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Initiative 18/11: What can we do About the Cost of Health Care?

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For many health actuaries, March 23, 2010, the day the Affordable Care Act (ACA) was signed into law, was a career-changing day. Suddenly, there were regulations to be read, new policies to be written, new pricing methods to be developed and so much more.

In the midst of this activity, however, there was, and still is, an elephant in the room: the cost of health care. Currently, health care in the U.S. represents 18 percent of the gross domestic product (GDP) compared to 11 percent in comparable countries like the United Kingdom. In dollar terms, the cost of health care here is roughly double that of comparable countries. (See Figure 1).

Clearly, this cost level is not affordable and it is not sustainable. But, what can we as a nation do about it? What is the role of actuaries in solving the problem?

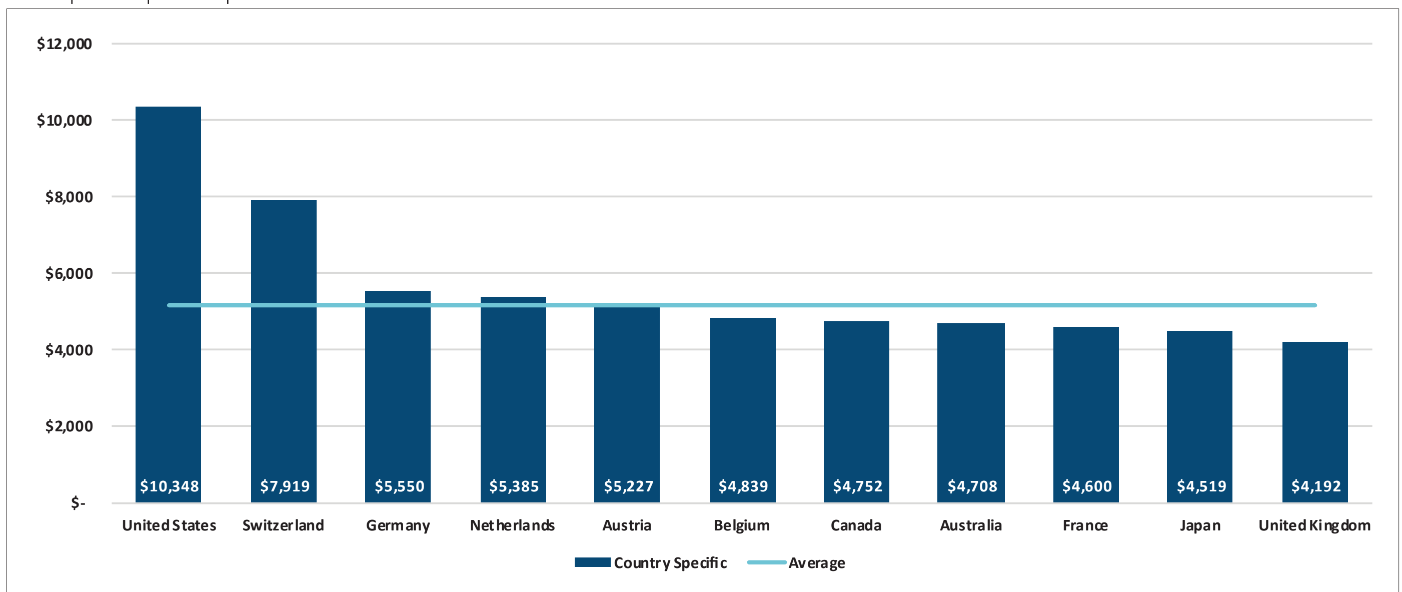
ABOUT INITIATIVE 18/11: WHAT CAN WE DO ABOUT THE COST OF HEALTH CARE?

Last year, the Society of Actuaries (SOA) joined forces with the Kaiser Family Foundation to charter Initiative 18/11: What Can We Do About the Cost of Health Care? The Kaiser Family Foundation is a nonpartisan source of analysis of current health policy issues, with a longstanding interest in how health spending growth affects government, employers and consumers. The phrase "18/11" is a reference to the relative percentages of GDP discussed previously.

The purpose of this initiative is threefold:

- Identify the key drivers of the cost of care in the U.S.
- Identify actionable steps that can be taken to reduce the cost of care without compromising quality
- Break down the silos between the actuarial profession and other professions to facilitate the process of addressing these issues

Figure 1
2016 per Capita Expenditures



Source: Sawyer, Bradley, and Cynthia Cox. How Does Health Spending in the U.S. Compare to Other Countries? Peterson-Kaiser Health System Tracker. *Healthsystemtracker.org*, Feb. 13, 2018, *https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/?_sf_s=compare#item-average-wealthy-countries-spend-half-much-per-person-health-u-s-spends* (accessed Aug. 2, 2018).

The emphasis in the first phase of this initiative was to begin the process of breaking down barriers and to identify the key issues that may be causing the cost of care to be so high. This phase is complete. The second phase, developing and implementing an action plan to meet our goals, is still in progress.

The team leading this initiative includes Brian Pauley, Joan Barrett and Joe Wurzburger from the SOA and Larry Levitt, Gary Claxton and Cynthia Cox from the Kaiser Family Foundation. Of course, the Health Section Council is providing valuable support, especially the leadership team of Sarah Osborne, Karen Shelton and Jackie Lee.

PHASE 1: IDENTIFYING THE ISSUES AND POTENTIAL SOLUTIONS

The inaugural event for Initiative 18/11 occurred on March 7, 2018, in Washington, D.C., at an all-day event moderated by Ian Morrison. Ian is an internationally known author, consultant and futurist specializing in long-term forecasting and planning with an emphasis on health care and the changing business environment. The attendees at this meeting included 30 thought leaders throughout the health care community, including actuaries, health economists, employee benefits experts and hospital administrators. Of course, representatives from the American Academy of Actuaries (AAA) were an integral part of the event and will be an integral part of the ongoing efforts. The conversation focused on identifying cost drivers, potential solutions and emerging issues.

Cost Drivers

Although there are several factors impacting the cost of care, including new technologies and aging, several key studies have posited that price is one of the major drivers of costs. In the conference, many participants referenced the term "health care identity." The term "health care identity" refers to the notion that health care costs = health care income. In other words, any attempt to reduce costs will result in lower income, so providers and administrators can be expected to develop countermeasures to keep income constant or increasing. The traditional laws of supply and demand do not necessarily hold in health care, so we quickly concluded that we cannot control costs without some type of forcing function. The group used analogies like trying to keep a "balloon in a box" or cutting off the spigot of water going into a funnel to describe forcing functions. Examples of forcing functions used in other countries include global budgets and price regulation. It is unlikely that the U.S. will adopt these types of methods on a national basis in the near future.

Chronic disease and consumerism were also a focus of many of the conversations. Consumers impact the cost of health care in two important ways: the management of personal risk factors and the demand for services. Although the demand for services often receives the most attention, the management of risk factors is key to managing chronic diseases. According to the Centers for Disease Control and Prevention (CDC), 86 percent of all costs are attributable to chronic diseases like hypertension, diabetes and cancer.[1] For many chronic diseases, the major risk factors include smoking and obesity, both of which are influenced by consumer behavior. Health actuaries will be key to determining the best ways to influence consumers in terms of incentives, population health and other techniques.

Finally, several studies have pointed to potential savings by simplifying and improving administrative processes with an emphasis on reducing fraud. Two potential obstacles to these efforts are the lack of consistency in data systems and duplicative and/or ineffective regulation.

Potential Solutions

As noted earlier, with all the current emphasis still on the ACA, it is unlikely that there will be any type of coordinated national effort to reduce the cost of health care in the near future. That said, there are many smaller efforts underway that may have a significant impact.

Currently, value-based reimbursement methodologies are a major focus of attention. Under a value-based reimbursement

methodology, provider reimbursement depends on meeting specified quality and efficiency; there is a possibility these methodologies will serve as the forcing functions described earlier.

Direct care models are expected to evolve rapidly over the next few years, as new technologies, data sources and analytical tools become available. We can expect each effort to claim significant savings. That said, undoubtedly, there will be significant overlap between these activities, which will make it difficult to measure the overall impact on the cost of care and to prioritize activities. New evaluation methods will be needed to measure this impact.

Third-party players, like public health organizations, nongovernmental organizations, disease management programs and employer wellness programs, have always played an important role in health care delivery by supplementing direct care. In many cases, solutions to the health care issues depend on local conditions like the availability of providers and adequate social support, such as housing. The CMS Innovation Center and several states are actively seeking innovative state and local solutions focused not only on costs but also on meeting the needs of individuals. While many of these efforts have been successful, there has been no overall evaluation of the results at this point.

Although we tend to think of health care in broad terms, at the end of the day, health care is personal. Every individual's needs are determined by his or her own genetic make-up, risk factors and health status. An important part of finding a solution to the health care cost problem will be understanding various subgroups of the population with an emphasis on understanding the needs and possible solutions for that group. The group was particularly interested in the 5 percent of the population that causes 50 percent of the health care costs since that group would provide the opportunity for targeted interventions.

Emerging Issues

Perhaps the emerging issue that is receiving the most attention right now has to do with the health care workforce structure. The proportion of physicians in the U.S. is lower than in comparable countries. In addition, over 23 percent of all active physicians are over age 65. One potential solution to this issue is to promote the growth of professionals who can practice at a lower level of licensure, like physician assistants. To be effective, however, this strategy will need to ensure that services performed are substitutions for more expensive providers and not in addition to.

These issues will be discussed in more detail in the conference report, which can be found under the resources tab at *www.soa.org/health*.

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PHASE 2: TAKING ACTION

The first step in determining an action plan is to take stock of the tools the SOA and the Kaiser Family Foundation have available, which include:

- **Research projects.** The 18/11 leadership committee is exploring the possibility of research projects funded by the SOA alone or with other partners.
- **Health Section Council strategic initiatives.** The Health Section Council often sponsors volunteer efforts to examine specified issues in-depth, such as the recent report on the role of the actuary in self-insurance. The Health Section Council is considering several possible 18/11-related initiatives.
- **Health Section Council subgroups.** Currently the Health Section Council sponsors subgroups tasked with facilitating targeted continuing education and fostering ongoing education among interested parties. These subgroups present opportunities to address Initiative 18/11 issues through webinars and articles.
- **The American Academy of Actuaries.** The American Academy of Actuaries addresses cost-of-care issues through such activities as issue briefs, Capitol Hill visits, and letters to policymakers.
- **Joint research and continuing education efforts.** There is now an opportunity for joint ventures with other organizations like the Kaiser Family Foundation and the Healthcare Financial Management Association.

The 18/11 leadership team has determined priorities in consultation with the Health Section Council using the following criteria:

- Will the proposed priority help us understand the drivers of health care cost and potential solutions?
- Is the proposed priority data-driven and/or analytical in nature?

- Will the proposed priority advance the profession by:
  - Ensuring that the voice of the actuary is heard outside our traditional venues?
  - Helping us identify and develop the data and analytical techniques we need to do our work?

The agreed-upon priorities include:

- **5/50 Research Project.** An SOA-sponsored research project focusing on the 5 percent of the population that causes 50 percent of health care costs.
- **Pharmacy Strategic Initiative.** The purpose of this Health Section Council Strategic Initiative is to document the pharmacy development and pricing process in order to increase its transparency.
- **Managed Care 3.0 Strategic Initiative.** This initiative, also sponsored by the Health Section Council, will examine anticipated changes in the clinical landscape due to increased utilization of predictive analytics and new technologies.

We invite you to participate in Initiative 18/11 by providing comments, asking questions or volunteering to help out. Just send a note to Brian Pauley at *brian.pauley@highmark.com*, Joan Barrett at *joan.barrett@axenehp.com* or Joe Wurzburger at *jwurzburger@soa.com*. ■

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ENDNOTE

1 Gerteis, Jessie, David Izrael, Deborah Deitz, Lisa LeRoy, Richard Ricciardi, Therese Miller, and Jayasree Basu. 2014. *Multiple Chronic Conditions Chartbook: 2010 Medical Expenditure Panel Survey Data*, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, Pub. No. 14-0038. *https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf* (accessed August 17, 2018).