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Moderator: JAMES J. MURPHY
Panelists: WILLIAM F. BLUHM
THOMAS R. CORCORAN
Recorder: JAMES J. MURPHY

Summary: This session is an open meeting of the Society's Health Benefit Systems Practice Advancement Committee and Health Section Council, as well as the American Academy of Actuaries' Health Practice Council. The three committees review ongoing projects in the Health Practice Area.

Mr. James J. Murphy: I'm vice president for the Society of Actuaries and Chairman of the Health Benefit Systems Practice Advancement Committee, or Practice Advancement Committee for short. Bill Bluhm is the American Academy of Actuaries' vice president and chairman of the Health Practice Council, and Tom Corcoran is chairman of the Health Section Council. We'll be giving you a brief update on our activities on your behalf in the three organizations, starting with the Academy. Then Tom and I will together present some information on the SOA activities both within the Advancement Committee and the Health Section.

Mr. William F. Bluhm: This is probably my last talk as the health vice president for the Academy. I just wanted to take the opportunity to thank everyone involved with the Academy during my term. We have had some real tough times, and I think we've been amazingly successful despite that because of a lot of committed hard work by volunteers and staff.

I want to talk about three things. First is the Health Practice Council goals,

essentially what we call the 1988 goals, which will run until there's a new vice president in October or September. Each year the Health Practice Council goes through a process of visiting Capitol Hill, talking to a lot of staff people, sitting around a table, brainstorming, evaluating, and figuring out what the most critical issues are to be addressed in the next year. Those become what we call the key issues and are defined within the terms of the Academy's mission statement and strategic direction.

The mission statement reads "to ensure the American public recognizes and benefits from (1) the independent expertise of the actuarial profession in the formulation of public policy, and (2) the adherence of actuaries to high professional standards in discharging their responsibilities." That mission statement is on the verge of being replaced by a new version. I'm sure I'll like the next one, too, but making sure the public recognizes and benefits from our expertise in forming public policy is pretty much what we're all about.

That mission got translated into a bunch of strategic directions. The first is "to identify, assess, and prioritize key public policy issues." The second is "to identify, establish, and strengthen Academy access to key public policy makers." That has been an enormous success over the last six to eight years. Third is "provide guidance to the profession's research area so as to develop research projects supportive of public policy initiatives," and that's something we have been trying to do for a lot of years, and sooner or later we're going to figure out how to do that right. That's really our big challenge And it's starting to happen. We're starting to have research in place in time for the public policy stuff. And the fourth strategic direction is "to provide technical expertise of the profession to decision makers on key public policy issues." That's been our bread and butter.

For 1998, there were three key issues. The first was Medicare reform, and we set up several working groups to address that. The second was solvency issues in an evolving market, and that included risk-based capital issues as well as the new provider sponsored organizations (PSO) solvency issues. And the third was mandated benefits and other health-care reforms, including managed care backlash reforms.

We also had some ongoing priorities: health insurance coverage for uninsured children, long-term care, Medicaid managed care, medical savings accounts, and loss ratios. Here's an example of the impact we've had. There's a now-famous quote from President Clinton when he was launching his health-care reform initiative talking about "giving his numbers to actuaries from major accounting firms and major *Fortune* 500 firms who have no stake other than to see that the efforts

succeed.” So, he believes the numbers are good and achievable. There were eight or ten actuaries involved in that as peer reviewers of the process.

From the Floor: Some of whom refused to sign.

Mr. Bluhm: Yes. I’m not suggesting that the outcome was ideal, but from the point of view of achieving our recognition, the outcome was ideal. There’s no such thing as bad PR. PR is PR. The second testimony to how much we’ve accomplished is that periodically we testify before Congress. During the last four years, we’ve testified about eight times and responded, through the Academy staff, to 200 or so requests from congressional staffers, aides, administration agencies, and media sources.

This is all happening because of the changes in the medical insurance market: the dominance of managed care, the backlash that you’re all aware of, and changes in delivery systems, insurance companies, mergers and acquisitions, and so forth. There are incremental reforms going on, now that they appear to have given up on major reforms. And Medicare reform is not in the crisis mode it was because of the extension in time before it is expected to go bankrupt.

Managed care has become pretty much universal around the country, although the definition of what managed care is keeps changing. Eighty percent of employer-sponsored health insurance is now through managed care. Media and film anecdotes abound about people who wrongfully had health care withheld from them because of this rotten managed care system that they’re part of. And there are White House and congressional “reform” initiatives. Reform is in quotes because sometimes it’s the reverse of reform. They throw the baby out with the bath water and don’t see the value in some of the things that are happening. The patient rights legislation that’s coming along is an example, and we have a new working group to address that.

Health Insurance Profitability and Accountability Act of 1996 (HIPAA) is an example of the feds starting to regulate insurance. It happened again with the Balanced Budget Amendment (BBA). And it is likely to happen more, so we, as a profession—and the Academy especially—must pay attention to that and evolve what we’re doing to match what’s happening in the legislative arena. For example, we have a Medicare Expansion Issue Brief, developed primarily by Tom Wildsmith, which is a nice piece of work.

We were quoted on the front page of *The New York Times* regarding the Clinton Medicare buy-in and this issue brief. The quote says Julia Philips and I said in an

interview that “we doubted that Mr. Clinton’s plan would pay for itself at the premium rates he has proposed.” You need to put these things in context. That was said at a time when the administration had announced this new plan and refused to give any details about it. And the way it was being described made it sound pretty doubtful that it would be self-supporting at the time. An expanded version of those comments is the issue brief, which describes our opinion in greater detail, rather than condensing it into a single sentence sound bite. It is, however, a good example of the success the profession has had in making itself known and respected when the Academy is quoted on the front page of *The New York Times* as authorities about whether the administration’s plan is going to work or not.

The PSO solvency issue was really a big win for us in my mind. It was the first example of the feds deciding to become regulators of health insurance. The fact that they were coming out with regulations to determine solvency standards for these new insurers, PSOs, I saw as an absolutely critical strategic issue for us. When they first put their foot in the door, we wanted them to recognize who we are and that they were fighting a losing battle. And primarily through John Trout’s deft management efforts and his connections at the Health Care Financing Administration (HCFA), we had them change the regulation and determine that being a member of the Academy qualifies one for this purpose. It didn’t require that PSOs get actuarial opinions, but strongly recommended it. Is that right, John?

From the Floor: It did.

Mr. Bluhm: It did require an actuarial opinion? OK. I’m really proud that we did this. We’ll never know for sure what would have happened if we hadn’t done it, but it got us headed in the right direction. My guess is that HCFA and other agencies will not find it so hard to include us in the future, recognizing the definition of a qualified actuary or the value of an actuarial opinion.

Another great quote came from Nancy Kassebaum, of the infamous Kennedy-Kassebaum Bill, who said, “I marvel at what actuaries do, the information that they provide, and the objectivity and credibility that they bring to the public debate. The Academy has helped us to confront the facts behind the political rhetoric no matter how the chips may fall”—which was a nice thing for her to say. That effort happened a couple years ago now, but it still stands out as one of the major things we’ve accomplished.

Following *The New York Times* quote, the White House asked for and got a meeting with us on the Medicare buy-in proposals. It was kind of neat. We’ve been knocking on doors trying to get meetings with them for the last ten years, and

the White House called us to ask us for a meeting. We also had a request from Representative Fortney Pete Stark (D-CA) to talk about the alternatives for reforming Medicare. He is hopeful that things can be pieced together without being dramatic, by nudging it here and there, raising the age or increasing the premiums and copayments a little. We've built a volunteer structure, and we're going to build some models and so forth that we can use to respond to that.

We also have the issue brief, Actuarial Issues in Medicare Expansion, which came out in May 1998 and the Negotiated Rulemaking presentation to the PSO Solvency Task Force. Congress told HCFA to go through a process called negotiated rulemaking. They put everybody involved in an industry that's going to get regulated in one room and told them to come up with the right regulation, which was how the PSO solvency regulation evolved. That law also required HCFA to consult with us along the way, and we were quite disappointed in the form that took. They had about a half-hour meeting with us in advance and told us that we were welcome to provide public comments just like anybody else when they were done. That's why it's such an amazing turnaround for them to have included us in that regulation the way they did. The State Health Committee did provide comments at the end of that discussion. There were also comments from our Mental Health Parity Work Group to the Department of Labor. And, there have been a lot of comments to the NAIC on a wide variety of subjects. We have a separate mechanism to deal with all that.

The Academy's Health Practice Council tries to direct things in a strategic and policy setting way. I chair that council, and the vice-chair is Peter Perkins. Peter is also the chair of the State Health Committee. We have changed the structure a bit, although it's not official. In the *Yearbook*, you'll still see State Health Committee, Federal Health Committee, and so forth. But we had a series of discussions and ended up creating a group we call the State Health Relationships Group, essentially a committee that's responsible for building and maintaining ongoing relationships with the NAIC and state regulators. And the Federal Health Relationships Group does the same thing for Capitol Hill and federal agencies. Donna Novak is chairing that.

Another group, called the Project Management Committee, is headed by Al Ford. His group is responsible for managing individual work groups that are producing monographs, issue briefs, and other topical item that are only around for a couple of years.

The Medicare Task Force is chaired by Tom Wildsmith. There's a Long-Term-Care Committee because long-term care is a unique, separate thing, and a Joint Communications Committee with the Society. We have a Managed Care Work

Group that Al Bingham is chairing, and a Multiple Employer Welfare Association (MEWA) Work Group that John Schubert is chairing, and a Risk Adjustment Work Group that I'm chairing, which is responding to HCFA's request for a peer-review process of their risk adjuster stuff.

Under the State Health Relationships Group, we have two task forces. There's the Health Organization Risk-Based Capital (HORBC) Task Force—the evolution of the third iteration of this task force—which is in a maintenance mode with the NAIC on HORBC and hoping to interact regularly as the HORBC formula evolves. Burt Jay is heading the HORBC group. And Bill Bugg and Burt Jay are working on a Loss Ratio Work Group that is trying to address some specific loss ratio issues for the NAIC's Life and Health Actuarial Task Force.

Under the Medicare Steering Committee that Tom Wildsmith is heading there are currently four working groups. There's a Medigap Subgroup that Julia Philips is heading, a Medicare Cost Saving Task Force that Dennis Hulet is heading, a Cost Containment Task Force (which is that Representative Stark request) that Donna Novak and Tom Wildsmith are chairing, and an Expanding Beneficiary Choice Task Force that Mike Thompson is chairing. There's more going on behind the scenes, and I encourage you to get involved.

Mr. Thomas R. Corcoran: I'm Chairman of the Health Section Council, and I'm going to talk about both the Health Practice Advancement Committee and the Health Section Council. We have an excellent write-up of all the issues in *The Health Section News*. Jim Murphy and I will take turns going through different aspects of the work that the two committees do. Our work overlaps quite heavily, and like Bill, we cover a lot of area.

We want to cover three sections: a financial report of the Health Section, strategic plan issues, and other activities. The Health Section funds most of the work of both the Practice Advancement Committee and the Health Section, mainly because the Practice Advancement Committee doesn't have any sources of revenue. For the Health Section, the main source of revenue is dues from the membership. That's the \$20 a year times approximately 3,000 members. In addition, we have built up a fairly substantial fund balance. We have \$186,000 of adjusted fund balance, representing the cash balance less any committed funds. The actual cash balance at the beginning of the year was close to \$250,000, and on that we earn about \$8,000 investment income.

We've broken our expenses down into four, main categories:

- Administrative. This is primarily the Society office staff and support of all the projects we do.

- The newsletter. Starting this year, we will do four issues a year, at about \$5,000 each for printing and postage.
- Meetings and seminars. The newsletter and the meetings and seminars are clearly the main activities of the Health Section Council. This meeting is our biggest meeting of the year. The \$40,000 this year is greater than the last three years combined because Hawaii is an expensive location. We also do the annual meeting and special symposiums, such as the Managed Care Symposium. These funds cover the receptions, outside speakers, travel for outside speakers, and so on.
- Research commitments. We developed a definition of managed-care effectiveness, and conducted another research project on responsible health-care purchasing. We also did a survey of the membership.

We have a reduction in the total fund balance, which is what we'd like to do. Our adjusted fund balance will be down to \$150,000 at the end of the year, which is still, I think, the highest of any of the sections. In past years, we haven't had as many good things to spend money on as we would have liked. This year we have found some very nice projects to fund.

Mr. Murphy: I'm going to take you through the strategic plan and then look at some of our activities in particular. About a year ago, the Section Council and the Practice Advancement Committee jointly developed six categories of strategic plan issues to help guide our activities. On the Practice Advancement Committee we have as an ex-officio member Mr. Bluhm from the Academy, and I serve on behalf of the SOA as a member of his Health Practice Council. We're constantly trying to maintain relationships between and across those lines so that we can be mutually supportive, and some of this will speak to that. We identified managed-care effectiveness and managed-care, in general, as a high priority issue for the SOA to address, and that has led to some specific activities in research, continuing education seminars, and so forth.

The second major issue is public policy. Our efforts support the public policy efforts of the Academy and, when appropriate, the CIA. We had a meeting of all three committees, and our primary agenda item was discussing how we can better cross-communicate in the area of research to help the Academy be even better prepared to respond to public policy issues near- and long-term.

Ms. Anna M. Rappaport: We should not forget that about 10% of our members are outside of North America. We haven't gotten there yet in the health area, but we had a meeting to discuss support for some of those members in five countries on

other issues. So, although it's the Academy and CIA right now, it may well go beyond that before too long.

Mr. Murphy: That's a very appropriate comment in terms of where we're going. The third major issue is strengthening ties with centers of influence, a term we coined to apply to a number of areas: the academic community, industry groups, regulatory groups, and others. In the regulatory arena, we aren't trying to replace the Academy but again be supportive, particularly from a technical perspective. One of the projects Tom will talk about later is the result of a request from the NAIC for us to do some research in the area of disability income. And that involves working with the Academy.

The fourth primary issue on the strategic plan is meeting the needs of the practicing actuary. Even though we are looking outward in other areas, we want to make sure that research and continuing education efforts are focused particularly on helping you, the practicing actuary, do your job better. You might say that meeting the needs of practicing actuaries involves giving them the opportunity to exercise their practice and their profession in terms of appropriate employment areas, and we're studying that in our surveys.

The fifth area is expanding recognition by our publics and customers. We often attempt to publicize some of our activities and work jointly with other organizations. The Managed Care Symposium was done in conjunction with a number of public policy people in the health area, and that helps build our recognition. When we do a paper, such as the Large Claims Experience Study which was done last year, we are able to publicize that and get some good press, and that helps build recognition by our publics and customers. Now there's a full committee continuing that effort.

It was thought that there were some specialized areas of practice within the health area that we should focus on. Tom, in particular, has been moving on the disability area. We have long-term-care issues, and the Academy has a committee in that area. We don't have a lot going on with workers' compensation yet, but we want to stay involved with the Casualty Actuarial Society and keep up on what's happening. Finally, we want to focus on international health practice, the very point Anna just referred to.

In the area of managed-care research, we are involved in a joint project with Northwestern University and a number of nonactuaries and actuaries to define managed care effectiveness in terms of the various stakeholders in the managed-care system. We also have two studies evaluating the Health Plan Employer Data and

Information Set (HEDIS) measures, one being done by the Utah Department of Health, analyzing what Tom?

Mr. Thomas P. Edwalds: In the Utah study they were looking at the measures themselves for internal consistency and predictive stability. Basically, they summarized their question as, “Do HEDIS measures give us a tool—from the point of view of a purchaser or regulator— for distinguishing between a good-performing health plan and a bad-performing health plan?”

The Michigan study was a follow-up to previous studies done by researchers Michael Chernew and Dennis Gamon. They studied a large national employer with multiple sites that had created some HEDIS indexes for its employees and published them at the time of open enrollment. They’d done an initial study, which showed there was almost no correlation whatsoever between these indexes and employee choices. They then helped the employer to update the indexes and report them better, and did a follow-up study to see if that changed things. But they also were looking at the underlying HEDIS measures to see if there was any correlation between what HEDIS is measuring and what employees value when they are electing a health plan. They looked specifically at the choices made by a large set of employees during an open enrollment period.

Mr. Murphy: These three research projects, along with significant papers and presentation by a number of nonactuaries, created the basis for a symposium, Managed Care in a Time of Transition, held in early May 1998 in Minneapolis. I felt this was a very successful symposium.

Ms. Rappaport: We were very fortunate to have a panel of purchasers, a major corporate plan sponsor, a representative of the Minnesota Health Care Action Group, a purchaser on behalf of a government agency, someone from HCFA, one of the HEDIS people, and the National Committee for Quality Assurance people at the seminar. We also had a panel that represented groups that work with consumers. One of the fascinating things is that one of the people from, I believe it was, Aetna talked about how satisfied all its customers were with their health care. Then we had the people from the consumer groups in the next panel, and my reaction was, “Excuse me? Are these people talking about the same thing?” The consumer group panel consisted of people who were seriously ill talking about their experiences. It was a real good group of people.

I thought it was a great program, and was thrilled to be associated with it. I’m concerned that we also do a good job of publishing this information because for both the actuaries and the other people there it was a set of information that’s not around or not around in that format. And it was a good learning experience and a

good chance for us to mix with some high-profile people. Were you thinking about doing something similar again?

Mr. Murphy: We've talked about it but haven't finalized it. Maybe in the fall with some additional people in a different part of the country, though. We have a lot of symposium and seminar activity in mind right now. So, we may have to set some priorities.

One other managed care area that we've been focusing on is a paper developed under Bruce Pyenson's direction that will be published in the July 1998 issue of *North American Actuarial Journal*. The SOA's public relation staff is seeking to place it in other media, as well, particularly media that would be read by health-care professionals in various organizations. The idea in this paper is to present examples of the roles actuaries currently play and can play in a managed-care environment. We've been feeling that there's a dearth of actuaries actively involved in managed care and, to some extent, that may be part of the problem, when managed-care organizations do have problems, particularly financial ones. We're hopeful that this will increase some of the interest and awareness of how an actuary can be helpful in that area.

Moving to continuing education, maybe I should ask Jerry to give us a little update on these particular seminars.

Mr. Jerome H. Vance: First of all, I'd like to follow-up on Anna's remarks about the symposium. Tapes are available from Teach'em. The next thing we have in mind is a dual track managed care seminar on Aug. 27–28 in Chicago. The first track is for beginners and referred to as "nuts and bolts" It will be run by Walter Hoskins, who is basically going to follow Sutton and Sorbo's, *Actuaries Issues: In The Fee-For Service/Prepaid Medical Group*, and then embellish with some of the developments that have occurred since that document was published.

At the same time that nuts-and-bolts session is going on, Richard Kipp will be doing a more advanced session consisting of health data sources, followed by a regulation session—federal and state regulation of managed care and provider organizations—and then risk contracting. For that last session, he has a number of legal people who will show how to structure a contract.

On the second day of the seminar, two groups will come together for some specialty work, including a study of specialty risk transfer mechanisms, capitation, stop-loss, case rates—the whole gamut of how risk transfers. The last item on that day will be a two-hour session on risk adjustment. It will not by any means cover

the entire subject of risk adjustment, but present the topic in very broad scale. A couple of years ago the Society did a very successful session on risk adjustment, and we haven't done much since. Just getting in the plans right now is another whole session for risk adjustment, which Jim and I need to talk about.

Mr. Murphy: That probably will occur some time before the end of this year. We hope to work with the Academy and the current chair of the Risk Adjustment Working Group, Mr. Bluhm. And we hope to get people from HCFA involved as well, as they have a serious challenge dealing with risk adjustment on their plate,.

We also try to involve the centers of influence , which include the academics and the regulators, in our strategic plans.

From the Floor: The other thing that is going on is the Credibility Seminar.

Mr. Murphy: Yes. There is a tentative date set for a joint SOA/AAA symposium on credibility.

We're looking at continuing to improve our use of the World Wide Web in support of communication of activities within the SOA. One Web site that's not listed is www.actuary.org, the Academy's Web site. The SOA Web site has links to other sites, including the National Association of Health Data Organizations' (NAHDO) National Health Information Resource Center (NHIRC) sites. The joint AAA/SOA Communications Committee developed a Web site before these others were anywhere near completion that helps to communicate activities, issues, and developments in the health area. We spent some time at our joint meeting this week discussing how this Web site should or should not continue to be used, given the other Web sites and, in a more general way, how and what we want to put up on these sites.

Mr. Corcoran: I received some feedback from Leigh Wachenheim, the newsletter editor, who indicated that she's initiating some efforts on the Society Web site to fill the gaps the newsletter leaves behind. It would include announcements, help wanted for committee work, news flashes, things that people need to be interested in, and minutes of the meetings. Those types of things would be a natural communication adjunct to *The Health Section News*.

Regarding NAHDO, it started out as an affiliation of state data collection agencies that were reporting to the federal government on Medicare and Medicaid, and expanded to include other organizations and individuals interested in the use and collection of health data. We got together with them on NHIRC to compile a

directory of available data. Data is available for analysis of health issues, but sometimes it's hard to know exactly where to find it. The NHIRC Web site includes a directory of Web sites and a lot of other data sets that are publicly available and tells you how to get them. It was initiated with a grant from us and the Robert Wood Johnson Foundation.

From the Floor: Mostly it was Robert Wood Johnson, although percentage-wise, we're nontrivial. And it has since gotten an additional grant from both of us. The new Robert Wood Johnson grant is covering technical features of the Web site, and we're looking at building a search engine that will help locate specific databases by specific features. As it stands right now, we've got a lot of stuff listed, but you have to page through it to find what you want, so they're looking to build an indexing feature and a search engine. As a supporting member of NAHDO, we have access to their board of directors and there's no charge for using the site. We have an agreement that our members won't have to pay for at least two years after they initiate a charge.

From the Floor: This was an interesting example of a situation we identified a couple years ago that we felt needed to be done and found somebody else who was already working on it. So we joined forces rather than trying to do it over, but we also had a slot on the advisory committee so that we've been able to work to get what we wanted, rather than letting them just do their own thing.

Mr. Corcoran: It looks like it has a password or it's a for-fee site, but you just charge ahead and submit a password, and it'll accept it, and you get a hold of your data. It's a very interesting site.

Mr. Murphy: You want to talk about the fact-finding surveys?

Mr. Corcoran: Sure. The Health Practice Advancement Committee and the Health Section have put together a series of surveys to assess certain issues, mainly whether we are meeting the needs of practicing health actuaries, what can we do to better meet those needs, what the status of nontraditional employment is for health actuaries, and what we can do to improve the environment for both making the public more aware of our member's skills and making our members more aware of what may be available out there. We've sent out two surveys so far. One went to the entire Health Section membership, getting lot of information about how they practice, where they practice, and what they're interested in seeing the Practice Advancement Committee and the Health Section do.

Our second survey went to health actuaries in nontraditional roles to try to get a picture of what is happening in that environment. Again, the twofold objective is to publicize that with the rest of our membership and make things available to that nontraditional group to support their needs. Those two surveys just completed a compilation and analysis phase. We will be interpreting the results and publishing them in the third quarter of *The Health Section News*. We're currently putting together plans for an employer survey to identify what employers are looking for and what the Section can do to meet their needs.

Mr. Murphy: We have established a committee on Health Issues in Social Insurance. Part of its focus will be on international practice because a lot of health care is provided through social insurance outside the U.S. We hope to identify issues and support actuaries practicing in other countries as well as provide a basis for input and review of activities that might be helpful in the U.S., such as Medicare or perhaps Canada with its national health program.

We've already referred to the Credibility Seminar. It's one of the efforts of the Task Force on Credibility, which is also trying to develop some educational material for actuaries in that area. An arm of the task force has been working with the Academy on efforts involving the use of credibility in rate filings, etc. Do you want to cover the Task Force to Recommend Statutory Morbidity Standards for Individual and Group Disability Benefits?

Mr. Corcoran: I figured if I made the name of the task force long enough, I wouldn't have to explain anything. This task force has been formed at the request of the NAIC, which has some concerns that the morbidity standards for particular individual disability contracts, namely the 1985 Commissioners Individual Disability tables (CIDA and CIDB), may not be producing adequate reserves in all situations. The NAIC also asked the Society to take a look at and expand on the reserving standards for all disability benefits, both group and individual, short- and long-term. I'm the chairman of a task force to review that, and there's a write-up in *The Health Section News* that gives additional details.

It's interesting that we're doing the presentation in the reverse of the importance to the Health Section. I would say the primary role of the Section is the meeting content and speakers. At this meeting, we sponsored 47 sessions and a reception. We'll have 16 sessions at the annual meeting.

The second most important thing is using *The Health Section News* to keep our membership informed. We've made an extra effort this year to get a newsletter out on a regular basis. We have already sent two issues, the third one is being written

right now, and the fourth one is being planned. We're proud of that and a couple of other things we've worked on in terms of identifying potential services to members. There's the *Statistics for Employee Benefits Actuary*, a book of databases of use to practicing actuaries, that is sent to all the pension and health actuaries. These data also are on the Web site. And, finally, the Employee Benefit Research Institute (EBRI) publishes a book that includes a variety of insurance and public statistics on employment benefits and health statistics. It's about a 1,500-page book, and we were able to get a bulk order for the SOA and make it available to the membership at an extremely discounted cost—approximately 90% off. For this book, EBRI took data that was buried in a lot of places, recompiled it, and put it in a reasonably easy-to-use format. It's well-indexed so you can find what you're looking for easily. And it's on sale.

Mr. Murphy: To Health Section members?

Mr. Corcoran: No, we've expanded it to the entire membership. You can get a copy for \$10, and it's \$100 retail.

Last, but not least, are the experience studies that the Society is conducting. Most are fairly major undertakings. They're described in some detail in *The Health Section News*, so, I'm not going to go through them unless anybody has a question.

Ms. Rappaport: I'd like to make a comment. One of the things we haven't done as well as we would like to is get experience studies out on a timely basis. We know it's a problem, but there's a small group working under the direction of Norm Crowder, the Vice President for Research, to look at the whole process of experience studies and try to see how to get them out faster.

I also wanted to report to you about an exciting meeting that I had and to encourage any of you that want to participate in this to certainly do so. Lee Launer gave a session on Alternative Health Care, and we met afterwards. About half of Americans spend their own money on alternative health care, so there's really very little question that they think they're getting something for it because it works. From the point of view of actuaries and the kind of work we do, the situation is a bit different. We don't have enough data to tell whether it works or not, but we have a task force on alternative health care that is gathering a group of people together from different companies that are starting to introduce some alternative care. The task force will determine what kind of data needs to be collected and try to get some people to participate in coding and submitting data so it can be collected. I, for one, am very excited because I think this is important to the American public.

It's an area that actuaries ought to be involved in, and we're not going to do a very good job without information. So, any support would be very welcome.

Mr. Corcoran: The task force that Lee Launer is chairing also is working with Dr. David Eisenberg at Harvard. The initial phase of their work was to help fund a follow-up he's doing on a prior study. The paper has been submitted to the Journal of the American Medical Association (*JAMA*) for publication, and there's a good chance it might appear in the fall.

From the Floor: One of the outcomes of our discussion with George Lundberg the other night is that *JAMA* would welcome articles that involve actuaries or actuaries in combination with other people, as long as appropriate information is submitted in accordance with its guidelines.

Mr. Murphy: We're starting to review our papers and progress for candidates for submission already. That was a very positive experience, along with a great keynote talk.

From the Floor: I just want to make a comment about the Group Medical Large Claims Experience study. Three years ago that wouldn't have been on the list. The large claims monograph that we published last year was the first effort of the SOA in a very long time to collect and publish any kind of information about medical claims experience, and we are going to redo that study. It is very important for us to get a good study out to follow-up on that first one as timely as we can. When that data request goes out, I would strongly encourage all of you to get your organizations to contribute whatever data you have to the large claims study. In fact, the Credibility Task Force is also hoping to use that data to calculate parameters for some credibility formulas that could be useful.

From the Floor: There was a big conference on genetic testing and the Academy recently put something out on life insurance genetic testing. Should we, the Academy, the Society, or anybody, be doing something in that area to influence policy making?

Mr. Murphy: I know the foundation sponsored a session earlier this year on that topic.

From the Floor: We recognize the importance of genetic testing, but like everybody else, we have our silos. We think that's a Life Insurance Practice Area initiative. So, the answer is, yes, we clearly should be doing something. Maybe it's in the wrong silo, but being addressed.

Mr. Murphy: To some extent the public thinks it's a more serious issue with health insurance than it probably is, because so much of health insurance is moving into a you-can't-underwrite-anyway mode, that the genetic testing becomes moot. But on the life insurance side, that hasn't happened yet.

From the Floor: Genetic testing is a big issue for the individual life, long-term-care, and other ancillary health products.

From the Floor: So, Jim, maybe you should work with the Life Practice Area. I wasn't present, but genetic testing was covered at the Congress in the U.K.

Mr. Murphy: Jerry, Tom, and I will follow up on that. We very much want to know that we're doing things that you believe are appropriate for your dues to be used for and that are supporting your activities as well as the overall goals of the Society of Actuaries.