FAST FACTS

WHY DOES HEALTHCARE COST SO MUCH?

PALMETTO PROMISE INSTITUTE

AMERICA'S SKYROCKETING HEALTHCARE COSTS: A TIMELINE

THE PROBLEM: 3rd party payer insurance contributes dramatically to America's rising healthcare costs.
THE ANSWER: Restore doctor/patient relationships and make consumers shoppers.

In 1930, Americans spent $2.8 billion on healthcare—$23 per person and only 3.5% of the GDP. We currently spend $3.5 trillion, which comes to over $10,000 per person and 18% of the US GDP. Over the span of 90 years, when adjusted for inflation, spending on healthcare in America increased by over 3,000%, an absolutely staggering number, and it begs the question – how did we get here?

MID-1800s

Around 40,000 people consider themselves physicians. That's **1.7 doctors per 1,000 Americans** (There are now 1.1 million physicians as of 2015, about 3.4 doctors per 1,000 Americans). It is during this time that a major shift occurred in the way diseases are treated with the development of the germ theory of disease.

1870-1890

Due to this important shift in the way bacteria is understood, along with important discoveries related to sterilization, the number of hospitals and those seeking treatment begins to increase exponentially. In 1873, there are **only 149 hospitals** in the country. That number would eventually grow to 7,000 100 years later.

1891-1925

American children suffer a **mortality rate of 125 per 10,000** babies born. Just 34 years later, it's reduced to 15.8 per 10,000 babies born.

With the rise of hospitals being used as a place for treatment comes financial concerns—**how will they cover their expenses?**

1929

To address that question, Justin Kimball, the executive vice-president of Baylor University, creates **a type of hospital insurance, which eventually becomes the model for Blue Cross**. Over 1,000 school teachers from the Dallas area pay **$6** a year in premiums in exchange for up to 21 days of hospital care at Baylor University Hospital.

This scheme to increase cash flow for hospitals quickly spreads across the country. **There are a few problems with this model**:

1. **It does not protect from catastrophe.** This hospital plan simply pays costs up to a specified limit.
2. The plans do pay all medical expenses, but **only if those expenses incurred in the hospital.** This makes all treatment, regardless of what kind, more likely to be treated in the hospital, which is the most expensive place for treatment.
3. The insurance company does not offer indemnity coverage to participants, but instead just pays the bill for what is covered under the plan. Due to these issues, there is almost **no incentive for consumers to pay attention to the price** of services, because if they aren't footing the bill then it doesn't matter to them how much it costs.

This set-up works well for the hospitals as they can raise prices for their services because **there is no competition to keep prices in check**. Thus, they can maximize their cash flow.

1930s

Medical professionals lobby to retain the existing system. The American Hospital Association and the American Medical Association are able to help prevent Blue Cross from being regulated like other insurance companies. IRS rules that Blue Cross is a charitable organization and is thereby exempt from federal taxes. Blue Cross and Blue Shield hold half of the insurance policies in the US by the end of 1940.

From that point, hospitals are paid on a **cost-plus** basis, receiving not only the cost of services but also 10% for invested capital. They no longer have any real incentive to reduce their prices, because **instead of competing for patients, they are competing for doctor referrals**.

Hospital costs on a per-patient basis increase drastically.

POST WORLD WAR II

The US allows development of **employer-paid insurance plans, which further separate consumers from the decision-making process**. Employees no longer have to analyze different providers and decide on the most cost-effective plan, but rather must accept whatever plan their employer chose. Not only that, but because health insurance can be based on the data provided by each company regarding their employees, insurers can choose companies with healthier employees.

1965 & 1966

Medicaid and Medicare come on the scene. They are designed similarly to Blue Cross and Blue Shield, but with government paying for services. As more and more people can afford medical care, **medical professional incomes double** by the end of 1969. This shift **gives state governments a massive increase in power over hospitals**, as they hold the largest source of funds. Because of the government's involvement, political posturing and special interest lobbying prevent money from going to areas of greatest need, as politicians pick winners and losers.

LATE 1960s

Medical malpractice lawsuits become popular, further driving up costs as **patients and insurance companies foot the bill for malpractice insurance** for doctors.

2006

Medicare Part D (Prescription Drugs) passes in the Bush Administration **giving the drug lobby more influence**. Under the legislation passed, Medicare does not have the ability to negotiate drug prices with pharmaceutical companies resulting in continued increase of prices across the country.

2010

Affordable Care Act (Obamacare) is signed into law. Costs continue to grow as competition decreases, along with cost-effective health care choices for families. In addition to decreased choices and competition due to provider consolidation, **the ACA increases most Americans' deductibles and premiums**, and adds $274 billion dollars of projected spending between 2014 and 2022.

2011-2018

States Expand Medicaid under the ACA further contributing to the federal government's unsustainable spending direction and busting state budget projections. Data shows that expansion states spent 95 percent more in 2018 compared to 2010, on their own state funds on Medicaid. Arizona, for example, found that Medicaid expansion did benefit some politically connected hospitals, but ultimately had a negative effect on consumers, resulting in **higher premiums** and **benefits to urban hospitals at the expense of rural ones**.

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