Concerned Actuaries Group

AMERICAN HEALTH CARE

Rethinking the Challenges, Opportunities and Possibilities

...a series of expert briefings on how the American Health Care economy affects the nation's overall economic wellbeing.

Big Benefits

A collaborative initiative of the Committee for a Federal Budget and the Concerned Actuaries Group

Spring 2018
American Health Care

Rethinking the Challenges, Opportunities and Possibilities

Big Benefits

A look at the relationship between benefits, usage and costs

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Background

The Concerned Actuaries Group, Inc. (CAG) is a 501(c)(3) organization that grew out of a conviction on the part of a number of prominent actuaries that the nation's social insurance and public pension programs were not being financed or managed in a sustainable manner and were, as a result, creating significant generational equity concerns.

Dedicated to addressing these concerns, the CAG focuses on activities that increase the likelihood, “…that the nation's public finance and social insurance programs are designed and managed with the actuarial discipline and transparency such programs deserve and should require.” In pursuit of that effort, the organization strives to encourage responsible change by developing and strategically disseminating, “…full, accurate, and easily understood analyses of the financial realities affecting the funding and security of our nation's public finance and social insurance programs.”

CAG directors concluded that furthering the organization’s mission in an age of misinformation and polarized politics would require a more concentrated and collaborative effort. To that end, the CAG decided to:

- focus on a high profile issue that had already captured policy maker, public and media interest and that demonstrated the validity of our concerns;
- establish a formal working collaboration on that issue with another non-partisan organization that enjoys standing and reach with policy makers and the major news media; and
- over time broaden that collaborative effort to include others affected by and/or interested in and/or with special skills related to the issue.

Since that time, the CAG has:

- identified as its major issue of focus the fiscal and operational challenges, opportunities and possibilities facing American health care;
- entered into a formal collaboration agreement with the Committee for a Responsible Federal Budget (CRFB), a highly regarded 501(c)(3) organization that grew out of the 2010 National Commission on Fiscal Responsibility and Reform (often called the Simpson-Bowles Commission) that provides respected analysis of national fiscal policy; and
- designed, in collaboration with the CRFB, a public information outreach initiative called Rethinking the Challenges, Opportunities and Possibilities of American Health Care.

This article is one part of a portfolio of materials that includes: 1) a video presentation on Big Numbers; 2) this article; 3) an article by Mr. Marc Goldwein of the Committee for a Responsible Federal Budget; and 4) a pdf of the all of the charts and graphs used in this article and the video. The CAG is responsible for the content and comments in the video, this article and the charts and graphics. CRFB is responsible for the content and comments in Mr. Goldwein’s article. All the materials referenced can be found at both www.concernedactuaries.org and www.crfb.org.
Introduction

The current national discussion about health care in America is not really about health care. It is about paying for health care.

As a result, the dialogue is concentrated on questions related to the structure and cost of public and private insurance coverage and the subsidies related to that coverage. In this narrowly defined arena, attainment of health insurance coverage is portrayed or seen as the solution to the nation’s health care needs.

Policy makers, however, are not focused on how to improve the quality, availability, and management of health care. They are arguing instead about how many people are insured, whether people with pre-existing conditions are protected, the cost of premiums and the level of out-of-pocket expenses.

Coverage is, of course, one of the issues that must be addressed. But we cannot find the answers we seek and need, by addressing coverage in a vacuum that ignores the many challenges facing our health care system; the demographics driving both the usage and the cost of health care; the economic realities related to individual and institutional ability to pay and the economic implications of the policies currently already adopted; and a host of equity issues including the shifting of costs amongst current populations and to future generations. In short, as this two-dimensional debate rages, broader strategic and operational questions central to our health care needs are being ignored; our understanding of the system is distorted; unintended adverse effects are obscured; and we are encouraged to ignore important actuarial, economic, and accounting principles.

In an effort to enhance public awareness and understanding, the Concerned Actuaries Group and the Committee for a Responsible Federal Budget are co-hosting a series of expert presentations and conversations on the broader and more complex spectrum of issues that must be considered in the search for an equitable, sustainable American health care system.

The series, American Health Care: Rethinking the Challenges, Opportunities and Possibilities, first program, Big Numbers, focused on the interaction between population demographics, cost of care, and the impact on the payment for and delivery of health care.

This second program looks at the relationship between benefits, usage, and costs; and, the third program examines the allocation and management of public and private costs and payments.

In all of these presentations, we will highlight the conclusions we think critical to informed discussion of health care in America and share examples of the data and research findings that support those conclusions.
Key Take Aways

The conclusions in our BIG BENEFITS presentation, include…

- Benefit payments for health care in America are paid at or after time of service by a variety of different entities and are financed in a variety of different ways.
- The public tax-supported program enrollment and payment criteria do not meet the basic risk management criteria historically required by private insurance programs.
- The public tax-supported program enrollment and payment criteria do not meet basic sustainability criteria historically required by private insurance programs.
- Health Care Services and related costs are driven, if not determined, by the nature of the care required”.
- The allocation and distribution of payment of “benefits” has led to a series of use-driven distortions in America’s health care system.

1. Benefit payments for health care in America are paid at or after time of service by a variety of different entities and are financed in a variety of different ways.

Health care benefit payments are made by a variety of different entities and are financed in different ways. There are, for example, public tax-supported programs including Medicare, Medicaid, the Affordable Care Act and the Children's Health Insurance Program.
There are also employer and individual sponsored premium financed insurance programs. And, of course, there are out of pocket costs paid for by individuals and families.

In 2017, we spent $3.5 Trillion on health – that’s about $10,700 per person. Deducting the out of pocket and premium costs paid by individuals and families - about $1,850 - the average being paid by a public payor or a private insurance payor, is about $8,850 a person, which means that individuals and families paid about $600 Billion and the other payors paid $2.9 TRILLION,
2. Public tax-supported programs are not insurance programs because they do not meet the basic risk management criteria historically required by insurers.

To understand this point we need to spend a minute understanding how the words “risk,” “coverage,” and “benefits”
* were understood and used historically by people who bought and sold insurance;
* how those words are understood and being used very differently today in discussions and decisions about American Health Care;
* and how that shift in understanding and use has affected and distorted the cost and delivery of health care in America.

Without getting too much into the weeds, it is safe to say that insurance originally developed as a mechanism for transferring and sharing risk.

Commerce expanded, for example, because insurance enabled shippers to manage losses by sharing risk with their peers and competitors. Understanding and quantifying the risk was central to sharing it – that is, to determining what was an equitable price for those participating to pay for their share of the risk – or as Chris Pope, a Senior Fellow at the Manhattan Institute put it recently in a Wall Street Journal column, “In most insurance markets, people seek coverage in proportion to the risk they expect to face, and insurers receive payment in proportion to the cost they expect to cover.”

To do that, it is essential to know how a prospective customer’s individual and situational characteristics increased or decreased their risk compared to others in what eventually came to be called the “risk pool.”
In the day of sailing ships, for example, factors affecting risk would include the size of the ship, the waters upon which it was sailing, ultimate destination, frequency of trips, skill of the captain and crew, and many more.

When it come to health care insurance, higher risk individuals are those with higher health care needs and costs. Broad, homogenous risk pools are those where a targeted balance of higher and lower risk individuals are maintained over time.

3. The public tax-supported programs are not insurance programs because they do not meet basic sustainability criteria.

Plans that cannot reasonably maintain the mix of higher and lower needs and costs run the risk of requiring premiums that are too high to attract or keep lower risk individuals - thus starting a plan’s “death spiral” as depicted in the graphic.

With that in mind, it is important to note that participation in Medicare for ages 65+ is based on almost exclusively on age, not risk. And that participation in Medicaid is based on income, not risk.

Which means that more than one out of every three dollars spent on health care in America - $1.2 Trillion - is financed by state and federal tax dollars on programs in which neither the need for nor the cost of services required are enrollment considerations and suggests that it is not appropriate to portray either Medicare or Medicaid as a health care “insurance” program.
In a traditional insurance model, the incidents for which the insurer is liable are identified and when an incident occurs the insured receives the benefit of a payment for that incident. Doing this in a responsible and sustainable fashion requires calculating the risk, determining the costs; identifying a risk pool that effectively balances risk and cost; and setting a price for the pool estimated to cover their projected costs and profits, while being marketable to the identified consumers.

More specifically, sustainable insurance plans ultimately depend upon the simple premise that coverage can be broad and benefits sufficient to generous only if paid benefits and expenses to date plus future projections of these items do not exceed premiums collected over the plan lifetime.

4. **The Health Care Services and related costs are driven, if not determined, by the nature of the care required**.

National health care expenditures projected for 2017 are about equally divided between publicly funded program payments and private insurance benefit payments, which means that half of all payments were made via programs that do not meet the criteria normally accepted for a successful insurance model.

![Health Care Costs Diagram](image)

Not surprisingly, costs tend to correlate with the severity of the condition of the patient and as you can see nearly two-thirds of health care payments go to
provide services to those with chronic conditions and those who need care for acute illness and/or injury.

Health care costs for the approximately 298 million people in the American health care system are, as noted earlier, paid from different sources. Medicare, for example, pays for about 53.5 million or 18% of that total. Medicaid pays for another 68.5 million or 23%. And, private insurers and employers and individuals pay costs for about 176 million or 59%.

Each of these populations – that is, Medicare, Medicaid and private insurance – present different profiles in terms of their need for care. For example, over $600 billion of Medicare's nearly $700 billion of patient payments go to pay for chronic illness, acute illness/injury and last year of life care.

On the other hand, more than $300 billion of Medicaid payments go for chronic, and acute care, while just over $100 billion of patient care costs pays for nursing home care.
And, nearly $1 Trillion in employer and individual insurance payments pays are either for care for healthy people or for those suffering from chronic and acute illnesses.

When we look at America’s three main health care payment platforms – Medicare, Medicaid and private insurance – two conclusions are obvious. First, each platform is grappling with a different mix of demand for services. Second, charges for chronic and acute care combined represent the largest expense for each platform population.
When one looks at the size of each population compared to the percentage of the costs allocated to their care, we see that the Medicare population represents roughly 18% of the total population and accounts for 18% of the costs, while Medicaid participants account for about 23% of the population, and 20% of the costs. And those with employer and individual insurance represent 59% of the total population but account for 50% of all cost.

These relatively small percentage differences sometimes obscure two other critical conclusions. First, because the size and nature of the three populations is different, each platform allocates its costs differently. So, for example, the employer population accounts for 53% of all chronic illness costs, while Medicare accounts for 78% of all last year of life costs.

Given all of this, the data indicates that the average per person cost by platform varies significantly with Medicare averaging more than $13,000 per person; Medicaid averaging nearly $9,500 a person, and employer and individual payments averaging just under $7,000 a person.
If both Medicare and Medicaid expenditures grow at currently projected rates, **by 2027** public payments for health care will account for 56% of all payments.

![Diagram showing health care benefits distribution](Diagram.png)

And, it is important to note that the sustainability of the publicly funded programs is at-risk. In 2017, for example, allocated general purpose revenues and dedicated income amounted to $914 Billion. Federal health care payment expenditures totaled $1.08 Trillion, which generated a $166 Billion deficit and accounted for 25% of the federal government’s total 2017 deficit of $664 Billion.

5. **The allocation and distribution of payment of “benefits” has led to a series of use-driven distortions in America’s health care system.**

These brief presentations do not allow for enough time to cover all of the unintended consequences generated over the past decades by ill-advised spending and management, but we can highlight a few examples.
Starting with the fact that the nation is suffering from a shortage of primary care physicians.

Look again at what we spend money on paying particular attention to the three largest categories of expenditures indicating that well over half the money spent on all health care in America was spent on acutely and chronically ill patients and that twice as much money was spent on those suffering from chronic and acute illnesses as was spent on healthy patients.

That in turn has produced a greater demand for specialists who could treat those populations. At the same time, reductions in provider reimbursements and other factors such as training costs and timeframes have discouraged entrants of new providers and retirements. The bottom line is that incomes have gone much higher relatively for specialists than for primary care doctors while the number of doctors has declined relative to the demand created by population aging and growth.
Neither is the urbanization of full-service health care in America. Look at the map below showing America’s over 65 population by county and think Medicare. Everywhere you see darker purple you are looking at an urban area.

Now look at a similar map showing where poverty is concentrated in America and think Medicaid. Again, the darker areas are all urban areas. Now look at this graph showing a decades old pattern of youth migration to urban areas and the graph projecting declining workforce participation rates and think employers and individuals who understand that they have to locate and expand in urban areas. Now think population concentrations and money and you can understand why full-service health care is becoming an urban rather than universal phenomenon.

A third example would be the distortion of utilization and access.

Remember that while nearly all employer and individual private coverage and Medicare require premium and out of pocket payments, Medicaid coverage requires neither and Medicare premiums and out of pocket costs are much lower on average than for employer/individual coverage.
Designating payor payments made by employers insurers as “1,” allows us to visualize important comparative differences in utilization.

And you will notice that Medicare recipient benefit utilization averages roughly 20% to 25% higher than private sector payments, driven primarily by very limited out-of-pocket costs due to supplemental coverages filling most cost sharing under Medicare.

You will also notice that Medicaid recipient benefit utilization averages roughly 40% to 50% higher than private sector payments. You will also note that the usage percentages have been adjusted for age, gender and other factors to be comparable to the employer benefit utilization base line, which suggests that any lack of premium payments and out of pocket costs tends to increase usage dramatically.

As both government and employer and individual payors have grappled over the years with the rising health care costs we discussed in our first program, both have set or negotiated lower reimbursement rates and you will notice, once again, that the Medicaid profile deviates furthest from the employer norm, which highlights the pressure higher benefit utilization puts on limited state and federal resources and may suggest that higher usage and lower reimbursement rates are resulting in more than 12,000,000 Medicaid recipients not being able to access care in a timely manner.
One last example demonstrates that governmental health care spending is distorting the ability of States and the federal government to provide other important governmental services.

In March of this year, the Wall Street Journal ran a page 1 story headlined “State Budgets Face Historic Squeeze” in which they report a 2008 comment from then Secretary Leavitt which reads “Medicaid costs, said then Secretary of Health and Human Services Michael Leavitt [said in 2008], were projected to grow so fast that within 10 years they would ‘crowd out virtually every other category of spending.’ State spending on higher education, infrastructure and safety, he predicted would all get squeezed.”

His prediction has turned out to be painfully true. Consider the following examples cited in the Wall Street Journal article.

Medicaid’s share of ALL federal aid to states and local governments was already 55% when Secretary Leavitt made his prediction. Just 8 years later in 2016 it exceeded two-thirds of all state and local federal dollars.

SOURCE: Wall Street Journal, March 29, 2018
During that same time period, state and local governments nationwide cut 286,000 employees. State and local government investments in infrastructure have declined. State revenue sharing with local units of government has fallen.

SOURCE: Wall Street Journal, March 29, 2018
And state support for public colleges continued to diminish as support compared to 1980 fell in 49 of the 50 states.

**Percentage of public-college budgets funded by state aid**

![Chart showing percentage of public-college budgets funded by state aid.](source)

**Conclusion**

The main take away from our first presentation on Big Numbers was that the magnitude of the enrollment and dollars was arguably not sustainable in terms of any reasonable projection of either governmental or household income.

This presentation on Big Benefits leads to two additional inescapable conclusions. First, the way in which government healthcare revenues are currently incurred, administered and allocated is placing a very significant burden on the cost of doing business in the United States. Second, it is eroding the quality of life in this country by inevitably forcing major damaging cuts in revenues for state and local services and funds needed for education.