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# **MMC Perspectives on Health Care Reform:**

## **The Eve of Reform**



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## The Eve of Reform

***As the saga of health reform 2010 draws to a close, MMC health care experts reflect on the bill, the implications of reform, and what comes next.***

It couldn't be clearer that something needs to be done about health care. Health care spending in the United States hit an estimated \$2.5 trillion in 2008 – roughly \$8,000 per person, and a daunting 17.3 percent of gross domestic product. Medical trend – the percentage of increase in medical expenditures, factoring in both unit cost and utilization—has increased more rapidly than the Consumer Price Index for decades, to the point where medical and insurance costs have priced tens of millions of Americans out of the market. On a per capita basis, the United States spends about 50 percent more on health care than its nearest peer-nation competitor, and two or three times as much as the rest of the OECD nations, with relatively little to show for it. The current situation is widely regarded as unsustainable.

And now, with Sunday's vote, Congress has taken an unprecedented step toward changing the way Americans receive their health care, and the ultimate passage of comprehensive national health reform is all but guaranteed. The issue of health care, of course, is of vital importance to many of the Operating Companies of MMC. So in the days leading up to the vote, as the nation awaited the final chapter in the saga of health reform 2010, we took advantage of the opportunity to speak with experts from across the organization to gain their perspective on the bill, as well as to learn what they think will come next, and how their companies and clients would be affected.

### Moving the ball forward

*"The reform bill is about as far as Democrats believe they can go politically . . ."*

**By Arnold Milstein, MD**

No elected or appointed official in Washington seriously believes that anything either party has proposed over the last 10 years will close the U.S. health care system's "value gap" in comparison with health care systems in other wealthy democracies. When either party ascends, it proposes the biggest improvement that it thinks is politically salable. These are inevitably mild incremental solutions. Under President Bush it was, "Let's invest a little bit of money in health care IT, let's be a little stricter on Medicare price increases, and let's create performance transparency and health spending accounts so consumers can drive value." Yes, there were probably some Republicans who believed that health spending accounts would fully close the value gap, but I think most realized that they would prove insufficient with an emotionally charged service like health care that is mostly used by very sick people. Now the Democrats have moved the ball. Their bill was about as far as they sensed that they could go politically without drawing fatal opposition.

One thing I have learned through six years as a Congressional advisor on the Medicare Payment Advisory Commission is that both parties' view of the health reform battle line is largely the same. Both realize that there are four big, politically powerful components of the US health care industry that worry that health reform efforts will jeopardize their revenue growth – the pharma/device industry, insurers, doctors, and hospitals. The prevailing wisdom among both political parties is that you can afford to make any one of those four power blocks mad, but if you come up with a reform plan that makes two or more mad, you're doomed.

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## **Re-energizing the conversation**

*“President Obama has re-energized Congress to decide one way or another on the proposed legislation. We all recognize that this legislation is not perfect – it is the start of a longer battle to improve outcomes and cost efficiency.”*

**By Linda Havlin**

Clearly, President Obama has a passion for keeping the health care agenda moving ahead, and I think the Blair House summit was simply a way of re-energizing the conversation. He got both Republicans and Democrats to agree that doing nothing is not a viable solution, that Medicare is likely to be bankrupt if we do not change course, that our economy cannot survive continuation of business as usual, and that there is general agreement around the problems in the individual market.

The legislation just passed by the House should be viewed as a first step toward real reform. It focuses on expanding access to coverage, but it really doesn't address cost control. Clients are concerned about potential additional costs related to expanded eligibility, elimination of cost sharing limits and the potential free-rider provisions. And there are actions at the state level that add additional complexities to their current health care costs and expense. Quite frankly, they feel that the current bill and the “sidecar” modifications don't do much to control the cost trend. Employers will be forced to find their own solutions to improve outcomes and make their health plans more cost effective.

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## Solving the mandate

*“What’s to stop a 30-year-old healthy male from saying, ‘I can’t afford coverage’?”*

**By Holly Meidl**

You would think that the concept of the individual mandate would benefit providers, because it would mean that everyone who walks into their doors would have some level of coverage, where many of them today do not. At present, they have to provide care for them, whether or not they can pay. But there’s a natural flaw in the plan. The idea is that we’re going to force the individual to buy coverage so that the spread of risk is maintained for the insurance carriers. With that, the insurers can then do away with exclusions for pre-existing conditions, limit rate increases for overutilization, and write to an 85 percent medical loss ratio – and it works actuarially because they now have 31 million more customers.

But there’s no guarantee they will get those extra customers. The penalties for not buying insurance are relatively low. What’s to stop a 30-year-old healthy male from saying: “I can’t afford coverage. I’ll pay the \$650 penalty in my tax return and go without. Then if they discover I’ve got cancer, I can go buy a policy, and my premium’s only going to be one and a half or two times higher than it would have been, because it’s restricted by law from being any higher.”

There is concern among providers that post-reform they will be treating more patients, and actually receiving less money per patient than they do today. Currently providers receive reimbursement for insured patients that helps subsidize the costs of uninsured patients. Providers fear that insurers will drop reimbursement rates to government-payer levels with the argument that the cost shifting is no longer needed after reform. The result could easily be that total provider revenues drop below current levels while demand moves to record highs. The issue of an unsustainable system remains, but this time, the squeeze on the provider is life threatening.

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## Fee-for-service world

*“The role of the federal government on this ought to be to help facilitate change, not regulate price increases.”*

**By Mike Weissel**

Health care in the United States today is delivered in the fee-for-service world. And no matter how honest and good everyone is, in that world the underlying incentive to the physician is to do more. I'm not saying they do it consciously, but if they have a choice between doing nothing or doing a little more to make everybody feel a little bit better, they're apt sometimes to do a little bit more.

Meanwhile, we have trained citizens to believe that the most you pay for health care is a \$20 co-pay and that you have any choice that you want in this arena. And we've trained consumers to think that they don't have to take any personal accountability. You overeat, you misbehave on your diet, you don't take your drug, that's OK. It still costs the same amount for your insurance as it did before. Doctor visits are still the same.

The health insurance industry knows it has to reform. We talk to CEOs at a lot of plans – National Blues, large, small, regional, public, not-for-profit. There's not a single one of them that doesn't believe reform is necessary. There's not a single one that's not experimenting with changes around reform.

I think the role of the federal government on this ought to be to help facilitate change, not regulate price increases. The government has taken some steps in the right direction. It has pilot programs around accountable-care organizations and special-needs plans, and it's invested \$20 billion or so in health IT. But compared to what it's trying to accomplish, these are a drop in the bucket.

Don't forget, the U.S. government, through all the government programs – Medicare, Medicaid, Federal Employee Health, military – spends \$800 billion or \$900 billion a year on health care. The real opportunity is not to regulate minimum medical loss ratios, it's to revamp the way half the health care in the United States is paid for and delivered.

An approach like that would revamp the health care infrastructure. It would change the way physicians practice. It would change the way people approach quality, evidence-based medicine. But it would require a change in the social contract to some extent with patients and members and others. Just because you think you want an x-ray or you need an x-ray doesn't always mean you're going to get an x-ray if people don't think it makes sense.

***Mike Weissel** is the Managing Partner of the global Health & Life Sciences Practice of Oliver Wyman. His work focuses on strategic business, sales effectiveness and operational redesign issues in the Health and Life Sciences Sector.*

## The big question: cost and quality of care

*“Can we really bend medical trend while improving the quality of care? Our overwhelming view is yes.”*

**By Tom Main**

There are a few reasons to expect medical costs to continue to grow even with reform. We are adding over 30 million newly insured into our existing health care system without changing how health care is delivered—and we think they are less healthy than people already insured in the individual market. As they join the pool they could be cost accelerators. And as Medicare and Medicaid both clamp down on unit costs, I'd expect two or three more points of cost shifting to the individual and employer-funded markets.

Overall, medical trend post-reform is going to be what it has been recently or possibly slightly higher. Funding sources are going to grow at CPI, and health care costs probably at 7 to 12 percent. On the high end of that range, health care spending outpaces funding and gobbles up money.

Meanwhile, the whole shape of our age distribution is changing. The front wave of the Baby Boom is just hitting age 65. On average, people over 65 are three times more expensive than the average under 65. Ten years from now, when the bulk of the Boomers are in their 70s, the cost wave will be higher. There's nothing we can do about that, but it's going to produce higher trend – especially with all the new medical technologies and specialty therapeutics coming to market.

Can we really bend medical trend? Our overwhelming view is yes. Health plans need to do everything they can to take their 15 points of administrative cost and cut them in half at least. But then the big play is in medical costs.

Costs are very unevenly distributed; in a typical commercial population, about 15 percent of the members tally up to 55 or 60 percent of the cost. In a senior population, it's skewed even more. These are pretty sick people. In our fee-for-service environment, there are limited incentives for providers to deal with wellness; deal with prevention; deal with treatment compliance; move to evidence-based medicine; do a much, much better job of care coordination and triage. The sicker patients end up spread across 8 to 12 docs with limited coordination. And with that population, small unattended things quickly escalate and become very, very expensive. The current fee-for-service system gives physicians incentives to use more resources and work in transactional silos.

It doesn't have to be that way. There are organizations in the marketplace that have designed models specifically to treat medically complex patients. And they've vastly improved the patient experience, the family experience, and quality and outcomes across a wide variety of measures. And they've taken out 30 to 40 percent of costs. So we know it can be done.

***Tom Main** is a Partner and U.S. Market Leader for Oliver Wyman's Health & Life Sciences Practice. He focuses on issues of strategy, health care reform, and is an industry leader on designing and driving innovation into the health benefits, management and delivery markets.*

## **Learn from the leaders: big leaps in quality and affordability in care**

*"Though it may take a saint or genius to go first, others can follow in their footsteps."*

**By Arnold Milstein, MD**

Yesterday I spoke at a conference on rewarding higher-value health care providers with more market share and/or payment. The person on the podium with me is deservedly becoming a national hero: Dr. Gary Kaplan, the CEO of Virginia Mason Medical Center ("VM") in Seattle. Like most in the U.S. health industry, Virginia Mason was a comfortable health care system without a "burning platform" to motivate ambitious clinical improvement. But a spontaneous mutation occurred in Gary's DNA, leading him to conclude that 'we could deliver a ton more value for our patients if we applied modern industrial performance management methods used in other industries; we're going to adopt them and then use them to radically reduce defects and waste in our care.'

Some thought he had lost his sanity; but he convinced his board to back him. Then he began to methodically execute his plan. A ballroom full of doctors and hospitals from around the country listened to his story of high-risk organizational disruption and transformation with awe and, I suspect, no small amount of personal discomfort. There are a handful of other U.S. health systems that are also delivering breakthroughs in quality and affordability such as ThedaCare in Wisconsin and Intermountain Health Care in Utah. Though it may take a saint or a genius to go first, others can now follow in their footsteps. In open testimony at the Medicare Payment Advisory Commission, Dr. Kaplan predicted that as VM continues to mature, it will eventually deliver care for half of what it used to cost, and that the rate of quality defects will be reduced by more than 90 percent.

Big leaps are attainable. The barrier to major movement is not a lack of improvement potential. The barrier is a narrow vision of health care professionalism and a shortage of political will to intensify market and regulatory demand for more health with fewer dollars.

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