



# Health Care in Crisis:

How Special Interests Could Double Health Costs  
and How We Can Stop It

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# Executive Summary

Our health care system is in crisis. Without swift action, that crisis could threaten every Connecticut family's health and finances.

Unless the new Congress and Administration act to reduce health care costs, the yearly cost of the average employer-paid family health policy in Connecticut is projected to more than double from \$12,416 in 2006 to \$25,109 by 2016 even after adjusting for inflation. If recent trends continue, wages and household incomes will simply not keep up with these high costs. Nor will the business sector be immune to this crisis. Unchecked, this cost epidemic could also severely impact the small businesses that drive job creation in the Connecticut's economy.

Unfortunately, too much of these astronomic costs are going to enrich special interests, not buy the best health care. The Congressional Budget Office estimates that nationally as much as one third of health care spending is wasted and does not improve outcomes. That means that, in 2007, one out of every three dollars that Americans spent on health care, or \$730 billion, went to the insurance bureaucracies, drug companies, medical device manufacturers, and providers without improving a single person's health. In Connecticut, one third of health spending amounts to \$7.39 billion.

This report examines three important sources of this unproductive spending. We conclude with a package of urgently needed reforms which target those causes, improve quality of care, and rein in this unnecessary spending. As part of

comprehensive health reform, these policies will enable America to emerge from this crisis with a health system that consumers and businesses can afford and families can depend on.

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## **Unnecessary Medical Care Undermines Patient Health and Increases Costs**

Research has shown that patients who live in regions with above-average health care spending are not any healthier than people in lower-cost regions. In parts of the country where more specialists and hospital beds are available, doctors send patients to specialists or to the hospital more frequently, yet the patient outcomes are no better.

- Medicare and private insurance payment policies compensate doctors on the basis of how many tests and procedures are ordered, not on the basis of whether effective treatment is delivered.
- Payment for care does not adequately support effective strategies that improve patient health and reduce the amount of unnecessary care prescribed such as primary care, coordinated care, patient involvement in care decisions, and the use of evidence-based care.
- High-performing health systems that seek to reduce unnecessary care, like the Mayo Clinic and Utah's Intermountain Health System, can reduce costs per patient by as much as 43%, while providing quality care. If America's hospitals achieved Intermountain's level of quality

and efficiency, we would spend \$299 billion less a year for hospital care. If Connecticut hospitals improved their efficiency by 43%, the state would save \$3.02 billion.

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### **Excessive Administrative Expenses Inflate Insurance and Medical Prices**

Many administrative costs within America's health care system are the result of efforts to shift costs from one payer to another—from the insurance company to a hospital, or from a physician to a patient. This paperwork increases total costs without improving outcomes for patients.

- Unnecessarily duplicative and complex billing and insurance certification requirements add billions in additional administrative costs.
- The credentialing process by which physicians are certified as providers is unnecessarily burdensome and wasteful
- Insurers and providers spend tens of billions a year nationally on insurance-related paperwork that does not contribute to the quality of care.

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### **Unchecked Pharmaceutical Marketing Drives Up Costs**

Americans spend billions of dollars annually on prescription drugs that are no better than cheaper alternatives or that may have dangerous or unrecognized side-effects. Worse, drug companies' marketing campaigns in support their most expensive drugs cost \$11.5 billion in 2005.

- Drug advertising generally encourages the use of newer,

more expensive medications, even if they are no more effective than existing ones

- Pharmaceutical companies increased prescription drug advertising by 250 percent from 1997 to 2007. In response, physicians prescribe and consumers purchase billions of dollars of unnecessary and even risky medicine each year.
- Direct marketing to physicians, which has been shown to rely on misleading information, boosts the total number of prescriptions and increases the number of prescriptions for newer and more expensive drugs that are no better than old ones.

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### **Solutions**

Fortunately, the high cost of care can be reduced and wasted spending is preventable. America can fix this problem now. In light of the 2008 election, health care reform will be on Congress' agenda in 2009. If these reforms are to be economically sustainable, they must tackle unproductive spending that doesn't improve health. This report recommends the adoption of the following policy initiatives:

#### *Reduce Ineffective Medical Care While Improving Quality*

- Fund comparative effectiveness research that studies which medical procedures, regimens and drugs work and which do not.
- Broadly implement and incentivize coordinated care systems such as

medical homes.

Compensate primary care providers adequately.

- Expand information provided to patients and encourage them to share in decision making about their care
- Reform public and private payment systems to provide the right incentives for high-quality care and reduce unnecessary but costly tests and procedures.

#### *Reduce Expensive Administrative Bureaucracy*

- Standardize systems for enrollment, credentialing, billing and insurance payment.
- Limit insurers' administrative expenditures to a certain percentage of premium dollars.

#### *Reduce Prescription Drug Costs*

- Strengthen FDA monitoring of false statements in direct-to-consumer advertising and marketing materials
- Undertake a publicly funded effort to publicize the benefits and prices of drugs to counter the unreliable information provided by pharmaceutical companies.
- Limit industry's gifts to physicians and require drug companies to disclose more information about their marketing practices

Some of these reforms could happen fairly quickly; others will take years. But it is critical that we start now by addressing overspending that does not deliver results. Residents of Connecticut simply can not afford any more years of spiraling health care costs.

## Introduction

Our health care system is in crisis, and without dramatic action soon, it threatens the health and economic future of all Connecticut residents.

The crisis can be recognized in the shrinking pool of employers offering coverage, in the growing number of uninsured, in the strain on state budgets caused by health care costs. But most Americans recognize it in their monthly

budgets and their mounting health care bills.

What American families don't know is how much worse the cost of health care could get without health reform. And they do not fully realize that the health care system they pay for is designed primarily to generate profits for insurers and drug companies, not to provide them quality care.

## The Cost of Inaction

The total premium cost for employer-sponsored family health insurance has ballooned by over 100% in less than ten years.<sup>i</sup> While the resulting pain has been felt acutely by consumers, business has suffered too. In the face of high-cost premiums, employers, especially small businesses, face tough choices: shoulder greater costs and potentially harm their competitiveness, pass large increases on to employees who aren't equipped to pay them, or reduce coverage. In many cases, employers are covering less of employees' premiums and requiring increased deductibles.<sup>ii</sup> The percentage of employers who offer any coverage has declined from 66% in 1999 to 63% in 2008.<sup>iii</sup>

As a result of these dynamics, more and more Americans are on their own when struggling with rising health care costs. It's no wonder that polls show that the cost of health care is one of American families' biggest worries.<sup>iv</sup>

High costs also hurt small businesses and the economy that depends on them. After all, two thirds of net new jobs are

created by small businesses each year.<sup>v</sup> But employee health care costs for small businesses, which lack the buying power of larger firms, are 18% higher than for bigger companies.<sup>vi</sup> The additional dollars spent on health care are dollars not spent on growing their businesses or hiring new staff.

As these pressures on families and small businesses have increased, a consensus has begun to emerge that broad health reform is necessary, even while the details of reform are subject to debate. Some political leaders have stated that the new administration and Congress offer the best opportunity for major reform in decades.<sup>vii</sup> Doctors groups and business lobbies have shown an unprecedented willingness to work on the issue.<sup>viii</sup>

Perhaps most importantly, the costs of inaction to the public would be simply overwhelming. If Connecticut residents do not win reforms that squeeze out our system's costly inefficiencies, the full cost of premiums will climb to \$25,109 for family and \$8,055 for individual

employer-sponsored insurance by 2016. With these projected increases, the cost of a family health insurance policy will be equal to 34.2% of median household income.<sup>ix</sup>

The outlook for consumers gets even worse when other forms of cost-sharing are examined. The average yearly

deductible is projected to rise from see \$1,436 to \$3,672 in constant dollars. Co-pays for doctor visits are projected to increase from \$20 to \$36.

Figure 1 below details the projected growth of monthly premiums, deductibles and co-pays, if no changes are made.

**Figure 1: Projected Health Care Costs for 2008 to 2016**

<b>The Cost of Inaction: Connecticut</b>	<b>2006</b>	<b>2016</b>	<b>% Increase</b>
<b>Average Yearly Deductible</b>	<b>\$12,416</b>	<b>\$25,109</b>	<b>102%</b>
<b>Avg. Total Cost of Family Employer-provided Insurance</b>	<b>20.5</b>	<b>34.2</b>	<b>67%</b>
<b>Avg. Total Cost of Individual Employer-provided Insurance</b>	<b>\$2,947</b>	<b>\$6,544</b>	<b>122%</b>
<b>Avg. Employee Contribution to Premium for Family Employer-provided Insurance</b>	<b>\$4,402</b>	<b>\$8,055</b>	<b>83%</b>
<b>Average Co-pay for Doctor Visits</b>	<b>\$20</b>	<b>\$36</b>	<b>80%</b>

*All costs are in constant 2006 dollars.*

It should also be noted that these projections do not capture the full impact on health costs. Increased costs may be hard to bear for consumers as is, but they could lead to even greater system costs if higher deductibles and co-pays discourage patients from seeking needed care. For example, a patient with a high deductible might forego care until a

health condition becomes acute. Then the patient may be forced to seek expensive hospital care, driving up premiums for everyone.

The rising costs that drive premium growth also mean higher prices for health care services purchased outright. Thus, a family's \$3,000 deductible in



2016 won't buy the same amount of care that \$3,000 buys today.

Further, projected employee

contributions to insurance will likely be even greater as employers will have an incentive to shift more of the premium cost to employees as costs go up.

## Myths of High Health Care Costs

High health care costs have been attributed to many different factors, often mistakenly. Some of the most common are addressed below.

**Aging population.** *The argument:* As the U.S. population ages, Americans require more health care, on average, to maintain their health. *In reality:* While older patients do indeed require more care, data from the federal government on why costs for Medicaid and Medicare (which serves older Americans) are rising shows that the aging population is only a small factor in the cost of health care.<sup>x</sup>

**Malpractice insurance.** *The argument:* The cost of malpractice insurance has been rising rapidly, driving up health care costs, as doctors charge more to cover the cost of insurance and practice “defensive medicine” to avoid lawsuits. *In reality:* Malpractice rates have been on the rise, but malpractice suits may not be the cause of substantially greater health spending. One study of malpractice awards suggests that claims have been steady for years and are not a major cause of increases in malpractice insurance premiums.<sup>xi</sup> Thus, changes in malpractice insurance costs play a relatively small role in overall health care costs. The Congressional Budget Office has concluded that malpractice reform would not have a measurable impact on national health spending.<sup>xii</sup>

**Consumers pay for too little of their own care.** *The argument:* Consumers pay for such a small amount of their health care that they demand too much of it, thereby increasing costs for insurers. *In reality:* Research is not clear on the impact of requiring consumers to pay for a larger share of their health care. Economic modeling of health care plans with high deductibles suggests they may reduce overall health care spending by 4 to 15 percent.<sup>xiii</sup> However, such plans achieve savings in part because patients avoid both necessary and unnecessary care in equal measure. Thus, the long-term impacts on health care costs are unknown. Also, the finding that cost-sharing can save costs without harming patient health is based on a study conducted in the 1970s in which participants who faced large medical bills likely dropped out of the study before incurring those costs.<sup>xiv</sup>

**New drugs and better technology.** *The argument:* Health care costs are rising because we are spending more money on research and development of new technologies and drugs. These higher costs are acceptable because they make us healthier. *In reality:* Improvements in technology definitely can improve health, but spending on new drugs and technologies is imperfectly correlated to better health. For example, the breast cancer drug Herceptin offers a powerful treatment for women whose tumors include a particular genetic mutation. For women without that gene, which physicians can reliably test for,

the drug offers nothing. Nonetheless, approximately 12 to 20 percent of Herceptin prescriptions are for women who clearly will not benefit from it.<sup>xv</sup>

## Americans' Health Spending Fails to Deliver Quality Care

In 2007, health care spending amounted to 16.2% of the United States gross domestic product, or \$2.2 trillion.<sup>xvi</sup> To understand why Americans pay so much for health care now and face increased costs in the future, we must first confront a basic fact about America's health care system: increased health care spending does not deliver the quality of health care that it should.

The United States trails in many indicators of health and well-being. America ranks 44<sup>th</sup> in the world in average life expectancy and 41<sup>st</sup> in the world in infant mortality.<sup>xvii</sup> The U.S. fares poorly on measures such as babies' birth-weight and is only average in the percentage of children who receive immunizations.<sup>xviii</sup> Age-adjusted mortality from several chronic diseases is worse in the U.S. than in Canada, France, Germany, Greece, Japan and Britain because care of those with chronic diseases falls short. For example, nationwide, less than half of diabetics receive three basic tests for diabetes that provide an assessment of how the disease is being controlled and offer early warning of possible complications.<sup>xix</sup> Finally, a recent study examined the rate of amenable mortality, or deaths that could have been prevented by quality health care, and found that the US lagged far behind other industrialized nations. If the American amenable mortality rate was improved to

the average of the top 3 nations, 101,000 lives could be saved every year.<sup>xx</sup>

Why does America's huge investment in health care not yield better results? Researchers at the Congressional budget office estimate that as much as one-third of health care spending in the U.S. does not improve patient health.<sup>xxi</sup> In 2007, this estimate means that as much as \$733 billion of our \$2.2 trillion health spending was wasted. Connecticut would have wasted up to \$7.39 billion out of \$22.17 billion total spending. No matter who pays for this care, it does not help patients live better or longer, and thereby drives up health care costs without providing any corresponding benefit

Americans are paying for treatment that does not result in better outcomes for patients. No matter who pays for this care, it does not help patients live better or longer, and thereby drives up health care costs without providing any corresponding benefit. The next three sections of this report examine three major categories of unproductive spending: overuse of high-cost, uncoordinated specialty and acute care; excessive administrative costs; and prescription drug marketing that encourages the use of more drugs, more expensive drugs, and drugs with a less established record of safety.

## Unnecessary Medical Care Undermines Patient Health and Increases Costs

Americans are subjected to a wide variety of unnecessary medical treatments – treatments that cost the health care system billions of dollars and don't make Americans any healthier. But we often fail to get the basics right. Our health care system frequently fails to provide effective, low-cost treatments that work – triggering higher costs down the line. Too often, Americans' health care treatment is determined, deliberately or inadvertently, by the availability of medical resources in a community or by the profit motives of doctors, hospitals, drug companies, insurers, and other entities in the health care system – and not by what is most likely to make a patient well.

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### Variation in Health Spending Reveals Patterns of Overuse, Underuse

When discrepancies in spending and health outcomes between different regions of the country are examined, researchers have found that expensive forms of care, specifically hospital care and specialty care, are overused, i.e. used when not medically necessary. They also found that the types of care that are effective and cost-efficient are underused.<sup>xxii</sup>

The scale of this problem is quite large. Analyzing Medicare spending, the Dartmouth Institute of Medicine has found that some regions actually spend 250% than others to provide Medicare services.<sup>xxiii</sup> The explanation of this regional variation can be found in what that spending goes toward. Patients in

high-spending regions are more likely to receive less of the care that has been proven to be valuable and could save costs over the long term—such as treatment for high blood pressure, medication to reduce the risk of death for heart attack patients, and screening for colorectal cancer.<sup>xxiv</sup> Patients in areas of the country with high per capita health care spending have more appointments with physicians, see a larger number of doctors, and spend more days in the hospital—yet, on average, the quality of their care is worse, not better.

It has been observed that patients who fractured a hip, had surgery for colon cancer, or suffered a heart attack in regions with more health care resources and expenditures were more likely to die in the five years after the onset of their problem than patients in regions where resources and spending were less.<sup>xxv</sup> Patients treated for fractured hips at academic hospitals in high-spending regions were 1.9 percent more likely to die than their counterparts in low-spending regions, and colon cancer and heart attack patients were both 5.2 percent more likely to die.<sup>xxvi</sup> (Data adjusted for differences in patient health).<sup>xxvii</sup> This was true even though patients in high spending regions visit more doctors and spend more days in hospitals.

In fact, the Dartmouth Institute suggests that it is precisely the hospital- and specialty-focused structure of care in those high cost regions that leads to the poorer outcomes. The Dartmouth

Institute suggests that this pattern of underuse of some care and overuse of other, more expensive care is driven by what they call supply-sensitive care or supply driven demand. In layman's terms, this means that the more hospital beds, expensive hi-tech procedures or tests, and specialists are available, the more they will be used, regardless of patient need.

The source of supply-sensitive care is explainable. To remain competitive in today's market, health systems and provider groups expand hospitals, open diagnostic centers, acquire new high-tech medical devices, and bring on new specialists. In order to recover the expense of their investment, they have an incentive to encourage usage of these more costly care alternatives, and inevitably patients who could be treated adequately with primary or preventative care will tend to receive the high cost treatment instead. To address these costly patterns of unnecessary care and poor outcomes, we must first identify the incentives that create those patterns.

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### **Skewed Incentives Lead to Unnecessary Care**

The first factor is the payment system that Medicare and some private health insurance companies use. Under this system, known as "fee-for-service", health care providers receive payment for each visit with a patient, each test ordered, and each procedure performed. Payment is not based on whether a given service is needed or how well the patient is cared for overall. Instead, payment is based on how much care the patient receives. Thus, the fee-for-service payment structure encourages hospitals and doctors to deliver higher complexity

and quantity of tests and treatments in order to maximize revenue.

Second is the problem of uncoordinated care. Often, the doctor treating a patient fails to consult with the patient's other physicians. Without coordination, the patient's care becomes more fragmented, with no single person in charge of the patient's overall well-being. Poor communication among providers may result in the patient having the same test performed twice. The patient's treatment under one doctor may work at cross-purposes with another's. Different physicians may even prescribe drugs that should not be taken at the same time. Unaware of the overall picture, each physician attempts to give the patient only the care within the doctor's specialty. This results in both less effective care and wasted resources.

The lack of coordination in the delivery of health care is exacerbated by the way private and public payers compensate primary care physicians, who are the most likely source of care coordination. An important component of quality care is time spent in consultation with a patient, which is typically the duty of the primary care physician. The reimbursement system, established by Medicare, and followed by many insurance companies, places a higher value on procedures than on consultation, even if consultation is more useful to patient health. Quality primary care and coordinated care require more consultation. As a result, primary care physicians have a lower reimbursement rate for the time they do spend with patients than specialists. The imbalance between specialist and primary care income has become so bad that only 7% of medical students are planning careers

in general practice or primary care internal medicine,<sup>xxviii</sup> further restricting our system's ability to provide cost-saving care coordination.

A lack of patient knowledge and involvement in their care decisions also contributes to wasteful unnecessary care. Currently, physicians generally direct care decisions, with patients playing a passive role. But typically, when patients are more involved in treatment decisions and better understand the benefit and risks of their options, they prefer less intensive care, thus reducing costs.<sup>xxix</sup>

Finally, medical care given to patients too often lacks adequate basis in scientific evidence. Only half of medical interventions are supported by adequate evidence of clinical effectiveness.<sup>xxx</sup> Of those diseases for which there is an established, evidence-based course of treatment, patients receive the recommended care 54% of the time.<sup>xxxi</sup> Even when evidence exists and an established course of treatment is available, clinical evidence has been shown to fail to account for differing effects of the same treatment on different populations such as children or

minorities. In this environment of uncertainty, providers are more likely to provide the patient with excessive care, i.e. more hospital admissions, more tests, more expensive procedures. If evidence were available, however, the provider might use a more limited and less expensive set of treatments to address the case.

These sources of unnecessary and ineffective medical care are complex. Yet over time, respected health systems, such as the Mayo Clinic and the Intermountain Health system, have tackled them and succeeded. Both these institutions achieved low per patient costs while providing excellent quality of care and health outcomes.<sup>xxxii</sup> According to the Dartmouth Institute for Health Policy and Clinical Practice, hospital spending would decrease by 43% if the entire nation matched Intermountain Health's per patient costs.<sup>xxxiii</sup> If those savings had been achieved in 2007, the United States would have spent 13.5%, or \$299 billion less on health care.<sup>xxxiv</sup> In Connecticut, achieving a 43% reduction in hospital spending could save \$3.02 billion.

## **Excessive Administrative Costs Inflate Insurance and Medical Prices**

Some administrative spending is essential to the delivery of health care, but a large portion of administrative costs pay for billing and other insurance-related activities that have little bearing on the quality of health care that a patient receives. Much of this is unnecessarily complicated and duplicative. As Americans struggle to afford care today and face rising

premiums and deductible, we can ill afford spending on insurance company bureaucracy that does nothing to improve health. Billing and credentialing are two examples of the duplicative red tape in the insurance industry.

For doctors to be paid, doctors' offices need to send a bill to an insurance

company. Then they must record when reimbursement comes through. Unfortunately, the complexity of billing and insurance requirements can turn this seemingly simple task into an expensive process. A single insurance company may offer dozens of insurance plans that cover different procedures at different reimbursement levels and require different co-payments from patients. Complex billing systems do not add to the quality of care that the patient receives, but increase costs as physicians and hospitals require more time and personnel to handle all the paperwork.

Insurance companies want to ensure that doctors covered by an insurance plan are capable of providing high-quality care. To this end, insurance companies require physicians to submit information on their credentials before the insurance plan will cover their services. With few exceptions, every insurance plan asks for slightly different information, requires physicians to submit their credentials in a different format, and requests updated information every few years. Similarly, hospitals want to ensure that only physicians of skill and good training have admission privileges and thus require physicians to submit hospital-specific credential-review applications.

The Medical Group Management Association (MGMA), an organization that helps physicians deal with the administrative complexities of practicing medicine, surveyed physicians' group practices to learn more about credentialing demands. The survey found that, on average, each physician had to submit 17 credentialing applications annually to insurance companies, hospitals, and other health care facilities, and that completing each

application required nearly 90 minutes of staff time.<sup>xxxv</sup>

The MGMA estimated that the U.S. spends \$2.15 billion every year as every hospital and health insurance company verifies the credentials of the physicians with which they work, even if those physicians' credentials have been verified by the hospital next door. If this duplicative credentialing were eliminated, the U.S. would save \$1.95 billion annually.<sup>xxxvi</sup>

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### **Insurance Company Red Tape Costs Americans Tens of Billions**

A recent study suggests that administrative expenses by insurance companies contribute to the high cost of care. Conducted by Dr. James Kahn, the study examined the elements of administrative costs for insurers, hospitals, and doctors' offices in California.

They analyzed the portion of administrative costs dedicated to billing and insurance-related activities rather than to oversight and management, since the latter can directly improve patient care. The researchers studied hospitals, public and private insurance carriers, and physicians' offices of different sizes and specialties to determine the amount of time spent on administrative tasks that do not improve care. At insurance companies, for example, billing and insurance-related costs included all claims payment processing, sales, marketing, finance and underwriting. The costs incurred in reviewing the credentials of doctors, providing customer service, maintaining computer systems, and reviewing cases were counted partially as billing and

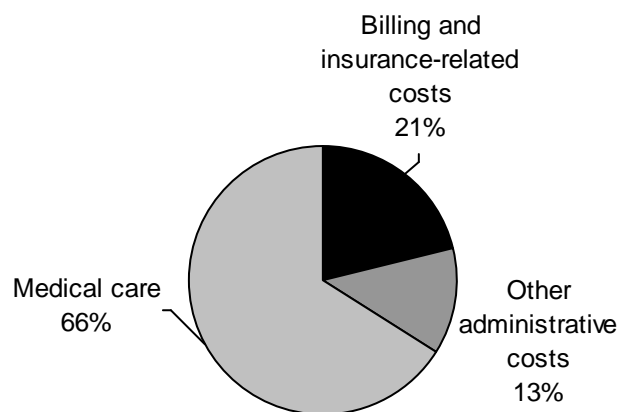


insurance-related and partially as quality of care issues.

They found that billing and insurance-related activities comprise 85 percent of internal administrative costs for commercial insurance plans, equal to 8 percent of total health care premiums.

Dr. Kahn and his co-authors concluded that billing and insurance-related costs represent 20 to 22 percent of privately insured spending in hospitals and for physician care in California (see Figure 3).<sup>xxxvii</sup>

**Figure 5. Spending by private insurers in California on share of billing and insurance-related costs compared to total hospital and physician care paid by private insurers in California<sup>xxxviii</sup>**



Using national figures on spending by private insurance and total California spending in hospitals and physicians' offices, an analysis by the California Public Interest Research Group found that the billing and insurance-related functions examined in the Kahn study consumed between \$9 billion to \$9.9 billion in California.<sup>xxxix</sup> That is 5.4 to 5.9 percent of total health care spending in the state.

This study's data and conclusions are limited to California. If the national level of administrative red tape were just half that of California, it would account for 2.7% of national health spending, or \$72.9 billion. 2.7% of Connecticut's health spending would be \$589.51 million.

## Unchecked Pharmaceutical Marketing Drives Up Costs

Extensive marketing of prescription drugs raises health care costs and fails to

improve patient health. Pharmaceutical marketing encourages patients to take

drugs that cost more and may be riskier than alternative medications. In some cases, it encourages use of drugs that patients do not need.

Pharmaceutical companies spent more than two and a half times as much money marketing drugs to consumers in 2007 as they did just ten years earlier. The amount of marketing to physicians

rose more slowly—though still increasing more than 40 percent—but the total cost of promoting drugs to physicians was nearly twice that of direct-to-consumer advertising.<sup>xi</sup> 2007 data did show a slight decrease in the pharmaceutical spending, but, at \$11.45 billion, it remains a staggering sum.

**Table 4. Drug Company Spending (billions of 2007 dollars)<sup>xii</sup>**

	1997	2007	Increase
Direct to consumer ads	\$1.34	\$4.77	256%
Promotion to physicians	\$4.75	\$6.68	41%
Total	\$6.09	\$11.45	88%

### **Direct To Consumers Drug Advertising Leads to Poor Care**

Physicians strive to respond to patient requests and ensure that the patient is in charge of his or her health care. However, doctors often have misgivings about writing a prescription requested by patients, when those requests are prompted by DTC ads.

Consumers are not very well informed by whatever they learn from pharmaceutical marketing. Drug ads—from brief TV commercials to glossy magazine ads to the fine print of those ads—are not designed to provide consumers with a complete understanding of the relative risks and advantages of drugs and to thoughtfully evaluate their options.

Doctors recognize that DTC ads leave consumers ill-informed, and as a result are often uncomfortable writing prescriptions requested by patients. In a study published in the *Canadian Medical Association Journal*, Dr. Barbara Mintzes and colleagues found that when physicians wrote a

prescription in response to a patient request, the doctor was reluctant about it

being the right choice in 50 percent of cases.<sup>xlii</sup>

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### **DTC Ads Promote the Use of Newer, More Expensive, Less-Tested Drugs**

Pharmaceutical companies undertake multi-million dollar marketing campaigns with extensive DTC advertising for new drugs to promote immediate and widespread prescribing, and to maximize profits before the company's patent expires. Often, these new drugs provide no additional benefit and may even impose greater risks on patients. Unlike medications that have been on the market for years and used by many patients, new drugs have been tested on only a few hundred or a few thousand patients, in controlled studies that might have been only a few months long.<sup>xliii</sup> As a result, the complete side effects of the drug are not known when millions of patients begin taking the medication.

In response to ads, patients regularly ask their doctors for a specific drug or for a

prescription to treat a problem they learned about through ads. Overall, the Government Accountability Office, in a study of DTC ads, estimates that “between 2 and 7 percent of consumers who saw DTC advertising requested and ultimately received a prescription for the advertised drug.”<sup>xliv</sup>

The end result of how consumers respond to DTC ads and how physicians respond to patient requests is that pharmaceutical companies earn an additional \$2.20 in sales for every \$1 spent on DTC ads.<sup>xlv</sup> From the perspective of a drug manufacturer, DTC ads are effective at increasing sales and profits. However, from a broader perspective, DTC ads raise health care costs without improving patient health.

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### **Marketing to Physicians Inflates Prices**

As significant as the effects of direct-to-consumer marketing are, studies have shown that physicians’ prescribing habits change further in response to visits from drug company representatives, ads in medical journals, and other approaches that directly target doctors.<sup>xlvi</sup>

In 2007, pharmaceutical companies spent 40 percent more money marketing their drugs to doctors than to consumers.<sup>xlvii</sup> Including the retail value of free samples provided to doctors, the cost of marketing to physicians is several times greater than the industry’s spending on DTC advertising.<sup>xlviii</sup> Overall, drug companies spent \$8,000 to \$15,000 on marketing for every doctor in the U.S.<sup>xlix</sup>

Drug companies market their products by providing free meals to doctors and

their staff, paying for doctors to attend conferences or continuing medical education events, paying speaking fees to doctors, placing ads in medical journals, and hiring thousands of marketing staff to visit physicians’ offices to meet with doctors and deliver drug samples. Professor Dick Wittink at Yale has estimated that every dollar that pharmaceutical companies spent on staff who visited physicians’ offices earned the company \$11.60 in additional sales.<sup>1</sup> Journal ads increased sales by \$12.20 for every dollar spent.

Dr. Ashley Wazana at McGill University in Quebec analyzed the results of 29 rigorous studies of how physicians respond to the influence of pharmaceutical advertising and found numerous negative effects. Doctors with the most interaction with drug companies wrote fewer prescriptions for generic drugs, failed more often to identify false claims about drugs, requested more drugs with no real advantage over those already available.<sup>li</sup>

Despite this powerful influence, information provided by drug companies has been shown to mislead doctors about the value and risk of various products, detracting from physicians’ ability to select the best drug for a patient. An examination of the statements made by drug company marketing staff when talking to doctors revealed that 10 percent of statements were wrong and that every mistake placed the company’s drug in a more favorable light.<sup>lii</sup> A survey of psychiatrists at the Department of Veteran’s Affairs found that “many assertions made by drug company representatives are inconsistent with prescribing information approved by the U.S. Food and Drug Administration.”<sup>liii</sup>

## Conclusion and Recommendations

The extent and causes of rising health costs described above are not new to health policy experts. In addition to this report, studies from the Congressional Budget Office, the Institute of Medicine,<sup>liv</sup> the Medicare Payment Advisory Commission,<sup>lv</sup> the Dartmouth Institute on Health Policy on Clinical Practice, and the Commonwealth Fund Commission on a High Performing Health System<sup>lvi</sup> have all spotlighted the need for delivery and payment reform highlighted here. States like New York, New Jersey, and Washington have limited the amount that insurers can spend on administrative expenses.<sup>lvii</sup> State and federal lawmakers are considering so-called sunshine laws to end the costly link between drug company marketing and prescribing practices.

To avert dramatically higher costs, health reform legislation must tackle these problems. If these wasteful practices are left unaddressed, Americans can expect their premiums and deductibles to rise dramatically, as discussed in the first section of the report. But the consequences don't stop there. Without reform, rising costs in Medicare and Medicaid will squeeze public sector budgets across the country.<sup>lviii</sup> And Connecticut's businesses, already struggling with a tough economy, will face ballooning health costs if they still offer coverage or sicker, less productive employees if they do not. There is no one silver bullet that will solve the problem of rising costs, but the analyses of misallocated care, administrative expenses, and drug costs

above do suggest a set of policy solutions, that together can reduce the growth in health care costs.

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### Reduce Ineffective Medical Care While Improving Quality

- **Reform public and private payment systems to provide incentives for quality of care, not quantity.** Doctors and hospitals should be rewarded for providing the type of care that improves patients' health—not simply for providing more medical care under today's fee-for service system.
- **Shift incentives to emphasize coordinated and primary care.** To reduce costly inefficient and uncoordinated care, innovative vehicles for coordination of medical care, such as medical homes, disease management, and community health teams must be adopted as broadly as practicable. Payment systems should be adjusted to compensate primary care physicians adequately.
- **Educate patients to help them make the right decisions.** Health reform legislation should expand the amount of information provided to patients to evaluate doctors and hospitals and promote "shared decision-making," in which patients are given detailed information about treatment options and

empowered to make decisions about their medical care.

- **Study what works and what doesn't.** The United States spends few resources on evaluating which courses of treatment provide the best results, known as comparative effectiveness research. This research funding should be dramatically increased. Research should compare efficacy of competing drugs. But, to maximize savings, it should also prioritize comparison of specific preventative approaches to more costly pharmaceutical and surgical treatments. Any such research must include funding to study the disparate effects of treatment on different populations, including minorities, immigrants and children.

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### **Reduce Expensive Administrative Bureaucracy**

- **Develop standardized systems for enrollment, credentialing, billing and insurance payment.** Financial incentives could be offered to health care providers who participate in a standard system, or such participation could be required for any insurer joining a Coector or national insurance subsidy program, or participation could be mandated for all insurers.
- **Limit insurers' administrative expenditures to a certain percentage of premium dollars.** This would ensure that premium payments are going to health

care, not administrative waste, by limiting insurer's spending that isn't related to care. It would create an incentive for efficient and simplified interactions with physicians and hospitals. Any such cap must ensure that the costs of disease management services, which can reduce costs for chronic care, are not restricted.

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### **Reduce Excessive Pharmaceutical Marketing Costs**

- **Increase Federal Monitoring of Advertising and Marketing.** The Food and Drug Administration should beef up its monitoring and enforcement efforts under existing laws governing pharmaceutical marketing. The agency should set a goal of stopping false statements before advertising or marketing materials get to providers and the public.
- **End Improper Marketing Practices to Doctors.** Restrict gifts to physicians and require drug companies to disclose more information about their marketing to physicians, including gifts, free meals, speaking fees, and paid consulting arrangements.
- **Provide Doctors Neutral, Unbiased Information on Drugs.** To counter the sometimes misleading information provided by pharmaceutical companies, independent efforts to provide objective information on the benefits and prices of drugs should receive public funding and support. Pennsylvania

already operates such an “academic detailing” program in which physicians and researchers evaluate drugs and provide impartial education about different prescription drugs.<sup>lix</sup>

Some of these reforms could happen fairly quickly; others will take years. But without action on health reform, high

costs will increasingly burden families, businesses, and the economy as a whole. As the new Congress and Administration take up health reform, it is critical that they do health reform right by reducing health care spending that does not deliver results.



## A Note on Projections

The projections of health costs contained in the section “Cost of Inaction” were taken wholly from the New America Foundation report, *The Cost of Doing Nothing*. That reports’ authors explain their projections in the following way:

*All of the projections in this paper are computed through the use of historical data. We assumed that if nothing is done to reform our health care system, then costs would continue to grow at a similar rate as they have been for the past decade. Therefore, to compute our projections, we took 10 years of data and determined a compound annual rate of growth over that 10 year period. In cases where 10 years of matching data was not available, we took the longest possible span-the shortest being 7 years. These compound annual growth rates were then applied to the most recent year of data, in most cases, data from 2006 or 2007. By continually applying the annual growth rate, year by year, until 2016, we were able to estimate how prohibitively expensive our health care system will be if we do not act soon.*

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