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Health Watch

Bundled Reimbursement: A Step in the Right Direction, or Another Flawed Idea?

By Todd Lueders

In the current environment of technological advances in claims processing and data modeling systems, along with the flood of new ideas regarding how to improve issues in the health care system, some advocates view the idea of "packaged" or "bundled" payments to providers as a move toward improving quality and lowering costs.

Some opponents, however, view bundled payments as merely another idea full of administrative complexities with little hope for any real long-term improvement in quality and cost. In addition, opponents feel that this is not true population health management and thus would not actually bend trend.

Below is a discussion of the potential advantages a bundled payment structure can offer, as well as issues and concerns that may prevent bundled payments from becoming a mainstream reimbursement methodology.

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What is Bundled Reimbursement?

Bundled reimbursement refers to a single payment for all services rendered during a clinically defined episode of care. This payment would cover all hospital, professional and ancillary services performed by a variety of providers relating to that specific episode. Many discussions and pilot programs on the potential benefits

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Letter from the Editor

by Mary van der Heijde

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A positive side-effect of all of the changes and challenges presented by health care reform is that there is no lack of interesting topics to discuss in *Health Watch*!

A key area in which actuaries add value in this new world is the realm of reimbursement mechanisms. The ability to understand and evaluate risks within this context can make the difference between success and failure. Without this insight, and within the context of increasingly complex mechanisms, it is challenging to establish a structure which is fair to both parties. Without this inherent equity, the stability and future of these alternative payment mechanisms can be undermined.

Given the importance and urgency related to reimbursement mechanisms, we have included several articles focusing on this area in this issue. Todd Lueders has contributed an article which discusses the potential advantages and concerns of a bundled reimbursement system. We are also pleased to include the winners of the recent SOA *Health Watch* article contest on provider payment reform. We received a large number of excellent submissions, and were heartened by the quality and thoughtfulness of the authors. Congratulations to our winning authors: John Dante, Jill Van Den Bos, and Hobson Carroll. We would also like to extend special congratulations to Mark Florian, for providing the best submission from an actuary with fewer than five years of experience as an actuary.

This year's Health Spring Meeting in Orlando had a distinct health care reform flavor, and despite tighter economic times was quite well attended. In this issue, we include a recap of the highlights of the session. We were also fortunate to have the opportunity to interview each of the three keynote speakers at the meeting: David Cutler, Grace-Marie Turner, and Matt Weinstein. Cutler and Turner provided a lively debate about health care reform as their keynote address, which we were able to continue during the interview. Matt Weinstein, the founding president (and "emperor") of his company, Playfair, gave an entertaining and motivating presentation about the power of humor and fun in the workplace. After our interview, Matt shared with us a list of thirteen ways we can have more fun at work. A bit of levity during such busy times can be quite a welcome relief—check it out!

For this issue's "Navigating New Horizons" feature we have included an interview with Dave Axene, who has recently been in the news for his role in identifying errors in a high profile rate filing. Axene shares more with us about his broad and varied experience, including his CERA credential, which contributed to his credibility and ability to perform these reviews.

Steve Melek has provided us with part two of a two-part series about the implementation and implications of the recent mental health parity changes. As with many regulatory changes, the "devil's in the details" with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 (MHPAEA).

There have been considerable efforts within both the SOA and the Academy of Actuaries related to health care reform and the changing market. This issue's "Chairperson's Corner" and "Soundbites from the Academy" include more detail about those important efforts. In addition to these efforts, we have also included articles about the recent study of medical errors sponsored by the SOA, about the risks and opportunities inherent with accountable care organizations (ACOs), and a summary of the results of a recent survey about actuaries' opinions on how to bend the cost curve.

We hope you enjoy perusing this issue, and encourage you to contact us with your thoughts and opinions. ■

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Health **Watch**

LETTER TO THE EDITOR

As states try to balance their budgets, we are seeing a shocking propensity to include arbitrary rate cuts to Medicaid Managed Care Organizations capitation rates that have no basis in actuarial soundness. I have concerns that the actuaries who certify rates for the states will feel pressured to choose assumptions in rate development that have no real basis and that are extremely aggressive in order to satisfy their clients and hit the budget targets. This is the very reason that CMS developed the Medicaid Managed Care Rate Setting Checklist and the reason the American Academy of Actuaries produced the Health Practice Council Practice Note on Actuarial Certification of Rates for Medicaid Managed Care Programs. These two documents make it clear that state budgets should not be considered when capitation rates are developed, and that instead, capitation rates must be based on actuarially sound assumptions and rate setting principles. The practice note says:

"Actuarially sound" rates or ranges of rates depend on the benefits provided and the population covered. These rates are normally independent of budget issues unless benefits or populations change.

It goes on to say:

In times of economic downturn, state budgets may exert pressure on rates that must be certified as "actuarially sound." ... Budgetary constraints may influence the selection of certain assumptions toward the low end of the range. However, the actuary would usually be prudent to select assumptions that are individually reasonable and appropriate when deriving the final premium rates.

This guidance makes it clear that it is the certifying actuary's responsibility to ensure that budget issues do not override sound actuarial rate development. Remember our motto as actuaries is:

"The work of science is to substitute facts for appearances and demonstrations for impressions."

Using assumptions that are not based in fact and feasibility diminishes our work and casts a poor light on our professionalism. The reason actuaries are required to certify rates is to prevent states from under or overpaying managed care organizations for the benefits they provide. If actuaries allow their professionalism to be compromised when developing rates, the intention of the CMS checklist and actuarial certification requirement is a useless safeguard, and this practice could lead to unwanted repercussions such as actuarial discipline, more oversight of actuarial work by CMS, or discontinuing the practice of requiring independent actuaries to perform this certification replacing them, instead, with CMS professionals. All of these options have been suggested at meetings between governmental organizations and professional trade group members, and need to be taken seriously.

As actuaries, we do not want our reputation tarnished and the general public to believe that we are biased in our work. Our professionalism is what sets us apart from other professions and what has built faith in our work products. We can not let this budget crisis interfere with our high standards of producing quality work. ■

— Sabrina Gibson

Editor's Note: The The Health Section Council chairperson addresses this question in her feature, *Chairperson's Corner.*

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This publication is free to section members. Current-year issues are available from the Communications Department. Back issues of section publications have been placed in the SOA library and on the SOA Web site: (www.soa.org). Photocopies of back issues may be requested for a nominal fee.

Chairperson's Corner

by Susan Pantely

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An Historic Year for Health Care (and Health Care Actuaries!)

My term as chairperson of the Health Section Council coincided with the largest change to the health care industry in decades—the passage of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010.

The major change posed by reform increases the importance of the SOA's continuing education programs, which are intended to provide basic education in the principles of actuarial science, advanced education and professional development in areas requiring specific technical or regulatory knowledge, and continuing education for practicing actuaries. The Health Section Council will continue to provide content-rich educational programs that address new issues related to the PPACA and respond to our market research findings in addition to our traditional offerings.

One example is the SOA's recent market research. We heard from respondents that actuaries could benefit from some additional clinical knowledge to better understand the perspective, terminology, and rigor of health care professionals. To address this need, we are adding a new session, "medical school for actuaries," at the next Actuarial Boot Camp.

The session is intended to allow actuaries to look beyond cost and utilization toward the underlying causes of those cost and utilization patterns, with an increased appreciation of the medical and pharmaceutical science behind many of the most impactful chronic conditions.

The Actuarial Boot Camp will be held in November 2010, to provide hands on training related to pricing and valuation issues. For the pricing track, actuaries may choose between small group and Medicare pricing. For the valuation track, there will be separate sessions for both experienced valuation actuaries and for those with less experience, as well as training for retiree health issues. We will also offer a half-day professionalism course, all in addition to the medical school for actuaries detailed above.

This issue of our newsletter includes a letter to the editor discussing the pressures faced by actuaries at this time when the financial infrastructure of the insurance industry and our country in general is under the microscope. I am confident that actuaries will respond to this pressure by relying on our basic and continuing actuarial science education to continue to do work that is based on actuarially sound principles and is of the highest professional and ethical standards. In addition to serving its members as an educational organization, the SOA serves as a professional organization. The SOA promotes high standards of professional competence and conduct within the actuarial profession. The SOA has adopted a Code of Professional Conduct, and in matters of conduct and discipline, it cooperates with the Canadian Institute of Actuaries and with the American Academy of Actuaries, including the Actuarial Standards Board and the Actuarial Board for Counseling and Discipline. I encourage actuaries to review the Code of Professional Conduct and Standards of Practice, and speak with colleagues if faced with pressure to produce any work product that does not conform to the highest professional and ethical standards of our profession.

We encourage you to reach out to any of the Health Section Council members listed on the masthead of this issue of *Health Watch* if you have ideas or suggestions regarding future webcasts or other educational events.

Recognition for a Job Well Done

I would like to thank the Health Section Council and the friends of the council for their hard work this year! Thanks to their efforts, we had successful meetings in Boston and Orlando and several well-received webinars. We published three issues of *Health Watch* offering a wide array of interesting articles. We finished the market research on Untapped Opportunities for Actuaries in Health and began moving ahead with the actionable items from the market research. We completed several research projects, kicked off other research projects, and worked with the Academy to publish two reports regarding health care reform issues.

Thank you to those who have finished their terms on the Health Section Council: Dan Bailey, Joan Barrett, and Grady Catterall. A special thanks to Sara Teppema, SOA health staff fellow and Jill Leprich, project support specialist, for their continued support. ■

of bundled reimbursement center on an acute inpatient admission and the skilled nursing, follow-up visits, and home health services that would occur afterward.

The philosophy behind bundled reimbursement is that providers would be given the proper incentives to provide efficient and effective care, resulting in the elimination of unnecessary tests, reduction in readmission rates, etc. Additionally, since there remains a link between the needs of members and provider revenue, health care providers would not be subject to undue insurance risk as they would under a full-risk capitation arrangement.

Under a single-episode payment system, it is generally up to the hospital or overarching provider entity to disburse payments to the individual providers. Determining the amount of these payments and the administrative process for disbursing them is a significant hurdle to overcome. For an integrated system such as a Physician-Hospital Organization (PHO), this process may be possible without large administrative changes. For individual physicians and hospitals not part of any integrated system, however, this represents a major change from current practices, with many issues to be addressed.

Improvements in data quality and the widespread availability of episode-grouping software has made episode-based reimbursement a very real possibility. In the past, this type of information and level of analytical sophistication was not available.

Advantages Over Today's Fee-for-Service Environment

Proponents of bundled or episode-based reimbursement point to the bundled-payment approach as a way to improve on the cost and quality concerns under current fee-for-service (FFS) based methods, including:

- Efficient use of resources
- Quality incentives
- Collaboration between providers

Efficient Use of Resources

Under the FFS system, revenue to providers is directly linked to the number of services they perform. There is little incentive to determine and implement a patient care plan that makes the most efficient use of limited resources. From a purely financial perspective, bringing a patient back to full health quickly and efficiently could mean lost revenue for the provider.

Under an episode-based reimbursement system, there is no extra revenue for additional visits or tests, so providers would have the incentive to bring patients back to full health quickly and efficiently. This type of system provides incentives for eliminating unnecessary physician visits during and after a hospitalization, along with the incentive to use fewer hospital resources.

Improvements in data quality and the widespread availability of episode-grouping software has made episode-based reimbursement a very real possibility.

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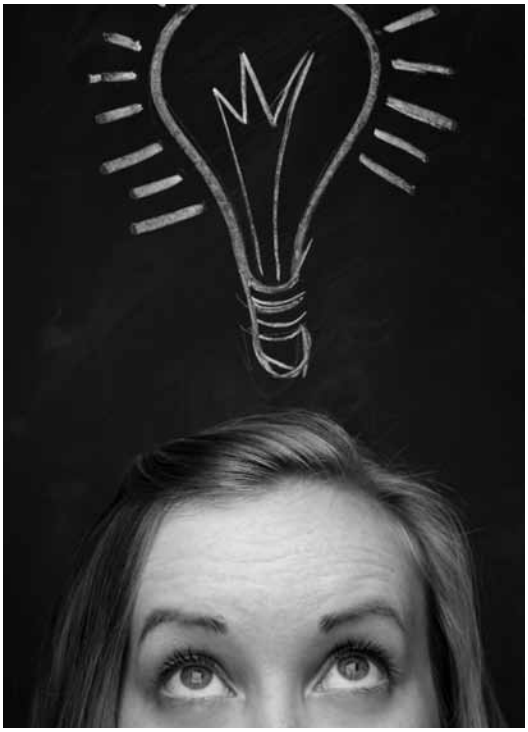

Quality Incentives

Unlike a quantity-based payment system, the episode-based reimbursement system inherently creates quality incentives. Although we generally believe health practitioners always act in the best interest of their patients to determine the best way to bring a patient back to health as quickly and efficiently as possible, removing the financial incentive to provide unnecessary services is likely to have an impact. This is the primary philosophy behind capitation arrangements; however, in the case of episode-based reimbursement, providers are not enduring the high level of insurance risk that most are not ready and/or willing to handle.

Collaboration between Providers

One of the major problems in today's system impacting both cost and quality is the lack of collaboration between the many providers interacting with a patient for a given episode. The financial and operating independence across providers can again lead to unnecessary visits and services, confusion and frustration for the patient, increased costs, and potentially harmful outcomes.

An episode-based system requires that providers come together (both financially and operationally) to provide the best and most efficient care for the patient. This type of collaboration is not unlike the provider collaboration theory discussed around patient-centered medical homes, where care for a patient is more closely coordinated across various health care professionals.

Criticisms/Obstacles

While the potential cost and quality improvements in episode-based reimbursement are intriguing, there are many roadblocks and pitfalls that may prevent this type of system from becoming a widespread methodology, including:

- Delay in final payment
- Distribution of funds
- Concerns regarding incentives

Delay in Final Payment

Since a patient episode may last several months, the ultimate payment may not be made until well after all services have been provided, which could be a very long time from when the initial services were rendered. Thus, some form of interim FFS-type payment with a final settlement would be needed to avoid provider cash flow issues.

This type of payment could cause significant administrative and financial problems for a health plan, since plans rely on timely and accurate claims data for reserving, underwriting, budgeting, and product pricing. Plans would need to know (or be able to accurately estimate) the net impact of the ultimate episode payment over the interim FFS payment, which could prove to be a difficult exercise.

Distribution of Funds

Under an episode-based system, it would likely be up to the hospitals to distribute the funds to each individual provider. This would be a serious administrative task that most hospitals today are not equipped to handle. Aside from the operational issues of distributing funds, there are several undesirable consequences that may occur:

- Hospitals may reward physicians who create more hospitalizations or episodes.

- In an effort to attract physicians, hospitals that are financially strained may be forced to keep physician payments high, limiting critical funds needed to cover their own operating costs.
- Hospitals may give physicians a financial incentive to code in such a way as to maximize revenue for the episode. In the FFS environment, physician reimbursement is generally not linked to the coding/intensity of the hospital admission; thus, there is currently not as much incentive for upcoding as there would be under episode-based payments.

Concerns Regarding Incentives

While the comments at the beginning of this article discussed how episode-based reimbursement may correct incentive problems in today's FFS world, episode-based reimbursement may produce its own set of incentive problems.

Rather than having an incentive to render more services (as with FFS), episode-based reimbursement would merely shift the incentive to create more episodes. This could result in providers delaying needed care until an episode end date was reached, which would then trigger a new episode. If manipulation like this occurs, it would likely result in a deterioration in the quality of care to the patient. Note that some plans have dealt with this issue using rigorous definitions of episode triggers.

Another potential quality-related concern is the incentive to withhold or limit needed follow-up care after the hospital admission. This is the same concern that exists with capitation agreements.

An additional capitation-related concern is the issue of providers "cherry-picking" the healthiest patients, with low risk of complication and readmission. Ideally, an episode-based approach would include appropriate risk adjustment to account for the likelihood of complications. Nonetheless, providers will likely be able to determine which patients are high-margin versus low-margin, and plans and patients would run the risk of providers acting on this information.

Can It Really Work?

Episode-based reimbursement's success is yet to be fully proven. There are various pilots and trial programs in place, some showing early signs of success. Whether or not this type of reimbursement will be successful and widely adapted over the long-term will depend on many factors, including:

- The ability of physicians and hospitals to become more fully integrated
- Resolution of issues pertaining to the distribution of funds
- Ability of episode-reimbursement programs to limit undesirable incentives

Of course, the largest factor in determining whether episode-based reimbursement will be widely accepted will be if and how the Centers for Medicare & Medicaid Services (CMS) implements this type of methodology to pay providers for Medicare patients. CMS has already conducted acute care episode (ACE) pilots for invasive cardiac and orthopedic procedures, which contain well-defined treatment patterns. Without specific and far-reaching government or CMS mandates, it is unlikely that the private sector will have the incentive to tackle all of the administrative issues necessary to implement episode-based payments on a large scale.

This is not to say that there may not be a place for episode payments. Certainly within integrated systems and for select types of medical conditions (e.g., CABG), there may continue to be a niche for this type of reimbursement methodology.

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Accountable Care Organizations: An Untapped Opportunity

by Sara Teppema and Jim Toole

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With the advent of Health Care Reform in the United States, the concept of an accountable care organization (ACO) has been receiving significant attention. This is an area where actuarial skills will be needed in order to achieve success.

A group of SOA members representing the Work Group for the "Untapped Opportunities for Actuaries in Health" strategic initiative attended an accountable care organization Summit, in Washington, D.C. June 7-9, 2010.

What is an ACO?

Section 3022 of the PPACA specifies that Medicare will establish a "shared savings program" by Jan. 1, 2012, to promote accountability for a patient population, through accountable care organizations (ACOs). According to the Medicare Payment Advisory Commission (MedPAC), an ACO is:

"A group of providers held responsible for the quality and cost of health care for a population of Medicare beneficiaries."

An ACO can be a combination of one or more hospitals, primary care physicians and possibly specialists, and is accountable for total Medicare spending and quality of care for the Medicare patients served. Bonuses and penalties are tied to overall Medicare spending and quality measures.

Although an ACO resembles an HMO or other managed care plan, one key difference is that Medicare beneficiaries will not actually enroll in any plan, but will instead be "attributed" to a group of providers based on their health care utilization patterns. Attribution is a key concept discussed later in this article.

ACOs: Risk and Opportunity

ACOs present a spectrum of provider risk options; the ACO Summit summarized the spectrum into three levels. Level 1 is a shared savings model, where providers can receive bonuses for high-efficiency care e.g., when overall actual costs are below target costs. Other than the shared savings bonus, providers would not assume any additional risk. The initial Medicare ACO program will fall into Level 1.

Level 2 is a symmetrical model, in which risk is shared between the payer and provider. In many cases, the ACO will accept payments retroactively (instead of fee-for-service payment to each provider), and the ACO will allocate revenue within its organization according to its own risk model. Savings would likely be shared between the payer and ACO.

Level 3 is a partial capitation model, in which the ACO accepts a prospective capitation payment for all or a portion of care for a given set of patients. The upside revenue potential is higher, but the downside risk is greater.

Themes of the ACO Summit

At the conference, we noted several important themes about ACOs and the future of provider payment, which hold important opportunities for actuaries.

Theme 1: The initial Medicare model of shared savings, with no real downside (Level 1 as outlined above), will not be enough to motivate change in the system.

Changing health care delivery practices is not a simple task. Without a downside risk to the current system, providers will not have enough financial incentive to make necessary investments in infrastructure, or to make higher-quality, efficient changes in their practice. Several experts at the summit spoke of the need to make the status quo unpalatable, in order to facilitate change in outcomes and efficiency.

Two-way risk needs to be part of the ultimate plan, if an ACO is going to be successful. ACOs need to begin incorporating greater risk into their long-term strategic planning if they are not already doing so. The ACO's current level of risk assumption will be an important factor in how far down the risk path, and how quickly, the organization will travel.

Opportunity for Actuaries: These organizations will need actuaries to evaluate risk and model shared savings strategies. They may also need a third-party, objective analysis when they are at the table bargain-

ing for risk sharing and shared savings payments from payers. To the extent that provider organizations are taking on increased risk, they will need to explore reserves and reinsurance alternatives. Providers may not realize it, but they need actuaries; regulators may need support as well, as innovative forms of risk sharing models proliferate.

Theme 2: The leadership of health care organizations who are, or wish to become, ACOs must make accountable care a strategic priority.

Leadership, and especially Boards of Directors, of ACOs will be of utmost importance. ACOs require investment in infrastructure, changes in administrative practice, coordination among providers, and adjustments in clinical practice in order to be successful.

Opportunity for Actuaries: Managed care might have been a longer-term, sustainable way to control health care costs if actuaries had been at the table with providers earlier in the process. ACO leadership should include actuaries, or at the very least have the counsel of actuaries in their strategic planning phases. The up-front planning will require pro-forma modeling, as well as initial capital, and possibly even risk-based capital.

Theme 3: Attribution—or how members/beneficiaries are assigned to an ACO—is a key factor in the success of the ACO

The concept that an ACO member/beneficiary does not need to enroll in a plan is new territory for both the payer and provider sides. However, most patients receive the majority of their care from a closely-aligned group of providers (hospitals, physicians, other providers); attributing a patient to a particular group encourages coordination of care and rewards providers of high quality, cost effective services with the opportunity to share the resulting savings.

Another concern in the discussion of attribution is the necessary size in the number of beneficiaries and in providers. The size will depend on many things, including (but not limited to) the ACO's

area population, provider capacity, mix of Medicare/Medicaid/Commercial group/Commercial individual insured business, and practice patterns.

The attribution method for the Medicare ACO program has not yet been finalized, but will likely be based on existing methods. Typical methods involve building a hierarchy based on a patient's actual provider utilization, with primary care at the top of the hierarchy. For example, a patient is attributed to a particular group of providers based first on primary care utilization, and then on utilization by other types of providers.

Attribution is also discussed in the context of Patient Centered Medical Homes (PCMHs), which can fit into the construct of an ACO, or can be an independent entity.

Opportunity for Actuaries: Attribution is an area where actuaries can lead the industry. We can begin with existing attribution methods, modeling the long-term impact of potential methods, and narrowing this analysis when a method is finalized for Medicare ACOs. We can assist in adapting the Medicare method to commercial populations as well. We can develop new methods of attribution for ACOs, based on our experience with claims data and risk adjustment. Finally, we can assist with the

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statistical analysis of required population and membership for a viable ACO with credible results for shared savings.

Theme 4: Measurement will be more important than ever.

If ACOs are to achieve high quality, efficient care, they must develop and maintain a measureable set of goals and track their success in achieving these goals. Health care organizations have metrics for quality and efficiency, and they must be applied rigorously within the context of an ACO.

For Medicare ACOs, the development of the target per capita cost benchmark will be critical in the measurement of shared savings. PPACA specifies that that the benchmark be adjusted for beneficiary characteristics and other factors.

Opportunity for Actuaries: Actuaries can get involved now to help establish standard metrics to measure quality and efficiency within and across ACOs. We can also participate in ongoing measurement and improvement. The Medicare per capita benchmark, with its legislative mandate for risk adjustment, begs for actuarial expertise. Finally, actuaries can assist an ACO in appropriately allocating shared savings payments among the ACO's providers.

Want to learn more?

To learn more about ACOs, here are some additional resources

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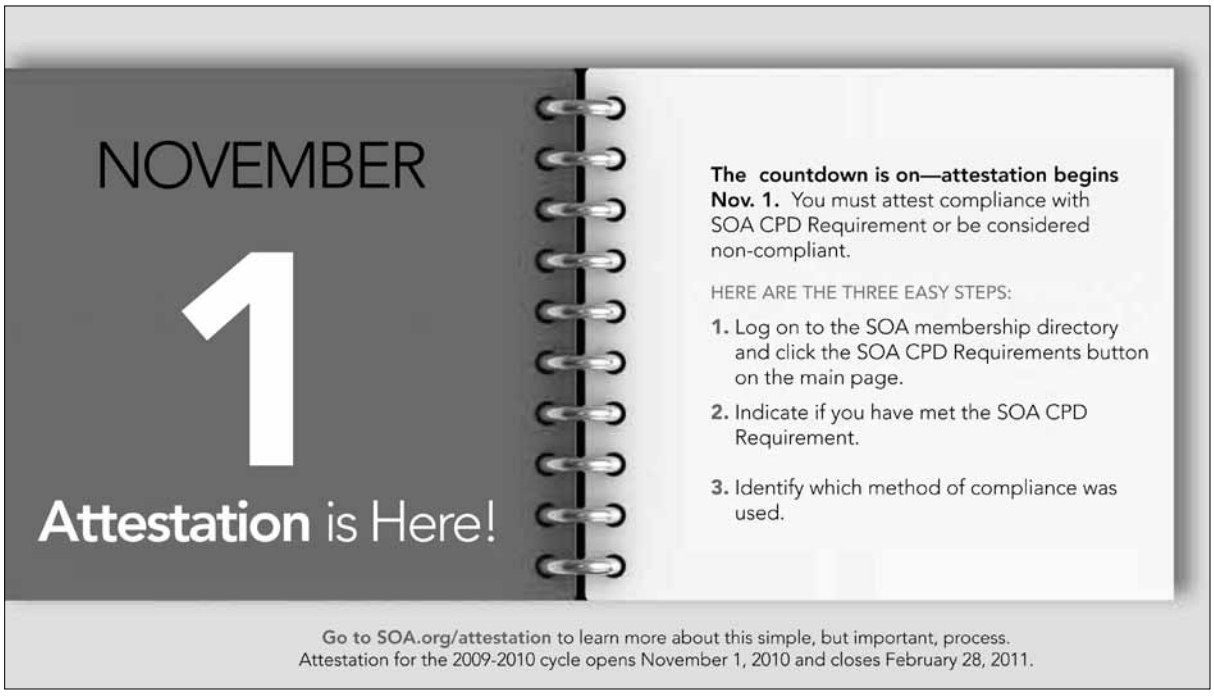
The website for the Brookings-Dartmouth Accountable Care Organization Learning Network, including this information page: *https://xteam.brookings.edu/bdacoln/Pages/BackgroundInformationonACOs.aspx* ■



Implementing Parity: Investing in Behavioral Health – Part 2

by Steve Melek

"There's no way to completely dismantle the stigma associated with mental illness. But there was a way for us to change the law. And that's what we did. And by changing the law, we began to dismantle the stigma because we made it illegal for people to discriminate. In doing so, we're starting to change the practice of delivering mental health coverage and mental health services. For people like me who suffer from mental illness, this is about lifting the cloud of stigma and shame associated with our illness. As much as we have come forward as *stigma-busters*, it's hard to not feel the tinge of judgment that people make on mental illness."*—U.S. Rep. Patrick Kennedy*

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The Department of Labor, Health and Human Services, and the Treasury released interim final rules (IFR) under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 (MHPAEA) in February 2010. These regulations specify what it means to provide behavioral health benefits that are in parity with medical and surgical benefits, and establish a requirement for group health plans and group health insurance issuers to be compliant with parity for plan years beginning on or after July 1, 2010. Understanding compliance with MHPAEA is of great importance to all interested parties, including health insurance companies, health plans, employers, providers, and consumers of behavioral health care. Part 1 of this article was published in the May 2010 issue of *Health Watch* and addressed details of implementation. Here in Part 2, I address the new enforcement safe harbor, how the regulations could impact the business of behavioral health care and the impending decisions for payors, employers, providers, and insureds.

Enforcement Safe Harbor Issued

On July 1, 2010 the sponsoring agencies of MHPAEA "determined that they will establish an enforcement safe harbor under which the agencies will not take enforcement action against a plan or issuer that divides its benefits furnished on an outpatient basis into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules under MHPAEA: (1) office visits, and (2) all other outpatient items and services." (Department of Labor, 7/1/2010). All other aspects of the IFR remain unchanged.

The first step in applying the MHPAEA requirement is to determine whether a financial requirement or quantitative treatment limitation applies to *substantially all* medical/surgical benefits in a classification. For many plan sponsors and insurers of hybrid plans, whose plans use a mix of copays and coinsurance depending on the type of service, this safe harbor change is great news and a welcomed surprise. This change will likely result in an increase in *substantially all* pass rates for financial requirements in the outpatient classifications. Before the safe harbor was issued, many plans were failing the *substantially all* test and were therefore going to have to offer free mental health and substance use disorder benefits in the outpatient class, which did not seem like a sensible result. For example, let's say a plan design has 50 percent of services for which a $20 copay is applied, and 50 percent for which 20 percent coinsurance is applied for outpatient medical/surgical benefits, and is charging a $20 copay for outpatient mental health and substance abuse services. In this case, neither the $20 copay nor the 20 percent coinsurance exist

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One of the most unexpected new requirements in the regulations is the inclusion of non-quantitative treatment limitations

for *substantially all* services, which is defined as at least two-thirds of service costs by MHPA 1996 regulation. Therefore, since no single cost sharing type exists which is for *substantially all* services, the result was that plans could not charge any member cost sharing for the mental health and substance abuse services in the outpatient class. However, after the issuance of the safe harbor, the copay and coinsurance services may be tested separately. When tested separately, 100 percent of the copay services have a $20 copay applied, and therefore *substantially all* services have a $20 copay, therefore, the plan could continue to charge a $20 copay for the outpatient class (office visit sub-class) of mental health and substance abuse services, as opposed to $0 as per the IFR prior to this safe harbor.

While this change does shed light on the intent of the IFR in this one area, it does bring back the episodic copay issue in an even more important way. Can ancillary medical/surgical services that are provided during an office visit be included as subject to copays for the purposes of testing (to achieve two-thirds or *substantially all*)? And how far can you stretch with this mapping? The more services that are linked to copays, the easier it will be to pass the *substantially all* tests in both sub-classes for hybrid plans.

Looking Below the Surface

Part 1 of this article addressed some of the key provisions of the IFR, especially as it relates to quantitative restrictions and compliance. After assisting multiple plans with MHPAEA compliance testing under the IFR, the items listed below have surfaced as key additional items to consider when testing for MHPAEA compliance.

Non-quantitative Treatment Limitations

One of the most unexpected new requirements in the regulations is the inclusion of non-quantitative treatment limitations (i.e., a limit not expressed numerically that otherwise limits the scope or duration of benefits). These non-quantitative limitations could include, but are not limited to

- medical management standards
- prescription drug formulary designs
- standards for provider admission to participate in a network
- determination of usual, customary, and reasonable amounts
- requirements for using lower-cost therapies before a plan will cover more expensive therapies
- conditional benefits based on completion of a course of treatment

Under the IFR, any process or standard a plan uses to apply non-quantitative treatment limitations to mental health/substance use disorder benefits *must be comparable to, and applied no more stringently than,* those used for medical/surgical benefits.

The IFR is quite specific about the testing procedure for MHPAEA compliance with the quantitative financial requirements and treatment limitations; it is less specific about what is required to be compliant as it relates to non-quantitative treatment limitations. However, under the IFR, compliance failure in this area is just as severe as compliance failure on benefit design. One area of uncertainty is how the *substantially all* test applies to non-quantitative treatment limitations. The IFR uses the *must be comparable to, and applied no more stringently than* terminology in comparing mental health and substance use disorder and medical/surgical benefits processes, strategies, evidentiary standards, and other factors in comparing non-quantitative treatment limitations after addressing the quantitative limits via the *substantially all* and *predominant* tests. One could interpret this to mean that such non-quantitative limits

1. must apply to substantially all medical/surgical benefits,
2. must be the predominant treatment limitation across medical/surgical benefits, and
3. must be applied no more restrictively than the comparable medical/surgical limitation.

For many health plans, a comparison of the non-quantitative treatment limitations of behavioral health benefits to those of medical/surgical benefits has likely never been done because prior parity legislation did not require it. Under the MHPAEA IFR, such comparisons must be done and health

plans should be actively analyzing these items and be prepared to defend the processes they use to manage behavioral health benefits.

Cover One, *Cover All*

The MHPAEA IFR requires that health plans and self-funded employers who provide benefits for a mental health or substance use disorder in one classification (in-network inpatient, in-network outpatient, out-of-network inpatient, out-of-network outpatient, emergency services, or prescription drugs) must provide benefits for that condition in all classifications in which it provides medical/surgical benefits.

This requirement could be especially important to employers whose response to the parity requirements is to remove the coverage for some or all mental health and substance use disorders. Suppose an individual goes to their primary care physician, who prescribes an anti-depressant for treatment. Anti-depressants are included in the drug formulary, but outpatient mental health visits are not a covered benefit. By including anti-depressants on the drug formulary for the treatment of depression, the employer has violated MHPAEA—if an employer wants to cover prescription drugs used to treat behavioral conditions, it must also provide behavioral benefits in the other classifications where medical/surgical benefits are offered.

Another item that recurs in plans is a specific provision related to the coverage of tobacco cessation products and services. Keep in mind that if a tobacco cessation benefit (to cover nicotine addiction, a substance use disorder) is provided in any of the classifications for which medical/surgical benefits are provided, it must be covered in all of them. In addition, rules limiting the duration of use of tobacco cessation benefits must be removed if comparable limitations for medical/surgical services or drugs do not exist and pass the *substantially all* and *predominant* tests.

Determining the Dollar Amounts Expected to be Paid

Some confusion has arisen about whether paid claims or allowed claims are appropriate for parity testing. The IFR description suggests that using plan payments prior to member responsibility is appropriate. However, the IFR does include the phrase *expected to be paid under the plan.* Many actuaries involved in MHPAEA compliance testing believe that the use of allowed dollars makes more sense when testing the quantitative financial requirements.

In an extreme case, consider the situation where the copay equals the cost of the service. In this situation, using paid dollars would result in zero paid dollars for that benefit and therefore costs associated with the coverage for that benefit would be excluded from the testing altogether. The IFR includes language that permits the use of any reasonable method to determine the dollar amounts, and using allowed dollars is a reasonable approach.

Episodic Copays

Office visits to a provider could result in numerous services being delivered, such as the office visit itself, an x-ray, and some lab work. In this situation, which medical services should be treated as being subject to the copay? If the answer is all of them, then how does the copay get split between the services? Because office visits and related costs typically represent a non-trivial amount of costs for a plan, understanding how to implement the quantitative financial requirement testing for these episodic copays is important. How to perform the substantially all and predominant testing for this type of copay is unclear in the IFR and further guidance is needed on this subject.

Tiered Networks

Some plans use a tiered network approach in their benefit designs where the cost-sharing requirements differ depending upon the tier placement of the provider. The IFR does not separately address how to test this type of plan design. Using the standard approach, a plan would need to separate medical/surgical costs by tier so that cost-sharing requirements within each tier could be applied and accurate *predominant* levels could be determined. If all mental health and substance use disorder benefits are covered at the top tier levels, then testing each tier separately would not be necessary.

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State Mandates for Autism

Some states mandate specific dollar amounts for the treatment of autism and other pervasive developmental disorders (PDDs), commonly including applied behavioral analysis (ABA). Key questions regarding PDDs include how they are classified, how are ABA providers credentialed, and how do medical necessity criteria apply to ABA benefits. Is treatment for these disorders a combination of medical and behavioral benefits? If PDDs are considered behavioral disorders and dollar limits have to be removed in order to comply, will this cause plans to meet the MHPAEA cost exemption threshold which will allow them to opt-out of parity in subsequent (alternate) years? The IFR does not specifically address the treatment of autism and other PDDs.

Scope of Services

The IFR did not address how treatments for behavioral disorders without analogous medical/surgical treatments (partial hospitalization, residential treatment facilities, ABA) should be handled. The federal agencies did receive many comments regarding the continuum of care issue. The comments received covered the entire spectrum. Some requested that the regulations clarify that a plan is not required to provide benefits for any particular treatment or treatment setting if benefits for the treatment or treatment setting are not provided for medical/surgical benefits (such as non-hospital residential treatment, partial hospital services, and ABA). Others requested that beneficiaries should have access to the full scope of medically appropriate services to treat mental disorders and substance use disorders if the plan covers the full scope of medically appropriate services to treat medical/surgical conditions.

A key element in this discussion is the need for medically appropriate services delivered by qualified, licensed and credentialed providers. Because such a wide range in qualifications and credentials exists within the behavioral healthcare field, some plans have historically limited what benefits are covered under the plan.

One solution to this scope of services issue is for health plans to use specific behavioral healthcare guidelines that incorporate the full spectrum of services in order to achieve the quality and efficiency outcomes desired for medically necessary care.

The Response of Self-funded Plan Sponsors

Since the release of the IFR, it appears that many fully insured plans have been actively engaged in parity compliance and making decisions which will bring their plans into compliance. From my observations, self-funded plans which are also affected by MHPAEA and the IFR have been slower to react to the legislation. For a self-funded plan to perform the detailed testing involved, they must have access to the cost data which will likely be provided by the contracted ASO. It is the employer's responsibility to ensure that the plans offered are in compliance with the law. However, as a service to their customers, some ASOs have proactively contacted their customers regarding MHPAEA.

For employers who offer behavioral healthcare coverage through a managed behavioral healthcare organization (MBHO) on a carve-out basis, the employer must communicate any benefit design changes that have to be made as a result of the compliance testing. Some MBHOs are assisting self-funded employers directly by making benefit design change recommendations and determining price impacts as a result.

MHPAEA: Just Another Mandate or an Opportunity?

The MHPAEA could be viewed as yet another federal mandate that requires compliance and increases costs. On the other hand, the MHPAEA could be viewed as a reason to revisit how behavioral health conditions are treated and how services are delivered to arrive at optimal clinical outcomes which could ultimately result in cost reductions. With increased access to behavioral healthcare benefits as a result of parity, payors should be looking for ways to improve the delivery of behavioral healthcare services. Here are some of these considerations.

Access to Specialists. Providing more comprehensive behavioral healthcare benefits will not mean much if access to the behavioral specialists who can deliver effective behavioral healthcare services is limited. There are many areas across the country where there are problems in obtaining care. Research has shown that the longer the wait for diagnostic and therapeutic services for people with mental illnesses or substance use disorders, the higher the no-show rate for such services. If one of the elements of success in behavioral health is getting the right treatment by the right provider at the right time, provider networks must be established to accomplish that goal. Employers and health plans should review their behavioral healthcare provider network capacity at all levels—MDs, PhDs, MSWs, other counselors, addiction specialists, etc.—to ensure that they have the capacity to provide effective treatment under the expanded parity benefits.

Support of Primary Care. There will be geographic areas where maintaining a sufficient behavioral specialty network to provide the desired access and clinical outcomes will be impossible. Patients will then rely on their primary care providers (PCPs) for behavioral healthcare. Systems of support will need to be developed to help PCPs improve their diagnostic and treatment capabilities of behavioral disorders. This could include increased funding for care management of behavioral illnesses provided through nurse practitioners, increased funding of diagnostic behavioral screening/testing in primary care settings, and increased support for work processes that improve clinical outcomes. There is a huge opportunity for such improvement in primary care settings.

Care Quality and Outcomes. Employers and health plans should evaluate the clinical outcomes obtained through the various behavioral healthcare providers and programs. These could include psychiatric symptom ratings, daily functioning, member/family satisfaction rates, psychotropic treatment adherence, psychotherapy treatment completion, follow-up visits after facility discharges, and financial outcomes (i.e., cost effectiveness).

Preventive Care. Many preventive care services within medical benefits have small or no copays associated with them. Consider providing screenings for mental illness and substance use disorders as preventive care, with the same level of copays used for preventive medical services (and be careful with compliance testing if you do so).

Pay for Performance. Consider the prospect of rewarding providers for achieving targeted outcomes in their treatment of behavioral illnesses. This could come in the form of additional payments to providers for treated patients that hit medication adherence objectives or therapeutic objectives through counseling. Incentives could be paid to facility-based programs for effective clinical outcomes that continue over time. ■

Navigating New Horizons …

an Interview with Dave Axene

By Sarah Lawrence

David Axene

To say that Dave Axene has had an interesting year would be an understatement. In the past 12 months he earned a new professional designation, overcame a serious illness, published a book and played an important role in the largest actuarial malpractice settlement in history. On top of that, he also uncovered errors in the rate increase proposals of two major California insurers which affected rates by tens of millions of dollars—an issue so important that even President Barack Obama took note.

Axene is the president, founding LLC member and consulting actuary of Axene Health Partners, LLC, out of Winchester California. The firm, which he founded in 2003, specializes in providing health care consulting services that emphasize the integration of actuarial science with the practice of medicine as a way of fostering greater understanding and, in turn, eliminating waste. It was this business theory that evidently caught the attention of the California Department of Insurance when they were searching for somebody to evaluate the reasonableness of rate filings by four insurers: Anthem Blue Cross, Aetna, and Blue Shield of California and HealthNet.

Making the Difference

The rate filings were calling for large rate increases—as high as 39 percent in the case of Anthem Blue Cross—and were causing great consternation for not only consumers, but also politicians including President Obama, who publicly criticized the company's proposal during a televised appearance. Enter Axene, who discovered errors so significant in the filings of Anthem and Aetna that the companies were forced to withdrawal their filings and redo them. Both accomplishments made front-page news and a human-interest feature that highlighted Axene was published by the *Los Angeles Times* under a headline that read, "A mathematical David stuns a health care Goliath."

It's not every day that an actuary is branded a hero in the media, but Axene hasn't let all the attention and esteem go to his head. "I'm this relatively quiet, introverted guy who has been very fortunate in his actuarial career," he said. "Ironically I'm just sitting back saying, 'Why does everybody care?'"

Axene's career has spanned almost four decades and has been so successful that one might assume his progression was the result of early grooming, careful planning and the orchestration of many complicated and long-term goals. This actually couldn't be further from the truth. In reality Axene seems to simply have a wonderful ability to go with the flow of life, putting everything he has into what he is doing that moment and taking full advantage of any opportunities that are presented along the way.

"It's funny because when you look at my career it's basically me bumping into things … and it sure feels like that at times," he said. "But it's also an insatiable curiosity of how to fix things and there have also been some amazing things that have happened through my career. I am a person of great faith and sometimes I wonder if it's God, sometimes I wonder if it's my ineptitude of stumbling. Who knows?"

The Early Years

Axene was born in Canada and lived there until his family moved to Vancouver, Washington, where he attended high school. A gifted math student, he dreamed of a career in aeronautical engineering and, with that goal in mind, earned his Bachelor's degree in engineering science and physics from Seattle Pacific University. He went on to earn a Master's degree in applied mathematics from the University

of Washington and was entertaining the idea of going for his doctorate when life led him in a different direction. He fell in love and wanted to get married, but his prospective father-in-law would not give his full blessing until Axene had obtained a "real job."

Axene decided to apply for a group sales representative job at an insurance company, but failed to convince the person conducting the interview of his skills as a salesperson. In fact, according to Axene, he "failed miserably," but the interviewer did ask if he had ever considered becoming an actuary. Though neither man actually knew what an actuary was or what they did, the interviewer assured him that they sat in on his meetings all the time and were really good at math. "So they turned my resume in and, lo and behold, I got a job as an actuarial student," Axene said.

The job initially took him to Hartford, Conn. for three years where he worked for Travelers Insurance Company and said he was consistently amazed that he was actually getting paid good money to do math. From there he began making his way back west by accepting a position with American Republic Insurance Company in Des Moines, Iowa. "I think I had three or four exams and I was very green, but I got hired as their group actuary, of all things," he said. "Basically I worked with small group medical and learned the hard way how to do that because sometimes we made money and sometimes we lost money."

Axene said that it was at American Republic that he really learned the ropes and grew as an actuary, but when the company discontinued the line of business he was working in he ended up moving across the street to work as an assistant actuary for American Mutual Life Insurance Company. After two years in that position, he was given the opportunity to return to the West Coast by accepting a job as a group actuary with SAFECO Life Insurance Company in Seattle, Wash.

"By that time I had a lot of experience in the small group medical business and they brought me in as the first group actuary that they had," he said. "I was housed within the group insurance division and because of that prior experience I was really feeling pretty good about stuff and was able to help the company as they got into several other lines of business."

Axene said he found a mentor in the form of the company's former chief actuary, who was by then working with Milliman & Robertson Inc. and often provided insight to Axene during his frequent visits. "I've since learned he was just developing business with SAFECO, but it seemed that he was so interested in helping me learn more and we actually became good friends. He eventually hired me from SAFECO shortly after I became an FSA."

Settling In

The move to Milliman was the beginning of a 25-year career with the company, although Axene did not know it at the time.

"I was being put into positions which helped me advance my career, but it was more by chance or by accident rather than by careful planning," he said. "When I accepted the job at SAFECO the primary purpose was getting back to Seattle, yet it was a great training ground to expand my actuarial skills. When they hired me to come to Milliman I wasn't even sure what it meant to be a consultant, but eventually I advanced myself and became a partner of the firm and had one of the largest consulting practices in the company. So it was another opportunity to advance myself, but I hate to admit it wasn't my doing to really want to go to there. I had no idea how good of a company it was when I went there."

Axene worked his way up to principal at Milliman in just six years and said he enjoyed the fact that working in that position often felt like he was running his own firm. It also gave him the freedom to start developing some of his own ideas. "In the late '80s I started to pursue something very unusual which was the whole theory of trying to understand how doctors deliver health care, and through that effort I developed a product which eventually became a whole consulting unit and today is more

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than a $50 or $60 million operation for them," he said. "It's called *Care Guidelines*, which is a tool that actually is used to help change the behavior of doctors and how they deliver health care. We developed the tool under my practice and I ended up hiring lots of doctors and nurses to help me do that. It continues today as a very successful business venture for them, but I'm no longer associated with it."

Moving Forward

Axene ended up resigning from Milliman in early 2001 and was hired on as a partner with Ernst & Young of San Diego and Irvine, Calif. shortly thereafter. He was given the task of growing a new consulting firm, but unfortunately a new law was passed that interfered with the practice's business plan and it folded after two years. Luckily the lay off came with a severance package that gave Axene the means to start his own consulting firm and, as a result, Axene Health Partners was born before his last day at Ernst & Young had even passed.

Axene partnered with a physician he had worked with at Milliman to create a consulting firm that expanded on the idea of health care professionals and actuaries working closely together. "The one thing that has helped me in my business development is that when I have a good clinical understanding of how health care is working, I can do a much better job as an actuary," he said. "That has helped me in every kind of work. For example, one of the projects we do a lot of is to assess the effectiveness of various health care organizations, whether it's a hospital or an HMO or a medical group or a health care innovator or whatever. And so by adding that clinical perspective that's something very unique about what we do and it's been very beneficial for us and has led to many excellent opportunities."

Among the opportunities that Axene said he has found the most challenging and interesting is offering expert testimony. He recently offered testimony in an actuarial malpractice lawsuit that resulted in a $500 million settlement—the largest settlement that has ever been offered in this type of court case. "I hate to see actuaries make mistakes, but when they do somebody needs to hold them accountable and I'm one of the actuaries who was willing to work with the organization to make sure people did right," he said. "More and more insurance departments and other insurance companies are curious as to whether they've done their work right and although this sounds a little bit like it could anger some actuaries, it's turning out to be a very good thing for the actuarial profession because we are such an important, trusted profession and we have to do our work right."

Axene said he is also excited about an ongoing project he has been working on that measures the effectiveness of health and wellness programs. The hope is that this will lead to more effective programs that will improve overall wellness and therefore create an opportunity to save a lot of health care dollars.

Risk Management

Axene recently took the opportunity to earn his designation as a Chartered Enterprise Risk Analyst (CERA), a relatively new designation offered through the Society of Actuaries. It can take several years to earn this designation, however Axene was able to complete the program in about a year because of his previous and extensive experience in the field. Axene said he believes having this credential could create many opportunities for the actuaries who take the time to earn it.

"I think the credential has the potential to really open up doors," he said. "As an actuary with a CERA, what we're able to do is get into the key financial and analytic areas of an organization and help them mitigate risk, plan for risk, take advantage of risk and whatever else. And that's what is very excit-

ing. As an entrepreneur I enjoy managing risk and so this is an opportunity to get into what I really enjoy, which is trying to understand and manage risk. Plus the enterprise risk management is getting into a bigger space to actually apply those principals and help organizations manage it in ways that they perhaps haven't thought of."

Key to Success

Axene said actuarial students sometimes ask him how he was able to achieve so much success in his career and he offers several pieces of advice, the first one being to always make sure you completely understand what you're doing today. "What I mean by that is even if it's a simple process, make sure you totally understand it," he said. "Not just understand it on the surface, but totally understand it so you can know it better than anybody else that's ever done it before and why you're doing what you're doing and how it fits in to the rest of the organization. … Taking apart what you're doing and trying to see why it's working or not working will always help you do a better job because what happens is as you understand how all these different things work, you can pull them all together."

Axene also suggested that people should not be afraid to admit when they don't know something because it creates an opportunity to learn and questions can often lead to new ideas.

"What I've found over the years—even though I've worked 40 years—is that the more I learn about stuff the more I realize how much I don't know," he said. "That's one of the reasons why I started to work with doctors. The fact is that I don't know medicine that well, but if I learn and understand how they make choices I can better analyze what's going on."

Axene recently published a book on how to run a business effectively. "Clearing the Mud: Simplifying the Complexities of Running Your Business" is available online at *Amazon.com*. ■

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PPACA Heats Up Actuaries in Orlando

A Tour of the SOA '10 Health Meeting

by Doug Norris

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The Patient Protection and Affordable Care Act (PPACA), the landmark health care reform bill passed by the American government in March, was on the minds of the more than 700 actuaries who descended upon the great city of Orlando in late June for the SOA '10 Health Meeting. Although the weather outside the JW Marriott Grande Lakes was frightful, the conversations inside were delightful. Health care experts young and old engaged in discussions ranging from implications of the new legislation, to untapped opportunities for health care actuaries, to trends and pricing concerns.

Surprisingly, I did not have the chance to attend all eighty-six sessions on the agenda. However, here is a sampling of what one may have found as an attendee of the meeting.

Health Meeting chair Barbara Niehus kicked off the opening session by recognizing those who have contributed to the success of the discipline over the past year. David Cutler and Grace-Marie Turner tossed some peppers into the morning's continental breakfast festivities with a spirited debate about the state of American health care reform legislation. In 1995, Turner founded the Galen Institute as an advocacy group whose mission is to put individuals rather than corporate or government bureaucrats in charge of health care decisions. Cutler served in the administration of Bill Clinton, and was senior health care advisor to Barack Obama. Each was well-spoken during the debate, which lasted for more than an hour, with Cutler and Turner disagreeing vociferously on the ramifications of the act. *(Ksenia Draaghtel and I had the chance to continue the debate with Cutler and Turner shortly after the opening session. For more on their exchange, please see the interview later in this issue.)*

SOA President Mike McLaughlin presided over Monday's lunch session, hosting "A Conversation with the 2010 President.". McLaughlin focused on the two unofficial themes of the 2010 meeting—health care reform and opportunity. "With the scale of transforming changes that we are seeing taking place with health care in our economy in the U.S., we are going to have a large number of unpredictable consequences, and a large number of opportunities. If you as health actuaries thought that your opportunities were diminishing, I think that the ACA will put your fears to rest."

McLaughlin gave several examples of initiatives initiated in the health area, including the publishing of a wide variety of essays on the global financial crisis by leading minds such as Ian Duncan, Dave Axene, and Hobson Carroll. Efforts to educate the public and promote the actuarial image, such as the series of articles in *The Actuary* on health care reform, and collaboration with other organizations such as the AAA and CCA, were highlighted.

Monday's session 29 looked at issues and trends for health insurance companies and reinsurers. David Vnenchak walked us through a "Reinsurer's View of PPACA," talking about the new unlimited annual and lifetime benefit maximums, the temporary high-risk pool (and how those members would be back on the market in 2014), and the high cost of specialty drugs. Todd Watson focused on risks to the reinsurer, such as data risk, rearview mirror risk, predisposition risk, banking mentality risk, and modeling risk. Hobson Carroll closed the session on the subject of opportunities for innovative reinsurers, such as integrating with other types of insurance (auto, home, liability, malpractice), international travel medical coverage, or micro-reinsurance for micro-insurance products. Carroll recommended two books on randomness, *The Black Swan* and *Fooled By Randomness*, which explore and explain the disproportionate role of high-impact rare events which are difficult to predict and outside the realm of normal expectations. Clearly, large-dollar rare events have a major impact upon the reinsurer's bottom line.

Tuesday started off right with the health section hot breakfast, a veritable feast of eggs, sausages, bacon,

fresh fruit, bacon, pastries, coffee, and bacon. While we ate, Judy Strachan and Sara Teppema walked us through the recent research activities, webcasts, boot camps, and meetings of the section. The results of the health section member survey were revealed, and the "Bending the Cost Curve" press release was announced. Teppema showcased the results of the SOA summary report, "Untapped Opportunities for Actuaries in Health Care," which highlights nontraditional roles and employers for actuaries and skills needed.

"The Delivery of Health Care" was the topic of session 38, led by Geraint Lewis and Ian Duncan. Lewis focused upon three chronic conditions—diabetes, COPD, and heart failure—which together cost the American economy about $300 million per year. Characteristics and markers of each were shown, as well as care and prevention of complications. Duncan finished the session talking on the financial implications of chronic disease. Under the CDC definition, nearly 50 percent of Americans suffer from one or more chronic condition. An important consideration in disease management studies is whether or not the measured results represent the cost of the condition, or the cost of the person. This is particularly troubling when looking at patients with comorbid conditions.

Tuesday's lunch could best be described as a festival of positive energy, with Matt Weinstein emceeing the proceedings. A consulting speaker on the topic of introducing humor into the workplace setting, Weinstein had the entire audience up and moving during his presentation. Weinstein presented techniques for making things a little brighter in these tough actuarial times, while reducing stress on the job and fostering a season of teamwork. Many of those I spoke with considered Weinstein's presentation to be the highlight of the meetings. *(Mary van der Heijde and I were able to sit down with Weinstein prior to lunch, where we discussed everything from introverted actuaries to the possibility of having too much fun at work. For the highlights of our conversation, please see the interview later in this issue.)*

Session 55, "Actuarial Presentation and Selling," discussed the changes which have been made in the actuarial world since the most recent writing of ASOP #41 (Actuarial Communications). Shawn Maloney and Ben Rayburn went through case studies and topics involving e-mails, instant messages, journalistic interviews, tweets, and Facebook posts, with the audience debating over the appropriate level of detail involved. ASOP #41 is currently being revised to take into account some of these new realities.

Harvey Sobel and Barbara Niehus chaired session 61, "Health Care Reform—What Did We Miss?" This was an interactive and open discussion on the various aspects of health care reform, what is good about PPACA, and what could have been done better. This talk may not have been as contentious as the Turner-Cutler opening session debate, but it was close. Personal responsibility of consumers was a hot button item, as was cost transparency to the patient (why can cosmetic surgeons quote a price for their services, but PCPs cannot?). We talked about strategies for improving access, bending the cost curve, quality and efficiency, and the financing and funding of all of the above. American subsidization of pharmaceutical research and development, electronic health records, the efficacy of wellness programs, and the penalty levels for patients without insurance under PPACA were all on the menu. How can we increase the number of PCPs? Should insurance cover routine care, or should it only be there

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for unexpected high-cost incidents? What about a national fee schedule? Should there be a discount on insurance for those who are personally compliant with their care program?

Wednesday may have been only a half day of sessions, but I found two of the more entertaining talks on this short day. Alan Mills awakened everyone in the audience with his 8:00 a.m. session, "Complexity Science—Applications for Health Actuaries" (session 78). Using a highly-interactive multimedia presentation, Mills opened our minds to the subject of complexity science. What is it? How can health actuaries use it? Complex systems analysis is the study of complex systems, and how they form, evolve, and die. The beauty of these systems is that they can produce results so intricate that they cannot be described in a fashion simpler than the entirety of the results themselves. The lecture started with an overview on the topic, showing us agents, agent relationships, behavior rules, environments, and led into potential applications for health actuaries. These included provider decision networks, disease propagation studies, health care opinion dynamics, and policyholder lapse behavior. If you missed this session, I encourage you to check out Mills' SOA research report on the topic.[1]

Session 83, "Predictive Modeling Update," closed the meetings (for me, at least). Rong Yi began by showing us the current state of predictive modeling, with uses including patient management, financial and budget management, provider profiling, return-on-investment studies, and underwriting. Tzu-Chun Kuo showed a case study on holistic health modeling for the health system in the city of Abu Dhabi. Geraint Lewis finished with an update on predictive modeling in the United Kingdom, talking about propensity score modeling, and impactability models (it is not merely enough to identify those who need help; one must also identify those who are willing to get help).

As suddenly as it started, it was over. Long-lost acquaintances gave their goodbyes, the hotel staff began disassembling the meeting rooms, and we made our way to the front lobby amidst a gaggle of sorority girls who had also held a conference at the same time as ours, all the while searching for safe passage to the Orlando airport. For more on the SOA '10 Health Meeting, please visit the SOA's website[2] (), where you will find PowerPoint slides for nearly all of the sessions and presentations. Many of the meetings, presentations, and lectures are also available in an MP3 format synchronized with the presented slides.

Slides and MP3s may satisfy your continuing education requirements, but they are no substitute for the real thing. Therefore, we hope to see you next year, at the Westin Copley Place in Boston. Save the date(s), June 13–15! ■

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1 *http://www.soa.org/files/pdf/research-complexity-report-v1a.pdf*

2 *http://www.soa.org/professional-development/archive/2010-health-spring.aspx*

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An Interview

with David Cutler and Grace-Marie Turner

by Doug Norris and Ksenia Draaghtel

David Cutler

As part of the SOA '10 Health Meeting, a lively debate was held between two leading voices in health care reform. Grace-Marie Turner founded the Galen Institute in 1995, as an advocacy group against the increasing role of the federal government in the American health sector. David Cutler is the Otto Eckstein Professor of Applied Economics at Harvard University, and was senior health care advisor to Barack Obama. Cutler and Turner kicked off the SOA '10 Health Meeting with a bang, debating the principles behind the Patient Protection and Affordable Care Act (PPACA) for more than an hour. We were fortunate to be able to spend more time with Turner and Cutler after the main session ended, and share highlights of that discussion here.

Grace-Marie Turner

What do you see as the role of actuaries in the implementation of PPACA, and where can we be of best use?

David: I think that actuaries are going to play a hugely important role. The system is changing, or it's going to change, and the actuaries are going to be incredibly important. Let me just give one example from accountable care organizations. Lots of provider groups are now integrating because they want to be able to coordinate care. They think that that is where the money is going; they think that is what will deliver higher value, and they don't have much experience with how they are going to handle all of the patients. How they should price it out, how they should do the internal transfers, and things like that, and they really need actuaries to help them with that. They really need the actuaries to say, "Look, here's how we should do the risk for it, here's how we should think about the costing, here's how we can do some of these transfers." Anytime there is change, we need all hands on deck. We need the doctors there, the clinical folks, the financial folks, and you really have to have the actuaries there as well.

Grace-Marie: I'd look at it also from the perspective of implementation. I think actuaries really need to continue to have an active voice in responding to the regulations that come out, and making recommendations for legislation to fix problems with this bill that may move us in what they know will be the wrong direction. This is not settled policy; there is still a lot that needs to be fixed, and for it to work so that the American people accept it. And I think that actuaries bring a real-world perspective: "will this work or won't that work?" and rather than going down that road and finding out if it did or didn't work, actuaries need to be engaged up front and say, "we can anticipate that this is what's going to happen, and you need to make changes now to get to a better result or to avoid a bad result."

If you had carte blanche to design health care reform from scratch, what would your top three requirements be?

Grace-Marie: I really think that we have to do entitlement reform. You can't have a program that is 38 trillion dollars in deficit, as Medicare is, and not address that. You can't take the money out of Medicare, and put it into creating new entitlement programs which are themselves unsustainable, and create more problems, and not solve the initial problem. I think dealing fundamentally with entitlement reform in a way that moves us towards a 21st-century system of medical care delivery, so that consumers have more choices, more options. A defined contribution model, and refundable tax credits, and giving people control of the resources

to make better decisions about protecting themselves, both against how they're going to arrange payment for routine care, as well as protecting themselves against larger financial risks for medical care. We've got to address the financing of this and entitlement reform and getting that right. We need to provide real incentives for the marketplace to respond to consumers with more affordable options, and that means moving power and control over payment decisions and spending decisions to consumers. That can be allowing them to decide the kind of health insurance they want to purchase, and to balance that with their other spending or other family priorities. And giving them the resources to be able to make those decisions. Thirdly, to give the states more authority to create that safety net, because states are so different, and their needs and their resources are so different. I just think that a "one size fits all" federal solution is not going to work. We need to empower the states to be much more engaged, to have much better information in order to be much bigger and better players in the safety net equation.

David: Our current policy for cost containment in health care is that every year three million lose private coverage, one million go on public plans, and 1.5-2 million go uninsured. That just doesn't strike me as a very good system. So that's the first thing, is providing coverage. The second thing, is to put in place a process for the delivery of medical care so that it is higher quality and lower cost. I think that the impact of this reform is going to be far greater than what the estimates are, because we are changing the incentives a lot, and those are not factored into any of the current estimates at all. So I think the impact on the delivery of care and on the cost and on the quality is just going to be immense. The third thing to do is to tackle some of the hard issues in society, which is going to help us in lots of margins. The fact that we've been able to do something for people is going to enable us to maybe raise the age of eligibility for Medicare, or go back and do new trade agreements, or do something, but the fact that we've actually done something for the lower class, for the lower- or middle-income people, I think it's going to have huge spillover benefits.

What do you see as the unintended consequences of the affordable care act?

Grace-Marie: We already see that now a third of employers are considering dropping health insurance. If you would have talked about that as a likely result of this legislation before it passed, I think people would have said "that's not what we want." We see health care costs likely going up faster than they otherwise would have. In all this, 500 billion dollars in new taxes on the medical devices industry, health insurers, pharmacy, [these cost increases] can only be pushed through to patients and employers in the form of higher premiums. I think that one of the unintended consequences is that it is going to destabilize the market for employer-provided health insurance. It's going to turn health insurers into basically regulated utilities. It's going to increase costs, and it's going to increase the federal deficit. And people are going to be very demoralized, because it's not going to achieve a lot of the goals that were promised. "If you like your doctor, you'll be able to keep your doctor." Not true. "If you like your health insurance, you'll be able to keep your health insurance." Not true. Employers were thinking that they would be grandfathered and protected from the provisions of this legislation, and we know from the administration's own analysis that 51 percent of employers are likely not to be able to be grandfathered. 80 percent of small employers—small employers facing the brunt of the high costs, the higher costs, and they were the ones who most wanted to see lower costs. So I see a whole cascade of unintended consequences, and at some point, Congress is going to have to put a firewall up and say we need to stop this and go back and rethink, "Did we try to do too much, too fast, all at once?"

David: The experience in Massachusetts is the opposite—the experience in Massachusetts is that it has stabilized the market. Remember that this was built without much in the way of cost savings to Massachusetts, just to cover people. The experience in Massachusetts is that more people have coverage,

CONTINUED ON **PAGE 26**

and more people have employer-based coverage, and by three-to-one, people are happy with it. So maybe the national reform will work differently than Massachusetts, but that is the evidence that we have to go on. I don't know if it's unintended consequences, but when you talk about costs, the Congressional Budget Office, when they did their costs, and the Medicare actuaries, when they did their costs, they didn't really know how to deal with any of the payment reform changes. They didn't really know how to deal with anything about accountable care organizations, or any kind of payment performed in Medicare, so as a result they assumed that those wouldn't save anything. According to their analysis, those provisions cost more money than they saved. Now, it may be that those are correct, and that all the payment reform that everyone agrees upon will actually wind up costing more money than it saves, or it may be that these things will actually work in the way that the vast bulk of the medical profession thinks they will work. And the vast bulk of the analyst community thinks that they will work, and that they'll wind up leading to enormous cost savings and value enhancements. Again, we don't know for sure, because we've never tried it on a big-scale basis, but I would put at least a fair amount of weight on what the people who work in the industry say, and how they describe the way that their life works and the likely impact of these sorts of changes.

Grace-Marie: As David says, the penalty to employers for non-compliance is not very high, but we're a law-abiding country. People don't want to break the law, especially employers. They want to comply, so if you say that you have to provide health insurance, they'll do it. And with those who signed up for insurance, especially through Commonwealth Care, it was heavily subsidized. The great majority of people who signed up for that were signing up for free, or nearly-free, coverage, so of course you're going to expand coverage among them. The fact that they didn't talk about costs, they just wanted to talk about coverage, now they're saying "oh my goodness, this is going to fail if we don't address the cost equation." Well, the cost equation has to be built into the structure of this so that you move toward a system that is affordable. But don't say, "OK, now we're going to come and deal with the cost issue," so what does government do? They say, "Well, we're going to do price controls," as they propose. What the governor is saying is that we are just going to cap premiums for health insurance—well, you can't do that, because that's illegal. So what are they going to do now? Price controls are their tool. If they don't fundamentally change the market forces, and they didn't do it in Massachusetts, I'm worried that they aren't going to do it in this legislation as well.

The British health care system was based upon the premise that all citizens should have access to care independent of their ability to pay. It has been said that the U.S. health care system does not have any founding basis like that. What do you think it should be, or it is already?

Grace-Marie: We don't have a system. The British National Health System is a system, a government organized entity, and is now more than sixty years old. We have a fundamentally different philosophy in this country about what our country is about. Theirs is solidarity and making sure that everybody is in it together, and we're all going to make sacrifices for each other. That's not the American ethic. The American ethic is freedom and independence, and yes, we are a compassionate people. We spent 300 billion dollars last year in charitable contributions. People want to help others. The whole question between equality and liberty is really fundamentally at issue here. In this legislation, we want to find a balance. We want to make sure that we take care of everybody, but that we to do it in a way that allows people to have freedom and liberty in their choices. And I worry that we have lost the liberty and we haven't really gotten to equality. I think we're still going to wind up very likely with a two tiered system in this country, because people with means and resources are always going to figure a way to buy their way out, and get what they need, and people in the system are going to have a harder time.

David: The very interesting thing is that everyone agreed that we need to save money. And as we're

talking about the recession, there weren't a ton of different ideas at that table on how to save money that weren't already floating around. Where there was a difference of opinion was the Democrats said that it's a social responsibility to make sure everybody is covered, and the Republicans said that we would like to see everyone covered, but we don't think we can afford it. That was basically the consensus.

Grace-Marie: I don't think that's right. I would disagree with that.

David: And I come down on the side that we as a country are rich enough that we ought to be able to afford to cover people. And I think it ought to be a right as an American to get health insurance coverage. I don't think that's the only philosophy, but I think that's a place where we are coming to, and I feel comfortable that the vast bulk of Americans are there.

Grace-Marie: You know, I talked to Republicans, and they, too, want us to get to a system where everybody has access to affordable care and affordable coverage. But we want to do it in a way that allows people many more choices in a much more competitive market that empowers individuals to decide the kind of care arrangements that work best for them. Not to have government tell them what they must do, or what they must have, or how much of their income they must pay for health insurance. It's just fundamentally opposed to what happens in every other sector of the economy.

Any final comments?

David: I'm actually encouraged when I go talk to all sorts of groups that oppose reform, or that were on the fence about reform, or that didn't know what they thought. All sorts of groups are starting to say, "OK, maybe I liked it, maybe I didn't like it, maybe I liked parts of it, maybe I didn't like parts of it, but now the job is to make it work." And that gives me some hope, because what I'm not seeing is "Damn it! I didn't like this part; I'm going to fight it." I was on a panel with the head of the hospital association, who said "Well, there were parts that we liked of course, and parts we didn't like, but our job now is to make it work." When you talk to physician groups, "our job now is to make it work." When you talk to health insurance, "our job is to make it work." And I'm cautiously optimistic that what we will do is make it work, and we'll find things that go right and we'll strengthen them, and we'll find things that go wrong and we'll fix them, and we'll find things that are unintended in a good way and we'll be happy, and things that are unintended in a bad way and we'll adjust to them. But that's really what our mission is for the next five, 10, 15 years—to take this and find a way to make it work for people. And as I say, I'm fairly optimistic with how it's starting out.

Grace-Marie: The American people didn't support this. You know you had 30 percent approval for passage of this legislation, so you've passed a major overhaul of the health care system with the majority of the American people opposed. I think that makes it so much more difficult for this to work and for people to accept it, and we are a law-abiding country. People aren't going to break the law. This is what we are going to deal with. President Obama is here at least until 2013, and maybe until 2017, and so they're not going to be able to override it. People want health reform, just not so much all at once with so many problems, with unintended consequences, that really works against the way that rest of the economy works. Power and control is devolving to Washington and to bureaucracies, rather than to individuals. ■

An Interview

with Matt Weinstein

By Doug Norris and Mary van der Heijde

Matt Weinstein

Matt Weinstein is the founding president of Playfair, Inc., an international consulting company that presents innovative team-building programs for more than 400 clients each year. He has appeared nationally on PBS, and is the author of many books and articles on the nature of work. As a keynote at the SOA '10 Health Meeting, Matt gave an engaging and powerful presentation on the power and importance of using humor in the workplace. We sat down with Matt to ask him some questions and allow him to share more of his thoughts with the *Health Watch* readers.

What would you say are the most common misconceptions or myths that people have about being serious or having fun?

The classic [misconception] is that people who are having fun are goofing off, and they're not taking their work seriously, and they can't possibly be productive if they're having a good time. The evidence is so overwhelmingly the opposite—that the "command and control" kind of management style burns people out, and after a while you don't have any creative thoughts, if you're just doing the same thing over and over again. You know, the classic nose to the grindstone. Sometimes taking a break, even though in the moment it may not be productive, people come back so re-energized and so full of new creative possibilities that you just leap ahead from there. I know it really is something a lot of people still believe, but only because they've not educated to the present realities.

We've been doing this work for 35 years now, and the old attitude used to be that work isn't supposed to be fun. That's why it's called work! But that has horrible consequences. You really have to think of what are you going to give people besides money to retain them and get corporate loyalty and get them to give you even more. It doesn't cost a lot of money to bring a sense of community, a sense of reward, of recognition or appreciation to the people there to let them know you care about them.

How would one go about changing the culture of their workplace?

I've written a number of books on this, and the basic one is called Managing to Have Fun. The idea of that book is that you try to do one fun thing a week. It's divided into 52 chapters and each one has one idea. You don't try to change it overnight. You take a whole year and you take 15 minutes a week and, boy, it looks so different! Who wouldn't want to be a part of that? Well, there are people who won't, but mostly you get them about the 30th, 40th week, people are excited about knowing what's happening!

What about techniques or ideas for reducing job stress?

The thing to remember is that everyone has a different idea of what's fun. So what's fun for one person is not necessarily what is fun for someone else. You can't just get a bag of tricks and dump them indiscriminately on people. You have to pay attention to your employees, and you have to say "OK, what are the kind of things that are fun to them?" Then you can do something that's specific to them that they can really appreciate, because they can see the thought behind it. The other thing about this, especially for people in management, is "YOU WILL HAVE FUN FROM NOW ON!" You have to model it. If you're not having fun, it doesn't seem safe for anyone else to have fun. People always look to their managers to set the tone. So this is something you have to lead by example.

Do you have tips for introverts about how to get out of your shell?

I was once on a cruise with all the Price-Waterhouse-Coopers partners from Canada. A three-day cruise. My friend said to me, "This is going to be horrible! Trapped on a boat with all those introverted accountants!" When the community, when the holding environment, feels safe, then of course people [will still be] introverts, but people are much more free to express themselves.

The classic work environment is unsafe for people. It's not about changing yourself. Who you are is fine! It's about changing your environment and what's acceptable and what's not. The end result of having fun at work is people feeling connected to each other, feeling a part of a community, feeling appreciated, and you don't need to be an extrovert to do that. In fact, many times extroverts take too much focus on themselves and it's much more difficult. A group of introverts hanging together can have fantastic results as long as they look out for each other and make it safe. This is not about performance; doing something where people look at you. This is more about paying attention to other people and making their life at work more appreciated. If everyone takes that as their mission, just the feeling inside an organization transforms. I won't say instantly, because it doesn't happen overnight. Change is not like an on/off switch, it's more like a dimmer switch. Tiny little increments, and then everyone starts getting the idea, and everyone does it. Then, a year later, "WOW! Is this the same company!?"

What about those old-school people that just don't want to have fun?

You try not to be bothered by them. If one of them is your immediate supervisor, you have a problem. But, there's a lot of literature right now. You can do an education campaign. When people are exposed to this idea, they think, "Oh yeah, common wisdom was totally wrong about this!" The title [of my new book] is "Work Like your Dog" and that's another common wisdom that's so ridiculous. People say, "I've been working like a dog. My boss is treating me like a dog." Have you ever taken a look at how your dog spends his day? That's a pretty good life, actually! We have a lot of things we say in our head every day that if we took a look at them we'd think, "Wait a minute, that makes no sense! We expect people to be more productive if we give them a hard time and make them miserable? How can that possibly be the truth?"

It seems so intuitive when you explain it in that fashion. I wonder why this has become conventional wisdom. Why do you think that is?

A lot of it is the Puritan heritage of this country. Back in the 1700s, if you acted the way I tell people to act, you'd be burned like a witch or something. Times have evolved a lot of our customs. They move slowly.

What do you think are the best ways for team building in a group? Is there a structured way to do this? Like you said, we can't command a group that, "we're going to have fun now, from 10 to 11."

There's no one right answer. Even groups that get together and have a rotating thing where every once a month we'll do something after work and one person picks what we do, and whatever that person picks we'll do it. Of course, those things can have wonderful effects! It's people, self guided, giving to each other, and experiencing what's fun for each other. In the book Managing to Have Fun, I write about this one company in California that has tasks no one likes to do. Getting rid of the toner. Taking the mail to the post office. Bank deposits. They write out all those tasks and put them in balloons. At the top of the day, everyone gets a knife and pops a balloon and whatever's in there, that's your job for the

CONTINUED ON **PAGE 30**

The end result of having fun at work is people feeling connected to each other, feeling a part of a community, feeling appreciated, and you don't need to be an extrovert to do that.

day. It's so random and silly and fun that people say, "OK, I picked it, I got it." Those things have the sense of everybody's participating. It's not like one person handing out the dirty jobs. People are very creative. . .

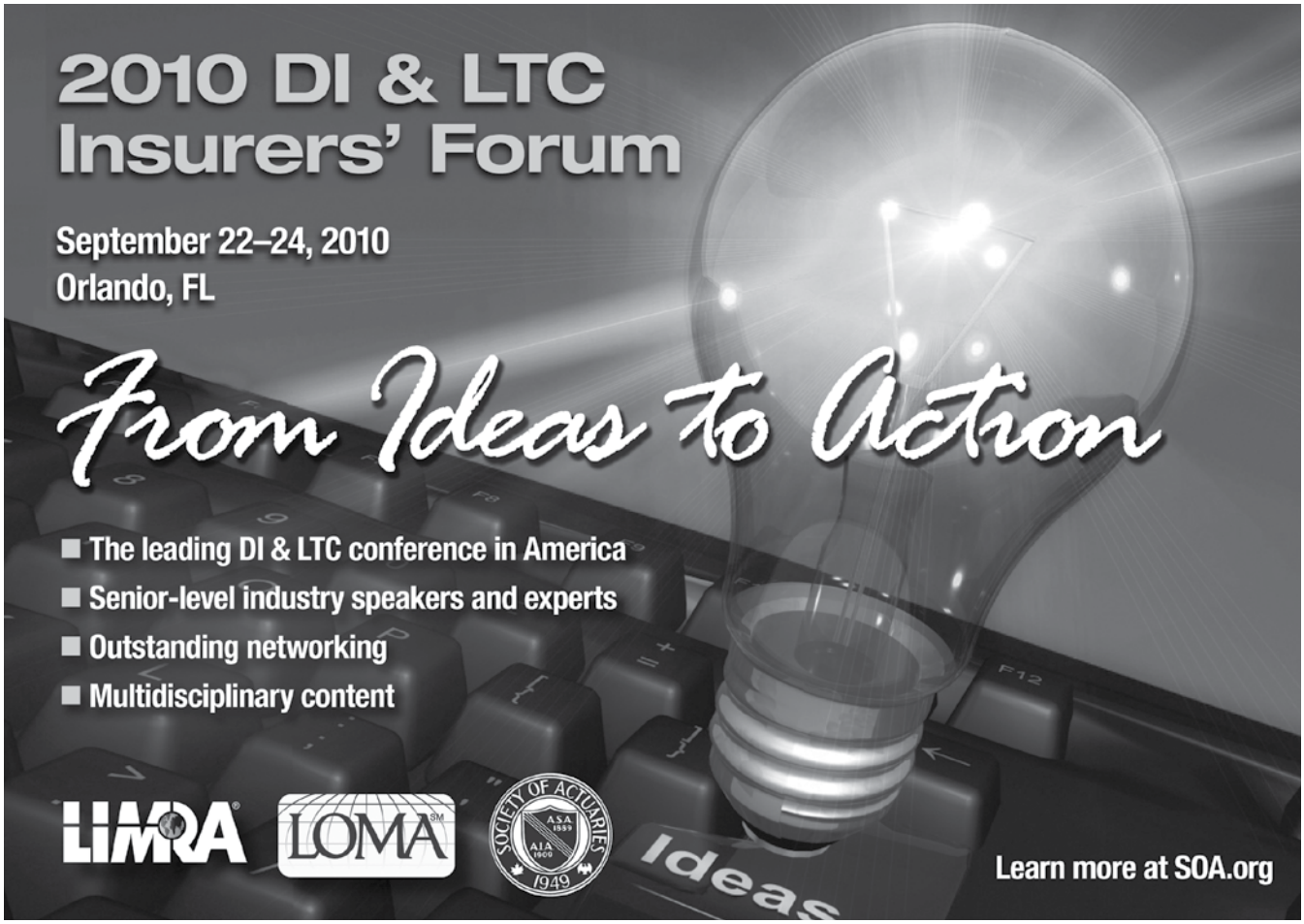
Is it possible to have too much fun in the office?

The short answer is yes, it's possible. But it's much, much, much more likely to have too little fun in the workplace. I would say the chances of you going overboard are not that great. The tricky thing is, under the guise of fun, a lot of people do some veiled hostility. They make fun of somebody, they say something that's going to be hurtful. "Aww, I was just joking! Can't you take a joke?" That's not fun, that's veiled aggression, veiled hostility. And that's very destructive. To understand what's the intention behind the fun is the important thing for people to see. If the intention was to bring people closer together, sometimes you go too far, but you're forgiven. If the intention was to be divisive, then you can't really call it fun. If someone feels hurt by the end of it, it's important to look at the result of what happens, but it's also important to look at the intent. ■

"Fun At Work Day"

Here are thirteen lucky ways to celebrate the day with your coworkers (graciously provided by Matt):

1. **Give each of your employees a (small) cash bonus** and go to the mall for a company shopping spree.
2. **Bring in a bouquet of flowers** and present it to one of your coworkers.Tell him or her, "I want you to keep this on your desk for the next half-hour. Then pass it on to someone else and tell them to do the same!"
3. **Ask all employees to bring in** baby photos or pet pictures or high school yearbook photos to post on the bulletin board. Then guess who's who.
4. **Hold a lottery** where the winner gets driven to and from work in the company limo. (If you don't have a company limo, rent one for the day!)
5. **Take some "joy breaks"** during the day where you teach all the employees the art of scarf juggling . . . or play marbles together.
6. **Hire an on-site masseuse** for the day to give chair massages on demand.
7. **How about clash dressing day** ... or dress in Polka dots day ... or Hawaiian dress day ... or Suspender Thursday ... or Pajama Day!
8. **Dog Days of Winter:** Let your employees bring their pets to work with them for this fun day celebration!
9. **Hide clown noses around the office** and announce a clown nose hunt.
10. **Bring in some champagne** (or sparkling apple juice) and take time to toast each other, your successes and your fabulous failures of the past few weeks.
11. **Have all employees switch jobs** for an hour. One employee gets this opportunity: "The company president does your job for the day—you train and supervise."
12. **During the lunch hour,** divide into teams of five, give each team a disposable camera, and send them out on a **photo safari.** Each team must bring back photos of themselves in unusual team building situations from the photo safari instruction list, like:waiting tables in a restaurant, sitting on a police car, running around a track, playing catch with a dog ...
13. **Hold an employee pizza party** ... with the name of your company spelled out across the top of the pies in mushrooms! Or have a popcorn pop off and tasting contest.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Transparency Leads Actuarial Survey of Trend-Benders

by Sara Teppema

Sara Teppema, FSA, FCA, MAAA, is staff fellow, health at the Society of Actuaries. She can be reached at *steppema@soa.org*.

A common criticism of the Patient Protection and Accountable Care Act (PPACA) is that the new law does not do enough to impact health care costs and their continued high projected trends. Recent articles in several prominent health care journals (including a *Health Affairs* article by SOA '10 Health Meeting keynote speaker David Cutler) have debated the PPACA's potential to moderate future health care trends.

This past May, over 600 U.S. based Health Section members participated in a survey about ways to "Bend the Cost Curve." In addition, the SOA fielded a brief survey of consumers to gauge their understanding and ability to bend the curve. So, where exactly do actuaries and consumers stand on this issue?

First of all, actuaries believe that health care needs to be more transparent in terms of quality and especially in terms of costs.

"The focus on transparency is essential for the future of the United States health care system, as pricing, effectiveness of procedures and quality of provider care are needed to help the medical community be more transparent in the ways in which to deliver care to patients," says Susan Pantely, FSA, MAAA, and Consulting Actuary for Milliman, Inc.

Table 1 conveys this belief, ranking the responses to the question *"From your actuarial perspective, please rate the below recommendations in terms of how effectively they will reduce the trend of either price or utilization (or both) for commercial (i.e., non-Medicare) populations."* Price transparency is the recommendation that was rated most often as "very effective."

In addition to transparency, the vast majority of actuaries believe that additional costs could be carved out of the system by combating fraud and abuse and reducing medical errors.

CHART 1

EFFECTIVENESS OF INITIATIVES FOR COMMERCIAL POPULATION

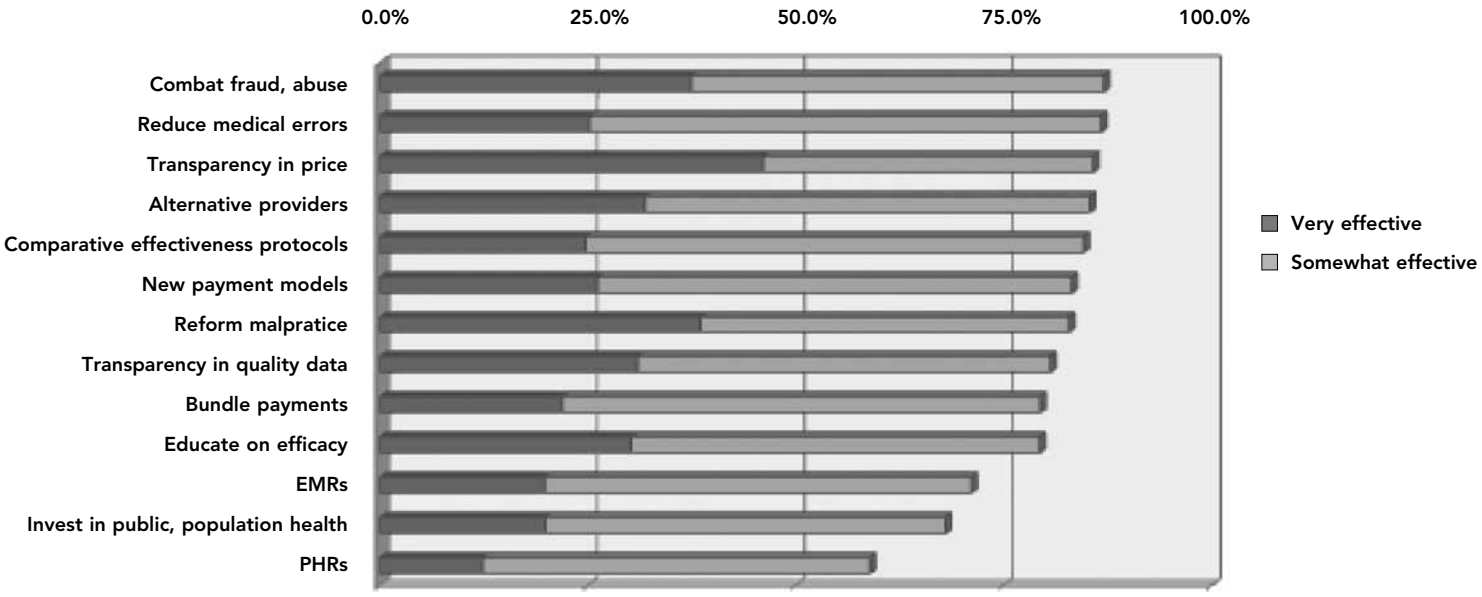
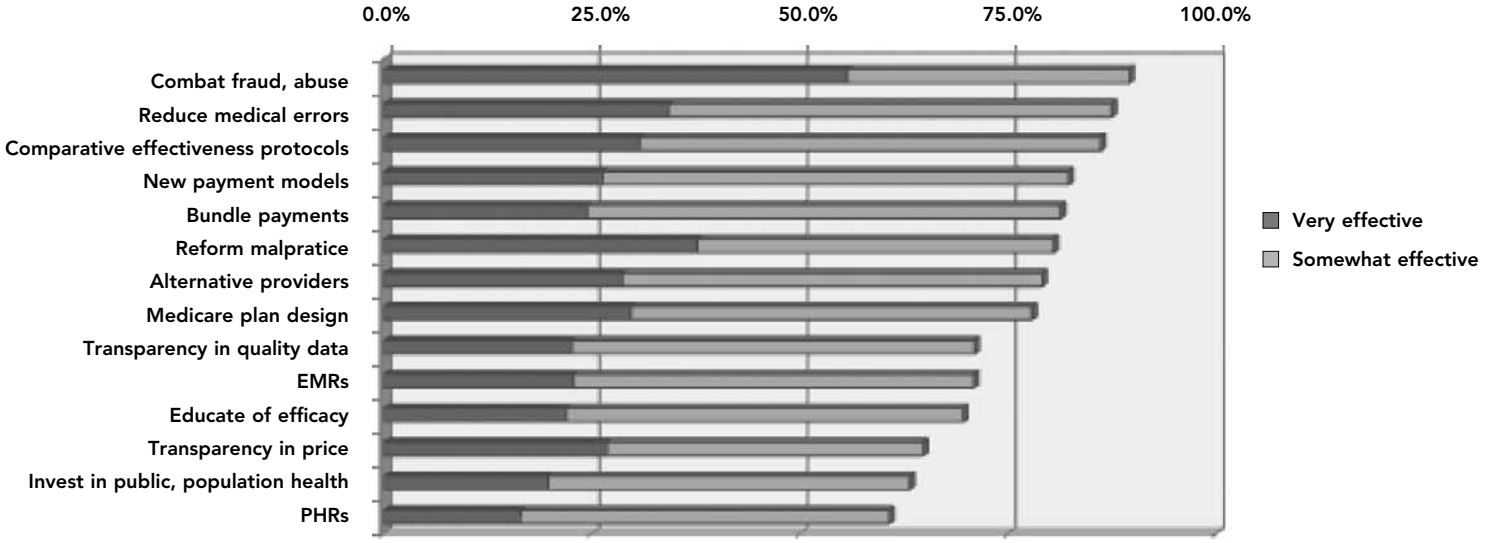


CHART 2

EFFECTIVENESS OF INITIATIVES FOR MEDICARE POPULATION



A large majority of actuaries believe that provider payment systems reforms can be effective to reduce trend. These include alternative providers (such as retail clinics, nurse practitioners, etc), comparative effectiveness protocols, new payment models (such as accountable care organizations), and bundled payments.

Worth noting is the fact that 39 percent of respondents cited malpractice reforms as a "very effective" strategy—this is the second-highest number of "very effective," after price transparency.

When the same question was asked of the **Medicare** population *("From your actuarial perspective, please rate the below recommendations in terms of how effectively they will reduce the trend of either price or utilization (or both) for the Medicare population,")* the responses show different priorities. As Chart 2 shows, reducing fraud and abuse is deemed the most effective way to bend the Medicare trend, with more than half of survey respondents saying that combating fraud and abuse would be "very effective."Medical errors is the next most-effective strategy (although fewer actuaries rated "reduce medical errors" as "very effective" than "somewhat effective"), and provider payment reforms such as comparative effectiveness protocols, new models and bundled payments are next on the list of effective strategies.

As was the case with the commercial population question, malpractice reform received the second-highest number of "very effective" responses for the Medicare population.

The survey asked for a response to several statements about employer-sponsored health care coverage: "Please rate your agreement with the following arguments for or against the effectiveness of employer-sponsored coverage to bend the cost curve downward."

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CHART 3

EMPLOYER-SPONSORED COVERAGE

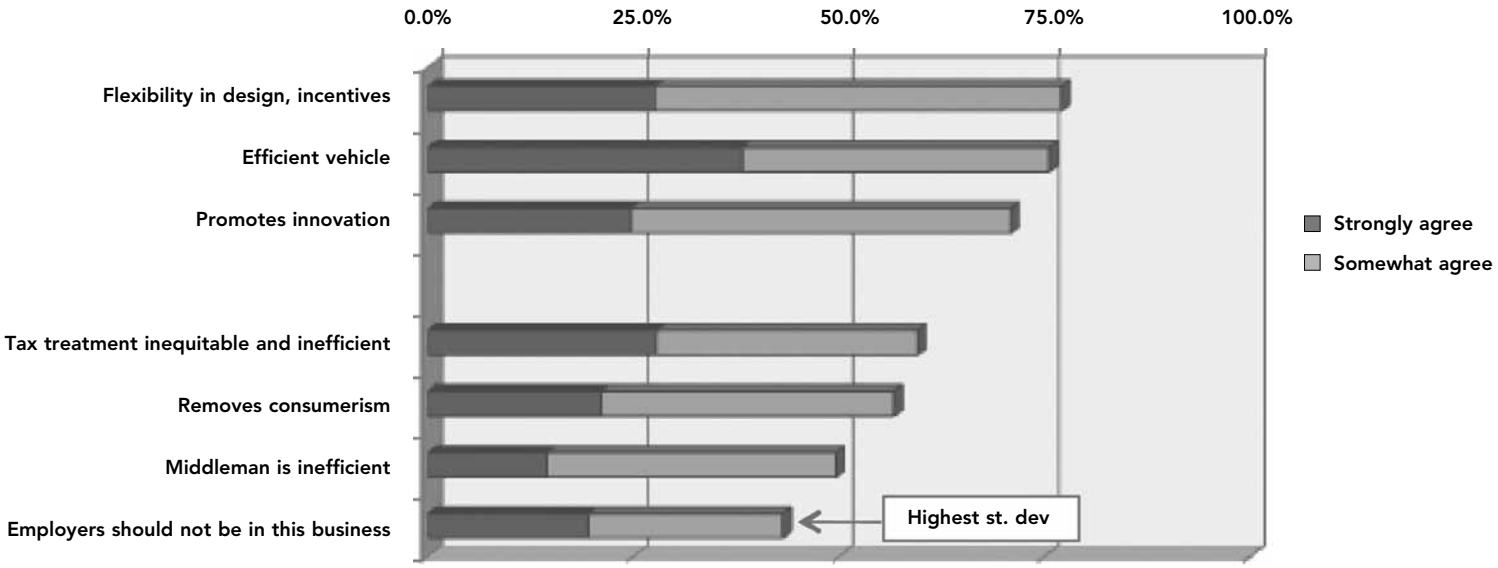


Chart 3 summarizes the level of agreement with several statements about employer coverage.

The top three statements demonstrate a level of agreement in favor of employer-sponsored coverage, and the bottom four statements demonstrate a level of agreement against employer-sponsored coverage. Graphically, it is clear that actuaries are generally in favor of employer-sponsored coverage, but not by an overwhelming majority. In fact, more than half of respondents agree that the tax treatment of employer-sponsored coverage is inequitable and inefficient. The last statement may be the most interesting: 43 percent of respondents agree that "Employers should not be in the business of providing health care," with about half of these in strong agreement. The responses to this statement, however, have the highest variance of all the statements, demonstrating that actuaries disagree considerably on whether or not employers should provide health care benefits.

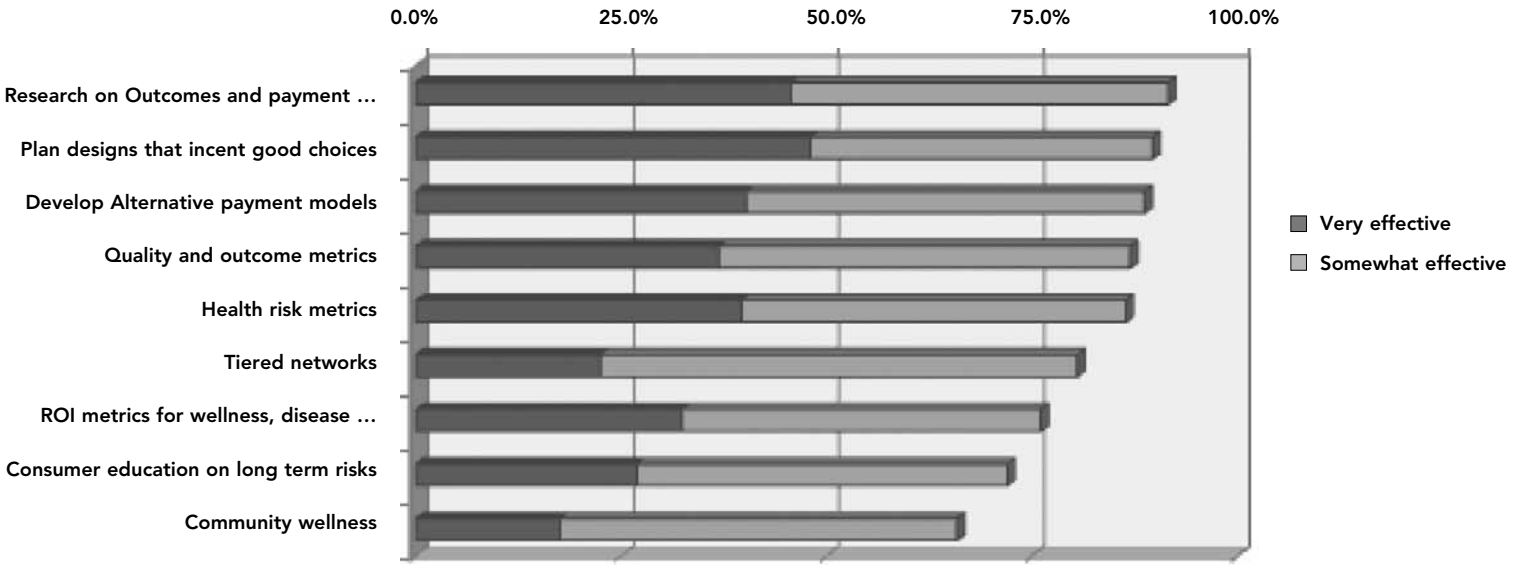
The last rating question was "Thinking of the roles in which actuaries may help individuals make better choices as patients and consumers, how effective are each of the following?"

Many strategies are considered to be effective in helping individuals, including actuarial research on outcomes and payment models, development of new payment models, and development of metrics for quality, outcomes and health risk. Nearly half of respondents think that a "very effective" solution is to assist in designing plans that incent good choices by patients and consumers.

Interestingly, this need was magnified by the responses from consumers. 1,000 consumers were asked to complete the following statement: "I would be able to make better decisions about my health if I …" More than one-third of responding consumers—35 percent—responded "There is nothing that would give me the ability to make better decisions about my health." Clearly this is an opportunity for actuaries to assist consumers in making the right choices through education, research and creative plan designs!

CHART 4

EMPLOYER-SPONSORED COVERAGE



In response to that same statement, 26-30 percent of consumers said that they would make better decisions about their health if they knew more about their long-term health risks (30 percent); if they had access to a wellness program to get information on nutrition and exercise (27 percent) and if they had better information to manage a medical condition (26 percent).

Consumers also responded to the statement "I would be able to better control my health care costs if…" And once again, the strongest response (39 percent!) was "There is nothing that would give me the ability to better control my health care costs."Other popular responses were "health care providers told me ahead of time about the costs and quality of services so I could choose my provider" (37 percent); and "My physician informed me ahead of time about the cost of a procedure, the number of times s/he has performed the procedure and the results, before administering the procedure" (30 percent).

Finally, 83 percent of consumers surveyed agreed (and just under half of these strongly agreed) that they "would be willing to participate in a program that encourages me, through financial incentives, to follow my prescribed treatment plan for disease(s) I currently have, as well as prevent future illness by following a healthy lifestyle."

The survey to the Health Section asked additional questions regarding respondents' opinions on the best and worst aspects of the PPACA, and what else is missing from the act. See future issues of the *Health e-News* and *Health Watch* for more reporting of these results.

I encourage you to consider how you may be of service to consumers and the public as health reform unfolds. A clear need exists to educate and engage patients and consumers! I welcome your ideas as to how the Society of Actuaries and the Health Section can further this mission as well. ■

Soundbites

from the American Academy of Actuaries' Health Practice Council

by Heather Jerbi and Tim Mahony

What's New

On March 23, President Obama signed the *Patient Protection and Affordable Care Act (PPACA)* into law, bringing to a close the legislative portion of the health care reform debate. With the enactment of PPACA, and the *Health Care and Education Reconciliation Act* that made a number of adjustments to PPACA, the Academy's Health Practice Council (HPC) turned its attention to the regulatory phase. After a broad call for volunteers, the HPC established a number of work groups charged with identifying areas in the law that need clarification through regulation. The objective of these groups has been to work with and provide input to the Department of Health and Human Services (HHS), the National Association of Insurance Commissioners (NAIC), and other relevant organizations as regulations to implement PPACA are being developed.

The HPC has focused immediate attention to those provisions in PPACA that go into effect in 2010 and 2011 including medical loss ratio and reporting, the new rate review process, grandfathering provisions, the temporary high risk pool, the early retiree reinsurance program, and many of the near term benefit and eligibility changes (e.g., prohibition on lifetime limits and extension of dependent coverage to age 26).

In April, the Academy began its outreach by meeting with representatives of HHS on several issues of interest including medical loss ratios, the premium review process, the creation of a temporary reinsurance program for early retirees, and the creation of a new voluntary long-term care program (commonly referred to as the CLASS Act). In June, the Medicaid Work Group also met with representatives of CMS regarding the Medicaid Managed Care program and offered assistance as CMS develops new regulations based on PPACA. The initial, formal communications from the Academy to HHS and the NAIC on some of these issues are highlighted below.

Medical Loss Ratio Reporting and Rebates

The Academy's Medical Loss Ratio Regulation (MLR) Work Group has been active since the enactment of PPACA, providing input to both HHS and NAIC. The group's work began with a letter[1] to Lou Felice, chair of the NAIC Accident and Health Working Group, which identified eight key questions related to medical loss ratios under the new Public Health Services Act (PHSA) Section 2718 that was created by PPACA. The issues identified in the letter were singled out because the work group felt they would be fundamental to the NAIC charge. They included discussion of the type of health insurance products subject to Sec. 2718, implications of "plan year," and whether there is some discretion to define if the requirements apply on a nationwide or state-by-state basis. On April 28, the work group sent another letter[2] to the NAIC that addressed statutory minimum MLR considerations and the potential disruptive impact that certain approaches to implementation could have on the individual market.

On May 12, the work group provided comments[3] to the NAIC in response to a specific request for input on defining an appropriate way to maintain statistical validity within the rebate process. The work group outlined three potential approaches for maintaining greater validity that could be used independently or in combination: aggregation of multiple blocks of business to enhance credibility, application of adjustments for statistical tolerance, and application of large claim pooling mechanisms. After considering the work group's initial letter, the NAIC asked for additional information related to the meaning of the confidence interval referenced in the first letter. As such, the work group submitted a second letter[4] on the issue of statistical credibility in response to that request.

In response to a public request for comments from the departments of HHS, Labor and the Treasury

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1 *http://www.actuary.org/pdf/health/letter_medical_loss_ratio_provisions_042110.pdf*

2 *http://www.actuary.org/pdf/health/letter_academy_mlr_individual_market.pdf*

3 *http://www.actuary.org/pdf/health/aaa_statistical_credibility_to_naic_051210_final.pdf*

4 *http://www.actuary.org/pdf/health/aaa_statistical_credibility_response_100520_final.pdf*

on the MLR provisions in PPACA, the work group submitted a detailed letter[5] on May 14. Some of the major issues explored in the 45-page comment letter include the dimensions of loss ratio variation, issues that are specific to the individual market, confusion regarding the statutory language used to define MLR for reporting and rebate calculations, aggregation and credibility issues, and timing concerns.

On June 7, the work group provided another comment letter[6] to the NAIC regarding the potential inclusion of a change in contract reserves in the numerator of the MLR rebate calculation. The letter discusses the need to consider contract reserves as a component of MLR to account for durational MLR variation in a market in which pricing is often based on lifetime rather than annual MLR.

Premium Review

Sec. 2794 of PHSA, which was created by the enactment of PPACA, requires the HHS secretary to work with states to establish an annual review of unreasonable rate increases, to monitor premium increases, and to award grants to states to carry out their rate review processes. In response to a request for comments from the HHS, the Academy's Premium Review Work Group submitted a letter[7], outlining a number of issues that need to be considered as HHS develops regulations to implement the new rate review process. Specifically, it highlights the need for any premium oversight mechanisms to be based on actuarial principles. Those principles include ensuring health insurance premiums are adequate to pay projected claims, expenses, and supporting risk charges; ensuring premium oversight is done in conjunction with insurer solvency oversight; and recognizing the need for appropriate risk-based capital levels. On May 8, the work group sent a similar letter[8] to the NAIC and included a proposed approach for defining reasonable/unreasonable rate increases.

Prior to the enactment of health reform, the Academy's HPC and Individual Medical Market Task Force released a new statement that addressed the potential for a new premium oversight mechanism. The *Critical Issues in Health Reform* paper, *Premium Setting in the Individual Market*[9], provided an overview of premium components, solvency requirements, the factors influencing premium increases, and the implications of additional premium oversight.

Early Retiree Reinsurance

The Academy's Joint Committee on Retiree Health provided comments[10] on June 3 to HHS on the interim final rule that implemented the new temporary reinsurance program for early retirees (Sec. 1102 of PPACA). The letter offered comments on the data requirements to file a reinsurance program, the requirement to project expected reimbursements for the first two years of the program, and the allocation of funding on a first-come, first-served basis.

Risk Adjustment

At the end of May, the HPC released a new issue brief, *Risk Assessment and Risk Adjustment*.[11] The issue brief provided an overview of risk adjustment, outlined how it is currently used in the health care industry, and discussed general issues for consideration when determining how to implement risk adjustment under PPACA. The risk-sharing mechanisms in PPACA will be addressed in more detail during the next phase of the Academy's work related to the implementation of health reform.

Other NAIC activities

On June 11, the Solvency Work Group submitted a letter to the NAIC's Capital Adequacy Task Force, responding to the task force's request that the group evaluate the current health risk-based capital covariance formula calculation for potential changes to the calculation or methodology.

The risk-sharing mechanisms in PPACA will be addressed in more detail during the next phase of the Academy's work related to the implementation of health reform.

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5 http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf

6 http://www.actuary.org/pdf/health/AAA_Contract_Reserves_060710_final.pdf

7 http://www.actuary.org/pdf/health/aaa_premium_peview_rfi_response_051410_final.pdf

8 http://www.actuary.org/pdf/health/aaa_prem_review_ltr_to_naic_050710.pdf

9 http://www.actuary.org/pdf/health/premiums_mar10.pdf

10 http://www.actuary.org/pdf/health/AAA_letter_on_retiree_reinsurance_060310_final.pdf

11 http://www.actuary.org/pdf/health/Risk_Adjustment_Issue_Brief_Final_5-26-10.pdf

CONTINUED ON **PAGE 38**

On May 21, the Health Practice Financial Reporting Committee sent a comment letter[12] to the chair of the NAIC's Blanks Working Group on the proposed changes to the Health Annual Statement Instructions related to actuarial opinions.

On May 17, the MLR work group provided comments[13] to the NAIC Health Care Reform Solvency Impact Subgroup on the exposure draft of a new proposed financial reporting exhibit—the Supplemental Health Care Exhibit. One of the purposes in exposing the exhibit it to delineate the NAIC's stance on appropriate definitions to be used in calculating MLR for federal rebate purposes.

Ongoing Activities

The Academy's Health Practice Council has many ongoing activities. Below is a snapshot of some current projects.

Health Practice Financial Reporting Committee (Darrell Knapp, chairperson) – The committee currently has one practice note on contract reserves under review.

Long-Term Care Principles-Based Work Group (Bob Yee, chairperson) – This work group has formed a joint Academy/SOA task force to develop and recommend valuation morbidity tables for long-term care insurance at the request of the NAIC's Accident and Health Working Group. The group is working with a company to help solicit the data for and determine the structure of the morbidity tables.

Stop-Loss Work Group (Eric Smithback, chairperson) – This work group is continuing to update a 1994 report to the NAIC on stop-loss factors, and is currently checking data calculations prior to restarting the modeling phase of their work.

Disease Management Work Group (Ian Duncan, chairperson) – This work group is in the final stages of developing a public statement on evaluating wellness programs.

Medicare Supplement Work Group (Michael Carstens, chairperson) – This work group has submitted recommended changes to the Medicare Supplement Refund Formula to the NAIC's Medicare Supplement Refund Formula Subgroup, of the Accident and Health Working Group, and continues to work with the NAIC to develop a refund formula.

Solvency Work Group (Donna Novak, chairperson) – The work group has been representing the health perspective for a joint project with the life and casualty councils on deferred tax assets (DTA). The purpose of the project is to review the risks associated with DTA in all three RBC formulas and evaluate the need for a risk charge for health DTA. The group submitted a preliminary report on June 15 and the final report is expected to be completed by September 15.

Academy/SOA Cancer Claims Cost Tables Work Group (Brad Spenney, chairperson) – The work group has been charged with evaluating and updating the 1985 cancer claims cost tables.

Health Practice International Task Force (April Choi, chairperson) – A subgroup of the task force will publish an article in the September issue of Contingencies on risk adjustment.

If you want to participate in any of these activities or you want more information about the work of the Academy's Health Practice Council, contact Heather Jerbi at *Jerbi@actuary.org* or Tim Mahony at *mahony@actuary.org.* ■

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[12] *http://www.actuary.org/pdf/health/Academy_letter_on_NAIC_Statement_of_Health_Actuarial_Opinion.pdf*

[13] *http://www.actuary.org/pdf/health/aaa_mlr_naic_letter_on_exhibit_051710_final.pdf*

To Err is Humamn; To Estimate is Actuarial

by Steven Siegel

Alexander Pope, the greatest poet of his age, who lived in the eighteenth century and wrote the famous line "to err is human, to forgive divine," might have sought treatment for his ailments using the cutting edge medical technology at the time—leeches. Although we might laugh (or be grossed out) at the primitive nature of such treatment in light of the incredible advances in medical science over the past three centuries, a sobering fact remains—errors in medical practice happened then and still do now. I hope those reading this article have never experienced or known first-hand the potentially devastating consequences of a medical error. Yet, the frequency of medical errors and their impact on costs to the U.S. health care system and overall economy is an undeniably critical component of the system that bears further examination.

Realizing the importance of medical errors on the U.S. health care system, the Health Section commissioned the Denver office of Milliman to conduct a research project to measure the annual frequency of medical errors and the total measurable cost to the U.S. economy of these errors. The genesis of the project was an idea from Jim Toole, former chair of the Health Section Council, who had been reviewing previous studies on this topic. Based on his vision for the project, a request for proposals was issued and the team from Milliman led by Jon Shreve was ultimately selected to do the work.

Using an extensive medical claim database, Milliman identified costs of medical errors in the United States of $19.5 billion in 2008. Of this amount, the vast majority identified (about 87percent or $17 billion) was a direct increase in the medical costs of providing inpatient, outpatient, and prescription drug services to individuals who were affected by medical errors. Milliman also identified increases in indirect costs of approximately $1.4 billion related to increased mortality rates among individuals who experienced medical errors and approximately $1.1 billion related to lost productivity due to short-term disability claims.

In terms of frequency, the claims database used represented a large insured population and was extrapolated to the U.S. population. The results of this extrapolation yielded an estimate of 6.3 million measurable medical injuries that occurred in 2008. For inpatient settings, seven percent of admissions in the claims database resulted in some type of medical injury. For purposes of the study, medical injuries identified in the database were translated into estimated medical errors using reference information found in prior studies and consultation with medical professionals. Of the 6.3 million injuries, Milliman estimated that 1.5 million were associated with a medical error. The total cost per error was measured as approximately $13,000, resulting in the total cost estimate to the U.S. economy of $19.5 billion. In addition, these errors resulted in over 2,500 excess deaths and over 10 million excess days missed from work due to short-term disability.

A few notes on the relative magnitude of the figures include that estimates of mortality costs and lost productivity are based on limited data and are likely to be underestimated, as both are limited to a one-year period following an error, and deaths are further limited to those which occur in the hospital. Furthermore, not all material costs related to medical errors can be identified through using medical claims data, such as pain and suffering. As such, the actual costs of medical errors could be much higher than is actually measurable.

I would encourage you to read the entire report which also contains an extensive appendix that details the development of the frequency and cost estimate for each individual type of error. The report can be found in the Health Research section of the SOA website at *www.soa.org*. One of the hoped for outcomes of this report is that the information will ultimately be used to help inform approaches and processes for reducing errors. In this regard, if you have any ideas for applications of this information or other thoughts, I'd love to hear about it. Please e-mail me at *ssiegel@soa.org*. And as Pope might say, while we, as humans, will continue to make errors, perhaps this information can help us reduce the occasions for the need for forgiveness. ■

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The U.S. Health Care Revolution

Give Me an Incentivized Provider Payment System or Give Me Death!

By John Dante

Note: This essay won first prize in the contest sponsored by the SOA Health Section.

The health care expenditures in the United States are currently more than two and a half times that of the average of other developed countries, and for the most part, we don't get what we're paying for. Our quality measures such as life expectancy and infant mortality lag behind those of these same countries. The two main goals of the recent health care reform legislation were to cover the millions of people lacking health insurance and to curb the long term growth of health care costs. However, according to the chief Medicare actuary, the legislation is actually expected to increase costs. The legislation is also going to make the world's most complicated health care system even more complicated. The time is ripe for a U.S. health care revolution that will lower costs and simplify the system. Provider payment reform is likely the best way to address this. Why? To quote a phrase that is incorrectly attributed to bank robber, Willie Sutton, "because that's where the money is."

Current State of the Provider Payment System: Taxation without Representation

Let me see if I have got this straight. You have this Fee for Service (FFS) system where a physician can maximize his profits by making sure that I stay sick. Then you have this discount system where the largest commercial insurers get the biggest discounts from providers thereby shutting the smaller players out of the market so there is less choice for consumers. Neither the providers nor the patients know what the prices are because there are so many different networks and payment arrangements. On top of this, the government gets the biggest discounts of all for older, disabled and low income people. When this government's group grows from high unemployment or aging Baby Boomers, cost shifting occurs. Since providers deem the government's rates to be inadequate, they shift or increase charges to the commercial insurers, employers and taxpayers to make up for the shortfall. Finally, the uninsured, who may be the ones that have the least ability to afford to pay for health care, are expected to pay 100 percent of the provider's rates (no discount). What am I missing? When you step back and think about it, why would any country create such a convoluted system? I think that it is definitely cause to start dumping tea in Boston Harbor again.

Who actually sets the prices under this system? Good question. Maybe understanding who pays is the first step in figuring this out. The government pays 50 percent of all health care costs and everyone else (insurers, employers, consumers, etc.) pay the other 50 percent. Since the providers are not happy with what the government pays, it looks like the government is setting the price for their 50 percent. Since the others negotiate prices with providers, it appears that the payers are more influential in setting the prices than the providers. Does this mean we don't have a free market? Some will say that health care is akin to a product like electricity whose price should be regulated. Others point out that we are the only developed country that doesn't have a budget for their health care expenditures. Who wants to sign a blank check for health care? These issues should be kept in mind as you read the rest of this paper.

National Fee Schedule: The "Shot Heard 'Round the World"

The health care revolution could start with a national fee schedule. Why not take some of the people across the country working for payers and providers who are busy every day negotiating fee schedules and have them create a single national fee schedule. The fee schedule would be a living document in that it would be evaluated and updated on a regular basis. It could have adjustments built in for things such as regional cost differences, types of provider, treatment complexities, etc. The fee schedule would be available at the offices of all providers and posted on the internet for all to see.

One of the major advantages of a national fee schedule is that we will finally know what our health care costs us. It would not be much of a leap from here to have physicians obtain our cost share information when they check our eligibility before we arrive, or even provide it for our considered treatment before we leave. We give up the convoluted system that shuts competition out of the insurance market and shifts costs from the government to everyone else. The uninsured will now pay what everyone else pays. A national fee schedule should simplify provider billing and the payment of claims as multiple fee schedules no longer have to be loaded into the systems of providers and payers. Usual, Reasonable and Customary (UCR) databases and balanced billing will also be things of the past.

Promoting Primary Care Physicians (PCPs): The Battle of Bunker Hill

Is anyone here a doctor? Fifty years ago, the percentage of PCPs was 50 percent. Today, 75 percent of physicians are specialists and fewer than two percent of today's medical school students are choosing to become primary care physicians. PCPs are not a happy bunch. Their compensation has actually been decreasing while their responsibilities and the required amount of paper work have been increasing. So many physicians are considering career changes that there are now consultants out there who are making a living helping unhappy physicians transition to other occupations. On top of all this, 34 million additional people are expected to be eligible for insurance and services in 2014. Can we help these physicians out before they become extinct? How about we take that national fee schedule and move some money away from the specialists to pay the PCPs more? I know of at least one other country where specialists make less in relation to PCPs than the United States, and I suspect that this is probably the case in other countries as well. Medicare has discovered that areas with a higher concentration of PCPs versus specialists actually have lower health care costs without a reduction in quality. While the physicians' share of health care costs is only 10 percent, they have control over 80 percent of the health care costs. Therefore, it is critical to enlist the help of the PCP to control health care costs.

Expanding the Primary Care System: Minutemen and Minute Clinics

We see many people using emergency rooms for conditions that should be addressed through the primary care system or for conditions that end up as emergency situations because of the lack of a good primary care system. How about further modifying the national fee schedule to support clinics and alternative providers such as nurse practitioners and physician assistants? Not all conditions need the diagnostic expertise of a physician. I realize that it may take more than just adjusting fee schedules to

make this happen as this has to do with how medicine is practiced, but I would think that any alignment of monetary incentives should help.
To further promote the primary care system by providing people with scheduling alternatives, how about paying a surcharge in the national fee schedule for treatments that occur outside of the normal Monday to Friday 9 a.m. to 5 p.m. hours?

If we are successful in creating a robust primary care system, it should help satisfy the demand for health care and rein in health care costs. Then our emergency rooms can return to what they were meant for, urgent care.

Integrated Health Systems – "Common Sense" by Thomas Paine

Let's get back to that faulty FFS system. How about we create a system that properly incentivizes providers? We should start by looking at the history of Medicare's Diagnostic Related Groups (DRGs), which is a single shared payment for each condition. This system originated in the 1980s when hospital costs were rising at unprecedented rates. Medicare decided to change their payments to DRGs where hospitals would get a single payment for a patient's entire hospital stay. The DRG payment covers room charges, medicines, physical therapy, blood tests and more. This change to DRGs resulted in a drop in cost and length of stay without any decline in quality of care. Physician payments were not included in DRGs.

Perhaps it makes sense to go one step further and create a single payment that would be shared by both hospitals and physicians. In 1992 to 1996, Medicare conducted a single payment demonstration project with seven hospitals for bypass surgery. The physicians received fixed fees and sometimes a percent of profit as well. Medicare savings were ten percent higher than expected through shorter hospital stays including shorter ICU stays. They also experienced lower drug costs. This demonstration appeared to be successful as they experienced a lower mortality rate and found that patients had higher satisfaction rates. Everyone involved in this project worked together as a team. However, in some instances, surgeons resisted the changes and savings were less. My understanding is that this could work seamlessly for some common diagnoses such as pneumonia, heart attack and congestive heart failure but may be more challenging for outpatient services as they require multiple doctors, radiology and lab services. If it can be successful in managing chronic illnesses, it would be addressing 78 percent of all the health care expenses in Medicare.

There are examples around the country (e.g., accountable care organizations, patient centered medical homes and other integrated hospital/ physician systems) where this concept is in place and producing good results. How about we use our national fee schedule to promote these? We could make payments more lucrative for the providers under these arrangements versus the payments for those working under the status quo. The maximum payments could be reserved for the most comprehensive systems (i.e., systems that have a large number of and varied types of providers so that patients can receive all of the care that they need within the system). Moving towards a single shared payment system would help align the incentives to keep our health care costs under control.

Evidence Based Medicine: One if by Land, Two if by Sea

It has been demonstrated that implementing best practices saves money and leads to more effective treatment. An example of this is what Geisinger Health System in Pennsylvania does for heart bypass surgery. Therefore, another way to properly incentivize the health care system would be creating higher payments for more effective treatments. A program like this would also be very beneficial with prescription drugs even though it exists in some plans already through tiering. Providers would make less for treatments that are not as effective, and hopefully this will mean that the additional costs will make their way to consumers in order to change behavior. However, I think that it is most critical to make sure that the greater payments for more effective treatments and medications result in lower cost sharing for patients. Aligning the savings incentives to impact

both the provider and patients must be done to make this work properly.

Pay for Performance: The Incentives are coming!

To complete the goal of an incentivized system, how about we implement a pay for performance program for providers? Monies could be set aside to pay for success such as quality measures, error reduction, successful diagnosis/treatment, etc. It would create a stream of additional income for providers when they engage their patients more and encourage healthy behavior such as checkups and flu shots. Hospitals would be rewarded for efficiencies such as low infection rates.

Risk Sharing Mechanism: The First Continental Congress

The last finishing touch on our new health care system developed through provider payment reform is a risk sharing mechanism for providers. This equalizing mechanism would consist of a risk transfer payment system so that providers will neither benefit from treating the mostly healthy nor get hurt from treating a large number of patients with chronic illnesses.

Putting it all Together: We hold these truths to be self-evident….

The transition to the new health care system using the above mentioned changes to the provider payment system will not be an easy task. We are talking about developing multiple programs that take today's health care payment dollars and moves them around in a lot of different ways. We will need to take from the resources that exist today in the provider community, insurance companies and government agencies to help create the system to make this happen. It will likely require some quasi-governmental agency to oversee this. In order to ensure that total payments do not exceed what we pay today, we will need the help of actuaries along with other statistical and financial people. The good news is that the system is set up to be self correcting if it works out as planned. The more we spend on these programs, the more likely we will see savings in our health care costs.

I expect that the greatest challenge in implementing the new health care system will be the resistance from those who are currently profiting from the existing system. They will likely bring up the same flashpoints that incited the public during last year's health reform debate: rationing, death panels, and interference with the physician/patient relationship. I think it would be best to continue to draw attention to what life will be like under the new health care system in order to push it through:

- Price simplification and actually knowing what the costs are.
- A robust primary care system that offers patients a lot of choices and is convenient to everyone's schedules.
- No more waiting for hours in emergency rooms.
- Physicians, hospitals and other providers who are more concerned about my continued health because they make more money when I am healthy.
- Less consumer cost sharing for more effective treatments and medications.

And finally, the item that we most urgently need in this country: Lower Health Care Costs for All! ■

"The time is near at hand which must determine whether Americans are to be free men or slaves."

- George Washington

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Providers: Reorganize and Refinance

By Jill Van Den Bos

*"I told the doctor I broke my leg in two places. He told me to quit going to those places."—**Henny Youngman***

Note: This essay won second prize in the contest sponsored by the SOA Health Section.

The short and long term functionality of the U.S. health care system is heavily dependent on the quality, and perhaps happiness, of its providers. To the extent that physicians get beaten up in the course of reforming the payment system, the overall health care system may face a shortage in the supply of qualified providers in the long run, particularly primary care physicians. This is good for no one. The viability of the system as a whole is dependent on the industry's ability to address the incorrect financial incentives that have encouraged expensive and sometimes poor care delivery by physicians who are understandably responding to these incentives.

The common reaction on the part of payers is to control costs by simply cutting physician and hospital fee schedules. The recent 21 percent fee cuts for Medicare physicians are a particularly harsh example. This approach, while reducing costs in the short run, does nothing to incentivize improved care or ensure the long-term health of the delivery system by enticing new physician entrants.

High quality care delivered in the most efficient manner should be the expectation of every insured individual in the United States, and it is health care providers who are ultimately responsible for making sure that we receive it. Providers need to be enabled and financially incentivized to provide the best evidence-based care possible.

In order for meaningful provider payment reform to take place, there must be provider organizational rearrangement. We need to move away from fragmented and piecemeal delivery of care to more organized providers better capable of delivering contiguous, high quality, and efficient care. It is within the context of such an organized approach to care delivery that payment reform and all its intended consequences can occur in a meaningful way.

I therefore suggest a two-pronged approach to implementing provider payment reform:

- first, health plans should seek to contract with integrated provider organizations that make collaborative, evidence-based medical decisions; and
- second, payment to members of these organizations needs to be organized primarily around larger episodes of care within which providers are enabled, and indeed encouraged, to practice good evidence-based medical decision making.

Provider Organization

Last time I visited a sports medicine physician after a minor wipe-out on the ski slopes, I didn't remember to say anything about the incident to my primary care physician, so no record of all that was done to me ever made it back to her. This couldn't be a good thing; she had no idea that I was taking Celebrex, for example. Shouldn't she? Lack of direct and obvious avenues for communication among providers caring for a single patient seems like an obvious lapse in good medical care.

Not only the availability of easy provider communications, but a provider organization with a culture of coordinated decision making and collaborative peer review should be the ideal for achieving quality, efficient patient care. This has been demonstrated in provider organizations whose care is both low cost and high quality. The Mayo Clinic, for example, exercises its focus on quality of care in a collaborative fashion. This feature is mirrored in another group of physicians in Grand Junction, Colorado which operates with collaborative peer review committees to study patient cases together. Both achieve very good patient care at low cost.

Payment Alternatives

The predominant current provider payment paradigm is typically called fee-for-service, but it really should be called fee-for-procedure. There are many services that are done, or that should be done, that

are not readily compensated under the current system largely because they don't have a procedure code. Payment tied to a code is part of the problem—this encourages, even necessitates, a piecework approach to billing and therefore to providing services. A consequence of the system is that providers who perform a lot of procedures (like surgeries or MRIs) are at a financial advantage relative to providers who perform services that are harder to capture in a billing code yet may result in better overall health outcomes (such as care coordination with multiple providers, or phone calls to follow up with patients). This can't be best for patients.

Think of the "care" received for your car after an auto accident. You don't pay different providers for their services, you take your car to one shop where the needed technicians, facility, and tools are present. And your insurance company writes one check, the amount of which is determined in advance by an insurance adjuster. The repair shop will get this amount only, and can pocket any savings realized by being efficient. Of course, if the repair is not done properly, the car owner will be back to have the repair done again. With auto repair, it is usually quickly apparent if the repair was not done correctly; many repair shops will even guarantee their work for some period of time.

While treating people is naturally a more intricate issue, involving the very complex human body and human psyche, much of the analogy is applicable. Payment for discrete episodes of care can be calculated in advance based on what services are called for to deliver the best evidence-based medicine for the patient and the condition, and global episodic case rates can be developed for these. What makes use of this payment algorithm particularly appealing for inpatient care and outpatient surgeries is the readily definable start of the event and reasonably definable time period that the case rate should cover. What further makes this payment method appealing in these cases is the cost associated with care that has a facility component. If the providers in question are organized into a cohesive provider organization, use of a global episodic case rate seems all the more functional.

Not all care falls into a category that is easily billable. For those services that could be provided by a physician in a care coordination role, which I believe has clear value, a monthly fee per patient assigned has been proposed as compensation and I endorse this concept.

Generally, more health care procedures do not equate to better health care outcomes. Some excess is simple fee-for-procedure entrepreneurship—waste. Some excess is downright harmful. Back surgeries to relieve pain, for example, are in most cases no better than nonsurgical options. Yet 600,000 of these back surgeries are performed each year, as reported in a *New York Times* article highlighting medical practices that run contrary to evidence. Undoubtedly, some care is given due to pressure from family, even though the physician knows that it won't benefit the patient.

Just as CMS and other payers have put a stop to payment for "never events," I propose putting a stop, or at least a big slow down, on payments for expensive end-of-life treatments that are not recommended standard of care and are not shown to have much chance of being effective treatments. While quantifying the impact of this particular restriction is difficult, I know that overall end-of-life cost of care is enormous. In November 2009 CBS did a story reporting that, in the last year in the United States, $50 billion was spent on care in the last two months of life. Of this, it was estimated that 20 percent to 30 percent of these expenditures had no meaningful impact. It is in this cost that I hope to see providers, and society, empowered to make a dent.

Make no mistake, I do not advocate withholding care for critically ill patients, but I do advocate making it much easier for providers to say no to a request or to resist the inclination to try expensive new treatments with low proven probabilities of success. As uncomfortable as this topic this is for many people, I believe meaningful provider payment reform should address it.

My Vision

I can envision full payment reform having both revolutionary and evolutionary elements. I will discuss the former—those elements that I believe should be addressed first, and immediately. Other features

should develop over time.

1. Providers need to combine themselves into integrated care-giving, decision-making organizations. I believe the "lone physician with his shingle out" model, or even separate groups of physicians, is not conducive to efficient care but rather results in a patchwork of care that may or may not provide what is best for patients. Further, the patchwork arrangement is not conducive to the types of payment that promote the best care.

   For these provider organizations to be most effective, I believe they need to include both physicians and a hospital—the "extended hospital medical staff" described by Fisher and colleagues in *Health Affairs* in 2006—as the basis for an accountable care organization (ACO). Such an alliance of providers is best poised to deliver fully vertically integrated care to its patients. As it turns out, the health care reform legislation, both at a federal level and in some states (e.g., Colorado), is encouraging the development of ACOs for the treatment of Medicare and Medicaid insureds; providers are moving to assemble themselves into these organizations already. Commercial payers, too, can contract with such organizations to the betterment of the health care provided to their patients.

   Having all the players in one place, these groups can focus on quality and efficiency of care for their patients. The presence of a spectrum of expertise with aligned goals seems a far better opportunity for providing organized and rational patient care than does the current model. Having a collaborative decision-making element, perhaps functioning in a peer review capacity for difficult patient cases, would be all the better.

   Note that some legislative changes may be needed to facilitate the ability of providers to create ACOs, including antitrust and insurance law.

2. Properly organized providers will contract with health plans using global episodic case rate payments for hospital inpatient cases and outpatient surgeries where an index date and end of care are readily definable. Later, other types of care should also be covered by case rates as the industry gains experience with the method.

   Such case rates are good payment mechanisms for providers for two reasons. First, properly calculated case rates will be severity-adjusted, accounting for all the care needed to conform to best medical practices (with margin for complications); this will align incentives between the payer, provider, and patients. This alignment is largely missing in the current reimbursement environment. Second, properly calculated case rates leave the medical care decision making in the hands of medical providers, where it belongs. Providers who stay abreast of what constitutes best practices will benefit from this compensation method. Others should quickly learn to stay up to date in their patient care, to the benefit of us all.

3. Payment of a severity-adjusted monthly case management fee for the care-coordinating provider, whom the patient will choose and must remain with for a prescribed period of time. This physician will be the go-to provider for this patient, overseeing care by all providers of care for the patient, making phone calls, etc. This case rate will compensate the care coordinator for the effort that falls outside of the typically billed face-to-face patient visit, providing a financial incentive for the care coordinating physician to perform and really own this function. This person, in many cases, will be a patient's primary care physician, although for a chronically ill patient more likely to frequent a specialist that provider might be most appropriate.

4. Services not covered under items 2 or 3 above would be billed on a fee for procedure basis as is currently done. Over time, this bucket of "leftover" services should diminish as global case rate development becomes honed. At the end of the plan year, the total per patient rate of all compensation paid to providers in the ACO,

including all types of payment—case rates, case management fees, and fees for individually billed services, can be compared to a total age/gender/severity adjusted per member per year target and any savings experienced compared to the agreed upon target will be shared between the health plan and the ACO, much like what is recommended in the PPACA.

5. Treatments that are not standard of care for terminally ill patients should be subject to a risk-taking penalty. Any non-standard curative treatment that does not have evidence showing a mean extension of life of at least six months will be considered subject to a performance guarantee clawback. If such a treatment is used and the patient dies of the condition treated (or the treatment itself) within six months of the treatment start date, the treatment will be deemed ineffective and payment for that treatment will be reimbursed to the health plan. Health plans can review the clinical studies to determine what new treatments should be on this list. This stipulation should provide a disincentive for frivolous use of treatments that are experimental, and/or not demonstrated to be reasonably effective.

In summary, provider payment reform must simultaneously accomplish the goals of improving efficiency and quality for patients while allowing providers to focus on their core expertise of practicing medicine. At the same time, some element of accountability must be present. The changes outlined above steer providers in this direction without relying on previous methods of cost containment focused on simply cutting reimbursement rates or shifting risk. Instead, these changes steer providers toward approaches that stress professional collaboration, adherence to evidence-based care, and avoidance of costly and potentially ineffective care near the end of life when trying such options becomes tempting. ■

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Escaping the Addiction

From Preferred Payer to Rational Pricing

By Hobson D. Carroll

Note: This essay won third prize in the contest sponsored by the SOA Health Section.

How do you want your doctor to be paid? Answering this question is crucial to get at the heart of any health care financing system and to help identify what features of provider compensation are potentially compatible with that system and which are not. It is just as important, however, and perhaps more so, to state and define the general rules we need to be able to choose amongst alternatives that might be put forth in answer to the question.

So, how should our doctors get paid? Given the human tendency to a self-serving bias, a truly honest answer often boils down to something like: "I am happy for *your* doctor to be paid on some basis that holds cost to society to a minimum, but *my* doctor should be paid whatever it takes so that I can have the best care possible." But even this answer begs a series of questions: what should the mechanism be? Should they be paid a salary within a larger organization? Should we allow private practice, or should all physicians be employees of the state?

Thus far, attempts to answer these questions have failed because there is no true way to measure the cost of health care. All sides of the reform debate to date have talked about the need to bend the cost curve. Part of the problem is figuring out what the cost is, and that is one of the reasons no one seems to have come up with a set of proposals that will bend that curve, at least as consistently reported from the GAO every time they analyze the latest package or bill. By leveling the playing field for the basic economic transactions of health care, we allow for creative and innovative solutions to function in their ability to impact cost levels immediately and with lasting effect. Arguing about benefit levels, preventative care, package pricing, who is covered, and (heaven help us) establishing *commissions* whose purpose is to control costs by controlling the inexorable rise in the Medicare *budget*, etc., all miss the target because they aren't even taking aim.

Considering our historical and current financial dilemmas within the health care system, we need an additional reform that will establish the principle rules necessary for making rational choices. By constructing an appropriate, logical formulation for evaluation of financial parameters, we may choose one or several of the provider reimbursement schemes that will positively impact our health care provision system. If the rules are fair, rational, and consistent, the winner, or winners, will evolve naturally. What is needed is a proper metric and a structure in which it is allowed to function.

At the core of the myriad problems woven through the current health care financing system is the fact that there is no basic, fundamental, usable "metric" for evaluating alternatives for care provision, treatment protocols, or financing options. The ideal economic transaction, whereby money is paid by a patient to a provider for a medical service, which would allow the determination of such a metric, has been shunted aside. And what replaced it? Payment by third party payers, be they a government program, one of the jumbo health plans/carriers, or a small regional insurer or local HMO.

The combination of the historical development of Medicare and the government's regulation of it is the major culprit in creating this displacement. I do not for one minute discount the positive results that Medicare has accomplished in terms of lifting the economic burden from the elderly since its enactment. I aim to remind society about what the program has cost, what it is costing, and how it has resulted in a disruption in the general health care financing sector of the economy.

Currently, Medicare fixes prices, denies variation based on quality differences, causes a huge cost shift to the general economy, and allows the government to feign control of health care costs. The differential by which Medicare underpays providers equates to a massive tax on the economy. Congress avoids responsibility through controlling a *budget* rather than actual costs because they are trapped in a vicious cycle. They dare not increase taxes directly to cover the true cost of benefits, cut the benefits provided, or increase user premiums because none of those choices are politically palatable. Instead, they ratchet down the screws on providers, and then,

to put icing on the cake, claim that they are controlling health care costs, when they are merely playing with figures in a budget.

The government plays the "pusher" in the analogy where Medicare has transformed providers into "revenue addicts." It started when providers discovered the euphoria of having a steady and reliable revenue stream in the early days of Medicare, when reimbursement was essentially at a fee for service level. Compared to the traditional difficulty of collecting bills directly from elderly patients, Medicare was like the pleasure of the first hit. As the population of senior citizens covered by Medicare grew, and Medicaid programs also came into being covering a more demographically diverse population, this stream of government revenue became an important part of providers' income, too important to ever turn down.

The resulting negative impact on the Federal budget provided the impetus for a change in the reimbursement methodology from fee for service to something else, something that would allow for more control on the part of the government. In other words, they needed a way to "cut" the strength of the revenue stream. The result, after the initial implementation phase when the goal was largely one of revenue neutrality in order to "set the hook," was a mechanism that provided exactly what the Congressperson—I mean the doctor—ordered: a way to control the budget impact of Medicare financing, and in a manner that hid the true cost of the program.

Medicare patients simply made up too big a chunk of their business flow for providers to escape the trap. They had become fully addicted to the steady, if now lower strength, flow of funds from the government programs. In order to feed their habit, providers had to make up the revenue loss that those cuts represented by getting money elsewhere to cover the deficit created by the too-low payment rates of the government traffic. (In the analogy, providers are like addicts who go steal stuff from the neighborhood in order to pawn it to get the extra cash they need for their next fix.) For decades now, the providers have cost shifted to non-governmental payers of services in order to make up for the Medicare and Medicaid deficiencies.

This historical cost shifting produced the inexorable upward spiral in *billed* charges by providers; currently, the bill master is a concept that has no realistic relationship to actual cost in most situations. If the government programs were paying a fair rate of reimbursement to providers (leaving aside the issue of value for different quality of services), then why shouldn't the rest of society have been able to pay something similar? If they were not paying a fair rate, then why have we let the government get away with it?

Why weren't the providers yelling and screaming considering they were being so materially shortchanged by such an important source of income? Probably because they had a false sense of security from their now routine addiction—the steady injection of the revenue they received, even though it kept getting increasingly diluted each time Congress ratcheted down the payment schedules. And what about senior citizens? They have most certainly been co-dependent on the addiction. Senior citizens do not want to lose what has become an entitlement, regardless of the price to the rest of society. Can you blame them? It is one heck of a good deal! And their political power completes the circle of addictive contagion, freezing the politicians who control

the Medicare provider reimbursement button into political cowardice; we are stuck in a rut of a dysfunctional system. And you know the difference between a rut and a coffin? The lid.

The inertia on the part of both parties in this distorted transactional structure reflects a "preferred payer" system that causes disruption, disinformation, and destruction to the limited market system that has been allowed to barely survive in the health care sector. What the government does and what the large health plans have done in their own version of cost shifting has created a system with no controls on the increase in the infamous "bill master." Because of the lack of logical rationality and transparency in pricing, there is no economic equilibrium through competitive supply and demand. Current bill masters and fee schedules are useless instruments as guides to actual costs and prices; they have no value as a metric.

How do we accomplish truly effective change through establishing a valid, usable metric? Firstly, require that all providers establish their pricing schedule however they wish. The pricing, however, must be applied consistently to all comers. (An alternate approach for hospitals and other facilities is to use some variation on the Maryland hospital commission system for establishing the rate/bill schedule by facility.) To facilitate comparison and allow for quality and effectiveness analysis, the "format" of the fee schedules will need to be regulated. For example, a template similar to the current DRG system for hospitals and the RBRVS system for physicians could be utilized, but sufficiently robust and dynamic to allow for change, variation, and innovation. The key is that providers will be free to set their own rates/prices by item in the template to reflect quality and market conditions as they see fit. (In any such approach, an "emergency care" feature should establish an all-payer charge basis that must be accepted as the allowed charge by all third party payers as well as the providers. Appropriate legal and contractual definitions of what comprises such care will need to be established, but that should be straightforward in applying to the large majority of relevant situations.) The fundamental principle holding sway is that there can be no discounting allowed for third-party payer affiliation, including any government program.

While providers are given freedom to establish what they charge, the insurer/health plans and the government programs will be free to establish whatever schedule they will allow for non-emergency care. Third-party payers will not, however, be permitted to pressure or negotiate with any provider to accept any amount as total payment unless the provider agrees to the same for every patient they have for the same service. Note that there is nothing here that suggests that third-party payers *must* agree to pay benefits based on whatever a provider's charge schedule happens to be. Third-party payers *may* pay benefits on that basis, however. The price set by providers for services rendered to their patient must, however, be the full charge submitted to any third-party payers involved with that patient.

This scenario redefines the role of the patient in his/her interaction with the provider as regards the economic transaction from the assignment dynamic of recent decades. Any insured patient will be responsible for any benefit cost sharing such as copayments, deductibles, and coinsurance. In addition, the patient will be responsible for any "non-eligible" amount of the charges being made, which can arise either from services not covered by the benefit plan, or provider charges that exceed any defined maximum schedule set contractually (in the benefit plan agreement) by the third-party payer as *allowed* charges. Thus, *balance billing* will be an essential feature in such situations, though providers are allowed to discount or waive net amounts owed by patients *only after* the claim has been processed (and policy cost sharing elements applied) so that the total final amount reimbursed by the third party payer is already a known quantity. This will allow true consumerism in the marketplace, will serve as an arbiter of quality and its value in that marketplace, and allow true competition between third-party payers (private insurers), vendors of health care utilization services, etc.

Such an environment allows for substantial flexibility in the design of different provider reimbursement structures, including traditional HMOs, scheduled benefits, and packaged or global pricing initiatives. True "value for money" networks of providers can be established instead of the current "preferred" provider networks. None of these need run afoul of the required principles of rational pricing espoused herein. Innovation and creativity will have a playing field on which to flourish and not be totally shackled, as has been the case for decades.

Critics will decry the imposition and unfairness of balance billing, and that people reliant on government programs will be reduced to receiving services from low cost (read "low quality") networks of providers. Isn't this what is already happening to Medicaid and even Medicare patients in many communities? Rationing of care is inevitable, at least for the foreseeable future and in any reasonable scenarios of provision and financing. There is rationing of access to care (whether or not it is available at all) and then there is rationing in quality. An egalitarian position will demand that no class subset of society be favored in obtaining access to services or the best levels of quality of those services. Practical people will recognize that human nature demands that there be variability. And while it might be possible to more or less guarantee access to service at a satisfactorily minimal level (and we should most assuredly work to accomplish this through universal coverage initiatives), guaranteeing access to the "best" service is simply a non-starter—as they say in some regions of the country, "That dog won't hunt." The only mechanism that can reasonably sort out how quality and price can be brought into a workable equilibrium is a moderately regulated but essentially free market system. We can address perceived inequities through other means, and where the efforts can be accurately measured (income tax subsidies, vouchers, etc.). It is vital to discontinue the disruption to the economic equilibrium of the health care sector by price-fixing and coerced provider participation as has happened heretofore.

With rational pricing rules implemented, our myriad problems can be addressed anew without the distortion of the old habits. Then, and only then, will alternative concepts and ideas for reforming provider reimbursement become both viable and measureable. Then we can identify what works and where, which is not possible today because the landscape is socked in with the fog of obfuscation created by our lack of a rational pricing mechanism. Then we can require standardization of medical records, technology and administration, etc., and measure the impact. Then we can save billions in administration costs because providers will not have to maintain dozens of price schedules. Then we can escape the addiction to the "preferred" payer. ■

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Provider Payment Reform

An Accountable Care Approach to Alignment of Health Care Goals and Incentives

By Mark Florian

Note: This article was deemed Best Article written by a Health Section member who has been employed five years or less as an actuary in the Health Watch *Article Contest on Provider Payment Reform*

Introduction

While most people would agree that quality of care, efficiency, and cost effectiveness are desirable traits for a health care system, the dominant modes of provider payment conflict with these traits. Traditional capitated arrangements incentivize doctors to provide the least amount of care as possible and often lead to patient dissatisfaction. The downfall of many HMO-style health plans in the 1990s clearly demonstrated that most Americans are not willing to trade choice and quality for cost savings. Traditional fee-for-service (FFS) arrangements have the opposite problem. These arrangements incentivize providers to perform as many services as possible, even when less costly alternatives are available. FFS arrangements have contributed to double-digit medical trends, resulting in unreasonable premium rate increases. These rate increases coupled with the recent economic recession have made health insurance unaffordable for many individuals and employers. This environment spurred the passage of the health care reform legislation earlier this year.

While the purpose of the new legislation is to provide affordable health care for all Americans, most of the provisions will actually make health care more expensive in the near term. These provisions include dependent coverage up to age 26, the elimination of member cost sharing on preventive care services, and the elimination of annual and lifetime benefit limits. While most in the actuarial community would agree that restructuring the provider payment system is a crucial aspect of health care reform, there likely are as many opinions on how to achieve this reform as there are actuaries. It is clear that without a dramatic change to the provider payment system, the goals of health care quality, access, and affordability will remain out of reach and the legislative efforts towards health care reform will prove fruitless.

I am proposing a system that returns to a more capitated form of provider payment that capitalizes on some of the changes brought about by PPACA and HCERA. An overnight across-the-board change in provider payment policy would be both undesirable and unachievable. Rather, this system must be industry-driven, not imposed by state or federal government. The ideal implementation approach would consist of a pilot program whereby a carrier forges a partnership with the dominant physician group in one particular community. This would allow the carrier to limit its risk during the evaluation stage, and would also allow the carrier to compare the experience in the pilot community to the rest of its block of business to determine if health outcomes were improved and costs contained.

A 'Twist' on Cap: The Accountable Care Organization

An effective provider payment system must be financially sound and create appropriate incentives which align with the goals of quality, efficiency, and cost effectiveness. One of the chief complaints in the provider community with regard to capitation is a lack of equity. Two physicians may each be responsible for 100 patients and thus receive the same income, but one physician may be fortunate enough to treat mostly young, healthy individuals while the other sees primarily elderly, chronically ill patients. In order for a capitated system to work, the payments must be risk-adjusted. I propose that higher capitation rates be paid for the elderly and for individuals with chronic disease. This system ensures that the providers are adequately compensated for caring for people of all ages and health statuses.

In addition to paying capitation fees to the physician group, the carrier will set aside funds to cover hospital costs. The amount of money in the fund should be equal to the expected hospital costs for the population. A stop-loss arrangement will be included to prevent one or two shock claims from exhausting the hospital fund. Most capitation arrangements include some form of a bonus program. The bonus program for this system will be based on several criteria:

(1) The maximum bonus payment is a percentage of the amount remaining in the hospitalization fund at the end of the year. The insurer will retain the other portion of the savings.

(2) Bonus payment will be contingent on achieving a certain level of compliance with services recommended by the U.S. Preventive Services Task Force as outlined in PPACA.
(3) Bonus payment will also be contingent on improved health care outcomes and overall provider performance.

Item #1 is fairly straightforward and typical of a capitation arrangement, as it gives the physician incentive to treat in a way that emphasizes preventive care in order to avoid expensive hospitalization. It is an equitable system because it allows the physician group to share in the cost savings with the insurer.

Item #2 capitalizes on the efforts of PPACA to encourage wellness and preventive medicine. Under PPACA, all benefit plans sold after Sept. 23, 2010 will provide preventive care services at no cost to the policyholder. This clearly incentivizes the patient to seek preventive care services with no cost sharing now and avoid potentially costly treatment later. Current fee-for-service provider payment conflicts with this incentive, whereas this new payment system effectively aligns the incentives of the insurer, the providers, and the patients.

Item #3 ensures that cost savings is not achieved at the expense of quality. Several different quality measures could be used, but it is important that they be easily understood by the insurer and the physician group. The important concept is that the bonus payment will be contingent on adherence to nationally recognized standards of care and on achievement of positive health outcomes. Patient satisfaction is an important measure of the performance of the system, and should be factored into the bonus payment calculation.

Items 2 and 3 should lead to new outreach mechanisms initiated by the provider group. In order to receive the bonus, the physician group will have to more actively manage its patients to ensure they are complying with the prescribed treatment and current on all recommended preventive care services. Attaining buy-in from the provider community is a critical ingredient to shifting the emphasis from treatment to prevention.

The bonus program should not be an "all-or-nothing" arrangement. Rather, a minimum level of performance should be required for payout, and then the amount of the bonus should increase depending on the actual level of performance. In addition, as a community-based system, bonuses should be paid based on the level of performance for the entire organization, not that of the individual physician. This will encourage better coordination of care and should also encourage "best practices" to emerge as physicians challenge each other to improve the performance of the organization as a whole.

This model falls under the accountable care organization (ACO) family, in that the group of physicians has the collective responsibility of caring for patients and achieving cost savings. This particular form of the ACO relies on the physician group to make appropriate decisions on hospitalization, and the financial incentives should steer physicians away from unnecessary surgery and hospitalization while encouraging wellness and preventive medicine. Ideally, this new provider payment system will result in immediate savings and also reduce the increase in costs year to year. The emphasis on prevention and wellness should help curb the inflationary tendencies of the cost associated with medical technology and expensive treatment.

The Ideal Case Study

The ideal pilot community for this program will need to possess several important traits. First, the community must contain a physician group that can provide comprehensive care. Most specialty care must remain inside the participating physician group in order for cost containment to be effective. A physician group which refers a substantive number of cases to outside clinics would not realize the potential cost savings.

Secondly, the insurer must have a good relationship with the physician group. A project of this magnitude can only succeed through the cooperation and motivation of all parties. Without a good long-term relationship with the carrier, the physician group would not be motivated to enter into a potentially risky arrangement.

Finally, the insurer must have good contracts with the major area hospitals. While the goal of the project is to emphasize preventive care and limit hospitalization, the insurer must have competitive contracts in order to achieve cost savings. One advantage of this system is that the cost and quality of hospital care directly impacts

the reimbursement to the physician. The primary care physician will be incentivized to direct his/her patient to the hospital that provides the best care at the lowest cost. This is obviously favorable to the insurer and patient as well. The price sensitivity of the referring physician should be helpful to the insurer negotiating reimbursement rates with area hospitals, as hospitals will be competing for referrals from the physician group.

The patients involved in the pilot program will be those who are using one of the physicians in the group as their primary care physician. This helps limit member disruption and dissatisfaction. Insurers who do not have their members formally designate a primary care physician (PCP) will need to perform a claim data analysis in order to identify the members who have effectively chosen a doctor in the group as their PCP.

The Role of Government

The recommended implementation plan may seem conservative, but a gradual rollout is essential to limit the risk faced by insurers and provider groups. This payment system is a radical change for most carriers, and it involves a fair amount of financial and operational risk. As such, the carrier, not the government, should determine the best course of implementation. If the expected cost savings are realized, the insurer will naturally implement the system in more communities.

I do believe the government must be involved, but through incentive rather than mandate. The government could offer tax breaks to provider groups and insurers who implement this prevention and wellness-based payment system. This encourages carriers to proactively implement the system but does not penalize carriers for exercising caution through a gradual rollout. A pilot program allows carriers and providers to evaluate the effectiveness and financial impact of the new system without a significant increase in risk. The new financial arrangement is certain to require refinement; having this system in place in a single community allows necessary adjustments to be made easily and efficiently.

Challenges

One of the greatest challenges facing this proposed model is overcoming the negative perception of capitated payment arrangements. If patients perceive that care is being withheld in order to increase profits, the system will likely suffer the same fate as the HMO model of the 1990s. In order to succeed, the insurer and the provider group must work together to educate the patient about the merits of the system, particularly the focus on improvement of quality and health outcomes. For this reason, the compatibility of the insurer and the pilot physician group is of the utmost importance. A successful pilot can pave the way for a large-scale launch of the ACO system.

The physician group will find it challenging to balance cost savings with patient satisfaction. This is a challenge for both the providers and the insurer, because the insurer must develop the right formula for the bonus program. The size of the bonus fund must be significant enough to create change in physician behavior and yet not so large that the physician group is at risk of financial ruin if it does not receive the bonus. The goal of the insurer is to achieve cost savings through more efficient and effective care, not through short-changing the providers.

Summary

The proposed ACO model provider payment system combines the waste-cutting ideals of capitation with a bonus program that encourages preventive care and rewards providers for quality care. The bonus program achieves balance by incentivizing physicians to avoid unnecessary hospitalization and treatment while not withholding needed care. This new provider payment system can best be achieved through a pilot program in a single community to allow for evaluation and refinement of the system with a manageable level of financial risk. The proposed ACO model capitalizes on the preventive care provision of the new health care reform bill to align the incentives of the insurer, the providers, and the patients. ■

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