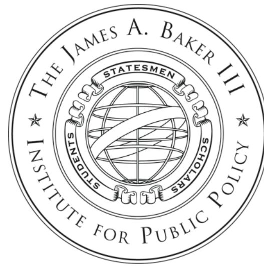

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The U.S. Health Cost Crisis: Recommendations for the Next Administration

By

Vivian Ho, Ph.D.

James A. Baker III Institute Chair in Health Economics
James A. Baker III Institute for Public Policy
Rice University

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Overview

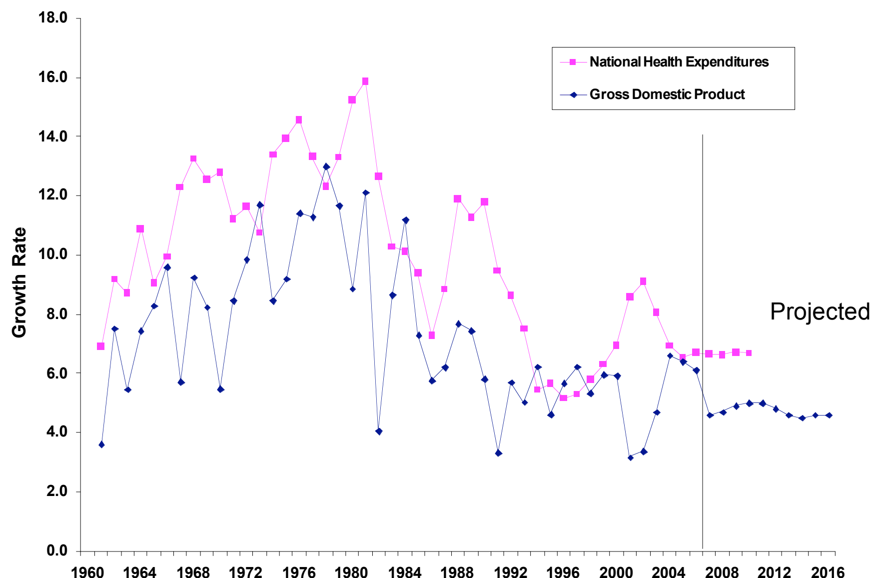
Revising Medicare policies will directly influence health care spending on the elderly, who account for one-third of all U.S. health care spending and thus indirectly influence spending decisions for the 200 million Americans covered by private health insurance. Specifically, the Centers for Medicare & Medicaid Services (CMS) should take two significant steps towards reforming Medicare by:

- **Recommendation 1**: Requiring coverage only for cost-effective technologies, and
- **Recommendation 2**: Basing reimbursement of providers on pay for performance.

Background

Since 1970, the annual growth rate of U.S. national health expenditures has exceeded the growth of the nation's economy in almost every year. National health expenditures surpassed $2 trillion in 2006 and are projected to exceed $4 trillion in 2016. In 1970, health care comprised 7.2 percent of gross domestic product (GDP). Health care now comprises 16 percent of the economy and is projected to account for 19 percent of GDP in 2016.

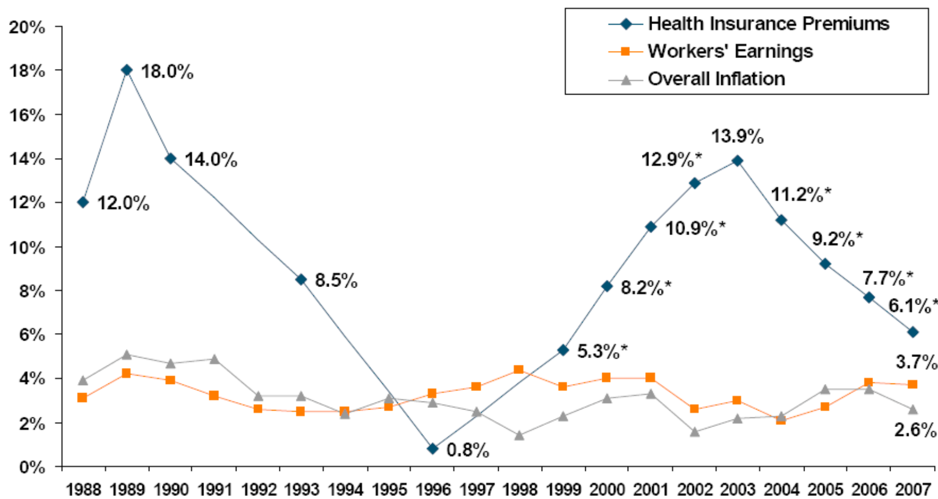
Figure 1: U.S. National Health Expenditures and GDP Growth Rates, 1960–2016



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Expenditure Data

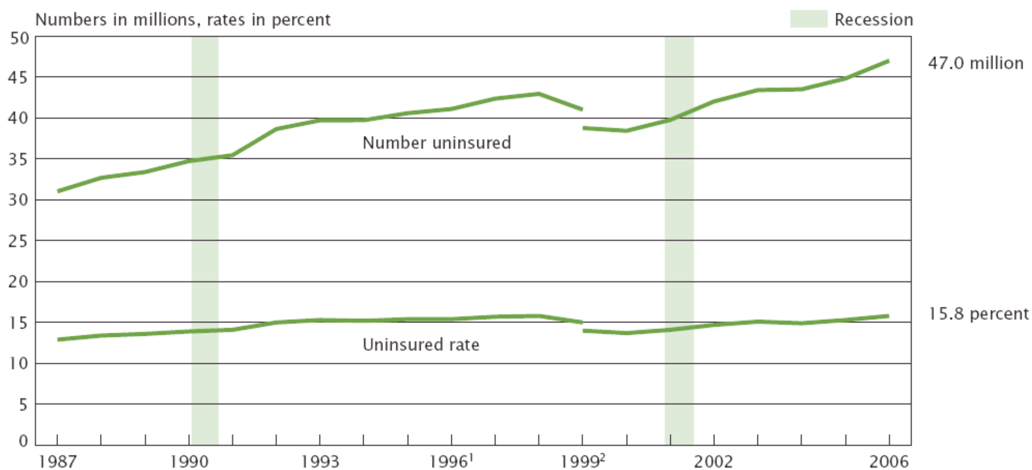
Correspondingly, insurers have raised premiums on health insurance in order to cover the rising costs of reimbursing health care providers for patient care. Since 1999, increases in health insurance premiums have vastly exceeded wage inflation and overall inflation in every year. Rising health insurance premiums have gradually priced increasing numbers of consumers out of the health insurance market, so that 47 million U.S. residents, or 16 percent of the population, lack health insurance coverage.

Figure 2: Health Insurance Premium Increases Compared to Other Indicators, 1988–2007



Source: Kaiser/HRET Survey of Employer Health Benefits 2007, Chart Pack, Exhibit 1

Figure 3: Number Uninsured and Uninsured Rate, 1987–2006



Source: U.S. Census Bureau, Current Population Reports, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, Figure 6

Several past studies have documented the devastating effects of living without health insurance coverage. An estimated 18,000 individuals die prematurely each year due to lack of insurance.[1] Medical problems contribute to half of all bankruptcies in the United States, and these bankrupt-cies are directly linked to lack of health insurance or under-insurance.[2] The plight of the uninsured has also been documented by the media and in popular books.[3-5]

Indeed, health insurance coverage was a major issue for voters during the 2008 presidential campaign, and the new president and Congress are likely to enact legislation to expand health insurance coverage for children within the first ninety days of taking office. Yet the drive to expand health insurance coverage fails to acknowledge the root cause of the rising uninsured rate: Americans cannot afford to purchase health insurance because health care has become too costly. Unless we can control rising health care costs, we will expend valuable resources to bring more individuals into a system that is fundamentally broken. The effort will ultimately fail, as govern-ment expenditures on health care will become unsustainable.

Recommendations

Recommendation 1: Requiring coverage only for cost-effective technologies

Medicare currently reimburses providers for medical treatments based only on effectiveness, not on value. As stated in Congressional testimony in 2007 by Peter Orszag, Congressional Budget Office (CBO) director, "The Medicare program has not taken costs into account in determining what services are covered and has made only limited use of comparative effectiveness data." That is, Medicare is paying for some expensive technologies that "work," but they don't work very well.

An example of a technology covered by Medicare that is costly but of limited value is the left ventricular assist device (LVAD). LVADs are heart pumps for acute heart failure patients who are ineligible for heart transplant. A recent study calculated that the cost per quality-adjusted life year gained from using LVADs is £170,616.[6] This figure represents the incremental costs of providing a patient with an LVAD, divided by the gain in life expectancy from the LVAD, adjusted for the fact that this increased life expectancy would not be spent in perfect health.

Another U.S. study attempted to factor in future improvements in health technology and assumed that LVADs will be able to achieve a 15 percent reduction in mortality for heart failure patients by the year 2015.[7] Even with this optimistic assumption, LVADs were predicted to cost $511,962 (in 1999 dollars) per additional life year gained. The additional cost of LVAD use to Medicare was predicted to reach $10.1 billion in 2015.

Health economists tend to view medical technologies that cost $100,000 per life-year saved or lower as cost-effective and worth paying for. A recent study based on detailed economic modeling estimated that the value of a life-year peaks at $350,000 at around age 50.[8] Under either criterion, the price tag for the LVAD indicates that it does not provide sufficient value to the patient, relative to its costs. The additional cost per improvement in health status is just too high, and LVADs should not be covered by Medicare.

A second example of high-cost low-value health care is treatments for back pain. A 2002 U.S. survey found that 26 percent of adults reported low back pain. Thus, the condition is widespread and accounts for a significant portion of health expenditures. Researchers estimated that the medical costs per patient of treating individuals with spine problems rose from $4,695 in 1997 to $6,096 in 2005.[9] Yet over this same time period, self-reported mental health, physical functioning, work/school limitations and social limitations were all worse. In a span of eight years, this increase in expenditures was estimated to represent $85.9 billion in added costs to the health care system, but there was no demonstrated improvement in patient outcomes. Policymakers and clinicians must carefully review coverage decisions for back pain treatments to determine whether any of these treatments are of value to patients.

In other cases, Medicare and private insurers reimburse health care providers for high-cost treatments that are provided to the wrong patient population. For example, patients with stable coronary artery disease may benefit from an angioplasty to widen narrowed blood vessels. Clinical guidelines state that patients must undergo a stress test before undergoing elective angioplasty in order to confirm the presence of restricted blood supply. However, a recent study determined that only 44.5 percent of Medicare patients underwent stress tests prior to angioplasty.[10] These figures suggest that a significant portion of angioplasties reimbursed by Medicare

were unnecessary and needlessly placed patients at risk of complications from a complex medical procedure. Over 800,000 angioplasties are performed in the United States each year, and Medicare reimburses $10,000 to $15,000 per case. Therefore, there are significant savings to be achieved by requiring confirmation of the necessity of an angioplasty through a stress test.

Moving the Medicare system (and, in turn, the U.S. health care system) towards high-quality, efficient health care requires the application of cost-effectiveness analysis when making coverage decisions for all costly medical treatments. These treatments may be costly because individual treatments are extremely expensive, or because the treatments are moderately costly and administered to substantial numbers of patients. In either case, policymakers and clinicians must determine whether each medical intervention yields health improvements to the patient that are worth the additional costs. The methodology for conducting such economic evaluations has matured over the last two decades, and we now have sufficient data and expertise for conducting these analyses.

One of the challenges of redirecting Medicare's focus to cost-effective technologies is shielding coverage decisions from the influence of health care providers and health technology manufacturers who are in danger of losing significant sources of revenue based on specific changes in reimbursement policy. For example, the Agency for Healthcare Research and Quality was in danger of elimination in the mid-1990s after issuing practice guidelines for back pain treatment which excluded existing forms of care for which physicians were receiving significant reimbursement. Whether CMS directly conducts cost-effectiveness analysis, or the task is assigned to a separate government agency, funding must not be linked to sources which can be influenced by political lobbying.

In addition, efforts must be made to educate the public on the intent of cost-effectiveness analysis. Patients are accustomed to believing that any treatment recommended by their physician must be highly effective. We must help patients understand that Medicare cannot and should not cover every possible medical treatment offered by the medical establishment. The government can dramatically improve its ability to identify technologies that are worth the additional cost and eliminate waste from the health care system. By reining in health care cost

increases, the public will benefit from lower taxes to pay for Medicare, lower private health insurance premiums, and increasing rates of health insurance coverage.

Recommendation 2: Basing reimbursement of providers on pay for performance

The current reimbursement methodologies for hospitals (the DRG system) and for physicians (the RBRVS system) reimburse providers for the quantity of care, rather than the quality of care provided. For example, the intent behind the DRG system was to reimburse hospitals a preset fixed rate based on the diagnosis for which the patient was admitted, regardless of the patient's length of stay. Prospective reimbursement would encourage hospitals to treat patients and prepare them for discharge as soon as possible, so that hospitals could earn profits by retaining the difference between the DRG reimbursement rates and their costs of patient care. Yet over 40 percent of DRGs are related not to diagnoses such as coronary heart disease, but to the performance of specific intensive procedures such as open heart surgery.[11] Instead of reimbursing hospitals and physicians for each additional procedure performed, Medicare should be basing payment on patient outcomes.

Medicare has already made some movement towards pay for performance. For example, just this year CMS has discontinued reimbursement for preventable complications of medical care. Previously, if a patient suffered a pressure ulcer or a catheter-associated urinary tract infection during a hospital stay, the hospital would receive additional reimbursement for treating these complications. Yet such complications are the consequence of low-quality hospital care, so hospitals were essentially being rewarded for providing substandard treatment. With the elimination of reimbursement for treating these complications, hospitals now have increased financial incentive to provide higher-quality care.

Yet CMS could do much more to encourage higher-quality care. Currently physicians and hospitals bill Medicare separately for services provided to patients. Thus, there is no financial incentive for these two entities to coordinate care. For example, I am aware of a quality improvement officer for a major teaching hospital who asked the hospital's chief financial officer for pilot project funding to initiate an outpatient care program for congestive heart failure patients that would reduce their need for hospital admissions. The CFO refused, on the grounds

that fewer admissions of congestive heart failure patients would result in lower hospital revenues.

To remedy such problems, Medicare should move toward bundled payments of health care providers. For example, Medicare could pay a single entity (a hospital and its affiliated physicians) a fixed amount to cover the costs of providing all Medicare-covered services for an episode of care.[12] In the case of congestive heart failure patients, Medicare could pay a fixed amount for all care related to congestive heart failure for an initial hospital stay and up to six months following discharge.

Hospitals and physicians will argue that coordinating care and determining which share of revenues each party should receive is too complicated. Yet pilot projects with bundled payments conducted by Medicare in the early 1990s for coronary bypass surgery demonstrated drastic reductions in expenditures with this reimbursement approach. Providers will also argue that bundled payments cannot take into account important differences in patient severity that will influence patient costs and outcomes. Yet advances in information technology have lowered the costs of obtaining detailed patient information, so that risk adjustment has become more accurate and feasible for many patient cases.

Conclusion

We are living in a remarkable new age of advanced technologies and improved quality of life. Physicians and scientists have developed several important new technologies over the past three decades that have contributed to significant gains in life expectancy and health status. The Medicare program has provided an invaluable safety net to the country's elderly, many of whom would not be able to afford the complex advances in medical care otherwise.

Yet the Medicare program has been poorly structured to encourage the provision of efficient, high-quality medicine. Instead, the unchecked dissemination of medical technology has led to the diffusion of many expensive treatments that have little benefit for patients, and the application of many treatments to inappropriate patient populations. Policymakers, health care providers, and

private insurers must collaborate to reform coverage decisions and provider payment. The public must also be educated on the meaning and benefit of cost-effective medical care. Controlling rising health care costs is essential to insurance access to high-quality care for as many Americans as possible. Failure to control health care expenditures will place the physical and economic health of our nation at risk for years to come.

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