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Health Care Cost Management in Massachusetts: A Discussion of Options

Meeting #1: Overview of Cost Management Strategies

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Conference Report

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Growth in Health Care Spending: Can or Should It Be Controlled to Prevent a "Health System Meltdown"?

Presenter: **Stuart Altman**, PhD, Dean and Sol C. Chaikin Professor of National Health Policy, Brandeis University

Overview

Over the past forty years health care spending has consistently grown faster than the U.S. economy. Despite cost containment efforts ranging from regulation in the 1970s, to competition in the 1980s and managed care in the 1990s, spending growth has always bounced back. The 21st century trend thus far exceeds the historical norm. At current spending levels, the question no longer is *whether* spending should be controlled, but *how*. Unfettered adoption of expensive medical technology has driven health spending well beyond that of other nations. Medicare and Medicaid spending is rising dramatically, but provider payments are being limited. The private market cannot indefinitely cross-subsidize providers as public payments fall further below the costs of care. Continued rapid spending growth will eventually result in a melt-down of employer-sponsored health insurance.

There are many possible cost management strategies, but those likely to be most effective will encounter strong resistance. Bending the cost trend is difficult and success will require all stakeholders to accept painful choices. Doing so with the least possible disruption will require unprecedented collaboration across stakeholder groups.

Context

Through an historical data analysis, Stuart Altman examined the problem of runaway growth in U.S. health expenditures, presented data specific to Massachusetts, and demonstrated the imperative for industry leaders to focus on cost management. To start the discussion, Professor Altman offered a number of techniques for curtailing this growth, organized according to their potential impact.

Key Issues

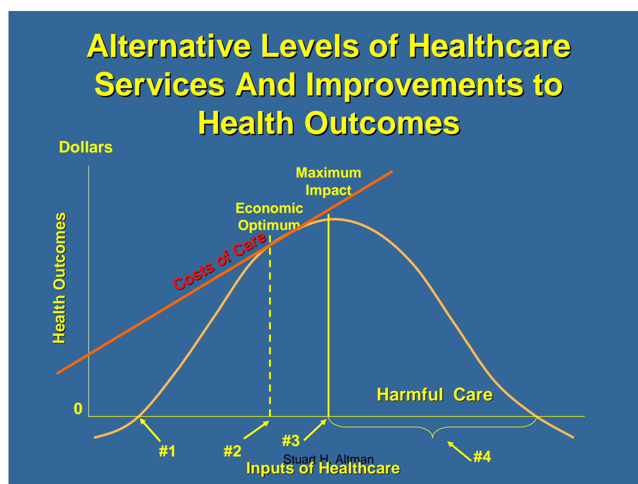
- **Pressures to control spending in Massachusetts reflect a broader national challenge.**

  Controlling the growth of health spending in Massachusetts warrants urgent attention. Although statistics are frequently cited showing state per capita health spending 30% to 40% higher than the national average, the true costs to payers and patients is closer to US averages: 14% higher for Medicare payments per beneficiary and 6% higher for health insurance premiums. That said, the challenge of controlling future spending growth in Massachusetts reflects broader national forces. Acknowledging this parallel, Professor Altman focused his comments on health spending at the national level.

- **Technology utilization is the principal driver behind the nation's relatively high health care expenditures.**

  Even when income levels are taken into account, the U.S. spends disproportionately more on health care than other OECD nations. For example, in 2002-03, U.S. health care expenditures accounted for 15% of total GDP, versus only 8% in Japan and 10% in Germany. Counter to conventional wisdom, this excess spending is not driven by higher utilization of hospital services. Compared to many other OECD nations, the U.S. has among the lowest inpatient utilization rates. Nor does the data suggest that higher spending is driven by excess physician capacity or higher use of physician services. Americans spend slightly more on drugs than other OECD countries, but this difference is driven more by the pharmaceutical prices than higher utilization.

  Where the U.S. differs significantly from other nations is in use of technology. Across a number of procedures—MRIs, cardiac catheterization, renal dialysis, and liver transplants to name a few—use rates are markedly higher in the U.S. While technology often improves clinical outcomes, and in some instances expedites care delivery, research suggests that the effectiveness of technology follows the law of diminishing returns. After a certain point, increased inputs yield marginally smaller outputs. Overuse of technology causes more harm than good.



  Nations that have succeeded in controlling health care spending have infrastructure that restricts technology use and supports comparative effectiveness research (CER). CER is the practice of gathering data to evaluate available treatments and technologies to determine which work best, from both a clinical and an economic standpoint. Professor Altman suggested that the U.S. needs to develop a national CER capacity. He also stressed the

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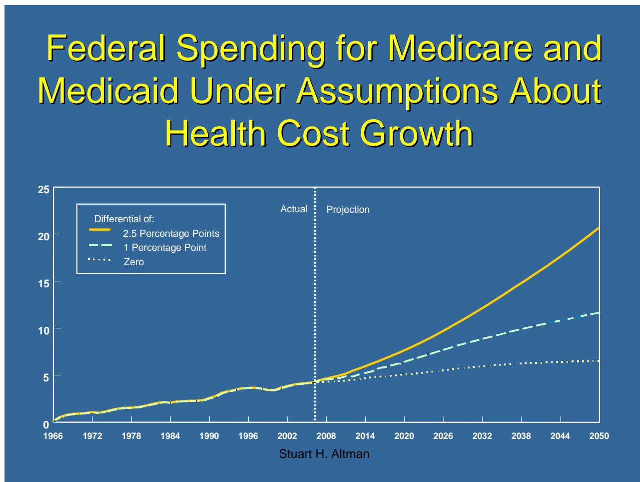
need for Massachusetts to gather data for evaluating the clinical and cost effectiveness of medical technologies.

> *"Technology is a major driver of health care spending…it's also a major factor in improving our health care system."*
> — Stuart Altman, PhD

▪ Private payers cannot continue offsetting the gap in federal payments.

Paralell to the overall growth in health spending are increases in federal spending for Medicare and Medicaid. These increases are driven to a small extent by demographic changes (the aging of the U.S. population) but to a greater extent by growing utilization of health care services. Professor Altman cited projections from the Congressional Budget Office showing that if growth in health spending continues at its current rate of 2.5% above GDP growth, net federal spending on just Medicare and Medicaid would grow to 20% of GDP by 2050 – equal to the share of the total federal budget relative to GDP today.



Although Medicare was considered an attractive payer in the era of managed care, Medicare rates have declined. Today, Medicare and Medicaid patients are unprofitable for many hospitals. This is particularly problematic because by 2025 a typical hospital is projected to receive 66% of its revenue from government payers, up from 54% today. Given likely limitations in future growth in government payments, hospitals will need to negotiate higher payment rates from private insurers.

While increases in private payments have historically offset declines in government payments, this cost shift is unsustainable in the long term. To illustrate this point, Professor Altman estimated that hospitals would need to negotiate private payments 140% above actual costs to compensate for the increasing share of government payments discussed above, even assuming no reduction in the ratio of government payments to actual costs. Reigning in spending growth is the only way to reduce future cost shifting. This will require all stakeholders to share responsibility for addressing the problem.

▪ Past attempts to control spending have had limited success. Future success requires difficult choices.

Although regulatory mechanisms imposed by the government in the 1970s controlled spending in the short term, gains disappeared when the Reagan Administration brought about a deregulated, market-driven system. Growth in spending was again moderated in the early 1990s with the advent of managed care, but this was short-lived due to the unpopularity of managed care among providers, patients, politicians, and the press. Spending growth today stands at unprecedented rates.

Cost control is complicated by the economics of the health care industry and the unwillingness of stakeholders to be accountable. Significant spending limits would translate to financial losses and increased regulatory burdens for providers and insurers, as well as reduced patient access and choice. Health care in America is "big business," making meaningful reform extremely difficult.

> *"Everyone is paying lip service to controlling costs but little consensus about how to make it happen."*
> — Stuart Altman, PhD

▪ Health care leaders need to explore different strategies for reducing the health spending growth.

Professor Altman outlined approaches for limiting growth in health spending, noting that those with the most potential impact are also the most politically challenging. He urged attendees to begin a dialogue around these approaches and share their feedback on which strategies they believe are most feasible from a practical and political standpoint.

Very limited impact:

— Encourage greater use of preventive services (short term).

Limited impact:

— Provide better price and quality information.
— Require patients to pay more.
— Restrict use of harmful care.
— Reduce expense and waste of medical malpractice system.
— Reduce administrative costs of insurance.
— Develop and use government-supported comparative effectiveness studies.

Greater impact:

— Restructure payment system (replace fee-for-service with bundled payments and value-based pricing).
— Restructure delivery system (integrated care).
— Restrict use of marginally useful care.
— Limit supply of expensive services.
— Encourage greater use of preventive services (long term).
— Expand and restructure primary care.
— Create a governmental "high cost reinsurance system" with effective disease management systems for chronic conditions.

Greatest potential impact:

— Have government regulation of payments to providers.
— Establish global budgets.

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Health Care Cost Management Strategies: Participant Roundtable

Presenters: **JudyAnn Bigby**, MD, Secretary, Executive Offices of Health and Human Services
Ellen Zane, President and Chief Executive Officer, Tufts-New England Medical Center

Overview

Controlling health spending in Massachusetts requires multi-faceted solutions. Participants expressed a wide range of views about the best starting point, but comments converged on several strategies: restructuring the current fee-for-service reimbursement system to bring provider incentives in line with cost management; emphasizing the role of primary and preventive care in managing disease and promoting appropriate utilization; and educating patients to become more responsible health care consumers.

Government must play a leadership role in reforming the payment system, promoting consistent IT standards across organizations, and supporting payer and provider collaboration by helping navigate antitrust issues. Developing a broad-based strategy for cost management will require public/private collaboration.

Context

Following Professor Altman's presentation on health spending, Secretary Bigby discussed cost management from the Executive Office of Health and Human Services' (EOHHS) perspective as well as the important role for primary care.

Ellen Zane presented a provider perspective on major cost management issues in the current health care environment. Other participants including employers, insurers, and consumer representatives shared their views on these issues.

Key Issues

- **EOHHS supports an integrated approach to reducing state health care expenditures.**

  Secretary Bigby began by noting that funding for health care services is not unlimited. EOHHS plans to take a multi-faceted approach to cost management, combining strategies to increase access to care, improve the quality of care, and promote prevention and wellness among health care consumers. These strategies focus on:

  1. *Measuring the value of health care services*. Purchasing decisions must be carefully evaluated to ensure appropriate expenditure of Medicaid dollars.
  2. *Government regulation*. EOHHS would consider using regulation to address health care spending and reforming the payment system to ensure more appropriate use of services and technologies.
  3. *Addressing both overuse and underuse*. Reducing unnecessary utilization would allow resources to be redirected to cost-effective activities that are currently underutilized like cholesterol management and blood pressure control.
  4. *Reducing racial and ethnic disparities*. Greater attention should be given to providing equal access to medical advances across ethnic and socio-economic groups.
  5. *Wellness and prevention*. Investments in wellness and prevention in the short term will yield savings in the long run.
  6. *Primary care reimbursement*. More aggressive primary care patient management can help reduce unnecessary spending, but the current payment system does not support the development of medical homes, strong physician-patient relationships, or the role of primary care physicians as health educators.

     > *"We need to reform the way we pay [primary care] providers for services."*
     > — JudyAnn Bigby, MD

  7. *Provider accountability*. Providers must be held accountable for care quality and outcomes. The Massachusetts Hospital Association's recent pledge to forego payments for care involving preventable errors is a step in the right direction.

- **Unmanaged consumer expectations drive hospital costs.**

  Ms. Zane urged employers to take a more active role educating consumers and promoting realistic expectations about using health services. Consumers are demanding, and generally have benefit plans that provide unfettered access and choice. It is unrealistic to ask providers to play the role of utilization "police" in the face of consumer demand. Ms. Zane recommended redesigning benefits to better manage consumer expectations.

  > *"It's the people, the doctors and the patients, with their expectations…that ramp up costs."*
  > — Ellen Zane

  One attendee asserted that providers are equally (if not more) responsible than consumers for health care costs, referencing a *New York Times Magazine* article highlighting stories of physicians making medical decisions based on their profit potential alone.

  Professor Altman weighed in, stating that perhaps the most effective way to reduce costs is to say "no" to some utilization, but questioning whether the industry is prepared to do that.

- **Providers should be compensated based on adherence to evidence-based practice.**

  Data from the Dartmouth Atlas and other sources document the substantial unwarranted variations in health care utilization. Under the current fee-for-service payment system, providers face perverse incentives that fly in the face of cost containment. Fee-for-service must be replaced with a system that rewards efficient delivery of evidence-based care. While the word "capitation" carries negative connotations among providers, the concept of

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"bundling payments" could be effective if the population was actuarially sound.

> *"I've seen physicians and other providers do much more creative things, much more cost effectively, with much better outcomes, in a world where the incentives are aligned."*
> — Ellen Zane

Other attendees agreed that effective spending control will require a fundamental restructuring of the payment system. Until providers are rewarded for quality and outcomes, rather than volume and intensity of care, other cost control strategies will have minimal impact. Charlie Baker, president and CEO of Harvard Pilgrim Health Care, remarked that these type of payment system changes are "easy to talk about but difficult to execute." He questioned whether a new approach should initially focus on a specific subset of care or service line in order to establish proof of concept.

- **Standardized IT systems could lower administrative costs.**

  Disparate information systems may offer individual organizations a competitive advantage, but they also increase administrative complexity. Ms. Zane suggested that the system would benefit by having government require use of common IT standards across all organizations. A standardized system would simplify administrative processes and lower costs.

- **A multi-pronged, incremental cost management approach is the most realistic strategy.**

  During the discussion no single cost management strategy rose to the top of the list. There was a substantial disagreement about the factors (and stakeholders) most responsible for health spending growth as well as which solutions could have the greatest impact.

  One participant stressed the importance of choosing a select number of cost management techniques to pursue initially, rather than attacking the entire list of at once. He noted, however, that to solve the health care cost problem, all parties must be willing to accept that there will be winners and losers; some participants will simply make less money under a more tightly managed system.

  Other participants noted that the level of coordination among organizations required to pursue uniform cost management strategies (for example piloting a uniform bundled payment methodology across all payers) could raise antitrust concerns without active involvement by state governmental.

Other Important Points

- **Medicare and Medicaid.** The impact of private payment policy on delivery system incentives are limited if Medicare and Medicaid continue to reimburse primarily based on fee-for-service. Medicaid can more easily collaborate on local payment policy initiatives while opportunities to work with Medicare could come through demonstration projects. It is important to recognize that Medicare and Medicaid have unique patient populations with distinct needs. Cost containment strategies for these programs must be appropriate for their unique populations and objectives.
- **Managed care foundation.** Massachusetts is one of only three states in the country that have both a significant level of managed care penetration and high satisfaction among members of managed care plans. This offers a solid base that state health care leaders could use to explore new cost containment mechanisms, such as medical homes and bundled payments.
- **Consumer expectations.** More appropriate health spending also requires better consumer engagement. Several participants argued that consumer education is the key to effecting changes in lifestyle that can improve health and ultimately lower spending.

For more information about this series:

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Additional materials are available at:
www.heller.brandeis.edu/costmanagement

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