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Health care spending is transferred out of ICU

By Dennis Cauchon

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Health care spending last year rose at one of the lowest rates in a half-century, partly the result of cost-saving measures put in place by the 2009 health care law, a USA TODAY analysis finds.

Spending for medical care has increased modestly for five consecutive years, the longest period of slow growth since Medicare began in 1966. This respite comes just before a massive expansion of health insurance starts Jan. 1, 2014. Another 21 million people will get insurance, adding about \$100 billion a year to total health care spending in 2014, according to the government's actuary.

Health care spending hit a record \$2.67 trillion last year, but its share of the overall economy shrank, from 17.12% of gross domestic product in 2011 to 17.04%, because other parts of the economy grew faster, an analysis of Bureau of Economic Analysis data found.

Cost-saving measures under the health care law appear to be helping keep medical prices flat, according to health care providers and analysts. Also, weak demand may linger from the recession, which ended in June 2009, especially for optional care such as cosmetic surgery.

In 2012, the average price paid for medical care — a doctor's visit, an operation, a pair of glasses — rose at about the same rate as other prices in the economy, an inflation rate of less than 2%.

Total health care spending still rose 1.7 percentage points faster than inflation in 2012 because of an increased use of medical services, such as hospitals, home health care and drugs. However, even this extra demand for care was modest compared with past years, especially for an aging population.

"We're beginning a long period of adjustment in health care," says Dan Mendelson, CEO of Avalere Health, which advises health care companies and investors. "Institutions are taking both cost control and quality improvement more seriously."

He predicts modest cost growth is a long-term trend, not a short-term blip. "There's a lot more to squeeze without hurting quality," he says.

Also keeping costs lower:

Government insurance. More people are getting health insurance from Medicare and Medicaid, which pay less to doctors and hospitals than private insurers. Medicaid, which pays the least, covers 56 million poor people, up 10 million from five years ago. It will add nearly 20 million enrollees next year.

Generic drugs. About four of five drugs used today are less expensive generic medicines. The nation's top-selling drug, Lipitor, for high blood pressure, lost patent protection last year.

Competition. Health care exchanges, which start next year, may keep insurance prices down while limiting consumer choice. In early deals, hospitals and doctors are agreeing to lower rates than traditional private insurance in exchange for more volume.

New law has impact

USA TODAY computed health care spending from the nation's gross domestic product data to get the first comprehensive look at what happened in 2012.

In the four years leading to expanded health insurance, the government has used authority in the Patient Protection and Affordable Care Act to try to reshape the economics of health care through regulation and financial incentives. That appears to be keeping a lid on medical costs, at least in the short-term.

"It all goes back to (the Affordable Care Act) and how it changes so many components of the way we do business," says Peter Person, chief executive of Essentia Health, a 12,800-employee hospital system based in Duluth, Minn. "The language I use now in the health care business is completely different than the language I used even five years ago."

One big change is the government's revived push toward managed care. The government wants to pay a lump sum for a patient or diagnosis, demand higher standards and expect the medical provider to get the job done for that cost. Rather than cutting reimbursement rates, the government is raising the bar for what it expects for every dollar it spends.

Example: Medicare won't pay a penny more if a patient suffering congestive heart failure is readmitted to a hospital within 30 days of a discharge. The original lump sum is supposed to be enough and the refusal to pay more is designed to encourage hospitals to give top-notch care the first time.

How it saves money: Essentia now provides 300 of the sickest congestive heart failure patients with electronic home scales that relay information, such as weight and symptoms, to a nurse

several times a week. The steady monitoring of small things has cut 30-day admissions to less than one-tenth of the national average and saved millions of dollars.

"Until now, the government has paid on volume. Now, it's trying to pay more on quality," says Person, a doctor of internal medicine, as well as CEO of Essentia, which has 18 hospitals and 68 clinics.

Incentives to lower costs

The government's new approach attaches financial rewards and penalties to a long list of practices — from giving antibiotics before surgery to using electronic medical records — in an effort to simultaneously improve quality and lower costs. In addition to changing how Medicare and Medicaid pay for medical care, the administration is providing grants and legal waivers to states and medical providers to experiment with approaches that try to align financial rewards with what studies show are best medical practices.

Among the most visible successes are efforts to save money on the most expensive patients by permitting the use of a hospice rather than a hospital for end-of-life care and emphasizing home health care over nursing homes.

Wisconsin's Family Care program now pays \$3,200 monthly per person to provide mostly home health care to 40,000 poor seniors and disabled people. That's \$600 a month less than it pays under an old program, which tends to use nursing homes to care for the most expensive population of patients, who are on both Medicare and Medicaid, the health program for poor people.

What's not clear is whether thousands of pages of new regulations and ideas can keep a lid on health care costs for long. In the past, regulations to solve one problem have created new financial incentives elsewhere in the reimbursement system.

The new efficiency push resembles earlier efforts, one under then-president Ronald Reagan and another under then-president Bill Clinton. In the 1980s, Medicare started paying fixed amounts for a diagnosis. In the 1990s, health maintenance organizations were widely seen as a powerful cost-containment tool.

Both initiatives tamed costs briefly and left managed care unpopular with many patients and medical providers. Managed care and other cost savings will stick this time because they aren't voluntary, says Person, the hospital chief.

"It is now the law, and it has teeth. We're getting paid less," he says. "We have to be more productive and efficient."