



SPEAKERS' CORNER

HEALTH CARE REFORM is near the top of President Barack Obama's burgeoning to-do list. Clearly, change is needed in an ailing and creaky system whose many weaknesses have been exacerbated by the recent economic downturn.

Ideas about how best to achieve that reform abound, particularly (and this should come as no surprise) in the actuarial community. In the November/December issue of *Contingencies*, health actuary Dennis Barry offered his prescription for reform, "Tough Medicine: Apportioning the True Cost of Health Care." In this issue, two more health actuaries have stepped forward with their own proposals. While not strictly point-counterpoint, Tony Batory and Hobson Carroll each offer an informed analysis of the issue that reflects their professional expertise as working health actuaries.

They also display the independent thinking that actuaries are capable of bringing to this (and any other) debate. Health care reform is certainly not the only issue that is subject to differing opinions within the profession (pension reform comes to mind). While they may come to different conclusions, however, all actuaries at least start from the same premise: An issue is best resolved by factual analysis that's unencumbered by emotion or political fashion.

It's in that spirit that *Contingencies* continues to open its pages to the thoughtful commentary of its readers. We invite your thoughts and welcome the opportunity to give them a wider forum for discussion. Your analysis may be contrarian, controversial, or both. But as long as it's well-reasoned and shines a light on a subject of actuarial interest, we'd like to give you the chance to air it.

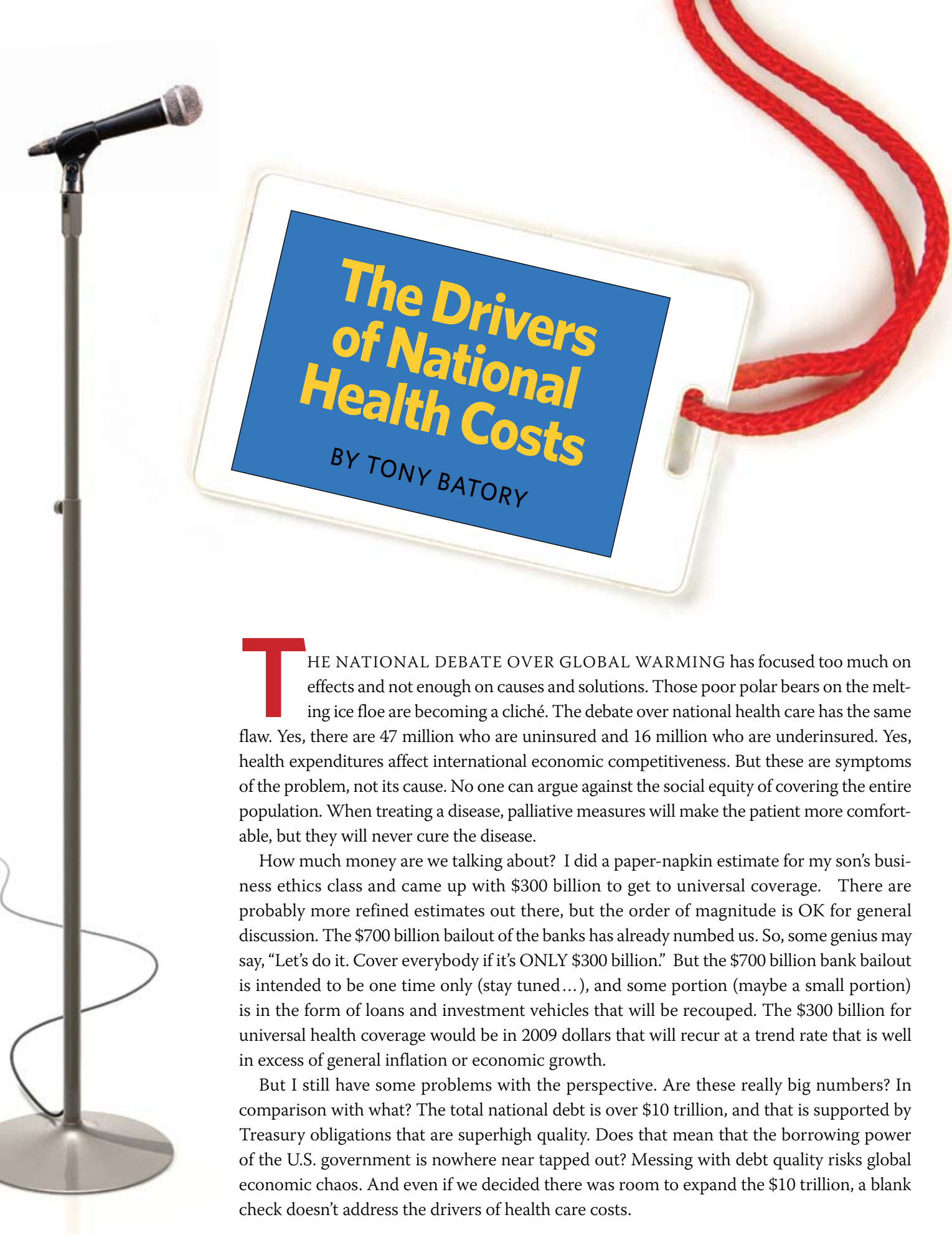


The system
is broken and
needs fixing.
Two health actuaries
offer their prescription.



HEALTH
CARE
REFORM

DIETER SPEARS/ISTOCKPHOTO



The Drivers of National Health Costs

BY TONY BATORY

THE NATIONAL DEBATE OVER GLOBAL WARMING has focused too much on effects and not enough on causes and solutions. Those poor polar bears on the melting ice floe are becoming a cliché. The debate over national health care has the same flaw. Yes, there are 47 million who are uninsured and 16 million who are underinsured. Yes, health expenditures affect international economic competitiveness. But these are symptoms of the problem, not its cause. No one can argue against the social equity of covering the entire population. When treating a disease, palliative measures will make the patient more comfortable, but they will never cure the disease.

How much money are we talking about? I did a paper-napkin estimate for my son's business ethics class and came up with \$300 billion to get to universal coverage. There are probably more refined estimates out there, but the order of magnitude is OK for general discussion. The \$700 billion bailout of the banks has already numbed us. So, some genius may say, "Let's do it. Cover everybody if it's ONLY \$300 billion." But the \$700 billion bank bailout is intended to be one time only (stay tuned...), and some portion (maybe a small portion) is in the form of loans and investment vehicles that will be recouped. The \$300 billion for universal health coverage would be in 2009 dollars that will recur at a trend rate that is well in excess of general inflation or economic growth.

But I still have some problems with the perspective. Are these really big numbers? In comparison with what? The total national debt is over \$10 trillion, and that is supported by Treasury obligations that are superhigh quality. Does that mean that the borrowing power of the U.S. government is nowhere near tapped out? Messing with debt quality risks global economic chaos. And even if we decided there was room to expand the \$10 trillion, a blank check doesn't address the drivers of health care costs.

The Root of the Problem

Let's get to the actual causes of excessive trend in health care:

- › Population dynamics—General aging of the population coupled with the baby boomer spike is increasing the intensity and frequency of major chronic diseases.
- › Lifestyle—There are lots of negatives, from obesity and diet to the way we drive our cars.
- › Medical malpractice—This is the No. 1 item in a doctor's office budget. Obstetricians and some surgical specialists are being forced out of practice because they simply can't afford it.
- › Inappropriate use of medical technology—New devices, tests, and drugs can increase efficiency. But contradictory objectives, like recovering the investment cost, often interfere.
- › Inappropriate variations in clinical practice—Treatments are determined by location and the mix of specialists and primary-care providers in a given area, not by a proven medical standard.
- › Antiquated and deteriorating infrastructure—The cost of upgrading both brick-and-mortar facilities and administrative systems puts a strain on capital structures, and the lack of upgrades holds down efficiency.
- › Demand for treatments that are ineffective—Societal mores and standards spur patient demand, ranging from antibiotics for viral conditions (thus reducing their future effectiveness) to experimental procedures for terminal patients, without regard for clinical effectiveness.
- › Coverage mandates—State-mandated wigs for chemotherapy patients? Federal mandates in a \$700 billion bailout bill?
- › Drug advertising—Television commercials for drugs are common. Who is the target of this advertising? Is this the best way to disseminate unbiased information?
- › Geophysical risks—The increasing concentration of population fuels the spread of infectious diseases.

Even a cursory look at this list reveals that the U.S. experience is significantly worse than average, with only an indirect correlation to our unique approach to financing. In addition, some of our cost drivers invalidate traditional measures of effectiveness, like life expectancy. For example, obesity raises health costs and lowers life expectancy quite independent of the financing system. And is there any country as fat as we are?

Per capita health expenditures in the U.S. are double those of other countries, even without taking into account the uninsured. Rather than using flawed measures like life expectancy, the following criteria can more accurately measure what bang for the buck we get for our health care expenditures:

- › Patient safety
- › Effectiveness
- › Patient centeredness
- › Timeliness
- › Efficiency
- › Equity.

International surveys put the U.S. at the top in effectiveness, as measured by the treatment of specific conditions, and we're in the middle for timeliness. But we are at the bottom for everything else. The overall bang for the buck is negative, and equity is a huge social issue. So what do we do about it?

A Single-Payer, Government-Based System?

We've already tried a single-payer, government-based system. Sure, Medicare is universal only for those older than 65, and new programs like Part D go beyond single payer. But we can draw some conclusions after 50 years of operation. Has it been a financial, benefits, and administrative disaster? The tax rates are nowhere near self-supporting, relying on general revenues and on a hidden surcharge to the private sector called cost-shifting. Benefits are incomplete, seniors have to pay for Part B and still need supplementary coverage. Benefit design is way too complex; I had a hard time understanding Part D myself, let alone explaining it to my 90-year-old mother-in-law. Various Medicare administrative functions and the Medicare Advantage programs have been outsourced to the private sector.

There are other historical precedents at the macroeconomic level. In the 1990s, we fought an economic war with the Soviet Union and kicked its butt. And try to imagine the extent of commercial development of the Internet as a purely educational institution or as a government agency. Profit provides the incentive for advancement. So why are there still supporters for a single-payer health system? It does get to universal coverage in the most straightforward way. But that's a symptom of the problem, not the actual problem. When I look at the list of drivers above, it's hard to see how a government program would directly affect any of them. No, since the drivers are many and diverse, we have to stop looking for a single answer. There's no silver bullet.

The Middlemen and Insurers

I didn't include the additional layers of bureaucracy in my list of cost drivers. It's true that the employers and the states have an unnecessary middleman relationship. But it's questionable whether they contribute to the double-digit cost trend. There would be one-time savings in reducing administrative layers, but it has to be offset by the one-time cost of changing transfer payments. General Motors has repeatedly said that its health care costs make it uncompetitive. But the risk/revenue matching is entirely appropriate; it's precisely the costs that GM employees are generating. If we remove GM from the picture and replace its direct expense with a flat corporate tax, costs may go down. But it would be at the expense of other employers. How is that equitable? The bottom line is that neither set of transfers addresses the drivers.

All this brings us to the HMOs, health plans, and insurers. It's a myth that insurer profits have precipitated the crisis. Depending on what time period you use, total profits come to \$10 billion. Not in the same order of magnitude as

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the missing \$300 billion, let alone the level of total expenditures. The fierce competition between insurers acts as a direct check on profit objectives. And as with the administrative expense, the impact on trend isn't clear.

Properly directed, the health plans can positively affect most of the drivers above. It's been said that the practice of medicine is an art. The literal touchy-feely relationship between the doctor and patient cannot be disturbed. But the practice of medicine is also a science. As a brief example, consider the 7,000 prescription drugs that are currently available, with hundreds of new approvals every year. There are databases that define applications, interactions, and side effects, but they barely scratch the surface of effectiveness. They aren't comprehensive even across the insured population, and they don't provide the most effective drug given the patient's diagnosis and specific medical profile. For the other thousands of medical procedures, these processes are only

at the beginning stages. There's significant room for improvement in efficiency based on the technology and science that are currently available.

Preventive care has positive effects because early detection reduces intensity. If the patient waits until the coronary condition or diabetes clearly manifests itself, the ultimate claim will be higher. Consumer education, disease management, lifestyle intervention, disability integration, and other programs are under development. But economic inertia is tough to deal with. A substantial upfront investment with no immediate impact on the bottom line is tough to implement when Wall Street is so focused on next quarter's earnings. Another aspect of economic inertia is proprietary information. I can't provide details of these because they aren't my intellectual property.

Capital for these programs comes out of insurer profits and could come from other sources, like government programs. But it's the competitive environment that provides the direct incentive for their development, economic inertia notwithstanding (this should be distinguished from political inertia—for example, tort reform is unlikely when Congress is 98 percent lawyers).

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The Role of the Actuary

The casual observer may say that I'm biased in favor of the insurers because I work for one. *Au contraire*. I know what they are capable of in the most negative of contexts. When I first became a fellow of the Society of Actuaries, I got through several difficult assignments by focusing on a quote by John Ruskin: "The work of science is to substitute facts for appearances." I sometimes paraphrase this by saying, "The work of science is to substitute facts for opinions, and the work of political science is to substitute opinions for facts."

I've dressed up my writing with some colorful metaphors, but in general it's pretty focused on facts, not opinions. We do not need more opinions but a clearer understanding of the facts. I would welcome a truing up of the \$300 billion, \$10 billion, and 98 percent figures, a quantification of malpractice cost as a percent of a provider's operating budget, a way to quantify the present value of intervention programs, and detailed population projections that focus on the impact of aging.

Health actuaries have been accused of being insensitive to the issues. It's too easy to just tack on 18 percent net to the rates each year and send them out. But in fact, so much more is going on and there is so much more analysis yet to do.

TONY BATORY is a member of the Academy and a fellow of the Society of Actuaries. He thanks Mike Gross and Brian Edwards for their helpful comments.



TODAY'S HEALTH CARE FINANCING MESS REQUIRES AN AMERICAN FIX. We need a rational solution that recognizes where we have come from in paying and providing for health care in this country, as well as our government, history, culture, economic system, and all the other things that define us as a nation. The entire world is struggling with health care financing. Solutions need to be locally relevant, and the United States is no exception. My modest proposal for reforming core elements in the health care system is as follows.

EVERYONE IS COVERED—A significant percentage of our population is either not covered by any formal insurance program or is inadequately covered. This flies in the face of effective risk pooling. The only way to reach anything approaching universal coverage is to require it, full stop. Everyone must be in the pool if the principles of social solidarity and individual equity are to be in balance. Details of how to mandate coverage, how it is enforced, how violations are punished, etc., are very solvable (if not simple) issues. Various financing mechanisms to provide necessary subsidies related to income and other measures can be established via tax policy.

Choice of coverage essentially should be left to an open and revitalized marketplace, which will grow out of new demand and other changes that I discuss further on. However, coverage must provide at least a

minimum level of acceptable and reasonable insurance benefits. This can be monitored through a supervising entity that sets a minimum standard and oversees the demonstration of actuarial equivalence for benefit variations.

EVERYONE IS CHARGED THE SAME AMOUNT—Currently, the same service from the same provider costs different parties different amounts depending on who is paying. This is patently ridiculous for something society has effectively stated is a right, or at least a social utility. We must require all-payer, transparent pricing from providers for their products and services. All providers are free to set prices as they deem appropriate, but those prices must be the same to all purchasers.

I am referring to a price that represents the true,

bottom-line net charge that the provider bills and collects. Payers won't be able to negotiate with providers for special discounts or pricing concessions for any reason. If a provider agrees to a particular schedule of fees or prices with a given payer, fine. But it then applies to every other payer as well.

This doesn't mean that insurance benefits must cover whatever the provider charges. Schedules of allowed maximum charges, or networks of providers for which the insurer will cover 100 percent of the provider's fees, will come into play. Applied against these will be the usual cost-sharing devices of copayments, deductibles, and coinsurance.

Provider charges that exceed the insurer's allowed charge schedule, however, must be balance-billed to the patient and should be treated the same as other cost sharing under the benefit plan. This will be critical in bringing true competition to the marketplace of health care services.

Providers will be allowed to waive collection of the patient's portion of their bill, as a charity adjustment or for other economic need as perceived by the provider. However, provider flexibility on the patient's balance must not be used as a loophole to effectively discount charges of one group or another by, for example, promising to waive copayments for those in a particular network that has negotiated with the third-party payer for copay forgiveness. No deals will be allowed that essentially change the provider's charge schedule for persons covered by that payer's program.

The same goes for government programs, especially Medicare and Medicaid, except for some possible minor concessions for administrative savings. A full discussion of how important this is and why it is at the core of health care reform is larger than the scope of this article. But Medicare and Medicaid are among the chief culprits creating the current turmoil, and basic tenets of

their design need to be corrected. Making these programs pay on the same basis as others is right, fair, and necessary. There's no way we can have such a significant portion of medical services being paid for through a price-setting mechanism that dodges responsibility and creates cost-shifting distortions whose effect touches the rest of the economic sector.

EVERYONE IS TAXED THE SAME AMOUNT—We must balance tax policy and health care financing costs by allowing qualified medical expenses, whether out-of-pocket claims or insurance premiums, to be deductible no matter who is paying them. The maximum deductible amount could vary based on taxpayer demographics. Tax policy could be integrated with a subsidy program so as to promote affordability of mandated universal coverage.

Maximum benefit levels for deductibility should be established in conjunction with the valuation of benefit plans against a minimum standard. The definitions of "affordability," "qualified," "minimum," "maximum," as well as other tax policy details are subject to practical resolution. (I recognize that deciding exactly who or what entity makes such determinations will prove to be an interesting challenge.)

EVERYONE IS ELIGIBLE FOR COVERAGE—The current system requires not only underwriting by both group and individual insurers but also the resulting inherent discontinuities that arise through actuarial discrimination (classification). This not only generates practical, ethical, and economic distortions; it also undercuts the idea of pooling, a critical societal tool for managing health care financing. In addition, it creates significant and unnecessary administrative, legal, and marketing costs.

In both the individual and group market arenas, we must do away with underwriting that's based on claim history and medical conditions. This will eliminate the need for so-called high-risk pools. To interweave these elements with universal coverage, there will be a need for risk-adjustment programs, such as reinsurance pools that ensure actuarial balance between insuring entities. With anti-selection eliminated, minimized, or made equitable across the entire market through universal coverage, underwriting will no longer be necessary and the societal goals of broad coverage and relative equity can be maintained.

EVERYONE RECEIVES FAIR AND OPEN INSURANCE PRICING—Pricing transparency must be established within the new insurance marketplace. In particular, mandatory full disclosure of all marketing/sales compensation (in whatever form) should be required for all medical expense insurance. In addition, serious consideration should be given to moving insurance product pricing to some variation of a modified community-rating basis. This can be integrated with changes in the tax system, so as to provide necessary cross-subsidization.

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EVERYONE HAS INFORMATION—Between “Everyone Is Charged the Same Amount” and “Everyone Receives Fair and Open Insurance Pricing,” a foundation has been laid for true consumer empowerment in the purchase of health care services and insurance. But there’s still a piece missing—rational and efficient management of medical records and measurement of provider quality.

Everyone seems to agree that significant information technology advances are attainable in the health care arena. But writing about it doesn’t make it happen, and talking is about all that we get from the politicians, academicians, and physicians who are active in the current movement for health care reform. Someone with authority needs to make a decision on what the universal standards will be (incorporating a dynamic that anticipates continuous improvement) and then require all relevant parties to meet those standards in very short order and with no exceptions.

There are no acceptable excuses for why America can’t revamp its health care system to harness the tremendous productivity and quality improvement that is available through the application of appropriate technology. In reality, the solution lies less in technical know-how than in political will.

A Solution That Works

Are these the only things that would contribute to improving the situation in which our country finds itself? What about an empha-

sis on primary and preventive care, the importance of individual responsibility, or controlling the apparent runaway increases in health care costs that confront us every day?

The first two are matters for benefit design, and the latter is a symptom of the underlying problems, not a cause. By addressing basic issues and allowing the resulting managed (but corrected) marketplace to come into being, primary care and individual responsibility will be emphasized and enhanced through meaningful, creative, and cost-effective benefit packages. Innovation in reimbursement and information will follow.

The current system has stymied creativity and entrepreneurship, both among America’s greatest strengths. The medical industrial and financial complex needs to be fixed at the core, not patched to death on the periphery. Goals for comprehensive care, a higher quality of care, the proper kind of care, and the most cost-effective care are actually different facets of the same single goal: financing and providing for the best care. This starts with simple and rational changes at the fundamental level, so as to create a health care financing system that’s consistent with the history, cultural trajectory, and creative powers of the American experience. ●

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