SOCIETY OF ACTUARIES

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COST CONTROL/ EFFICIENCY

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5. **Price and Quality Transparency**
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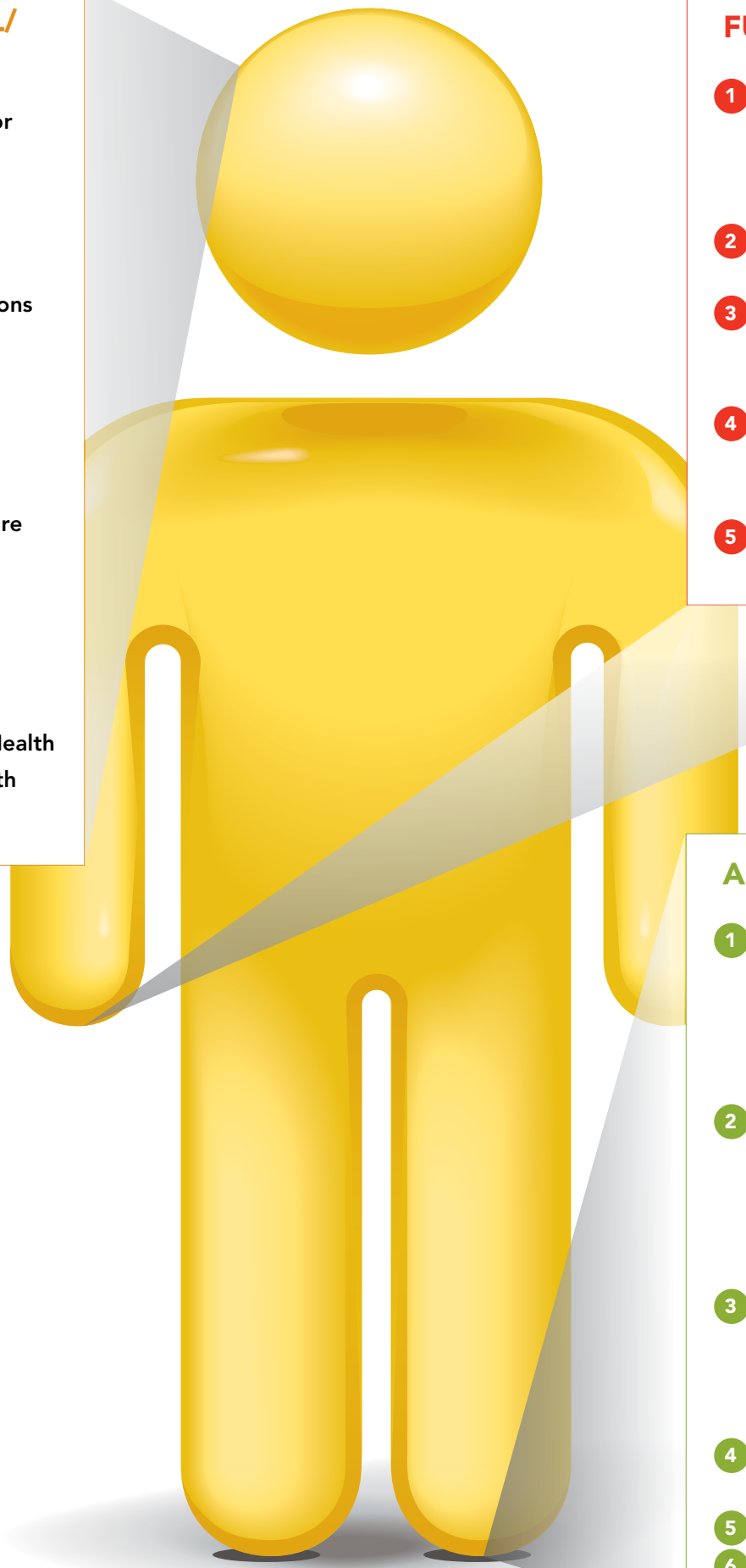
7. **Cost Shifting and Uncompensated Care**
8. **Health Information Technology**
9. **Accountable Care Organizations and Networks**
10. **Improve Personal Health**
11. **Role of Public Health**



FUNDING/FINANCING

1. **Role of:**
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   - other safety nets
2. **Paying for Coverage for the Currently Uninsured**
3. **Taxation**
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ACCESS TO CARE

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OVERVIEW

Responsible HEALTH CARE REFORM

BY MAC MCCARTHY AND MICHELLE RALEIGH

This article is the FIRST IN A FOUR-PART SERIES about what actuaries see as ideal components of a health care reform package.

An interesting thing happened last November at the Conference of Consulting Actuaries' (CCA) Annual Meeting in Tucson, Ariz. A diverse group of actuaries, approximately 40 in number and mostly from the health care discipline, gathered in a room for one hour and 15 minutes to discuss health care reform. That, in and of itself, would not be unusual given that practically everybody in the United States seems to be engaged in the debate over what they like, and dislike, about the various reform proposals coming out of Washington.

What was different at this workshop, besides the fact that the participants were uniquely qualified to address health care issues, was that the purpose was not to argue over the merits of a particular bill[1] in the House or Senate. Rather, the purpose was to allow ideas to be shared about what actuaries see as ideal components to be included in any reform package. The participants were asked to build a reform package from an actuarial perspective, starting with a clean slate and suggesting ideas for fixing what most agree is a flawed system.

Of course, there was no way such a monumental task could be confined to a mere 75 minutes, so we took notes and carried the discussion over to the CCA's Health Reform Taskforce (HRT), which has been meeting by conference call on a weekly basis. This

FOOTNOTES:

[1] As of the date of the workshop, the House of Representatives had just passed America's Affordable Health Choices Act, and Senate leadership was still struggling to merge the HELP committee bill and the Finance Committee bill.

article will attempt to summarize, at a high level, the meeting results; look for future articles here in the next few issues of *The Actuary*, providing more substantive detail on health care reform suggestions from an actuarial perspective. Where we state or imply preferences or conclusions, please note that these are the personal opinions of the authors, not a consensus of the meeting attendees, nor a position of the CCA, the SOA or any other organization.

TUCSON HEALTH CARE REFORM WORKSHOP

No vote was taken, but we believe there was universal agreement that the U.S. health care system is not delivering the value it should for the price being paid, and that there is significant potential for improvement. On almost everything else, though, the ideas covered a wide range of options and much debate ensued.

The group quickly divided the issues into three categories: Access to Care; Cost Control/Efficiency; and Finance/Funding. Subsequent articles (in future issues of *The Actuary*) will delve into each of these areas separately; what follows here are preliminary thoughts from the meeting in Tucson.

ACCESS TO CARE

Some actuaries felt that a public plan of some sort is necessary to ensure humane care for those not eligible for private coverage, unable to afford it, or who have simply made poor choices. Others expressed concern that a public plan that competes with private plans will lead to adverse selection, but it was not clear which plan would get the bad risks. Either way, a public plan could introduce inefficiencies in the market that would lead to unnecessary added costs, which will be paid by the working public either through higher taxes or higher premiums.

Possible ways to provide a public plan that avoids these concerns include expansion of the current Medicaid program or enhancing (or emulating) the Veterans' Administration system to provide care to the uninsured through a system of public hospitals and community care clinics.

The concept of subsidies for low income Americans to purchase private insurance was discussed, but there was much concern over the ability to adequately set premiums and over unintended consequences of government requirements for plan design that are usually associated with such proposals.

In addition, the group discussed the access to care issues that exist now and are projected to get worse in certain provider sectors, especially primary care physicians. This shortage is contributing to the long existing issue of the public using the emergency room for nonemergency reasons. The group discussed the benefits of retail clinics and urgent care centers and the need to have after-hours access to such facilities.

One recommendation for dealing with this was to initiate a system where the government stipulates, and funds, a standard minimum package of benefits, to be provided by private carriers. Insurance carriers would administer the benefits and be free to enrich the standard package and to set their final premium rates. Each individual would select the plan best for him or her on the basis of benefits, premium rates and provider network. This could operate much like the current Medicare Advantage program.

COST CONTROL/EFFICIENCY

It was generally agreed that any reform effort must include, as core elements, measures that have a reasonable expectation to lower health care costs.

The opportunities for eliminating waste in the system seem to be many and varied. These include:

- Reducing medical errors, through initiation of, and adherence to, data-backed clinical guidelines;
- Reduction in the number of unnecessary and possibly harmful tests and procedures through tort reform, coupled with elimination of perverse financial incentives in the current payment system;
- Greater efforts to weed out fraud and abuse;
- Changing the way providers are reimbursed so focus is placed on improving the health of the patient;
- Public health initiatives to address the burgeoning incidence of obesity and inactivity, and other societal/cultural issues that contribute to health costs;
- Greater transparency of provider prices and, most especially, quality measures; and
- Increasing personal responsibility for unhealthy behavior and unnecessary use of medical resources through plan design and education.

... ACTUARIES HAVE THE PERSPECTIVE AND TOOLS TO MAKE A POSITIVE DIFFERENCE. ...

Health information technology and electronic medical records were offered as keys to provide the necessary data to develop, monitor and refine the above initiatives.

Additionally, the group discussed how increasing access to care by providing insurance would reduce the number of Americans that are uninsured and, therefore, decrease the country's uncompensated care. This will reduce the need of the providers to cost shift where traditionally the enrollees who purchased private insurance pay more to cover the provider expenses not covered by those in public programs.

FUNDING/FINANCING

There was agreement on one other concept: financial constraints dictate what we can and cannot afford to do. Many in the room were of the opinion that cost control initiatives should be given first priority and only as savings from these are realized does expanded access for the uninsured become economically feasible. Others felt that some expansion should take place in the first phase, but generally agreed that the government should not require rich and unlimited benefits to all individuals. Opinion was divided as to whether priority should be given to a safety net in the form of high deductible insurance to protect families from bankruptcy, or to an aggressive, preventive maintenance program to head off avoidable illness.

Regardless of the priorities and scope of a reform initiative, the group was realistic in expecting that there would likely be significant additional costs that must be funded from outside the health care system. Taxing health insurance, or certain health care components, may support certain policy objectives, but will result in increases in the overall cost of health care, frustrating efforts to lower it. There were advocates for taxing unhealthy foods (for example: those with high fat and sugar content or with low nutritional value), which would promote healthier diets. While these may be appropriate goals, such taxes are likely to be insufficient and difficult to administer, not to mention somewhat regressive with regard to income. Some form of broad based tax option will probably be necessary, either income/payroll based, like Social Security, or a general tax on goods or services.

CONCLUSION

Sometimes it seems that there are as many actuarial opinions as there are actuaries in the room. The session was successful in that we were able to openly share ideas and work through alternatives. Intelligent discourse on difficult topics by knowledgeable individuals is the key to finding solutions that work and are sustainable. We are sure that many were exposed to sides of the issue that had not previously occurred to them. Some opinions were altered if not reversed; others felt vindicated that they are not alone in their positions.

The next step is to use this new knowledge or validation to become proactive in helping legislators, businesses and health care providers find ways to improve the health status of our fellow Americans. Whatever your position, actuaries have the perspective and tools to make a positive difference, but we must speak out not only as a group, but also as individuals. Bear in mind that health care reform will not end if and when Congress passes a bill—the health care system is the best candidate for continuous quality improvement that can be imagined.

Note once again that this article was written from the authors' perspectives. Others in attendance may have perceived the discussions differently. We invite those actuaries to share those views with us so they can be incorporated into the dialogue.

Future articles in this series will separately address access, cost control and financing in greater detail, taking into account HRT discussions and feedback from this article. We encourage readers to share their thoughts on these three major themes, or other health care reform related ideas, and we will attempt to incorporate them into the upcoming articles in the next three issues of *The Actuary*. Please send your comments and suggestions to Sara Teppema, staff fellow for Health at the SOA at *steppema@soa.org*. A

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