



SOCIETY OF ACTUARIES

**Health Spring Meeting
May 2008**

**Health Policy Question and Answer: Where are
We Headed and What Will It Mean to Me?**

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Moderator

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Health System Reform: Why Now, What, and What If...?

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Society of Actuaries Health Spring Meeting
 May 28, 2008
 Los Angeles, CA

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Overview

- Why Now
- Competing Visions
- Why a purchase requirement is a good idea
- 2008 Presidential Candidates, then and now
- Congressional groundwork for 2009-2010
- Themes to Expect
- How to "Break the Chain"

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Why Are We Here?

- 3 Health System Problems
 - Low value for dollar
 - Mediocre and uneven quality
 - Inequitable access
- Problems are Serious, Linked, and Festering from Neglect

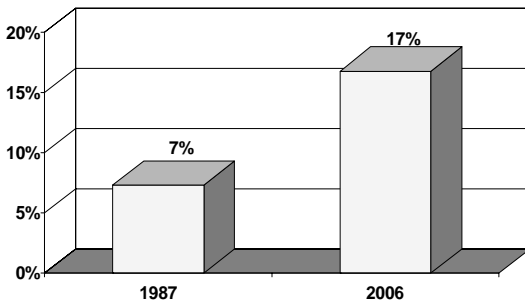
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Why NOW?

- Premium / income is higher and growing

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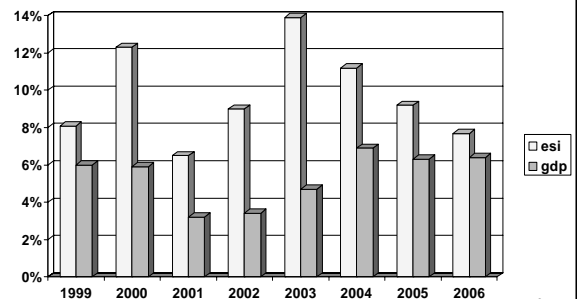
Percent of median family income required to buy family health insurance



Source: Author's calculations, using KFF and AHRQ premium data, CPS income data.

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Premium Payments v. GDP Growth Rate



Source: NIPA, BEA/Commerce Dept.

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Why NOW?

- Premium / income is higher and growing
- International competition is more pervasive

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Employer Contribution Rates and Hourly Cost of Health Benefits, Selected Top Trading Partners

Country (rank in total trade with the US, 2005)	Employer Contribution Rate	Hourly Pay, Manufacturing U.S. dollars	Hourly Cost of Health Benefits, Manufacturing US dollars
United States	11.3%		
	13.0% for Manufacturing	\$18.32	\$2.38
Canada (1)	4.5%*	\$19.21	\$0.86
Japan (4)	3.74%	\$18.06	\$0.68
Germany (5)	6.65%**	\$25.53	\$1.70
United Kingdom (6)	1.92%***	\$20.91	\$0.40
France (9)	12.8%****	\$16.93	\$2.17
Weighted avg.	4.9%	\$19.79	\$0.96 ⁸

Why NOW?

- Premium / income is higher and growing
- International competition is more threatening
- More awareness of LINKAGES among problems
 - costs of spotty quality
 - consequences of being uninsured

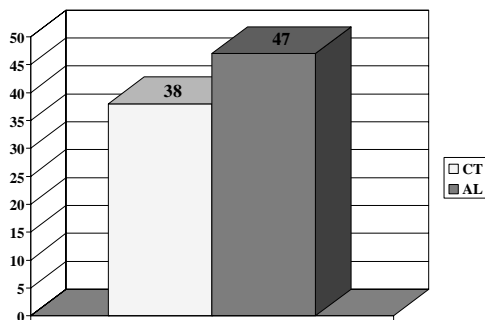
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Quality and Efficiency

- Beth McGlynn
- Brent James
- Dartmouth
- IOM/IHI

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Death / Incidence , All Cancers



Source: CDC

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Uninsured Cancer Patients Are...

- ...1.5-2.5 times as likely to be diagnosed later in disease progression as privately insured
- ...1.6 times as likely to die within 5 years as privately insured
- Results stand up when controlling for age, race, sex, income, and type of cancer
- Within races, insurance matters as well

Source: American Cancer Society, CA: A Cancer Journal for Clinicians, v. 58 #1 (Jan-Feb 2008).

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Share of Family Income Required for Family Coverage, by Income Class

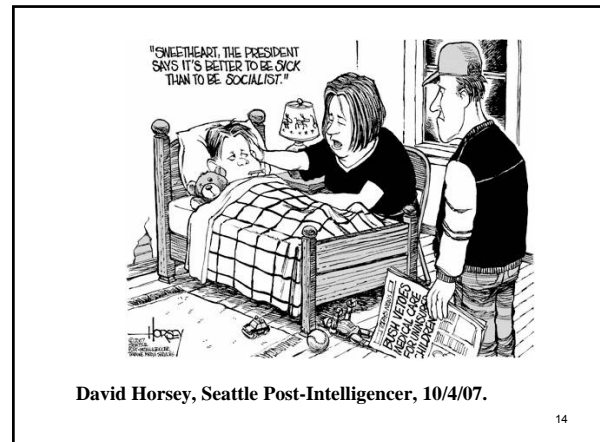
Single Mother with two Children

Average Premium= \$12,106 per year	Annual Income	Percent of Income Spent on Premium
At FPL	\$17,170	70.5%
2 times FPL	\$34,340	35.2%
3 times FPL	\$51,510	23.5%
4 times FPL	\$68,680	17.6%

Two wage-earners with two Children

Average Premium= \$12,106 per year	Annual Income	Percent of Income Spent on Premium
At FPL	\$20,650	58.6%
2 times FPL	\$41,300	29.3%
3 times FPL	\$61,950	19.5%
4 times FPL	\$82,600	14.7%

Sources: NAF Analysis Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007 and HHS Federal Poverty Levels, 2007.



David Horsey, Seattle Post-Intelligencer, 10/4/07.

Consequences of Inequitable Access

- Cost of uninsurance \approx cost of coverage expansion, \$65-130B per year (\$87-174 in 2007)
- 18,000 premature deaths *annually* (22m now)
- Acutely and chronically ill receive fewer timely services and have worse morbidity, days lost, etc. than similar insured patients
- 60 million suffer financial insecurity each year
- People in high uninsured areas suffer from lack of health resources available to them

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Why NOW?

- Premium / income is higher and growing
- International competition is more threatening
- More awareness of LINKAGES among problems
 - costs of spotty quality
 - consequences of being uninsured
- System stresses appear more unsustainable to more people
 - ER waiting times, generalized access problems
 - Cost-shifting from "hidden tax" part of low value per dollar
 - State and Federal fiscal stress

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Competing Visions of Reform

- Markets are Perfect
 - Deregulation is one answer
 - Consumer/patient incentives are the other
- Markets are Hopeless (and Cruel)
 - Government is the only effective answer
- Real Life (practical idealism)
 - Markets are powerful, but flawed
 - Smart regulation *and* re-aligned incentives can make them work better
 - People need information tools to improve choices
 - Health care costs too much
 - More people need more subsidies than most think

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Smart Regulations

- Are you *kidding* me?
- Health insurance is not like ice cream
- Depends on goal:
 - Health of population?
 - Want insurers to help *keep* and *make ALL* healthy
 - Want insurance market to work for all
 - Absolute economic liberty and health of some?
 - Want insurers to continue to profit from selecting risk
 - Value freedom of insurers over health of unlucky

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Tools for better choices

- Comparative quality information
 - About tests and procedures
 - About providers, networks, and insurance customer service
- Comparative price information
 - About episode of care, not specific services
- Standard benefit package
 - So shopping (apples to apples) is easier
- Cost-sharing adjusted for health benefit, income
- Incentives to choose health homes, care coordinators/guides, healthy lifestyles

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The Good News

- Dems have discovered markets and the importance of cost-growth control \approx value enhancement/cost
 - Modal proposal has regulated private insurance markets, purchase requirements, emphasizes information system and comparative effectiveness, some payment reforms
- Repubs have acknowledged that many cannot afford health insurance as we know it
- McCain has discovered supply-side incentives are important, too
- Huckabee stressed behavioral change
- Romney “owned” Massachusetts reform model

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Meanwhile, Back in Washington...

- Massachusetts and California got noticed
- “Strange” coalitions formed in 2007
 - BHCT, Divided We Fail
- Vision of many trade groups remarkably similar to modal Dem proposal
 - FAH, ERIC, CED, Advamed (save Comp. Effectiveness)
- Wyden-Bennett (S. 334) has 12 co-sponsors
 - Bennett, Gregg, Grassley, Alexander, Coleman, Crapo
 - Wyden, Nelson (FL), Stabenow, Lieberman, Carper, Landrieu
 - Has mandate, “health home,” FDA reform, new markets, subsidies, phases down employer financing, uses existing tax \$
- At least 3 other bi-partisan conversations in House
 - Baird-Emerson, Langevin-Shays, Cooper-Castle

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Common Themes To Expect

- We Cannot Afford It (whatever “IT” is)
- Trust, but Verify
 - Transparency of price and comparative quality info
 - Market outcomes will need to be monitored
 - Government programs will need to be evaluated
- Shared Responsibility *is* the American Way
 - Individual responsibility is central
 - Community responsibility is to make it possible for each individual to take responsibility for himself or herself
- Economic cost of doing nothing is high
- Moral cost of doing nothing is possibly higher

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Cost Growth Matters Because...

- Opportunity Cost
 - Crowding out other priorities
 - Households
 - Employers
 - Governments
 - System stakeholders
- We are not willing to cover everyone with current system trajectories
- We must cover everyone, or risk yet more social segmentation

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Capturing Savings from Delivery System Reform

- Good Idea
- It will be hard
 - One person’s cost is another’s income
 - “Excess” cost is income too
 - Business case for savings weak for many providers
- It will take time
 - Cost-shifts have multiple participants, time horizons
- It must be sought
 - We simply cannot afford current trajectories, period

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Incentive Mis-Alignment

- Fee-for-service for providers + low-cost sharing for most patients + small effective evidence base => too much low value/redundant care
 - Share savings from smarter care with providers and patients
 - Set bundled payment at “efficient” level
- Technology “approval” = ticket to market
 - Beating placebo ≠ adding clinical value
 - Raise approval bar in exchange for longer period of exclusivity
 - Set cost-sharing according to value added

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Promising Examples

- Medical Home in NC Medicaid
 - Community Care North Carolina
 - Paid MDs and care management network \$3 pmpm each
 - Focus on chronic disease management
 - Saved 3% of total Medicaid spending, 11% of state Medicaid spending, from '04-06 (mercer) and “educators”

Source: Community Care of North Carolina, www.communitycarenc.com.

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Promising Examples

- Sumner Clinic in Gallatin, Tennessee
 - Protocols plus nurse care coordinator
 - But sans payment reform, would turn savings over to Medicare
 - Struck incentive deal with MA plan (HealthSpring)
 - All quality measures exceeded 90%
 - ER down 23%
 - Admissions down 16%
 - Loss ratio fell from 87% to 77%, now down to 69%
 - Quality, income, and profits up, costs down

Source: Guy Clifton, *Flatlined: the Resuscitation of American Medicine*, Rutgers Press: (forthcoming 2008)

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Promising Examples

- Intermountain Health Care using information and protocols
 - Brent James studied variations within LDS hospital
 - Shared info, let specialists develop own protocols
 - Care improved, savings achieved
 - Much turned back to Medicare, health plan created/expanded to help capture savings

Source: Guy Clifton, *Flatlined: the Resuscitation of American Medicine*, Rutgers Press: (forthcoming 2008)

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Promising Examples

- Virtual Group (Hill, an IPA) using info system and “health educators”
- “Never Event” approach of Medicare, Pennsylvania, Geisinger, Mayo
- Generic use up to 57% of scripts
- Shared savings payment reform ideas of COPE

Source: Coster, in *US Pharmacist*, Vol. No: 32:6 Posted: 6/19/2007

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Vision

- Electronic information infrastructure
 - eHRs, decision support, data exchanges for care coordination and research base
- Incentive re-alignment
 - Shared savings with providers
 - Evidence-based cost-sharing
 - Malpractice reform
- Comparative Effectiveness Infrastructure
 - Turbo-charge production of evidence base
 - Incentive re-alignment plus information turbocharges drive toward efficiency in all things, allows bureaucracies to stop back
- Some/most/all of cost of coverage expansion can be financed this way in the long run (1.5T over 10 years, per CMWF and Lewin)

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Who Will Win?

- Those who can produce value and verify contributions to sophisticated buyers *and* to patients
- Those who are better at science than marketing
 - Patients' agents will set coverage, payment, and cost-sharing policies
 - McCain vs. Dems on who will be the agents?

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Who Will Be the Agents?

- McCain
 - Individuals (reduce employer role, regulation)
 - Emphasize individual insurance market
 - Government can require transparency + Medicare payment reform
- Dems
 - HIT + Comparative effectiveness institute
 - Emphasize GROUP purchasing, exchange
 - Payment reform throughout system

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Why Health Reform Is Hard



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How To "Break The Chain"

- Pursue Bi-Partisan Reform
 - Not milquetoast, but real reform
 - Both parties' values must be reflected
 - 60 ≈ 70
- Work to PROTECT the Debate from Saboteurs
 - Inside-outside strategies
 - Collaborations
 - Develop credible policies that can earn (divided) stakeholder support

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Is SCHIP struggle a proxy war for system reform in 2009?

- Yes, but...
- SCHIP is NOT a partisan war between Ds and Rs (18Rs in Senate, 41 in House)
- SCHIP is a civil war for the soul of R health policy
- Larger battle is over whether status quo trajectory is still preferred to serious reform

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David Horsey, Seattle Post-Intelligencer, 10/4/07.

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Landscape at the Moment

Public only	Public and private	Private only	Non-universal
Conyers	Stark Kennedy-Dingell	Clinton/Obama	Wyden-Bennett Baird-Emerson Langevin-Shays
			McCain

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