Session 34PD, Initiative 18/11: What Can We Do About the Cost of Health Care?

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Presenters:
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SOA Antitrust Disclaimer
SOA Presentation Disclaimer
What Can We Do About the Cost of Health Care?
Initiative 18 | 11

- The story of Initiative 18|11
  - What can we do about the cost of health care?
- The Path
- Funding
- Contributors
- Inaugural event on March 7, 2018
- Next steps
About Kaiser Family Foundation
Larry Levitt
About the Kaiser Family Foundation

What we are not:

  Connected with Kaiser Permanente
  A foundation

What we are:

  A health information organization that analyzes policy issues, tracks public opinion through polling, and informs the public through journalism
Poll: Partisan Voters' Views on President Trump Outweigh the Issues, Including Health Care

Interactive: Who are the Health Care Voters?
Read the News Release

Analysis: Short-Term Health Plans Have Significant Gaps in Coverage for Essential Benefits
Related: Insurance Options that Don't Comply with ACA Rules
Sticker Shock Jolts Oklahoma Patient: $15,076 For Four Tiny Screws

By Liz Szabo • 5:00 AM EDT

A woman with foot pain was floored by the high cost of titanium screws used in her surgery. "Unless the metal [was] mined on an asteroid, I do not know why it should cost that amount," she says.

MORE FROM OUR SERIES: For Toenail Fungus, A $1,500 Prescription
A College Student's $17,000 Urine Test

First, Marijuana. Are Magic Mushrooms Next?

By Barbara Feder Ostrov

Trump Vows (Again) To Lower Drug Prices But Skeptics Doubt Much Will Change

Why Did Novartis Pay Trump's Lawyer $1.2 Million? Look At Its Drug Prices

Consumers Brace For Premium Hikes While Lawmakers Grasp At Remedies

Apart From A Few 'Sacrificial Lambs,' Pharma Emerges From Trump's Speech Largely Unscathed

Scientists Looking To Better Orchestrate Those Happy Accidents That Lead To Groundbreaking Drugs

In Politically Charged Year, Democrats Talk Up Expanded Government Role In Health Care

State Requests For Medicaid Work Requirement Seem Like A Sure Bet. But CMS Says 'Not So Fast' To Some.

Vermont's Successful Experiment To Lower Health Costs Closely Watched By Other States, Experts

Number Of Women Who Die In Childbirth Just 'Tip Of Iceberg' When It Comes To America's Maternal Crisis
Webcast: Why are Healthcare Prices So High, and What can be Done about Them?

WATCH THE WEBCAST

Why are Healthcare Prices So High, and What can be Done about Them?

May 9th Event

Nearly a fifth of the United States’ economy goes to healthcare spending - a far larger share than in any other large, wealthy country in the world. Research suggests that price, rather than the volume of services, is the main driver of this disparity, and price is also a primary factor in pushing up the [...]
Potential upcoming policy debates and opportunities for influence

- Drug pricing
- All-payer rate setting
- Price transparency
- Single payer/Medicare for All
- Opioids
Inpatient hospital prices grew faster for private insurance than for Medicare/Medicaid

Average inflation-adjusted, standardized payment rates per inpatient hospital stay, by primary payer

Source: Thomas M. Selden analysis of AHRQ's Medical Expenditure Panel Survey for the Kaiser Family Foundation.
Key Facts

Joan Barrett
Per Capita Expenditures

Comments:
• The 2016 per capita expenditures in the U.S. is $10,348, roughly twice that of comparable countries.
• This translates to 18% of GDP for the United States compared to 11% for comparable countries.

## Healthcare Systems Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Applications</th>
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</table>
| Bismarck Model      | • Private Initiatives/companies  
• Non-Profit only  
• No pre-existing conditions  
• Government cost-control | • Germany and Japan  
• U.S. commercial, except for non-profit requirement and government cost control |
| Beveridge Model     | • Government is single-payer  
• Most doctors are government employees | • United Kingdom  
• U.S.: Native Americans, military personnel and veterans             |
| National Health Insurance | • Government is single-payer  
• Providers are private entities | • Canada  
• U.S. Medicare          |
| Out-of-Pocket       | • Most services paid out of pocket  
• Some core services may be available | • India, most poor countries  
• U.S. uninsured           |


**Comments:**
- Micro-insurance and non-government organizations play a key role in out-of-pocket countries like India and many African countries.
Price Comparisons

Comments:

• Cost control strategies
  • U.K.: Global budget, but running at a deficit
  • Spain: a conglomeration of health centers, mostly salaried physicians
  • Switzerland: private and public funding of hospitals. New cost cutting proposals include reducing mandatory benefits, revision of current fee schedules, further concentration of specialized care to reduce duplication
Health Care System Performance Rankings

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<th>AUS</th>
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<th>FRA</th>
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<td>4</td>
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<td>Care Process</td>
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<td>Administrative Efficiency</td>
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<td>Health Outcomes</td>
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Comments:
- The U.S. ranks in the middle on Care Process with stronger performance on the subdomains of prevention, safety and engagement.
- The U.S. tends to excel on measures that involve the doctor-patient relationship including wellness counseling, chronic disease management and end-of-life discussions.
- The U.S. performs poorly on coordination measures like information flows between PCPs and specialists and social service providers.
Risk Factors

Comments
• The U.S. tends to be younger than comparable countries and has fewer smokers.
• The obesity rate, however, is 88% higher than in other countries.

Source: https://www.healthsystemtracker.org/chart-collection/compare-social-determinants-health-u-s-comparable-countries/?_sft_category=health-well-being#item-though-u-s-population-aging-younger-average-age-smaller-elderly-population-comparable-countries
Relative Resources

Comments
- The U.S. has fewer hospitals and physicians than comparable countries.
- The U.S. has more MRI machines and does more diagnostic tests than comparable countries.

National Expenditures by Source of Funds

Comments

• Total spending in the U.S. in 2016 was approximately $3.3 trillion or 18% of GDP.
  • In 2016 dollars, a 1.0% change in expenditures translates to $33 billion and a 0.1% change translates to $3 billion.
• There has been a significant decrease in out-of-pocket spending since 1990 offset by increases in private health insurance, Medicare and Medicaid spending.
• Additional explanatory comments on note page.

Chronic Disease Overview

Comments

• Chronic diseases are those that are expected to last at least 3 months. For adults, the most prevalent conditions are uncontrolled hypertension (high blood pressure) and hyperlipidemia (high cholesterol and high triglycerides). For children the most common conditions are asthma and allergies.

• 86% of healthcare spending is for patients with one or more chronic conditions; 71% of spending is for patients with more than one chronic condition.

Source

• https://www.cdc.gov/nchs/data/hus/hus16.pdf#053
Comments

- The top 5% of all patients account for 50% of the costs.
- From 2013 to 2015, less than 40% of the top 5% spenders were in the top 5% in the previous years.
- About 25% of all traditional Medicare spending is for patients in the last year of life and this proportion has held for many years.
What Can We Do About It?

1. The health care identity: Global budgets/price controls
2. Pricing and transparency
3. Consumerism and chronic disease
4. Care transformation models/Managed care 3.0
5. Administrative simplicity and effectiveness: Fraud, systems compatibilities
6. Work force structure: More emphasis on lower licensure levels
7. Local and state solutions
8. Sub-populations, disparities, income levels, etc.
9. Access and financing
10. Key cost drivers: An academic study of the drivers
Our Toolkit

• **The SOA**
  • Funded Research
  • Health Section Council strategic initiatives
  • Open Health Section Council Sub-groups
  • Continuing/basic education

• **The Academy**
  • Issue briefs
  • Hill visits
  • Letters to policymakers

• **Initiative 18/11**
  • Joint sponsorships with other organizations: Research, webinars, etc.
Key Challenges to the Profession

• What skills do we need to build or enhance?

• What can we do to build our knowledge base?

• How can we make sure the voice of the actuary is heard?
Your Input

• Question/comments today

• Coming soon to the resources tab of the Health Section website: soa.org/health

• Email joan.barrett@axenehp.com or jwurzburger@soa.org

• Join us for further conversation on the dedicated Initiative 18/11 Channel in the SOA Event App
Recap: Questions and Comments

What can we do about the cost of health care?

1. The health care identity: Global budgets/price controls
2. Pricing and transparency
3. Consumerism and chronic disease
4. Care transformation models/Managed care 3.0
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Challenges to the profession

- What skills do we need to build or enhance?
- What can we do to build our knowledge base?
- How can we make sure the voice of the actuary is heard?

Our toolkit

- The SOA
  - Funded Research
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- The Academy
  - Issue briefs, Hill visits, letters to policymakers
- Initiative 18/11
  - Joint sponsorships with other organizations: Research, webinars, etc.
Poll: What are the three top priorities for the cost of health care?
What are the three top priorities for the cost of health care?

- The health care identity: Global
- Pricing and transparency
- Consumerism and chronic disease
- Care transformation...
- Administrative simplicity and...
- Work force structure More emphasis...
- Local and state solutions
- Sub-populations, disparities, income...
- Access and financing
- Key cost drivers An academic study...

- 81%
- 60%
- 33%
- 20%
- 14%
- 11%
- 9%
- 14%
- 27%
- 22%
Poll: What are the three least important priorities for the cost of health care?
What are the three least important priorities for the cost of health care?

- The health care identity Global...: 10%
- Pricing and transparency: 3%
- Consumerism and chronic disease: 5%
- Care transformation: 35%
- Administrative simplicity and...: 47%
- Workforce structure More...: 54%
- Local and state solutions: 46%
- Sub-populations, disparities...: 26%
- Access and financing: 19%
- Key cost drivers An academic...: 42%
Poll: What else should be considered when reviewing the cost of health care?
Provider shortages
VBC
Lifestyle influences
Quality
Public health connection, innovation, collaboration with all aspects of the system
How nutrition studies and education can influence American health spend.
Incentive structures
Quality
Political impediments
Hospital finances
Cost of educating medical professionals
Virtual doctors
Life style and culture
Better health: prevention
End of life care
Quality
Malpractice reform
Public readiness
Market competition
Cost incentive
Value based outcomes
Payer provider relationship
Multiple diagnoses/complexity of each case
Legal environment
Healthcare is set up as a monopoly
Quality
Accountability at the personal level (for example, taking care of ourselves)
Individual involvement

Medical Tourism
customer attitudes about their health
Quality of care
Trends in health/ disease
Profit expectations of all supply chain items
EMS
Premiums
Value based outcomes
Provider training
Doctor immigration
Cost of Medical School and Nurse training
For profit companies all trying to make money off of healthcare
Primary care accounts for 1/3 of physicians in the US, as opposed to 2/3 in other countries
Supply - incentivize med school
Employment costs
Competition

Limited FDA regulations regarding alternative medicine. Overall life quality. Diverse population in the US, majority of all races and backgrounds are represented in the USA with unique challenges. Overall lifestyle changes-cutting processed food, lowering plastic use, reducing stress, increasing knowledge, etc. Expecting short term results when long term view is needed.
Investment in public health/social determinants
waste on healthcare that has not proven efficacy
Reducing obesity
The affect of capitalism a
Gaming the system
Technology
Preventive health incentives
Patient’s rights/privacy
<table>
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<tr>
<th>Topic</th>
<th>Details</th>
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<tr>
<td>Personal responsibility versus public policy</td>
<td>Lack of political will&lt;br&gt;Oversight on drug company pricing&lt;br&gt;The ever increasing cost issue&lt;br&gt;Quality&lt;br&gt;Access for lower income demographics&lt;br&gt;What is driving chronic conditions like inflammation/obesity (our food source, preservatives, etc)&lt;br&gt;Diabetes should become the public enemy that smoking once was&lt;br&gt;Sugar consumption&lt;br&gt;Quality&lt;br&gt;Private monopoly&lt;br&gt;30/11&lt;br&gt;Provider cooperation&lt;br&gt;Cost of doctors virtually&lt;br&gt;Demographic impact on trend&lt;br&gt;Politics&lt;br&gt;Low cost unhealthy food, high cost healthy foods&lt;br&gt;Ice cream prices&lt;br&gt;Quality&lt;br&gt;Health Education for the Public&lt;br&gt;What unpopular things will have to be implemented?&lt;br&gt;Quality&lt;br&gt;Access to preventative care for lower income&lt;br&gt;Attractiveness of becoming a PCP vs. a specialist&lt;br&gt;Diet&lt;br&gt;Member/public education&lt;br&gt;Market Competition&lt;br&gt;End of life&lt;br&gt;Health outcomes&lt;br&gt;Need more Public Health campaigns&lt;br&gt;Incentives for payers and providers to keep cost of care high&lt;br&gt;End of life spending&lt;br&gt;Consumerism doesn't work when you can't control what tests, procedures, etc that your doctor orders.&lt;br&gt;Increasing costs associated with technological advancements</td>
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