



## Leader Interview With David Axene



**David Axene**, FSA, CERA, FCA, MAAA, founded Axene Health Partners LLC in 2003 with a unique vision to integrate actuarial science and the practice of medicine to improve the health care industry. He is internationally recognized as a strategist, industry thought leader and health consultant for all types of health care organizations. He is a frequent speaker and writer on health care issues. He previously served as chairperson of the Society of Actuaries (SOA) Health Section and the Entrepreneurial Actuaries Section.

### ON BEING AN ACTUARY

**Health Watch (HW):** How and when did you decide to become an actuary?

**David Axene (DA):** Only after getting my bachelor of science in physics and engineering and working on my master of science in aeronautical engineering did I hear about the profession. I had

attended school with others who became actuaries but we hadn't talked about actuarial science. I was soon to get married and I applied for a job with a major insurance company (no experience necessary, but a degree was required). Turned out to be a sales job in group insurance and I didn't get it, but an inciteful interviewer said, "Have you ever thought about being an actuary?" No, I hadn't. In fact, I didn't know what that was. That led to my first actuarial job and the rest is history.

**HW:** What other careers did you consider? Or if you have had other careers, can you describe them?

**DA:** Engineering and astrophysics. Never had a job, just education.

**HW:** What was your favorite job before you became an actuary?

**DA:** Only summer jobs: work at a gas station while in grad school, and teacher's assistant in undergrad and grad school. Learned that you can enjoy anything if you have the right mindset.

**HW:** What has been most crucial in your development as an actuary?

**DA:** I had multiple excellent mentors, many of them actuaries, who had a significant influence on my career, each teaching something valuable:

- **Walt Steffen.** People will listen to you and important people will take interest in you when you do excellent work.
- **Ros Bond.** What you have done is important, now just tell us (taught me self-confidence in public speaking).
- **Allan Affleck.** Double check your work; careless errors will ruin the message.
- **Bob Maule.** Learn as much as possible about what you are doing and you can become the expert. Foster your insatiable curiosity about what you do.

**HW:** Looking at your career as an actuary, do you see any important learning milestones or turning points in your career?

**DA:** Developing my first client as a consultant showed me I could be a successful consulting actuary. How my manager handled

that process in my development taught me the importance of affirmation in the life of an emerging leader. He, for some reason, chose not to affirm me. His response was, “It doesn’t take much to please some people.” I learned that affirmation of development, no matter how big or small, is critical. I have applied that in mentoring my staff since that time.

My interest in finding a solution to our U.S. health care crisis really took hold when I read an article by John Wennberg in *Science* magazine discussing the significant variation in health care delivery patterns in New England towns close to each other. This showed me that much of the variation nationally was practice style. The excess variation leads to excess costs that are not necessary. This learning led to much of my direction through most of my consulting career.

**HW: As an actuary, what keeps you awake at night?**

DA: My primary business focus has been about fixing our health care system. It is so obvious to me how we might do that, but it seems we make so little progress toward that. I am often thinking about that and strategizing how we might accomplish that. My pursuit of new clients is focused on that. The consulting practice I manage pursues that. Fortunately, significant opportunities have come our way to actually impact that as current as this week.

## ON BEING A LEADER

**HW: How much did your actuarial training prepare you for this role? What additional training—formal, informal or otherwise—did you need to be successful?**

DA: Most of what I learned of value was from outside the actuarial world. I have had no formal training in leadership. I picked up bits and pieces from different places, but most of what I learned came from my father, who frankly wasn’t a business leader. In fact, this led to a book I wrote called *Clearing the Mud*, with the subtitle *Simplifying the Complexities of Running a Business*. I learned to plagiarize (in a good way) all of the good practices I observed from other leaders. The combination of all of these ideas has become a major driver of the business culture I encourage today.

Some of the formal training I have had that has been of great value include a technical writing class, learning styles and life coaching.

**HW: What are the most important lessons you’ve learned in your role?**

DA: Be open and transparent, learn to listen more than you talk, even the most complex topics are simple when you understand them, admit your mistakes, emulate others whom you respect,

always look for a better way to do things, foster your insatiable curiosity so you can be a lifetime learner.

**HW: Let’s say you’re hiring your successor. If you’re presented with two actuaries with equivalent experience and training, what characteristics will help you choose one over the other?**

DA: Even though I take pride in my ability to select good talent, I have made hiring mistakes. I have learned several key things over the years:

- An SOA fellow designation doesn’t mean an actuary is good; you have to look for more.
- Don’t fall for the good communicators; they will eat your lunch.
- When in doubt, focus on integrity and values.
- Find out what they are good at and how they do what they are good at; make sure it isn’t what others have done or are doing.
- Listen to what others outside your organization say about people.
- Trust your first insight; don’t overthink it.
- When all else is equal, seek out technical excellence.

**HW: Describe the biggest one or two challenges that you have faced in your role.**

DA: The biggest challenge in my career has been transitioning to new leadership. Understanding how people will actually lead before they take over is important. I am a big fan of leadership before the big day happens. In our consulting practice, we have an intermediate leadership position called “workgroup leader” where people demonstrate their leadership skills before they become the “real” leader. This helps us observe their approach and success before it is critical. So important, although not without its challenges. One of the best recruiters I have used had a special “learning styles” test he gave all candidates that enabled me to understand who they are and how they act in peaceful situations and who they are and how they act in stressful situations. Great learning. Showed that you need to understand reactions in stress to really know who they are.

**HW: What advice would you give to another actuary going into a leadership position for the first time?**

DA: Be yourself, listen to others, be willing to be open and transparent, and don’t be bossy. Consider your staff as peers. Pursue servant-based leadership, not command-and-control leadership. Understand the “principle of the path” (you can’t

expect to get to a different place without changing your heading). If you think you are a leader, be sure to turn around and see who is following. If there isn't anyone there, you need to reconsider.

## LOOKING FORWARD

**HW: Where do you see the actuarial profession going in the next few years?**

DA: From a health care perspective, I see the profession as being central to finding the solution to our health care woes. If we are successful at positioning ourselves in that space, we will find a solution. If we are unsuccessful or excluded from that space, I am doubtful a solution will be made.

The profession needs more thoughtful actuaries, ones with business maturity or those with a clear understanding of how businesses function. Practical business skills are needed for actuaries to thrive in tomorrow's challenges.

The enterprise risk management side of what we do will become increasingly important. We will probably hire more actuaries with economic training or who are economics majors.

Actuaries will definitely need to handle large datasets and big data, and have strong data management skills. In today's world, I see a need for most actuaries to be able to use high-level data management tools (e.g., SAS, SQL, R, etc.).

**HW: What does the actuarial profession need to do to be prepared for these changes?**

DA: I am a big fan of the "big tent." I think it is a shame that the SOA and Casualty Actuarial Society (CAS) could not find some middle ground. There is so much about health that people could learn from the CAS people and vice versa. Without increased collaboration, the diverse publics we serve will not respect us if we are coming from different "camps." Our profession is too confusing to expect our public to understand why one kind of actuary is different from another kind. Solidarity will win the day and competition will hurt us in this space.

**HW: What advice would you give actuaries regarding integrity and professionalism?**

DA: Integrity is No. 1. Professionalism is right there at the top. Without these, our profession cannot last. In my role as a testifying expert in litigations involving actuaries, I have been surprised at the misunderstanding of Actuarial Standards of Practice (ASOPs) within the actuarial world. ASOPs are our lifeblood and will do more to preserve our ability to continue to be effective actuaries than anything else. Don't mess that up! Become an expert on ASOPs if you aren't already. Too many actuaries ignore the obvious. The last thing we need to do is to lose the trust of our stakeholders regarding our profession. ■



# Is Direct-to-Provider Contracting a Potential Silver Bullet for Achieving Value-Based Care for Employer-Sponsored Plans?

By Andrew Timcheck, Cory Gusland and Mike Gaal

*Editor's note: This article first appeared at <http://www.milliman.com/insight/2019/Is-direct-to-provider-contracting-a-potential-silver-bullet-for-achieving-value-based-care-for-employer-sponsored-plans/>. Copyright © 2019 by Milliman Inc. Reprinted by permission.*

Recent announcements, such as the one by General Motors (GM) in 2018 that it had engaged the Henry Ford Health System to provide healthcare services to a portion of GM's employees,<sup>1</sup> have once again raised awareness of direct-to-provider contracting by employers and plan sponsors. Direct-to-provider contracting is a strategy in which a self-insured entity negotiates a contract directly with a provider of healthcare services rather than through a third-party administrator (TPA), often with the goal of driving value-based care. As part of a value-based contract, the provider is held accountable for improving patient outcomes through achieving key quality, cost and utilization metrics on a wide range of services. This provides the "value" in value-based care for the self-insured entity.

It's tempting to see these recent announcements as a bellwether of the direction of value-based care in the United States, cutting out the middleman role of the TPA. TPAs come in all shapes and sizes, but many self-insured employer groups contract with large insurance companies to access their network and provider contracts in performing these administrative services. TPAs navigate the competing priorities between



employers, who want to make the highest-quality healthcare available to their employees at the lowest cost, and providers, who want to offer the most effective healthcare services with the greatest degree of business efficiency. They do so by negotiating discounts with providers and developing networks, but TPAs charge a price for this service, adding a layer of cost.

It's not surprising that direct-to-provider contracting as a route to value-based care has been a popular idea among providers and employers for some time. Both parties appear to regard direct-to-provider contracting as an opportunity, although they have different reasons and different opinions on what this solution entails. Providers see an opportunity to increase volume from employers through a narrower network. And employers see an opportunity to more directly influence the delivery and costs of health care.

The interest that providers and employers have expressed for direct-to-provider solutions is complicated by the numerous ways these arrangements can be structured. Direct-to-provider contracts can take many different forms, some of which will work better than others for individual providers and employers. It might mean something like the GM deal, which involves contracting with a health system for only a small portion of GM's employee base. Alternatively, it might mean working with providers to establish onsite clinics, contracting directly with physicians to provide direct primary care (DPC), or developing a center of excellence (COE) model for specific procedures and/

or conditions. For the purpose of this article, direct-to-provider contracting is defined as an employer contracting directly with a health system to provide comprehensive healthcare coverage to its employees and its dependents. We do not consider onsite clinics, DPC, or COE models as part of our definition because those more narrow forms of contracting between employers and providers do not offer the same potential for large-scale, population-level cost savings across all covered services under employer-sponsored health plans.

### GETTING FROM HERE TO THERE

The key challenge to direct-to-provider contracting is implementing a model that is acceptable to both the employer and the provider. According to a survey of large employers from the National Business Group on Health (NBGH), 11 percent of large U.S. employers have adopted direct-to-employer arrangements with health systems and providers for 2019.<sup>2</sup> But most of the remaining 89 percent of employers don't necessarily have the size and geographic concentration of an employer like GM and may face difficulties scaling up direct-to-provider contracting in a practical manner. So a critical question remains how far can it be grown beyond that 11 percent, and, further, what *exactly* is being defined as direct-to-provider contracting. The fundamental problem, which has yet to be adequately resolved, is how to implement a program that reflects both the objectives of providers and employers, especially when these items are often in direct conflict.

### MAKING DIRECT-TO-PROVIDER CONTRACTING WORK

While the overall concept of direct-to-provider contracting makes sense, there are key issues that make it difficult to implement broadly in the employer market—the typical employer geography and employer commitment to the approach.

Some employers may not be geographically structured in a way that would make direct-to-provider contracting feasible. For example, an employer may have a geographically dispersed workforce without sufficient scale for direct-to-provider contracting in any one region. Additionally, the majority of an employer's workforce may be located in geographies where there is one dominant health system in the area, thus making negotiations difficult between the employer and the health system due to lack of competition.

In addition, employers will need to commit on a large scale to value-based, direct-to-provider arrangements for there to be any possibility for *meaningful* transformation within the U.S. health care system to a value-based approach. For example, over the long term, employers can't have only 10 percent of their employees in a value-based, direct-to-provider arrangement while the other 90 percent remain in traditional fee-for-service models. Sufficient scale is needed for direct-to-provider contracting to have a significant impact on cost and improved health outcomes.

The fundamental problem is how to implement a program that reflects both the objectives of providers and employers, especially when these are in direct conflict.

### WHAT DO EMPLOYERS AND PROVIDERS WANT?

In an ideal world, an employer would like to have a single healthcare solution that it can administer across all the geographic regions where its employees live and work. The preferred provider organization (PPO) approach has tended to work well for employers because of the administrative simplicity of large open-access networks. While it's simpler, and provides plan participants with excellent access to health care, it unfortunately does not promote efficient health care utilization because providers are generally paid on a fee-for-service basis.

In this context, it doesn't take long for the challenges of employer direct-to-provider contracts to appear. If, for example, an employer's health benefits program touches 10 different markets then it might be touching 20 to 40 different health systems that account for the majority of health care services being delivered to plan participants. The requirements for negotiating 40 or more contracts with individual health systems quickly become onerous for most employers, and this is before considering professional services (e.g., primary and specialty care) that fall outside of individual health systems. It's simply not practical for an employer to negotiate this many arrangements.

Providers, for their part, also want to use their preferred models, which they would like to roll out uniformly across all the different employers they would serve. The number of employers whose employees are touched by a provider or health system can run well into the hundreds. Additionally, providers serve many other key populations: Medicare, Medicare Advantage, Medicaid, and individual commercial insurers as well as individual self-insured employers. Providers would prefer employers to engage in relatively standard models without extensive negotiation and customization efforts, in order to reduce administrative complexity. It's already complicated for them. If one employer

wants to negotiate an individual contract, and then another employer, and then 200 more employers, it quickly becomes onerous for providers too, whose primary goal is to deliver high-quality health care to patients, not to negotiate payment arrangements.

The essential conflict we see in today's healthcare market is a structural one. Employer-sponsored plans, one of the primary delivery methods of healthcare benefits in the United States, tend to be geographically dispersed, while the actual providers of healthcare services tend to be geographically concentrated. Each side has a model that addresses the problems from its own perspective and each side would like to utilize that model in a direct-to-provider contract. But the two models don't always mesh well on a case-by-case basis and likely require lengthy negotiations between individual employers and providers. This remains one of the most daunting barriers to growing direct-to-provider contracting.

## CONCLUSION

Until now, a key role of TPAs and insurers has been to facilitate purchasing between employers and providers. In many ways, all the efforts toward direct contracting have been employer attempts to replace the rate negotiation role of TPAs and tap into more efficiency (i.e., higher value at lower cost) and transparency, and ideally achieve value-based care.

A compelling case can be made that direct-to-provider contracting is worth the effort for employers with enough scale in certain geographies, which is evidenced by marketplace activity. And alternatives to contracting directly with a health system, such as onsite clinics, DPC solutions, and COEs for specific procedures and/or conditions, have been effective at reducing costs and increasing efficiencies for some employers. These approaches may continue to gain additional traction. Conversely, a case can be made that there is a ceiling on direct-to-provider contracting as employers look to expand value-based approaches in geographies where they lack scale or market leverage. Developing unique value-based care contracts for each individual employer does not

make sense administratively or financially for most provider organizations. And many employers are not sold on the concept of varying their programs across geographies due to the added complexity.

Direct-to-provider contracting is an idea that has the potential to be successful in specific instances, particularly when there is scale and geographic concentration, and when the objectives of employers and providers are aligned. However, like many other strategies, it's probably not a silver bullet for controlling costs or expanding access to value-based care for the vast majority of employer-sponsored plans. ■



Andrew Timcheck, FSA, CERA, EA, MAAA, is a consulting actuary at Milliman. He can be reached at [andrew.timcheck@milliman.com](mailto:andrew.timcheck@milliman.com).



Cory Gusland, FSA, MAAA, is a consulting actuary at Milliman. He can be reached at [cory.gusland@milliman.com](mailto:cory.gusland@milliman.com).



Mike Gaal, FSA, MAAA, is a principal and consulting actuary at Milliman. He can be reached at [mike.gaal@milliman.com](mailto:mike.gaal@milliman.com).

## ENDNOTES

- 1 Henry Ford Health System (August 6, 2018). Henry Ford Health System launches "direct to employer" healthcare contract with General Motors. Retrieved Nov. 25, 2019, from <https://www.henryford.com/news/2018/08/direct-to-employer-announcement>.
- 2 NBGH (August 7, 2018). Large U.S. employers eye changes to health care delivery system as cost to provide health benefits nears \$15,000 per employee. Press release. Retrieved July 9, 2019, from <https://www.businessgrouphealth.org/news/nbgh-news/press-releases/press-release-details/?ID=348>.