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EDITORIAL

Health care reform and malpractice

by Robert H. Dobson

Last October, when my term as president of the Conference of Consulting Actuaries ended, I vowed to just say "no" when asked to volunteer for the profession. You can see how long that resolution lasted — this is my first issue as associate editor of *The Actuary*. The opportunity to communicate with the profession about my specialty, health care (of current interest to all), and other important topics was irresistible.

This editorial connects health care reform with actuarial malpractice or professional liability, not medical malpractice. I have a history of linking malpractice with other topics (for example, my presidential address for the CCA was on "Marriage and Malpractice"). Why? Because I think actuaries should be more aware of the risks and consequences of malpractice.

What do we know about health care reform that might make us aware of possible professional pitfalls for actuaries? We know that the world as we know it is changing very fast. In a time of rapid change, there are winners and losers. The losers will not be happy and will look for someone to blame. The danger is that they will blame those who advised them.

Three elements of health care reform come to mind as areas where caution is advised: solvency, risk adjustment, and pricing.

Many aspects of health care reform can cause solvency problems. Premium caps is one in which I have been involved. President Clinton's Health Security Act contains limits on premium rates that kick in if competition does not hold health care costs below some very aggressive targets. If a health plan's premiums are above its target, the plan has the choice of voluntarily reducing premiums or accepting a plan payment reduction. The latter option reduces amounts paid to health care services providers. It is not hard to imagine a plan becoming insolvent from accepting voluntary reductions. It also is not hard to imagine the plan's owners blaming their actuary.

Risk adjustment is one of the bright spots in the health care reform picture for actuaries. The need for actuarial involvement is recognized. The problem is that no risk adjustment system can work perfectly, because the element of random fluctuation cannot be eliminated. Will actuaries be blamed when this inevitability becomes apparent? Perhaps not, if we are honest about the limitations of such systems now.

Another concern about risk adjustment systems is that privacy issues can prevent the use of potentially valuable information (i.e., sexual habits). The best source of information could be genetic testing, but privacy issues and costs probably will prevent its use.

Some have speculated that pricing under a Clinton-type health care system might be based more on gaming (choosing the price strategically to try to optimize profits) than on actuarial techniques. If this is true, additional areas of professional liability will arise. Actuaries may be held accountable for premiums that are too low (the solvency issue) or too high (not actuarially justifiable).

Of course, we cannot let the fear of lawsuits prevent us from moving into new areas. Our actuarial training in problem solving will be an invaluable asset to health plans, alliances, and policymakers under any health care reform scenario. We protect ourselves

best by doing good work, which involves peer review and good documentation.

This may be my only column directly devoted to malpractice, but it will not be the last on the changes occurring in our health care system and related professional issues. Readers reactions are more than welcome; they are encouraged (dare I say mandated?).

Editor's note: We are pleased that an expert in the financing and delivery of health care, Bob Dobson, has joined the editorial board. He takes the place of Tony Spano, who served on the editorial board from 1990-93. Spano had filled several publication roles for the Society since 1973 and was director of publications in 1986 when The Actuary *restructured with its present system of revolving associate editors. We owe Tony our gratitude for his long, capable service.*

Dobson is a consulting actuary with Milliman and Robertson's Atlanta office. In addition to being a frequent speaker at Society meetings, he is the immediate past president of the Conference of Consulting Actuaries and has been a vice president of the American Academy of Actuaries.

Original vs. actual (continued from page 1)

Hospital costs had been increasing much faster than wages for many years before 1965, and this fact was well-known at the time. H. Lewis Reitz, executive vice president of the Great Southern Life Insurance Company, testified against the forerunner of Medicare before the Senate Finance Committee on August 13, 1964. His testimony, complete with a comprehensive actuarial memorandum, stated, "Regarding the administration's estimate, 'It relies upon the questionable assumption that hospitalization costs will increase after 1971 at the same rate as any increase in earnings levels, whereas the increase in hospital costs has outstripped the increase in earnings levels through 1963. ...We concur with the opinion of most hospital authorities and medical economists, that hospital per diem costs will continue to rise faster than average wages for the foreseeable future." The actuarial memorandum (author unknown) had identified a key source of projection error in the original Medicare cost projections.

Those who are interested in a more detailed explanation of the difference between the administration estimates and the insurance industry estimates can find an explanation in the *Transactions*. A memorandum documenting the difference in the estimates and signed jointly by Robert J. Myers (representing the administration) and D.W. Pettengill (representing the insurance industry) was inserted in the *Transactions* (Volume XVII, Part I, 1965; p. 534) by Gordon Trapnell.

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Fact sheet

Following is a comparison of actual results with the original estimates for Section 2991 of the 1972 Social Security Amendments. Section 2991 established eligibility for Medicare for persons suffering from End Stage Renal Disease (ESRD), then called Chronic Renal Disease (CRD). Both aged and disabled beneficiaries may receive ESRD services, but the 2991 beneficiaries are those people who qualify for Medicare solely on the basis of having ESRD.

As the table shows, the original estimates were reasonable compared with the actuarial experience. Because the ESRD program has grown rapidly, observers often jump to the erroneous conclusion that the original cost estimates were grossly understated.

In addition, some uninformed observers have contributed to the confusion by inappropriately comparing all ESRD expenditures with the original estimates for the 2991 group only. Persons who qualify for Medicare as aged or disabled beneficiaries also can receive ESRD services, but the costs of those services were already included in other cost estimates for the 1972 Amendments. For example, costs of ESRD services for the disabled population were not included in the 2991 estimates, but instead were part of the cost estimates for extending Medicare coverage to the disabled population. The cost for the disabled population also was not underestimated.

Originally, long-range estimates beyond five years were only prepared for the Hospital Insurance (HI) program, and the estimates for the Supplementary Medical Insurance (SMI) program did not extend beyond five years. For the comparison of the long-range estimates shown below, the SMI ESRD benefit estimates were extended beyond five years by assuming the same ratio of SMI to HI ESRD benefits as in the short range. Part of the reason for the lower comparison ratio in more recent years is the various cuts in provider payment levels caused by legislation in the 1980s. These cuts affected providers of ESRD services as well.

Short-range estimates:

Fiscal Year	Orig. Est.	Actuals	Ratio*
1974	$ 98 M	$ 99 M	1.01
1975	152	187	1.23
1976	190	236	1.24
1977	242	267	1.10

Long-range estimates:

Fiscal Year	Orig. Est.	Actuals	Ratio*
1980	$ 481 M	$ 488 M	1.01
1985	1293	1094	0.85
1990	2326	1861	0.80

* Ratio is the actual expenditures divided by the original expenditure estimates.