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SOA 2012 Health Meeting Interview with Paul Ginsburg

By T.J. Gray and Doug Norris

Dr. Paul Ginsburg, president of the Center for Studying Health System Change, presented on upcoming changes in health care financing and delivery during the 2012 SOA Health Meeting. We met with Ginsburg in advance of his presentation to get his thoughts on the upcoming environment for health care providers, payers and consumers, and the role of actuaries in that environment.

Doug Norris: What are your thoughts on whether the Affordable Care Act (ACA) does enough to rein in health care spending?
Paul Ginsburg: I would say that the law is not really a cost containment law; it's really a law to expand coverage. I would say that the most powerful part of the law that addresses cost is the "Cadillac" tax—in 2018, having a tax on premiums, or employer contributions above certain amounts.

What I have gotten optimistic about is the program of pilots and provider payment reform—the accountable care organizations (ACOs), episode bundling, medical homes. That's really capturing something that there is broad support for in the provider community and the payer community, and I think that provisions of the law that permit Medicare to participate in that have been a significant catalyst. One thing I wouldn't have mentioned a few months ago but I do mention now is some of the rate cuts in Medicare that will take place in the future, particularly for hospitals. For example, the change in the formula for productivity increases, which is expected to lead to some very substantial cuts year after year. When I talk to hospitals, this has really spurred them to become much more serious about cost containment and to really get engaged in pilot programs to change payments. So even though it's just a Medicare thing, it really seems to engage hospitals, in particular, in looking for long-term ways to reduce costs.

T.J. Gray: What are some of the payment structures that you've been recommending to hospitals to help them?
PG: You have the payment structures that I would call, in general, "global payments," which really are "capitation-lites." These structures have elements of capitation with some shared savings provisions, and whether it's the alternative quality contract with Blue Cross Massachusetts or a Pioneer ACO or a shared savings ACO, I see a lot of experimentation along those lines. I actually think what's easiest for a provider to pursue is episode bundles because they are very focused and limited. You might just be working on orthopedic episodes and that's probably a lot easier for a hospital to handle than doing something which is capitation-based, where it has to worry about the whole range of not only all the services it provides, but all the services that a lot of other providers provide for patients who would be attributed to the ACO.

DN: Do you think the individual and Small Business Health Options Program (SHOP) exchanges will have some effect in terms of adding competition to the mix and getting more people into the game?
PG: Yes. I think that these state exchanges will create a much more competitive insurance market than we've seen for individuals and probably for small groups as well. It's very uncertain as to what kind of small group participation you'll have in the exchanges, but for individuals it's a really competitive market. It's a much easier market to enter than current individual markets. It helps individual consumers line up plans and compare them because there will be a gold, a bronze and a silver benefit structure. The websites will be usable tools. So I think it will be a more competitive market: margins are going to be lower than they are. I think a lot of inefficient players in the individual market will go out of business, which would be a good thing.

TG: What kind of role do you see for the new organizations that are forming, like co-ops and new ACOs?
PG: I'm very skeptical whether co-ops will really be a significant factor in most, if not all, markets. It seems to me that so few organizations are co-ops today, and many of them started decades ago and probably continued despite the fact that they are co-ops. I envision many of these starting co-ops either not succeeding at all, or just not being very large. There was an example in the 1970s where the federal government really did a lot to try to promote HMOs, and a lot of today's companies started back then with some of that assistance. That was a model that turned out to have a lot going for it, and I don't see the co-ops as bringing anything. It was really a sop to single-payer people.

DN: What role do you see consumers having in keeping their own health care costs under control?

PG: I think that's really starting to happen now as consumers are asked to pay a lot more of the bill and asked to think differently. I think we're going to see more products which have patients focus on choosing providers based on who is expensive and who's not expensive, such as narrow network products and tiered designs. When the ACA focused on patients, which was in the Medicare program, I thought that it went out of its way to not involve patients. The absence of financial incentives to choose providers or to choose an ACO, I think is an omission. It wouldn't have been easy because of all the supplemental coverage, but pretty soon Congress will have to start recognizing that Medicare beneficiaries are living in such a different financing environment than privately insured people that this is not sustainable.

TG: What do you see as the optimal role for actuaries in helping keep the cost of care reasonable?

PG: I think that with these developments, for example provider payment reforms, there is an enormous amount of work for actuaries in designing and getting those systems to run. Many of them are shared savings based, which means projections of what spending would have been in their absence are needed. I actually think that the exchanges are going to promote new entries, new products, so I see it as somewhat of an "employment act" for actuaries.

DN: I read your New England Journal of Medicine article about the slowdown in the Medicare trends lately. Do you think that is a bellwether for the commercial market trends, or do you think that there is a payment shift in terms of where the dollars are coming from?

PG: When we got into that article we concluded that a lot of the slowdown in the projection in Medicare, over the long term, is the various price reductions that have been enacted, which really brings up "What is the model of cost shifting?" I say this with more hesitation because, in my organization, we're actually engaged in a fairly large scale quantitative study of cost shifting, and we're actually not finding it. We're actually finding that when Medicare squeezes its rates, providers cut their costs, and in the aggregate they don't increase prices to private insurance. You have a real distinction because you see some hospitals with so much leverage, not using it all the time. They can shift. But you also have a lot of hospitals that don't have that much leverage so when Medicare cuts rates, they have to cut their costs and they have no choice but to do what they have to do to avoid negative Medicare margins.

Paul Ginsburg

TG: What's the most important thing you'd say to an audience with 500 actuaries about this upcoming market?

PG: This is going to be a very exciting time. There is going to be a lot of change in health care financing, and some if it might depend on your personality as to whether you say, "Hey, this is terrific! I'm going to have a great time participating in this change," as opposed to, "Oh, these problems are overwhelming. There is so much for me to do." I get the benefit of looking in from the outside. I don't have to make some of these really tough decisions about, "What are the people who are uninsured now, who become insured because of the tax credits, what's their likely health care use?"

Some actuaries will say, "Oh, boy. I don't know how to do that. I'm uneasy because I'm not going to be able to be very precise about it," whereas others will say, "I haven't had a challenge like this in a while. I'll do my best at it."