

Statement of Dr. Gerard Anderson, Ph.D.
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Mr. Chairman, members of the Committee, fellow presenters and assembled guests, I am pleased to be part of this Committee forum. My name is Gerard Anderson, Ph.D. and I am Director of the Johns Hopkins Center for Hospital Finance and Management and Professor of Health Policy and Management, International Health, and Medicine at Johns Hopkins University.

I have been working for the past fifteen years on issues related to the chronically ill and managed care. First, I helped develop payment systems that will pay managed care organizations the higher expected costs of treating the chronically ill. Versions of these payment systems are now being implemented by the Medicare program, some Medicaid programs, and managed care organizations. More work needs to be done to refine these payment systems before they truly reflect the high expected costs associated with specific chronic illnesses although keeping the current systems in place until the "perfect" system is developed should not be an option.

Second, I have tried to educate managed care organizations and providers about the costs and utilization patterns of the chronically ill. Surprisingly little is known about how the chronically ill receive their care over the course of a year. It is only in the last few years that clinicians have begun to recognize the multitude of providers that care for a chronically ill person. In addition, we have learned that it is not simply the medical system, but also educational services, social services, transportation services that many chronically ill persons require. Frequently they are confronted with multiple care coordinators.

Finally, I have tried to educate policymakers about the various ways to monitor the managed care industry. State legislatures began to pass legislation regulating the managed care industry in the mid-1990s and now every state has passed legislation monitoring some aspect of the managed care industry. Congress is now beginning to debate this very important issue. One key point that I have tried to stress with state legislatures and Medicaid directors is that there is a choice between more sophisticated payment systems and more regulation. If the payment system does not recognize the higher expected cost of care for the chronically ill, then more regulation will be necessary. Managed care organizations and capitated physicians will not be able to provide appropriate care if they do not receive sufficient funds to care for the chronically ill. This is a special problem for providers who specialize in caring for the chronically ill. Capitation rates have to reflect the higher expected costs of the chronically ill.

My testimony today has three main themes.

First, persons with chronic illness have much higher expected costs than other individuals. This is shown in charts 1 and 2. Children with chronic illness have expected costs that are 2.3 to almost 50 times more expensive than the average child. Medicare beneficiaries have expected costs that are 1.3 to almost 4.0 times greater than the "typical" Medicare beneficiary. This suggests that risk adjusters are necessary to protect the chronically ill. Demographic risk adjusters, such as the Adjusted Average Per Capita Cost (AAPCC) which is currently used by Medicare, are simply not adequate. They do not recognize the higher cost of the chronically ill.

Second, persons with chronic illness use a different group of providers than other individuals. The chronically ill are especially dependent on home health care, durable medical equipment, and certain clinical specialties. This is shown in charts 3 and 4. Children with cystic fibrosis, for example, use

almost 80 times the level of home health services as the typical child. By selecting certain providers, managed care organizations are able to influence what individuals will join their plan, since the chronically ill are very aware of what providers they currently use and will need in the future. The chronically ill must be assured access to a broad range of providers. Much of the managed care legislation at the state level is to assure appropriate access to these providers for the chronically ill.

Third, policymakers have a choice -- implement payment systems that reflect the expected cost of caring for individuals with chronic illnesses or spend time writing regulations preventing a few managed care plans from taking actions which would jeopardize their access to managed care and their quality of care if they enroll. My final chart illustrates how one of the payment systems would operate. It compares a payment system that includes clinical information to the current Medicare model for three women aged 65-69 with very different levels of illness. Under the current Medicare model, the capitation rate would be the same for each woman. However, under the proposed model, capitation rates would be lower for a relatively healthy woman and would increase as the illness burden of the woman increased.

I have attached a series of charts which explain these three main points in greater detail.

I appreciate the opportunity to present this information to the Committee today.

Individuals with Chronic illness

- Are more expensive on a per capita basis -- especially children
- Have a skewed distribution of expenditures
- Often have comorbidities /complications that contribute to higher expenditures

Policy Implications

Need risk adjustment methods that account for:

- the higher costs of care for the chronically ill
- cost variations within similar chronic conditions

Need to monitor and ensure access to appropriate services and providers for chronically ill enrolled in managed care.

Adjustment Mechanisms.

Reduce the effects of risk selection when individuals have a choice among health plans.

Risk adjustment mechanisms can protect:

- Medicaid programs
- chronically ill individuals
- managed care organizations
- providers

Components of Risk Adjustment Systems

Reinsurance

- protection against very high cost individuals

Carve-outs

- separate payment and/or delivery system for individuals with specific medical conditions or for specific services

Prospective risk adjusters

- adjusts payments to reflect the expected cost of a group of individuals

Possible Reinsurance Thresholds

- \$5,000
- \$25,000
- \$50,000
- \$75,000
- \$100,000

Reinsurance Issues

- Lower thresholds - more money set aside for reinsurance
- May minimally protect the chronically ill

Condition Carve Outs

- Clinical conditions where more than 50 percent of cases have expected costs greater than, \$25,000
- Clinical conditions where mean costs are greater than \$25,000
- Clinical conditions with minimal discretion involving diagnosis and coding

Carve Out Issues

- More carve outs - more dollars carved out
- Cost variation within carve out conditions

Prospective Risk Adjusters

- Use characteristics of all individuals in a group to predict future needs for medical services and their expected costs

Criteria for Evaluating Risk Adjusters

- Predictive accuracy
- Incentives for appropriate care
- Susceptibility to manipulations
- Administrative feasibility
- Patient confidentiality

Possible Risk Adjustors

- Demographics
- Self-reported health status
- Functional health status
- Prior utilization
- Clinical indicators

Clinical Indicator Models

- ACG
- HCC
- DPS
- NACHRI Model

Conclusions

Payment systems

- existing risk adjustment may not protect chronically ill
- risk adjustment not widely used

Provider networks

- broad network needed
- certain services heavily used by chronically ill
- clinical and non-clinical services needed

Treatment protocols / quality measures

- difficult to generalize across conditions