Reducing the Cost of Health Care

Current Innovations & Future Possibilities

Texas Medical Center Health Policy Institute
February 2018

TMC | HEALTH POLICY

February 2018

Texas Medical Center Health Policy Institute
6550 Bertner Avenue, Executive Offices, 6th Floor
Houston, TX 77030
www.tmc.edu/health-policy

For more information, contact TMCHealthPolicy@tmc.edu.

For media requests, contact rholeywell@tmc.edu.

About This Report

The United States spends a staggering sum of money on health care – an estimated $3.4 trillion annually – and that figure rises each year. The federal government projects that by 2024, health care spending will account for nearly a fifth of the U.S. gross domestic product.

The trend coincides with a harsh reality facing U.S. consumers: Many of them struggle to pay for their health care. In a new survey of 9,000 consumers, the Texas Medical Center Health Policy Institute found that half of respondents said they must make cuts in other areas of their lives to pay for their health care. In particular, they cut back on saving, as well as spending on food and clothing. These sacrifices are not luxuries like high-end electronics or vacation travel. They're serious expenses in family budgets. These trends are not sustainable.

The Texas Medical Center Health Policy Institute convened 10 of the country's top health policy leaders at a forum in Houston in the fall of 2017 to help us address this pressing problem. Their charge was to answer the question, "Specifically, what can we do to reduce the cost of health care?" It would be virtually impossible to assemble a better-qualified group, which included top government officials, national and regional insurance executives, public health experts and top representatives from the physician and hospital communities.

This paper highlights some of the most promising solutions this esteemed group identified. Some are "big picture" ideas, like reforming the "fee-for-service" model that provides incentives for expensive overtreatment with little or no benefit to patients. Others are more specific, such as new ways to transition care for patients leaving the hospital. In all, we identified eight promising solutions.

This paper will serve as a roadmap for advocates, policymakers, health care providers and others seeking creative ways of reducing the cost of health care. The country cannot afford to continue along its current path, but fortunately, we know exactly how we can reverse this trend.

Regards,

Arthur "Tim" Garson, Jr., MD, MPH
Director, Texas Medical Center Health Policy Institute

About the Texas Medical Center

The Texas Medical Center (TMC) in Houston, home to 59 member institutions, is the world's largest medical city. Since opening in 1945, TMC has been pioneering patient care, research, education and prevention. Today, TMC continues its dedication to reinventing life sciences to improve the health and wellness of Houston and the world. More information at www.tmc.edu.

About the Texas Medical Center Health Policy Institute

The Texas Medical Center Health Policy Institute was established to inform, define and lead health policy with the goal of developing the most effective solutions to improve the health of diverse populations around the globe. By driving innovative, evidence-based health policy initiatives across the Texas Medical Center's 59 member institutions, the Texas Medical Center Health Policy Institute addresses fundamental health policy issues important to Houston, Texas and the nation. More information at www.tmc.edu/health-policy.

Policy Forum Participants

Arthur "Tim" Garson, Jr., MD, MPH
Director, Texas Medical Center Health Policy Institute
Former Dean of Medicine and Provost of the University, University of Virginia

Frederick Isasi, JD, MPH
Executive Director, Families USA

Ken Janda, JD
President and Chief Executive Officer, Community Health Choice, Inc.

Stephen Linder, PhD
Associate Director, Texas Medical Center Health Policy Institute
Director, Institute for Health Policy at University of Texas School of Public Health

Cindy Mann, JD
Partner, Manatt, Phelps & Phillips
Former Deputy Administrator, Centers for Medicare and Medicaid Services

George Masi, CHE, FACHE
President & Chief Executive Officer, Harris Health System

Mark McClellan, MD, PhD
Director, Duke University Robert J. Margolis Center for Health Policy
Former Administrator, Centers for Medicare and Medicaid Services
Former Commissioner, U.S. Food and Drug Administration

Robert Morrow, MD, MBA
Southeast Texas Market President, Blue Cross and Blue Shield of Texas

Raymond Scheppach, PhD
University of Virginia Professor of Public Policy
Former Executive Director, National Governors Association

Marilyn Tavenner, MHA
President and Chief Executive Officer, America's Health Insurance Plans
Former Administrator, Centers for Medicare and Medicaid Services

Full biographical information for participants available at www.tmcreducingcosts.org

Texas Medical Center Leadership

William F. McKeon
President and Chief Executive Officer

Shawn W. Cloonan
Chief Operating Officer and Executive Vice President

Denise Castillo-Rhodes
Chief Financial Officer and Executive Vice President

Texas Medical Center Health Policy Institute Staff

Arthur "Tim" Garson, Jr.
Director

Stephen Linder
Associate Director

Ryan Holeywell
Communications Manager

Stephanie Campbell
Report Author

Executive Summary

Background

The cost of health care in the United States is growing at an unsustainable rate. In 2016, the country spent an estimated $3.4 trillion on health care, representing about 18 percent of gross domestic product or more than $10,000 spent on health care for every man, woman and child. By comparison, U.S. per-capita health care spending is 20 percent more than that of the second-most expensive developed country, Switzerland, and more than double the median spending of OECD nations.[1]

Given those vast costs, it's no surprise that health care remains out of reach for many people. Though the Affordable Care Act (ACA) expanded health insurance to nearly 20 million people, a large portion of the population – more than 10 percent of the non-elderly – still has no health insurance.[2] The ACA largely ignored the impact of expensive deductibles, often as high as $6,000 per person, which continue to make health care unaffordable for many. New survey data produced by the Texas Medical Center Health Policy Institute indicate that half of respondents – regardless of whether they're insured – say they must reduce spending in other areas of their lives to pay for health care.

Policy Forum

Debates about federal health care policy often focus on the cost of providing government-supported health insurance. However, those debates rarely focus on the cost of health care itself. Experts estimate that a third or more of annual U.S. health care spending is waste, or spending that can be cut without harming patients or reducing their quality of care.[3] Reducing that figure can help make health care more affordable for American families.

The Texas Medical Center Health Policy Institute convened 10 of the country's leading experts on health care policy to develop recommendations that, collectively, could reduce the cost of health care and cut the more than $1 trillion in annual wasteful health care spending. Their recommendations are listed below and described in greater depth throughout this report.

Specific Recommendations

1. Allow the government to use cost and cost-effectiveness in decision-making
2. Eliminate fee-for-service
3. Standardize quality-of-care metrics
4. Empower patients to be responsible for their own health and health care
5. Improve care coordination through task shifting
6. Reduce Emergency Department utilization and readmissions
7. Develop more specific approaches to improving end-of-life care
8. Meaningfully address the impacts of adverse childhood experiences

Introduction

The cost of health care in the United States is growing at an unsustainable rate. In 2016, the country spent an estimated $3.4 trillion on health care, representing about 18 percent of gross domestic product, according to the Centers for Medicare & Medical Services. That total equates to more than $10,000 spent on health care for every man, woman and child in the nation. By comparison, U.S. per-capita health care spending is 20 percent more than that of the second-most expensive developed country, Switzerland, and more than double the median spending of OECD nations.

That vast level of spending, however, does not equate to unparalleled quality. A 2017 study by the Commonwealth Fund, for example, ranked the United States health care system last among 11 high-income countries in measures such as access, equity and health care outcomes; it ranked next-to-last in administrative efficiency. [4] Life expectancy has worsened in recent years for some populations, and chronic conditions like obesity-related diabetes are placing pressure on health care systems to act.

Given those costs, affordable health care remains elusive for many families living in the U.S. Though the Affordable Care Act expanded health insurance to nearly 20 million people, a large portion of the population – more than 10 percent of the non-elderly – lacks health insurance altogether.[5] High deductibles often make health care unaffordable, even for those who are covered by health insurance. In fact, many plans purchased through the Affordable Care Act carry deductibles upwards of $6,000.

New survey data produced by the Texas Medical Center Health Policy Institute indicate that half of respondents – regardless of whether they're insured – say they must reduce spending in other areas of their lives to pay for health care. Specifically, survey respondents said they cut back on savings and reduce spending on food and clothing to pay for health care.

One way to ensure more people can afford the care they need is to increase the number of people who are covered by health insurance. Another approach – the focus of this paper – is to reduce the cost of health care itself.

Waste accounts for a third of U.S. medical spending. The term refers to spending that can be cut without harming patients or reducing their quality of care. It includes administrative inefficiency, overuse of tests and procedures and overpriced drugs that total upwards of $1 trillion per year. Reducing that number can increase Americans' ability to afford needed health care.

Congress enacted the ACA in 2010 to accomplish three primary goals: to make affordable health insurance available to more people; to attempt to expand the Medicaid program to cover all adults with income below 138 percent of the federal poverty level; and to support innovative medical care delivery methods designed to lower the costs of health care.

Though ACA succeeded by some measures, it failed to control health care costs, which remain a burden for many Americans. Meanwhile, the health care system is mired by inefficiencies, providers face ever-increasing administrative requirements and the population is aging rapidly. These circumstances call for action.

In the fall of 2017, the Texas Medical Center Health Policy Institute hosted 10 of country's top health policy thinkers at a national forum in Houston. The expert panelists included doctors, public health experts, top government officials, a hospital system CEO and insurance executives. More than 250 people representing institutions across the Texas Medical Center attended the policy forum titled "Reducing the Cost of Health Care: Current Innovations and Future Possibilities."

Each panelist offered tangible, actionable ideas for how the cost of health care can be reduced over the course of the next three years. This paper highlights eight of the solutions they identified to help health providers, insurers, government agencies and consumers realistically reduce the cost of health care in the U.S.

Texas Medical Center Health Policy Institute Cost-Saving Recommendations

1. Allow the government to use cost and cost-effectiveness in decision-making
2. Eliminate fee-for-service
3. Standardize quality-of-care metrics
4. Empower patients to be responsible for their own health and health care
5. Improve care coordination through task shifting
6. Reduce Emergency Department utilization and readmissions
7. Develop more specific approaches to improving end-of-life care
8. Meaningfully address the impacts of adverse childhood experiences

1. Allow the government to use cost and cost-effectiveness in decision-making

Amazingly, Medicare is not permitted to consider cost and cost-effectiveness in its coverage decisions. This must change.

The ACA prevents the federal government from using the cost of care, as well as information about the cost-effectiveness of care, in Medicare coverage decisions. Currently, only comparative effectiveness analysis is permitted. In other words, when determining which care should be provided, treatment effectiveness and potential for harm may be compared, but cost may not be a consideration. Legally, Medicare cannot consider the cost of medical care when deciding whether it will pay for a particular treatment.[6]

The U.S. "needs to broaden the scope of what's on the table for getting value out of health care dollars," said Cindy Mann, former deputy administrator of the Centers for Medicare and Medicaid Services. In fact, each of the policy experts at the TMC policy forum vehemently agreed that cost must be considered.

There are lessons to be learned from the United Kingdom on this topic. The National Institute for Health and Care Excellence (NICE) is a non-governmental body created in 1999 that provides essential health care information to stakeholders, including general practitioners, local government, public health professionals and members of the public.[7] It uses cost prominently in its analyses and shares guidelines on the use of technologies, clinical practice, ways to avoid illness and techniques to promote health.

More than 250 attendees gathered at the Texas Medical Center's September 20, 2017 policy forum in Houston titled "Reducing the Cost of Health Care: Current Innovations and Future Possibilities." Photo by Cody Duty.

Dr. Arthur "Tim" Garson, Jr., director of the Texas Medical Center Health Policy Institute, listens along with Dr. Mark McClellan, who previously led the FDA and CMS. Photo by Cody Duty.

Guidelines are developed only on treatments submitted to NICE by the Secretary of State for Health for the National Health Services (NHS), and they are prioritized if they have potential for significant benefit and offer the best value for money.[8]

To develop these guidelines, NICE uses a formula that measures "disease burden, including both the quality and the quantity of life lived," measured in Quality Adjusted Life Years (QALYs)." If a new treatment is less expensive than the current practice, with similar or better outcomes, then NICE recommends the new treatment. In most cases though, new treatments are more expensive with potentially better outcomes. In those cases, NICE assesses the additional increase in health divided by the extra increase in spending to give an incremental cost-effectiveness ratio (ICER).[9] Both QALYs and ICERs are ways of determining the value of a specific treatment, and they drive the guidelines developed by NICE.

NICE methods also apply to drug approvals. If a drug is more cost-effective than the current treatment, it can be priced higher. It's a model worthy of consideration, given the vast difference in drug costs between the U.S. and the UK. According to a Commonwealth Fund report, "per capita drug spending on prescription drugs was higher in the U.S. than in all other nations and was twice the level in the UK, the lowest spender."[10] Changes to the FDA drug approval process could help curb this waste. For example, increased speed of review for drugs that are potentially price-competitive with an expensive drug could help reduce costs, as the competitive drug would come to market earlier. Ken Janda, president and CEO of health insurer Community Health Choice, advocated for an FDA approval process that considers whether a drug "improves quality and is more cost-effective."

Finally, George Masi, CEO of Harris Health System – one of the country's largest county hospital systems – suggested that Congress could use "anti-gouging" laws as models to reduce drug prices. The average American spends far more on prescription medications each year than residents of any other nation, including 40 percent more than the average Canadian, and double what the average German spends.[11] The cost of drugs has gained heightened attention following several recent price hikes of off-patent medicines such as EpiPen, which prompted public backlash.

States are already taking the lead on this issue. In May 2017, the Maryland General Assembly passed a bill prohibiting price gouging on essential off-patent or generic drugs. The law authorizes Maryland's attorney general to prosecute firms that engage in price increases in noncompetitive, off-patent-drug markets that are dramatic enough to "shock the conscience" of any reasonable consumer.[12]

At the end of the policy forum, Dr. Arthur "Tim" Garson, Jr., the meeting host and director of the TMC Health Policy Institute, started at one end of the 10-person panel and asked respondents to simply answer, "Yes or no: the government *must* consider cost and cost-effectiveness." Every panelist responded with a resounding "yes."

From left: Dr. Robert Morrow, executive at Blue Cross Blue Shield of Texas; Cindy Mann, former CMS deputy administrator; Ken Janda, CEO of Community Health Choice; and Ray Scheppach, former executive director of the National Governors Association, attend the policy forum in Houston. Photo by Cody Duty.

2. Eliminate fee-for-service

We should reform payment methods that risk putting the health care needs of patients and the financial incentives of health care providers at odds with each other.

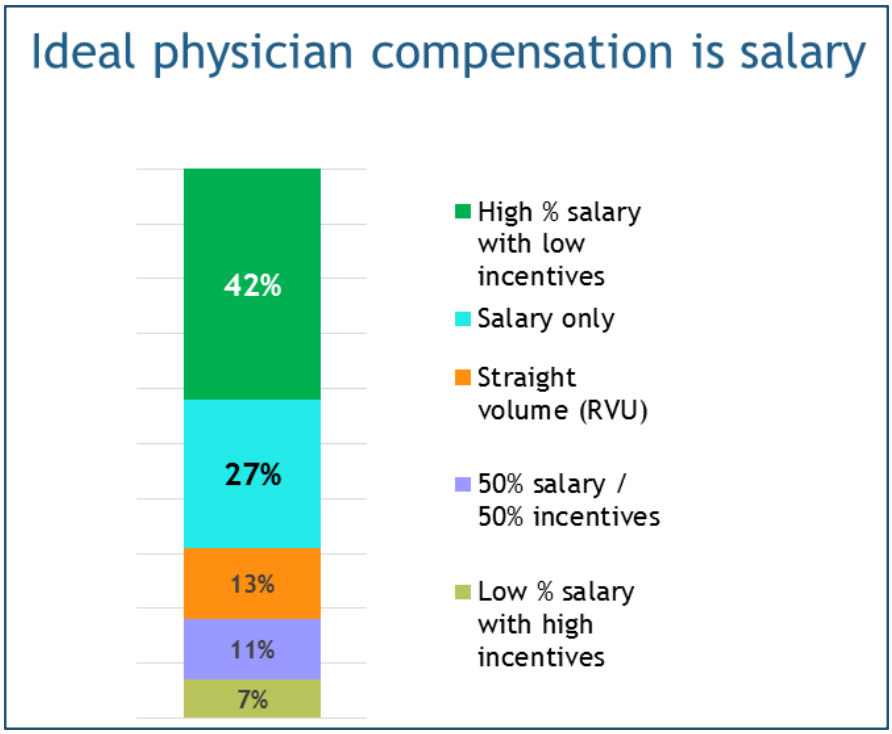
The fee-for-service payment model creates incentives that may prompt physicians to act in ways that aren't exclusively in the best interest of patients. Others have been blunter in their assessment of the potential for conflicts in the fee-for-service model, in which physician compensation is largely tied to the quantity of services provided. "Fee-for-service is bad for patients and leads to bad outcomes," said Frederick Isasi, executive director of the nonprofit Families USA.

Policymakers and regulators are showing signs that they agree. In fact, the Centers for Medicare and Medicaid Services (CMS) has announced that by the end of 2018, more than half of Medicare dollars will be paid via alternative payment models that focus on reducing the negative incentives associated with paying physicians based on a fee-for-service basis. In 2015, Congress enacted the Medicare Access and CHIP Reauthorization Act (MACRA), which among other provisions, modifies physician payment to compensate physicians based on performance. At the Texas Medical Center policy meeting, Marilyn Tavenner, president and CEO of America's Health Insurance Plans (AHIP), said all of the AHIP's members are interested in moving away from fee-for-service and want the health care providers they work with to help make that a reality.

However, physicians have pushed back against the complexity of implementing MACRA. Another major problem is that MACRA continues to use incentives within the fee-for-service system.

New payment models, such as those being used by many Accountable Care Organizations (ACO) that attempt to shift the focus of payment from quantity to quality, may create significant cost savings. A shared-savings payment policy incentivizes providers to reduce costs for a defined patient population by "offering them a percentage of any net savings realized as a result of their efforts."[13] For example, Dr. Robert Morrow, a Blue Cross and Blue Shield (BCBS) of Texas executive, said BCBS is putting significant efforts into supporting ACOs.

Physicians are typically wary of such payment agreements because they take the risk of assuming the costs above and beyond the monthly payment. "Most alternative payment models are not yet working," said Dr. Mark McClellan, director of the Margolis Center for Health Policy at Duke University. These results suggest that if payment reform is to be successfully adopted, concern over individual physician risk must be addressed. There are a variety of methods that may help to reduce this risk and incentivize physicians, such as compensating them via salaries with bonus incentives for performance.



Source: The Nation's Pulse: The Texas Medical Center's Consumer & Physician Survey

A new national survey by the TMC Health Policy Institute indicates that U.S. doctors prefer salaries over the existing forms of payment (see "The Nation's Pulse: The Texas Medical Center's Consumer & Physician Survey"). The survey found that 69 percent of doctors said their preferred method of compensation would be a high proportion of their pay as straight salary, with a low proportion of their pay based on incentives, or a straight salary with no incentives at all (see "Ideal Physician Compensation").

For physicians that are already part of hospital systems or ACOs, it would be reasonable to convert to a salaried system (at their current yearly income), with a relatively modest bonus of 5 to 10 percent for quality. Importantly, physician income does not need to decrease with these changes. Some of the best health care systems in the country salary their physicians including Mayo Clinic, Cleveland Clinic and Kaiser Permanente.

Changing from fee-for-service to salary has demonstrated savings between 20 percent and 46 percent due to a decrease in tests ordered and procedures performed.[14] Former CMS Administrator Donald Berwick has estimated that nationally, overtreatment stimulated by fee-for-service wastes about $200 billion per year. Dr. Arthur "Tim" Garson, Jr. said, "If we could add to the MACRA regulations, a bonus for physician groups with 75 percent of their physicians paid 75 percent or more by salary, this would be a great start. Commercial insurers could follow suit."

3. Standardize quality-of-care metrics

Enormous time and resources go into measuring disparate quality-of-care metrics. A consistent approach can save money without affecting patient care.

The demand for affordable, quality health care is increasing. Meanwhile, health care providers are increasingly being evaluated by patients and payers on a range of metrics, with the potential for those providers enjoying financial incentives or suffering financial penalties based on their performance. However, it is difficult for payers and patients to evaluate and compare affordability and quality without the existence of clear, consistent quality-of-care metrics.

The problem is that each payer has its own metrics. For example, a health insurance company's medical director may decide that 30-day readmission rates for patients with heart failure is an important criterion for quality – and then arbitrarily apply that standard to other treatments and diagnoses. Other insurers develop their own standards, and there is little stimulus for a payer to have similar metrics to other payers. This creates bureaucracy for health providers, as physicians and hospitals must collect different data for each payer.

The infrastructure required to satisfy these multiple constituencies is enormous. The National Quality Forum, a public/private multi-stakeholder initiative launched in 1999 that wields significant influence over the establishment, maintenance and removal of quality indicators, recently added to the discussion with its 2017 guidance for quality measures. Of the 634 quality measures the NQF tracks, it suggested removing 51 of them, largely to reduce administrative burden. While it may seem that there's no such thing as too much quality information, reporting mandates do impose a real cost on providers. A hospital may need to report more than 100 indicators to regulators and payers, which requires dedicated staff and software applications, increasing costs without any direct impact on care.

A 2012 study estimated that quality measurements and analysis cost health care providers $190 billion annually,[15] a figure that has likely increased over the past five years. The cost is especially high for organizations that participate in multiple quality initiatives.[16] As the drive for value-based care advances, U.S. medical practices in just four specialties spend an estimated $15.4 billion each year reporting whether they are meeting their quality targets, according to a survey, costing an estimated $40,000 per physician per year.

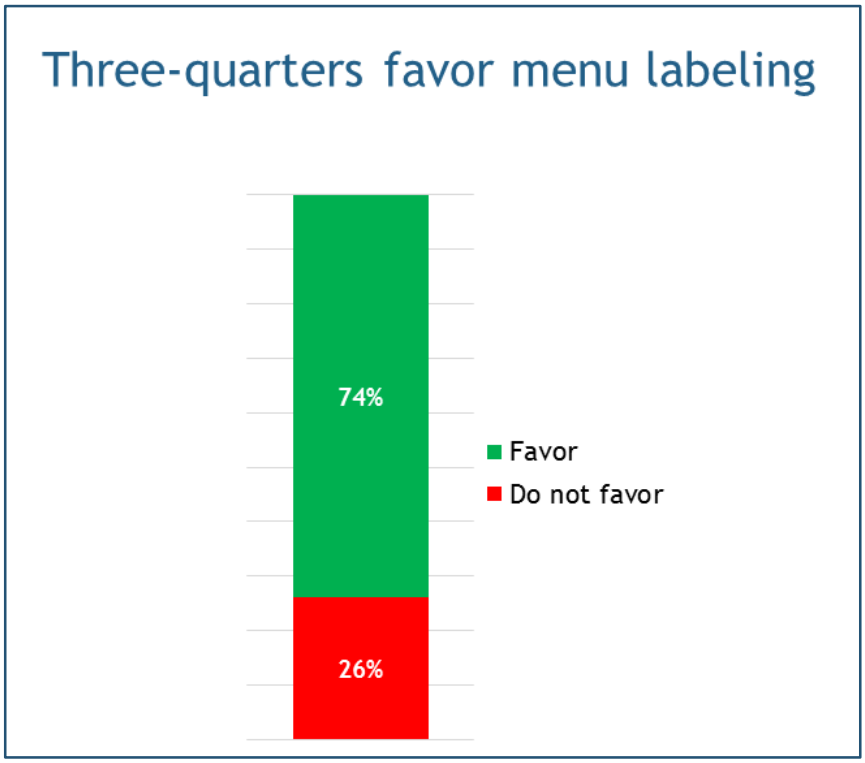
What can be done? The Core Quality Measures Collaborative brought together stakeholders including the Centers for Medicare & Medicaid Services (CMS), commercial plans, Medicare and Medicaid managed care plans, purchasers, physicians and other care provider organizations, along with consumers. It worked to identify core sets of quality measures that payers have committed to using for reporting as soon as feasible.[17] Such groups must be given the ability to establish national metrics for different conditions that are widely agreed upon. This consolidation would likely save at least half of the $190 billion currently spent annually on quality measurement and analysis.

4. Empower patients to be responsible for their own health and health care

Patients currently under-use quality data in their decision-making. They need better tools that speak to them at their level of education.

What is the role patients themselves play in keeping costs down? For patients to receive quality and effective care, they should take increased responsibility for their health. An oft-quoted paper estimates that 40 percent of life expectancy is due to people's own behavior such as smoking and overeating.[18]

According to the Texas Medical Center Health Policy Institute's 2017 survey of 9,000 consumers across 15 states, consumers and physicians alike say individuals with bad behaviors should pay more for health insurance. Additionally, more than 50 percent of consumers support a "fat tax" that includes charging more for food and sugary drinks that could lead to obesity. Three-quarters of respondents support labeling of menus with calories and/or easy-to-read labels that are coded for red, yellow and green, for example, and that trend was seen in virtually identical numbers across red, blue and swing states.



Source: The Nation's Pulse: The Texas Medical Center's Consumer & Physician Survey

However, a Kaiser Family Foundation poll found only about 6 percent of people ever used quality information in making a decision regarding an insurer, hospital or doctor. And fewer than 9 percent used information about prices, most commonly in relation to health plans. Only 3 percent of respondents said they used price information about physicians, the poll found.[19]

We have to do better. Education is the key to enabling consumers to make the best health and health care decisions. Insurers should encourage consumers to be good shoppers by creating cost-comparison and quality-rating tools that patients can easily access and use, as well as consider cost-sharing programs in the same way they have started to incentivize physicians. Dr. Mark McClellan argued that patients need to have more skin in the game. Incentivizing consumers with savings – in other words, allowing them to keep a portion of money they save their insurers when they are smart shoppers – could help them make the right choices regarding services and their health.

Physicians must also ensure that patients understand *how* to take control of their health. By providing materials that patients can understand, there is a better chance that patients will actually follow a doctor's orders and be able to take responsibility for his or her own health. In order for "consumer-directed health care" to be effective, every consumer needs to be able to access and understand health information.

But a statistic frequently forgotten is that half of America has an IQ below 100. People need to receive information at their level of education. One approach that would be effective for both insurers and physicians is the Tailored Educational Approaches for Consumer Health (TEACH) program.[20] It aims to improve the quality and effectiveness of patient education and health communication. The TEACH method provides a customized way of conveying information to patients that's suited to their particular preferences and learning style. TEACH assesses consumers' personal characteristics and preferences for both the *type* of information they want to receive and the *way* they want to receive it. Based on a short assessment, individuals can be appropriately placed into the correct segment and have materials matched efficiently to their needs. The TEACH method can cover a range of information, such as how to

choose an insurance plan, how to understand preventive health information or how to take medication. The goal is for employers, health care providers and health insurers to improve the delivery of health information and care.

Leaders must learn to do better than simply providing patients with the right information. They must provide the right information, in the right format, at the right time, through the right medium.[21]

5. Improve care coordination through task shifting

Health care providers should ensure they're allocating their resources appropriately and not using more expensive individuals to complete tasks that other workers can perform at a lower cost with similar outcomes.

The UK has popularized "task shifting" in health care. The term refers to managing personnel so that expensive professionals are only performing tasks that they are uniquely capable of performing, saving time and reducing costs by utilizing less expensive personnel to perform ancillary tasks. "Task shifting" ensures generalists provide the care generalists can provide (that does not require a specialist), nurse practitioners perform the work that they can provide, and so on, across personnel such as registered nurses, pharmacists and paraprofessionals. The concept is not limited exclusively to the medical field and can be applied to a variety of professions in different sectors.

The UK seems to emphasize a model of task shifting that focuses on the transfer of tasks from physicians to nurse practitioners.[22] In the U.S., some physicians oppose the increased use of nurse practitioners.[23] On the other hand, a recent study in the U.S. found Medicare evaluation and management payments for patients assigned to a nurse practitioner were 29 percent lower than those assigned to primary care physicians. Notably, Medicare only permits nurse practitioners to bill at 85 percent of physician fees, but the study controlled for that difference. The savings are likely due to nurse practitioners' tendency to order fewer costly tests and pricey diagnostic procedures, relative to physicians.[24] The results suggest increasing access to primary care performed by nurse practitioners could provide cost savings. Other payers could consider this concept as well.[25]

Notably, those savings don't result from lesser-quality care. Numerous studies have found that in many situations, the patients of nurses who have the same authority and responsibilities as physicians perform just as well as patients under the care of doctors (and by some measures, they do even better).[26] In some cases, in addition to patients having better health outcomes under nurse practitioners, their satisfaction is similar to or better than that of patients under the care of doctors.[27] Currently, nurse practitioners have "full-practice authority" – allowing them to provide patients the full slate of services they're trained to deliver, without the supervision of a doctor – in 23 states and the District of Columbia, as of March 2017.[28]

Task shifting need not be limited to work transferring from physicians to nurse practitioners. The Grand-Aides program, for example, helps health systems provide continuity of care by extending health care into the home, reducing patients' perceived need for ED treatment. Grand-Aides relies on nurse aides who are closely supervised by nurse practitioners. Nurse aides foster relationships with patients and their families with the goal of working to avoid unnecessary hospital visits (TMC Health Policy Institute Director Arthur "Tim" Garson, Jr. also serves as chairman of Grand-Aides).

Generally, one nurse supervises six Grand-Aides, who send photos or video back to the supervisor by mobile phone. A typical salary for a Grand-Aide is $25,000 per year, which allows the program to leverage the expertise of the nurse to more locations than she could possibly visit on her own at a relatively low cost.[29]

The forum explored ways of reducing wasteful health care spending, which accounts for an estimated one-third of all health care spending. Photo by Cody Duty.

Another example of effective use of paraprofessionals is community health workers, sometimes known by other names such as "promotores" and "navigators," who support members of their communities through health advising, referrals, translation services, advocacy and some chronic disease counseling. The utilization of Community Health Workers (CHWs) presents the opportunity to capitalize on community-specific knowledge. CHWs are typically hired for their intimate understanding of the communities they serve and their language skills, though they lack credentials and formalized health education.

Due to lack of standardized training, certification and reimbursement, the CHWs have not been widely instituted in the United States, despite the promise this innovation has shown for years and recognition from the Institute of Medicine, the Affordable Care Act and the U.S. Department of Labor. While standardization and certification is the clear path to reimbursement for CHWs, some CHWs are concerned a standardized process could create obstacles for well-suited CHW candidates in low-income communities. However, reimbursement is not the only mechanism by which this goal can be achieved. While reimbursement was more important to this model in years past, today, new payment models are evolving in which health systems are increasingly being paid based on outcomes.

If the U.S. aims to achieve health care cost savings through task shifting, it must increase the use of nurse practitioners where appropriate and standardize curricula and certification for paraprofessionals as a pathway to public and private funding.

In order to provide better care, health systems are seeking opportunities to train more physicians, lose fewer physicians, find adequate alternatives, waste less time and use time more efficiently. Improving communication and task shifting has the opportunity to free up the primary care physician to provide more specialty care and alleviate part of the specialty care shortage.

Of course, the ultimate "task shift" is away from health care professionals and to patients themselves. As discussed previously, when patients are empowered to make healthy, responsible choices – and given information in a manner that suits their needs – patients can avoid costly medical care.

6. Reduce Emergency Department utilization and readmissions

Innovative programs are encouraging patients to avoid taking unnecessary – and costly – trips to the Emergency Department.

The overuse of emergency departments (EDs) is a large drain of health care resources. Routine care provided in an ED setting can be two to five times more expensive than the same care provided in an alternate setting such as an urgent care clinic.[30] For example, according to the California HealthCare

Foundation, a recent study discovered charges for treating strep throat at $328 in an ED, $130 at an urgent care center and $122 in a primary care office.[31]

It is estimated that in the U.S., anywhere from 13 percent to 71 percent[32] of ED visits are preventable, avoidable and could be addressed by a physician's office, clinic or urgent care center at a savings of $4.4 billion annually.[33] Based on these figures, it is critical to find ways to treat as many patients as possible outside of an ED.

The most effective program to reduce ED usage is one that prevents trips to the ED when they aren't necessary. For example, George Masi, president and CEO of Harris Health System, said programs like Grand-Aides, mentioned earlier, has significant potential to reduce patients' perceived need for ED treatment. A study of Grand-Aides calculated the cost of the average home visit by a nurse aide at $16.88, compared to Medicaid payments of $175 per Emergency Department visit in rural Virginia.[34]

7. Develop more specific approaches to improving end-of-life care

Advance directives are vastly underutilized. They can reduce the cost of end-of-life care while honoring the wishes of patients and their families.

Approximately $205 billion is spent in the U.S. on patients in the last year of life, amounting to 13 percent of the annual total spending on health care.[35] Strategies around end-of-life care must be extremely sensitive and should focus on the quality-of-life of patients and loved ones. The confusion and misunderstanding about "death panels" in recent years has set back important conversations. The goal is simply to have discussions with patients and families – not curtail life.

The most successful approaches to end-of-life care involve ways of recording the wishes of the individual patient and family, broadly called "advance directives," which fall into three categories: living wills, power of attorney and health care proxy. One calculation places the savings through advance directives at $5,585 per patient due to "significantly lower levels of Medicare spending, lower likelihood of in-hospital death and higher utilization of hospice care."[36]

Importantly, advance planning for end-of-life care has the potential to not only save money but also to improve quality-of-life. Advocates for improved end-of-life care note that there often comes a point when more treatment doesn't necessarily equate to better care.[37] A 2010 Dartmouth study, for example, examined the use of three life-sustaining treatments associated with end-of-life care: endotracheal intubation, feeding tube placement and CPR. The procedures can save lives, but in patients with advanced chronic illness, the likelihood that they'll prolong life is low. Even worse, they can cause harm and prolong suffering. In some areas, including Los Angeles and Chicago, more than 15 percent of patients received these treatments during their last month of life, according to a recent study. Yet patients who are more involved in their end-of-life care often decline those procedures.[38]

In 2011, a New York state law took effect that requires health care providers to offer counseling regarding end-of-life and palliative care to terminally ill patients expected to die within six months. New York officials say the law is not intended to limit patients' options, but instead, it aims to empower them to make choices consistent with their own goals.[39] A study of patient data at one New York hospital showed that the percentage of terminal patients who received palliative care consults tripled after the law took effect.[40]

Unfortunately, those conversations aren't the norm. For example, only 65 percent of nursing home patients have an advance directive.[41] There is great opportunity to increase the frequency of these discussions, as up to 90 percent of nursing home patients and families will complete advance directives if a physician initiates the discussion.[42]

Frederick Isasi (left) of Families USA speaks while Dr. Arthur "Tim" Garson, Jr. (center), director of the Texas Medical Center Health Policy Institute, and Dr. Mark McClellan (right) of the Duke University Margolis Center for Health Policy, participate along with the audience in Houston. Photo by Cody Duty.

8. Meaningfully address the impacts of adverse childhood experiences

Childhood trauma is correlated with poor health outcomes – including early death. Early interventions to mitigate its effects are critical.

Many studies show that childhood adversity is correlated with adult morbidity and mortality. Adverse childhood experiences (ACE) are traumatic or stressful events that occur before the age of 18 that can include abuse, neglect, sexual assault, household drug abuse or incarceration. According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), adverse childhood experiences "are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse."[43]

New data from the Robert Wood Johnson Foundation show that at least 38 percent of children in every state have had at least one ACE such as the death or jailing of a parent, seeing or being victim to domestic violence or living with someone who is suicidal or suffers from addiction. Nationally, 46 percent of U.S. youth have experienced at least once ACE.[44]

Savings may result from social work programs that address the needs of those who've faced childhood trauma, such as positive parenting and enhanced family support. Addressing ACEs early is critical to reduce the rising cost of health care. A recent study in the UK found that individuals with at least four ACEs are at an increased risk of poor health outcomes. According to the study, risks "were strong for sexual risk taking, mental (illness) and problematic alcohol use, and strongest for problematic drug use and interpersonal and self-directed violence."[45] The same study found that the effects were

(From left): Dr. Mark McClellan, Dr. Arthur "Tim" Garson, Jr., Frederick Isasi, George Masi and Stephen Linder open the policy forum Sept. 20, 2017 in Houston. Photo by Cody Duty.

more pronounced on women, who had a 66 percent increased risk of early death with one adversity and 80 percent increased risk with two or more ACEs. Comparatively, men with two or more ACEs had a 57 percent increased risk of early death.

RWJF's ACE strategy encourages paid family leave so caregivers are able to support their children, improved access to high-quality child care and early education, and safe, affordable housing. It also encourages states to support home visiting programs, in which trained personnel visit new parents and offer advice on how to promote social and emotional development in children.[46]

Stephen Linder, director of the Institute for Health Policy at University of Texas School of Public Health, said policymakers and health providers would be wise to take the long view of health care and focus on children. Linder suggested incorporating social services programs, such as behavioral health programs, into schools.

SAMHSA, meanwhile, offers eight trauma-specific interventions that have been used in public settings, including various recovery models used in prisons and jail diversion programs, as well as peer-to-peer models used in survivor groups.[47] Public agencies are also taking steps to address trauma. Prevention Lane, a program of Lane County, Oregon, argues that to reduce the impact of ACE and other traumas, communities need to increase their understanding of these issues and invest in trauma "resiliency" programs. Its public education campaigns offer tips on ways to nurture resilience in children, such as showing children ways to self-soothe and demonstrating empathy towards children.

Conclusion: We must reduce the cost of care in order to afford significant changes in our health system

For many years, policymakers have pursued various reforms to the nation's health care system. Those efforts have largely focused on finding the right mix of government support and subsidies for public and private health insurance.

However, those efforts typically ignore a more fundamental issue, namely, the cost of health care itself. Former Medicare and Medicaid chief Donald Berwick estimates the U.S. wastes up to one-third of its health care dollars – about $ 1 trillion – every year. Much of that is due to overtreatment and overhead. None of it benefits the patient.

We can lower health care costs for everyone if we work towards reducing that $1 trillion in waste. Doing so would have major implications on our country's ability to provide health care for those who struggle to afford it. For example, two of the foundations of the Affordable Care Act – subsidies to insurance companies that make health care more affordable to Obamacare enrollees, and the expansion of Medicaid – cost the U.S. $110 billion in 2016. If we just cut overtreatment – doing too many things to patients that they don't need – in half, we could pay for that.

Eventually, cutting health care waste could allow us to reduce the number of people receiving entitlements and put the nation on a path towards affordable health care for all. Concepts like those should have wide, bipartisan appeal.

The eight recommendations in this paper serve as a roadmap for advocates, policymakers, health care providers and others who seek to seriously address rising health care costs and better serve millions of Americans.

TMC | HEALTH POLICY

The Nation's Pulse: The Texas Medical Center's Consumer & Physician Survey

The Texas Medical Center Health Policy Institute surveyed more than 9,000 consumers across 15 states, and more than 450 physicians nationwide, in the summer of 2017. The goal was to understand the extent to which consumers value health insurance and their ability to afford health care. The survey also explores ways consumers and physicians believe the country can reduce the soaring cost of health care, which today amounts to roughly 18 percent of the U.S. GDP. The findings are especially relevant today, as Congress and President Trump are considering major health policy reforms.

Americans are virtually unanimous: they value health insurance

At a time when federal lawmakers are debating the future of health care, **98 percent of consumers surveyed consider health insurance important to them and their families.** That figure was virtually unchanged across red, blue and swing states. The findings suggest Americans are more united on the issue than federal policymakers might realize.

Half of the country makes sacrifices to pay for health care

The survey examines the question of affordability in several ways, but one figure stands out in particular: **49 percent of consumers surveyed must cut other expenses to pay for health care.** Consumers said they cut back on savings, as well as spending on food and clothes, to pay for their health expenses. Health care isn't just a health issue, it's an economic issue.

Consumers and lawmakers don't see eye to eye on "affordability"

Most respondents say they can only afford spending about 2 percent of their income on health care. Why is this figure significant? The Affordable Care Act's individual mandate requires people to obtain health insurance or pay a penalty. Those who lack access to "affordable" coverage are exempt from that penalty. But under ACA, coverage is considered "affordable" if it doesn't exceed 8.2 percent of income. **This suggests the public's view of what's affordable is vastly different from lawmakers' view of affordability.**

Physicians and consumers are united in identifying causes of – and solutions to – rising health care costs

Forty-seven percent of physicians surveyed blamed insurance companies for rising health care costs, compared to 28 percent of consumers. Meanwhile, 19 percent of physicians and 30 percent of consumers blamed drug and device manufactures for rising costs. However, relatively few respondents from both categories blamed hospitals or physicians. Both groups agreed that the most effective ways to reduce health care costs are to increase costs for those with unhealthy habits – such as people who smoke or are obese – and to make affordable catastrophic health care plans available to consumers.

Paying doctors salaries, instead of fee-for-service, could reduce health care costs

It is estimated that nearly $200 billion per year is spent on overtreatment, or care that can't possibly help patients. If more doctors were paid with salaries, instead of paid based on the volume of care they provide, research suggests they'd order fewer tests and procedures, reducing costs. The survey indicates doctors would actually support this solution, with **69 percent of physicians preferring to be compensated via a straight salary or a salary with relatively small incentives.**

*For more information, contact **Ryan Holeywell** rholeywell@tmc.edu | O: 713.791.8809 C: 202.277.0802*

Visit tmc.edu/health-policy for the full survey results.

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