Comments on "Risk Equalization in an individual health insurance market: the only escape from the tradeoff between affordability, efficiency and selection: the Netherlands as a case study.

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A contribution to the project "FRESH-THINKING" directed by Ezekiel Emanuel and Victor Fuchs.

1. First, I would like to congratulate Wynand van de Ven and Frederik Schut on preparing the clearest and most thorough explanation of the issues and tradeoffs in managed competition that I have ever seen. I learned from it. This paper deserves to be a standard reference on the subject. If I were teaching a course on health policy I would assign it to my students. They have seen and analyzed the various possibilities for how to make health insurance affordable to all in a competitive market, considering realistically the importance of risk selection. In 1977, developing the Consumer Choice Health Plan in a hurry, I made some intuitive leaps of judgment to what appeared to be a feasible plan, without the benefit of their work. I agree with their conclusion that risk adjusted premium subsidies or risk equalization is the preferred strategy. Also I agree that "Good risk equalization offers the only effective escape from the tradeoff between affordability, efficiency and selection." So I think continuing research on improved methods of risk equalization is very important, and should be supported. I also think that with improving use of electronic health records, improving predictive modeling should be possible. And I agree that there are good "arguments why we do not need a 'perfect' formula.". "The risk equalization formula should be refined to such an extent that insurers expect the costs of [further] selection to exceed its profits."

2. Second, I am very impressed by their description of the political process in the Netherlands that was able to pursue this sophisticated strategy over nearly a 20 year period. We suffer from Anglo Saxon oppositional politics. We seem to hear much more from the extremes than from the center in health care. That makes it tough to sell or enact a model of universal health insurance based on managed competition in the private sector which is a centrist strategy. It has been described in this country as "Liberal ends by conservative means."
3. My 1977 articles mentioned the need for a system of risk stratification, measurement and compensation, but they were not very clear on how to do it. Like most ancient sacred scriptures, their meaning is obscure on some points and subject to various reasonable interpretations. But at the time, and also today, I was thinking mainly about *delivery systems,* and not *insurance companies* as the main competitors. I was thinking mainly of the main emerging actors in my neighborhood: Prepaid Group Practice, as exemplified by Kaiser Permanente, network model "carrier HMOs" linking and marketing the services of large Multi Specialty Group Practices, like the Palo Alto Medical Foundation, Individual Practice Associations like those being developed by our adjacent county medical associations to enable their members to compete more effectively with Kaiser and Palo Alto, and also Capitated Primary Care Networks with primary care physicians acting as gatekeepers being paid per capita for primary care services, which was being developed by HMO Pennsylvania, and also concepts like "Health Care Alliances" proposed by Paul Ellwood and Walter McClure, and "variable cost insurance" suggested by Newhouse and Taylor, and which we today would probably call "narrow network PPOs." Also similar developments in the Twin Cities. I wanted to open the market to all sorts of innovations in high quality efficient care.

   The Dutch, quite understandably, were thinking mainly of insurance companies, understandably because, when trying to improve the world, you have to start with what you have, what exists now. Of course, at the time, the Dutch were also

thinking about insurers contracting selectively with providers and also experimenting with innovative ways of paying for care.

From the point of view of managed competition, there is a lot of difference between pure insurance companies on the one hand and organized delivery systems with their own associated insurance plans on the other.
There is not a great deal insurers can do in a "fee for service-indemnity"world other than to play games to select risks, to "lemon drop" if they can. They can improve service, train better call center people, and deploy better software to make processes faster and more accurate. But this is working on only a small part of total spending covered by the premium. Most of the money is spent in the delivery system, and also that is where the outcomes and quality are determined.

There are many things that a delivery system can do to cut cost while improving the quality of care. For example, they can pursue process improvement systematically. I think of the innovations that brought the average length of hospital stay for total hip replacement down from about 9 days to about 3.5 days, while improving quality. And I think of a large multi specialty group practice that noticed that some of their TURP patients spent 5 days in hospital while others were out in two. Medical management noticed this, searched their continuous comprehensive records for any sign of difference in outcomes, found none, and recommended to the 5-day doctors that they visit their 2-day doctors and consider adopting their more economical practices.
Delivery systems can deploy HIT in combination with redesign of their care and business processes. This is likely to be more important than most people realize. American medicine is shot through with what George Halvorson calls "clinical linkage deficiencies" (I have suggested "connectile dysfunction.") that occur when patients are transferred from one provider to another without the latter being fully informed about the history and condition of the patient. I think of the brother of a friend of mine whose cardiologist prescribed anti-coagulant without knowing that the patient suffered from bleeding stomach ulcers. Or I think of the 90 year

old father of another friend who visited ten different specialists for his different conditions, but who died from pneumonia, probably because he had not had pneumonia vaccine, and none of the doctors knew that or had a reliable way of knowing it. Studies by the IOM and others document cases of adverse drug reactions because people are prescribed conflicting drugs or from errors in transmission of prescriptions. In this country, pharmacy benefit management companies that deal in computerized systems for entering and delivering prescriptions have programs to spot and notify the doctor or patient of the conflicts. But most American primary care physicians do not use electronic systems in their care management. Most hospitals still rely on physicians' bad handwriting to transmit prescriptions. Computerized physician order entry is still an innovation being urged by major employers.

I found quite persuasive the analysis of an author who found that deployment of HIT was not in the economic interest of individual doctors, lab testing companies and hospitals because it would be used to reduce the need for services and therefore reduce revenues. HIT is being deployed on a large scale in the integrated delivery systems like Kaiser Permanente and the Palo Alto Medical Foundation.

There are many things that a prepaid multi specialty group practice can do to modify risk factors. They can organize disease management programs for many serious chronic conditions, with nurses and other non-physician personnel supporting the primary care doctors: asthma, diabetes, COPD, CHF, and more. Good outpatient management can reduce the patients' need for hospitalization for all of these. (Prepaid group practices can do this because their capitation payments can be used to support disease management infrastructure such as nurses, dieticians, health educators, etc. which are usually not paid for under fee for service.) They can organize preventive services, as happened in the case of one of my sons who had a history of lower back problems. He joined a prepaid group practice which saw his history, called him in to meet the physical therapist

who told him just which exercises he should follow to prevent further problems. Not only does fee for service not pay for that, but in fact such advice is against the economic interest of doctors in the fee for service sector.

One large multi specialty group practice decided to convert from mainly fee for service to "managed care", that is per capita prepayment. One of the things they did was to review records and identify all their "frequent visitors," that is patients who initiated doctor visits 200 times a year or more. In the fee for service days, those patients were considered geese laying golden eggs, that is best customers. From the new perspective, physicians realized that somehow the health care system was failing these patients, was not really getting at what their real problems were. So they assigned their primary care physicians to be extra diligent in diagnosing these patients. When they did, they found cases of undiagnosed depression. For patients who were just lonely, they could organize nurse-led mutual support groups where the patients could meet with others with the same problems and share experiences and insights, without taking up a lot of doctor time. One primary care physician experimented with group visits. Of course, a pure insurance company is not in a position to do this kind of thing.

I thought of this when I read the very interesting Table 2 in the van de Ven Schut paper: "Predictable losses for subgroups of consumers given the Dutch risk equalization formula (2005), community rating and open enrollment." Some of the variables in the table would seem to me to be potentially includable in a risk equalization model: three or more diseases, (perhaps with interaction terms), stomach problems, anxiety neurosis, depression, type 2 diabetic, hypertension, degenerative osteoarthritis, migraine, psychosis, and high cholesterol. But many of these could also be mitigated by good disease management programs, or at least could generate a lot fewer expensive doctor visits.

A delivery system interested in cutting cost without cutting the quality of care might also save a great deal by using skilled trained paramedical personnel,

instead of doctors, to do routine tasks such as sewing up patients with cuts. Fuchs wrote about this years ago and experienced it recently. (Personal communication.)

It has become increasingly clear to me that uncoordinated fee for service small practice is antithetical to quality and economy. RAND has documented overuse in the form of inappropriate surgery. RAND has also documented under-use in the case of failure to deliver some 45% of recommended care processes in a large sample of patients. So I believe the goal of competition should be to transform the delivery system: to align provider incentives with the needs and wants of patients for high quality affordable care, to promote clinical linkages, to innovate in payment methods to support cost reducing innovation, to support paramedicals doing disease management.

There is a great deal that a smart committed insurance company could do to move things in this direction, starting with information systems and comprehensive longitudinal medical records and payment systems. There could be "referral based capitation" payment of specialists whereby a specialist accepts a capitation payment per month for a referred patient for as long as the patient needs to be under his or her care. They could create a preferred provider insurance plan in which each patient is expected to choose a participating primary care physician to manage all referrals, and in which all participating doctors agree to contribute all diagnosis and treatment information to the patient's record so that each doctor seeing a patient can see the results of tests ordered by other doctors as well as diagnoses and treatments. This could, among other things, promote collaboration among specialists seeing the same patient and, of course, reduce unnecessary duplication of tests. I was happy to hear from van de Ven last November that a Dutch insurance company had announced a plan to open 50 primary care centers.

4. Van de Ven-Schut talk about the problems added by for-profit insurance companies whose mission is maximization of shareholder wealth and not social insurance. I do see health insurance and health care essentially as social insurance,

a necessary service for human well-being in the 21st century. But there are tradeoffs. For profit companies are likely to be more aggressive about risk selection. All the more reason to continue to improve the risk equalization methods. But for profits are more aggressive about cost reduction and also about entering new markets. Our experience has been that when for profit insurance companies were few, the non profit sector was very complacent in the face of calls for better cost management. This is very dependent on culture, but I believe that in our situation, the mix of for profit and non profit is healthy.

5. I was disappointed to read that the R-square in the Dutch 2004 model was 0.17. [1]As I understand Newhouse on this subject, an ideal risk adjuster should be able to explain at least a fifth of the variance.[2] A great deal of medical expense in a given year must be random. We can predict that a man with prostate cancer is very likely to have a costly hospital episode in the next few years, but it would be hard to predict whether or not it is next year. But the Dutch wisely manage the "outlier risk sharing threshold" in relation to the power of the predictive modeling, and reinsurance or stop loss comes in at an annual outlay of 12,500 euros. The most costly cases add the most to R-squared, so it is necessary to have a reinsurance threshold to protect the health plans that got the most costly cases, and to mitigate their incentive to "lemon drop." But I believe that it is important to do reinsurance in such a way as to not destroy incentives to work harder to keep people out of the high cost category, and so as not to destroy incentives to manage the high cost cases efficiently. For example, the reinsurance plan might be designed to pay health plans fixed dollar payments per organ transplant case set at the price of the most efficient producers. A 2002 study by the American Society of Actuaries found, for example, that the DxCG Version 5.1 commercial all-encounter model, released in 2000, achieved an R-square of 0.198 when claims were truncated at $100,000, is encouraging in relation to the Newhouse standard.[3] A study from Johns Hopkins found that in 2004, nearly half the American population had at least one chronic condition and that in 2001, people with chronic conditions accounted for 83 per cent of health care spending. [4]I conjecture that as the prevalence of treatable chronic conditions increases, our

ability to detect this and predict costs will improve. I also conjecture that as more and more health records are translated to electronic form, data availability will improve and the ability to predict will improve.

I am most impressed that the Dutch government is able to manage the program in such a sophisticated way. I would find it hard to imagine the U.S. government as we currently know it to be able to do that. One conclusion I draw from this is that an American system of universal health insurance based on managed competition in the private sector must be overseen by an organization that has the independence, sophistication, and resources of the Federal Reserve System. It wouldn't work if the Congress had to adjust the reinsurance threshold annually.

6. While on the subject of risk selection, I would like to comment on two features of the present Dutch model. As van de Ven and Schut point out, the existence of supplemental insurance, which 93 per cent of the population wants to buy, and which the insurers can underwrite and select members, adds considerably to the ability of the insurance companies to select risks. I conjecture that this was a necessary political compromise because it is certainly an exception to the managed competition model. I would hope and expect that at some point, it would become politically possible to consolidate basic and supplemental insurance into a single policy that would have open enrollment and community rating, in which the insurers would be blinded to the characteristics of possible enrollees at enrollment. Another problem I see is with the existence of "group discounts" for insurance purchasing. Groups are likely to hinder individual choice, and individual choice is important in the era of managed care because people, understandably, want to be able to select their doctors, and hence must be able to select their managed care plan, unhindered by the preferences of others in the group. I was encouraged to read that diabetics formed a group and negotiated with an insurer for improved disease management. That is a testimony to the quality of and value of risk adjustment. We will know that risk adjustment has succeeded when health plans are actively recruiting patients with chronic conditions.

7. Implications for USA:

- It is feasible to do universal mandatory health insurance based on managed competition in the private sector. The United States should have an advantage in this because we have a comparatively well developed population of managed care organizations in great variety that could lead the competition and serve as models for others. But I am grateful to the Dutch for proving the feasibility of this kind of scheme in practical operation. I hope that in the future, American people will look to Holland for a model instead of to Canada.
- The Dutch have an individual mandate with significant penalties for failure to enroll and pay. Apparently that works in the Dutch political and cultural context. My judgment is that it would be very hard to enforce an individual mandate in the American political and cultural context unless the government pays in full or nearly in full the premium of the premium of the low priced plan so that people do not see much to gain by not paying their premiums. This is important because the Massachusetts plan and Governor Schwarzenegger's proposal for California rely heavily on individual mandates. Perhaps we will learn from these "laboratories of democracy."
- We must move forward with risk equalization. FEHBP would be a good place to start next. In fact the need for Risk Equalization is just one more good reason why employment-based health insurance will not be viable and should be replaced. It is hard to imagine millions of American employers offering choices and doing risk adjustment. We need major institutional innovations just to make the offering of choices feasible.
- I have been working with the Committee for Economic Development to design a model of universal health insurance based on managed competition in the private sector. Its main features include replacement of the employment-based system with universal taxpayer financed premium support payments approximating the price of the low priced plan in each region; regional exchanges to organize and market the multiple choices and to perform risk equalization, product standardization; cost-conscious

multiple choice of health plan by every individual; oversight by a new organization modeled on the Federal Reserve System; an independent and well financed Institute of Medical Outcomes and Technology Assessment as proposed by Ezekiel, Garber and Fuchs. The goal is to create a market for innovative quality improving cost reducing health care delivery systems, and to close the gap between NHE growth and GDP growth.

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[1] I read the Garber paper after this paper and I note that Garber reports that the Dutch model predicts 22.8% of the variation and Medicare's 64 health based groups explain about 25% of the variation.. Se we may have reached the Newhouse ideal.

[2] J.P. Newhouse, *Pricing the Priceless,* MIT Press, London, 2002.

[3] R.B. Cumming, D. Knutson, B.A. Cameron and B. Derrick, *A Comparative Analysis of Claims-based methods of Health Risk Assessment for Commercial Populations.*

[4] Johns Hopkins University, Partnership for Solutions: *Chronic Conditions: Making the Case for Ongoing Care, September 2004 update.*