LAW & MEDICINE

Runaway Health Costs

BY MILES J. ZAREMSKI, J.D.

Time.com ran a recent article, "Is There a Cure for Miami's Soaring Health Care Costs?" As reported there, the Milliman Medical Cost Index listed the 2008 average private-provider costs for a Miami family of four at $20,282. This was the highest among 14 major U.S. cities that were studied. Of that total, 40% came from Miamians' household funds.

This result is similar to findings by Medicare, by the consumer group Families USA (which estimated that more than a million Floridians spend greater than 25% of their family incomes on health care), and by Dartmouth College. Curiously, Miami's problem, according to the author, is not the law of medical supply and demand, but just the opposite. With Florida having become a haven for retirees since the 1960s, health care providers and institutions have followed the money, chasing the Medicare dollars and those more senior in our population.

So what happened in Miami? Inefficiencies, wasteful spending, and redundancies, as if in microcosm to what threatens our health care system. Let's take a look at what Dartmouth found.

The Dartmouth Institute for Health Policy and Clinical Practice issued "Hospital and Physician Capacity Update," A Dartmouth Atlas Project brief report, on March 30, 2009. While it reiterates that health care reform is "an unattractive choice between quality and affordability" (after all, more than 45 million remain uninsured, with millions more underinsured), it looks at reform from a different angle.

Costs encompass what it takes to provide health care, such as the number of round-the-clock providers needed. Then there is the physical plant—hospitals, for example—where those services are performed. It takes many folks to run these facilities. The Dartmouth report calls it "health care capacity."

Capacity represents the capital investments and labor that permit delivery of medical services. The first type is hospital capacity, including the beds, imaging devices, and procedure suites. The second type is health care labor.

The entire report is worth reading; one of its conclusions is that "research conducted over the last 30 years shows that lower capacity is compatible with high quality and comparable outcomes. Better planning of hospital and physician capacity is an essential part of reforming the health care system toward improved outcomes and affordability." Interestingly, while hospital bed supply per capita contracted over the last 10 years or so, the number of hospital-based employees and registered nurses actually grew.

"The distribution of hospital capacity fails to reflect the regional need for hospital care, either for beds or for hospital staff," the report says. In addition, during the decade ending in 2006, 105,000 new physicians came on board (45,000 in primary care and 60,000 in various specialties). These numbers exceeded population growth. Such data provide a peek into a window requiring extensive examination by those writing health care reform legislation.

The data remind us that part of the health reform equation must include what to do about costs. Providers who cannot manage health care costs and are inefficient in delivering services must take part of the blame for the skyrocketing costs.

We will soon see health care reform legislation introduced in Congress. And we have been deluged with stories in the popular press about various plans, proposals, meetings and conferences. I have addressed the topic in previous columns. The latest controversies include whether or not Americans should have choice in health care plans, including a publicly financed option.

Regardless of the politicking and the gamesmanship that goes on with any proposed legislation that offers a sea change in health care access and delivery, health care professionals must become part of the solution. They must consider what they are willing to give up for more Americans to have access to care.

Parenthetically, the time.com article also keyed in on the vast amount of health care fraud ongoing in the Miami-Dade arena, particularly on Medicare and Medicaid scams. While prosecutions in this area are vigorous, most of the responsibility for solving this problem lies at the feet of those in the medical and health care professions. It brings to mind the phrase, "People who live glass houses should not throw stones." It's time to clean house.

Finally, with this column, I bid you adieu. As with many other items in our lives that have been affected by the economic downturn, so has the need for this column. It has been a pleasure serving you for the last 18 months. I hope that the issues I have raised have been interesting, possibly inspiring conversations among your colleagues, or at the dinner table. I can be reached at mzaresmski@gmail.com if you have any further questions or comments. My sincerest best wishes and collegial regards. ■

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Lowered Copays Lead to Better Adherence in Diabetes Patients

LONG BEACH, CALIF. — Modest reductions in medication copayments can encourage patients with diabetes to fill their prescriptions and use their drugs, according to an experiment at the University of Michigan.

As part of the Michigan Healthy Communities Initiative, the university tested the "value-based benefit design" concept, in which cost-sharing is based not just on the acquisition cost of medication, but also on the likelihood of benefit, Dr. William Herman explained at a diabetes meeting sponsored by the Centers for Disease Control and Prevention. The greater the benefit to the patient, the lower the copayment.

The concept provides a financial incentive to targeted patients "to use therapies from which they are most likely to benefit," said Dr. Herman of the university, in Ann Arbor.

The university identified 1,777 of its employees and dependents with diabetes and offered them copayment reductions on antihyperglycemics, antihypertensives, antihyperlipidemics, and antidepressants.

The price of tier-1 generic medications was reduced 100%, from $7 to zero; tier-2 preferred-brand medications, 50%, from $14 to $7; and tier-3 nonpreferred brand medications, 25%, from $24 to $18.

For controls, investigators identified 3,273 patients with diabetes and similar demographics from the same health plan but with employers other than the university. They were not offered this reduction in copayments.

Over 2 years, patients in the intervention group filled significantly more prescriptions in all medication groups. For example, there was a 3% absolute increase in filled metformin prescriptions and a 5% absolute increase in filled statin prescriptions.

Using the medication possession ratio (MPR) metric, defined as the amount of medication filled divided by the amount needed to fill to take as prescribed, the researchers saw a statistically significant 7% absolute increase in MPR for ACE inhibitors and angiotensin II receptor blockers.

In all, the health system granted copayment relief for 86,655 claims, at a cost of $869,767 over 2 years. Almost three quarters (74%) of the copayment relief went for tier-1 medications; 21% went to tier 2 and 5% went to tier 3.

Neither Dr. Herman nor Dr. Keeler reported any conflicts of interest related to their presentations.

—Robert Finn