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"For Professional Recognition of the Health Actuary"

The 2007 Health Policy Summit:
Celebrating 25 Years of Health Affairs

by Grady Catterall

About mid-way through the Health Policy Summit held on Nov. 1, 2007 in Washington, D.C. in honor of *Health Affairs*' 25th anniversary, it hits me: this is a big deal. Here's how you know: J. D. Kleinke, a nationally recognized speaker on health care innovation, a contributor of a dozen or so *Health Affairs* articles himself, and an author whose books (*Bleeding Edge: The Business of Health Care in the New Century and Oxymorons: The Myth of a U.S. Health Care System*) are considered "required reading" by many in the field, is attending the conference as…a member of the audience. Just like me. At most gatherings of this sort, Kleinke would be the keynote speaker, but here he's just one of the crowd. That's because the auditorium at the Ronald Reagan Building is filled with so many other health care luminaries that at least a few of that elite company can just sit back and enjoy the proceedings.

For me and all the other health policy junkies in the room, it's like being at a banquet where they're serving 20 or 30 five-star, world-class, gourmet-level entrees. And we don't even have to pick and choose; there's room on the plate (but just barely) for all we can eat, even if it's a little bit of everything.

The day begins with the presentation of awards "for bipartisan health policy collaboration" to Senator Max Baucus (D-MT) and Senator Chuck Grassley (R-IA). As the current and former chairman (respectively) of the Senate Finance Committee, these two have held more influence over the Medicare and Medicaid programs than all but a handful of government officials over the last few years. Like most members of The world's greatest deliberative body, Senators Baucus and Grassley are far too busy to stick around for long—which is why the awards presentation has been squeezed into an 8 a.m. time slot, prior to the official "Introduction and Welcome" presentation.

With the senatorial awards taken care of, Leonard Schaeffer and James Robinson can now come out and officially welcome us to the Health Policy Summit. Schaeffer, the founding chairman and former CEO of WellPoint, is the principal sponsor—personally, not through his company—of today's

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event (which suggests that there's a fair amount of money to be made in turning a local Blue Cross organization into the nation's largest health plan). Robinson is the new editor-in-chief of *Health Affairs*, having taken over the job a few weeks earlier from founding editor John Iglehart. Schaeffer describes Robinson as one of the few health services researchers who really understands the health care business, having "talked his way" into an internship at WellPoint while taking a break from his day job as a professor and departmental chairman at UC-Berkeley.

Robinson notes that there are two breathtaking features of America's health care system. The first is the dizzying pace of clinical innovation, leading to cures and treatments which, just a few years ago, we could scarcely have expected to achieve (or even imagined, in some cases). The second is the astronomical cost of the system, not just in terms of new technology but in terms of almost every aspect of how care is delivered and financed in this country. Robinson then introduces the first three speakers: National Institutes of Health (NIH) Director Elias Zerhouni, Aetna CEO Ronald Williams, and Merck CEO Richard Clark. The idea is to have one panelist (Zerhouni) representing public-sector researchers, another (Williams) representing private-sector payers, and a third (Clark) representing private-sector "innovators."

Once upon a time, we might have expected the director of the NIH to focus on the first feature of the health care system that Robinson talked about (clinical innovation) and the CEO of Aetna to focus on the second feature (high costs). But the two issues are inseparable, as all three speakers acknowledge. Zerhouni offers two compelling examples of this:

- The cost of treating chronic conditions is eating up an ever-larger share of the health care pie. In order to control this cost, we need to be able to detect the biochemical changes that occur 20 or 30 years before a chronic disease starts to present diagnosable symptoms. This is a huge scientific challenge, but it's one where a breakthrough could lead to dramatically lower costs in the long run.
- In order for new health care technology to become more affordable, we need to prevent our reimbursement systems from getting stuck in the earliest phase of the innovation cycle. Like any innovative technology, a new health care product (such as a drug or diagnostic device) starts out with a very high unit cost. As the product becomes more widely used, the unit cost declines, often precipitously, since the huge expenses associated with research and development can now be spread over a larger base. But in the health care arena, reimbursements are often set in the early (high unit-cost) phase of the cycle, and remain frozen at that level even if unit costs plummet.

Next on the agenda is Mark McClellan. In the next 20 minutes I'll realize that—just as I'd feared—there's barely enough room on my plate for the informational feast that today's speakers have to offer. Dr. McClellan was a member of the President's Council of Economic Advisers, the commissioner of the Food and Drug Administration, and the administrator of the Centers for Medicare and Medicaid Services, all by the age of 40. In a room where almost everybody has at least one graduate degree, Mark has three (MPA from Harvard, PhD in economics from MIT, and MD from both). A guy with his vast experience and expertise could easily fill a whole day with insightful analysis and cogent arguments, but he's been allotted less than half an hour. McClellan compensates for this by talking very fast. I manage to squeeze most of his key points into a few pages of furiously scribbled notes, hoping after it's over that my right hand will recover in time for the next presentation—and thinking that perhaps the most apt metaphor for today is not a sumptuous banquet but instead an attempt to get a sip of water from a fire hose.

Having left the federal government, McClellan is now affiliated with both the American Enterprise Institute and the Brookings Institution, which means he has the ideological spectrum pretty well covered as far as think tanks go. He starts out by noting that, at the present time, we don't know the relative efficacy of most of the care that's being delivered today. And the

knowledge gap is growing: over the last few years, there's been a huge increase in the number of health care products and procedures that are available, without anything close to a commensurate increase in the number of cost effectiveness studies being performed to evaluate all these new treatments. The problem is compounded by the increasing personalization of medicine, which means that we can't just focus on the average patient in performing our evaluations. (As Dr. Zerhouni noted earlier, any given treatment—even if it's generally considered safe and effective—will have a noticeably beneficial effect on only a fairly small percentage of the patients for which it's indicated. For most patients, the treatment will have little or no therapeutic effect, and for another small percentage of the patients, it actually will be harmful.) The solution, according to McClellan, is to develop a "learning" health care system in which the collection and evaluation of outcomes data (not just claims data) is integrated into the delivery of health care. Among other effects, this could facilitate the development of "value-based" insurance, in which reimbursement policies take into account not just the cost of a treatment but its likely effect as well.

The last session before we break for lunch is a panel discussion on the alignment of provider incentives with health care quality goals. The moderator is Risa Lavizzo-Mourey, president of the Robert Wood Johnson Foundation, and the panel includes Donald Berwick, president of the Institute for Healthcare Improvement; David Eddy, co-inventor of the Archimedes health care simulation model; and George Halvorson, CEO of Kaiser Permanente (which makes him my boss's boss's … boss's boss). The underlying principle of the discussion is that, in going about their jobs, most people—including doctors and others health care providers—will do what they're paid to do, but won't spend much time or effort performing tasks for which they're not rewarded. Thus if we want to have more high quality, cost-effective care, we have to arrange the financial incentives so that the doctors who provide it will earn more, not less, than the ones who (understandably, given the current system) don't bother to do so.

The lunch program features a talk by Cheryl Scott, chief operating officer of the Bill and Melinda Gates Foundation. Unlike most of the conference attendees, Scott's professional focus is more on health care in developing countries than on the U.S. health care system. Still, she controls more money than most of us will ever see in our lifetimes, so it's always worthwhile to hear what's on her mind.

The lunch program concludes with the presentation of an award to John Wennberg for being the "most influential health services researcher over the past 25 years." As a professor and departmental chairman at the Dartmouth Medical School, Dr. Wennberg has led the way in the development and application of small area analysis to study geographical variations in health care utilization and resource allocation. The results of his and his colleagues' research can be found in The Dartmouth Atlas of Health Care, another bit of "required reading" among health care analysts.

The afternoon sessions include two roundtable discussions. The first one, a "CEO Roundtable" moderated by Susan Dentzer of PBS's "The News Hour," is enlivened by the inclusion of Linda Golodner, president of the National Consumers League, and Andrew Stern, president of the Service Employees International Union. Other participants include Bill Novelli, CEO of AARP, and Gail Wilensky, a prominent

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health economist who worked in the first Bush administration. And, of course, there are the corporate CEOs, although they're in the minority here: Jack Bovender (HCA), Angela Braly (WellPoint), and Joseph Hogan (GE Healthcare). The conversation turns out to be more about politics than about business or management. Hogan offers one of the more intriguing thoughts to come out of the discussion: while everyone wants to reduce emergency room utilization through increased access to primary care, if we were actually to achieve that, our current primary care system would be completely overwhelmed. For me, though, the highlight of the discussion is Braly's observation that there's an "actuarial law of gravity" (adverse selection) which can be neither defied nor ignored. It's nice to know that the higher-ups have an appropriate degree of respect for our profession and its "laws."

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The second discussion, a "Presidential Candidates' Health Policy Adviser Roundtable," is moderated by Drew Altman, president of the Kaiser Family Foundation. This would have been an interesting session to report on were it not for the fact that most of the candidates have dropped out of the race by now. Still, it gives me another opportunity to hear Len Nichols, director of health policy at the New America Foundation and one of the keynote speakers for this year's Society of Actuaries Health Spring Meeting. I come out of the session very pleased with our choice!

The last two speakers of the day are Uwe Reinhardt, of Princeton University and the Commonwealth Fund, and Mark Smith, president of the California HealthCare Foundation. Prof. Reinhardt might be considered the dean of health services researchers in the U.S. (or at least at this gathering), having taught economics at Princeton since 1968, and being the only member of the Health Affairs editorial board to have served in that capacity since the journal's founding. He delivers his talk on the ethical and philosophical issues surrounding health care reform with his characteristic wit and charm.

Dr. Smith is also witty, but his wit has more of a bite to it. He starts off by saying that while all the other speakers have expressed how glad they are to be here today, he's not happy at all, given that his presentation is the last one of the day and thus will be delivered after every interesting remark that possibly could be made about the health care system has already been made. Nonetheless, he manages to give us a quite interesting and entertaining analysis of what ails the health care delivery system in this country. As Smith sees it, there's no point in reforming the health care financing system if we don't first reform the delivery process to reduce costs and increase customer satisfaction. Two keys to accomplishing this are (a) having much more self-service and self-care than we currently do, and (b) matching caregiving tasks with providers who have the appropriate level of skill and training (for example, not requiring a doctor to do a task that a registered nurses can perform, and not requiring a nurse to do a job that can be handled by a health aide).

For me—looking at it from an actuarial perspective—the key takeaway from the Health Policy Summit was contained in a comment made during Dr. McClellan's presentation. He noted that, before all the reforms that all the speakers have been talking about can be accomplished, "a lot of challenging statistical issues" need to be tackled. I'm interpreting this as an open invitation for the actuarial profession to jump in and take a stab at it.

Editor's note: Both a transcript and a video of the Health Affairs *2007 Health Policy Summit is available at:* http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2424