SOCIETY OF ACTUARIES

Article from:

The Actuary

April 1997 – Volume 31, No. 4

Medicare testimony

Actuary addresses Congressional subcommittee

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Actuaries and their work stepped into the public spotlight through Congressional testimony on Medicare provided by the American Academy of Actuaries.

Alice Rosenblatt, Academy Board of Directors member and a member of the 1994-96 SOA Board of Governors, offered six suggestions to help ease the Medicare funding crisis to the Subcommittee on Health of the Committee on Ways and Means in Washington on February 25.

Rosenblatt was selected to present the Academy's testimony as an expert on risk assessment and adjustment. She and Daniel L. Dunn were lead investigators of a Society-sponsored report, *A Comparative Analysis of Methods of Health Risk Assessment,* published as part of the SOA's Monograph Series in 1996. She also serves on a study panel sponsored by the National Academy of Social Insurance on the effect consumer choices have on Medicare now that a wide range of private plans are available. Rosenblatt is senior vice president and chief actuary of Wellpoint Health Networks, Woodland Hills, Calif.

4 topics of testimony

Testimony was requested by the subcommittee on:

- Health risk assessment and risk adjustment
- How they relate to the current Medicare risk contracting program
- How improvements can be made to the current risk contracting program
- Provisions in the administration's 1998 budget proposal regarding HMO payments

Rosenblatt's testimony on the first three points concluded with six suggestions for improving the current payment method used by Medicare, which relies on the average adjusted per capita cost method (AAPCC). This approach bases risk adjustment on age, sex, welfare status, institutional status, and basis for Medicare eligibility. The AAPCC is applied to a managed care plan's population, and the results are modified by a further factor, called the adjusted community rate (ACR), which attempts to adjust for the health plan's cost structure.

Suggestions for improvement were:

- Reduce the wide variations in the geographic region values of the AAPCC since the variation is not an accurate reflection of the geographic-driven costs.
- Use a "credibility" approach, possibly one that bases payments to health plans on a combination of prepayments and a plan's actual experience.
- Consider carving out particular disease populations or procedures to separate more costly situations from the base, thereby limiting the variation in costs due to risk differentials.
- Reengineer the ACR methodology.
- Base the AAPCC methodology on something other than fee-for-service payments, possibly the use of competitive bidding.
- Continue studies and demonstration projects on risk assessment and adjustment methods to improve on those currently in use.

Focus on the federal budget

Commenting on the administration's budget proposal, Rosenblatt addressed the alternatives to the proposal's suggested phased-in reduction in HMO payments from the current 95% of fee-for-service payments to 90%. Her testimony on behalf of the Academy said two alternatives worthy of discussion are modifying the risk-assessment method or modifying the current payment method linking HMO payments to fee-for-service payments.

The budget plan would remove from the HMO payment formula two current elements: payments on graduate medical education and disproportionate-share hospital payments. These would be redirected accordingly. The Academy calls this an improvement, saying it would reflect the actual costs for Medicare enrollees.

Alice Rosenblatt

Also under the administration's budget plan, provider-sponsored organizations (PSOs) and preferred provider organizations would be allowed to participate in Medicare under minimum federal standards, with states allowed to impose more stringent standards after four years. In her testimony, Rosenblatt said that PSOs should be subject to similar regulatory requirements as HMOs and traditional insurers if a level playing field is to exist. She told the subcommittee that the Academy is concerned about adequate solvency of new health entities such as PSOs.

Under-the-wire response

This was Rosenblatt's fourth appearance testifying before a Congressional group. Her three earlier sessions in 1993 offered testimony on risk assessment related to President Bill Clinton's health care plan, subject of much heated discussion before its rejection during his first term.

As an experienced witness, Rosenblatt knows both the frustrations and opportunities of the process. "It's difficult. Everything is timed. You have only five minutes to express your statement. Also, every question the Congressional representatives can ask is also timed.

That keeps you from speaking up when a question is asked of someone else and you have helpful information."

Lights in the hearing room turn yellow to warn that a speaker's time is almost up and red to signal the end. Rosenblatt spoke up when the red light appeared. "I said that I knew my time was up, but I had two points to make about comments expressed by the first panel earlier that day. The chairman, William Thomas, said, 'Go ahead.'"

First, Rosenblatt told the subcommittee that suggestions made earlier that day to use loss ratios for Medicare risk plans ignored the fact that "there are lots of problems with any kind of loss ratio tests. Specifically, there is no standardized definition of the numerator or the denominator of the ratio. Also, there are significant problems that can distort test results."

Second, she objected to an implication that Medicare's population of frequent (high-risk) users was not a significant element of a plan's cost. Rosenblatt was able to cite the fact that "for under-65 populations, 5% of the claimants in an insured plan generate 50% of the claim dollars." She observed, "While the number of people is small, the cost implications are great."

Copies available of testimony, monograph

Copies of Rosenblatt's nine-page Congressional testimony are available free of charge from Doreen Evans, American Academy of Actuaries, 1100 17th Street N.W., Washington, DC 20036-4601 (phone: 202/223-8196; fax: 202/872-1948).

Copies of the 127-page monograph presenting Rosenblatt's and Dunn's risk assessment study are available for $35 from the Society of Actuaries' Books Department (phone: 847/706-3526; fax: 847/706-3599; e-mail, for information requests only: ccimo@soa.org).

2 more actuaries testify

Two actuaries presented further testimony on Medicare to Congressional groups on March 19 on behalf of the American Academy of Actuaries.

William Bluhm, vice president heading the Academy's Health Practice Council, appeared before the House Conference Subcommittee on Health and Environment. He warned that proposed minimum solvency standards for provider-sponsored organizations may create undue financial risk.

Michael Thompson, chair of the Academy's Medigap Work Group, addressed the Senate Finance Committee. He cautioned that easing Medigap open-enrollment requirements may increase the cost of coverage for Medigap enrollees.

The wired future (continued from page 4)

"The medical profession is still in many ways a 'cottage industry,'" McCall pointed out. "If anyone thinks we can successfully commoditize the delivery of health care, they're wrong. We never will."

"It's so tempting to say that technology will tell us the right timing, the right decisions. No machine will think for you. Strategy is not that easy, whether it's for patient care or management of a health care network. If you focus solely on technology or data warehouses to deliver your information, you'll cut out more than half the information you'll need to run your business. The data that isn't in a warehouse is so important, if you don't find a way to integrate it, you'll miss the big picture."

Davlin observed that health actuaries will need to be aware of the consumer uses of technology. With information and competitive physician consultations available worldwide, some consumers may be able to use health information in a way insurers would see as anti-selective: that is, consumers would seek insurance because information they found on the Internet or another online source signals a possible health threat. On the positive side, "It may become much more difficult for insurers to detect pre-existing conditions," Davlin noted. "People will be taking more responsibility for their health, and this could reduce health care and insurer costs in the long run."

Current and emerging technology may not be a substitute for human judgment, but it could allow better medical decisions. "Encryption will make it possible to send patient information, even images, over the Internet, and this will allow highly experienced doctors to render second opinions — no matter how far the doctor is from the patient," Davlin said. "What I imagine is that fewer doctors who are better at what they do will get more of the available work."

Nohl observed that today's imaging technology is already enabling health care delivery at a distance, particularly the rendering of second opinions and the reading of X-rays. However, improvements in encryption will expand the practice, he said.

Patients could benefit from other changes as well, noted Evans. "It would be nice to see computerized medical records instead of these charts no one can find. In the emergency room today, no one has access to your records if you weren't a patient at that hospital before. When institutions finally agree on (system standards to exchange information), no longer will patient records be lost."

He said that health actuaries and others who analyze health care data have a tremendous responsibility. "We look at numbers and more numbers, but what you do with them has a great impact on people. In health care, it's literally life and death," he said. "The goal of using technology in health care management is not just to cut costs. It's to do the right thing first. We want to help people get better. Technology can help partly to make us aware of the costs but also to know the effectiveness of treatments."