Health Care Cost Containment Initiatives:
Inextricably Linked to Access, Quality and Health Policy

"Medicine used to be simple, ineffective and relatively safe. Now it is complex, effective and potentially dangerous."[1]
- **Sir Cyril Chantler, former Dean Guy's King and St. Thomas' Medical and Dental School**

"These stunningly high rates of medical errors - resulting in deaths, permanent disability, and unnecessary suffering – are simply unacceptable to a system that promises to first 'do no harm'."[2]
- **William Richardson, IOM Report**

"We practice healthcare as if we never wrote anything down. It is a spectacle of fragmented intention."[3]
- **L. Weed, M.D.**

"From nearly anywhere in the world we can withdraw money from our bank accounts, pay bills, apply for a mortgage, book airline tickets and even order groceries online. But more often than not, we can't share an X-ray digitally from one hospital to another, even if they are on opposing street corners."[4]
- **Michael Leavitt, Secretary of the U.S. DHHS**

The main purpose of expanding health insurance coverage is to improve the health and well-being of the uninsured population. However, in a system burdened by uncompensated care and cost-shifting, this goal can only be achieved alongside a concurrent effort to constrain health care cost growth to reasonable levels. The rapid growth of health care costs is a national issue, and of deep concern to payers, purchasers, providers, the public, and policymakers.

In 2004, the total expense for all health care goods and services by all payers in the U.S. was $1.8 trillion.[5] Michigan's share of that spending was between $57 billion and $63 billion.[6] In other terms, total health care spending in the U.S. comprises more than 15 percent of the Gross Domestic Product (GDP). Given current trends in health care spending and the state of the economy, estimated growth in health care spending is expected to reach nearly 19 percent of the GDP by 2014.[5] As the cost of health care continues to rise at a greater rate than inflation, this trend will become unsustainable.

Extensive reform is required at all levels (local, state and national) to curb the growth of health care costs. Two key health policy challenges are maintaining a high level of quality and access in the effort to contain costs, and striking the right policy balance in monitoring and regulating the quality of health care.[7]

The Advisory Council to Michigan's State Planning Project for the Uninsured has identified the need for the creation of a health cost containment council. The goal of this paper is to identify critical issues contributing to health care cost escalation and recommend cost control initiatives. Concurrent to the Advisory Council's recommendation, is the release of the Governor's Council of Economic Advisors report, with its *Recommendations to Reduce the Economic Burden of Providing Employer-Sponsored Health Care Benefits*.[6] This report addresses nine aspects of the health care system in which significant reform can occur, resulting in cost-savings, while maintaining or substantially increasing quality and access.[6] Several of these categories of recommendations correlate with the objective of a health cost containment council.

Five priority initiatives will be addressed in this report as important measures to be addressed by a health cost containment council. They include:
- Advance Health Information Technology;
- Improve Patient Safety, Reduce Medical Errors and Support Efficacy in Medical Care;
- Control Prescription Drug Costs;
- Strengthen Certificate of Need Program; and
- Encourage Healthy Lifestyle Programs and Improve Health Status.

Advance Health Information Technology

Information technology is changing America's industries. At the close of the 1990s, the majority of American industries were spending approximately $8,000 per worker for IT, while the health care industry investment in IT was only around $1,000 per worker.[8] Despite being the leader in innovative medical care, the U.S. continues to encounter major hurdles in its health information systems. Moving into the 21st century, the U.S. spends $1.8 trillion on health care, yet must address serious concerns related to avoidable medical errors, administrative inefficiencies, and poor coordination – all of which are closely linked to the failure to effectively incorporate health information technology into our health care system.

Simple innovations in technology can streamline care, reduce duplicative tests and procedures, boost doctors' use of evidence-based practices, eliminate transcription and dispensing errors and simplify billing and reimbursement. The Office of the National Coordinator for Health Information Technology (HIT) estimates that a fully integrated national HIT system would reduce costs in the health care delivery system by 20 percent.[9] Building capacity for HIT infrastructure will entail considerable developmental costs initially, but is a necessary investment for long-term health care efficiency and cost containment. Developmental costs are estimated at $400 billion over a five-year period, with savings of $78 billion per year.[10] Given this scenario, developmental costs should be offset by the savings in just a little over five years.

Better health information technology is essential to saving lives and improving health care. ER doctors typically know little about their patients. However, thanks to an online

registry containing the health care records of 1.5 million central Indiana patients, ER doctors in Indianapolis can instantaneously review a patient's medical background to learn about a patient's recent hospitalizations, ER visits, medications, allergies, lab results, and previous diagnoses.[11] This information is gathered from a simple Google-type search of a patient's medical records from 21 area hospitals, 800 local doctors, and area pharmacies, imaging centers, laboratories, and public health departments. This immediate health record check may stop an ER doc from prescribing medicine that can harm or kill patients in certain situations; such as antibiotics infused into an unconscious patient on a blood thinner that would cause the anticoagulant to "get out of control"; or nitroglycerin given to a man suffering chest pain who fails to mention he takes Viagra, a combination that could cause severe or life-threatening low blood pressure.[11]

A fully modernized electronic health record (EHR) could become a reality without any innovative technological advances. Former DHHS Secretary Tommy Thompson estimated in 2004 that nationwide adoption of EHR systems could save 10 percent of the nation's annual health spending.[4] If health care spending is estimated at $1.8 trillion a year, that amounts to $180 billion annually. For Medicaid, a 10 percent annual savings would equate to a cost reduction of about $33 billion per year.[4] These savings would likely be associated with better medical care, a greater capacity to deal with more home-based care, improved preventive care and greater adoption of disease management.

President Bush's Health Information Technology Plan has a goal of assuring that most Americans have electronic health records within the next 10 years, and the U.S. Department of Health and Human Services has taken the lead in bringing public and private entities to the table, forging consensus on how to move ahead with HIT.[8] However, 10 years is a long time frame, and even the Governor's Council of Economic Advisors in Michigan has recommended that the federal government should reduce intended development time of EHRs from 10 years to five years.[6] As prudently quoted, "Why is HHS's time frame for wide-scale implementation – an implementation that would use technology we already have – the same as President John F. Kennedy's was for landing on the moon, using technology nobody had developed yet?"[4]

While a nationwide EHR program is in planning, there is movement and some HIT progress in individual state Medicaid programs. Currently, the federal government provides a match of 75 to 90 percent on most Medicaid IT infrastructure investments, allowing many states to improve their existing Medicaid Management Information Systems (MMIS). For example, Wisconsin has updated its MMIS to be web-based, with 90 percent of claims submission and real-time adjudication of pharmacy claims online, for a saving of $90 million in administrative costs over five years.[4]

It is critical that the State of Michigan be at the forefront of HIT efforts occurring nationally, so as to track HIT developments, maximize collaboration among all public and private parties to advance HIT, and disseminate emerging best practices across the state.

Improve Patient Safety, Reduce Medical Errors & Support Efficacy in Medical Care

Since the Institute of Medicine (IOM) shined a spotlight on the problem of preventable medical errors in 1999, Federal and State policy makers, health care providers, employers, consumers, and researchers have mobilized substantial resources to improve patient safety.[12] The IOM report estimated that errors in American hospitals cause as many s 98,000 deaths and more than one million patient injuries each year.[2] More people die from medical errors than from motor vehicle accidents, breast cancer, or AIDS.[13] One of the recommendations from the report was that large purchasers (such as General Motors) use their clout to reinforce the need for quality and patient safety. Despite the urgency of the situation, and a growing concern about patient safety in a variety of health care settings, progress on patient safety across the nation is still lagging.

The Leapfrog Group, a consortium of over 130 Fortune 500 and other companies, continues as one of the nationally recognized leaders in advancing the cause of quality, customer service, and affordability in health care.[14] Leapfrog initially identified three practices, or Leaps of Care, that influence the number of preventable mistakes in hospitals; a fourth Leap of Care has since been added. Cost savings are estimated for each of the measures; implementation costs vary and are not included here. They are as follows:

- Computer Physician Order Entry (CPOE): CPOE systems allow physicians to enter medication orders into a computer that is linked to error-prevention software.
  CPOE has shown to reduce serious prescribing errors in hospital up to 88%.[14]
  Cost savings result from fewer medication errors and adverse drug events, ranging from $180,000-$900,000 per year, depending on hospital size.[15]
  However, the potential of CPOE to reduce resource utilization in other ways result in greater savings. Sources of savings include medication substitution, reduced laboratory testing and imaging, increased use of clinical pathways, and gains in clinical efficiency. While these savings are difficult to quantify and vary by hospital, some hospitals which have implemented CPOE report annual savings exceeding $5 million.[15]
- Evidence-Based Hospital Referral: Patients who need complex medical procedures are referred to hospitals offering the best survival odds (based on proven outcomes or extensive experience with specific procedures or diagnosis).
  Research indicates that a patient's risk of dying could be reduced using this practice by more that 30%.[14]
  Evidence-based hospital referral may reduce the per unit average costs of performing operations in a given community because high volume hospitals tend to have better economies of scale for delivering complex, resource-intensive procedures, as well as shorter lengths of stay for many procedures. Savings may be offset by the administrative costs.[15]
- Intensive Care Unit (ICU) Physician Staffing:
  ICU's with physicians who have credentials in critical care medicine have shown to lessen the risk of dying in the ICU by almost 30%.[14]

> ***Savings include potential reduction in inappropriate ICU admissions, ICU and hospital length of stay, ancillary costs, and costs associated with complications that occur in the ICU. Estimates indicate that ICU Physician Staffing would produce net annual per hospital savings ranging from $800,000 for small ICUs to $3.4 million for large ICUs.*** [15]

- NEW Quality Index: 27 Safe Practices for hospitals to use to help prevent medical errors and improve patient safety.

The Michigan Health and Safety Coalition (MH&SC) is an organization dedicated to improving patient safety in Michigan; the group actively promotes the principles established by the Leapfrog Group. In 2004, MH&SC accepted the Governor's request to serve as the State Commission on Patient Safety (SCPS) for the purpose of examining ways to improve patient safety and reduce medical errors. The SCPS's report to the Governor with recommendations on improving patient safety is due to be released shortly. It is anticipated that the report will specify 12 recommendations addressing the following concerns:

- Establish and fund a state-level focal point for patient safety information and activities (i.e., patient safety center).
- Establish and fund a statewide voluntary health-care and near miss reporting system.
- Enact statutory protection for patient safety data and reporting activities; permit certain disclosures consistent with federal law.
- Establish statewide patient safety standards and goals for improvement.
- Modify licensing requirements to reinforce patient safety recommendations.
- Educate new health care professionals and ensure that continuing education is consistent with patient safety goals.
- Ensure Michigan interests, perspectives and concerns are represented as national standards are developed.
- Create facilities and physical environments that take patient safety into account. [16]

The process of identifying and reporting medical errors, near misses and system failures would allow for a safer health care environment, benefiting individuals through the reduction of harm, while allowing health care organizations to realize cost savings due to efficiencies in care. While the main motivation for focus on reduction of medical errors is naturally to improve patient safety and well-being, the estimated cost savings is substantial. [17] The cost of medical errors exceeds $38 billion per year; almost $20 billion of this cost can be eliminated by reducing preventable medical errors. [2]

The practice of evidence-based medicine is just as critical. Despite established clinical guidelines, Americans only receive about half of applicable services. [18] As a nation, we are uncertain about the clinical benefit of the other 50 percent of care that is provided. [19] The uncertainty extends over all medical services, including hospital stays, diagnostic tests and prescription drugs. There is a significant amount of overuse, underuse, misuse, and waste in the health care system. Several examples include:

- Overuse (Unnecessary or inappropriate services) – About 76% of women receive unnecessary hysterectomies because providers didn't try alternative therapies first.[19]
- Underuse (Should be 100%) – Of Medicaid patients experiencing a heart attack, 65% receive beta blocker acutely, and 72% at discharge.[20]
- Misuse – Diagnostic error: 20% of patients dying in an ICU had wrong ante-mortem diagnosis. 44% of these would have different therapy with correct diagnosis.[21]
- Waste – Utilization Review: United Healthcare spent $108 million on UR of 85 million claims, even though physician decision was upheld 99% of the time.[22]

The Dartmouth Atlas of Health Care is a valuable tool, using Blues' claims data and information from other sources to analyze the use and supply of health care services in Michigan, allowing for analysis based on geographical areas.[23] The Dartmouth Atlas raises important questions about how health care services are used throughout the state and shows that their use varies among communities. The Governor's Council of Economic Advisors in Michigan recommends that a collaborate effort take place to evaluate Michigan's variations in measures reported in the Dartmouth Altlas, and pilot cross-payer projects that advance the use of best practices to reduce variation.[6]

A comprehensive approach is needed in the State of Michigan, to systematically and continuously improve patient safety. Leadership and broad organizational culture change are needed to address this crisis. The State can use its purchasing and regulatory role to educate the public and work with stakeholders across the spectrum to improve patient safety.[24] Collectively there is an incredible opportunity to improve the quality of health care, thereby reducing unnecessary costs.

Control Prescription Drug Costs

It is estimated that retail pharmaceutical costs will account for 12 percent of the cost of all health care services and supplies in 2005, exceeding $223 billion.[5] Private insurance will have carried almost 47 percent of this cost, greater than $105 billion.[5] The average percent of an employer's premium allocated to prescription drugs is 20 percent.

While pharmaceutical costs continue to spiral upwards, Michigan has taken significant and successful measures to curb this growth over the past few years. In December 2001, the Michigan Medicaid program combined three new strategies: 1) the state published a lengthy preferred drug list covering 40 major disease conditions, each with "preferred" and "non-preferred" selections; 2) prescribers were required to obtain "prior authorization" for each patient when a non-preferred drug was ordered; and 3) a supplemental rebate was established, directed at pharmaceutical manufacturers.[25] In 2003, Michigan and Vermont created the first multi-state pool, entitled the National Medicaid Pooling Initiative. A year later, Alaska, Nevada and New Hampshire joined the multi-state pool. As a result of the price discounts generated from 40 manufacturers, the State of Michigan saved $13 million in 2004 by purchasing through the pool.[4]

However, Michigan's successes may soon be overturned by the latest Medicare prescription drug bill. Starting in 2006, the dual-eligible population (those entitled to Medicare who are poor enough to qualify for Medicaid as well) will receive their pharmacy benefit from Medicare. While these dual eligible have historically had their pharmacy costs covered by Medicaid and constituted almost half of Medicaid's drug costs, the State may now lose the leverage it had previously as a large purchaser when negotiating price with pharmaceutical companies. In addition, the State may lose access to critical data. Under the Medicare Prescription Drug Improvement and Modernization Act of 2003, prescription drug plans under Medicare are not mandated to share their data on dual-eligibles with Medicaid programs. This could result in lowering quality of care, weakening other important Medicaid programs, like disease management and care-coordination efforts that depend heavily on such information. Finally, the "clawback" provision of the Medicare prescription drug bill, requiring the State to return 90 percent of pharmacy costs to the federal government's Medicare program to compensate it for assuming the expense of the dual-eligibles, may cost Michigan up to $20 million dollars.[4]

Such changes will require new approaches to curb pharmacy costs, maximizing the State's purchasing power in other ways. Michigan's Council of Economic Advisors suggests exploring partnerships among the Michigan Office of the State Employer, county and local government, and businesses to maximize purchasing leverage for pharmaceuticals.[6] Further, the State must take the lead in applying findings of scientifically sound, comparative studies of the relative efficacy of therapeutically equivalent drugs and new drugs to the benefit design and the purchase of pharmaceuticals for state-funded health programs.

Strengthen Certificate of Need Program

Efforts to control increases in health care costs must include a focus on the supply of services. States use Certificate of Need (CON) programs to promote cost containment by decreasing both service duplication and investment in excess capacity.[26] Michigan's CON program is a necessary regulatory means of addressing the capacity and cost of health care technologies and services throughout the state. The idea is to prevent health care facilities from over-expanding or purchasing excessive amounts of expensive, high-tech capacity.[25] Michigan's Council of Economic Advisors recommends that the State should apply continuous improvement principles and practices to the ongoing evaluation and evolution of its CON program, making it strong and credible.[6] There is a demonstrated correlation between CON and the provision of indigent care, redirecting funds from investments in capital to subsidization of care.[26] In terms of quality of care, CON may be useful in promoting regionalization of services, allowing for improvement in patient outcomes for selected, high-risk services.[26]

Encourage Healthy Lifestyle Programs and Improve Health Status

Chronic diseases related to lifestyle account for 70% of total healthcare spending.[27] Lifestyle induced disease continues to increase rapidly, and the incidence of many diseases will increase as the population ages. The Centers for Disease Control (CDC)

estimates that 23 percent of employer premiums for those over 40 can be attributed to the costs of obesity and sedentary lifestyles.[28] This percentage is likely higher in Michigan, given our higher than average rates of obesity and sedentary behavior. The CDC attributes at least eight percent of all health care costs to smoking.[29]

There is significant potential of reducing health care costs through the promotion of healthier lifestyles. Pitney Bowes, a Fortune 500 company with a global team of more than 35,000 employees, designed a strategy to decrease its health care costs by focusing on a model taking into account the total cost of health (i.e., medical claims, pharmacy, behavioral health, disability, absenteeism, and workers compensation).[30] Analysis indicated that the burden of illness and health care costs were being driven by a lack of preventive services and pharmaceutical compliance. An integrative approach encouraging a healthy work environment (on-site medical facilities and fitness centers, ergonomic workspaces, non-smoking worksites, healthy food options in cafeterias and lactation rooms) as well as personal responsibility (wellness/prevention, demand and disease management) led to a reduction in health care costs. For instance, average annual cost of care decreased by 6 percent for diabetes, and by 15 percent for asthma.[30] Related to the decreased use of drugs to treat the complications, average annual pharmacy costs decreased by 7 percent for diabetes and 19 percent for asthma.[30]

Michigan's Council of Economic Advisors recommends that Michigan should require HMOs, insurers, and BCBSM to incorporate wellness and personal responsibility options into the benefit design of all health insurance policies.[6] The State should provide certification of worksite wellness programs, allowing employers to identify effective-evidence based programs. Any program that helps individuals achieve healthier lifestyles will help prevent disease, improve quality of life, reduce health care costs, and increase productivity.

The Role of the Health Cost Containment Council

In summary, these are some of the key initiatives to be addressed by the creation of a health cost containment council. Michigan must take advantage of the information age and new technologies that will enable the State to reshape the health care system, allowing for cost-efficient and appropriate health care. It is due time to rethink how insurance products, health benefits, provider accountability and administrative services are organized, focusing them around improving quality and access to care, and re-thinking the role of long-term policy development. Significant progress on these complex issues will necessitate active participation from all sectors and bipartisan commitment from the government.

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