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An Interview with Rick Foster

By Mary van der Heijde and Doug Norris

After his keynote address at the Society of Actuaries (SOA) Health Meeting, we were fortunate to sit down with Rick Foster, the chief actuary at the Centers for Medicare & Medicaid Services (CMS). We have summarized some of the highlights of our conversation below.

Richard S. Foster, FSA, MAAA
Chief Actuary
Centers for Medicare & Medicaid Services

Mary van der Heijde: Many of our members are not working day to day on public policy. Would you say that there are lessons you've learned that might particularly apply to somebody working in the corporate sector?

Rick Foster: In particular, actuaries have this very important responsibility to come up with objective technical information that is not biased, and not intended to provide the "right" answer, and to help advise—whether it's government policymakers or corporate leadership—about the financial implications and other aspects of the products and programs that they work with. And if you think about it, if we ever were inclined to tilt our analysis,

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Health Section Council has identified the following list of tasks to pursue over the next year:

- Continue to explore the application of complexity science for improving the quality and usefulness of actuarial models of health care systems,
- Expand ideas for clinical training beyond boot camp material,
- Continue to review SOA health research assets for opportunities to leverage at conferences, for use in articles, to use as vehicles for networking with other organizations and to enhance the health actuary brand, and
- Continue to review SOA educational programs for gaps in education and exposure to emerging areas of practice.

Health Actuarial Research Initiative (HARI)

HARI, an initiative of the SOA board of directors, was inspired by the discussions between the SOA Health Section Council and the Academy Health Practice Council in June 2010. The Board has committed $300,000 per year for 2011 and 2012 for health research. The first project the oversight group identified is a study of risk adjustment as it pertains to the Patient Protection and Affordable Care Act (PPACA). The Request for Proposals (RFP) for the risk adjustment project was released on May 13 and is available on the SOA website. The oversight group has identified the next two HARI topics, a comparative study of health care trend drivers, and of accountable care organizations and risk; work has begun on defining these projects in greater detail with a goal of issuing RFPs this year for one of them and next year for the second.

Wrap-Up

My term as chair of the Health Section Council ends this month, and Kevin Law will take over the chair. My three years on the council have been busy and interesting, and the future for the Health Section Council promises more of the same for Kevin. ■

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or to skew it one way or another, to achieve some purpose, and not follow all of the objectivity and the requirements of the profession, then the result might be handy for one brief moment, but from then on our work would be useless, and would have no value whatsoever. I think that is exactly the same in the private sector as it is in the government.

MV: You talked about how technical neutrality, in some cases, can be seen as opposition to a particular viewpoint. Do you feel that we have any risk of becoming irrelevant, or that our voice would not be heard in the future because of that, or do you think that our obligation continues regardless?

RF: Well, our obligation continues without question, but I do have that concern—I'll be honest about that. In recent years, as we've seen the level of partisanship in the public sector go up, there's been less interest, it seems, in the technical aspects of the programs, and more interest in the political aspects. So I do worry about us being marginalized or no longer being useful for the very things that we're so good at, and the very things that should be paid attention to. Even though it seems that fewer and fewer public leaders and politicians tend to pay attention to the formality of the technical details which will make or break the success of any product or program in real life. So, I think we may be marginalized for a little while, but it may take only one or two spectacular failures before we're back in business the way we've always been, and the lessons learned.

MV: Tell us about the role that the media has played in this partisanship, and in your role in trying to provide technical information and unbiased information.

RF: The media is very interested in reporting all of this. They tend to focus a little more on the more sensational aspects, I'm afraid. Still, it's been a valuable voice on behalf of our work, and we try to assist the media behind the scenes in understanding

what they're reporting on. We don't need to be in the media so much, but we do like them to get the story straight.

MV: Do you receive calls frequently from the media, asking behind-the-scenes questions?

RF: Yes, all of the time.

MV: That's encouraging, because you made the point that attention to the sensational can sometimes cloud accurate reporting. It's good to know that you're quietly helping them to be accurate on technical issues.

What is your forecast for the future of Medicare policy changes, in the next few months, and then after the 2012 elections?

RF: There were many changes in the Affordable Care Act legislation affecting Medicare, and a number of provisions that will result in lower costs for the program and more revenue. So, it's sometimes a little hard to think of what more can be done right now on the heels of everything that's been done. But in the longer term, we're still facing the significant issue of the retirement of the baby boom generation, and the traditional cost pressure where health care costs—whether it's Medicare, Medicaid or private health insurance—all tend to grow faster than the economy, for a variety of reasons that actuaries well understand, but they're hard to fix. So, I expect that there will be continuing attention on Medicare and there will be the need for further legislation—if nothing else, to fix the problem of physician payments. I think we'll be very busy in that respect for years to come. I think actuaries in general, and health actuaries in particular, will continue to find that health insurance is a growth industry in this country.

MV: Do you think that the 2012 election will change that, in terms of budgets and the partisan makeup of Congress?

RF: Possibly. I'm always hesitant to forecast political events and that sort of thing. There is, of course, a lot of interest in repeal of the Affordable Care Act, in whole or in part, so if the presidency were to change hands, there would probably be more attention focused on that. I used the example of Senator Dole and Senator Moynihan, how they used to work together despite their different philosophical preferences, to come up with effective policy that they had for the country and for the public. I would love to see more of that. I view a world where our elected leaders have in mind first and foremost and always the interest of the public, which I think they do, but are willing to go the next step, which is to work together for the most effective solutions for the problems that we are facing.

MV: What do you think would be a tenable solution for Medicare funding, or what do you think are key considerations that actuaries need to be thinking about in terms of funding?

RF: It's a sweeping question, and there are lots of things that ought to be done, some things that could be done, and other things that you can at least think about, but it's a very open question whether they should or should not be done.

One thing that clearly ought to be done is the issue of fraud and abuse. We have way too much fraud and abuse in Medicare. It's become a favorite target for criminals, organized and disorganized. Congress has invested a lot more in program integrity in recent years, and that's having a good impact, but we should do more. If you look at the typical private health insurance company, these companies typically do monthly, or even sometimes weekly, reviews of the claims data as it comes in, looking for anomalies or anything strange or out of the ordinary, then acting on it very quickly. Too often, we find a bad trend only a year or two—or even three or four years—after it's already started, and after we've already spent a billion dollars on it. So our fast response needs to be improved; our automated capabilities, through predictive modeling and other techniques, need to be improved. We're just launching into a predictive modeling effort in this regard for program integrity, so I'm optimistic about that. That's one important step: quit paying the crooks, and quit paying people for services that are never performed.

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"So far we haven't done anything about cost growth."

In addition, if you think about the balance between traditional fee-for-service Medicare and Medicare Advantage, what we've seen typically is ideologically you either like Medicare Advantage, or you don't like Medicare Advantage and you like the opposite. That's led to changes in the program to promote it or to not so much promote it. What we ought to do is consider the inherent advantages that are available between fee-for-service and Medicare Advantage. For example, in many parts of the country, even though private smaller insurance plans have higher administrative costs, they can still do a better job of controlling costs compared to fee-for-service because of utilization management or preventing fraud and abuse. In the more rural parts, they don't really have much of an opportunity; it's hard to beat fee-for-service costs in Minnesota, or much of the Midwest, or Oregon or Washington. Even though some places have a heavy managed care presence, it's hard to beat the fee-for-service costs, because the practice of medicine is not so—I'll say "over the top"; that's too strong of an expression but you know what I mean: do every last test, every last check you can possibly do, and when in doubt put them in the hospital, and so forth. In areas where care is provided on a reasonable basis and does not reach extremes, it's really hard for the private plans to be very competitive against fee-for-service. So why not take advantage, and set up what amounts to a system of competition among the different formats including private plans and fee-for-service Medicare, across the country? Those plans that can achieve more efficiency while still being consistent with high quality, that translates into lower premiums for people who participate in this lower-cost form, whichever it is, fee-for-service or a private plan. Use competition in a way to get to a lower cost.

So far we haven't done anything about cost growth. Because it's one thing to get to the lowest cost you can get consistent with good quality, but the drivers of cost growth, to a large degree, tend to be technology. We all want the newest, latest, best care for ourselves and our loved ones. In some cases, the newest care isn't such a great deal. Some years back, there was a radioactive injectable dye that was used for heart scans and so forth. There was one on the market that had been around for a long time; it had an incredibly low incidence of adverse side effects, and it was very inexpensive. Then, a new one came along and took that incredibly low rate of adverse side effects, and lowered it like a third more. So, it was virtually indistinguishable, but it was better. Of course, everybody wanted the better one. And Medicare adopted it for use, as did all of the private plans. But it cost 10 times as much as the old one, even though the improvement was very, very small. We tend to adopt any new technology that is either better, even if it's just only a little bit, or even if somebody just can claim that it's better, even if it's not really any different. We all tend to adopt that, and it's not necessarily cost-efficient to do that. So, we could be a lot more prudent in the new technology that we adopt. Now, we would still adopt most of it, because we want the benefits of the new life-saving, life-enhancing treatments, devices and drugs, but we don't have to adopt everything that comes along.

Moreover, maybe there is a way to get the medical research and development community to focus less on cost-increasing technologies, which is what they've done through most of their history, and focus more on cost-reducing technologies, much the way that auto manufacturers and computer makers do. As one example of that, a few years ago implantable defibrillators came along, an excellent device that can prevent somebody's death in an emergency situation. Very, very expensive to build, and fairly expensive for the operation to implant it, but Medicare covered this, and it's a good thing. Somebody's now working on a one-time-use implantable defibrillator. Because the ones to date can be used over and over again, and for the most part they sit in there and do nothing. They sit there, and absolutely nothing happens until there's an emergency. Then it kicks in; it defibrillates your heart action. They rush you off to the hospital, and they give you drugs and other treatments, and it's not doing anything else. It sits there, but it's really expensive. Instead, if there was a much, much cheaper one-time-use device that saves your life in an emergency, and they rush you off to the hospital, and then they put another one in, that's going to be cheaper.

Down the road you have questions like: for health care generally—not just Medicare—should there be a single payer system? Should there be global budgeting? Representative Paul Ryan's plan is a lot like premium support of the type that I described earlier, this national competition, but it has an adjustment for the payments that is probably too low. He would adjust the payments year-to-year by the Consumer Price Index (CPI), and we know that health care premiums tend to go up because of the general CPI, excess medical-specific inflation, increases in utilization and increases in intensity. All of those outweigh the CPI. I'll give him credit; he's the only person who has seriously tried to tackle the long-range financial problems coming from Medicare and Medicaid. He's done it in a way that I wouldn't say has a high probability of working, but it is possible that the financial pressure that would be caused by his approach—or global budgeting, or even the productivity adjustments for Medicare—that the financial pressure caused by all of these could feed back to the research and development community, and they might conclude that they have to change the way they've been doing business, because they will not have an automatic market in the future for whatever they come up with, no matter how marginal the benefit, and no matter how high the cost. But that's a big if for all these approaches.

MV: How do you see the actuary's role in comparative effectiveness studies?

RF: That's a good example, and I know the SOA's doing a lot on this, and researchers are doing a lot. It's controversial—it starts off just fine; everything's great when it starts off. Using my example of the radioactive dye, if we had a more prudent adoption of technology, by Medicare and by the private sector, and we all said, "No, we're not going to do it, because it's not cost effective," then everybody would say, "Great." But the next step is: How would you do this more formally for Medicare? Because right now, we're not really doing that, except in a very, very minor way. And Tom Daschle, when he was slated to become the secretary for the Department of Health and Human Services (HHS), had a proposal for a comparative effectiveness board that would decide on behalf of the health care sector at large which treatments and devices and so forth were a good idea, and which ones were not. And that's not a bad idea, but the next step that usually comes up is: How do you decide if it's cost-effective? And in my example, it was easy—anybody could decide that probably wasn't cost-effective. In more difficult examples, before long it takes you to: "What is the value of a human life?" If you adopt this, you can save so many lives; if you don't adopt it, you won't save those lives. It costs so much to adopt it, and what are you saving? And while there's a lot of research on the value of human life, there's less research, or less bulletproof research, on what is the value of a better quality of life. But that's when you end up with these difficult questions, and that's when partisans tend to say "Death panels," or "You're throwing granny under the bus," or "You're going to ration care that I want." I think that men and women of goodwill can work their way through those issues, debate them, and come up with a solution that would work. But if it's going to be an opportunity for people to point fingers and make political charges, we'll never get there. So I'm a big believer in the potential for comparative effectiveness, particularly if you get to the point where you can have recommended treatment protocols for a given disease or given set of symptoms, and then you tie that in with electronic health records. Consider what happens when you go to your doctor, and if you see his or her office, you'll see a pile of books on the floor—a big pile. And maybe they're keeping up with it, maybe they're not, but it is really, really hard. It's hard for us as actuaries to keep up with all the studies, all the reports, all the evidence, all the data. It's even worse for doctors. But if what came out of comparative effectiveness were these treatment protocols, which were then built into the electronic system, so that not only could you call up your patient's health record, but you could also get advice for a given set of symptoms and so forth, test results, you could get advice on the optimal treatment. And you don't have to go off to your office and look through the middle book in the pile; it's right there for you, and there's science behind it. Good, demonstrable science that people have carefully developed. I think that would be good for all of us. So I think there's a lot of potential for comparative effectiveness, and

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"Our independence and our ability to give all policymakers the objective advice and information they need to develop sound programs is crucial"

we're just really at the tip of the iceberg in terms of exploring it.

MV: You shared with us many of the changes and challenges and progress that have defined much of your career. What would you say is your most significant accomplishment, or one thing that was defining for you?

RF: I'll confess that the first thing that jumps into my mind has nothing to do with actuarial work. Back before I became chief actuary for CMS, I worked at Social Security. We had the 1983 amendments which solved the program's financial problems for a long time to come, and there hasn't been any major legislation since for Social Security. So when I was deputy chief actuary, I had time. I could do what I felt like doing and we did a lot of good studies and good research. And in my private life, I went car racing, which I'd wanted to do all my life. I remember winning the Mid-Atlantic Road Racing series twice, and it was all very exciting.

Of course, ever since I became chief actuary at CMS, there's not much time for hobbies and things like that. Professionally, I think what I'm proudest of is less for what I've done as an actuary, the technical aspects and so forth, but more what I've helped to create. The Office of the Actuary at CMS, I believe, is the largest actuarial component in federal government. We have almost 100 people, not all of them actuaries—many are economists, some are statisticians, some are programmers, and so forth. But within CMS, we are considered the best place to work in the whole agency. Our employee evaluations, or the survey of employee satisfaction, we're number one every year. I didn't cause that to happen, but I like to think that I helped to encourage it at least a little bit; helped set in place the circumstances and conditions where people can prosper, where they can be excited about their jobs. Where they know that they can charge ahead with something, and if it succeeds brilliantly, that's going to get recognized, and if it falls apart completely, they're not going to be fired or chastised—they're going to be encouraged for having tried something. Then we figure out if we can do something to make it better. It's a really good office; it's a bunch of great folks, and that's the satisfaction I get day to day. The most important thing for me is watching these people thrive and work so well together and cooperate, share information, not stab each other in the back. That's what I'm proudest of.

I'm also proud of our efforts to restore the actuarial independence of the office; I hope that will continue to serve me and whoever succeeds me someday, for many more decades in the future. Our independence and our ability to give all policymakers the objective advice and information they need to develop sound programs is crucial (for the reasons we talked about before).

MV: Finally, do you have any recommendations for your fellow actuaries, of resources that you think are particularly useful or helpful, either for staying on top of changes within CMS or health care reform? What are your bookmarks, your favorite resources?

RF: There are a lot of things that come out—I don't have a good list of them all, but I'll mention a few. I'll put a plug in for the new publication by CMS—it used to be the Health Care Financing Review. It's now called something entirely different, and the first issue in the new format will come out in another month or two. So that's an in-house research publication, peer-reviewed. [Editor's note: the new publication is titled the "Medicare & Medicaid Research Review"].

Health Affairs – [Editor in Chief] Susan Dentzer's going to be here later on—is the premier health policy journal; it really does an outstanding job. Not only their journal, of course, but also the forums that they hold. I'll put in a plug for Milliman—the Milliman studies that they post periodically to the world at large are almost always really, really good. Once in a while we find something and ask, "Huh, how did they reach that conclusion?" but that's the exception by a wide margin. Particularly the series on the Affordable Care Act that's come out in the last year or so, and really before that—very valuable information.

There's something called the Social Science Research Network (SSRN)—it's an informal website, and one of its departments is for health. It has another for Social Security, another for poverty, another for workers' compensation, and so forth. The health one is like a clearing house of good studies and good information. Milliman studies

will show up there, and our articles will show up there from time to time, and it's very rare that I get an email from them that doesn't have at least one study that I really want to read. The Congressional Budget Office (CBO) puts out a ton of very good studies; I wish that we had their research staff and their research opportunities. What they do is almost always very well-thought-out and very well-expressed. Their periodic booklet on policy options for addressing budget deficits—an awful lot of what gets enacted comes out of that book. Another good Congressional source is the Congressional Research Service (CRS). Its reports are also uniformly first-rate, although you have to work to find them. The CRS reports are not directly available on its website. I'm leaving out a lot of important ones. The Employee Benefit Research Institute is very good. The reports from the National Bureau of Economic Research. The think tanks produce a number of studies on health issues, with the Urban Institute, Brookings Institution, Kaiser Family Foundation, RAND, National Health Policy Forum and American Enterprise Institute being particularly prolific. In addition to the SOA and AAA reports, the American Economic Association has a wealth of technical analyses. You can also check the Office of the Actuary page on the CMS website. You'll find the trustees' reports there, the National Health Expenditures articles and data, our separate memos such as for the financial estimates for the health reform legislation, all these things. If you go to the CMS website and search on "actuary" it will take you there. Of course, the well-known health publications are also quite valuable, such as the New England Journal of Medicine, Journal of the American Medical Association and others. Overall, it's a lot harder to keep up with all the excellent articles that are available than it is to find them!

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