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EDITORIAL

Managed care creates key role for actuaries

by Janet M. Carstens

A wave of class action lawsuits, proposed state and federal regulation, and the occasional multi-million dollar ruling on individual suits have rocked the managed care industry. Health plans and insurers cannot ignore these developments, but neither can they overreact by settling dubious suits too quickly or pulling back from the cost and care improvements brought about by managed care.

Rather, because many of the issues that invite lawsuits are exactly the issues that compromise health plan financial success, now is an ideal time for plans to conduct a risk assessment that incorporates a company's strategic goals. The risk management program that emerges from such a process can reduce a company's exposure to litigation and ensure compliance with state and federal law. Equally important, it can maximize profits by aligning all pieces of a health plan's operation with an overall strategy focused on improving quality and reducing the cost of health care. Improved medical management, for example, might ward off claims that inconsistent or inefficient programs led to negligent care, while at the same time increasing the return on investment for such programs.

Developing a comprehensive risk management program also demonstrates how creative actuaries can add value to the businesses they serve. Health care is one of many industries requiring reliable models to quantify risk in ways that go beyond traditional number-crunching. In the case of helping health care organizations cope with legal risk, actuaries can team with clinicians and operations experts to provide crucial intelligence to management and legal counsel.

How each organization prepares for potential lawsuits will differ, of course, but all plans will need to focus on the business functions most likely to be under attack: finance, operations, medical management and marketing, sales, and customer service.

For example, in a suit that takes aim at the whole concept of managed care, plans must ensure that sound and ethical business practices are in place so conflict of interest claims about the levels of care being delivered can be legitimately dismissed. Here, actuaries can run utilization comparisons and patient outcome comparisons, as well as analyze the effects of any financial incentive arrangements on the level of care. At the same time, clinicians can evaluate the propriety of care, and operations experts can examine the processes in place for protocol development and staff training. The team can then integrate these analyses so management or a defense team can draw balanced conclusions about the business and its risks.

Or, suppose a suit alleges medical malpractice on the part of the provider, as well as culpability on the part of the plan due to negligence in its provider selection and credentialing process — neither of which is spelled out in the plan's marketing materials. In this case, actuaries could work closely with clinicians and operations experts to examine provider financial incentives

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Who lacks health insurance coverage? (continued from page 1)

modest, however, and has occurred during the strongest economic expansion in recent memory. An economic recession would have the potential to significantly reduce the prevalence of private health insurance coverage. The drop in public coverage appears to be associated with welfare reform. While the intent of the reforms was to allow families to maintain public coverage as they moved into the labor force, miscommunication and implementation problems may have resulted in many losing coverage.

An article in the October 23/30, 1996, issue of the *Journal of the American Medical Association,* "Whatever Happened to the Health Insurance Crisis in the United States?" reported results of a national survey. The uninsured were asked why they lack health insurance, and two-thirds said that coverage is too expensive. Employment-related reasons were cited by 17%, and 8% indicated that they either do not want or do not need insurance. Only 1% said that they have a pre-existing medical condition and cannot obtain coverage. Similarly, the March/April 1999 issue of *Health Affairs* ("Why Are Workers Uninsured?") reports that when uninsured workers who were offered employer-sponsored health insurance in 1997 were asked why they declined it, two-thirds cite its high cost. These results are consistent with the relatively low enrollment levels of most state-sponsored high-risk pools.

Efforts to extend coverage to more Americans are unlikely to be successful unless they address the real reasons people often lack health insurance coverage. Most of the uninsured simply cannot afford the cost of coverage.

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Percentage by Income Categories						
						400% or
	Total	0–99%	100%–199%	200%–299%	300%–399%	More
Private	71%	24%	52%	74%	84%	90%
Employment-based	66%	18%	45%	68%	78%	86%
Other Private	7%	9%	9%	7%	6%	5%
Public	14%	45%	23%	11%	6%	5%
Uninsured	18%	36%	31%	20%	13%	8%

Source: William Custer and Pat Kelsche, *Health Insurance Coverage and the Uninsured: 1990-1998,* Health Insurance Association of America, December 1999
Note: The total for insurance categories may exceed 100% because individuals may have multiple sources of coverage.

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and determine if these incentives compromise acceptable levels of care. Actuaries could also gather valid samples and project whether a statistical difference exists among incentive plans and groups. At the same time, operations experts could examine how actual practices vary from marketing materials and interactions, along with evaluating the provider selection and credentialing process and the peer review and corrective process. Clinicians could analyze the degree to which the patient suffered harm. Again, the team would then present an integrated analysis to management so it can make informed decisions about what the company's risk management program should look like.

What is particularly appealing about this process is the way it clearly identifies the legal and business issues that spur litigation. This not only provides for the strongest possible defense if a company is sued, but it also positions the company to recover and protect itself from future litigation. Most importantly, however, it is good business.

Actuarial projections are invaluable in this and other risk management processes that fall outside the traditional boundaries for actuarial work. By creatively applying our skills, we serve our clients better and broaden the possibilities for our profession.