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An Interview with Susan Dentzer

By Mary van der Heijde and Doug Norris

Susan Dentzer
Editor-in-Chief
Health Affairs

We were pleased to have the opportunity to sit down with Susan Dentzer, editor-in-chief of *Health Affairs*, after her excellent keynote address at the SOA Health Meeting in Boston. We have included here highlights of that discussion.

Mary van der Heijde: Directionally, where do you see health care and health policy going for the rest of this year?

Susan Dentzer: I think that we're going to see the status quo perpetuate for the rest of this year in the following sense: the Affordable Care Act is the law of the land, and it is intact, at least until we see a change of administration in the White House, if in fact that occurs. Now, there are some known unknowns. We don't know the outcome of some of the lawsuits that have challenged the constitutionality of the Affordable Care Act. Barring that, I think that we believe that most of the things that are playing out now, as the law is put into effect, will continue to play out. For example, there is a lot of emphasis now on delivery and payment system innovation, the experiments that are being set up now around accountable care organizations (ACOs), the pioneer program, and the Medicare shared savings program. We're going to see these processes continue to play out. We're also seeing a lot of energy in the private sector, as organizations get ready for these broader changes. We see a lot of ACO-type contracts forming now between private payers and health care delivery systems that will be the analog to the ACO contracts that are formed under Medicare and Medicaid. So I think we're beginning to see the system recognize the fact that the ground is shifting, and the law has changed. And of course, lots of people are focused on getting ready for 2014, when we'll have potentially 32 million more Americans coming into the coverage environment. Creating insurance exchanges, looking at the expansion of the Medicaid program, figuring out how we're going to pay for that, or how we're going to create models to accommodate the new people coming into the system. All of those things now become increasingly urgent matters for people to focus on and for the system to be more accountable.

MV: How do you think actuaries can best have an integral role in reducing health care expenses and ensuring the sustainability of Medicare?

SD: Of course, actuaries are usually sitting on a pile of claims data, and therefore have the ability to analyze what we're spending our money on now, and to put that together with what increasingly we understand to be the evidence basis of medicine, or of health care, or the lack thereof. When we get clear evidence, as we do at least in a number of situations, that dollars are not going directly to improve outcomes of care, that's where we know that we can potentially achieve some savings, or certainly some different patterns of spending—putting money more toward the things that really do achieve value in health care. Actuaries are sort of our "great white hope," among others, in understanding where our dollars are going currently. Over time, we develop even a better evidence base in terms of understanding the clinical outcomes of what we achieve—[how] we devote dollars to a particular area of health care. That's where we're going to have the ability to make a difference, and shift spending to the things that do produce value.

MV: What would you see as the primary role of actuaries within health care, and what should we be doing as members of the SOA to get involved?

SD: I showed one example of a piece that we ran, done by folks at Milliman, who are looking at the actuarial cost of preventable errors in hospitals, and identifying that those costs are $17 billion per year, judging from claims data. This is literally what the claims numbers are which are associated with these avoidable errors—$17 billion. It's not chicken feed. It's obviously money that we could use for more productive ends, and the claims data enabled them to go on to look at exactly what those dollars were traceable to. Some of the errors are things like pressure ulcers—well, we know how to avoid pressure ulcers. You have to have enough staff to turn the patients often enough, and do other things to keep them from developing [pressure ulcers], which can be very, very dangerous conditions, and have a lot of expense attached to them to boot. That's just a very useful metric, because it enables a health system to say, "Okay, there are large costs atten-

dant to this. As a hospital administrator, I get paid more if a patient if—in effect, not literally by salary terms, but the system earns more—somebody's in the hospital longer because they have a pressure ulcer." Not necessarily under Medicare, because of the diagnosis-related group (DRG) restriction, but certainly in terms of the private pay. Essentially, it's counterintuitive that the system actually could come out better because somebody is sicker.

Well, most people did not go into health care for those objectives. They went into health care generally because they want people to be healthier. So, if I'm a system administrator, and I understand that this is the cost that's being imposed on society because I'm not preventing the pressure ulcers in patients in my institution, I'm going to be more mobilized to do something about them. And if I'm not mobilized, the regulators and others are going to mobilize around me, because these things can be prevented. So helping us understand the pockets of excessive spending, the costs that are attendant, things that are in the system that we don't like anyway—that alone is an extremely useful function. I think as we go forward into new delivery models, we're going to have to be analyzing different things—where savings are coming from, where we can achieve, where we need to make greater investments. That's a very important point to make, too, because as important as it is to save money in health care, we also have to invest our dollars in the areas where we will achieve the greatest value, both in terms of the health of our population, and long-term sustainability in health care spending. Based on the evidence of what we see in terms of expenditures today, helping us decide where we'll get the greatest returns for that investment will also be a very important job that actuaries can perform.

MV: We've heard a lot about the challenges of independence and political pressures, and maintaining that independence in our role as an actuary. I know this must be a challenge that you face as editor of *Health Affairs*. How do you present information in a way that doesn't seem biased or skewed, and doesn't have a political lean? What have been your challenges with *Health Affairs*, and what advice might you have for us as actuaries?

SD: Well, it is a challenge, particularly in the current environment in Washington D.C., which is, as many people have noted, highly, highly partisan—probably more than anybody ever remembers in the lifetimes of those of us around today. I think that the truth is its own best defense, and you just have to keep focusing on the evidence and essentially focusing on what the numbers are showing you, or what the facts seem to be telling you. This morning, Rick Foster used the example of the CLASS [Community Living Assistance Services and Supports] Act portion of the law, which is widely agreed now is actuarially, among other things, a non-starter. It's simply financially not going to work as it is currently structured. The secretary of Health and Human Services recognizes that, and now there's an effort to try to figure out a way to make that program sustainable, and create a basis of long-term solvency for it. These kinds of things need to be said, where laws have been written hastily, and good, well-intentioned people have put together ideas that they think will make sense. And of course, what isn't sensible about trying to figure out a way to help Americans who face high potential long-term care expenditures? What isn't sensible about trying to structure a program to help them? The evidence shows that people aren't willing to buy as much private insurance coverage for long-term care insurance as they probably should, so is there a role of government solving that problem? Possibly so, but you can't just solve it any which way. You have to put in place a program that is strong and sensible, and is going to be solvent over time. So, the ability to sort of come in and say, "Look, folks, this is what the evidence shows, regardless of your political party or political persuasion." Just cueing to the facts, that's the best that any of us can do in this environment, and that's certainly what we try to do at *Health Affairs*.

Mary van der Heijde, FSA, MAAA, is principal and consulting actuary at Milliman, Inc. in Denver, Colo. She can be reached at *mary.vanderheijde@milliman.com.*

Doug Norris, ASA, MAAA, PhD is an associate actuary at Milliman, Inc. in Denver, Colo. He can be reached at *doug.norris@milliman.com.* ■