



## Progressive Ideas on Improving the Efficiency and Reining In Costs in the U.S. Health Care System

**H**ealth care costs are rising out of control. With health care premiums increasing five-times faster than wages, families cannot keep up with rising health burdens. The ranks of the under-insured and uninsured are rising. But this is not just an individual problem; it is an economic problem as well. American businesses are forced to choose between providing health benefits and investing in their companies through job creation and research and development. For these reasons and more, our health care system is fundamentally broken. Real reform is needed to decrease overall health care costs. Six types of ideas are described below: (1) reducing prescription drug costs, (2) eliminating government overpayments and complexity; (3) improving health insurance markets; (4) reducing cost shifting; (5) promoting quality-oriented, efficient health care; and (6) making smart investments with long-run returns. Examples of policies and results are included for each. Although not a comprehensive list, it aims to demonstrate that meaningful cost containment tools are available to help address the growing crisis.

**1. Reducing Prescription Drug Costs:** The cost of prescription drugs is one of several drivers in health care spending. In 2004, prescription drugs made up 10% of national health expenditures and made up nearly 15% of the increase in total health care spending between 1994 and 2004.<sup>1</sup>

- *Allowing Medicare to Negotiate Drug Prices:* The Medicare law prohibits price negotiation on behalf of the 42 million Medicare beneficiaries, instead relying on multiple, competing private insurers to reduce costs. Citizens of other countries where such negotiation occurs (e.g. Canada, the United Kingdom, and France) pay at most 59% of what Americans pay for prescription drugs. Similarly, Medicare prescription drug prices are 48.2% higher than the lowest price available through the Department of Veteran Affairs. Creating price negotiation authority for the Medicare program would enable Medicare to obtain pharmaceutical prices equal to pharmaceutical prices in other countries, which would create savings sufficient to close the “doughnut hole” in the benefit design of Medicare Part D.<sup>2</sup> Alternatively, Medicare could use negotiation authority similar to the VA to reduce drug prices.<sup>3</sup>
- *Increasing Access to and Use of Generic Drugs:* More than 53% of all prescriptions in the United States currently are filled with generic medicines, yet they account for 12% of total pharmaceutical costs. Data show that just a 1% increase in generic utilization could save the government \$4 billion dollars.<sup>4</sup>
  - *Reforming Patent Law:* Changing the 180-day exclusivity provision would allow more generic drugs to market within the six-month period. The resulting greater availability of lower-priced generic drugs would reduce direct federal spending for drugs under Medicare, Medicaid, FEHB, and Department of Defense by \$1 million in 2006 and \$169 million over five years.<sup>5</sup>

- *Increasing Use of Generic Drugs in Medicare:* Medicare beneficiaries enrolled in the prescription drug benefit can significantly reduce their medication costs by switching from brand name treatments to generic drugs or lower-cost therapeutic equivalents. For example, Medicare beneficiaries who take five common drugs could save between \$2,300 and \$5,000 by switching to lower-cost alternatives. These savings could prevent seniors from falling into the “doughnut hole” coverage gap of Medicare Part D.<sup>6</sup>
  - *Increasing Use of Generic Drugs in Medicaid:* Having generics make up 55% of the prescription drug use by Medicaid enrollees could save the program between \$1 billion and \$1.5 billion a year.<sup>7</sup>
  - *Increasing Use of Generic Drugs in Private Plans:* Kaiser Permanente actively educates providers and consumers about the utilization of generic drugs, resulting in a higher uptake of generic drugs than the national standard – roughly 66% of Kaisers prescriptions are for generic drugs with total cost savings of \$500 million.<sup>8</sup>
- *Reimportation of American Pharmaceuticals:* U.S. consumers pay markedly more than Canadians for the same prescription drugs. In 2002, Americans paid 67% more than Canadians for patented drug products.<sup>9</sup> Legalizing reimportation of American pharmaceuticals would create prescription drug savings for consumers.
  - *Evaluating and Using Research on the Comparative Effectiveness of Drugs:* The Drug Effectiveness Review Project (DERP) of Oregon is a collaboration of organizations that have joined together to obtain the best available evidence on effectiveness and safety comparisons between drugs in the same class, and to apply the information to public policy and related activities. For example, North Carolina Area Health Education Center used this information to create a provider education tool that increased the use of generic drugs and saved the state \$80 million in 2003.<sup>10</sup>
  - *Promoting State Prescription Drug Purchasing Pools:* States can use their market power to increase purchasing power and efficiency, improve benefits management, and realize cost savings.
    - *Intra-State Pooling:* Georgia uses a single Pharmacy Benefits Manager (PBM) to negotiate manufacturer discounts and to manage prescription drug benefits across state employee health plans and the state’s Medicaid program. This comprehensive approach saved the state \$60 million overall between late 2000 and early 2003.<sup>11</sup>
    - *Inter-State Pooling:* The Michigan Multi-State Pooling Agreement is one of the first-ever Medicaid multi-state prescription drug purchasing pool. In 2004, savings were as high as \$12.2 million for the then, 5-state drug purchasing pool.<sup>12</sup>
  - *Reducing Marketing-Induced Overuse of Drugs:* In 2000, every dollar spent in direct-to-consumer advertising increased pharmaceutical sales by \$4.20. Thus, direct-to-consumer advertising accounted for 12% – \$2.6 billion – of the total growth in drug spending.<sup>13</sup> Wyden-Sununu Pharmaceutical Advertising and Prudent Purchasing Act, which would eliminate pharmaceutical companies’ ability to shift advertising costs on to Medicaid, could potentially save the Federal government \$300 million to \$500 million.<sup>14</sup>

- *Reducing Physician Drug Samples and “Gifts”*: Reducing the amount the pharmaceutical industry spends on promotions for doctors is one cost-savings method. Currently, the industry spends about 90% of its annual \$21 billion marketing budget on promotions for physicians.<sup>15</sup> Patients who receive samples typically consume more of the drug through paid prescriptions than patients who do not receive samples.<sup>16</sup>

**2. Eliminating Government Overpayments and Complexity:** Each year millions of dollars are lost in government overpayments, waste, fraud, and abuse. In addition, the complexity of program rules creates unnecessary bureaucratic costs.

- *Reducing Medicare Overpayments for Private Plans*: Currently, Medicare pays private plans 7% more than it pays for the same beneficiary in traditional Medicare. Equalizing the payment level would reduce Medicare spending by about \$1.3 billion in 2006 and \$11.3 billion over five years.<sup>17</sup> Also, eliminating the regional plan stabilization fund would free up \$10 billion of earmarked funding from 2007 to 2013.<sup>18</sup>
- *Reducing Medicaid Overpayment for Prescription Drugs*: Traditionally, states and the Federal government have recouped a portion of their drug spending through a manufacturer rebate. With Medicare assuming financial responsibility for Medicare-Medicaid dual eligibles, states have less leverage to get these supplemental rebates. By increasing the amount of this rebate from 15.1% to 20%, this would reduce mandatory federal spending by \$0.6 billion in 2006 and by \$3.2 billion through 2010.<sup>19</sup>
- *Reduce Administrative Costs through Common Enrollment Processes*: The enrollment processes for Temporary Assistance for Needy Families (TANF), Food Stamps, and Medicaid require that potential enrollees provide information about their family’s income, assets, and demographic characteristics. Currently, some states receive funding from both the Medicaid and the TANF programs to cover this administrative cost. Streamlining and simplifying the eligibility process for these programs would save the government \$280 million in 2006 and nearly \$1.8 billion through 2010.<sup>20</sup>

**3. Improving Health Insurance Markets:** The fragmented nature of the insurance system results in high administrative costs – made worse by the move to the individual market and health savings accounts. Individuals and small employers typically pay 15 to 40 percent of their premium dollars on “insurance” costs that often have nothing to do with ensuring efficient, high-quality care. In addition, health care providers incur major administrative expenses as a result of variations in billing and payment rules across insurers and public programs. About 20 to 30 percent of hospital and physicians’ costs result from administration, largely due to the complex nature of the health insurance system.

- *Creating Common Billing*: Standardizing and promoting common practices across all private and public insurers will decrease the administrative cost burden for hospitals and physicians.<sup>21</sup>
- *Creating Purchasing Pools*: Due to cost and administrative barriers, small businesses find it very difficult to provide health care to their employees. Through pooling, small employers and employees below 350% of poverty, the California PacAdvantage Premium Program has captured administrative efficiency by leveraging economies of scale.<sup>22</sup>
- *Allowing Risk Sharing for High-Costs Cases*: The top 10% of individuals who use health care services account for 70% of all health care spending. Government reinsurance would relieve health insurers the risk of adverse selection; and therefore, insurers could lower premiums so

that coverage would be affordable to more people.<sup>23</sup> The Kerry plan included a reinsurance pool. The design of the reinsurance pool would have reduced the cost of coverage by roughly 10% for employers that met a certain criteria.<sup>24</sup>

**4. Reducing Cost Shifting:** Currently, individuals without health insurance pay approximately 35% of the cost for needed health care out-of-pocket. Of the remaining 65%, one-third of the cost is paid for by government programs and the remaining two-thirds is paid through higher insurance premiums incurred by those with insurance. Guaranteeing all Americans affordable health care would eliminate the cost-shifting onto taxpayers for uncompensated care.

- *Reducing the Cost Shift in Premiums:* In 2005, family health insurance premiums were \$922 higher and individual health insurance premiums were \$341 higher due to the cost of health care for those without health insurance. Providing affordable coverage to all Americans would reduce this shift.<sup>25</sup>
- *Reducing National Health Spending:* Experts predict that health spending would increase by 3-6% and raise health care's share of GDP by less than 1 percentage point if all the uninsured gained coverage.<sup>26</sup> However, this does not take into account other efficiencies that would result. The Health Security Act would have initially increased national health spending. However, by 2004, national health expenditures would have been \$2 billion below the baseline for that year.<sup>27</sup>
- *Improving Productivity:* The Institute of Medicine estimated that the benefits to the economy of insuring all people would range from \$65 to \$130 billion per year. This results largely from better health and longer lives of individuals with coverage; but also includes the decrease in Medicare and disability support payments, lessens the demands on the public health infrastructure, and increases the local health service capacity.<sup>28</sup>

**5. Promoting Quality-Oriented, Efficient Health Care:** Purchasers of health care want their health care dollars to be well spent. Efficient purchasing focuses on ensuring that high-quality, error-free care is provided at the most appropriate site. Promoting this type of care improves health outcomes and reduces costs.

- *Promoting Best Practices:* Following clinical guidelines is another way to be cost-effective. For example, practice guidelines for diabetic patients improved the individual's health and reduced average treatment costs by \$650-\$950 per patient per year.<sup>29</sup> And, one Pennsylvania hospital's focus on quality reduced ventilator associated pneumonias (VAP). Its reduction of VAP occurrences resulted in cost savings of \$2.2 million.<sup>30</sup>
- *Using Payment Bonuses and "Withholds" to Encourage Quality:* Awarding physicians who achieve performance thresholds on outcome as well as process measures. For example, Bridges to Excellence, a premier pay-for-performance effort in the country, has set-up awards ranging from \$85-\$100 per patient for doctors that meet the cost-effecting medical threshold.<sup>31</sup> Encouraging Medicare providers to provide additional payments to providers that provide high quality care would reduce Medicare spending by \$7.2 billion over the 2006-2015 period.<sup>32</sup>
- *Responsibly Reforming the Medical Malpractice System:* Clearly, malpractice insurance for health care providers is too high, and the fear of malpractice results in "defensive medicine". An estimated 14% of all adults and 18% of sicker adults receive duplicate tests, in part due to the fear of law suits.<sup>33</sup> Policies that limit frivolous lawsuits, provide alternatives to courts, rein in the high cost of malpractice insurance, and prevent medical errors in the first place could reduce this unnecessary cost.

- *Promoting Hospice Care:* End-of-life care is costly for both Medicare and Medicaid and may not be delivered efficiently. Although the research is not definitive, hospice and advance directives can save between 25% and 40% of health care costs during the last month of life, with savings decreasing to 10% to 17% over the last 6 months of life and decreasing further.<sup>34</sup>
- *Lowering Inappropriate Use of Emergency Rooms:* It is a fact that emergency room care is among the most expensive health care. Yet, three-fifths of patients without health insurance have no regular doctor. Furthermore 50 percent of the uninsured receive their usual care from high cost emergency rooms.<sup>35</sup>
- *Creating More Effective Utilization of Health Care Professionals:* More effective utilization of nurse practitioners would save lives as well as reduce hospital costs. Estimates show that 5,000 fewer patient deaths per year and net savings of \$242 million over the short term and \$1.8 billion over time.<sup>36</sup>

**6. Making Smart Investments with Long-Run Returns:** By investing in preventive health care services, health information technology, and chronic care management overall health care costs will decrease, especially in the long-run.

- *Promoting Health and Prevention:* Rising disease prevalence and the medical services that go with them account for the majority of the rise in health care spending. A greater emphasis should be on making prevention a national priority.
  - *Health Promotion in the Workforce:* For every dollar invested in a health promotion program in the workplace, average savings equals \$3.93.<sup>37</sup> Other research shows that savings in medical costs and absenteeism range from \$2.30 to \$10.10.<sup>38</sup>
  - *Health Promotion in Schools:* Health care spending for obese adults and children was 37 % higher than that of normal weight individuals according to 2001 estimates. Severely overweight students miss on average one day per month, or nine days per school year.<sup>39</sup> Providing incentives for schools to invest in health promotion would decrease obesity related absenteeism and overall health care costs.
  - *Reducing Obesity:* If current trends continue, up to one-fifth of health care expenditures would be devoted to treating the consequences of obesity.<sup>40</sup> For example, spending for diabetes and heart disease increased 38% and 41% respectively during 1987 and 2001.<sup>41</sup> Medicare would especially be at risk for increased costs due to obesity seeing as approximately 100 million elderly will enter Medicare over the next 25 years. Reducing obesity would yield great improvement in morbidity with a Medicare cost savings of \$1 trillion.<sup>42</sup>
  - *Preventive Screenings:* Cancer is the second leading cause of death in the U.S. In 2002, cancer cost the country \$110 billion in loss productivity and \$60 billion for direct medical costs.<sup>43</sup>
    - Breast cancer treatment costs nearly \$7 billion a year. By investing in preventive screenings, such as mammograms, illness and death could be prevented.<sup>44</sup>



- Care management for individuals with four chronic conditions - asthma, congestive heart failure, chronic obstructive pulmonary disease, and diabetes – could save up to \$28.5 billion in overall health care costs.<sup>53</sup>
- Care management would increase productivity for individuals with those same four chronic conditions: 28 million fewer workdays and 13 million fewer school days would be lost.<sup>54</sup>

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