Medical Spending Control: How Do We Get There?

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Medical spending increases have consistently outpaced GDP/sales/tax/income growth.
Medical spending in MA has outpaced the rest of the country

Ratio of per capita medical spending: MA / US
The outlook for the federal budget is grim.
The Increasing Costs of Health Care Squeeze Out Other Public Spending Priorities

Massachusetts State Budget, FY2001 vs. FY2011

State Spending (Billions of Dollars)

<table>
<thead>
<tr>
<th>Category</th>
<th>FY2001</th>
<th>FY2011</th>
<th>Change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Coverage (State Employees/GIC; Medicaid/Health Reform)</td>
<td>$5.1 B</td>
<td>$4.0 B</td>
<td>-20%</td>
</tr>
<tr>
<td>Public Health</td>
<td></td>
<td></td>
<td>-38%</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td>-33%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td>-15%</td>
</tr>
<tr>
<td>Infrastructure/Housing</td>
<td></td>
<td></td>
<td>-23%</td>
</tr>
<tr>
<td>Human Services</td>
<td></td>
<td></td>
<td>-13%</td>
</tr>
<tr>
<td>Local Aid</td>
<td></td>
<td></td>
<td>-50%</td>
</tr>
<tr>
<td>Public Safety</td>
<td></td>
<td></td>
<td>-11%</td>
</tr>
</tbody>
</table>

Source: Massachusetts Budget and Policy Center Budget Browser.
These are tough times

“Can anybody remember when the times were not hard and money not scarce?”
- Ralph Waldo Emerson
The Magnitude of Waste
Best guess: 1/3 of medical spending is unnecessary

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor care delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unnecessary services</td>
<td>$192 billion</td>
<td>7%</td>
</tr>
<tr>
<td>Failures of care delivery</td>
<td>$128 billion</td>
<td>5%</td>
</tr>
<tr>
<td>Failures of care coordination</td>
<td>$35 billion</td>
<td>1%</td>
</tr>
<tr>
<td>Excessive prices</td>
<td>$248 billion</td>
<td>9%</td>
</tr>
<tr>
<td>Administrative costs</td>
<td>$131 billion</td>
<td>5%</td>
</tr>
<tr>
<td>Fraud and abuse</td>
<td>$177 billion</td>
<td>7%</td>
</tr>
<tr>
<td>Total</td>
<td>$910 billion</td>
<td>34%</td>
</tr>
</tbody>
</table>
# Examples of cost savings

<table>
<thead>
<tr>
<th>Provider</th>
<th>Type of care</th>
<th>Specific problem</th>
<th>Intervention</th>
<th>Annual cost savings</th>
<th>Projected national savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser</td>
<td>Primary care</td>
<td>Wasted visits</td>
<td>EHR</td>
<td>$500 m</td>
<td>---</td>
</tr>
<tr>
<td>Mayo clinic</td>
<td>Primary care</td>
<td>Specialist consultations</td>
<td>Team approach</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Geisinger</td>
<td>Acute</td>
<td>CABG</td>
<td>ProvenCare</td>
<td>5% of hospital</td>
<td>$400 m</td>
</tr>
<tr>
<td>Inter-mountain</td>
<td>Acute</td>
<td>Pre-term births</td>
<td>Collaborative</td>
<td>$50 m</td>
<td>$3.5 b</td>
</tr>
<tr>
<td>Virginia Mason</td>
<td>Acute</td>
<td>Back surgery</td>
<td>Collaborative</td>
<td>$1.7 m</td>
<td>$45 b</td>
</tr>
</tbody>
</table>
Example: Bipolar illness

Diagnosis of Bipolar I, Bipolar II, or Bipolar NOS

Bipolar depression:
- Start with:
  - Quetiapine
  - OR Lamotrigine

Mania/mixed mania:
- Start with:
  - Lithium carbonate (mania)
  - OR Divalproex sodium (mania/mixed)
  - OR An atypical antipsychotic:
    - Aripiprazole
    - Olanzapine
    - Quetiapine
    - Risperidone
    - Ziprasidone

For moderate to severe symptoms:
- Combine lithium and valproic acid with each other or with an atypical antipsychotic

Hyponmania:
- Consider watchful waiting unless:
  - Patient preference for treatment
  - Functional disability

Start monotherapy with a medication with mood stabilizing properties
- Start with a mood stabilizer with “A” quality data for treatment of the appropriate pole. See the medication table on pages 12 and 13 for details.

Follow up in 1-2 weeks as indicated by acuity and severity

Adequate response?
- Yes
  - Somewhat or much improved
    - CGI global improvement score 1-3

Follow up in 4 weeks until remission. At every follow-up visit:
- Achieve target doses
- Use outcome measures to assess progress (see page 18)
- Monitor side effects and adherence
- Assess educational needs
- Assess therapeutic alliance (see page 17)
- Assess for substance abuse (see page 8)

Improved?
- Much improved
  - CGI global improvement score 1-2
    - Continue at present dosage.
    - Follow up every 4 weeks until remission (CGI severity score 1-2)
    - When in remission, follow up at least every 6 months to monitor symptoms, lab values, and functional outcomes

TARGET: FULL REMISSION
(CGI severity score 1-2)

Somewhat improved
- CGI global improvement score 3
  - Raise dose of mood stabilizer as tolerated
  - Add a second mood stabilizer for the appropriate pole.
  - OR If depressed, add SSRI or bupropion

No improvement or worsening
- CGI global improvement score 4-7
  - Change to another primary mood stabilizer for the appropriate pole if target dose has been achieved
  - OR For bipolar depression, consider augmenting with SSRI or bupropion

*Note: In emergency situations with acute symptoms, rapid titration and more than one medication may be necessary to reduce time to response. However, lamotrigine should never be rapidly titrated due to increased risk of allergic rash.

*Note: The combination of olanzapine and fluoxetine is FDA-approved for depression.
The Drivers of Productive Industries

- IT and its use [ARRA, 2009]
- Move from pay-for-volume to pay-for-value [PPACA, 2010]
- Engaging employees and consumers in continuous quality improvement

Diagram:

1. IT and its use
2. Appropriate Information
3. Compensation Arrangements
4. Empowered Employees/Consumers
5. Move from pay-for-volume to pay-for-value
6. Engaging employees and consumers in continuous quality improvement
The goal: slow down cost increases

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Approximate magnitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiums</td>
<td>8.0%</td>
</tr>
<tr>
<td>Forecast medical spending per capita</td>
<td>5.5% - 6.0%</td>
</tr>
<tr>
<td>Forecast GSP per capita</td>
<td>4.0%</td>
</tr>
<tr>
<td>Inflation rate</td>
<td>2%</td>
</tr>
</tbody>
</table>
Components of Reform
1. Supply side – payment reform

• Move to global payments for all payers, with a residual FFS vs. the reverse now
  ▪ Start with Medicaid, Medicare, GIC, Connector
  ▪ Follow-up with private insurance
2. Invigorated demand side

1. Tiering/sensitive cost sharing for more expensive care

2. Standards for shared decision-making models

3. Defined contribution model for small businesses in GIC

4. Dissemination of price, quality information
Other components

3. Medical malpractice: less litigation
4. Administrative simplification
How long does it take to save one-third?

- Prevention; Pat. engagement
- Process redesign
- Eliminating errors
- Administrative savings
- Change in site of care
- Changes within institutions

Overall impact vs. Timeliness of action
One Proposal

**GOAL:**

- By 3 years: Potential GSP
- By 5 years: Potential GSP - 0.5%
- After 15 years: Potential GSP +1%

Savings are $150 billion - $180 billion total.
Information and its use

Data organization, retrieval, and analysis are key areas

- Patient encounters
- Cost-effectiveness analysis
- Learning which providers are better and worse

We’re spending $30 bn on this.
A Note On Organization

In every industry where information has become a key commodity, firms have gotten bigger

- Retail trade (Wal-Mart, Target, Best Buy)
- Banking (Bank of America)
- Legal services

Look for more in health care

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* Los Angeles is excluded because in its largest system (which has 11% of admissions), hospital profits are not differentiated from those of the physician group.

† In Minneapolis, one hospital system has 29% of the profits but a smaller share of admissions.
Advice from famous economists

“If something cannot go on forever, it will stop.”
- Herb Stein

“Somebody has to do something, and it's just incredibly pathetic that it has to be us.”
- Jerry Garcia
Questions?