SOCIETY OF ACTUARIES

Article from:

The Actuary

October 1996 – Volume 30, No. 8

Is a physician in your future?

by Brent Greenwood and Dr. David Epstein

To date, insurers and government have taken the "supply side" approach to reforming the nation's health care system. Cost containment has relied primarily on managing the utilization of health care services and negotiating reduced payments for services provided. These approaches have taken the form of discounted fee schedules, per diem arrangements, capitation, and utilization management programs. Rarely do these different forms of cost containment connect and relate to each other across the spectrum of health care management.

However, supply side strategies usually do not address the impact of increased access to care, advances in medical technology, and the apparently insatiable appetite for health care services by Americans covered under insured health plans. With government promising increased access at lower prices, successful health care reform cannot take place until the demand for health care services is addressed. As the health system evolves to the "demand side," actuaries will need to understand how this will impact their analysis of health care expenses and operations. Actuaries will also quickly discover the need to work with physicians to better understand the impact of these new programs.

The spectrum of health care management

Reducing aggregate demand for health care services requires comprehensive medical management. This includes reducing individual patients' disease burden, managing acute care (inpatient) crises, and managing (ambulatory) chronic illness.

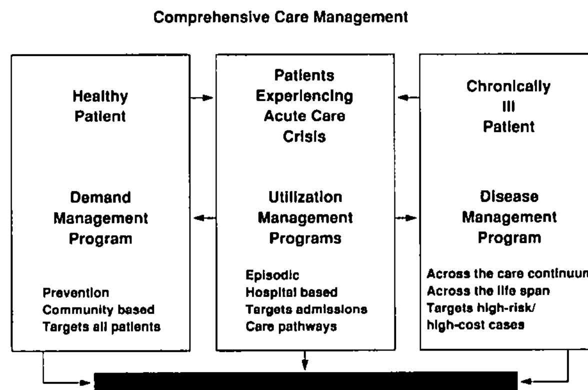
Historically, insured managed care plans have focused primarily on the acute-care phase because as much as 40% of the health care dollar was spent for inpatient care. Health plans have been successful in reducing inpatient costs through aggressive contracting for inpatient services and pre-certification and concurrent utilization review programs, including fixed reimbursement strategies (e.g., capitation, percent of premium, and fee schedules).

Now, cost pressures are likely to escalate due to the following trends:

- Consolidation of provider systems, exerting more price pressure on payers and purchasers
- Increasing volume of services
- More expensive medical technology

Comprehensive care management

Comprehensive care management represents a revolutionary shift in health care delivery. It changes the focus from crisis management and acute disease interventions to a public health approach that promotes prevention, education, and periodic health care. The goal is to provide individuals information and timely interventions to reduce the future need for more intensive services.



The three components of a comprehensive care management program are:

- Demand management
- Utilization management
- Disease management

Few plans have integrated all three components into an effective care management program.

Demand management

Demand management challenges health plans to understand the health characteristics of the populations for which they are responsible and to design interventions to reduce the disease burden of those populations. Successful programs offer enrollees stress prevention, improvement of health behaviors, promotion of proper self-care, and education on using the health care system appropriately. These are accomplished through patient communications and wellness programs, health risk assessments, telephone-based triage and nurse advice lines, and drug compliance programs.

Utilization management

Despite demand management initiatives, patients will still need acute care services, and utilization management programs will continue to be an essential component of effective care management. Utilization

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which gave me the opportunity to think through what a principle is and to reach a conclusion.

Here is the result. A principle is, perhaps unfortunately, often best stated in the negative. A good example of a set of principles is the Ten Commandments. Consider only one: Thou shalt not kill. That is a principle, clearly and succinctly stated, needing no elaboration. Or does it? What about killing in a just war, which on its face violates this principle? And what about self-defense and accidents? Society needs something else to sanction certain killings and to except others from punishment.

Enter standards. Society determines what constitutes a killing and what doesn't. Further, it distinguishes between various kinds of punishable killing — murder in various degrees, vehicular homicide, manslaughter, murder of a policeman or president. The latter are not principles. They are standards related to that principle.

Thus, principles are general while standards are specific. Standards help define violations of principle, because multiple standards probably constitute one principle.

A good rule is, "If you can't express it in a simple declarative sentence, it isn't a principle." More likely, it's a standard or a mixture of the two.

I don't think the Lindsay committee finished its work before it was replaced, and its successors have had a difficult time with this "forest and trees" problem. The result is no clear exposition of principles such as we have in the Ten Commandments. Moses had no truck to carry his tablets, for which we should be grateful. Imagine trying to rattle off ten statements along the lines of those emerging from our profession's various committees.

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Physician (continued from page 7)

management programs focus on episodic hospital-based services and target admission management. These programs will ensure that care is delivered in the most appropriate setting (i.e., intensive care, acute care, subacute skilled nursing facility, or home health care). Future programs will focus on reducing hospital admissions rather than just managing lengths of stay. This approach addresses the need for services, not just where services are best delivered.

The components of comprehensive utilization management programs include pre-admission review, medical necessity determination, concurrent review, and discharge planning. Well-managed programs incorporate practice guidelines, formal technology assessment, and inpatient critical pathways to assure clinical appropriateness and efficient health care delivery. To date, this is where most health plans have concentrated their efforts.

Disease management

Disease management is a relatively recent development. Some view the concept as new, while many contend that disease management is simply a term for continuity of care. Regardless, disease management challenges health plans and capitated integrated delivery systems to manage the delivery of care across the continuum of diseases and health care settings.

Most disease management activity focuses on chronic conditions. The objectives include identifying high-risk individuals and assuring access to the most appropriate providers in the most cost-effective settings. To do this successfully, plans must have information linking patients' clinical and financial data across the various settings of health care delivery — from the enrollment process to ambulatory and institutional-based services to claims processing and reporting. The health care system's fragmented nature and data limitations have made results difficult to measure. The lack of information systems linkages poses the most significant barrier to disease management.

Actuarial challenges

Comprehensive care management strategies will pose many new challenges to actuaries. As these programs evolve, they will obviously have an impact on provider reimbursement methods, product pricing, benefit design, persistency studies, and the analysis of administrative expenses. Historically, actuaries have concentrated their health care analysis on the utilization of procedures and fee schedules. The comprehensive care management strategy will likely move a health system to a more "budget-based" approach from the traditional utilization of procedures.

While capitation appears to be the reimbursement of the 1990s, it may not be the reimbursement of the next century. As health plans realize that capitation does not optimize their operational structure and providers realize that capitation cannot effectively account for the health status of patients, provider reimbursement may eventually evolve to episode or case reimbursement of specific diseases. In this situation, actuaries need enough clinical and financial information to predict the incidence and cost of specific diseases in a given population. More long-term analysis will be required to better understand the cost across the entire health care spectrum.

All actuaries involved in health care will admit that health care products and the underlying provider reimbursement strategies are becoming much more sophisticated. As we move into the next century, it is clear that actuaries and clinicians will need to work much closer together to best analyze the health care data and products of the future.

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