Growing Healthcare Spending:
Can or Should It Be Controlled to Prevent a Health System "Meltdown" ?

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Overall Healthcare Spending Per Capita In Massachusetts Much Higher Than U.S. --- *But!*

- Mass. Per-Person Spending 30 to 45 percent Above National Average
- Spending in Mass. Have Grown Faster Than National Average

---- But Not A Good Measure of Spending By Massachusetts Residents

Massachusetts Spending for Medicare Slightly Higher Than U.S.

- Medicare payments per beneficiary in Massachusetts adjusted for IME/GME
  - Total payments 14% above US average
  - Payments for acute care services 6% above US average
- Why is this so much lower than personal health spending per capita
  - Excludes clinical research, out of state patients, IME/GME payments
  - Adjusts for local price differences

Massachusetts 2005 Health Insurance Premiums Are Higher Than US Average —But Gap Is Less

	MA	US	Difference	MA Rank out of 50
Family Premium	**$11,435**	**$10,728**	**6.6%**	**8th**
Single Premium	**$4,235**	**$3,991**	**6.1%**	**12th**

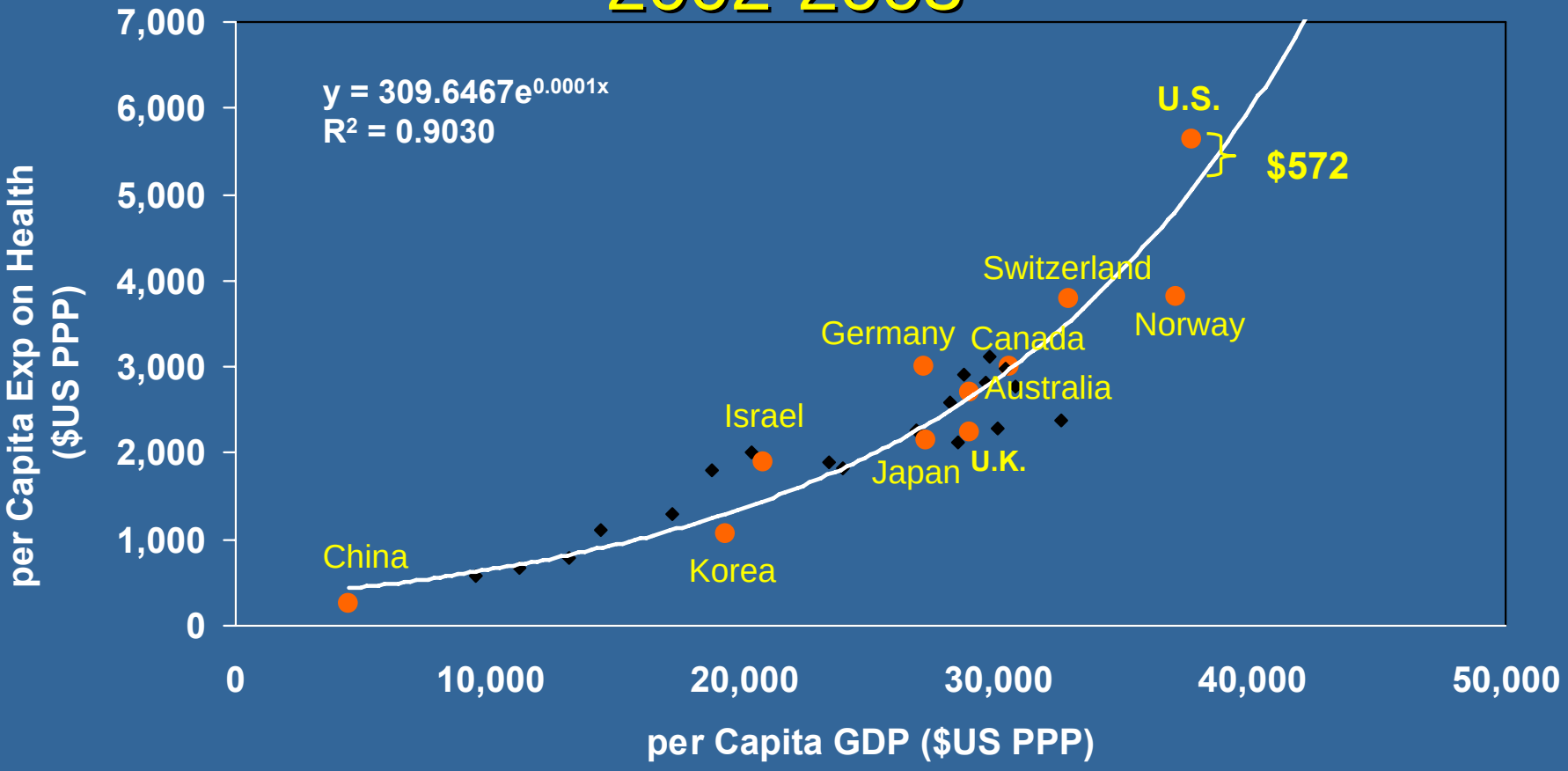
Source: Agency for Healthcare Research and Quality, 2007.

Therefore Pressures To Increase Healthcare Spending In Massachusetts Similar To Overall U.S.

Thus Will Focus Remarks on National Figures!

How Does U.S. Compare To Other Countries?

Correlation Between Per Capita Expenditure on Health Care and GDP, 2002-2003



The figure for Japan is 2002 estimate; the figures for Australia, Austria, China, Hungary, Ireland, Israel, Poland, Sweden and United Kingdom are of 2002; the figures for Canada, France, Iceland, Norway and Switzerland are 2003 estimates. The rest are of 2003.

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Source: OECD Health Data 2005 and WHO.

Why Is Health Spending Higher In U.S.

Do We Use More Services or Just Spend More for The Services We Use?

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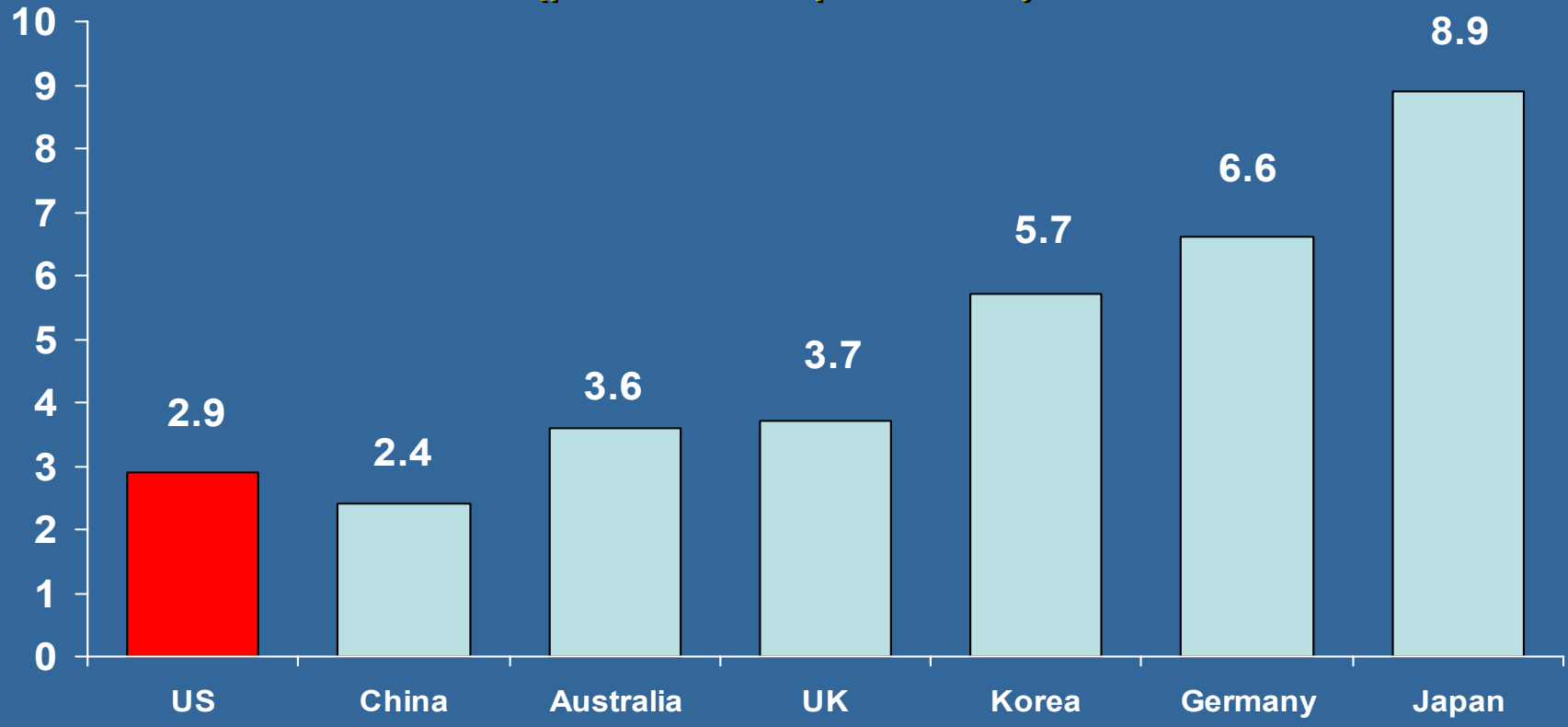
In-Patient Acute Care Beds in Selected Countries 2002

(per 1,000 persons)



Sources: OECD HEALTH DATA 2005

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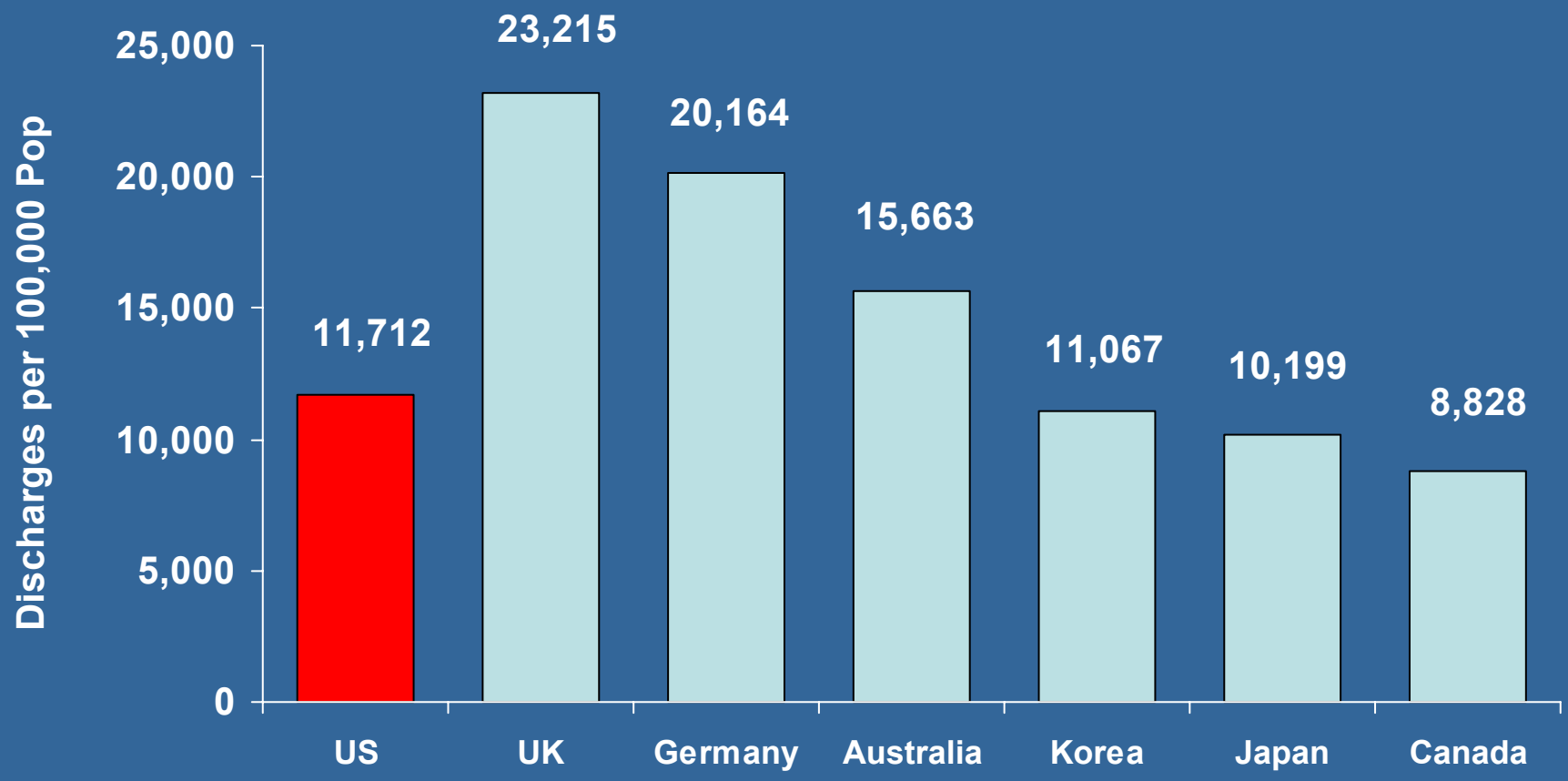
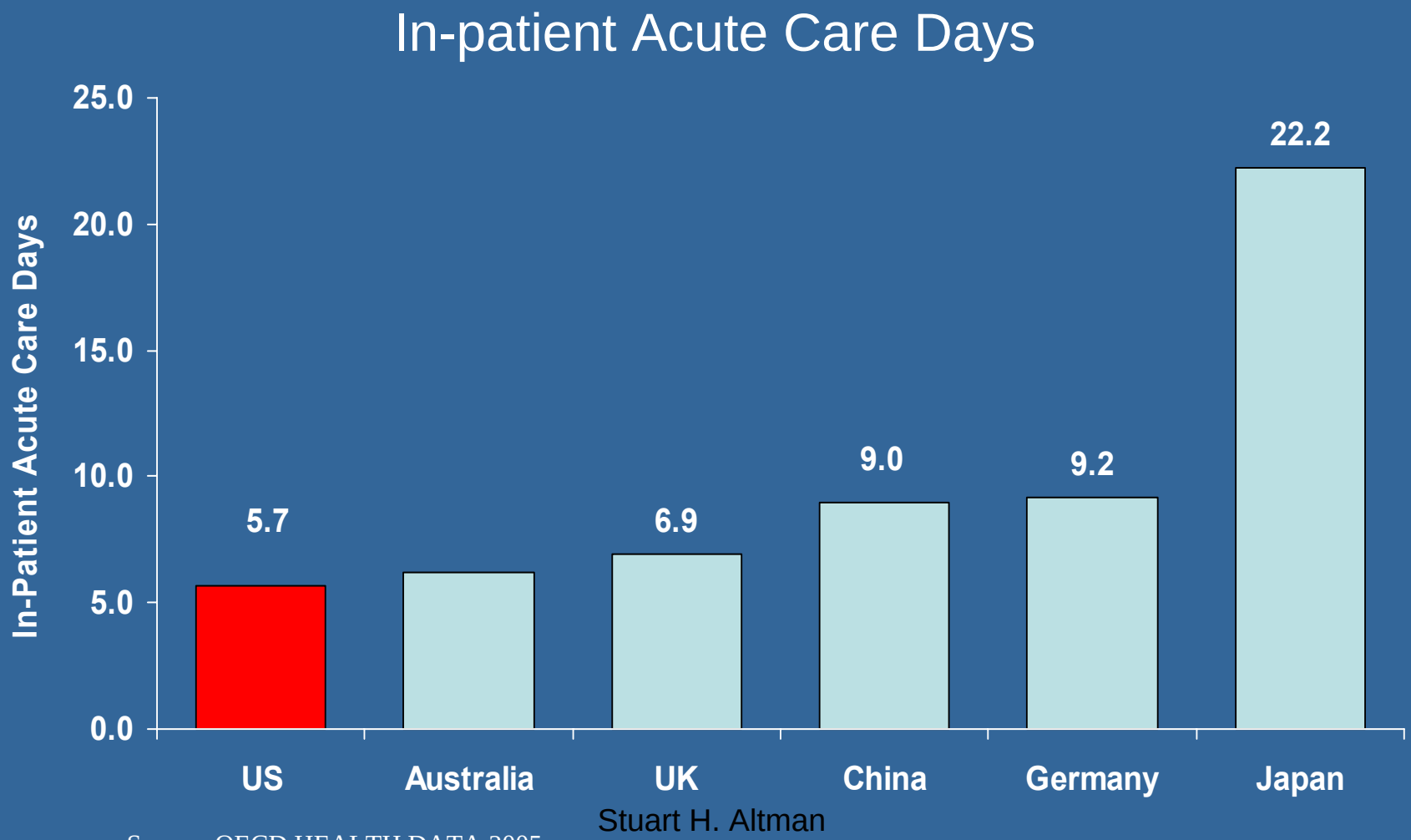
Hospital Discharge Rate in Selected Countries 2002



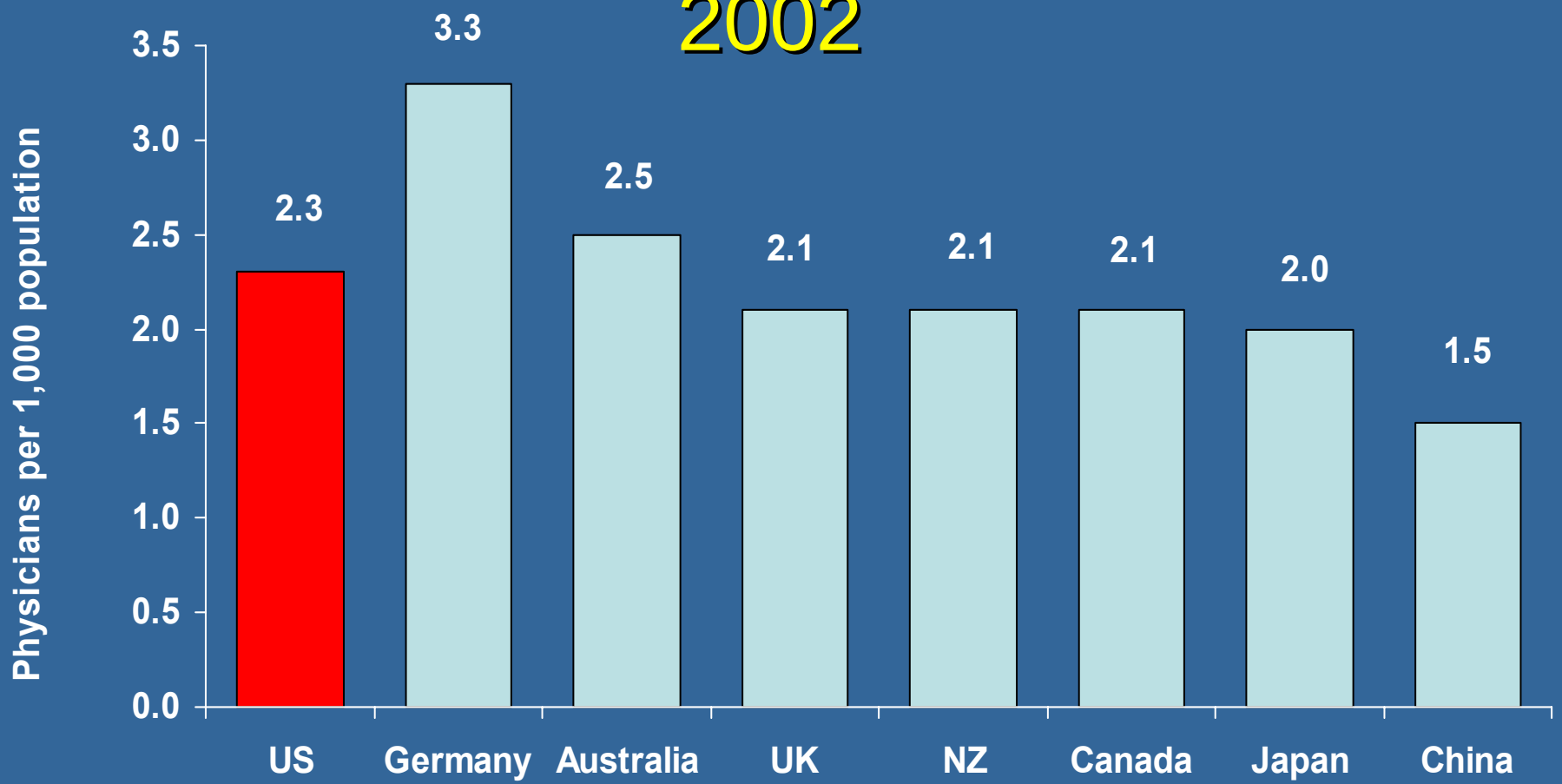
Source: OECD HEALTH DATA 2005

Average Length of Stay in Hospital in Selected Countries



Source: OECD HEALTH DATA 2005

Practicing Physicians in Selected Countries 2002



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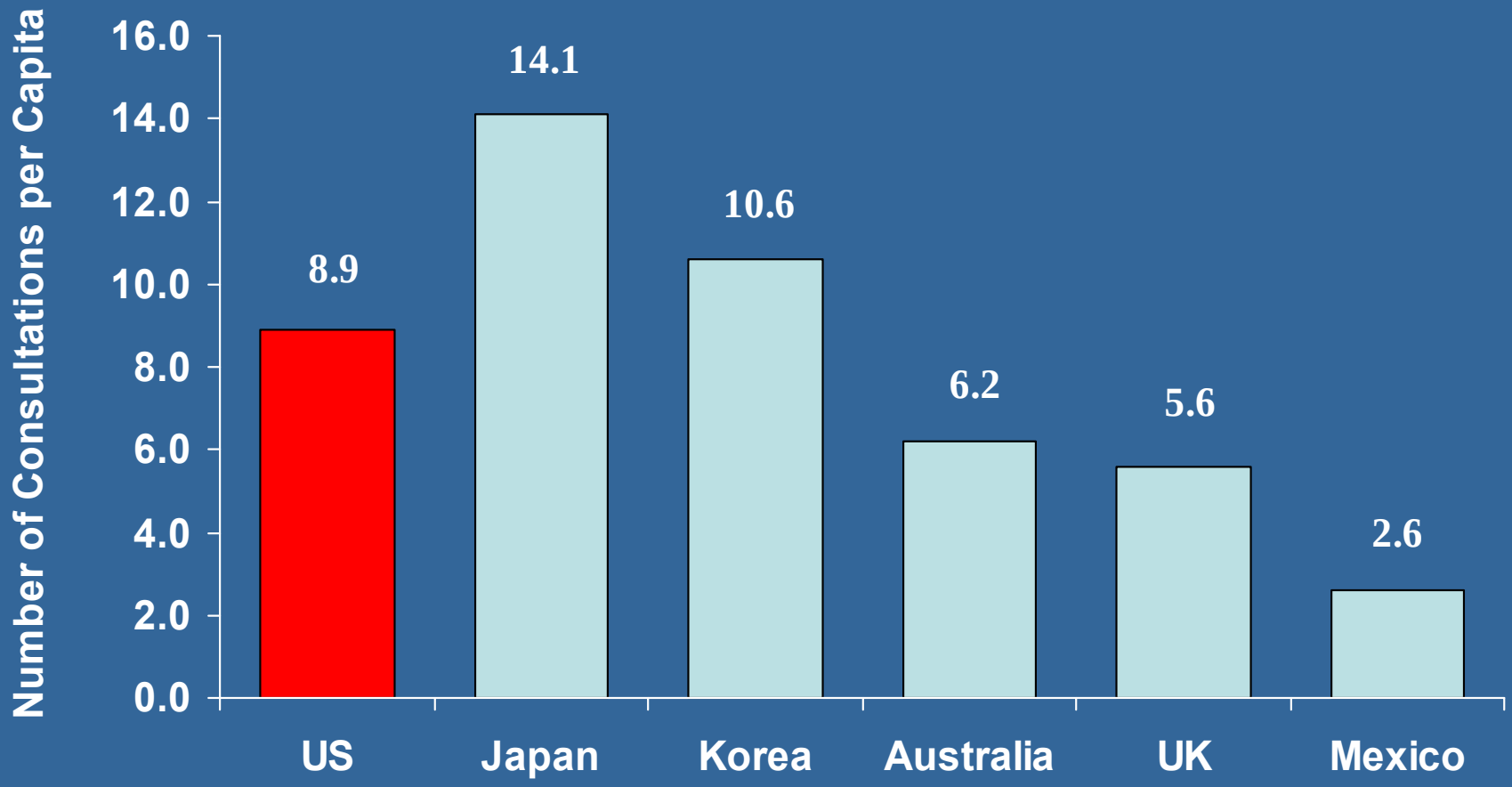
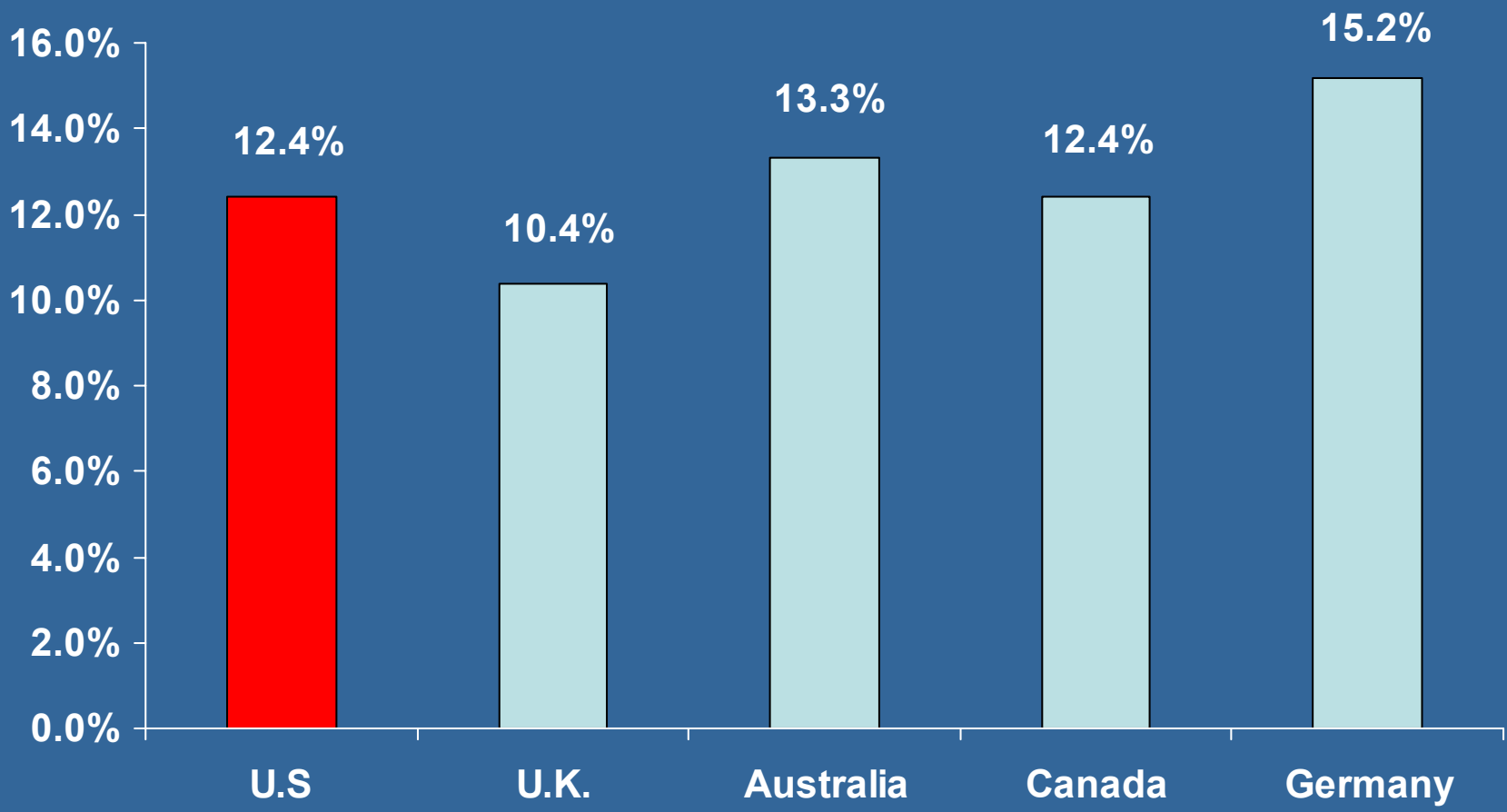
Source: OECD HEALTH DATA 2005

Doctors' Consultations per Capita in Selected Countries 2002



Source: OECD HEALTH DATA 2005

Percent of Total Healthcare Expenditures on Pharmaceuticals



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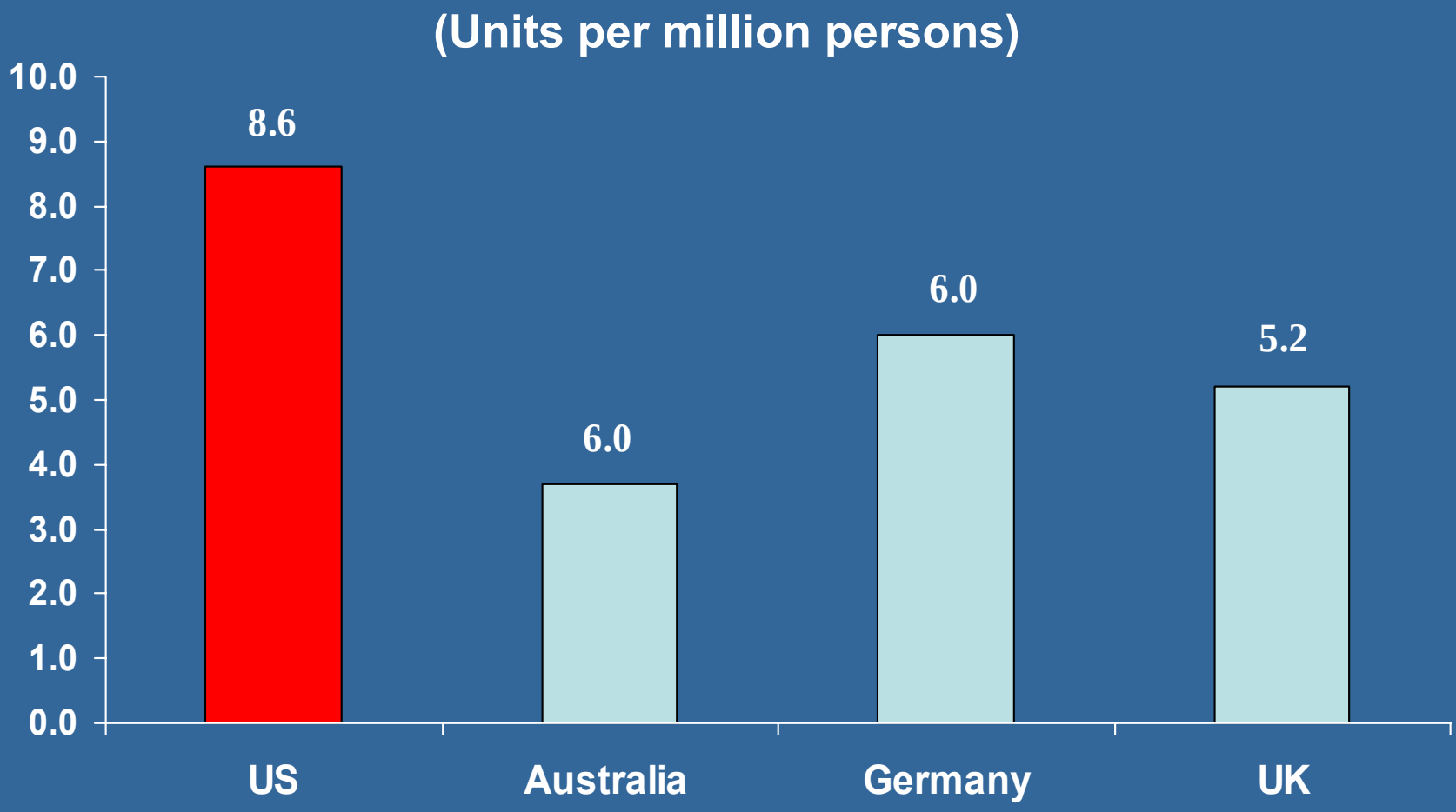
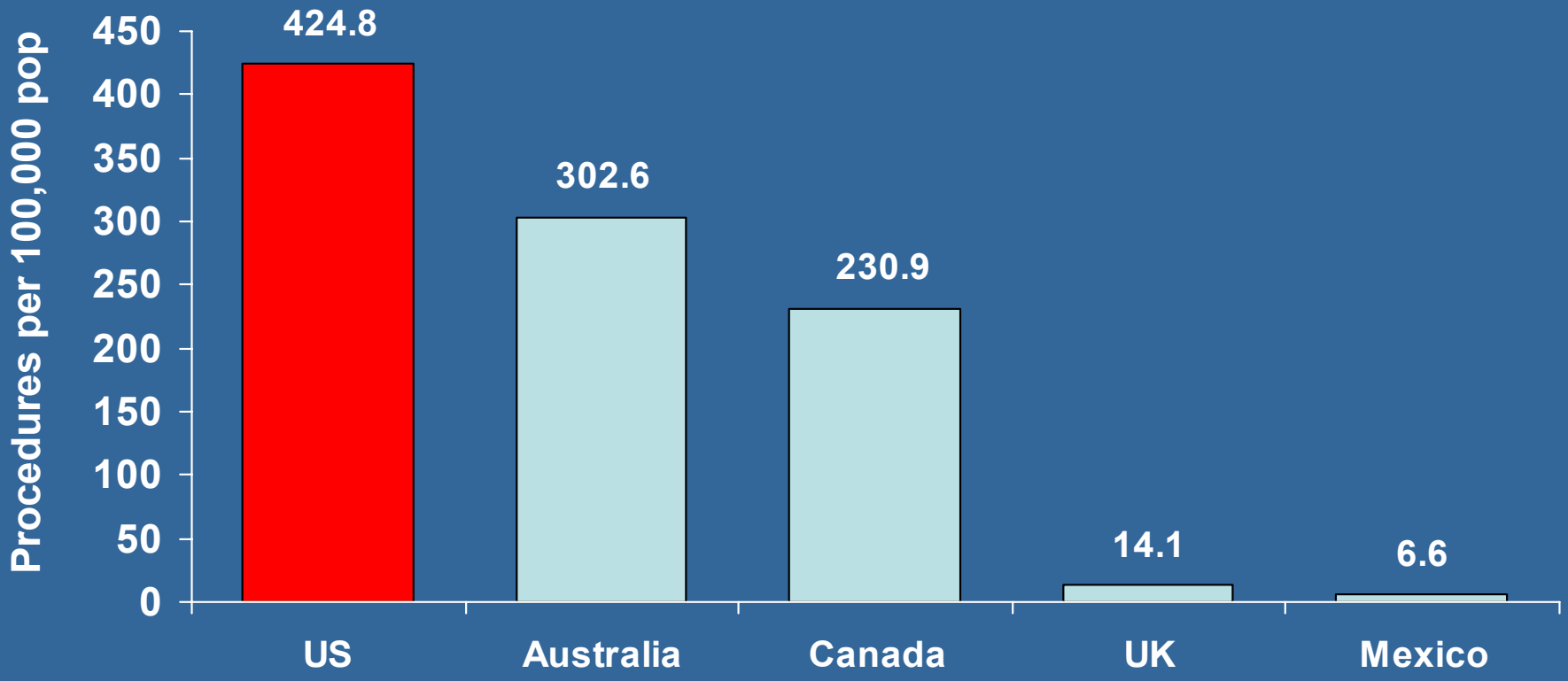
What About The Availability of Expensive Medical Technology and Procedures?

MRIs in Selected Countries 2002



Sources: OECD HEALTH DATA 2005

Cardiac Cauterization Procedures in Selected Countries 2003



Source: OECD HEALTH DATA 2005

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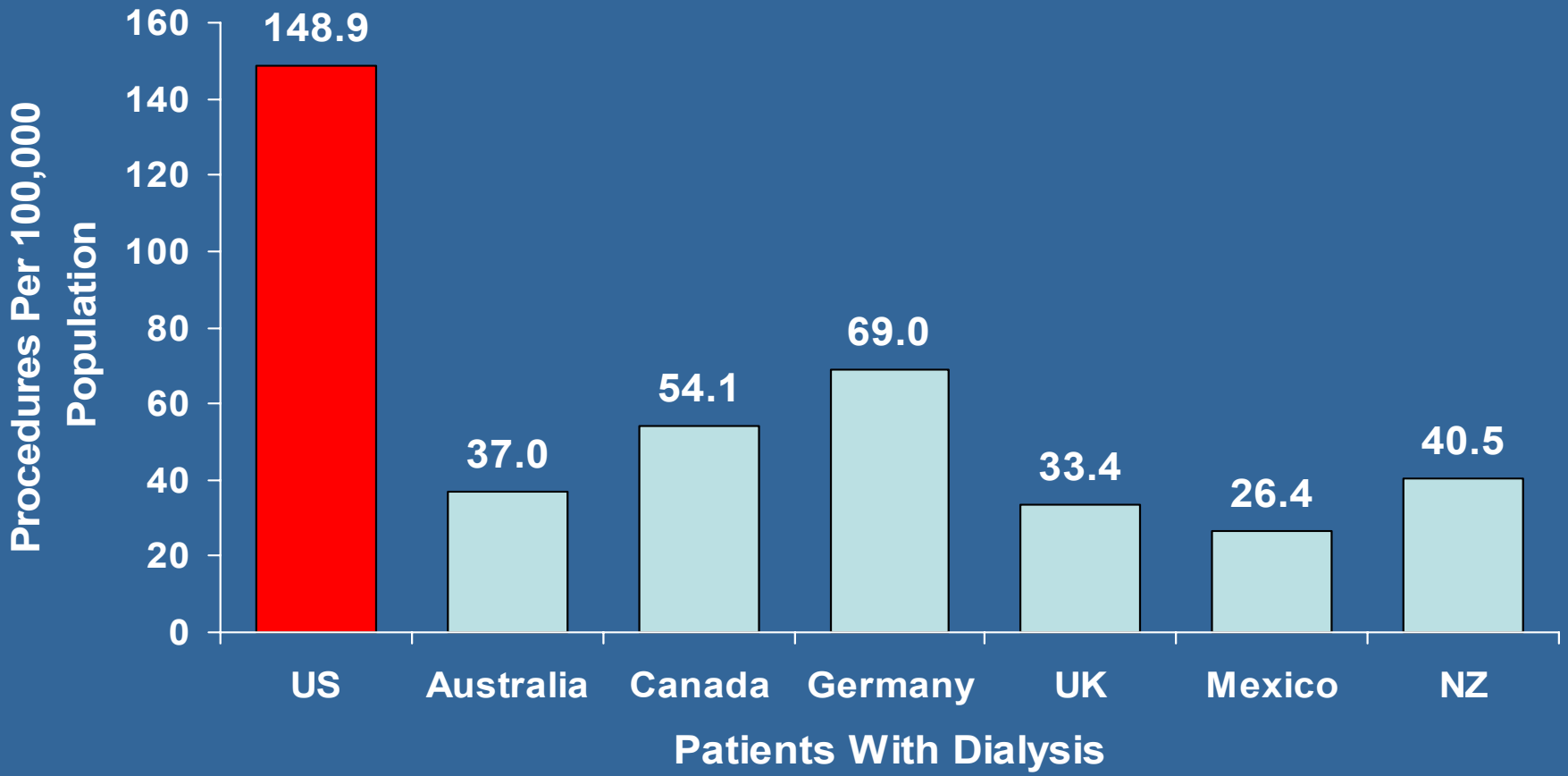
Patients Using Renal Dialysis Treatment in Selected Countries 2002



Source: OECD HEALTH DATA 2005

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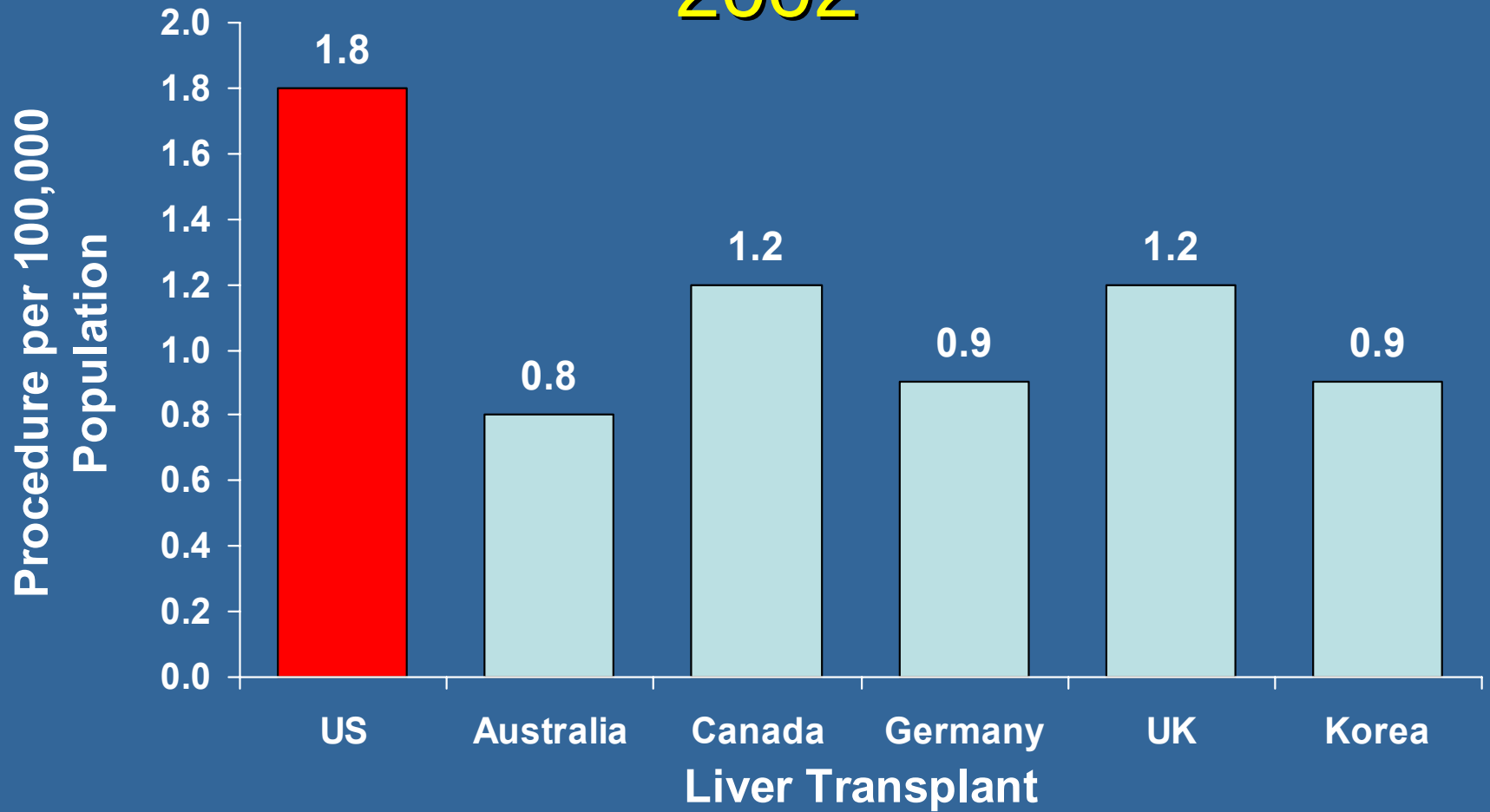
Liver Transplant Procedures in Selected Countries 2002



Source: OECD HEALTH DATA 2005

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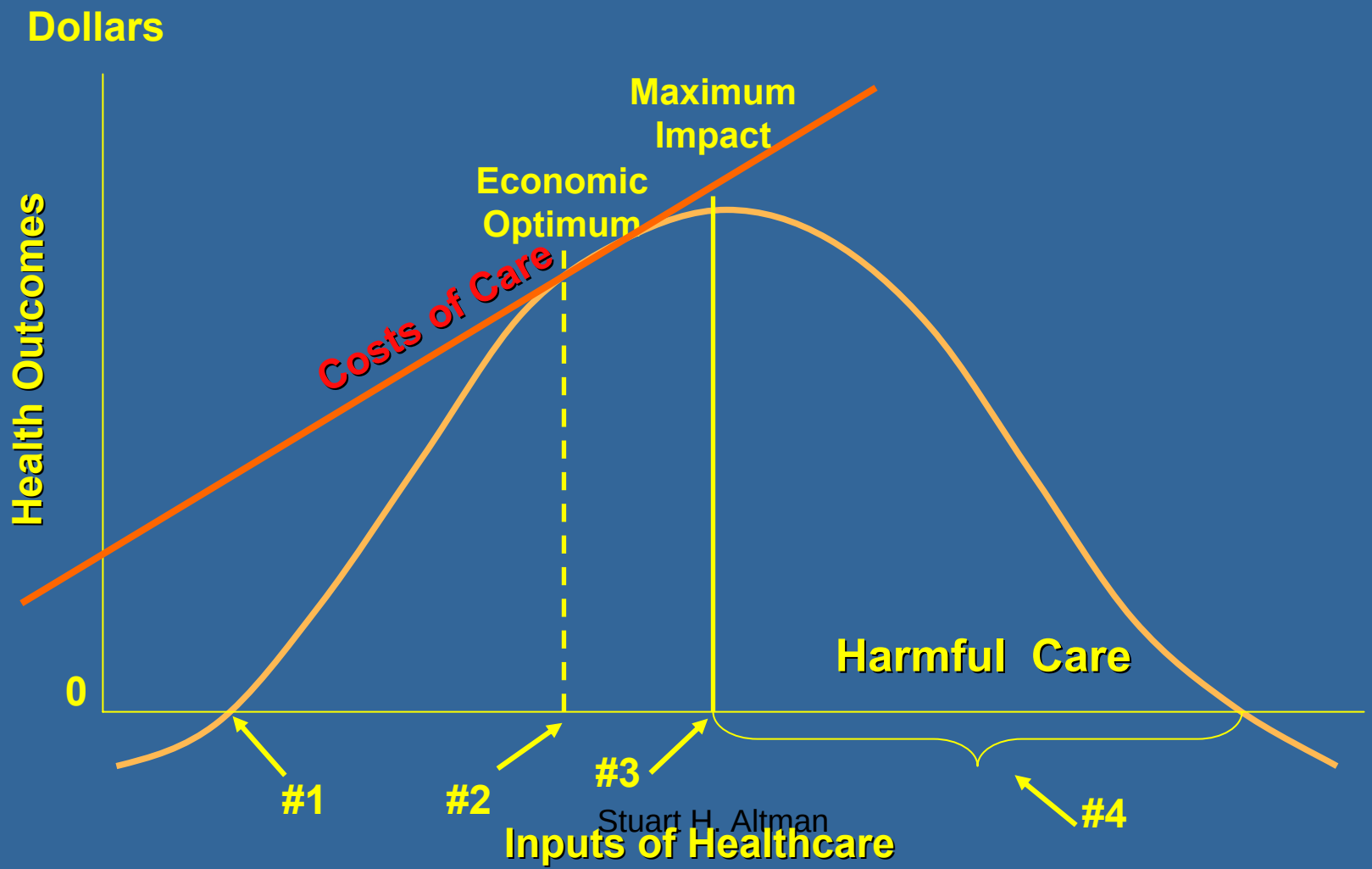
Technology Is a Major Driver in Health Care Expenditure Growth.--Is it Worth It?

"When costs and benefits are weighed together, technological advances have proved to be worth far more than their costs."

David M. Cutler and Mark McClellan, "Is Technological Change In Medicine Worth It?" *Health Affairs*, September/ October 2001. Can be found at:
http://www/laskerfoundation.org/reports/pdf/cutler_mcclellan_2001.pdf

But Is Every Technology That Has Some Medical Benefit Worth The Costs?

Alternative Levels of Healthcare Services And Improvements to Health Outcomes



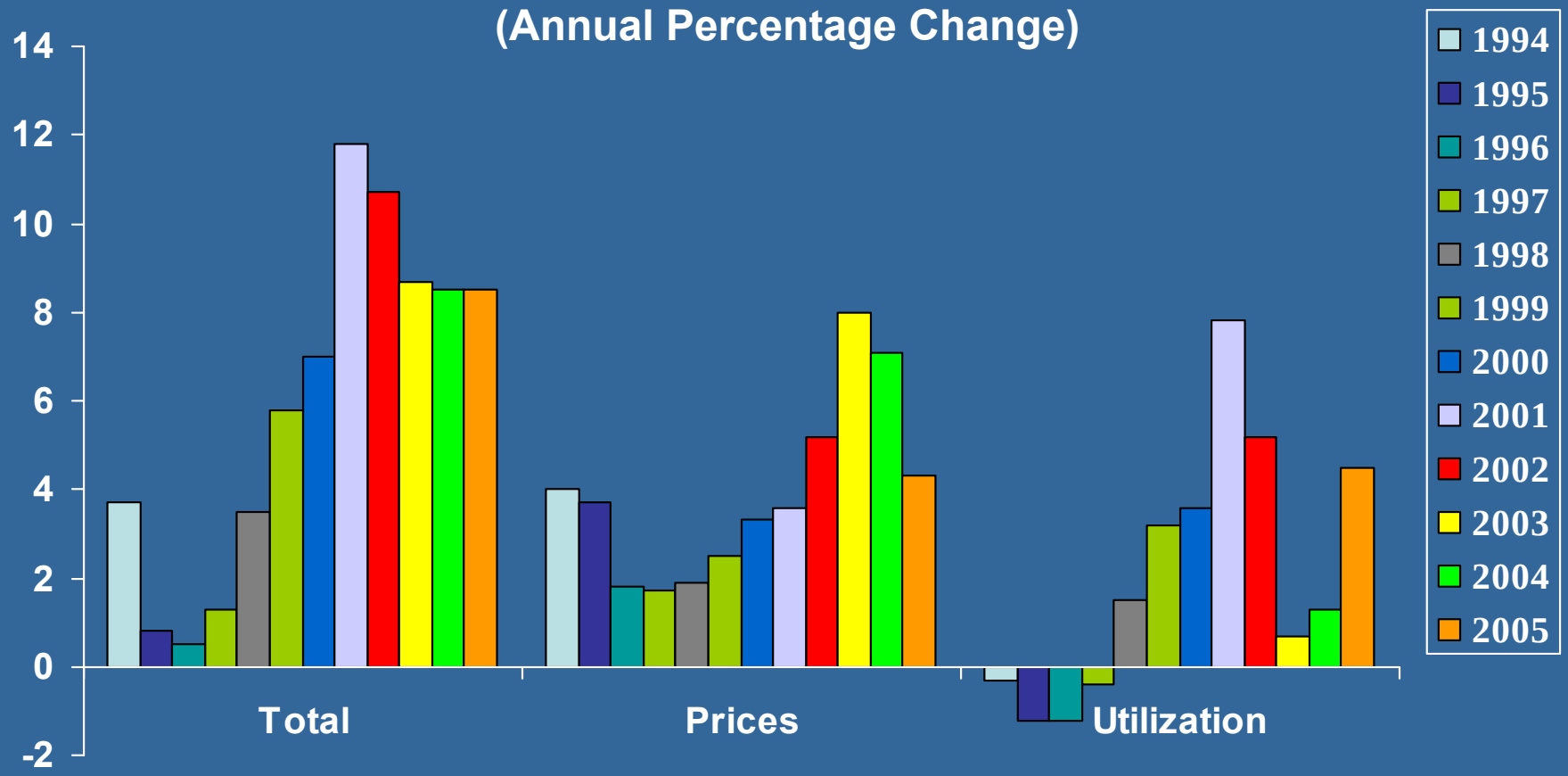
In Other Countries They Control Spending By Limiting Use of High Cost Medical Procedures Closer To #2

We Can Start By Eliminating The Harmful Services in Category #4.

But Also May Need To Move Toward #2

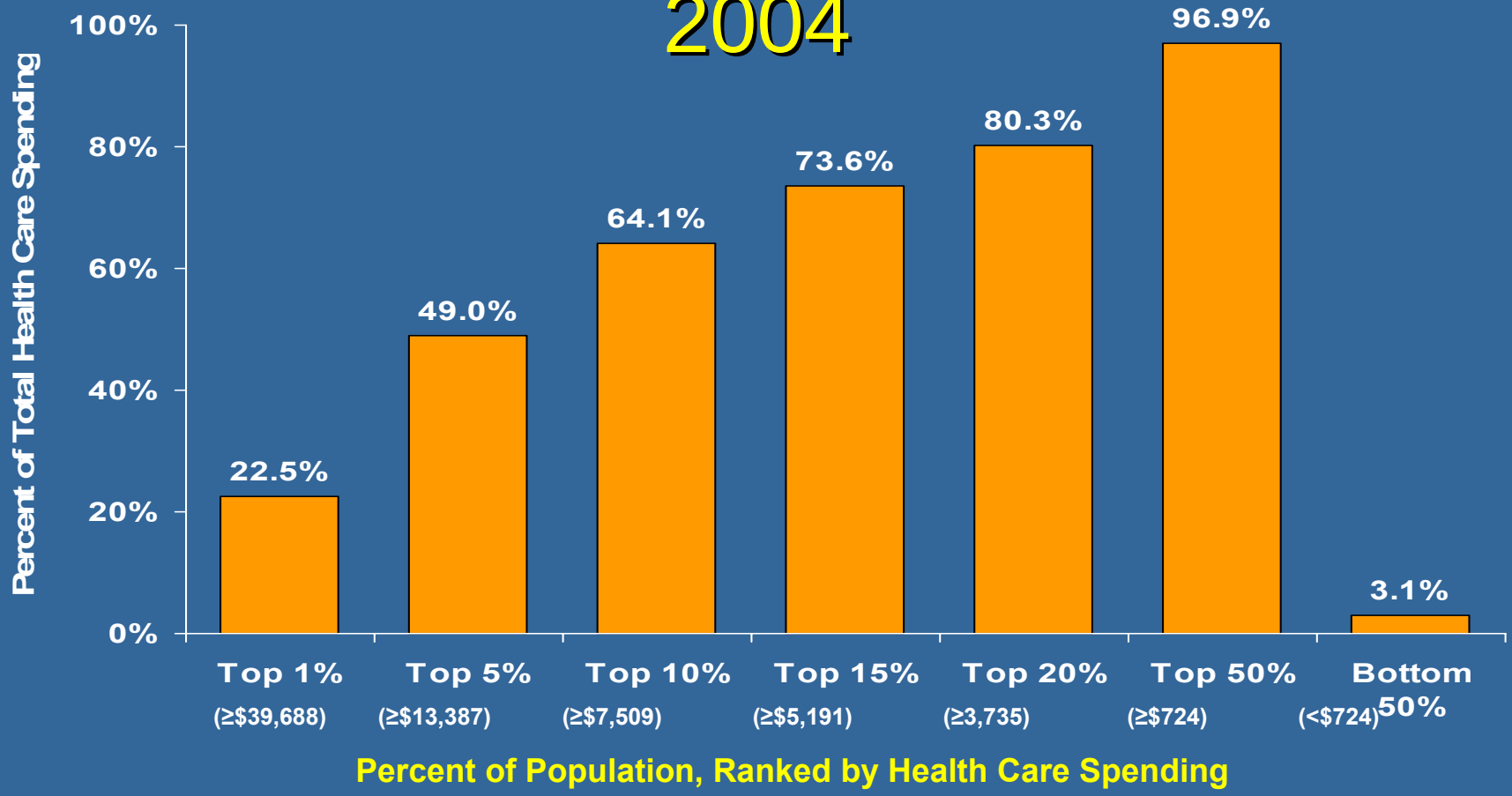
What Has been Happening Recently In The U.S. In Terms of Healthcare Use?

The Growing Utilization of Hospital Services



Souce: Ginsburg, Strunk, Banker & Cookson "Health Affairs (Web Addition) October 2006
For 2006, figures provided are early estimates.

Concentration of Health Care Spending in the U.S. Population, 2004



Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2004.

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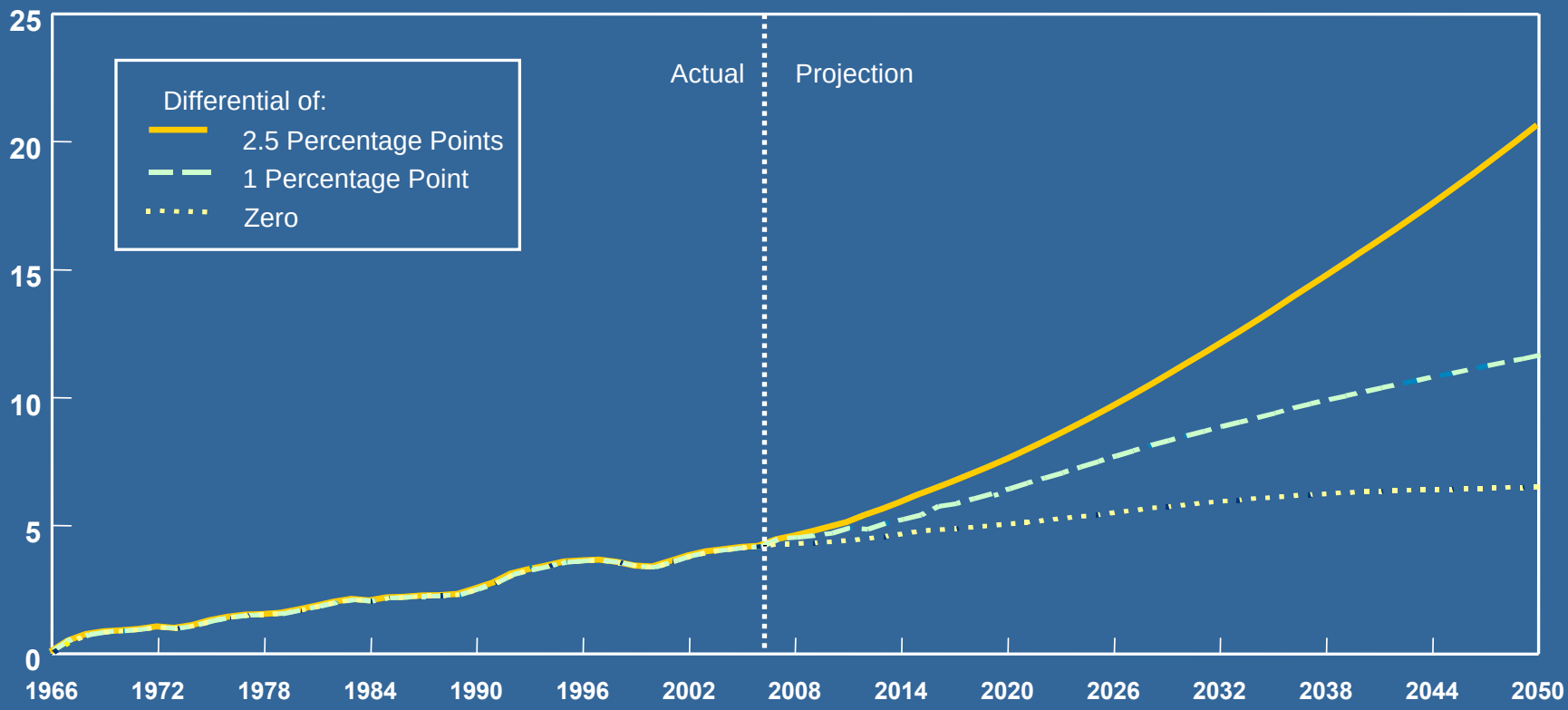
Where Are We Going?

Federal Spending for Medicare and Medicaid Under Assumptions About Health Cost Growth



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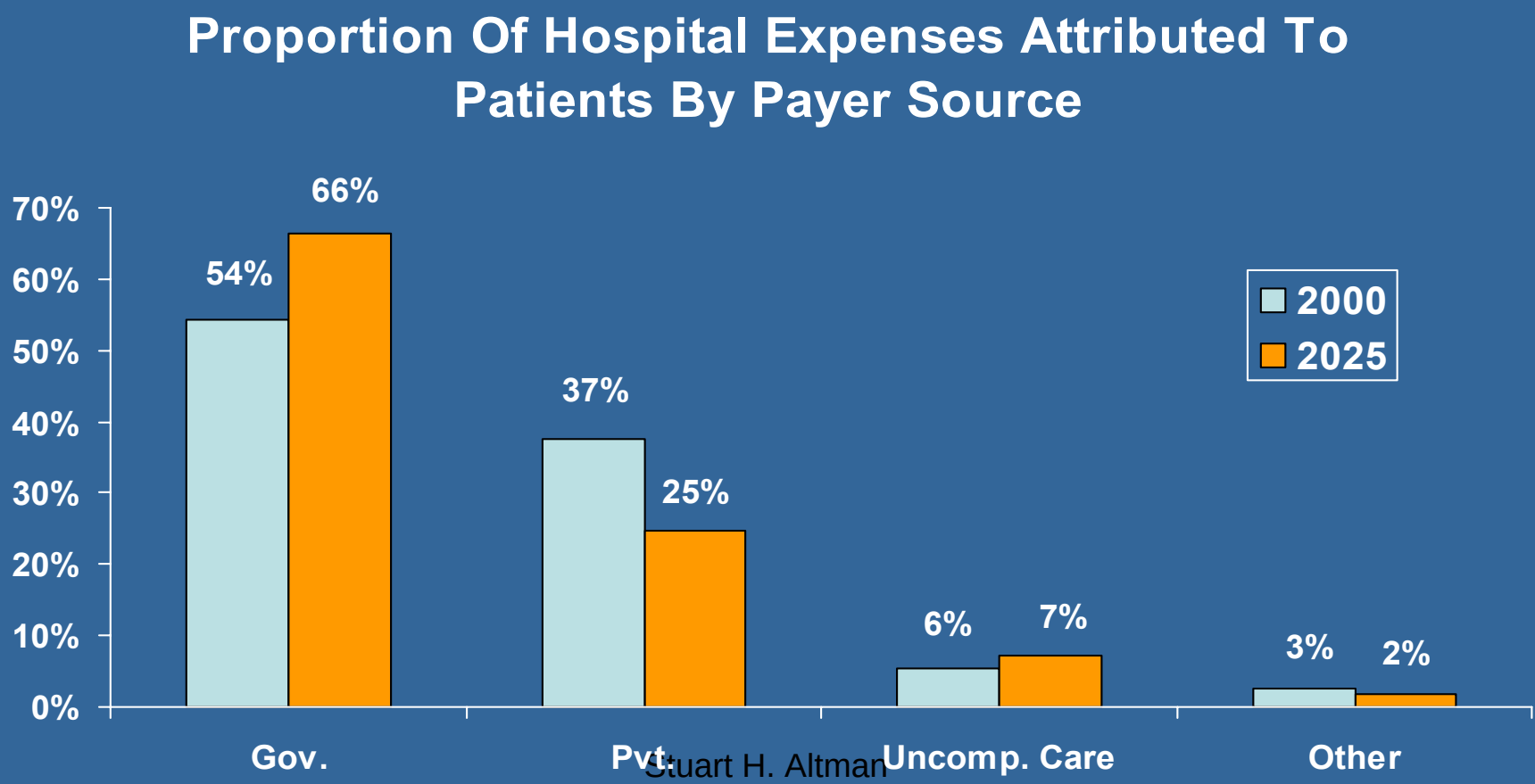
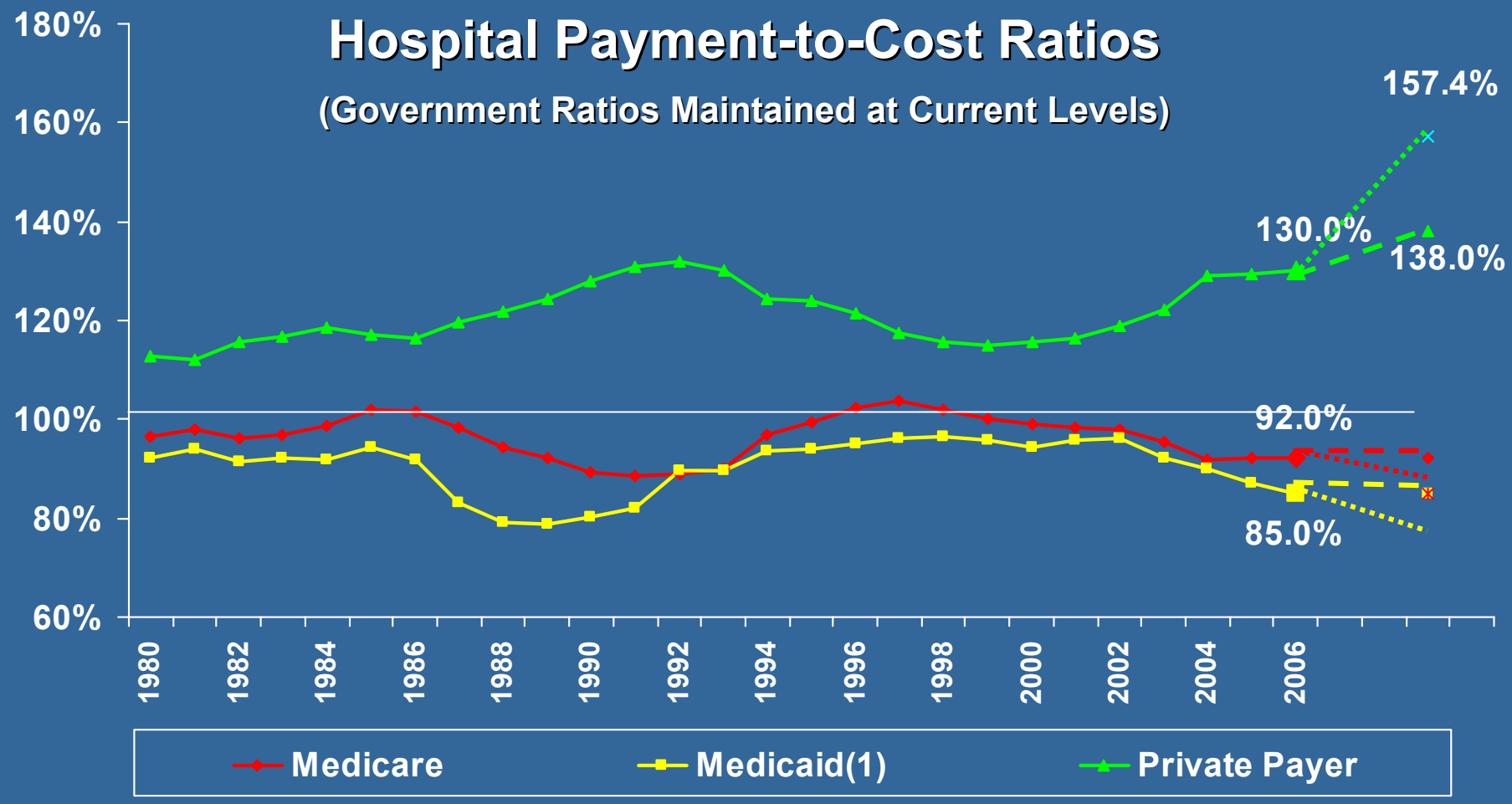
Even With No Change In Coverage Government Will Dominate Institutional Payments



Can Private Insurance Payments Continue To Pay For The Shortfall In Government Payments



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2005, for community hospitals.
(1) Includes Medicaid Disproportionate Share payments.

Controlling Healthcare Spending In The U.S. Is Not Easy!

We Have Tried To Control it Before With Only Limited Success

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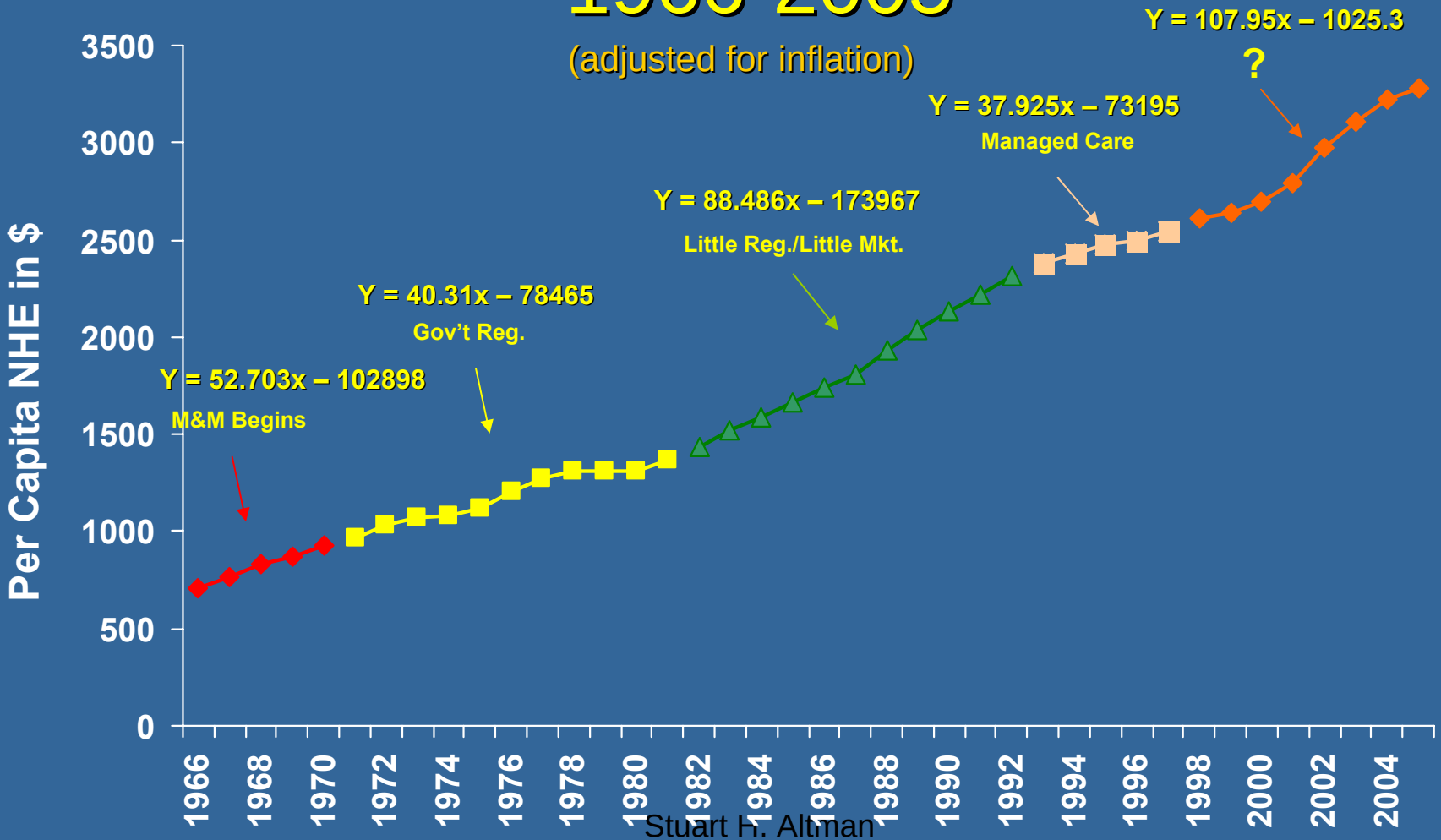
Growth In Per Capita National Health Expenditure 1966-2005

(adjusted for inflation)



Why Is Controlling Spending So Difficult?

- The Forces Against Significant Reductions Are Very Powerful
  - Providers, Insurers and Healthcare Suppliers
    - Concern About---
      - Reductions In Wages
      - Reductions In Earnings
      - Regulatory Hoops
  - Patients
      - Reduced Access to Services
      - Bureaucratic Restrictions
      - Freedom of Choice of Providers
  - Politicians
      - Need I Say More

Health Care In America Is Big Business---In Other Countries It's a Social Service

Are We Really Going To Change That !

Nevertheless We Must Limit Growth in Healthcare Spending or Face A "Meltdown In our Public and Private Financing Systems!

What Techniques Can We Use?

What Presidential Candidates Are Proposing To Lower Costs!

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What Presidential Candidates Are Proposing To Lower Costs

- **Republicans**
  - *Giuliani*
    - *Health information technology*
    - *Transparency for prices, provider qualifications*
    - *Information on risk adjusted outcomes of individual providers*
    - *Medical liability reform*
  - *Romney*
    - *Medical liability reform*

What Presidential Candidates Are Proposing To Lower Costs

- **Democrats**
  - ***Clinton***
    - National prevention initiative
    - Health information technology
    - Chronic care coordination
    - Establishment of a Best Practices Institute
    - Information for better use of prescription drugs and limit direct-to-consumer advertising of drugs
    - Negotiate lower prescription drug prices and revise patent laws to increase use of generic drugs
    - Linking medical error disclosure with physician liability protection

What Presidential Candidates Are Proposing To Lower Costs

- **Democrats**
  - **Obama**
    - Invest in electronic medical records and other health IT
    - limit administrative costs of health insurers
    - Promote insurer competition through health insurance exchange
    - Improve prevention and management of chronic conditions
    - Require hospitals and other providers to report measurers to lower healthcare costs and improve quality
    - Promote and strengthen public health and promotion
    - Reform medical malpractice and foster new models of addressing physician errors

Where Should We Begin?

Techniques for Limiting Growth In Health Spending and Likely Impact

- ***Very Limited Impact***
  - Encourage Greater Use of Preventive Services (Short-term)
- ***Limited Impact***
  - Provide Better Price and Quality Information
  - Require Patients To Pay More
  - Restrict Use of Harmful Care
  - Reduce Expense and Waste of Medical Mal-Practice System
  - Reduce Administrative Costs of Insurance
  - Develop and Use Government Supported "Comparative Effectiveness Studies
- ***Greater Impact***
  - Restructure Payment System--- (Bundled Payment and Value Based Pricing)
  - Restructure Delivery System (Integrated Care)
  - Restrict Use of Marginally Useful Care
  - Limit Supply of Expensive Services
  - Incentives to Use Preventive Services (Long-Term)
  - Expand and Restructure Primary Care---Create Effective "Medical Homes for Patients)
  - Create a Governmental "High Cost Reinsurance System" with Effective Disease Management Systems for Chronic Conditions
  -
- ***Greatest Potential Impact***
  - Gov. Regulation of Payments To Providers
  - Establish Global Budgets

--- Now Match Up Impact With Political or Practical Reality of Implementation ---