



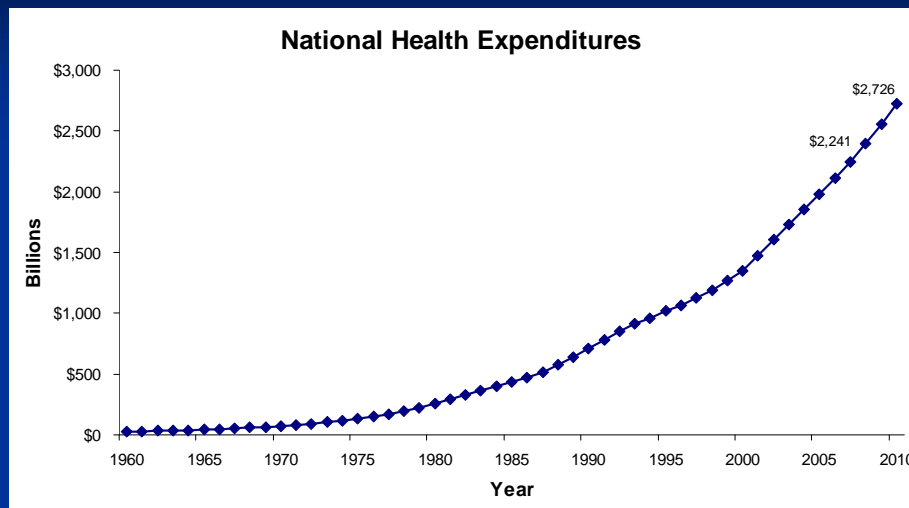
The American Health Cost Crisis

Vivian Ho, Ph.D.

Baker Institute Chair in Health Economics, Rice University
And Baylor College of Medicine

June 10, 2009

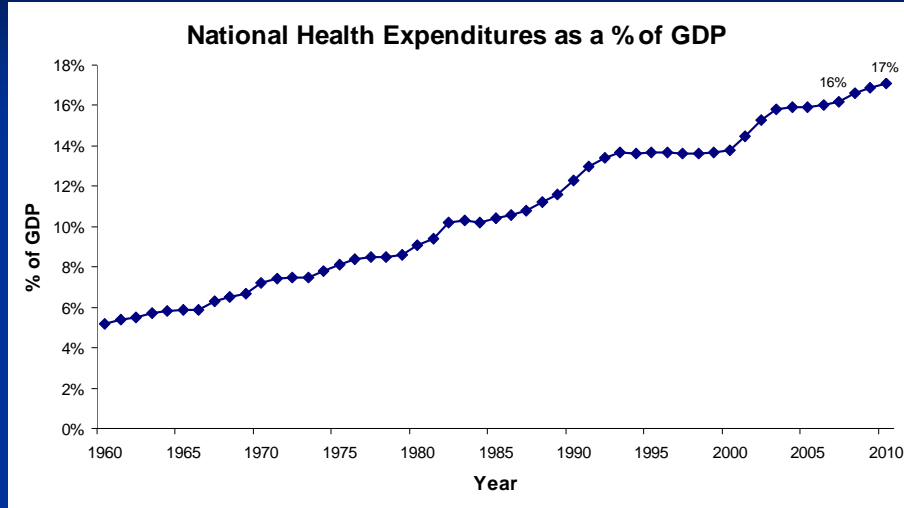
Rising Healthcare Costs



Data from 2008-2010 are projected values.

Source: <http://www.cms.hhs.gov/nationalhealthexpenddata/>

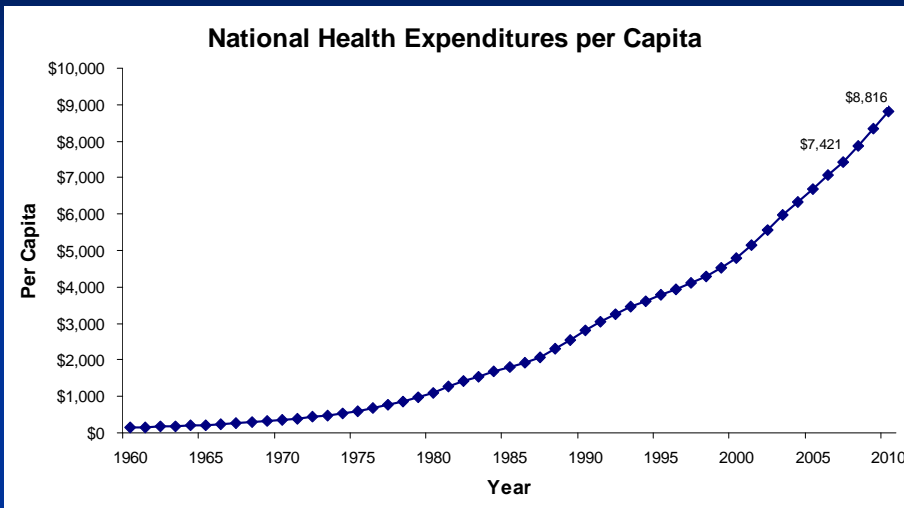
Rising Healthcare Costs



Data from 2008-2010 are projected values.

Source: <http://www.cms.hhs.gov/nationalhealthexpenddata/>

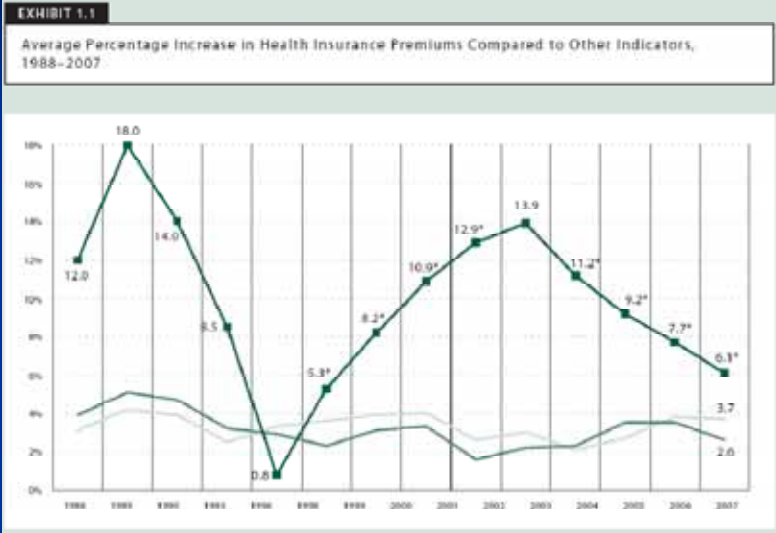
Rising Healthcare Costs



Data from 2008-2010 are projected values.

Source: <http://www.cms.hhs.gov/nationalhealthexpenddata/>

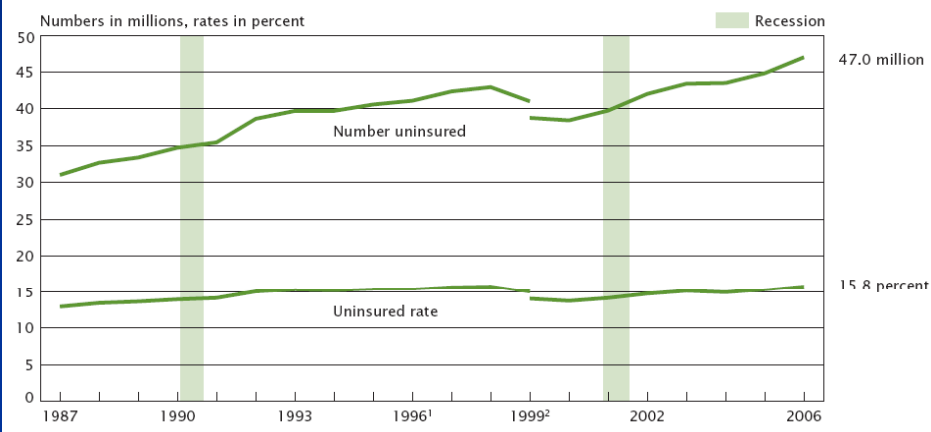
Rising Health Insurance Premiums



Source: KFF/HRET Survey of Employer-Sponsored Health Benefits, 2007

Rising Number of Uninsured

Figure 6.
Number Uninsured and Uninsured Rate: 1987 to 2006



Source: U.S Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States 2006

Controlling health care costs is essential for increasing insurance coverage.

Pay only for what works

- Some treatments are high cost and provide little benefit
- Some treatments are high cost and used to treat the wrong patients

High cost treatments with little benefit

- Medicare covers treatments based on effectiveness, but not *value*.

“...the Medicare program has not taken costs into account in determining what services are covered and has made only limited use of comparative effectiveness data...”

(Congressional testimony, Peter Orszag, CBO director, June 2007)

- Some expensive technologies “work,” but they don’t work all that well.

High cost treatments with little benefit

- Left Ventricular Assist Device
 - Cost per quality-adjusted life year £170,616
(Int’l Journal of Technology Assessment in Health Care 2007)
 - \$511,962/yr in 2015 (1999 \$’s), assuming mortality improvement of 15 percent.
 - \$10.1b more Medicare spending.
- Medical technologies < \$100,000/life year commonly considered cost-effective.

High cost treatments with little benefit

- 26% of adults in a 2002 U.S. survey reported low back pain.
- Costs per patient w/ spine problems rose from \$4,695 to \$6,096 from 1997 to 2005.
 - \$85.9b in added costs.
- But self-reported mental health, physical functioning, work/school limitations, & social limitations were all worse.

(Martin et al, JAMA 2008)

High cost treatments with little benefit

- Colonoscopy vs. Computed tomography colonography (CTC) in colon cancer screening
- Compared to no screening, CTC costs \$1,500/life yr saved.
- If compare CTC every 5 years to colonoscopy every 10 years, CTC costs \$600,000 per additional life year saved.

High cost treatments for the wrong patients

- Stress test before elective PCI (angioplasty)
 - Patients w/ stable coronary artery disease should undergo stress test to confirm presence of ischemia before receiving PCI.
 - But only 44.5% of Medicare patients underwent stress test prior to PCI.

(Dudley et al, JAMA 2008)

- >800,000 PCIs performed/yr, Medicare pays \$10k-\$15k per case

High cost treatments for the wrong patients

- Advanced Diagnostic Imaging
- From 2000 to 2004, PET use rose 400%, MRI & CT rose >50% in California
 - Physicians learned they could “self-refer” patients, earn ~\$400/patient.
- CMS is finally limiting self-referral this year, but previous efforts stalled by physician lobbyists.

Strategies for Cost Control

- Comparative Effectiveness
- Rigorous evaluation of the impact of different options that are available for treating a given medical condition for a particular set of patients
- Medical procedures can achieve widespread use without extensive clinical evaluation.

(Research on the comparative effectiveness of medical treatments, CBO Paper Dec 2007)

Comparative Effectiveness

- When evaluating options, consider both effectiveness and costs
- Previous example: colonoscopy vs. CTC.

Challenges to Comparative Effectiveness

- Educating the public
 - Medicare cannot afford to pay for every treatment a doctor offers.
 - Convince consumers to choose insurance that covers only cost-effective care, in return for substantial premium savings.

- Achieving unbiased recommendations
 - The AHRQ was in danger of elimination in the mid-1990's after issuing practice guidelines for back pain treatment.
 - CMS was heavily lobbied when it first tried to restrict self-referral for diagnostic imaging.

Challenges to Comparative Effectiveness

- Reaction to \$1.1b in stimulus spending for CER
 - The CER, which would dramatically advance government control -- and rationing -- of health care, should be thoroughly debated, not stealthily created in the name of "stimulus." George Will, The Washington Post, 1/29/09

- It's a shame it has gotten to this point...wanting to deny senior citizens their Social Security or cut their benefits or whatever, basically telling them, "Get out of the way and die," ... Rush Limbaugh, 2/29/09

Strategies for Cost Control

- Pay for performance
 - Pay doctors for the quality of their care, not the quantity of services provided.
 - Medicare reimburses physicians for procedures, not for outcomes.

Pay for performance

- Example: Medicare has stopped reimbursing for preventable complications of medical care.

Condition	# of FY2006 Cases
Object left in patient during surgery	764
Air embolism	45
Blood incompatibility	33
Catheter-associated urinary tract infection	11,780
Pressure ulcer	322,946
Mediastinitis after coronary-artery bypass grafting	108
Fall from bed	2,591

Source: Rosenthal NEJM 2007

Pay for performance

- Bundled payments
 - Medicare should pay a single entity (a hospital and its affiliated docs) a fixed amount to cover the costs of providing all Medicare-covered services for an episode of care (e.g. hospital stay + 30 days post discharge).
 - Reduce cost variation resulting from readmissions and post-acute care.

Pay for performance

Average Risk-Adjusted Standardized Spending between the Start of a Hospital Stay & 30 Days after Discharge for Congestive Heart Failure			
Type of Service	Spending at Hospitals w/ Low Resource Use	Spending at Hospitals w/ High Resource Use	Difference Between Spending at Hospitals w/ High Resource Use & Ave. Spending
Total episode	7,757	11,019	18.8%
Hospital	4,837	4,824	0.0%
Physician	612	650	0.5%
Readmission	1,102	2,965	49.3%
Post-acute care	842	2,041	48.1%
Other	363	539	22.2%

Source: Hackbarth et. Al. NEJM 2008

Conclusions

- We live in a remarkable new age.
 - **New technologies**
 - **Longer life expectancy, better quality of life.**
- Government and payers must move to reform coverage decisions and provider payment.
 - Controlling rising health care costs is essential to insuring access to high-quality care for the most people possible.

