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"For Professional Recognition of the Health Actuary"

An Actuarial Response to the Health Care Crisis

by Dan Wolak

Second of a two-part series

In the April 2004 issue of Health Section News, we attempted to give an actuarial perspective to two of four questions originally posed to a group of approximately 100 leaders in the health care industry in the June 23, 2003 issue of *Business Insurance*. The April issue addressed:

1. Who is responsible for cost increases?
2. What should be the government's role to ensure health care coverage and keep costs down?

In this issue, we will continue our examination of the reasons behind health care cost increases and explore potential solutions by answering the following questions:

1. What are the most important steps that can be taken to control costs?
2. How will health care plan design change in the future?

To have the final responses fit within the confines of this newsletter, some individual responses were shortened to only one or two paragraphs of the full response. If you would like to see the entire transcript, please go to the SOA Web site at http://www.soa.org/ccm/content/areas-of-practice/special-interest-sections/health/health-section-news/

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NOTE: These responses were solicited prior to the Medicare changes being finalized.

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1. What are the most important steps that can be taken to control costs?

Carl Desrochers, FSA

In today's era of technology, we need to create a central repository for medical records that is readily accessible to physicians. As patients are seeing more than one physician, many costs are incurred by requesting duplicate diagnostic tests. Automated Medical Records (AMR) would contain all the medical history of a patient and therefore, unnecessary tests could be avoided. Not to mention that every physician could see what the other physicians have prescribed, thus avoiding drug interactions that lead to additional medical problems.

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When you take a step back and look at it, the health care financing is pervasive. Physicians and hospitals receive income when someone is sick and needs treatment to get back to health. Therefore, the sicker the population, the greater their income. There is no incentive to prevent disease and many incentives to just treat patients. In fact, acceptable ranges for certain test results (e.g. blood pressure) have changed. The result is including a larger portion of the population in the "at risk" categories.

Howard Bolnick, FSA

Theoretically, government can devise a reform consistent with our unique culture and politics that provides universal access to high-quality, cost-effective health care—with some sort of universal budget cap. For example, the UK National Health Insurance system has better population health outcomes at about one-half the cost of our system. Realistically, it is highly unlikely that our government will adopt any sort of sweeping reforms or cost-controlled system. I also do not believe that private sector solutions like managed care or consumer-driven health care plans will be effective in controlling costs. Our best hope rests in medical technology developing low-cost, less intensive, and more effective cures for diseases that are today very costly to treat. This is unlikely to occur in the next decade or two, but it is a real possibility in the next 50 years.

- Wolak: So, we are stuck with the high costs for, well, the rest of our careers, and thereafter?

- Bolnick: Well, when costs get high enough (which cannot be measured) then perhaps the U.S. health care system will change. But, it's hard to envision changes that will do much to actually lower costs. I guess I'm rather pessimistic about prospects for "solving" the problem of high and continuously escalating health care costs in the near or intermediate term.

John Cookson, FSA

I think we need to have an independent entity established to assess the quality and efficacy of treatments, reflecting evidence-based medicine. This would allow coverage to be structured in a tiered approach: a) with reimbursement at a high level, similar to current plan design, for proven effective, high-quality treatments, and b) progressively lower coverage (higher co-payments), or no insurance coverage for services determined to be ineffective or of low quality. Such organization could also establish protocols for funding unproven but promising treatments on an experimental basis. This would then become the process for new medical treatments moving up the quality and efficacy scale to more comprehensive insured reimbursement. This treatment information can be combined with provider-specific quality and cost assessments to make good information available to all consumers and insurers.

David R. Nelson, FSA

New models for managed care will be developed so that risk-adjusted data is used by providers to improve outcomes, and so that providers can steer patients to effective caregivers.

- Wolak: Why do we think that providers will use such data effectively? Do we have any points of reference?

- Nelson: Concern about the willingness of providers to change is a point well taken. Only time will tell if a new model for managed care can be built. Certainly there are forces which support a change:

  (1) Employers and government need cost relief, and
  (2) Physicians generally want to be good performers and they respond to data.

  But, change will be difficult given the large number of people who currently benefit from the current system.

Craig S. Kalman, FSA

Make the consumer—versus the employer's cost of health insurance—more responsible and responsive to its costs.

Dale Yamamoto, FSA

Make everyone better health care consumers.

Michael G. Sturm, FSA

It depends on who you are. Employers should review their plan annually to ensure they are getting the best discounts, providing competitive benefits (i.e., cost sharing and services), charging employees a competitive premium share, whether disease management makes sense, etc. Employers might also consider helping health plans monitor their employees' illnesses by making their health care contribution contingent on the employee submitting a quarterly health status report. This type of report would serve as a sentinel to the health plan's disease management staff, assist with pay for performance (and other cost-quality initiatives), and help the health plan appropriately rate various groups.

David V. Axene, FSA

It is one thing to control costs, it is something different to identify where unnecessary and wasted costs exist and to try to first eliminate these. I have published multiple papers and documents on the significant extent of medically unnecessary/ potentially avoidable/wasted health care resources. As soon as the public really understands how big this is, it is likely that they could be convinced that more can be done to not cut their benefits but help them to consume the system more wisely. Until the public understands the truth on this they will continue to harangue about the woes of "managing care" and despise those who have the solutions to stop the problems. So, initially we need to understand where savings can be made without hurting quality of care and without creating bad outcomes.

We need some way to help providers also understand this since many of them do not realize how much savings can occur. Unfortunately, their fee-for-service experience means that some will make less and get less. They don't like this.

A role of the government might be to establish some methodology to force this issue.

➢ Wolak: We currently have a pricing system that is very difficult to understand. What would happen if all services were provided as a percentage of the resource-based, relative value schedule (RBRVS), though not necessarily the same percent for all payers?

➢ Axene: I prefer that approach, since payers can be compared to each other and you can see what value you are getting. There is a problem with that approach since it doesn't encourage quality; it is a price-fixing system.

William F. Bluhm, FSA

What makes you think that costs can be controlled? The American public has clearly decided that health care costs are not yet too expensive, and are willing to at least partially socialize them through the tax system. The economic forces at play here are too big to be changed with the solutions being offered today. The number one impediment to lower costs is the sense of entitlement of the American public; entitlement to a seemingly unlimited level of care.

Van A. Jones, FSA

First, we have to recognize the contradictory and competing objectives of government in health care. Second, we have to recognize that the problems are huge and multi-faceted, such that the greatest potential for resolution lies in a successive process of good decisions followed by better decisions.

Some good first priorities would include the following:

(1) Equalizing tax policy for health costs between the employed and the self-employed.
(2) Educating the masses on the costs and decision processes in individual health care treatment.
(3) Extend Medicare retail charge limits to all markets.
(4) Extend coverage standardization, already instituted for Medicare Supplement, to all comprehensive health coverages.

Items 3 and 4 probably require some explanation. Currently, physicians who choose not to accept Medicare "assignment" by law cannot charge more than 115 percent of Medicare payment schedules to Medicare eligible patients. While I'm opposed to price controls and I'm uncomfortable with the current equity within the Medicare RBRVS payment schedule, this structure has provided a valuable reference point for comparing costs.

I suggest that government initially mandate that providers could not charge more than, say 200 percent of Medicare RBRVS, DRG or ACP reimbursement levels. Initially, a provider could exceed the maximum charge only if they clearly disclosed

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the percentage by which their charges exceed the maximums in advance of the procedures. Most current medical procedures would fall within this range and minimal administrative cost would be incurred. Logically, all providers would react by expressing their charges in terms of the government reimbursement schedules. Most consumers would not understand the government schedules, but they would understand that a provider charging 180 percent of the schedule costs a lot more than a provider charging 120 percent.

- *Wolak*: How should or could actuaries support such a change?

- *Jones*: Actuaries can add value to this process by assessing the financial impact of such limits and the range of responses from various provider segments. The short-term impact will be that many providers will simply produce a standardized disclosure statement that identifies that their charges are above the guidelines. Actuaries can help quantify reasonable expectations of this. If limits are properly set, the longer term impact is that providers who can provide care within defined guidelines will tout that occurrence, and those above will be readily recognized by the consumer. Actuaries can help structure the mechanisms that will measure and adjust guideline values and quantify the impacts of changes relative to the designed intent.

Chandler Lincoln, ASA

At this time, the most important step that can be taken effectively is to put consumers "at interest" for their own health care. This means allowing them the right to choose their own providers and the responsibility of sharing in the costs of those providers.

For consumers covered by employer medical plans, this means ensuring that employees have various plan options to choose from that include well-designed cost sharing features.

For consumers without employer medical plans, it means the right to participate in medical purchasing pools that allow them to reap the benefit of volume discounts from providers as well as the ability to choose various medical plans suited to their cost sharing abilities.

In concert with putting consumers "at interest" is the necessity of putting them "at ability to pay." This means giving them the ability to accumulate tax-free dollars to pay for future medical expenses (including medical insurance premiums and long-term care premiums). The HSA provisions coming out of the new Medicare bill are a start, but 401(k) and IRA type investments are needed.

Timothy K. Robinson, FSA

The most important step is implementation of effective disease management programs for chronic and catastrophic conditions. This may require a willingness on the part of early adapters to implement disease management strategies that intuitively (based upon common sense and early research) work, without waiting on "proof" of ROI that is probably a moving target at this point in the industry's development. The industry needs to move beyond its focus on cost shifting (provider risk sharing, network discounts, member cost sharing), to truly understanding and targeting what is driving utilization and cost. This will require investments in data and supporting structures that provide clinical insight, early identification of potential chronic and catastrophic cases, stratification of such cases into appropriate management programs, and accurate projections of claim costs.

- *Wolak:* What's stopping the market from implementing changes? Employers want to save money on their health care. Is there a fear that disease management (DM) can be another qualitative measure that would end up costing money? Is disease management viewed by the market as a catchall phrase, much like wellness programs?

- *Robinson:* On one hand you have the fundamental issue that you can't measure what didn't happen. This is essentially what any DM program tries to do, in estimating its ROI. How would cost and utilization for this member or group of members differ, had the DM program not been in place? This makes the sale more difficult right up front. It's much easier for a managed care organization to understand (and value) an additional 5 percent savings in their provider payments rates, or a 10 percent increase in member coinsurance. Another issue is probably the hesitance of managed care organizations to bring in a vendor to do something that in theory they are already doing (or responsible to do): manage the health of their sickest members. There are also access issues. It's currently difficult for smaller to medium-sized self-funded employers to access the larger DM companies that are targeting the

health plan and jumbo employer markets. Within this market there are probably also definitional issues, as you mention above the possibility that "disease management" is seen as a catchall phrase. Self-funded employers and/or their TPAs may feel that existing case management services or wellness programs offered through the TPA are the same thing as disease management, and do not appreciate the need for specialized chronic and catastrophic management offered by DM companies.

Cynthia S. Miller, FSA

Developing evidence-based protocols for the delivery of care, and then providing full disclosure to consumers regarding providers who follow those protocols and meet proscribed safety standards would reduce costs while improving the care provided, because care that is unnecessary and/or harmful would be reduced. Having benefit designs that give incentive to the patient to be engaged and knowledgeable about the care that they are receiving and the costs of that care would clearly help to control the escalation in health care costs. Moving our health care system to one focused on more holistic treatment, rather than specialized treatment of acute episodes, would increase the overall health status of Americans and thus reduce health care costs.

- Wolak: As actuaries, we can be frustrated that the medical profession has not followed consistent protocols. Do the medical providers really want to be given support to manage the risk? Is it something that can be expected?

- Miller: I believe that the medical profession truly wants to provide the best care possible to their patients. Many medical practitioners are very open to any information or tools that help them to keep up-to-date with the rapidly changing medical landscape and further the quality of the care provided to their patients.

Mark E. Litow, FSA

The most important steps that can be taken to control costs include: changing the tax code, followed by a total overhaul of Medicare and Medicaid so that we create personal responsibility; subsidies for those who need it; disclosure, education, restoration of actuarial risk classification principles; gradual elimination of most if not all mandated benefits and price controls; and restoration of the physician/patient relationship.

2. How will health care plans change in the future?

Mike Sturm

I predict cost sharing in the short-term will continue to increase with inflation and in the long-term will vary by condition and provider to encourage efficient consumer spending. For example, drugs available to treat specific conditions will have different copays based on drug efficacy, diagnosis and patient-specific characteristics. Health plans will differentiate patient cost sharing by service and provider. For example, expectant couples will select their delivering physician and hospital based on price as well as the usual factors (i.e., convenience, perceived quality, etc.). Facilities providing the most value (i.e., quality services relative to price) will have the lowest copays. Patients will have to pay more for higher-priced facilities. I believe this type of differentiation will lead to providers specializing in services they provide most efficiently and increased volume, both of which should increase quality.

Dave Tuomala

There is certainly increasing interest in consumer-driven plan designs in the employer market. I think we will see more new plan designs that include some form of consumerism element as an integral part of the plan design in the short term. This will include both the account-based plans currently being offered as well as other variations. As the consumer-driven plans mature, we may start to see less emphasis on plan design features as we currently know them (e.g., deductibles and coinsurance) and more designs with cost-sharing features based on specific treatment choices and their associated costs.

For the more traditional plans, I think we will continue to see increased employee cost sharing in the form of deductibles, copays and employee contributions as employer costs increase. As costs increase, we may see a shift in philosophy by employers to providing health coverage as catastrophic protection rather than as first-dollar benefits.

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Dave Axene:

A typical benefit of the future might start with a few questions:

- How much are you willing to pay each month (this will limit the choices to acceptable prices)?
- Which list of doctors or which list of providers do you want to access within your personalized network (this will help set a price point to define benefit levels)?
- What type of benefits do you want (i.e., copay levels, deductibles, coinsurance, etc.)

These three questions will define what a program might look like and various options around these choices will derive possible choices. The "efficiency" of the network selected will help get high benefits for the same price or lower prices for the same benefits. This is where true consumer choices will begin. Benefit administration will need to be very flexible, as benefit choices between employees will be different yet still covered by the same employer and health plan.

Howard Bolnick:

In the next five years, consumer-driven plans seem to be the next "solution" to "solve" our health care problems. I suspect that this "solution" will be even less effective than managed care and, perhaps, as controversial. What follows this latest "fad" is anyone's guess.

Dale Yamamoto:

We need more financial incentives to make people do the right thing. Managed care worked for a while to help the providers understand that they needed to be efficient, but we missed on the consumer side of things. We need higher up-front costs to make people aware of the little costs (generic versus brand drugs, the cost of an office visit isn't $10), more coinsurance to ensure that consumers stay aware of costs—maybe even to the point where the plan never pays 100 percent—maybe 95 percent—so that there is always financial incentive to not accept any and all treatment offered.

Bill Bluhm:

Ultimately, cost drivers will force the purchasers of insurance to limit coverage in some dimension. Those dimensions might be:

- Who's covered (increasing the uninsured)
- Increasing consumer deductibles/copays/reimbursement accounts/etc. (shifting increases to the insured)
- What services are covered (perhaps through tiered quality or access)
- What diseases or procedures are covered (a la Oregon, Canada or the UK)
- Which providers can provide covered services—such as through EPOs or closed panel HMOs, or a combination of these.

Van Jones:

Ultimately, two to four dominant health financial systems will evolve in each community and all employers will provide payroll deduction options for the employee's plan choice. Several, and in some communities all, of the community health financial systems will be the nationally recognized names. If the government "levels the playing field" in terms of standardizing benefits, then the competition within each community will exist based on the price and the perceived quality of care provided among the providers of each system. It is likely that a low-cost financial system will emerge in each community as the primary provider of care. The government-financed health plans would then be based on a moderate coverage level among the assortment of established benefit choices.

Chandler Lincoln:

Changes in health care plan design will emphasize higher payments by insureds. That means higher deductibles and copays, lower coinsurance and higher out-of-pocket limits. Three-tiered drug plans and separate drug deductibles will become more prevalent. These changes will occur more quickly in employer plans than in union or negotiated labor plans. At the same time there will be a decrease in employer contribution levels, which may also include lower contribution levels for dependents than for employees.

Medical savings accounts and consumer-driven health plans will become more popular and there will be increasing support for pension-type defined contribution health plans.

Tim Robinson:

Plan design changes will be focused on encouraging members with chronic or catastrophic conditions to participate in and comply with offered disease management programs. For exam-

ple, copayments might be reduced or waived when associated with lab procedures or prescription drugs necessary to control a chronic condition. Plan design considerations in today's insurance programs generally take the opposite approach, increasing cost sharing across the board in the hopes of reducing "unnecessary" utilization. An exception is prescription drug plan design, which has evolved to encourage cost-effective utilization. This approach should be expanded to other service categories, recognizing that incentives and barriers to cost-effective care differ according to the health status of the individual member.

Cindy Miller:

We already see the movement to benefit designs that require more cost sharing by the consumer, and I imagine that this will continue. Given the continued demand for more individual choice, and the desire of many employers to reduce or eliminate their role in purchasing health insurance for their employees, it is likely that we will see more movement to individual products and perhaps a blurring of the distinction between group and individual policies. Benefits and networks will emphasize quality and incent the patient to use providers that meet quality standards. While I'm not sure that this is likely, I would like to see benefit designs that reward individuals who choose healthy lifestyles. That is, provide richer benefits or reduced rates to individuals who don't smoke, who exercise, maintain a healthy weight, consistently take medications required to control chronic conditions, etc.

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Who Is to Blame for Cost Increases?

by Dinkar Koppikar

Almost all respondents blamed "we" for cost increases without defining "we." As many have correctly pointed out, we must expect cost increases as advances in medical technology conquer many illnesses and the population becomes older. If people live longer and healthier lives, the increasing proportion of health care cost in our per-capita income is nothing to complain about. In fact, enlightened public opinion will expect that to happen. However, certain anomalies in the way the costs are assessed aggravate the cost crisis and the appearances thereof. Unfortunately, neither pure market mechanisms nor pure governmental regulations would be sufficient to correct those.

Let me first point out the anomaly in group health insurance pricing that aggravates the crisis in health insurance pricing, as well as appearances thereof. Most elements in an employee benefit plan are of the deferred compensation type, in that the resources set aside are available for use by an employee only in the event of some future contingent event, when an employee has no income from employment. However, the resources earmarked for group health insurance are available while income from employment continues. Thus, group health insurance effectively supplements current income, that too on a pre-tax and partially or fully employer subsidized basis. As soon as he loses his job or retires, he receives a COBRA notice of his "right" to continue health insurance, at a premium rate several times what he used to pay during employment, at a time when he has little or no income, so any tax subsidies are meaningless. While employed, even if the employee and their family use health care services in a profligate manner, they rarely see big bills coming their way. Their health care problems may be minor. With unemployment, dormant health problems may upsurge. With big medical bills in the mailbox the perception of costly and unaffordable health care gets aggravated.

In short, the culprit "we" are the affluent sections of the society getting tax and employment subsidized health care (high income, self-employed can incorporate and get benefits as "employees"), who seduce health care providers to charge big bills for

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