SOCIETY OF ACTUARIES Health Section

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Health Watch

Behind Clinical Integration

by Steve Tutewohl

Clinical integration is a term that is thrown around a lot these days. It is not a new concept, but health care reform and the Health Information Technology for Economic and Clinical Health (HITECH) Act have made clinical integration a household term. We all can conceptually understand what clinical integration means and why there is value in it, but yet the specifics are fuzzy for most of us.

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What Does It Mean?

The Department of Justice and the Federal Trade Commission have stated that clinical integration can be evidenced by a network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.[1] They expanded on their definition and provided these four signs of clinical integration. [2]

- Use of common information technology to ensure exchange of all relevant patient data
- Development and adoption of clinical protocols
- Care review based on implementation of protocols
- Mechanisms to ensure adherence to protocols

[1] "Statements of Antitrust Enforcement in Health Care," Department of Justice and Federal Trade Commission, August 1996

[2] "Improving Health Care: A Dose of Competition," Department of Justice and Federal Trade Commission, July 2004

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Untapped Opportunities for Actuaries in Health

by Susan Pantely

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Earlier this year, actuary was ranked as the number one job in America according to a widely publicized study for CareerCast.com. The study attempted to rank 200 jobs by measuring environment, income, hiring outlook, physical demands and stress. Despite being ranked number one, it is hard not to feel complacent given the high unemployment rate, uncertain economy, and the still unresolved outcome of health care reform efforts.

The health care industry continues to thrive. Employment in the health care industry is poised to grow another 30 percent in the next 10 years. However, the actuarial profession may need additional skills or visibility to be considered for many of the emerging opportunities.

With this in mind, the SOA Board of Directors voted to focus on four priorities that should be explored in order to determine where SOA resources could provide value to its membership. They are:

1. Create recommended paths for credentialed actuaries to transition to the health practice area.
2. Create or recommend courses of study or on-the-job experiences for health actuaries to compete effectively in new and traditional markets.
3. Sponsor original research to support penetration into new markets.
4. Ensure SOA basic education responds to changing (i.e., health opportunities) market needs.

The complete market research report will be available to SOA members in May 2010. For more detail on the market research, see Sara Teppema's article later in this issue of *Health Watch*. Following are some highlights.

The market research concluded that opportunities exist for actuaries in many industry segments. Analytics and data experts are needed in wellness/disease management companies, clinical outcomes and studies, health plans and pharmacy benefit management companies, and health care management consulting.

The need for business skills, such as strategic thinking, communication, and adaptability to change, was consistently mentioned. The barriers most often mentioned were lack of clinical background and lack of knowledge related to study design and health policy.

The market research found that familiarity with actuaries is limited in much of the health industry. However, those respondents familiar with actuaries had a high opinion of their value. Additionally, most hiring managers indicated they looked for previous health care industry experience when considering candidates.

Most respondents considered actuaries to have a neutral and objective voice. The respondents also viewed actuaries as highly trained in data and modeling. However, there may be valuable educational opportunities related to clinical knowledge and other advanced modeling techniques that could broaden opportunities for health actuaries. Based on the limited familiarity with actuaries in the health industry, the actuarial brand needs to be strengthened.

The next steps include:

- A plan for branding to the broader health industry,
- exploring research opportunities,
- changes to educational programs including consideration of business skills education, and
- exploring affiliations with other organizations, including potential research opportunities.

We are eager to use this market research to advance our profession through new education and research opportunities for health actuaries. We encourage you to reach out to any of the Health Section Council members listed on the masthead of this issue of *Health Watch* if you have thoughts or suggestions regarding the future of actuaries in the health industry. ■

Letter from the Editor

by Mary van der Heijde

I am sure we all relate to this situation: someone asks me what I do for a living, I respond that I am an actuary, and am met with a blank stare. Despite the actuarial profession often being ranked as the #1 job in the country, many folks simply don't know what we do. However, this is changing. What an interesting evolution, from those within my own extended family not knowing what an actuary is, to major news outlets interviewing actuaries or making reference to actuaries in prime time. Health care reform has clarified the need for the understanding and measurement of risks, and it is exciting to see how this new focus has increased awareness of the role of the actuary.

As evidenced by the wide spectrum of topics contained in this issue, the role of the actuary has become increasingly broad. As our roles continue to expand, it strikes me that in many ways we are moving from being those who merely measure and forecast risk, to those who help design creative approaches to mitigate the risk in the first place. You can't manage what you can't measure, and in developing improved approaches to measuring risk, we are increasing the value of the actuary in managing risk.

In this issue, Steve Tutewohl's article offers helpful background about what clinical integration is, why it is important, and how to measure its value. We have included part one of a two part series by Steve Melek, about the new requirements of mental health parity. Part one includes the logistics and implementation details to comply with new parity requirements. Part two will appear in the next issue, and will focus on understanding how these rules could impact business decisions going forward.

Max Rudolph provides a follow-up piece to the enterprise risk management features in the last issue, and John Cameron conveys information about health risk assessments within the limitations of the new Genetic Information Nondiscrimination Act (GINA). Troy Filipek's article provides great insight into the notable changes in the market for and use of generic drugs.

This issue's Navigating New Horizons feature focuses on Jeff Miller, and how his entrepreneurial spirit has guided his actuarial career. As well, Carolyn Young shares her non-traditional role at Independence Blue Cross, and some of the exciting new areas in which she is involved.

I would like to introduce the new members of the Health Watch editorial board: Karin Swenson-Moore, Pat Kinney, and Jeff Miller. We are fortunate to have their additional vision and input.

We hope you enjoy this issue of Health Watch, and encourage you to contact us with your thoughts and opinions. ■

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The key to clinical integration is measuring clinical performance objectively.

Why Do It?

A logical question is why are the Department of Justice and Federal Trade Commission commenting on clinical integration. Intuitively clinical integration is about quality, but there are two main reasons for becoming clinically integrated.

- Improve quality, safety and efficiency of patient care
- Leverage clinical integration when negotiating with payors and in reimbursement strategies

The impacts on quality and efficiency have been well documented. They include, but are not limited to,

- Better chronic disease management
- Reduced adverse drug events
- Reduced medical errors
- Increased adherence to evidence based medicine and preventative care
- Reduced misuse of services
- Better coordination of care across providers

Because the FTC believed strongly in the possibility of improved quality, safety, and efficiency they created an incentive for practices to become clinically integrated. In 1982 in the case of Arizona v. Maricopa County Medical Society, the Supreme Court ruled that physicians in independent practices are supposed to compete. When they don't compete, by collectively setting the prices at which they sell their individual services, they can be guilty of illegal price fixing. The FTC has clarified that joint contracting and negotiation of fees is permitted for organized provider groups (IPAs/PHOs) only under the following two circumstances.

- The providers have at least 15 percent of their fees at risk
- The providers are clinically integrated

For provider groups that don't meet the criteria, a messenger model must be utilized in fee schedule negotiation. In this model each individual physician must review and either accept or refuse the proposed fee schedule independently. For groups that do meet the criteria, the collective group can negotiate with the payor thus greatly increasing their leverage.

As a collective group, the providers can push for higher fee schedules and they can work with the payor to design pay-for-performance incentives that build off the data they are tracking with their clinical integration program. The later is an appealing option for all parties because it creates a direct monetary incentive to support the quality initiatives that the provider group has defined as important to them. The quality initiatives will theoretically provide better patient care at a lower cost thus aligning the incentives of the providers and the payors.

How to Create the Database?

The key to clinical integration is measuring clinical performance objectively. This cannot be done without various forms of data. Access to the required data can be difficult. Many believe that the only way to become clinically integrated is through a full Electronic Medical Record (EMR) solution. There are actually multiple ways to create the database necessary to become clinically integrated and each has its pros and cons. They vary greatly in cost and complexity, time to implementation, impact on physician offices, and the scale of the data integration. The objectives and resources of the provider organization should determine the approach taken.

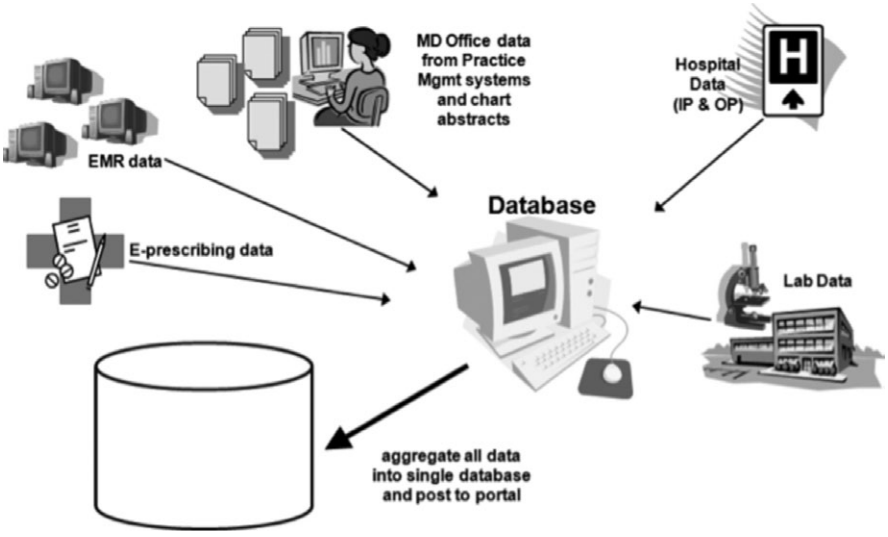
Approach	From Payors	As Payor	EMR	Health Information Exchange	Practice Management Systems	Paper Medical Record
Timing	6 months	6 months	Years	Years	6 months	6 months
Cost	Inexpensive - ~$250K/yr	Inexpensive - ~250K/yr	Very Expensive - Millions	Very Expensive - Millions	Moderate – ~ $80-$120/physician/month	Cheap to moderate - ~$300-400K/yr
Physician office Effort	Almost no effort	Almost no effort	Extensive set up time	Set up time	Almost no effort	Significant effort
Magnitude of Data	Limited to Payor's data	Limited to Payor's data	Most extensive	Extensive	Extensive	Sampling

The first two options are to work with the payors (either independently or as provider sponsored payor) to acquire the data. While these options are quick, inexpensive, and put little burden on the physicians, it is limited to data only from the payors that participate. The EMR solution is the Cadillac version that clinically integrates as well as provides a point of care tool that contains patient information and practice protocols at the hands of the physicians. However, the cost, implementation time, and burden on physicians are significant. A Health Information Exchange is an organized effort across providers and payers to collect data for an entire region. While this approach can be the most comprehensive, it is very difficult to coordinate and implement. Pulling data from the Practice Management Systems is challenging because a large provider organization will likely have many different Practice Management Systems and programs must be written for each to pull the data. The last option is to build the database manually with data samples. The lack of data robustness is a critical issue with this approach.

An End-to-End Example

A Midwestern PHO with approximately 500 physician members implemented a clinical integration solution. The database was created by combining data from 25 different physician practice management systems, their hospital data, and lab data (Quest and Labcorp). This approach exceeds the requirements of clinical integration, at a reasonable cost, puts no burden on the physician office, and has a short implementation. The backbone of the process is an application that is installed remotely on the physician practice computers which extracts and transmits encounter data on a scheduled basis. Furthermore it offers minimal disruption to practice workflow and requires no hardware investment.

As the database was being created the physicians worked together to determine what they would like to measure and what could be measured. Much has been written on various ways to measure quality. The more data sources that are collected, the more robust the measurements can become. The PHO selected about 40 different clinical guidelines to measure and an example of one follows.



CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS	
REFERENCE	HEDIS 2007, American College of Cardiology/American Heart Association
PATIENT POPULATION	Adults age 18 and older
PROTOCOL	Patients who were discharged from the inpatient setting with the diagnoses of Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG) or Percutaneous Transluminal Coronary Angioplasty (PTCA) - or - who have a diagnosis of Ischemic Vascular Disease (IVD), should have the following test: - Full lipid profile
COMPLIANCE MEASUREMENT	Those patients with diagnoses listed above that were discharged from the hospital between January 1 and November 1 of the year prior to the measurement year and Those patients with a diagnosis of IVD (at least one outpatient/non acute inpatient or acute inpatient/ED visit with any diagnosis of IVD) between January 1 and November 1 of the year prior to the measurement year will have the following test completed during the measurement year: - Full Lipid Profile

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The last component of the solution is delivering the data back to the providers and administrators. A secure web portal is used to deliver compliance measures against the clinical guidelines by physician. It also delivers lists of patients that are compliant, not compliant, and those that are due a service in the near future to become compliant.

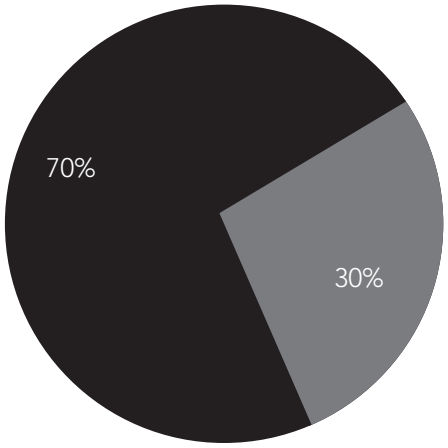
Clinical integration is a critical component of a better health care delivery system. The primary benefits of clinical integration are better quality and better ability for physicians to negotiate and create reimbursement systems. Many believe that an EMR system is the only way to become clinically integrated, but there is a wide spectrum of options available and each provider organization needs to determine which solution best meets their objectives. ■

Sample IPA
Cholesterol Management for Patients with Cardiovascular Conditions Compliance
Reporting Period: 1/2007 - 12/2007

Eligible Population: Adults ages 18 and over with cardiovascular conditions

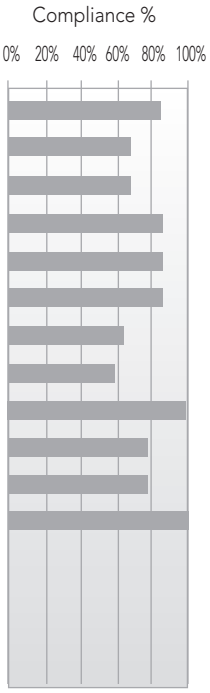
Full Lipid Profile

Eligible Population	151
Compliant Population	105

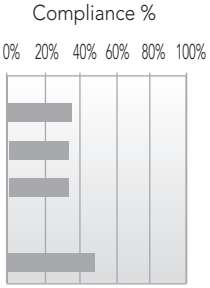


■ Full Lipid Profile Compliant
■ Full Lipid Profile Non-Compliant

	Full Lipid Profile		
Top Quartile	Eligible	Compliant	Compliance %
Cardiologist A	19	16	84%
Cardiologist B	10	7	70%
Cardiologist C	9	6	67%
Cardiologist D	8	7	88%
Cardiologist E	8	7	88%
Cardiologist F	7	6	86%
Cardiologist G	6	4	67%
Cardiologist H	5	3	60%
Cardiologist I	5	5	100%
Cardiologist J	5	4	80%
Cardiologist K	4	3	75%
Cardiologist L	3	3	100%
Top 25% Practices	89	71	80%
Bottom 25% Practices	48	22	46%
Total Practices	151	105	70%



Bottom Quartile			
Cardiologist V	3	1	33%
Cardiologist W	3	1	33%
Cardiologist X	3	1	33%
Cardiologist Y	2	-	0%
Cardiologist Z	2	1	50%



Implementing Parity: Investing in Behavioral Health—Part 1

by Steve Melek

"Change is the law of life. And those who look only to the past or present are certain to miss the future."—John F. Kennedy

After much anticipation, interim final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) have been released by the Departments of Labor, Health and Human Services, and the Treasury. These regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010. Understanding compliance with MHPAEA is of great importance to all interested parties including health insurance companies, health plans, employers, providers, and consumers of behavioral health care. Part 1 of this article will address implementation details. Understanding how the rules could impact the business of behavioral health care and the decisions that follow is of even greater importance. This will be covered in Part 2, which will be included in the September 2010 issue of *Health Watch.*

Areas Clarified by the Regulations

The interim final regulations clear up many of the issues that were unclear in the legislation which was passed on Oct. 3, 2008 and generally effective for plan years beginning after Oct. 3, 2009:

Deductibles and Out-of-Pocket Limits The Departments' view is that prohibiting separately accumulating financial restrictions and quantitative treatment limitations is more consistent with the policy goals that led to the enactment of MHPAEA. Consequently, a plan may not apply cumulative financial requirements or cumulative treatment limitations to mental health or substance use disorder benefits that accumulate separately from similar requirements for medical/surgical benefits. This is the death of the separate but equal deductible approach, and requires separate claim systems for behavioral health care benefits and medical/surgical benefits to be interfaced.

Nonquantitative Treatment Limitations The regulations require that any processes, strategies, evidentiary standards, or other factors used in applying nonquantitative treatment limitations (limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment, such as medical management standards, prescription drug formulary design, standards for provider admission to participate in a network, determination of usual, customary and reasonable amounts, requirements for using lower-cost therapies before a plan will cover more expensive therapies, conditional benefits on completion of a course of treatment, etc.) to mental health and substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits. This enables separate processes for utilization management of behavioral health care and medical/surgical care as long as they are applied no more stringently to behavioral health care benefits. Disparate results do not mean that the treatment limitations do not comply with parity.

EAP as Gatekeepers The provisions of an EAP in addition to the benefits of a major medical program that otherwise complies with the parity rules would not violate MHPAEA. However, having a requirement that participants must exhaust the EAP mental health or substance abuse disorder counseling sessions before they are eligible for the major medical program's mental health or substance use disorder benefits would violate MHPAEA.

Separate Coverages or Benefit Packages The parity requirements apply separately to each combination of medical/surgical coverage and mental health or substance use disorder coverage that any participant can simultaneously receive, and all such combinations constitute a single group health plan for purposes of the parity requirements. If an employer offered three medical/surgical plan options, Gold, Silver and Bronze and a mental health and substance use disorder benefit, Healthy Mind, that could be combined with each of Gold, Silver and Bronze,

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The regulations provide that the plan terms defining whether the benefits are mental health or substance use disorder benefits must be consistent with generally recognized independent standards of current medical practice.

then the parity requirements must be satisfied with respect to each combination of benefits, that is Gold + Healthy Mind, Silver + Healthy Mind, and Bronze + Healthy Mind. And if the Gold plan option also had separate Gold Plus and Gold Standard options, each of these would also have to satisfy the parity requirements when combined with the Healthy Mind benefits.

Behavioral Health Care Providers, Specialists or Primary Care The regulations do not allow the separate classification of generalists and specialists in determining the predominant financial requirements that applies to substantially all medical/surgical benefits. Therefore, you cannot just set copays for behavioral health care specialists equal to the copays for medical/surgical specialists; rather, you must complete the determination of the "substantially all" and "predominant" requirements for the various financial requirements and quantitative treatment limitations for medical/surgical benefits (see below).

Interaction with State Insurance Laws MHPAEA requirements are not to be construed to supersede State laws except to the extent that such State standards or requirements prevent the application of a requirement of MHPAEA. A State law that, for example, mandates a minimum coverage amount of $50,000 for autism, does not prevent the application of MHPAEA. However, an issuer subject to MHPAEA may be required to provide mental health or substance use disorder benefits beyond the State law minimum in order to comply with MHPAEA.

MHPA 1996 Impact MHPAEA expands the parity requirements for aggregate lifetime and annual dollar limits to include protections for substance use disorder benefits. Plans with small lifetime limits of substance use disorder benefits will be making significant changes to those benefits.

Areas of Requested Input Within the Regulations

The Departments invite written comments on specific issues:

- Additional examples to illustrate the application of the nonquantitative treatment limitation rule to other features of medical management or general plan design.
- Scope of Service Issue—the Departments recognize that not all treatments or treatment settings for mental health conditions or substance abuse disorders have analogous treatments for medical/surgical conditions, but do not specifically address how to comply with MHPAEA for such conditions, and ask whether and to what extent MHPAEA addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage.
- The regulations withdraw the MHPA 1996 regulatory guidance on the increased cost exemption and intend to issue, in the near future, guidance implementing the new requirements for the increased cost exemption under MHPAEA.

Determining Compliance

The regulations provide that the plan terms defining whether the benefits are mental health or substance use disorder benefits must be consistent with generally recognized independent standards of current medical practice. This is not meant to imply that the standard must be a national standard, but that it must be generally accepted in the relevant medical community. Sample sources include the DSM, ICD, or a State guideline. This requirement is included to ensure that a plan does not misclassify a benefit in order to avoid complying with the parity requirements.

The regulations give specific meaning to certain terms for the purposes of MHPAEA:

"Classification of benefits" Six classifications of benefits are specified which each require parity compliance: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs. If a plan has no network of providers, all benefits in the classification are characterized as out-of-network.

"Type" This is used to refer to financial requirements and treatment limitations of the same nature. Different types include copayments, coinsurance, annual visit limits and episode visit limits. A financial requirement or treatment limitation must be compared only to financial requirements or treatment limitations of the same type within a classifi-

cation (copayments only compared to other copayments, annual visit limits only compared to other annual visit limits).

"Level" This refers to the magnitude of a type of financial requirement or treatment limitation (such as the dollar, percentage, day or visit amount).

"Coverage unit" This refers to how a plan groups individuals for purposes of determining benefits, premiums or contributions (such as single participant, participant plus spouse, participant plus children, or family).

The regulations require that the general parity requirement of MHPAEA for financial requirements and treatment limitations be applied separately for each classification of benefits and for each coverage unit. Additionally, the six classifications are the only ones used for purposes of satisfying the parity requirements of MHPAEA.

The regulations do not require an expansion of the range of mental health conditions or substance use disorder benefits covered under the plan; it merely requires parity for those covered conditions or disorders.

The regulations do not define inpatient, outpatient or emergency care. These terms are subject to plan design and their meanings may differ from plan to plan. Additionally, State health insurance laws may define these terms.

Measuring Plan Benefits

The portion of plan payments subject to a financial requirement or quantitative treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in a classification to be paid under the plan year. Any reasonable method may be used to determine the expected paid dollar amount under the plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

For purposes of deductibles, the dollar amount of plan payments includes all payments with respect to claims that would be subject to the deductible if it had not been satisfied. For purposes of

out-of-pocket maximums, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that were taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Other threshold requirements are treated similarly.

"Substantially all" The first step in applying the MHPAEA requirement is to determine whether a financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification. Regulations issued under MHPA 1996 interpreted the term "substantially all" to mean at least two-thirds. Under the regulations, a financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification if it applies to at least two-thirds of the benefits in that classification. Benefits expressed as subject to a zero level of a type of financial requirement or an unlimited quantitative treatment limitation are treated the same as benefits that are not subject to that requirement or limitation (i.e., a $0 copayment for a benefit, such as well baby care, is treated as not subject to a copayment).

If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of the medical/surgical benefits in a classification, that type of requirement or limitation **cannot be applied** to mental health or substance use disorder benefits in that classification. If a single level of a type of financial requirement or quantitative treat-

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ment limitation applies to at least two-thirds of the medical/surgical benefits in a classification, then it is also the predominant level, and that is the end of the comparative analysis.

However, if the financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification but has multiple levels, and no single level applies to at least two-thirds of all medical/surgical benefits in the classification, then additional analysis is required—determining which level of the financial requirement or quantitative treatment limitation is considered predominant.

"Predominant" MHPAEA provides that a financial requirement or treatment limitation is predominant if it is the most common or frequent of a type of limit or requirement, and applies to more than one-half of medical/surgical benefits subject to the financial requirement or treatment limitation in that classification. If a single level of a type of financial requirement or quantitative treatment limitation applies to **more than one-half** of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in a classification (based on plan costs), the plan may not apply that particular financial requirement of quantitative treatment limitation to mental health and substance use disorder benefits at a level that is more restrictive than the level that has been determined to be predominant.

If no single level applies to more than one-half of medical/surgical benefits subject to a financial requirement or quantitative treatment limitation in a classification, plan payments for multiple levels can be combined until the portion of plan payments subject to the financial requirement or quantitative treatment limitation **exceeds** one-half. Then, the plan may not apply that particular financial requirement of quantitative treatment limitation to mental health and substance use disorder benefits at a level that is more restrictive than the **least** restrictive level within that combination. The plan may combine plan payments for the most restrictive levels first, with each less restrictive level added until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.

When a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of medical/surgical benefits in a classification, but no single level applies to more than one-half of the medical/surgical benefits, a plan is permitted to treat the least restrictive level of the financial requirement or quantitative treatment limitation applied to medical/surgical benefits in that classification as the predominant level. Determining the predominant level of a particular financial requirement or quantitative treatment limitation must be done separately for each coverage unit.

Prescription Drug Benefits If a plan imposes different levels of financial requirements on different tiers of prescription drugs based on reasonable factors (such as cost, efficacy, generic vs. brand name, and mail order vs. pharmacy pick-up) determined in accordance with the requirements for nonquantitative treatment limitations, and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or mental health or substance use disorder benefits, the plan satisfies the parity requirements with respect to the prescription drug classification of benefits. The special rule for prescription drugs, in effect, allows a plan or issuer to subdivide the prescription drug classification into tiers and apply the general parity requirement separately to each tier of prescription drug benefits.

For any tier, the financial requirements and treatment limitations imposed with respect to the drugs prescribed for medical/surgical conditions are the same as the financial requirements and treatment limitations imposed with respect to the drugs prescribed for mental health conditions and substance use disorder benefits in the tier. Moreover, because the financial requirements and treatment limitations apply to 100 percent of the medical/surgical drug benefits in the tier, they are the predominant financial requirements and treatment limitations that apply to substantially all of the medical/surgical drug benefits in the tier.

Part 2 of this article in the September 2010 issue of *Health Watch* will address how these regulations could impact the business of behavioral health care and the decisions that follow for payors, employers, providers and insureds. ■

A Non-Traditional Actuarial Role

by Carolyn Young

I have been working at Independence Blue Cross (IBC) for the last five years in a "non-traditional" health actuarial role. IBC is a traditional company, with traditional health actuarial roles—primarily pricing, reserving, etc. My role was crafted because IBC was willing to explore the value of a non-traditional role focusing on medical cost analysis and forecasting, which I like to think of as both retrospective and prospective analysis. The prospective analysis piece is rooted in the traditional—that is setting the medical cost trends the pricing area uses to set the rates. The not so traditional part is the retrospective analysis and our "MCAP" approach. More on MCAP in moment…

The retrospective analysis results in monthly medical cost analysis and reporting. We separate our reports into product (Commercial vs. Medicare, HMO vs. PPO), service type (inpatient, outpatient, and professional) and then analyze the drivers of trends—at the provider, procedure, diagnosis code level, etc. This is real detective work! The analysis combines technical and analytical skills. Anywhere we see a high trend, or an unexpected variance, we dive down to the lowest level of detail to be able to explain the driver. Then the really interesting work begins. We present the analysis to our business partners in Contracting, Legal, Medical Directors, Care Management staff, Medical Policy, and Operations and partner with them to determine the drivers. This is the beginning of the MCAP (Medical Cost Action Program) approach.

The variances may be caused by new medical technology, a change in a provider contract that we were not aware of, or it may even be caused by simple billing errors. It could also be the unexpected result of an updated fee schedule, changes in provider billing or behavior, or system set up issues or system errors. If the reason for the variance is something we did not expect, we would work with our business partners to resolve the issue. MCAP **drives** all these issues to conclusion.

Typically, the actuarial department will see adverse results, factor them into their trend forecasts or prices, and then move on. In IBC's MCAP world, Actuarial is a **leader** of this group driving the team to resolve the issue and recover funds where appropriate. These work efforts are then factored into our trends (as we are positively influencing trends) and reserves (if there is a recovery effort). MCAP allows Actuarial to drive projects to conclusion and become an active business partner in directing the company's time and resources to address issues that have material value and impact on trends and medical costs. Because of this process, we have become a much more valuable partner within the organization and this has facilitated our knowledge of how claims process, items that are considered in the provider contracting process and furthered our general health care knowledge. Instead of reporting and analyzing the numbers, we are helping to drive the results!

Since we instituted this process in 2006, we have highlighted significant issues in our medical costs and positively influenced our medical cost trend. The biggest challenges we had were convincing our business partners that the items being highlighted in our cost reports were priorities. Once we were able to size these issues, we were able to gain their support. This still required significant senior management buy-in from the Claims & Operations areas. They typically addressed issues either in the order they received them, or they bumped up issues to high priority status if it affected a large customer. Our reporting was able to show them that financial impact across our book of business is an important criteria as well.

MCAP is fully functioning at our company and we have had great success. Leading this team of cross-functional people has given me new exposure to areas of the company that actuaries do not typically ever see or understand. It has expanded my knowledge of health care significantly and given me a new appreciation of how health care works. I urge every actuary in the health care industry to spend some time getting to know how the business is run and how claims are paid. I guarantee it will make you a better actuary. I know it did for me. ■

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Generic Dispensing Rates: Silver Bullet No More?

by Troy Filipek

Generic prescription drugs emerged years ago with major patent expirations and have been a focus of cost containment efforts for insurers and employers in managing overall medical costs. By offering to share the savings with patients through cost sharing decreases, the value proposition makes sense to both the payer and the patient. For example, if a patient can switch from a $100 brand prescription to a $30 generic prescription and reduce their copayment by $10 or $20, both the plan and the patient save money. This has led to an increase in generic dispensing rates (GDR) over time.

GDRs increased significantly over the past several years, helping to mitigate drug trends to their lowest levels in recent years.

In particular, GDRs increased significantly over the past several years, helping to mitigate drug trends to their lowest levels in recent years. While overall utilization and drug prices increased, the mix of drugs shifted dramatically toward more generics to offset these utilization and price increases. Excluding specialty drugs makes the trend picture even more favorable for generics. Table 1 contains a summary of recent drug trend reports from the three major pharmacy benefit managers (PBMs).

Table 1
Pharmacy Trends Mitigated Through GDR Increases

PBM	Total 2008/2009 Trend *			Generic Dispensing Rate *		
	All Drugs	Non-Specialty Drugs	Specialty Drugs	2006	2007	2008
Medco	3.3%	1.3%	15.8%	55.2%	59.7%	64.1%
CVS Caremark	3.9%	2.8%	13.5%	55.7%	59.9%	65.1%
Express Scripts	3.0%	1.5%	15.4%	N/A	60.5%	64.8%

* Note that the covered populations underlying the PBM trend and GDR figures may vary (PBM book of business versus overall industry, Medicare versus Commercial, etc.). Used most recent report from each PBM (2009 for Medco and Caremark, 2008 for Express Scripts).

The logical questions arising from these figures include:

- What is the upper bound for the GDR?
- What does the pipeline for new drugs and expiring patents look like?
- When the GDR increase slows, will prescription drug trend return to the high single digits or even double digits?

Let's review some background on the recent GDR increases and the resulting implications to help assess what may happen in the future.

Drivers of GDR Increases

The GDR increase over the past several years has been fueled by big-name patent expirations in some major therapeutic classes, as well as other efforts from PBMs, employers, and health plans. All of these entities pushed for increased generic use to mitigate costs through benefit plan design, formulary design, utilization management programs, and other programs. The following have been major drivers of the GDR increase:

- **Big-Name Patent Expirations in Recent Years:** Patents recently expired on a number of heavily prescribed medications and are now available as generics, including:
  - 2009: Topamax, Prevacid, Adderall, Valtrex
  - 2008: Nexium, Fosamax, Risperdal, Lamictal, Imitrex, Altace, Depakote
  - 2007: Norvasc, Ambien, Lotrel, Toprol XL, Protonix, Coreg
  - 2006: Plavix, Flonase, Pravachol, Zocor, Zoloft

- **Strong Plan Design and Formulary Incentives:** Temporary waivers of generic copays, multisource brand penalties, wider copay differentials, step therapy/prior authorization programs, closed formularies, and coinsurance-based cost sharing are a few examples of benefit and formulary design creating financial incentives for members to choose less-expensive generics.

- **Increased Public Acceptance:** Increased marketing of the generic cost savings, therapeutic

equivalence, and comparable safety relative to brands has led to wider public acceptance and utilization of generics.

- **"Wal-Mart" Programs:** Retail outlets encourage generic drug use by using aggressive marketing for select generics ($4/$10 copays for 30/90 days). These programs were piloted by Wal-Mart several years ago and most retailers now offer comparable programs, with the intent of generating more in-store traffic and sales of higher-markup ancillary items.

Table 3
Medicare Part D National Average Values Per Member Per Month

	2006 *	2007	2008	2009	2010	Change 2006-2010
National Average Bid Amount	$92.30	$80.43	$80.52	$84.33	$88.33	-4.3%
National Average Member Premium	$32.20	$27.35	$27.93	$30.36	$31.94	-0.8%
National Average Direct Subsidy	$60.10	$53.08	$52.59	$53.97	$56.39	-6.2%

** Straight average weighting methodology for determining national averages. Subsequent years reflect some or all member weighting.*

Impact of Population Differences

The GDR is significantly higher under the Medicare Part D program, relative to commercial plans. Table 2 compares the GDR changes for the two populations.

Table 2
GDR by Population

Population	2006 GDR	2007 GDR	2008 GDR
Medicare Part D *	60.3%	64.1%	69.4%
Commercial **	49.7%	53.1%	59.2%

* As published by CMS; program began in 2006.

** From Takeda Prescription Drug Benefit Cost and Plan Design Report

Why the significant GDR gap between commercial and Medicare? Several likely reasons are:

- The Part D benefit design encourages more consumerism to avoid reaching the Medicare Part D coverage gap (i.e., the "donut hole") where the member pays 100 percent of the costs.
- Drug mix differences, where seniors likely use prescription drugs more heavily in categories where generics are available.
- The budget-conscious nature of the senior population relative to younger generations.

The Part D program has benefited significantly from this uptick in GDR, as reflected by the Part D national averages by year in Table 3.

Other factors certainly contributed to this decline (e.g., change in the national average calculation methodology, changing carrier pricing strategies, competitiveness of the program, the use of experience in pricing, etc.), but GDR increases were one main contributor. Further, the Part D program has come in under budget relative to early projections for the program, quite unusual for a government program.

What Will the Future Hold?

The immediate future still holds promise for further increasing the GDR. The following are future drug patent expirations likely to have a big impact:

- **2010:** Flomax, Effexor, Cozaar
- **2011:** Lipitor, Actos, Zyprexa, Levaquin, Aricept

Beyond this timeframe, though, the generic upside could be fairly limited. There is also a limited pipeline of new traditional non-specialty drugs in the pipeline. What might we see beyond the immediate future?

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- **GDR reaching a saturation point:** Industry-wide in the 70-80 percent range, with the highest achieving plans in the 80-90 percent range. Also, expect to see commercial and Medicare GDRs converge slowly over time.
- **The rising influence of specialty drugs:** Escalating trends in the specialty market over the past several years become a bigger issue in the future, with new blockbuster specialty releases and new indications far exceeding non-specialty new development, and slowing GDR increases no longer masking the trend.
- **Overall trends emerging higher:** Likely in the high single digits or low double digits.

No one can safely predict what to expect in the pharmaceutical space with all of the uncertainty in health care recently. Government regulation looms as a big concern, but an aging population likely continues to mean higher use of prescription drugs in this country. As things stand currently, one can expect the trend-mitigating force of an increasing GDR to fade. Unfortunately, the low trends we are currently experiencing likely will become pleasant history, and finding the next silver bullet for reducing health care trends won't be as easy. ■

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Navigating New Horizons … An Interview with Jeffrey D. Miller

by Sarah Lawrence

Jeffrey D. Miller

Now that the recession seems to finally be at a turning point, many actuaries recently affected by layoffs, consolidation or mergers within the industry will find themselves facing an inevitable turning point of their own. While most will find themselves back in the office earning a steady paycheck from an established company, a few entrepreneurial-minded folks may find this the perfect time to pursue a dream of striking out on their own.

Becoming a sole-practitioner consulting actuary carries with it all of the potential risks and rewards of starting any business and is most certainly a huge undertaking, but if all of the factors for success are there it can lead down a highly rewarding and interesting path. Such has been the case for Jeffrey D. Miller, who has acted as the sole proprietor for his own life and health insurance actuarial consulting business for almost 15 years. For Miller, the business is the culmination of more than three decades of experience in the industry and, while not necessarily the path he originally sought when first starting out as an actuary, has turned out to be the most natural and fitting path that his career could take.

An Early Start

While growing up in the Kansas City area, becoming an actuary was on Miller's radar from an unusually early age. This is thanks to his father, a successful actuary in his own right who exposed his son to the industry in ways that would attract any young boy with a natural ability for math, reasoning and statistics—such as through professional baseball.

"My dad was in the reinsurance business and would write special kinds of risks," Miller said. "There was one time back in the late '60s when the baseball team that is now the Oakland Athletics was the Kansas City Athletics and they had a special game where one player who was being honored played all positions on the field—one per inning. My dad wrote a special insurance policy on him that would pay a million dollars if he died from an accident during that baseball game."

Miller said he and his father not only attended the game, but they also got to sit with the owner of the baseball team. While the actuarial profession rarely gets this exciting, it certainly left an indelible impression on a young Miller. As a freshman in high school he was assigned to create a careers notebook and titled his, "So I Want to be an Actuary."

"It's just something I've always wanted to do," he said.

Beginning His Career

In 1977 Miller graduated from Drake University in Des Moines, Iowa having earned a Bachelor of Science degree in business administration with an emphasis in actuarial science and accounting. His first move was to spend two years as an actuarial student with accounting firm Coopers & Lybrand before taking his first position as a consulting actuary for William M. Buchanan & Associates of Kansas City. It was there that he was able to finish the last of his actuarial exams and began working with a group of clients, including assisting with at least one major client called Jackson National Life.

After four years with the company, Miller decided it was time to move on. "Through my experience working in accounting firm, where becoming a partner was such a big deal, that became my primary goal," he said. "With Bill's firm it became clear that the firm wasn't going to get big enough for both of us, so when I left there I joined a large firm where I could become a partner."

In 1983 Miller joined Tillinghast in re-starting their life and health insurance consulting practice in Kansas City and achieved his goal of becoming a partner in less than two years. Having basically

started from scratch under the Tillinghast umbrella, Miller got his first taste of what marketing and owning his own firm might be like.

"Very early in my career with Tillinghast I had to go out and find new clients for the office by calling on insurance companies and trying to sell them consulting services, which is not something many actuaries would do very often," Miller said. "But then later on in my career with them, they asked me to head up a practice area that would coordinate the firm's consulting services relating to the marketing of insurance products."

When Miller left the Tillinghast firm in 1990, he had grown the Kansas City office from nothing to a staff of 30 employees that earned the company an annual revenue of $3 million. He was also a vice president, principal and leader of practice area in marketing, distribution and product development worldwide. With that experience under his belt, Miller decided it was time to pursue his dream of starting a large firm of his own.

"I did have some contacts with companies that were interested in using me, so I had a couple of clients right from the beginning and that was a big help," Miller said. "And I was also approached by a number of actuaries here in Kansas City who were interested in joining my firm and we added quite a few actuaries very quickly."

Within three years his firm, The Miller Group, employed 20 people including eight actuaries. Miller focused primarily on building new client relationships through marketing and sales, but ultimately the business ended up steadily shrinking after one major client crashed without paying for a large amount of work. In 1996, Miller released his final employee with a new goal of successfully operating as a sole proprietor.

A One-Man Show

Miller said it's only natural to feel slightly uneasy when making a decision to go it alone. "You never know where your money is coming from, so I was very nervous," he said. "I think anybody is, but I think we all find ourselves in circumstances from time to time that lead us in a direction we might not have anticipated. There may be actuaries today who are striking out on their own who didn't really plan on doing that and they are certainly nervous about it. I can understand that."

Luckily, Miller was able to settle into his new career fairly quickly after finding an anchor client to provide a significant portion of his yearly earnings. Miller said finding a client such as this is one of the key factors to succeeding as a sole-practitioner consulting actuary.

"You begin marketing your services to other clients, while at the same time you're working with that anchor client," he said. "I think that's a critical step. If you're going out on your own without an anchor client, it becomes very difficult. And finding one is not easy. You have to find a company that wants to spend that much money with you."

Miller said he has found that he can only serve about three primary clients at one time, plus occasionally take on some one-shot projects. Any more than that and it can become too overwhelming, but finding clients in the first place is still the tricky part.

"You just never know where the clients are going to come from," he said "I think one of the most important things you can do is just expose yourself. Go to meetings, visit people, write articles. These days I think there are some opportunities in social networking online. Not necessarily Facebook, but a site like LinkedIn is for business people and may end up providing some good opportunities."

Help Wanted

One doesn't have to be a jack-of-all-trades in order to do work as a sole proprietor, Miller said. In fact many companies are looking for actuaries who can dole out expert advice in specialized areas. "Right now I think there's always a market for the sole practitioner who becomes a world expert on a particular topic. I know of one guy, for example, who is a world expert on long-term care. He's marketed himself among actuaries so that actuaries know if they have a question or want to do a project related to long-term care and nursing home insurance, they can call that person."

Miller said the area he has worked in most involves filling part-time temporary and part-time permanent positions with different companies. For example,

There may be actuaries today who are striking out on their own who didn't really plan on doing that and they are certainly nervous about it. I can understand that.

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Miller has served as chief actuary on a part-time basis at one company for 20 years. At the same time, he has also filled roles on a temporary basis at many start-up companies as they search for the right person to permanently fill a position. He has also worked on several court cases and served as an expert witness in two trials.

While he usually works for an hourly fee, Miller said he will sometimes do work for a fixed monthly retainer. Many sole practitioners also choose to work on a contingency basis, but Miller said he avoids that as much as possible since he prefers to have compensation for his work agreed upon from the beginning. "One of the important lessons is that you have to collect your fees," he said. "A lot of folks would like to have you do work and not pay your fees, and if you don't collect your fees then you can't stay in business. Sometimes you have to be fairly mean about it."

Miller said there are plenty of opportunities for actuaries who want to work as sole proprietors, but it is definitely not the path for everybody.

What It Takes

Miller said there are plenty of opportunities for actuaries who want to work as sole proprietors, but it is definitely not the path for everybody. It is a very different experience from working for an insurance company or large consulting firm and Miller said it is important for people to determine if it is the right career choice before jumping in.

"I think one question is how much do you enjoy working by yourself as opposed to working in teams? Because if you're a sole proprietor you are going to spend quite a bit of time working by yourself," he said, "If you like that sort of thing, then that's terrific. If you don't, then you might not enjoy what you're doing."

A passion for sales and marketing is another characteristic that comes in handy, Miller said, as well as a healthy sense of confidence. "You also need to be able to talk on your feet and sometimes that's not easy. If you are an actuary that doesn't ever want to communicate a conclusion until you've had a long time to work on it—and had several other people look at it—then being an entrepreneur actuarial consultant probably is not for you."

Future Plans

But if all of the pieces do come together, Miller said being a sole-practitioner consulting actuary is an extremely rewarding career. With little to no overhead costs, plenty of travel, no need to spend time managing other people and the ability to work from anywhere through the marvels of modern technology, it has certainly been a good fit for him.

"I hope I continue doing what I'm doing for another 20 years," he said. "I certainly enjoy it and I make a pretty good living. It's kind of nice because now that my kids are out of college and my expenses are a lot lower, I might even save some money some day." ■

Soundbites from the American Academy of Actuaries' Health Practice Council

by Heather Jerbi and Tim Mahony

What's New

Over the past year, the Academy's Health Practice Council (HPC) has been actively engaged in the dialogue on health care reform. Even in the weeks leading up to the final passage of the Patient Protection and Affordable Care Act (PPACA), the HPC continued to offer comments on various aspects of the reform bill. Many of those statements are highlighted below. With the passage of health care reform in March, the HPC has shifted its attention to providing input as the relevant government agencies begin to develop regulations to facilitate the implementation of the new law. Details on those efforts will be outlined in the next edition of Health Watch.

Federal Health Reform – Policy Statements

In advance of the administration's bipartisan health reform summit on February 25 at the Blair House, the HPC sent a letter[1] to each of the policymakers invited to participate in the meeting. The letter reiterates the HPC's key criteria to viable health care reform and urges the policymakers to view these criteria as requirements for a sustainable health insurance system. The administration extended the invitation to this summit to both House and Senate Democrats and Republicans in leadership positions, and put forward its own proposal (largely made up of potential reconciliation "fixes" intended to move current comprehensive legislation forward) in advance of the summit.

That administration proposal included a provision that would create a federal Health Insurance Rate Authority to enforce and monitor a new rate review process. The HPC urged policymakers to base any oversight of health insurance premiums on actuarial principles[2] in response to this proposal. The council stressed that health insurance premiums should be adequate to pay projected claims, expenses, and supporting risk charges; that premium rating oversight should be done in conjunction with insurer solvency oversight; and that premium oversight requires strong actuarial representation.

Beginning in November, the HPC released several comment letters at the various stages in the legislative process for both the House and Senate bills.

- On November 20, the Academy's Health Practice Council (HPC) submitted a comment letter[3] to Senate Majority Leader Harry Reid and Minority Leader Mitch McConnell on the *Patient Protection and Affordable Care Act.* The letter outlined the key issues that need to be considered when evaluating whether the Senate's health care reform bill will lead to a viable health insurance system and discusses whether the *Patient Protection and Affordable Care Act* addresses these issues.

- A similar letter[4] was sent to Speaker of the House Nancy Pelosi and House Republican Leader John Boehner on November 6. That letter specifically addressed issues related to the *Affordable Health Care for America Act* (H.R. 3962).

- On November 23, the HPC sent a comment letter[5] to the leadership of the Senate Committee on Health, Education, Labor and Pensions. This letter was in response to a request from the committee for analysis of the grandfathering provisions contained in the *Patient Protection and Affordable Care Act* and whether they would mitigate "rate shock" for those individuals who keep the coverage they have.

- On January 14, the HPC released a comment letter[6] to House and Senate leadership on the differences between the *Patient Protection and Affordable Care Act* and the *Affordable Health Care for America Act* (H.R. 3962). The council developed the letter to provide input to policymakers during the reconciliation process. The letter discusses the implications of these differences and, where appropriate, offers recommendations on which chamber's approach (if either) would be more viable.

In addition to these comment letters, a joint work group of the Academy and the Society of Actuaries (SOA) released a new technical report[7] on the potential implications of an excise tax on high-cost employer health plans (often called "Cadillac Plans"). The Senate-approved health care reform bill included the 40 percent excise tax on coverage in excess of specified dollar thresholds. The thresholds would be higher for some individuals based on age,

1 *http://www.actuary.org/pdf/health/summit_feb10.pdf*
2 *http://actuary.org/newsroom/pdf/premium_feb24.pdf*
3 *http://www.actuary.org/pdf/health/ppaca_nov09.pdf*
4 *http://www.actuary.org/pdf/health/ahcaa_nov09.pdf*
5 *http://www.actuary.org/pdf/health/ppaca_grandfather_nov09.pdf*
6 *http://www.actuary.org/pdf/health/differences_jan10.pdf*
7 *http://www.actuary.org/pdf/health/cadillac_jan10.pdf*

CONTINUED ON **PAGE 20**

occupation, and geographic area. According to the Academy/SOA report, an excise tax based on plan benefits rather than the proposed premium dollar threshold would more accurately target overly generous plans.

Finally, the newest additions to the *Critical Issues in Health Reform* series include: *State Level Impacts*[8] and the accompanying chart[9] that illustrates the relative and directional impact of health care reform on premiums by state, as well as an update of the *Minimum Loss Ratios*[10] *paper*. This series was developed in response to feedback received during the course of the annual Capitol Hill visits.

In an effort to inform actuaries (in all specialties) about the status of health care reform and the Academy's activities during the debate, the HPC hosted a webcast[11] in January, co-sponsored by the Conference of Consulting Actuaries and the Society of Actuaries. Webcast panelists David Shea, Tom Wildsmith and Cori Uccello provided attendees with an overview of the current status of health care reform, outlined some of the more significant differences between the House and Senate bills, and discussed the Academy's involvement in the health care reform debate (including publications, interactions with policymakers and inquiries from media).

As an ongoing part of this effort, the Academy also implemented a weekly newsletter, the Health Check, which is sent out to all members on Fridays. The newsletter includes a legislative update, the HPC's reform-related activities, and a list of relevant media inquiries for the week.

For reference, each of the HPC's policy statements related to health reform can be found on a dedicated webpage[12] through the Academy's Web site, which was developed in order to highlight these new statements, as well as additional materials related to health care reform.

Outreach to Policymakers and the Media

While the development of various policy statements and technical reports (those projects done in conjunction with the Society of Actuaries) are often the more tangible activities undertaken by the HPC, the often "behind-the-scenes" outreach and response to policymakers is just as significant. During the height of the congressional debate on health care reform, Academy staff and members of the HPC and its work groups/task forces have responded to requests for information related to reform provisions from congressional committees (e.g., majority and minority staff from the Senate Health, Education, Labor and Pensions Committee; House Energy and Commerce Committee; Senate Budget Committee; Senate Small Business and Entrepreneurship Committee), personal offices (e.g., Sen. Susan Collins (R-ME), Sen. Nelson (D-NE), Sen. Wyden (D-OR), Rep. Terry (R-NE), Sen. Rockefeller (D-WV)), and government agencies (e.g., Dept. of Health and Human Services, Centers for Medicare and Medicaid Services and Congressional Budget Office).

In terms of media, various publications/policy statements have been quoted in the *New York Times*, *Washington Post*, *Wall Street Journal*, *Time*, *Newsweek*, *Fortune*, *The Hill*, and *National Underwriter*. In addition to print media, Cori Uccello, the Academy's senior health fellow, has appeared on Fox Business, PBS Nightly Business Report and National Public Radio to discuss various aspects of health reform.

We continue to receive and respond to inquiries from policymakers, as well as the media, related to health care reform.

State Health Reform

Shari Westerfield submitted written testimony[13] in February to the Massachusetts House and Senate Joint Committee on Financial Services for their hearing regarding Bill 3447, *An Act Providing for Equitable Coverage in Disability Policies.* The bill seeks to prohibit gender discrimination in the area of disability insurance. The testimony described some of the unintended consequences that could arise as a result of the bill's passage. In addition, the Academy noted that life and auto insurance could also be affected due to the broad wording of the bill.

Medicare

In light of President Obama's State of the Union pledge to create a bipartisan commission to address deficit reduction and the release of his adminis-

8 *http://www.actuary.org/pdf/health/state_level_nov09.pdf*
9 *http://www.actuary.org/pdf/health/state_characteristics_nov09.pdf*
10 *http://www.actuary.org/pdf/health/loss_feb10.pdf*
11 *http://www.actuary.org/webcasts/health_jan10.asp*
12 *http://www.actuary.org/issues/health_reform.asp*
13 *http://www.actuary.org/pdf/health/mabill3477_feb10.pdf*

tration's 2011 budget proposal, the Academy's Health Practice Council continues to urge the president and Congress to undertake comprehensive Medicare reform. An updated Call to Action[14] outlines four goals that any comprehensive reform of the program must seek to achieve: the Hospital Insurance trust fund must meet short-range financial adequacy, the fund must meet long-range actuarial balance, the program's growing demand on the federal budget must be reigned in by a reduction in the growth in general revenue contributions, and overall Medicare spending must be limited by a reduction in the growth of spending.

NAIC Activities

The Academy's Medicare Supplement Work Group issued a letter[15] in February to the co-chairs of the NAIC Medicare Supplement Compliance Manual Subgroup of the Accident and Health Working Group of the Life and Health Actuarial Task Force. The letter highlighted specific areas in which the Academy believes that the Medicare Supplement Compliance Manual could be improved regarding 1990 and 2010 standard plans.

On December 4, Shari Westerfield provided testimony[16] at a public hearing on health care reform during the National Association of Insurance Commissioners' (NAIC) Winter 2009 National Meeting. The testimony outlined several issues that the NAIC would need to address (in terms of implementation at the state level) if federal health care reform is enacted.

New Practice Notes

In December, the Health Practice Financial Reporting Committee released a new practice note[17] on the actuarial certification of restrictions relating to premium rates in the small group market. The practice note was originally developed to provide guidance to actuaries who prepared small group actuarial certifications required by state laws and regulations. The updated version of the practice note incorporates the passage of Actuarial Standard of Practice (ASOP) 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*. It also has been updated to reflect relevant revisions of certification requirements in various states and practical changes that have occurred since the original publication.

Ongoing Activities

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

Health Practice Financial Reporting Committee (Darrell Knapp, Chairperson)—The committee currently has one practice note on contract reserves under review.

Long-Term Care Principles-Based Work Group (Bob Yee, Chairperson)—This work group is forming a joint Academy/SOA task force to develop and recommend valuation morbidity tables for long-term care insurance at the request of the NAIC's Accident and Health Working Group.

Stop-Loss Work Group (Eric Smithback, 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.

Disease Management Work Group (Ian Duncan, Chairperson) – This work group has begun development of a public statement on evaluating wellness programs.

Medicare Supplement Work Group (Michael Carstens, Chairperson)—This work group has submitted recommended changes to the Medicare Supplement Refund Formula to the NAIC's Medicare Supplement Refund Formula Subgroup, of the Accident and Health Working Group, and continues to work with the NAIC to develop a refund formula.

Solvency Work Group (Donna Novak, Chairperson)—The NAIC International Solvency Working Group released a paper related to regulatory capital requirements. There were 60 questions posed in the paper and the Academy responded to those questions. This work group provided comments for inclusion in the overall Academy response.

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 Tim Mahony at *mahony@actuary.org*. ■

[14] *http://www.actuary.org/pdf/medicare/med_reform_feb10.pdf*

[15] *http://www.actuary.org/pdf/health/compliance_manual_feb10.pdf*

[16] *http://www.actuary.org/pdf/health/naic_dec09.pdf http://www.actuary.org/pdf/health/smallgroup_dec09.pdf*

[17] *http://www.actuary.org/pdf/health/smallgroup_dec09.pdf*

Health Risk Assessments in a Protected Environment

by John C. Cameron

This article discusses the use and collection of genetic information for Health Risk Assessments and wellness programs under the Genetic Information Nondiscrimination Act of 2008 (GINA), Public Law 110-233. Title I of GINA was enacted to prohibit discrimination with respect to health insurance on the basis of genetic information. Recently, three federal agencies, the U.S. Departments of Treasury, Labor, and Health and Human Services, issued interim final regulations which govern the use and collection of genetic information by health insurance issuers and group health plans. Many employers use health risk assessment tools in wellness programs to assist them in developing personal health improvement plans. Often these health risk assessment tools are used in disease management programs to control costs, maintain quality of care and the continuation of coverage. The health plan actuary uses claims data and demographic information for the development of the group ratings. The many disciplines that use health risk assessments need to evaluate their programs for compliance with these new federal regulations.

GINA prohibits group health plans and health insurance carriers in the group and individual markets from using genetic information to increase premiums or contribution amounts to the individual or the group. However, nothing in the regulations limits group rating based on health factors, review of claims experience and the blending of the rate. Health insurers and group health plans may increase premiums or contribution amounts for the entire group health plan based on the manifestation of the disease or disorders of individuals who are enrolled under the plan. A disease is considered manifested when a health care professional has made a diagnosis based on an examination, symptoms or test results; but a disease is not manifested if a diagnosis is based principally on genetic information. It is permissible for the plan to include the cost of genetic testing or genetic services with the aggregate costs of the plan for purposes of determining premiums. Lastly, the plan is not permitted to increase premiums by using information about a manifested disease of one individual as genetic information about other members of the group, e.g. similarly situated individuals or dependent children.

Individuals and family members cannot be required nor requested by health insurers or group health plans to undergo genetic testing. However, a health care professional may still recommend and order a genetic test for the individual. Insurers and plans are permitted to obtain and use genetic test results to

determine if payment for services is appropriate. A plan is permitted to condition the payment for a service on the outcome of a genetic test to determine the appropriateness of certain courses of treatment. The plan is permitted to request a participant to undergo a genetic test under the research exception, so long as all the conditions of the research exception are met. Naturally, the plan cannot mandatorily require the individual to participate in the research, and no collected or acquired genetic information can be used for underwriting purposes.

Genetic information cannot be collected prior to or in connection with enrollment or at any time for underwriting purposes. The regulations define genetic information as information about an individual's genetic tests or tests of family members, the manifestation of a disease or disorder in family members which is disclosed in a family medical history or the fact that a request was made by the individual or family member for genetic services such as testing, counseling or education. This broad definition makes the collection of genetic information, including a family medical history, subject to the federal regulations.

Wellness programs that reward individuals for completing health risk assessments and disclosing genetic information and family medical history information would be in violation of the regulations. However, as long as no rewards are offered, a plan can collect genetic information after enrollment through the health risk assessment process. Similarly, a plan can offer rewards for completing the health risk assessment so long as genetic information is not solicited. So, a plan could administer two distinct health risk assessments after enrollment in the plan: one with the option for a reward without soliciting genetic information, and the option for soliciting genetic information without a reward incentive.

GINA does not allow the collection of genetic information for underwriting purposes. In addition to insurance rating or pricing a group policy, underwriting purposes are broadly defined to include eligibility rules for benefits, computation of premiums or contribution amounts, the use of preexisting condition exclusions, changes in deductibles, cost-sharing mechanisms, discounts, rebates, payments in kind or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program. Health insurers and group health plans will have to conduct compliance reviews to ensure that genetic information is not being used prior to or in connection with enrollment or for underwriting purposes.

However, the regulations allow plans to collect genetic information which happens to be incidental to the collection of other information, so long as the genetic information is not used for underwriting purposes. In order to qualify for this incidental collection exception, the collection form must contain an explicit statement to inform the individual that genetic information should not be provided.

Further, a plan may request genetic or family medical history information to make determinations regarding payment of a claim. Payment can be limited or denied for an actual claim submission based upon a determination of whether the provided care was medically appropriate and indicated. This payment exception process would not be considered an underwriting purpose.

The administrative agencies believe that implementing underwriting safeguards will reduce the fears of individuals from the health coverage-related consequences of undergoing genetic testing and participating in research studies that examine genetic information. More genetic testing will lead to greater knowledge of genetic disorders, earlier diagnosis and treatment of individuals predisposed to developing certain diseases and the development of new discoveries and treatments.

The administrative agencies are also cognizant of the fact that curtailment of genetic information for use by the underwriter could increase the potential for adverse selection in the insurance market. Individuals having prior knowledge of genetic testing results could influence the timing and purchasing

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of health coverage. Individuals with low genetic risk factors might forgo health coverage. Those individuals at risk of contracting a serious medical condition could benefit from obtaining health coverage. If the ability to accurately assess the medical risks is compromised, then plans may be forced to raise premiums for all insureds. Experience data will need to be monitored.

The administrative agencies expect that the premiums for health care coverage will increase to offset increased costs as genetic testing and associated expenditures increase. However, the direct cost of testing could be offset by lower costs associated with the treatment of manifested diseases.

To assure compliance with the provisions contained in the federal regulations, plans may need to modify the operations of their health risk assessment programs, conduct training sessions with underwriters, conduct compliance reviews, coordinate with outside vendors, modify enrollment application forms and practices, update training manuals, and amend policies and procedures. The health plan actuary should determine that genetic information is not used for group rating purposes. Plans will need to advise health care providers and others that the portions of the medical records dealing with genetic information and family medical history information should be removed or redacted prior to submission to the plan. These internal safeguards are recommended to assure compliance with the federal regulations.

Health Risk Assessments are used by health insurance carriers, group health plans, and employers to motivate individuals to improve their health and lifestyle, in connection with enrollment or for underwriting purposes. Health insurers, group health plans, and employers will need to redesign their incentive programs, enrollment processes and underwriting purposes to comply with the legislative and administrative mandates under the Genetic Information Nondiscrimination Act. Since the health risk assessment is the centerpiece of wellness programs and disease management programs, health insurance issuers, group health plans and employers will need to strive to achieve high levels of participation and to promote employee health and wellness in a protected environment.

This article is written for informational purposes only and should not be construed as legal advice. ■

Reaching Out for New Opportunities—New Market Research About Actuaries in the Health Care Industry

by Sara Teppema

The ever-changing climate of health care brings considerable uncertainty to our future roles as health actuaries but will also open doors to new exciting opportunities for our profession. On the one hand, the health insurance industry may change dramatically, decreasing opportunities for health actuaries in our traditional health insurance-centric roles. On the other hand, the future of health care is certain to be much more focused on data and analytics, the perfect environment for actuaries to flex our technical muscles and grow in new areas. Among the various unknown parameters, the one sure thing is that our work will change, and we need to be ready to embrace it.

As the SOA Staff health actuary I am excited to help the profession adapt to and embrace the new health care world. One of my top priorities is to facilitate the SOA's strategic initiative called "Untapped Opportunities for Actuaries in Health."

In 2009, the main work of this initiative was a major market research study to identify areas where health care actuaries' skills can be of value outside our traditional boundaries of the health insurance industry.

The market research was done in three phases:

1. Interviews with health actuarial leaders in traditional and nontraditional roles (qualitative research)
2. Interviews with health care executives who are *not* actuaries (qualitative research)
3. Survey of health care executives, recruiters and hiring managers in various traditional and nontraditional health care companies (quantitative research)

The market researchers interviewed and surveyed health industry executives about their staffing needs for professionals in an area defined as "health care analytics and forecasting." These executives work for several types of organizations, including health plans, management consulting firms, hospitals/health systems, pharmaceutical companies (including clinical study organizations), and wellness/disease management companies.

Health plans already value the health actuary's skill set, but the research showed that actuaries can bring a lot to the table at organizations that don't traditionally hire actuaries. We bring an independent and objective voice, with expertise in modeling and data. The level of sophistication, rigor, discipline and transparency that actuaries bring is seen as equally (if not more) important as our technical ability. Actuarial credentials per se are not as well recognized, even though the skills and integrity of actuaries are valued.

As an actuary specializing in health care for 20 years, I was particularly taken by a few key findings:

Revelation No. 1

Although we have done a great job over the past few years in branding our entire profession, we aren't as branded in health care as I would have thought. Many health care executives have heard of actuaries, but they think of us primarily in the context of life insurance practice. When executives were presented with an actuary who also has health care expertise, they were much more interested in hiring that individual to manage health care analytics and forecasting functions in their organizations. The branding of the health actuary may take some time, as we need to establish our expertise in these new workplaces, consulting firms, or research space, before we can tout our abilities.

Revelation No. 2

Health actuaries who have taken non-traditional paths in their careers have generally taken the initiative, and risk, to seize new opportunities. They have not waited for someone to hand them a promotion or role, but have instead proactively sought these positions or filled a gap in a client's or organization's need.

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Revelation No. 3
The health care industry as a whole struggles to find people with the same "big picture" business skills that many actuaries seek to develop. Strategic thinking, problem solving, decision making, and written and oral communication top the list of important skills for professionals who work in health care analytics and forecasting.

Revelation No. 4
The health care industry is seeking people with certain skills that tend to be very strong in health actuaries. Financial acumen, knowledge of health systems and financing, and knowledge of policy and regulation are skills that have unmet needs in the broader health industry. These skills tend to be less important to health care executives than the big picture skills.

Revelation No. 5
A newer set of skills (well, new to us) reflects the growing need for health care analytics and measurement: clinical knowledge, study design and clinical trial design. Actuaries who can develop these skills will have an edge over other professionals (actuaries and others) in finding new roles in the broader health industry.

A work group is meeting regularly, to develop plans for education and research that will move the health actuarial profession into these new areas. On the work group: Jim Toole (chair), Bob Cosway, Kate Fitch (clinician), Jennifer Gillespie, Francois Joseph Poirier, Alice Rosenblatt. Mayur Shah (health economist), Judy Strachan, Sara Teppema and Meg Weber. Jill Leprich and Sara Teppema are providing staff support.

At the time of this writing, we are preparing a report to SOA members on the detailed outcomes of the market research, which will be posted on the Health Section page of the SOA Web site *(http://www.soa.org/professional-interests/health/hlth-detail.aspx)* sometime in May 2010.

At the SOA Health Meeting in June, three sessions will expand on various implications of the market research.

- The session entitled "Do we know what we don't know" will explore how we move SOA's research, organizational partnerships and networking into the broader health industry
- The session entitled "Untap your career potential in health care" will discuss how actuaries can capitalize on opportunities for growth into new roles
- The Health Section hot breakfast will have a report on the details of the market research results

We have added a half-day module to our health Boot Camps, (scheduled for Nov. 8–12, 2010) called "Medical School for Actuaries," which will provide an introductory deeper dive into clinical medical issues that actuaries should understand in this changing world of predictive modeling and health outcomes measurement.

The work group is working on other educational and research opportunities as well. Please watch for future communications in *Health Watch, Health e-News, The Actuary* and other communications.

We welcome your thoughts and suggestions in bringing value from this strategic initiative to health section members, and other actuaries practicing in health care. Please contact Sara Teppema at *steppema@soa.org.* ■

Reconvened Health Research Committee Ready for Action!

by Steven Siegel

The last two years have seen an explosive growth in general interest related to health care issues. With health care reform leading the current administration's domestic agenda, the public has been introduced daily to the arcane twists and turns of the current health care system. Although health actuaries have ably navigated this territory for years, there is no escaping the need and urgency for more research on health related matters. Recognizing a stepped up need for objective research, the SOA's Health Section Council has recently reconvened the Health Section Research Committee to oversee funding and project selection for health section research.

With new Health Section Council member, Ross Winkelman, agreeing to chair the team, a call went out last fall for volunteers to become members of the research committee. We are happy to report that there was an outstanding response to the recruiting e-mail and notice that went into the health e-news, resulting in a highly qualified team of health experts. Committee members include:

- Ross Winkelman, Chair
- Tim Adams
- Joan Barrett
- John Cookson
- Walter James
- Dan Pribe
- Tim Rice
- Tia Sawhney
- Steele Stewart
- Steven Siegel, SOA Research Actuary
- Sara Teppema, SOA Health Staff Fellow
- Barb Scott, SOA Research Administrator

Prior to the formation of the new committee, research was overseen by a small advisory team consisting of John Cookson and Jim Toole. They skillfully handled a wide variety of decisions and recommendations that resulted in much meaningful research since 2006. The Health Section Council expresses its thanks to both of them for all of their hard work in furthering health research.

The new committee began its work in January and has been meeting by conference call regularly. Among its primary duties are deciding how to allocate the Health Section research budget as well as brainstorm on new topics for research. Initial ideas for research efforts include an exploration of wellness programs and a call for articles related to payment reform. Look for more information on those efforts in the coming weeks.

In the meantime, it's your turn! The committee would greatly appreciate hearing from you. Please send your thoughts and suggestions for research ideas that would be useful to you or even research projects you would like to tackle. The research committee is open to new ideas—don't wait for us to post an RFP. Some of the best projects have been proposed by Health Section members. Your feedback is essential to helping the committee make the best decisions possible. While you're coming up with ideas, please consider joining one of the many project oversight groups that are formed to oversee particular research efforts. Not only is it a wonderful opportunity to expand your health care knowledge, but it's a great way to network and meet other experts in your specialty. You can find the latest information on research in progress and recent results by checking the Health Research page on the SOA web site. We're sure you'll find it thought-provoking.

There's no doubt—The Health Section Research Committee is ready for action and hoping to hear from you! ■

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

ERM Opportunities for Health Practitioners

by Max J. Rudolph

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Health actuaries use risk management techniques to better understand the risks taken. These practices have been developed over many years, allowing practitioners to make better decisions based on unique risk preferences and exposures. These practices continue to evolve, expanding to consider all risks as well as their interactions and correlations. This article is based on recent research conducted for the SOA Health Section titled Enterprise Risk Management (ERM) Practices as applied to Health Insurers, Self-Insured Plans, and Health Finance Professionals. It can be found at *http://www.soa.org/research/health/hlth-erm-practice-health-insurers.aspx.* The research included a literature search as well as a practitioner survey to determine the current state of ERM within the industry, and made suggestions for future research projects.

Some have complained that ERM allowed the recent financial crisis to occur or that it is just a buzzword for practices already being done. The reality is that ERM does not eliminate risk but helps you to better understand the risks accepted. There will always be people willing to take risks. Many times they do not understand the risks taken or incentives are misaligned. Many examples of both have occurred, but there are also examples of companies that kept debt low and stockpiled cash so they could exploit the underpriced risks offered up when liquidity was in short supply. Risk management balances risks and returns and goes well beyond risk mitigation techniques.

Not Hypothetical in Today's Connected World

An example specific to health insurers may help the reader to better understand ERM's focus on risks to the enterprise that includes risk combinations. In late 2008 publicly traded health insurers found themselves faced with multiple challenges. Few had tested scenarios where all happened at the same time, but this group of risks turned out to be highly correlated. The rapid fall in stock prices led some publicly traded companies to lose more than 50 percent of their market value. Their own balance sheet was hit hard at the same time (including defined benefit pension plans and assets purchased for the surplus account). Financial risks including liquidity, interest rate, and credit risks all saw downside volatility. In addition, many of the companies that health insurers provided coverage for through insurance or servicing self funded plans significantly reduced staff. This decreased the number of covered lives and reduced insurer coverage of fixed expenses. As these risks impacted health insurers at the same time, those with an ERM process in place recognizing the possible occurrence of a combination of emerging risks were better able to anticipate and respond flexibly.

Few sectors have consistently addressed combinations of fundamental or emerging risks. Although some health insurers are moving to this approach now, according to survey respondents few have shown the desire, or ability, to optimize the risk-return relationship across all risks. The survey, and follow-up discussions, showed that company culture has not allowed full program implementation. Truly best practice ERM merges results into incentive compensation across a longer time horizon. To date that is not happening across the industry. This situation may change as existing ERM programs mature and fully implemented programs demonstrate success relative to their peers. Some health insurers have created a Chief Risk Officer position and many have created Risk Committees.

Current and Best Practices

Considering that relatively few health insurers have fully implemented an ERM process, best practices at firms that have done so are quite good. Risks have been catalogued, interactions considered and marginal impacts of decisions tested. Risk culture and board interaction remain an issue even at best practice companies, as is the case with firms in other industries. It remains challenging to get the message heard. An enterprise risk management (ERM) process is an iterative dynamic. The field is evolving as new issues and solutions arise. The recent financial crisis taught many practitioners that an overreliance on quantitative solutions can be problematic. Emerging risks such as global warming and technological advancements are hard to fully anticipate but cause a need for rapid adjustments. Many emerging risks have implications for health insurers. Some

could reduce costs, such as a preventive vaccine for cancer. Others are expected to increase costs, such as an influenza pandemic. Many health insurers are performing the bare minimum ERM duties as they respond to rating agency requests and prioritize the multitude of tasks required in today's complex industry. ERM as practiced by rating agencies continues to evolve, but it clearly is an area to watch going forward as the recent financial crisis has focused rating agency interest on this topic. Communication to external stakeholders must also be improved. Each firm's culture will drive the level of commitment to ERM.

The primary findings of this research project are

1. Health insurers are still getting their hands around what enterprise risk management is. According to survey participants, they practice solid silo risk management but often struggle to implement risk interactions and discuss how risk analysis can be used to make better decisions. Their responses indicate that this is sometimes driven by poorly written but well meaning governmental regulations.
2. Best practice enterprise risk management is a process, evolving iteratively, rather than a one time project. Health companies are at various stages on this continuum. Practices range from doing nothing beyond solid silo risk management to fully implemented plans that collect leading indicators used to make decisions. Few have a fully functioning risk culture that allows challenges of ideas coming from the top of the organizational structure. Better practices are often driven by company size. Larger firms have more resources and other processes are more likely to be relatively sophisticated (e.g., a company with extensive systems capabilities is more likely to practice strong ERM).
3. Most health insurers that have implemented best practice ERM have done so internally with minimal external help.

Some recommendations for future research include exploring correlations between risks, quantification of regulatory risk, emerging risks and asset-liability management projects.

Role of Actuaries in ERM

No one person understands every risk taken by a company. Even if one did, this would lead to a concentration risk around knowledge as the firm relied on a single person. Great ERM, just like great leadership, depends on a risk culture that spreads throughout an organization. ERM leadership requires general risk management knowledge, along with unique industry and company knowledge. A single educational program can't do it all. An effective ERM specialist will likely have a general background regarding risk along with specific expertise tied to the company's primary risks. Actuaries have a broad set of skills that make it appropriate for them to take a seat at the ERM table and be considered to head this team. As with any senior management position, soft skills involving communication and management are required. Few others have been exposed to assets, liabilities, pricing, underwriting and strategic planning. Especially if a company is optimizing the risk/return relationship versus undertaking a perfunctory checklist exercise of basic operational risks, the actuarial skill set can help a company meet its goals.

Some health practitioners currently hold the Chief Risk Officer title and 35 have earned the CERA (Chartered Enterprise Risk Analyst) designation. The actuarial profession must bring both technical expertise and strong communication skills to take a lead role in ERM efforts. The topic is positioned for growth. Actuaries must reach out to add value by understanding interactions between risks and tools to look at risks both qualitatively and quantitatively. Risk is Opportunity! ■

Health Watch Article Contest on Provider Payment Reform

SPONSORED BY SOCIETY OF ACTUARIES' HEALTH SECTION RESEARCH COMMITTEE

OVERVIEW

As the uncertainties surrounding comprehensive health care reform continue to grab headlines, few health actuaries would disagree that an important component of reform encompasses the current provider payment system. Many have argued that the current health care payment system does not contribute to desirable health care policy goals, but rather is a hindrance to them. Worthy benefits such as quality, efficiency, and cost effectiveness are viewed by many as at odds with the current payment system. Furthermore, perverse incentives have been created that reward expensive treatments and interventions over prevention and wellness. In light of the current situation, it is clear that there is room for improvement.

STATEMENT OF TOPIC

What is your vision of a financially sound, equitable, properly incentivized health care provider payment system? How could a reformed provider payment system, in part or whole, be achieved?

CONTENT

The Health Section's Research Committee is issuing this call for articles for the Health Section's newsletter Health Watch, inviting Health Section members and others to write an article related to an aspect of provider payment reform. One of the goals of this call for articles is to encourage both experienced actuaries and those who have more recently joined the profession to consider writing an article. As a result, a special category of monetary prizes has been created (please note only Health Section members are eligible for prizes).

Articles may either address the topic as a whole or focus on a particular aspect. Articles may also focus a particular stakeholder in the health care industry, such as providers, insurers, or the government.

Examples of aspects that might be covered include, but are not necessarily limited to, the following:

- proper alignment of incentives among stakeholders
- simplification vs. complexity
- nationwide vs. regional considerations
- administrative issues
- information technology challenges
- government imposition of system vs. industry driven
- legal and regulatory challenges
- indexing
- price transparency and disclosure
- differential pricing
- spreads between billed versus contractual amounts

Please note these suggestions are only intended to serve as examples and are not meant to restrict potential ideas in any way.

SUBMISSION OF ARTICLES AND FORMAT REQUIREMENTS

Please submit your article via e–mail by June 7, 2010 to:

Barbara Scott, Research Administrator
Society of Actuaries
e-mail: bscott@soa.org

Articles should be kept to a maximum of 2500 words, excluding the article title and author information, and should be in Microsoft Word file format. Author information must be submitted with the article and include name; credentials or designations (if appropriate); title; organization/company; years of employment as an actuary, if applicable (see Cash Award section for more details); e-mail address; and phone number. Please provide all author information at the beginning of the article. In the event that an article exceeds 2500 words, the article may be declined or returned to the author with a request for further editing and resubmission.

Articles will be considered for publication regardless of whether they qualify for or are chosen for an award.

Articles that contain any overt political statements, commercial content, and other inappropriate material will not be accepted. Articles must comply with the Society of Actuaries' antitrust policy.

REVIEWING ARTICLES AND PUBLICATION

Articles will be evaluated on the basis of their originality, clarity, thoroughness, and practical applicability. Previously published articles will not be considered.

Submitted articles will be evaluated by a committee of reviewers for their potential for inclusion in an issue of Health Watch or potentially, a standalone collection of articles. If accepted, articles will be copy edited by Society of Actuaries staff in preparation for publication. Authors will be given an opportunity to review the articles after copy editing and prior to publication. In addition, authors of accepted articles must provide additional biographical information to assist in publicizing the article, if requested. The Health Section Research Committee reserves the right to reject or not publish any of the submitted articles.

CASH AWARDS

A committee of reviewers will select up to four articles for monetary awards. There are two categories of awards:

Best Overall Article	• $5,000 for First Place • $3,000 for Second Place • $1,000 for Third Place

Best Article written by a Health Section member who has been employed 5 years or less as an actuary.

- $2,000

Only Health Section members are eligible for prizes. Please note years of employment status with other author information at the beginning of the article. An author may be eligible for prizes in both categories, if applicable.

RIGHTS GRANTED

The article authors grant the Society of Actuaries the right to reprint, republish, and repackage their article.

QUESTIONS

Please direct any questions regarding this Call for Articles to:
Steven Siegel, Research Actuary
Society of Actuaries
ph. 847.706.3578 e-mail: ssiegel@soa.org

SUNDAY, JUNE 27, 2010

5-6:30 P.M.

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