ACA and the Triple Aim: Musings of a Health Care Actuary

In 2008, the Institute for Healthcare Improvement (IHI) promulgated the Triple Aim, which advocates simultaneous improvements in patient experiences, improved population health and lower cost per capita. In 2010, the Patient Protection and Affordable Care Act (ACA) promised quality, affordable health care for all Americans. It’s fair to assume that the framers of ACA were aware of the Triple Aim, and it is likely that much of ACA was heavily influenced by IHI’s positions. So it is reasonable, from time to time, to assess ACA’s impact on health care against the Triple Aim principles.

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Holding the Affordable Care Act (ACA) up to the Triple Aim light is a prodigious task, given the size and complexity of the law and the ambitious nature of the Triple Aim, not to mention space limitations. My focus will be limited to aspects of the bill with which I have experience as a consulting health care actuary. This experience has been supplemented by lengthy and ongoing debates with actuarial colleagues and augmented by the personal experiences of family and friends.

The Society of Actuaries, of which I am a member, has a motto: “The work of science is to substitute facts for appearances and demonstrations for impressions.” Despite a career-long appreciation for this sentiment, for the sake of this discourse I will depart from it. Most, if not all, of my commentary is based on appearances, not facts. I hope that over time we will be able to replace impressions with demonstrations as reliable data emerges.

The Triple Aim

The Institute for Healthcare Improvement (IHI) developed the Triple Aim in 2008 as a guide for the development of new approaches to address the appropriate delivery of health care services that move beyond what has been accomplished to date and correct some of the problems evident in our current methods. The three components are: (1) improve the patient experience, (2) improve population health and (3) reduce per capita cost.

My actuarial experience designing, pricing and implementing health care plans and evaluating the subsequent experience leads me to concerns about inherent conflicts between the IHI goals. But they are all worthwhile and laudable objectives, and it is good to consider them together in order to make informed choices and reasoned compromises between them.

Part of the issue, from an actuarial perspective, is the
somewhat ambiguous nature of the goals. What does improve the patient experience really mean? Does this mean the patient is “happy” or that the patient’s outcome is optimal? Which population’s health are we trying to improve? What if one population’s improvement comes at the cost of another population’s health? And which costs are we trying to reduce—those of the individual, the employer, a government, a country or the global community?

To gauge patient experience, the IHI’s Guide to Measuring the Triple Aim suggests using patient surveys and asking how likely a person would be to refer someone else to one or another provider. Given that most of us have limited, if any, knowledge by which to judge provider competency, patient preferences are likely to be based on personality rather than capability. And won’t the population, on average, always prefer the easy short-term path regardless of long-term risks and consequences? For example, lose weight with a pill instead of eating right and exercising—despite potential side effects and forgoing general fitness. Too much emphasis on improving patients’ satisfaction will put health improvement and cost control in jeopardy.

Efforts to improve health generally will involve getting people to do things they don’t want to do. Exercise, healthy eating, cancer screenings, etc., are viewed dimly or actively avoided (e.g., colonoscopy) or mistrusted (vaccinations) by much of the population, which will frustrate the first goal.

Whether efforts to improve health lead to lower cost depends on the measurement time frame. While health improvements likely yield short-term savings, lifetime costs surely will be greater due to initial screening and subsequent treatment, resulting in postponed, rather than avoided, disease. These health improvements should lead to longer life spans and, thus, exposure to risks and costs associated with aging such as Alzheimer’s disease. The long-term cost equation for improved health at younger ages also depends on what one defines as health care. Consider the costs of assisted living and nursing homes (and perhaps lost productivity for family caregivers) to address long-term care needs of the growing ranks of the aged.

My grandfather had cardiovascular issues in the 1940s and died of a stroke in middle age. My father had his first cardiac incident in his mid-40s but was successfully treated for it until he succumbed to vascular disease at age 83. Essentially, better diagnosis and health treatment—and positive lifestyle changes—doubled his life span and allowed many years of contributions to society and family. But along the way, he incurred tremendous expenses, borne for the most part by his employer and Medicare.

Clearly, I am not advocating against early diagnosis and care leading to ongoing health improvement. I agree with the generally held notion that our cost per capita is out of control; and the patient experience, however defined, is too often abysmal. But it is unrealistic to assume we can achieve significant gains in all three areas (cost, population health and patient experience) simultaneously. I believe the Triple Aim should be all about compromise, and we should expect and plan for ongoing refinement and possibly significant course corrections.

ACA
ACA was passed by Congress and signed into law by President Obama on March 23, 2010. The legislation outlined significant and varied changes to how health care is paid for and, in some cases, delivered with effective dates spread from 2010 through 2018.

These changes include:
- Extensive modifications to how individual and small employer health plans may be sold, underwritten and priced
- Participation requirements and penalties for individuals and large employers
- A complex system of federal premium subsidies for a very significant portion of the population
- Mandated benefits and limitations on cost sharing
- Significant Medicaid expansion
- Some comparatively minor changes for Medicare
- Very significant expansion of regulatory authority necessary for the implementation and administration of these new rules.

Revenue provisions of ACA include a variety of fees assessed on the health care industry, insurance companies and employers, as well as additional taxes for some individuals and high-cost employer-provided health plans.
Assessment

So, how does ACA look when viewed through the Triple Aim lens? Perhaps not so good, particularly since the Triple Aim advocates simultaneous progress on each of the three goals. Much of the early push of ACA has been toward expanding insurance coverage through private insurance and Medicaid, which perhaps can be seen as setting the stage for delivery of care improvements down the road.

For the sake of this discussion, I will consider the population at issue to be all legal residents of the United States. In other words, if health improvements or cost savings for one subpopulation come at the expense of health/cost for another subpopulation, it is my opinion that ACA fails to meet the Triple Aim objectives.

Patient Experience

If we interpret the patient experience broadly to include the process of securing and maintaining insurance coverage, then it seems that ACA has, so far, led to deterioration rather than improvement, considering the exchange debacles, coverage disruptions and the subsidy gap in states that have elected not to expand Medicaid. There are also concerns about increasing difficulty in obtaining care, particularly primary care, due to heightened demand as more individuals have health insurance.

On the other hand, ACA may have played a part in the recent reenergizing of the retail clinic and employer-sponsored clinic industries. These clinics offer convenience in terms of location and business hours, lower and more transparent prices and a business model that emphasizes consumer satisfaction. The positive response from the public is encouraging these businesses to expand the health care services they offer.

Population Health

ACA may be having some incremental impact on population health through Medicare accountable care organizations (ACOs) and other payment innovations that reward providers for doing the right things. But there is much disagreement as to how to measure this, and so far only a small fraction of the population is impacted. ACA also encourages employer-sponsored plans to implement more aggressive incentives for their wellness and disease management programs. However, while some of these employer-sponsored population health programs can show evidence of improvements, most cannot.

It seems reasonable to assume that those Americans who did not previously have access to rich benefits at an affordable cost will see improved health as a result—if not now, then in the future. However, workers who receive their benefits from their employers are likely to see a deterioration of their benefits as a result of the new “standards” for employer-sponsored plans. A plan with an actuarial value of 60% is deemed adequate, and a plan that costs 9.5% of income (for single coverage) is considered affordable.

Most employees today have plans that are considerably more generous, at lower employee costs. Setting the bar this low will accelerate recent trends of cost shifting to employees. And the looming high-cost plan excise tax scheduled to take effect in 2018 already has employers cutting benefits to avoid or delay triggering this additional cost item. If rich benefits levels are necessary to promote health, won’t reducing them have the opposite effect?

Per Capita Cost

Cost redistribution does not equal cost reduction, so when assessing whether or not ACA reduces per capita costs, it is appropriate to consider not just insurance premiums but also taxes, fees and administrative costs (for both private and public sectors) associated with health care and health care benefits delivery. Viewed this way, it is clear that, to date, ACA has increased rather than decreased the per capita cost of health care.

Giving large numbers of people access to health care that they did not have before, and expanding the coverage for already insured individuals, can only increase the overall cost. These additional costs likely will be offset somewhat by lower emergency room expenditures, but not nearly completely. And the oft-cited logic that per capita costs are lowered by expanding the risk pool works only if the denominator in the equation changes. When viewed as a societal issue, the risk pool is and always has been the entire population, not just the insured portion of it.

Whether or not per capita costs are reduced down the road depends in large part on whether or not the various al-
ternative payment innovations are successful in generating savings without shifting costs to other subpopulations and if they can be expanded to enough of the population to be meaningful. Of course, we also need to be concerned about avoiding unintended negative consequences for population health and patient experience.

The Triple Aim goal seems to call for reduction of per capita costs in absolute terms, which is extremely unlikely given the aging of the U.S. population and continued demand for medical advancement and new treatments, combined with the politicization of the issue. More realistic—but still extremely difficult—is to strive for a relative cost reduction where health care costs increase less than the rest of the economy.

While there may be much to be gained through administrative efficiencies, those will be temporary gains. The bottom line is that health care costs will reduce only if the total revenue of health care providers is less in the future than it is today (either on an absolute or relative basis).

**Summary**

It is too early to deem ACA a success or a failure, in Triple Aim terms, but to date it does not appear to have succeeded on any of the three goals—patient experience, population health or per capita cost—and, in fact, has moved us in the opposite directions. That does not mean it will not eventually succeed along these lines, but to do so will likely require the ability to adapt to emerging evidence and knowledge.

Willingness to respectfully debate and reach reasonable compromises will be key to finding a path to a better situation than we now find ourselves in. Sadly, the history of ACA in the current political climate seems to make this unlikely.

Some may maintain that the Triple Aim was not intended to be applied nationally. Much of the literature on it includes discussions on defining the subpopulations that a particular health system serves. For instance, a Medicare ACO needs worry only about the population of Medicare-eligible individuals who are assigned to it. It can achieve the goals of improved health, patient experience and lower costs by neglecting the needs of, and shifting costs to, the non-Medicare population.

However, governmental programs have a responsibility to all constituents and, while some resource reallocation may be appropriate, the net effect should be improvement along each of the Triple Aims for the total population.

**Endnote**


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