10 Ways to Cut Health-Care Costs Right Now

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By Catherine Arnst
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Seven hundred billion dollars. That's a ballpark estimate of how much money is wasted in the U.S. medical system every single year, according to a new Thomson Reuters (NYSE:TRI - News) report. A sum equal to roughly one-third of the nation's total health-care spending is flushed away on unnecessary treatments, redundant tests, fraud, errors, and myriad other monetary sinkholes that do nothing to improve the nation's health. Cut that figure by half, and there would be more than enough money to offer top-notch care to every one of America's 46 million uninsured.

None of the health-care reform bills on the table in Washington do anything meaningful to address that wasted $700 billion. Nor do they call for changes in the underlying flaw that drives much of the waste -- the fee-for-service system that pays doctors and hospitals for the amount of medical care delivered rather than for its quality. Under fee-for-service there is no financial incentive for doctors to eliminate waste, since they wouldn't pocket any of the resulting savings. They would just earn less.

By leaving this perverse reward system in place, Congress is virtually guaranteeing that health-care reform legislation, if passed, will do nothing to "bend the curve" of rising health-care costs, as President Barack Obama originally set out to do. Even the few cost-cutting efforts that the bills do include won't go into effect until at least 2013. As a result, U.S. health spending is on track to double over the next 10 years, to $5.2 trillion, about 21% of the gross domestic product.

Or possibly not. Politicians may be reluctant to rein in the medical-industrial complex, but the private sector is forging ahead. Faced with health-care costs that keep rising 6% to 7% every year -- even during this year of negative overall inflation -- plenty of insurers, hospitals, employers, and communities are figuring out how to offer better care for less money. They are willing to take experimental leaps in an attempt to solve some of the health system's most intractable problems.

A Big Step Forward

BusinessWeek has looked at 10 such attempts to lower health-care costs and improve patient care. These innovations cannot have the same impact as a comprehensive federal bill. Nor are the gains from private efforts assured. Paul B. Ginsburg, president of the nonprofit Center for Studying Health System Change, cautions that "there are a lot of things we know can improve health, such as wellness programs. But we don't know if they can save money on a large scale."

Still, companies and hospitals are taking the initiative, and some results are in plain view. "Three years ago, professional medical organizations were very reluctant to talk about inappropriate treatments, but I already see that changing," says Robert Kelley, vice-president for health-care analytics at Thomson Reuters. He points out that the American College of Cardiology recently published several standards of

care for angioplasty and other common treatments, aimed at preventing unnecessary and costly interventions. Given that about one in six U.S. health-care dollars is currently spent on cardiovascular procedures, "that's a big step forward," says Kelly. Here are some others.

1. Crack Down On Fraud And Abuse
Crime pays big when it comes to health care. This huge industry is run pretty much on the honor system. As law enforcement agencies have cracked down harder on illegal drugs, organized crime has diverted resources into multimillion-dollar medical scams, where there is less chance for detection. The FBI figures that fraudulent billings to Medicare, Medicaid, and private insurers account for 3% to 10% of total health spending, and the bureau concedes its estimates may be low. "Everywhere we look, we see evidence of fraud," says Lewis Morris, chief counsel for the Office of the Inspector General at the U.S. Health & Human Services Dept.

Medical fraud can range from fake claims to kickbacks to doctors to rigged payment schemes spanning several states. For years private insurers relied on law enforcement to chase down scams, with little effect. Now the industry is seizing the initiative. The Blue Cross & Blue Shield Assn. reports that its antifraud efforts resulted in savings of $350 million last year, a 43% increase from 2007. "Previously we had claims people investigate fraud," says Lee S. Arian, head of WellPoint's (NYSE:WLP - News) antifraud unit and a former federal prosecutor. "Now we hire law enforcement professionals with experience investigating crime."

Insurers are also trying to stop crime before it starts. Anthem Blue Cross of California came up with a strategy designed to identify so-called phantom providers of medical equipment, phony companies set up to file fake reimbursement claims. Working with federal files on fraudsters, Anthem fingered 10% of 500 newly registered companies as fakes. An added bonus: News coverage of the effort caused requests at Anthem for new provider ID numbers to drop dramatically.

2. Develop A Healthy Workforce
When Johnson & Johnson (JNJ) CEO William C. Weldon met with President Obama over the summer, he communicated a key message: Prevention pays. Weldon knows, because J&J has been offering comprehensive wellness programs to its 100,000 employees since 1995. Internal studies found that in the four years ended in 2002, those efforts saved $225 per employee per year.

J&J's experience proves wrong the conventional medical wisdom that it takes decades before efforts to help people develop healthier lifestyles can produce savings. Although many workplace wellness programs are little more than window dressing, serious efforts can yield important reductions.

J&J offers a huge array of programs, including free smoking cessation classes, online tools for weight and stress management, and 30 on-site fitness centers. Employees who enroll get a $500 discount on their insurance premiums. About 85% of employees participate as a result. "Seventy percent of health-care costs could be prevented through lifestyle modification," says Dr. Fikry W. Isaac, J&J's executive director of global health services.

3. Coordinate Care Through Family Doctors
A patient suffering from one or more chronic diseases may depend on several doctors, and rarely do they communicate with one another. This lack of care coordination means it's nearly impossible to arrange complementary treatments, cross-check prescriptions, and avoid ordering the same diagnostic tests over and over. The resulting duplications and follow-up care cost the nation $25 billion to $50 billion a year.

A solution is emerging from the medical trenches in the form of the "patient-centered medical home." Under this model, a primary-care doctor is the point person for all of a patient's medical needs, organizing care with specialists, pharmacists, and physical therapists and sharing electronic medical records with all. A 2004 study estimated the U.S. health-care bill could fall by 5.6% if every patient had a medical home.

North Carolina is already reaping savings. In 1998 the state set up Community Care of North Carolina (CCNC), a partnership between the state and some 4,000 primary-care doctors. Enrolled in the program are 870,000 Medicaid recipients and 97,000 children. CCNC pays doctors Medicare rates plus a monthly fee of $2.50 per enrollee to cover the extra time the doctors need to manage overall care. A Mercer study found that the program saved the state $161 million on health-care costs in 2006 alone.

4. Make Health A Community Effort
We are not a fit nation. One-third of U.S. adults are obese, and health spending on this group grew 80% from 2001 to 2006, to $166.7 billion. Rochester, N.Y., has decided to do something about it.

In 2005, Wegmans Food Markets CEO Danny Wegman recruited six other local employers, including Bausch & Lomb, Eastman Kodak (NYSE:EK - News), and Xerox (NYSE:XRX - News), along with the Rochester Business Alliance, to set up a health and fitness program for all of the metropolitan area's 1.04 million people. The campaign, called "Eat Well. Live Well," challenges individuals to eat five cups of fruit and vegetables and walk 10,000 steps each day. More than 44,000 people have participated over the past three years, making it the world's largest wellness program.

The group's collaboration didn't stop at fitness. The companies joined with doctors and insurers to substitute generic drugs for brand-name medicines, had their own efficiency experts help three hospitals streamline operations free of charge, and contributed $685,000 toward establishing a regional electronic health records system. Wegmans Vice-Chairman Paul S. Speranza says Rochester's health costs have dropped from 5% below the national average in 2005 to 15% below this year. "We believe collaboration, in Rochester or nationally, is the answer," he says, "whether there is legislation or not."

5. Stop Infections In Hospitals
Far too often, the biggest danger to patients is not their disease but the hospitals that treat them. Every year 1.7 million patients develop infections while in hospital, and 99,000 die as a result. These hospital-acquired infections add $30 billion to the nation's annual health-care bill -- and almost all are preventable. "For a long time there was a sense that a lot of these infections were inevitable," says Dr. Donald Goldmann, senior vice-president of the nonprofit Institute for Healthcare Improvement. "But in the last five or six years medical professionals have come to realize we can do a lot better if we follow a zero-tolerance policy."

The key is keeping the hands and clothes of hospital personnel clean, as well as any tools that come in contact with patients. In 2001, Dr. Peter Pronovost of Baltimore's Johns Hopkins Hospital came up with a five-item checklist that proved highly effective at curbing contamination. It calls for all staff to wash their hands before touching patients; clean patients' skin with strong antiseptic; wear masks, caps, and gowns; and take other common-sense precautions. Using the list, the Keystone Project, a collaboration of 77 Michigan hospitals started in 2003, reduced catheter-related infections to zero. The state hospital association estimates 1,700 lives and $246 million were saved in the project's first three years. Keystone is now being rolled out to all 50 states.

6. Get Patients To Take Their Medicine
Three out of four Americans do not take their medicine as directed. This noncompliance leads to additional doctor visits, hospitalizations, and treatments that together add some $177 billion a year to the nation's health-care bill, according to the National Council on Patient Information & Education.

People don't take their pills because they forget, they don't think the drugs work, they neglect to refill prescriptions, or they can't afford the medications. To address the problem, GlaxoSmithKline (NYSE:GSK - News) and the American Pharmacists Association Foundation joined forces four years ago to start the Diabetes Ten City Challenge. Pharmacists closely monitored the medications of more than 1,000 participants at 30 companies and waived co-pays for prescriptions. Average care costs dropped nearly $1,100 per participant per year -- and patients were healthier.

A 2005 study estimated that every dollar spent on such medication-adherence programs can save $7 for patients with diabetes, $5 for those with high cholesterol, and $4 for high blood pressure. It's "one of the best ways to improve care ... and get more out of each health-care dollar,"says Dr. John O'Brien, an assistant professor at the College of Notre Dame School of Pharmacy in Maryland. Consequently, the National Consumers League is planning a major campaign next year to persuade the public to take their pills.

7. Discuss Options Near The End Of Life
One-quarter of Medicare dollars are spent in the last year of patients' lives. The costs of end-of-life care vary wildly, however. The Dartmouth Institute for Health Policy has found that spending is nearly three times higher in Manhattan than in areas of Colorado, mainly because patients in Manhattan average 21.9 days in the hospital during their last six months, compared with only 6.3 days in Grand Junction, Colo. Yet higher costs don't translate to longer or better lives.

Aetna (NYSE:AET - News) discovered that high-quality care for the dying actually lowers costs. The insurer started its Compassionate Care program in 2004 to educate terminally ill patients and their families about treatments, living wills, and hospice care. "It was about dignity, not cost control," says Dr. John W. Rowe, former CEO of Aetna. Instead of unneeded tests and futile treatments, patients got more nursing care, pain management, and psychological support, says Rowe, now a Columbia University professor.

Program participants were twice as likely as average patients to choose hospice care. Costs came down 20%, yet surveys showed that both patients and their families were more satisfied than those not in the program. Such counseling efforts "are not about 'death panels,'" says Dr. Elliott S. Fisher, a professor at Dartmouth Medical School. "This is about better care, aligned with what patients want."

8. Use Insurance To Manage Chronic Disease
In 2009, UnitedHealthcare (UNH) introduced the Diabetes Health Plan, a new type of benefit that offers financial rewards to patients who manage their disease properly. Three companies, including General Electric (GE), are testing the plan, and 15 more workplaces signed on to roll it out in 2010. Employees who participate in the UnitedHealthcare plan must adhere to specific treatment guidelines and agree to be tracked by the insurer to make certain they are sticking with the program. In return, co-pays on their diabetes drugs are waived, along with other fees related to managing their disease.

The United plan is part of a larger trend in managed care called "value-based insurance design." The idea is to contain costs by giving financial incentives to patients based on their particular health issues rather

than offering one-size-fits-all plans. "One issue in the health-reform debate is that we're paying an awful lot for health care and yet we don't have the healthiest outcomes," says Dr. Edmund J. Pezalla, national medical director for pharmacy management at Aetna (NYSE:AET - News), which is also experimenting with value-based insurance design. "There are things providers and patients can do together to achieve better outcomes."

The impact of tailoring plans to employees with specific diseases could be significant. United estimates that diabetes costs the health-care system $174 billion a year.

9. Let Well-Informed Patients Decide
When Floyd "Jack" Fowler Jr. holds focus groups of heart patients, he's amazed at their misplaced faith in the benefits of medical procedures. "They all think they'll die if they don't have bypass surgery or angioplasty," says Fowler -- even though studies show that both procedures extend lives or prevent heart attacks in only a tiny minority of especially sick patients. But hardly anyone knows this, he says.

Fowler's nonprofit Foundation for Informed Medical Decision Making has sought for years to give patients both that knowledge -- and a choice. The idea is to explain thoroughly to people the benefits and risks of medical procedures they may be facing. At the Spine Center at Dartmouth-Hitchcock Medical Center, for example, patients with back problems are shown a video that walks them through various procedures and provides data showing that outcomes are similar whether or not they have surgery. Once the program started, spinal surgery rates dropped 30%.

So far, shared decision-making efforts reach only a small number of patients. But given that as much as 37% of health spending is wasted on unnecessary care, the idea is catching on. Washington State passed the nation's first law two years ago encouraging informed decision-making, and other states are expected to follow, says Dr. Lance Lang, senior medical director at Health Dialog.

10. Apologize To The Patient
Doctors regularly complain that fear of malpractice suits forces them to order far more tests and procedures than necessary. Although President Obama has said he is open to legislation that would limit malpractice awards, there may be a simpler solution. Sometimes all it takes is an apology.

The Sorry Works! Coalition, founded in 2005, is persuading hospitals to disclose mistakes to patients and their families. Under the policy, as soon as a hospital discovers an error, the patient is informed, the cause is investigated, and changes in procedure are recommended. If the provider is at fault, the patient is offered a settlement.

The University of Michigan Health System adopted the policy in 2001 and reports that malpractice claims fell from 121 a year to 61 in 2006. The honesty "takes away some of the anger of patients and the 'gotcha' of plaintiff lawyers," says Douglas B. Wojcieszak, who founded Sorry Works! after losing his brother to a medical error. "You don't need any legislation, judge, or politician to do this -- it's simply customer service." The University of Illinois Medical Center in Chicago started a formal apology program in 2006 and says the number of claims has since declined 40%, despite a 20% increase in clinical activity.