Controlling Health Care Costs

Below are articles related to health care costs posted in order of original posting from most recent to earliest:

Are Rising Health Care Costs the US' Biggest Problem and Should I care?

By Jeff Adams October 22, 2014

Most people in the US have already been affected by the rapid rise in health care costs over the past several decades. This could include higher payments for health care services due to higher deductibles, copays, or other cost-sharing, or it could be paying higher contributions towards the premium as insurers charge higher and higher premium rates. The individual may no longer be covered under an employer plan if the employer decides that covering health care for employees has gotten too costly. Individuals may also be affected when a state, federal, or local government stops or reduces funding to a program on which the individual relies because money previously used for that program now is used to cover health care costs. Health care costs are gobbling up a larger and larger portion of the governments' budgets resulting in elimination of funding to other programs such as funding for the arts or education.

The purpose of this article is to try to present some of the basics of the health care issue for those not familiar with the workings of the health care system as a whole. Misinformation often dominates the discussion of the health care cost crisis due to biases and to the complexity of the health care system.

In particular, this article will try to answer the following questions:

When I see an article on rising health care costs, what is meant by "health care costs"?
Are health care costs rising faster than in the past?
What causes health care costs to increase?
Is ObamaCare causing health care costs to increase?
Will ObamaCare cause a loss of jobs?
I have health care coverage through my employer, why should I care?
I have Medicare coverage, why should I care?
I have subsidized coverage on the Exchange, why should I care?
I do not have Medicare or Medicaid, why should I care about cost increases in these programs?
If this is such a huge problem, why do I not hear anything about it?

Hopefully the reader will get a better understanding of the scope of the issue and why more and more people believe that rising health care costs may be our country's biggest problem.

1. When I see an article on rising health care costs, what is meant by "health care costs"?

Part of the difficulty in understanding the health care cost issue is that the term "health care costs" is used in many different ways. Health care costs can mean how much is paid in the

US for health care in aggregate, how much an employer is paying towards coverage for its employees, the Medical Consumer Price Index, health care costs as a percent of the total US economy, or any of a myriad of other definitions.

The differences in meaning can cause confusion and the impression that studies are contradictory. For example, studies from earlier this year indicate that employer health care costs were not increasing as fast as in previous years, while another recent study by the Office of the Actuary at the Centers for Medicare & Medicaid Systems indicated that health care costs in the United States were projected to increase faster than in previous years. These may not be contradictory as employers may be reacting to higher health care costs by reducing benefits or not increasing its employer contribution towards the premium as fast as the overall premium is increasing, causing employees to pick up a higher portion of the cost. Both of the articles talked about "health care costs", leading to confusion about why one said costs were increasing and one said costs were decreasing. In reality, one was talking about health care claims costs and the other was talking about employer contributions to health care premiums for its employees. When reading an article on health care costs, the reader has to understand what the author is using as the definition of health care costs.

2. Are health care costs rising faster than in the past?

No. Health care costs as a whole in the US have been rising steadily over the past several decades. Increases may be temporarily reduced for a couple years due to events like recessions (and the loss of insurance coverage due to job loss) and introduction of health care reform legislation (Hillary Clinton in the early 1990s and ObamaCare in 2010) but these are short-term slowdowns.

Health care costs as a percent of the US economy (Gross Domestic Product) has risen from approximately 12% in the 1990s to approximately 18% currently. This means that much more of our economy is dedicated to health care than in the past. These additional costs have to be passed on to those receiving care or those paying premiums for coverage for this care, such as employer-purchased health care or government-sponsored health care programs. An oversimplification is that health care costs in this period have increased (18%/12% - 100% =) 50% more than the economy as a whole.

Actuaries in recent decades had models that limited long-term health care trends under the assumption that action would be taken to prevent health care costs from exceeding 20% of our economy, as it was believed by health care experts that health care costs exceeding 20% of our economy would cause major economic issues. These issues included excessive costs to employers of providing health care to its employees and critical budget issues for federal, state, and local governments. We are now within a couple percent of that 20% mark and we are beginning to see some of the issues that were predicted decades ago if health care costs remained unchecked.

Health care costs as a percent of the Federal budget has increased from 12% to approximately 25% over the last several decades. That means that (25% minus 12% =) 13% of the money in the Federal budget that was used for other programs has now been transferred over to cover the cost of government health care programs. This means a reduction in funding for, or elimination of, federal funding of non-health programs to make up the difference. Cuts in

your favorite federal, state, or locally funded programs over the past couple decades may be due to increased health care costs.

3. What causes health care costs to increase?

Usually between 80% to 87% of premium paid to insurance companies by employers, individuals, or other groups purchasing health care coverage goes towards actual claims incurred by the beneficiaries. The remaining 13% to 20% goes towards administrative costs such as the cost of processing claims, utilization management of claims, membership services, product development, marketing, profit loading, finance, and actuarial. The proportion of costs for self-insured plans (employer uses to pay claims administrator to simply process claims incurred by its employees) that go towards administrative costs is similar.

The onus for controlling health costs varies depending on if a plan is insured through an insurance company or if it is self-insured through a claims administrator. When coverage is purchased through an insurance company, the cost is the premium rate that is paid to the insurance company for coverage. An individual or employer may shop for coverage among insurers by looking at these premium rates as a measure of the cost of the plans. The insurance company is primarily responsible for controlling costs, which means controlling both administrative costs and claims costs.

When an employer purchases a self-insured plan, the “rate” that the employer will pay to the claims administrator is only for the administrative cost. The employer will pay the claims as the providers are paid. Controlling increases in claims costs is often not the main objective for the claims administrator, as they are often more concerned about controlling the administrative costs than controlling the claims costs. Employers often overlook the fact that it should research the impact on claims when trying to determine the cost change in going self-insured. Provider discounts and utilization management are a large part in controlling the claims side of health care costs. Many claims administrators do a good job on this, but it does add a little on the administrative cost side to obtain a higher savings on the claims side.

Controlling administrative cost increases are easier to control than claims cost increases. A significant portion of the administrative cost can be altered by altering the number of persons employed, as long as essential services can still be provided. Some controls can be placed on other items such as marketing costs or mailing costs, etc. One difficulty in controlling administrative costs, though, is that the unintended impact of raising claims costs may be caused as a result of efforts of lowering administrative costs. For example, nurses are used in utilization management to try to ensure that care that is given is proper and necessary. Elimination of utilization management positions may, thus, result in an increase in unnecessary or inefficient services and a corresponding increase in health care costs.

Claims cost increases are much more difficult to control. People tend to forget that hospitals, physician practices, pharmaceutical companies, and other health care vendors are businesses and, as such, need to bring in enough income to cover its expenses, which can include the cost of the building in which it resides, expansion, salaries, medical supplies, and more. Its method of obtaining revenue is through billing for services to payors, including insurance companies, self-insured plans, and government programs. Often the provider can increase the revenue it receives by simply increasing the amount that it charges for each service, resulting

in increased payments by the insurer, the patient, or both. Another reason claims costs are difficult to control is that patients often ask for additional services or products, such as prescription drugs, and the provider or facility provides it rather than having an unhappy patient and possibly losing that patient to the provider or facility down the road. Utilization management is helpful and can reduce some unnecessary services but it has limited impact and insurers tend to not want overly intrusive red tape that might anger its members. This payors' desire to eliminate payment for unnecessary claims results in constant tension between the providers, who are trying to keep their patients healthy and satisfied, and the insurers, who are also trying to keep their members satisfied but also trying to lessen the 30% of health care costs that studies say are due to fraud, waste, and abuse.

Increases in claims costs from year to year are due to increases in the amounts charged by providers and facilities for each procedure, increases in the number of procedures performed, and increased use of higher cost procedures. These are the major categories although they could be further defined. For example, procedures developed from new technology might increase the number of services and it also might be higher cost than a service that it might replace thus increasing the use of higher cost services. Utilization may also increase due to effective marketing activities, such as with television ads for prescription drugs. On the physician side, utilization for specialists has historically increased significantly faster than utilization for primary care physicians.

These are the very general reasons why health care costs are increasing. Reducing these increases will be a difficult task as health care represents 18% of our economy and has become a very highly politicized issue.

4. *Is ObamaCare causing health care costs to increase?*

It depends on your definition of "costs". One of the major goals of ObamaCare was to decrease the number of uninsured individuals. To the extent that these millions now have coverage and are now going to the doctor on a more regular basis, health care costs have increased as a whole in the US. Also, in order to set up the health care exchanges, employers have been required to pay fees in order to subsidize these exchanges. This results in slightly higher employer costs but it is a transferred to offset the cost of coverage for those purchasing coverage through the Exchanges.

There are also components in ObamaCare that are designed to help control health care costs through encouragement of the use of high quality and efficient health care treatment. It is much too early to determine whether these components will be effective.

Some of those claiming that ObamaCare increases costs are those who are not proponents of programs to cover the uninsured population. We have 40 million or so uninsured individuals in this country. Many who have health care coverage through an employer or otherwise, tend to take their coverage for granted and have little sympathy for those without coverage.

5. *Will ObamaCare cause a loss of jobs?*

The answer to this question is somewhat complicated. Health care is 18% of our economy, as was stated before. If left unchecked, many additional jobs will be created in the health care

field as the percent of our economy grows from 18% to 20% to 25%, etc. This implies that there will be a smaller increase in jobs in the future under ObamaCare, if cost controls are effective, than there would be if health care cost increases remained unchecked.

However, companies who offer health care will find this to be a daunting expense and it may cause a limit on the number of employees that it can hire, implying that there may be a smaller number of employees if health care costs are unchecked. More likely they will stop covering health care before laying off a significant number of employees so that the number of people covered under employer policies will decrease as health care costs increase.

6. I have health care coverage through my employer, why should I care?

The continued rapid growth in health care costs means that increased costs of covering health care for employers. Health care costs are rising faster than employer revenues (the money available to pay for employee health care benefits) putting increased pressure on the company's bottom line. Over the past couple decades, employers have reacted to this by reducing benefits or dropping coverage completely, a trend that will continue indefinitely into the future in the current environment.

Thus, employees covered under employer health care plans will increasingly find themselves without coverage through employers. They would then be able to purchase coverage through an exchange but the coverage would be much more expensive than employer-subsidized coverage. Subsidies for lower income individuals who purchase exchange coverage will help initially but if health care costs continue to rise rapidly then these subsidies would erode over time, possibly leaving coverage unaffordable for many, leaving them uninsured.

7. I have Medicare coverage, why should I care?

A continuation of the rapidly increasing health care costs that we have seen over the past several decades would, out of necessity, mean a fundamental change in the Medicare system in the future. It could mean significantly increased premiums for Seniors or a loss of a portion or all benefits.

Medicare and Medicaid have been eating up an increasing portion of the federal budget in the past several decades. An increase from 12% of the federal budget to 25% of the federal budget means that 13% of the budget that was used for other programs now have to be used for health care. Continued increases in the portion of the federal budget used for Medicare would soon mean decreases in essential programs such as our country's ability to defend itself and maintaining the basic infrastructure in our society such as roads and bridges. Since this is not a viable option then other alternatives would need to be enacted.

One such alternative has been to decrease payments to providers or hospitals for Medicare patients. This is becoming an increasingly impractical option as it only transfers health care costs to the already stressed employer health care market, to the exchanges, or other commercial markets.

Another option is the premium subsidy program (sometimes called the voucher program). This will only pass high health care cost increases on to Seniors. With the idea that this would be enacted as a means to control government spending on Medicare, we can

expect that the vouchers will only be increased by inflation (the Consumer Price Index) each year. Insurance companies would have minimal incentive to reduce costs so trends would remain at current levels that are well in excess of inflation. As an example, if we assume that average Senior costs per month are $1,000 currently or $12,000 per year, that CPI/voucher increases are 3% per year, and that health care trends are 7% per year, then under this proposal the Medicare beneficiary would have to spend over $7,000 in premium in 10 years and almost $25,000 in premium for coverage in 20 years. This would make the program quickly affordable for only the wealthy.

8. I have subsidized coverage on the Exchange, why should I care?

After a two-year transition period, these subsidies are only increased by the inflation (Consumer Price Index) portion of health care trend, remember that health care trend also includes utilization and mix of service components. This means that the subsidies will erode over time as the health care cost increases in excess of CPI will be paid by the exchange enrollee, even if he or she has a subsidy. In an overly-simplified, if a plan premium was $8,000 in 2016, a beneficiary paid $1,000 for the benefit, the CPI increase into 2017 was 3%, and the premium increased by 10%, then the beneficiary contribution to the premium would increase by ($8,000 x (.10 - .03 =) $560 for 2017 for a total of $1,560. These increases in premium would grow significantly over time, leaving coverage unaffordable for most individuals currently receiving subsidies.

9. I do not have Medicare or Medicaid, why should I care about cost increases in these programs?

Most people will eventually get Medicare coverage. This will help pay for very senior health care costs. Health care costs increase as individuals age. Costs for Seniors may be three to five times costs for an individual in his or her 30s. Health care costs will be very expensive without Medicare. See the section about Medicare.

Even if you will not get Medicare or Medicaid in the future, you will probably be affected by increasing costs of those programs as they take up a larger portion of the federal budget. Increases in costs for these programs are squeezing out other essential items in the budget. The bridge down the road may not be able to be fixed due to a lack of money in the federal coffers. Money spent to protect Americans from terrorism may need to be cut at some point if health care costs are left uncontrolled. Funding for education will continue to be limited. Funding for arts, parks, and other programs will continue to be reduced or eliminated. Taxes may need to be raised to offset increases in Medicare and Medicaid costs since much of it is funded out of general tax revenues.

10. If this is such a huge problem, why do I not hear anything about it?

This is a very serious problem but involves a very complex and politicized issue: our health care system. Due to this complexity, the issue is rife with disinformation, accusations, and scare tactics. Attempts by either political party to enact controls on health care cost increases are greeted by the other side with charges such as “rationing health care” and “cutting jobs”. Attempts to control Medicare costs are met with immediate accusations about “cutting Medicare”, even though what is being attempted is only to slow the growth in Medicare.

For this and other reasons, much of the discussions are taking place behind the scenes in a lower profile environment. One of the efforts to keep politics out of the issue was the development of an independent task force that will recommend changes to Medicare. If Congress does not act to overturn these recommended changes, then these changes will automatically take place. The thought is that it would be easier to get effective change through this task force then to rely on Congress to come up with a plan and have both houses agree on it and the President sign off on it.

Other groups and associations such as the American Academy of Actuaries have been given the task of developing and commenting on proposals to improve quality and efficiency in our health care system. This is a major undertaking and will not be accomplished in a year or two.

Summary

A growing number of people believe that health care is the number one issue in the United States. Failure to modify our health care system could lead to massive uninsured rates and government entities that spend so much money on health care that they cannot appropriately protect the infrastructure, security, and future of its residents.

Changes need to be made to our health care system sooner rather than later. These changes need to resolve issues with all sectors of our health care system and not just transfer costs from one sector to another, such as from Medicare to the commercial sector. Waiting until the problem is critical would eliminate some of the better options that would fix problems gradually. There some who believe that the longer we wait to fix the problem, the more likely the fix will be drastic, such as a nationalized health care system such as that in Canada and Great Britain.

ObamaCare was not the best option available but it was better than the status quo. Congress and the President need to work together to improve ObamaCare, not repeal it and return to the status quo. Continued politicization of this issue will, once again, cause nothing to be done and create a crisis situation in a matter of ten years or so, if not sooner.

CMS Innovation Center Grants

By Jeff Adams June 12, 2013

The rapid increase in health care costs continues to be problematic in the United States for employers, individuals, and the government. For decades employers have been, and continue to, drop coverage for employees due to the high cost of care. Individuals in many states have been unable to purchase coverage due its high cost, especially after years of the adverse selection spiral. Costs for healthy individuals in some states have been more affordable due to medical underwriting but this will no longer be the case due to health care reform, as the Affordable Care Act endeavors to make health care more affordable for individuals who have higher health care costs. Individual coverage for lower income persons will be subsidized and more affordable in the short term but this subsidy will fade after a few years making health

care coverage, once again, unaffordable for those with low income.

Government health care costs (including Medicare, Medicare, and Children's Health Insurance Program) are increasing rapidly as a percent of the federal and state budgets. Health care is now around 24% of the Federal budget. Each year this percent increases meaning that funding for other programs or funding for states will need to decrease. It is possible that in 20 years or so health care costs will be 50% of the Federal budget if costs continue to grow at the current rate of increase.

As a result of these cost issues and quality of care issues, the Affordable Care Act ("ACA") created the Innovation Center within the Centers for Medicare and Medicaid ("CMS"). This Innovation Center was designed to encourage new ideas by providing grants for development of models that increase quality of care without increasing costs or that decrease costs without decreasing quality of care. Once these models prove successful it is hoped that the successful models will be duplicated to increase quality of care and decrease costs in both government-sponsored and commercial health care.

As part of the approval process for a grant, CMS must get a certification from its Chief Actuary regarding the cost impact of the proposed model. An application to obtain a grant from the Innovation Center should contain specific financial impacts that are well laid out and supportable. This is often difficult due to the fact that these models may be entirely new and no historical studies may be available. The grant application must be reviewed by an actuary so that the actuary can comment on the reasonableness of the assumptions in the application.

More information about the process may be obtained by going to the Innovation Center web site:

http://innovation.cms.gov/

Feel free to contact me at jeff.adams@health-actuary.com if you need actuarial assistance for your grant application.

Controlling Health Care Costs

By Jeff Adams   January 7, 2013

If health care costs continue to increase on their current pace, they have the potential to bankrupt Federal and state governments. Employers will continue to drop coverage for employees as costs to cover employees increase faster than corporate revenues. Policyholders who are purchasing coverage through direct pay policies will eventually not be able to afford coverage. Even policyholders qualifying for the Premium Tax Subsidy through the new Exchanges under ACA will not be able to afford coverage as they will have to pay substantially more for coverage as premium increases far exceed the Consumer Price Index ("CPI") increases on which future government subsidies will be based.

Health care currently represents approximately 17% of our economy. This means that care needs to be taken to prevent not only significant future health care cost increases, as described above, but to prevent large decreases in health care spending which would possibly send our

economy into another recession. For example, if health care costs were to decrease by 10% from 2013 to 2014 then that would be an impact on the overall economy of -1.7% or a 1.7% reduction in the economy due to the health care cost decrease. If the rest of the economy grew at 2% during that same period then the overall economy would grow at roughly 0%. Instead of substantial decreases in health care costs, controls that would limit future health care cost increases to between 0% and the overall CPI increase would be the preferred method to proceed.

No other nation has health care costs at 13% or above, as compared to the 17% in the US. In spite of this the United States ranks low in overall health care quality of care by most independent, objective studies.

Studies show some of the reasons for the high costs in the US. Various studies show that 25% to 30% of all health care costs are fraud, waste, and abuse. Other studies show that 10% of all hospital claims are a result of abuse and misuse of prescription drugs. A final study indicates that 20% of health care costs in the United States are a result of the majority of the population is either overweight or obese. Even if we only reduced half of the above then we would decrease costs by 30%, excluding cross-correlation of the factor impacts. This would reduce the health care costs from 17% of the economy down to slightly greater than 12% of the economy, similar to several other countries. Obviously there are many issues in our health care system in addition to those stated above and additional savings can be obtained. There is no "silver bullet" and, in fact, looking for THE silver bullet causes substantial harm to the process of fixing our health care system. The solution will be a combination of many different fixes which will combine to make our health care system efficient but with a higher quality of care.

Described below are several ideas for reducing costs while maintaining or increasing quality of care. These are not intended to be the end-all solutions, just some sample ideas. Comments and suggestions are welcome, as always.

Eliminating the entire 30% of health care costs that are estimated to be fraud, waste, and abuse is probably not possible but much of it can be cut out. Combination quality of care and efficiency incentive programs such as the Accountable Care Organizations ("ACOs") created by health care reform could reduce costs by 5% for those providers in ACOs. Much-talked-about malpractice reform could cut an additional 1% from health care costs. Comparative treatment research such as that contained in health care reform and standardized treatment protocol could eliminate more waste and 5% of health care costs by redirecting services to more efficient venues. For example, a patient could be directed to extensive physical therapy instead of higher cost and lower quality of care surgery. Also, treatment could include education on better diet and exercise habits instead of prescribing drugs for Type 2 Diabetes or instead of bariatric surgery. Staff model HMOs are more efficient than fee-for-service payors and would show significant efficiencies but must be accompanied by strong quality of care programs. The issue of too few primary care physicians and too many specialists needs to be addressed as it causes overutilization of specialist services and also causes excess services due to a lack of coordination of care for the individual's treatment plan.

Of the 30% fraud, waste, and abuse, prescription drugs usage is a significant problem. In this

era of the "Rx Generation" a study has shown that 50% of all drugs that are prescribed are not necessary. Many attempts have been, and will continue to be made, at lessening prescription drug fraud and abuse and no additional comments will be made on that aspect here. Additionally however, overprescribing of drugs is a huge problem. Reducing overprescribing rates will require cooperation between various parties such as patients, physicians, pharmacies, pharmaceutical companies, governments, and others. As an example, studies have shown that patients see drug advertisements on television, decide they "need" that particular drug, go to their physician, and demand the drug. The physician is faced with the dilemma of giving the patient his or her desired drug, even if it is not the best treatment, or losing that patient, and the corresponding income, to the physician down the street who will prescribe the drug. This is a difficult situation with no easy solution. One possible solution is to ban drug commercials from television under the premise that patients should be learning treatment options from the physicians and Internet instead of from, possibly misleading, commercials produced by the pharmaceuticals themselves. Another method of reducing unnecessary prescription drug usage is to limit money that pharmaceuticals pour into "advertising" in its many forms including money used to pay for education seminars for young physicians and direct or indirect gifts to physicians.

A further complication that arises out of overuse of prescription drug is the cost of dealing with the side effects of the drugs. Most drugs have side effects, some of which can be problematic. At least one study has shown that 10% of all hospital costs are due to abuse and misuse of prescription drugs so to the extent we reduce the abuse and misuse of prescription drugs we reduce this 10% of hospital costs.

We may never be able to completely eliminate the 20% of our health care costs that are due to the increasing portion of our population that is overweight and obese. We may not even be able to decrease this percent for a few years but we need to at least stop the increase soon. The obesity problem will also be difficult to overcome due to the underlying behavioral modifications necessary and the delicacy of the topic. People in the US tend not to eat the correct foods or do not get enough exercise, resulting in a much higher obesity rate than other countries. Studies have shown that physicians are uncomfortable broaching the subject with their patients for fear of angering them and losing the patient and corresponding income to the physician down the street. People want to take the easy way out, including taking medicine, having surgery, or just dealing with the consequences of being overweight. Since there are currently no real incentives to correct this situation, this problem will increase with time. One solution could be a form of benefit plan that gives increased benefits to those who are not overweight or who are overweight but in a weight loss or nutrition program. I will leave it to more intelligent people to determine the best weight levels to use and what exceptions to allow.

The current fee-for-service payment structure in our health care system may not be the optimal system as it encourages providers to increase utilization of services in order to increase revenues. Much research is being done to determine other payment models that do a better job at combining quality of care and efficiency. Having said that, our fee-for-service payment method will probably be here for some years to come, at least in some form. In addition to possible incentives for providers to increase utilization to increase revenue, the current fee-for-service payment rate negotiations between physician groups, hospitals, or

other vendors and insurance companies, HMOs or health insurance funds are sometimes problematic. A physician group, hospital, or other vendor may have a "monopoly" on services in a given area causing the insurer, HMO, or health insurance fund to have no leverage in contract negotiation, resulting in excessive payment rates. There are also situations where cuts to Medicare and Medicaid would cause physicians, hospitals, and vendors to seek more higher payment rates from the commercial insurers and HMOs. A possible solution to these problems is to cap the payments to physicians, hospitals, and other vendors at the Medicare payment rate for all lines of business. There would be a transition period so that fees would not actually decrease from one year to the next due to the cap.

Other good suggestions that I have heard include health coaching, wellness programs, population management and behavior modification, enhanced use of non-physicians, and use of telemedicine.

Part of the excess in health care costs is due to administrative costs either at the place of treatment or at the HMO or insurer. Standardization and automation of the process could reduce administrative costs and thus reduce overall health care costs by a percent or two. Many insurers and HMOs are not-for-profit meaning that they are not in the business of making money other than the profit required by state law. There are also For-Profit HMOs and insurers that intend to make profits. Although I am not keen on these entities making a profit on health care I do believe that the premiums for these For-Profit are actually generally less than the not-for-profit entities due to increased efficiencies so I am not overly concerned about mandating decreased profits for these entities, although I am not against it either.

These are just some of my thoughts on changes in our health care system that might lead to more efficient health care along with a higher quality of care. I welcome any and all comments and suggestions on the topic.