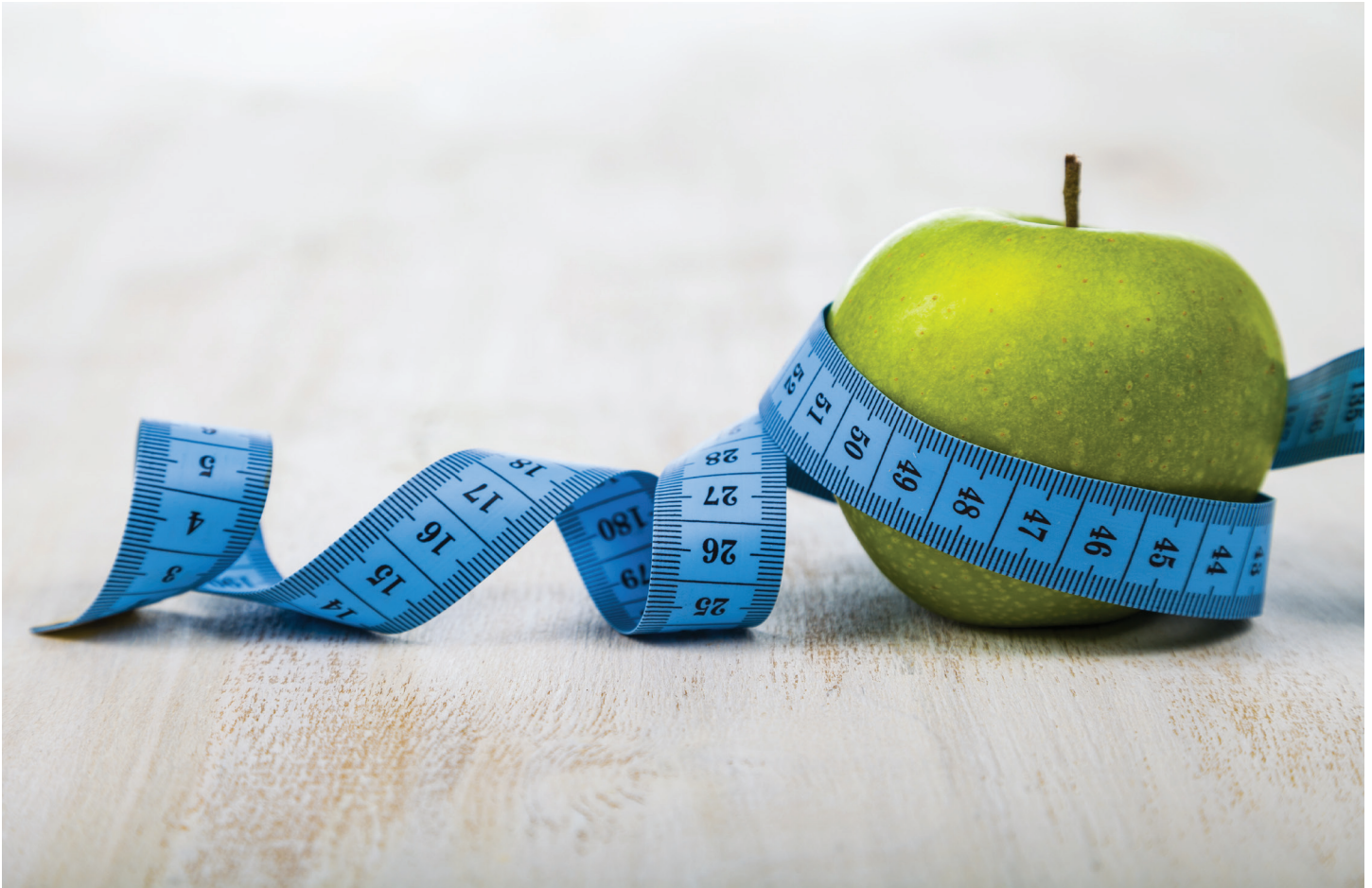




Inspire



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 health 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 (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 fat¹. Within the context that since the 1970s the number of fast food restaurants has more than doubled¹, 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 costs¹.

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.”**

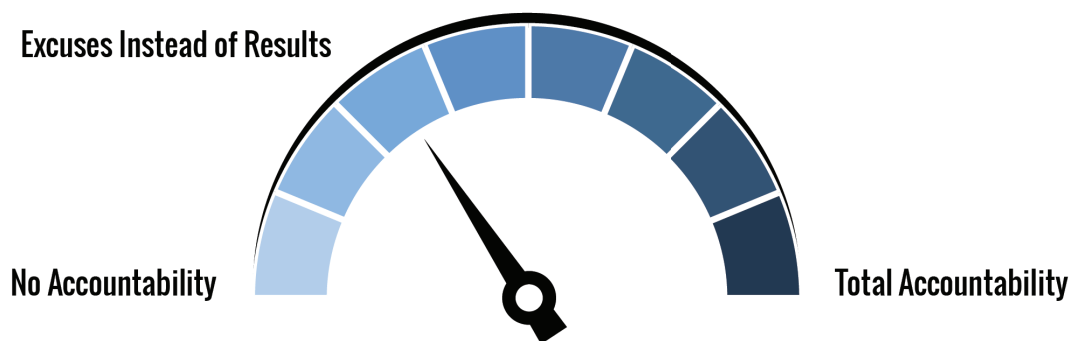
AHP Accountability Index Score

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.



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

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