

TOUGH MEDICINE

Apportioning the True Cost of Health Care

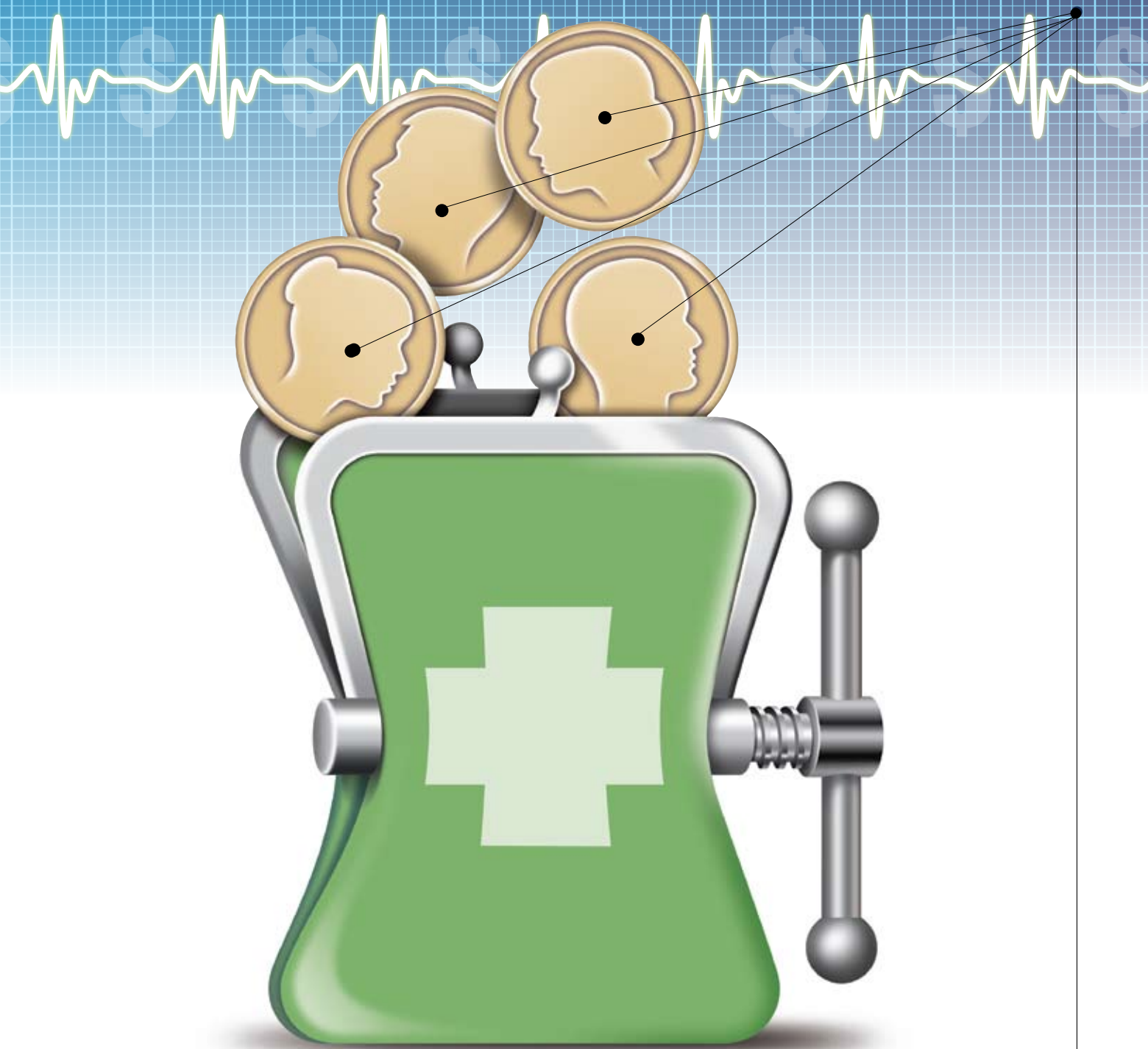
BY DENNIS BARRY

People need to be responsible for funding their own health expenditures to the extent that they can. Nothing else can stop the continuing upward spiral in health care costs.

THERE'S BEEN A LOT OF TALK RECENTLY about finding a way to drive down the cost of health insurance. But when all is said and done, the basic question regarding delivery of health care in the United States has little to do with insurance and everything to do with the cost of services to individual patients.

To gain a better understanding of the issue, let's look at U.S. health insurance as it is now. There are at least five elements that are of interest:

- ▶ Coverage isn't universal. Everyone is focused on how to get insurance to those who don't have it but without much thought as to what will be covered or what it might cost.
- ▶ Coverage is neither comprehensive nor uniform. Plans come in all shapes and sizes, and comprehensive coverage is rare and becoming rarer. Services are excluded, or severely limited, in a lot of plans.
- ▶ Coverage often is available for things that aren't medically necessary but not available for things that are. Cutting-edge and potentially lifesaving procedures are designated "experimental" and aren't covered, while services for minor conditions are covered, no questions asked.
- ▶ Excluding Medicare and Medicaid, coverage is commonly tied to employment. This is a vestige of another time and now makes little sense other than for tax savings. Employer-sponsored medical insurance largely arose out of the wage freeze during World War II. Some unions, unable to win direct pay increases for their members, bargained for fringe benefits, including hospital, surgical, and/or medical coverage. Ultimately, these programs (for both premiums and claims) were determined not to be subject to federal income tax for employees and to be deductible for employers.
- ▶ What we see today isn't altogether true insurance. Major medical plans maintain elements of insurance at the upper end, but they also feature a lot of other things that are neither entirely—or even mostly—insurance, including prepayment of health care for low-cost services, dollar-swapping features at the low end, tax-free wages for those whose insurance comes



through employers, an admission ticket to the health care system, and service as a very efficient collection agency for health care providers.

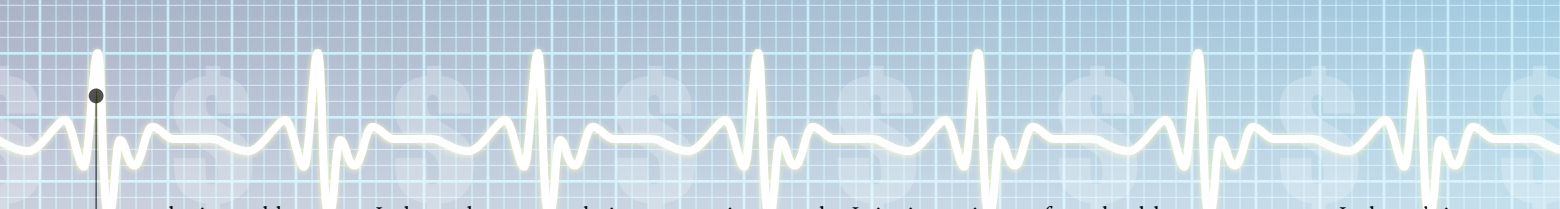
Insurance—classic insurance with real risk transfer—requires three elements:

- ▶ Randomness in the event being insured against and a non-trivial chance of it happening;
- ▶ A potential non-monetary loss that the insured would rather not suffer (life insurance is the ultimate example of this aspect);
- ▶ A meaningful potential monetary loss.

Many of today's major medical plans violate the third of these three basic elements (they frequently don't meet one or both of

the other two basic elements either). For most readers, a \$100 charge for a physician office visit isn't an insurable event because it doesn't create a meaningful economic loss. (Of course, there are those for whom a \$100 doctor bill is a serious loss, and I will address their situation subsequently.) With a \$750 charge for some sort of diagnostic test, the amount will become significant to more people, but there will still be many for whom it's not yet economically meaningful. As we move up the expense scale, the number of people for whom the expense is significant (and therefore insurable) will get larger, until at some point the expense will be so high that it's an insurable event for all but the very richest.

The point is that insurance is personal. An event that I consider insurable (i.e., potentially damaging financially) may or may



not be insurable to you. It depends on our relative economic resources and, to a lesser degree, on our personal risk tolerance. When it comes to real insurance, one size doesn't fit all, at least not economically. But reimbursement for items that aren't economically meaningful is never insurance. It's inefficient and expensive dollar-swapping.

The Health Care Market

Health care in the United States is a strange mix. At its base are the fundamental public health initiatives that keep us safe. The most recent public health buzz has been over epidemic risks—either natural or resulting from terrorism. We expect our leaders to protect us from these risks through whatever means necessary, and most would agree that money spent on this is, generally, money well spent. Clean water, compulsory standards of preventive health for schoolchildren, functioning sewer and other waste disposal systems, among other things, are taken for granted here.

But most of the health care system goes well beyond that simple beginning. We have the greatest array of health care facilities, technology, and personnel anywhere in the world. By large margins, we lead the world in health care spending. Yet this doesn't translate into improved life expectancy. It seems there's a disconnect between expenditure and result. The reasons for that disconnect are many, but two in particular stand out:

- ▶ The U.S. economic system encourages innovation in the health care industry. It comes in many forms—drugs, diagnostic tools, hardware, prostheses—that lead to additional health care costs and, to varying degrees, to improved health. Innovation sells. And one of the necessary goals for every innovation in health care is coverage under insurance, whether or not it improves health in general.
- ▶ The marketing of health care to both providers and consumers is intensive in the United States. To the former, the pitch has several angles—better care for patients leading to greater numbers of paying patients; a potential ancillary profit source from the technology itself; and, if insurance pays, free or significantly discounted services for patients. On the consumer side, the pitch is more direct and personal, appealing to the desire for immortality, even if only temporary.

There are lots of products and services available to us that feature both innovation and high levels of marketing pressure, but health care is unique in one aspect: It's the only one in which the consumer isn't directly, 100 percent economically involved. Go ask your employer or congressman to provide funding for a new flat-screen TV, and the response is likely to be less than encouraging. Same for an expensive steak dinner for four at the Palm. Or a trip around the world. But current health insurance products take the sting of expenditure out of the equation to some degree. And frankly, there aren't many things more appealing than free, or deeply discounted, temporary immortality.

Finding a Better Way

So what should we be doing? The extension of current forms of health insurance to everyone is about the worst thing we could

do. It invites misuse of our health care resources. It doesn't in any way offer universal or uniform levels of care. It provides reimbursement for things that aren't always completely necessary and excludes some things that are. Worst of all, based on where we are versus the rest of the world, it doesn't improve our health much either.

Any successful health care financing system must have at least the following characteristics:

- ▶ Universal access for everyone to *necessary* health care.
- ▶ Out-of-pocket limitations on *necessary* expenditures at the individual and/or family level. People shouldn't have to go broke acquiring needed health care. Nor should they get that care for free unless they cannot pay.
- ▶ A connection between the amount an individual or family pays out of pocket for *necessary* health care and the ability to pay.
- ▶ Financial involvement of the patient/family in all treatment. There should always be some out-of-pocket cost, not reimbursable from any source, for every encounter with a health care provider.

Of the four points listed above, only the second and third have anything to do with insurance. Access, the first bullet, doesn't require insurance, although it does require money. Personal involvement in paying for care, the fourth point, is the exact opposite of insurance. The second and third bullets are the basis for insurance that would only come into play after a meaningful, personal, unreimbursable outlay for health care services had taken place. Any other form of money transfer between individuals for the purpose of health care isn't insurance—it's purely extra expense for our health care system and its constituents, with no gain in terms of actual care delivered or received.

However, as simple as this seems economically, it's anything but simple politically. If the cost of care is based on ability to pay, that means poor people will get their health care for less out-of-pocket cost than those with more assets. In fact, the very poorest will get first-dollar coverage. That's a tough political pill to swallow, but in fact that's what happens now. The poor, via Medicaid, get what is effectively full coverage while those with money either pay for their treatment or pay for their insurance or both.

For the elderly, such a system would mean that Medicare would be subject to means testing. Another political poison pill, but economically, what else is there to do? If our seniors don't pay for their own care, at least to the extent they can without radically reducing their standard of living, who is going to pay? The current Medicare financing system is on the verge of failing. Raising the Medicare tax will put the burden on workers. On the other hand, asking seniors to pay based on ability to pay will have many of those same workers saying that their inheritance is being taken from them. There's no good political solution here, but having people pay for their own health care—not for insurance, but for some of their direct care—seems the most equitable and the most efficient approach in the long run.

Politics aside, there are two very difficult, fundamental issues with this sort of system:

- ▶ Determining what is necessary health care;
- ▶ Determining what amount an individual/family can afford



If all treatment is left entirely to the discretion of the providers with no financial consequences to the patients, the result will be a program that outspends an unlimited budget.

so that the insurance available beyond that point is equitably paid out.

The answer to the first is that some payment should be required for every health care encounter. It is to be hoped that patients would self-screen and get rid of some of the excesses. While that outlook may seem overly hopeful, perhaps to the point of naiveté, the alternatives aren't good. If all treatment is left entirely to the discretion of the providers with no financial consequence to the patients, the result will be a program that outspends an unlimited budget. Patients must always be economically involved in determining necessity.

The second issue is one that the Internal Revenue Service (IRS) has been trying to figure out since it came into being. How can a supposedly impartial bureaucracy determine, on a self-reporting basis, how much people either earn or have available to them (or both)? There's no easy answer. Economically, a balance between personal responsibility and real insurance in the use of health services has to be found and adjudicated. The fact of the matter is that in health care, as in everything else, there's no free lunch. We are going to have to pay for our basic health care, and it's impractical to set the same out-of-pocket limit for everyone, regardless of financial and other assets. The cost has to be tied to what people can afford, and somebody is going to have to figure out, on an equitable basis, how much that is. Only after that amount is spent, in real money that isn't coming back from another source, can insurance be applied—simple, economically efficient, and effective real insurance.

Is It Practical?

So, how to design such a program? Here's my suggestion, admittedly with some details to be fleshed out:

► Build a stop-loss insurance structure, either through private insurers or a government pool, that provides reimbursement

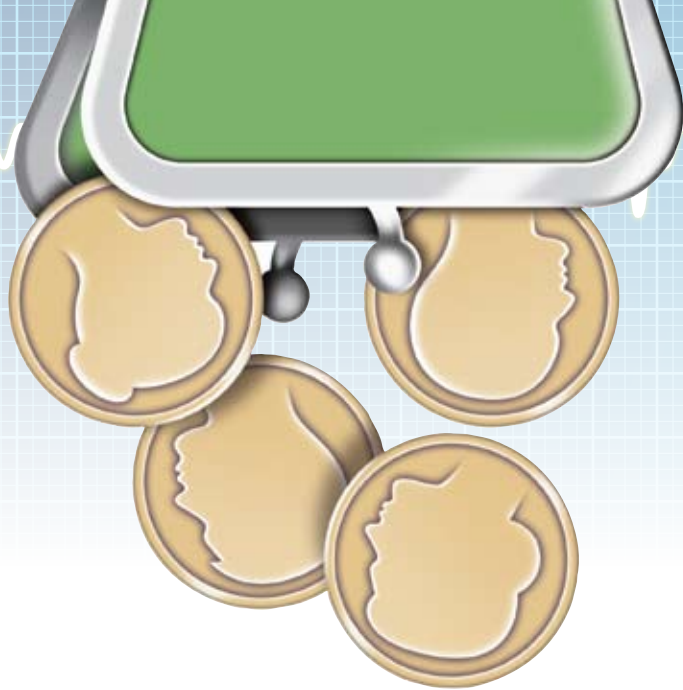
for expenses in a year beyond the individual's or family's means. Health administrators would determine those means, based on tax returns and other financial information. Setting the level where insurance begins would be the only place where the government would be involved. (For example, as a start point for such a determination, the IRS currently limits deductibility of health care expenses to amounts in excess of 7 1/2 percent of adjusted gross income.) Families could opt for a higher deductible than called for, but not lower.

► Use existing health insurance administrators and/or carriers with provider networks in place and an ability to keep track of expenditures. Health administrators can market for customers based on those networks and their services. They can also determine when an individual or family reaches the point where insurance begins. The infrastructure for the latter will require some work, but it isn't unmanageable. There will have to be close communication between those who know the cut-in point and those who will use it.

► Involve banks with health administrators to issue credit cards for use for health services, thereby solving the collection issues for health care providers. Terms of such credit cards would have to be less onerous than current credit cards. Even on reasonable terms, there is still a profit to be made.

► Individuals and families would have to pay a premium through the year for participation in the insurance program. Rates should vary by age and by means. Note that the wealthier would pay less for their insurance since they get less insurance. The political payoff for those of lesser means is that they will have lower out-of-pocket expenses before insurance begins reimbursement. Geographic area might be another rate variable, but that would need some study.

► Reimbursement of health care expenses below the government-set limit at which insurance begins wouldn't be permitted in any



scenario. Expenditures must be out of pocket up to that point, with no offset from any source.

Obviously, there are a lot of holes in this brief summary. One of the biggest is how to transition something like this into the current Medicare population. It would probably be unrealistic to try to make such a massive transition all at once. However, it certainly shouldn't be an unreasonable goal to have such a program in place for new Medicare entrants to be effective beginning when the first baby boomers reach age 65 in 2011.

Another big issue is where to have the stop-loss insurance cut in. If the point is too low, premiums for the low-asset group will be so high as to be unaffordable. If the point is too high, those same folks will end up broke if they have a big medical problem. This will be a hard balance to find and may eventually involve some sort of government subsidy, through either tax credits or direct monetary subsidies. That's not a good outcome, but it may be reality. Of course, the very poorest will have to be dealt with separately, as they are now.

This aspect of the program is where actuaries are needed. As noted above, rate classes might be based only on age and means, but other factors would come into play as well. Health care costs and age are strongly correlated. Health care costs and means are negatively correlated to some degree—people are sometimes poor because their health is poor, or perhaps their health is poor because of lack of money for care. Gender is a factor as well, as is geography. There are a lot of complex interrelationships that will come into play in setting both stop-loss points and premium rates for insurance beyond those points.

Consumer-Driven Health Plans

The rise of consumer-driven health plans (CDHPs) is a step toward the type of plan described above but misses the target in many respects. CDHPs generally have a single deductible, chosen by the employer and unrelated to income in any meaningful way. There's also an employer-sponsored fund from which money can be drawn to provide first-dollar coverage. Often a preventive care element is included as well, offering both education and first-dollar coverage for certain types of procedures.

How to deal with preventive care is one of the toughest issues facing any program attempting to curb health care costs. It's indisputable that preventive measures ultimately save by catching problems that if untreated might require far more costly therapy. It's also indisputable that unless paid by a third party, many people won't seek preventive care in the first place. However, if an exception allowing first-dollar coverage is made for preventive care, a lot of resources and money will be spent to get treatments categorized as "preventive," thereby qualifying them for first-dollar coverage. This isn't a trivial problem. After all, what is a five-way coronary artery bypass operation if not preventive? This is a very tough nut but one that has to be solved.

Patient education, while a good first step, may not be enough in the long run. But anything beyond education has short-term political and long-term economic risks. Politically, if a first-dollar exception is made for some preventive treatments, the sad history of mandated benefits tells us it won't be long before there

The current system doesn't work. It's inefficient, it's ineffective, and it's hugely expensive.

are more exceptions and ultimately nothing but preventive procedures. At that point, we'll be back where we started!

My proposal has other problems as well, which can be worked out, but it has as its strongest point the fact that it moves primary responsibility for funding health care costs to the person receiving care. The current system doesn't work. It's inefficient, it's ineffective, and it's hugely expensive. Making people acquire one of the current forms of health insurance will make things worse, not better.

There are two ways, and only two ways, to control health care costs. One is for the government to ration health care, as we see in Canada and much of Europe. That approach doesn't fit well with the freedoms that Americans cherish. The other way is to involve people directly in the cost of their own care, not through insurance premiums (payment of premiums often is taken as a challenge to use enough services to get the money back) but directly in the cost of care itself.

There need to be protections in place so that people don't go broke just because they're sick or injured, but people need to be responsible for funding their own care to the extent that they can. Nothing else can stop this ongoing upward spiral in health care costs.

DENNIS BARRY is a member of the Academy, a fellow in the Society of Actuaries, and a principal with Barry Consulting Services in Little Rock, Ark.

This article 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.