Changing Expectations in Healthcare

Jonathan Shreve
FSA, MAAA

Widespread evidence that our healthcare system is in need of substantial reform continues to mount. Most of this agreement centers on issues of access to affordable health insurance, the need to improve the quality and efficacy of care, and the costs associated with our present system. In order to achieve meaningful reform, a solution must address all three problems.

Of course this is easier said than done. While there may be general agreement on common goals for healthcare–increased access, improved quality, and reduced costs–there is no such agreement when it comes to how we accomplish these goals. If comprehensive healthcare reform is to occur, it should start with a clarification of the fundamental expectations for those involved in healthcare, and then incorporate policies designed to meet these fundamental expectations. Such expectations can help the healthcare system coalesce around interrelated responsibilities for patients, for care providers, and for payers. These expectations might be stated as follows:

1. We expect every individual to obtain health insurance.

2. We expect healthcare providers to align health practices with evidence-based medicine, and measure and report the outcomes.

3. We expect payers to develop financial incentives that reward outcomes rather than simply paying for procedures.

Establishing expectations and aligning the responsibilities of each group creates the foundation on which supporting elements for pursuing specific reform goals can then be built.

ACCESS

For many years, conventional wisdom assumed that barriers such as price or underwriting restrictions accounted for the large number of uninsured Americans. Remove the barriers, the reasoning went, and the problem would disappear. So there was reliance on subsidies to lower the entry cost to access–from government for low income individuals, from employers for employees, from the young for the old.

A number of states have introduced low-cost options for low-income people (sometimes at four times the federal poverty level), only to capture a very low percentage of the uninsured.[1] [2] Even free expansions of Medicaid have often experienced take-up rates of only 60% or less.[3] [4] [5] [6] [7] [8] Others imposed restrictive rules on medical underwriting and/or community rating, with similar results–little change in the uninsured rates.[9] Our own research of health consumer behavior shows that offering an affordable insurance option to the uninsured does not necessarily compel them to purchase insurance.[10]

But reform enacted in Massachusetts accomplished the unexpected: Take-up rates skyrocketed. Why? The economic incentives, by themselves, were insufficient to induce the widespread purchase of health insurance that occurred, because the tax penalty was below the cost of insurance. Perhaps the most important factor that drove large numbers of individuals into the system was acceptance of the *expectation* that every individual should have insurance. People without health insurance decreased by 324,000 in the first year of the legislation (2006).[11] [12]

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QUALITY

Increasing access is not the only goal of real reform, however; improving overall quality and efficacy is also an important goal. Simply pumping more money–or people–into the present healthcare system does nothing to improve the underlying quality of care. Provider practices and patient demands that result in low-quality care are not only bad for the patients involved, they also force on all of us a kind of rationing driven by the inefficient use of resources.

A consensus, however, is forming around the expectation that evidence-based medicine is the key to improving the quality of care. Why?

- Inconsistent care–unfounded variations in the approach that physicians may take when recommending care–leads to contradictory results and higher costs.

- Conversely, the higher costs associated with more procedures and services do not automatically assure better quality. Examples abound where procedures are routinely performed by some physicians that, over the long term, reap no significant benefit in clinical outcomes.

- Inappropriate care produces adverse outcomes. *Overuse* of procedures exposes patients to unnecessary risks for complications, increasing costs without enhancing benefits. *Underuse*—not providing medically beneficial services—costs less in the short term but much more in the long run, especially for chronic diseases. *Misuse*—like medical mistakes or complications—is detrimental to patients, providers, and payers.

Evidence-based medical guidelines are well established within the private sector today, and the vast majority of third-party payers use them to determine medical effectiveness. This same approach could guide every physician's bedside practice.

AFFORDABILITY

Increases in medical costs in the United States have steadily outpaced inflation, and now such costs comprise more then 16% of GDP. Left unchecked, they are projected to grow to 20% in 10 years.[13] Uneven quality, lack of integrated care, outdated information systems, and the wrong financial incentives have all contributed to the rise.

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The basis for paying for healthcare must shift to one that rewards healthy outcomes and that provides financial incentives for following evidence-based medical practices. Such a shift is difficult in a system dominated by fee-for-service pricing with little or no accountability for performance. Several past and recent innovations may be useful in future reforms.

- During the 1990s, physicians were often paid for the number of patients they treated rather than the volume of services they generated. The capitation approaches used often were not refined or adequately supported, which in part led to the *managed-care backlash*. Still, medical cost trends were at a lower level than they have been before or since. This was a far from perfect but nevertheless elementary example of beginning to pay providers at a level consistent with our expectations for them.

- Another solution, risk-adjusted *episodic payment*, envisions payers like insurance companies paying all hospitals or medical professionals fixed amounts per episode of care, depending on the condition being treated.

- Recent movements toward *pay for performance* or *medical home* head in this direction, but without a change in the underlying compensation scheme, each additional service generates an additional fee.

Whatever form it takes, restructuring the payment system can motivate healthcare providers to perform—and payers and patients to pay for—only those procedures consistent with the best medical evidence and the needs of the patient. A system driven by results allows physicians more time to focus on the treatment they deliver rather than the quantity of services they provide.[14]

CONCLUSION

There is broad agreement on the overarching goals of healthcare reform, but there is also much debate about their details and how to reach them. We should clarify the underlying expectations for all the participants before setting the policies that will be needed to attain effective healthcare reform.

Jon Shreve is a principal and consulting actuary with the Denver office of Milliman. He is also chairman of the Milliman Care Guidelines. For more information, contact Jon at jon.shreve@milliman.com or at 303.299.9018.

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ENDNOTES

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Jonathan Shreve

1099 Eighteenth Street, Suite 3100
Denver, CO 80202-1931
+1 303 299-9400
www.milliman.com