SOCIETY OF ACTUARIES Health Section

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HealthWatch

Full Medicare Part D Coverage through the Gap—an Endangered Benefit?

Taking a Closer Look at the Payment Demonstration

by Julia Lambert

As evidenced by the 2009 plan landscape, Part D gap coverage for Medicare beneficiaries is hard to come by. No stand-alone Part D plans with full brand coverage through the gap are available in 2008 or 2009. On the MA-PD side, there are a few options, but only a handful. Despite CMS encouragement to offer rich benefit options, why do insurers continue to gravitate towards lower cost plans with less coverage through the gap? The main issues include:

- low member premium plans continue to be attractive in the marketplace
- medical and pharmacy trends are increasing faster than the benchmark rates, causing insurers to reduce benefits in order to maintain premiums
- even with risk adjusted rates, anti-selection issues cause pricing difficulties for rich benefit plans

Julia Lambert, FSA, MAAA, is a consulting actuary and principal in the Clearwater office of Wakely Consulting Group. She can be reached at (727) 507-9858, extension 115 or at *julial@wakelyconsulting.com*

Exhibit A illustrates the decline in the percentage of plans with full formulary coverage between 2007 and 2009. This data was collected from multiple files within the CMS Landscape Source Data files on the CMS website.

One option provided by CMS that still remains, at least through the 2011 benefit year, is the Part D Payment Demonstration option. Although it was first introduced in February 2006 as a mechanism for enhanced benefit plans to offset the "federal reinsurance penalty," relatively few plans have taken advantage of the option.

Exhibit A: Percent of Each Plan Type offering Full Formulary Coverage Through the Gap

Plan Type	2007	2008	2009
PDP Stand-alone	1.3%	0.0%	0.0%
MA-PD non-SNP	1.8%	1.5%	0.6%
MA-PD SNP	n/a	3.4%	1.3%

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Actuaries
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Chairperson's Corner

by Jennifer Gillespie

Jennifer Gillespie, FSA, MAAA, is VP & actuary, Underwriting at Blue Cross/Blue Shield of MN in St. Paul, Minn. She can be reached at *jennifer_gillespie@bluecrossmn.com.*

Thank you to all of you who participated in our recent Health Section member survey. It's been two years since we last conducted one. The 2006 survey has been very helpful for directing the work of the council regarding education, research and other ways we can meet the needs of section members. We will study the results of the recent survey just as carefully and will be alert to new activities we should undertake.

One outcome of the 2006 survey that has recently taken flight is a new Special Interest Group for those members of the Health Section who work with any of the parts of Medicare and retiree benefits. We hope that this topically focused group will successfully serve actuaries under the umbrella of the Health Section as just the Disability Special Interest Group does.

Another outcome of the previous study was the educational Boot Camp concept. The Pricing and Valuation Boot Camps achieved near sellout attendance in August 2008 and we have undertaken to bring them back bigger and even better for August 2009. The plan is to expand to four topics and run two tracks concurrently for the first two days, then cover professionalism, and follow with two more days of concurrent tracks. Watch for more information on specific topics, dates and location.

We continue to advance the strategies around Untapped Opportunities for Actuaries. At this point we are in the research stage and are doing "deep dives." Thank you to the section members who responded to the request for stories of successful or attempted forays in to new fields for actuaries. Interviews are being conducted with actuaries and employers to research the issues surrounding these opportunities. We need to understand what aspects of actuarial training are thought to be the most applicable to new fields, which aspects it turns out are the most applicable, and where we are deemed to have shortcomings. Similarly in order to create a path for credentialed actuaries to transition to health, we need to know what health employers are seeking from these candidates. Then we can look for ways to help other actuaries be prepared for the health industry. We are also working with the SOA to conduct an assessment of the greater health care employer market so that we can better understand other employer needs and identify new opportunities for future employment and growth.

The Health Section has several active research projects at this time. Two of the most recent have been focused on quality initiatives. If you have an idea for a research project you think would have relevance to many in the industry, please consider submitting it to the SOA Health Section. We fund new research each year and are also willing to partner with other sections if the research is cross disciplinary in nature.

HealthWatch and our hard working editors, are always seeking new authors and new topics for articles. If you have completed interesting research, finished an important project, or have a different perspective to share, please consider submitting an article for publication. Also if there is a topic you would like to read about or somebody you have heard speak who you think should be published, those suggestions are welcome as well. ■

Letter From the Editor

by Ross Winkelman

A common refrain among health actuaries and others working in health care is that the practice of medicine is fragmented and inconsistent. As an example, caesarian rates in Italy are very high at about 40 percent of births and lowest in Nordic countries at around 14 percent. Significant variations exist across the United States. Interestingly, Italy and the Nordic countries are routinely regarded as having some of the best outcomes—clearly, this variation has more to do with financing and practice patterns than evidence based medicine. This is a critical discussion because inconsistencies can result in poor outcomes and wasted resources. However, I'll leave that discussion to more qualified individuals.

In thinking through this issue and reviewing other actuaries' work, it struck me that this discussion is also appropriate for the actuarial profession. Given the same set of data and information (i.e., the same patient), should two qualified actuaries arrive at similar answers (treatment), and should those answers be communicated in a consistent manner? The struggle, like it is in medicine, is to try to achieve consistency based on best practices while not prescribing approaches that cannot consider all of the specifics of all of the various situations. The Actuarial Standards of Practice (ASOPs) are the tool that the profession uses to achieve a measure of consistency. The Actuarial Standards Board (ASB) establishes the ASOPs, and the ASB's stated goal is for the ASOPs to "identify what the actuary should consider, document, and disclose when performing an actuarial assignment." Interestingly, this does not mention results, which is arguably what really matters.

Should we consider setting a higher goal for the ASOPs—namely that two qualified actuaries, given the same set of information and assumptions, should reach a similar conclusion? Some circumstances might support this type of a shift in the ASOPs (rate filings with fully credible experience come to mind) while others might not (long term health care cost trends based on the discussion in this issue!). The basic question that we need to collectively answer is what is the best way to improve our identification and compliance with best practices? Maybe modifying the basic purpose of the ASOPs is not the answer because of their binding nature. However, I think it is important that we seek out new ways to improve the quality and consistency of our work—just like we ask the medical community to do the same. ■

Ross Winkelman is a consulting actuary and managing director for Wakely Consulting Group. He can be reached at *rossw@wakelyconsulting.com* or (720) 279-2446.

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HealthWatch

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Letters to the Editor

We appreciate the article by Wes Edwards that helps to advance actuarial thinking regarding the Long-Term Health Care Resource Model (Model). We share Professor Tom Getzen's view that while we cannot predict what part of GDP might shrink to accommodate a greater share allocated to health care costs in the long-term future, such a shift in resources is certainly a realistic assumption that reasonable actuaries can make.

We are somewhat puzzled by Mr. Edwards' conclusion that since under one set of input assumptions the Model produces a long-term percentage of GDP allocated to health care that is much higher than he believes to be reasonable, then the Model itself is of little or no value.

In fact, Mr. Edwards' criticism points to what is arguably the greatest strength of the Model: by forcing actuaries to document the building blocks used to develop long-term medical trend assumptions, it helps generate the kind of healthy debate initiated by Mr. Edwards.

If a plan sponsor meets with a panel of economists and futurists and they conclude that the percentage of GDP could never exceed 20 percent, because of global energy shortages, terrorism, climate change etc., then we believe the Model is sufficiently flexible to meet the needs of the plan sponsor. For example, we changed the Baseline assumptions for three of the Model inputs to reduce the ultimate percent of GDP spent on health care from 34 to 20 percent of GDP. The current percentage of GDP that goes to health care is 16.5 percent. The table compares the Baseline assumptions to the alternative scenario that we labeled "pessimistic."

We would not recommend this type of assumption setting without a thorough reading of the supporting documentation and an understanding of how the assumptions interact but it is possible to do so.

We think there may be a misunderstanding of what the Model is intended to do.

The Model forces users of the model (including the plan sponsor and auditors) to think about the underlying economic assumptions behind the long-term health care trend assumption.

The reason Baseline assumptions are provided is because the Project Oversight Group (POG) believe that the typical actuary would need guidance as to how select the assumptions, and as to what economists believe are reasonable assumptions. Accordingly we asked Professor Getzen to document how he arrived at his range and Baseline assumptions. This document is posted on the SOA Web page, and should be read carefully by users and others who explore the model results.

The Baseline assumptions are provided as a resource for actuaries who do not have the time (and budget) to work closely with economists and futurists when doing first time OPEB valuations for City X or County Y with a limited budget, and by actuaries doing FAS 106 and VEBA valuations for private sector clients who may want to use a more rigorous assumption setting process than was perhaps used in prior valuations.

Alternatively, the model input assumptions can be changed. If a user does so, it is our belief that the user should be prepared to explain why the alternate set of economic assumptions is reasonable. The July 2008 issue of the Watson Wyatt Insider has an excellent article on the Model with four alternative sets of economic assumptions, and the reasoning behind each set of assumptions.

The POG encourages actuaries to use the Model to set their assumptions and to disclose the Model inputs. Two sample disclosures are provided on the SOA Web page that were drafted by the POG, one using the Baseline assumptions and a second varying those assumptions. We believe if the user varies the baseline input values, the rationale for the change should be disclosed in the actuarial report.

Before the Model was released there was no generally accepted resource for actuaries to use to set these assumptions. Medical trend assumptions were set using a variety of methods that were not particularly transparent, and as Mr. Edwards points out one result of this lack of transparency was that trend assumptions had arguably begun to become somewhat optimistic when compared to actual experience over the past decade.

Yes, the Model is simple. That is partly because our goal was to make a model that was transparent and usable. In addition, the POG's hope is that the current model will be periodically reviewed against actual experience and improved over time as more practitioners join Mr. Edwards in probing the underlying model process.

To summarize we believe that the Model

- Is a considerable improvement over the previous methods used by actuaries to determine long-term medical trend,
- Makes available to actuaries one of many possible well thought out set of reasonable Baseline assumptions (with documentation),
- Provides flexibility to allow actuaries to use other sets of economic assumptions, and
- Is just the first step in producing tools actuaries can use to set long-term medical trend assumptions.

We encourage further critical examination of the model so that constructive improvements can be made. Ultimately, the hope of the POG that developed this initial model is that within a couple of years, a new POG can be convened by volunteers who will move the state of the model to the next level, whatever that turns out to be.

Kevin Binder, John Cookson, Russell Weatherholtz, Keith Williams, Adam Reese and Marilyn Oliver—The authors are members of the long-term medical trend POG. ■

Response

The POG members' response to my piece on the Getzen model asserts I suggested "the Model itself is of little or no value." Nothing could be further from the truth. I stated I welcome the study and I believe the model is a valuable starting point. The sole point of my article was to highlight areas, especially the need to expand beyond any potential implication of an authoritative "baseline" assumption set, and to encourage individual actuaries to go beyond the model and the accompanying assumption set; indeed I suggest as a profession we must further expand upon what the POG members concede is a simple model.

I solicited opinions from economists with think tanks (e.g., National Heritage Foundation) and academia, but they were not so bold as the POG and Professor Getzen to express a single baseline assumption opinion. As a result, I confess I do believe the "baseline" assumptions drafted by the Professor and endorsed by the POG warrant a more thorough vetting. I am not familiar with the Watson Wyatt Insider or the article referenced by the POG members, but I am confident the actuarial community would welcome the wider publication of alternative macroeconomic assumption sets.

—Wes Edwards

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Dear Editor,
I enjoyed reading the article from Mr. John Ahrens in the last HealthWatch newsletter. I would like to comment on each "myth" in Mr. Ahren's article.

Myth 1

Financial strength ratings do matter. What also matters is an understanding of the market and the risk, which typically is strengthened by longevity in the market. The fact that clients and Errors & Omissions coverage writers prefer (A) rated more than (B or C) rated companies does not surprise me. A promise to pay is only as good as the one making the promise. Although arguments can be made that even (A) rated carriers face financial difficulties and fail, there is some value to the work of rating agencies. Therefore, I believe rating should have some significance along with the carrier's track record in the employer stop loss marketplace.

Myth 2

Reinsurers are key partners. I agree that issuing carriers should take more risk. It's always a better sign when you "eat what you cook." However, since this is not always the current environment in which managing underwriters operate, the quality of the reinsurer is very important, as they are the ultimate risk-taker. It is important to have individuals on staff who have significant employer stop loss expertise and experience and can provide insights into problems and opportunities that arise. A long-term horizon is best as it is with most investments. A six-month termination notice seems fair to all parties.

Myth 3

Given the amount of time, energy and thought that goes into a manual rating approach, at least in my company, rate to manual does mean something. If you use an "off the shelf" manual that fails to capture the unique features of the provider networks and case management protocols of the companies involved (TPAs and other vendors), I understand why there would be less emphasis on rate to manual. Our greatest loss ratio problems arise out of instances where the rate to manual was 80 percent, but the group's historical experience points to a fact that it should have been at 120 percent of manual! Our manual, in most instances, is a very good starting point for assessing the risk. The underwriters need to underwrite cases and be cognizant of the risk factors, particularly when an argument is to be made that we are at, below, or above manual. Given the size of the group and the expected frequency of a catastrophic claim, there should be very little experience rating of specific stop loss premiums.

Myth 4

Unfortunately, the competition rarely keeps compensation to TPAs, brokers, carriers and managing underwriters to a level as described in Mr. Ahren's article. Competition typically forces underwriters (willing to do so) to cut rates without thinking about lowering the "expense loads." Suggesting all parties reduce their fees does not make it happen. I'm with Mr. Ahrens philosophically on this point, i.e., I'd like to figure out a way to reduce expenses across all categories in this line of business. Each player is free currently to volume discount their expenses and this would be a great start. Charging for new business quotes is creative, but unpractical in a soft market in particular.

Myth 5

This is the crux of the article commentary, i.e., is employer stop loss experience credible? I think Mr. Ahrens is chasing good experience (a.k.a. attempting to "cherry pick") by analyzing expected catastrophic claim frequencies on very small groups. At the end of the day, if the group properly sets their specific deductible at a point in which claims are random and unpredictable, why should you rely on the prior experience to establish a current premium rate?

I appreciate Mr. Ahren's comments regarding the state of the market and its myths.

Mark Troutman, President, Summit Reinsurance Services, Inc. ■

The Modernization of Medigap Plans

Legislative Summary

by Marianne Miller

Because Medigap coverage supplements a federal program, the federal government has assumed an active role in the regulation of this product. Congress has established certain minimum federal standards that the NAIC has incorporated into their Medigap model regulation. As long as a state's Medigap regulations meet (or exceed) the federal minimum standards, the state retains its jurisdiction over Medigap regulation. There are minimum federal standards for a range of key product elements including plan design, underwriting, minimum loss ratios, agent compensation and others.

On Nov. 5, 1990, Medigap plans were standardized nationwide into a uniform set of benefit packages (Plan A through Plan J) with the exception of three states. In the Conference Report to the Medicare Modernization Act of 2003, Congress encouraged the NAIC to modernize the 1990 benefit packages. On Sept. 24, 2008, the NAIC approved new standard benefit plans in a revised Medigap Model Regulation. This journey will end on June 1, 2010, as all policies that become effective on or after that date must contain the new benefit definitions.

Legislative Summary

In 2003, Congress passed the Medicare Modernization Act (MMA) which created a voluntary Medicare outpatient prescription drug benefit (Part D).[1] The MMA directed the NAIC to make changes to its Medigap Model Regulation to conform to MMA and for states to adopt such changes into their laws and/or regulations.[2] Additionally, the Conference Report to the MMA encouraged the NAIC to consider broader changes in Medigap standards, beyond those specifically required in the Act. In particular, the conferees suggested consideration of changes to the standardized Medigap benefit packages which had been in place since 1990.[3]

The NAIC, in consultation with stakeholders, developed changes to the 1990 standardized benefit packages that are responsive to changes in the marketplace

and consumer preferences that have arisen since the creation of the original benefit packages in 1990. On March 11, 2007, the NAIC approved an amended Medigap Model Regulation which provided for various changes to the current Medigap standardized plans. However, the NAIC instructed states not to adopt or implement these changes until the passage of federal legislation amending Section 1882 of the Social Security Act, providing for inclusion of the 2007 revised NAIC Medigap Model Regulation as part of the federal minimum standards. The changes made by the NAIC to the Medigap benefit packages are as follows:

Elimination of Plans:

- Elimination of Plans H, I, and J (which contained prescription drug benefits prior to the Medicare Modernization Act).
- Elimination of Plan E (as it becomes identical to Plan D, once the Preventive Care Benefit and the At-Home Recovery benefit are removed).

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Marianne Miller, M.A., is product policy director at America's Health Insurance Plans in Washington, DC. She can be reached at *mmiller@ahip.org*.

[1] The Medicare outpatient prescription drug benefit, entitled Medicare Part D, was established by H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

[2] See "State-Adopted Changes to Medigap Minimum Standards to Conform to MMA, September 2004 – Present," AHIP, Dec. 20, 2006.

[3] See the Conference Report to H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, under the description of present law regarding the bill's Medigap amendments.

Addition of New Benefit Plans Options with higher Cost-Sharing and Lower Premiums:

- Creation of new Plan M—with increased cost-sharing (50 percent coverage of the Part A Deductible, and no coverage for the Part B Deductible).
- Creation of new Plan N—with a new copay structure ($10 copay for physician visits; $50 copay on Emergency Room), and no coverage for the Part B Deductible.

Modernization of Benefits:

- Elimination of the limited At-Home Recovery benefit (which was offered only in Plans D, G, I, and J) in favor of a new Hospice benefit to be added as a Core benefit to every plan.
- Elimination of the underutilized Preventive Care Benefit (which was offered in Plans E and J) in recognition of the fact that the Medicare program has changed over the years to include significantly more preventive care benefits.
- Replacement of the 80 percent Part B Excess Benefit in Plan G to 100 percent coverage.

States must incorporate GINA provision into their statutes or regulations to the NAIC model law no later than July 1, 2009.

2008 Changes to the Federal Medigap Minimum Standards

On July 15, 2008, Congress passed into law H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which directed the Secretary of HHS to implement the March 11, 2007 NAIC Medigap model regulations, as amended to meet additional Medigap federal standards established in MIPPA and in H.R. 493, the Genetic Information Nondiscrimination Act of 2008 (GINA).

MIPPA Medigap Provisions and Transition Period:

- MIPPA provides a timeline for the implementation of new (2010) standardized plans:
- By Oct. 31, 2008, the NAIC must approve an amended Medigap Model Regulation reflecting changes to the standardized Medigap plan types (as approved by the NAIC on March 11, 2007), and other new federal Medigap standards contained in PL 110-275 (MIPPA) and PL 110-233 (GINA). [The NAIC approved amendments to their Medigap Model Regulation on Sept. 24, 2008.]
- Within 1 year of the NAIC Model approval date, which is Sept. 24, 2009, states must incorporate these new federal standards into their laws and regulations.
- June 1, 2010 is established as the earliest effective date for coverage under a 2010 standardized plan policy, and as the cut-off date for carriers issuing policies with the 1990 standardized benefit packages.
- The Act requires carriers offering any Medigap plan in addition to the core benefit package (Plan A) in a state to also make either a Plan C or a Plan F policy available for sale.
- It also provides that any health insurance policy that is designed to supplement a Medicare Advantage plan is subject to the federal Medigap requirements.
- Carriers are not required to offer existing policyholders the opportunity to exchange their existing 1990 policies for a 2010 policy without medical underwriting. If a carrier chooses to allow such exchanges, it is subject to several "fairness" requirements related to rating and pre-existing condition limitations.

GINA Medigap Provisions:

- Beginning May 21, 2009, Medigap carriers are prohibited from using an individual's genetic information to determine eligibility, establish premiums or premium contributions, or impose any benefit exclusions based upon a pre-existing condition.
- GINA also prohibits Medigap carriers from requiring an individual to undergo a genetic test.
- States must incorporate GINA provision into their statutes or regulations to the NAIC model law no later than July 1, 2009.

The Seniors Issues Task force of the NAIC has prepared a Medigap implementation guide for state insurance departments. The guide is available on the NAIC Web site at: *www.naic.org/documents/committees_b_senior_issues_medigap_impl_guide.pdf.* ■

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The Modernization of Medigap Plans

Managing the Change

by Gail M. Lawrence

Gail M. Lawrence, FSA, MAAA, is a consulting actuary. She can be reached at 515.224.4380 or at *LawrenceConsulting@mchsi.com.*

Even if we're trying to sit still, change still happens around us through our ever evolving environment. While some may see change as just lemons, others will seize the opportunity to try a new recipe for lemonade. The chance for a successful result can be improved with a thorough assessment of the options and careful attention to execution.

It's not too early to begin planning for the changes that will occur with the new Medigap policies, which will be effective on or after June 1, 2010. The modernization of the Medigap plans creates some unique opportunities for change that have not existed since their introduction beginning in 1991.

Critical Deadlines

Because few, if any, carriers currently use genetic testing in the medical underwriting of their Medigap coverage, the industry is probably already in compliance with GINA provisions. However, implementation of the new Medigap plans will take considerable effort as carriers will need to get new policy forms, rates and, if necessary, advertising approved by the state insurance departments.

It is important to note that the implementation date of the 2010 plans applies to the effective date of coverage. Seniors often shop for Medigap coverage well in advance of their desired effective date of coverage. This is especially true for seniors turning 65, who can apply for Medicare coverage up to three months in advance of their Medicare effective date.

To accommodate all possible effective dates, there will be a period of time when companies will want to market both existing and new Medigap plans, where the coverage placed will depend upon the desired effective date. In order to prevent a disruption to marketing, Medigap carriers may want to plan on having materials approved and ready for marketing at least six months prior to the June 1, 2010 effective date. This will allow sufficient time for the distribution of new materials, agent training and the continuation of marketing to new Medicare beneficiaries.

If states wait until the deadline of Sept. 24th, 2009 to adopt the new model regulations, filing and approval timelines may be very tight. However, it is anticipated that most states will not want to go through two sets of changes to their Medigap laws and regulations, one for GINA and one for the benefit changes. It is expected that many states will adopt both sets of changes by the GINA required deadline of July 1, 2009.

Assessing Options and Making Decisions

Some options are obvious. For example, will carriers want to offer the new benefit plans M and N? Based on the distribution of existing policyholders by benefit plan, the first dollar coverage offered with Plan F has been the preferred choice of seniors. This plan provides seniors with the peace of mind of complete protection for all Medicare Part A and B cost sharing and the hassle-free handling of all medical bills by their insurance carriers. The new plans M and N are lower benefit options where claim costs can expect to average around 84 percent and 69 percent of those for Plan F. Lower premium and benefit options are available today, so it remains to be seen if additional lower cost benefit plans will garner much marketplace interest.

Some options may be less obvious. There are no changes pertaining to rating requirements. Unless a state passes regulations that are more stringent than the new model, it appears that carriers will have the opportunity to re-price all plans using a new set of pricing assumptions and to implement changes to their rating methodology. It also appears that carriers will have the option to consider the 2010 plans to be separate blocks of business for experience rating purposes.

As the new 2010 plans hit the marketplace, it will be important for carriers to consider a retention strategy for existing business. This is true not only for alternatives that may come from competitors, but also for 2010 plans offered by the carrier that may be of interest to existing policyholders. A carrier will want to carefully consider the regulatory provision that gives carriers the option to offer all existing policyholders a 2010 plan, subject to "fairness" requirements for such an offer.

A change to a rating methodology is not a new concept with Medigap coverage as existing regulations allow rating changes that are actuarially equivalent. For example, companies have changed from unisex

to gender specific rates with lower female and higher male rates. In implementing this change, companies have been confronted by the issue of existing policyholders who could benefit from the rating change—specifically, the existing female policyholders. In this case, a conversion offer to all existing policyholders would invite anti-selection, causing degradation of experience on the existing block.

Similar issues have occurred as some companies have shifted their marketing focus from individual to group plans, from one standard plan to another, or from one subsidiary to another. Recently, with the elimination of the prescription drug benefit from Plan J a number of carriers have ramped up marketing efforts for Plan J by offering rates that were lower than those on other plans with fewer benefits.

In the case of the 2010 plans, transition dilemmas may be exacerbated by the fact that most of the new plans are very similar to the existing plans. For example, the 2010 Plan F does have an additional benefit to covered Medicare cost sharing on hospice benefits; however, the cost of providing this additional benefit is minimal. The 2010 Plan D also has the new hospice benefit, but the at home recovery benefit has been dropped.

Carriers may want to price the 2010 plans with lower compensation and expenses than the comparable existing plans in order to become more competitive. If the carrier then offers all existing policyholders the 2010 plans, it could disrupt otherwise content customers and alienate agents who may receive less compensation with the 2010 plan. If companies choose not to make the conversion offer, lapse rates could increase as discontent customers seek coverage with other carriers. Clearly, carriers will need to consider their options carefully in order to maximize retention of existing policyholders and to ensure a good partnership with agents.

Outstanding Transition Issues

Some carriers may want to comply with the new model regulation by filing entirely new policy forms while other carriers may want to modify existing approved policy forms through policy riders or endorsements. Filing options will ultimately be determined by the state regulatory authorities, so state variations can be expected. Actuaries may want to consider whether the format of the policy changes will impact their ability to implement rating changes and to gather experience data for the 1990 and 2010 blocks of business.

In recent years, a number of actuarial reports have been published advocating improvements to the refund formula process. However, the new model regulation contains no changes to the refund provisions and it is unclear as to what options may exist for the pooling of 1990 and 2010 experience within the refund calculation. Similar questions are outstanding with respect to the reporting requirements for the annual statement Medicare supplement policy experience exhibit. Further guidance on this topic may be forthcoming in the NAIC Medicare Supplement Compliance Manual, which will be updated by the NAIC Accident and Health Working Group.

Previously, states have determined the constitution of an appropriate innovative benefit. A new drafting note in section 9.1, "recommends that states consider making publically available all approved new or innovative benefits, and requests that states report the approval of these benefits to the NAIC Senior Issues Task Force who will maintain a record of these benefits for use by regulators and others. The Task Force intends to periodically review these approved benefits and consider whether to recommend that they be made part of standard benefit plan designs."

In Closing

Market leaders are most likely looking forward to the opportunity to refresh their product offerings and strategies. For others, Medicare supplement may be considered a distraction to their core business and this change may prompt some rethinking on their commitment to this market. Change can be less chaotic if managed well with thoughtful decisions and careful execution, helping to ensure a successful and smooth transition. ■

Carriers will need to consider their options carefully in order to maximize retention of existing policyholders to ensure a good partnership with agents.

An Electronic Prescription for Health Care Efficiency

by Susan Pantely

Computers and other advanced technology have changed the way we live and do business. Most industries by now have adopted electronic transactions as the norm rather than the exception. Our daily lives consist of a myriad of these instantaneous dealings—banking, shopping, and dining. We can transfer money, check balances, order a new suit, and send a document with only a few clicks.

Businesses without such electronic capabilities could be considered dinosaurs. This has arguably been true of health care, but change appears to be on the way. One example is e-prescribing, a transaction in which a physician transmits a prescription directly to a pharmacy.

With the often bewildering welter of health plans, formularies and other considerations, managing prescriptions currently presents difficult problems. After a patient has left a doctor's office with prescription in hand, the potential to take advantage of maximum efficiencies—cost savings opportunities that deliver the best quality of results—diminishes considerably. Sometimes problems can be addressed at the point of sale, but that usually requires a call to the doctor from the pharmacy, and then a delay while waiting for a response. Meanwhile, somebody is at the pharmacy who wants their prescription now.

That's been the traditional way to manage prescriptions and many would agree that it has not been entirely effective. Making appropriate determinations of the best drug fit for an individual patient is clearly more efficient right in the doctor's office when the physician is most focused on the patient. E-prescribing is uniquely poised to offer exactly that capability.

E-prescribing: Prove it

By most measures, e-prescribing is still in its infancy. But proponents see a bright future, arguing that e-prescribing offers a significantly effective strategy for both cost savings and improved health outcomes, particularly in combination with the use of an electronic health record (EHR).

Can the exciting potential for this technology be demonstrated in practice? It appears the answer to that question is yes. As e-prescribing evolves, a number of actuarial projections are easily transformed to help with forecasting claims under an e-prescribing system and to better understand its effects, even with the limited experience we now have. By comparison, vendor claims may be overstated or not reproducible in a different environment.

Actuaries typically look at utilization patterns—doctors that have more prescriptions obviously present the greatest opportunities for efficiencies. Another strategy for actuaries is to examine generic proportions; the lower the use of generics, the more potential there is for saving money.

Susan Pantely, FSA, MAAA, is a consulting actuary at Milliman Inc. in San Francisco, Calif. She can be reached at *Susan.Pantely@milliman.com.*

Getting Down to the Nuts and Bolts

Several actuarial issues and considerations should be taken into account when projecting and evaluating experience after implementation of e-prescribing. These include measures designed to cut costs as well as those likely to enhance drug treatment compliance and lead to better health outcomes.

Increase in Formulary Compliance

Currently physicians have no good way of knowing the formulary for any individual patient's prescription drug plan. If a physician sees 10 patients, that could mean dealing with 10 different health plans, each plan with its own formulary. The potential for higher costs for the patient with the choice of a non-formulary drug is clear. A physician can't keep all this information handy, and it can be a lot of work to track down for patients.

E-prescribing can put that information into a doctor's hands right in the doctor's office, via a simple handheld device. That alone could serve significantly to increase formulary compliance. Not only does it help as an aggregate cost saving to the health plan, but it also helps patients minimize their copays. And the physician can remain focused on medical care rather than become distracted by details of health plans.

E-prescribing systems also have the benefit of being constantly updated with information about new drugs, new generics, changing formularies, shifting price points, and more. These are things that until now a physician couldn't possibly keep up with as they happen. Simple updates to the e-prescribing program would allow them to do that quickly and easily.

Increase in use of Generics

This is similar to the situation with formulary compliance. A lot of times a physician may not know that a generic is available. Also, many patients have questions about their various options, many related to the terms of their health plans. Currently, the pharmacy may be able to catch that a generic is available for a branded drug that's been prescribed, but confirming prescription changes with the physician can still require a round of phone calls and delays in actually dispensing the needed drug to the patient.

With e-prescribing, if a generic alternative is available physicians know on the spot, allowing them to change the prescription to generic if warranted. E-prescribing thus enables the adoption of generics to accelerate wherever it's appropriate, providing fast and easy cost comparisons on the fly. There has been a significant push in recent years toward the use of generics, in terms of setting copay levels and other efforts, and e-prescribing clearly offers the next wave of what can be done to influence and increase their use.

For actuaries quantifying the savings from e-prescribing related to increasing generic use, it is important to recognize that generic utilization is expected to increase over the next few years with more generic alternatives currently on the horizon than brand drugs.

Promoting Over-the-Counter Drugs When Possible

Similar to the indication of generic alternatives, an e-prescribing program can also identify and provide information about appropriate over-the-counter drugs that may be less costly, based on the diagnosis and preferred drugs entered. Right now, most health plans don't cover over-the-counter drugs but that could change. If it does, based on evidence-based medicine and proven outcomes, e-prescribing programs will be able to support that move efficiently. Most physicians currently don't even consider over-the-counter options. E-prescribing will help keep that option more top of mind.

Avoiding Adverse Drug Events

Particularly when used in combination with an EHR, e-prescribing has the capability of identifying adverse reactions that may result from complex drug interactions. Again, this is a matter of streamlining the process for the physician, whose patient charts may not be organized specifically to flag drug conflicts and interactions. The potential is apparent. If the patient's information is in the e-prescribing program via an EHR and the physician prescribes a drug that interacts with another that the patient is already on, an e-prescribing program can quickly identify

CONTINUED ON **PAGE 14**

Currently, the pharmacy may be able to catch that a generic is available for a branded drug that's been prescribed, but confirming prescription charges with the physician can still require a round of phone calls and delays in actually dispensing the needed drug to the patient.

Targeting physicians who have the most potential for shifting members to lower cost alternatives will produce savings much faster than implementing physicians on a random or voluntary basis.

that and the physician can make a decision based on that. This might be a decision not to prescribe the drug at all, or to warn the patient to watch for specific symptoms that would warrant discontinuation of the drug, or simply to instruct the patient on a different way to take the drug, perhaps at different times of the day. Drugs can be very complicated in the way they interact, and an e-prescribing program can help physicians make better and more informed decision for their patients.

For actuaries, this aspect of e-prescribing is harder to quantify and model. There's not yet enough information out there. But it remains one of the obvious potential benefits of e-prescribing and one that people will be looking for. This also underlines the necessity, or at least the utility, of building an EHR system. The more information that can be included in it—not just the drugs that patients are taking, but their various diagnoses and conditions—the greater the potential for improved outcomes.

Dose Optimization

The dose of medication that is prescribed can affect two separate issues—both how that drug will interact with other drugs a patient is taking, and also its price points. It's often possible to identify an optimal level to prescribe. In the first case, that's based on the other drugs being taken, body weight, diagnosis, and other factors; in the second case, price points, it's based on health plan formularies. Many times, currently, physicians are already aware of dose ranges but not necessarily the specifics within them and so, for the sake of time, rather than prescribing the optimal dose they prescribe what they know will be a safe dose. E-prescribing enables them to calculate and prescribe the more highly effective optimal doses quickly and efficiently.

Fill Notification

E-prescribing comes with the capability to notify physicians when prescriptions or refills are not picked up by a patient. The physician is then able to follow up with the patient, possibly increasing compliance. This is potentially one of the most significant benefits that e-prescribing can offer. As is well known, today compliance with drug treatments probably stands at 50 percent or less. Patients just don't take their drugs the way they're supposed to, for whatever reason: they forget, they don't have time to pick them up from the pharmacy, they're having side effects, or for other reasons. In many cases, particularly for people with chronic conditions, it's critical to successful treatment that they maintain appropriate compliance.

E-prescribing enables a physician to know, practically in real time, when a patient appears to fall out of compliance. If a prescription is written for three months and the patient doesn't pick up the refill a month later, the physician is notified and his staff can follow up to find out what's going on and emphasize the importance of compliance to the patient. If there's an issue with side effects, for example, it can be addressed promptly and effectively—by switching drugs, changing the dosage, or in some other way—rather than waiting months for the next office visit.

This feature not only provides information that would be cost-prohibitive to gather otherwise, but it can also potentially work very well with such new industry trends as value-based insurance design, the medical home, or pay-for-performance programs. It's one of the strongest benefits of e-prescribing. It can also be highly useful for elderly populations, who are often on multiple prescriptions that are that much more difficult to manage.

What's Next?

It may be happening slowly, but the move toward e-prescribing appears to be on its way. Already the Centers for Medicare & Medicaid Services (CMS) has produced standards for health plans adopting e-prescribing. CMS has also implemented pilot projects to study the cost savings and outcome improvement possibly achieved by e-prescribing.

The list above addresses the most obvious potential savings areas that e-prescribing may help to realize. These savings are dependent on several other factors that contribute to the success (or failure) of the e-prescribing program, many of them related to physician behavior.

When implementing an e-prescribing program, the acceptance and participation of physicians will influence savings. Initial physician experiences

with the program are crucial. User-friendly interfaces combined with complete patient information have shown strong correlations to physician acceptance. Computer glitches, errors or difficulties in process are likely to discourage physician participation.

Targeted physician recruitment will also be important to realize potential savings. It is important to target not only physicians who write the most prescriptions but those who have low generic or formulary utilization. Targeting physicians who have the most potential for shifting members to lower cost alternatives will produce savings much faster than implementing physicians on a random or voluntary basis.

Physician investment in this technology is another consideration when projecting participation. E-prescribing vendors vary widely in their licensing charges but most charge a monthly fee. Physicians may be initially reluctant to invest in this technology without tangible evidence of benefits to their practice such as time savings or improved outcomes. Physicians may not have to bear the cost of the entire licensing agreement under some arrangements. For example, a managed-care organization may subsidize the licensing fee if it believes its prescription cost savings will exceed the cost of the licenses. However, a physician's commitment to using e-prescribing is likely increased when they are responsible for the licensing fee.

Moving forward, widespread adoption of e-prescribing will likely be dependent on more detailed and accurate projections regarding the potential savings and improved outcomes of the early pioneers—information that actuaries are especially qualified to provide. ■

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Navigating New Horizons...

an Interview with Nancy Walczak

by Sarah Lawrence

Perhaps nobody takes the old adage that "history repeats itself" as seriously as an actuary. While it's true that past events are often the best indicators of what will happen in the future, projections can be improved by considering how innovation can change everything. Nowhere in the actuarial field is this more obvious than in health insurance, where companies can abruptly find their product over- or under-priced following the release of a new prescription medication or medical device. As a result, a new field has opened to actuaries such as Nancy Walczak, who has built her career on following advancements in medical care and treatments in order to predict and advise about the impact these changes will have on insurance pricing.

Nancy Walczak, Ph.D., FSA, is a senior consultant at Ingenix Consulting in Eden Prarie, Minn. She can be reached at *nancy.walczak@ingenixconsulting.com*.

An Unlikely Path

Walczak, a Minnesota native, did not even have actuarial work on the radar when she began attending Northwestern University in Evanston, Ill. After years of hard work, she graduated with a doctoral degree in neuroscience and, like many college graduates, decided at that time to go in a completely different direction.

"As I completed my Ph.D. and was thinking about my career path and doing the kinds of things that a post-doctoral student does, it became pretty clear to me that the world probably had all of the Ph.D.s in neurophysiology that it needed," Walczak said. "After really thinking about skills transfer and reading the Department of Labor's report on the actuarial profession at the time, and also at some urging of a friend of mine to consider the actuarial profession, I took a look at it."

Walczak completed her first actuarial exam and found she did have a lot of skills that would lend themselves to a career in the field. From that time on "there's been no looking back," she said. Shortly after, she accepted her first actuarial position with Group Operations of Prudential Financial Services in Roseland N.J. It was here that she got her first taste of what would later become the focus of her career.

"Group Operations served large, self-funded employer groups and many of them were forward thinking and interested in understanding how new medical technologies might affect their benefit costs," she said. "And so some of the first analyses I did at the time were ad hoc projects for these large clients. I didn't do very many, but it was the first time that I began to think about this."

In her next position with ING Financial Services of Minneapolis, Minn., Walczak continued to work with this type of analysis on a part-time basis.

"I saw my fair share of actuarial modeling, whether it was through cash flow testing or through valuation modeling or for economic value added modeling," she said. "So I became very aware of the concept of modeling streams of future cash flows and had excellent opportunity to do that in a variety of assignments."

Walczak's focus had turned to being a valuation actuary when, in 2003, she was offered a position with Reden & Anders of Minneapolis as senior consultant assisting in the development of a new product.

"They had a very clear idea that there is a growing need at health insurance organizations to have a better understanding of the impact of new medical technologies and other kinds of developments that completely alter the utilization of services and benefit costs in health care," she said. "I was hired to develop the product and I've been working on it ever since."

Making Predictions

Walczak said the most important part of her job is predicting disruptive events—unexpected changes in health care that severely increase or decrease demand for a product or service. The benefits of being able to make and use models that predict these events are clear.

"Underestimating the potential impact and cost of a new technology is something that is perilous for most payers," she said. "Many payers have had to endure in the last five years or so drug eluting stents and ICDs [implantable cardioverter-defibrillators] and Lucentis and Avastin and Enbrel. If things like this are not included in their trend, it could result in a premium shortfall and that's going to be paid for somehow—usually out of the bottom line."

In addition to new medications or medical equipment hitting the market, new mandates from organizations such as the American Cancer Society can have a huge effect.

"The American Cancer Society is not a regulatory body, but when they came out with new guidelines for breast cancer screening involving an MRI, they set treatment guidelines that have the force of regulation," she said. "So suddenly overnight health insurance companies found themselves having to adopt a benefit that perhaps in the past they weren't extending to their members."

Walczak said over-pricing is also easy to do, for example when a company fails to predict a trend toward increased use of generic drugs and prices are not lowered accordingly. What makes the whole situation worse is that one instance of over- or under-pricing can put a company in a cycle of bad pricing that is hard to break, since inputs to actuarial models tend to assume that a temporary discrete event represents the steady state.

But creating models that forecast these disruptive events is not easy.

"We do a lot of horizon scanning, first of all to identify a full range of technologies," Walczak said. "We identify technologies and begin to follow them well before they are approved by the FDA or well before they would meet the broad standards for evidence-based medicine and be adopted by most payers."

The next step is determining what the demand for that product might be.

"For example, we really don't care about a new oral contraceptive because there are so many oral contraceptives out there," she said. "If a woman desires an oral contraceptive there are many to choose from, and many generic, so the new one is unlikely to significantly change the future with respect to the past. On the other hand, when the HPV vaccine came out, there was nothing like it. There was a huge possible population that might use it out there and state mandates also became a question."

Walczak said creating the models is very complicated and she is the first to admit the results are not always perfect.

"Overall this job does teach you to be humble because no matter how good your model is, there's always a high probability that you will be wrong," she said. "This means that we need to revise our models monthly and we do keep a constant eye on all of the models that we provide to our clients and revise them if there is some sort of change."

Actuarial Method Application

Walczak said creating these forecast models is not so different from traditional actuarial methods, which is why help from actuaries is essential.

"One of the things that actuaries do very well is forecast expected costs and expected utilization and there is a very well developed practice doing what we call trend forecasting," she said. "Trend in this instance means medical inflation and medical inflation can come about because people are using more of the same services, or because the price of that service has increased."

Those models are quite accurate, except when the unexpected happens. Walczak said her forecasts take things a step further and help actuaries "understand and make provisions for the things that they couldn't possibly anticipate—things that make a good model go bad."

Walczak said it is easy for actuaries to make this jump themselves by recognizing that most medical treatments can be modeled as if they are an annuity.

"They are simply a stream of future cash flows and when you're looking at the economic cost of new technologies, it really looks like an annuity in that you will make adjustments for survival adjusted cash flow streams and you may make adjustments for interest or inflation," she said. "A lot of those things make it look like an annuity and in particular it makes it look like an annuity that needs to be modeled under CARVM, because you may have to model a variety of different outcomes."

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Walczak said the most important part of her job is predicting disruptive events—unexpected changes in health care that severely increase or decrease demand for a product or service.

Examples of different outcomes would include modeling the potential for a person to use a drug for some period of time and then switch, or to model the expected cost for a person who has never used any drug before versus a person who might be using an existing therapy and is changing.

I would love to see all actuaries, particularly all health care actuaries, understand that they can play a role in helping their organizations estimate the impact of medical technology or really begin to provide a prudent provision for medical technology in their forecasting, she said.

"I'm pretty sure that a pricing actuary who works with a fairly complicated annuity model would recognize a lot of what we do," Walczak said. "We start out by creating streams of future cash flows and then combining them to create probability-weighted streams of cash flows based on the likeliest outcomes and then we apply those to populations. The result is something that looks a lot like a paid by incurred triangle."

Walczak said an example of this application would be a new cancer therapy that is administered weekly until the disease progresses. The median time to progression is 40 weeks and 50 percent of the people have stopped using the drug at 40 weeks.

"Therefore we can create or back into a survival function where survival here isn't life or death of the patient, but is the continuation of using the therapy week after week," she said. "It's a little more complicated than the way I've described it, but the basic concept is there."

"So using that information we can create a stream of cash flows that will allow us to much better estimate the expected cost for a single patient," she said. "And now if we know that 10 patients will begin using this drug on January 1, another 10 will begin to use it on February 1, another 10 will begin to use it on March 1, and so on through the year, we can line up those streams of cash flows for each of these groups of 10 and will have a pretty good idea of what the cost of that drug will be in August of the year."

Personally Speaking

Walczak said one of her favorite parts about her job is how much everything changes from day to day. Keeping up with the latest in health technology is a constant battle, and estimating the impact of that technology is even more consuming.

"Lately we've been doing a lot of work on what's called the 'present on admission' requirements from Medicare and what it might mean for a variety of payers to adopt similar provisions," she said. "Effective October 1 of last year, this program is being instituted such that hospitals have to identify a short list of hospital acquired conditions that Medicare felt was associated with poor quality care."
In short, Walczak said Medicare will not pay for care and support provided as a result of medical errors, such as medication mix-ups or a patient being burned by a piece of equipment.

"Theoretically the patient does not pick up that cost and theoretically that cost is bore by the hospital," she said. "But the issue is complicated because there is no such thing as uncompensated care. The intention of the 'present on admission' program is to create a very real incentive to improve the kind of quality care that hospitals give so that these errors are avoided in the first place."

Walczak said a number of organizations are interested in understanding the potential short-term cost savings of such a program for themselves, the potential long-term impact, what it might mean if they decided to act alone and what it might mean if they waited for a more consensus policy and more organizations to adopt similar programs. What kind of contracting would have to be undertaken? What would such a program mean for benefit costs?

Ultimately, Walczak said it is up to the individual company to decide how to act.

"I would love to see all actuaries, particularly all health care actuaries, understand that they can play a role in helping their organizations estimate the impact of medical technology or really begin to provide a prudent provision for medical technology in their forecasting," she said. "It's not going to go away. Culturally, Americans demand the latest technology, the latest medical therapy and the latest cure for their diseases. Culturally, it is something we have come to expect." ■

Health Section Pricing and Valuation Boot Camp

by Bill Lane

Bill Lane, FSA, MAAA, is principal at Heartland Actuarial Consulting LLC in Omaha, Neb. He can be reached at *WMRLane@aol.com*.

Four years ago, I was elected to the Health Section Council. One of the council's main roles is to seek out the needs of our members, and then to find ways to satisfy those needs. The council sponsored a member survey and discussed issues with a number of health actuaries. It became apparent that there was a lack of basic training in some of the most fundamental functions that health actuaries perform. Two areas in particular were pricing and valuation. It was not that there were no avenues for training in these disciplines. The problem was that the available training opportunities were insufficient. This became the genesis for the first Pricing and Valuation Boot Camp held in August of 2008.

As Mae West used to say, "I am easily satisfied with perfection." I simply wanted the Boot Camp to be perfect, no more, no less. Didn't happen. All in all, it was generally successful, but perfection is going to have to wait until at least the second Boot Camp.

Most of my comments will be focused on the Pricing and Professionalism sessions since I taught during the Pricing session and attended the Professionalism session. Time did not permit me to stay for the Valuation session, however I did hear good comments about this session.

For Pricing, our challenge was to create a curriculum that covered the basics of medical pricing, and also covered many of the specifics of Individual, Small Group, Large Group and Employer Stop Loss. For this we had a day and a half. On paper, it seemed that we could cover these topics, and our slides were timed to about 12 hours. However, we got a large number of questions from the audience and timing ended up being an issue. Because you have to cover the basics first, and then cover more advanced topics, some of the later material got rushed.

Experience will help us to time the material better in the future. We may even (horrors of horrors) send out some material in advance with an expectation that the audience will have studied it in advance (could this mean homework?). This would allow more time for more advanced topics while having some assurance that the audience understood the basics to at least some extent.

The mixture of knowledge in the audience also contributed. We asked for a show of hands at the beginning and about a third of the audience had essentially no health pricing experience, and about another third had only three years or less of experience. Because we got a lot of questions from the uninitiated, we lost time for our more experienced participants. Contributing to this mixture of experience and inexperience is the fact that some people were experienced in one or two of the product lines, but were generally unexposed to the others.

We got a lot of positive responses for the session, but we also got a significant number of comments suggesting that improvement was needed.

In my opinion, the Professionalism session went very well. Here again, we had a number of people who had attended an American Academy of Actuaries webcast on the subject of the new continuing education requirements, but many who had not. There are a lot of nuances to the new requirements that I had not known. For example, if I attend an actuarial meeting session and merely confirm that my knowledge on the subject is current, but don't actually learn anything new, then, by my understanding of the new rules, that time cannot be counted as continuing education. However, if I glean just one new thought, then the whole time can be counted. There was a lot of audience participation and I believe everyone learned something from this session. (So everyone can count the time!)

The location had a great set-up for the sessions. It was an amphitheater which allowed for everyone to hear and participate.

We are now beginning to plan for next year's Boot Camp. The problem of providing quality education to an audience that will have diverse backgrounds is not likely to go away. We may try to have basic sessions followed by more advanced sessions. We may try advanced material to cover some of the basics. We do intend to develop the curriculum much earlier so we can be more specific in our marketing material as to what will be presented.

There is a need for continuing education for all of us. I am excited that the Health Section is moving forward in meeting this need for its members and I am proud to be a part of it. I am confident Boot Camp will continue to improve. ■

SOA Health Section and CMS:

A Continuing Dialogue

by John Cookson and Steven Siegel

One of the ongoing missions of the Health Section has been to reach out to other organizations and seek productive relationships. Given the range and diversity of health care issues today, it clearly benefits both the profession and individual Health Section members to showcase the expertise and talent that health actuaries bring in such relationships. Among the longer-term relationships the Health Section has forged in recent years has been with the Centers for Medicare and Medicaid Services (CMS). Indeed, the Health Section has had a mutually beneficial relationship with CMS for over five years now. In that time, a small group of volunteers from the Health Section has provided input and advice to CMS on trends actuaries are observing in the health insurance market. This information has been used by CMS to support their annual National Health Expenditures (NHE) and Forecast Update.

This year CMS raised questions about private health insurance related to some of their historical data sources. As a result, on August 29, the Health Section hosted a conference call between section members representing many of the large commercial insurance companies, actuarial consulting firms active in the health insurance market, and CMS representatives from the National Health Expenditures (NHE) Group. The objective was to assemble a representative group of SOA participants who would provide broad perspective on what has been happening on the Private Insurance side of national health expenditures. The list of SOA Health Section participants included: Jeff Allen, Joan Barrett, John Cookson, Michael Fedyna, Cindy Miller, Vince Sherwin, Steven Siegel, and Robert Tate. CMS participants included Stephen Heffler, Pat McDonnell, Micah Hartman, and Cathy Cowan.

The objective of this meeting was to discuss sources of data and general information to support the baseline historical Private Health Insurance portion of National Health Expenditures included by CMS in their annual update of NHE and 10 year forecasts. This represents a very intensive effort on the part of CMS each year, which gets into full gear in the late summer and fall of each year to develop the estimates of the various components of NHE from the previous calendar year, along with adjustments to previous historical estimates, and the updating of the 10 year NHE forecast published in Health Affairs in January or February of the succeeding year. This process also contributes to the knowledge and understanding of the direction of health care which must be considered each year by CMS when they do the long term forecasts for the Medicare Trustee's Report.

Some of the important components reported in the NHE study include Medicare and Medicaid expenditures, and Private Health Insurance (including self-funded or self-insured expenditures) and estimates of direct medical out-of-pocket expenditures by individuals; expenditures are also reported by type of provider (hospital, physician, etc.). CMS collects and analyses many sources of data to develop their estimates each year. They have first hand sources of Medicare and Medicaid expenditures, but other sources are more derivative in nature. Thus, it was considered valuable to try to get direct or indirect information from SOA members working in Private Health Insurance to confirm or supplement the other sources of information available.

This particular discussion about the baseline Private Health Expenditures arose at the request of CMS and as a direct result of the relationship described earlier that developed over the years from the ongoing annual discussions that have been held each fall (since 2003) between CMS and representatives of the Health Section. This series initially started as a direct result of informal discussions held in early 2003 between Steve Heffler, currently Director of the CMS Health Expenditures Group, which is responsible for the NHE projections, and myself who was Health Section Council Chair at the time. CMS has considered these annual meetings to be one of the highlights of the annual NHE update process, and have always been very grateful for the input and insights they receive. The Health Section Council participants have also found this a rewarding opportunity to learn about the process used by CMS in making these estimates, as well seeing what may be developing in the publicly financed side of health care, since many of the participants continue to volunteer year after year.

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John Cookson, FSA, MAAA, is a consulting actuary at Milliman Inc. in Wayne, Penn. He can be reached at *john.cookson@milliman.com.*

Steven Siegel, FSA, MAAA, is a research actuary with Society of Actuaries in Schaumburg, Ill. He can be reached at *ssiegel@soa.org.*

The ABC's of Health Section Research

by Steven Siegel

Steven Siegel, FSA, MAAA, is a research actuary with Society of Actuaries in Schaumburg, Ill. He can be reached at *ssiegel@soa.org.*

Before I joined the research staff of the Society of Actuaries, I primarily associated health care research with syringes, placebos, and white lab coats. Although you won't find any of those items here in the SOA offices (at least not yet), it is no secret that the Health Section is an important source of health care research that benefits both the profession and society at large. This article provides a basic overview of how Health Section research is initiated and conducted including the roles different parties play. I hope readers will come away with a better understanding of the process and consider getting involved in the various opportunities available to them.

Where it Begins…an Idea

The first step in any research effort is an idea. Ideas may vary in both their expected scope and path of emergence.

In terms of scope, ideas can generally be categorized as follows:

1. Ideas that apply narrowly and primarily benefit the Health Section.
2. Ideas that cut across several sections besides the Health Section.
3. Ideas that impact the entire profession.
4. Ideas that impact the broader financial community and/or the general public.

Clearly, the expected scope of an idea is an important factor in determining its feasibility for funding.

Besides the scope, another important factor affecting the selection of ideas to be researched is from where they emerge. There are several paths of emergence for ideas:

1. Ideas that emerge through direct solicitation of a Health Section member. These solicitations are usually done either through e-mails, the section newsletter and other SOA publications, or at continuing education events.
2. Ideas that emerge as a result of discussion or brainstorming by the Health Section Council.
3. Ideas that emerge unsolicited from members and non-members. Typically, an individual will contact a representative from the Health Section or SOA staff member with an idea.
4. Ideas suggested by an entity of SOA governance.
5. Ideas suggested by an outside entity such as the American Academy of Actuaries or the NAIC.
6. Ideas that emerge from major external or societal issues, or mega trends (e.g., research related to prescription drug costs, Medicare, etc.).

Evaluating an Idea…

With an idea in hand, it needs to be evaluated against the research mission of the Health Section. In this respect, several factors are weighed to determine its viability for funding including:

1. Value and Impact—How would the results of the research provide value to the intended membership audience, or outside parties such as the general public? Does it dovetail to the Health Section's overall strategic initiatives? Will it have significant impact for health actuaries?
2. Scope—Can the idea be reasonably and efficiently researched? Ideas such as a proposed comprehensive replacement of the current U.S. health care system may be simply too large an undertaking. On the flipside, an idea may be deemed as too narrow in scope and require information or data that does not exist.
3. Expected Price—Is the project that follows from the idea expected to have a reasonable cost in line with funding constraints? Many ideas that are judged well in all other factors may be rejected because they would be too expensive to undertake.
4. Duplication—Does the idea duplicate already existing work? If it does and there is no other way to redefine the idea, it is normally rejected. An exception is where the idea is to essentially update work that has been previously completed and is out of date.
5. Other Factors—Any other information related to the idea such as the requirement of special data, software, or other material.

Ideas may be judged against other ideas contending for funding, or they may be considered on an ad hoc basis. It will depend on the urgency of the idea and the timing in which it has emerged. The process of consideration and weighing the above factors normally occurs over a number of meetings in an iterative fashion. This length of time for the process is needed

because, in most cases, additional information gathering is needed to fully consider the idea. Given the large number and wide range of ideas considered, it is the general situation that there are more ideas generated than can be funded. This is why the Health Section weighs the decision on a particular idea very carefully. Having subject matter experts involved in the decision process is another assurance that the evaluation proceeds in a careful and deliberative manner. The process has been specifically designed so that only the best ideas advance and receive funding.

Once an idea passes this evaluation, the next step is to issue either a request for proposals, call for papers, or in the case where a researcher submitted an unsolicited proposal, prepare a contract for the work.

Funding

Funding for Health Section research comes primarily from two sources. First, each year the SOA provides an annual budget for research studies that includes an allocation for research related to health topics. The other primary source is from the Health Section's own budget. In addition, projects may be co-funded with other sections within the SOA or organizations outside the SOA.

Who Does What?

Health Section research is accomplished through a strong partnership of volunteers, contracted researchers and SOA staff. The following are high level descriptions of the roles played by each party in conducting research:

Health Section Council—This group of volunteers makes the ultimate decision on which ideas are funded. The Health Section Council includes a special position known as Research Coordinator, which is currently held by John Cookson. The responsibilities of this position are to help provide guidance and recommendations for the Health Section's research agenda and initiatives. In addition, another volunteer connected with the Health Section acts as a primary advisor. This advisory role is currently held by Jim Toole, immediate past chair of the Health Section Council.

Project Oversight Group—A group of volunteers that manages individual projects. A complete description of the role of Project Oversight Groups is given in the next section of this article.

Contracted Researchers—An individual or team hired to conduct a research project or responding to a Call for Papers. Researchers include both actuaries and non-actuaries, and come from a wide variety of backgrounds.

SOA Research Staff—The SOA Research Actuary and Research Administrator provide management and administrative support throughout the course of a research effort.

Managing the Project—The Role of a POG (One of Our Favorite Acronyms)

To help the Health Section manage the projects, oversight groups are formed. A Project Oversight Group (POG) is typically composed of five to seven member and non-member volunteers who are experts in the subject under study and represent differing stakeholder viewpoints. Depending on the subject matter, professionals from other disciplines may be needed to produce the best end product.

For each project, a POG will work closely with the researcher to ensure objectives are met. The interaction between the researcher and the oversight group of subject matter experts is intended to produce a higher-quality end product.

General responsibilities of a POG are to provide guidance to the research team and peer review research deliverables. Other duties might include:

- Developing the solicitation document (Request for Proposal or Call for Papers) for the project.
- Evaluating proposals or abstracts/papers submitted in response to the Request for Proposals or Call for Papers.
- Recommending a proposal or abstract/paper to the Health Section for funding consideration.
- Reviewing letters of agreement and negotiating contract terms with the research team as necessary.

CONTINUED ON **PAGE 30**

Having subject matter experts involved in the decision process is another assurance that the evaluation proceeds in a careful and deliberative manner.

This article takes a closer look at what the Payment Demonstration is, when an MCO may consider it, and its risks and rewards.

What's the "Federal Reinsurance Penalty?"

Federal reinsurance covers 80 percent of the catastrophic plan costs. Catastrophic plan costs are defined as the benefit period after the members cost-sharing reaches the TrOOP (true out of pocket) threshold ($4,350 in 2009). For a Defined Standard plan, this translates to $6,153.75 of total covered drug expense in 2009. When a Part D plan provides enhanced benefit coverage, the point where catastrophic coverage begins is later than the catastrophic coverage point in the Defined Standard plan. This results in reduced amounts of federal reinsurance in an enhanced plan relative to a Defined Standard plan and higher premiums for the members. In effect, the member must pay for the increase in the benefit during the deductible period and the donut hole PLUS the increased length of gap coverage due to the delay of the federal reinsurance period.

Exhibit B diagrams the Defined Standard benefit plan and the catastrophic coverage period where federal reinsurance applies. Exhibit C shows the delay of the catastrophic coverage for a simple plan design where the plan pays a straight 70 percent coinsurance for all drugs until catastrophic coverage begins ("70/30 Plan"). For an average membership base (allowed cost of $160 PMPM), the loss of federal reinsurance for this benefit plan is approximately $7 PMPM. However, the loss in federal reinsurance for richer plan designs and/or sicker members could be materially more, up to amounts as high as $30 PMPM.

What Does the Payment Demonstration Do?

In a nutshell, payment demonstrations pay the federal reinsurance amount corresponding to the Defined Standard benefit to the plan. That is, it removes the federal reinsurance penalty. In exchange, the plan must use the moneys to offer supplemental Part D benefits and share in the catastrophic risk.

There are three types of demonstration plans: 1) Flexible Capitation, 2) Fixed Capitation and 3) MA Rebate. For purposes of this article, we will focus on the Flexible Capitation option and review how it impacts the following components of an enhanced benefit plan:

- Member Premium
- Benefits, including TrOOP, Cost-sharing, and Catastrophic Coverage
- Administrative Costs
- Risk Sharing

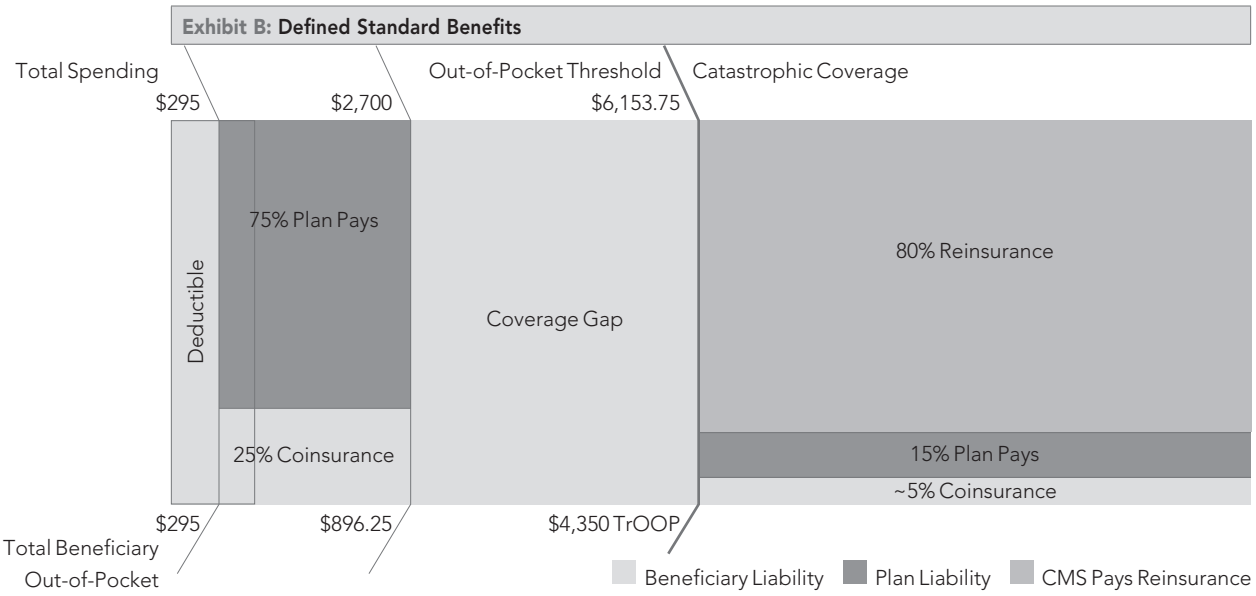

Exhibit C: Enhanced Coverage No Demo

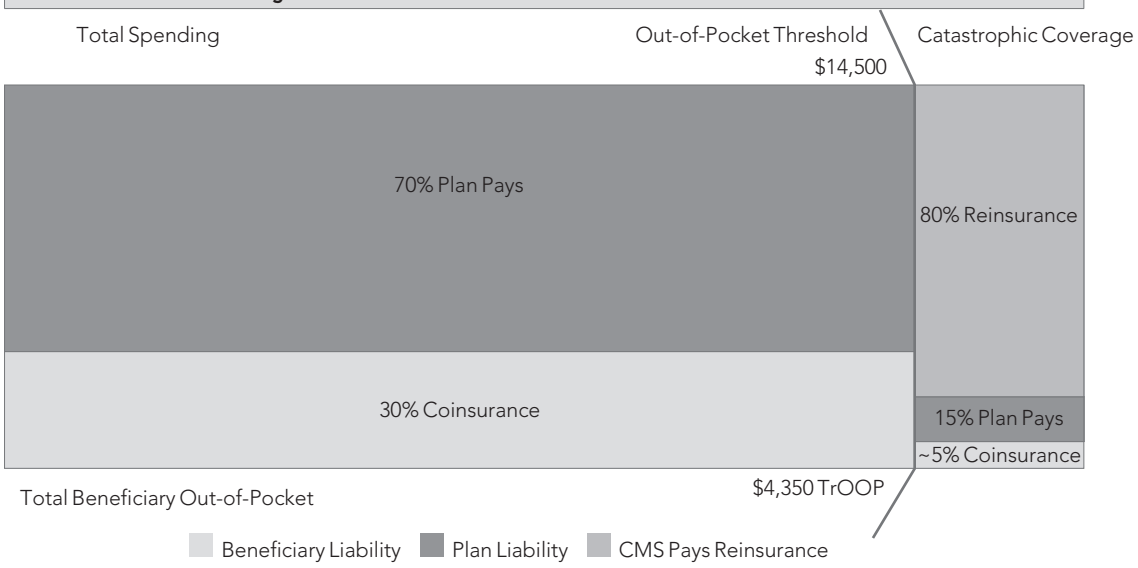

Exhibit D: 2009 PMPM Member Premium Savings under Flexible Capitation

Rx Risk Score	0.9	1	1.1	1.2	1.5
Part D Allowed PMPM	$135	$160	$180	$200	$270
Benefit Design[1]	**PMPM Member Premium Savings**				
Plan A	$1.75	$2.55	$3.60	$4.20	$7.40
Plan B	$3.60	$5.05	$7.30	$8.50	$15.05
Plan C	$5.20	$7.05	$10.55	$12.25	$21.85
Plan D	$6.90	$8.95	$13.20	$15.20	$27.10

[1]Benefit Design Descriptions
Plan A: Defined Standard plus 25% plan coinsurance on all drugs through gap
Plan B: Defined Standard plus 50% coninusrance on all drugs through gap
Plan C: 70% plan coinsurance on all drugs until catastrophic coverage
Plan D: 85% plan coinsurance on all drugs until catastrophic coverage

Member Premium

Member premium under the Flexible Capitation demonstration is reduced by the additional amount of federal reinsurance paid to the plan. In essence, the penalty amount is paid back to the plan to help reduce the member premium amount. As discussed earlier, the exact amount will depend on the specifics of the plan design. Exhibit D presents the member premium savings for various populations and benefit plans.

Benefits

The Flexible Capitation option does not change the benefit plan. The TrOOP cost amount ($4,350 in 2009), catastrophic coverage, and the member cost-sharing amounts remain the same under the Flexible Capitation option as the amounts without the payment demonstration.

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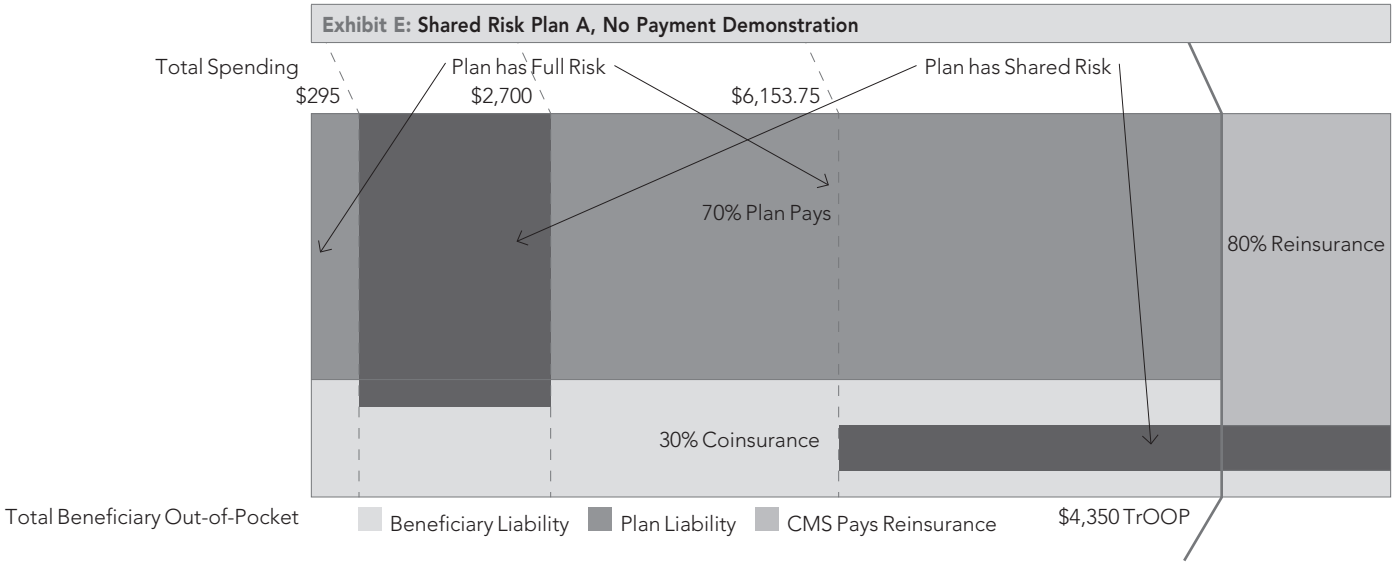

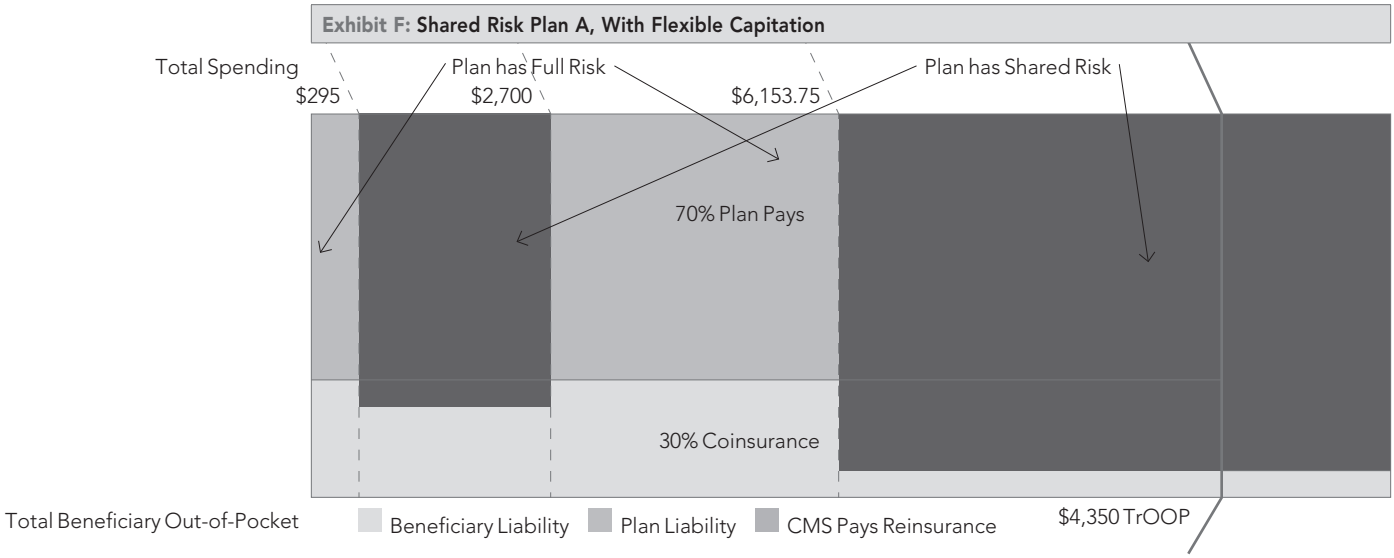

Risk Sharing

Risk sharing for plans under the Payment Demonstration is different than for plans without the Payment Demonstration. It's generally known that the federal reinsurance of 80 percent of catastrophic costs are forfeited when doing a demonstration, but the change in the risk share is really more extensive than this simple notion.

First, we should review the risk provisions of an enhanced plan without a Payment Demonstration. Exhibit E diagrams the various risk sharing provisions for the 70/30 Plan for all drugs assuming no Payment Demonstration is in place. Generally:

- Plan takes no risk (CMS takes full risk) on the federal reinsurance piece
- Plans share risk with CMS (with risk corridors) on the plan liability piece of the Defined Standard benefit. This includes 75 percent of costs between the thresholds of $295 and $2,700 and 15 percent of all costs beyond $6,153.75.
- Plan takes full risk for everything else.

For 70/30 plan under the Flexible Capitation Payment Demonstration:

- CMS no longer takes risk on the federal reinsurance piece. It becomes shared risk.
- Plans share risk with CMS (with risk corridors) on the plan liability piece of the Defined Standard benefit PLUS the piece that is the federal reinsured piece for the Defined Standard plan. In total, the shared risk component reflects 75 percent of costs between the thresholds of $295 and $2,700 and 95 percent of all costs beyond $6,153.75.
- Plan takes the full risk for everything else.

See Exhibit F for a diagram of the risk components under the Flexible Capitation.

A comparison of Exhibit E and Exhibit F clarifies that the full risk component is reduced and the shared risk component is significantly increased when under the Flexible Capitation Payment Demonstration. Depending on the population and the data available to price, this change in the risk provisions actually may make the Payment Demonstrations more attractive to some plans.

Administrative Costs

For budget neutrality, CMS charges a per-member per-year (PMPY) amount to participating plans. For 2009, the PMPY for all payment demonstration options is $10 PMPY or $0.83 PMPM. These amounts should be built into the direct non-benefit components of the bid. It's important to note that these costs offset the reduction in premiums shown in Exhibit D.

When should you consider the Payment Demonstration?

Considerations for participating in the payment demonstration include:

1. Some material amount of enhanced coverage must be provided. The more enhanced coverage, the greater the federal reinsurance penalty, and the more member premium savings. This can be particularly attractive for chronic care plans, where full formulary coverage through the gap is essential to gain compliance with drug regimens and realize hospital savings.
2. The actuarial and accounting departments need to have a good understanding of the option. Payment demonstrations will change how bids are created, how revenue is booked, how much margin is needed and how Part D settlements are estimated.
3. Plans must analyze the change in risk sharing. Although the Flexible Capitation option allows plans to cede some risk to CMS in the gap, they pick up shared risk of the catastrophic coverage. Plans must be comfortable with their ability to price the catastrophic component of the benefit.
4. The PBM needs to be comfortable with the Payment Demonstration chosen, especially as it relates to changes in the PDE records and Part D settlement calculations. ■

SOA Health Section and CMS: A Continuing Dialogue | FROM PAGE 23

These annual discussions provide the opportunity for Health Section representatives to react to initial data summaries and issues and questions identified by CMS in the course of their annual NHE update process. For example, CMS is looking for input on such questions as: 1) differences between HMO and PPO trends, 2) changes in insurance enrollment rates of employees, 3) specific changes in pharmacy benefits, 4) growth in Consumer Driven Health Plan options, 5) impacts of the underwriting cycle, and 6) other issues affecting the changes in health costs for private insurance.

This process has worked well and the Health Section is pleased to support CMS in this important service. We want to thank the volunteer SOA members who have contributed their time to this relationship over the years, and we would like to see this effort continue and expand as part of our ongoing interchange with other groups involved in health care. Feel free to contact us if you would like to become involved in future activities. ■

- Finalizing project scope and expectations with the researcher.
- Monitoring and evaluating research progress and recommending corrective action, if needed.
- Developing a dissemination strategy for the research.
- Providing project status reports to the Health Section.
- Recommending to the Health Section an end-product suitable for member and/or public publication/dissemination.

Research feeds content for continuing education, and continuing education provides idea generation for research.

For the majority of research projects, POG work is accomplished via e-mail and conference calls that are typically an hour in duration. Members are asked to review deliverables and other meeting materials prior to the conference calls and comment deadlines. To minimize the time commitment of a POG member, conference calls are usually limited to no more than once a month. However, the frequency of the conference calls will vary by project. In addition, research deliverables are usually distributed at least 2 weeks prior to a conference call or comment deadline to allow POG members enough time to prepare.

For longer duration and/or costlier research projects, the POG may decide that occasional face-to-face meetings are necessary to produce the best research outcome.

Publication/Dissemination of Research and Links to Other Activities

The final step for most research efforts is the publication and dissemination of the results. Throughout the progression of a particular research effort and especially as it approaches completion, the range of publication and media outreach options is considered. To determine an appropriate media outreach level, discussions are held with internal public relations staff along with an outside PR firm.

All research reports share several basic publishing activities:

1. Posting on the SOA Web site as a separate pdf or part of an online monograph
2. Announcement in the electronic *SOA News Today*
3. Blast e-mail announcement to Health Section members

Other publishing and dissemination activities are then decided based on the expected interest of the individual project. These activities may include special newsletter articles, announcement on the SOA Web site home page, and webcasts. As well, articles may appear in journals such as the NAAJ and the Actuarial Practice Forum. For certain efforts with expected broad audience interest, a dedicated media strategy may be devised. This may also include a press release or conference. Finally, depending on the expected level of audience interest, research may also be printed in specially designed and branded versions to distribute at meetings, send to outside interested parties, etc.

Research is also disseminated through presentations at actuarial and other industry meetings. In this regard, research and continuing education have a strong and mutually beneficial link. Research feeds content for continuing education, and continuing education provides idea generation for research.

In addition, research is strongly linked to other activities of the SOA. The ways in which research is integrated and leveraged include:

1. Providing the foundation for a number of SOA exam syllabus materials.
2. Enhancing and promoting the image of the actuary.
3. Building desirable external relationships.
4. Supporting policy decision-making, when requested and coordinated through appropriate organizations such as the American Academy of Actuaries.

Conclusion

Now that you know the ABC's of Health Section research, I hope you will consider taking the next step and become involved. We're always on the lookout for new ideas, volunteers for Project Oversight Groups, and proposals from researchers. Please contact me if you'd like further information on how to get involved or with any other comments or feedback. I look forward to hearing from you in the coming months! ■

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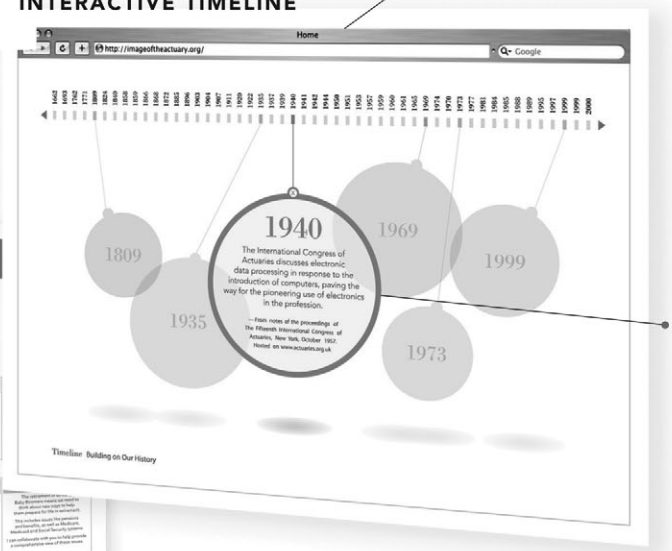

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