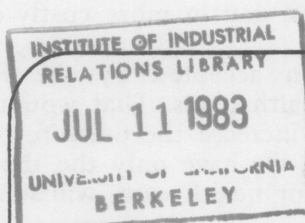


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## HEALTH CARE COSTS: BUYERS BEWARE

by Bruce Poyer

1. **Scope of Current Health Care Cost Inflation** – Since 1974, when the Nixon Administration's wage and price controls were lifted from the health care industry, costs of health care have risen two to three times faster than costs of other goods and services. In the late 1970s, the rate of health care cost increases slackened, but the inflationary pace has resumed again, as clearly indicated by the following data:

Selected Health Care Cost Increases  
1980-1982 (percentage rates)

|   | 1980  | 1981 | 1982 |
|---|-------|------|------|
| Consumer Price Index: All Items<br>(all urban consumers)  | 12.3% | 8.9% | 3.9% |
| CPI: Medical Care Component<br>(commodities and services) | 15.2  | 12.5 | 11.0 |
| Commodities: Prescription Drugs                           | 9.8   | 12.6 | 12.0 |
| Services: Physicians                                      | 11.0  | 11.7 | 7.5  |
| Services: Dental  | 10.7  | 10.2 | 5.9  |
| Services: Hospital Rooms                                  | 13.9  | 17.0 | 13.3 |
| Medicare Costs: U.S. total (1)                            | 21.4  | 15.0 | 16.0 |
| MediCal Costs: California (2)                             | 18.0  | 18.0 | 18.0 |

(1) Source: *New York Times* and *Social Security Bulletin*; 1982 is estimated based on preliminary data.

(2) Source: California Senate Office of Research; figures are average percentage increases for 1976-1982.

Costs associated with hospitals account for more than 40% of all health care spending, and continue to show the highest annual rates of increase. California now has the most expensive hospital room rates in the nation, and San Francisco has the highest rates among all large cities in the U.S. (\$319.50 average per day for a semi-private room in 1982).

Some analysts believe that health care costs are simply out of control, and they can cite impressive evidence. While the 1982 CPI for all items increased only 3.9%, the medical care component of the CPI increased by 11.0%. Worse still, the cost of health insurance in 1982 shot up by 15.9%. And on January 1 of this year, Blue Cross rates increased in California by an average of 45%. Blue Cross contends that it still will not "break even" on most of its coverage.

In the government programs, MediCal has been one of the nation's worst examples of inflation. Its costs escalated 18% each year between 1976 and the end of 1982. In 1976, a fairly liberal California program cost \$2 billion; in 1983, a reduced program with some inhumane cuts in benefits and services (especially for medically indigent adults) will cost over \$5 billion.

2. **Reasons for Exorbitant Cost Increases** – When rates of inflation of other goods and services are declining, what accounts for health care cost increases of such magnitude? There are many reasons, and they are complex. Among them is a great deal of expensive new technology in medical care. We demand the latest and the best (for ourselves) in health care skills, equipment, and facilities--and it is all very costly. But some now believe that we are being over-treated, over-hospitalized, and over-medicated--or at least those who can pay the bills are alleged to confront these problems. (It is still acknowledged, however, that many others do not have equal access to basic health care, let alone to the more expensive kinds of high-tech treatment.)

The most popular current theory about health care inflation is that others pay too much of the consumer's bill--especially the government, the insurance companies, and the health service organizations. The chief inflation culprit is the first dollar coverage that still exists in some health plans. If the

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consumer were required to pay more out-of-pocket for health care, the theory goes, he/she would exercise more cost control. Lack of any convincing evidence to support this theory has not kept it from inspiring employers to seek to shift the increasing cost of health plan coverage to employees (not only in co-payment of premiums, but also in new coverage and benefit limitations, and in more costly deductible and co-insurance requirements).

The same theory about the cause of health care inflation has been accepted by the Reagan Administration, which proposes to tax employer contributions to prepaid health plans. That would make prepaid coverage more expensive to the employer, and would immediately increase the pressure to pass more of the cost of health care directly to the employee. But at this point, we have only the theory to rely on: we are told to have faith that the employee who must pay more for health care, will somehow find a way to pay less.

The theory simply assumes that the market for health care is both free and competitive. But the most expensive kinds of health care (which usually begin with hospitalization) are not rendered in a competitive situation. It is the providers, and primarily the doctors, who decide not only what the "customer" will need, but also how much it will cost. Just to use a simple example, how many hernia patients are likely to go shopping among doctors and hospitals in order to find the best "price" for the operation? How many would even have an option to go shopping if they are already enrolled in a prepaid program?

Medicare, Medicaid and other government programs have given no cost control leadership to the health care industry, because their reimbursement structures have been controlled directly by the provider groups, or indirectly by their "fiscal intermediaries" (i.e., the insurance industry and the health service organizations). It can even be argued that uncontrolled inflation in the major government programs in California has added to the inflation of health care costs in the state's employer-employee plans.

**3. The Impact of Health Care Inflation** - Most of the government health care programs are now cutting benefits and services to meet requirements dictated not by health considerations, but by budgetary constraints. The nation's hospital associations make a convincing argument that some of these cuts will be restored by the hospitals, and paid for with higher charges to the private sector health plans. Such cost shifting may be a factor in the 15.9% increase in health insurance costs in 1982, vs. the 11% increase in total health care costs. However, basic cuts in the government programs always impose greater financial and health burdens on those least able to bear them. The shifting of some costs may alleviate but will not solve the health care problems of the poor, the aged, or the unemployed.

In California, it is estimated that Medicare now purchases about \$5 billion in health care services annually. MediCal will pay a little more than that for health care this year. The bill for prepaid health plan coverage for California's 2.2 million union members and their dependents is even greater: it amounts to \$6-7 billion annually. (The median contribution from payroll, per union employee per month in California in 1981, was \$175. This is the level at which the taxation of payroll contributions would begin, as proposed by the Reagan Administration; thus the health plan premiums of half of California's unionized workers would be taxed.)

The cost of prepaid health plan coverage for California's union employees is a negotiable issue in collective bargaining. But the \$6-7 billion annual bill for prepaid coverage represents less than half of the total health care costs of union members and their families. They are required to pay the rest out-of-pocket, or to get help from a government program, or to do without needed health care. As cost pressures increase in collective bargaining, all three alternatives confront more and more workers.

The recession has already forced these difficult alternatives on the unemployed. The Congressional Budget Office estimates that a total of nearly 11 million employees and their dependents lost workplace group coverage because of involuntary unemployment. The cost of comparable coverage in an individual health insurance policy (if one is available) is usually prohibitive for an unemployed worker.

What is coming at the federal level and what is being done in California to cope with the inflation of health care costs? And how can California's major purchasers of group health plans—especially the employer-employee plans—protect themselves against continual erosion of benefit levels? These questions will be considered in the next issue of LCR.

- Bruce Poyer

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