

**Controlling Health Care
Spending: Likely *Impact on
Structure of Delivery System***

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**U.S. Health Care Spending Has
Been Growing Rapidly Since
1970---**

But Has Slowed Recently

Average Annual Percent Change in National Health Expenditures, 1960-2011



Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2010; file nhe2010.zip).

Past Efforts To Control Spending

---Regulation in 1970's

---Managed Care in 1990's

**Strong Negative
Reactions To Both**

**Current Improvements Likely To
Be More Positively Received**

Slow Down May Be Permanent

- **David Cutler (Harvard) Believes Many Small Positive Changes In Market**
 - Providers Becoming More Efficient
 - *Less Hospital Acquired Infections*
 - *Reduced Re-Hospitalization*
 - *More Patient Cost Sharing*
 - *Greater Use of Limited and Tiered Insurance Networks*
- **States Becoming More Active In Slowing Total Spending**

**But---Most Policy Analysts Still
Very Skeptical !!!**

*What Happens When General
Inflation In Economy Heats Up?*

Why Are Health Care Costs Rising?

Do We Use Too Much Health Care Services?

*How Do We Compare With
Other Industrialized Countries?*

Hospital Care!!!

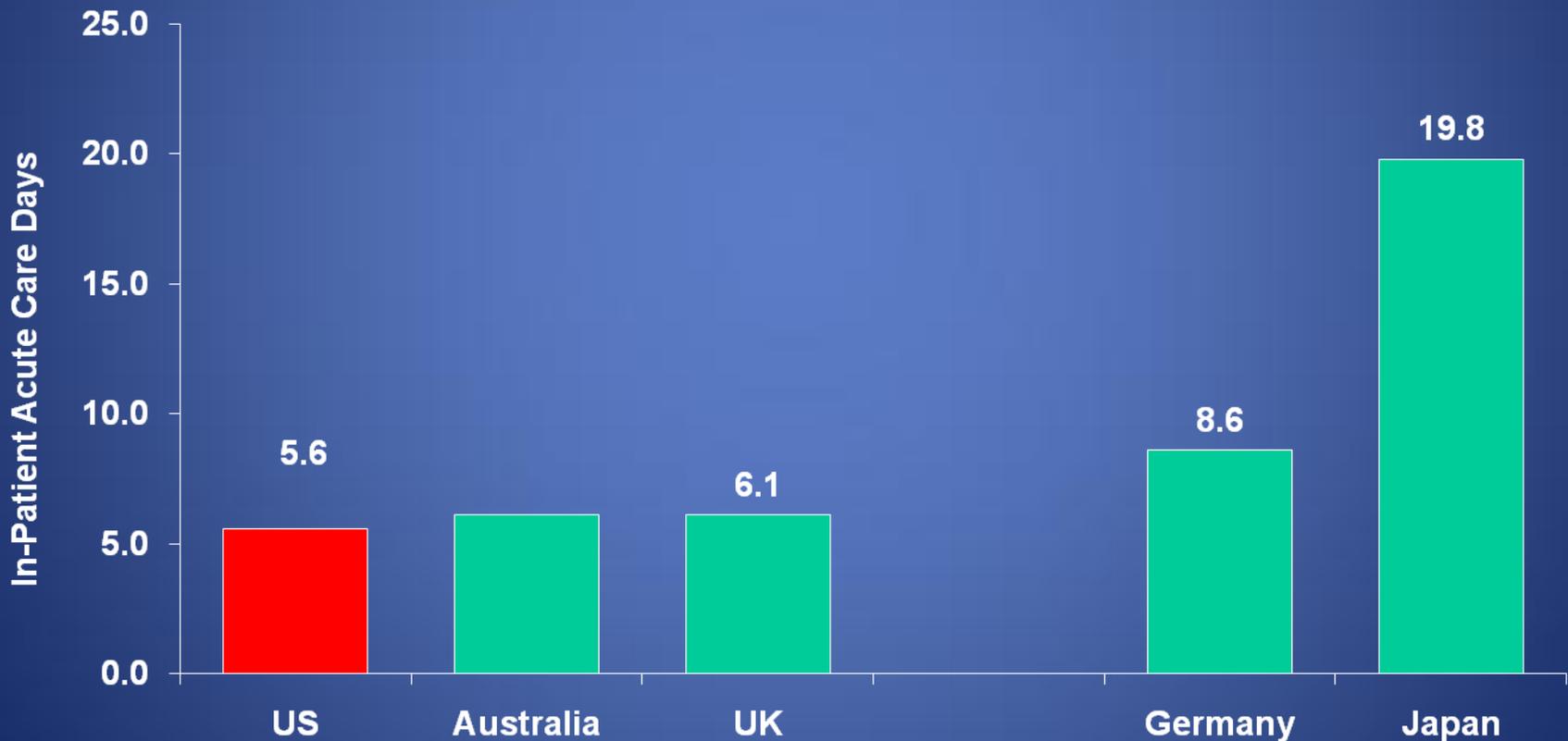
Hospital Discharge Rate in Selected Countries 2005



Source: OECD HEALTH DATA 2007

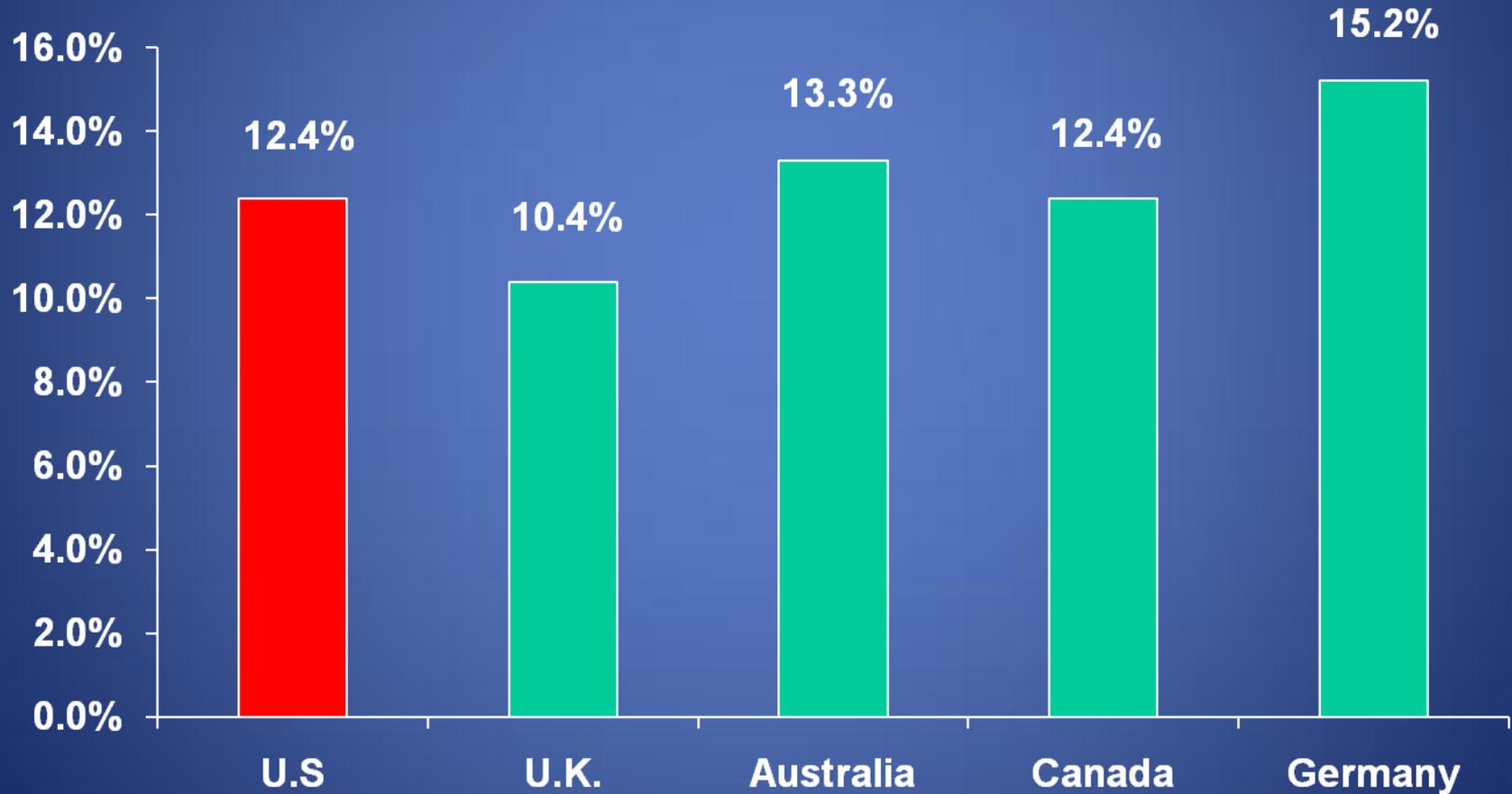
Average Length of Stay in Hospital in Selected Countries 2005

In-patient Acute Care Days



Drugs?

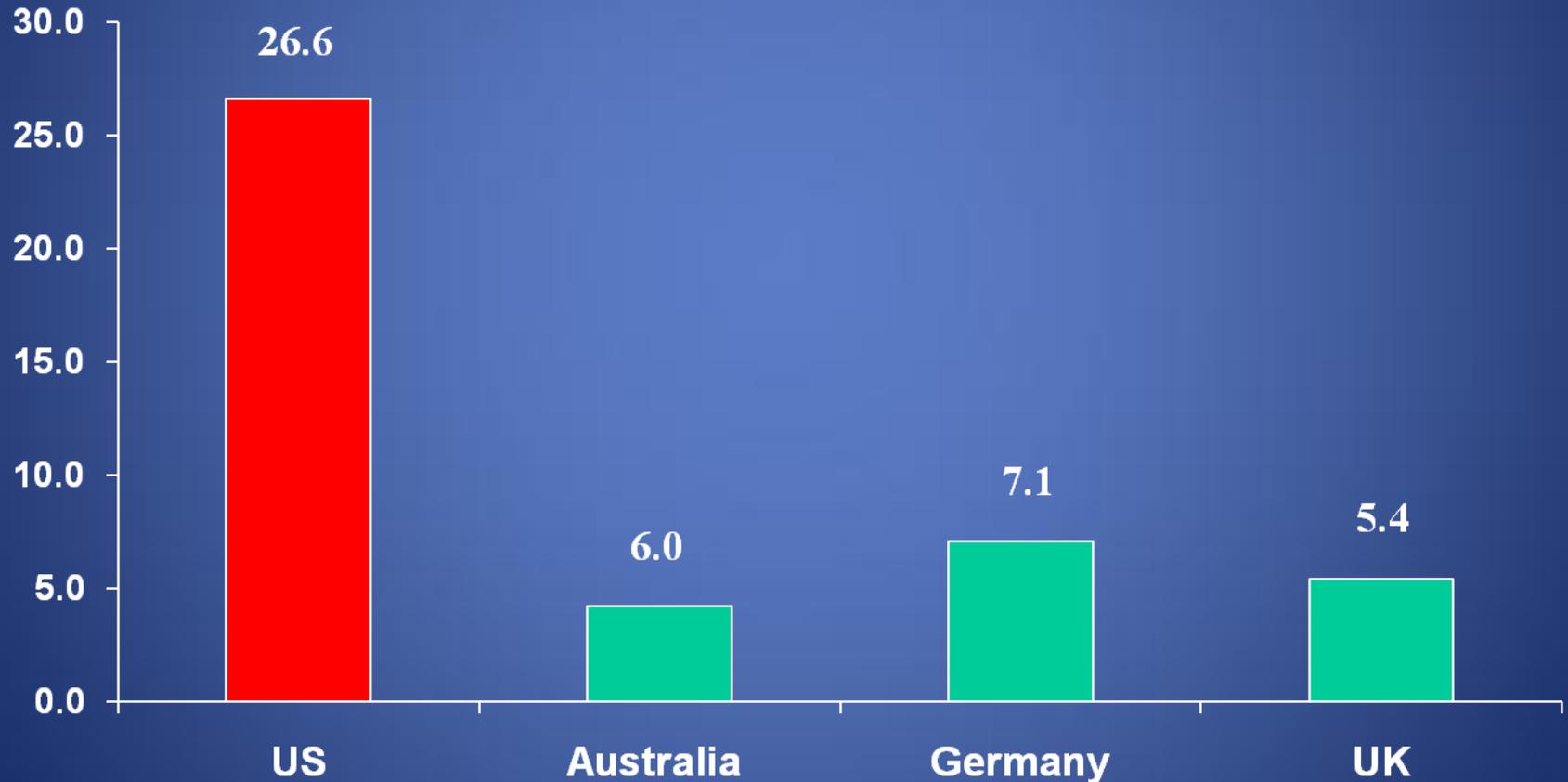
Percent of Total Healthcare Expenditures on Pharmaceuticals



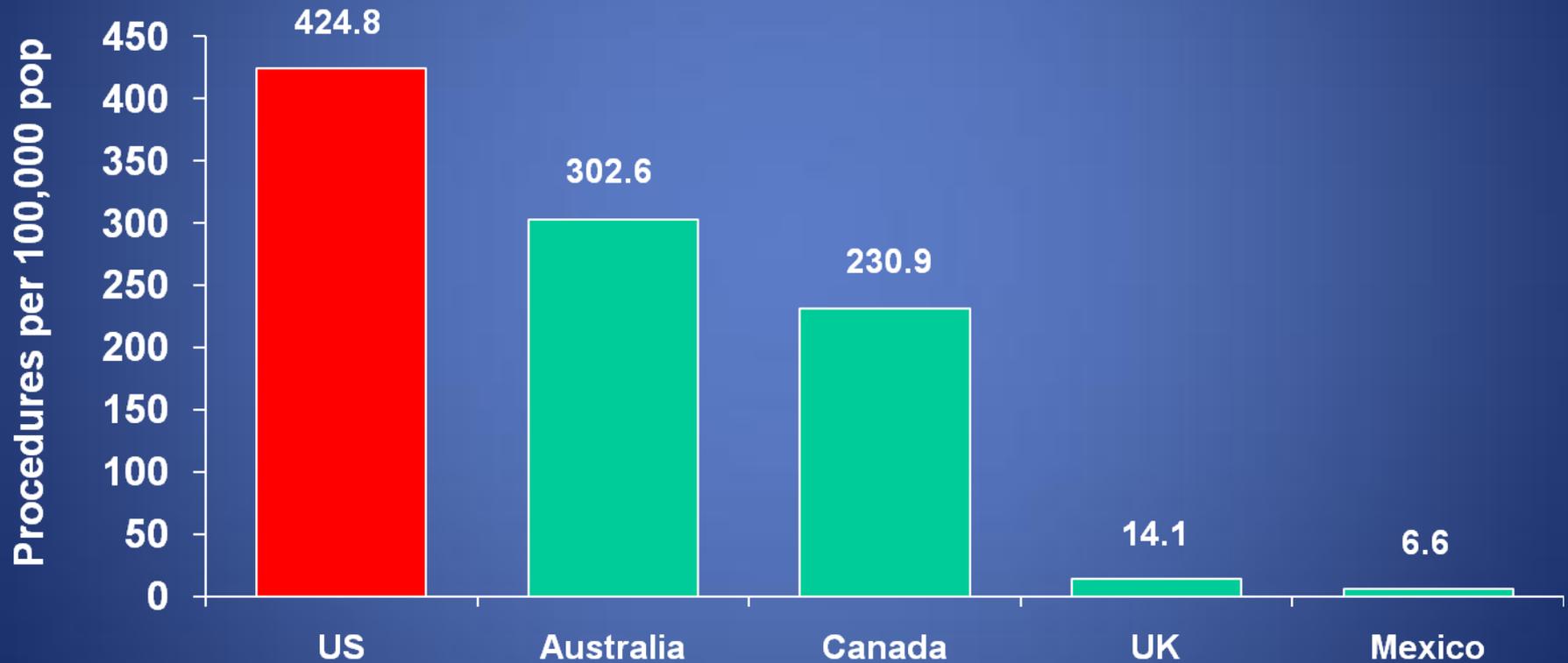
***Ok---Lets Move To Expensive
Procedures***

MRI in Selected Countries 2005

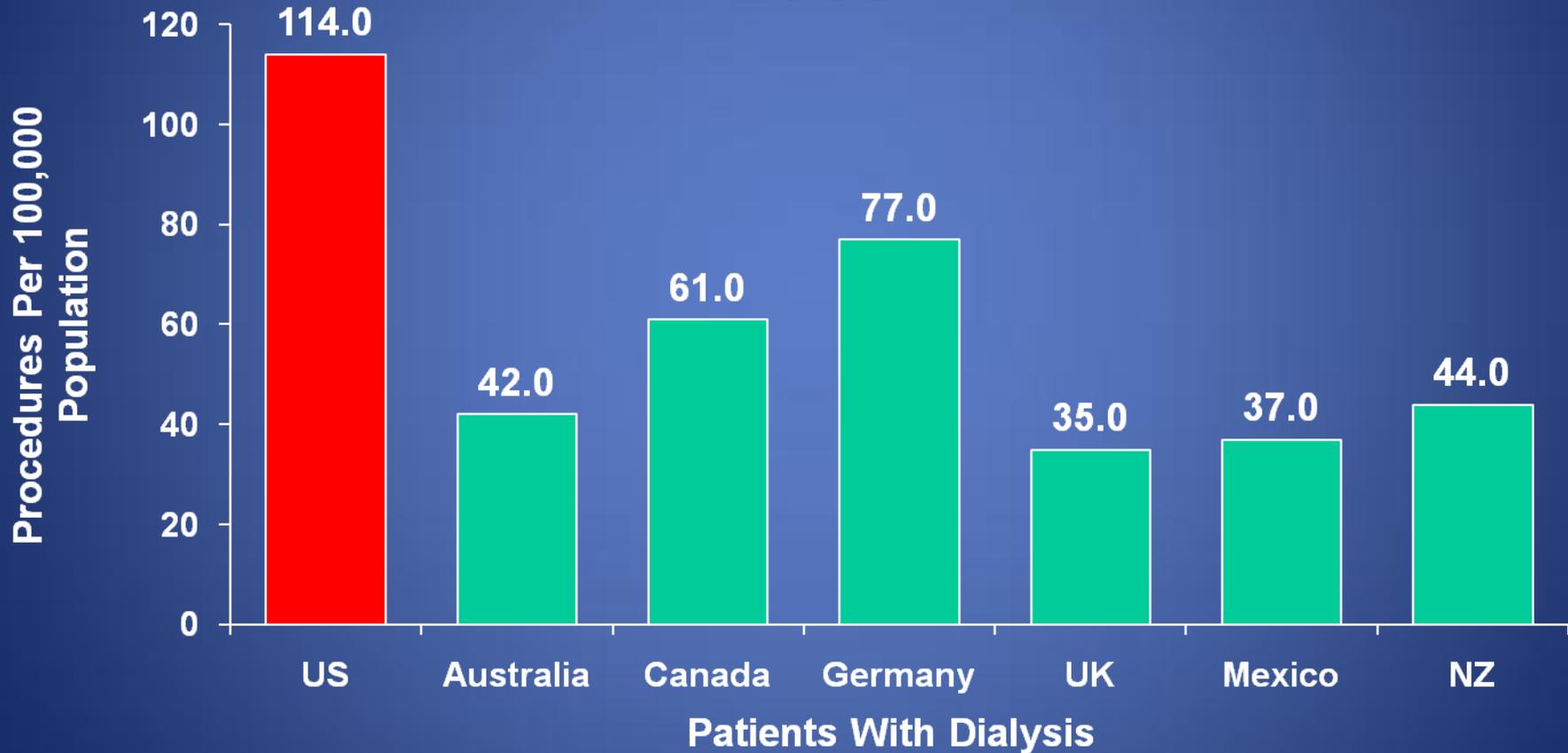
(Units per million persons)



Cardiac Catheterization Procedures in Selected Countries 2003

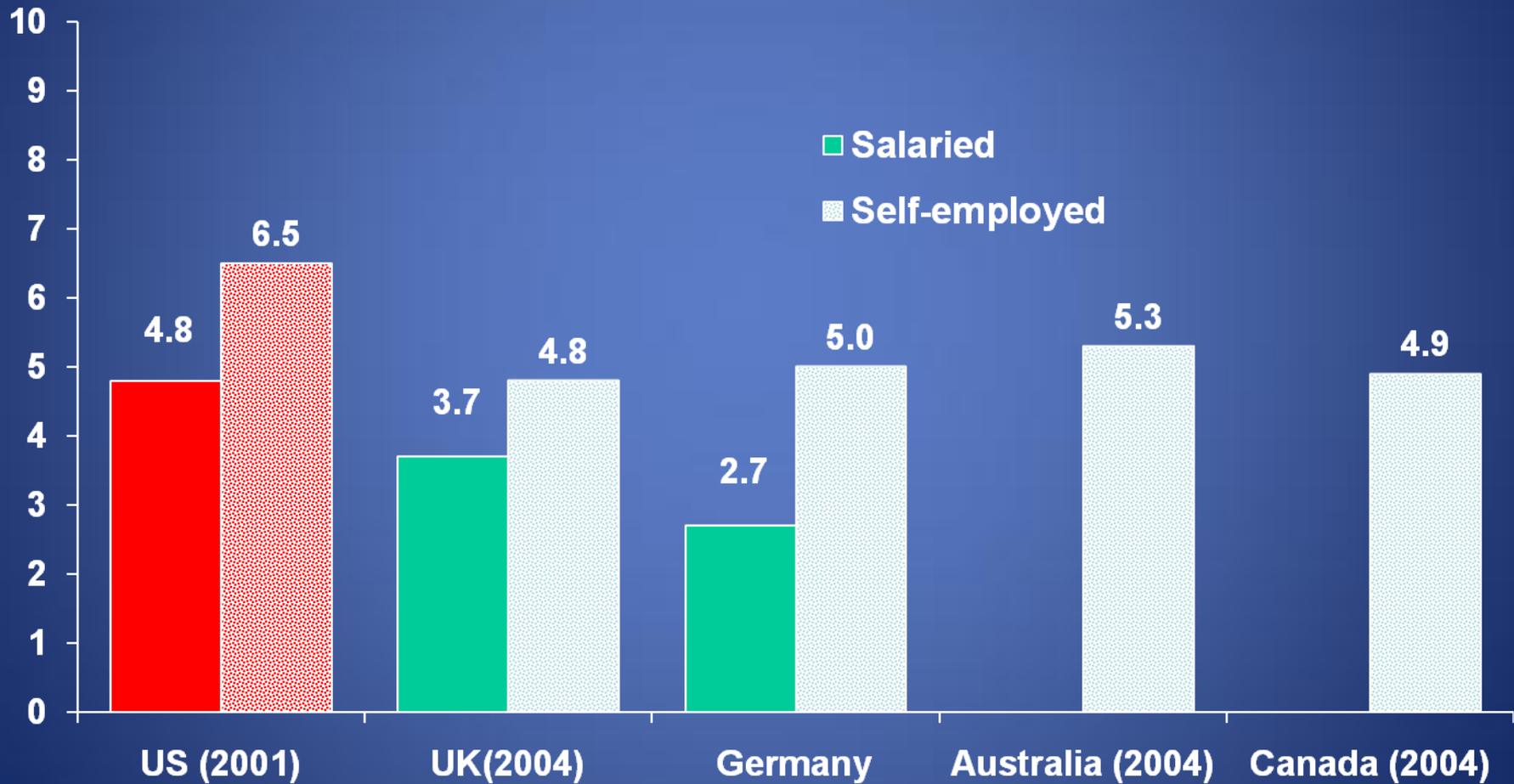


Patients Using Renal Dialysis Treatment in Selected Countries 2005



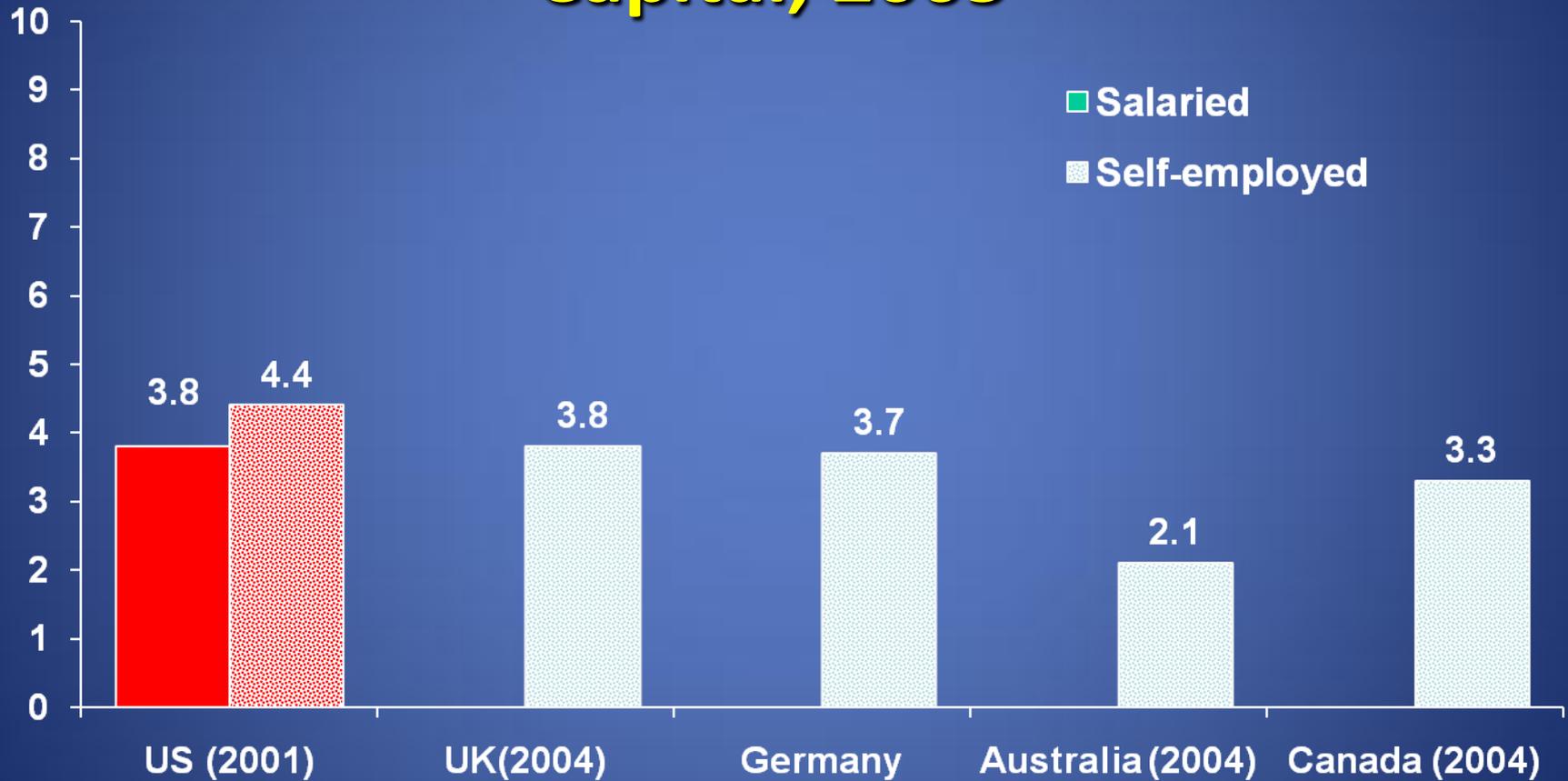
What About Physician Income?

Specialist Physicians' Remunerations, Ratio To GDP Per Capita, 2005



Source: OECD HEALTH DATA 2007

General Practitioners' (GPs) Remunerations, Ratio To GDP Per Capital, 2005

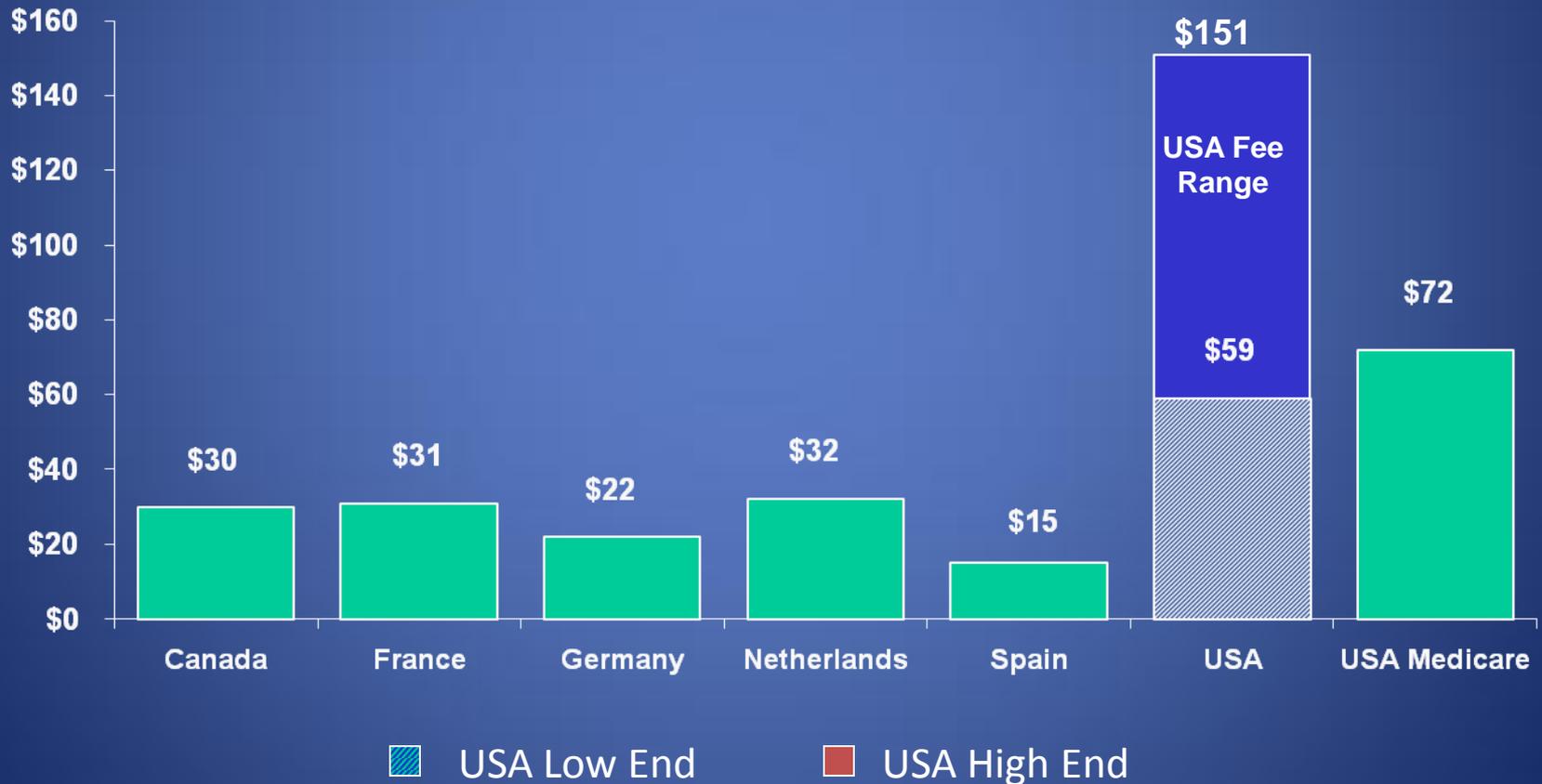


Now Lets Turn To Prices

How Do Prices for Medical Services In
The US Compare To Western
European Medical Prices

Physician Fees

Routine Office Visits (US\$)



Scans and Imaging

CT Scan: Head (US\$)



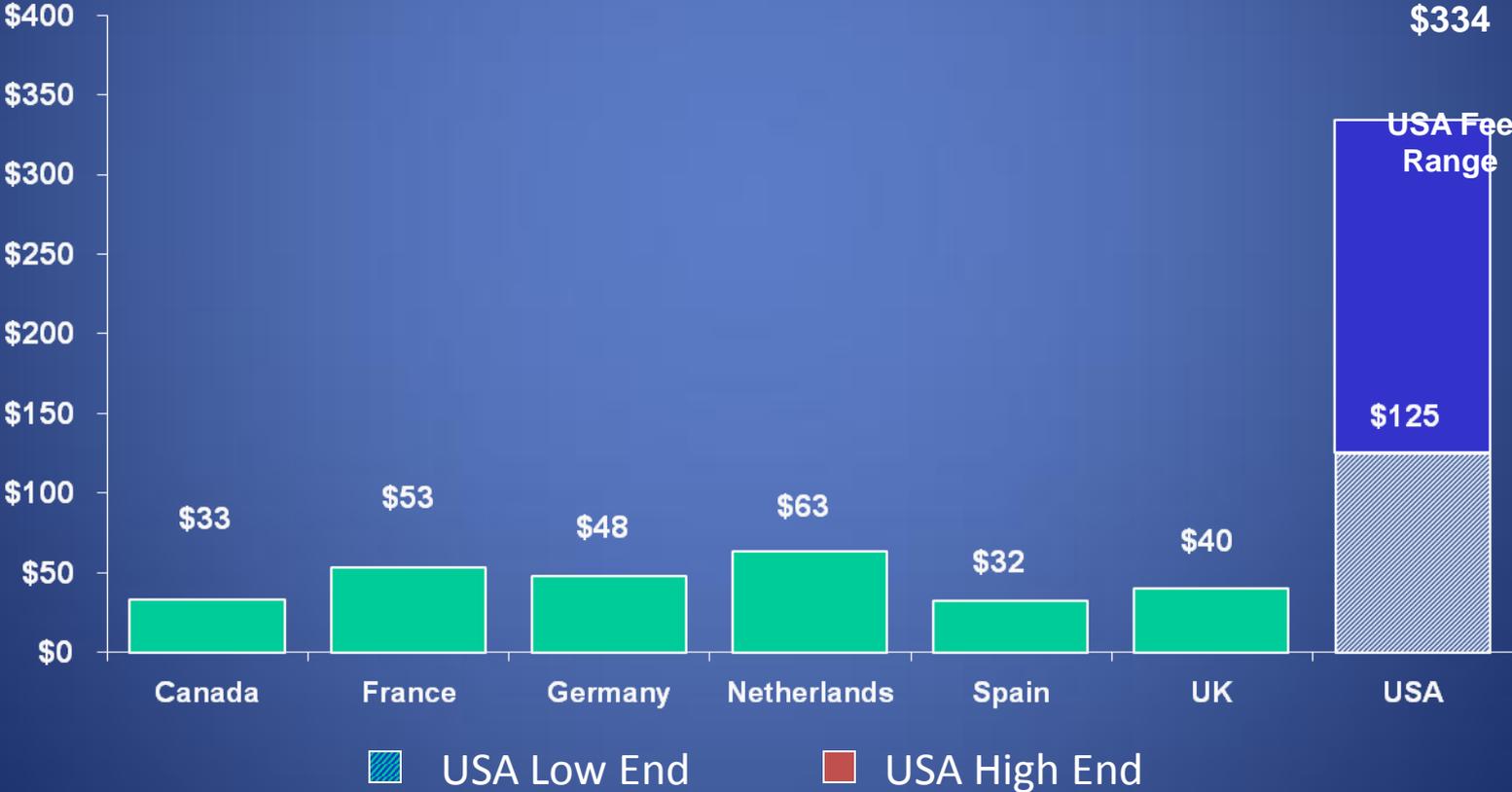
Hospital Charges

Average Cost Per Hospital Day (US\$)



Drug Prices

Lipitor (US\$)



Comparison of Healthcare Prices in the U.S. and European

Fee Type	Procedure	Canada	France	Germany	Netherlands	Spain	UK	USA Average/ Low-end	USA High-End	USA Medicare
Scans and Imaging	CT Scan Abdomen	\$83/530	\$248	\$319	\$258	\$161	\$179	\$750*	\$1,600	\$400
Physician Fees	Routine Office Visit	\$30	\$31	\$22	\$32	\$15	Primary care capitation Specialty salaries No Fees	\$59	\$151	\$72
	Normal Delivery	\$498	\$1,023	TBD	\$622	\$1,041		\$2,384	\$4,847	\$1,601**
Hospital Charges	Ave Cost Per Hospital Stay	\$9,043	\$9,840	TBD	\$3,535	\$2,261	\$3,388	\$12,549*	\$40,680	\$12,000
Total Hospital and Physician Costs	Bypass Surgery	\$14,111	\$11,916	TBD	TBD	\$15,761	\$12,868	\$56,472*	\$116,798	\$22,092**
	Hip Replacement	\$8,483	\$8,200	\$8,500	\$7,600	\$9,152	\$8,347	\$32,093*	\$67,983	\$17,500
Tests and Cultures	Pap Smear	\$27	\$14	\$26	\$16	\$20	See note above	\$24	\$64	\$17
Drug Prices	Lipitor	\$33	\$53	\$48	\$63	\$32	\$40	\$125	\$334	No Medicare Rx fees
	Nexium	\$65	\$67	\$37	\$102	\$36	\$41	\$154	\$424	

Non-US fees shown above came from both government sources and data files of IFHP member plans. For countries with multiple health plans or multiple regions with different payment systems, the fees reflect a representative sample of estimated average prices.

Canadian scans include the government “reading” fees and the charges used by private scanning facilities for patients who pay their own expenses. There are no government fees associated with MRIs because this equipment is typically purchased by local health authorities and is included with fees for facility-level use.

*Represents USA average fees rather than USA low-end fees.

** Representative Medicare fees from Portland, Oregon market or CMS Medicare average for tests and cultures; all other Medicare fees are averages provided by a global consulting and actuarial firm.

**Even Though It's *PRICE* Increases
That Dominate Spending
Growth**

***Slowing Growth In Spending Needs
to Focus on Delivery System Changes***

ACO's and Bundled Payments Offer Some Real Opportunities ---

- They Encourage **Integration of Care**
 - Where Possible Substitute Less Expensive for More Expensive Care
 - Reduce the Use of Marginal and Ineffective Care
 - Limit the Stockpiling of Substitutable types of Services
- They Facilitate the Working Together of Hospitals, Physicians , Post Acute Care and Other Health Professionals
- They Lower the Cost of Expensive Treatments
- Bundled Payments Can Be an Interim Step To a Global Payment System

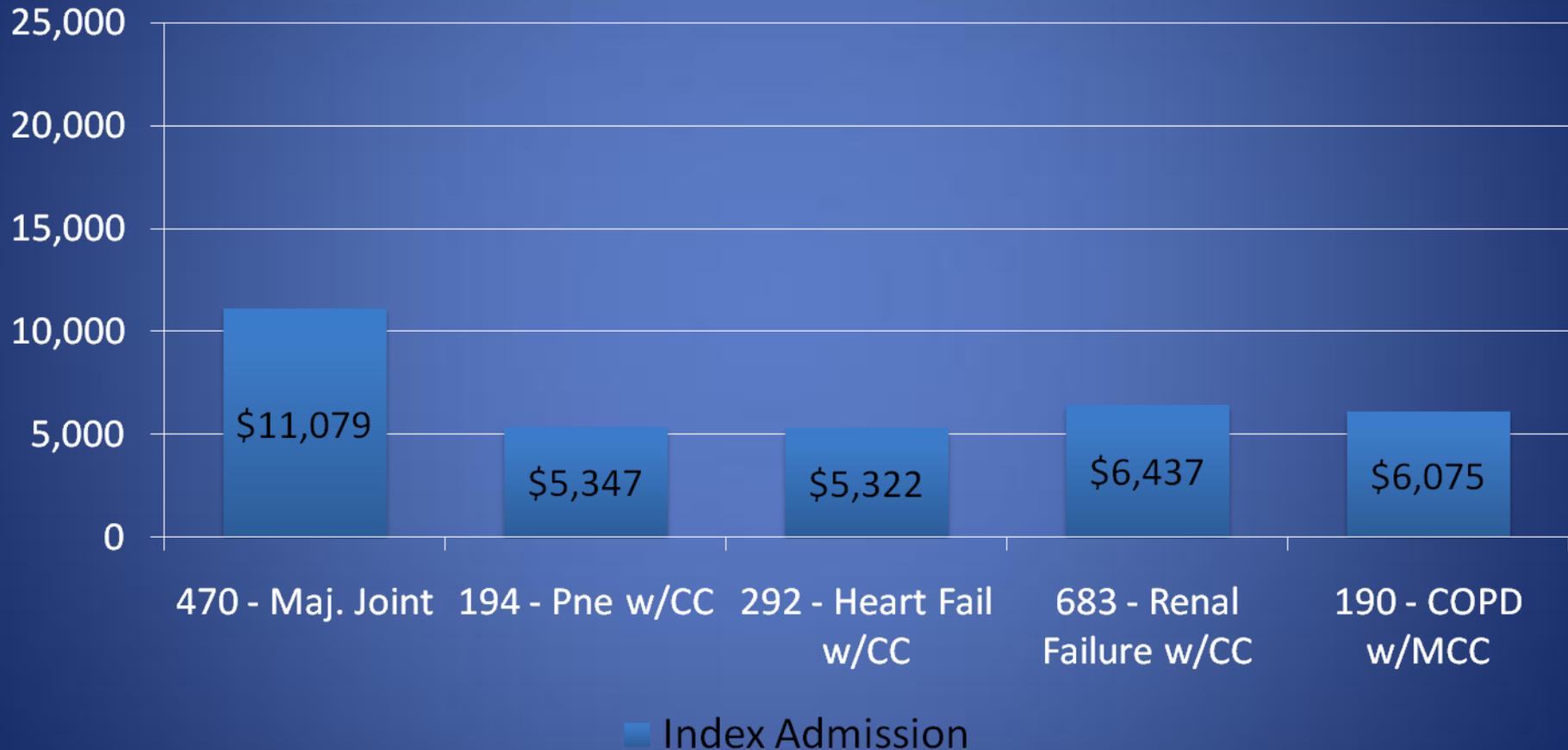
The Key To Making Accountable Care Organizations Work

*Better Use of Primary Care and The
Critical Need to Improve “Care
Coodination”*

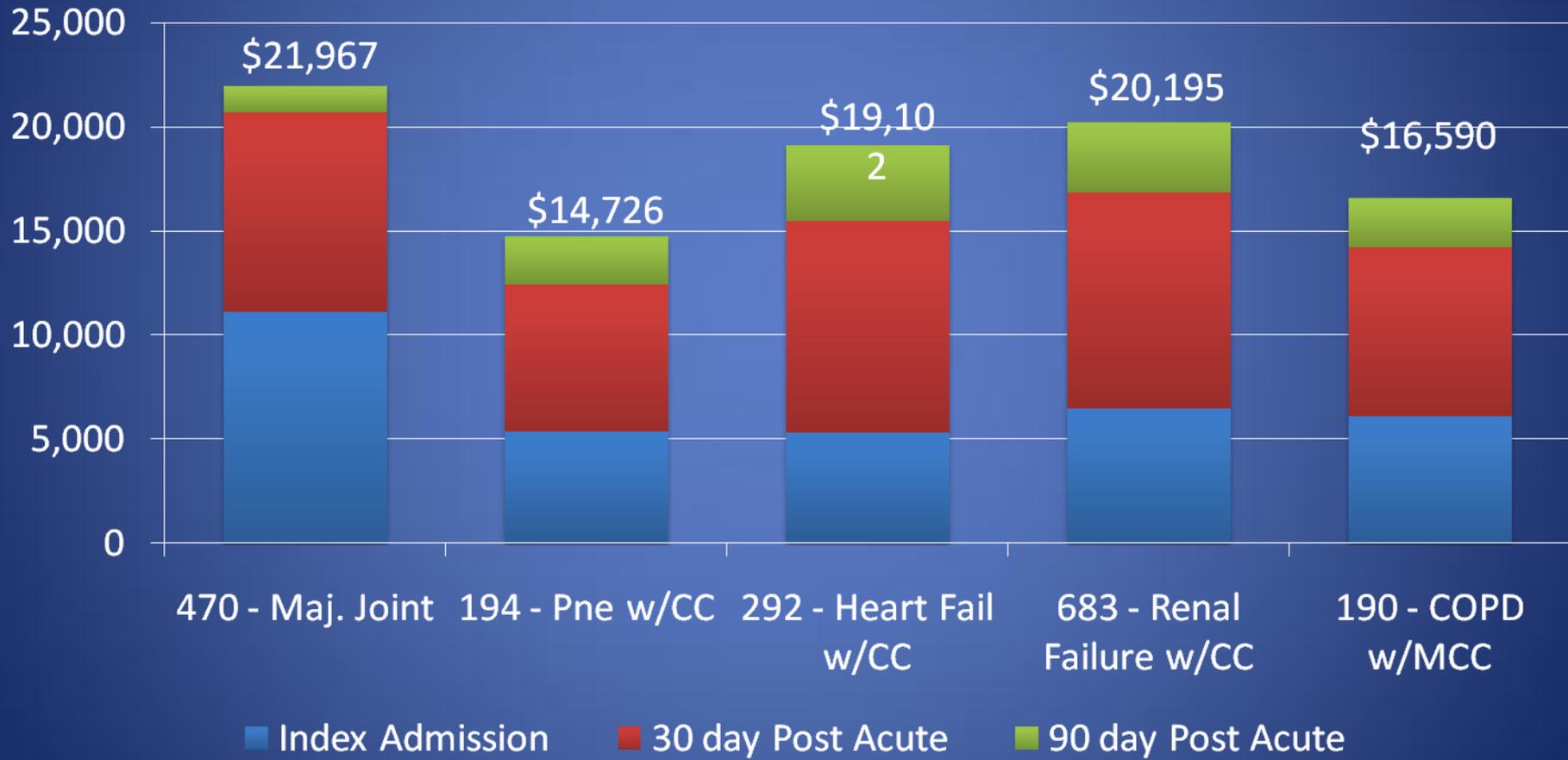
The Key To Making Bundled Payment Work

*Control Post-Acute Care
Spending!!!*

Avg. 2008 Medicare Payment for In-Hospital Care for Select DRGs



2008 Medicare Acute and Post-Acute Payments for Inpatient-Initiated 90-Day Episodes



Both Approaches Require Payment System To Change

*Need To Eliminate Fee-for-Service and
Provide Payment for Non-Covered
Providers (Care Coordinators)*

**Medicare Experimenting With
“Shared Savings” Global
Payment System---**

*And---Expanded “Bundled
Payment System*

Results To Date---Slightly Encouraging, But----

*Substantial Investments Must Be
Made By Provider Systems and 2%
Hurdle Can Be a Problem*

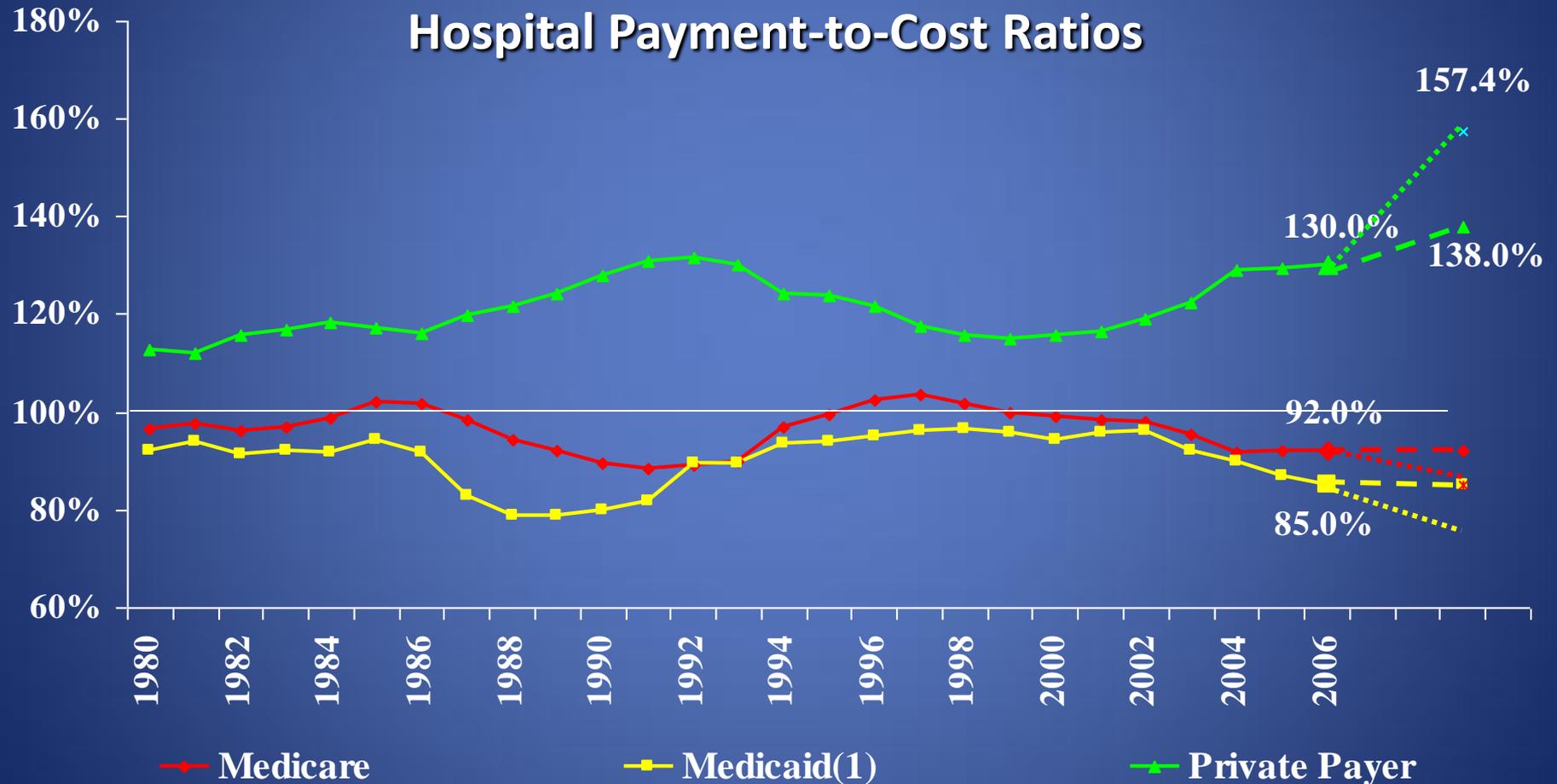
The Importance of State Activities

**States Being Pushed to Be
Concerned About *TOTAL* (Not
Just Medicaid) Health Care
Spending---**

*Why--- Problem of Rising
Private Insurance Premiums*

The Cost-Shift Issue---

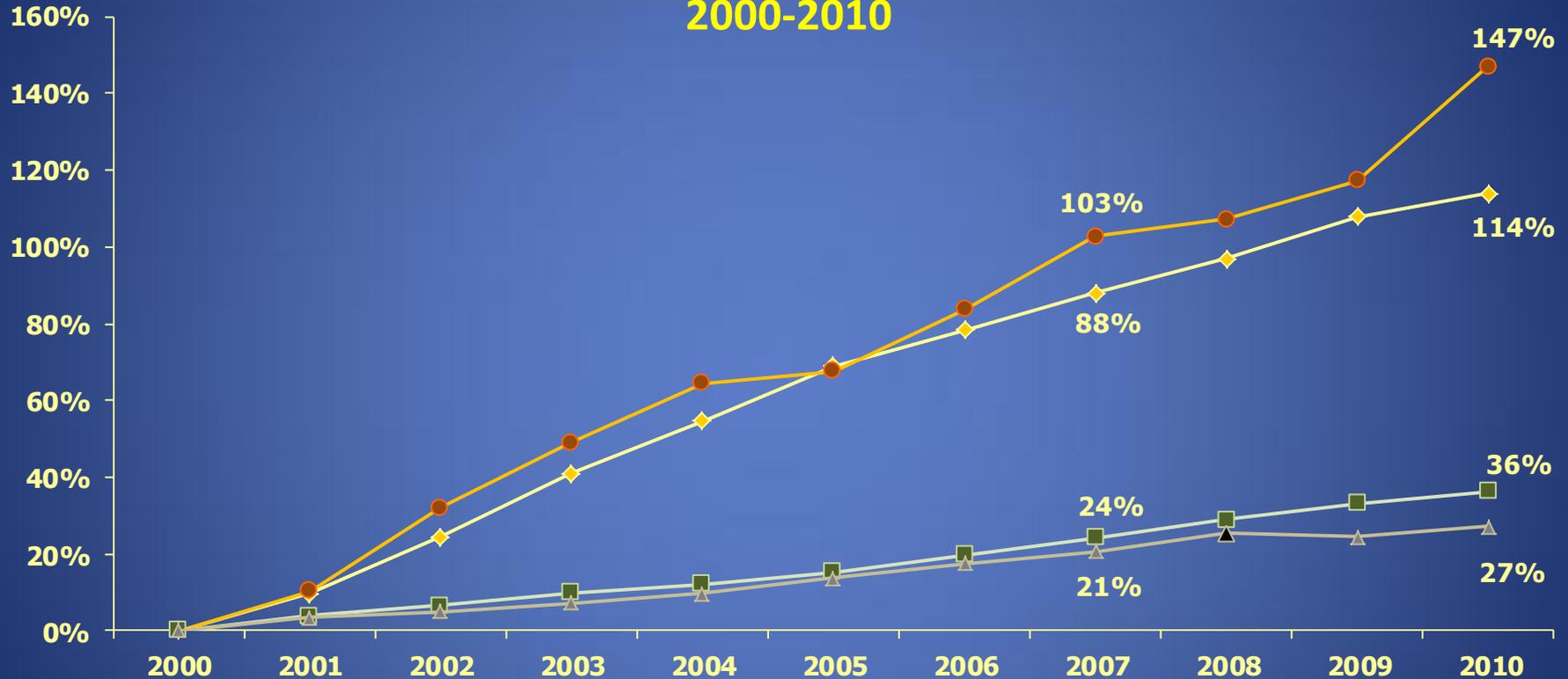
Private Insurance Payments Used To Pay For Lower Government Payments



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2005, for community hospitals.
 (1) Includes Medicaid Disproportionate Share payments.

High Premiums Limiting Worker Compensation and Employment!

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 2000-2010



Notes: Health insurance premiums and worker contributions are for family premiums based on a family of four.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2011. Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2011 (April to April).



States Need To Be An Active Participant In Promoting New Delivery System Options

Limit Regulatory Hurdles and Provide Financial Assistance to Financially Stressed Systems (Because of Unfavorable Payer Mix)

The Massachusetts Story

Massachusetts First State To Pass Universal Coverage Legislation

*Commonwealth Has Long History of
Expanding Coverage and Regulating
Health Spending*

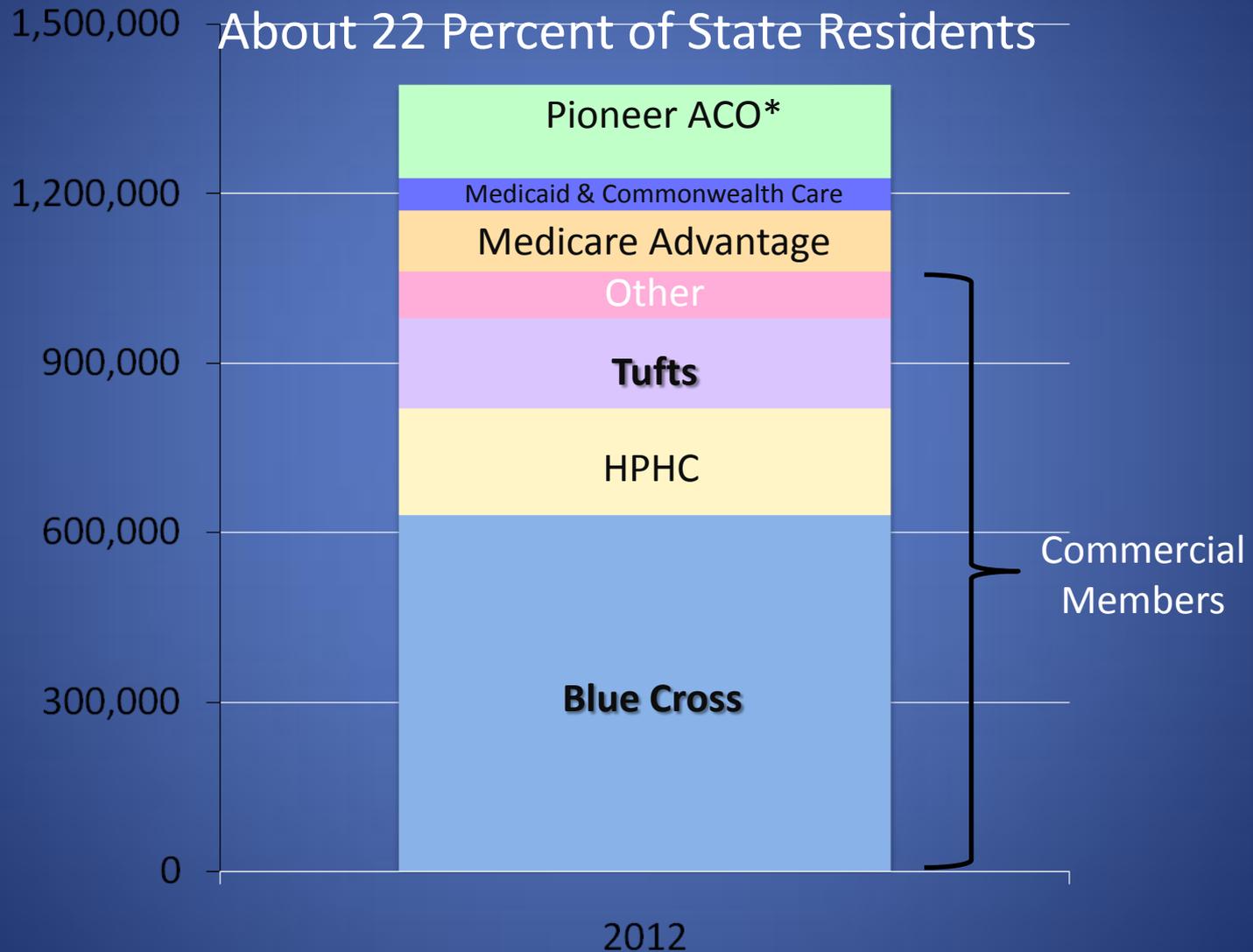
Private Sector (Insurers and Providers) Join Government Efforts to Reform Health System

Expanded Activity In Private Insurance Market

- **After State Set Limits on Premium Increase** *(Could Be Below Underlying Health Service Trend)*
 - *Insurers Restructure and Toughen Payment Models*
 - *Introduce Limited and Tiered Network Plans*
 - *Increase in High Deductible Plans*

Major Healthcare Providers Promote Reform Delivery System Changes

Massachusetts Enrollment in Global Payment



Source: The Boston Globe, February 13, 2012. Figures for Pioneer ACO are estimated.

**Massachusetts Legislature Passes
Compromise Cost Containment
Legislation**
(August of 2012)

Includes Many Pieces

Chapter 224: Cost Control & Payment Reform

Alternative
Payment
Models

Review Provider
Price Variation

Health
Workforce
Support

Health
Planning

Medicaid
Payment
Reform

Health IT
Requirements

**New State
Oversight
Bodies**

Transparency
& Reporting
Requirements

Annual
Spending
Targets

Administrative
Simplification

ACO
Certification
& Oversight

Infrastructure
Support

Spending & Delivery Reform Oversight

Health Policy Commission*
(11-member board)

Distressed
Hospital Fund

Executive
Director and
Staff

Payment
Reform
Fund

Center for Healthcare Information and Analysis

* In EOHS but not subject to EOHS control. Exempt from state civil service requirements and pay scales.

How Is The Health Policy Commission Organized---

Sub-Committees of Commission

Cost Trends and Market Performance

- Establish the annual health care cost growth benchmark for total health care expenditures in the Commonwealth.
- Conduct annual cost trends hearings and issue a final report on health care trends.
- Conduct cost and market impact reviews of health providers and health plans proposing significant market changes to the health care industry, considering the impact of these changes on cost, access, quality, and market competitiveness.
- Oversee the development and implementation of performance improvement plans for certain providers and plans.

Quality Improvement and Patient Protection

- Examine the impact of health system changes on the quality of health care in the Commonwealth, including the impact on patient access to care, and on the providers of health care, including front-line practitioners and health care workers.
- Establish the role and responsibilities of the Office of Patient Protection.
- Track the progress of efforts regarding mental health coverage parity and ensure the integration of mental health, substance abuse disorder and behavioral health services with physical care in the development of new care delivery and payment models.
- Develop guidance relative to the prohibition of mandatory overtime for hospital nurses.

Sub-Committees of Commission

Care Delivery and Payment System Reform

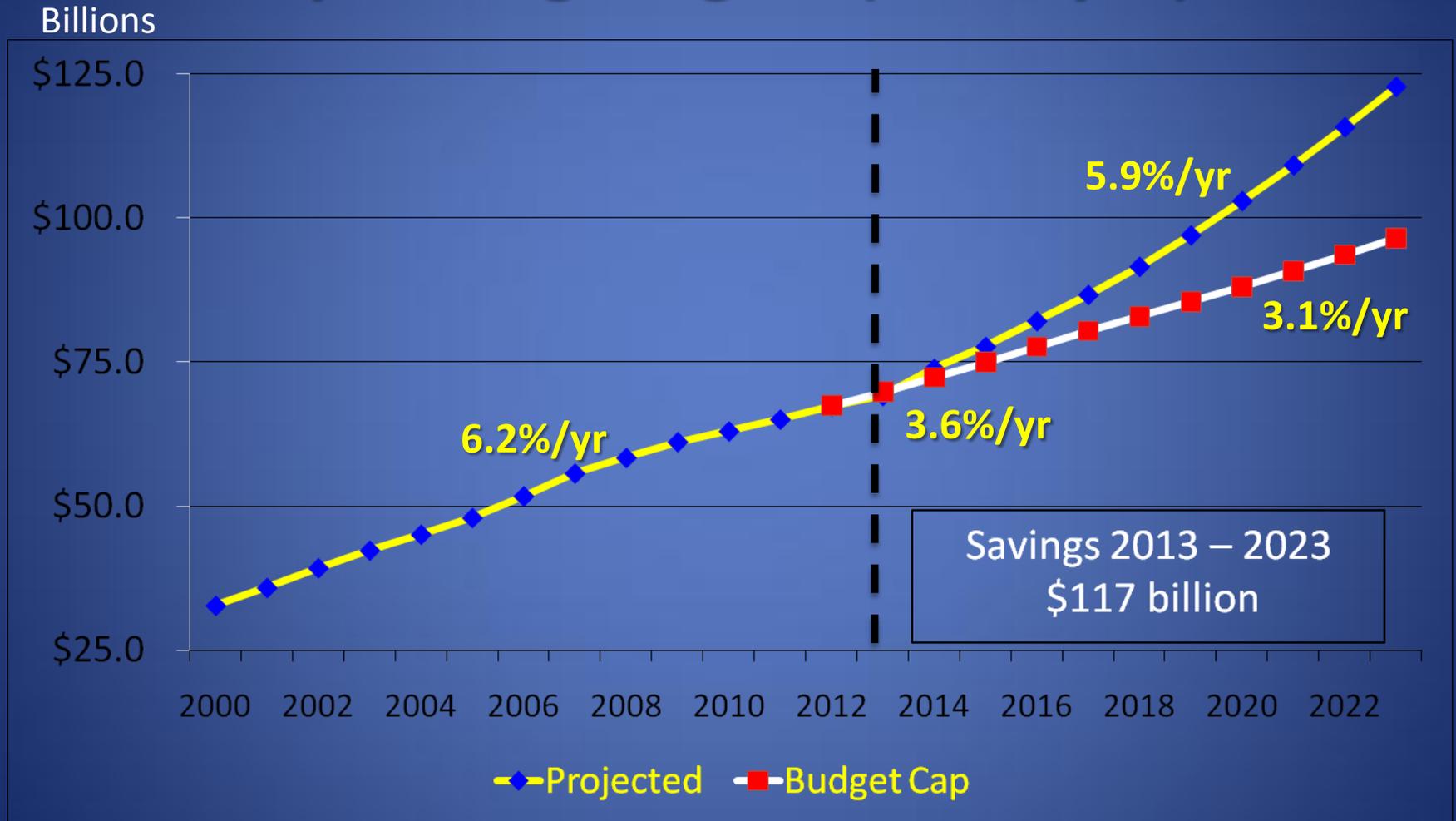
- Establish a provider organization registration program.
- Develop and implement standards for a certification program of Patient-Centered Medical Homes (PCMH) and Accountable Care Organizations (ACOs) and develop model payment standards to support PCMHs.
- Administer a competitive grant program to foster the development and evaluation of innovative health care delivery, payment models, and quality of care measures.
- Coordinate the advancement, adoption, and measurement of alternative payment methodologies.
- Coordinate with the DOI regarding the development of regulations relative to the certification of risk-bearing provider organizations.

Community Health Care Investment and Consumer Involvement

- Develop and administer a competitive grant program to enhance the ability of certain distressed community hospitals to implement system transformation.
- Develop strategies for engaging with various constituencies and a communications plan for educating providers, businesses, consumers, and the general public regarding the implementation of Chapter 224.
- Develop strategies for helping consumers navigate health care cost and quality.
- Conduct an investigation relative to increased adoption of flexible spending accounts, health reimbursement arrangements, and health savings accounts.
- Work with other state agencies to minimize duplicative requirements.

Reaching The Goal of The Law---

Massachusetts Statewide Health Care Spending Targets (All Payer)



Source: Author's calculation based on historical state spending estimates and projected national health spending growth from the CMS Office of the Actuary and targets set forth in Chapter 224
 Brandeis University

Commission and Other Components of Law Can Assist System To Reform

*Ultimate Responsibility
Still Within Private Sector!*

So, Not Sure What I Am---

Perhaps I Am Like The Systems

MOTHER---

Telling It to Eat Its Vegetables



And If It Doesn't?

What Could Be Next?



Which Option Do Think Health System Prefers?

