

HEALTH SPENDING: THE GOOD, THE BAD, AND THE UGLY

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I. Why is health spending/health costs an issue of concern?

- a. Health costs are the number one concern of business, especially small business
- b. Health spending of publicly-sponsored health programs is a key challenge for state, local and federal budget decisions
- c. Health costs challenge the sustainability of retiree health benefits
- d. Health costs challenge the ability of individuals to afford coverage and pay for health services
- e. Health cost concern creates an emphasis on the liability side of health that often overlooks the investment value of health, including the relationships between:
 - Health and economic growth
 - Health and economic development
 - Health and business performance
 - Health and childhood development
 - Health and learning
 - Health and personal income
 - Health and family stability
 - Health and demand for other government-provided social services
 - Health and cycle of poverty

II. Factors that affect health spending

- a. Price – amount spent per unit of service
 - i. Increase in fee for a given service
 - ii. Substitution of a higher price service for a lower priced service
- b. Utilization - number of services used per person
 - i. Rise in complementary services that augment existing treatments, e.g. additional medications, additional tests
 - ii. Rise in number of services may be ordered as part of defensive medicine
 - iii. Rise in new treatments for conditions where treatment was not readily available
 - iv. Increased diagnostic tools that identify conditions needing treatment
- c. Number of people being covered or served

- i. Higher total number of people being covered or caseload (especially important for publicly-financed programs such as Medicaid)
 - ii. Higher total number of people having a given condition requiring treatment (treated number of cases)
- d. Per Ken Thorpe growth in real per capita health care spending is simply the growth in spending per treated case times the number of medical conditions treated (treated disease prevalence). He and his associates estimate that 63% of the rise in real per capita spending links to a rise in treated prevalence. This rise is caused by rising prevalence of disease in the population, changing clinical thresholds for diagnosing and treating disease, and innovations (new technology) in treatment. He notes that some of this new spending is likely desirable, while other is preventable and not desirable.

III. **Different timeframes and perspectives affect how one looks at the issue of health spending and strategies to control costs**

a. Timeframes

- i. Daily time schedule
- ii. Daily financial situation
- iii. Monthly family budget reality
- iv. Monthly business bills to pay
- v. Quarterly reporting cycle to investment analysts
- vi. Annual premium cycle
- vii. Annual shareholders meeting
- viii. Annual or biennial government budgeting cycle
- ix. Annual or multi-year grant funding and reporting cycle
- x. Multiple years before return on investment for many interventions/activities

b. Perspectives

- i. Program budget versus total system budget (e.g. Medicaid funding versus total public system spending on health services)
- ii. Employer spending on health benefits versus total costs from poor health of employees (disability, absenteeism, presenteeism)
- iii. Employer reluctance to spend as much on high turnover employees versus health challenges of pool of high turnover employees hired
- iv. Payment per service versus total payment for services

IV. **Realities of health spending**

- **Reality 1: The high preponderance of U.S. health spending focuses on curative care; little is spent on clinical preventive services and community-based prevention**

Roughly 97% of US health spending goes for direct health care services, only 3% for public health.

- **Reality 2: Health spending creates more value overall than it costs.**

A 2004 American Hospital Association co-commissioned study, by MEDTAP International, concluded that each dollar spent on health care produces a return of between \$2.40 and \$3.00. According to its report, “Simply put without the above improvements in health and the associated investment, the U.S. would have spent \$634 billion less on health care in 2000, but we would have experienced:

- 470,000 more deaths,
- 2.3 million more people with disabilities, and
- 206 million more days spent in the hospital.

According to health economist David Cutler, half of the increase in life expectancy since 1960 is due to spending on medical care services. Per Cutler, “although medical spending has increased substantially during the past 40 years, the money spent has provided good value.”

Economists Murphy and Topel estimated the economic value of the gains to health and longevity to be “enormous”, estimating that increased longevity alone added \$2.8 trillion (in 1992 dollars) to national wealth **per year**. They further estimated that a 1% reduction in cancer mortality would be worth \$500 billion.

Reality 3: Not all health spending produces value.

A study for the Midwest Business Group on Health concluded that thirty percent (30%) of all health spending produces no value or creates negative value. This lack of value occurs from a combination of some people getting too much care, others not getting appropriate care, others experiencing medical errors and the need to spend additional money to correct those errors, and administrative inefficiencies.

Researchers with the Dartmouth Atlas estimate that Medicare spending could decrease by 30% for people with severe chronic illnesses if “the resources and utilization of efficient providers were realized by all providers managing the care of people with severe chronic illnesses during the last two years of their lives.”

The Leapfrog Group, a collection of major purchasers of health care, compares the effectiveness of the delivery of health care with the handling of baggage in the airline industry.

An Agency for Healthcare Research and Quality study found that 1.12 million patient safety problems occurred in 1.07 million hospitalizations, about one per hospitalization.

A 2006 Institute of Medicine Report (IOM) estimates that there are 1.5 million people affected by medication errors which add at least \$3.5 billion in hospital costs each year

alone. This cost estimate does not include costs associated with lost productivity or additional health-related costs to treat people.

Also, according to David Cutler, the older the population the less economic value gained from medical spending.

Therefore, the return on investment from health spending should be even higher if the U.S. had a more effective and efficient health system.

For an interesting discussion on this point see Robin Hanson's essay of September 10, 2007 Cut Medicine in Half CATO UNBOUND and the three expert reaction essays. Hanson argues that it is possible to cut total health care spending by 50% with no appreciable negative consequences to health outcomes.

www.cato-unbound.org/2007/09/10/robin-hanson/cut-medicine-in-half

- **Reality 4: Existing payment systems and lack of coordination among payers create barriers to cost control**

Various studies on reducing inefficiency in health spending have found that more efficient practices may result in lower revenues for providers

Per researchers at the Dartmouth Atlas, Medicare physician payment policy rewards high volume practices with ways to increase revenue while reducing income to efficient providers

- **Reality 5: Overall, there may be greater under-use of care than overuse.**

The Rand Corporation has conducted a series of studies assessing the quality of care patients receive in the United States. This research estimates that patients receive care that meets best practice recommendations only 54.9 percent of the time. This research has further found that patients fail to receive needed services 46 percent of the time, while receiving services that they do not need 11 percent of the time.

- **Reality 6: There will need to be a short-term increase in health spending in some areas to generate long term improvement in cost savings, improved outcomes, and greater safety.**

Various proposals call for increased spending on health information technology, chronic care management, primary care, clinical preventive services, and better ambulatory care, for example, to create a more efficient and effective delivery of health care services. In addition, efforts to reduce or delay the onset of chronic health conditions call for investment in community-based prevention activities. Further, providing coverage to the uninsured will increase the demand for health services in the short run as we see when uninsured adults reach 65 and obtain Medicare coverage. These investments will take

new funds and may not show an immediate return on the investment, especially in a two-year government budget cycle.

- **Reality 7: The return from health spending may not accrue directly to those spending the money, which can reduce the willingness to support spending.**

The funding for health care comes from several sources, most prominently government, employers, individuals, and providers. Firms facing high levels of employee turnover may be reluctant to invest in long-term clinical preventive services or chronic care management services or to adopt value-based cost sharing approaches because the return on these payments will likely benefit a future employer. Providers believe that they will bear a disproportionate amount of the cost to investment in health information technology because they expect it to produce greater returns to insurance plans, patients, and employers than to providers.

- **Reality 8: Reducing the uninsured costs money; having people who are uninsured costs money and has other community costs.**

Studies indicate that the uninsured get less total care than the insured. Almost half the care received is by those who are insured. Therefore, expanding coverage will require some additional funds, especially if we cover the uninsured into the current health system.

According to the Health Policy Institute of Ohio's (HPIO) analysis of Ohio health spending, Ohio would need an additional \$3.9 billion would provide universal coverage that expands coverage to Ohio's uninsured population. This increase spending equals a 6% increase in health spending to provide full coverage to over 12% of Ohio's population.

According to the IOM, the U.S. loses \$65 to \$130 billion annually in diminished health and lower life expectancy of the uninsured.

Per HPIO's spending study, Ohio's estimated loss in productivity resulting from its uninsured population is between \$2.1 and \$5.8 billion.

Jack Hadley calculates that Medicare and Medicaid spend an additional \$10 billion a year on care to 66-68 year olds because of declines in health associated with being uninsured in the years before they turned 65.

Mark Pauly and Jose Pagan find that problems of health services quality and access for insured people increase when the proportion in communities that have a higher portion of uninsured people.

- **Reality 9: The business case for health spending often counts the direct costs of spending and fails to account for its indirect benefits.**

Businesses experience health costs in four ways: direct outlays for health care coverage; direct costs through outlays for disability benefits; indirect costs through lost days of work (absenteeism); and indirect costs through decreased productivity from workers who are working but in diminished health (presenteeism). Most calculations of business costs focus only on the direct outlays for providing coverage. Only recently have studies begun to emphasize and estimate the costs of lost productivity due to poor health or on costs of disability benefits. According to the Integrated Benefits Institute, the full costs of absence are more than four times total medical payments.

- **Reality 10: Most health spending occurs among a small percent of the population**

One percent of the US population accounts for 22% of total health spending in 2002, which is lower than the percent in 1996 (28%)

Five percent of the US population accounts for 49% of total health spending, while 10% account for 64% of total health spending.

Half of the US population account for only 3% of total US health spending.

In SFY 2003, just over 8,100 of Ohio Medicaid's 1.6 million consumers accounted for over \$1.1 billion of spending through ODJFS (or 0.5% of the Medicaid population accounted for over 11% of total spending). Some of these Medicaid consumers obtained their Medicaid coverage because of their high cost medical situation.

Five percent of Medicare fee-for-service members accounted for 43% of total spending and 25% accounted for 85% of Medicare spending in 2001.

Medicare reports that 27% of Medicare spending occurs in the last year of life of Medicare recipients. This spending does not include spending by Medicaid, the individual, or other third party coverage.

- **Reality 11: Most health spending relates chronic health conditions, yet chronic care prevention and management are just being developed**

According to the Partnership to Fight Chronic Disease, over 75% of total national health spending went toward the treatment of chronic disease, with this amount being even higher for Medicare (96%) and for Medicaid (83%).

Chronic health conditions account for 7 out of 10 deaths a year or 1.7 million Americans.

- **Reality 12: Rises in health premiums greatly exceed growth in inflation and real wages.**

In 2007, average employer health insurance premiums rose by 6.1%, while wages rose by 3.7% and general inflation rose by 2.6%, according to the Employer Health Benefits Survey of the Kaiser Family Foundation.

Between 2000 and 2006, health insurance premiums have increased, on average, by 84% compared to average wages increasing by 20% and general inflation increasing by 18%

- **Reality 13: Many reform proposals and health economists call for making consumers more cost conscious about their health care choices. Yet, an increasing number of studies show that most currently structured cost sharing approaches result in poor health outcomes and higher health costs in the long run.**

Recent research from the Rand Corporation finds that doubling co-payments reduced the use of medications for chronically ill consumers by 8 to 23 percent. The authors conclude, “that significant increases in co-payments raise concerns about adverse health consequences, especially among diabetic patients.” As a result, some employers and health plans have begun to reduce or eliminate their co-payments for maintenance drugs for chronically ill patients.

In a review of cost sharing studies, Braithwaite and Rosen note that modeling studies suggest substantial benefit from targeted reductions in copayment reductions, including the potential to avert nearly 80,000 cardiac hospitalizations annually.

Pitney Bowes changed its cost-sharing program, especially for people with chronic health conditions, after concluding that the old approach was counterproductive.

The cost-sharing burden falls highest on people facing high health costs. According to research from AHRQ, 34% of people in the top 5% of health spenders had out-of-pocket costs that exceeded 10% of their income, while another 18% had out-of-pocket costs that exceeded 20% of their income. At the same time, 5% of people in the bottom 50% of health spenders had out-of-pocket costs that exceeded 10% of their income and another 3% had out-of-pocket costs that exceeded 20% of their income.

According to Jason Furman “Like any major public policy—especially one designed to reduce health-care spending—increased cost sharing will produce winners and losers. But far from derailing such reform, this should be an impetus to reformers to be careful about the way in which cost sharing is implemented, and to make adjustments as the emerging evidence warrants.”

- **Reality 14: Most current cost sharing programs are regressive, resulting in higher cost sharing burdens on lower income populations, a population with a higher likelihood of fair or poor health status**

If cost sharing is to create an equal level of cost consciousness among consumers then the cost-sharing burden must be comparable across income levels. However, most insurance policies, including health deductible plans, impose the same deductible, coinsurance, copayments, and premium sharing requirements to everyone. A \$20 copayment or a \$7,000 health savings account deductible places a greater burden on families with further down the income spectrum. Jason Furman argues for a progressive cost sharing design to

correct for this problem in part to avoid lower income populations forgoing needed care at rates higher than higher income populations.

- **Reality 15: The health service industry has been one of the few growth sectors and is the largest employer in many communities.**

According to the September 25th issue of Business Week, “Since 2001, the health-care industry has added 1.7 million jobs. The rest of the private sector? None.” The article estimates that the U.S. unemployment rate would be 1 to 2 percentage points higher without health care industry hiring between 2001 and 2006.

Throughout Ohio, hospitals are often one of the largest, if not the largest, employer.

Total health care spending is the largest source of revenue and employment in most Ohio counties.

Ohio’s Medicaid spending alone accounts for 3% of Ohio’s economy.

- **Reality 16: One person’s cost is another person’s revenue.**

Spending that studies define as wasteful may not be wasteful to everyone. Much of that spending generates work, income, and profit from those providing the services and activities.

As Hoangmal Ham, Paul Ginsburg, Kelly McKenzie, and Arnold Milstein conclude in their analysis of redesigning health care delivery to reduce spending at the Virginia Mason health system, “there is no escaping the equity issues associated with reducing the 30–40 percent of U.S. health care spending judged to be wasteful. That magnitude of spending reduction implies the loss of many health industry jobs and current income levels. Every dollar used to cushion pain for providers means less spending relief for globally competitive purchasers and increasingly hard-pressed consumers. A blended approach that allows more-efficient providers to retain some savings that would otherwise accrue to payers, while expanding their market share and capacity may represent an intuitive middle ground.”

- **Reality 17: The U.S. spends more on health care than any other country, yet this spending has not resulted better overall quality or better health outcomes than in other countries.**

While total health spending exceeds that for all other countries, the U.S. annual increase in health spending does not exceed that for other countries. Between 1990 and 2002, Norway, the United Kingdom, Luxembourg, and Japan all had higher annual rates of growth in spending.

- **Reality 18: Health cost increases are not simply an American experience. Annual increases in health spending in the U.S. are not higher than spending increases in many other countries and even less than increases in some countries.**

Per a January 2007 report from the McKinsey Global Institute, the United States spends \$477 billion more dollars - \$1,645 per capita - on health care than peer countries, a 28% difference in spending. The U.S. spends more in five areas of care – hospital care; outpatient care; drugs; administration and insurance, and public investment – and less in two areas – long term care and durable medical equipment

- **Reality 19: There is a tension between personal freedom to choose one’s own health behaviors and the social, community, and business costs of those behaviors.**

The CDC estimates that three risks factors – poor diet, inactivity, and smoking –, which are modifiable, account for a large amount of heart disease and stroke (80%), type II diabetes (80%), and cancer (40%).

According to the Commonwealth Fund, Ohio ranks 41st on its measure of healthy lives.

Companies are increasingly adopting no smoking workplace policies, with a growing number refusing to hire anyone who smokes or continue to employ anyone who keeps smoking.

- **Reality 20: Improving individual health behavior is not enough. Promoting individual health behavior requires creating communities that enhance the health of citizens. However, policies to create healthy communities may create tensions with some existing business and development practices.**

Research shows that many community-based factors influence individual health behaviors. For instance, one Rand study found that teenage girls who live within a mile of green space are much more likely to engage in physical activity. Other studies indicate that street lighting and other strategies to increase neighborhood safety result in improved health behavior practices and lower health costs. The design of neighborhoods, proximity to air pollution, and proximity to affordable, healthy food alternatives affect health choices and health outcomes. Moreover, behavioral economists are identifying school, workplace, and community strategies that may promote healthier lifestyles. Arkansas imposed many restrictions on school-based nutrition and financing practices that appear to be helping to reduce the increase in weight among Arkansas children.

Greater Ohio has recommended use of health impact assessments in Ohio to consider the health consequences of different public policy options, options that go beyond traditional health policy. The CDC is also promoting the use of this tool.

V. What policy tools are available to policymakers and state government?

- a. Leadership
- b. Purchasing power of state-based health programs (e.g. employees, Medicaid, retiree systems, prison system, BCMH, mental health system)
- c. Regulator of health plans and of providers

- d. Regulator of health and safety practices
- e. Legislation to affect individual health opportunities and behaviors
- f. Employer who can establish incentives or penalties to promote wellness, prevention, and more effective use of health care services
- g. Incentives to employers to promote health and effective health coverage
- h. Financer and supporter of community development and business development
- i. Tax policy
- j. Financial support for technology adoption and other reforms
- k. Use health impact assessments in state and local policy making processes

VI. What are policy areas to focus on to address health spending concerns?

- a. Health before care
- b. Access to health care
- c. Effectiveness, safety, and quality of health care
- d. Monitoring of health trends and evaluation of effect of public and private policies that affect health

VII. More effective adoption of health information technology and exchange of health information is essential to improve quality, safety, and cost effectiveness

a. Why is HIT important?

Under the current system of paper records (or no records):

- Treating physicians were unaware of 1 in 4 patient prescriptions.
- The same drug or radiology exams were ordered 11 percent of the time.
- Patients agreed to duplicate testing 50 percent of the time.
- Problems with retrieval of information accounted for 1 in 7 admissions and 1 of 5 lab tests and radiology exams.
- Physicians could not find information previously recorded in a paper chart 30 percent of the time.
- The cost of tracking down and obtaining information on the data user/originator sides range from \$12 - \$28 per patient visit

Per the Technology CEO Council's October 2005 report on health information technology:

“What is beyond dispute is that this disaggregated information regime is an important reason the American health care system ranks a mere 37th in the world in quality and a sobering 48th in life expectancy.”

b. What are states are called to do?

Per the Technology CEO Council report on health information technology, states need to convene dialogues to consider ways to improve health care through better information management, including the passage of legislation to support those ends. Proposed features of state level activities include:

- Create a state level entity responsible for overseeing development and implementation of HIT plan
- Base Medicaid payment on value, with additional incentives for HIT adoption
- Encourage formation of regional health initiatives through loans, grants, and/or regional tax exempt bonding authority
- Remove legal and regulatory impediments to use of HIT and exchange of information
- Make better use of health care data collected by state agencies
- Enable telemedicine through licensing reforms and Medicaid payment rates
- Provide adequate state level funding for health care IT leadership and change

c. *What are other states doing?*

According to an August 2006 eHealth Initiative report examining state activities over the past two years:

- 10 states have issued executive orders supporting HIT efforts: AZ, CA, FL, IL, KS, MO, NC, TN, VA, and WI
- 24 states have introduced legislation and passed legislation relating to HIT: CT, FL, GA, ID, IL, IN, KY, LA, MA, MD, ME, MI, MN, NH, NY, OK, RI, SC, TX, UT, VA, VT, WA, WV
- 7 states have authorized or appropriated funding by statute for HIT: ID, MA, MI, RI, UT, VT, VA
- Several other states had appropriated funds and developed exchange efforts before 2004, including UT and NY

d. *What can Ohio do?*

Ohio is notably absent from these states. Ohio HIT activities are occurring in some local areas and through two processes convened by HPIO. One process is the Health Information Security and Privacy Collaboration contract that HPIO secured for Ohio at the request of Governor Taft. The other is a process to bring together stakeholders to develop a HIT roadmap for Ohio. Successful adoption of the HISPC and Roadmap recommendations requires leadership and other support from state policy makers. The roadmap identifies policy recommendations in four areas:

- Organizational structure
- Adoption of HIT by providers
- Interoperability
- Health information exchange

These recommendations underscore the need to create sufficient infrastructure capacity to allow for electronic exchange of health information across Ohio, especially in the southeastern portion of the state and other rural areas. Several state agency efforts are underway to pursue advantages of health information technology. The Ohio Department of Corrections hopes to invest in

electronic medical records to better serve its population and save money. Ohio Medicaid submitted a Medicaid Infrastructure Transformation Grant that emphasized the need to promote more effective health information exchange through Ohio. The Ohio Public Employees Retirement System (OPERS) has expressed an interest in fostering health information exchange as well.

VIII. Creating a value driven health system

The need for improved use of health information technology is one of four cornerstones to the Bush Administration's effort to create a value-driven health system and for the Commonwealth Fund's effort to create a high performance health system.

Secretary Leavitt and the Bush Administration are encouraging employers to join the federal government in building a value-driven health care system. Employers are asked to sign a Statement of Support for Value-Driven Health Care, which calls on them to support the four cornerstones of value-driven health care and encourage the health insurance plans, third party administrators, providers, and others with which they contract to take consistent actions to achieve these goals.

The four cornerstones for a value-driven health system are:

- Support health information technology
- Provide quality information
- Provide pricing information
- Promote quality and efficiency of care

At the City Club of Cleveland, on January 30, 2007, Michael Leavitt, Secretary, U.S. Department of Health and Human Services, singled out the Health Action Council (HAC) and thanked HAC members -- Sherwin-Williams, Novelis, Parker Hannifin, KeyCorp, Danaher, National City, OPERS, and Cleveland Clinic-- for signing a Statement of Support for the Four Cornerstones of Value-driven Health Care. Eaton, Timken, and University Hospitals also signed.

“If every major employer, be it a corporation or state government, would embrace these four cornerstones, we could indeed build a value-based system that delivers more choices of greater quality at lower cost to every single American. But to get there, we need continued leadership and immediate action from everyone in health care--now.” (Newt Gingrich, 1/31/07)

Per the Commonwealth Fund and its Commission on a High Performance Health System, potential strategies to move the U.S. to a higher value, more efficient health care system cluster into six main areas:

- increasing the effectiveness of markets by improving access to information on the quality and costs of care, promoting greater competition, and developing better information on the cost-effectiveness of health care technology and procedures

- Reducing high insurance administrative overhead and achieving more competitive prices;
- Providing payment incentives to promote efficient and effective care;
- Changing the health care system to promote patient-centered primary care;
- Investing in infrastructure such as health information technology and information exchange systems;
- Investing strategically to improve access, affordability, and equity.