ISSUE BRIEF
AMERICAN ACADEMY of ACTUARIES
SEPTEMBER 2008

TAKING CONTROL: An Actuarial Perspective on Health Spending Growth

With the number of uninsured individuals in the United States at nearly 46 million, state and federal policymakers have been pursuing various approaches to expanding health insurance coverage. Most comprehensive proposals would focus on the private insurance market as well as expansions of public coverage. Proposals to achieve universal coverage address only part of the problem of the uninsured, however. For the most part, they don't address the root of the problem—the rising costs of health care.

Recent National Health Expenditure data reveal that health care spending increased 6.7 percent in 2006. This rate is lower than earlier in the decade, but it is still more than twice the general inflation rate and exceeds the growth in the overall economy. If health spending continues to grow at this pace, health insurance premiums will increase as well.

Unless health care costs are controlled, efforts to achieve universal coverage may be in vain. Reducing health insurance premiums near term will be for naught if rising health costs mean that premiums will return to their original levels within a few years, and continue to rise rapidly thereafter. Therefore, to have the potential for sustainable success, health reform proposals need to focus seriously on controlling the rate of health spending growth.

Researchers and industry specialists have been commenting on the drivers of health care cost increases for some time, yet despite some temporary periods of lower growth, high spending growth continues to challenge us today. This issue brief, prepared by the American Academy of Actuaries' Uninsured Work Group, reviews some of the major causes of health spending growth. It focuses on drivers of health spending growth that are actuarial in nature and examines various options that have been proposed to address them.

There are no easy answers, and it is unclear whether some of the solutions currently being touted to address these drivers will ultimately be successful. As such, this brief provides comments on the limitations of certain proposals and highlights those that appear to have significant potential. To help assess the impact of a potential cost control measure, it is important to consider not only the magnitude of any cost savings, but also whether they are one-time or permanent in nature, whether they will accrue in the short-term or the long-term, any associated implementation expenses, and the effect on health care quality.

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AMERICAN ACADEMY of ACTUARIES

1100 Seventeenth Street NW Seventh Floor
Washington, DC 20036
Tel 202 223 8196 Fax 202 872 1948
www.actuary.org

Grace Hinchman, Executive Director
Steve Sullivan, Director of Communications
Craig Hanna, Director of Public Policy
Heather Jerbi, Senior Health Policy Analyst

WHY DO HEALTH CARE COSTS INCREASE SO RAPIDLY?

In general, the drivers of health spending growth that are discussed in this issue brief can be thought of in terms of those that contribute to increases in the price paid for health care services, and those that contribute to higher levels of health care utilization.[1]

Health care service prices increase for reasons such as:

- Broader provider networks limiting the ability of health care purchasers to negotiate discounts;
- The shortage of primary care physicians resulting in greater use of specialist care at higher service fees; and
- Provider consolidation increasing size and leverage, potentially reducing price competition.

Health care utilization increases for reasons such as:

- New medical technology that can be more expensive than the technology that it replaces;
- Predominant provider reimbursement structures that reward health care providers for providing more services;
- Comprehensive benefit packages that lower the out-of-pocket costs that consumers face at the point of service; and
- Less healthy lifestyle choices that increase the need for medical services to treat and manage chronic diseases.

Each of these primary drivers is discussed in more detail below. In addition, the brief discusses two factors that don't affect health spending overall, but do affect health insurance premiums—adverse selection and cost shifting.

DRIVERS THAT INCREASE THE PRICE OF SERVICES

Broader Access Provider Networks

In recent years, health insurance plans have moved away from narrow provider networks (e.g., health maintenance organizations (HMOs)) toward broader networks (e.g., preferred provider organizations (PPOs)) because of consumer demand—insureds were dissatisfied with the narrow networks of the 1990s. However, having broader networks limits a health plan's ability to negotiate provider discounts, because the plan cannot impose strict efficiency standards on providers or negotiate lower rates by directing a larger share of members to a smaller number of providers. Ideally, the provider network would be narrow enough to keep costs low, but broad enough to enable appropriate levels of provider access for the plan's members.

While, in theory, narrow networks can be an effective way to manage cost increases, health care consumers have generally preferred greater choice of providers, even at the expense of higher prices. Therefore, it seems unlikely, at least in the short term, that narrower networks could be implemented as a material cost control mechanism.

Provider Capacity

Recent reports have indicated shortages in the primary care workforce.[2] Because of this shortage, individuals often resort to using specialists for routine care, even though the cost for the same service can be higher when provided by a specialist rather than by a primary care physician. Providing incentives to use primary care physicians, physician assistants, and nurse practitioners rather than specialists, whenever possible, should help moderate average unit costs. Nevertheless, until the primary-care workforce shortage is reduced, average costs per service will remain high. Increasing the supply of primary care providers will require a more long-term

[1]Other factors that may contribute to health spending growth, but are not discussed in this issue brief, include general inflation, increases in disposable income, the aging of the population, medical malpractice/defensive medicine, and direct-to-consumer advertising.

[2]See, for example, National Association of Community Health Centers. *Access Transformed: Building a Primary Care Workforce for the 21st Century.* (August 2008).

solution, including incentives for doctors to choose primary care rather than a specialty.

Provider Consolidation

On one hand, consolidation of providers can help control health spending through greater economies of scale. Under many circumstances, however, consolidation may actually have the opposite effect by reducing competition. Consolidations generally increase the size of the provider and in turn, its leverage. As a result, consolidations may give providers more bargaining power when negotiating reimbursement rates with health plans, leading to higher unit costs. One option for addressing this problem may be regulation that limits consolidation beyond that needed to create economies of scale.

DRIVERS THAT INCREASE UTILIZATION

New Technology and Treatments

The development of new medical technologies is one of the largest drivers of health spending growth. New technologies can increase health care spending by increasing the utilization of health care services, and the utilization of higher intensity services in particular. While advances in technology and pharmaceuticals have brought breakthroughs that have increased life expectancy, many advances are additive and supplement existing treatments, rather than replace prior treatments. As a result, improvements in longevity and quality of life have come with tremendous costs. Complicating the issue is the fact that, unlike some other types of technology, medical technology does not typically decrease in price over time. In addition, new technology and treatments may not always be better or more cost-effective than prior treatments.

Increasing comparative effectiveness research could help improve the process by which new medical technologies are incorporated into the health care system. Although assessments of new technologies are currently available to at least some extent, they are often limited by a lack of credible clinical data. Either there are no data at all or the data that are available do not offer enough high-quality evidence comparing the new technology to existing treatments or technologies. Comparative effectiveness research that focuses on primary research—head-to-head clinical trials comparing new and existing treatments and technologies—could help inform treatment decisions. And because a large share of services currently provided to patients and reimbursed by insurers has no underlying evidence base,[3] research should include studies of existing technologies.

Comparative effectiveness research can refocus the health care delivery system on the value of care received and facilitate a shift toward more evidence-based medicine. In doing so, it has the potential to increase the quality and value of care as well as reduce the variations in health care treatments and spending across the country that are not associated with better health care outcomes. As these efforts aim to increase the quality and value of care received, they may not necessarily result in lower health care spending or lower health care spending growth.[4]

Provider Reimbursement

Current provider payment systems do not align provider financial incentives with the goal of maximizing the quality and value of health care provided. Instead, the most common provider payment mechanisms reward more care, and more intense care, but not necessarily more coordinated, cost-effective, or quality care. Typically, the more services provided by hospitals and physicians, the higher their revenue. In the current environment, providers have little financial incentive to provide cost-effective care. Moreover, provider reimbursements are not tied to treatment outcomes.

Pay-for-performance programs provide one means of aligning financial reimbursement with improved health outcomes. The long-term viability of any pay-for-perfor-

[3]"What Proportion of Healthcare is Evidence Based? Resource Guide," www.shef.ac.uk/~scharr/ir/percent.html
[4]More information on how advances in health technology are incorporated into the health care system and the potential implications of a more formalized comparative effectiveness research process, see the American Academy of Actuaries issue brief, *Health Insurance Coverage and Reimbursement Decisions: Implications for Increased Comparative Effectiveness Research.*

mance program, however, will rely on its ability to influence provider behavior primarily through the size of any financial reward or penalty. While there is reason to believe that these programs would improve quality and reduce health care costs through the provision of best-practice medicine on a cost-effective basis, issues related to measures of relative performance and credible data to assess performance still need to be addressed.

More structural reorganizations of the health care delivery and reimbursement systems are also being explored. For instance, the Medical Home approach would provide more patient-centered care managed and coordinated by a personal physician. Accountable Care Organizations would group together physicians, such as those affiliated with the same hospital. The group would be responsible for improving the quality and controlling the costs of their patients' care. Enhanced health information technologies would facilitate care coordination under these types of approaches.

More Generous Benefit Packages

Most employer- and government-sponsored health insurance programs in use today cover a comprehensive set of medical services. This comprehensiveness lowers the out-of-pocket cost of care to the insured—insureds face cost-sharing requirements that are only a fraction of the total cost and few services fall outside of the insurance coverage. This results in increased utilization of medical services. Although some of the increased utilization is for necessary care, some is for unnecessary care. "Essential" and "unnecessary" care have yet to be defined to the satisfaction of all parties, and continue to be a matter of debate in most reform discussions. In addition to affecting the utilization of care directly, more generous benefit packages can also increase utilization indirectly, by encouraging the development of new technologies and treatments.

Although most types of insurance generally do not provide coverage for predictable budgetable expenses, health insurance will often cover preventive care (such as flu shots), wellness benefits, and other budgetable expenses. Coverage of such benefits has the potential to avoid more expensive, acute care in the future. Nevertheless, the savings from the avoidance of future acute-care episodes will not necessarily offset the costs of providing such benefits. That is because everyone receives the wellness benefit, but not everyone would have had the acute episode.

Benefit-design features such as cost-sharing requirements can be used to encourage more effective use of health care services. For example, charging a lower copayment for an urgent care visit than an emergency room visit will encourage care to be received at the less expensive urgent care facility. The cost of the lower copayment is more than offset by the reduced cost of the urgent care visit. Higher cost-sharing can also be used to discourage unnecessary care.

Any incentives to make insureds more sensitive to benefit costs, however, should be balanced with the desire to avoid penalizing those individuals for whom that service is non-discretionary, particularly individuals with chronic conditions. A relatively new concept in insurance benefit design is the Value Based Insurance Design (VBID) concept. Under a VBID benefit design, cost sharing on maintenance measures for chronic individuals is reduced to encourage them to manage their conditions. The theory behind this design is that the increased plan cost now is offset by lower future costs that would otherwise have been associated with deteriorating conditions. It is still too soon to know if the theory has been borne out through actual experience on these new products. Since not everyone who benefits from the lower cost sharing would have experienced a deteriorated condition, it is not clear that the savings on the few will pay for the lower cost sharing for all. Still, the premise, which could be expanded to include other types of practices that have shown to be cost effective through comparative effectiveness research, appears to have the potential for improved value-based health care purchasing.

Lifestyle

Lack of exercise, poor eating habits, and smoking can all increase health care costs. For instance, increases in obesity rates have

led to increases in the prevalence of diabetes; smoking can lead to lung cancer and heart disease. Such lifestyle choices increase the need for and utilization of health services to manage chronic conditions.

The onset of many chronic conditions could be prevented, delayed, or mitigated by better nutrition, more exercise, and smoking cessation. Many insurers and employers have developed wellness and disease-management programs to encourage lifestyle changes and to manage the chronic conditions that arise due to unhealthy lifestyle choices or other reasons. Expansion of these types of programs, along with an increased emphasis on preventive care, has been touted as a potentially effective means of cost containment. They do, in fact, have potential for long-term cost control, but contain features that may limit significant expansion.

WELLNESS PROGRAMS

A number of employers have implemented wellness benefits such as onsite workout facilities, full or partial funding of health club memberships, smoking cessation programs, and/or weight control programs. Some employers have also incorporated penalties for unhealthy choices, such as higher premiums for smokers. Greater emphasis on penalties, especially if based on weight or other physical conditions, could be difficult to implement and could draw opposition based on discrimination issues. There is a fine line between discrimination and the adjustment of premiums by health status, and certain federal and state laws limit employers and insurers in terms of imposing penalties. However, some employers have experimented with providing incentives for enrollment in wellness programs, such as compensation for a specified percentage of weight loss.

Wellness programs can have high short-term costs with the hope for overall savings in the long term. Employers and insurers have both questioned the cost-effectiveness of these programs, however. And even if cost-effectiveness can be demonstrated, cost savings may not emerge until years after program participation, when the individual may be with another employer or retired. In other words, employers bear the short-term program costs, but don't necessarily realize the long-term savings. This may discourage employers from offering these kinds of programs, even though they may reap other program benefits, such as reduced employee stress levels, improved attitude, reduced absenteeism, and increased productivity.

CHRONIC CARE AND DISEASE MANAGEMENT

Chronic care and disease management involves trained professionals providing integrated care coordination to individuals with chronic or high-cost diseases. Through treatment protocols and educational efforts around self-care, these programs aim to keep patients' conditions from deteriorating and deliver care on a more cost-effective basis. Some conditions that lend themselves to care management include diabetes, congestive heart failure, asthma, and end-of-life care.

Chronic care and disease management protocols are monitored by care managers who communicate regularly with patients. They can be staffed with nurses or, in some cases, with non-medical personnel who use computer software that provides language scripts and patient tracking. Patients are called to verify that they are following protocols and to track health indicators such as insulin intake. When a problem is suspected, notification is made to the patient's physician, who can then follow up with the patient as appropriate.

To have the most effect on costs, care management programs need to be based on sound medical protocols that have been proven to increase healthy outcomes and decrease costs. In addition to the cost associated with program implementation, these protocols take time and money to develop and prove effective. It is unclear whether, in the aggregate, the administrative costs will be more than offset by the savings they create. While these programs may increase quality of life and the value of health care provided, they may not produce the reduction in health care costs that are often hoped for, or promised. Attention must be paid to review the cost and benefits of such programs and have realistic expectations as to their impact on costs.

OTHER DRIVERS

In addition to factors that increase overall health spending, either through increases in prices or increases in utilization, other factors will affect private health insurance premiums—adverse selection and cost shifting.

Adverse Selection

In a voluntary health insurance market, individuals who are more likely to be high users of medical care are more likely not only to purchase coverage, but also to purchase more generous coverage. This is known as adverse selection, and is due in part to asymmetric knowledge between individuals and insurers—individuals are more knowledgeable about their potential future health needs than are insurers. As a result, insurers increase premiums to cover the impact of this selection.

Certain insurance issue and rating regulations can exacerbate adverse selection. For instance, guaranteed-issue requirements allow individuals to delay purchasing insurance until their health needs arise. Pure community rating rules increase premiums for individuals at lower risk of high health costs. Both of these work to increase the average premiums of those purchasing coverage. And as premiums are set higher to reflect the higher costs of enrollees, even fewer new applicants or existing healthy enrollees are willing to pay them. This further increases adverse selection and the resulting premiums.

As individuals assess their own health conditions in light of an insurance system that seeks to charge premiums appropriate for the risks being insured, they will consider entering the system under terms that will provide them with the best benefit value for their dollar (i.e., highest benefit return per premium dollar paid). The healthiest individuals may wish to stay out of the insurance system completely because their risk is perceived to be below any premium requirement. Thus, the remaining individuals are left to divide their costs among a group with existing or expected near-term health expenses, leading to higher average unit costs for the plan. Also, those individuals who perceived their own risk to be low may enter the system at a time when specific health needs arise, requiring substantial treatments for conditions that were not addressed during periods of un- or under-insurance. As such, they cost the system more initially than they would have otherwise.

Increasing overall participation in health insurance plans, in particular among those with average or lower-than-average expected claim costs, would be one of the most effective ways to minimize adverse selection. That way, there will be enough healthy enrollees over which to spread the costs of those with high health costs. Aside from mandating coverage—which wouldn't necessarily guarantee 100 percent participation—potential options to help minimize adverse selection include providing premium subsidies, making enrollment the default option, penalizing delayed enrollment through higher premiums, providing lower benefits, or instituting longer waiting periods. The Medicare program, for example, discourages adverse selection by charging higher premiums for certain individuals who delay enrollment in Parts B and D. Implementing risk adjustment mechanisms could also be used to mitigate the impact of adverse selection.

Cost Shifting

The term "cost shifting" refers to the phenomenon in which health care providers charge higher rates to private payers to compensate for below-cost payments received from Medicare and Medicaid, free care provided to uninsured patients, and uncollectable patient cost sharing. While an important driver of per-unit cost increases in private insurance, cost shifting is not a driver of underlying health care costs, but rather a dynamic of cost distribution among different payers.

The extent of cost shifting varies over time and across markets, depending in part on the relative bargaining power between providers and purchasers as well as on the other options providers have for absorbing lower public payment levels (e.g., eliminating inefficiencies, reducing the number of public beneficiaries they serve, seeking increased charitable contributions or general revenue funding). A particular concern with

cost shifting is the potential for a spiral effect, particularly during economic downturns when Medicaid and uninsured rolls typically grow. Given budgetary pressures, states may try to cut or freeze provider payment levels. If public program payment levels are frozen or increases lag behind providers' cost increases, the resulting cost shifting to private payers could accelerate declines in private insurance coverage due to premium increases. This could push even more individuals into public programs or uninsured status. For similar reasons, coverage expansion programs should take particular care to avoid crowd-out—in which individuals drop private coverage for public coverage—which could produce even greater pressure to shift costs.

CONCLUSION

As a society, we value medical advances and the life-saving results they can provide. We value autonomy and the ability to make choices about our health care in consultation with our physicians. These values and choices have implications for what health care services cost. Within that environment, however, policymakers considering health care reform initiatives may be able to address systematic characteristics that can help to control costs without violating strong cultural preferences. Without controlling health spending growth, significant coverage initiatives may be unsustainable.

Many factors contribute to why health spending increases faster than general inflation. Managing these increases, while retaining and improving health care quality, will involve creative programs. There may need to be trade-offs, financial and otherwise, among the several stakeholder groups in order to achieve even incremental goals.

There is no one solution to controlling the rising costs of health care. Researching comparative effectiveness, restructuring the provider payment system, making benefit design changes, and instituting care management and coordination programs, however, have the potential to significantly reduce health-spending growth. Policymakers should explore these strategies and attempt to maximize the extent to which their potential can be realized.

AMERICAN ACADEMY *of* ACTUARIES

1100 Seventeenth Street NW
Seventh Floor
Washington, DC 20036
Tel 202 223 8196
Fax 202 872 1948
www.actuary.org