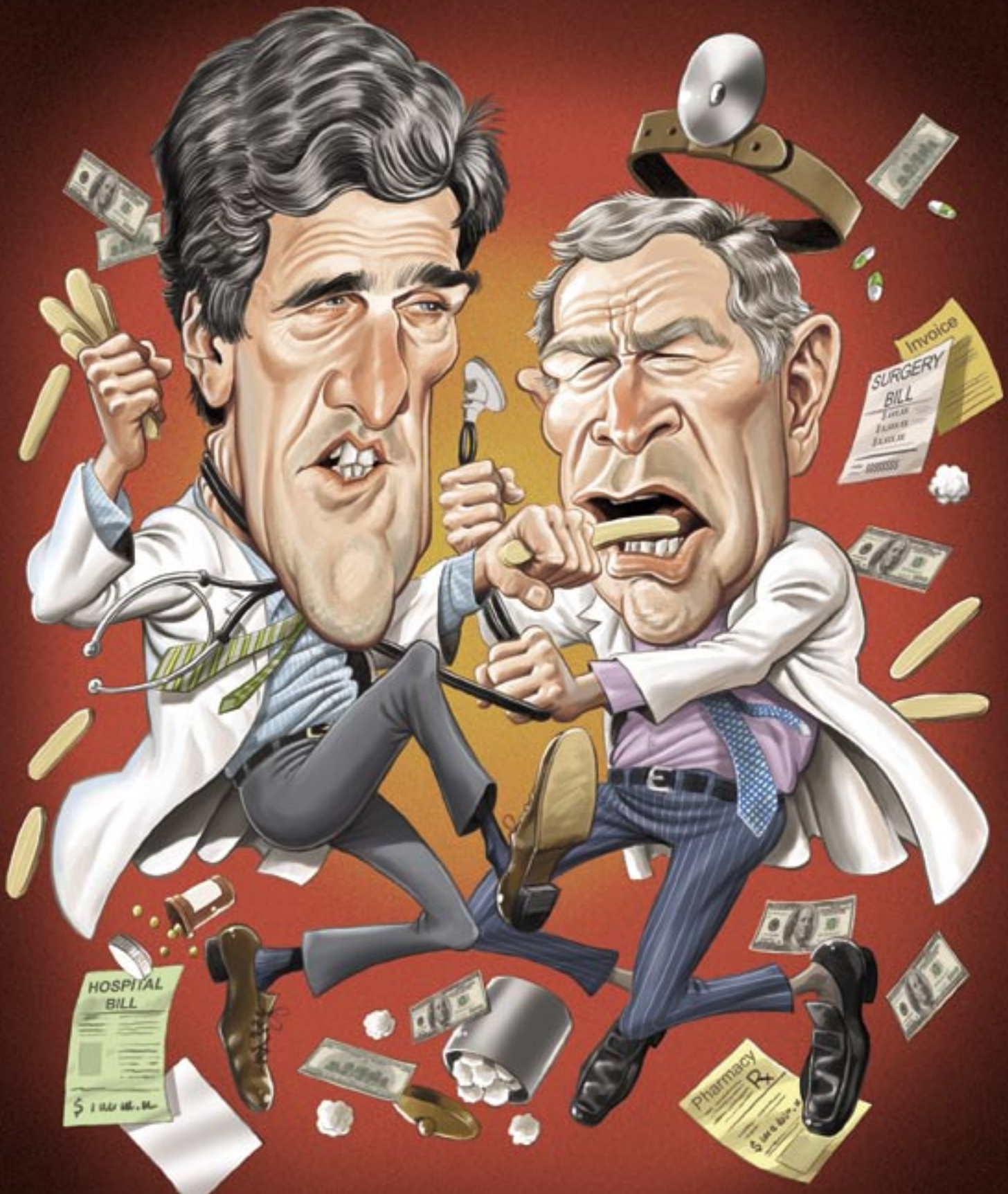
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Presidential Prescriptions for Our Ailing Health Care System

Health care takes a big bite out of the budget—not just yours and mine, but the country's GDP as well. And if you're one of the estimated 44 million people who don't have health insurance, that bite can gobble you up. So it's not surprising that along with the economy and the war (in Iraq, in Afghanistan, on terror), health care reform has become a major issue in the upcoming presidential election.

Because making health insurance available and affordable is a challenge many actuaries face, *Contingencies* asked the candidates what they plan to do about reforming the health care system, reducing its exorbitant cost, and covering the uninsured.

We also asked two actuaries active on the Academy's Health Practice Council to provide nonpartisan comments on the competing proposals. Their comments are their own and do not reflect their individual companies, *Contingencies*, or the American Academy of Actuaries.

George W. Bush: Health Care and the Middle Class

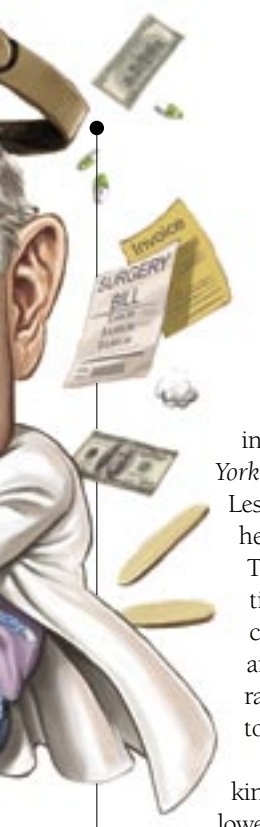
The Bush administration is working to reduce health care costs for working Americans. Health care costs, which are not set by the federal government, have been rising steadily for decades. In the past few years, however, this administration has helped slow the rate of increase for the first time in eight years.

John Kerry is anxious to complain about health care costs but has done little to help solve the problem. In fact, Kerry's solution to this problem is to shift more of the costs to the federal government, which will increase the burden on American taxpayers, without affecting the cost of health care.

Increasing health care costs is not a new trend. Kerry is just discovering a trend that he has ignored for the 20 years he has been in the Senate. According to the Congressional Budget Office (CBO), per capita spending increased from about $1,300 in 1970 (in 2002 dollars) to about $5,450 in 2002, for an average rate of real growth of 4.5 percent per year (www.cbo.gov; Jan. 28, 2004, testimony of CBO Director Douglas Holtz-Eakin before Senate HELP Committee).

The rate of health spending growth is slowing. According to the Center for Studying Health System Change, health care costs are finally slowing down following a "steep acceleration during 1996-2001." In 2001, health care spending per privately insured person was 10 percent, it fell to 9.5 percent in 2002, and now to 7.4 percent in 2003 (June 9, 2004, *Health Affairs*. "Tracking Health Care Costs: Trends Turn Downward in 2003," Strunk & Ginsburg).

Lower health care spending means lower premium increases. Employer health insurance premiums have been steadily rising since 1996, according to the Kaiser Family Foundation (www.kff.org; April 2004, "Trends and Indicators in the Changing Health Care Marketplace, 2004 Update"). As a result of the slowing of health care spending, employer-sponsored health insurance premiums grew more slowly in 2004, marking the first downtick



People consider health care a right, but they consider health insurance an imposition.

in premium growth since 1996 (May 27, 2004, *New York Times*; "Health Insurance Premiums to Increase Less than Predicted," Freudenheim). Competition in health care has helped to lower spending growth. This administration is acting to promote competition, which puts downward pressure on health care costs. According to the same *New York Times* article, "insurers would be less likely to curb their rate increases if it were not for a second, related factor: growing competitive pressure."

President Bush supports, and has implemented, the kind of consumer-driven health care that is proven to lower costs. The new Medicare law created health savings accounts that offer flexible, affordable insurance options for small businesses and individuals. Sen. Kerry opposes health savings accounts despite the fact that studies show that consumer-driven health care lowers costs. Moreover, Kerry's proposal would lead to higher costs by making patients, doctors, employers, and insurers less involved in key health care decisions.

Kerry does nothing to reduce health care costs. Kerry's solution is to expand existing federal health care programs and create new government-regulated insurance pools, shifting the costs to the American taxpayers without giving consumers more control over their health care. Kerry's "savings" of 10 percent is simply a shift of health care costs to the American taxpayer.

In addition, Kerry's proposals are available only to employers and insurers who agree to comply with Kerry's stringent requirements regarding the level of coverage, the use of savings, and the eligibility of workers.

To lower the cost of health care, President Bush attacks the underlying problems.

■ President Bush proposes to address skyrocketing medical malpractice premiums through adoption of proven minimum standards to make the medical liability system more fair, predictable, and timely. Medical liability adds $60 billion to $110 billion to the costs of health care each year, leading to higher health insurance premiums and higher medical costs for all Americans (July 25, 2002, HHS study: "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System"; www.hhs.gov). But Kerry opposes plans to reduce frivolous medical liability lawsuits and has voted 10 times in the past decade to block reform.

■ President Bush has acted to reduce prescription drug spending, which has been increasing at a much higher rate than all other components of health care spending. According to the Kaiser Family Foundation, "from 1995 to 2002, increases in drug spending were two to five times larger than increases in spending on hospital care and physician services." President Bush has addressed the cost issue by providing a voluntary Medicare drug benefit for 40 million seniors that will relieve the burden of out-of-pocket drug spending for millions of American middle-class families. Seniors now paying the full retail price for prescription drugs will be able to cut their drug costs roughly in half in exchange for a monthly premium of about $35.

■ Generic drugs have largely contributed to a slowing in the rate of prescription drug spending growth. The availability of cheaper generic drugs that are now off-patent has resulted in lower costs, thanks to the actions of the Bush administration. In addition, the incentives for patients to use generic alternatives have created pressure on drug companies to keep the cost of brand-name drugs lower. All Americans will save from the president's efforts in the new Medicare law to bring safe, lower-cost generic drugs to market sooner, which the Department of Health and Human Services estimates will save American consumers about $35 billion over the next 10 years.

Health care technology will help bring costs down. The president proposes to use modern information technology to improve medical information flow, resulting in fewer medical errors, more appropriate levels of care, improved treatment of chronic illnesses, reduced liability exposure, and less administrative overhead to improve the quality of care. President Bush has created a new senior position at HHS to lead health IT efforts.

John F. Kerry: Plan to Address Rising Health Care Costs

Skyrocketing health care costs are one of the major economic stresses for America's families and businesses. Since George W. Bush took office, the cost of family health insurance has increased more than $2,600, and has almost reached $10,000. Health care costs have risen four times as fast as wages in the past year and are consuming a larger part of the family budget. Rising health care costs are also a major strain on America's economy, as businesses are having a harder time expanding to cover health care and a harder time competing against countries with lower health care costs.

George W. Bush has offered no solutions to address rising health care costs and has done nothing as millions of families have been priced out of the employer-based health care market. John Kerry has a plan to stop spiraling health care costs by:

1. Saving families up to $1,000 a year by providing premium relief and tax credits;
2. Cutting the costs of prescription drugs that are a major driver of rising health care costs;
3. Using America's technological know-how to eliminate the

billions of dollars lost through waste, fraud, and abuse;

4. Cutting costs through incentives to improve efficiency and quality of care;
5. Reducing the number of medical malpractice cases in the system.

John Kerry's plan will:

- ***Control costs by giving relief to businesses and passing on savings to workers.***

John Kerry's plan will provide relief for employers who do the right thing by offering their employees quality health care coverage with choices. His plan will help make health care more affordable for all employers and employees by helping out with certain high-cost health cases. This will save employees up to $1,000 in family premiums.

Kerry's plan will also give Americans access to the Federal Employees Health Benefits Program (FEHBP) giving them more choices for high-quality affordable health care, which is often less expensive than their health insurance costs today.

In addition, Kerry supports $177 billion in tax credits to make health insurance more affordable for small businesses, people between the ages of 55 and 64, the unemployed, and other low- and moderate-income families. Kerry's health care tax credits are more than twice as generous as Bush's tax credits for health insurance.

- ***Cut health care costs by making prescription drugs more affordable.***

Prescription drug costs have increased by 17 percent in the past year alone. These rising prescription drug costs are a major driver of rising health care costs. George Bush passed a Medicare prescription drug bill that did nothing to stop soaring prescription drug costs. John Kerry will cut prescription drug costs by:

1. Requiring the secretary of Health and Human Services to negotiate better prices for prescription drugs, rather than paying the highest prices;
2. Allowing reimportation so that Americans can get the discounts on medications that are available in Canada;
3. Requiring transparency rules for pharmacy benefit managers that do business with the federal government to reveal their profits from the drug industry and bulk purchasing;
4. Helping states provide discounts to other populations by giving them incentives to implement more efficient contracting to obtain better rates for prescription drugs.

- ***Cut administrative costs by eliminating waste, fraud, and abuse.***

The annual cost of health care today is $1.6 trillion. About 25 percent is spent on non-medical costs, principally the costs of the paperwork burden, including those costs associated with the preparation, submission, calculation, and payment of bills. While settling a single transaction in the health care system can cost as much as $12 to $25, banks have cut their costs to less than a penny per transaction by using modern information technology. John Kerry will cut administrative costs by:

1 Ensuring all Americans have secure, private electronic medical records by 2008, which will eliminate unnecessary tests and reduce serious medical errors by as much as 88 percent;

2 Giving health providers technology bonuses to simplify and streamline their paperwork so patients can spend more time with doctors and less time filling out forms.

■ ***Reduce costs by improving efficiency and the quality of care.*** Inefficiencies in the health care system threaten lives and waste billions of dollars in unnecessary care. A recent Institute of Medicine study found that between 44,000 and 98,000 people die of medical errors every year. The vast majority of injuries come not from negligent doctors or hospitals, but from outmoded practices, habits, and systems that are poorly designed to protect patients from errors.

As president, John Kerry will offer a "quality bonus" that would enable purchasers and providers to use upfront capital to make changes in quality that reduce errors and improve outcomes. He will also make sure that those health care organizations and physicians investing in IT to improve care are rewarded with financial incentives, including funds to install computerized prescribing systems that can reduce medication errors by 80 percent or more.

■ ***Make malpractice insurance more affordable.*** John Kerry wants to make our medical liability system fairer for doctors and patients alike by substantially reducing meritless claims and enhancing opportunities to resolve claims fairly without protracted litigation. He strongly opposes arbitrarily capping damages in medical malpractice lawsuits that will not lower the cost of health care for Americans, but will only deny justice to those who suffer life-shattering injuries. As president, John Kerry would:

1 Prohibit individuals from bringing a medical malpractice liability action unless a qualified specialist determines that a reasonable claim exists;

2 Require states to make available nonbinding mediation in all cases before permitting plaintiffs to proceed to trial on any medical liability claim;

3 Support sanctions for improper claims and defenses, including those that are not warranted by existing law or by an argument with merit for changes in existing law.

An Actuarial Response

We posed questions based on the two candidates' proposals to two health actuaries. Jeffrey Petertil is an independent consulting actuary in Oak Park, Ill. David Shea is executive director and actuary for Anthem Blue Cross and Blue Shield in Richmond, Va. The opinions expressed here are their own and do not reflect their individual companies, *Contingencies*, or the American Academy of Actuaries.

Questions About the Bush Plan

Will a $1,000 tax credit be enough to make health care coverage in the individual market affordable for low-income Americans?

■ **JEFFREY PETERTIL:** A main concern of low-income people in the individual market will be the affordability of health coverage. Given that comprehensive health care in the individual market will rarely have a premium much below $4,000 annually, $1,000 will often not be enough to motivate a low-income person to spend the significant additional amounts necessary to obtain coverage. A $1,000 tax credit is much harder to understand, of course, than $1,000 in cash or discount, so I am skeptical of its efficacy.

■ **DAVID SHEA:** The answer hinges on the definition of "enough." It certainly couldn't hurt. Any time you create an incentive for health insurance coverage it can only help. But I doubt that's going to solve the problem of the uninsured. It really doesn't get at the root cause of the cost of health insurance, which is that health care is expensive. Over time, Americans have come to consider accessibility to the health care system as a right, which has driven up the cost of health care and consequently the cost of health insurance. Since health insurance today is not mandatory, you have a lot of people making choices individually about whether they want coverage. Allowing them to have a $1,000 tax credit, to the degree that low-income folks pay that level of taxes today, it may provide some help. I'm not quite sure how the tax credit will work, whether it's money in their pocket or a reduction of their tax liability. If it's money in their pocket, it'll be discretionary as to how they spend it. If the intention is to create an account from which they can pay for health insurance coverage, that will probably help a little more.

How will employers respond to the new tax credits if they are available for use only in the individual market?

■ **PETERTIL:** Employers' experience with health insurance is almost entirely in a group market that caters to employers' needs for minimal hassles with financing, administration, and communications. Few employers will be enthusiastic about spending time in the market for individual insurance.

■ **SHEA:** You're going to see the biggest impact on the small employer. Every employer struggles with the cost of health care. You can see that with the reduction in benefits and increase in employee contributions, and also the increase in consumer-driven health care where the employer provides money for employees to purchase health insurance on their own. From the tax credit standpoint, it'll start affecting the small employers more, who may struggle more than larger employers.

Will medical malpractice reform proposals significantly reduce the cost of health care?

■ **PETERTIL:** Both candidates recognize that malpractice reform is needed and significant savings might result, particularly if expenses from defensive medical practices are reduced as an indirect byproduct. But even a reform that was very successful financially would only slow the rise in health care costs. Direct medical malpractice costs are about 2 percent of total health care costs, whereas the annual increase in costs is usually at least 6 percent.

■ **SHEA:** Again, it couldn't hurt. Buried underneath the cost of health care is the cost of physicians' malpractice insurance. There seems to be a link between the cost of the insurance pre-

The salient points about health care in America are that it's expensive, essential but with little predictability as to an individual's need, and has bureaucratic barriers to access.

miums and the large punitive damage awards in states where there's no limit on the amount that can be awarded. If you start connecting the dots, then anything you can do to limit the level of awards should have a downstream effect on health insurance premiums. Will it be significant? I can't say, but it stands to reason that it should have an impact.

Will high-deductible health plans/HSAs reduce the cost of health care?

■ **PETERTIL:** I believe that health deductibles should be higher than what we typically see and that HSAs can promote the concept that many health care costs can be budgeted. I've seen no persuasive evidence, however, that what is driving the substantial increases in the cost of health care can be found in the first $1,000 of an individual's annual incurred expense.

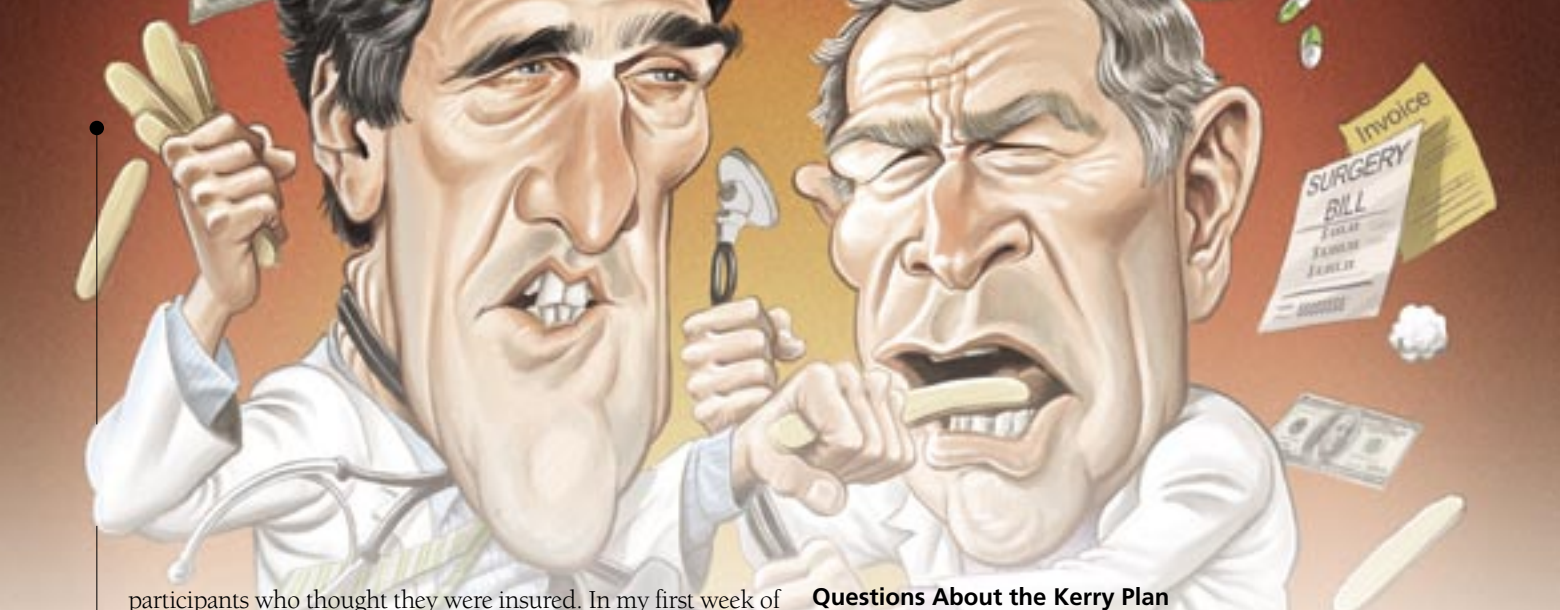
■ **SHEA:** If everyone were to purchase a high-deductible health plan, then the health care costs that insurance carriers see will be reduced because more of the burden will be placed on the individual. At that level, it's just dollar

There's a school of thought out there when individuals assume more of th their health insurance, it tends to supp zation to a degree. You tend to make l sions when you are directly affected by jury's still out on whether this will be

because employer groups don't generally offer deductibles at that level right now. Maybe this will change the market. The first folks this will appeal to are those who are financially savvy and aware of what happens with their dollars. If it brings them into the market and they're relatively healthy, health care costs on a per-member per-month basis could go down.

Are there potential market segmentation problems with Bush's AHP proposal?

■ **PETERTIL:** Yes, although the bigger problem is that a disagreeable portion of these AHPs will fail and leave large medical bills



participants who thought they were insured. In my first week of consulting in 1981, we were called on to provide last-minute reserving help for an association plan whose management had not previously been interested in the concept of claim reserves. The last minute is too late, of course, and I am afraid there will not be the safeguards in the AHPs to prevent similar occurrences.

■ **SHEA:** As it currently sits, it seems to create an unlevel playing field, particularly with regard to operating in the individual states, because it allows an AHP to essentially pick and choose the regulations it wants to operate under. To the degree that those are more liberal than the state they operate in, it creates two entities that follow different rules. And that would create an unfair advantage.

Questions About the Kerry Plan

Are public expansions the most effective way to target low-income uninsured?

■ **PETERTIL:** Yes, by default. To paraphrase Churchill, it is the worst effective way except all those other ways that have been tried. Without giving blanket approval to publicly funded health care or ignoring the problems of Medicaid, I view the private-sector response for the low-income market as inadequate and unlikely to improve within an employer-financed market.

■ **SHEA:** That's one effective way. Of course the ultimate question is, where's the money coming from? It's got to come from somewhere, either a reduction in state budgets, from other programs, or an increase in taxes. With regard to managing care, I'm not all that aware of how well public entities can manage care. But certainly an increase in public programs can bring more people into the system.

Will tax incentives be enough to encourage small-group employers to offer coverage?

■ **PETERTIL:** For employers "on the fence" as to whether or not to offer coverage, adequate tax incentives might make the difference and allow for some elements of long-term planning. But as long as small employers face the prospect of large rate increases (30 percent or more) in any year, many of them will hold back. Such increases can play havoc with business margins and overwhelm economic plans.

■ **SHEA:** The devil's in the details on that one. Each small employer has to look at his or her individual tax situation. Employers get a tax benefit from offering health care coverage to their employees today. It's a matter of how much that incentive supplements the employer's tax situation. Again, the cost of health insurance and health care is expensive.

How much would reimbursing 75 percent of more than $50,000 in catastrophic claims reduce health insurance premiums?

■ **PETERTIL:** The "how much" question can only be answered with a great deal of clarification and caveats, but if we want to reduce health costs, large claims should be a target. This is an interesting idea that would make premiums more predictable. But it supplants the reinsurance market and could have a huge cost, so it is a bigger step toward national health insurance than may be evident from a quick read of the idea.

■ **SHEA:** It will reduce it somewhat; I haven't done the math. You're talking about catastrophic levels. Fifty-thousand dollars

in claims for an individual is probably about 10 percent of the cost of health insurance, spread over everybody. That cost just doesn't go away. It gets absorbed by the whole system, so it's a matter of pooling and spreading that cost back to everybody. It could reduce it somewhat, but I don't think it would be major. It's not eliminating costs, it's just spreading it. The focus should be on how claims at that level and beyond can be mitigated by programs such as disease and care management.

How would a "technology bonus" to health care providers reduce the cost of health care?

■ **PETERTIL:** Both candidates seem to understand that an improved flow of vital information to providers and consumers could reap rewards for individuals and society. Whether a technology bonus would be a cost-effective incentive probably depends on whether cost is the barrier preventing providers and insurers from doing what it is already in their best interest to do.

■ **SHEA:** I'm not that familiar with the details, but I'd say the jury's out on this one, too. One of the major causes of the rising cost of health care has been improvements in technology. If you fall back on history, encouraging providers to use the latest and greatest may cause costs to go up. To the degree that it eliminated redundant services, that could lower some costs. But improvements in technology could find things that aren't necessarily life threatening but would encourage people to use more services. On the surface it sounds good, but it's largely unproven.

It's an intriguing approach, though, because it goes back a level. It's not overlaying solutions on health insurance premiums. It's at least acknowledging that there's something driving health insurance premiums up, so let's peel that layer of the onion off and take a look at it.

Are there potential market segmentation problems with Kerry's FEHBP buy-in?

■ **PETERTIL:** Market segmentation and the associated problems of price spirals, cherry-picking, etc. would seem to be a function of the size and diversity of the health plan risk pools. It should be less of a problem with an FEHBP buy-in than with AHPs.

■ **SHEA:** If this is an option, therein lies the issue. People have options today. I think the notion is that the FEHBP works for government workers; why wouldn't it work for everyone? That's because you're drawing on millions of federal employees. You've got a captive audience right there. Through their employer, they're allowed to purchase a vast array of product options. But making outsiders eligible doesn't make them insured. Opening it up to 20 million eligible people doesn't create 20 million insureds. Each of those 20 million folks would make the choice of whether or not to enroll.

Will it make it cheaper? It depends. Healthy individuals applying for and qualifying for health insurance can probably find it cheaper than what they can get in the FEHBP, so those folks aren't going to enroll. But if you open it up to individuals and don't require screening for health conditions, then the only people who will enroll are those for whom it's an economic benefit. If more and more of those people do it, that drives the cost of the FEHBP up.

What is the most basic problem confronting presidents and policy-makers about U.S. health care financing?

■ **PETERTIL:** The salient points about health care in America are that it's expensive, essential but with little predictability as to an individual's need, and has bureaucratic barriers to access.

After more than 30 years of involvement in the financial aspects of health care, I'm convinced it will always be expensive because, in a prosperous society of flesh-and-blood people, it will always be essential. Nevertheless, health care in America is a success story, albeit a success marred by the fact that substantial numbers of Americans fear the financial consequences of health problems more than the physical impairment. Policymakers could help, however, with the financial predictability and with the red tape, as could actuaries.

■ **SHEA:** The bottom line is, until health care coverage is mandatory for everybody, there are going to be individuals and groups that make the decision not to buy health insurance. People consider health care a right, but they consider health insurance an imposition. It boils down to a basic economic decision. Those who will benefit by having insurance will enroll; those who won't benefit won't enroll. If the costs for the folks who don't enroll are less than for those who do, the costs continue to go up. ●