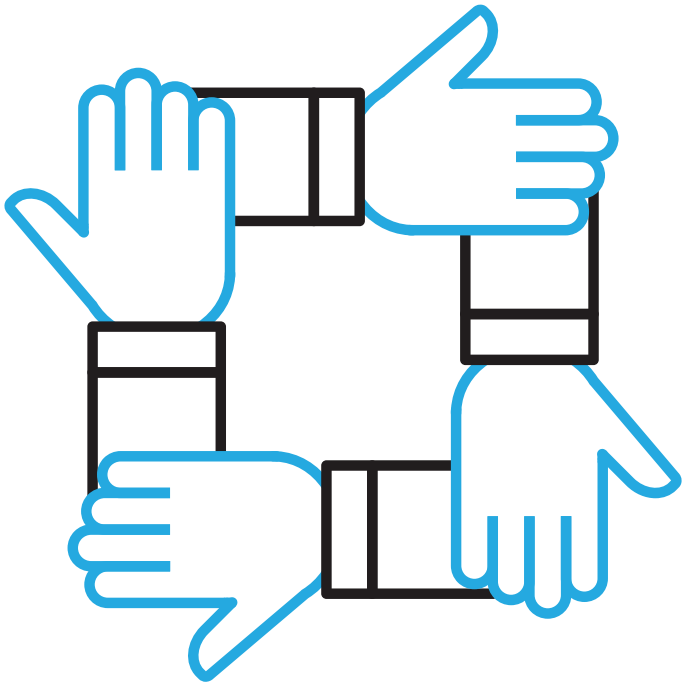

Healthcare Accountability: An Inspire Series

Prepared by Axene Health Partners, LLC
with an Introduction by Joshua Axene, ASA, FCA, MAAA

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HEALTH ACTUARIES & CONSULTANTS

Inspire

Healthcare Accountability: An Introduction

Joshua Axene, ASA, FCA, MAAA

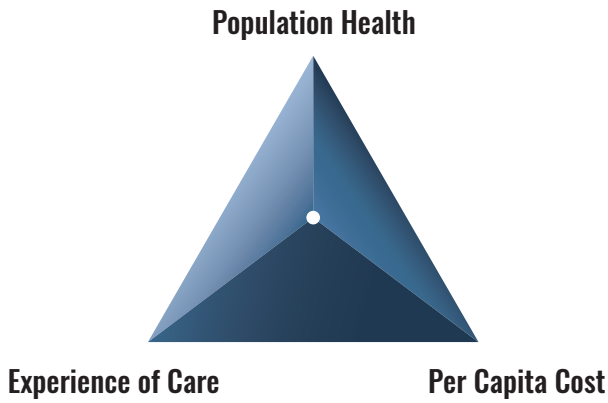
In America, individuals demand or expect accountability, ranging from holding elected officials accountable for what they promised during the campaign, to holding a kindergarten teacher accountable to appropriately educate children. Accountability, as defined by the Webster's dictionary, is "the quality or state of being accountable; especially: an obligation or willingness to accept responsibility or to account for one's actions." There is constant tension between responsibility and accountability. Accountability is impossible without defining responsibilities. The definition of responsible, again as stated by Webster's dictionary is, "able to answer for one's conduct and obligations". It is unreasonable to believe that everyone will act responsibly most or all the time without an effective accountability or measurement systems in place. Accountability is the mechanism that helps individuals act in a manner that increases the chances of attaining the goals, both personal and community wide.

The healthcare system is probably the most important sector of the US economy with the greatest assumed responsibility. There is nothing more valuable to a person than their health, as loss of health often leads to loss of life. The US healthcare system helps individuals maintain and perhaps increase their health. Although individuals are the end consumer/users of the healthcare system, these same individuals are often the same ones complaining about the lack of accountability of the providers and insurers. The health care system has almost no direct accountability assigned to the members/users. As soon as the members/users feel that they are being held accountable, lawsuits and headlines emerge. Even with such high responsibility, the question remains if there is a process established to hold all stakeholders accountable.

There are two major types of accountability in the healthcare system: financial accountability and non-financial accountability. Financial accountability is by far more common and can be seen in either incentives or punishments for actions taken. For example, a doctor might be financially incented to have higher quality ratings. The higher quality ratings might be directly connected to a payment level for their quality. Non-financial accountability can be seen with doctors as well, when a failure to perform in a manner considered correct could result in a loss of license. Though listed as a non-financial accountability, most non-financial accountability structures have financial repercussions.

This collection of articles will attempt to identify the existing accountability mechanisms in place in the healthcare system for the major stakeholders. Furthermore, these articles will index the stakeholders on their accountability to furthering the Institute for Healthcare Improvement's Triple Aim[1]. As stated on the Institute for Healthcare Improvement (IHI) website: The Triple Aim is a framework developed by the IHI that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, called the "Triple Aim":

THE IHI TRIPLE AIM



The Triple Aim Defined

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations; and
3. Reducing the per capita cost of health care.

The enclosed articles are not intended to provide a moral code or to criticize stakeholders for participating in the market as it has been established, but rather provide an assessment of the system and its ability to attain the goals of Triple Aim. For some stakeholders, there are multiple forms of accountability in place, while for others there appears to be no or limited direct accountability. There may be accountability conflict as a single stakeholder has competing forms of accountability assessment. Performance under one system might have a negative impact on another system and potentially the Triple AIM .

When assessing accountability in any system, a constant or standard measuring stick is required. As mentioned above, we have decided to use the IHI Triple Aim as the standard measuring stick for these articles. The measurement of accountability is based upon how each stakeholder is enhancing high quality and cost effective care that improves the health of the population at large (aka Triple Aim). Aggregate index scores will be presented for each stakeholder. A higher index score does not mean that the stakeholder is excelling on all facets of Triple Aim, but rather that the combination of the three parts of the Triple Aim create the score. In other words, a stakeholder could clearly be increasing quality and the health of the population, but be also driving up cost.

There are many different approaches to assess accountability. Most often accountability is associated with a single person, but can also be applied to different market segments. A common tool used to measure personal accountability is the accountability ladder. The accountability ladder has a spectrum of accountability ranging from no accountability to full accountability. For this analysis, we have leveraged this idea into what we are calling the AHP Accountability Index (AAI). AAI has 8 levels of accountability and projects assumed accountability of each stakeholder to helping the United States healthcare system achieve its goals related to the Triple Aim.

The levels of accountability found in the AHP Accountability Index are listed below, the first four are examples of no accountability and the later four are examples of partial to full accountability:

1. **No Accountability/Unaware -** These are the parties who are not aware of the problem/goal and are often a major catalyst creating the problem or inhibiting a goal. Many are unaware that an issue exists and even worse that they could be a major part of the issue.
2. **Blame/Complain -** It is always easy to point the blame at others when overall goals or responsibilities are not achieved. Often this level of accountability is where stakeholders might claim to be a "victim". It is easier to point the finger at others than it is to see the fingers pointing back at you. This level of accountability often includes irrational views and also external elements beyond the control of the stakeholder or the market at large.
3. **Excuses instead of results -** When a problem is identified, it is easy to attempt to justify or excuse your way out of it. Excuses are not part of the solution. They are most often at the root of the problem. Improper planning, lack of focus, and misaligned incentives are often present when excuses are used.
4. **Wait and Hope -** Waiting and hoping is an extension of excuses. Often there is knowledge of an issue, but one waits and hopes that others will find a way around it. Often this step is amplified by a leadership failure in communicating the plan and expectations associated with it. This has been referred to as "kicking the can down the road". People often say that the definition of insanity is doing the same things repeatedly and expecting a different outcome.
5. **Acknowledge reality -** This level of accountability begins by looking at the situation and realizing there are things which need to get done to find success. Denial is not involved and planning for action has begun. This would be the first step towards becoming fully accountable.
6. **Accept Ownership -** After acknowledging the reality of the situation, a decision needs to be made that decided if we are going to regress down the AAI and make excuses and blame, or if ownership of the problem is going to be taken and move forward in creating solutions. Courage, commitment, determination is needed to be different and stand out.
7. **Pursue Solutions -** Solutions cannot be fully pursued until full ownership of the issue and especially the stakeholder's part of the issue is attained (step 7). This step begins the pursuit of developing solutions. Solutions of all types are considered including published, tested, and uniquely developed solutions. Honest assessment is key as there is a difference in thinking you are doing something and doing it.
8. **Total Accountability/Take Action -** Now that you own it, solutions have been identified, it is time to implement, act, and assume total responsibility. New and innovative ideas start to take action when they are transferred from the mind to the market and at this point full accountability is taken.

There are eight separate articles in this document that will assess different stakeholders in the healthcare system. There are many more stakeholders, but these are the ones that are the most obvious when it comes to creating a well-functioning healthcare system.

As shown in this series of articles, the various stakeholders of the US healthcare system have widely varying accountability compared to the Triple Aim. According to the AHP Accountability Index, we have assessed the overall accountability of the US healthcare system to be 36%. This level is defined as "Excuses instead of results". This score is the simple average of the individual AAI scores for each of the 8 stakeholders addressed in this series.

Though premium rates are often the highest source of anxiety and controversy in the healthcare system, it's accountability score was the highest out of any stakeholder. There is significant oversight holding health plans accountable. The general public and also the media received the lowest scores of any stakeholder and this is not surprising as the media often steers the general public's view on the system. The US healthcare system is often viewed as one of the best on the planet, but with increased accountability it has the opportunity to get even better, presumably with lower costs, higher quality, and patient satisfaction.

Healthcare Accountability: Inspire Series Contents

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Inspire

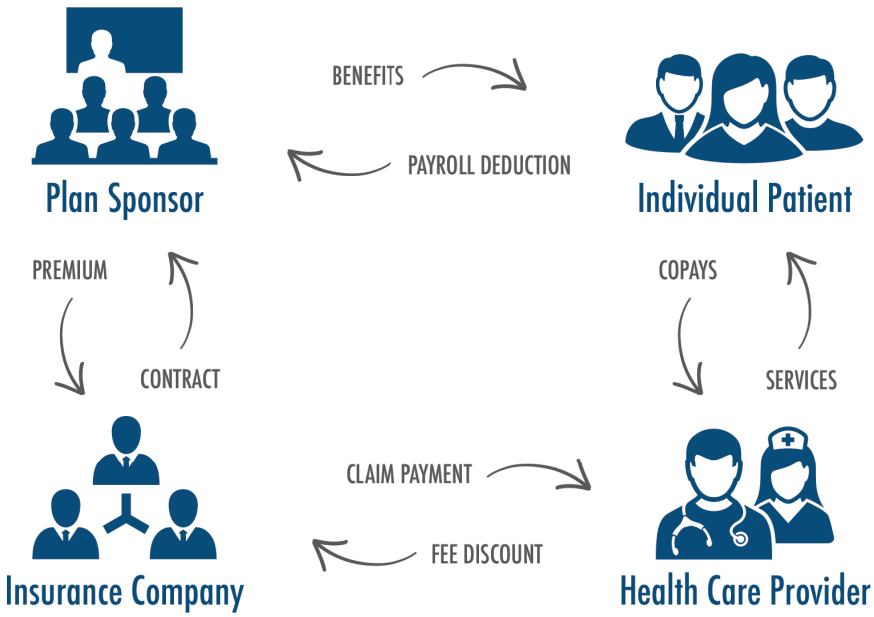
Accountability: Hospital and Health System Pricing

David V. Axene, FSA, CERA, FCA, MAAA

Introduction

In a traditional economic business model, the tension and interaction between supply and demand in a competitive environment usually leads to rational pricing and reasonable pricing/profit margins. Today's US health care system varies from the traditional economic business model and faces some unique challenges.

For most beneficiaries, the US health care system has four major stakeholders: individual patient, plan sponsor (i.e., employer or government), the insurance company, and the health care provider. The chart below visually shows this and the various relationships.



The individual patient is what might be called the customer, however, their customer relationship is filtered through multiple stakeholders:

- In the case of work-based insurance and government sponsored programs (i.e., Medicare and Medicaid), much of the health care cost is subsidized by their employer or plan sponsor
- There is limited transparency of the actual provider cost to the individual or patient
- The impact of the provider's financial and pricing decisions are filtered and diluted through their relationship with the insurance company and the insurance company's relationship with the plan sponsor, and the plan sponsor's relationship with the individual.
- To the extent that individual decisions regarding healthcare choices are required, the individual makes these on very limited, diluted and incomplete information.

This article will discuss one aspect of this complex set of relationships, the pricing of hospital and health system services. This article will discuss hospital/health systems accountability as it relates to the pricing of their services. As with other articles, the accountability will be evaluated in terms of Triple AIM, the AHP Accountability Index, and the Accountability Ladder.

Charge-Master Basics

Hospitals and health systems utilize charge-masters to bill their patients for services provided by them. The charge for each service is identified by charge-master code. Services provided to the patient are recorded in the patient's chart with the total bill for that patient based upon each of these services. In today's world of electronic medical records, technology is used to capture this inventory of services and related charges, including the submission of this to the insurance company for payment (i.e., using the UB-04 and Form 1500).

The charge-master provides "gross charges" for each service. Payers negotiate discounts with individual providers which results in "net charges" (or what becomes net revenues). The difference between gross charges and net charges (i.e., the discount) is often called the "contractual" or "contractual adjustment".

The charge-master is a list of thousands of individual charges. For example, an individual hospital might have more than 25,000 items on their charge-master. Each hospital or health system builds their charge-master to meet their unique needs. There is no consistency between different hospitals unless they are part of a group of hospitals using common practices. The following is an extract of an actual charge-master from California's OSHPD Charge-master database[1].

ChargeCode	ChargeCode Description	Fee Schedule Charge 1
301100011	202 MICU	$8,883.00
301100012	206 INTERMEDIATE CARE	$7,075.00
301100550	OUTPAT OBSERVATION UNIT	$258.00
301100555	OUTPATIENT OBS/HR	$258.00
301200011	201 SICU	$8,883.00
301200012	206 INTERMEDIATE CARE	$7,075.00
301200550	OUTPAT OBSERVATION UNIT	$258.00
301200555	OUTPATIENT OBS/HR	$258.00
303000011	121 MED/SURG ACUTE	$3,601.00
303000012	206 INTERMEDIATE CARE	$7,075.00
303000550	OUTPAT OBSERVATION UNIT	$258.00
303000555	OUTPATIENT OBS/HR	$258.00
303100011	121 MED/SURG ACUTE	$3,601.00
303100012	206 INTERMEDIATE CARE UNIT	$7,075.00

In addition to the hospital services as shown in the above table, the charge-master will also include charges for supplies, pharmaceuticals and perhaps even professional charges for facility based providers. These latter items are usually based upon a combination of the actual acquisition cost and a mark-up assumption (e.g., $100 x (3.0) for a mark-up of 200%). The service portion of the charge-master is most frequently updated from the prior period charge levels based upon some financial analysis determining

[1] *https://www.oshpd.ca.gov/chargemaster/default.aspx*

how much more revenue is required to meet the institution's revenue targets. This analysis reflects an adjustment for contractuals and the mix of business between key categories of payers. Any major change in payment levels or mix of payers (e.g., Medicaid) requires an adjustment in overall charge-master levels to preserve the required revenue base. Unless there is a major change in how the service items are constructed, the update from one year to the next is fairly straightforward. A recent client project was much more complex as the health system was converting to an integrated charge-master compatible with its new electronic medical record. This required considerable changes in charge-master categories and codes including the mapping of former categories into the new categories.

This process of building the charge-master in this way has resulted in net to gross revenue ratios much less than 40% - 50%, many times as low as 20%. The standard charges are much more than is actually paid. If a price tag was attached to each service as in the retail industry, everything is on sale without people knowing what the sales price is. No other industry has comparable ratios or standard discounts. In most industries, you pay the price on the tag, perhaps with a discount for the sale or closeout pricing.

Pricing Assumptions

Unlike the regulations and limitations affecting health plans in establishing their premium rates, there are no regulatory restrictions affecting how a hospital or health system builds or updates their charge-master. There are no regulations or limitations on the maximum margin built into the pricing. There are no definitions as to what is reasonable.

Medicare, and in some states Medicaid, has some restrictions in terms of what they will consider as an acceptable charge level for services. This is analyzed as part of the Medicare cost reports that hospitals and health systems must complete and file on a regular basis. Commercial payers usually limit their payments to hospitals and health systems based upon negotiated provider contracts. Neither of these approaches (i.e., Medicare cost reports or contractual negotiations) limit or restrict the margin built into the charge-master or resulting net payment.

Reasonable Assumptions

The author is not aware of any restriction or definition of what is a reasonable assumption to be used in building a charge-master or setting individual prices on the charge-master. How much margin is reasonable? When is a charge too large? What responsibility does a hospital or health system have to establish reasonable charges on their charge-master? Is it the responsibility of the health plan or payer to limit these charges to a reasonable level? Would it be better for society if gross billed charges were set at a lesser level, closer to what is actually reimbursed?

Perhaps a more specific example would provide some useful background information. In establishing charge-master prices for supplies or drugs, how much mark-up is reasonable? What factors should be considered in determining that mark-up? In a recent client assignment, the proposed mark-up for supplies was in excess of 500% of the price of the individual supplies, and for lower priced supplies the mark-up was greater than 1000% of the price of the individual supply item. Similar margins were also proposed for pharmaceuticals. What level of mark-up is reasonable? When does it become too much?

I find the use of a continuum helpful in answering these types of questions. At one end of the continuum is financial self-interest. At the other end we have greed. I refer to the G-line as the point where we have moved from financial self-interest to greed. Financial self-interest is not bad or inappropriate behavior. This is where a hospital or health system is trying to be sure they are covering the cost of doing business or the cost of goods, while making a reasonable margin. As charges transition past the G-line, they might be considered egregious, this is a much different situation. I am sure most will agree that at some point along this continuum that the charge is unacceptable or inappropriate. Where is that point? With the fragmented oversight of providers and their charges, the extremely diluted charge awareness of the individual patient, the potential for excessive charges exists.

Learnings from Health Plan Oversight

Concerns about the portion of the premium going towards benefits versus carrier overhead and profit led to minimum loss ratio requirements and oversight. Insurance departments provided a convenient oversight vantage point and process to be sure the consumer was protected from pricing abuse. As this oversight matured the rules were modified to meet the market needs with PPACA providing the latest controls and oversight. These processes recognized the potential for unhealthy behavior by the health plans.

Hospital and health system claims comprise a major component of the health care cost used to calculate the health plan's loss ratio, yet there is no known oversight of how those health care costs are developed or established. The question is whether or not some level of responsibility and accountability needs to be defined for the hospital and health system providers. How do we protect the health system from unhealthy behavior of health care providers?

AHP Accountability Index™ (AAI) and Hospital and Health System Pricing

Although pricing issues naturally affect the cost of patient care more than the other two Triple AIM issues (quality of care and health of the population), they do have some residual effect on all of these issues. The following chart summarizes the author's assessment of AAI for hospital and health system pricing for each of the Triple Aim issues.

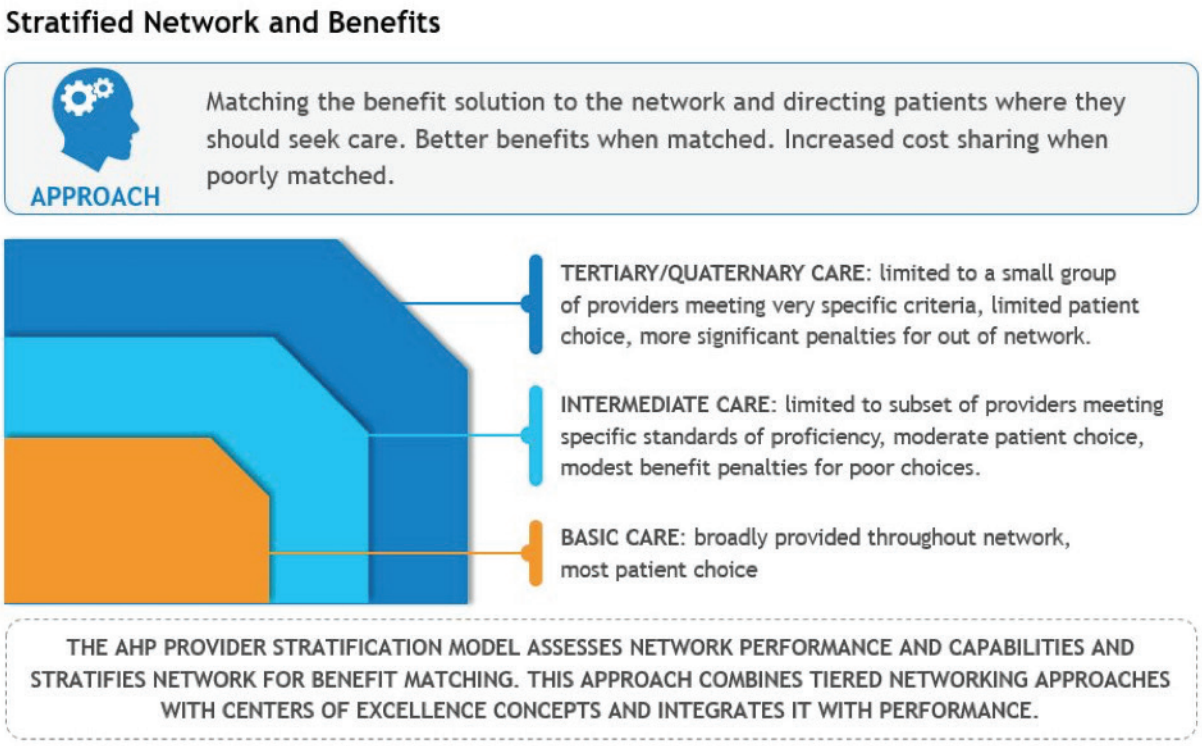
Triple Aim Category	Weight	Rating
Patient Experience	0.333	37.5%
Population Health	0.333	37.5%
Cost of Care	0.334	12.5%
Overall	**1.000**	**29.2%**

The first two categories have been rated at level 3 of the Accountability Ladder (i.e., Excuses instead of results). This is demonstrated by providers justifying their way out of the question. The higher prices even though diluted through the health system negatively impact the patient experience (i.e., impacting patient satisfaction) and population health. Many patients will not seek the care they need because they can't afford the care as a result of the high prices. The third category was rated at level 1 since there appears to be no accountability or very limited accountability.

Impact of Improvements in Accountability/Responsibility

Accountability and responsibility can be increased in the health care system through a variety of mechanisms that could readily be implemented. Increasing the transparency of prices in the system is one indirect approach, but assumes that stakeholders will be able to make valid comparisons and take appropriate action. The cost of care, as measured by premium rates, will reduce if inappropriate margins and mark-ups are eliminated or minimized. Providing stakeholders a valid comparison methodology or standard will probably help the process more than anything else.

One such methodology that has been used involves the stratification of hospital and health system care into three standardized categories. One approach is shown in the following chart.



Each of these categories of care can be readily defined by MS-DRG for inpatient services. Similar definitions can be developed for outpatient care also. In the example of Basic Care, this level of care is provided by all hospitals no matter how big or small, whether community or academic medical centers. However, the price for Basic Care should be compared across all hospitals with a norm developed for what this type of care should cost. If the same care, obviously meeting appropriate quality and outcome standards can be provided for $X, then comparable care at a higher price suggests unreasonable or inappropriate pricing or an inappropriate setting. For example, if a community hospital is able to provide a specific service for $10,000, then that might be the maximum price any facility should be paid to perform that service. If it costs much more at an alternate facility, then that facility could be deleted from the network or payment to that facility would be limited to the $10,000. This type of

pricing constraint would clearly raise the AAI to a much higher level than exists today. For the higher levels of complexity (e.g., Tertiary/Quaternary care), the potential providers would likely be limited to a narrow set of providers where quality outcomes could be assured. The same type of approach could be implemented for Intermediate Care.

This is one approach to implementing more intense accountability into the health system and can be used to increase the AAI to more desirable levels. Such action would significantly improve the results from a Triple Aim perspective also.

Summary Conclusions

There is limited accountability for reasonable pricing in the current health care system. Unfortunately, this has raised the cost of care without appropriate oversight. Much more can be done to improve this without onerous regulations. One aspect of improving our current health care system is the introduction of more intense accountability into the pricing of health care services by hospitals and health systems.

About the Author:

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Inspire

Accountability: Physician and Professional Providers

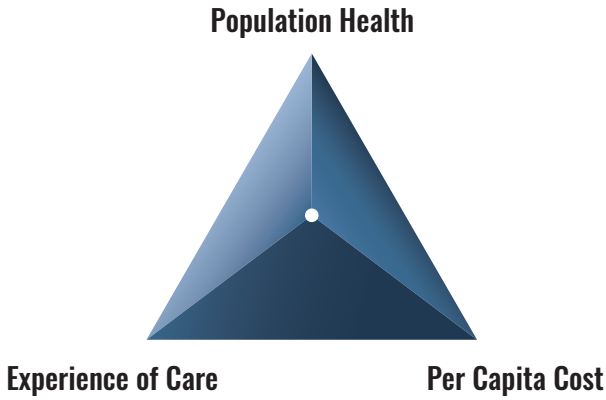
Doing the Right Thing by Maximizing Quality

By Richard Liliedahl, MD and Oscar Lucas, ASA, MAAA, FCA

Introduction

This article is part of the Inspire series exploring accountability in key areas of today's healthcare system. This article focuses on the accountability of physicians and other professional providers to "do the right thing" by maximizing quality. As described in the series overview, we have focused all the articles on what is known as the IHI Triple Aim.

THE IHI TRIPLE AIM



In this article, the authors review the changing view of physician accountability and quality relative to each of the three Aims. This includes how quality is measured, how quality is used as incentive in physician reimbursement arrangements, and the resulting challenges and opportunities. We close with an informal rating of current provider accountability and offer some suggestions for next steps.

Accountability, Quality and "Doing the Right Thing"

Success in accountability requires knowledge of, and agreement to, what someone is being held accountable for. In this case it is useful to start by defining a few terms:

- **Doing the right thing –** According to Desmond Berghofer at the Institute for Ethical Leadership, this means to "make a choice among possibilities in favor of something the collective wisdom of humanity knows to be the way to act". [1] *YourDictionary* defines it more concisely as *"to do what is ethical or just."*[2]
- **Quality –** The Oxford Dictionary[3] defines quality as: *The standard of something as measured against other things of a similar kind; the degree of excellence of something.*
- **Quality in Healthcare –** In its report *Crossing the Quality Chasm: A New Health System for the 21st Century*, the IOM (institute of Medicine) defines quality in healthcare as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge".
- **Accountability in Healthcare –** For purposes of this article we will use a working definition of accountability in healthcare as "maximizing quality" in one or more of the three Aims.

Based upon our findings from the literature and interviews with active physicians, we conclude that some physicians may not agree with the last definition above. Their definition often, understandably and importantly, begins with "accountability to their patients". For purposes of this article we define "Doing the right thing by maximizing quality" as taking actions in healthcare that optimize the outcomes of one or more element of the Triple Aim.

Measuring Quality

Success in maximizing quality in healthcare requires not only defining quality, but also measuring it. While it is important to know what quality in healthcare is, it is also useful to know what it isn't. In healthcare, quantity is often confused with quality. In fact, overuse, underuse, and misuse are all indicators of poor quality in healthcare.

While quality measures may be independently developed, there are various organizations who develop and maintain quality measures (e.g., AHRQ, NCQA). Using professionally developed and maintained measures can provide a number advantages, including broader acceptance, greater range of measures to match specific provider needs, and ability to focus limited internal resources on developing and implementing improvement plans. Quality measurement was developed in some of the first managed care organizations who understand the significance of measuring the health of a population.

Before looking at a couple of examples, it is important to understand that some quality indicators used today do not truly measure outcomes of healthcare, but are proxies or process measures. These include the process measurement that are currently accepted such as percent of a female population with completed mammograms. While beyond the scope of this article, it is important to acknowledge the fact that no perfect system or set of measures exist for measuring quality of care. This is especially important when professional reputations and financial rewards are involved.

Following are two examples of broadly accepted organizational and physician/provider quality measures: The first is related to control of diabetes, the second is related to the overuse of antibiotics in treating adult sinusitis.

Example 1: Diabetes Hemoglobin A1c (HbA1c) Poor Control (>9%)

Measure Description: *Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period*

Quality Domain: *Effective Clinical Care*

Applicable Specialties:

- Internal Medicine
- Preventive Medicine
- General Practice/Family Practice

Primary Measure Steward: NCQA

The above measure provides a means of quantifying effectiveness of adult diabetic care, for a panel of diabetic patients using the ratio of patients with poor control (HbA1c > 9%) (numerator) to total panel (denominator). The results, when appropriately matched and compared to baseline or "best practice" results are often used as a proxy for measuring quality of care. Importantly, providing insights to where

opportunities to maximize quality may exist. This is an example of an **outcome** measure; one that looks at the result or outcome (poor control of HbA1c) as opposed to a **process** measure (was a process performed), which is based on whether a procedure was performed.

Example 2: Adult Sinusitis - Antibiotic Prescribed for Adult Sinusitis (Overuse)

Measure description: *Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms*

Quality Domain: Efficiency and Cost Reduction

Applicable Specialties:
- *Allergy/Immunology*
- *Internal Medicine*
- *Otolaryngology*
- *General Practice/Family Medicine*

Primary Measure Steward: *American Academy of Otolaryngology-Head and Neck Surgery*

The second measure is an example of a **process** measure. The focus is on identifying potential overuse of antibiotics in treating adults with sinusitis. Example 2 illustrates a potential for conflict of interest that occurs in many quality measurements. That is, the patient thinks what they need for their problem or complaint may or may not reflect best practice care. In this case an antibiotic for non-bacterial sinusitis. The physician/provider must always negotiate and educate the patient on what is best care. In most examples of this; the physician/provider knows that the patient does not need antibiotics and must convince the patient what is best care (i.e. no antibiotics). This is often a time-consuming process for the physician where the result of following best practice medicine may be an unhappy patient who receives no antibiotics. This is one of the pitfalls of some of the metrics.

Incentivizing Quality and MACRA

For illustrative purposes, we include an overview of one of the newer quality measurement systems being put into place in part due to the current focus on quality and emergence of CMS as a source of these measurements.

Traditionally physicians have often been reimbursed for their services on a fee-for-service basis (FFS). In effect, the provider charges a fee for each service (e.g., office visit, injection, test, etc.) delivered. A downside risk with the “do more, get more” FFS reimbursement approach is the over utilization of services and resulting excess cost. In recent years, various modified reimbursement approaches have emerged seeking to incentivize or reward desired physician behaviors, such as quality outcomes, patient experience, and management of per capita cost. These approaches tend to go collectively under the title “value based reimbursement” (VBR) or “pay for performance” (P4P). Common to each version, the provider’s (individual or group) performance is calculated based on a predefined set of measures and results used to adjust up or down reimbursement.

Recently CMS has begun implementing MACRA, (Medicare Access and CHIP Reauthorization ACT) a replacement to the historic SGR (Sustainable Growth Rate) method for determining increases in its Medicare Part B fee schedules. Its MIPS (Merit-based Incentive Payment System) represents a material shift by CMS away from traditional FFS reimbursement to a pay for value focus. Under MIPS, affected providers will receive a performance score based on the weighted results of their performances in each of four categories. This score will be used to adjust their future fee schedule payment up or down. Importantly all four categories (see Table 1) align in supporting the goals of the Triple Aim.

TABLE 1 – Performance Category Weights by Reward Year

MIPS Performance Category	2019	2020	2021+
Quality of Care	60%	50%	30%
Resource Use	0%	10%	30%
Advancing Care Information	25%	25%	25%
Clinical Practice Improvements	15%	15%	15%

The resulting weighted score (X) will be applied to the maximum bonus or penalty to determine a bonus or penalty adjustment to the standard fee schedule. See Table 2.

TABLE 2 – Maximum Bonus/Penalty by Year

2019	2020	2021	2022+
+/- 4%	+/- 5%	+/- 7%	+/- 9%

When fully implemented in 2022, high performing providers could see a fee schedule difference of nearly 20% over low performers. (1 – (1.09/.91) =0.198 =19.8%). The Table 2 adjustments (plus and minus) are intended to be revenue neutral. That is, reductions from low performers will be used to fund the increases to high performers. Additionally, a $500 million fund has been budgeted to reward exceptional performers.

MACRA represents a step forward in several areas. For participants in the MIPS program, quality performance will be determined on a limited number of measures selected by the participant (see prior two examples). This will bring a level of simplification in terms of number of measures, as well as, the ability to align measures with current quality improvement efforts within an organization.

Based on the sheer number of lives covered by Medicare part B benefits (over 37 million as of 2015) any positive impact of MIPS on quality could be material. It also should be noted that traditionally what occurs in Medicare regarding reimbursement, measurements, etc. trickles down to Medicaid and Commercially insured populations.

Challenges and Opportunities

One of the current roadblocks to maximizing quality by providers is their concern, discomfort, and even anger at the rewards, incentives, and disincentives created by others to help them provide "better quality healthcare to their patients".

On April 12, 2016 Donald Berwick defined medicine into 3 eras:

- **Era 1-The ascendancy –** dating back to ancient Greece where it was grounded in a belief that the profession had "special knowledge, inaccessibility to laity and would self-regulate. Researchers identified huge variation in practice, errors, profiteering and wasteful spending
- **Era 2-The present –** current backers believe in accountability, scrutiny, measurement, incentives and markets through manipulation of contingencies: rewards, punishments, and pay for performance. This has put the morale of the clinicians, healthcare managers in jeopardy as they feel misunderstood, and over controlled. Payers, consumers, and government feel suspicious, resisted, and helpless. This disconnect has caused both to dig in further and to some degree we are at an impasse.
- **Era 3 – "the moral era"** He suggests that this era will require updated beliefs rejecting the protectionism of era 1 and reductionism of era 2

He defines 9 needed changes:

- Reduced mandatory measurement
- Stop complex individual incentives
- Shift business strategy from revenue to quality
- Give up professional prerogative when it harms the team
- Use improvement science- plan, do, check, act
- Ensure complete transparency
- Protect civility
- Hear the voice of patients and families
- Rejecting greed

Our experience at AHP is consistent with what Berwick describes here and we will address a couple of his needed changes in the following description of Accountability and Triple Aim.

Accountability, Quality and The Triple Aim

As stated in the introduction, the focus of this article is the accountability of physicians and other professional providers for "doing the right thing" by maximizing quality. In this section we conclude with an informal assessment of physician accountability for maximizing quality in healthcare relative to the three components goals of the Triple Aim.

When we look at the provider community, and using the definition of accountability as "maximizing quality" by currently available metrics, we think that there is a long way to go, especially with accountability for per capita cost and population health.

Diagram 1, is intended to illustrate this assessment: the primary alignment of physician accountability has been to the patient, with per capita cost and population health as marginal secondary accountability.

Diagram 1

Diagram 2 illustrates the goal of a more accountable system where patient experience remains the primary accountability for physicians, but per capita cost and population health, while still secondary are more fully aligned with the physician's overall accountability.

Diagram 2

It is our opinion that the key to moving toward diagram 2 is to gain provider buy-in. This will require many changes, such as the need to reduce the number of mandatory measurements, while also reducing the complexity of incentive payment arrangements. This may also require removal or simplification of certain physician accountabilities currently crowding out the components of the Triple Aim, (e.g.,

excessive paper work for insurance companies, ineffective tools for referring patients to highest quality/ cost efficient providers, excessive data and measurements from payers to providers that are not actionable and different incentives from different payers).

The buy-in may also be dependent on the number of physicians/providers in healthcare systems, size of practices, as well as their time since graduation from medical school. The younger physicians are trained to be part of a team, transparent, to measure their performance, listen to patients, and families. This includes being comfortable with email and other telecommunications and other modern ways of communication.

We believe the Triple Aim objectives are a good set of values that is consistent with modern medical education and the way physicians/providers are currently educated.

We think the current accountability by physician/providers (being maximizing quality by current available metrics) is only 40%.

We believe that the current metrics being used are only 40% of the way to maximizing quality.

We believe that the current incentive systems are much too complex and at most 30% of the way to maximizing quality.

Overall, we score physician accountability according to the Axene Accountability Index (AAI) as 40%. Physicians are held to a certain level accountability, but there is more that could be done to increase their accountability.

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[1] *www.ethicalleadership.com/DoingRightThing.htm, Desmond Berghofer , Institute for Ethical Leadership*

[2] *http://www.yourdictionary.com/do-the-right-thing#wiktionary, definition "to do the right thing" , Your Dictionary*

[3] *https://en.oxforddictionaries.com/definition/quality, definition of quality, Oxford English Dictionary*

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Inspire

Media Accountability & Health Care

David V. Axene, FSA, CERA, FCA, MAAA and Joshua Axene, ASA, FCA, MAAA

Introduction

For the past year or so, there has been significant public discussion about the media. Is it biased? Is it giving us the facts? Who do we trust? What is an accurate source of information? No matter what one's political views are, questions are frequently raised as to what the truth really is. Fact checking is increasingly popular, as statements in the press and by politicians are frequently challenged.

The use of social media has increased the number of sources of information we face. It has increased the importance of the questions above and the need to get answers, especially as it relates to health care. As the country considers health care reform and its various ramifications, accurate reporting is of keen importance.

Wikipedia defines media accountability as:

> *Media accountability is a phrase that refers to the general (especially western) belief that mass media has to be accountable in the public's interest - that is, they are expected to behave in certain ways that contribute to the public good.*
>
> *The concept is not clearly defined, and often collides with commercial interests of media owners; legal issues, such as the constitutional right to the freedom of the press in the U.S.; and governmental concerns about public security and order.*[1]

This article will discuss this issue as part of our series on accountability and will present an AHP Accountability Index as it relates to health care.

Reporting the Facts

The old story of the blind men explaining what an elephant looks like is applicable to this topic. One grabbed the elephant's trunk and described it like a snake. Another the tusk and described a horn like on a Brahma bull. Another grabbed the leg and described a tree. All were perfectly accurate in their description, but failed to holistically describe the elephant correctly.

Today's health care system is often like this. While a reporter accurately describes an issue (e.g., rate increases) he is reporting only on a segment of the health system and may be missing other key items. For example, why are the rate increases so large? What is causing that? Few seem to get to the issue of the matter while creating significant sensation around the topic. Yes, it sells plenty of newspapers, but is it helping the public understand some of the causes?

Similar situations emerge when talking about alternatives such as single payer systems. Reporters will accurately report the facts about health care costs in other countries with socialized systems, oftentimes pointing out the problems with the US system, but without discussing some of the items that make the comparisons less reasonable. A prior article on the differences in the United States addresses some of these issues.[2]

Health care is a complex issue and needs to be recognized as such. It is critical that the media take the time to present ancillary issues that help explain the problem.

Minimizing Political Bias

The United States seems to be as polarized politically as it has ever been. The concept of working across the aisle seems to have faded to the point that few expect it to emerge. Recent proposals to reform and repeal ACA show how challenging things are in Washington, DC. Even though the Republicans have the majority, they aren't even able to come to agreement on their proposals with the minority Democrats standing firm opposing much of what the Republicans have to say.

This polarity seeps into the media. The left leaning press oftentimes sides with the Democrats and tells their story. The right leaning media siding with the Republicans. But what are the facts? What are the issues? What is the right story? The journalistic approach of the past has morphed into opinion reporting without any true commitment to share the facts. It is difficult to find a source of factual based reporting.

A Practical Example

There has been significant discussion about high rate increases for ACA products in 2018. I have shown portions of two articles addressing this issue. The first from a right leaning publication and the second from a left leaning publication. Very interesting differences in these articles.

> **Insurers Have Requested Astronomical Rate Increases In 2018, Meaning Obamacare Is Going to Become Even More Unaffordable**[3]
>
> **TOP TAKEAWAYS**
> Insurers have started releasing their proposed premium increases for states participating in the 2018 Obamacare individual exchanges, and it looks like Obamacare is going to become even more unaffordable.
>
> Among the individual premium rates released, Cigna Health and Life Insurance Company of Virginia announced the highest proposed maximum rate increase at 179.9 percent.
>
> Among the averages of the premium rates released, HealthNow New York requested the highest average rate increase of 47.3 percent.
>
> These rate increases contradict years of Democratic promises that Obamacare would lower the cost of care for Americans.

The second article describes the same situation, but somewhat differently.

> **Here's How Much Obamacare Premiums Will Increase in 2018**[4]
> Individuals would face significantly steeper premium increases if the administration decides to stop funding the cost-sharing reductions, and the Trump administration has been vague about whether they will or won't. "We are weighing our options and still evaluating the issues," a spokesperson for the Department of Health and Human Services told the Washington Examiner. "Congress could resolve any uncertainty about the payments by passing the AHCA and reforming Obamacare's failed funding structure." (The Hill reported late Wednesday that the secret Senate health care bill would fund the cost-sharing reductions through 2019.)

> But the Trump administration's decision to say whether or not they will continue to fund them is doing enough damage. Insurers and state insurance commissioners have stated point blank that all of the uncertainty coming out of the White House and Capitol Hill is leading to more dramatic premium increases.
>
> "Put yourself in an insurer's shoes. You're trying to price a product and there is significant debate going on that could shape the future of the product," Avalere's Vice President Elizabeth Carpenter tells MONEY.
>
> Meanwhile, actuarial firm Oliver Wyman reports that two-thirds of rate spikes can be attributed to uncertainty about the cost-sharing reductions and the individual mandate.

Although the first article is a Republican document, it doesn't include information related to the uncertainty of funding for Cost Sharing Reductions (i.e., CSR). It simply talks about the big rate increases and then says how this is so different than that promised by the Democrats.

The second article focuses on the uncertainty of the ongoing funding status of cost sharing reductions and its impact on rate increases.

What are the realities? Why are the rate increases so big? Here are some other reasons not frequently mentioned in the press but part of the actual reality:

- Inadequate initial cost estimates by actuaries back in 2013 that carriers have tried to recover from for the past 5 years
- Losses from eliminated funding of risk corridors (i.e., one of the 3 Rs)
- Delayed implementation of the program (i.e., switched rules)
- Termination of federal reinsurance as scheduled
- Improper risk adjustment process across carriers
- Impact of 3:1 capped age factors on demographic mix
- Unreasonable restrictions on pricing considerations (e.g., metallic level AV calculations)
- Excessive Rx costs of subset of members enrolling in plans (e.g., Hep-C and HIV) that created risk magnets not reflected in risk adjustment process
- Inadequate high-risk pool protection for health plans (e.g., Iowa hemophilia case)

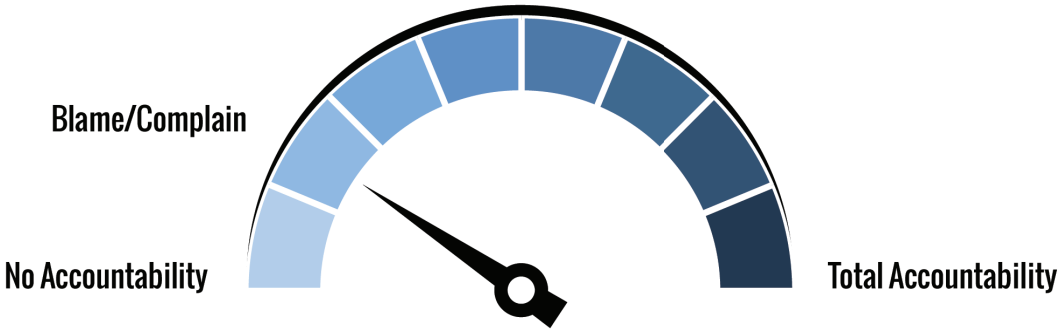
How are we doing?

So how accountable is the media? The following chart summarizes the author's assessment of AAI for the media for each of the Triple Aim issues.

Triple Aim Category	Weight	Rating
Patient Experience	0.333	25.0%
Population Health	0.333	12.5%
Cost of Care	0.334	25.0%
Overall	**1.000**	**20.8%**

The first and last categories have been rated at level 2 of the Accountability Ladder (i.e., Blame and Complain). The Population Health aspect is rated the lowest (I.E., no accountability/unaware).

Overall the media has significant opportunity to improve its accountability.



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[1] *https://en.wikipedia.org/wiki/Media_accountability.*

[2] *http://axenehp.com/makes-america-different.*

[3] *https://gop.com/obamacare-premium-rates-expected-to-soar-in-2018.*

[4] *http://time.com/money/4826591/aca-premiums-cost-2018.*

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Inspire

Accountability of Members/Patients to Maintain a Healthy Lifestyle

by William Bednar, FSA, FCA, MAAA and Sean Lorentz, ASA, MAAA

Introduction

How much is your health worth to you? How much do you invest (or sacrifice) in pursuit of good health? Are your responses to those questions in sync or out of sync with each other? Most people would agree that their health is worth a lot to them, in fact, worth so much that most people consider their health to be an invaluable asset. It is less clear, however, that the level of personal commitment towards achieving and maintaining good health is reflective of its invaluable nature.

The U.S. has the most advanced health care system in the world, and is correspondingly by far the most expensive. There is a saying that money cannot buy happiness. Unfortunately, this saying applies to health status as well. Healthcare services are invaluable for the treatment of illnesses. The advanced healthcare services available in the U.S. system provide treatment for a wide variety and high severity of illnesses. But even the most expensive and most advanced treatments cannot endow a person with good health. The only way to achieve and maintain good physical and mental health is through a lifelong commitment of personal investment, sacrifice, self-motivation, and accountability towards healthy lifestyle choices. A bonus feature is that good health does not entail an expensive health care system. In fact, it is the opposite. Good health leads to a decreased need for health care services, which means a less expensive heath care system. The issue is that while people want to have good health and want to have a lower cost health care system, self-motivation and commitment to a healthy lifestyle is difficult or inconvenient for many people. In theory, everyone should be fully committed to pursuing good health, but, in reality, there is a lack of self-motivation, a lack of appreciation, and an absence of personal accountability when it comes to healthy lifestyle.

The U.S. has more medical malpractice lawsuits than all other developed countries combined. We have the highest expectations of the health care providers in our system, and we hold them accountable when they don't meet high expectations. Doctors, hospitals, or all other health care providers are at risk of getting sued for improper actions (or lack of action) that have negative consequences on a patient's health outcome. However, the patient has no liability or accountability for their actions (or lack of) that put their health at risk. What if the system reciprocated some expectations onto the patient and held the patient accountable for doing their part to achieve and maintain good health; perhaps rewarding the patient for compliance and sanctioning the patient for non-compliance?

The rest of this article explores the characteristics of the U.S. health care system that contribute to the absence of personal accountability, and then explores some ideas on how to introduce personal accountability into the system. The absence of accountability begins with the fact that health care costs are not transparent and mostly hidden from the members' perspective. Additionally, an increasingly sedentary lifestyle with unhealthy diet leads to a rise in preventable chronic conditions. Higher rates of chronic conditions make up a large portion of costs in the system and those costs eventually make their way into higher premiums and leaner benefits. Freedom of choice in the U.S. includes the freedom to make unhealthy lifestyle choices, but that should not entail a total lack of personal accountability.

Cost Transparency in U.S. Insurance Markets

From a health plan members' perspective, health care costs come in two forms: (1) premiums that are paid in advance, and (2) cost-sharing that is paid at the point of service. Cost-sharing commonly takes the form of deductibles, co-payments, and coinsurance. The health care industry is unique in the sense that its consumers are, by and large, unaware of its underlying costs in both areas. Plan sponsors subsidize most of the premium cost and health plans pay for most of the benefit costs. In most cases, the member rarely actually experiences the full premium or full benefit cost, and when they do experience it, they are overwhelmed with sticker shock. We cannot have, or expect to have, individual accountability if the consumer is not aware of the full underlying cost of their benefits.

The United States is the only industrialized country in the world that does not have Universal Health Coverage for all citizens. There are four main ways that individuals obtain health insurance. Each type of program is very different in how the benefit plans are administered, where the funding comes from, and how much the members contribute directly. They are listed below with their approximately percent of individuals that are enrolled in each type of program.

- 60% are enrolled in Employer-Sponsored programs
- 20% are enrolled in State Medicaid programs
- 15% enrolled in the Federal Medicare program
- 6% are enrolled in the Individual State exchanges
- 9% are uninsured

> “Only a small percent of individuals experience the full cost of the US health care system.”

Below is a summary of how each of the four programs are funded:

- Employer-Sponsored programs are funded mostly through the employer’s general revenues. The amount varies by employer, but typically the employer directly funds about 75%-80% of total premium. The employees will then pay the residual premium (e.g., 20%-25%) as a payroll deduction, and employees are also subject to some degree of cost-sharing upon the utilization of services (e.g., deductibles, copays, coinsurance).
- Medicaid programs are jointly funded through State and Federal general tax revenues. Eligible individuals are not required to pay a premium nor contribute towards cost-sharing.
- Medicare programs are mostly funded through the Medicare tax. Part A (hospitalization insurance) has no premium requirement, while Part B (supplemental medical insurance) requires a small monthly premium (roughly $150/month). Both Part A and Part B require some degree of member cost-sharing upon the utilization of services.
- The Individual State Exchanges are funded through a combination of federal subsidies and member contributions. About half of the members receive some degree of premium and cost-sharing subsidy, while the other half do not receive any subsidies. The members that do not receive any subsidy pay the full premium and cost-sharing amounts out of pocket.

The above summary makes it apparent that only a small percent of individuals experience the full cost of the U.S. health care system. The members on the individual ACA exchanges that do not receive subsidies are the only ones that pay full premium for their benefit plans. These premiums can exceed several thousands of dollars per month for family coverage that also requires them to pay thousands of dollars in annual cost-sharing. These enormous premiums for seemingly poor coverage has been a political focal point over the past several years for opponents of the ACA.

How Risk Pooling & Premium Setting Affect Member Costs

A common misconception is that the premiums, whether it be for individual or family coverage, is based solely on one's own claim experience. It can be frustrating to see premiums increase when a member has very few or no claims. The truth is that premiums are not based solely on one's own claim experience. If they were, premiums would vary greatly and defeat the principle of insurance. Most people would have extremely low premiums, while the unfortunate sickly members would have premiums so high they would be priced out of the market. To stabilize premiums, insurance companies combine the claims from large pools of its members, and spread the cost of those claims across everyone in that pool (thereby creating "risk pools").

This risk pool mechanism smooths individual costs across a large group. This is important because it makes health care affordable for the participants that require expensive medical treatment. These few participants would otherwise not be able to afford the treatment that they need. In exchange for paying an insurance premium, members of the risk pool are indemnified of the cost of medical services (subject to cost-sharing provisions).

Pooling claim experience is the basis for the premium setting process. Once the claims are pooled, the premiums can be determined in the following fashion:

- Historical medical costs are aggregated across the risk pool.
- Aggregate costs are adjusted to reflect the expected changes for the future period (e.g., health care trends, population changes, benefit changes).
- The trended costs are adjusted for member cost-sharing (i.e., actuarial value).
- The net cost is loaded for insurer overhead costs (e.g., administration, taxes, risk margin).
- The loaded costs are then divided amongst the members as premium.

The first two steps are directly related to the risk pools historical and prospective costs. As members incur more claims, more premium is needed to cover those costs, which then results in continuous premium increases over time. The third step allows health plans to reduce premium increases by shifting more costs onto the member by raising deductibles, copayments and coinsurance. For example, a 20% premium increase may be reduced to 10% by increasing a $1,000 deductible to $2,000. However, this increases the financial responsibility of each member when they utilize medical services. The more the member needs to pay towards the cost of their services, the more likely they will be to forego services. This is both good and bad. It is good because the members will think twice about if they really need medical attention. It is bad because the members may forego needed medical attention because they can't afford the cost-share. Foregoing needed medical attention can lead to a deterioration in health which then may lead to a more severe (and more costly) medical episode.

Diet and its effect on Chronic Conditions and Cost

It's no surprise that most peoples' diet isn't as health conscience as they would like it to be. In fact, the typical American diet exceeds the recommended intake levels in four categories: calories from solid fats

and added sugars; refined grains; sodium; and saturated fat[1]. Within the context that since the 1970s the number of fast food restaurants has more than doubled[1], it's easy to see why diets are difficult to keep in check and why obesity among adults has more than doubled from 15% to 34%[1]. This type of diet leads to weight gain, metabolic disorders, and circulatory disorders.

The increased sedentary lifestyle of Americans is the result of the continued trend towards office jobs that consists of sitting in front of a computer all day long. In addition to that, many Americans spend their evenings in their cars driving home from work, sitting in front of a television set, and finally laying down in bed. The lack of standing-up and moving around during the day is very detrimental to circulatory health. The combination of poor diet and low activity leads to a rise in chronic conditions.

The treatment of chronic conditions accounts for approximately 70% of all costs in the U.S. health care system. Unlike acute medical conditions, the patient has a large degree of control over the status of a chronic condition, and if left unmanaged, the corresponding health care costs persist over time. There are about 17 chronic conditions that contribute to the 70%. The condition that gets the most attention, because it is the one that is the most attributable to behavior, is obesity. Along with its common co-morbidities (such as diabetes, heart disease, and hypertension), obesity is an epidemic that is plaguing our country and contributing significant costs to our health care system. Projections estimate that by 2018, obesity will cost the U.S. 21% of our total healthcare costs[1].

At its core, obesity is a self-inflicted disease that is the culmination of long-term sedentary lifestyle and unhealthy diet. Unlike chronic conditions that have risk factors largely out of one's control such as family history, genetics, and aging, obesity lends itself well to changes because it is greatly influenced by diet and exercise. Diet and exercise are two aspects of life that affect all Americans equally, and they have the best potential for significant improvement.

Our Health is Invaluable

No amount of money can reverse bad health and replace it with good health. Good health, and the reversal of bad health, must be earned through hard work and commitment throughout one's lifetime. As a society, our belief is that human health is too important to put a price tag on health care services. A patient should be entitled to get the best care available, when they need it, regardless of the cost. Because of this belief, patients do not see the price tags of the services they are receiving. The health plans negotiate the price directly with the providers so that the patient does not have to worry about the price. Health care is unique in this regard. Very few goods or services in the U.S. receive this type of treatment.

In addition to being shielded from the price of health care services, the patient has little accountability for utilizing services. Besides patient cost-sharing, there is a complete absence of accountability. This is also a unique characteristic of the health care system. As an example, when adults take out loans for higher education or a mortgage, the lender expects that the loan will be repaid, and there are repercussions for non-payment. The lender can repossess the house for failure to pay the mortgage, or garnish your wages for failure to repay student loans. Another example, if an employee does not perform their job to their employer's satisfaction or skips a day of work unexcused, the employer will

most likely respond by terminating the employee and removing them from the payroll. These are both examples of common accountabilities that adults in the U.S. have come to accept as standard practices of adult life. U.S. adults have numerous accountabilities that are a normal aspect of their lives, but for some reason, the medial cost associated with unhealthy lifestyle choices is not one of those accountabilities. Healthcare is different than other goods and services, but that does not mean there cannot be personal accountability.

Defining the Goal and the Issues

Before we can start developing solutions, we must first sufficiently define the goals of the health care system and the problems with the system in its current state. In the healthcare industry, there is a concept referred to as the "Triple Aim" that serves as a belief that policies should aim to advance three dimensions: improve the health of populations, improve the quality and satisfaction of care, and reduce the per capita cost. It is understood that no single entity is accountable for all three, however, there are areas where personal accountability could contribute. The areas directly under each persons' control are their diet and physical activity.

With the three goals of the Triple Aim in mind, the next step is to assess how the current system scores against those goals. Overall the current system is succeeding with patient experience. U.S. patients have access to the best medical technologies and shortest wait times. There is room for improvement though. Access to health care is not yet universal. The ACA increased the number of people insured, but approximately 9% are still uninsured. As for the other two goals, the system has not been quite as successful. The U.S. spends approximately 18% of GDP on health care spending ($3.2 trillion or nearly $10,000 per person). This amount far exceeds all other developed countries by all measures. As mentioned earlier, the treatment of chronic conditions is a main reason why costs are so high. The high prevalence of chronic conditions is a double whammy on our health care system. It both compromises the health of the U.S. population as well as bloats the system with preventable costs. This is the main driver for the failure of goals #2 and #3 of the Triple Aim.

Plausible Solutions

Now that we have defined the goals of the health care system and how the current system scores against those goals, we can now discuss plausible methods to work towards those goals, and specifically, how to hold individuals accountable for their contribution to those goals. Knowledge is power. Every user of the system first needs to have a good understanding of how the system works (and how it doesn't work), why the system is broke, and how each person can contribute to getting it back on the right track. The first step towards accountability is having the knowledge needed to make corrective changes.

The next step is to apply that knowledge, make necessary lifestyle changes, and be held accountable for not making the changes. That last statement presents a major issue. The laws and culture in the U.S. make it very difficult, if not impossible, to force people into healthy lifestyle habits. Even if there was an authority that can do so, who gets to define the characteristics and measurements of a healthy lifestyle? Americans enjoy the freedom of choice, and that right should not be taken away, even if their choices are detrimental to their own health and bloat the system with preventable costs.

Because of the conflicting nature with personal rights and freedoms, one way to induce change could be to implement collective responsibility combined with financial incentives for healthy behaviors. Collective responsibility means that all Americans are working toward common goals (i.e., fight the obesity epidemic, lower premiums) where most people will voluntarily participate for the better good of society. Even though there would not be any legal repercussions for non-participation, certain actions (or inactions) that are in opposition to the collective responsibility may be viewed as social stigmas. For example, tobacco was considered "cool" in recent U.S. history, but U.S. society has since deemed tobacco as a social stigma due to its unhealthy nature. Tobacco companies are now prohibited from commercial advertising, tobacco products are required to have warning labels, and smoking tobacco is not allowed in most public areas. Tobacco use is much less popular today because of societal efforts to mark it as a social stigma. A lower prevalence of tobacco use makes Americans collectively healthier.

Financial incentives for health lifestyle currently exist in parts of the employer-sponsored market. Some employers offer HSA accounts to their employees and fund money into their employees' accounts if they accomplish certain goals such as the completion of wellness programs or scheduling preventive services. A possible solution could be to expand similar incentives to all markets, but pegging those incentives to be aligned with the health system. For example, a health plan member can earn a premium rebate or cost-share waiver if they comply with physician orders or participate in wellness programs or recreational activities. The patient's doctor (or wellness coach) can create a report card for the patient that grades the patient on their compliance with the system (or program attendance), and then send it to the patient's health plan for review. Such grades may include showing up to scheduled appointments, take drugs as prescribed, monitoring biometrics (e.g., blood pressure), and following through on doctor recommendations (e.g., diet, avoiding certain activities).

> "Rising health care costs lead to higher premiums for the people that pay the full cost out-of-pocket."

AHP Accountability Index Score

Individual member accountably ranks very low on the AHP Accountability Index (i.e.,AAI). From a clinical perspective, there are no direct accountabilities for individual members of the U.S. healthcare system. Without the fear of facing any enforceable penalties, members can choose to ignore the advice of their doctors, choose not to take their prescriptions as directed, choose to make unhealthy lifestyle choices that increase their risk factors for chronic and acute conditions, and choose to not contribute to the successful management of any chronic conditions that they may have already developed.

Nevertheless, there is some financial accountability in the system, but it is at the group-level rather than the individual-level. Rising health care costs lead to higher premiums for the people that pay the full cost out-of-pocket (e.g., the unsubsidized portion of the ACA market), higher costs for employers that offer coverage to their employees (which leads to wage stagnation), and higher costs for taxpayers that fund the expenses for Medicare, Medicaid, and the subsidized portion of the ACA market.

Conclusion

Mostly, when the topic of accountability comes up within the context of the healthcare system, it is generally aimed at providers and health plans. Doctors are accountable for managing their patients, hospitals are accountable for treating illness, and insurance companies are accountable for the premiums they charge and the benefits they provide. The culture in the United States views healthcare as invaluable and has high expectations of the system. The expectation is to have the best outcomes, short wait times, and access to a large network of providers. The system has mostly responded in kind and the U.S. has the most advanced, albeit also the most expensive, system in the world. However, little is made of the role and accountability of the patients in the system. Should there be a mechanism to hold individuals accountable for lifestyles and diets that bloat the system with high costs? A high prevalence of chronic conditions in our country accounts for 70% of the total health care expense, and those high costs funnel down to the premiums and cost-sharing that must be absorbed by tax payers and individuals paying out of pocket.

[1]*Dietary Statistics, activity level (1) https://www.hhs.gov/fitness/resource-center/facts-and-statistics/index.html*

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Inspire

Accountability: Government Accountability

Greg Fann, FSA, FCA, MAAA

In 2004, the General Accounting Office changed its name to the Government Accountability Office (GAO). The name change was intended to alleviate confusion regarding the scope of services provided and to better reflect the mission of the agency. More subtly, it proudly acknowledged the fact that government itself is indeed accountable.

Today, the GAO is the government agency that analyzes the value of government division results relative to allocated taxpayer dollars. From a health care perspective, the GAO often weighs in on appropriate oversight of the Medicare and Medicaid programs.

While some aspects of government are self-monitored for accountability, the breadth of accountability requirements exceeds the metrics that can be objectively measured. An understanding of general accountability principles will enable government leaders to do their jobs more effectively and deliver appropriate services more confidently to citizens. The focus of this series is health care, and this article is focused in that arena, but the principles of government accountability hold true in all capacities.

As government[1] continues to play a larger role in the health care economy, it is important for policy and regulatory leaders to understand appropriate accountability requirements. Government is unique and has a different perspective than private market entities that operate in the health care marketplace. Private health care requires a functioning business model. A private organization may have a missional goal but cannot function without revenue from a marketplace[2] that supports that goal.

Government, on the other hand, receives revenue through taxation and seeks to spend money to fulfill determined purposes. There is often not a market or other frame of reference to benchmark government's actions and performance. This could expose government to accountability lapses as competitive pressures are not present. For example, a physician group having challenges with one insurer could realign its business model with a comparable insurer while the same group could not change its contractual relationships to another government that provided the same services or funding.

Throughout this article, the Patient Protection and Affordable Care Act (ACA) is used as an example to illustrate understandings of government accountability. The legislation was passed in 2010, and continues to be very visible and controversial. The significance of the legislation, which impacts all health care stakeholders, and the execution that followed provides good opportunities to illustrate damages caused by accountability lapses.

While the ACA is the example used throughout this article, government accountability applies to all areas where government touches the health care system. Experimentation with new value-based reimbursement models require transparency and adherence to government-communicated methodologies. The Medicare Access & CHIP Reauthorization Act (MACRA) changes the way Medicare physicians are paid. Government is accountable for clearly communicating the new rules, and providing appropriate notice of future changes.

The sections that follow include important accountability requirements that are necessary for effective governing. As government moves forward with health reform, understanding and adhering to accountability requirements will facilitate optimal long-term solutions.

Appropriate Advice

Government leaders often bring different experiences and perspectives to their office. Members of Congress have traditionally been well versed in law; more recently, medical practitioners have sought public office and succeeded at the ballot box. As legislative responsibilities are all-encompassing, legislators will ultimately have to pass laws that are outside of their area of proficiency. This requires reliance on colleagues, staff or outside entities.

This raises an interesting and very important question. Who should advise government leaders on the complicated issues that are not in their scope of expertise? It's safe to say that health care policy involving insurance markets is a relevant topic here.

There are more attorneys in Washington, DC than there are actuaries worldwide, and most of them earn a living by offering their opinions related to the impact of various policies. Of course, their paychecks often come from entities who have a financial interest in policy decisions. This creates somewhat of a dilemma; those with the best understanding of policy impacts usually have the largest conflict of interest.

While money from businesses always support informed views of policy impact, opinions on health care have been more abundant, and many academic professionals also weighed in on the ACA debate. As one would expect, not all opinions were accepted without question. Actuaries, generally known for providing dispassionate advice, released a report[3] in 2013 warning of higher costs due to new rating requirements. While not used to being labeled as controversial, the report was dismissed by one senator who attached actuaries to the health insurance lobby[4].

Ultimately, the market was designed to require a risk pool with a higher percentage of young adults than it actually achieved.[5] Some commentators, without a complete technical understanding of the mechanics[6], had argued that premium subsidies would attract young men to the market and achieve the desired risk mix. There is now acknowledgment that "the ACA has some problems but can be fixed" but little consensus on the underlying structural problems. A member of Congress recently remarked that allowing insurers to vary rates by age (and other rating factors) is wasteful and not cost-effective. With one of the major challenges of the risk pool already being an unbalanced age mix, comments suggest that bad advice is still easy to find.

How does government determine what is "appropriate advice"? One beneficial insight is the understanding is that real solutions are not divisive and segmented. In the health policy arena, many unfortunate opinions are of the mindset of consumers vs. insurers, or physicians vs. patients, or "big pharma" vs. everyone. Functioning markets require mutual benefit for buyers and sellers. Advice that suggests deliberate harm to one party as part of a solution is likely to be implemented ineffectively and not well received, and should be avoided.

One other effective tool is actually an often-overlooked requirement in the actual analysis of health policy design. Health policy considerations should include considerations of health care stakeholder incentives; likewise, government should understand the incentives of who is providing policy advice. If

one has a preconceived policy goal, it's easy to find data to support that position. Actuaries have broad responsibilities to be objective and impartial, and possess the technical expertise to provide a full and complete analysis.[7]

The Importance of Consensus

When businesses engage in transactions, it is generally assumed that each party will abide to certain behavior once an agreement is reached. Over time, employee turnover occurs but new employees often are hired to continue the business model. The owner of a business does not usually hire someone who has goals and ideals incompatible with his own.

Government has been known to operate differently. Government representatives are often elected by citizens as opposed to being selected by someone already in government. This often leads to different views and different missions. Elected officials may represent constituents with different views and have different perceptions about what they are elected to do.

Major legislation that lacks consensus often presents execution challenges. The ACA was passed by the narrowest of margins. In fact, the replacement of a US Senator changed the political makeup in the Senate, and the House of Representatives accepted the Senate bill without modification to avoid the Senate having to vote again. Many "drafting errors", which would normally be resolved through a conference committee, remained in the final legislation. Due to a lack of continued lack of consensus, many issues (that virtually everyone acknowledges are real problems) remain unresolved.

One example is the so-called "family glitch". Individuals with access to affordable employer-sponsored coverage are not eligible for premium and cost-sharing subsidies. The 'affordable' definition is based on the required premium contribution relative to the employee's household income. The affordability test is based on employee-only coverage and not family coverage. This results in some families not having affordable employer-sponsored coverage and also not being eligible for premium and cost-sharing subsidies.

The current attention over reimbursements for Cost Sharing Reductions (CSR)[8] highlights another downfall of lack of consensus. The ACA requires insurers to reduce cost-sharing for certain low income enrollees with the expectation that the costs will be passed through to the government. At the same time, Congress never formally appropriated these funds but they were paid by the Obama administration. Legal challenges followed, and President Trump entered office with somewhat of a dilemma – to either continue making the CSRs payments which contracted insurers were expecting or stop the payments and risk insurers exiting the market and potential lawsuits. Legal predicaments such as these rarely occur with consensus legislation.

Know The Legal Limits

It goes without saying that legislative bodies should only pass laws that are legal. As almost all legislation provokes perceived harm for some groups or some people, any questionable elements of a law could be challenged in court. The likelihood of a legal challenge is also related to the magnitude of the law and a lack of consensus. A contentious bill that has significant impact to certain stakeholders is more likely to be challenged.

There have been numerous lawsuits associated with the ACA. Many have revolved around the implementation of some of the regulatory rules. A case challenging the constitutional fidelity of the law was elevated to the US Supreme Court and had mixed results. Legislation that lack a legal stable foothold also creates uncertainty in the market and may repel participants. As legislators debate significant issues that lack appropriate consensus, they should be intensely sensitive to potential legal challenges.

Reliable Business Partner

The business of health insurance and the associated regulatory requirements necessitate significant lead time for developing premium rates before they become effective. Premium rates are generally effective for one year, and cannot be changed mid-year due to unanticipated developments.

The pricing of health insurance is complicated and technical, and relies on many factors. Actuaries are well aware of the necessary considerations, but government leaders could logically be insensitive to potentially inflicting market damage. With the ACA, many rules have not been enforced or have subsequently been changed, often "through the use of executive decisions, waivers, and deadline extensions."[9] The allowance of transitional (or grandmothered) plans were not anticipated by insurers, which would have resulted in higher premiums to reflect healthier individuals delaying migration into ACA markets. Businesses will not continue to participate in markets where they cannot rely on their partners to keep their promises.

In summary, as government plays a larger role in the health care economy, it must be an accountable and trusted business partner.

Transfer of Responsibility

When government passes laws that transfer responsibilities to government from private enterprises, government becomes accountable for those results. Rating restrictions are a common limitation that government imposes on insurance companies.

Prior to the ACA, insurers would develop rates for small employers based on the characteristics of the employees. Insurers typically had flexibility to develop rating factors based on actuarial data. If an insurer applied inappropriate factors, it would likely result in negative enrollment and financial results. In this scenario, the insurer would have no justification to shift blame as it had control over the applied factors. If it recognized the problem, it would update its factors to improve results in following years.

With the ACA, government removed some of the rating flexibility for insurers. Rates could no long vary by gender and health status, age rating was compressed and factors developed by the government were mandated. In a sense, the government took ownership of the rating factors. As the new factors were not actuarially appropriate, government implemented a risk adjustment system to actuarially reconcile the limited factors. Insurers had to live by the government's assumptions and apply factors that they previously developed internally. It is fair to say that they were formerly responsible for the accuracy of their own estimates. With the ACA, that responsibility now lies with government and is out of the control of insurers; insurers are justified in demanding that the government factors and associated adjustments are correct.

I highlight the risk adjustment example with the knowledge of ongoing challenges[10] and charges of inequities in the methodology. Without going into technical details[11] in this article, the government agreed to accept a major challenge to develop an equitable budget-neutral program. In March 2016, the government released a Discussion Paper[12] highlighting potential changes to the risk adjustment model based on industry feedback. Some of the characteristics of the methodology posed unique challenges on the CO-OPs, organization that were catalyzed by ACA funding. Most of these organizations have since become financially insolvent and have ceased operations.

As insurers are not able to select risks or price accordingly for the risk received, they must rely on government methodology for an appropriate and adequate financial accommodation. It is imperative that the operational methodology is therefore precise and impartial, and accurately transfer risk payments and not be influenced by other factors.

The intent of this section is not to cast blame on government for the failure of certain companies, but to highlight the enormous accountability and risk that government assumes when it transfers private market decisions to government agencies.

Unintended Consequences

They are likely drinking more beer in the City of Brotherly Love these days. It is not related to the Phillies being last in their division (they are) and it has nothing to do with the weather. It's the soda tax. The tax on soda products, intended to raise revenue,[13] has resulted in prices higher than the cost of beer, and presumably shifted consumption patterns, generating far less revenue than expected.

Legislation that involves tax policy often has an intention to either raise revenue or change behavior. Often, the results include a mixture of both outcomes, and usually some unintended and unexpected effects.

The ACA included a litany of tax subsidies and mandates that resulted in tax penalties for non-compliance. Measuring the isolated impact of each one is subjective but the directional impacts of each are trivial. Individual subsidies and mandates will have upward impact on enrollment patterns. Subsidies that decrease with income will discourage work to some extent. Mandates that apply to employers based on number of employees and hours worked will impact hiring patterns and work schedules.

Unbiased technical expertise is needed to model the impact of such changes. Unlike the Medicare and Medicaid programs, the free market element of purchasing insurance coverage without significant financial assistance[14] is much more challenging to project.

With traditional government programs, funding is often the primary lever to consider. When regulating and subsidizing insurance markets, accountable government requires utilization of appropriate expertise that is likely outside of the traditional government sources.

The Buck Stops Here

President Harry Truman is well known for having a small sign on his desk reminding anyone who may be in his office (and himself) that "The Buck Stops Here". The phrase is derived from the slang expression "pass the buck" which means to defer one's responsibility to someone else. "The Buck Stops Here" signifies where decisions are made and where responsibility lies. As government takes ownership of decisions previous held by private enterprises, it accepts new responsibilities.

If government action creates new problems, it seems evident that government should be responsible for necessary corrections. There have been numerous instances with the ACA where government has attempted to "pass the buck." Most notably, insurer participation has diminished since 2015 and various geographic markets have been unattractive and in danger of not having any participating carriers. Government leaders have sometimes suggested that insurers who operate in other markets should be forced to participate in the individual market regardless of financial outlook. This ignores both general principles of actuarial soundness and rules that disallow other government programs to subsidize losses in other lines of business. At a recent hearing, a senator told an insurance company witness that his company was "holding a knife to their own throat"[15] by not participating in counties where there were no other insurers, creating "incredible pressure for us to provide a solution".[16]

For health insurance to function effectively, each line of business should be self-sustaining. Insurance principles and various regulations require this. If government enforces new rules on a market, government is accountable for the impact of those rules.

It is troubling to hear government over promise market success, and then react to failure by mandating participation for some insurers. Insurers have different characteristics: some are specialized to serve the Medicare market, others may have invested significantly in developing a network with limited geographical breadth, and some markets/area may not make sense for their business model. Required insurer participation in new markets or geographic areas would have inequitable effects on various insurers and change profitability requirements in other lines of business and create competitive disadvantages. In a sense, it is also a soft admission of government failure. If government is going to craft market solutions, government is accountable for functioning markets, which includes attracting suppliers. Requiring participation of insurers to substitute for government accountability is untenable.

Any effort by government to significantly redesign markets will likely have positive and negative impacts, some expected and some unexpected. A natural tendency for government may be to accept the benefit of the positive changes and cast the accountability of the negative impact on market players. Government should have a "Buck Stops Here" attitude with regard to both desired and unintended outcomes. A recognition of this accountability is a catalyst for designing markets that are attractive to both buyers and sellers.

AHP Accountability Index™ (AAI) and Government

Rating government accountability is a subjective process. The Triple Aim aspects (patient experience, population health, cost of care) were formally implemented in the government structure when one of the founders of the framework accepted a leadership role in the Obama administration. The scope of government's role in the health care system is massive and all stakeholders would likely have biased views based on their own limited government interactions. Consistent with the theme of this article, the Index estimates are based on the author's opinions of ACA markets, which have been the most impacted by government's actions in this decade.

Patient experience is largely poor. The shift to government-sponsored exchanges from traditional distribution channels was supposed to foster a competitive environment with smooth transactions. The early implementation was largely regarded as an operational failure and competition is sparse in many areas. Actual enrollment in individual markets is about half of what was expected. The market rules impacting premium rates and the associated government subsidies reduced the costs for lower-income individuals but increased the costs for many others. With the amount of government funding allocated to the ACA, better results should have been achieved.

Population health is mixed. The ACA has been an impetus for more awareness of the need of health insurance. It cannot be ignored that the benefit of having insurance also provides incentives for unnecessary care. The appropriateness of the increased use of opioid for newly-insured individuals is a major concern.

One of the early promises of the ACA was reduced costs. It's a fairly universal view that the ACA has resulted in more people being insured, but has done nothing to control costs. In fact, it's hard to hear a debate on ACA that doesn't get distracted by a "health care costs (rather than insurance premiums) are the real problem" argument.

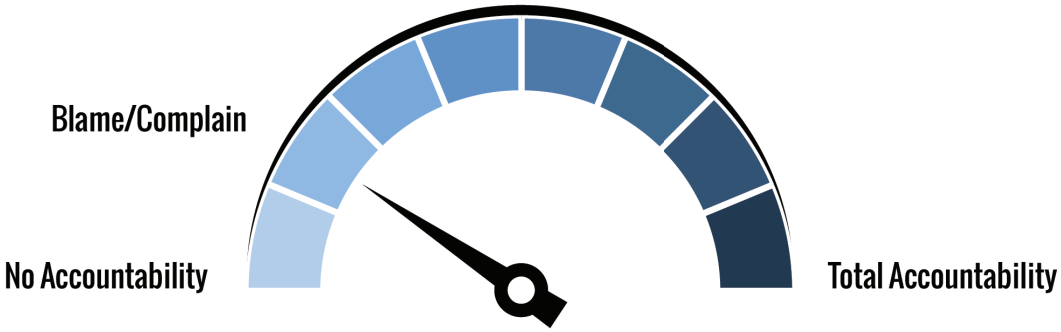
With those considerations in mind, the following chart summarizes a government assessment of AAI.

Triple Aim Category	Weight	Rating
Patient Experience	0.333	20.0%
Population Health	0.333	50.0%
Cost of Care	0.334	0.0%
Overall	**1.000**	**23.3%**

Conclusion

It is important for government leaders to understand the appropriate role of government and accountability requirements. A free market economy requires attractive options for buyers and sellers. Government can play a positive role, but ambitious well-intended government policy often fosters unintended consequences. Regulation of insurance markets is challenging, and appropriate unbiased expert advice is crucial.

The lesson learned from the ACA experience include the need for appropriate advice, an understanding of incentives, the importance of consensus, the need to be a reliable business partner, and the acceptance of accountability. Adherence to these principles will foster good policy and a competitive market that attracts buyers and sellers. The health care system will flourish when appropriate accountability is implemented for public as well as private market participants.



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[1]*The term "government" is used generally to represent various governmental entities. The purpose of this article is to demonstrate the unique accountability of government agencies. A particular agency or political party affiliation is often inconsequential (and perhaps distracting) to understand the larger point.*

[2]*While health care in the U.S. is delivered through private businesses, there is an element of charitable dollars used to fund hospital construction, care, and other missional activities.*

[3]*http://cdn-files.soa.org/web/research-cost-aca-report.pdf*

[4]*https://hotair.com/headlines/archives/2013/04/health-actuaries-obamacare-rates-are-going-to-soar/*

[5]*http://www.theactuarymagazine.org/the-true-cost-of-coverage/*

[6]*https://www.soa.org/Library/Newsletters/In-Public-Interest/2016/september/ipi-2016-iss13-fann.aspx*

[7]*https://www.soa.org/Library/Newsletters/The-Actuary-Magazine/2015/june/act-2015-vol12-iss3-tofc.aspx*

[8]*http://axenehp.com/wp-content/uploads/2017/08/ahp_inspire_20170809.pdf*

[9]*http://www.washingtonexaminer.com/how-obama-knee-capped-his-own-health-reform/article/2635220*

[10]*https://www.bizjournals.com/albuquerque/news/2016/08/01/nm-health-connections-files-lawsuit-against-feds.html*

[11]*https://minutemanhealth.org/MinutemanHealth/media/Outreach%20and%20Comms/Oct2016/Comment%20Letter%20Appendix%20I_Part1.pdf*

[12]*https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf*

[13]*https://townhall.com/tipsheet/mattvespa/2017/08/10/disaster-phillys-soda-tax-has-produced-miserable-results-n2366836*

[14]*https://stateofreform.com/wp-content/uploads/2017/08/AHP-Inspire-Free-Market.pdf*

[15]*http://www.thinkadvisor.com/2017/09/14/insurers-are-holding-a-knife-to-their-own-throat-k?slreturn=1506638522*

[16]*http://www.thinkadvisor.com/2017/09/14/insurers-are-holding-a-knife-to-their-own-throat-k?slreturn=1506638522*

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Inspire

Accountability: Rates

Joan Barrett, FSA, MAAA

Introduction

One of the primary responsibilities of health plans, like Aetna, Cigna and UnitedHealth Group, is to remain financially viable in order to meet its financial and legal obligations to members, plan sponsors, providers and employees. In many cases the reason a health plan suffers financial losses is that the premium rates charged for its insured business are simply too low.

This may happen if the actuary underestimated costs during the rate-making process, but it may also happen if management made a business decision to lower rates in an attempt to sell more business. Of course, there is also a possibility that state regulators will deny a requested rate increase.

In addition to its financial and legal obligations, a health plan has a moral obligation to make sure that members have reasonable access to quality health care by keeping costs as low as possible, providing a reasonable level of benefits and providing quality customer service. Failure to meet these moral obligations may have financial implications. Member dissatisfaction may result in many members leaving the health plan, leaving the health plan without enough members to support the infrastructure.

Although health plans generally maintain several blocks of business, in this article, we will focus on the commercial insured block of business sold to individuals and groups since this block generally has the most financial impact. Also, health plans generally follow similar business practices for each block of business it manages.

Manual Rates

Health plans use manual rates to determine premium rates for individual health plans and small employer groups. Manual rates represent the health plan's expected overall experience for the effective period, adjusted for policy-specific rating factors like benefit plan, area, and age-gender. Manual rates are developed in three phases: an analytical phase, a business decision phase, and a regulatory oversight phase.

During the analytical phase, the actuary starts by projecting past claims experience for the health plan to the future rating period. The projection usually reflects adjustments for:

- External factors like changes in clinical practice and in the economy
- Benefit, care management and other structural changes
- New legislation
- Price increases
- Fluctuations in experience due to large claims
- Changes in the disease burden for the risk pool that will not be reflected through other rating adjustments

Although each of these adjustments require considerable skill and care, the most difficult part of the process is often estimating the expected change in disease burden. Unpredictable changes in the disease burden are often the result of adverse selection. Typically, adverse selection occurs when a member enrolls in a plan, incurs a high number of claims, then drops coverage or moves to another health plan. Adverse selection may also occur if the rates favor one group over another. For example, if the rates are structured so that younger members subsidize older members, younger members may leave the health plan. If that occurs, the rates for the older members will be insufficient.

The actuary performs numerous tests during the rate development process to make sure the rates are indeed a best estimate, including comparing actual results to expected results in prior projections and explaining the variances. The test results are used to improve the projection process going forward.

A similar process is used to determine the expense portion of the premium, except that the underlying analysis is often based on the budget. The final premium is the projected claims, the projected expenses, and a provision for adverse deviation (PAD). PADs are usually expressed as a percent of premium. By law, the expense portion of the premium must meet loss ratio requirements.

The final decision as to what the premium rates should be is generally made with input from senior management in various areas like underwriting, finance, and sales. One of the key questions asked during this phase is how the health plans compare to rates from other companies. If the proposed rates are higher than the competition, then the health plan will most likely try to determine the reason for this. The health plan may want to lower the premiums to be more competitive. More sophisticated health plans will do additional testing at this point to determine whether or not this is a wise decision.

Once the final rates are determined, the actuary must file the rates with the state department of insurance and, for plans sold on the Exchanges, with the federal government. In the rate filing, the actuary has to attest that:

- The rates are adequate
- The rates are not overly conservative
- The rates are fair
- The rates and underlying plan designs comply with all state and Federal regulation

The degree of regulatory oversights varies considerably. In some states, the health plans can simply file and use the rates. In others, there is considerable scrutiny, including public hearings.

Experience Rating

If a health plan deems a group to be large enough to be fully credible, then the health plan relies solely on just the group's past experience as the starting point for determining the premium rates. That experience is adjusted in a manner similar to that used for manual rates. In fact, the adjustment process and values are often identical to that used in the manual rating factor. In some cases, a group may be considered partially credible, which means that the initial premium rate is a blend of the manual rate and the experience-rated value.

Once the initial rate is determined, the decision-making process is similar to the one used in determining with manual rates, except that the final decision is made by individuals associated with the group rather than senior management. Also, some policy specific analytics may be done at this phase to estimate expected gains and losses.

The health plan must file rates on a regular basis, but there is no regulatory oversight at the policy level.

AHP Accountability Index and Health Plan

The Axene Health Partners Accountability Index (AAI) provides a consistent method for measuring how well an organization's accountability mechanism meets it obligations as defined by the Triple Aim:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

Our score for health plan rates is 79.2%, based on the following evaluation of typical practices:

Triple Aim Category	Weight	Rating	Description
Patient Experience	0.333	75.0%	The next step is to accept ownership and responsibility
Population Health	0.333	75.0%	The next step is to accept ownership and responsibility
Cost of Care	0.334	87.5%	Apply known solutions to predictive tasks and challenges
Overall	**1.000**	**79.2%**	

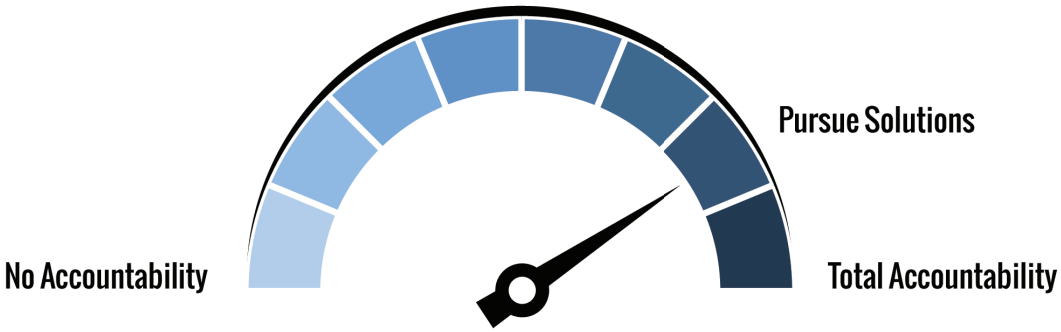
Most health plans have an extensive infrastructure designed to ensure that a patient's experience is positive. The infrastructure almost always includes on-line information about member benefits, customer service lines to answer questions, provider quality requirements, reporting, and member satisfaction surveys. Although the infrastructure is there, members are not entirely satisfied with the results. For example, according to the 2017 J.D. Power Member Health Survey[1] 25% of members are unsatisfied with the coordination among health plans and providers. This presents considerable growth opportunities for health plans willing to invest in improving their member experience infrastructure.

Similarly, most health plans have an infrastructure in place to improve population health through education and direct care. In some cases, a program may be available only to members. For example, a health plan may send out reminders to its members to receive a physical, mammogram or other preventive care. In other cases, a health plan may provide services to the local community through a foundation. Although these programs play an important role in improving the health of a population, there is considerable overlap between various efforts both inside a health plan and between health plans and other population health providers. We recommend health plans use the considerable data at their disposal to determine ways to improve the effectiveness of their programs and to optimize resources.

We ranked the cost of care category higher than the other two categories because health plans not only have a strong rate-making infrastructure in place, but there is also considerable internal and external oversight. That said, the overall cost of care is higher than most policy holders want to pay. More sophisticated health plans regularly review opportunities for lowering cost using methods like the AHP's 24 Lever model[2]. One note. It is not only the overall cost level of health care that creates a problem for members, but also the year over year increases which may put health care out of reach at least for a while. Again, we recommend that health plans improve their analytical capabilities in an effort to minimize unnecessary swings.

Conclusions

Although health plans are generally well-run, there are still considerable opportunities to grow the bottom line, reduce the cost of care, and improve the patient experience. To some extent this can be done through on-going reviews of the process underlying the health plans infrastructure. More importantly, health plans have considerable data that can be mined to address key issues.



[1] *http://www.jdpower.com/sites/default/files/2017065.pdf*

[2] *http://axenehp.com/the-24-lever-model-lowering-insurance-premiums/*

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Accountability: Public Health

By Bethany McAleer, FSA, MAAA

Introduction

In the debate around healthcare reform or in conversations about what's wrong with the U.S. healthcare system, public health rarely earns a mention. Insurance companies, hospital systems, providers, pharmaceutical companies, government, and individuals all seem to contribute to the problem in one way or another – where does public health fit in? And really, what does "public health" even mean and what types of services does it span?

This article will explain the broad set of roles and responsibilities of public health in general – how it touches you and me, and how it influences the state of health in our country. This article will also take a closer look at public health operations – how it is funded, who determines how money is spent, and what mechanisms hold public health accountable to improve population health.

Roles, Responsibilities, and Impacts of Public Health

Defining Public Health

Before we can begin to understand the complicated web of funding and determination of priorities of public health, we need to have a grasp of both its goals and its span of services. Public health fundamentally promotes and protects the health of people and their communities. While most of the U.S. healthcare system is devoted to treating people who are already sick, public health focuses on keeping people healthy. The three primary ways in which public health systems influence our lives are (1) through the development of community programs, (2) through advocating for health- and safety-promoting policies, and (3) through dissemination of evidence-based information.

Span of Services

When we think about our health, we often focus on diet and exercise alone, and overlook other significant influences. There are many social and environmental factors that have a big impact on both our health and our ability to make healthy choices. Some of these factors include: income, education, race, family/support networks, working conditions, living conditions, community safety, and stress levels. Public health organizations must consider and influence all of these elements. A few examples of the broad array of public health activities include:

- Protecting communities from the spread of infectious disease through vaccinations, education, and medical research/advancements
- Creating and monitoring standards around environmental contaminants (lead exposure, safe drinking water, air pollution, etc.)
- Educating the public on harmful effects of drug, alcohol, and tobacco use and developing support programs for those struggling with substance abuse
- Advocating for safe communities by researching and lobbying for programs and policies that reduce gun violence and create safe infrastructure for walking/bicycling (to work, to school)
- Promoting policies that make healthy choices accessible and affordable (e.g., school lunch programs)

Impacts on Population Health

When you start to think about health status as being influenced by all aspects of our lives, you begin to understand that healthcare itself is only a small part of what contributes to individual or population health. Yet, in the U.S. we put almost all of our healthcare money towards the treatment of conditions vs. prevention – less than 5% of total healthcare expenditures are spent on public health.

According to one study, the U.S. could save a significant amount of money ($16.5B over five years, in 2004 dollars) on healthcare costs if we were to invest as little as $10 per person into "evidence-based programs that improve physical activity and nutrition and lower smoking rates in communities" (Levi, Segal, & Juliano, February 2009). Those savings come in the form of preventing the development and managing the progression of costly chronic illnesses. Another study shows that for each 10% increase in strategic local public health spending, infant mortality rates and deaths due to cancer, diabetes, and cardiovascular disease decrease by 1-7% (Mays & Smith, July 2011).

While there are studies out there showing the potential financial benefits that would come from spending more on public health, much of the reason for lack of investment in this area is a lack of clear, or clearly communicated, information on the ROI (return on investment) of specific preventive and health-promoting activities. Public health institutions would greatly benefit from policymakers and other key stakeholders in the healthcare industry having a better understanding of how to curb long-term costs through the expansion of health-promoting programs.

Structure, Funding, and Spending of Public Health

The public health system in our country is, in the simplest terms, complicated and inconsistent. There are various levels and many branches of public health, but for a basic overview let's break it up into Federal, State, and Local (community) programs and funding.

Federal
Federal public health agencies, such as the Centers for Disease Control and Prevention (CDC), are financed by federal discretionary funding, which essentially means that any money set aside for public health spending cannot be allocated without congressional approval. Direct federal spending on public health is typically focused on disaster relief or mitigation (e.g., Hurricane Katrina, H1N1 flu pandemic). Most of the federal money set aside for public health is allocated down to states and localities categorically, which means that the federal government has already prescribed how that money must be spent (e.g., $X for WIC, $Y for Infectious Disease, etc.). The rest of the money is allocated down through block grants, where states and localities can request funding for specific programs/services.

State
State health departments (SHD) are financed through a combination of federal funds (through grants and categorical allocations, per above), general state funds, Medicare/Medicaid, and public health fees/fines. However, since "general funds" cover a wide variety of public services, public health entities are competing with education, law enforcement, etc. for that money. The proportion of funding that comes from these four areas varies widely by state, but federal funding makes up the majority.

Receiving a significant portion of funding through federal categorical allocation often causes many State Health Departments (SHD) to develop programs based on what is funded rather than what is needed – i.e., this money is not able to be used at the discretion of the SHD, based on their state's specific needs. Funding through block grants is more tailored to specific needs, but the money received through those grants must be used for a very specific purpose.

Local

Local health departments (LHD) get some funding from both federally- and state- allocated funds, but, while there is wide variation in communities across the county, generally most of the funding for LHDs comes from the locality itself – general funds, local taxes, and property taxes. LHDs often have more flexibility in how to spend their money than SHDs do.

Funding is a real challenge for public health systems at all levels. Funding streams are unpredictable, are in competition with other public services, and are often predetermined as to how they must be spent. There is very little consistency across states and localities with how revenue is allocated to various initiatives and, due to the complex nature of the funding, there is little transparency to the public of how public health dollars are being spent. Some of these complexities, in addition to heavy administrative and reporting burdens, also contribute to the difficulty of performing accurate analyses of program outcomes.

AHP Accountability Index™ (AAI) and Public Health

Rating accountability for public health is not a straightforward task. While public health entities no doubt have a great deal of focus on improving all three aspects of the Triple Aim (patient experience, population health, cost of care), they are often constrained in reaching their full potential by infrastructure, administrative, and funding challenges. Who should be held accountable for addressing those limitations? Is it the responsibility of public health organizations to simply do the best with what they have, or should those organizations move beyond that mindset? And what is "the best"? Who should be determining the priorities and investments of various public health entities?

In reality, every different public health system will rate differently. Some will fall more into the "make excuses" mindset when it comes to administrative burdens and funding shortages. They will take their allocated funding and use it as prescribed and do the best with what they have left to meet community needs. Others will embrace their role as an advocate for the public's needs, take full responsibility for improving the welfare of their communities and come up with innovative solutions in the face of significant challenges.

With those considerations in mind, the following chart summarizes the author's assessment of AAI for public health's responsibility to each of the Triple Aim issues.

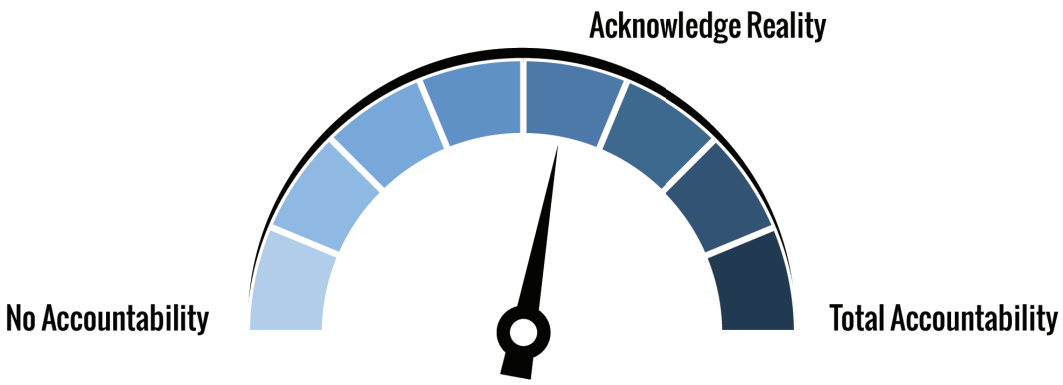
Triple Aim Category	Weight	Rating
Patient Experience	0.333	62.5%
Population Health	0.333	75.0%
Cost of Care	0.334	37.5%
Overall	**1.000**	**58.3%**

Public health entities generally have less of a focus on the cost of care itself and more of a focus in preventing the need for care in the first place – reducing costs overall by improving our nation's health. While funding challenges are not going away, more state and local health departments are committing to improving the health of their communities even if they don't have all the resources at their disposal that they may like.

Conclusion

Public health is a fascinating, complex, and far-reaching topic. This article focused on explaining in simple terms what public health is – what are its goals, what is its basic structure, and what are its key challenges. While the article touched briefly on some of the opportunities within public health to improve our nation's population health, and therefore our healthcare system, additional details on various public health initiatives (and success stories) are out of scope. There is a "Further Reading" section included in the Appendix of this article for anyone who is interested in doing additional research of their own.

At the end of the day, a critical activity for all public health entities is the dissemination of accurate and persuasive information around positive program outcomes to those who make funding decisions. Policymakers need to be convinced of the financial value of investing in public health, for the benefit of us as individuals and as a nation. Public health has yet to move into the spotlight in healthcare reform discussions, but it will become an increasingly important part of any solution as U.S. healthcare costs continue to rise.



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Appendix: Further Reading

GENERAL READING

The websites for each of the organizations listed below contain an immense amount of information related to the work those entities do and how they impact population health.

American Public Health Association

https://www.apha.org/

> APHA champions the health of all people and all communities. We strengthen the public health profession. We speak out for public health issues and policies backed by science. We are the only organization that influences federal policy, has a 145-year perspective and brings together members from all fields of public health.

Centers for Disease Control and Prevention

https://www.cdc.gov/

> The CDC is one of the major operating components of the Department of Health and Human Services. CDC increases the health security of our nation. As the nation's health protection agency, CDC saves lives and protects people from health threats. To accomplish our mission, CDC conducts critical science and provides health information that protects our nation against expensive and dangerous health threats, and responds when these arise.

SPECIFIC TOPICS

The specific websites listed below showcase some of the efforts of various public health entities, in order to provide a small window into the many population health improvement opportunities. I have also included one study done by The Commonwealth Fund showing how the U.S. compares to other countries on a variety of metrics that can be influenced through public health systems.

Generation Public Health

https://www.apha.org/what-is-public-health/generation-public-health

> In the U.S., where you live, your income, education, race and access to health care mean as much as a 15-year difference in how long you will live. Equally shocking: studies show that even wealthy, highly educated Americans with access to quality care suffer a health disadvantage to peers in other high-income countries. That's why APHA created Generation Public Health.

Healthy People 2030

https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030

> Every decade, the Healthy People initiative develops a new set of science-based, 10-year national objectives with the goal of improving the health of all Americans. The development of Healthy People 2030 includes establishing a framework for the initiative (including the vision, mission, foundational principles, plan of action, and overarching goals) and identifying new objectives.

Healthiest Cities Challenge – Success Stories
http://www.healthiestcities.org/resources/success-stories

The Healthiest Cities & Counties Challenge is a partnership between the Aetna Foundation, the American Public Health Association and the National Association of Counties, and is administered by CEOs For Cities. The partnership empowers small to mid-size U.S. cities and counties to create a positive health impact. This link highlights some of the success stories seen to-date.

Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care by Eric C. Schneider, Dana O. Sarnak, David Squires, Arnav Shah, and Michelle M. Doty
http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/

The Commonwealth Fund provides an analysis of U.S. healthcare compared to other developed nations across key performance metrics, including health equity and health outcomes. Included on the site are interactive graphics showing how the U.S. stacks up.

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Inspire

Accountability: The General Public

Joe Slater, FSA, MAAA

"We have met the enemy and he is us." – Walt Kelly, Pogo

Introduction

The general consensus is that the U.S. health care system is too expensive, provides less than desired levels of quality, and does not effectively cover enough of the country's population. While deficiencies in quality and coverage aspects of the system are pressing concerns. The escalating cost of the U.S. health care system is a threat to the federal government's ability to meet its future fiscal obligations.

For example, to put Medicare on a sustainable path given current levels of spending and life expectancy would require a 15% payroll tax, according to the Affordable Care Act's (i.e., ACA) architect and MIT health economist Jonathan Gruber.[1]

Richard Nathan of the Rockefeller Institute hypothesizes that there are two main approaches to reforming the U.S. healthcare system. The first emphasizes government action to integrate services and in other ways increase the productivity, quality, and efficiency of care.[2] The second approach seeks to leverage the power of consumers to negotiate better costs, quality, and efficiency in the U.S. health care system.[3] While it is beyond the scope of this article to debate the positive and negatives of either approach, it is fair to say that they both have promise. Both approaches also have in common the need to obtain "buy-in" and support from the general public. A consumer-directed approach would need the active and enthusiastic involvement of the public acting as consumers to work. Likewise, a provider-value approach, would require the acceptance, or at least acquiescence, of the general public in regards to limits on provider access and consumer choice.

A health care reform effort not supported by the public will fail for practical, economic, and political reasons. For example, the broad implementation of managed care practices in the U.S. in the 1990s led to a significant slow-down in the rate of increase in the cost of care in the U.S.[4] Unfortunately, the general public and most health care professionals were not happy with managed care practices. In response to provider and consumer dissatisfaction, many managed care organizations dropped or loosened the business practices that allowed them to successfully control the cost of the care, i.e., provider risk contracting, limits of patient access to providers, and utilization management practices. The pullback on successful managed care practices led to a significant rebound in the rate of increase of the cost of care by the early 2000s.[5]

To date the general public has not shown a great deal of enthusiasm for accepting any real responsibility or limits when it comes to health care spending in the U.S. This will need to change regardless of the route health care reform takes in the future. Simply put, the status quo is not sustainable, and the American public must balance its expectations when it comes to access, quality, and cost to ensure that we meet our goal of universal high-quality affordable health care in the country.

The General Public and Health Care Access

Even with the implementation of the ACA, almost 30 million people living in the U.S. did not have any health insurance coverage for the entirety of 2015.[6] As a result, there continues to be a strong push to provide universal health insurance coverage in the United States. With the failure of congressional Republicans to repeal and replace the ACA in early to mid-2017, 57% of Americans now support a single-payer approach, under which all Americans would receive health care coverage from a single government-sponsored plan.[7] However, the same poll shows that support for a single-payer plan declines to 34% if enactment of the plan would require Americans to pay more in taxes.[8]

Is it possible to provide a single-payer health plan in the U.S. without raising taxes? According to a research report released by the Urban Institute in May 2016, the answer is "no". During the 2016 presidential election campaign, Vermont Senator Bernie Sanders, then a presidential candidate, released

a plan for a single-payer health care system in the U.S. The Urban Institute found that Senator Sanders' plan would increase federal government expenditures by $2.5 trillion annually, and total national healthcare spending by $518.9 billion a year.[9] Senator Sanders' proposal called for 2.2% income based tax on individuals, a 6.2% payroll tax on employers, and other increases in the estate, capital gains, and income taxes of higher-income taxpayers.[10] These taxes would raise approximately $1.4 trillion annually, leaving about $1.1 trillion per year of Sanders' plan unfunded by the Urban Institute's estimate.[11] Just funding the incremental increase in total annual national healthcare spending of $0.5 trillion would cost each of the 325 million people living in the U.S. over $1,500 per year.

The General Public and Health Care Quality

Notwithstanding the claims of some health care experts, the vast majority of Americans rate the quality of the health care they receive as excellent or good.[12] Additionally, polls show that Americans are very protective of the quality of the health care they receive. A Cato Institute/YouGov survey conducted in February 2017 showed that 77% respondents favor the ACA's protections for persons with pre-existing conditions.[13] However, when asked if they would favor the ACA's protections if those protections caused the quality of health care to worsen, only 20% of respondents (a 57% swing!) would still do so.[14]

One idea to control health care costs is the implementation, in one form or another, of price controls. The theory of price controls might be more popular with the general public than health care economists. Significant majorities of Americans favor price controls on drug and device manufacturers, hospitals, and doctors (73%, 70%, and 63%, respectively).[15] However, health care price control measures have historically had an unfavorable impact on the quality care delivered by professional providers. During the 1970s and 1980s, many states experimented with hospital rate setting (i.e., price controls on hospital services). A 1988 study in the New England Journal of Medicine found that states with the most stringent hospital rate setting regulations had actual to expected mortality rates 6% higher than states with less stringent hospital rate setting regulations.[16] Other countries also use price controls to deleterious effect. For example, Japan currently uses price control regulations to set prices for services accounting for 95% of hospital and physician revenue.[17] These price controls have led Japanese health care professionals to focus on providing a higher relative volume of less-expensive and lower intensity services, and a lower relative volume of more expensive, higher intensity services. As a result, the quality of the more expensive, higher intensity services in Japan lags the quality of those same services provided in other countries. For example, the Japanese are only 25% as likely as Americans to suffer heart attacks, but are twice as likely to die from them.[18]

The General Public and Health Care Costs

Of the three main attributes of the U.S. health care system (i.e., access, quality, and cost), the general public is least satisfied with the cost of the system. A CNN/ORC poll taken in March 2017 showed that a significant majority of Americans are generally satisfied with the quality of health care they received and their personal health insurance coverage (78% and 68% respectively).[19] The same poll showed that a slight majority (53%) of Americans are generally dissatisfied with the total cost of their personal health care, including health insurance premiums and other expenses, and a substantial majority of Americans are generally dissatisfied with the total cost of health care in the U.S. (84%).[20]

While the general public appears to be unhappy with the cost of the U.S. health care system, they favor public policy measures that would most likely increase the overall cost of the system. For example, according to the same CNN/ORC poll mentioned earlier, 87% of Americans want to maintain the protections offered to people with pre-existing conditions under the ACA (I.e., guaranteed issue and community rating).[21] However, the same poll found that only 50% wanted to keep the ACA's individual mandate requiring everyone to purchase insurance.[22]

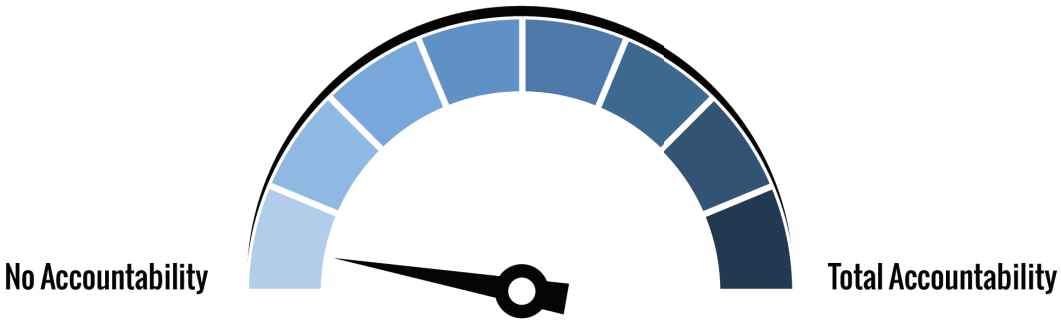
Pre-existing condition protections without an individual coverage mandate will lead to lower enrollment and higher prices as the healthy abstain from acquiring insurance until they need it, leaving the insurance pool with only high-risk (i.e., expensive) participants. For example, the state of New Jersey instituted guarantee issue and community rating requirements without a coverage mandate in its Individual health insurance market in the mid-1990s. Between 1996 and 2001, enrollment in New Jersey's Individual health insurance market dropped from 186,000 to 85,000, the median age of enrollees jumped from 41.9 to 48.4 years, and the premiums increased between 48 percent and 155 percent, depending on the plan.[23]

Conclusion

With the rising cost of care, the increased focus on health care quality issues, and the large number of uninsured, further reform of the U.S. health care system appears inevitable. However, the success of any workable reform program requires the acceptance and support of the general public.

Current polling suggests that the American public believes that it will have to make few, if any, sacrifices to reform the U.S. health care system. In reality, something has to give. To make universal, high quality, and affordable health care a reality in the U.S., a balance will have to be met between cost, quality, and access since optimizing all three at the same time defies the laws of economics.

For too long the American public has been a passive and critical participant rather than an active stakeholder in the U.S. health care system. By ignoring basic economics and entertaining pie-in-the-sky fantasies disseminated by politicians on both ends of the political spectrum, the general public has convinced themselves that there is a free lunch in health care. No free lunch has, will, or can exist, and until the American general public comes to accept this basic reality and understand that sacrifices will need to made by all parties, the vision of meaningful and lasting health care reform will never become a reality.



On the AHP Accountability Index (i.e., AAI), I score the general public's accountability in regards to the U.S. system to be very low. I believe that the general public is essentially unaware of the role that they play in the U.S. healthcare system. As a result, the American general public is the most significant impediment to any meaningful and permanent reform. Therefore, I assign the general public the lowest possible AAI score: "No Accountability/Unaware".

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[4]*"Current and future developments in managed care in the United States and implications for Europe", Health Research Policy and Systems, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1079919/*

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