

EXECUTIVE SUMMARY

HEALTH CARE USA: A Cancer on the American Dream

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EXECUTIVE SUMMARY

There has been considerable angst of late about the fading of the American Dream, often blamed on burgeoning income inequality, flawed immigration policy and enforcement, globalization and technology. Many manufacturing and lower-skilled service jobs have disappeared, leaving less well-educated American workers struggling with job losses and declining incomes. Former middle earners have been pushed into lower-skilled and lower-paying employment, while workers with more education are forging ahead in technical and other specialized careers. Meanwhile, rising health care costs—not usually viewed as having much to do with wage stagnation—have also been diminishing the prosperity of American workers, albeit accompanied by a lot less fanfare.

Employers' health care costs started small—in 1950, health benefits amounted to only 0.5 percent of total compensation. But employers' health insurance premiums rose 3.1 times faster than total compensation in the 1950s and over twice as fast in the 1960s. Over the next 40 years, the growth of health plan costs outpaced compensation growth by 3.4 times in the 1970s, 2.1 times in the 1980s and 1.2 times in the 1990s. By the first decade of the new millennium, health care costs were again rising 3.4 times faster than compensation. This analysis shows that the escalation of premiums is edging out pay growth for many workers, leaving nothing to add to their paychecks—what should be their ticket for the ride to the American Dream. The analysis also addresses the dynamics driving health cost increases, including the growing consolidation of health care services, the regulatory approval process and patent protections for drugs, and inefficient or even harmful practice patterns in the delivery of health services.

U.S. HEALTH CARE IN PERSPECTIVE

In 1970, the United States and Canada spent nearly the same share of their gross domestic product on health care—6.9 percent versus 6.4 percent. Today, we spend about 7.5 percent more of our domestic output on health care than Canada, amounting to roughly an extra \$1.5 trillion this year. Adding up the spending differential between the two countries and accounting for the time-value of money since 1970, as of 2017 we had spent around \$34 trillion more for health care than we would have if our spending as a share of GDP had remained comparable to that of Canada. Applying the same comparison to a broader set of 19 highly developed countries around the world produces similar, although slightly less dramatic, results.

Despite spending so much more on health care than other countries, there is considerable evidence we are receiving less in the way of good health care or good health. We have fewer doctors and fewer doctor visits per capita. We have fewer hospital beds and lower hospital occupancy rates. We undergo many more MRI and CT exams, and spend more than twice as much on drugs per capita, on average, than residents of other highly developed countries. Yet U.S. life expectancy at birth is about 3.3 years less than in these other highly developed countries, and recent trends appear to be taking us in the wrong direction.

Spending trillions more on health care than other countries reduces the funds available for other priorities, many arguably just as important. Financing the growing cost of Medicare and Medicaid leaves less in the budget to build and support our national infrastructure, maintain our national defense, finance education and development programs, and meet other needs. Higher employer premiums for health insurance bleeds away money that could otherwise be paid to workers as wages. The higher cost of health insurance and expenses paid out of household budgets siphons off resources that could be used for housing, transportation, education and other needs.

HEALTH COSTS AND PAYCHECKS

According to the Centers for Medicare and Medicaid Services, U.S. health care spending reached \$3.3 trillion and absorbed 17.9 percent of GDP in 2016. But viewing health care costs in terms of trillions of dollars and percentages of GDP are macro concepts, while the consequences of excessive health spending are lived at the micro level, where people buy houses, save for retirement, launch their children into adulthood and otherwise try to get ahead in life.

Most people consider their compensation to be their hourly wage or annual salary, but employers lump workers' "pay" together with other costs of employment, such as what they pay for benefits and payroll taxes. If total compensation costs exceed workers' productivity for any length of time, something has to give. Employers might provide smaller raises or freeze them altogether, cut benefits, or shift costs directly to workers by increasing their health premiums or copays. They can also require employees to work additional hours, thereby reducing the number of health plan participants. If higher health premiums consume too large a share of compensation for lower earners, companies can contract out entire classes of jobs to firms with less generous wage and benefit packages or eliminate positions entirely.

The following estimates are based on an analytical framework developed by the authors to distribute compensation and benefit costs across the U.S. workforce segmented by earnings deciles¹ using data from the U.S. Census Bureau's *Annual Social and Economic Supplement* to the *Current Population Survey* (CPS). Workers' hourly pay is estimated from CPS reports of pay amounts and basis (hourly, weekly or other), and average hours per week from 1980 through 2015. Reported wages are used to impute benefits to individual workers, and hourly wages and benefits are summed to estimate total hourly compensation. The distribution of total compensation varies considerably from the distribution of wages because of the cap on earnings subject to payroll taxes, differences in coverage rates and benefits levels under employer-sponsored retirement and health plans, and variations in the generosity of plans and worker participation. Benefits absorbed roughly 14 percent of compensation in 1980 versus 19 percent in 2015 according to our estimates, which closely track other government estimates of these costs.

Average hourly compensation for all workers rose between 1980 and 2015. The gains generally favored higher earners during the 1980s, were relatively broad-based during the 1990s and tilted toward higher earners again in the first decade of the 2000s. The 2010-2015 period was a difficult one for workers, with six out of the 10 earnings deciles registering declines in average hourly compensation rates. The declines fell most heavily on workers in the third through sixth deciles. The economic crisis starting in 2008 and the slow recovery took a heavy toll on the middle-class workforce.

The record of compensation growth is the foundation of the story told here but the history of benefit costs from decade-to-decade is equally important in explaining workers' evolving pay patterns. Employee benefit costs grew rapidly in the 1980s, absorbing half of total compensation growth, on average. About half of all benefit cost growth was driven by rising health insurance premiums, while payroll tax increases—arising from Social Security legislation adopted in the early 1980s—were responsible for roughly a third.

¹ The first nine deciles each represent one-tenth of the workforce. The tenth decile—the highest-earning decile—includes only the top 9 percent of the workforce by earnings level. The top 1 percent of earners are not included because the analysis relied on U.S. Census data and these individuals' reported earnings are "top coded" in the data files released to the public to avoid possible public identification of the respondents to the Census surveys.



- For the bottom three earnings deciles in the 1980s, employers' health premiums absorbed around three-fourths of all compensation growth. For workers in the bottom two deciles, the higher costs of employer premiums and payroll taxes actually reduced their hourly wages over the decade.
- For the fourth and fifth deciles, health insurance costs consumed about two-thirds of compensation growth.
- For the sixth through eighth deciles, premiums absorbed more than half of compensation growth.

Over the 1990s, the compound annual growth rate in workers' hourly productivity was a relatively healthy 1.8 percent and, with the tight labor market, compensation growth picked up to 2.2 percent per year and benefit cost growth generally slowed. During the decade, hourly compensation increases, in inflation-adjusted dollars, averaged about 2.5 times the growth registered in the 1980s.

- Compensation growth during the 1990s tilted heavily toward the bottom of the earnings distribution in relative terms, but the largest absolute gains were at the upper end.
- Health costs grew more slowly than during the 1980s but still accounted for two-thirds to three-fourths of employers' benefit cost increases for 70 percent of the workforce.
- With slower benefit cost growth, three-quarters or more of compensation growth ended up in workers' paychecks across virtually all pay levels.

For all but the top earners, compensation growth during the first decade of the 2000s was higher than it had been in the 1980s but generally lower than it was during the 1990s. During both earlier decades, compensation gains were largest for the highest-earning workers, but during the first decade of the 2000s, growth rates for top earners were significantly lower than those for lower earners as many employers shifted to pay-for-performance for senior and middle managers. While compensation grew for most workers between 2000 and 2010, the growth rate for employers' health premiums was 2.25 times that in the previous decade, and the cost of retirement benefits grew by 3.25 times the 1990s rate. A significant factor behind the higher pension cost was employers meeting their unfunded obligations in traditional defined benefit plans.

- Workers in the bottom earnings decile received 75 percent of their compensation growth and those in the second decile received 51 percent, but employers trimmed benefit costs largely by cutting back health plan coverage for this segment of the workforce.
- Hourly wage increases for workers in the third through the seventh deciles of the earnings distribution amounted to less than half their compensation growth as benefit cost increases siphoned off the remainder.

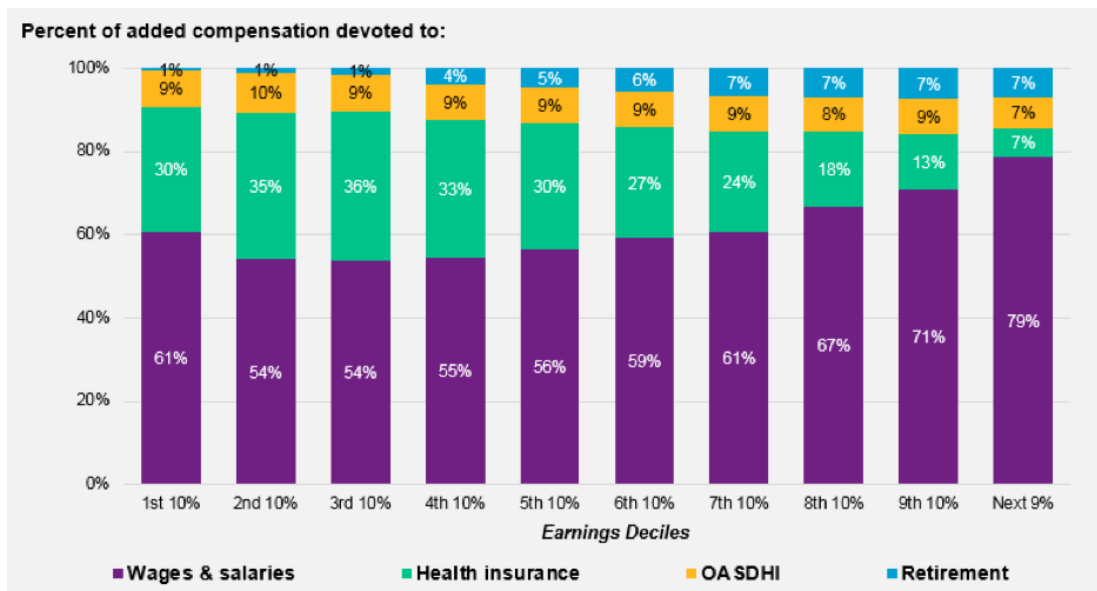
The early 2010s were a losing proposition for the average earner in the bottom 70 percent of the workforce.

- Employers held the line on health costs more stringently than they had over the prior three decades; employers' average hourly health premiums rose only \$0.02 per hour in inflation-adjusted dollars from 2010 through 2015.
- Employers' average hourly contributions to retirement plans declined \$0.22 over the period compared to the prior decade.

- Average hourly wages declined for the bottom six deciles of the earnings distribution.

Figure 1 shows how compensation growth was distributed among wages/salaries, health insurance, payroll taxes and retirement benefits between 1980 and 2015 by earnings decile. Benefits and payroll taxes combined grew by 40% or more in the first through seventh deciles, while benefits make up less than 20 percent of compensation. Figure 1 clearly illustrates the underlying forces behind the upward trends in benefits as a share of employee compensation.

Figure 1. Changes in hourly compensation and the distribution of compensation growth to wages and salaries, health insurance, payroll taxes and retirement benefits, 1980–2015



Notes: Amounts are in 2015 dollars. OASDHI include payroll taxes for Old Age, Survivors, Disability and Health Insurance.

Source: Based on Table 9 of the full report.

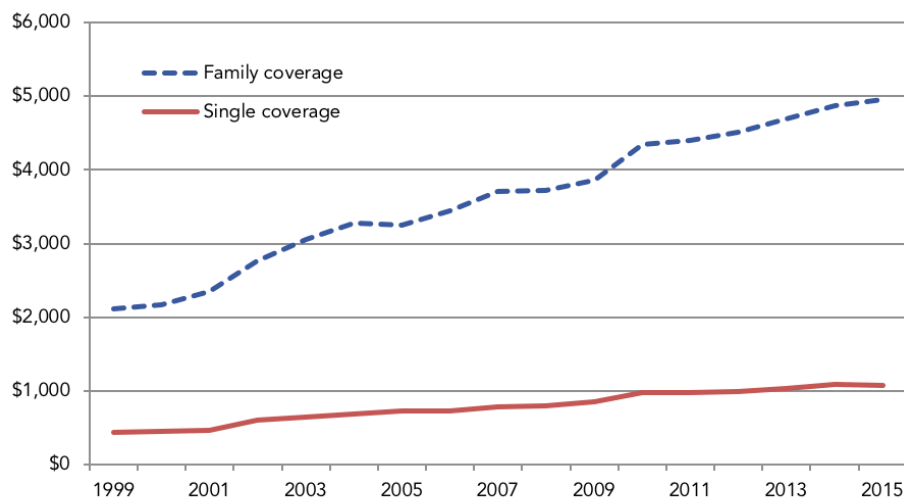
In addition to leeching compensation from workers' paychecks, rising health insurance costs have gradually diminished the retirement share of benefits. According to estimates by Willis Towers Watson based on a large sample of benefit plans, employer allocations to health and retirement benefits were 41.9 percent for health and 58.1 percent for retirement in 2001. By 2015, the split was in the other direction: 63.5 percent for health benefits and 36.5 percent for retirement benefits.



GETTING TO THE BOTTOM LINE

Health cost inflation also drives up employee premiums, which deplete disposable pay much more visibly than the employer's share of premiums. *Figure 2* shows average employee premiums for single and family coverage under employer health plans and highlights an important consequence of premium inflation. Converting the results in *Figure 2* into 2015 dollars, the annual premiums for full-time, full-year single workers rose from \$415 in 1999 to \$1,068 in 2015, an increase of \$653 per year or \$0.30 per hour. For those buying family coverage, employee premiums rose from \$2,127 to \$4,956 in 2015 dollars, an increase of \$2,829 per year or \$1.36 per hour.

Figure 2. Average annual employee premiums converted to 2015 dollars for individual and family coverage under employer health plans, 1999–2015



Note: Results are shown in 2015 dollars.

Source: Kaiser Family Foundation and Health Research & Educational Trust (KFF-HRET) *Employer Health Benefits, 2017 Annual Survey*, Figures 6.3 and 6.4.

To put the higher employee premiums in context, we estimate that, between 1999 and 2015, average pay for the full-time workers in our analysis rose by \$3.39 per hour in 2015 dollars. In the fifth decile, average hourly pay rose by \$1.31 an hour: from \$17.43 in 1999 to \$18.74 in 2015. So, over the 16-year period, average wage growth in the fifth decile fell just short of covering the average premium increase charged directly to workers for family coverage. For many workers, rising health insurance premiums were eating up every last cent of their pay increases and more.

To isolate the effects of health insurance costs on workers' economic gains, or lack thereof, we estimated compensation growth from 1999 through 2015 after employers had paid their share of payroll taxes and retirement plan contributions. *Table 1* shows how the higher health premiums whittled away workers' wage increases. After premiums were deducted, workers in the bottom three deciles with individual coverage suffered net wage losses, while workers in the fourth decile broke roughly even. For average workers in the bottom 40 percent of the earnings distribution, enrolling in employer health care actually drove their disposable earnings down over the 16-year period. Workers in the fifth decile retained about one-sixth of their pre-premium compensation gains, and those in the seventh decile received less than one-half their compensation gains. The outcomes were even worse for workers in the bottom 60 percent of the earnings distribution with family coverage.

Table 1. Average hourly compensation growth before and after reductions for employer and employee portions of health premiums, 1999 through 2015

	Single-earner household			Dual-earner household		
	Growth in pre-health care compensation	Change in pay after health care for:		Growth in pre-health care compensation	Change in pay after health care for:	
		Individual coverage	Family coverage		Single-plan coverage	Two-plan coverage
1st 10%	\$1.35	-\$0.50	-\$1.56	\$2.25	-\$2.21	-\$2.51
2nd 10%	\$1.40	-\$0.45	-\$1.51	\$2.34	-\$2.12	-\$2.42
3rd 10%	\$1.52	-\$0.33	-\$1.39	\$2.54	-\$1.92	-\$2.22
4th 10%	\$1.84	-\$0.01	-\$1.07	\$3.07	-\$1.39	-\$1.69
5th 10%	\$2.22	\$0.37	-\$0.69	\$3.69	-\$0.77	-\$1.07
6th 10%	\$2.38	\$0.53	-\$0.53	\$3.96	-\$0.50	-\$0.80
7th 10%	\$3.49	\$1.64	\$0.58	\$5.82	\$1.36	\$1.06
8th 10%	\$4.90	\$3.05	\$1.99	\$8.17	\$3.71	\$3.41
9th 10%	\$6.93	\$5.08	\$4.02	\$11.56	\$7.10	\$6.80
Next 9%	\$11.53	\$9.68	\$8.62	\$19.21	\$14.75	\$14.45

Note: Changes in hourly compensation and benefit costs are in 2015 dollars.

Source: Growth in the pre-health-care compensation was developed from the augmented CPS by Willis Towers Watson as described in the text. Growth in the employer and employee premiums in this case are derived by the authors from KFF-HRET (2017) as described in the full report.

For the two-earner households, the analysis assumes that the second earner realized compensation gains, net of employers' retirement plan increases, that were only two-thirds of the first earner's net gains. Further, we assume that both workers' employers sponsored a health plan, so both their compensation packages reflected average employer costs for sponsoring a plan.

After paying their health premiums, the bottom 60 percent of these hypothetical two-earner households would have seen their net earnings decline between 1999 and 2015. Higher earners in the seventh decile would have realized modest net gains over the period, but excessive health costs still would have absorbed 75 percent to 80 percent of their compensation gains. Those families that managed to acquire health insurance from a single employer would get off a little easier than those who had to acquire it from two employers. The costs of employer-sponsored health benefits were sucking the lifeblood out of the potential economic gains for many, if not most, of these workers.

HEALTH COST INFLATION AND THE CONCENTRATION OF INCOME

The decade-by-decade synopsis of disappearing compensation provides additional context to the story of economic stagnation. From 1980 through 2015, progressively higher earners gained more than lower earners in real dollars, which is consistent with claims that income gains have been moderate for middle earners and sizable for those at the top since the 1970s.

Compensation for average earners in the bottom decile increased by roughly \$4,000 between 1980 and 2015, but only about \$2,500 of that made it into their paychecks. In 2015, workers at the fifth decile were \$11,000 ahead on the compensation ledger but only \$6,200 ahead in cash earnings. For the bottom four earnings deciles, three-fourths of the benefit draw on compensation growth went to higher-cost employer-financed health insurance, declining to two-thirds for the fifth



through seventh deciles. Even at the ninth decile, premium increases consumed 46 percent of the benefit drawn on workers' compensation growth.

Because of the regressive effects of higher health premiums on wages, higher earners suffered less financial pain than lower earners. This is borne out in *Table 2*, which first shows changes to compensation after deducting payroll taxes and retirement benefits, then after deducting employer health premiums and, finally, the disposable wages remaining after workers paid their share of premiums. For example, workers in the sixth earnings decile lost 0.8 percent of aggregate compensation paid to all workers from 1980 through 2015 but lost 0.9 percent of cash wages and 1.0% of take-home pay—that is, cash wages minus the worker's health premium, which we refer to as disposable wages. For each category, the first column shows the changes for each decile and the second column shows the cumulative changes for that decile plus all lower deciles.

Table 2. Changes in the distribution of full-time, full-year workers' rewards by earnings decile, 1980–2015

Income deciles	<i>Compensation less employers' payroll taxes and retirement benefits</i>		<i>Cash wages after employer health premiums</i>		<i>Disposable wages after employee health premiums</i>	
	Change in shares	Change in cumulative shares	Change in shares	Change in cumulative shares	Change in shares	Change in cumulative shares
	1980-2015	1980-2015	1980-2015	1980-2015	1980-2015	1980-2015
	(1)	(2)	(3)	(4)	(5)	(6)
1st 10%	-0.2%	-0.2%	-0.2%	-0.2%	-0.3%	-0.3%
2nd 10%	-0.7%	-0.9%	-0.7%	-1.0%	-0.8%	-1.0%
3rd 10%	-0.7%	-1.6%	-0.8%	-1.7%	-0.9%	-1.9%
4th 10%	-0.6%	-2.2%	-0.8%	-2.5%	-0.9%	-2.8%
5th 10%	-0.7%	-3.0%	-0.9%	-3.4%	-1.0%	-3.7%
6th 10%	-0.8%	-3.8%	-0.9%	-4.3%	-1.0%	-4.7%
7th 10%	-0.8%	-4.6%	-0.9%	-5.2%	-0.9%	-5.7%
8th 10%	-0.3%	-4.9%	-0.3%	-5.5%	-0.3%	-5.9%
9th 10%	0.7%	-4.2%	0.8%	-4.7%	0.8%	-5.1%
Next 9%	4.2%	0.0%	4.7%	0.0%	5.1%	0.0%

Source: Developed from the augmented CPS by Willis Towers Watson as described in the text.

For lower-earning workers, the losses in aggregate share of compensation were essentially equal to the losses in aggregate share of disposable wages. That's because lower-earning workers were far less likely to receive health insurance from their employer in 2015 than in 1980, so the higher health insurance costs for those with insurance were being masked by declining health insurance take-up rates for lower earners. For the first eight earnings deciles combined, their share of total compensation fell by 4.9 percent while the share of total disposable wages fell by 5.9 percent.

Between 1980 and 2015, 24 percent of the decline in the share of aggregate take-home pay for workers in the third earnings decile was attributable to higher employer and employee health insurance premiums. For workers in the fourth decile, 36 percent of the loss of disposable wages was

due to higher premiums; for those in the fifth decile, it was 31 percent. Even those in the seventh decile lost 24 percent. The rising cost of employer-sponsored health insurance was not the only precipitating factor in shifting disposable earnings from lower- and middle-earners toward those at the top of the distribution, but it played a significant role.

ADDRESSING CAUSES VERSUS SYMPTOMS

To the extent that cost control has entered into health policy discussions, it has generally taken a back seat to expanding access to health insurance. The coverage mandates in the Affordable Care Act required individuals without coverage to purchase it or pay a penalty. The ACA established subsidies for those with low incomes who could not otherwise afford insurance in the open marketplace or even in an employer plan. The ACA also promised to moderate health cost inflation, but the average premium for individual coverage under an employer plan increased by 18.25 percent in inflation-adjusted dollars between 2010 and 2017, and the increase was 21.6 percent for family coverage during a period when compensation and wage growth was flat or negative for a large swath of the workforce. As measured by premiums in employer-sponsored plans, the upward trajectory of health cost inflation has persisted.

While this analysis was not designed to produce comprehensive policy recommendations, it has yielded some observations we believe deserve attention. Some of the developments, trends and practices calling out for a new public health response include:

- Market concentration of hospitals and health care providers
- Uneven and often irrational pricing of medical goods and services (including drugs)
- Inadequate medical management of treatments, often resulting in inefficiencies and waste
- Insufficient testing of the efficacy of medical procedures and drugs, and failure to curtail those that are found to be ineffective
- Failure to incorporate study results and best practices into physicians' treatment patterns

There has been significant consolidation of hospitals and other health service providers in recent years, and ample evidence suggests that higher prices have been the result. The pricing of pharmaceuticals in the United States is one cause of the differentials between our spending patterns and those of other developed countries. Moreover, there is an enormous divergence between the cost of health services delivered under public insurance programs versus those delivered under private plans or provided directly to consumers that has nothing to do with the quantity or quality of the care. Finally, the concentration of utilization in services by a small minority of patients suggests that these high-cost cases could use more aggressive case management.

While this is not an exhaustive area of emphasis, we look at each of these in turn to provide further insight into the widespread inefficiencies throughout the U.S. health care marketplace and the complex set of choices we must make to control a socioeconomic disorder that is metastasizing at an alarming rate.



INCREASING MARKET CONCENTRATION

Over the last 20 years or so, extensive economic literature has analyzed the effect of hospital concentration on the cost of health services. The evidence shows that hospital consolidation in recent years has left almost all consumers of hospital care with fewer choices, while hospitals benefit from less competition and more market control. More recently, the number of primary physicians being employed by hospitals or health care systems has grown dramatically—from 28 percent in 2010 to 44 percent by 2016—and the evidence here suggests the outcome is often higher prices.

There are a wide range of studies that document the increasing concentration of providers in most geographical areas across the country and generally confirm that ever-increasing market concentration has driven health care prices higher. A measurable improvement in the post-merger quality of health services could justify some of the price differential, but researchers have generally found that consolidation between competitors substantially increases prices without improving quality or efficiency.

HEALTH CARE PRICING, SOME FISH AND SOME FOUL

According to one CBO study of costs in 2013, after controlling for the mix of patients and hospitals, average commercial rates were 89 percent higher than Medicare fee-for-service (FFS) rates for hospital stays: 88 percent higher for surgical procedures and 89 percent higher for medical stays. However, there has been surprisingly little demand for more aggressive price regulation of privately financed health goods and services. Such regulation would not require anyone to give up their current health plan or physicians, and there is already a nationwide, administered pricing payment system purchasing health services at lower costs than commercial insurance plans.

Prescription drugs are another piece of health cost story, in some ways more complicated than all the rest. Generic drugs account for 89 percent of dispensed prescriptions but only 26 percent of U.S. drug costs. The *Express Scripts Prescription Price Index* tracks prices for the most commonly prescribed generic medications, the most commonly prescribed brand medications and the Bureau of Labor Statistics' Consumer Price Index. Between 2008 and 2016, generic drug prices fell 74 percent, brand drug prices rose 208 percent and consumer prices rose 14 percent. The process for developing generic versions of prescriptions complicates consumer choices and often delays the arrival of cheaper generic versions of what are essentially the same or very similar drugs. For example, insulin for treatment of diabetes has been around for nearly 100 years, yet there is still no generic version in the United States. Many brand-name drugs become part of a process known as "evergreening," where drug companies repeatedly obtain a new patent for a marginally improved version of a drug, thus extending its patented status indefinitely.

The broader analysis examines in more detail the opportunity to address the wide variances in prices of services delivered under the major insurance alternatives. The discounts negotiated by private insurers for insulin and other drugs are further confirmation that aggregation on the demand side can ameliorate prices, even from monopolistic or oligopolistic suppliers of drugs. There is much to leverage from the current discounting regimes under Medicare Part D, Medicaid's "best-price offer" approach and the Veterans' Administration's program of most-favored commercial customer pricing or a statutorily established discount of 24 percent.

Drug-price rebates may reduce Medicaid expenditures, but they create problems elsewhere in the system. The Medicaid rebate program was created by the Omnibus Budget Reconciliation Act of 1990. By 1994, it was clear that the program's best-price feature was pushing prices higher under private plans because drug manufacturers were less willing to offer private purchasers large drug discounts that would have to be passed along to Medicaid. In broad terms, requiring drug companies to offer Medicaid the best price in the marketplace is blocking the shift to value-based drug pricing.

MOVING FROM VOLUME TO VALUE; FROM HEALTH SERVICE DELIVERY TO HEALTH

Average per capita spending on personal health care in 2016 was \$8,771, but one must dig deeper for meaningful numbers. Among those in the bottom half of the spending distribution, average per capita spending was only \$491. People in the 50th to the 80th percentile of the spending distribution averaged \$4,415, while those in the 80th to the 90th percentile averaged \$13,946. Average costs rose to \$27,717 for people in the 90th to the 95th percentile, to \$60,522 for those in the 95th to 99th percentile and, finally, to \$199,985 for the top 1 percent.

The concentration of spending on a small percentage of the population suggests tremendous leveraging opportunities. The health problems faced by many of these patients are multifaceted and complex, and they are cared for under a health system plagued by both high prices and inadequate management of service delivery. Author Sandeep Jauhar, M.D., describes the treatment of a 50-year-old patient admitted to the hospital with shortness of breath:

During his month long stay, which probably cost upward of \$200,000, he was seen by a hematologist; an endocrinologist; a kidney specialist; a podiatrist; two cardiologists; a cardiac electrophysiologist; an infectious-disease specialist; a pulmonologist; an ear, nose and throat specialist; a urologist; a gastroenterologist; a neurologist; a nutritionist; a general surgeon; a thoracic surgeon; and a pain specialist. The man underwent 12 procedures, including cardiac catheterization, a pacemaker implant and a bone-marrow biopsy (to work up mild chronic anemia). Every day he was in the hospital, his insurance company probably got billed nearly \$1,000 for doctor visits alone. ... When he was discharged (with only minimal improvement in his shortness of breath), follow-up visits were scheduled for him with seven specialists.

This case, in which expert consultations sprouted with little rhyme, reason or coordination, reinforced a lesson I learned many times in my first year as an attending [physician]: In our health care system, if you have a slew of physicians and a willing patient, almost any sort of terrible excess can occur (Jauhar, 2014, p. 94).

In recent years, there has been growing interest in “value-based” care, which attempts to coordinate the delivery of the services patients need to get better and stay better. At least in theory, providers are reimbursed for value—which means delivering services and treatments that improve health, reduce or at least manage the effects of chronic ailments, and help patients attain healthier lifestyles—rather than for individual services. In one value-based Medicare Advantage plan called CareMore, the approach resulted in fewer hospital admissions, fewer bed days, shorter stays and lower costs.



MOVING FROM A DIVINING-ROD MODEL TO EVIDENCE-BASED BEST PRACTICES

A major barrier to a better care delivery system is the widespread clinician indifference to empirical evidence supporting best practices, thus leaving in place practice patterns that are more expensive, less effective and often higher risk.

For example, according to the World Health Organization, C-section births should not exceed 10 percent to 15 percent of all births. In the United States, however, slightly less than one-third of all babies were delivered by C-section in 2016, ranging from a high of 38.2 percent in Mississippi to a low of 22.3 percent in Utah. Intermountain Healthcare in Utah offers an interesting example of using data and analysis to improve outcomes and reduce costs. After an evaluation of maternity services, Intermountain Healthcare hospitals restricted induced labor before 39 weeks to cases of medical necessity. Following the intervention, the C-section rate, which had been close to the national average of 32 percent, dropped to 12 percent for first births and to 21 percent overall.

Atherosclerosis offers another example of common practices bearing little relation to best practices. While there is widespread agreement that percutaneous coronary intervention (PCI) reduces deaths for people having heart attacks, its use for stable coronary artery disease has been much less universally accepted. According to study results published in the mid-1980s, for most people, medical therapy is just as effective as surgery: 97 percent of those who underwent coronary artery bypass grafting (CABG) surgery were no better off than those treated with medical therapy. While these and other study results should have ruled out the CABG procedure for most heart patients, the surgeries were still being performed—roughly 500,000 a year—20 years later. Trying to explain these results, the authors of “Impact of National Clinical Guideline Recommendations for Revascularization of Persistently Occluded Infarct-Related Arteries on Clinical Practice in the United States” offered:

Analysis of physician behaviors suggest a wide spectrum of factors contributing to this clinical inertia, including lack of agreement regarding interpretation of data especially when it contradicts long-held beliefs and external influences, such as conflicting patient expectations and financial incentives to perform the unindicated procedure and fear of litigation.

GOING FORWARD

Other countries have found a variety of ways to control their health care costs and still achieve better health outcomes than we do: socializing both financing and delivery under bureaucratic budgeting and control; or creating single or a small number of financing systems, with limits on their health budgets, like the model adopted by our neighbor to the north. Canada’s socialized health financing system strictly manages the revenues fed into the private delivery system. There seems to be reflexive opposition to any of those models in the United States, despite incontrovertible evidence that other highly developed countries are living comfortably—and longer—with them.

In most U.S. health care markets, the concentration of providers has gone far beyond what antitrust laws commonly allow. Concentration is nearly absolute in the hospital and brand-name drug sectors and is quickly engulfing the independent physician sector as well, and evidence confirms that this market concentration has pushed prices higher, often much higher.

Where monopolies exist, policymakers in the past have effectively used antitrust enforcement or regulation to ameliorate the pricing effects of concentrated market power. If policymakers want unregulated, purely market-driven health care markets, they should enforce antitrust laws more

aggressively and legislate greater price transparency. If consolidation is allowed to continue on its current course, policymakers need to regulate the market. Administered prices are already widespread under both Medicare and Medicaid, so extending this pricing to other insured and uninsured consumers should be relatively easy.

The U.S. is in dire need of an organization with budgetary resources that can systematically assess medical practices, procedures and pharmaceutical prescriptions, and then provide scientifically reliable, evidentiary assessments of efficacy. The fellow with stable coronary artery disease who dies on the operating table during CABG surgery most likely did not need the surgery that killed him. The 37-week pregnant woman on the C-section table without any precipitating medical indication who is injured or whose baby is injured by the procedure could have avoided the surgery.

Assuming that we can contrive better approaches to developing evidence about what works in the medicine bag, providers of care will need to be convinced to follow the evidence. According to some researchers, most medical school curriculums do not teach students much about the development of evidence or its interpretation. This lack could be resolved over time by changing the educational curriculum for medical students. Within hospitals and other clinical settings, some of the resistance to rethinking discredited practices could be addressed at the organizational level.

A number of economic forces have created barriers to the American Dream in recent years, but one culprit that generally has been overlooked is our singularly expensive health-care system. A large share of the resources poured into health care has proven to be money ill spent, ineffective on many health measures and so expensive as to have considerably dimmed the prospect that hard work over time would deliver financial security to Americans and even greater opportunities for their children. The forces driving our excessive health care spending have been widely documented and just as widely brushed aside for a long time. If we continue ignoring the reasons for our out-of-control health care spending, the deleterious effects on workers will exact an ever-higher claim on the American Dream of economic progress for all those willing to work for it.





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COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

About the Council for Affordable Health Coverage

The Council for Affordable Health Coverage (CAHC) is a broad-based alliance with a primary focus: bringing down the cost of health care for all Americans. CAHC promotes policies that lower health costs through increased competition, informed consumers and more choices.

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