

Why is health care so expensive?

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Objectives of this talk

- Why is health care in the U.S. so expensive?
- Why do health care costs go up?
- Uncompensated care
- Markets
- Variations in care
- Chronic illnesses
- What can be done to control costs?

Why is health care in the U.S. so expensive?

Why is health care in the U.S. so expensive?

- U.S. per capita spending 2.5 times greater than median Organization for Economic Cooperation and Development (OECD) country
- 50% higher than the second highest (Switzerland)
- Why so much higher than other countries?

“It’s the prices, stupid.”

Anderson et al, Health Affairs 2003

- Expenses = Price * Quantity
- Utilization measures are lower
 - Fewer physicians, nurses, and hospital beds per capita than OECD median
 - Fewer office visits, acute care bed days, shorter inpatient bed stays than OECD median
 - MRI/CT scans equal to OECD median
- Prices are higher
 - Oregon insurance CEOs focus on “unit price increases”
 - Payments to providers
 - “Quality” of services
 - Some of this is good, some of it is questionable

Why do health care costs go up?



Why do health care costs go up?

- Costs are high, but *will get higher*
 - In the US and in the OECD
 - The rate of cost increases is similar across countries
 - Just hurts us more because our baseline levels are so high to begin with
- What drives health care costs up?
 - Lots of little reasons
 - One big one....

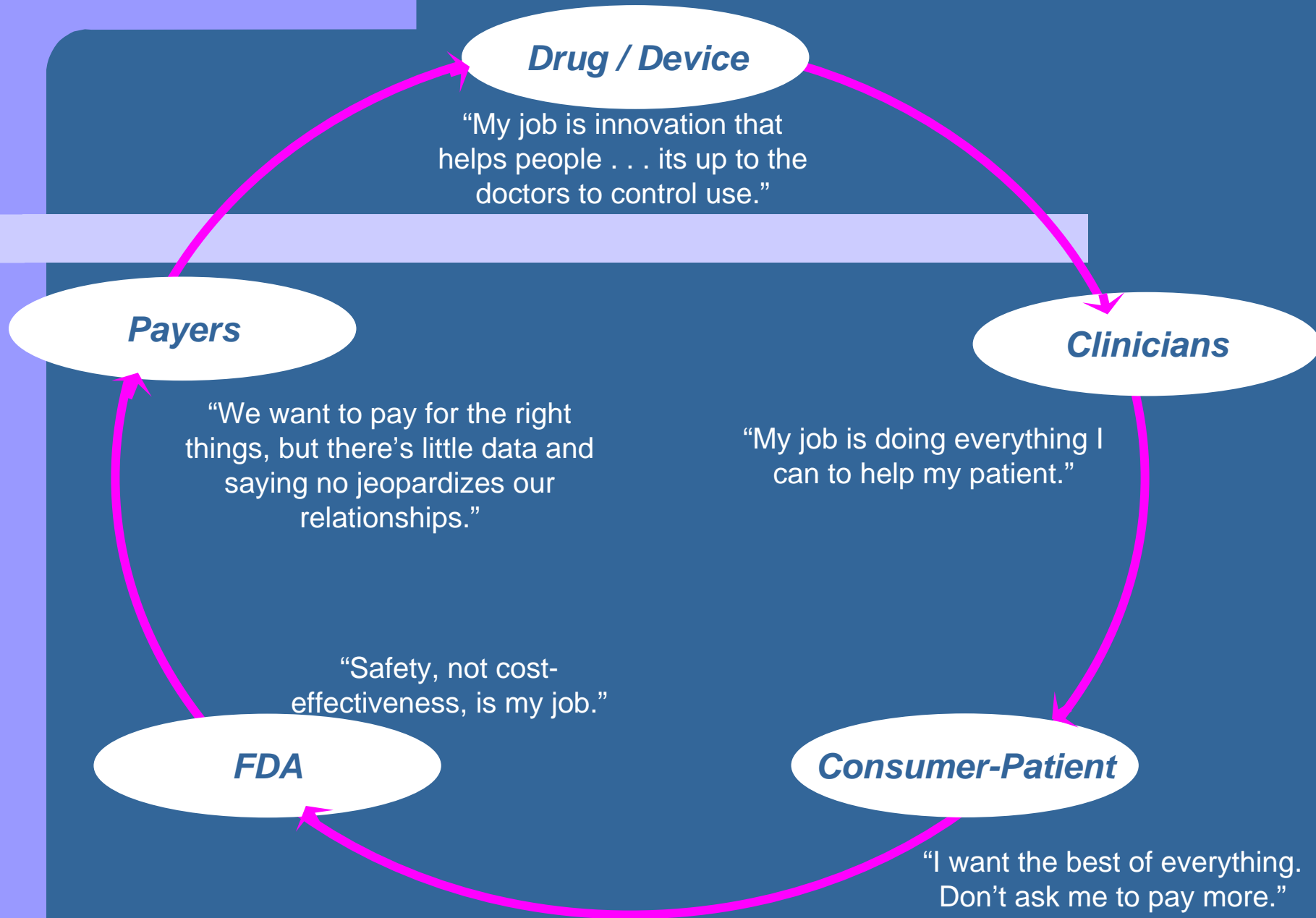
Technological change

- New procedures, drugs, equipment
 - Many of which lead to longer, healthier lives
 - All of which increase total health care costs
- Example:
 - 1956: heart disease = death
 - 2006: heart disease + \$40,000 = life
- Spending related to new technology (procedures/drugs/devices) accounts for 50% to 75% of increases in spending

What lies ahead?

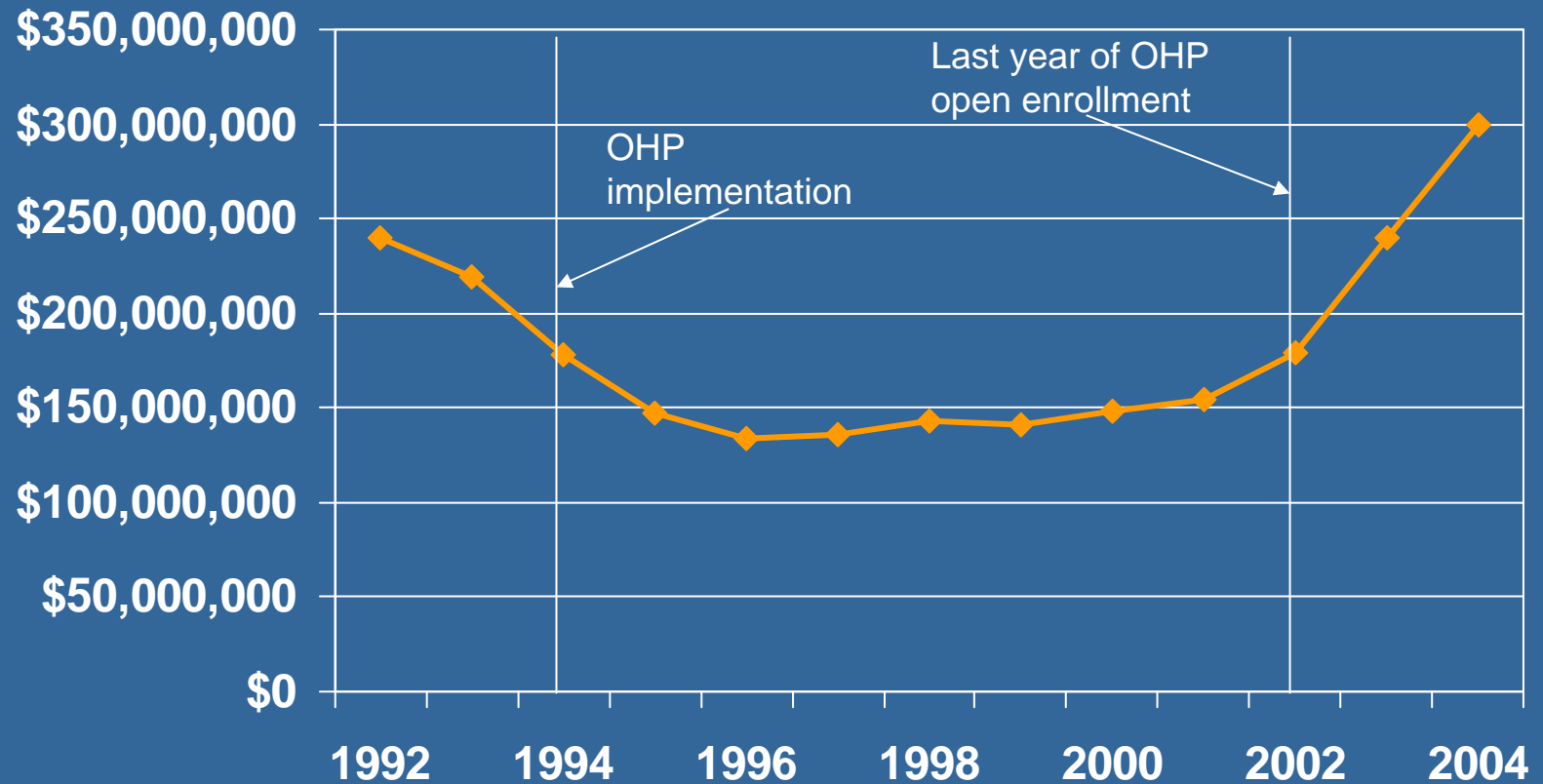
- System will be increasingly burdened with growth of
 - Imaging-treatment combinations
 - Personalized medicine breakthroughs
 - Unraveling the human genome
 - Tinkering with the human life span
- No accountability in the system...

The Cycle of Unaccountability



Uncompensated care and cost shifting

Uncompensated care in hospitals in Oregon



Uncompensated care in Oregon (preliminary estimates)

- 2004 hospital uncompensated care: \$299M
 - Total uncompensated care for 2004 estimated to be \$425M
- What is the burden on those with commercial insurance?
 - Approximately 6% - 9% of 2004 Oregon family premium of \$9,906

Health reform & the cost-shift

- Cost shifting not a viable long-term strategy
 - An “inefficient” hidden tax
 - Implicit agreement to support catastrophic care over preventive care
 - Adds to the increasing cost of commercial premiums and erosion of employer-sponsored health insurance
- The magnitude of uncompensated care in Oregon is large
- Substantial savings for employers/employees from policies that cover the uninsured

Markets and competition

A lot of interest in what markets and competition can do for health care

- This is a natural response
- Markets are the “American way”
- Concern about moral hazard
 - Consumers aren’t consumers
 - More shopping would lead to better utilization and/or lower prices
 - Focus on consumer-driven health plans (CDHP), high deductibles, health savings accounts (HSAs)
- So what’s the (theory) and evidence on markets?

Market theory & evidence

- Economic theory says markets are great under conditions of perfect competition
 - Many providers, many consumers
 - No externalities
 - No asymmetric information
 - What does “great” mean? Essentially – we are maximizing social welfare
- Markets may not maximize social welfare when we deviate from perfect competition
 - Theory of the second best

Markets – supply side and demand side

- Supply side
 - Focus on the provider/health plan
 - *Ex ante* price setting
- Demand side
 - Focus on the patient/consumer
 - *Ex post* price setting

Supply side - the evidence

- Focus on provider
- Real (inflation-adjusted) health care spending was flat for much of the 1990s
- Complaints from providers & patients
 - But no observed quality/outcome problems
- How did managed care do it?
 - Most savings came from rate reductions & provider discounts
 - Not from gatekeeping, better utilization review or other ways of managing care
- Were there “process improvements” from providers?
 - Some – but a lot of focus on achieving counterbalancing market power
 - Some lessons from prepaid group model
 - Freedom from FFS & chances to innovate (group visits)
 - Some evidence of process improvements, costs savings

Demand side - the evidence

- Yes, in fact, moral hazard exists
- BUT - savings smaller than you would think
- Co-payments/deductibles have the biggest impact on access, not on price
 - Whether or not you go
 - Not how much you pay once you are there.
- Estimated savings if *everyone* moved into Health Savings Account:
 - Range of 2.5%-7.5%
 - One-time only savings - does not do much for the technology problem
- Evidence on HSA take-up
- Co-payments for poor/Medicaid populations?

Can markets tackle long-term growth?

- In 2007, TramGenix releases a cure for Alzheimer's. Cost: \$20,000/year
 - This is great! (and “cost-effective” by conventional standards)
 - 50K Oregonians with Alzheimer's, another 26K with related disease
 - Implies an additional \$3000 in health premiums or taxes for an Oregon family of four
 - Best estimate: adds another 100K to 200K to uninsured through increased premiums
 - This is bad!
- It is very difficult to manage a drug that costs \$20,000 (or \$100,000) with no substitute
- Is there a market solution for this problem?

Summarizing markets

- If markets have been successful at cost control, it has been primarily by extracting discounts from providers (supply side)
 - i.e., impact on “price” not “quantity”
 - Public programs can do this, too
- Evidence on savings from “consumerism” is real but so far relatively small
- Markets don’t have a great answer for the technology-cost relationship
- Markets don’t do subsidies

Variations in care



Variations

- The Wennberg variations
 - Pick your procedure (Back surgery, MRIs, CABG, Vioxx) and your region (states, counties with states)
 - E.g., Medicare's costs per enrollee by region varied from \$4,500 to nearly \$12,000 in 2003
 - Better outcomes not associated with higher spending
 - Estimates of 20% - 30% of spending could be eliminated
- Big savings – how to capture it?
 - More rigorous use of evidence-based medicine
 - Investment in Information Technology
 - Better coordination of care

Chronic Illnesses



Spending on chronic disease

- 5% of the population accounts for 56% of health care expenditures
- Fastest area of health care cost growth
- Bodenheimer: “Can we decrease costs for our sickest patients by 50%?”
 - Large theoretical savings from disease management/EMR/HIT
 - “Care Management Plus” model at OHSU – nurse-based care management + IT for patients with multiple chronic illnesses

What can we do about costs?



How can reform affect costs?

- Chronic illnesses
 - Prevention
 - Care/disease management
- Variations
 - IT
 - Care management
- Markets
 - Some savings are possible
 - Not a panacea
- Cost shifting
 - Some savings from (6% - 9% of commercial premiums)
- What about long term cost growth?
 - Should the Health Fund Board tackle this?

Constraining health care cost growth

- If health reform policies are to be sustainable, they should (must?) address cost growth
- We should not be “anti-technology”
- New technology has been a boon on average
- Innovation should be encouraged
- Ideally:
 - We continue to pay more for new technology but at a slower rate
 - Reduce inappropriate technology
- Acknowledge the tension and tradeoffs
 - Scientific advances improve the quality/length of life (good)
 - Expensive, life saving drugs/devices/procedures raise the cost of healthcare (bad: higher premiums, higher taxes, more uninsured)
- Jonathan Gruber & Uwe Reinhardt: this is hard and other states aren’t doing this and that’s ok – worry about coverage first
- John McConnell – well, maybe
 - Might be critical for financially sustainable reform
 - This is Oregon and there are opportunities for real innovation here

Oregon is different

- There are hundreds of academic papers written on cost, cost growth, and potential market and policy solutions
- The problem has captured the attention of leading scholars throughout the country and is discussed in journals from many fields – health care, economics, public policy, finance
- As you read these articles, you find that one word comes up again and again
- That word is “Oregon”



Rare archival photograph of John Kitzhaber & Barney Speight drafting Oregon Health Plan framework

Oregon is ahead of other states when it comes to thinking about cost control

- Ideally, health reform bill would have a plan to confront cost control, or at least be financially sustainable
- Tension here is between what is politically feasible (Gruber/Reinhardt) vs. best policy
- Don't want to let perfect be the enemy of the good
- Nonetheless, there are opportunities for innovation

What's in place?

- We have the Oregon Health Resources Commission
 - Role is to “encourage the rational and appropriate allocation and use of medical technology in Oregon”
 - Currently engaged in a Technology Assessment Program to address the diffusion of health technology
- Limitations
 - Limited to Medicaid/OHP
 - Most emphasis on drugs, not procedures/devices
- But:
 - Some interest from commercial plans
 - Recent emphasis on bariatric surgery (new procedures)
- This is great, but with real teeth and broader scope, could provide tremendous benefits

How to extend the Technology Assessment Program

- Engage the commercial health plans
- Engage employers

Engaging commercial health plans

1. Coordination with HRC TAP
 - Commercial plans already make choices about what to cover
 - Rationales are not always evidence-based or transparent
 - Legal concerns, public relations, provider relations?
2. RFP process for commercial plans: demonstrate how benefits can be structured explicitly to constrain technology-related cost growth
 - This could be a hypothetical offering
 - Or, could be adopted in pilot programs by selected employers
 - RFP process will highlight
 - Legal barriers & difficult decisions
 - Adequacy of resources for HRC

Some possibilities for innovation

- Differentiation in plans: cheaper plans that offer “go-slow” policies toward technology?
- Instead of first-dollar HSA/high-deductible, can we have more sophisticated plans that put financial pressure on decisions related to new technology?
 - “Value-based” insurance
 - E.g., no co-payments for maintenance medications
 - Successful at Pitney Bowes, Ashland NC
 - Offer tiered benefits around technology?
 - Vary co-payments according to Prioritized Line?

Engaging employers

- Employers need to understand that health care costs are going up because of new technology
 - 4/5 large employers lack confidence in ability to address cost issues
 - Less than half perform financial analysis on their health care costs
 - Little/no emphasis on new technology and what drives spending up
- PEBB has been specific about quality requirements
 - Other employers are learning from PEBB about quality
 - Can we do something similar for technology diffusion?

Thank you...

...and questions?

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