

## The Hard Choices of Health Care Reform

**■ WAS PLEASSED TO READ HOLLY KWIATKOWSKI'S ARTICLE** in the November/December issue of *Contingencies*, saying that actuaries, working largely through the Academy and its various health-oriented committees, will have an opportunity to influence the desperately needed reform of health care and health insurance in the United States.

The overwhelming need for basic change is irrefutable. The facts supporting this conclusion are as follows:

■ As Ms. Kwiatkowski points out, in 2005 we had 46.6 million Americans lacking health insurance, representing 15.9 percent of the population. Many of those with insurance have inadequate coverage; a major illness will leave them with bills exceeding coverage payments by a catastrophic amount.

and infant mortality rate. As reported in the 2006 statistical abstract cited above, in the United States, as of 2004, life expectancy at birth was 77.4 years and the infant mortality rate was 6.6 per 1,000. Comparative figures are: Canada, 80.0 and 4.8; France 79.4 and 4.3; Italy, 79.5 and 6.4; Japan, 81.0 and 3.3; United Kingdom, 78.3 and 5.2.

These facts have long been known by both experts in the field such as economists and actuaries, and by politicians who make national health care policy. The lack of political will to address this deteriorating picture is, it seems to me, driven by competing values: the right to individual choice in health care decisions; the desire to limit intrusion by third parties, particularly government, in health care decisions; the primacy of individual responsibility for oneself; the avoidance of governmental price setting, etc. The time has come, however, when we need to consider whether those trade-offs make sense for the future.

Here are some things I think we should keep in mind while considering systemic reform of health care in the United States:

■ Historically, much of the problem has been created by the separation of consumers (patients), health care providers (doctors and hospitals), and financing entities (employers or government). If consumers have little financial stake in the cost of health care, they'll tend to opt for more (and more expensive) health care. And providers will encourage this type of thinking to increase demand for their services.

In the 1990s, we saw a slowing of growth in health care expenditures as a percent of GDP. Much of this slowing could be attributed to the growth of health maintenance organizations (HMOs). These organizations, by their nature, transferred the decision-making power about health care from consumers and providers to the insurers, the HMOs.

Unfortunately, because this transfer of power ran counter to many of the values previously stated, it led to an outcry against "bean counters" making health care decisions. Many states have passed patient protection legislation limiting the right of HMOs to make inherently unpopular decisions, thus rendering them less effective in cost control. Furthermore, HMOs have lost market share to other types of plans, such as preferred provider organi-



■ According to the *Statistical Abstract of the United States: 2006*, in 2003 national health expenditures amounted to \$1.7 trillion, or 15.3 percent of gross domestic product (GDP). The amount and percentage have been growing steadily for many years. In 1990, for example, the figures were \$0.7 trillion and 12.0 percent. This percentage is far in excess of those in other nations that provide what we would consider modern progressive health care. For 2002, a sample of percentages is as follows: Canada, 9.6 percent; France, 9.7 percent; Italy, 8.4 percent; Japan, 7.9 percent; Sweden, 9.2 percent; United Kingdom, 7.7 percent.

■ Arguably, we get less for our high health care expenditures than other nations with more modest expenditures, as measured by vital statistics such as life expectancy at birth

DWIGHT K. BARTLETT III is a consulting actuary in Annapolis, Md. He was chief actuary for the Social Security Administration from 1979 to 1981.

**I do believe, regrettably, that successful health care reform is going to require some rebalancing of our national values with some resulting loss of personal control—I hope limited—over what kind of health care we get and how it's paid for.**

zations (PPOs) and point-of-service plans (POSs).

More recently, health care cost control has centered on transferring the financing cost burden back to the consumer. More traditional plans have increased plan deductibles and the consumer's share of premium cost. A more innovative approach has been the combination of health savings accounts (HSAs) with high-deductible health insurance. Under this type of plan, insureds are encouraged to consider carefully how much routine health care they want to purchase, because they're spending a finite amount of money held in the HSA, even if the money originally came from an employer. Whether this type of plan will appeal to a significant number of people—other than the young, the healthy, and the affluent—remains to be seen.

■ Our country's enormously complex mix of health insurance plans, both governmental and private, makes the distribution and administration costs of health insurance unacceptably high, especially when compared with health care in other countries. Witness the public outcry over the complexity of our new Medicare Part D, providing prescription drug coverage for the elderly.

Individual medical expense policies are the most egregious example of our excessively expensive health insurance plans. The National Association of Insurance Commissioners, in its "Guidelines for Filing of Rates for Individual Health Insurance Forms," doesn't consider premium rates to be unreasonable in relation to benefits unless the anticipated loss ratio is less than 50 percent. Compare this with traditional Medicare Parts A and B, where administrative expenses amount to less than 2 percent of income, as reported by the trustees in their annual reports.

There is some hope that increasing use of record-keeping and communications technology may improve this picture, but the common argument that more options

will create greater competitive pressures to control costs doesn't seem to be working. Reform should focus not only on improving utilization of technology but also on achieving economies of scale. Reforms that would throw more people into the individual medical insurance market would seem counterproductive.

■ Our health care systems need to focus less on crisis care and more on health maintenance. It's often said that the United States makes available the best medical care in the world for those who can afford it, and that may be true. But it ignores that most of the improvements in health measurements for the past century are a result of improved public health programs such as clean food, clean water, vaccinations, public education, etc.

HMOs were originally conceived as a way of reorienting medical care away from crisis care to health maintenance. They were to accomplish this, in part, by reinstating the primacy of primary care and managing the health of both well and sick people in an integrated, longitudinal fashion. Unfortunately, HMOs have largely lost this original approach to health care, for reasons mentioned above.

■ Our medical malpractice problem needs to be addressed. While there is no consensus on how much the present tort system adds to health care costs in the United States, it would certainly seem to be significant. States that have adopted limits on non-economic damages, such as California, seem to have achieved some worthwhile progress in controlling this particular cost element. Other proposals for adopting some form of no-fault coverage seem worthy of exploration.

■ Recognize that the out-of-control growth in the costs of Medicare and Medicaid, which pay for nearly one-half of all medical care in the United States, can't be solved in isolation from the systemic reform of the general financing and delivery of health care. Past efforts have focused

on cutting provider reimbursement rates or increasing competition. The former step would seem to have gone as far as it can and may simply have resulted in shifting of costs to private payers without bringing down the total national health care bill. The argument that increased competition will help to control costs, while appealing in concept, has yet to be proven.

In summary, I do believe, regrettably, that successful health care reform is going to require some rebalancing of our national values with some resulting loss of personal control—I hope limited—over what kind of health care we get and how it's paid for. I'm encouraged by the broad public support for the health care systems in other Western nations that have moved in this direction. ●

## References

- Statistical Abstract of the United States: 2006*, U.S. Census Bureau, U.S. Dept. of Commerce, Washington, DC 20005.
- Baltimore Sun*, "As Costs Rise, HMOs Losing Ground to PPOs," Bruce Japsen, November 19, 2006.
- Model Laws, Regulations and Guidelines*, National Association of Insurance Commissioners, Kansas City, MO, 2001, Volume II.
- 2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Washington, DC, 2004, Table I.C1.
- Life Tables for the United States Social Security Area 1900-2100*, Actuarial Study #120, Office of the Actuary, U.S. Social Security Administration, Baltimore, MD, 2006, Section E, Historical Trends and Projections.
- Our Liability Predicament*, J. T. H. Johnson, University Press of America, Lanham, MD, 1997.

This commentary is solely the opinion of its author. It does not express the official policy of the American Academy of Actuaries; nor does it necessarily reflect the opinions of the Academy's individual officers, members, or staff.