The Future Of Health Care In The United States

by Thomas Persichetti

The vision for a U.S. health care system that is financially sound, broadly accessible and operationally efficient begins by asking the following questions:

- Is health insurance real insurance, and if so, what is the appropriate role of insurance companies within the health care system?
- Is there a more efficient and economical way to care for chronic illnesses?
- Is there a maximum price society is willing to pay to support the ongoing life of any one individual?

Is Health Insurance Real Insurance?

The conditions that make a risk insurable are:

1. The insured is subject to losses that are definite and random in nature.
2. The group of insureds must be homogeneous and subject to the same loss events.
3. The cost of insuring the loss must be economically feasible.
4. Losses must be unlikely to affect all insured simultaneously.
5. Losses must have a potential to be financially serious.[1]

Most acute illnesses—sudden onset of illness, broken bones, myocardial infarction, etc.—certainly meet all of the above conditions of insurability. However, an argument could be made that individuals with chronic diseases such as diabetes, cystic fibrosis and morbid obesity fail the first condition of insurability. Losses associated with these individuals are definite; however, they are random only in the magnitude of the expected losses, not in the chance that loss occurs.

The question should be asked: is it possible to restrict the role of health insurance to only those individuals that meet the definition of an insurable risk?

Is There A More Efficient And Economical Way To Care For Chronic Illness?

If you attend any seminar regarding the cost of health care in the United States, you are likely to see a slide in the presentation that claims that individuals with chronic illness account for around 75 percent of all health care spending. Current health care expenditures are approximately $2.6 trillion, which, in case you have never seen it before, looks like this: $2,600,000,000,000. This implies that spending for chronic conditions is approximately $1.95 trillion. The management of these conditions represents the greatest opportunity for improved efficiency, cost and outcomes in the system.

The current U.S. population is approximately 305 million. It is estimated that 45 percent (about 137 million) of all Americans have one or more chronic conditions. Therefore, the cost per person is about $14,200 for those with chronic conditions, $3,900 for those without chronic conditions, and about $8,500 for the group as a whole. Please note that these figures are understated on the per capita basis because not all Americans are covered under one of the various forms of insurance.

As noted earlier, individuals with chronic conditions generally fail the first condition of insurability listed above. Currently, insurers implement disease management and care management programs to manage the costs of the chronically ill. There is some evidence that these programs reduce cost and improve outcomes. However, I have not seen a study that definitively supports their effectiveness in making a meaningful impact to cost or quality of care. A new solution is needed to improve the efficiency of caring for the chronically ill.

One possible solution is to establish a national high risk pool and enroll everyone with one or more chronic conditions in it. By pooling the chronically ill, the health care system would:

- Lower the average cost for the general insurance pool by removing the substandard risk.
- Enable the design of a benefits plan that is tailored to the needs of this population.
- Provide a centralized data source for:
  - establishing best practices in coordinating care for the chronically ill.
  - health economists, epidemiologists, and actuaries to perform meaningful studies on this population.
- Gain considerable leverage in implementing reimbursement arrangements with the medical providers and pharmaceutical companies that reward efficiency and quality of care.

The risk pool would be made up of the high risk individuals from all segments of the current health care spectrum. Individuals currently enrolled in Medicare, Medicaid, the individual and group markets and the uninsured would all be represented in this new pool. A tentative outline of the financing of the high risk pool would be:

- Medicare enrollees would pay no more than the current cost of Medicare Parts B and D, with a possible adjustment on a means basis.
- Medicaid enrollees would pay nothing.
- Individual market members would pay 150 percent of the prevailing market rate, adjusted on a means basis.
- Group plan sponsors would contribute 150 percent of their average premium rates, but would still be able to collect employee contributions.
- The remainder of the plans' funds will be supported by the general revenues of the federal government and state revenues.

So How Does This Save Money?

The goal of the program would be to ultimately reduce the costs of care for the chronically ill by one-third. To achieve this, the high risk pool administrators will need to determine the most efficient practice guidelines for treating the chronically ill. This will require a reduction in unnecessary services and an adjustment to provider reimbursement rates. This plan will likely elicit a negative response from patient advocate groups, the medical provider community and the pharmaceutical industry. Proponents of the free market system will find the financing and structure of this proposal in contrast to their views.

Who Is The High Risk Pool Administrator?

The obvious choice would be the administrator for Medicare, CMS, who currently administers benefits to a significant portion of the chronically ill. A case could also be made for the selection of a private administrator with the possibility to reap financial rewards if program objectives are met.

The question should be asked, will a high risk pool provide a more effective and economical way to care for chronic illness?

Is There A Maximum Price Society Is Willing To Pay To Support The Ongoing Life Of Any One Individual?

There seems to be a considerable reluctance to deal with this question in American society. It is a difficult question, one that requires us to apply rational principles to an issue that is laden with humanitarian concerns. It surely will elicit a passionate debate. However, if we carefully study the economics of health care and its impact on the American economy as a whole, we would come up with a dollar figure for which it is no longer economically feasible to support health care for any one individual, particularly if the funds required to do so are public funds.

American society's willingness to consume unlimited resources under the purview of, "if it saves at least one life it is worth it," is a fiscally irresponsible mantra. Society needs to consider the amount of medical resources it is willing to provide on behalf of individuals in relation to the overall economic output of the average individual. At this unsustainable rate of spending, we will get to a point at which the present value of future benefits will exceed the present value of economic output for the average American.

Most of the technological advances in the medical and pharmaceutical sciences are geared towards treating chronic and terminally ill patients. While modern advancements in technology are typically more successful than the treatments they are replacing, the additional cost associated with these procedures may outweigh their benefit. Because the elderly are much more likely to consume these technological advancements, society as a whole is increasing funding for a population that is no longer adding to the economic growth of the nation. The wage base to support this increased funding could eventually grow to a point where American products and services—due to increased cost of production—would be uncompetitive in the global economy.

I am the first to admit I do not have a solution to this issue, but I am offering insight into a serious problem that, if dealt with sooner than later, will help navigate the health care system towards a more sustainable pattern.

Conclusion

The current housing/subprime lending/credit crisis had warning signs that should have been identified early. The failure of those in the financial and risk communities—including some in the actuarial community—to aggressively pursue changes in lending practices and derivative pricing contributed to the current economic recession.

If spending on health care continues unchecked, it will lead to a similar crisis. This time losses will impact not only financial assets, but human lives as well. I believe that the proposed high risk pool is a sensible solution to lower the aggregate cost of care for all, while improving the quality of care for the chronically ill. The high risk pool is not intended to replace the insurance markets as they exist today; a primary market for insurance could still operate in a competitive environment that would spur innovation and real insurance for the nonchronically ill.

Thomas Persichetti, ASA, MAAA, is a consulting actuary in Arlington, Virginia. He can be reached at tom.persichetti@persichettillc.com.

[1] *Based on definitions from various sources, especially Introduction to Ratemaking and Loss Reserving for Property and Casualty Insurance, by R.L. Brown and L.R. Gotlieb.*