SOCIETY OF ACTUARIES Health Section

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HealthWatch

Strategies for a Healthy Dialogue on Health Care Financing Reform

by Bill Lane

It's an election year. This early in the contest, it's too soon to predict a winner. Even so, there seems to be a reasonable probability that we could end up with a Democratic president, plus a Congress with a majority of Democrats in both the House and the Senate. The last time that happened was the election in 1992. Bill Clinton was elected president, and Hillary Clinton was appointed to chair a task force to implement a complete reform of the health care system. It is 16 years later and health care, both its availability and its financing, may well be the issue of 2009, just as it was in 1993.

Last time around, I was privileged to be an active participant in the health care debate. I spent a considerable amount of my time analyzing proposals, participating in industry meetings, pulling together data for an eventual SOA research project on Risk Adjustment, and spending time on Capital Hill trying to educate staffers and members. It was an exciting time, and I learned a lot about the political process in this country.

Given the current circumstances, I thought it important to pass along some of my thoughts to those of you who may be participating in the process this time around.

Point #1 - Everybody and his brother will be telling Congress what they should or shouldn't be doing.

If that is your approach to participation, it is likely to be a very small voice in a very large conversation.

Point #2 - Members of Congress and their staffers are expected to be knowledgeable about more subjects than I could list.

This simply isn't humanly possible. Hence, if you are knowledgeable about the subject at hand, and if you are willing to simply educate, rather than advocate, you have the chance to be heard.

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Actuaries
Risk is Opportunity.®

2008 Year in Review

by Jim Toole

Chairperson's Corner

Jim Toole, FSA, MAAA, is a managing director, life & health, for MBA Actuaries in Winston-Salem, N.C. He can be reached at *jim.toole@mbaactuaries.com.*

This corner serves to update the membership of some of the section's milestones for this year, set the trajectory for 2009, and thank the many dedicated individuals and teams who made it happen.

Untapped Opportunities Board Issue

From a strategic perspective, the most important project has been the ongoing discussion with the SOA Board of Directors on how to invest SOA resources to unlock untapped opportunities for actuaries in the health discipline.

By way of background, in 2007 the SOA Board approved a motion to move forward with the development of a detailed set of possible strategies to respond to these untapped opportunities. Jeff Allen, Kara Clark, Jennifer Gillespie, Jim Toole and Meg Weber, with the input from the Health Section Council (HSC) and Issues Advisory Council, prepared the background documents provided to the Board, while Jeff and Jennifer made the live presentation. Discussions included eleven potential directions under the areas of Basic Education, Continuing Education, Intellectual Capital and Marketplace R&D.

At the conclusion of the meeting, board members voted to develop plans for potential initiatives relating to the following priorities:

- Create or recommend courses of study or on-the-job experiences for health actuaries to compete effectively in new and traditional markets.
- Sponsor original research to support penetration into new markets.
- Create recommended paths for credentialed actuaries to transition to the health practice area.

The KMSAT, with representatives from the HSC, has been tasked to take the next steps. Please feel free to contact Jim Toole or Jennifer Gillespie if you have questions or want additional information about the Untapped Opportunities board issue.

Continuing Education

The year started off with a bang at the annual meeting in Washington, D.C. Approximately 150 health actuaries participated in 14 section sponsored sessions, including an innovative three part series on the U.S. Health Care Crisis. The series was capped by a spirited debate featuring Bill Bluhm, Ian Duncan, and Georgetown law professor Lawrence Gostin to a standing room only crowd of over 200. Thanks to Lisa Tourville for her work planning the meeting and taking on the additional challenge of designing the Crisis series.

In April, Tom Getzen, PhD, discussed his long term medical cost trends model in a webcast co-sponsored with the Pension Section. Building off the research funded by the two sections, the event drew a crowd of over 400 participants, making it one of the most successful of its kind for the section. We see more events like this in our future as an efficient means of providing low cost CE opportunities while responding more nimbly to changing marketplace needs. Whereas a physical meeting may take nine months or more to plan, a webcast can be up and running in as little as two months, with up to the minute content and low financial risk to the section.

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The Health Spring Meeting, of course, is the jewel in the CE crown. This year over 750 people attended the meeting in Los Angeles, defying expectations of low turnout. Thanks to the heroic effort of Barb Niehus and full support of the expanded section council, the meeting was loaded with interesting and innovative content and enriched by the attendance of over 120 non-members, 50 of whom presented at one or more sessions. Examples of innovative learning opportunities included the Speed Networking for "Young" Actuaries session, a workshop on the Health Plan Value Proposition, concurrent individual and small group market sessions with limited attendance to encourage participation, and interactive CHAT®[1] sessions where participants worked collaboratively to make decisions on basic community health plan coverages on a limited budget.

The biggest investment in new infrastructure in 2008, the Pricing and Valuation boot camps, are up and running! The first section sponsored health seminars in five years, the boot camps are a direct result of input from the 2006 member and employer surveys which indicated a need for more in-depth CE offerings on core pricing and valuation topics. The August time-frame was chosen to provide alternatives for health actuaries who are not able to attend the spring meetings due to Medicare bids. Designed to satisfy Academy Specific Qualification Standards requirements and country specific basic education needs, the scope is ideal for actuaries in other practice areas considering transitioning into health work. We envision the boot camp being repeated on a regular basis, periodically swapping out topics as we build a portfolio of in depth learning opportunities. Thanks to former Health Section Chair Bill Lane for bringing his dedication and experience to the project and council member Beth Grice for organizing the valuation seminar.

Of course, none of this is possible without the support of the SOA staff. Linda Damitz, Amy Wojcik and newcomer Kerri Leo are proficient at keeping unruly herds of actuaries moving more or less in the same direction at the same time, and keeping things running smoothly when we get there. Finally, thanks to Lisa Tourville for staying on for an extra tour of duty as section CE Coordinator after the expiration of her role on the council. We love it when our council members can't get away… I mean, stay on to help out.

Intellectual Capital

In the information age, intellectual capital defines your worth in the same way mineral rights define wealth for extraction based economies. In the context of health discipline, intellectual capital consists primarily of research and knowledge capture. Knowledge capture is a fancy way of saying get people to write down current best practices. Newsletters and production of study notes are the traditional forms of knowledge capture. Although I lament the passing of *The Record*, MP3 recordings of meetings are also an excellent resource.

Kudos to Gail Lawrence and Ross Winkleman, co-editors of *Health Watch*, for producing three high quality newsletters each year in a continuous process of wrangling articles and authors. We are fortunate to have such dedicated volunteers for our newsletter. There is so much for us to say, but we are often too busy to say it. If you haven't written previously for *Health Watch* I encourage you to do so; we are always looking for new voices. We are pleased to offer a new feature called "Navigating New Horizons," featuring interviews with leaders of our discipline. If you have any suggestions for potential subjects, please contact Gail Lawrence or Ross Winkleman.

[1] Choosing Health Plans All Together

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Chatting with the Uninsured

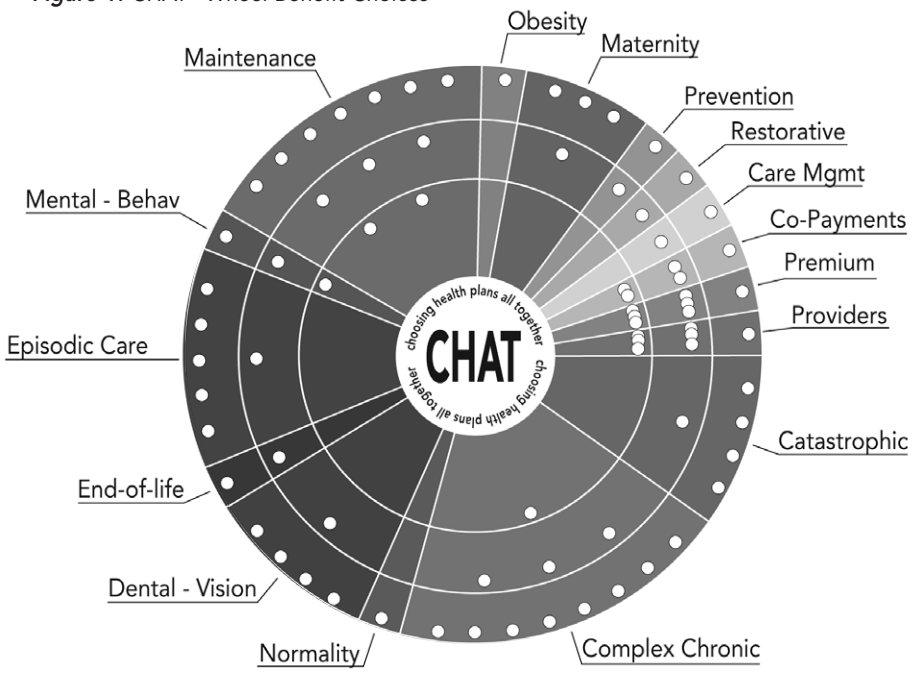
A Letter from the Editor

by Gail M. Lawrence

It has been fascinating to watch the debate evolve and mature on the topic of health care financing reform. Some states have now taken bold steps toward the goal of universal coverage while other states are taking a more incremental approach. I am encouraged by this forward progress and the spotlight on this critical issue at the federal level.

Health care policy continues to be a popular topic at our health meetings and the meeting in Los Angeles this past May was no exception. Len Nichols, a highly respected economist and policy wonk with New American Foundation, was a fascinating general luncheon speaker. There was also a follow-up session for questions from participants. Self described as part-preacher, he was quite engaging as he shared insights into the political and cultural challenges for effecting change and proposed several key reforms. If you're a policy junkie, I highly recommend you check out sessions 13 and 14 of the meeting record.

Figure 1: *CHAT® Wheel Benefit Choices*



Another policy pioneer, Marge Ginsburg, executive director of Sacramento Healthcare Decisions (SHD), hosted two "CHAT® sessions" where participants designed a health insurance plan for low income uninsureds based on two-thirds of the cost of typical employment-based coverage. Sacramento Healthcare Decisions is a non-profit, non-partisan organization whose purpose is to bring community values into health care policy and practice. SHD is funded primarily by grants from philanthropic foundations, such as the California HealthCare Foundation.

The computer-based CHAT® program is an interactive software tool developed by physician-ethicists at the University of Michigan and National Institutes of Health. I was a participant in one of the two CHAT® sessions, each with 15-20 conference attendees. Using the CHAT® pie chart shown in Figure 1, participants were asked to allocate a fixed budget to a variety of health care services with varying levels of coverage. The available funds could also be used to lower premiums and co-payments and/or limit provider choice, but there were only 50 "markers" to spend and 76 possible places to put them. Definitions were provided for the types and comprehensiveness of the varying levels of services. We were first asked to each make our own plan design based on our individual views and values. We then worked in groups of three to begin the process of compromise and finally the entire group had to come to agreement on what this basic plan should look like.

While evidence-based medicine can help provide a strong foundation for helping us make choices as a society, the concept of minimum acceptable coverage may in large part be based on value judgments. It was certainly a lively discussion as each participant brought a unique perspective to the table. As expected, many participants were wearing their actuarial hats as they advocated the elimination of non-catastrophic, dollar-trading benefits such as dental or vision coverage.

My own perspective was influenced by watching my young adult children grapple with lapses in

Len Nichols, Lisa Trouville, and Marge Ginsburg enjoy some engaging conversation at the Health Spring Meeting reception.

coverage between jobs, waiting periods for benefits and employment layoffs. One's perspective and priorities are certainly different when you have no assets to protect, a limited income and a slight sense of invincibility. A high-deductible plan is not exactly appealing when you're bankrupt before you can even satisfy the deductible. With no assets to protect, the value of an insurance policy seems to be measured in terms of likely benefits received, making dental and vision coverage relatively appealing.

At the Spring Meeting, CHAT® was offered as a way of introducing actuaries to a different approach to benefits design—to challenge us to consider the trade-offs in a way that few of us had done before. But as a research exercise, CHAT® is also being used in different states to capture specific data on coverage priorities, as well as identify broad themes on how trade-offs are viewed by different populations. For example, SHD conducted a project with the uninsured in California last year. The results are available at *www.chcf.org/documents/insurance/DesignCoverageForUninsured.pdf*.

Some of the findings may surprise you. As a group, the uninsured had a strong sense of personal responsibility, which had several implications in their benefit design. First, they felt it was important to contribute toward the cost in terms of premium and cost sharing on services. However, the cost must be affordable within the context of their income or they would not be able to either participate in the program or access health care services. In order to get more comprehensive benefits elsewhere, they were willing to give up their choice of providers and were receptive to requiring care management, including such things as mandatory patient education. Echoing the personal responsibility theme, the uninsured were willing to trade away coverage for health conditions created by poor choices in behavior, such as treatment for drug addition or smoking cessation programs. These priorities often differed from those with higher income who already had insurance.

CHAT® participants also tended to exclude treatments that are not likely to be effective or less likely to be used, such as heart transplants and last-ditch efforts. Desirable benefits included those where "many people" had a need and could benefit, such as dental and vision care. Coverage related to keeping patients functioning, such as joint replacements, also had great appeal.

There are a number of takeaways for policy makers and even product development actuaries. Affordability is a critical issue and cost sharing may have to vary by income with special consideration for the chronically ill. Cost sharing could also be based on the relative effectiveness or cost-effectiveness of the treatment and financial incentives could be used to encourage healthy behaviors.

Thought-provoking and highly-engaging, CHAT® sessions can be arranged for other conferences and retreats. If interested, contact Marge Ginsburg at (916) 851-2828 or *ginsburg@sacdecisions.org*. To learn about using the CHAT® software for a local or state wide project, Marge Ginsburg can also give you information on how to obtain the software to do this. Other descriptions and results of CHAT® projects conducted by SHD can be accessed at *www.sachealthdecisions.org*. ■

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Reawakened Focus

of IDI Carriers in the Physician Market

by Robert W. Beal

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Physicians have represented a major market for many individual disability income (IDI) carriers over the last 30 years. The emphasis on doctor sales brought the IDI market to its knees during the 1990s. Since then, claim experience has slowly improved and industry profitability has recovered. But lackluster sales have encouraged many IDI carriers to return to aggressively targeting doctors, raising the fear that the difficult lessons of the 1990s may well be forgotten.

The Lessons of the Past

The excesses of the IDI market during the 1980s and the first half of the 1990s have been well documented.[1] There was a period of about 15 years, beginning around 1980 when IDI carriers by and large threw caution (and sound risk management principles) to the wind. Products were continuously liberalized, premium rates dropped and underwriting became lax as companies competed for more and more sales.

At this time, physicians were viewed as the ideal market. They were considered the premier motivated professionals with a strong appreciation of the value of IDI insurance. Carriers offered physicians their richest policies (e.g., noncan, pure own occupation, cost-of-living benefits, and lifetime benefit periods) and the highest amounts of coverage. Monthly benefits of $25,000+ were not uncommon among medical professionals. For many of the key IDI competitors, doctors represented at least 30 percent of their in-force premium.

Until the early 1990s, the morbidity experience associated with physicians was favorable, but this trend reversed sharply when physicians' income and motivation dropped.

Until the early 1990s, the morbidity experience associated with physicians was favorable, but this trend reversed sharply when physicians' income and motivation dropped as the medical industry suddenly shifted more to managed care, the cost of malpractice insurance continued to climb and universal health care became a distinct possibility. Many physicians who had been working with potentially disabling conditions realized that their IDI policies allowed them to maintain their lifestyles and avoid the economic realities of their profession and subsequently filed disability claims.

Chart 1 compares IDI industry new claim incidence rates (as percentages of 85 CIDA rates) for medical occupations during the 1990s to those of non-medical executives, physicians and white-collar occupations combined. These results are from a study conducted by the Individual Disability Experience Committee (IDEC) of the Society of Actuaries.[2] The chart shows claim incidence for medical occupations increasing in the early 1990s and remaining high for most of the decade thereafter. In comparison, new claim incidence for non-medical occupations, which are lower than medical incidence, were relatively stable for the first half of the 1990s and then reducing steadily thereafter.

The downturn in the medical market and the excessive practices of IDI carriers led to dramatic financial losses for IDI carriers during the first half of the 1990s, peaking in 1995. As a result of the unprofitability of their IDI businesses, over thirty-five carriers exited the IDI market, many of whom sold their in-force businesses to other IDI carriers.

Since approximately 90 percent of the business was noncancellable, the remaining IDI carriers were unable to increase premiums or modify contracts on in-force business. However during the second half of the 1990s, they were able to focus their efforts on rehabilitating their IDI products on new sales and avoiding markets that were contributing a disproportionate share of the financial losses. Carriers instituted significant tightening of their products and underwriting practices and increased premium rates on new sales. Most IDI

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[1] One source is the paper written by this author titled, "Individual Disability Income Insurance in the United States," 2006. The paper is available at *www.soa.org*.

[2] "Report of the Individual Disability Experience Committee Analysis of Industry Experience from 1900 to 1999," available at *www.soa.org*.

carriers restricted the types of coverage offered to doctors and other medical occupations and lowered their maximum issue limits to these occupations to $10,000 or less. As a result of these actions and a fortunate stabilization of the claim experience on the older business, the overall profitability of the industry has been able to slowly turnaround.

The history of severe IDI losses during the 1990s followed by a road to recovery is well illustrated in the annual studies of the statutory profits of the noncancellable IDI business[3] performed by Mark Seliber and Duane Kidwell for many years. Chart 1 shows the pre-tax statutory margins for years 1988 to 2006 from their most recent study for 16 IDI carriers which represent a large majority of the IDI market.

Re-emerging Focus in the Physician Market

While it is clear from this chart that industry profits have been strong since 2000, new sales have been stagnant. A study of the IDI market conducted by Milliman in 2007[4] showed that new premium grew at an annual rate of less than 1 percent over the 2002-06 period. As a result, competitive pressures have returned as many carriers are chasing the same traditional IDI markets, including physicians. Milliman's 2007 IDI Market Study showed that 22 percent of all new premiums in this five-year period has been from sales to physicians, second only to executives. Premium share for doctors for at least four of the more active IDI carriers exceeded 30 percent. At least half the IDI carriers will now issue $15,000 of monthly benefits to doctors and participate at $20,000 or higher.

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Chart 1: *IDI Industry Claim Incidence Rates During 1990-99*
Occ Class 1 (Executives, Professionals and White Collar Occs)

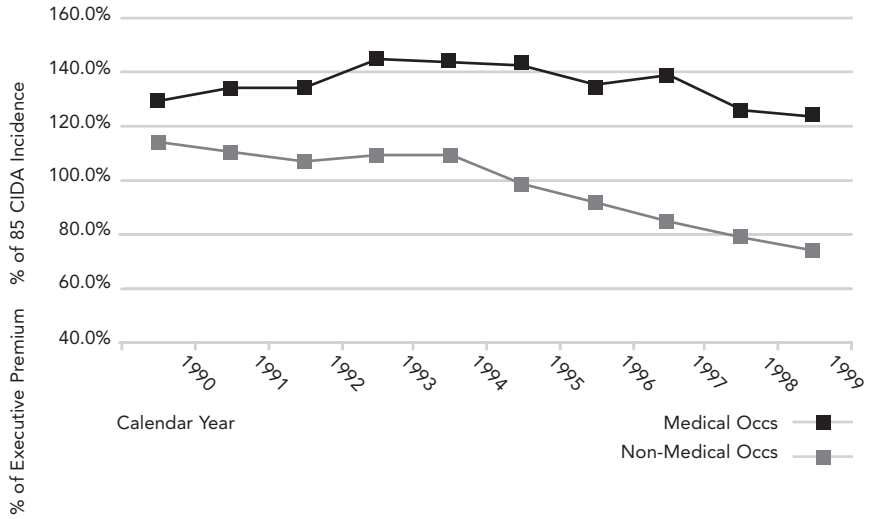
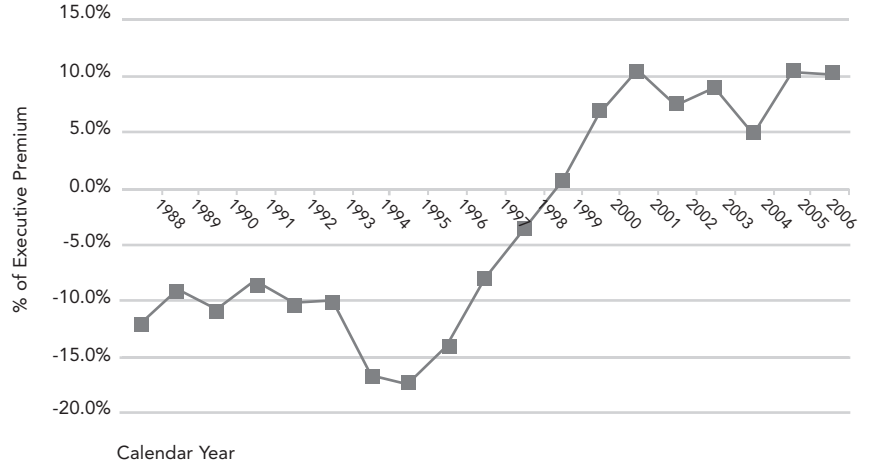


Chart 2: *Statutory Pre-tax Profit Margins After Dividends*
16 Companies



[3] The most recent study was published in Milliman's Disability Newsletter, August 2007.

[4] Milliman's 2007 IDI Market Survey may be obtained by contacting the author (*bob.beal@milliman.com*).

Navigating New Horizons. . .

An Interview with Alice Rosenblatt

by Sarah Lawrence

It's no secret that the actuarial field has traditionally been a man's world. Still, every year the number of women entering the profession increases—and it's all thanks to pioneers such as Alice Rosenblatt, who not only started her career at a time when women made up less than five percent of the actuarial workforce, but also worked her way up to become an executive for the largest health insurance company in the United States.

Alice Rosenblatt

Getting Started

Rosenblatt was born and raised in the Bronx, New York, where she found she had an affinity for math, but had never heard the term "actuary." She earned a master's degree in mathematics from City University of New York in 1971 and was planning on earning her doctorate and starting a career as a professor when a particularly boring college lecture led her down a different path.

"I was sitting in a class one day, there were only four or five people in the class and it was just so theoretical," she said. "The teacher was talking to us as if he was talking to a lecture hall of 100 people rather than just talking to four or five people. It was totally boring and I just raised my hand and asked, 'Can anyone use this stuff?'"

The answer, according to her professor, was no. It would take another Einstein with an Einstein's knowledge of physics to make the math useful.

"I sat there and thought, 'Do I really want to spend my life waiting for the next Einstein to come along?'" she said. "The very next day I went looking for what else I could do with my math degree. I went to an employment agency and that's where I heard the word actuary for the first time."

After doing some research and setting up several interviews, Rosenblatt landed a job as an actuarial trainee at Mutual of New York. At the time her only goals were to pass her exams and become a Fellow of the Society of Actuaries (FSA). With no experience, the executive office seemed too lofty a goal to even think about and there were no women in those positions anyway. In fact, there were hardly any women in the profession at all, a reality that became painfully obvious during Rosenblatt's first Society of Actuaries meeting.

"There were at least 1,000 people at this big meeting in Philadelphia, business dress was very formal and all of the men were wearing suits and ties," she said. "I remember I wore a suit with a red jacket to the opening general session and just stood out in this sea of dark suits. I felt like I was the only woman there, although there were a few others."

Moving Up

Rosenblatt was not intimidated and proceeded to embark on a career that would lead her across the country several times in pursuit of success. From Mutual of New York she moved on to become assistant vice president and managing consultant for William M. Mercer in Boston, then vice president of The New England of Boston. Her first long-distance move came in 1987, when she took a position as senior vice president and chief actuary for Blue Cross of California, where she was promoted to senior vice president of HMO and group services within a year.

In 1989 it was back to Boston, where Rosenblatt became senior vice president and chief actuary for Blue Cross and Blue Shield of Massachusetts. By 1994, she had moved on to become principal in the human resource advisory group for Coopers & Lybrand. Finally, in 1996 she took her position as senior vice president and chief actuary for Wellpoint, Inc. in California and was later promoted to executive vice president—a job that she retired from in February of this year.

Rosenblatt said her career moves were not usually the result of actively seeking out and applying for new positions, but rather exploring the opportunities that came to her. She never considered jobs

that were lateral moves, focusing instead on those that would get her ahead.

"I wish I could say that all of my career moves were planned as a way to advance," she said. "The truth is that most of my moves were the result of responding to calls from recruiters and being willing to consider changing companies and locations."

She added, "for the most part I selected companies that were true meritocracies. It was really a question of if you did the job well, you were rewarded for doing the job well."

While women currently make up a much larger percentage of the actuarial workforce than when Rosenblatt got her start in 1971, they are still a minority and very few rise to executive positions.

"There are certainly more women in executive positions at companies and more on boards than way back when I started," she said. "There has been a lot of progress, but I think there is room for even more."

During her career, Rosenblatt said some of her proudest moments were becoming an FSA, working on the merger of Anthem with WellPoint, and testifying before several subcommittees of the United States Congress during President Bill Clinton's first term. She said breaking through the "glass ceiling" only became a problem at one company.

Gaining an edge

That's not to say success in the actuarial field comes easily for anyone. Rosenblatt said her management style and willingness to learn non-actuarial jobs helped her get ahead, as well as a natural ability to communicate effectively.

"Because I believe in the merit system, I have always set clear goals for myself and my staff and measured performance against those goals," she said. "I also learned how to communicate to non-actuaries and to all levels of the various organizations I worked in. Also, my consulting experience taught me how to sell myself and how to communicate with clients."

Rosenblatt said she has always placed importance on knowledge of the details in her management style.

"I would meet frequently with my staff to review progress on projects and interim deliverables," she said. "That way I was never surprised by a project going off course or being late. I think those who worked for me would say I was a bit of a micro-manager, but that management style was very useful for integration work."

Rosenblatt said it was her work with integration and mergers that ultimately gave her an edge and earned her an executive position. She said at most companies, actuaries are not part of the executive office and most often report to a company's chief financial officer (CFO). Those who seek the top should be prepared to gain some non-traditional experience.

"I know several actuaries that became general business managers in order to get a seat at the executive table," she said. "So, there are several paths—as chief actuary, as CFO, or as a general business manager. A new path might be as an enterprise risk officer."

Rosenblatt said WellPoint has a succession planning system, which gives each officer in the company the ability, once a year, to document future positions he or she is interested in and list potential successors.

"Any large company with a formal succession planning system might provide better opportunities for those that want to advance," she said.

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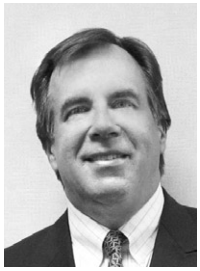
For the most part I selected companies that were true meritocracies. It was really a question of if you did the job well, you were rewarded for doing the job well.

Stop Loss Myths Debunked

by John Ahrens



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Having been involved with medical stop loss for 30 years, I'm surprised at the number of myths that have persisted over three decades. In this article I will share some opinions and observations derived from my experiences as a major reinsurer of stop loss in the early 80's and as a rapidly growing stop loss MGU (managing general underwriter) in the 90's.

Starting as a Reinsurer

As a reinsurer in 1981, I provided the specific stop loss rates to MGUs and they determined the aggregate attachments. The stop loss market was growing very fast, so distribution channels and TPA relationships were more important to success than sophisticated rating approaches. On the other hand, I had an MGU on the HMO excess side, R.W. Morey, whose pioneering rate and contract approach on provider excess shaped that industry. Bob Morey kept his approach entirely proprietary and that business segment enjoyed tremendous financial success based primarily on his rating skills and sales efforts. His success motivated me to consider a new approach to rating stop loss.

Beginning Small and Evolving to a Large MGU

I was hired in 1993 to be MGU for a Blues owned TPA whose small life insurer affiliate took all the risk. After gaining over 40 percent market share and excellent profit margins due to a new experience rating technique in one market, I formed a national MGU in 1995 with a partner and traditional underwriters and used issuing companies taking 10 percent of the risk with 90 percent quota share reinsurance arranged by intermediaries.

By mid 1997 the traditional underwriting approach was not producing adequate results, so traditional underwriters were replaced with my experience rating approach on all groups and I reviewed every case. My firm, AFS, grew rapidly although much of the growth was in the riskier under 100 employee market. By late 1999 the stop loss rating cycle was very difficult for MGUs and the lack of profits discouraged reinsurers. In 2000, without a strong reinsurance relationship or a risk-taking carrier, I was forced to liquidate my large, 80 person MGU. Although the hardening of the market in 2000 was celebrated by the survivors, stop loss has continued to be characterized by rating cycles and continued disruptions to participants.

TPA Market vs. ASO Carriers

ASO carriers with proprietary networks have made steep inroads in to the TPA market. Stop loss has become harder to find for groups with fewer than 100 employees which should be a key market for TPAs who are having trouble retaining large groups. Even now, it seems significant changes have not taken place regarding stop loss rating approaches. Pooling provided by a carrier as part of their ASO services has a captive audience and thus faces fewer obstacles to profits as compared to MGUs in the TPA stop loss market. However, they still face "rate" competition in the form of consultants to the employer deciding on the level of stop loss or possibly going without. Small and mid-size MGUs are being squeezed by large carriers that take all the risk in the TPA market with their own underwriting departments and by large MGUs that have been bought or merged with insurers.

Having seen stop loss from many angles, I offer my opinions. It seems that little has changed with regard to common "myths" and lack of change is not necessarily a positive thing, since stop loss is a line of business where few risk takers have consistently made money. I hope to provide insight for those relatively new to the marketplace, and possibly provoke some spirited discussion and stimulate action for seasoned veterans of the "stop loss wars."

MYTH 1: Only Buy Stop Loss from Insurers Rated A or Higher

Myth Promulgators

E&O Carriers, Employers

The Reality

- Many employers are unaware or confused about the roles played by TPAs, MGUs, issuing companies and reinsurers so think a high rating provides security.
- Many agents are required to use A and higher-rated insurers by their E&O insurer.
- The employer usually follows the stop loss recommendation of the TPA/broker without independent verification.
- For the TPA, the most important criterion is often their relationship with the MGU underwriters and executives and TPAs follow them to other firms.
- Most employers and TPAs expect to get a reasonable renewal from the stop loss insurer.
- Highly-rated insurers are often reluctant to get in to a line of business that executives know little about.
- Stop loss is a one-year contract with no guaranteed renewals, so insurer insolvency is a very low risk compared to the relatively high likelihood of the issuing carrier or reinsurer leaving the market, often with very little warning.

Resulting Problems

- B+ insurers and some A- that are interested in writing stop loss and even taking substantial risk have to get a highly rated front company, at significant cost.
- Employers and TPAs are constantly at risk that the current stop loss MGU or carrier will not be there to provide a renewal quote.
- Many TPAs have to trust the MGU and are not equipped to make informed decisions about the MGUs future.
- If an MGU or reinsurer treats a client poorly, usually only the affected client and TPA know about the issue. Sometimes, the highest rated entity (often the reinsurer) is the one most likely to cause slow or only partial claim reimbursement, since they have significantly more legal resources and may play hardball to limit losses.

A Solution—Transparency and Education

Employers and TPAs/brokers need to know much more about key players at the MGU, issuing insurers and even reinsurers. E&O carriers need to be educated on the real sources of lawsuit risks in stop loss—and there are many, but have nothing to do with the issuing company's rating.

Commentary

Greater disclosure by MGUs and risk takers in an ongoing, published format with negative implications for those not participating would be a first step. Ultimately, a subscription-based service with informed commentary and opinion would be very helpful in gaining real insights for decision making by employers and could reduce the number of lawsuits.

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Many employers are unaware or confused about the roles played by TPAs, MGUs, issuing companies and reinsurers so think a high rating provides security.

Georgia Collaboration Succeeds

in Passing HRA/HSA Health Insurance Reforms

by Ronald E. Bachman

An unprecedented collaboration of associations representing hospitals, physicians, insurers and sales agents, convened in late 2007, as the Georgia Uninsured Working Group (WG). The recommendations of the Georgia Uninsured Work Group, which was facilitated by Ron Bachman FSA, MAAA and senior fellow at the Center for Health Care Transformation, combined solutions for the uninsured with the recognition that solving the uninsured problem in Georgia is also an economic development opportunity.

The united effort succeeded. On May 7, 2008, Georgia's Governor Sonny Perdue signed into law health reform legislation that will allow insurers to develop significantly more affordable products for small companies and individuals. The new laws (HB 977 and SB 383) focus on the uninsured working poor. With increased health, prosperity, security and productivity this legislation is estimated to bring an annual increased value of $1.9 billion to Georgia.

Georgia has 1.7 million or about 18 percent of the state's 9 million citizens uninsured for health care at any point in time. Georgia has the fifth highest rate of uninsured citizens without Medicare, Medicaid, SCHIP, Tri-care or private health insurance. Georgians are uninsured for many reasons.

The WG considered four segments of uninsureds. The desire of the WG was to address all uninsureds; however, the WG determined that segments 1 and 2 below were the largest targets with over 1.1 million lives and segments where consensus solutions could potentially reach more than 500,000 uninsured Georgians, or about one-third of the state's uninsureds.

Uninsured Georgians by Segment	Percent	Number
1. Uninsured Not Needing Financial Assistance	30	510,000
2. Uninsured Needing Some Financial Assistance	35	595,000
3. Uninsured Eligible for Government Programs	20	340,000
4. The Uninsurable	15	255,000
	100	1,700,000

Segment 1 can afford insurance, but many find the products available unresponsive to their needs. Developing better products for segment 1 with alternative methods of affordability will also reach many in segment 2.

The WG felt that initial consensus of free-market solutions for these segments would establish a strong basis for ultimately addressing all uninsureds. The WG will stay intact to continue the development of free-market solutions that assure access to quality care and affordable insurance for all Georgians.

The new Georgia law is a market-based, individually centered package of reforms that eliminate out-dated insurance laws that unintentionally limit the offering of affordable insurance. To make insurance more affordable, the new law allows financial "dividends" to be placed into Health Savings Accounts (HSAs) for engaging in wellness, prevention and treatment compliance. In addition, Georgia eliminated all state and local sales taxes on HSA eligible plans (technically called premium taxes). As an incentive to offer insurance, companies (with fewer than 50 employees) are granted a $250 tax credit for each employee enrolled in an HSA eligible plan. For individual insurance buyers there is a special Georgia income tax deduction for the premium associated with the purchase of an HSA eligible plan. Finally, new more flexible plan designs are allowed that will offer choice, convenience and cost savings.

Georgia laws now open the doors to a new generation of health insurance that empowers individuals with choices and options for access to care, prevention, treatments and cures that are not available under existing policies. Already federally tax advantaged, HSA eligible plans are typically 25 to 40 percent lower cost than traditional health

insurance. The new Georgia law effective Jan. 1, 2009, will help:

1. Employers with Fully Insured Group Plans:

If employers are willing to offer HSA eligible group plans, the new Georgia law helps working uninsureds with:

a. HSA dividends for wellness, prevention and treatment compliance.

These shared savings were previously illegal under Georgia rebate laws. Under federal law, up to 20 percent of a policy's cost can be returned through rewards and incentives for healthy outcomes. Additionally, unlimited "dividends" can be provided for healthy activities.

b. Elimination of all state and local "sales taxes" for HSA eligible plans.

Georgia has the third highest insurance taxes in the country. The average state tax is 2.25 percent with added local insurance taxes the added cost burden is as much as 7 percent of premium. These "sales taxes" are all eliminated for HSA eligible plans.

c. A $250 "Small Group Tax Credit" per HSA eligible plan enrollee.

The average HSA eligible plan annual premium for a single employee is about $2500. The tax credit represents a 10 percent offset to the cost of the health insurance.

d. More flexible HSA eligible plan designs

Previous Georgia law prohibited some plan design options that would offer better coverage at lower premiums. These barriers have been eliminated for HSA eligible plans. The estimated savings are between 1-2 percent.

Overall, the new Georgia law can further lower the cost of HSA eligible group insurance by 20 to 40 percent, or more.

2. Employers without Group Plans:

Many small employers do not want the problems of establishing a formal group insurance plan, but are willing to contribute towards employee purchases of health care services and/or individual health insurance policies. For these employers willing to support a healthy work force, employees now have the option of:

a. Buying insurance with tax advantaged Health Reimbursement Arrangements (HRAs)

Under the new Georgia law, HRAs are allowed that encourage employers to allocate business tax-deductible funds directly to employee accounts. Employees will receive 100 percent of the employer contributions without any state or federal income taxes, and without any payroll taxes (e.g., Medicare, or FICA Social Security taxes).

b. Using HRAs funds to pay for health and health care expenses.

If an employee does not want to use HRA funds to purchase health insurance, employer HRA allocations can be used by the employee to pay for any medical expenses (e.g., prescription drugs, office visits, tests, lab work, etc.). Unused HRA dollars can be "left on account" to accumulate into future years for times of medical need.

Using pre-tax HRAs to fund health insurance and health care services provides an average income tax savings of 21 to 31 percent and an additional federal payroll tax savings of 15.3 percent. Overall, the new law allowing HRAs increases

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How Primary Care, America's Best- Kept Secret, Can Reduce Health Care Costs

for Self-Funded Employers

by Ernest Clevenger

Payors could make greater and wiser use of primary care health care providers resulting in healthier employees, lower costs and increased employee morale.

This article is directed to the payors—especially self-funded employers and TPAs—that seek to improve the health of the populations they cover in addition to administering the plan. Greater use of primary care is one way to better manage the health delivery. The results should also impact costs in a measurable way.

Primary care is America's best-kept secret for keeping costly conditions from happening in the first place. Primary care is the ideal coach or liaison to coordinate and oversee the specialty care that often operates in silos.

What is Primary Care?

Primary care includes family medicine doctors, general practitioners, pediatricians, nurse practitioners and physician assistants. Generally, these professionals treat acute conditions, and to some degree, chronic conditions. While many health care provider groups (specialty, pharma, hospitalization) experience double-digit cost increases, the group of primary care providers lags with an average three-percent annual increases. The result is pushing more and more primary care physicians into specialty care where reimbursements are greater.

Our payment systems pay more for specialty care. Our case management will often not permit procedures unless ordered by a specialist. The focus of our stop-loss community is on high-cost hospitalization and associated high-cost specialty care. While our focus is justified, it causes us to focus on specialty and hospitalization care, and gives little or no time and effort to promote the values of primary care.

Primary care is America's best-kept secret for keeping costly conditions from happening in the first place. Primary care is the ideal coach or liaison to coordinate and oversee the specialty care that often operates in silos. Patients will often have two or three specialists with each focused solely on their "special" part of the body or condition. Specialists prescribe medication to treat their focus often without knowledge of other specialty care being administered, whether treatments or medication. The primary care provider can serve as coordinator, patient advocate, and patient educator. The result can be vastly improved care, better coordination of treatments and medications, improved communication and education with the patient.

As few years ago, a 38-year-old female cafeteria worker with the self-funded assisted living facility management firm, American Retirement Corporation, said she was looking forward to seeing the onsite clinic physician because she was taking eight medications prescribed by three specialists. She had been diagnosed with high blood pressure, diabetes, and had a heart attack two years earlier. Her out-of-pocket on the medications alone was over $300 a month.

Several months later when visiting the clinic, she found me in the company cafeteria. With tears in her eyes, she pulled on my arm to step away from my colleagues at the table. She said, "I just want you to know that I love Dr. Gross (the onsite primary care physician). He has helped me reduce to only three drugs. I only need two of my three specialists now. My out-of-pocket is now only $80 a month. My headaches have stopped and I have never felt better."

It is not that Dr. Gross was necessarily any smarter than the specialists. But his care coordination and patient education made a huge difference, improving the health of this employee/patient and lowering the costs for both her and her employer.

Much of Specialty Care Spending is Unnecessary

Specialty care in the United States is the envy of the world. Dedicated professionals spend decades in education to refine their knowledge, skill and application to make a significant difference in

medicine and in the lives of patients. Nevertheless, as a nation, we overuse specialty care.

According to the *Dartmouth Atlas of Health Care*, almost one-third spending for the chronically ill is unnecessary. It's principal investigator, John E. Wennberg, M.D., M.P.H., states "Variation is the result of an unmanaged supply of resources, limited evidence about what kind of care really contributes to the health … and falsely optimistic assumptions about the benefits of more aggressive treatment of people."

Many high-intensity hospitals' care facilities are overly used with no evidence to support better outcomes, and may actually cause harm according to Wennberg. Dartmouth researchers studied Medicare patients with heart attacks, hip fractures and colon cancer. The data suggest that centers with the most high-intensity care actually have slightly higher death rates than those with a lower intensity of care. As a result, the researchers say, the bills for patients with similar illness may be two or three times higher at some prestigious institutions, with no apparent additional benefit—and perhaps some risk of harm.

High-intensity hospital cost for a certain procedure in the study varied from $30,000 to $110,000 with the predominant influencer of cost being the volume of services available. That is, the primary reason for the cost differences was the capacity of services, such as hospital beds, intensive care units and specialist physicians, within the community. There was no evidence that people are sicker in the markets of high-intensity services than in low ones, says Wennberg. When beds are available, physicians figure out a way to fill them.

"The problem of overuse of acute care hospitals and medical specialists in the management of chronic illness is rapidly getting worse," said Wennberg. He points to finding that the resources per capita allocated to managing chronic illness during the last two years of life are increasing steadily each year. For example, the nation's health care providers were using 13.6 percent more ICU beds in 2003 than they did in 2000.

Both doctors and patients generally believe that more services—that is, using every available resource such as specialists, hospital and ICU beds, diagnostic tests and imaging, etc.—produces better outcomes. The evidence is lacking to support the belief.

Only a Few Chronic Conditions Account for the Majority of Health Care Costs

In 1999, the Institute of Medicine, issued "To Err is Human," a report describing issues relating to medical errors and patient safety. The report stated that the needs of the American public have been shifting from predominantly acute, episodic care, to care for chronic conditions. Chronic conditions are now the leading cause of illness, disability, and death. They affect almost half of the U.S. population and account for the majority of health care expenditures.

Yet there remains a dearth of clinical programs with the infrastructure required to provide the full complement of services needed by people with heart disease, diabetes, asthma, and other common chronic conditions. The fact that more than 40 percent of people with chronic conditions have more than one such condition argues strongly for more sophisticated mechanisms to communicate and coordinate care.

Physician groups, hospitals, and other health care organizations operate as silos, often providing care without the benefit of complete information about the patient's condition, medical history, services provided in other settings, or medications prescribed by other clinicians.

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A Perspective on Long-Term Health Care Cost

Trend and Macroeconomic Modeling

by Wes Edwards

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I would like to thank Professor Thomas E. Getzen of Temple University for the attention he has brought to a critical long-term assumption in retiree medical liability valuation work. His study, "Modeling Long-Term Health Care Cost Trends," has contributed to a renewed focus on the reasonableness of a key premise in actuarial liability valuation work for health and welfare benefits. The ultimate health care cost trend rate assumption has been a subject of particular interest at least since the first Medicare Trust Fund projections and since the exposure draft for FASB's SFAS 106 was released. It is perhaps safe to say, the key to developing a realistic and reasonable assumption is an understanding of the factors influencing the statistic itself. I hope to expand the discussion by addressing some of these key factors.

An actuarial valuation's ultimate health care cost trend rate attempts to model expectations for private pay health care inflation. Private pay health care inflation as well as Medicare, Medicaid and other public pay health care inflation is a component of general inflation. If general inflation is an average of other inflationary components, not all components of general inflation can be above general inflation.

Actuarial education touches economics so actuaries have become aware of many of the forces that act on inflation. Inflation itself measures the increase in the costs of goods and services in the economy. The U.S. economy, and specifically U.S. economic growth, is measured by the Gross Domestic Product (GDP). Nominal GDP is the GDP unadjusted for inflation, which makes a longitudinal GDP time series useful in studying the impact and potential impact of inflation.

It has long been cited by actuaries that the ultimate growth in health care expenditures is limited by the theoretical maximum share of GDP that health expenditures can comprise. This is the basis for macroeconomic modeling to attempt to identify maximum upper limits for ultimate health care trend rate assumptions. This article will highlight two considerations for an actuary attempting to construct a macroeconomic model for this purpose. These are:

- GDP Components other than health care expenditures—their share of total GDP and their ultimate expected inflation rates
- Sub-components of health care expenditures —their share of total national health expenditures (NHE) and their ultimate expected inflation rates.

These considerations are important to the discussion of private plan retiree health care expenditure trends because a one size fits all assumption for either health expenditures or non-health expenditure inflation rates masks to a great degree what is a very sensitive result: the share of GDP associated with health expenditures. I will not comment further on the Getzen paper or model, except to note that in varying only the input percentage of GDP "at which growth is assumed to meet resistance," the lowest ultimate share of GDP projected for NHE is 28.2 percent, while even when 50 percent is input, the ultimate share projected for GDP is only 40 percent. This indicates a priori expectations have been used to limit the model sensitivity. Whether these expectations are appropriate is and should be subject to productive debate.

Recent articles in Contingencies, including "Our Finite World: Implications for Actuaries" by Gail E. Tverberg and "Climate Change and the Role of the NAIC" by Evan Mills and "Borrowing Trouble" by Harper, Martin and Wolzenski, ask questions like, "Why are we still behaving as if world resources will last forever when they are fast being exhausted?" and "Will discontinuities cause past trends to be irrelevant?" I don't intend to forecast the impact of major worldwide economic shocks to U.S. GDP or NHE, but I do hope to raise questions about whether strictly using a portion of the past to predict a future where NHE is no less than 28.2 percent of GDP is reasonable.

GDP Components

Table 1 as produced from Bureau of Economic Analysis data and reflects the major components of U.S. GDP and their share of the total. A general understanding of these components is essential to evaluating the reasonableness of any forecasted increase in health care expenditures. (The private medical care component does not include all health care. Medicare, Medicaid and other public health expenditures representing four percent of GDP are included in the government components.)

Any projected increase in the share of GDP attributed to medical care must come at the expense of other components. Giving some thought about a forecast of health care expenditures topping 30 percent of GDP will allow us to better evaluate the reasonableness of such a forecast. We should be able to make some rational assessment of what components of GDP "pie" might decline in share and by how much.

The Bureau of Labor Statistics (BLS) makes projections of GDP by major components. (Unfortunately, they do not release projections of sub-components such as personal consumption of medical care.) The BLS has and continues to project government expenditures to constitute a shrinking share of GDP. In 1997, they projected that by 2006, federal defense spending would decrease to three percent of GDP[1]. This seemed logical following the end of the Cold War and the first Gulf War. However, the 2006 reality (shown in Table I) was much different. Clearly, national defense against immediate threats such as terrorism can continue to be a high priority and it is a possibility that such threats will continue to require national expenditures as will maintenance and modernization of conventional military assets. The latest BLS forecast of major GDP components for 2016 is shown in table 2.

Interestingly, this forecast again anticipates a decline in federal defense spending as a percentage of GDP. Whether this will be realized is worth consideration. The private investment component share is not forecast to change so would not appear to be a likely source of reallocation of GDP to health expenditures. The sum of federal non-defense and state and local components share of GDP is forecast to decline from 14.4 percent to 13.7 percent over the 10 year period. However, in 1997 it also was forecast to only be 13.5 percent in 2006 rather than 14.4 percent. Government expenditures include governmental social benefits to individuals. The projected increases of the latter have been studied in depth by actuaries. It is difficult to imagine any increase in medical spending not being shared by the governmental sector.

Other than these components, all increases in health care expenditures share of GDP must come from other personal consumption expenditures. Personal energy consumption including gasoline, fuel oil, household electricity and gas increased from 3.5 percent of GDP in 1996 to 4.2 percent of GDP in 2006. Will this trend continue or increase at a more rapid pace or will energy components decline? Futurists studying energy trends today do not sound optimistic, forecasting:

- Global demand for energy in the near future will outpace supply within twenty-five years unless new sources are found to support global growth.
- Energy terrorism and theft will become a future weapon of choice, threatening global peace and security.
- GDP, growth and productivity will decline if new and cost-effective non-oil energy sources are not found fast to protect future growth and prosperity, and to help rebalance the future of the world.

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Table 1: Actual 2006 GDP Components Percentage Share

Private Consumption, except	57.9%
Medical Care	12.0%
Private Investment	16.7%
Government	
State and Local	12.1%
Non-Defense - Fed	2.3%
Defense	4.7%
Net Exports	-5.8%

Source: *http://www.bea.gov/national/nipaweb*

Table 2: Projected 2016 GDP Components Percentage Share

Private Consumption	70.1%
Private Investment	16.6%
Government	
State and Local	11.8%
Non-Defense - Fed	1.9%
Defense	4.0%
Net Exports	-4.6%

Source: *http://www.bls.gov/opub/mlr/2007/11/art2full.pdf*

[1] *http://www.bls.gov/opub/mlr/1998/06/art3full.pdf*

What the New York Yankees and Boston Red Sox have Taught Me

about Health Insurance... and Life

by Jeffrey Stock

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If you can't stand baseball or the Yankees, keep reading anyway. This article is as much about insurance as it is about baseball!

Pre-Game Warm-Up:

The Yankees and Red Sox (and many insurance companies) have a long history of winning, success and profits. But winning games and attracting top talent are only part of the strategy. Ticket pricing levels must be set to retain and grow the customer base while the business entity continues to make a profit. Once they get you in the door, both baseball and insurance companies also tease you with additional product offerings such as sports souvenirs and insurance riders. Examples include commemorative bats for baseball and a dental PPO rider for insurance. These extra sales are an excellent strategy and tend to have higher margins, but sometimes the fans don't understand all the acronyms associated with them, and so they don't buy the product. For example, what are A-Rod and Big Papi bats anyway?

Do you think the Yankees could be a better team if only they hired you to be their team manager or consultant?

Let's learn some insurance lessons from the Yankees and Red Sox and play ball.

Top of the First Inning:

Tonight, the Yankees are at home against the Red Sox. Ellsbury leads off with a single but he's caught stealing. The next batter walks, but the Yankees retire Pedroia and Ortiz to end the inning.

What's to learn?

- A hit product only gets a team to first or maybe second base. Having the right pricing and distribution might be necessary to bring in the runs.
- Stealing business from a solid company is difficult and risky. Make sure to run on the right pitch.
- Also, watch out for the pick off if your price is too low. Pick-offs hurt run margins.
- Keep your eye out on the competition, and they will have a harder time stealing from you.

Bottom of the First Inning:

Curt Schilling strikes out the side on 12 pitches.

Moral of the story:

- The competition plays hard against you if they know you're a good team.
- Make sure to understand the competitor's sales pitch if you want to have a chance against them.

Second Inning:

Most of the action takes place in the stands. The fans load up on refreshments. The adults enjoy hot dogs and beer, while most of the youngsters overpay on pizza and cotton candy. There are some healthier alternatives ordered up as well (e.g., peanuts, cracker jacks). One bag of peanuts is hurled by the vender and falls into and out of the mitt of a small child. Meanwhile, security fails to catch a beach ball from the fans as the ball hovers and lands on the field interrupting play. Before you know it, the inning ends scoreless.

Ask yourself:

- Do you sell products or souvenirs that differentiate, improve margins and keep the customer coming back for more?
- Is your customer experiencing a beach ball distraction?
- Do your offerings target and segment different demographics?
- Do you have alternatives and options to attract healthy individuals?

Third Inning:

Pedroia doubles with two outs. The Yankees intentionally walk David Ortiz to put runners on first and second. Lowell homers to put the Red Sox in front 3-0. The Yankees bounce back with three solo home runs and tie the score 3-3.

Your takeaway:

- Use insight into competitor strengths and weaknesses to drive decision making.
- Sometimes it's better to face your pricing challenges than walk around them.
- The big hitters have a huge impact on your margins.
- Cross selling is valuable. A sequence of walks and hits can be as valuable as a few solo shots.

Fourth Inning:

With two outs, the Yankee pitcher gets hit on the shoulder on a ball wrapped sharply up the middle. The deflected ball heads toward the shortstop and he, according to the official scoreboard, makes a throwing error to first base. The pitcher winds up with a rotator cuff injury and is out for the rest of the season plus half of the next. His contract is $10 million a year for the next two years.

The Yankees have a choice.

A) Insert their rookie who pitched well in triple-A ball, or

B) Put in a pitcher with more experience but mixed results.

The Yankees choose the experienced pitcher, but he gets roughed up. The Red Sox score two more unearned runs to lead 5-3. The Yankees lose focus because of their injured player and have an unproductive bottom of the inning.

Questions to mull over:

- Are your rate guarantees as risky as the Yankees contracts?
- When are rate guarantees appropriate? Would you give a rate guarantee with an opt-out agreement to a pitcher with a recurring injury?
- Do you have reinsurance or protection against adverse events in case one of your key players goes down?
- Do you cross train employees in case someone is out for awhile?
- Do you train new employees so that you can be comfortable giving them responsibility if someone becomes absent?
- Do your infielder's errors cost the team runs? Do medical errors and claim processing errors lead to higher health care costs?
- Perhaps the Yankees shortstop should have taken a few more practice balls. Do your health insurance plans have tools that lead to better claim outcomes?
- Can a solid risk manager help his team win?

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Soundbites

from the American Academy of Actuaries Health Practice Council

by Heather Jerbi and Dianna Pell

What's New

On July 11, John Bertko and Cori Uccello, the Academy's senior health fellow, presented at a Capitol Hill briefing sponsored by the Academy on actuarial equivalence, specifically how it relates to health benefit plans. Similarly, on May 20, the Academy sponsored a Hill briefing on risk pooling and the potential effects of health care reform on the individual and small-group markets. David Shea, chairperson of the Academy's Federal Health Committee, and Cori Uccello presented at the briefing, which drew 45 attendees from congressional offices, the media and other external health policy organizations. The slides from the risk pooling briefing can be found at: *http://www.actuary.org/briefings/pool08.asp*. These are the first two in a series of 101-type Hill briefings planned for 2008.

Also, on July 11 Geoff Sandler of the Health Practice Council testified at the National Conference of Insurance Legislators (NCOIL) meeting on a proposed resolution in support of legislation extending dependent health benefits for young adults age 19-25. His comments concerned subjects that should be addressed in legislation extending dependent benefits, including eligibility and enrollment periods, and the premium costs and savings that may be associated with such legislation.

On May 30, the National Association of Insurance Commissioners held a public hearing on the rising costs of health care. Testifying on behalf of the Academy, Shari Westerfield, chairperson of the State Health Committee, outlined a number of health care cost drivers and options to address them. Cost drivers identified included those that increase per-unit costs such as inflation, expanded provider networks and provider consolidation, and those that increase utilization including new technology and treatments, lifestyle factors and more generous benefit packages.

On March 6-7, the HPC and Federal Health Committee held their annual Capitol Hill visits. Sixteen members visited 23 Congressional offices, government agencies, and external organizations over the course of two days. During the course of the visits, Academy members responded to questions on a wide variety of issues: the effect on premiums of risk pools in the group and non-group markets, the pros and cons of mandates, the role and experience of the recently implemented Massachusetts health reform program, the effectiveness of disease management programs, the Bush administration's tax proposal, and mental health parity legislation.

In late March, the Academy's Medicare Steering Committee released an updated version of its issue brief, *Medicare's Financial Condition: Beyond Actuarial Balance*, to reflect information from the 2008 Medicare Trustees' Report. The paper highlights the committee's view that Medicare faces serious long-term financing problems that should be addressed as soon as possible. The brief can be found online at: *http://www.actuary.org/pdf/medicare/trustees_08.pdf*.

Also in March, the Health Practice Council, as part of its 2008 election strategy, released a series of brief summaries of some of the relevant issues being discussed as part of the national dialogue on health care reform. The purpose of these papers is three-fold: to provide basic information for policymakers and the media, address issues policymakers need to consider as they engage in discussions on any of these topics, and to remind policymakers that the actuarial profession is an objective resource that is aware of the issues and ready to help with solutions. The series includes information on the following: rising costs of health care, medical reinsurance, medical insurance pools, Medicare and consumer-driven health plans.

Ongoing Activities

The Academy's Health Practice Council has many ongoing activities. Below is a snapshot of some current projects.

Consumer Driven Health Plans Emerging Data Subgroup (David Tuomala, chairperson)—This work group is developing a paper analyzing

emerging CDHP data, which is expected to be available in October 2008.

Health Practice Financial Reporting Committee (Darrell Knapp, chairperson)—The committee continues to work on updating several practice notes (Small Group Certification, Large Group Medical, and General Considerations). Also, having received a charge from the NAIC to create a health trend test, a joint work group of the Health Practice Financial Reporting Committee and the Committee on State Health Issues has been formed. The group developed a report on health trend tests, using data provided by the NAIC.

Individual Medical Market Task Force (Mike Abroe, chairperson)—This task force continues to work on a monograph related to how the current individual market operates. Issues examined in the paper relate to affordability and barriers in the individual medical insurance market. The paper is expected to be published in 2008.

Long-Term Care Principles-Based Work Group (Bob Yee, chairperson)—This work group is beginning the modeling phase of their work and will be providing an update to the NAIC in 2008.

Uninsured Work Group (Cathy Murphy-Barron, chairperson)—The work group released a paper on issues related to the fundamental principles of insurance and characteristics of health coverage in September 2008. The work group is also working on an issue brief that will address the drivers of health care costs, which is expected to be available in Fall 2008.

Health Care Quality Work Group (Michael Thompson, chairperson)—This work group is developing an issue brief that will examine health care quality today and the impact of comparative effectiveness research on the advancement of health care technologies and quality treatments.

State Mandated Coverage Task Force (Kevin Borchert, chairperson)—This task force is developing an issue brief that will discuss mandating the purchase of health insurance and the goals of such programs, funding considerations for implementing mandated coverage legislation, benefit design considerations, and modeling and data availability.

Stop-Loss Work Group (Shaun Peterson, chairperson)—This work group is continuing to update a 1994 report to the NAIC on stop-loss factors, and is currently checking data calculations prior to re-starting the modeling phase of their work.

Medicare Part D Risk-Based Capital Subgroup (Jim Braue, chairperson)—This subgroup is currently investigating data sources to be used for updating a 2005 report on Part D RBC risk factors.

Disease Management Work Group (Ian Duncan, chairperson)—This work group has begun development of an issue brief on evaluating wellness programs.

NAIC Projects

The Committee on State Health Issues and Health Practice Financial Reporting Committee continue to monitor issues, including LTC, health insurance issues, Medicare Part D, principles-based methodologies, Medigap modernization, etc.

If you want to participate in any of these activities or you want more information about the work of the Academy's Health Practice Council, contact Heather Jerbi at *Jerbi@actuary.org* or Dianna Pell at *Pell@actuary.org*. ■

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... if the folks on Capitol Hill can find someone who can take the time to explain how the system works and the critical areas, without advocating a partisan viewpoint, they can be interested in listening.

These first two points are critical in my mind. Congress is constantly bombarded by people seeking new legislation or seeking to modify or kill current proposals.

As a general rule, members of Congress and staffers do want legislative proposals that work, and don't want to create more problems than they solve. Given the complexity of our country, this is not an easy task. Given the length of most health care legislative proposals, and the myriad of important details within them, it is almost impossible. So if the folks on Capitol Hill can find someone who will take the time to explain how the system works in the critical areas, without advocating a partisan viewpoint, they can be interested in listening.

I realize that many of us have strong opinions on how the health care system should be changed, or not changed, as the case may be. The more your presentation tries to promote one and only one solution, the less likely it will find an interested audience. The more your presentation fairly presents the pros and cons of various options, the more likely it will find an interested audience.

To a great extent, it is important to have a rational confidence in the value of your company's participation in the system. I personally do believe that carriers have a valuable role within the system. We have produced innovation; we have strongly encouraged provider efficiencies; we have allowed for different products and solutions, rather than trying to force everyone into one universal package. If you really don't believe we add value, you will find yourself trying to "sell." If you really do believe we add value, you will only need to "educate," to explain as clearly as possible, with as many statistics as possible, what we have achieved in the past.

Point #3 - Members of Congress and their staffers have even less spare time than you have.

Even if they want to hear what you have to say, they have an extremely limited amount of time to spare listening to you. Any message you are privileged to give must be well prepared in advance, focused on the important topics, and easy for a non-technical person to understand.

This point means that you must spend a great deal of advance effort to thoroughly know your subject and be able to explain it quickly. You have to avoid jargon. For example, "Anti-selection" might be a topic you understand thoroughly, but most people have probably never heard the word. At best, they have only a vague understanding of its implications. This also means you must practice what you have to say.

Point #4 - Different members of the actuarial community will have different opportunities to participate in the debate.

- A few might be heard as citizens, but most likely very few, if any, will have this option.
- Some will be heard as experts when the American Academy of Actuaries provides information and analysis to members and staffers. The Academy is constantly working to educate Congress on many topics that would benefit from an actuarial perspective. In addition to proactively working with policymakers and others in the health policy community on health-related issues, members and staffers will often turn to the Academy as a resource for more in depth understanding of specific topics.
- Some will be heard as representatives of their companies. A few of the largest companies maintain offices in Washington D.C. for lobbying, and there will be a need for actuaries to come to Washington to help with the analysis and the explanations. Sixteen years ago, I worked for Mutual of Omaha and it was my privilege to participate in this manner. Even without a lobbying staff in D.C., some companies will at least ask their local senators and representatives to the home office for education. If a legislative proposal that otherwise looks acceptable will have an extremely adverse effect on employment in the state, members of Congress want to know this fact, and will take it into consideration.
- Some will be heard as part of educational efforts by trade associations. The work is more likely to be analysis as a part of a committee, but it is still important to the process.

You might ask why so many different organizations need to spend valuable time and resources in this effort. One reason is that each of these different organizations will have different focuses. They might agree with your thoughts, but their

priorities might differ and what you consider to be important might not be mentioned. Another reason is that the more someone hears a given message, the more likely they are to believe it. Last, but not least, there will be some members or staffers who will accept input from one source, but not another. Do what you can and let others do what they can.

Even if you are one of the few actuaries who can participate from a company standpoint, also support the efforts of your trade associations and the American Academy of Actuaries. If nothing else, the more people who consider a proposal, the better the resulting analysis.

Point #5 - There is such a wealth of material to consider and analyze that you will need a process to work through it and to be prepared to react quickly to changes and new proposals.

The following is a high-level overview of the process I attempted to follow 16 years ago. (Not the one I started with, but the one I ended up using because it worked.)

1. Review the high-level proposals. Begin to understand the broad structures that each proposal follows. Put the proposals into categories based on the overall structure of the resulting health care system.

2. Attempt to forecast the impact of the changes made by the proposal to the current health care system.

   A) Evaluate the ability of your company to participate in the changed system.

   B) Evaluate the ability of your competition, both current and possibly new, to have significant new market advantages.

   C) Evaluate the ability of the proposed market to maintain long-term stability.

   D) Evaluate whether or not the keys to market success under the proposed system would be significantly different from your current keys to market success.

   E) Evaluate, as best as possible, if the current health care cost increases continue to escalate above growth in GDP, where the pressure point on revenues will be. In other words, if costs continue to rise rapidly, will the impact be first felt by employers, who will then attempt to pass the costs along to employees; or, will the impact be felt on tax revenues, which the government might attempt to control by reducing provider reimbursements, or something else?

   F) Evaluate the impact of the proposal on key stakeholders: U.S. citizens, employers, health care providers, health care research and development, and government at all levels

3. Determine which general approaches are overall positive, neutral or negative and why (with specifics).

4. List the key details within each major general proposal.

   A) Repeat step #2 above for each key detail.

   B) Roll up the results for each proposal and put a value on each proposal

5. List critical issues in detail with the specific reasons they are critical. Few people and even fewer companies like change, but even though some change is deadly, other change might be neutral or positive. As much as possible, try to avoid negative evaluations simply because the system would change.

   A) List the general approaches that simply won't allow your company to participate in the proposed system.

   B) List the general approaches which might or might not allow your company to participate in the proposed system, depending on certain key details

   C) List the general approaches, which are likely to produce a future system in which your company can continue to thrive.

   D) Prioritize your key issues. This includes high-level proposals that don't work, or key details within high-level approaches that determine whether or not the proposal would work.

   E) Look again in depth at your list. Are the issues for your company also issues for the general public, or employers, or even the government? If your company is adding value to the system, then there probably is a strong correlation between

CONTINUED ON **PAGE 24**

issues that your company will face and issues that participants in the system will face.

F) Develop "story boards" or scripts that attempt to clearly describe the issues and how they will impact the people of this country. Unless you are talking to your local member of the House, most of your potential audience will not care much about the survival of your company. They will care about how it will impact voters.

G) Through whatever route you have, take your message to everyone who is willing to listen.

6. Review all new proposals and changes to existing proposals, and repeat the whole process.
7. As time allows, exhale.

Point #6 - You can expect that both the American Academy of Actuaries and the Society of Actuaries will be active in this effort.

The Academy, as would be expected, will focus on direct contact with the Hill and analysis, while the SOA will focus on needed research and analysis. Look for calls to participate and, if possible, find ways to contribute. This issue impacts all of us and is vital to the future of our country. To the extent we can add our knowledge to the results, we can create a better future for all of us. ■

Reawakended Focus... | FROM PAGE 7

Carriers tend to justify this renewed interest in the physician market by pointing to their stable claim experience since the late 1990s and higher premium rates charged for physicians and other medical occupations. However, this rationalization may be ignoring certain underlying economic realities facing U.S. health costs. For example,

- The most recent Physician Environment Index[5] published by the Massachusetts Medical Society, incorporating nine factors that impact the delivery of patient care in Massachusetts and the United States, deteriorated at an annual rate of 1.21 percent from 1992 to 1999 and 3.03 percent from 1999 to 2006.
- The 2007 Report of the Social Security Administration described the critical financial issues facing both the Social Security and Medicare programs and raised an alarm about the inaction of our government to address these issues. The report states, "Medicare's financial difficulties come sooner-and are much more severe-than those confronting Social Security."
- After the 2008 presidential election, there may be a renewed focus on fixing the issues associated with medical costs and the availability of medical insurance through some form of universal health care. Such discussions as well as the solutions, if they should emerge, could ignite a deterioration of physician claim experience similar to that seen in the mid-1990s.

Aggressive marketing of noncancellable IDI products with larger amounts of available coverage today appears to be short-sighted with respect to the current economic pressures facing physicians today and in the near future. Allowing over a quarter of IDI sales to be issued to physicians places the hard fought positive profitability of the industry at risk and ignores the lessons of the IDI industry's not-too-distant past.

Is There a Solution?

It is inevitable that physicians will continue to seek IDI coverage and companies will want to provide it. Physicians will always be a significant segment of the IDI industry. The higher premium rates that companies now charge physicians, which resulted from companies creating separate occupation classes for medical professionals, suggest that the today's products may be appropriately priced to reflect physician experience over the last ten years. However, abandoning many of the risk-related controls implemented in the late 1990s and allowing physicians to represent an increasing proportion of new sales could make IDI carriers' future profitability vulnerable.

The solution is not an easy one. It involves exercising discipline around the maintenance of sound risk controls and fostering an awareness that the economic turmoil facing the medical world during the early 1990s could very well occur again. Last but not least, the solution involves recognizing that a sound strategy for increasing new IDI sales should not rely solely on the physician market. ■

[5] *The Massachusetts Medical Society Physician Practice Environment Index Report*, MMS Index Report March 2007. *www.masmed.org*.

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SESSION 25	Monday, October 20	10:30 a.m. – Noon

Medical Management – What Does It Comprise?

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Actuaries in managed care now need to have a working knowledge of care management, its organization, economics and outcomes assessment. This session will provide an introduction to some of these topics for the managed care actuary, as well as cover some recent developments in the field.

SESSION 72	Tuesday, October 21	10:30 a. m. – Noon

The Presidential Candidates – A Comparison of Their Health Care Platforms

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Have you ever wanted to share your thoughts on the U.S. health care system? If so, join us for a highly interactive and timely session. Representatives from each presidential candidate's campaign will present their health care platforms.

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I believe we can achieve a remarkable return on our investment merely by unlocking access to existing resources.

On the lighter side, you have probably noticed a new e-mail popping up in your inbox, *Health E-News*. Councilmember Grady Catteral, Jill Leprich and Susie Ayala from the SOA branding area took a dowdy monthly e-mail and spruced it up with some nifty features to keep you apprised of what is going on in your Health Section in a timely fashion.

This brings us to the 800 pound gorilla, our research pipeline. On any given year, over one half of your dues are spent on research. Working closely with Steve Siegel at the SOA, former section chair John Cookson has been serving as the research coordinator for many years. Over the last year, three research projects have been completed: modeling long term health care cost trends, a paper on statistical methods for IBNR estimates, and a review of stochastic simulation literature and applications to the discipline.

These efforts alone involved 10 researchers and a score of project oversight members. Anyone who is interested in serving on a project oversight group or who has an idea for a research project should contact John Cookson or Steve Siegel. Projects currently in the pipeline include RFP's examining the accuracy of IBNR methods, researching the methodology and valuation practices for group long term disability benefit offsets, a call for papers on quality and efficiency in the health care system, and research into the potential impact of a pandemic on U.S. health insurers.

Projects under development include research and documentation of health ERM best practices and research into the societal cost of medical errors. Over the last decade, the industry has become increasingly aware of medical errors, but no one has estimated the potential economic cost—not just in medical terms but lost time, malpractice insurance, hospital capacity, etc. Done properly, the results would not only place a price tag for medical errors on the economy, but allow for quantitative estimation of the impact of investments in error reduction.

But simply producing content is not enough. Our ability to distribute this knowledge to stakeholders[2] and have them take notice is a critical and too often neglected step. If our intellectual capital remains landlocked and cannot reach the sea, the profession is poorer for it. The discipline lacks an effective means of distributing our intellectual assets outside the closed loop of the actuarial community, and in many areas we fall short even within these friendly confines. In 2007, there were no health themed articles in *The Actuary*. Given the importance of health care issues in the national stage, I would suggest it is more important than ever for authors to step up and contribute to this important discussion.

Because our contributions are so little known outside the discipline, I believe we can achieve a remarkable return on our investment merely by unlocking access to existing resources. As a base operating platform from which to address this strategic gap, the council has identified the goal of revamping the section web portal to organize and more effectively deliver content to both internal and external stakeholders. A team has been assembled to address this nagging problem but due to the lack of resources we were not able to realize the goal this year. By aligning this section project with the goals identified by the Board in support of the Untapped Opportunities issue, we can close the gap between our high quality health content and distribution to stakeholders.

Marketplace Relevance

I am excited to talk about a new network serving the needs of the Medicare community. 15 years ago, the first Health Section special interest group was formed to support the needs of the disability income community. Dan Skwire has been doing an admirable job of responding to the needs of this important constituency. Ashlee Mouton Borcan approached the section and proposed the idea of forming a new Medicare network to service this large and under served constituency.

The goals of the group are to provide a forum where actuaries operating in the Medicare space can discuss the implications of trends and changes in both the regulatory and economic environment. We hope to bring this community together by coordinating meeting sessions, research, and seminars to ben-

[2] Candidates, members, employers, and the broader family of professional communities

efit both consumers and providers. We look forward to seeing what develops from the Medicare SIG team.

Professional Communities

As actuaries, in order to work effectively within the complex U.S. health care system, we are dependant on an extended family of professional communities: we have much to offer them, and they have much to offer us. One of the section's goals is to establish and nurture these relationships, and one of our best is with the Disease Management Association of America (DMAA). Ian Duncan has created a dynamic relationship where we exchange ideas which not only improve our respective professions, but population health. Taking it further, the partnership has created a successful CE event in the Predictive Modeling Seminar, now in its fifth year.

Another long term relationship of the section is with CMS. Research coordinator John Cookson works with an SOA group that meets with CMS in the fall to provide support to the National Health Expenditure Update and Forecast that comes out early in the year. Representatives of several large insurers, consultants and the SOA staff meet to discuss questions CMS has concerning trends in private health expenditures. This provides them with valuable insight into what we are seeing in the private sector in terms of trends for various components of health costs.

Closer to home, the section has made concerted efforts to reach out to the Academy and the CAS. Representatives of these organizations receive council communications and participate in our monthly calls; likewise, the section provides representatives to participate in their meetings as well. We hope improving communication will increase opportunities to collaborate on projects, such as the medical errors research.

The council budgeted funds to underwrite outreach to professional organizations and send members to attend selected meetings. John Cookson attended the Quality Colloquium at Harvard University on behalf of the council and wrote up an article on his experience for *Health Watch*. Likewise, Grady Catterall attended *Health Affairs*' Silver Anniversary in Washington, D.C. and also wrote an article on the experience. As our local Washington, D.C. council member, Grady also had the opportunity to attend the Academy Health Meeting on our behalf.

With some care and feeding, one of the most potentially fruitful long term relationships may be with the American Society of Health Economists (ASHE). Tom Getzen (mentioned previously in the long term trend research) is the head of the International Society for Health Economists and works closely with the American counterpart. A close relationship is developing between the council and ASHE which we hope will bear fruit in the terms of interchange of ideas and presenters at our respective meetings, and the SOA is an institutional member of this fledgling organization. The next bi-annually meeting will be in Ithaca, New York on the campus of Cornell University in 2010.

The Health Section should definitely consider some level of sponsorship for the event to raise our visibility. Health economists have much in common with actuaries but we come at our research from different directions. At the 2008 meeting over 500 papers were presented representing the work of some of our most important and influential partners from academia, AHRQ, CBO, CDC, CMS, hospitals, pharma, public health, think tanks, and the U.S. Treasury. While clearly not every paper was relevant to the work that we do, there were enough sessions to choose from that you could not miss finding something of interest.

As mentioned earlier, non-member speakers are recruited to our meetings, but non-members who attend have an opportunity to learn from us as well. To strengthen this relationship, we have initiated a program of extending complementary one year memberships to non-members who had attended a CE event in the prior year. Over 100 people took us up on this offer; if they see the value in our content and communications, then they can renew at the same rate as any associate member. It is our hope that they will continue sharing their professional expertise with us by contributing articles to our intellectual capital and attending our CE events.

CONTINUED ON **PAGE 28**

In order to work effectively within the complex U.S. health care system, we are dependant on an extended family of professional communities.

Leadership Development

One of the most important long term strategic functions of the council is leadership development. It is not always the case that in our jobs we have this type of opportunity to lead and really make a difference. Service to the section helps to prepare for professional and civic responsibility; from service to the discipline, council members can go on to serve the profession on the SOA Board or with the Academy. Council members have the opportunity to develop their leadership skills through involvement in various ways, including chairing committees, writing articles, public speaking, recruiting and motivating volunteers, and participating actively in council activities.

One of the most important long term strategic functions of the council is leadership development.

The section is always looking for volunteers, and volunteer development is critical to maintaining our leadership pipeline. If you want to get involved but do not know in what capacity, reach out to the section volunteer coordinator, Susan Pantely. Susan maintains the data base of volunteers and has a good sense of what projects are underway that would fit your interests. We make every effort to personally contact every person who wants to volunteer to coordinate their interests, availability, and skills and plug them into a suitable project.

In Conclusion

Thanks to all council members, friends and dedicated volunteers who made this year such a success and continue to make the health discipline the most vibrant in the profession. Special thanks to outgoing council members Beth Grice, Jodie Kerchival and John Stenson for their service. Thanks to Meg Weber and Steve Siegel for stepping up to plate and filling the large gap left by untimely departure of our Health Staff Fellow (we miss you, Elaine!!) and the enthusiastic support from Jill Leprich.

I don't have a crystal ball, but I predict in the near future Jennifer Gillespie and Susan Pantely will be leading the section as Chair and Vice Chair. I would like to thank them for their hard work this past year and their willingness to take on the challenge of leading the third largest SOA section as we navigate the challenges and opportunities ahead. I hope that you will consider stepping up and find a way to participate in this process and put your stamp on the results. ■

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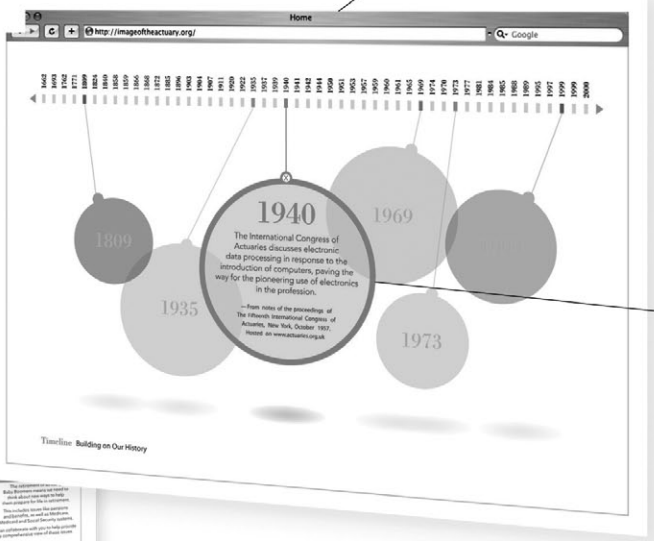

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the effective value of employer contributions by 60 to 85 percent versus a pay increase of the same amount.

3. Individual Health Plans:

Portable individual health insurance is independent of the employer and not subject to loss of coverage with a change in jobs. Twenty percent of uninsureds are between jobs and cannot afford the continuation of the employer plan with expensive COBRA rates. Under the new Georgia law, individuals can purchase an affordable individual HSA eligible plan with the following advantages:

a. Special Georgia income tax deduction for the premiums of HSA eligible plans.

This deduction lowers the net cost of HSA eligible plans by 6 percent. (Georgia's marginal income tax rate is 6 percent for singles with income over $7,000).

b. HSA "dividends" for wellness, prevention and treatment compliance.

These shared savings were previously illegal under Georgia rebate laws. Under federal law, up to 20 percent of a policy's cost can be returned through rewards and incentives for healthy outcomes. Additionally, unlimited "dividends" can be provided for healthy activities.

c. Elimination of all state and local "sales taxes" for HSA eligible plans.

Georgia has the third highest insurance taxes in the country. The average state tax is 2.25 percent with added local insurance taxes the added cost burden is as much as 7 percent of premium. These "sales taxes" are all eliminated for HSA eligible plans.

d. More flexible HSA eligible plan designs

Previous Georgia law prohibited some plan design options that would offer better coverage at lower premiums. These barriers have been eliminated for HSA eligible plans. The estimated savings are between 1 and 2 percent.

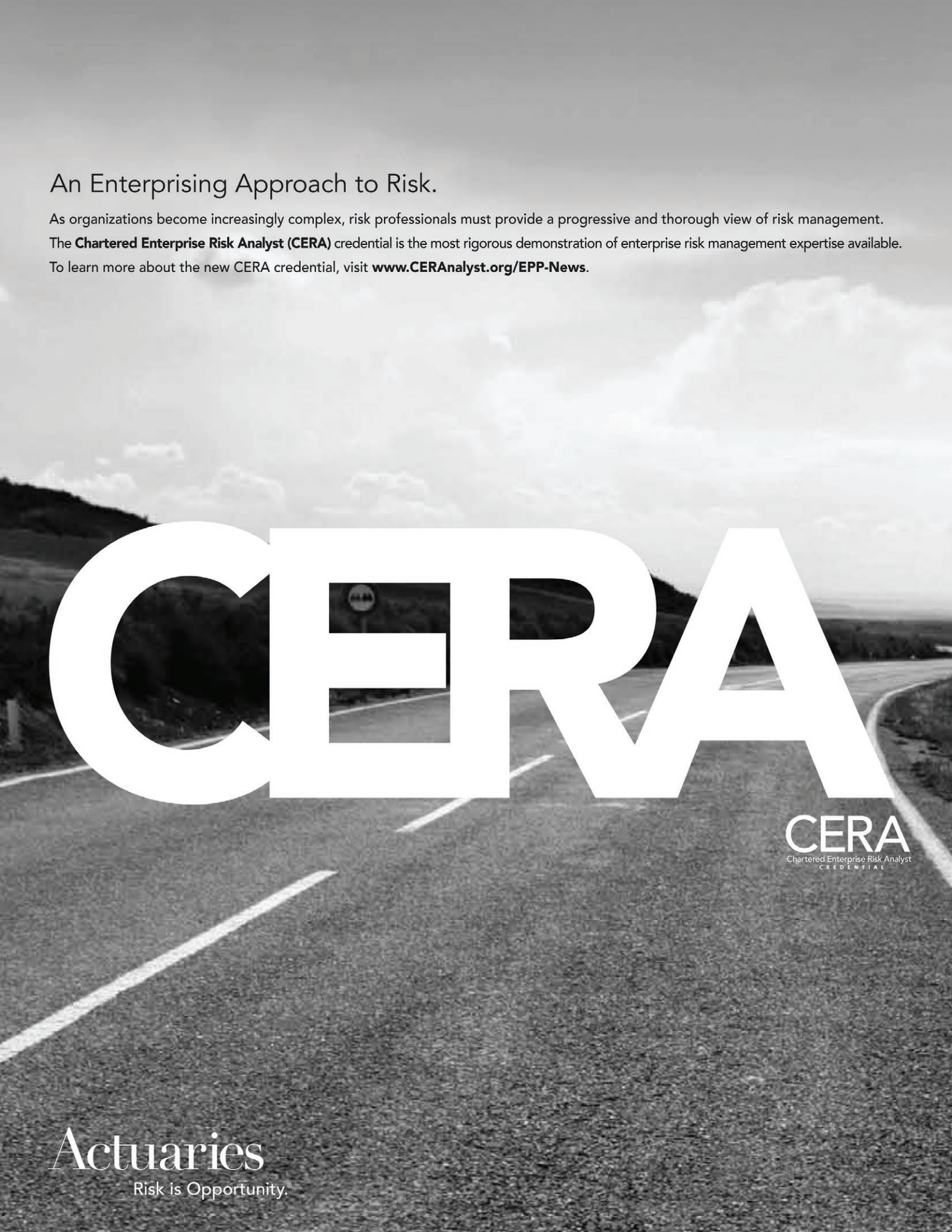
Overall, the new Georgia law can lower the cost of HSA eligible individual health insurance by 15 to 35 percent, or more.

A New Future:

Georgia passed into law a health reform initiative that eliminates all state government taxation on HSA eligible health insurance, removes state barriers to using employer funding of HRAs to fund individual policies, allows financial rewards and incentives for healthy behaviors, and supports products that better meet the needs of working class uninsureds. This legislation is not a panacea, but it is a model for other states to follow. It prepares Georgia for the next phase of helping all Georgians to find affordable private health insurance.

Under the new Georgia law, next generation HSA eligible plans change the debate around affordability of health insurance. Soon, Georgians will see products at a fraction of their current costs and be able to purchase portable new generation HSA eligible plans that can provide full coverage for those willing to take personal responsibility for their health and well-being. The old complaints that HSA eligible plans were simply high deductible coverage only for the young, healthy and wealthy is fully rebutted with these new changes provided under Georgia law. A new future for improved health and family security is unfolding and Georgia is showing the way. ■

Nothing written here is to be construed as necessarily reflecting the views of the Center for Health Transformation or as an attempt to aid or hinder the passage of any bill before any state legislature or the U.S. Congress.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The report argues that the health care system must focus greater attention on developing care processes for the common conditions that afflict many people. A limited number of such conditions, about 15 to 25, account for the majority of health care services and cost. According to the IOM report, the 15 priority conditions are:

- Cancer
- Diabetes
- Emphysema
- High cholesterol
- HIV/AIDS
- Hypertension
- Ischemic heart disease
- Stroke
- Arthritis
- Asthma
- Gall bladder disease
- Stomach ulcers
- Back problems
- Alzheimer's disease and other dementias
- Depression and anxiety disorders

Most of these conditions have fewer than 10 key markers or tests that can easily be followed by primary care providers instead of specialists. The primary care provider can easily refer to specialty care when one of these markers changes and merits the action.

Essentially, we are promoters of higher cost specialty care when lower cost primary care is being overlooked and not rewarded.

For example, the predominant diabetes markers include glucose, weight, HbA1C, and triglycerides. The primary care provider can monitor the marker levels. Treatment including diet, medications and education can be adjusted in response to changes in the markers. If satisfactory responses are not achieved, then the specialists can become an active participant in the treatment process.

A primary care provider can easily measure prothrombin time and INR for anticoagulant patients taking the blood-thinner, Coumadin or Warfarin, even on a stat basis. If the results merit a call to the cardiologist, the primary care provider can talk physician-to-physician to decide what next steps are in the best interest of the patient. The patient saves a trip to the Cardiologists and the self-funded health plan pays significantly less for a primary care visit instead of a specialty care visit.

How We have Encouraged the Growth of Specialty care

TPAs, self-funded employers and other payers have encouraged the drive toward specialty care, creating a huge imbalance in health care overpayments.

For specialty and optimization care, our financial incentives encourage the overuse of acute care hospital services and the proliferation of medical specialists. That is, we are willing to pay many times more to specialists, which drives more physicians to become specialists. Generally, we pay hospitals based on utilization instead of case rates. Imagine paying for car repairs based on the number of days the car is in the shop. Hospitals responded with outpatient facilities. Now, in many cases, outpatient costs exceed inpatient costs.

While payments for primary care as a health care component have declined relatively, our payments for specialty care have increased making specialty care much more attractive for physician salaries. The median income of specialists in 2004 was almost twice that of primary care physicians and the gap is widening. Data from the Medical Group Management Association indicate that from 1995 to 2004, the median income for primary care physicians increased by 21.4 percent (2.2 percent per year), while that for specialists increased by 37.5 percent (3.6 percent per year).

A 2006 report from the Center for Studying Health System Change reveals that from 1995 to 2003, inflation-adjusted income decreased by 7.1 percent for all physicians and by 10.2 percent for primary care physicians.

Essentially, we are promoters of higher cost specialty care when lower cost primary care is being overlooked and not rewarded. In fact, experience and studies are showing that primary care can deliver adequate quality health care in vastly more situations.

Primary Care Is At Risk of Collapse

The Primary Care component of the portfolio of health care providers is not doing well.

Fewer graduating medical students are seeking careers in primary care. In 2005, only four out of 100 University of Tennessee medical school graduates chose primary care careers according to Family Medicine Department Chair, J. Mack Worthington, M.D. Further, on average, only two of the four physicians entering the primary care arena will remain after 10 years of practice.

The New England Journal of Medicine reported, "The American College of Physicians recently warned that "primary care, the backbone of the nation's health care system, is at grave risk of collapse."

Yes, the great majority of patients prefer to seek initial care from a primary care physician rather than a specialist, but their unhappiness with their primary care experience is growing according to Wennberg. Patients are increasingly dissatisfied with their care and with the difficulty of gaining timely access to a primary care physician.

Compensating and Promoting Primary Care

We need to search for ways to reward and provide profit incentives for primary care providers to thrive and grow. With advances in accessing evidence-based medical guidelines on real-time systems, primary care providers can often rival and bypass the current state-of-the-art knowledge level of their specialty colleagues. Payors should have reimbursement systems to compensate and promote the use of these systems.

Reimbursement based primarily on the quantity of services delivered, rather than on quality, forces primary care physicians onto a treadmill, devaluing their professional work life. The short, rushed visits with overfilled agendas that cause patient dissatisfaction also breed frustration in physicians.

A growing number of patients report that they cannot schedule timely appointments with their physician. Emergency departments are overflowing with patients who do not have access to primary care. The majority of patients with diabetes, hypertension, and other chronic conditions do not receive adequate clinical care partly because half of all patients leave their office visits without having understood what the physician said.

Primary Care Providers as Heroes

Even as primary care spirals further into crisis, studies have demonstrated that a primary care-based health care system has the potential to reduce costs while maintaining quality.

The hospitalization rates for diagnoses that could be addressed in ambulatory care settings are higher in geographic areas where access to primary care physicians is more limited.

How TPAs and Self-Funded Employers Can Invest in & Promote Primary Care

There are several areas where the self-funded community could consider promoting primary care and encouraging providers to remain and thrive in the primary care arena. With each of these considerations, it is critically important to monitor health outcomes of the employee population to measure progress and identify key areas of concern.

The list below is not exhaustive and the considerations are not mutually exclusive. That is, a combination of considerations will often achieve the best results.

Better Payment Reimbursements for Primary Care Providers

- Pay primary care providers more; it will be a minor cost compared to the health plan costs. It can start the process to get the attention of key primary care providers to take a greater role in the self-funded plan.
- Pay based on population outcomes and shifts in improved health status.

CONTINUED ON **PAGE 34**

- Pay for e-mail consults between patient and primary care provider.
- Help primary care providers to use systems that access evidence-based medical guidelines as part of the process during the patient evaluation and management process.

While in its infancy, pay-for-performance (P4P) is growing in importance as a valuable means of paying providers and improving health. The various methods go beyond the scope of this article. Nevertheless, the P4P concept is consistent with the fundamentals of self-funding. That is, self-funding forces greater responsibility for management of plan assets. In a similar way, P4P forces greater responsibility for healthier outcomes.

The health care sector may reap a significantly positive return on investment by fostering a more effective primary care sector ...

Monitoring the clinic progress of the self-funded plan is important. The Health Risk Assessment is an important tool to report the health of the individual, but also measure the health of the population. Taking before and after "snap shots" of key clinical values will measure and define progress. Further, key areas of concern can be identified so that the self-funded employer can respond with plan design changes, adjustments mix and payments in provider networks, and most importantly, providing the individual employee a "report card" progress report of what is happening in their body. A well-designed Health Risk Assessment will help the individual relate lifestyle choices, taking medications, and following doctor's orders with changes in their personal values such as cholesterol, chemistry, liver, blood (serum and pressure values), and other clinic values.

Advances have also taken place with industry analysis tools and predictors such as those offered by Benefit Informatics, D2Hawkeye, Healthx, Ingenix, MEDai, and others. TPAs and self-funded employers must move beyond mere financial and utilization analysis and start monitoring overall health and clinical factors as well.

Plan Design Changes

- Redesign the PPO network to favor primary care providers.
- Redesign the employee incentives through reduced co-pays and deductibles that favor primary care providers

It is important to educate the employee/patient to understand that primary care providers can often meet treatment needs as well as specialty providers can. When an employee accesses the provider network online or via booklet or phone, the response should take inquiry opportunity to explain the benefits and offerings of primary care providers.

Employee co-pays and deductibles can be among the tools used to get the fastest response. Reducing co-pays and deductibles to increase access to primary care providers can be accomplished fairly easily with measurable results.

Onsite Medical Clinics

- Many self-funded employers are embracing onsite care, where a primary care physician becomes a trusted ally in providing care for employees and dependents.
- The onsite physician often becomes an advisor in addition to providing health care to employees and family members.

Onsite clinics are a consideration I favor and promote. While I have a vested interest, given that I own an onsite medical clinic, I strongly believe that onsite clinics produce results significantly beyond other initiatives. For example, measuring trend on a per employee per year (PEPY) basis, a self-funded county enjoys overall health care cost trend of less than two percent per year as the plans completes three years of having onsite clinics. Another self-funded organization experienced a PEPY health care cost decline. A self-funded printing firm in Wisconsin consistently runs $1,000 PEPY less than its business peers in the same area as reported in the Feb. 11, 2005, issue of the *Wall Street Journal*.

An onsite clinic is often the ideal environment for primary care providers to flourish by treating employees and dependents onsite. The areas of finances, operations, health and clinical outcomes, employee productivity and morale are being measured with favorable results.

Collaborate with Local Primary Care Physicians

- Develop a trusted relationship with a primary care physician to explore how primary care be access more by the health plan.
- Request the primary care physician to identify sources of educational material based on the key health concerns of the population.

- Use the primary care physician to work in concert with the disease/case management firm to help forge a more collaborative relationship between D/CM and other providers.

TPAs and self-funded plans who want to "touch the water before diving in" should consider forming a relationship with one or two primary care providers who currently treat employees covered under the plan. While all discussions will be mindful of HIPAA privacy and confidentiality, much can be explored in how to improve the perceived and delivered value of primary care providers.

Conclusion

The health care sector may reap a significantly positive return on investment by fostering a more effective primary care sector that will reduce health care costs and improve quality and patient satisfaction.

Ignoring the opportunities with primary care, we are subject to consequences of higher costs and lower quality as patients find themselves in a confusing, fragmented and over-specialized system in which no one physician accepts responsibility for their care, and no one physician is accountable to them for the quality of care provided. ■

Sources

New England Journal of Medicine, Volume 355:861-864, August 31, 2006. Primary Care—Will It Survive? Thomas Bodenheimer, M.D.

The Dartmouth Atlas Project run by Center for the Evaluative Clinical Sciences at Dartmouth Medical School. John Wennberg, MD.

"Crossing the Quality Chasm: A New Health System for the 21st Century" prepared by the Institute of Medicine (IOM).

This leaves durable goods, food, textiles and other services to decline from 53.7 percent to offset any projected increase in health expenditures.

Broader analysis and a more comprehensive macroeconomic model are necessary.

To gauge the implications of a large increase in the health expenditures share of GDP over thirty years, let's consider these trends collectively. NHE is currently 16 percent of GDP, but four percent of that is either governmental or investment and only 12 percent is in personal consumption. Then for NHE to increase from 16 percent to 28 percent, would mean personal health care consumption must increase from 12 percent to 24 percent. Based on the component trends previously discussed it doesn't seem unreasonable to assume that the expenditures including governmental, private investment, net balance of trade and fuel combined remain a constant percentage of GDP. Under this set of conditions, durable goods, food, textiles and other services must decline from 54 percent to 42 percent of total GDP. This is a decline of nearly one quarter. Is it reasonable to expect those components of personal consumption to experience a decline of that magnitude? It would seem a conceptual "stretch," when we see that collectively these components increased from 53.1 percent to 53.7 percent of GDP from 1996 to 2006 and have been increasing slightly but steadily from 1976 when they were 52.4 percent of GDP.

These are only some of the unanswered questions about any macroeconomic model that implicitly forecasts grand structural shocks to our economy as a result of health care trend. A macroeconomic model is needed because, health care trend clearly cannot be considered only in isolation. Broader analysis and a more comprehensive macroeconomic model are necessary to fully appreciate the reasonableness of health care trend rate projections.

NHE Components

NHE projections are made annually by CMS' actuary for eleven years into the future, and the latest projection released in 2007 projected expenditures for 2006–2016. The data is available in aggregate and per capita. The NHE projections are broken down by source of payment and by use of funds. The sources include individual out of pocket payments, private health insurance, other private funds, federal government and state/local government. These last two governmental sources include Medicare and Medicaid and these programs are also shown separately. Uses of NHE include governmental public health activity, program administration and investment in health care infrastructure. Excluding these uses, the majority of NHE are for personal health expenditures (PHE).

Using this data we can see the historical trend in PHE by source. For modeling, non-governmental plan sponsor trend, the payment sources of interest are private health insurance[2] (PHI) and individual out-of-pocket (OOP) payments (since deductibles and coinsurance out-of-pocket costs are a standard component of sponsor plan designs and both should be considered for purpose of gross health care cost trend). The latest CMS actuary's per capita projections for the sum of these two components increase at a 5.5 percent annual rate (from $1,546 and $701 for PHI and OOP, respectively in 2001 to $3,673 and $1,362 in 2016).[3]

Four years ago, when 2012 was the final year in the projection, per capita projected PHI in 2012 was $218 (seven percent) higher than they are in the latest projection. The projected per capita OOP in 2012 has similarly been revised downward over the last four years. Thus, retrospectively, it is evident that the CMS projections were conservative in assumed trend rates for these payment sources.

The NHE projections from the CMS actuary do not include projected Medicare and Medicaid expenditures on a per capita basis, however projected annual increases in aggregate expenditures for these programs between 2006[4] and 2016 is 7.7 percent. With expected growth in enrollment in the 2.0-2.2 percent range, the annual increase in per capita expenditures for these programs is in the neighborhood of 5.5 percent.

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[2] This includes self-funded plans.

[3] *http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf*

[4] Data prior to 2006 does not reflect the Part D program costs and is therefore not comparable to later periods for evaluating trend.

Other private funds (including charitable care) and other governmental programs including medical research expenditures, state child health insurance programs, subsidies to hospitals, etc. make up the balance of PHE. Overall, the CMS actuary projects per capita public expenditures to increase 6.8 percent during the last five years in the projection period, while per capita PHI increases 5.6 percent and OOP increases 4.8 percent over the same period. These projections reflect a continuation of the observed history of public expenditures per capita outpacing per capita privately paid expenditures.

History has shown and the actuaries at CMS project the future will continue to show that different components of PHE as well as NHE will trend at different rates. Any macroeconomic model which is designed for the purpose of projecting rates of increase in per capita private paid health care costs must account for the differences in components of NHE. Based on the historical data for NHE a model that attempts to forecast trend rates for all combined NHE will produce a trend rate that is too great to be used for projecting private paid per capita health care costs.

Summary

Not being an economist, I am left to wonder how to reconcile this data and these concerns with the new model from Professor Getzen. I will be the last person to argue that actuarial assumptions for short term and intermediate term health care trend rates in the past have been proven accurate. Fortunately, the issue that faces us as a profession today is what is reasonable as an assumption beyond 2008. So, before we leave the frying-pan for what may be a solution or simply the proverbial fire, let's carefully consider all aspects of the models and data available to the profession. With the help of economists and futurists, we as actuaries should continue to focus our efforts in this area. Only after such a rounded investigation, will we be able to move forward with confidence in our liability forecasting and valuation work.

Actuaries should reach out to economists and futurists to seek input in developing assumptions that can be used in a macroeconomic model to portray reasonably what the future might hold. A simple model that ignores other long-term trends and economic fundamentals will be inadequate and not advance the discussion of what is a reasonable assumption for long term health care cost trend rates. ■

Response

by Thomas E. Getzen,

The "Perspective" commentary by Wes Edwards on the Long-Term Health Care Cost Trends (Getzen) Resource Model raises two important points:

1) The impact of affordability (also called "sustainability" or "maximum share of GDP") on the overall economy

2) Growth of separate health care components (public/private; hospital/drugs): equal or not equal?

The ability of the nation to afford increasing health care costs displacing other kinds of spending has been raised repeatedly since the 1960s. Once it was felt that doom would befall corporate benefits managers and the federal government if health spending ever exceeded seven percent. Soon, the tipping point was raised to eight percent, and it has been subsequently pushed upward at intervals since then. After years of efforts to define and quantify "sustainability" with regard to medical cost growth, the Medicare trustees and their technical advisors finally concluded the task was not subject to scientific determination, (i.e., our certainty that some limit is fast approaching has been proven wrong so consistently over the prior four decades we don't even want to suggest that our answer is anything other than a "best guess") and thus what CMS and CBO should do was just to show that any projection of current trends led to untenable results—clarifying that at some point in the future some change would have to take place without specifying when or how.

During an interactive SOA webcast about the model held online in April 2008, a quick poll was conducted of the actuaries who attended (about

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100) regarding their beliefs about likely magnitudes of future spending, with the following result:

Q2: What do you expect total spending on health care as a percentage of the U.S. economy to be in 2050 (42 years from now)?
(SOA webcast poll April 2008, n= 58)

less than 15%	0%
15% - 25%	41%
26% - 35%	52%
36% - 45%	5%
above 45%	2%

One should not read too much into this informal and unscientific poll of actuaries, but it is apparent that the "average" and range is pretty much in line with the beliefs of medical experts, health economists, budget analysts and others who have some professional interest and experience in the question. Note that only 58 actuaries were willing to provide an answer to this question, while over ninety answered the other two questions posed during the webcast—indicative perhaps of the extraordinary degree of uncertainty involved in trying to answer this basic question.

The total tax revenues for the U.S. tend to stick around 20 percent, and this would seem to make it difficult to allow Medicare and Medicaid to continue to increase at the rate of private health insurance. Thus, more spending would be shifted to private payers as happened during the implementation of BBA 1997.

In short, we do not know what amount of medical spending is affordable or "sustainable" in the long run, except that it is a) a lot more than any professional would have said 30 years ago and b) something less than 100 percent. None of us is entirely comfortable with such uncertainty, but we may just have to live with it (and help our clients adjust to the reality of uncertainty) despite the demands for accountability posed by FASB 106 and GASB 43 & 45. What the Long-Term Health Care Cost Trend (Getzen) Resource Model does is to 1) accept that some limit or resistance is likely 2) provide a baseline estimate that can be modified under a range of assumptions 3) provide a means for a user to change the limits on growth and (perhaps most importantly) 4) make that process of "limiting" the model fully transparent.

The question of whether some components of medical spending will rise more or less rapidly than others arises repeatedly, most saliently with regard to whether a separate trend should be estimated by age group. Although for many decades per capita spending grew relatively more rapidly for the elderly, this excess growth appears to be mostly due to the implementation of Medicare, so that rates of growth for both young and old are about the same over the last decade, with some indications pointing toward relatively slower growth among the oldest old in the future. Thus, for the purposes of the Long-Term Health Care Cost Trend (Getzen) Resource Model, it was assumed that the relative growth rates would be approximately the same over the long run (the biggest disparity lies in the field of Nursing Home and LTC costs, which are a bit ambiguous with regard to placement among private employer health insurance benefits projections).

Edwards raises the disparity between public and private health spending growth as a particular concern, and I would agree, although I think that rates of increases for public spending are more likely to fall behind, rather than exceed, those for private spending as he suggests. In the past, periods of relative more rapid public (private) spending growth have alternated—comparison of the 1960s with the 1990s is quite instructive in this regard. For most of the last 40 years employer insurance premium growth has exceeded growth in out-of-pocket spending and overall NHE growth, primarily due to coverage expansions. This expansionary trend seems to have run its course and is perhaps even now being reversed with higher copays, employee premium contributions, HSAs, etc. Periods of sluggish growth in pharmaceutical spending have usually been preceded and followed by periods of more rapid growth in that component. What we observe overall is that the total health spending per capita (which is axiomatically equal to the total funding stream for the U.S. health system with its varied hospitals, physicians, technicians, pharmaceutical companies–and insurers) grows much more steadily than any particular component. This is true not just of health care, but of most categories of consumer spending (e.g., the relative growth of spending for food is much more constant than of any particular component such as fresh vegetables, lamb or garlic). The reason that I suspect public spending may grow relatively less rapidly than private spending has to do with the "crowding out" concerns that Edwards raised with regard to share of GDP. The total tax revenues for the U.S. tend to stick around 20 percent, and this would seem to make it difficult to allow Medicare and Medicaid to continue to increase at the rate of private health insurance. Thus, more spending would be shifted to private payers as happened during the implementation of BBA 1997. Of course, we are speaking as if we had a good set of expectations about future government budgets, and most of us are quite unsure if the aftermath of the 2008 election will be a) more privatiza-

tion b) more government control or c) continued muddling through with about the same policy confusions as before. Given the degree of uncertainty with regard to the next two years, a bit of humility is called for in making projections about budgetary pressures and outcomes over the next five decades.

I want to thank Mr. Edwards for his thoughtful comments on the Long-Term Health Care Cost Trends (Getzen) Resource Model and the efforts of our working group, and to suggest that we are going to have to live with much more uncertainty than any us, or our clients, are truly comfortable with. Thus it is incumbent upon actuaries to work creatively with clients to understand the implications of uncertainty and craft creative solutions based upon a range of possibilities, and to accept that the only way to get a perfect estimate of future medical costs trends is to wait until it no longer matters. ■

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Navigating New Horizons | FROM PAGE 9

Juggling work and life

Of course advancement means more responsibility and less time for everything else. Rosenblatt said balancing her career with that of her husband presented challenges at times, the hours were long and finding time to engage in recreational activities was almost unheard of.

"High aspirations are possible, but it's going to require a lot of work and I think there are tradeoffs," she said. "I didn't watch TV for years and years. I know some women juggle family life with a high-powered career and I think it's possible to do that. It's probably even harder than what I did without having children. So there are always risks to take and rewards to get and you need to put in a lot of effort if you want to succeed."

Now that she has retired, Rosenblatt said she has a new feeling about time. She and her husband are building a new house in a golf community and she has been working on her game.

"I'm playing golf almost every day," she said. "I'm also spending more time working out and just relaxing, enjoying myself and having a whole new view of time. I suddenly have time to just sit and watch TV if I want to!"

The couple also has two dogs, a cockatoo and a 20-year-old parrot to take care of and spend time with.

Making a Difference

Reflecting upon her career, Rosenblatt said it was very rewarding for reasons that go a lot deeper than just earning a salary.

"I do think health insurance plays a very important part in the lives of a lot of people, including my own," she said. "I'm a breast cancer survivor and I really appreciated the health insurance that I had when I was going through treatment for the disease. It was comforting to not have to worry about the financial impact of treatment decisions and knowing I was covered for chemotherapy and radiation treatments."

Rosenblatt said she believes the insurance industry is striving to improve health care in this country.

"I think they get a bad wrap politically by some, but they're doing good work," she said. "Health insurance companies are trying to figure out how they can help the consumer make good choices to get quality care." ■

MTYH 2: Reinsurers Are Key Partners

Myth Promulgators

Intermediaries, Issuing Insurer Executives, Reinsurers

The Reality

- A few reinsurers efficiently provide specialized services like transplant centers, network discount analysis and administrative functions by spreading the cost over a large client base.
- Although the stop loss claims tail is relatively short, reinsurers tend to move off MGU based programs quickly and also leave stop loss entirely.
- Reinsurers may abuse the spirit behind a 90 day termination clause by always providing provisional termination notice.
- Key persons often move from one reinsurer to another, so personal history and reputation is important.

Resulting Problems

- Accident and health is often considered a minor line for reinsurers, so senior management is often unfamiliar with the product, and likely to get out of the market without much concern for staff or clients.
- Most reinsurers only have a contractual relationship with the issuing company and not the MGU who does the rating.
- Typical reinsurance contracts are only for a treaty year, and are renewed without even a single month's completed contract year for the contract period.
- Issuing carriers prefer to reduce their risk exposure by taking a sizeable fronting fee but minimal risk.

A Solution—Issuing Carriers Need to Take the Majority of Risk

Issuing carriers should be prepared to take up to 50 percent of the risk, and even go for periods of time without any quota share reinsurance, otherwise their MGU market could disappear. MGUs, especially large ones, need to affiliate with insurers that can take sizeable risks and have a longer term risk horizon.

Commentary

It is risky to rely on a reinsurer that has not been in the stop loss market through an underwriting cycle (five to six years). Make sure the lead reinsurer contact is knowledgeable in stop loss, and become familiar with the decision-makers. Reinsurers or issuing companies taking a large portion of the risk should retain the right to review and approve final underwriting on every case. With that right, they should be willing to commit to a longer-term risk horizon (at least two years) and a six-month termination notice requirement.

Many firms fail to tie manual rates back to their experience before implementing them.

MYTH 3: The Relationship of Quoted Rates to Manual is the Key to Profitability

Myth Promulgators

Unsophisticated Reinsurers, Actuarial Consultants, Stop Loss Auditing Firms

The Reality

- The most important factor in rating is determining the true underlying claim cost.
- Manual rates can be manipulated by underwriters, especially on industry factors and network assumptions.
- Providers of manual rates are often secretive as to their sources of data.
- Many firms fail to tie manual rates back to their experience before implementing them.
- Reinsurers and MGUs often combine several rate manuals for their own unique blend.
- Surveys of manual rates don't seem to reflect real quotes and in-force rates.
- Reinsurers may forbid quoting below a figure such as 85 percent of approved manual rates.

Table 1: Analysis of Stop Loss Block Based on Manual and Experience Rated Rates

						Current Year Results (In 1,000s)					Three Year Results (In 1,000s)		
						Gross Premiums				Claims	Gross Premiums		Claims
Industry		Ees	Adult Units	Spec Level	EAF	EAF Renewal Trended	Manual Renewal Trended	Actual Renewal Trended	Current Premium	Current Yr. Actual Claims	EAF Renewal Est. Adj. Premium	Renewal Est. Adj. Premium	Total Claims
Clinic	(a)	285	458	60	1.70	$658.8	$387.5	$279.6	$271.2	$479.0	$1,527.0	$648.1	$809.3
VoTec Clg.	(b)	56	78	25	1.45	$131.7	$90.8	$72.3	$82.2	$150.4	$320.6	$176.0	$183.9
Mfg-Pckg	(c)	263	495	75	2.21	$566.9	$256.5	$184.1	$267.5	$327.2	$1,732.6	$562.6	$1,199.7
Mfg-Svcs	(d)*	335	749	75	0.80	$264.2	$330.3	$223.9	$236.6	$78.3	$814.7	$630.2	$459.7
Retail	(e)*	44	76	30	1.35	$129.3	$95.8	$122.1	$143.9	$29.9	$530.4	$501.0	$322.8
Hospital	(f)*	743	1,323	150	1.45	$637.1	$439.4	$173.6	$245.7	$557.3	$1,738.9	$474.0	$1,284.2
Mfg-Svcs	(g)	199	327	60	0.55	$124.0	$225.5	$128.4	$137.8	$61.5	$531.3	$515.0	$62.5
Bank	(h)	331	586	75	1.22	$475.6	$389.8	$185.4	$222.1	$422.3	$1,185.6	$462.3	$1,025.9
School	(i)	1,208	2,332	150	1.20	$814.4	$678.7	$495.2	$388.8	$859.2	$2,479.9	$1,423.4	$2,170.2
Retail	(j)	1,400	2,590	175	0.55	$322.3	$586.0	$242.2	$383.9	$0.0	$774.6	$582.0	$1,311.0
Total		4,864				$4,124.4	$3,480.3	$2,106.8	$2,379.9	$2,965.1	$11,635.7	$5,974.6	$8,829.2
Average		486.4				$412.4	$348.0	$210.7	$238.0	$296.5			
All Groups													
Est. Net Premium Avail for Claims & Profit						$2,929.2	$2,471.8	$1,496.3	$1,690.3		$8,264.0	$4,243.3	
Net Incurred Loss Ratio						101%	120%	198%	175%	$2,965.1	107%	208%	$8,829.2
*EAF Competitive Groups (d,e,g)													
Est. Net Premium Avail for Claims & Profit						$367.6		$336.9	$368.2		$1,332.7	$1,169.2	
Net Incurred Loss Ratio						46%		50%	46%	$169.7	63%	72%	$845.0
Remaining Groups													
Est. Net Premium Avail for Claims & Profit						$2,561.7		$1,159.4	$1,322.1		$6,931.3	$3,074.1	
Net Incurred Loss Ratio						109%		241%	211%	$2,795.4	115%	260%	$7,984.2

Resulting Problems

- Manual rates will usually be too high or too low for actual groups. If they are too low, writing the business will generate losses that could lead to higher rates and a death spiral. If they are too high, you may be letting your competitors pick off the better risks.

- Manual rates are usually not provided in a format that helps in analyzing the underlying risk—they do not provide an expected number of claims.

- Underwriters often are skeptical of manual rates and have difficulty selling significantly higher rates, especially if a group has good experience or no ongoing claims.

A Solution—
Re-Rate Based on Experience Analysis

The best way to maintain profitability is to independently re-rate a large proportion of business shortly after or just before it is written. Never quote without reviewing experience and modify the manual rate based on experience.

Commentary

Table 1 summarizes results of an analysis of actual groups that renewed in 2007 for a respected TPA. "EAF" stands for Experience Adjustment Factor and represents the ratio of the "true" rate deemed appropriate for a risk based on experience rating to the manual rate, which reflects demographics, area, industry and network. Under "Current Year Results," gross premiums for the renewal period are trended back to the midpoint of the current year on four bases: EAF, manual, sold renewal and actual premiums for the year. The fifth column shows the actual claims for that year. I also show the EAF based premium trended back for three years and the actual renewal rates sold trended back and compare them to total stop loss claims for the three years.

The EAF approach would have been competitive on three of the 10 groups and the loss ratios for the current year and the past three years on those three groups was very good. What is alarming is the reality of actual stop loss pricing where, despite losses in the current year and over three years, the renewal premiums overall actually decreased. The actual renewal rates sold

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in 2007, if trended back for the last three years, would have generated a 208 percent net loss ratio (claims divided by gross premium less expenses). Also, note that for two of the three EAF rated groups that are competitive, (d and g) the EAF is below what would often be allowed by reinsurers relative to manual.

MYTH 4: Competition Keeps Compensation to TPAs / Brokers and MGUs Reasonable

Myth Promulgators

Reinsurers, Employers

The Reality

- Almost all compensation is expressed as a flat percentage of premiums.
- MGUs compete for TPAs with TPAs focused on getting the highest percentage commission possible.
- A significant amount of underwriting effort is spent providing quotes on prospects with poor close ratios.
- Renewals are relatively easy to keep because of the last look process, except during aggressive pricing portions of the underwriting/ rating cycle.
- Reinsurers will try to improve loss ratios by reducing allowed compensation to MGUs and possibly TPA/brokers but it seldom lasts.

Resulting Problems

- Stop loss commissions to TPAs often exceed administration fees for smaller groups.

Table 2: Typical Expense Levels and an Alternate Approach

		Typical Levels		Alternative Approach		
Payee	Based On	High	Low	%	Fixed	Fixed Payout Based On
Risk Charge	Expected Claims	15.0%	10.0%	8.0%	$3,000	Add in to Claims
Lead Reinsurer & Int.	Net Premiums	3.0%	1.5%	2.0%	$0	Load in Net Premiums
Issuing Carrier-Pr. Tax	Gross Premiums	2.5%	2.5%	2.5%		Actual State Tax and Assessments
Issuing Carrier-Other	Gross Premiums	5.0%	3.5%	2.0%	$1,000	For Audit and Compliance Costs
MGU	Gross Premiums	12.0%	8.0%	5.0%	$4,000	$4,000 at Policy Issue
TPA/Broker	Gross Premiums	15.0%	10.0%	5.0%	$6,000	$3,000 at Issue, $3,000 at Renewal
		34.5%	24.0%	14.5%	$11,000	
Total Load Factor to Expected Claims*		1.810	1.469	*1.289*	*Incremental Factor, see below for total based on premium size*	

Alternative Approach Average Non-Risk Takers Fees at Different Gross Premium Levels				
	$ 60,000	$ 120,000	$ 200,000	$ 300,000
Issuing Carrier-Premium Tax	2.5%	2.5%	2.5%	2.5%
Issuing Carrier-Other	3.7%	2.8%	2.5%	2.3%
MGU	11.7%	8.3%	7.0%	6.3%
TPA/Broker	15.0%	10.0%	8.0%	7.0%
Non-Risk Takers Expense	32.8%	23.7%	20.0%	18.2%
Total Load Factor to Expected Claims*	1.775	1.493	1.404	1.363

Comparison of Alternative Approach to Typical Fee Levels				
Gross Premium	$ 60,000	$ 120,000	$ 200,000	$ 300,000
Net Premium to Risk Takers	39,510	89,804	156,863	240,686
Expected Claims	33,805	80,374	142,466	220,080
Premium at High Fees	61,189	145,479	257,866	398,350
Premium at Low Fees	49,674	118,102	209,340	323,387
Ratio of High Fees to Alternate	1.02	1.21	1.29	1.33
Ratio of Low Fees to Alternate	0.83	0.98	1.05	1.08

*Includes reinsurance and risk charge

- The level of fees adds dramatically to the cost of the self-funded plan for employers with less than 500 employees, and especially under 200 employees.
- Employers are generally unaware of the total compensation paid and how much of the premium is available for claims and the risk takers' profits.
- Smart employers should try to minimize premiums with specific corridors, which are also difficult to rate.
- TPA stop loss business has significantly higher expenses than carrier ASO business.

A Solution – Move to a Graded Fee Schedule, Possibly Using a Fixed Fee Plus Lower Percentage

Graded compensation arrangements based on a group's premium would better align the interests of all parties and improve competitiveness. TPAs and brokers must be held more accountable for cost levels on their blocks of business. Underwriting must become more efficient, perhaps MGUs should even charge for new business quotes.

Commentary

Many actual expenses per group in stop loss are relatively constant. As a result, a fixed-cost component works well to get more compensation on low premium groups and then a lower percentage keeps premium levels more competitive for groups with high premiums. In addition, the fixed fee component could be paid to encourage certain behavior that is desired. Profit commissions are complicated and generally discounted by affected parties so not covered here.

Table 2 shows some typical loads that may be common at different points in the underwriting cycle. The problem is the total load factor at "high" levels or on large premium groups is too high to expect to sell profitably. An alternative approach, grades down the overall fees as a percent of premium for the larger premium groups. This approach makes it more likely to sell larger groups on a profitable basis, although compensation is less.

MYTH 5: Specific Stop Loss Experience is Generally Not Credible

Myth Promulgators

Actuaries, Reinsurers

The Reality

- Many underwriters use experience rating, but primarily only on "really bad" groups.
- Few MGUs and reinsurers know the basis of the manual rates being used or how good the underlying data and assumptions are that go into building rate tables.
- There are many more factors affecting the risk than are reflected in manual rates.
- Risks are always evolving—hospital charges, network discounts by claim band, treatments, and new diseases.
- Many actuaries want over 25 claims before believing experience, and prefer hundreds.

Resulting Problems

- Homogenous risks are an illusion – for example, although many law firms run "bad," experience rating can uncover "good" ones.
- Manual rates don't provide tools needed to unlock important information provided in the experience.
- Manual rates are not tied in to in force experience and experience on prospective business.
- Manual rates generally fail to provide an expected number of claims.
- Grouping data for more "credibility" may hide key risk variances that should be noted, rather than hidden.

A Solution – Experience Rate Based on Claim Tiers

Relatively few claims can tell an underwriting actuary a lot about the underlying risk. Rather than assuming the manual expected claims are right, my recommended approach is to focus on what the actual claims would suggest as to the appropriateness of the manual rates. Experience

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Many underwriters use experience rating, but primarily only on "really bad" groups.

The Fifth Inning:

The Yankees gives up another home run, and the Sox are up 6-3.

As manager, you can choose:

A) To put in the rookie pitcher that shows promise and is eager to play, or

B) To send the pitching coach to the mound to meet and encourage the existing pitcher to finish the inning.

If based on what you thought might happen you chose B and stayed with the experience, the Red Sox got two more and are now up 8-3. You then bring in the rookie pitcher who takes over and ends the inning.

Make the right calls:

- Have good assumptions. What if you'd have chosen A? If you had chosen A, your score would still be 6-3. Having good assumptions will improve your margins. Most games are won or lost on the margin.
- Use data and experience to make informed decisions, and you'll improve margins.
- Was your trip to the mound merely to pass some time to get the next pitcher warmed up for action? Make sure your meetings aren't simply to pass time.
- Replace a product or person who isn't performing, especially if coaching and improvement plans don't work.
- Make sure to give opportunities to new employees. They'll get better and improve the whole team.

The Sixth Inning:

The Yankees get some close calls on patient hitting and load the bases on three walks with two outs. A-Rod (Alex Rodriguez) hits a clutch full-count double to right that lands inches short of a grand slam. The inning ends with an 8-5 Red Sox lead.

Does A-Rod's multi-season MVP make him worth his very expensive contract if the Yankees win?

- Are you willing to make an expensive investment if it will improve the quality of the customer's experience and improve your chances of winning the business?
- When your bases are loaded do you score a lot of runs or strike out?
- When the count is full, is it better to put it all on the line and go for the homer, or take a little off the swing and more consistently get doubles?
- Do you want homer-strikeout volatility or the stability of base hit after base hit? Does the score influence your answer? Is it more important to take a greater swing when you are behind and inch your rates for greater stability while in the lead?
- Do you win big contracts with expensive customized solutions, or do you play small ball and package the right combination of hits for your markets?

The Seventh Inning:

The Yankee rookie impresses the crowd and leaves three runners stranded in a scoreless inning. God Bless America. Beer sales end, and in its place we buy some more peanuts and cracker jacks.

The Yankees score one run to make it 8-6 and trail by two. Boston replaces Schilling and televisions in Japan tune in as Okajima, another of Boston's talented Japanese pitchers, secures the final out.

The takeaways:

- After a long stretch, fresh health insurance products will maximize performance.
- Sales and offerings should differ for groups with different risks.
- Value diversity in your employees and customers.

Eighth Inning:

Ellsbury leads off with a single. Given the sign to go, this time he successfully steals second base. He advances to third on a grounder to second and a sacrifice fly sends him home. Ortiz bats next and smacks one that ricochets off the center field wall. He's waved to second base but is too slow and is thrown out easily. Another impressive pitching inning by the Red Sox ends the inning 9-6.

The ball is in your field:

- Even if your first attempt doesn't succeed, keep taking calculated risks when chances are in your favor and eventually you'll succeed.
- Even when your outings don't appear to be very successful, your efforts may be productive and put you in the right direction to improve margins in the future. For example, even if you are beat by the competition on one sale, the relationships built may improve opportunities for a future sale.
- Pay attention to the signs and changes in the market. If you can move quickly and see how the ball is going to bounce next, it will improve your chances of success.
- If the next step is not likely to be successful, it may be better to stop and evaluate before continuing in a new direction but, once committed, don't hesitate. He who hesitates is out.
- Know your capabilities and the capability of your team, and you'll make better decisions.

Top of the Ninth:

The Red Sox come up empty and the score remains at 9-6, as we head to the last of the ninth.

Bottom of the 9th:

The Red Sox put in Jonathon Papelbon, their closer. He dances onto the field with deep concentration, confidence and conviction. Papelbon starts the inning by striking out Cano and Cabrera for the first two outs. It starts to rain but all fans stay to cheer on their Yankees. Jeter then connects and drives the ball out of the park making it 9-7 Red Sox. However, Papelbon bears down, wipes the wet from his face and, after fouling off six pitches, Abreu flies out to end the game. Red Sox win 9-7!

Even though the Red Sox won, experience shows us that:

- If you play hard and put up a good bid, you will win your fair share though you won't win every time. Even the best teams don't win every game. Be ready to come back strong for the next opportunity.
- Come in with a good lead and you'll improve your chances of winning.
- Play your hardest in all conditions.
- Concentration and conviction will lead to successful results.

Post Game Analysis:

If you had made the decision to replace the Yankee pitcher in the fifth inning, the game would still be tied. Your decisions determine how your game ends. Even small decisions can have a big impact. Injuries happen, but it's not an excuse for losing. Perhaps risk management professionals are needed for the Yankees. Past success doesn't guarantee future success. Make investments in top talent. Notice what works and what doesn't work and fix what isn't working. It only takes a one run margin to win a game. Winning by a 15-run margin and then losing the next three by a one-run margin is only one for four. Have fun, and enjoy the process. If your team is having fun, it will attract more fans and make everyone's life more enjoyable.

Post Season Analysis:

Baseball has had a lot of coverage around performance-enhancing drugs. Health insurance companies also have issues relating to drugs and coverage. Decisions on these issues affect lives and profit and need to be carefully considered to meet constituent needs.

The Yankees and Red Sox have been around a long time, but the times are always changing. Good teams anticipate the changes and adapt to the new situations. For example, the Yankees own the YES television network and their television contracts allow them to compete at a higher level and dominate the market. Similarly, health carriers can dominate and "own" the network in a region and dominate with higher margins and a competitive edge. As the health care industry changes in America, health insurers will need to continue to change and adapt for long-term success.

The Yankees, and recently the Red Sox, spend more money than any other team for their players. Does this mean they have the best team? The answer is yes. Before you boo me and have all your co-workers (or perhaps your family) wondering why you are making funny noises, let me explain:

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While the Yankees don't win every year or every game, they are consistently one of the best teams in baseball. If you don't yet agree, look at the long-run profitability of the franchise as an indicator of success. The Yankees are the clear winners.

Isn't long-run profitability also the goal of most insurance businesses?

The Yankees and Red Sox

- Invest in the most talented people.
- Offer a competitive product to attract fans.
- Win in the market and make fewer errors than most of their competitors.
- Find new management when they aren't winning championships.
- Sell out every game with huge demand for their product.
- Train and believe in their young players who show promising results.
- Combine good pitching with superb hitting to win games and championships.
- Use statistical analysis and scouting to make better data-driven decisions.
- Overcome obstacles and setbacks and prepare for the upcoming road trip.
- Value diversity in their players and fans, and
- Have fun and celebrate their successes.

Shouldn't we do the same in health insurance... and life? ■

rating unlocks true characteristics of a block as shown under Myth 3.

Commentary

From reviewing thousands of groups, I have developed an approach to applying credibility based on very few claims. Suppose you were looking at experience at a certain level, and over the past three years your manual basis would have expected 5.50 claims. However, there were actually only two. Some actuaries might consider a distribution like Poisson and think –there is a 10 percent likelihood that with 5.50 claims expected there would only be two or fewer claims so maybe they were just lucky. However, knowing the assumptions in developing manual rates and significant factors that are not reflected, with only two claims, I'd suggest it may not be reasonable to assume that 5.50 is the true underlying claim number. Therefore, I would look for an expected claim number, such as 3.63, that is more likely to have only two claims occur. Under this approach, the lowest experience adjustment factor (EAF) to consider using for rating would be .66 (3.63/5.50). Although only one consideration in rating, it does provide a statistical basis to vary rates from manual. Another important use of expected and actual claims is to look for areas where manual rates should be adjusted for future rating cycles (i.e., if several groups with one network all had significantly better than expected actual claims then probably the network factor should be lowered).

Conclusion

Stop loss is an exciting and challenging specialty area in health. I encourage more actuaries to take a close look at the underwriting side and review real case files. The experience may be insightful and you may draw some interesting conclusions. Enjoy! ■

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