

So Why All the Controversy About Health Care Reform?

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The US health care system provides some of the best, if not the best, health care in the world. However, the cost of that system continues to be the most expensive with overall health care expenditures exceeding 17% of GDP in 2009. The conundrum we face is how to reduce the cost of the system while maintaining its quality. Such a change most likely requires some type of overall system reform. 2009 has been a year of significant political discussion regarding reform, with both the House and the Senate acting on reform. Here in mid-December we await the latest Senate outcome.

Reform has become highly politicized; perhaps understandable, but so unfortunate. The health care issues facing Americans are significant and some of the most important issues are not being openly and accurately discussed. If we step back and take a closer look at some of the key issues, we might be able to find common ground. I have spent most of my professional life working to find solutions to the underlying health care problems. Most of this effort has been focused in the private sector, although a significant portion has also impacted the public sector.

So What are the Key Issues?

There are far too many issues to address completely in this essay, so I have limited my discussion to what I believe to be the most important. I will comment on the following ones:

- Efficiency of today's health care system (or how much potentially avoidable care is there?)
- Economic impact of continued health care increases as percent of GDP
- Size of public to private health care cost shift
- Significance of wellness and the impact of other lifestyle factors
- Who's responsible for the cost of the uninsured?
- Myths regarding tort reform
- Effectiveness of Medicare Advantage programs
- Undesirable effect of fee-for-service medicine

Efficiency of Today's Health Care System

I have spent the majority of my 38 year professional career measuring the efficiency of today's health care system and identifying ways of improving it and reducing the extent of potentially avoidable care. We have approached this from both an actuarial and clinical perspective and have developed a wide variety of tools to improve the

system's efficiency¹. For more than 20 years, the result of this analysis has consistently shown that there is significant opportunity to reduce the cost of care by merely eliminating potentially avoidable or medically unnecessary services. Most recent estimates show that nationally as much as 50% of today's inpatient services are potentially avoidable. These services should not be provided or provided in an alternative care setting. Estimates also show that as much as 35% of professional services are potentially avoidable.

Based upon the above estimates, it seems logical that significant efforts should be expended to try to improve the system's efficiency in any reform initiative. Our efforts to improve efficiency involve provider education and oversight (i.e., helping them understand how they might improve), incentives to motivate improved performance (i.e., carrots and sticks), and rule-making (i.e., determining what gets reimbursed and what doesn't). There has been expected provider resistance to some of this, but in most situations strong provider support as they are educated about some of the problems they were not aware of.

Unfortunately, much of this effort has been labeled "insurance company greed", "getting in the middle of the provider/patient relationship", "health care rationing", etc. A medical procedure unnecessarily performed on a patient is clearly expensive waste. When a patient is hospitalized one extra day that is even more expensive. Considering only the high rate of acquiring a hospital based infection, unnecessary days in the hospital are a clear breach in quality. Considering the expense of that day it is even a more grievous situation.

As documented in the Dartmouth Atlas² and by other sources, the efficiency and effectiveness of care varies significantly by region with some part of the country providing much more efficient care than others. My firm's proprietary data³ shows the high degree of variability of opportunity to reduce hospital inpatient utilization (See Table 1). The estimates for potential reduction shown in Table 1 are based upon a comparison of actual inpatient utilization by state to the ideal or most efficient rate possible. This is based upon the most recent and most efficient care delivered today for the under-age 65 population (i.e., 159 bed days/1,000 including SNF days). Our studies of the Medicare and Medicaid population show similar opportunities to save in these populations.

¹ The author while a partner at Milliman & Robertson, Inc., now known as Milliman was responsible for the developed of the Milliman Guidelines. He led the firm's efforts to develop, publish, and market this resource now used throughout the world.

² See www.dartmouthatlas.org

³ **AHP Best Practice Norms™**

**Table 1
Hospital Utilization Levels by State
(commercial under-age 65 bed-days/1,000)**

Alphabetical State	Days/1,000 (including SNF days)	% of National Average	Estimated Potential For Reduction
U.S. Total	316	100%	50%
Alabama	357	113%	55%
Alaska	245	77%	35%
Arizona	260	82%	39%
Arkansas	372	118%	57%
California	269	85%	41%
Colorado	251	79%	36%
Connecticut	294	93%	46%
Delaware	304	96%	48%
Florida	322	102%	51%
Georgia	305	97%	48%
Hawaii	320	101%	50%
Idaho	252	80%	37%
Illinois	341	108%	53%
Indiana	310	98%	49%
Iowa	339	107%	53%
Kansas	307	97%	48%
Kentucky	322	102%	51%
Louisiana	376	119%	58%
Maine	299	95%	47%
Maryland & DC	310	98%	49%
Massachusetts	335	106%	52%
Michigan	275	87%	42%
Minnesota	270	86%	41%
Mississippi	373	118%	57%
Missouri	310	98%	49%
Montana	280	89%	43%
Nebraska	296	94%	46%
Nevada	299	95%	47%
New Hampshire	265	84%	40%
New Jersey	400	127%	60%
New Mexico	278	88%	43%
New York	454	144%	65%
North Carolina	305	97%	48%
North Dakota	330	105%	52%
Ohio	304	96%	48%
Oklahoma	362	115%	56%
Oregon	228	72%	30%

Alphabetical State	Days/1,000 (including SNF days)	% of National Average	Estimated Potential For Reduction
Pennsylvania	384	121%	59%
Rhode Island	317	100%	50%
South Carolina	315	100%	49%
South Dakota	338	107%	53%
Tennessee	315	100%	49%
Texas	299	95%	47%
Utah	244	77%	35%
Vermont	260	82%	39%
Virginia	297	94%	46%
Washington	246	78%	35%
West Virginia	331	105%	52%
Wisconsin	274	87%	42%
Wyoming	259	82%	39%

There are many causes of this inefficiency, much of it physician centered. Physicians need oversight to be motivated to provide highly efficient care. Physicians have generally resisted the efforts of health plans to provide this oversight accusing it of being obtrusive to their ability to provide care. However, few if any, physician activities have focused on efficiency. If physicians won't take the necessary actions to do this on their own, if health plans are not able to broadly impact this without strong resistance, then it is mandatory that the government step in and provide this oversight to conserve our health care dollars to those who need it the most. Several proposals included a quasi-governmental agency to standardize this oversight. It is my opinion that this requires standardized practice guidelines and other oversight to assure that appropriate and highly efficient care is delivered.

Conclusion: Health care reform proposals need to address the significant inefficiencies occurring in our system today.

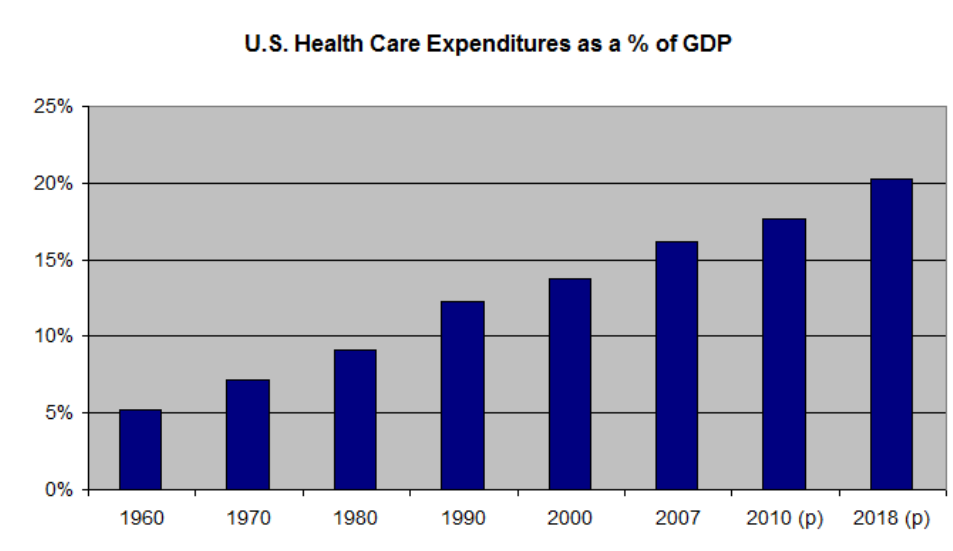
Economic Impact of Continued Health Care Increases as a Percent of GDP

US health care costs have increased in both dollars and as a percentage of GDP. Chart 1 shows the growth as a percentage of GDP. This is based upon national health care expenditure data.

Most of the discussion talks about the tragedy of continued increases or compares it to other countries with lower ratios. Very little of the discussions seems to focus on the overall economic impact which I believe to be an even more critical issue. The current 17% or about 1/6th of the economy is the highest it has ever been and the highest

recorded internationally. One might ask the question, how high can it go, or is there a point above which we have serious economic problems.

Chart 1



This is the most important issue. Writings by several economists including Uwe Rheinhardt of Princeton seem to suggest there is a “natural cap” that health care must remain below without unduly disrupting the economy. My estimates and as confirmed by others suggests that serious economic problems emerge if and when healthcare approaches the 22% of GDP level. The rest of the economy has a tolerance for its survival. In light of our global “just-in-time” economy, there is a risk that the entire economy could stumble to a stop if the US health care gets too big. Unfortunately, current projections show that the projected ratio for US health care as a percentage of GDP will grow to close to 22% by 2013 if nothing is done. Since the health care proposals currently under considerations don’t change the system until that time this is very urgent.

Much like the concerns voiced regarding a serious global pandemic cause by Avian flu, the unbridled growth of the US health care could cause a global economic disaster. No one knows how to jump start a stalled economy. This in itself is reason to do something to fix health care.

Conclusion: Health care reform proposals must limit the growth of health care to preserve our economy and reform must be started immediately to avoid serious problems.

Size of Public to Private Health Care Cost Shift

Much has been said about the public to private health care cost shift. Few seem to understand the significance of this cost shift. Government payers (i.e., Medicare and

Medicaid) reimburse health care services at a much lower rate than the private sector as low as 70% of the private sector for Medicare and 40% of the private sector for Medicaid. To the extent that these payment levels create a financial drain on providers, private sector payers are charged a surcharge (i.e., cost shift). Estimates vary, but recent reports published by Milliman⁴ suggest this is at least 15%. In other words, the private sector pays providers 15% more than would be required if all payers paid their fair share. Combining this with the burden of bed debt and charity care provided by providers that is also passed on to private sector payers, the problem is significant. The mis-allocation of health care costs raises the costs of care funded by the private sector burdening the entire economy. If the cost of the system was equalized to reasonable payment levels for all, a significant administrative expense burden could be eliminated from today's system. All providers would be reimbursed using a common fee schedule, perhaps developed by the government, perhaps the Medicare payment schedule. If the Medicare fee schedule this would reduce overall cost of care in the country by more than 8%. The provider community will oppose this as they claim that Medicare payment levels are too low. This may be the case in some physician specialties and in some institutional settings, however, this is a great starting point to equalize the cost of care.

Conclusion: The cost shift is significant and a reformed system should consider a common payment schedule across the entire system (i.e., all payer system)

Significance of Wellness and the Impact of Other Lifestyle Factors

A major contributing factor to today's high cost of care is personal wellness and healthy lifestyles. Research by Dee Eddington, PhD show the impact of health status and health costs.

Health & Wellness Level	Current Dist.*	% of Ave \$*	\$ Dist.	Modest Shift	\$ Dist.	Major Shift	\$ Dist.
Well	50%	20%	10%	52%	10%	55%	11%
Low Risk	20%	50%	10%	22%	11%	23%	12%
Moderate Risk	25%	100%	25%	23%	23%	20%	20%
High Risk	4%	750%	30%	2.5%	19%	1.5%	11%
Complex	1%	2500%	25%	0.5%	13%	0.5%	12%
Total	100%	100%	100%	100%	76%	100%	66%

* Source: Dee W. Eddington, Ph.D., Director of the Health Management Research Center at the University of Michigan

⁴ Milliman, "Payment Level Comparison of Medicare, Medicaid, and Commercial Payers", December 2008

Even a small reduction in health status has significant reductions in health care costs. Table 2 shows two very realistic shifts in health status showing opportunities of 24% to 34% reduction in overall health costs.

Is it possible to change personal behavior to achieve such improvements? Our experience is yes it is possible. We believe a tightly defined health and wellness program vision should include the following three items:

- A focused program – a program that begins with a particular aspect of health and wellness, rather than trying to be everything to everybody
- A hope-filled program – a program that provides hope to participants, showing that it can be done and success is likely
- A redemptive program – a program that encourages participants who participate, motivates them along the way, and incentivizes them to continue their transition. It is a program that gives “partial credit” for sincere participant efforts.

Programs designed like this significantly influence behavior and achieve dramatic improvements. More than 90% of the potential for improvement is directly tied to obesity related issues and smoking cessation. In other words, programs focused on these two areas will accomplish a significant portion of what savings exist. Obesity related efforts would focus on BMI (i.e., body mass index, weight reduction), improved fitness, reduced cholesterol, reduced blood pressure, and reduced blood sugar.

Conclusion: The reformed system must include provisions for improved health status.

Who’s responsible for the cost of the uninsured?

Today estimates suggest 45 million uninsured in the US. This includes a large number of the working well (i.e., those who could have coverage but have opted out of it since they don’t believe they need it). It also includes individuals who can’t afford it for themselves or their workers and others who don’t qualify for it because of ongoing health conditions. Excluding the large number of individuals who could have it but choose to not purchase it or opt in for it at their work setting, there still remain a significant number of individuals who need it and can’t get it or can’t afford to get it.

Today much of the cost of care for those without insurance is passed on to those who have it through increased provider prices resulting from bad debt and charity care. This somewhat hidden surcharge forces everyone to pay for it, at least the private sector. The surcharge is combined with the extreme discounts and cost shift from the public sector previously discussed.

The question becomes who should pay for it? Should anyone be able to not have health insurance in our environment of very expensive health care? Should there be personal bailouts when individuals without health insurance suffer a catastrophic loss and experience serious financial distress.

The unfortunate plight of the uninsured has been a major focus of most health care reform proposals this year. They seem to conclude that it is a societal problem and that no one should be without some form of health insurance, even if you choose not to purchase it. Whether one accepts this premise or not, society tends to pay for most of health care through hidden surcharges.

Should we as a society change the way we pay for this? Proponents of reform proposals assume yes and that is the basis for much of the current proposal. Assuming this leads to a reduction in health care premiums and costs then it potentially makes sense. I am not aware of any plan to recognize this in any reform proposal. As a result, the impact of explicitly subsidizing the uninsured will likely increase everyone's costs. Most reform proposals also change the allocation of costs for this expansion. In summary, it is important for the reform proposals to clearly specify what the new operating rules are and who's responsibility it is to provide health care for the uninsured.

Conclusion: Health care reform proposals are reallocating the costs for covering the uninsured population, transitioning them from a hidden surcharge to a more explicit cost which can be measured. It is critical that this cost shift be explicitly quantified to understand the impact of reform.

Myths Regarding Tort Reform

Tort reform has become a highly politicized topic in the health care reform discussions. Republicans urging Democrats to make appropriate changes and oftentimes suggesting that tort reform is the cure. Limited tort reform exists in any of the reform proposals indicating the Democrats position of status quo as far as tort reform.

Why do some believe this is so important while others ignore it? Who is right? This actually is a fairly simple question to answer if you understand how health care works. Begin with the obvious fact that providers today are paid for doing services (i.e., fee-for-service). They have a financial incentive to provide services. The more they do, the more they get.

Perhaps it is as simple as if I can find another excuse to do more without looking greedy, maybe I could take advantage of that for my benefit (i.e., financial self interest).

It is clear that providers have used defensive medicine as an excuse for providing additional services in their attempt to minimize malpractice lawsuits. But is it the real reason. I don't think so. In an environment where you can financially benefit from doing more, I believe it is more of a convenient reason to do more with or without the real fear of a malpractice claim. The frequency of malpractice claims and settlements against providers is far below the additional number of services provided. In the work we have done to identify areas of additional efficiency in the system, this is one of the areas where we find little if any reason for additional services. High quality care is more efficient. There is less chance of being sued or experiencing a malpractice claim when you are providing high quality, cost effective care. An admittedly outdated analysis completed for a major health plan in Seattle in the early 1990s shows a 30% less rate of malpractice claim than in the market as a whole. Similar studies in other markets confirm these findings. A major source of malpractice claim might be characterized as poor bedside manner and grumpy patients. This has little to do with less than thorough testing. There are the obvious mistakes (i.e., surgery on the wrong leg, wrong surgery, etc.) which are shameful, but few situations emerge in reality justifying significantly more services or additional tests.

A very recent analysis suggest that no more than \$30 billion could be saved from tort reform. This is less than 2% of the \$2 trillion health care system. Tort reform is beneficial but insignificant to the 30% - 50% potential for efficiency improvements and/or the 24% - 34% health status improvements.

Conclusion: Tort reform is valuable and important but not the overarching problem facing the health care system. Reform could include that but in itself tort reform is not health care reform.

Effectiveness of Medicare Advantage programs

One of the areas the administration is focusing on and the current reform initiatives are planning to use to fund the reform initiatives is "waste" in Medicare Advantage programs. I find this very interesting since the underlying premise of the Medicare Advantage program is to find untapped savings opportunities not realized by Medicare and turn these savings into additional benefits for beneficiaries.

In other words, see if you can save money that Medicare couldn't save or didn't save. If you find that savings, return a significant portion of that to the beneficiary willing to sign up with you in the form of increased benefits. For years these programs have found significant savings. The financing methodologies have changed over the years to the current program which recognizes the health status of the enrolled members eliminating most, if not all, of the selection bias within the program.

How this can be called wasted dollars and an opportunity to finance reform is confusing to me. The private sector health plans found the money and saved it. Medicare was not able to do that. This seems to be an unfair vendetta against the health plans and a lack of recognition of how ineffective Medicare's own practices have been.

The Medicare Advantage program has been a significant benefit to nearly 11 million beneficiaries, more than 20% of all Medicare beneficiaries. Most of these have enjoyed significant benefit upgrades as a result of the program. Their willingness to limit their choice of providers to a network and submit to more intense medical management has been rewarded by increased benefits.

Conclusion: Medicare Advantage has been effective and is not a source of funds for subsidizing health care reform. Rather it is an effective model showing how the private sector can add value in concert with a government sponsored program.

Undesirable Effect of Fee-for-service Medicine

US health care has predominantly used fee-for-service health care reimbursement. There have been a variety of reimbursement alternatives used over the years ranging from case rates to capitation, with the dominant method being fee-for-service. Considering that financial self-interest is intrinsic to human nature, it is not surprising to see health care costs being higher than what we would all like.

But the appropriateness of fee-for-service is brought into question further when we consider how health care operates as a whole. Consider an industry where the manufacturer sets the demand for purchase of services, sets the price for such services, is paid more for more complex services, is continually expanding the technological complexity of services to do more things, and is able to pass the predominant portion of the cost to a third party. If this model was applied to any other industry, the economics would be unstable and the cost high. Combine the industry with life threatening issues and it is fairly obvious that health care would gradually become unaffordable.

Multiple alternatives have been suggested to enhance the cost effectiveness and efficiency of care in light of the high level of potentially avoidable services and inefficiencies observed in the health care system. Reimbursement methodology is one of four very important issues: reimbursement methodology, care management, incentives and benefit level. It is critical to integrate all of these to obtain the ideal situation.

Package prices, appropriate incentives, outcomes, pay for performance all are critical to improving the cost of the system. Alternative payment methods make sense for some areas more than others. For example, capitation combined with the Medical Home

model provide significant opportunities for long term savings based upon initial experiments. Primary care capitation has been a proven option as long as the primary care provider has an adequate patient base and the definition of what is primary care is clear. Case rates have worked well for inpatient hospital although they in themselves have not adequately reduced length of stay. Ongoing care management is required to hold providers accountable. Package prices work well for easily enclosed services (i.e., surgery, maternity, etc.). Pay for performance makes sense when the incentive is material enough to change behavior.

Conclusion: Reform initiatives need to modify reimbursement methods to minimize the adverse impact of financial self interest of providers.

Summary

I don't understand why more can't agree on health care reform. It is a shame that it is so politicized. It is a shame the public doesn't really understand the issues. Contemporary politics focus on opinion polls and are hesitant to do what is right when the polls are against it. I compare health care reform opinion polls to asking a child whether or not his parents should discipline them. Most parents agree that a child left to their own choices will make significant mistakes and be unruly when they grow up. What child would beg for discipline yet the end result is much better when a child has been appropriately disciplined.

America needs health care reform. The issues I have discussed by themselves show that we need some major changes. When implemented we will all be better for it. Yes it will cost something to do it, but we can't continue on the track we are on without major changes. I just wished more understood why it is so important.