How Can We Move to a Quality-Focused, More Cost-Effective Health Care System

November 18, 2010

Peter R. Orszag
Council on Foreign Relations
Long-Term Fiscal Gap and Health Care Costs

Percentage Share of GDP

Actual | Projected


Medicare and Medicaid
Social Security
Other Spending (Excluding debt service)

Source: CBO (2007)
## Excess Cost Growth in Medicare, Medicaid, and All Other Spending on Health Care

<table>
<thead>
<tr>
<th>Percentage Points</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>All Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975 to 1990</td>
<td>2.9</td>
<td>2.9</td>
<td>2.4</td>
<td>2.6</td>
</tr>
<tr>
<td>1990 to 2005</td>
<td>1.8</td>
<td>1.3</td>
<td>1.4</td>
<td>1.5</td>
</tr>
<tr>
<td>1975 to 2005</td>
<td>2.4</td>
<td>2.2</td>
<td>2.0</td>
<td>2.1</td>
</tr>
</tbody>
</table>
Exhibit 2

BREAKDOWN OF ADDITIONAL SPENDING IN US HEALTH CARE SYSTEM
$ billion, 2003

- Total health care expenditure: 1,879
  - Hospital care: 561
  - Outpatient care: 488
  - Drugs: 224
  - Long-term and home care: 178
  - Durable medical equipment: 212
  - Health administration and insurance: 85
  - Public investment in health: 150

- Gap as a % of cost base:
  - Above ESAW*: 20%
  - Below ESAW*: 14%
  - 82%
  - 15%

* Estimated spending according to wealth
Source: OECD; MGI analysis
Medicare Spending per Capita, by Hospital Referral Region, 2006

Source: www.dartmouthatlas.org (2009)
The Relationship Between Quality and Medicare Spending, by State, 2004

Composite Measure of Quality of Care, 100 = Maximum

Annual Spending per Beneficiary (Thousands of dollars)

Source: CBO (2008)
What Additional Services Are Provided in High-Spending Regions?

Discrete: *Effective Care*
- Reperfusion in 12 hours (Heart attack)
- Aspirin at admission (Heart attack)
- Mammogram, Women 65–69
- Pneumococcal immunization (Ever)

Discrete: *Preference-Sensitive Care*
- Total hip replacement
- Total knee replacement
- Back surgery
- CABG following heart attack

Care Delivery: *Who / How Often / Where*
- Total inpatient days
- Inpatient days in ICU or CCU
- Evaluation and management (Visits)
- Imaging
- Diagnostic tests

Source: Elliot Fisher, Dartmouth Medical School.
# Variations Among Academic Medical Centers

## Use of Biologically Targeted Interventions and Care-Delivery Methods Among Three of U.S. News and World Report’s “Honor Roll” AMCs

<table>
<thead>
<tr>
<th></th>
<th>UCLA Medical Center</th>
<th>Massachusetts General Hospital</th>
<th>Mayo Clinic (St. Mary’s Hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biologically Targeted Interventions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Inpatient Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS composite quality score</td>
<td>81.5</td>
<td>85.9</td>
<td>90.4</td>
</tr>
<tr>
<td>Care Delivery—and Spending—Among</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Patients in Last Six Months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Medicare spending</td>
<td>50,522</td>
<td>40,181</td>
<td>26,330</td>
</tr>
<tr>
<td>Hospital days</td>
<td>19.2</td>
<td>17.7</td>
<td>12.9</td>
</tr>
<tr>
<td>Physician visits</td>
<td>52.1</td>
<td>42.2</td>
<td>23.9</td>
</tr>
<tr>
<td>Ratio, medical specialist / primary</td>
<td>2.9</td>
<td>1.0</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Source: Elliot Fisher, Dartmouth Medical School.
Perceptions and Reality?

• First impressions matter – crucial summer of 2009

• Real cost containment and quality improvement is messy – doesn’t fit on a bumper sticker
Possible Solutions

1. Price reductions

2. Rationing

3. Consumer directed health care

4. Provider information and incentives
Changes in Direct Spending, 2010-2019

$ Billions

-196

-136

-36

- Reductions in Annual Updates to Medicare FFS Payment Rates
- Medicare Advantage Rates based on Fee-for-Service Rates
- Medicare and Medicaid DSH Payments
Concentration of Total Annual Medicare Expenditures Among Beneficiaries, 2001

Source: Data from CMS.
Stimulus Bill
Health Information Technology (IT)

• Provides about $19 billion for Medicare and Medicaid health IT incentives over 5 years
• Codifies the Office of the National Coordinator for Health Information Technology to promote a nationwide infrastructure
• Provides financial incentives to encourage physicians and hospitals to use certified electronic health records (EHRs)

Source: AMA
Stimulus Bill
Comparative Effectiveness Research (CER)

• Invested $1.1 billion in CER
  – $400 million for HHS
  – $400 million for NIH
  – $300 million for AHRQ

• Federal Coordinating Council for CER
  – Coordinates the CER activities of federal agencies
  – Advises President and Congress on infrastructure needs

Source: AMA
Delivery System Reforms

a. Accountable care organizations (ACOs)
   Groups of health care providers who take responsibility for the cost and quality of care of a population of patients. If ACOs provide quality care and reduce costs, they can keep some of the savings.

b. Pay for performance
   Value-Based Purchasing program in Medicare to promote higher quality outcomes. High performing hospitals will be paid more than low performing hospitals.

c. Bundling
   Health care providers are paid a flat rate for an episode of care, rather than billing separately for each service. Can help to align the incentives of all providers to improve coordination and quality.

d. Hospital readmissions and hospital-acquired infections
Center for Medicare and Medicaid Innovation

- Tasked with testing new payment and delivery systems to reduce costs and improve quality
- Requires HHS to test and evaluate “Phase I” models using certain selection criteria
- Provides for “Phase II” expansion of models
- Must be operational by January 1, 2011
- Funding: $5 million for the “design, implementation, and evaluation of models” and $10 billion for CMI activities from 2011 to 2019
Independent Payment Advisory Board

• IPAB will have 15 members appointed by the President to 6 year terms
• The IPAB must put forward proposals that Medicare spending growth stays within a certain target (1 percent excess cost growth in outyears)
• Beginning in 2015 the IPAB must make recommendations to reduce Medicare spending when it is expected to exceed a target level
• Power of default and inertia
• Will it realize its potential?
Critiques

a. Should not have expanded coverage
b. Should have been bolder
c. Congress will reverse cost savings
d. Congress will underfund implementation
Figure 1:
Medicare Expenditures as a Percentage of GDP

Source: 2010 Medicare trustees’ report.

Center on Budget and Policy Priorities | cbpp.org