More for Our Health Care Dollar: Improving Quality to Cut Costs

The first in a series on consumer-friendly approaches to cost containment

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About Community Catalyst

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

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INTRODUCTION

Health care costs are growing so fast they could account for one-quarter of the nation's spending by 2025. While burdening consumers, employers, and state and federal governments, the $2.1 trillion we spend annually on health care[1] is delivering poor results. Increasingly, the health care debate in the United States is focused on how to slow down costs and get more for our dollar.

This paper endeavors to define a consumer-friendly approach to health care cost-containment. The first section reviews how quickly costs are rising, asks how consumers are affected by these trends, and makes the case that consumer advocates should take a lead role in the cost containment debate. The second section provides a broad overview of eight different consumer-friendly approaches to cost containment. Subsequent papers in this series will examine some of these strategies in greater detail.

HEALTH CARE SPENDING: WHAT'S HAPPENING AND WHY IT MATTERS

Health care costs in the United States are soaring

The United States spends twice per capita compared to other industrialized nations on health care.[2] Costs continue to soar, outpacing the growth of our economy as a whole. If the current rate of growth were to continue, health care spending would increase from 16 percent of gross domestic product (GDP) in 2007, to 25 percent by 2025 and then to 49 percent by 2082.[3]

This trend is troubling on two levels. First, when compared to other countries, the extra money we devote to our health care system is not improving the health of the nation. Second, growing health care costs are being shifted to insured consumers in the form of lower wages, higher premiums and cost-sharing, all of which are contributing to the growing ranks of the uninsured.

More health care spending does not necessarily lead to better health care

Despite its higher expenditures, the United States provides neither more coverage nor better care than other industrialized nations. Unlike other countries that cover all of its citizens, the current American system excludes millions of families from health insurance coverage, and it also provides a lower quality of care compared to other developed nations. A study by the Commonwealth Fund found that health care systems in comparable countries consistently outperformed the United States on measures of quality, access, equity and outcomes.[4] For example, the United States ranked last out of 19 countries on a number of deaths that might have been prevented with timely and effective care.

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[1] Total U.S. health expenditures reached $2.1 trillion in 2006 according to CMS (report available here.)
[2] The Commonwealth Fund Commission on a High Performance Health System, Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008, 2008), .
[3] Congressional Budget Office, The Long-Term Outlook for Health Care Spending, 2007.
[4] The Commonwealth Fund Commission on a High Performance Health System,

In addition, both health care costs and quality vary dramatically throughout the United States. For example, spending adjusted by sex, age and race for traditional Medicare in 1996 was $8,414 per enrollee living in or near Miami, Fla. compared with $3,341 per enrollee living in or near Minneapolis, Minn.[5] Research shows that while Medicare enrollees in the high-spending regions received *more* health care than their counterparts in lower-spending regions, they did not receive better quality care, experience higher satisfaction with their care, or enjoy better health outcomes[6].

The current system wastes money on ineffective care and high administrative costs

This seemingly paradoxical relationship between cost and quality can be partially explained by an important point: our health care system relies heavily on expensive, inefficient and unsafe care, and this costly care often replaces the use of more effective procedures. Though they do not have higher rates of illness, high-cost regions deliver care in more expensive settings. They tend to provide care for chronic diseases in inpatient settings, and overuse expensive specialist services. These regions also overuse diagnostic tests and minor medical procedures that are not proven to enhance the quality of care.[7] Despite their increased costs, these areas score worse on simple measures of health care quality, such as the administration of beta-blockers after heart attacks, mammograms for older women, influenza vaccines, and eye exams for diabetics.[8]

Also, our system too often delivers care that actually harms patients. The Institute of Medicine estimates that 98,000 people in the United States die each year from medical errors, and that these adverse events cost the nation about $37.6 billion each year, about half of which is direct medical costs.[9]

Furthermore, the United States devotes a higher fraction of its total health care spending to administrative costs than any other industrialized nation. According to one study, the combination of employers' costs to manage health care benefits, hospital, nursing home and home care agency administration, and the administrative costs of practitioners accounted for 31 percent of all U.S. health expenditures in 1999. The same study found that administrative costs accounted for only 16.7 percent of Canada's health expenditures.[10]

These higher administrative costs result from many unique characteristics of the American health care system. For example, insurance companies devote significant resources to assessing applicants' medical risk. They use complex algorithms and hire expensive analysts to determine whether to offer coverage, what rates to charge, and what

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[5] E. S. Fisher, et al, "The Implications of Regional Variations in Medicare Spending. Part 1: the content, quality and accessibility of care." Annals of Internal Medicine 138.4 (2003).

[6] Fisher, et al, 273, E. S. Fisher, et al, "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care," Annals of Internal Medicine 138.4 (2003).

[7] Fisher, et al, 288

[8] K. Baicker and A. Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," Health Affairs web exclusive (2004).

[9] Institute of Medicine, To Err is Human: Building a Safer Health System, 2000.

[10] S. Woolhandler, T. Campbell, and D. Himmelstein, "Costs of Health Care Administration in the United States and Canada," The New England Journal of Medicine 349.8 (2003).

pre-existing medical conditions to exclude. This administrative complexity is then passed on to providers, who have to hire multiple billing specialists to make sense of the wide variety of care packages, prior-approval rules and drug formularies associated with the different insurance companies. Not all administrative overhead is wasteful; some administrative services add value to the care delivered, like provider quality monitoring and mailings to beneficiaries about important preventive services. Most administrative overhead, however, add nothing to the quality of care in the United States, and it consumes a significant portion of our health care budget.

Increased costs are shifted onto vulnerable individuals

As overall health care expenditures rise, the burden trickles down to individual consumers in the form of increased premiums and cost-sharing. Nineteen percent of the population paid more than 10 percent of their incomes towards health care costs in 2003, up from 16 percent in 1996. Rising health care costs cut away disproportionately at the incomes of individuals below the Federal Poverty Level (FPL): One-third of impoverished families spent more than 10 percent of their incomes on health care in 2003, up from about one-quarter in 1996.[11] High costs are the number one reason cited by the uninsured for not having insurance. Even among the insured, 89 percent are "very" or "somewhat" concerned about their future health care costs, according to a 2007 CBS News/New York Times poll.[12]

Working families are also paying for rising health care costs through declining wages. Indeed, while worker productivity has been on the rise, inflation-adjusted median family income has dropped 2.6 percent, or nearly $1,000 annually since 2000.[13] Researchers find that as employers face higher premiums for their employees' health care, they pass these costs directly to their employees by reducing the size of pay increases.[14]

EIGHT POTENTIAL CONSUMER-FRIENDLY SOLUTIONS: AN OVERVIEW

Although governments, employers and individuals are all burdened by rising health care costs, each stakeholder group is primarily concerned with reducing its own share of the costs. And since all health care spending ultimately ends up in someone's pocket as income, policies aimed at containing aggregate health care costs are likely to face resistance from many powerful interest groups. Therefore, policymakers face a strong incentive to shift health care costs from the most influential interest groups – insurers, providers and employers – onto individuals, rather than to tackle overall health care costs. For example, some policymakers have proposed facilitating Health Saving's Accounts (HSAs) as a solution to the rising costs. While HSAs might reduce employers' health care costs, they do so largely by shifting those costs onto consumers, increasing their out-of-pocket expenditures while providing poorer coverage.

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[11] The Henry J. Kaiser Family Foundation
[12] That poll is available here.
[13] M. A. Fletcher, "Rising Health Costs Cut Into Wages," Washington Post March 24, 2008.
[14] The Henry J. Kaiser Family Foundation

To protect consumers from increased cost-sharing and less benefits, consumer advocates must take a leadership role in developing and promoting consumer-friendly cost containment strategies. ***We define consumer-friendly cost containment strategies as those that aim to slow the growth in aggregate health care costs, while improving the efficiency and effectiveness of medical care, without increasing the burden of out-of-pocket expenditures for consumers.***

Following are eight consumer-friendly approaches to cost-containment; forthcoming papers will address some of these strategies in greater detail.

1. Coordinate each patient's care

The problem: Many insured Americans lack a primary care physician that oversees their care. This leads to fragmented care and unnecessary duplication of expensive tests and procedures. This can lead individuals with serious health conditions to experience avoidable and costly emergency room visits and inpatient hospital and nursing homes admissions.
The solution: A variety of solutions have been proposed to better coordinate health care services. They range from implementing targeted disease management programs for individuals with specific chronic diseases to expanding electronic medical records to counter unnecessary duplication of health care services.

2. Improve administrative efficiency

The problem: Administrative costs consume a significant portion of our health care budget, adding nothing to the quality of our system.
The solution: Moving to a single-payer system could drastically reduce the burden of administrative costs in the United States. Being short of a complete system overhaul, potential policies include: limiting the percentage of premiums insurance companies spend on things other than health care benefits (Medical Loss Ratios); reducing fragmentation in the health care market; banning medical underwriting; requiring that insurance companies charge the same premium to all individuals for the same product (community rating); prohibiting insurance companies from denying coverage to applicants (guaranteed issue); standardizing rules for all insurance companies and providers governing medical necessity.

3. Promote primary care

The problem: Primary care physicians help lower health care costs by encouraging cost-effective preventive care. International comparisons confirm that countries with stronger primary care systems have lower health care costs.[15] These results also hold true *within* the United States; research shows that "states with more general practitioners use more effective care and have lower spending, while those with more specialists have higher costs and lower quality."[16] Despite their key role in holding down costs while providing

[15] B. Starfield and L. Shi, "Policy relevant determinants of health: an international perspective," Health Policy.60 (2002).
[16] Baicker and Chandra, W184

high-quality care, there is a severe shortage of primary care physicians practicing in the United States.[17]
The solution: Strategies include providing financial incentives aimed at encouraging providers to enter primary care (loan-forgiveness programs, for example) and strengthening the financial support for programs that train primary care providers. Additionally, states could boost the non-physician primary care workforce such as nurse practitioners.

4. Invest in public health programs

The problem: Chronic diseases account for more than 75 percent of the nation's $2 trillion medical care costs.[18] Many of these diseases are partially caused by lifestyle choices and environmental factors, such as obesity and tobacco smoking.
The solution: We need to increase our investment in public health. A strategy should include tobacco cessation programs, AIDS prevention, substance abuse programs, healthy school lunches and enhanced school-based physical education programs.

5. Create incentives for better care

The problem: Providers are paid for the *quantity* of care they provide, regardless of its quality or cost-effectiveness. As an extreme example, a surgeon who operates on the wrong shoulder might be paid twice: once for the erroneous surgery and once for the surgery on the correct shoulder.
The solution: Private and public payers are increasingly looking to pay-for-performance (P4P) strategies, such as providers receiving a bonus based on their percent improvement on quality or cost-effectiveness measures. Another solution, which Medicare is implementing this year, is to withhold payments for costs associated with preventable medical errors.[19]

6. Increase oversight

The problem: Those with most control over health care costs – insurers and providers – currently face little incentive to slow expenditures; providers simply get paid more for providing more services, and insurers can generally increase premiums to cover any new costs. Hospitals compete with each other by investing in more expensive and newer health care equipment to attract better doctors and more patients, which leads to unnecessary use of that equipment. For example, the Dartmouth Atlas Project has shown that areas in the United States with more staffed hospital beds have significantly higher rates of hospitalization for conditions that do not require surgery.[20]
The solution: States could promote legislation for voluntary or mandatory limits on cost growth for hospitals and provider fees and insurance premiums. They could mandate that insurance companies notify the insurance commissioner or hold a public hearing if they

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[17] American College of Physicians, The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care, 2006.
[18] Centers for Disease Control and Prevention, *The Burden of Chronic Diseases and Their Risk Factors: National and State Perspectives 2004*, 2004.
[19] J. DerGurahian, "NEVER PAY NEVER AGAIN: After the CMS ' changes, hospitals are now scrambling to deal with 'never events'-especially those not on their watch," Modern Healthcare March 10, 2008.
[20] See http://www.dartmouthatlas.org/topics/supply_sensitive.pdf.

want to raise premiums more than a specified percent. Another approach would be for states to prioritize needs for health care equipment and facilities. Approvals for expansion would be competitive and based on how well any proposed project addressed the identified priorities.

7. Establish the cost-effectiveness of new medical technologies

The problem: New medical devices, procedures and medications often cost significantly more than already existing treatment options. Sometimes the extra cost is well worth the added health benefit, but on other occasions the new technologies fail to provide better results. While the Food and Drug Administration (FDA) assures that new technology is effective and safe,[21] no institution reviews the new technology's cost-effectiveness in comparison with existing technologies.

The solution: Many industrialized nations routinely assess the cost-effectiveness of new technologies to help determine what should be covered in their public insurance plans. Absent federal action, states could encourage more cost-effective use of health care money by gathering existing research, and using it to decide which devices, procedures and medications are covered by state-financed health care programs. They could also make this research publicly accessible, and encourage private payers to use it in their coverage decisions.

8. Increase consumers' purchasing power

The problem: Insurance companies often face very little competition. In some states only one or two carriers offer coverage. This allows insurance companies to charge higher rates for fewer benefits. Unfortunately, adding to the number of carriers does not necessarily solve the problem. With each carrier covering a smaller share of the population, their ability to negotiate lower prices or create coherent financial incentives for providers is reduced.

The solution: Some states are exploring the idea of merging the individual and small-group markets to create a larger purchasing pool. When coupled with a "Connector-type" mechanism empowered to negotiate benefits and rates on behalf of individuals and small-groups, this strategy could help increase consumer bargaining power, reduce premiums, and lower overall health care expenditures.

CONCLUSION

Rising health care costs are outpacing the growth of our economy, government revenues and workers' wages, and forcing our country into a serious debate about how best to contain health care costs. Although they already shoulder the burden of these increasing costs through stagnated wages, increased premiums and out-of-pocket expenditures, working families would be made worse off by many proposed cost containment policies that shift even more costs onto consumers. To counter these regressive policies, consumer advocates must develop and promote consumer-friendly cost containment agendas that aim to slow the growth in aggregate health care costs, while improving the efficiency and

[21] It should be noted that not all new technologies require FDA approval. Many procedures, such as surgical techniques, are not assessed by the FDA.

its effectiveness on medical care, without increasing the burden of out-of-pocket expenditures for consumers..

