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HEALTH CARE REFORM AND THE ACTUARIAL PROFESSION

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The time has come for the actuarial profession to assert its views on significant policy steps which should be taken to rein in the cost of medical care in this country and state the impact of those steps on our federal and state budgets. While our profession provides much useful research in developing proposals for improving the health care system, the projected crisis is so severe that this is not enough. We should state our recommendations much more forcefully to policy makers and the public.

It is widely known that we spend close to 20 percent of our gross domestic product on health care, which is far greater than what is spent in most other economically rich countries. And we get far less for that expenditure than most other nations do, if life expectancies and infant mortality rates are used to measure the comparative effectiveness of health care systems. The United States ranks behind dozens of other nations in these statistics; see, for example, the ranking tables for these statistics in *Pocket World in Figures*, 2008 edition, published by *The Economist*. In my opinion, our present methods of providing and financing health care are dysfunctional.

It is, perhaps, easier to state what proposed solutions will be ineffective in making major progress in dealing with this crisis. Making reforms to Medicare may be part of the solution but will be insufficient by itself. For example, there is much talk about raising the minimum eligibility age for Medicare from 65 to 67 to be consistent with Social Security. The Congressional Budget Office (CBO) estimates that raising the age from 65 to 67 by two months per year will save $148 billion from 2012 to 2021. That is not chump change, but it would only have a minor impact on our total deficit spending of approximately $10 trillion in the period from 2013-2022.[1] Furthermore, much of that savings will be offset by increased costs within the Medicaid program, for the estimated (by CBO) 5.4 million people excluded from Medicare who would qualify for Medicaid.

Reducing Medicare reimbursement to providers is another nonstarter proposal. In every year since 2003 such legislated cuts to physicians have been rescinded by Congress. The fiscal cliff would have resulted in cuts in reimbursements to doctors of 27 percent. If these cuts had actually been realized, the percentage of doctors who refused to take Medicare patients may dramatically increase. Fortunately, for the time being, Congress has acted to postpone these cuts.

There are other tweaks to Medicare under consideration, but even if Medicare could be fixed to bring it into balance and improve the long-term federal deficit problem, it would not solve the larger issue of providing effective health care at an affordable cost to all Americans. Balancing Medicare long-term could, however, provide a model for broader reform.

What has contributed to our grossly expensive and dysfunctional health care system is multifaceted and will require a multifaceted approach to bring it under control. Following, in my view, are several components of an effective response.

First, we must reform medical malpractice insurance. This insurance annually costs many medical specialists premiums approaching six figures. Ten percent of the total cost of all medical services is linked to malpractice suits and the practice of defensive medicine, according to a 2006 report by Pricewaterhouse Coopers, LLP.

In 1972, California limited noneconomic medical liability damages to $250,000 by the Medical Injury Compensation Act. More recently, in 2003, Texas took a similar step. According to the Texas Insurance Department, those reforms have led to a 25 percent decrease in medical liability insurance rates for Texas physicians.[2]

But this is a problem that demands a national solution rather than a piecemeal state by state solution.

Another concern we must address is the overall shortage of general practitioners (GPs) relative to specialists. According to a recent *New York Times* (*NYT*) article,[3] the United States is projected to have a shortage of 50,000 GPs by the end of the decade. This shortage is, assuredly, aggravated by the recent development of concierge practices of GPs. What characterizes concierge practices is an annual patient fee of anywhere from $600 to $5000. For this fee, the patient client (supposedly) creates a special relationship with his GP. This includes enhanced access to the GP, a very comprehensive annual physical, and some additional premium services without additional charge. Many concierge practices will accept patients only on this basis. GPs who have adopted this style of practice have been able to reduce their patient load from 3,000 or 4,000 patients to a range of only 100 to 1,000 patients, while at the same time greatly increasing their income. Many such practices will not deal directly with any health insurance companies, including Medicare.

It is estimated that there are 1,000 to 5,000 concierge-style practices today. That amount may not be a major factor in the GP shortage right now, but the development of this style of practice is growing rapidly. At some point it will create a tipping point, where access to GPs will be significantly affected. Thus, effectively, a two-tier health care system is being created. Those who can afford the concierge practice enrollment fee will get very effective care, and those who can't will suffer the consequences of limited access to care by GPs.

Another factor contributing to the shortage of GPs is the high cost of medical school education and the resulting heavy student loan burden on medical school graduates. A recent *NYT* article[4] stated that the median loan level of medical school graduates is $160,000 and one-third of graduates' loan balances exceed $200,000. Doctors choosing residencies and contemplating how they are going to cope with their heavy loan burdens are, undoubtedly, influenced by their high loans to choose a higher income specialty rather than a lower income GP practice, apart from the concierge-style GP practices.

Whether government can afford to intervene or medical schools, themselves, will intervene to reduce this burden requires more research. However, the issue is so severe it demands a fix.

Finally, the reform that would be the most dramatic in "bending the curve," i.e., reducing the rate of increase in the cost of health care, is moving away from the fee-for-service (FFS) method of reimbursing providers, or principally paying hospitals and doctors for each service they give. That providers respond to the incentives of FFS by providing more expensive forms of health care, more frequently, is strongly suggested by direct and indirect evidence. Examples of this evidence are cited by Shannon Brownlee in her book, *Overtreated, Why Too Much Medicine Is Making Us Sicker and Poorer*.[5] She notes, for example, Medicare annual claims costs per enrollee averaged $8,414 in Miami and $3,341 in Minneapolis in 1996. Yet there is no reason to believe Medicare enrollees were any sicker in Miami than Minneapolis.[6]

Another example cited by Brownlee was the differing rates of tonsillectomies in two Vermont communities in a study in the early 1970s. In Stowe, 7 percent of children under age 16 had their tonsils removed, while the rate was an astonishing 70 percent in nearby Morrisville. These two communities were very homogeneous in their socio-economic and ethnic makeup.

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The increasing availability of high tech equipment, access to specialists, and access to hospital beds also drives up costs without necessarily resulting in more effective care. Ms. Brownlee notes the differing costs incurred by Medicare enrollees during the last two years of their lives. In two different hospitals in California, one group had costs of $104,000 and the other group had costs of $37,000. Not surprisingly, the more expensive hospital had many more specialists on staff and many more hospital beds per thousand Medicare patients served.[7]

Ms. Brownlee goes on to cite the lower cost of systems that currently operate on other-than-a-FFS basis. She cites, in particular, the Veteran's Health Administration (VHA), which in 2002 had claim costs of $2,910 per enrollee, versus $4,576 for the general population.[8]

These examples, while subject to criticism as anecdotal and outdated, are just a few of those cited in Brownlee's book, which is well worth reading.

Another, more recent (12/26/12), article in the *Baltimore Sun* titled, "Over Treatment Common, Study Finds," quoted a source as saying, "one component of the high health care costs is the overuse and misuse of therapies and interventions." It cited, in particular, prostate screening for older men and screening for older women for breast cancer. It did not attribute this overuse to FFS financing of health care, but the implication is clear.

There is clearly a growing consensus that FFS financing of health care is a major factor in driving the cost of health care upwards at rates which can sometimes be multiples of the general rate of inflation in our country. See, for example, an article which appeared in the Oct. 10, 2009, issue of the *Christian Science Monitor,* which gives a good summary of the case against FFS-financed health care.

The Affordable Care Act does take some timid steps away from FFS financing of health care. Most importantly, perhaps, it provides for the creation of Accountable Care Organizations (ACO). Made up of integrated hospitals and doctors, an ACO serves a substantial population. Although ACOs may charge patients for care on an FFS basis, their overall reimbursement will be modified each year by modest positive or negative adjustments, computed as a function of statistics measuring the effectiveness and cost of the health care provided. Whether these adjustments will be large enough to substantially modify the behavior of the providers in the ACO remains to be seen.

I have cited only three reforms to the financing and providing of health care, all of which I believe the actuarial profession should be more assertively advocating. In summary, these reforms are, (1) reform medical malpractice insurance and liability, (2) address the shortage of General Practioners, and (3) move away from FFS reimbursement of providers. Other reforms might be added to the list, such as moving away from employer-financed health insurance, which is currently the main form of health insurance for those not enrolled in Medicare or Medicaid. Employer-

financed health insurance, arguably, removes the incentive for the covered person to make more thoughtful decisions about the cost and effectiveness of the health care he/she is receiving. As you can imagine, there are many combined efforts that could help solve the health care cost problem that we face today.

If you have read this article in full, I hope you will understand why the actuarial profession needs to assume a more assertive leadership role in the public interest. We must pursue these and similar reforms to our health care system, where problems are reaching a crisis level.

END NOTES

1. "Hopes dim as lawmakers return to make a final push for deal," Washington Post, 12/26/12.
2. Medical Malpractice, *Wikipedia*, 12/16/12.
3. "Tackling the Problem of Medical Student Debt," Pauline Chen, *NY Times*, 12/13/12.
4. Ibid.
5. *Overtreated, Why Too Much Medicine Is Making Us Sicker and Poorer,* Shannon Brownlee, Bloomsbury USA, New York, 2007.
6. Ibid, p. 35.
7. Ibid, p. 116.
8. Ibid, p. 270.
9. Accountable Care Organizations, *Wikipedia*, 12/28/12.