The American Connection

Organised by Kring Internationaal
Johan de Witthuis, Utrecht,
1 October 2015
Welkom
Welcome
Bienvenida
Bienvenido
Velkommen
Benvenuto
Velkommen
Bem-vindo
Välkommen
Tervetuloa
Dobrodošli
Witaj
Program

16.30 Doors open

17.00 Welcome and introduction of the guests by Caroline Tuin, Chairperson Kring Internationaal

17.02 Introduction to the health care system in the Netherlands by Roel Willems, Chairperson Kring Zorg

17.15 Outline of Health Care in a global context and the work of the IAAHS by April Choi, Chairperson of the IAAHS (live from USA)

17.45 US Health Care System, ‘Obamacare’ by Mary van der Heijde and Judith Houtepen

18.15 Q&A

18.30 Closing drinks and networking opportunity

19.30 Doors close
Welcome and introduction of the speakers

Caroline Tuin
Agenda

- Welcome
- Introduction of our guests
Welcome

On the third meeting of the Kring Internationaal
Introduction of our guests

- **Drs. Roel Willems AAG:**
  - Founder and chairperson Kring Zorg
  - Roel is also member of the International Committee and chairperson of the working party on International Actuarial Standards
  - Dutch actuary since 1996
April S. Choi FSA MAAA

April Choi is an actuarial executive with over 35 years of health care experience. She is currently an independent actuarial consultant based in California.

- Is chairperson of the International Actuarial Association Health Section since 2014
- Was the chairperson of the Academy of Actuaries (AAA) Health Practice International Task Force from 2009 to 2014.
- Is currently the chairperson of AAA Public Programs Committee
- Is a member of the AAA Health Practice Council
- Has served on many of the Academy’s healthcare reform workgroups
- Is a Fellow of the Society of Actuaries
- Is Member of the American Academy of Actuaries
Introduction of our guests (3)

• Mary van der Heijde FSA MAAA:
  - Principal and consulting actuary with the health practice in the Denver office of Milliman (since 2001)
  - Fellow, Society of Actuaries
  - Member, American Academy of Actuaries
  - Certificate in Actuarial Science, University of Colorado, Boulder
  - BS, Applied Mathematics, University of Colorado, Boulder
Introduction of our guests (4)

• **Drs. Judith Houtepen AAG MBA:**
  - Senior manager and consulting actuary in the Amsterdam Office of Milliman (since 2012)
  - Before 2012, Judith was a Director of TRAG Performance Intelligence Group, senior advisor at Plexus and consultant at McKinsey
  - Member of the board of the Health subsection
  - Member of the Dutch “Research Working Group on Risk Equalization” (WOR)
  - Dutch actuary since 2013
No one excluded based on..
By regulated competition

Standard Cover
Obligation (cover & accept)

Arrangements (access, price, quality)

Choice
Accessibility
Quality

INSURED
☐ YES
☐ NO
Risk Equalization System enables solidarity in a competitive market.

Equalization Fund

- Government Contribution
- Income related premium
- Direct premium (18+)

Compensation depending on Risk Profile

Deductable

Health Care spend

No differentiation on Risk Profile
Slow down growth

% growth

Health care

Gross Domestic Product

Gross Public Spend excl. Health

International perspective

EHCI: “The Dutch system does not seem to have any weak spots.”
OESO: “The Dutch health Care system seems much better prepared to bend the cost curve in the coming years”
Questions
Global Health Care and IAAHS

Presented by:
April S. Choi, FSA, MAAA
October 1, 2015
I. Introduction
II. Healthcare around the world
III. IAA, Health Section and Health Committee
IV. American Academy of Actuaries, Health Practice International Committee
April S Choi, FSA, MAAA

- Independent actuarial consultant based in California, United States
- Actuarial executive with over 35 years of healthcare experience
- Chairperson of International Actuarial Association Health Section (IAAHS)
- Chairperson of AAA Public Programs Committee
- Member of AAA Health Practice Council, various committees and workgroups
II. HEALTHCARE AROUND THE WORLD
Why Look at Other Countries?

• Learn from other countries
• Help set improvement objectives and performance measures
• Serves as a benchmark, less about ranking
Challenges with Comparisons across Countries

- Know your data sources
- Use a wide range of indicators instead of a single indicator
- Track over a period of time
- Each country’s healthcare system is unique
- Be careful with using international data
International Healthcare Statistics

OECD, WHO, World Bank and Others

Example of data categories

- OECD:
  - Health status
  - Non-medical determinants of health
  - Health care resources and activities
  - Quality of care
  - Access to care
  - Health expenditure and financing
Examples of Healthcare Statistics

• Healthcare expenditure as a percent of Gross Domestic Product (GDP)

• Life Expectancy at birth

• Prevalence of obesity

• Selected Ten Countries:
  ✓ Australia
  ✓ Canada
  ✓ Chile
  ✓ Israel
  ✓ Japan
  ✓ Netherlands
  ✓ Singapore
  ✓ South Africa
  ✓ United Kingdom
  ✓ United States
Healthcare Expenditure as % of GDP vs Life Expectancy, 2013

Data sources: WHO

Health Expenditure as Pct of GDP

Life Expectancy

Healthcare Expenditure as % of GDP

Australia
Canada
Chile
Israel
Japan
Netherlands
Singapore
S Africa
UK
US

57
62
67
72
77
82

4,0%
6,0%
8,0%
10,0%
12,0%
14,0%
16,0%
18,0%
Age Standardized Prevalence of Obesity in Adults, 2013

III. International Actuarial Association (IAA)

- Health Section
- Health Committee
Moving the Profession Forward Internationally

- World wide association of professional actuarial associations
- Encourage development of global profession, acknowledged as technically competent and professionally reliable
- Ensure public interest is served

Sections:

- IAAHS - Health
- IAALS – Life
- IACA – Consulting
- PBSS – Pension, Benefits and Social Security
- AFIR/ERM – Financial Risks and ERM
- ASTIN- Non-Life Insurance
- AWB – Actuaries Without Border
• IAAHS promotes and facilitates international exchange of views, advice, research and practical information among actuaries involved with public and private health issues

Topic teams:
- Medical Expense Insurance
- Comparative Health Systems
- Long Term Care
- Micro-Health Insurance
- Critical Illness
- Income Protection
- Risk Adjustment
- Health Capital and Risk Management
IAAHS Activities - Conferences

- Joint Colloquia every two years
  - **2016** June 27-29, in **St John’s Newfoundland, Canada**
  - Jointly with IACA, PBSS, IPEBLA (lawyers) and in conjunction with Canadian Institute of Actuaries

- International Congress every 4 years
  - **2018**, May 30- Jun 2, in **Berlin, Germany**
  - Including all sections. Hosted by German Actuarial Association
IAAHS Activities - Webcasts

4 webcast in 2015

- Exploring Global Healthcare Cost Drivers
- Featuring 8 countries
- Held jointly with AAA HPIC

Other webcasts:

- Pre-Existing Conditions
- Risk Adjustment
- Big Data
- Micro-insurance
- Global healthcare utilization
- Gender equalization
- Stochastic modeling
IAAHS Activities – Virtual Library

- Newly revamped
- Includes healthcare articles, links to other actuarial associations, links to IAAHS colloquia presentations
- Encourages members to contribute new articles
- Currently only available to IAAHS members
IAA Health Committee

- To represent the IAA in discussions at the international level on matters relating to health systems, with a particular focus on actuarial aspects.
- To raise the profile of health actuaries in policy debates and research on health systems.
- To support, through IAA Member Associations, actuaries working in the health systems field, both private and public.
- Formed in 2013
- Membership of the Committee is open to all IAA Full Member associations.
- Published a paper on Ebola
• The Academy provides actuarial expertise and advice to public policy decision makers

• Sets qualification, practice, and professionalism standards for credentialed actuaries in the United States.
The committee assists in maintaining awareness and communication between the US-based health care actuary and the international actuarial community.

- Published Issue briefs and articles:
  - International wellness initiatives
  - Curbing the high cost of diabetes
  - Risk adjustment
  - Health care reform – learning from other countries featuring Germany, Japan, the Netherlands, Israel, Singapore
  - Long term care
  - End of Life care (to be published)

- Held joint webinars with IAAHS on Exploring Global Healthcare Cost Drivers.
Thank you!

• Hope we will have some joint activities in the future
Overview of the US Health Care System, ‘Obamacare’
Mary van der Heijde and Judith Houtepen
Introduction

- Overview of the health care market system in the United States, both before and after the Affordable Care Act (ACA)
  - How do US citizens get health insurance?
  - Why did we pass the Affordable Care Act?
  - What works well in the US? What is not working so well?
  - How did the ACA change our health care system?
Health Care in the US: Prior to the Affordable Care Act (ACA)
Health Care in the US: Pre-ACA

• Where did people get insurance coverage?
  – Fragmented market – coverage depended on age, income, employment status
  – Most people spent some time in one of multiple sources of coverage

• Four major categories of coverage:
  – Employer
  – Individual
  – Medicare
  – Medicaid
Employer-based insurance - 51% of pre-ACA population
- Most common source of coverage
- Not all employers offer coverage, varies by size
- Often self-insured, particularly with larger employers (500+)
- Limited to the coverage options offered by the employer
- Tax advantages
- Historically tended to be richer coverage
- Trend was towards leaner benefits and more employee contributions
Health Care in the US: Pre-ACA

• Individual Market – 4% of pre-ACA population
  – Most dysfunctional market segment
  – Great deal of turnover

  • People in between jobs, self-employed, recent college graduates, employer doesn’t offer coverage
    – Insurers had strict underwriting guidelines, only healthy people eligible
    – Plans leaner than employer coverage to keep prices lower
    – Very high annual rate increases, often double-digits
Health Care in the US: Pre-ACA

- Medicare – 14% of pre-ACA population
  - Government-run insurance for the elderly population (65+)
  - Three types of coverage:
    - Part A – Hospital
    - Part B – Physician
    - Part D – Prescription drugs
  - Funding sources:
    - Dedicated Medicare payroll tax (Part A)
    - General funds and beneficiary premiums (Part B, Part D)
    - Overall funding split: ~40% each from payroll tax and general revenue, 13% from premiums
Health Care in the US: Pre-ACA

• Medicare Advantage (aka Part C)
  – Increasingly popular private Medicare option with coverage offered by insurance companies
  – Covers same benefits as traditional Medicare Parts A and B
  – Insurers bid to be an MA carrier
    • Receive a risk-adjusted capitation payment from the government
    • If bid is below the true cost, government splits savings with insurer
    • Example:
      – Benchmark cost = $1000 PMPM
      – Insurer bid = $950 PMPM
      – Capitation payment = $975
      – Additional $25 must be used to provide supplemental benefits
Health Care in the US: Pre-ACA

• Medicare Part D
  – Prescription drug coverage for Medicare beneficiaries
  – Only available through private insurance companies, no “public option”
  – Prior to 2006 Medicare did not cover prescription drugs
  – Substantial cost sharing for beneficiaries
  – No dedicated funding source
    • Funded from general revenues and member premiums
    • Initial cost projections were very high, actual experience was more favorable
Health Care in the US: Pre-ACA

• Medicaid – 15% of pre-ACA population
  – Government run program for low-income families and the disabled
  – Jointly funded by federal and state governments
  – Administered by individual states
    • Eligibility and benefits varies by state
  – Coverage is limited, minimal cost-sharing
  – Beneficiaries have limited access to providers due to low reimbursements
    • Pre-ACA roughly one third of providers did not accept new Medicaid patients
Health Care in the US: Pre-ACA

• Uninsured – 17% of pre-ACA population
  – Over 50M people were uninsured, but this was not a static group
  – Difficulties receiving health care
    • Foregoing necessary care due to lack of funds
    • Using the emergency room
      – Cannot be turned away, but will not necessarily receive all needed care
    • Medical bankruptcy
  – Many uninsured were healthy and chose to go without
    • “Young invincibles”
    • Once they do need care, might not pass underwriting anymore
  – Providers recoup cost of uncompensated care from those with insurance
Pre-ACA: Why was health reform needed?

- Three-legged stool of health care: Cost, Quality, Access
  - Access to health care and the high number of uninsured was the primary problem the government chose to address
  - US has comparable quality of care, lagged behind in cost and access
- Losing a job often meant losing health insurance, with limited options
  - COBRA
  - HIPAA guaranteed issue plans
  - High risk pools
Pre-ACA: Why was health reform needed?

- Health insurance coverage was not standardized
  - Uninsured vs. underinsured
  - Annual and lifetime limits
- The individual market was particularly difficult
  - Complicated plan designs made comparing plans difficult to impossible for the layman
  - Huge annual rate increases because of churn and anti-selection
  - Rescissions
  - No tax benefits to buy coverage – not a level playing field with employer coverage
- Viewed as a social justice issue
  - Many became uninsured through no fault of their own
Affordable Care Act: Primary Stated Goals

- Providing access to affordable and high quality health insurance for all US citizens
  - Even the government projections did not anticipate 100% coverage, anticipating that some people still would not purchase, immigrants not eligible, etc

- Standardizing insurance coverage so that everyone has the same services covered with predictable levels of cost sharing

- Ending the ability of insurers to charge more for your gender or health status
  - Age rating still allowed, but limited to 3:1
  - No denying coverage or rating higher for health status allowed

- Providing financial assistance to the needy to purchase health insurance
What did the ACA do for insurance?

- Established a number of insurance market rules:
  - Guaranteed issue – must accept anyone who applies without rating higher for health status
  - Mandatory coverage for all citizens
  - Subsidies for those with low-income
    - Up to 400% of the federal poverty level
    - Cost-sharing subsidies also available for those at lower end
  - Standard plan designs
    - Metallic levels based on actuarial value
    - Essential Health Benefits
  - Free preventive care
  - No lifetime or annual limits
  - Deductible and annual out of pocket limits
  - Minimum loss ratio requirements
  - More rigorous review of premiums and rate increases
The ACA established health insurance exchanges
  - Online marketplace to shop and compare plans
  - Primarily for individual insurance
  - Can be administered by the state or federal government
  - Creates a mechanism to determine subsidy eligibility

36 states chose the federal exchange
  - Heavily influenced by political climate in state

Open enrollment periods
  - Annual timeframe for enrolling in coverage
  - Prevent anti-selection/gaming
  - Can enroll outside for a life event
ACA Impact on Employer Coverage

• Employer mandate
  – Employers of a certain size required to provide coverage or pay fines
  – Presents difficulties of defining employer size and full-time employees

• Self-funded/ASO plans are the largest segment of the employer market
  – Governed by different laws, many ACA rules do not apply
  – The plans are still subject to many of the additional fees used to fund the ACA

• Cadillac Tax
  – An indirect way of limiting the tax deductibility of employer insurance

• People with employer coverage available may still be eligible for subsidies in the individual market
  – Affordability threshold – 9.5% of income
ACA Impact on Medicaid (Low Income Population)

- Outside of the changes to the individual market, Medicaid represented the largest expansion of coverage in the ACA
  - If all states opted in, Medicaid expansion would cover roughly half of the existing uninsured
- Medicaid was expanded to cover all citizens with income below 133% of the federal poverty level
  - No longer limited to children and the disabled
  - Childless low income citizens were one of the larger cohorts of the uninsured
- Medicaid has always been jointly financed by states and the federal government
  - The federal government is funding the expansion of Medicaid initially, scaling down over time
- Supreme Court ruled that states could not be forced to expand Medicaid
  - 24 states have chosen not to, resulting in an estimated 5.7M people remaining uninsured
- Primary care reimbursement temporarily increased to improve beneficiary access
ACA Impact on Medicare (65+ or disabled population)

- Primary focus was on expanding coverage, so there was minimal impact on Medicare
  - Closing the Part D “donut hole”
  - Changes to various cost sharing rules
  - Increased payroll taxes to improve Medicare financing and solvency
  - Various reimbursement changes to improve Medicare’s financial sustainability
- Two new Medicare initiatives:
  - Independent Payment Advisory Board
    - Government agency responsible for researching areas for cost savings in Medicare and making recommendations to Congress
    - Political hot button issue (death panels!)
  - Accountable Care Organizations
    - Two pilot programs allowing providers to band together to coordinate care and improve cost and quality
    - Shared savings program with financial rewards for ACOs that generate Medicare savings
Funding for the ACA

• New federal taxes
  – Limiting income tax deductions for HSA/FSA deposits
  – Limiting deductions for health care expenses
  – Increased Medicare payroll taxes
  – Limiting deductions for employees with high salaries
  – Penalties for non-compliance with the mandate to purchase insurance
  – Cadillac tax

• Annual fees on pharmaceutical manufacturers
• Excise tax on medical device manufacturers
• Annual fees on health insurance carriers
• The ACA was primarily insurance reform, not health care reform
• Some programs were created to address the quality of care
  – Funding for comparative effectiveness research
  – Funding for states to develop medical malpractice improvements
  – A pilot program for bundled payments in Medicare
  – Value-based purchasing in Medicare
  – A new program to better coordinate care for citizens eligible for both Medicaid and Medicare
  – Bonuses for additional primary care physicians in Medicare
Market Stabilization Tools

- ACA made dramatic changes to the health insurance market, creating increased financial risk for insurance carriers
- To mitigate this risk, three market stabilization programs were launched
- The “3Rs”
  - Risk adjustment
  - Reinsurance
  - Risk Corridors
Transitional Reinsurance

- ACA Reinsurance is a temporary program to mitigate the risk of high cost claimants and stabilize premiums
- Applicable only to the individual market, beginning in 2014 and ending in 2016
- Reimburses insurers a portion of costs for a given member with annual claims between $45,000 and $250,000
  - The coinsurance varies depending on funding levels, for the 2014 plan year coinsurance was 100%
- Funded by a per member per month fee charged to all insurers
  - Fee applies to all insurers and includes self-funded plans
Risk Corridors

- The risk corridor program is designed to protect against inaccurate pricing by sharing risk of gains and losses between carriers
- Applies to individual and small group markets
- Program aims to mitigate excessive gains or losses
  - Plans that make “too much” money will pay in
  - Plans losing an amount above the threshold will receive funds
- No external funding for risk corridors, funds to reimburse carriers losing money will only come from those who pay in
- Uncertainty as to availability of money
  - If all carriers lose money, there is no funding for risk corridors
Risk Adjustment

- Began in 2014, participants are individual and small group insurers
- Risk adjustment is the only permanent program among the 3Rs
- Goal is to “level the playing field” by transferring money between carriers based on the relative risk of their members
- Relative risk is the crucial component
  - A risk score above or below 1.00 on its own does not mean you will receive or owe money
  - Overall market-wide risk is the key unknown
- Pre-ACA individual insurers had the incentive to seek the lowest risk members, risk adjustment changes that incentive
  - Key is managing risk, not avoiding it
Aim of Risk Adjustment

No underwriting allowed:
• No price differentiation
• No coverage differentiation, set by government

Partially allowed:
• A plan can charge higher premiums, within the 3:1 age bands
• Variation by area, tobacco use

To “level the playing field” by transferring money between carriers / insurers based on the relative risk of their members
Without incentive for cherry picking based on health status
But with incentive to manage the health care costs via:
- efficient Health purchase
- effective prevention measures
- and disease/medical management

Role of insurer/plan

✓ Attracting low-cost members is not always desirable
  - Managing risk, not avoiding it.
✓ From underwriter to care-optimizer?
  - In theory yes, but in practice?

Aim of the health care system

✓ To increase quality & affordability of care
  • To increase availability of care
✓ To offer 100% availability of basic care
  • To offer 100% availability of basic care

Underwriting

US and Dutch System Risk Adjustment comparison
### US and Dutch Risk Adjustment comparison

#### Type of model
- **BAMACARE**
  - ‘Concurrent’ - current year diagnoses
  - ‘Predictive’ - prior year diagnoses
  - ‘Somatic Cure’, ‘Mental Care’, ‘Elderly Care’
  - ‘Own risk’
- **Same model for all ages**
- **Different models for Somatic Cure, Mental Care, Elderly Care and Own risk**
- **'Concurrent’** - current year diagnoses
- **‘Predictive’** - prior year diagnoses
- **& drugs & medical device usage**

#### Data
- **Medical data only**
- **Medical and Rx data**

#### Criteria
- **Age/gender main criteria**
- **Diagnoses based on hierarchical condition**
- **Diagnoses, but not hierarchical**
- **And 5 other morbidity-type criteria**
- **And non-morbidity criteria (socio-economic status, region, source of income)**

#### Diagnoses
- **ICD-9 based**
- **Some procedure codes as well**
- **Hierarchical condition**
- **Currently DRG-type based -> ICD10?**
- **Both inpatient and outpatient**
- **Not hierarchical, overlap morbidity criteria**

#### % conditions flagged
- **Infants:** 45%
- **1-18:** 9%
- **18+:** 19%
- **18-:** 3%
- **18+:** 28%
- **18-65:** 20%
- **23%**
QUESTIONS??
Next event

14 April 2016
The Eurasian Connection
Please join us for drinks, snacks and talks