

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

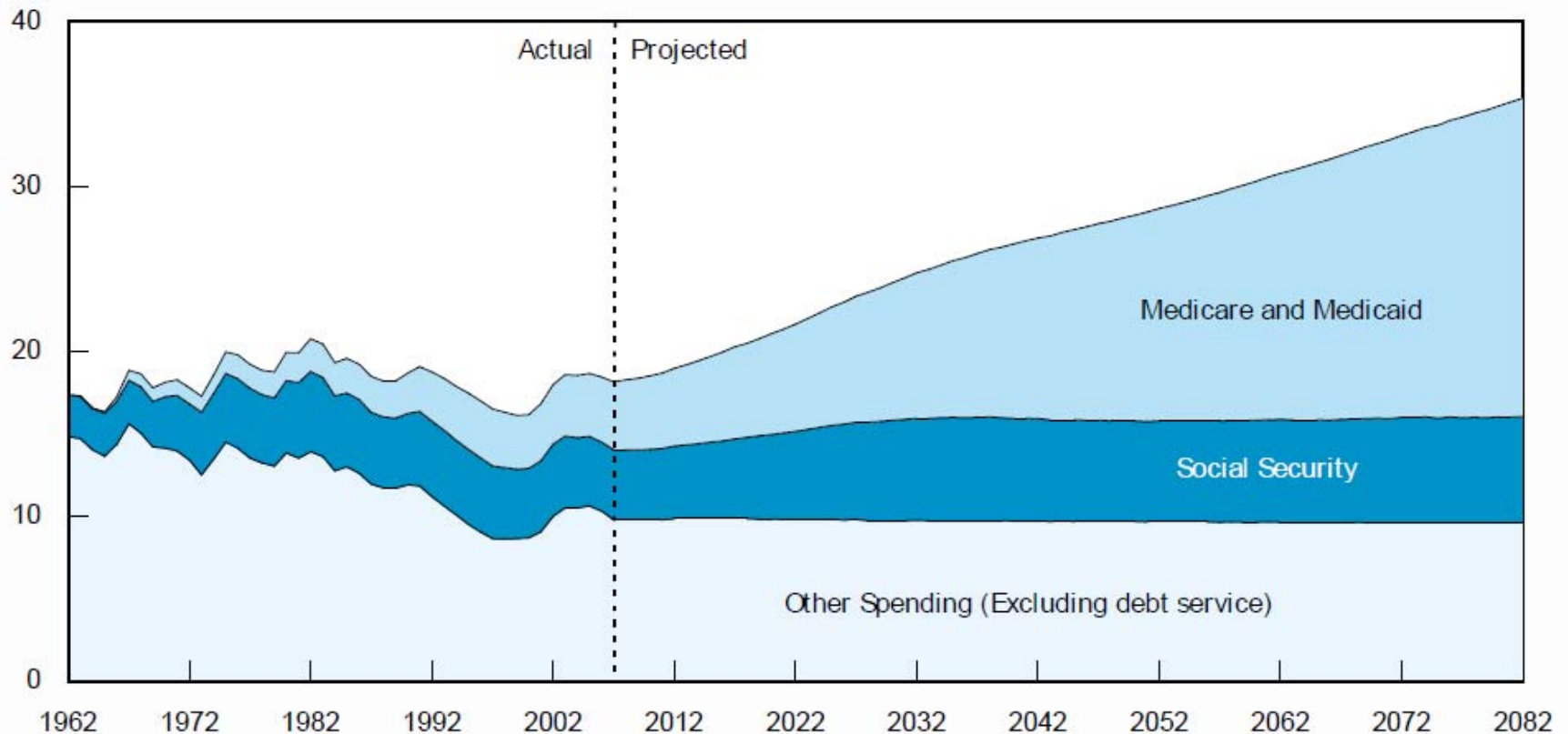
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Council on Foreign Relations



Long-Term Fiscal Gap and Health Care Costs

Percentage Share of GDP



Source: CBO (2007)



Excess Cost Growth in Medicare, Medicaid, and All Other Spending on Health Care

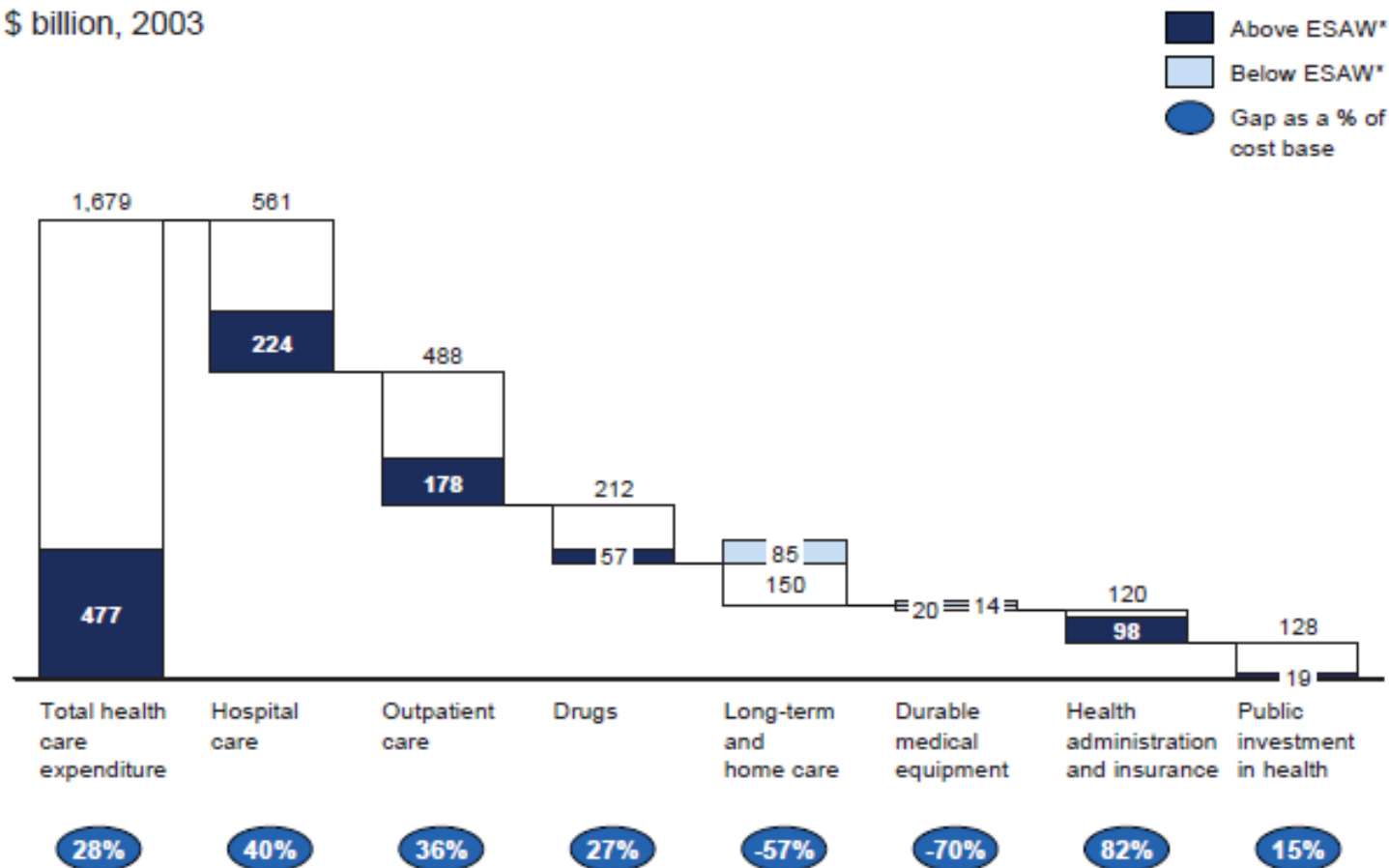
Percentage Points

	Medicare	Medicaid	All Other	Total
1975 to 1990	2.9	2.9	2.4	2.6
1990 to 2005	1.8	1.3	1.4	1.5
1975 to 2005	2.4	2.2	2.0	2.1

Exhibit 2

BREAKDOWN OF ADDITIONAL SPENDING IN US HEALTH CARE SYSTEM

\$ billion, 2003

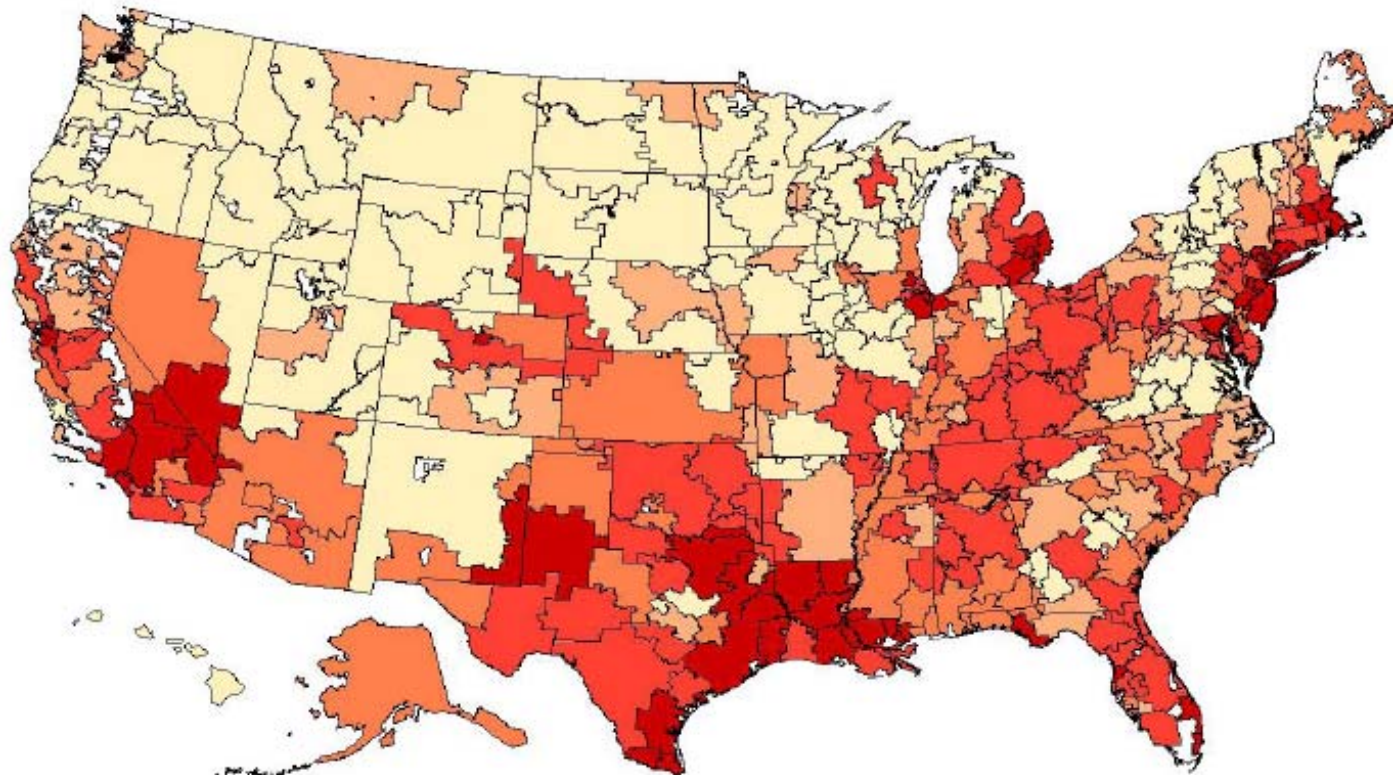


* Estimated spending according to wealth

Source: OECD; MGI analysis



Medicare Spending per Capita, by Hospital Referral Region, 2006



■ \$9,000 to 16,352 (57)	■ 7,500 to <8,000 (53)	■ 5,310 to <7,000 (75)
■ 8,000 to < 9,000 (79)	■ 7,000 to <7,500 (42)	□ Not Populated

Source: www.dartmouthatlas.org (2009)



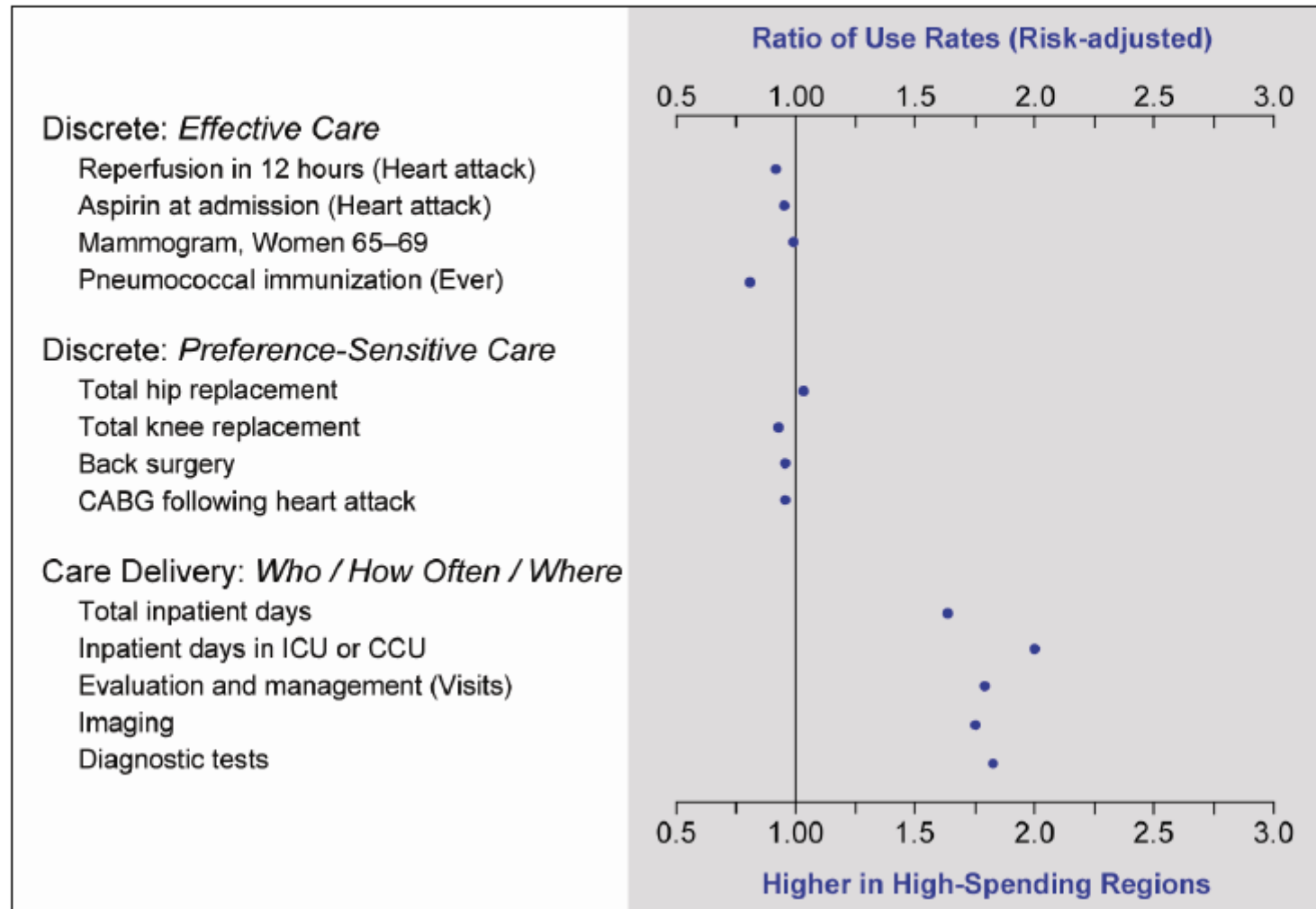
The Relationship Between Quality and Medicare Spending, by State, 2004



Source: CBO (2008)



What Additional Services Are Provided in High-Spending Regions?





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

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

Source: Elliot Fisher, Dartmouth Medical School.

Perceptions and Reality?

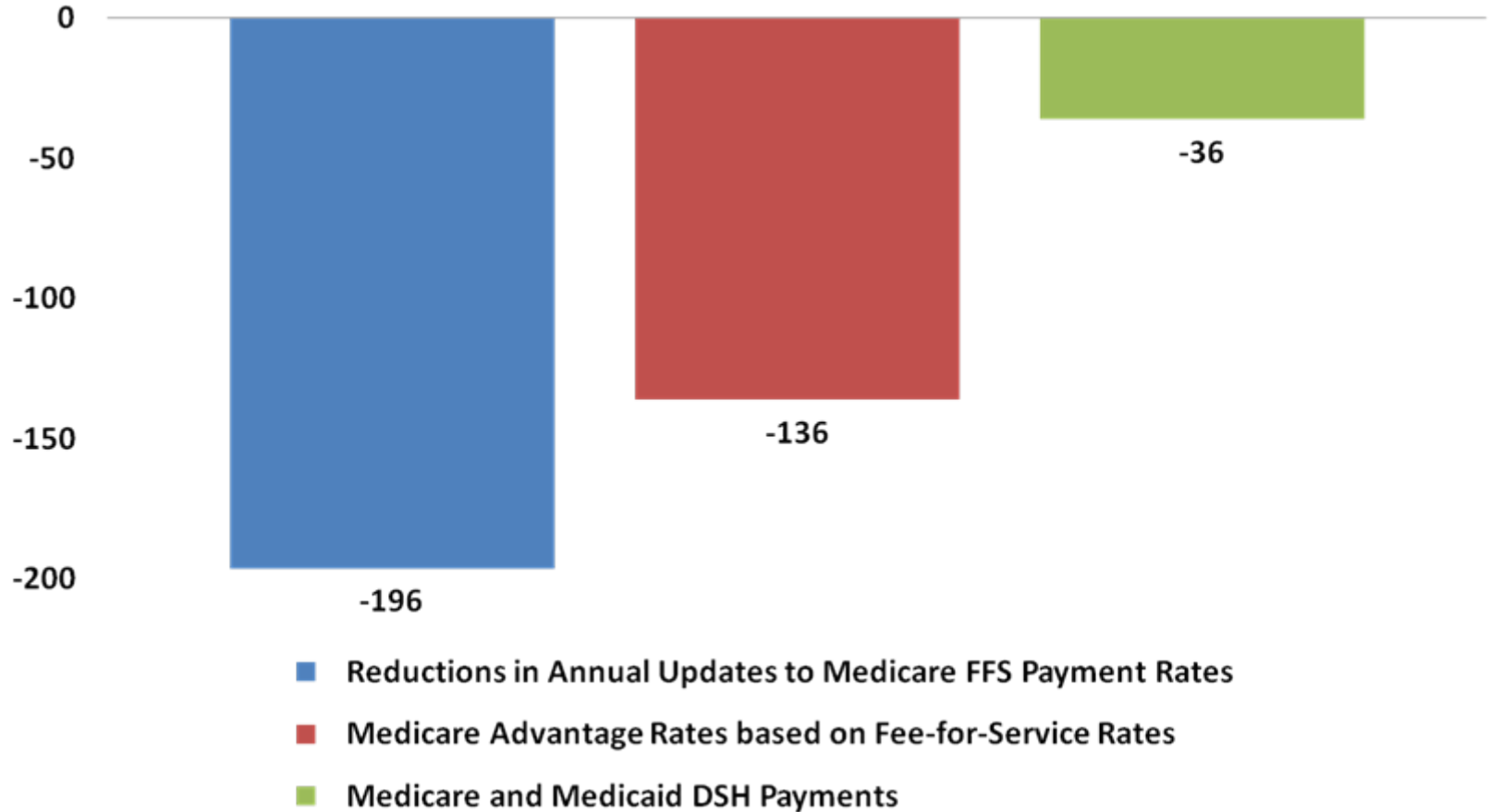
- First impressions matter – crucial summer of 2009
- Real cost containment and quality improvement is messy – doesn't fit on a bumper sticker

Possible Solutions

1. Price reductions
2. Rationing
3. Consumer directed health care
4. Provider information and incentives

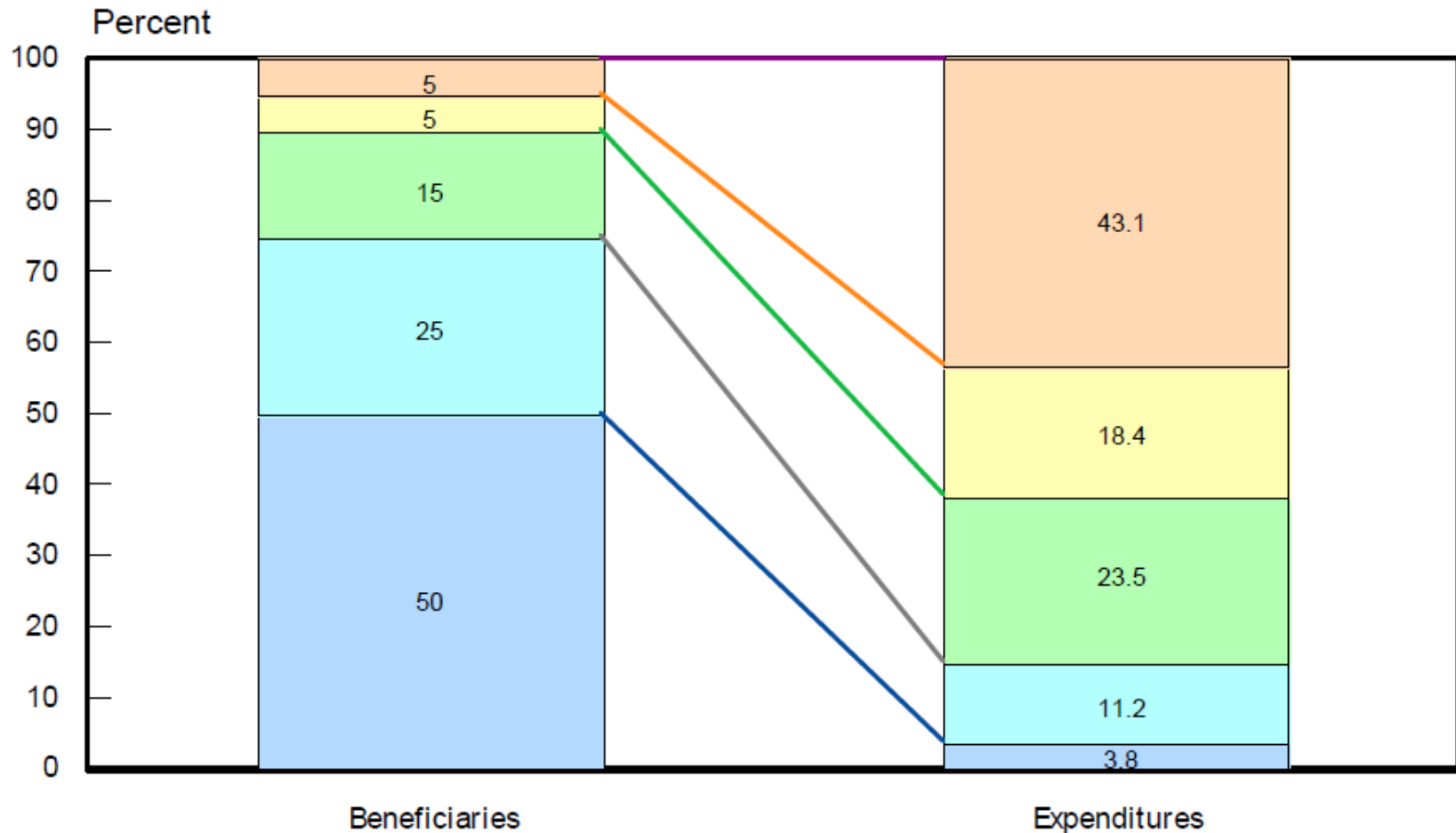
Changes in Direct Spending, 2010-2019

\$ Billions





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)

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

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

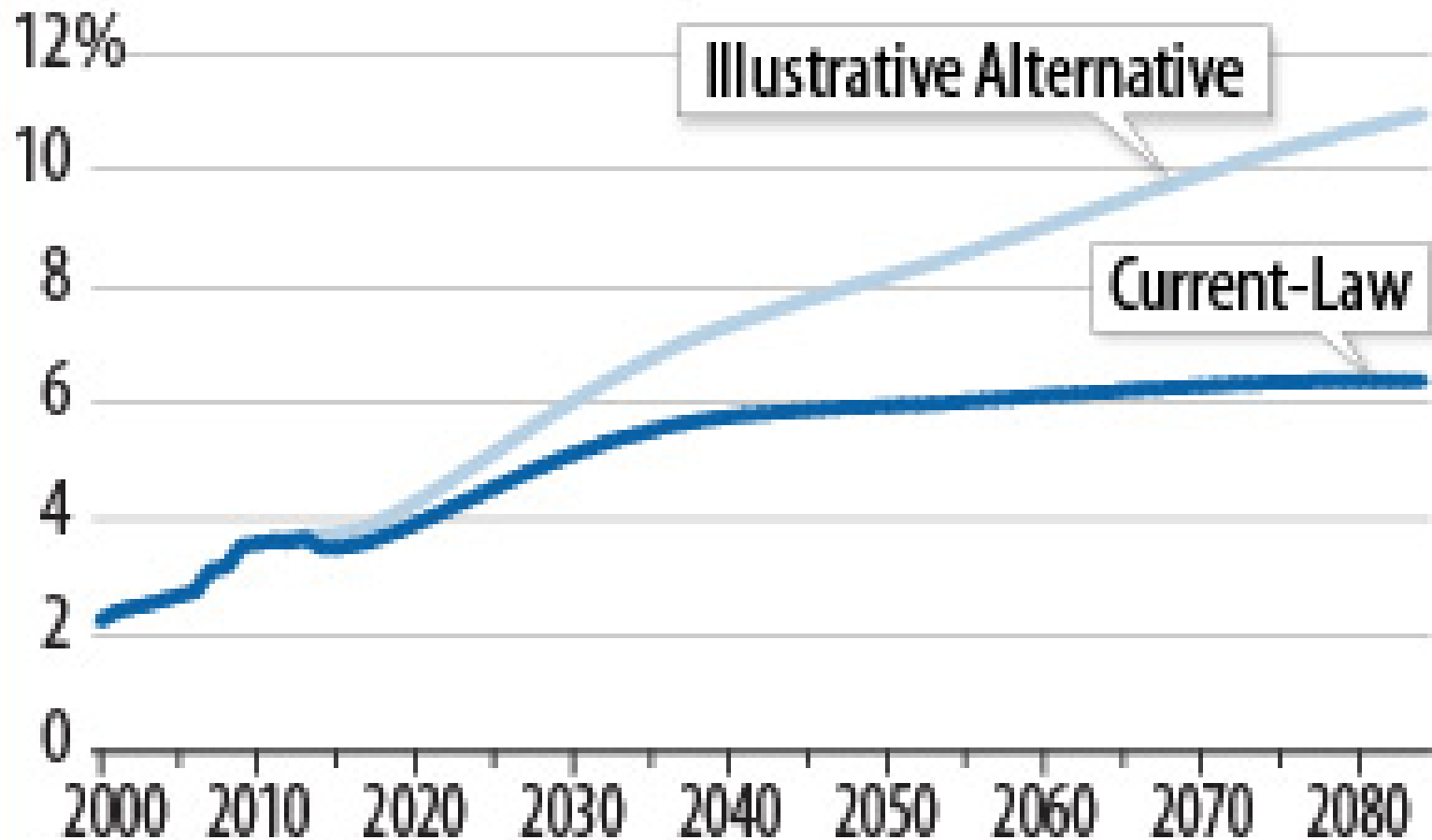
- IPAB will have 15 members appointed by the President to 6 year terms
- The IPAB must put forward proposals that Medicare spending growth stays within a certain target (1 percent excess cost growth in outyears)
- Beginning in 2015 the IPAB must make recommendations to reduce Medicare spending when it 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.