Economist probes the high cost of health care

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Zachary Cooper

When Zack Cooper arrived at Yale as assistant professor of public health and economics, he gained access to a first-of-its-kind dataset. Working with the non-profit Health Care Cost Institute, Cooper and colleagues at Carnegie Mellon University and the London School of Economics gathered insurance claims data from three of the nation's largest private health insurers. Buried deep within the large dataset are answers to long-standing questions about health care in the United States: Why is it so expensive? Why do prices vary so widely across the country? And what,

if anything, can stop costs from rising further? While answers to these questions are still being analyzed, YaleNews spoke to Cooper about his work and its potential impact on the health-care market. An edited transcript of that conversation follows.

Why did you embark upon this research project?

Health care is an enormous sector of the U.S. economy. It accounts for 18% of GDP and $2.9 trillion in spending. One of the biggest challenges is that most of what we know about healthcare spending comes from the Medicare system because that's where the data is available. But the rub is that Medicare only covers 16% of the population. Fifty percent of the population gets their health care covered by private insurers and, unfortunately, we just don't know much about health-care spending on the privately insured.

Historically, the data on the privately insured has been unavailable and this gap left a lot of questions unanswered—questions like whether or not regions where Medicare is expensive are also expensive for the privately insured. And how prices charged by hospitals vary within geographic areas and across geographic areas.

The database we now have includes nearly all of the claims data for individuals who received employer-sponsored health-care coverage through the three insurers—Aetna, UnitedHealth, and Humana—from 2007 to 2011. It is one of the largest databases assembled on privately insured individuals in the United States. The data includes more than 88 million unique individuals, or one-third of privately insured Americans, and captures 1% of GDP per year. It's the start of a large project that we're calling The Healthcare Pricing Project, which is designed to give the most rigorous analysis to date of how private healthcare spending varies across the United States.

Just how expensive is health care in the United States in 2015?

One in every six dollars spent in the U.S. economy is spent on health care. Over the last 40 years, health-care spending has grown 2-3% faster than the rest of economy. It's one of the largest single sectors of the economy. Simply put, health care is really at the root of some of the biggest problems the United States is facing: long-term debt, the competitiveness of our business environment, working to guarantee health to our citizens.

You recently were quoted as saying, "Health care spending is really the issue that will determine whether or not the United States is going to be financially secure over the next 50 years." What's the prognosis?

There's a great quote from Peter Fisher, who was treasury undersecretary for President George W. Bus. He said: "Think of the federal government as a gigantic insurance company with a side-line business in national defense and homeland security …" That quote does a pretty good job of capturing where our federal dollars go. And what we've seen year after year, until very recently, is that health-care spending has grown faster than the rest of the economy.

The challenge is, if that continues over time, it crowds out our ability to spend in other areas that we think are crucial to the competitiveness of the U.S. economy—like education, like infrastructure. The same applies to businesses. As health care occupies a larger share of, say, the cost of producing a Ford truck, we either have to become more efficient or produce lower-quality trucks. That's the challenge that we're all facing.

How has the Affordable Care Act affected the cost of health care?

The ACA does a really good job of getting insurance coverage to individuals who didn't have it previously and trying to guarantee universal access. It hasn't done a fantastic job of digging into the spending side and getting at the root causes of problems in American health care. I think that is the case for two reasons: The first is just the political complexity—we need to work in a political system where it's easier to say "no" to things than to say "yes" to things. Cutting spending means saying "no," and that's tough for politicians to do.

Second, the federal government only controls Medicare spending. But a lot of spending occurs outside of Medicare. What we're asking is: What happens to all the folks who get their insurance outside of Medicare, through their employers?

How does data on insurance claims of the privately insured provide insight into the cost of health care?

First, it's vital that we have an accurate picture of health spending for the privately insured. For that population, we just don't know what areas of the country are expensive, why they're expensive, and what providers are being paid for care. We're going to take a very rigorous look at spending variation for the privately insured and the variation in prices that hospitals charge.

Once we figure out why health care in certain regions is more expensive than in others, we can start getting into solutions, examining questions like whether better care is more expensive. If it turns out the answer is "no," then that provides a pretty good window into how we can begin to make things better.

We'll be able to see whether the most expensive health-care providers in the country are providing better care, and whether or not hospitals provide better care at lower prices in areas where they're forced to compete.

Will your analysis of the data help you pinpoint the number-one driver of spending or is it more complex than that?

It will start giving us clues about where we should focus our efforts. A few years ago, The Washington Post ran a story about the release of this data, and the title was "What could revolutionize health care? This database." That may be overstating it, but I believe the first step in addressing a big problem is accurately describing that problem. So far, we haven't been able to do that. We know from Medicare that regions that spend a lot are regions that do a lot. So the Miami's of the world, the L.A.'s of the world, and the McAllen, Texas's of the world, these are places that offer a lot of treatment. The question is whether or not that finding also generalizes to folks who get their health care through their employers.

Once we can do a better job identifying the problem, we'll be in a better place to come up with solutions.

By "a lot of treatment," do you mean more advanced treatment?

In all shapes and forms. When a patient comes to the hospital in these expensive regions, more care gets provided. In the last six months of life, more is spent on treatment. When a patient has a heart attack, more care is offered. I think what we're beginning to see is, when it comes to the privately insured, prices play a critical role in driving health-care

spending and determining which regions are more expensive.

And this makes a lot of sense. If you think about Medicare, Medicare basically sets the prices for everything. A hip replacement is $5,000, and the cost does not vary too much between providers. But for the privately insured, the prices that hospitals charge are a function of negotiations, so those prices are much more variable. And the question is: In regions that are expensive for the privately insured, is it because health-care workers are providing more care or because their prices are high? And that's the kind of detail we'll be able to dig into in this project.

We will not only be able to ask is it price or quantity that makes these regions expensive, but also why are the prices high in this area and why do they vary? Is it a story about competition? One of the most important trends that we've seen in health care in the last 20 years is an incredible rise in consolidation—i.e., hospitals buying other hospitals. That gives them tremendous bargaining power. Has that led to certain regions becoming much more expensive than others?

How can your research having an impact on this issue?

In three ways. The first is identifying where the problems are and giving policymakers a sense of where to focus. The onus is on us as researchers to communicate our findings and communicate them to policymakers and to industry leaders, and to the public so they know what's going on.

The second step is working with policymakers and industry leaders to explain the implications our findings and to figure out how to make the system work more efficiently.

And third—in the big picture—it's using our findings for future

research. This information will give my team and other research teams the opportunity to think about how to figure out and test solutions. So we'll describe what areas of the country are expensive and what areas have lower prices. Then it will be up to us and other research teams to figure out why that happens and think about ways to fix it.

What's next for you? Where will you focus your efforts now that the first phase of your research is coming to a close?

The first phase of this project is about answering the "what"—what does spending look like for the privately insured? The next step is going to be the "why"—why does spending vary like this? The third phase is going to be working with stakeholders in government and industry to figure out the solutions. We're starting to have some terrific conversations with private insurers about ways that they can begin to introduce strategies to make health care work more effectively. I think these collaborations are hugely important. I want to work with the insurers to make health care in the United States vastly more efficient. We should be able to provide world-class health care without bankrupting families and dragging down the economy. We'll get there.

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