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THE ACTUARIAL PROFESSION AND HEALTH CARE REFORM

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What role have actuaries played in developing/analyzing various federal health care reform proposals? What is the SOA and AAA role? What will the future hold for practicing health actuaries?

MR. SAM GUTTERMAN: We have two objectives. The first is to provide you a view of our actuarial organizations' activities relating to U.S. health care reform. Howard Bolnick gave an overview of this topic at the general session earlier. The second is to provide you food for thought and possible personal action regarding the role of the health actuary after health care reform is implemented. We heard earlier from Bill Gradison that if the health care reform act is enacted, it may turn out to be the actuarial employment act of 1994. We will discuss the implications of such a case.

We have a distinguished panel to discuss both of these major topics. We hope that you participate, not only in our discussions, but also in the overall health care reform discussions in the coming months.

Our three panelists are all former chairpersons of the Health Section Council of the Society of Actuaries. Howard Bolnick is currently active in actuarial activities, serving as the vice president of the American Academy of Actuaries in charge of its Health Practice Council, overseeing an unprecedented actuarial effort regarding a public policy issue. Howard has long been active in health insurance affairs and is currently president of Celtic Life Insurance Company. I have had the privilege of serving as the Vice President of the Society of Actuaries in charge of its newly created Health Benefits Systems Practice Area, and I am a consulting actuary with Price Waterhouse. Bob Dymowski and Alice Rosenblatt will address the future role of the actuary. Bob, who will address the future from a consultant's standpoint, is currently national director of Milliman & Robertson's health actuarial practice. Alice will address the future of the health actuary from the perspective of the health plan. She currently serves on the Board of the Society of Actuaries and is now a partner with Coopers & Lybrand, previously having served as senior vice president of Massachusetts Blue Cross & Blue Shield.

MR. HOWARD J. BOLNICK: I'd like to give you an overview of the work that the American Academy of Actuaries has done and give you my own personal feel for what the work group papers mean and the themes that cut across all these papers when you look at them from a high level. I think it's very helpful to focus in on those themes, because they help frame what is unique about the actuaries and about our efforts to influence the health care reform debate.

The general theme of our uniqueness is the idea of being able to take a theoretical construct, i.e. these bills, and take a look at them from a very practical point of view,

to point out where things are missing and where there's hazy and inconsistent thinking. We will be able to sit down and point out the pros and cons and what will happen when that bill gets passed and hits the real world. I think I have been most impressed with those types of issues as I read these papers and see these themes come through from many of the different work groups, all of whom came to these conclusions independently.

I think one of the most important things that these work groups have been saying is that there's a great deal of uncertainty in determining both the public cost of the program and the private premiums. As you might imagine, this is a cost-oriented topic—something that you would expect to have from the actuaries. I think we've pointed out some very interesting items to Congress.

We've said we spent a lot of time with our cost-estimate work group, looking at the starting point for the government's cost estimates—the national income accounts, the national health accounts, and the government data—and comparing that with survey data or data from the insurance industry about costs. We've noted a discrepancy of about 20% between the cost estimate used by government data and private data. To resolve those differences would be an enormous effort, but the fact is, as you look through it, it seems as though the discrepancy brings up many questions that need to be thought through regarding the accuracy of many of the cost estimates coming from the government and to some extent, cost estimates coming from the private sector. The biggest problem that we brought up is that this discrepancy exists and you can't explain it. All you can do is note that it *does* exist. Actually, one of the items that we're trying to resolve is to think about the next step, which would be for the actuarial profession to somehow get in there and try to explain these differences.

I think a second issue then is one that has to do with the pricing that we actuaries would be responsible for in the health plan. We've noted population shifts from the old system to the new system, new benefits, and provider payment issues. The new regulatory structures are going to make it very difficult and very risky for actuaries and private-sector health plans to price benefits, particularly in the early years. This is something that Congress really needs to take into account as it implements a program.

A third issue that we were able to focus in on really has to do with the Clinton program and the importance of the provider fee schedule for driving the cost estimates. There is a very intricate interplay between the fee schedules in the Clinton proposal and the premium caps. The main problem is that these fee schedules are extremely ill defined in the law. To do pricing you must make assumptions. To do pricing you must have some idea of what behavioral changes will take place in the provider community. Not enough attention has been focused on that issue. However, a paper from the cost-estimate work group did focus on it.

I think the fourth issue that comes in this uncertainty concept is the idea of capital. Obviously, taking the Clinton proposal, a lot of business or insurance coverage will move from the government because Medicaid is being done away with. Medicare is being moved over a period of time into the private sector, self-insurance programs are being undercut in that particular proposal, and many insurance dollars are being moved from sectors of the economy that don't really require capital, or the capital is a

guarantee by an employer or by government into the private sector. Is there, first of all, when you make this move and you get all these new people in the sectors, enough capital to cover those people? Second, what is the capital need? How do you define the capital need when you have this new system and these are two sides of the same issue? Is there going to be enough money to do what you intend to do with these reform systems? Those are the kinds of issues that have come up under the uncertainty.

Another issue that has come up is that the President's proposal depends heavily on the budget caps to constrain the premiums for health plans. The only reason that I think there's any value to our saying that quite clearly is that if you'll recall, the President has consistently stated that the premium caps are back-ups, and the private sector was intended to be able to operate within those premium caps quite easily. And yet, when you take a look at how the numbers will calculate, it doesn't appear to be true. It appears that immediately and forever the budget caps are going to be what constrains premiums. That is a point that with our practical knowledge, we can bring to Congress. I hope it would have some credibility, which is lacking in the political system.

A third point, which cuts across a number of papers, is that a significant portion of the data needed to accurately implement the President's proposal simply doesn't exist. With respect to global budgeting under his proposal, as we have talked about, there's this great uncertainty about what the starting point is. There aren't credible data to figure out what the costs will be in 1996 under the revised benefit package, because we can't figure out whether the national income accounts or the insurance data have a better starting point. And even if there were credible data and we were confident at a global or national level, there are simply no credible data at a state level or at the level of the regional health alliance to be able to take a global average down to those levels, which is really what needs to be done in operating. We're not the only ones saying this, but the profession has the ability to draw attention to this in a meaningful way.

Another issue is one that Bill Gradison talked about, and this is the concept of health risk adjusters. The idea that there's going to be a workable health risk adjustment system in effect by April 1995 is almost laughable. There are many issues involved with health risk adjusters, and I think what Alice Rosenblatt would say is there are some simple ways to get at it that could be workable by 1995. I'm not so sure that I would consider them as being really effective ones; instead, I would draw attention to the issues of the health risk adjusters as being one of these points that we've been trying to get across. The adjusters fall under the data and what it's going to take to make the system work that is currently missing.

The third area that isn't as important as the other two is with respect to some new benefits; there aren't enough accurate data about what might happen. Bill Gradison told the story of the Stark-Gradison catastrophic bill and the pricing of the prescription drug for the over-age market. Throughout the Clinton bill and the bills that are going through Congress, there are many new benefits where those same issues exist—issues of the possibility of induced demand behavioral changes that are very difficult, if not impossible, to factor into the calculations. Once again, a number of our papers were drawing attention to these types of issues.

Another global issue that is coming out here is that the private sector may not have the capacity to adequately serve the reformed health care system. There are really two elements to that. Once you shift insureds from the government and from self-insured into the private sector system where we must have capital behind the premium flow, is there going to be enough capital in the system? Another issue that comes up is, if you make all the shifts and the programs or the plan is effective in shifting people from fee for service to managed care, is there enough capacity in managed-care systems to handle all the flow or all the new influx of people? So the capacity risk has both capital issues and the provider capacity issue involved with it.

A more familiar topic that cuts across many papers is the idea that these new mandated benefits in the program are going to create numerous opportunities to increase demand for health care. Actuaries are used to working with the induced demand behavioral change concept day in and day out. But this sometimes comes as a surprise to policymakers; you have to worry about it or you have a very difficult time trying to gauge the effect of induced demand behavioral changes. There are many areas in the bill that have this kind of potential problem. Among them are the mental nervous benefits, another shot at Medicare prescription drug benefits, areas such as experimental treatment, which are going to be defined differently in the Clinton bill or in any bill than may be in insurance contracts today, and going from what is partial coverage for the uninsured today to a system where there is full coverage. Each of these types of benefits requires making some estimate of what's going to happen with the behavior of people who now have new benefits and what kind of induced demand is in there. While we were not, in these issue papers, trying to determine what the cost difference ought to be, we were continually pointing out to the policymakers that induced demand and behavioral changes were something that needed to be taken into account, and it wasn't going to be easy.

A rather subtle point that came out from a number of papers, and this one is somewhat controversial, but again I'm speaking for myself and not for the body of people who were doing this, was that the Clinton proposal and some of its structures really undermine the attractiveness and the effectiveness of managed-care plans. You can make some intricate arguments in terms of the budget cap and how it applies for the premium cap at the regional health alliance basis and how it applies to fee-for-service programs versus managed-care programs. The Clinton proposal is supposed to encourage managed care, but it has painted managed-care companies into a corner in their pricing vis-à-vis fee-for-service plans and has, in fact, undermined the ability of managed care to be an attractive option.

Another example of where the bill subtly undermines managed care, I believe, is that it requires all managed-care plans to offer a point-of-service option. Many of the more successful managed-care programs, of course, have argued that to execute good quality managed care they must keep people within their panel. Opening the panel up and requiring all these plans to let people out, if they want to go out, undermines the ability of managed-care plans to perform at their peak efficiencies. This is an area that probably only actuaries have brought to the attention of the policymakers.

Yet another area that is very much directed at one work group, the administrative costs work group, is that the anticipated savings and administrative costs that the Clinton Administration was projecting are quite unlikely to be realized. This work

group has done extensive amounts of work, drawing on the practical knowledge of not only actuaries but also people from some of the congressional agencies. There was at least one gentleman from the Congressional Research Service who was interested in this topic, who sat with this group and spent a lot of time going through administrative function by administrative function, thinking through what would happen under the Clinton proposal. I believe what they're going to end up finding is that short-term cost may actually go up and long-term cost might break even. But the idea that there is $100 billion worth of administrative costs that are going to flow from the Clinton reform bill, or many other reform bills because of forming alliances, is really a pipedream. Once again, this is an area that brings out our practical knowledge and ability to communicate what others can't. Others in the academic community and health policy community really aren't close enough to these functions to be able to say much. I know this is an area that has been of great interest to the people on the Hill and one where I think we have something to say that's very important to the debate.

Yet another area, which is a sleeper, where I think our ability to take these theoretical constructs and see the practical consequences is an important ability is the area of transition rules. Our groups are seeing that the transition rules from the current system to the reform system are likely to be very difficult and disruptive to both the consumers and the providers. These populations will be making new choices, not only of financing vehicles but of provider vehicles, under a whole new set of rules. There are 250 million people out there who are going to be doing something differently, and that is clearly disruptive. Managing that change is an area that needs to be thought through with a great deal of care. Unfortunately, none of the proposals out there has really given it the consideration that it deserves. We hope that by bringing up the issue and having some time, even postreform as we lead into things, that our input into the process will be very helpful in making the transition a reasonable one.

I think another thing that we've been able to point out, which would be obvious to any of you who have read the bill, is that there are many technical details needed to operate the reform system that simply aren't in the bill right now. Now that doesn't come as much of a surprise, because if you start out with a 1,300-page bill and you want to tack everything down, you'd probably have a 13,000-page bill. But what it's saying, in a sense, is that without some enabling legislation that gets into more detail, without certain regulations and without knowing what the states are going to do to implement it, there's a whole lot that's just unknown. That makes it very difficult for the system to operate.

Examples are the transition rules, which are very vague. We see them as being extremely important, relatively unexplored, and in need of becoming concrete before this thing goes too far. If you look at the global budgeting system, whereas you go through how it's intended to operate, you quickly come to all sorts of places where you have questions and wonder what they meant and how they're going to do that—questions of administrative rules all over the place and where things are said that should be done but without the guidance as to how to do them. That kind of commentary isn't saying we ought to have a bill that's ten times the length that it currently is. What it does note is that in a transition period, we have to make some sort of consideration for filling in some of the blanks before people are going to be able to operate effectively in a reform system.

The last thing that we pointed out consistently, which gets to the other parts of this discussion, is simply the actuaries are going to have a very important role in any reformed health care system. Through our activities to date, we're trying to demonstrate how we think about things to help improve the product that we then have to help flush out, once it's passed, and help operate once it's actually made to happen. We will all have many very difficult chores to take care of in trying to get our plans priced and working. The nice news is that, I think as Bill Gradison said and Sam Gutterman noted before, what we might be seeing here is the Full-Employment-For-Actuaries Act of 1994.

MR. GUTTERMAN: So far we have primarily discussed health actuaries and our input on public health policy issues, generally as they have related to the Academy's domain. The Society of Actuaries has also been significantly involved in activities related to health care reform, through its primary objectives of research and education. As a membership organization, we have been very concerned with membership services, which include communicating with our members on significant matters. In addition, as one of several actuarial organizations, we hope to improve our relationships with the actuarial profession and the other actuarial organizations affecting health care.

Even though during the last several years U.S. health care reform has been the single most important topic confronting the health actuary in North America, we have tried not to forget other health actuarial efforts; that is, those involved in disability, long-term care, and an issue that will confront some of us in the next year or two, the health actuarial role in Canada. Right now, because of the health care system in Canada, there are few practicing health actuaries. However, because the Canadian health care system has been subject to the same cost pressures that we have been under in the U.S., this will be an area of increasing concern to the actuarial profession in Canada.

The first area of Society activities I will discuss is research. We've been very active in developing health care research. Unfortunately, in many areas of research, a long lead time is necessary for valuable research to be completed. In many areas, our efforts are just beginning to be seen. Our research focus has attempted to relate to both significant public policy issues and the support of the practicing health actuary.

Several important projects have involved or will involve research conducted by outside independent parties. These are funded by general Society research funds and funds allocated by our Health Section. We also hope to attract additional funds from other sources as well.

A study of large medical-care claims is almost complete and has been underway for more than a year now. It has studied medical claims in excess of $25,000 and has more than two dozen contributing health carriers. This will report on the characteristics of these claims, such as diagnosis, size claim distribution, and type of health plan. The task force overseeing this effort is currently headed by Tony Houghton.

A project that has just gotten underway is an in-depth study of health carrier insolvencies. Its aim is to explore the causes of these insolvencies so that we may learn a little bit from history and so that we don't repeat them as often as we have in the

past. Its efforts are expected to be completed this fall. Bill Bugg is in charge of the group overseeing this effort.

An evaluation of alternative systems of health risk adjusters is planned for the remainder of the year. This is, as Howard mentioned, a very important topic that will also be referred to later. We have just made available a revised request for proposal for this rather large project. If you are associated with a health plan that has not yet made plans to contribute experience data to this important project, please see me or Bill Lane, the chair of the task force overseeing this project. We hope to begin early this fall.

We have received a few proposals for another project, which is a study of mental health and substance-abuse experience. This highly discussed area currently lacks publicly available experience from the private sector, but it is of vital importance both to the public policy debate and the cost control and analysis functions of health carriers. If you have such data available, we encourage you to contribute them to the Society's efforts. The chair of the task force who has been charged with the development of this effort is Steve Melek.

In addition.to these funded research projects, we have several other efforts underway utilizing our volunteer research task forces. One task force, entitled Medical Effectiveness, is in the process of developing principles that should underlie the development of report cards that are currently being developed, focusing on the measurement of the relative effectiveness or quality of care provided by health carriers and health plans. Lee Launer is heading this effort. We hope to get an initial report on this topic by the end of the summer.

Our Financial Issues Task Force, headed by Burt Jay, has been interested in several areas of financial concern to the health actuary and health carriers. It has assisted the development of the dynamic financial condition handbook, along with other practice areas. In addition, it intends to address several of the issues raised by the Academy's monograph on solvency.

The first topic to be addressed by the Lifestyle's task force is an actuarial evaluation of the impact of smoking on the cost of health care. Mostly what has been published has been experience on the impact of smoking on mortality. Very little has been published on the direct impact on morbidity.

Our Managed Care Task Force is currently writing a report summarizing various studies that have been prepared on the degree of the cost effectiveness of managed care. In particular, it has addressed the cost of alternative mechanisms of delivering care. David Wille's group is planning to have a report on this topic within the next several months.

The Joint Task Force on *FAS 106* covering retiree health has been very active to date in developing seminars and reviewing basic educational materials in this area. This joint effort of the retirement and health benefit systems practice areas has recently focused on trying to identify which research issues are significant to support the employee benefits actuaries. In particular, they are reviewing methodologies that can be used to establish claim costs for this purpose and are developing weighted trends.

Jean Wodarczyk is the health actuary in charge of this group, who we will hear further from in the coming months.

The Society staff has been busy preparing experience data for use by the Congressional Research Service for assistance in its review of several health care reform proposals. We have developed data from almost ten insurance carriers. Jeff Allen, a health actuary on the Society staff, has spearheaded this effort.

Finally, in the research area is an effort to identify and make available an increased number of health care data sources that can be available to health actuaries. Steve Brink is heading this effort. We hope to have a request for proposal ready on this topic shortly.

In the realm of education, we have emphasized both the education of our members and our students. In the continuing education area, our primary focus has been on meetings. This year's meetings include this one, full of relevant and valuable sessions, as well as our annual meeting this fall in Chicago. An amazing amount of effort and number of people are involved in developing these meetings. I would like to thank each of you who have participated in this effort.

In addition, we hope to develop a more extensive seminar program in the future. Some topics that we are planning include analysis of models being used to develop risk-based-capital requirements for health carriers, which will be held in September in Orlando. It will look at a case study, a practical view of the topic. A series of seminars is in the planning stage focusing on provider networks and various aspects of the health care system of the future. Also, once we complete some of the research efforts that we have underway, we'll be sponsoring seminars on those topics as well.

In the area of basic education, various education committees are continuously focusing and updating our syllabus. This is a particularly challenging effort in today's environment. A relatively new health policy course, G527, was developed to focus on public health policy issues and has been well received. We continuously attempt to update all of our educational material.

In the area of communications, we have focused our attention on our normal publications, including *The Actuary* and the *Health Section News*. In addition, as Howard mentioned, a joint task force of the SOA and the AAA has been created to focus on communication both within and outside the actuarial community on health and health care reform issues. Bart Clennon has played a major role in this effort. Julia Philips has agreed to take over from Bart later on this year. We hope to continue to improve the amount of information that we provide, not only to the people of the Congress and the administration in Washington, but also to you, our members. In our high-tech world, we must also consider our electronic communications as well. I believe that the development of the Society's bulletin board, in particular the Now Health! Forum, is something that I hope will be of increasing use. It will serve as an instant communications vehicle, and I hope an educational vehicle as well.

We have tried, with a reasonable degree of success so far, to work effectively with other actuarial organizations, such as the Academy, to coordinate our efforts on some of the most significant issues of interest to the health actuary. I believe that this is a welcome change. As a result, I hope that we have looked to the outside world as a seamless actuarial profession. I hope we will continue these efforts in the future.

At this point, I'd like to second the appreciation expressed by Howard for the number of volunteers we have both in the Society and the Academy. I am sure there are more than 200 or 300 on the Academy side and at least that number participating in Society activities. It is an amazing effort occurring at a time during which health actuaries are very busy.

In any discussion of the future of the health actuary, we must be aware that we are not the only quantitative-based profession attempting to serve the health care industry. Many other people and professions are active in the health care area. This competition is something that we have to be aware of in planning our future. The following is a brief discussion of some of these professions:

Health economists may have had more of a clinical and statistical base of knowledge than the typical health actuary. They have had greater credibility in some public forums, because they were viewed as being academic and unbiased. We have to keep in mind that health actuaries are still associated in many peoples' minds with the health insurance industry. I hope the Academy's recent objective input on public policy issues has helped to overcome this. However, we still have a long way to go in this area.

Hospital, financial, and cost-accounting personnel can either work within or be consultants to health carriers. They may be MBAs or management consultants. They sometimes have developed their own data as insiders. Many MBAs with experience in the health field may be viewed as having a broader business background than actuaries. They tend to use less technical jargon, so they may be more tuned into potential clients. They also may have a better knowledge of the overall health care system. They have the advantage of not necessarily being viewed as being tied to the insurance industry.

The strengths of biostatisticians and epidemiologists include their clinical knowledge and strong statistical skills. We will work to overcome these strengths.

Insurance underwriters have tended to be highly pragmatic and have traditionally been able to make quick decisions based on relatively limited facts. In addition, they are skilled in customer relations and have the advantage of having lower salaries than actuaries.

The strengths of health benefit consultants include customer relation skills, a good knowledge of the environment, and aggressive marketing skills.

Data and computer-related staff generally provide back room support. However, everyone relies on them to provide the basic information needed to survive in today's world. Because information represents power, these individuals should not be underestimated in terms of their ability to contribute.

Health policy experts, generally Ph.D.s, are academically oriented. They tend to have a global outlook. They are often viewed as being experts when macrosystem alternatives are being examined.

In summary, we have a great deal of competition. I believe that actuaries will have to earn their future reputation within the health care arena.

MR. ROBERT J. DYMOWSKI: I will talk more about the short-term future, perhaps, than the long-term future. I think that some of Sam's comments at the end were interesting—the talk about the different groups of people that we are perhaps competing with in some ways. I remember attending a Society meeting several years ago. Howard was one of the panelists at that session, and the group was talking about the potential role of health actuaries in the coming debate about health care reform. And I think that Howard and the efforts that the Academy and the Society have made have really improved our visibility in the area considerably. Of course it comes through the work of all the people who have been involved, not just the organizations. But I think that as we focus on how these plans are really going to work, the realization has been that actuaries are the ones with the practical experience, and actuaries do have the breadth of knowledge necessary to put them all together. We have a much better position in contributing to this process now than we had perhaps, at least as far as visibility is concerned, a year ago. The President helped a lot with his reference to us, of course, but that wasn't necessarily in the best context.

In thinking about the future of health actuaries from a consulting perspective, it's good to start with just a quick review of some of the topics we've already been talking about, such as the implications of health care reform on the things that consulting health actuaries have been doing and what that's going to mean for the future. First, it's quite likely that there's going to be a significant change in the role for insurance carriers. There is going to be a shift away from their risk-taking role and much more of a shift to their involvement in the management of care and perhaps transferring the risk to other parties. That depends, again, on which of these programs goes forward. There could be a possible reduction in the employer direct control of benefit programs. Employers may or may not be able to design their programs or benefit directly from the experience of their programs. So that's going to be another issue to contend with. There will possibly be new players coming into the arena. Either voluntary or mandatory, how are the alliances going to work? What are the implications that they have on the distribution system and the risk spread?

There certainly appears to be the likelihood of more regulation and governmental control. There's been a reference to the Health Care Reform Act as possibly being the full-employment act for health actuaries for 1994. I remember that was said about ERISA in 1973. And it was very true. I know that in our firm, the pension actuaries were extremely busy getting all of these plans up to speed and doing everything they needed to do with regard to that. But as most of you following the developments in that area realize, the increasing amount of government control and the focus on the pension system as a source of revenue has dried up much of the defined-benefit business that ERISA was involved with regulating. So those actuaries are now trying to develop health actuarial work. And we're trying to help them, because we'll need them.

There certainly is going to be an increase in the risk-taking role of providers, and in some form of these various organizations as part of this process. So what does this all mean for health consultants? First of all, there's going to be a new game in town. There are going to be new rules to play by—less emphasis on risk selection and more emphasis on risk management.

The tools and the research efforts that Sam talked about are very helpful in that regard. We have already seen increasing needs for new kinds of data. All of us who started out in this business 20 or more years ago, as I did, started out just knowing and dealing with expected values. And we began to deal with distributions of expected values. We knew that was important. All of a sudden, we're getting into the distributions of the distributions. And more and more levels of detail must be addressed. It's going to call for more data to meet the needs of the new people coming into the market. And certainly we need to educate these new players as to the skills and the roles of actuaries. We were walking by the registration desk this morning and my wife saw the Ask an Actuary button. She said, "Oh, do you have one of these?" And I said, "Oh yes, I have one of those." She has never seen me wear it. But we probably all should be wearing one and I'm sorry I didn't bring it. But we do need to educate new players. We meet with provider groups, and we meet with people who have heard of actuaries but who have never actually met any. And they want to know what it is we're going to do for them and explain why it is we're sending them these big bills. We have to be able to explain all that very well.

We must be to able to apply our skills to new situations. And I think that's where the experience that we've had with the flexible nature of health work, the need to dig and to try and do things in different ways will stand us in good stead. We can apply the traditional skills to these new situations.

One of the things that's going to be very important is to work very closely with clinical practitioners. Our firm has been looking for new ways to expand our areas of health practice, and one of the most important ways is that we have physicians and nurses who have joined the firm in recent years. So clinical practitioners have added significantly to the kinds of opportunities that we have, the kinds of data that we are beginning to develop, and the importance that we see in some of these new areas. And I think that we will also work with some of the people who Sam mentioned as competitors. So we need to work and to draw on their skills to complement ours and our knowledge.

So let's look a little bit at some of these new players and some of the continuing players and how their roles are going to change and what that's going to mean for us. Certainly, I think, the most important place to start is probably with the providers. As we said, they're going to be taking risks. One of the most frequent areas of activity that we see in our firm at the moment is working with different groups of providers. So everyone wants to understand what this new capitation arrangement would mean to them. What is a good deal? We're being approached by associations to try and develop guidelines for entire memberships of their groups, to help to understand proposed capitation and risk-sharing arrangements.

We are working with providers. We will need to work more with providers in their consideration of the formation of larger groups—hospital consortia, provider groups,

whatever it may be. Who are the good providers? Who are the "not so good" providers or less efficient providers? How do you determine who's doing a good job and who's not doing a good job? That requires data, and it requires an understanding of what that will be. We had a discussion, again at one of our meetings, about just developing a greater knowledge of the vocabulary that's being used in some of these specialties, and just being more familiar not only with what the frequency of a particular procedure is, but also what is that procedure? What does it really mean? We must have some knowledge of the business, because in any business, you have to know your customer's business. And these are going to be our customers, and we have to have a better understanding of that.

Certainly the risk and capital requirements that have been mentioned already are going to be important in this area. As providers take on more risk, they have not understood the need for these kinds of developments. They may be trying to take on more than they are capitalized to do.

They will need to deal with regulatory systems, different regulatory bodies perhaps, if they're involved in negotiating with alliances or whatever the case may be. But there are areas where we can help them there. We talked about the evaluation of efficiency, as part of the provider selection process. What do we need to be able to identify? What are effective methods of care, patterns of care? We have to extend beyond just looking at the days or the incidences to get into outcomes research. That's an extremely important area where we're going to have to combine the quantitative analysis that we can do with a qualitative appreciation of what the results of these activities produce.

There's going to be a need for our skills in data organization and analysis. We've been working with this kind of data, in many of our cases, for 10, 15, or 20 years. And we need to teach these people how to get the data they need to understand what it means in terms of risk taking and the efficiency of their operations.

As we move away from the providers, we see managed-care organizations are certainly in the next group and they need to be concerned with the same concerns that providers have. But now they are trying to manage their operations in dealing with groups of providers, on either a salaried basis or on a capitated basis, whatever the case may be. We need to be able to assist them in network selection, in monitoring their evaluation of reinsurance or risk-adjustment options, with these different proposals that are coming out. Which ones are going to make sense for them, and how do they best fit in with them? Certainly, if they deal with provider groups and offer them contracting and incentive arrangements, that's a traditional role for health actuaries.

There will be a consolidation in that marketplace, perhaps in many ways, and so the kinds of work that we are accustomed to doing in merger and acquisition analysis and assistance will be important there as well. A new area that's developing, and quite rapidly it seems, is integration of workers' compensation into the managed-care elements. Many managed-care organizations throughout the country have already begun workers' compensation programs. There are workers' compensation organizations that are looking to join with HMOs, to have access to the providers' networks that are involved. That's an important area, and it gives us a good opportunity to

work with casualty actuaries; in our firm, this can be a very positive result. We had a very good meeting recently where we had an opportunity to talk about the kinds of things that people were already doing, and the kinds of opportunities that we saw ahead. We see that as an important area of practice in the coming years.

Let's think back to the traditional insurance carriers. First of all, there's probably going to be a very great need for assistance in their transition to become managed-care organizations; that seems to be a very significant part of the future. There may still be opportunities for their more traditional modes of activity, but perhaps much fewer than they've had in the past. Of course, there could be opportunities for further development of supplemental products, but these are quite likely to be smaller areas than they have been traditionally.

Employers will need plenty of assistance to understand what all this means and to applying whatever their new responsibilities are under these programs. We need to help them to evaluate whatever the options may be. How does it compare with what they are currently doing? What does it currently mean to their cost? What is it likely to mean to their costs in the future? We need to help them transition to the new structure. If there is a time period for phasing in, what is the best way for them to react in that time period in order to make the transition as smooth as possible? There will be opportunities for monitoring and reporting on continuing programs. Certainly the whole concept of managed care is one that has such a wide variation and acceptance throughout the country. In some parts of the country, there are tremendous amounts of penetration of managed-care programs. Yet for the country as a whole, this penetration is probably only in the range of 20–30%. So if there's going to be a significant increase in that, many employers need to understand more about what that means for their opportunities to benefit from the experience of the program. How do they control it? What are the options for their employees? That could be an important role for us.

The question of the alliances is certainly one that we've heard mentioned several times. Where are they going to be, who are they going to be, and are they going to be mandatory or voluntary? We'll have to understand what their roles are going to be. We can help them in establishing monitoring and reporting requirements for the organizations that they're dealing with, helping them to create that efficient marketplace, if it comes to that. There may be a role, again, depending on what their responsibilities are, in evaluating the financial capacity of the risk takers that are presenting their products through the alliances. They're going to need to eventually apply whatever risk-adjustment mechanisms can be developed and come out of this process. And they may need help to comply with possible budget caps. We can help them with modeling, with understanding the implications of their current overall packages, what their historical trends have been, and what the future may hold in terms of what they're having to do.

So looking at all that I said, I think that that's the short-term future. I think there is a considerable amount of opportunity here for the health consulting actuary as the system anticipates the reform process and responds to it. I think there are going to be many longer-term opportunities, but we will need some retraining, some re-education, some redevelopment of efforts, and we need to learn to deal with new people,

new ideas, and new things. But that's not anything that's beyond the abilities of anybody here.

I've been with Milliman & Robertson for more than 22 years. Every now and then, at one of our meetings, someone will ask how many people knew Wendell Milliman. Fewer and fewer of us can raise our hands; fortunately, I was one who did have some contact with Wendell. There is one story about Wendell that Jim Curtis, our former CEO, always quoted. At some point, probably back in the 1950s, there was some concern about the future of actuaries and what their role was going to be. I don't remember the exact context, but at that point Wendell observed that as long as there was a risk, there would be a need for actuaries. And I think that's as true today as it was when Wendell said it. But in any event, I think there are plenty of opportunities for health consulting actuaries. There will be very many interesting and challenging things to do.

MS. ALICE ROSENBLATT: Bob spoke about the consultant perspective and what the future has in store, and I'll be talking about the carrier perspective. There will be some repetition, because consultants do consulting work for carriers and carriers have to negotiate with providers.

I started with a list of the skills and tasks of the "past." However, the "past" might represent the "present" for some carriers, depending on how far into the managed-care spectrum the carrier is. Some of these skills and tasks are: risk selection, experience rating, self-funding, negotiations, product development, settlement with policyholders, and policyholder reporting. I'm going to discuss each of these. If you think about the agendas of the Society of Actuaries meetings, you'll notice that this list includes some of the topics that were "hot" five years ago. You will also notice that different topics are currently on the agenda.

The first item on my list is risk selection. This includes medical underwriting and other risk-selection techniques. As many states ban medical underwriting as they implement small-group reform, these risk-selection techniques may become obsolete. On the larger cases, carriers have used case underwriting techniques to differentiate "good" cases and "good" industries and to screen out cases where there may be individuals with large ongoing claims. Other techniques include participation guidelines and preexisting-condition limitations.

Experience rating is the next skill. Actuaries who worked for carriers analyzed trend rates. Depending on how much data a particular carrier had, trend analysis might involve an analysis of your own experience by tracking the experience over a period of years and analyzing it by certain components such as inpatient, outpatient, and physician services. For carriers with little data, trend analysis might involve getting a consultant survey on the trend factors being used by other carriers and taking the average. There are also techniques for large-amount pooling, credibility adjustments, demographic rating, and for developing expense allocation formulas. The agendas at Society of Actuaries meetings of 5-10 years ago had sessions on ASO, minimum premium, cost plus, and other types of alternate funding. Actuaries who worked for carriers also needed to develop skills to negotiate with marketing people, policy-holders, and brokers and consultants who were advising policyholders on our prod-ucts. Product development used to be a competitive differentiator. We aimed to

design a product that would "stand out" in the marketplace. Settlement with policyholders might take the form of reinsurance or stop loss for ASO contracts and refunds or dividend formulas or retrospective-rate credits for those cases that were retrospec-tively experience rated.

Finally, policyholder reporting was generally what I'll call claims analysis. We produced reports of claims of the past year or two, perhaps comparing the claims of the previous year with the current year. These reports also might have contained some utilization and cost measures. How will health care reform change all of this? As Bob mentioned, there will be a shift away from risk selection, a shift toward medical management, a shift toward greater administrative efficiencies, and a shift to standard plan designs.

How are these changes going to affect the list of skills and tasks that we need now and in the future? The "new" list of skills includes: risk adjustment, community rating, medical management, administrative efficiency, and negotiations. When you compare the list of the "past" with the list of the "future" you will find that the words are different, but the skill sets are the same. The skills are being applied in different ways.

Let me start with risk adjustment. New York State, for example, has put in place a risk-adjustment mechanism. It uses a demographic risk-adjustment method, because pure community rating is required, and is a form of reinsurance. If you review my previous comments on experience rating, you will see that demographic adjustments and reinsurance were on the list. So these are things that we've done before. We would just be doing them in a different context. Community rating may be a new rating technique for some of you. Instead of looking at last year's claims overall and trending these claims forward to determine future claims, we're going to be looking at the actual experience in greater detail. For the various types of procedures or services, we're going to be looking at cost and utilization.

Medical management is going to be extremely important for actuaries who are doing pricing work for carriers, and it will require clinical input. Let me give you a simple example of that. If your companies have developed new utilization review procedures, you have probably received input from associates with the clinical expertise who were able to assist you in computing the savings to be expected from the new procedures.

Administrative efficiency is going to occur in several ways. Right now some of the large employers and consultants to those large employers are saying that service is very important and that they want financial service guarantees in addition to very low costs.

In the past, actuaries may have devoted a lot of resource to the task of allocating expenses in the experience-rating formula. In the future, we're going to spend more time figuring out how to get to lower costs, because we may be dealing with community rates and a single expense rate for a very broad range of cases involving cases of many types and sizes.

In terms of negotiations, the "new" list is very similar to the list we have currently. We'll still be negotiating with marketing people. We'll still be negotiating with policyholders. There might be new entities, alliances, that we'll be negotiating with. We'll be negotiating with providers, and the actuaries will be participating in the determination of provider compensation. I don't believe that alliances will cover the entire marketplace; we'll also still be negotiating with brokers and consultants. There will also continue to be settlements. I previously mentioned settlements to policyholders. In the future, we'll be doing settlements and reporting to providers. Many providers will be paid through arrangements that include incentive payments. The actuaries are going to help in the calculation of the settlement to the provider at the end of the accounting period. We'll also be performing outcome measurement, where we'll be measuring providers against peer groups while accounting for case severity.

Reporting to consumers is also going to change. It will no longer be a matter of simple claims analysis. It will involve health effectiveness data information set (HEDIS), which will include service measurement, financial measurement of the health plan, and utilization measurement.

MR. DONALD T. WEBER: I have a question relating to insolvency risk under health-care reform and its relation to the actuarial role of the future. Depending on the type of health reform that is implemented, I see it as maybe one of the most significant issues facing us. This issue relates to both providers as well as to the insurance carriers. The form of risk adjusters, that is, whether they are prospective versus retro-spective, will probably have a large influence on it. Could you comment on this?

MS. ROSENBLATT: I totally agree with you. The pricing implications that I discussed are going to lead to solvency issues.

MR. BOLNICK: When I was talking about level playing fields, I essentially was trying to bring out that same idea about solvency. Many of you may be aware that the State Health Committee of the American Academy of Actuaries has put forth a proposal for risk-based capital for health insurers that was put forward to the NAIC last weekend in Baltimore. It's a discussion draft and so we have been very involved with the development of solvency standards that we would hope would then be applied across the board.

MR. JOHN A. HARTNEDY: Actuaries have been accused in the insurance industry of being risk avoiders, and we, as a Society, have not seemed to take issue. In particular, we have dealt with risk through risk classification. I am troubled that in the Academy monographs, particularly with the one dealing with solvency, we have not really addressed the proper role of risk classification and the interplay between risk and social policy. It's almost like we've abandoned Actuarial Standard of Practice #12, which addresses risk classification. As a result, we may not be fulfilling our roles as actuaries to educate or give the facts. My concern is why haven't we made a connection between social policy and risk classification, the essence of the insur-ance business?

MS. ROSENBLATT: I think one of the issues is that a level playing field does not exist today. It's starting to exist in some states, but it doesn't exist everywhere.

Actuaries are often associated with the commercial insurance industry, yet many actuaries today work for Blues plans operating as insurers of last resort. These plans are not permitted to do risk classification and may be required to do community rating. There are other actuaries who work for HMOs that are federally qualified. These HMOs are also regulated as to risk classification and rating. Thus, it's hard for us to speak as one actuarial voice in the current environment.

When I have testified and talked to the press about the issue of community rating, I have stated that the Academy does not take a position on community rating because that is a public policy issue. However, the Academy wants to make sure that those who are going to be making those decisions understand the implications of community rating.

MR. BOLNICK: Bill Gradison made a comment during his speech that one of the issues that was underlying or driving the policy debate was, do we want to have a social insurance system? He then listed many attributes of social insurance. Or do we want to have essentially a free-market private system? That has been an issue that has come out in many things that the Academy and the Society of Actuaries have done. Some papers that I have seen that were written by actuaries began to address that issue. And I think we've had a lot of success in drawing attention to the fact that there is a distinction between the social insurance system, a private system, and what the attributes are. That's a political choice as to which way you go. And it's our role to clarify the debate, talk about the pros and cons of either system, how we make them operate for better or worse, and what the pitfalls are with them. Perhaps some of the work papers, as they came out, could have addressed that issue a little bit more directly. But if you think of that as a background issue and reread some of those work papers, you'll find that they do a good job of walking the line between those. We as a profession are not here to advocate for one system or another. We're here to bring clarity to the debate. We're here to bring the practical consequences, both pro and con, of whatever system is chosen by the body politic.

MR. DYMOWSKI: Well I could add a little bit to that. From our own perspective, many of our clients have had to address the implications of various reform proposals at the state level or certainly looking out to federal proposals. One of the things that we've struggled with within M&R is simply how we try to maintain a balance and not come across as advocating a particular position, but sticking to the role that we think that we have as actuaries, which is to identify the risks, to help the parties involved understand the implications of the risks, to help them model the risks. We've tried to focus very much on what the risks of all these issues are. But I think just as Howard and Alice said, our role is not to say whether the policy or the direction that's being chosen is right or wrong or indifferent. And I don't think there's been any abandonment of issues regarding a risk classification. I think it's just a matter of recognizing that ultimately there are decisions that are going to be made that are not just actuarial decisions. Our role certainly as actuaries is to help people understand all of the facts and the risks involved so that they can make the best informed decision that they can.

MS. SALLY T. BURNER: I'm with the Health Care Financing Administration Office of the Actuary and we're the ones responsible for the low premiums that everybody

takes potshots at. Our involvement in the process as the Office of the Actuary actually started a year-and-a-half ago. We had one of multiple models that were being considered for use in estimating the cost of the benefit package for the administration. Basically, because of our reputation and the reputation of actuaries in general and the reputation of our chief actuary and the work that had come out of our office in the past, our estimates were the ones that were finally chosen to be used. Coming out first is hard because everybody already has a target. I would like to make a couple of comments on the cost estimates work group. They did a really great job. We spent a great deal of time with them and they really tried to come in and learn all the ins and outs of the model. I think what has gotten headlines is that the numbers could be as much as 20% more. But they also said that we did a really good job. So I'd like to pat ourselves on the back a little over here on that.

The difference does come down to primarily what I think you said before was baseline differences; the difference between what we say is total spending on private health insurance benefits, as opposed to what comes out of rate books. I think that's an area that needs further investigation. I think it's the national health accounts that we use, which we also do in our office. So we have a little prejudice toward those numbers as well.

We think that's a good source. Because they're national and they're representative of the entire spending of the nation. We create those numbers from various sources and we balance provider revenues against sources of payments, as opposed to sort of rate-book approaches that are used for a specific population and a specific use. They don't have to be controlled to anything. If you took the numbers that come out of some rate books times the number of people who are insured, you would end up with much more spending. Instead of currently being 13% of gross domestic product (GDP), you might end up with 20% right now if you use numbers that come out of those kinds of sources.

I definitely think it's an area that needs further investigation, but we used what we had, which was the national health accounts as the beginning. Our model was scrutinized a couple of months ago by the task group that consisted of six actuaries and one economist. I'll be glad to answer any specific questions if there are any.

MR. BOLNICK: One thing Bill Gradison pointed to was this idea of a point estimate versus a range. Once again, we're slipping into that trap. I think the headlines were always, "Actuaries say there's a 20% discrepancy." In fact, the report did have a range in it. Do you want to comment on that, Alice?

MS. ROSENBLATT: Yes, I was going to comment on that. The range that we came up with was actually 98–120%. So the Health Care Finance Administration (HCFA) numbers were within our range.

MR. BOLNICK: I also would like to point out that one of the items that we've been talking about as a follow-up task was to somehow begin to get our hands around the discrepancy between rate-book data and the national income accounts. I can tell you from personal conversations with Guy King that he has a strong interest in finding out what the differences are, too. All of us are working toward the same goals, about what the right numbers are. Sally might even be willing to admit that there are some

questions there that are worthy of digging into deeper about the national income accounts. That would be wonderful to be able to answer in the context of the debate that's going on right now. Unfortunately, the task is so large and the time so short that I don't think it's going to get done before votes this year. But it's one of the tasks that I hope to find a way to get started with the Academy of Actuaries.