰

Costs for the same procedure vary greatly among providers. For instance, critical care charges in one state for the same critical care billing code varied as follows:

- 39% of providers charged less than \$200. These providers accounted for 32% of unit services and 12% of costs
- Two percent of providers charged over \$1,000. These high cost providers accounted for only three percent of unit services, but 38% of all Aetna allowed charges for this service.²¹

U.S. Pays More for Services Than European Countries

U.S. Costs on Selected Medical Services as a Percentage of Average Costs in Canada, France, and Germany*



*U.S. costs based on low/average estimates
Source: International Federation of Health Plans. September 2009.

In addition, many radiologists, anesthesiologists and ER physicians refuse to contract with health plans — even though they practice at hospitals that participate in health plan contracts. This leads to costly confusion for consumers that receive services at a network hospital only to receive bills from non-participating radiologists, anesthesiologists and ER physicians.

Non-participating ER physicians charge 170% of participating physicians’ rates on average. Non-participating anesthesiologists charge 150% of participating physicians’ rates.²¹ This translates into a particularly costly problem in certain states. The average charge for nonparticipating radiologists, ER physicians, anesthesiologists and pathologists are:

- 488% of Medicare in Florida
- 396% of Medicare in Illinois
- 464% of Medicare in Louisiana
- 346% of Medicare in Ohio
- 368% of Medicare in Washington.²¹

■ **Pharmaceuticals:** Pharmaceuticals accounted for nine percent of health care spending growth in 2009.²² The costs of many specialty drugs now reach extraordinary levels — with Forbes listing one drug that cost \$409,500 for a year’s supply²³ — and sales of this drug increased 49% in 2009.²⁴ In 2009, nine drugs cost more than \$200,000 annually.²⁵ Overall, prescription drugs experienced double-digit growth figures between 1996 and 2003.²⁶

Average prices for patented drugs in other industrialized countries are 35% to 55% lower than in the United States. For instance, Lipitor costs between \$125 and \$334 in the U.S. versus \$48 in Germany.²⁷ Nexium costs between \$154 and \$424 in the U.S. versus \$37 in Germany and Plavix costs between \$133 and \$540 in the U.S. versus \$85 in Germany.²⁸

A 2008 study found that underpayments by Medicare and Medicaid resulted in a typical insured family paying almost 11% more — or \$1,512 — in additional premium costs.

Cost shifting:

Underpayments by Medicare and Medicaid result in a typical insured family paying almost 11% more in premiums. This translates into about \$1,788 in additional costs per family — \$1,512 in higher premiums and \$276 in higher out of pocket costs.²⁸ The Kaiser Family Foundation has estimated that the average monthly premium of employer-sponsored family coverage is \$1,115 per month.²⁹ So the additional costs that result from cost shifting exceed the amount an average family pays in premiums.

These continual underpayments by public programs makes private health insurance significantly more expensive than it otherwise would be.³⁰ Medicare only covers 91%³¹ of hospital costs and pays 89% of the average physician payment rate.³² Medicaid pays a far smaller percentage of costs. For Medicaid, hospitals received payment of only 88¢ for every dollar spent by hospitals caring for Medicaid patients.³³

For some services and localities, the disparity between Medicare and private payments is extreme. One dialysis contract would have resulted in Medicare paying rates that were only 25% of private payment rates. Facility radiology costs for private payers are routinely between 210% and 500% of Medicare. Hospitals have cited Medicare underpayments as a rationale for increasing private contract rates. Recently, one hospital requested annual increases over 25% for a multi-year contract to compensate for underpayments from Medicare and Medicaid in almost 60% of their business.³⁴

In addition, a study by Families USA found that as much as \$1,017 of the typical family premium is due to cost shifting from the uninsured who receive health care services but have no way to pay.³⁵

Taxes:

Federal, state and local taxes paid by Aetna account for about 4% of premium income — this amount is higher than what Aetna retains in profit and does not include the myriad of additional taxes that would be levied under the new health law, the Patient Protection and Affordable Care Act. In total,

Aetna paid \$1.2 billion in federal and state taxes in the most recent tax filing.³⁶

Under the October 2009 Senate Finance Committee proposal, new fees on various healthcare industries would increase premiums by another 2.5%. It is likely that this tax assessment would increase annual costs for a family plan by \$487.³⁷ The proposed Cadillac tax also would likely increase premiums by approximately five percent.³⁷

Unhealthy Lifestyles:

Unhealthy lifestyle choices are driving an increase in chronic diseases such as diabetes, cardiovascular disease and cancer. In particular, these diseases are caused by:

- **Obesity:** 67% of Americans are either overweight or obese³⁸ and one in three children are obese. Obesity related costs totaled approximately \$147 billion³⁹ last year and medical spending for obese workers can be up to 117% greater than spending for workers with a normal weight.³⁹

The state by state change in obesity has been dramatic:

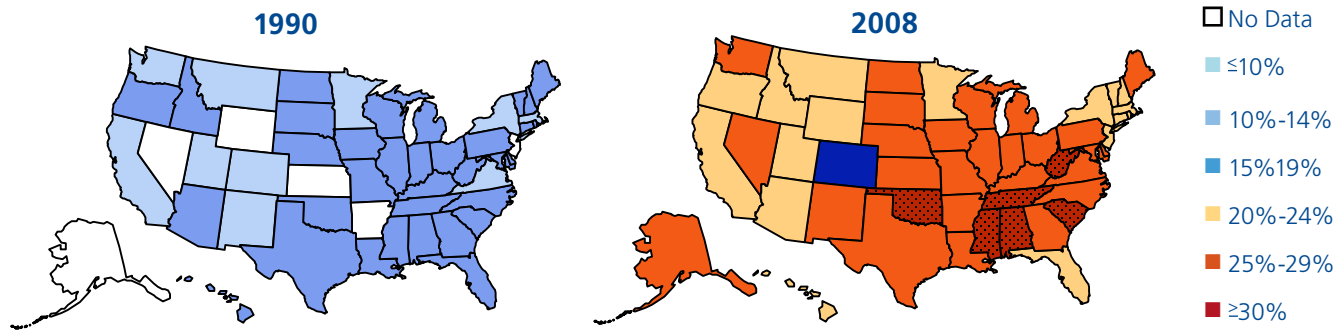
- In 1990, ten states had an obesity prevalence of less than 10% and no states had a prevalence of 15% or more.
- By 2008, only one state had a prevalence of less than 20%. Thirty-two states had a prevalence equal to or greater than 25%, with six of those states equal to or greater than 30%.

| Examples of Average Non-Participating Provider Charges in Comparison to Average Medicare Rates* | | | |
|---|----------|-----------|------|
| Florida | Illinois | Louisiana | Ohio |
| 488% | 396% | 464% | 346% |

*Non-participating providers include anesthesiologists, radiologists, ER physicians, and pathologists.

Source: Internal Aetna Analysis

Obesity Trends* Among U.S. Adults



*BMI>30, or about 30 lbs. overweight for 5'4" person)
Source CDC Behavioral Risk Factor Surveillance System.

As rates of obesity have increased, the prevalence of obesity-related illnesses has also increased. Diabetes rates nearly doubled between 1997 and 2007.⁴⁰ Obesity is directly linked to:

- **Diabetes:** As many as 90% of individuals with type two diabetes are reported to be overweight or obese.⁴¹
- **Gallstones:** Gallstones appear in persons with obesity at a rate of 30% versus 10% in non-obese.⁴¹
- **Hypertension:** Over 75% of hypertension cases are reported to be directly attributed to obesity.⁴¹
- **Sleep apnea:** There is a 12 to 30-fold higher incidence of obstructive sleep apnea among morbidly obese patients compared to the general population.⁴¹
- **Cancer:** Obesity and physical inactivity may account for 25% to 30% of several major cancers — colon, breast (postmenopausal), endometrial, kidney, and cancer of the esophagus.⁴²

American's per capita consumption of caloric sweeteners, including sugar and high fructose corn syrup, increased by approximately 40% from the 1950s to 2000s. During this same time period, American's annual consumption of red meat also increased from 138 pounds per person to 195 pounds per person.⁴³

- **Smoking:** Despite extensive education over the last half century, 18.3% of American women⁴⁴ and 23.1% of American men still smoke.⁴⁴ Of significant concern is the fact that 20% of teenagers smoke⁴⁵ — setting themselves up for a lifetime of poorer health. Smoking accounts for approximately \$157 billion in annual health-related economic losses.⁴⁶
- **Adverse Selection:** The costs of all insurance markets — individual, small, and large — are impacted by provider prices and activity, cost-shifting, and taxes. However, the individual market faces the additional cost pressures of adverse selection. A recent letter from the National Association of Insurance Commissioners (NAIC) explains that the individual market is particularly sensitive to adverse selection because individuals are responsible for paying their entire premiums.

According to the NAIC letter, "In weak economic times, young and healthy individuals tend to drop or reduce coverage at greater rates than older and sicker individuals, leaving risk pools with higher average costs. This adverse selection compounds the effects of high medical trend costs."


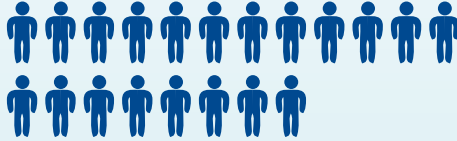
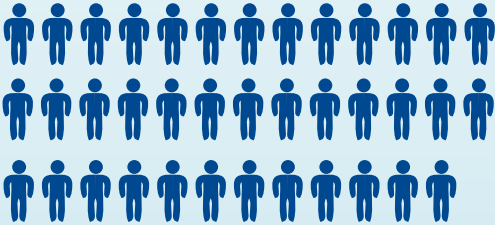
A 2002 Health Affairs article demonstrates the challenge of maintaining a balance of healthy and sick enrollees and affordability in the individual market.


"Some plans have found that even premiums of \$125 per month (\$1,500 per year) are viewed as too high by many healthy persons. Of course the smaller the premium charged the low risk person, the more of these persons it will take to subsidize a single high risk person. For instance, at \$1,500 per year, a plan would need approximately 22 low risk enrollees who do not use any services ("zero cost enrollees") to offset the costs of one enrollee with ovarian cancer (\$33,000). It would need 95 zero cost persons to offset an enrollee needing a kidney transplant (\$143,000) and 193 to cover the health care costs of a 24 week premature infant (\$290,000)."⁴⁷

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Number of Zero-Cost Enrollees Needed to Offset Costs of Selected Medical Conditions

A small number of patients drive costs in the private individual market. For instance, just three percent of enrollees generate 50% of costs in the individual market. About 13% of individuals generate 80% of costs in the individual market.⁴⁸

| Number of “Zero-Cost Enrollees” Needed to Offset Costs | Medical Condition |
|--|--------------------------------------|
|  | Ovarian Cancer (\$33,000) |
|  | Kidney Transplant (\$143,000) |
|  | 24-week Premature Infant (\$290,000) |

 = 5 people

What's NOT Driving Health Care Premium Increases?

The following items are not significant drivers of health insurance premiums:

Profits:

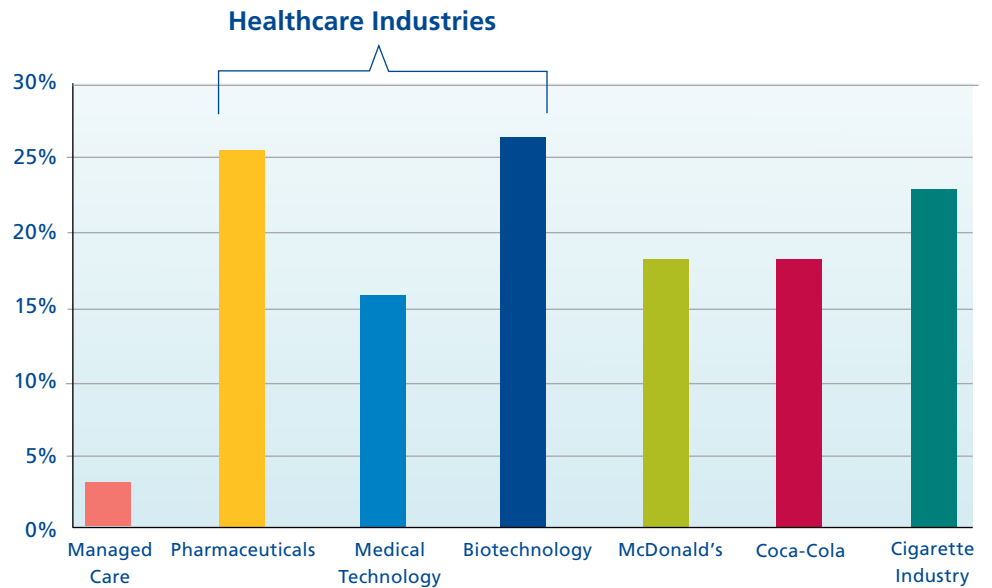
Profits of the health insurance industry represent about three percent⁴⁹ of every health care dollar expended in the United States. The insurance industry is far less profitable than many other industries:

- Managed Care: 3.5%
- Pharmaceuticals 25.5%
- Medical Technology 15.7%
- Biotechnology 26.6%

Importantly, while margins in managed care are shrinking (down from 5.9% in 2005), pharmaceutical margins have increased from 16.5% in 2005.⁵⁰

Moving outside the health sector, McDonald's has profits of 18%, Coca-Cola earns 18% and the cigarette industry earns 23%.⁵¹

The Health Insurance Industry is Less Profitable Than Many Other Industries



Administrative Costs:

Administrative costs represent less than two percent of healthcare spending growth.⁵² Private administrative costs are actually comparable to Medicare when comparing a similar set of services. When evaluating services, such as claims processing, auditing, and billing, private payers expend 68¢ less per member per month (PMPM). In 2009, private payers expended \$12.51 PMPM versus Medicare of \$13.19 PMPM.⁵³

Importantly, the administrative cost category includes critical investments in fraud detection, disease management, and health information technology. These investments improve quality of care for consumers while reducing unnecessary expenditures. For instance:

- **Fraud:** Though estimates vary, the more conservative estimates posit a minimum of \$68 billion in fraud in the U.S. health care system.⁵⁴ Although the federal government averaged a return on investment of six dollars for every one dollar spent on these efforts between 2006 and 2009,⁵⁵ Medicare has hesitated to invest in fraud prevention because it is seen as an “administrative cost.”

- **Disease Management:** Aetna Health Connections Disease Management helps people with chronic conditions obtain the treatment and preventive care they need. Aetna’s clinicians help members understand and follow their doctor’s treatment plan and better manage ongoing conditions. Through disease management, patients have had 26% fewer inpatient admissions for diabetes, coronary artery disease, congestive heart failure and stroke.

- **Health Information Technology:** The RAND Foundation estimates that widespread adoption of various Health Information Technologies could save up to \$77 billion annually.⁵⁶

Lack of Regulation:

Premiums are carefully constructed by insurers and filed with state insurance departments. When establishing premiums, actuaries must evaluate past experience, demographic and trend projections and predict future utilization and costs. In addition they must estimate the costs of any benefit changes and associated utilization or selection impacts, build in contributions to reserves to guard against insolvency, and include an administrative load that enables investment in information technology, quality advancement, customer service and other administrative functions. And finally, the premium also must adequately cover state and federal taxes.

Actuaries working for state insurance departments assure that health insurance premiums are actuarially justified. These state actuaries examine past loss and expense experience to determine if new rates are reasonable given the benefit design, ensure that premiums will be adequate to cover consumer claims and are not discriminatory, and review the insurer’s assumptions regarding medical costs and changes in the risk profile of enrollees.

27 states and the District of Columbia require prior approval of rates – although the vast majority include “deemer” clauses. In most “prior approval” states, if the Commissioner fails to take action within 30 to 45 days, the rate is deemed approved. About a dozen states have “file and use” rules where insurers must file their rates and regulators may have the authority to deny an insurer’s ability to implement those rates.⁵⁷

What Experts are Saying

"If you want to keep costs under control, it's not about managing health care premiums...it's about managing the underlying health care costs." — *Sandy Praegar, Kansas Insurance Commissioner*

"Insurance is not the problem. The problem is incentives. We have payment for procedures, not for results." — *Warren Buffett, CEO, Berkshire Hathaway*

"...a definite shift in negotiating strength toward providers, resulting in higher payment rates and premiums." — *The Center for Studying Health System Change*

"Health insurers have been squarely in the crosshairs and blamed for the high cost of private insurance, while the role of growing hospital and physician market power has escaped scrutiny." — *Robert Berenson, MD, Urban Institute*

"Price increases, not increases in utilization, caused most of the increases in healthcare costs during the past few years in Massachusetts." — *Massachusetts Attorney General*

"While rate review can help keep insurers focused on constraining the growth of these costs, it cannot fundamentally address the growth of health care costs, which must be addressed through payment reform, delivery system changes, an emphasis on prevention, and consumer engagement." — *National Association Insurance Commissioners*



- ¹Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. <http://www.cms.hhs.gov/NationalHealthExpendData/>; Historical data from CY 1960-2008; Projected data from NHE projections 2009-2018.
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- ⁵<http://seekingalpha.com/article/146992-comparing-u-s-healthcare-spending-with-other-oecd-countries>
- ⁶AHIP Statement on the Status of Health Care Reform. February 22, 2010.
- ⁷Office of Massachusetts Attorney General, Investigation of Health Care Cost Trends and Cost Drivers _ Preliminary Report, January 29, 2010
- ⁸U.S. Congress. Senate Finance Committee. March 10, 2009. (testimony of Peter Orszag)
- ⁹Kaiser Family Foundation U.S. Health Care Costs. July 2009.; John E. Wennberg and others, "Geography and the Debate Over Medicare Reform," Health Affairs, Web Exclusive (February 13, 2002), pp. W96–W114; and Elliott Fisher, "More Care Is Not Better Care," Expert Voices, Issue 7 (National Institute for Health Care Management, January 2005)
- ¹⁰The Dartmouth Institute (2008) "Improving Quality and Curbing Health Care Spending: Opportunities for Congress and the Obama Administration.
- ¹¹2008 National Healthcare Quality Report from the Agency for Healthcare Research and Quality
- ¹²Annual survey results can be accessed at: <http://www.cms.hhs.gov/nationalhealthexpenddata/>
- ¹³Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. <http://www.cms.hhs.gov/NationalHealthExpendData/>; Historical data from CY 1960-2008; Projected data from NHE projections 2009-2018.
- ¹⁴International Federation of Health Plans 2009 Comparative Price Report Medical and Hospital Fees by Country. September 2009.
- ¹⁵Health Affairs: Unchecked Provider Clout in California Foreshadows Challenges to Health Reform; April 2010
- ¹⁶Internal Aetna Data Analysis.
- ¹⁷Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. <http://www.cms.hhs.gov/NationalHealthExpendData/>; Historical data from CY 1960-2008; Projected data from NHE projections 2009-2018.
- ¹⁸Centers for Disease Control, National Center for Health Statistics. (2010) "Health, United States 2009, With a Special Feature on Medical Technology"
- ¹⁹International Federation of Health Plans 2009 Comparative Price Report Medical and Hospital Fees by Country. September 2009.
- ²⁰International Federation of Health Plans 2009 Comparative Price Report, September 2009.
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- ²²Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. <http://www.cms.hhs.gov/NationalHealthExpendData/>; Historical data from CY 1960-2008; Projected data from NHE projections 2009-2018.
- ²³Forbes The World's Most Expensive Drugs. February 22, 2010.
- ²⁴Alexion Reports Fourth Quarter and Full Year 2009 Results.
- ²⁵Forbes The World's Most Expensive Drugs. February 22, 2010.
- ²⁶Kaiser Family Foundation. "Prescription Drug Costs." February 2010.
- ²⁷International Federation of Health Plans 2009 Comparative Price Report Medical and Hospital Fees by Country. September 2009.
- ²⁸Milliman, Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers, December 2008.
- ²⁹Kaiser Family Foundation, Employer Health Benefits 2009 Annual Survey.
- ³⁰Milliman, Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers, December 2008.
- ³¹American Hospital Association Underpayment by Medicare and Medicaid Fact Sheet. November 2009.
- ³²Milliman, Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers, December 2008
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- ³⁸Centers for Disease Control and Prevention. National Center for Health Statistics. 2005-2006.
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- ⁴⁴Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey Raw Data, 2008.
- ⁴⁵Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance — United States, 2007. Morbidity and Mortality Weekly Report. June 6, 2008; 57(SS-04).
- ⁴⁶Centers for Disease Control and Prevention. Annual Smoking—Attributable Mortality, Years of Potential Life Lost, and Economic Costs, 1995-1999. April 12, 2002.
- ⁴⁷Health Affairs: The Individual Market: A Delicate Balance October 2002
- ⁴⁸Internal Aetna Data Analysis
- ⁴⁹PriceWaterhouseCoopers. "The Factors Fueling Rising Health Care Costs 2008."
- ⁵⁰Based on data accessed October 29, 2009. Managed care includes: AET, AGP, CI, CNC, CVH, HNT, HUM, MOH, UNH, WLP; Pharmaceuticals includes: BMY, LLY, MRK, PFE, SGP, WYE; Medical Technology includes: ABT, BAX, BDX, BSX, JNJ, MDT, STJ, SYK, ZMH; Biotechnology includes: AMGN, CELG, DNA, GENZ, GILD.
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- ⁵²Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. <http://www.cms.hhs.gov/NationalHealthExpendData/>; Historical data from CY 1960-2008; Projected data from NHE projections 2009-2018.
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- ⁵⁶RAND Foundation (2005). "Health Information Technology: Can HIT Lower Costs and Improve Quality?"
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Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

