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Session 62PD
Influencing Health Policy: Efforts and Impacts of the American Academy of Actuaries

Track: Health

Panelists: JANET M. CARSTENS
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Moderator: GEOFFREY C. SANDLER

Summary: Panelists discuss the various efforts the Academy has made regarding various health policy issues, for example: Medicare/prescription drugs, the uninsured, health care affordability, consumer-driven health care and long-term care.

MR. GEOFFREY C. SANDLER: I'm your moderator and a former chair of the Academy's Health Practice Council. In today's session our three panelists will describe the role that the Academy plays in helping policymakers understand the implications of health policy decisions.

First, Craig Hanna will give an overview of the Academy's approach to public policy issues. Next, Jan Carstens will discuss the structure and activities of the Academy's Health Practice Council. Then Cori Uccello will describe her role as the Academy senior health fellow, and give us some examples of specific issues she's been involved in. We'll follow this with an open discussion and questions. Let me introduce our panelists.

Craig Hanna is the Academy's director of public policy. He was former executive director of the House Democratic Policy Committee under Representative Richard

Gephardt and has more than 16 years of Capitol Hill experience working in a variety of positions. Most recently he served as senior policy advisor to Gephardt while formulating the Democratic agenda, beginning with the 104th Congress. While working on Capitol Hill, Craig was the key legislative coordinator for legislation passed in the wake of Sept. 11, 2001, including the Patriot Act and the supplemental appropriations for the war effort and recovery cleanup. Craig also represented Democratic leadership during the budget negotiations from 1995 to 1997. Originally from Ohio, Craig is a graduate of Kent State University, where he earned a bachelor's degree in political science and pursued a master's degree.

Jan Carstens is the vice president for health for the American Academy of Actuaries, where she chairs the Health Practice Council. She's also the chair of the Health Benefit System Practice Area for the Society of Actuaries and vice president of health for the Conference of Consulting Actuaries. Most recently, she was chief actuary and risk officer for Prime Therapeutics, where she managed the company's market planning and development, decision support and research and clinical departments. In this capacity, Jan was responsible for overseeing product development, benefit analysis, reporting, decision support and operations, drug, technology assessment, formulary management, clinical product and utilization programs. Prior to that she was consulting actuary in the Minneapolis office of Milliman, and she has more than 20 years of health care expertise. She's consulted with health plans on actuarial, underwriting, financial and operational issues. Before joining Milliman, she was a principal and unit manager with Tillinghast-Towers Perrin, leading that company's efforts to explore health care consulting opportunities in Europe. She holds a bachelor's degree in mathematics from the University of Minnesota; she's a frequent speaker at health industry meetings and has authored several articles on a variety of health care topics.

Cori Uccello is the senior health fellow at the American Academy of Actuaries. She's the actuarial profession's chief policy liaison on health care issues. In this role she participated in several briefings for and meetings with congressional staff on Medicare prescription drug and other health policy issues. She's also prepared testimony related to health insurance expansion and Medicare prescription drug coverage. Prior to joining the Academy she was a senior research associate at the Urban Institute, a Washington, D.C.-based think tank, where she focused on health insurance and retirement-related policy issues.

MR. CRAIG HANNA: Let me start out by picking up where Dr. Hughes left off yesterday in his presentation. In terms of the profession's impact on public policy, Dr. Hughes, right or wrong, portrayed the actuarial community's impact as marginal on the shaping of public policy. I can make a very strong case as to why that is not the case. I will later on. But for the time being I'm going to let that statement rest and operate as if it is a truism.

Before we get into this presentation, I'd like to see a show of hands for those of you who have been active either with the Academy or through your professional lives, or for that matter, non-professional lives, interacting with government officials either at the federal, state or local level. This is a pretty savvy audience. I just wanted to get a gauge of exactly whether we have a community here within this room that has already plugged in or is perhaps looking for this opportunity.

Let me begin by talking about how the American Academy of Actuaries approaches its mission of interfacing with government officials and quasi-government officials in order to represent the actuarial profession. The mission of the Academy is one that is being perpetually discussed and reshaped. We are constantly looking for ways to focus and perhaps lend more muscle to the activities in the strategic directions that the Academy utilizes as it engages in its various functions. We are most likely to come out with a new mission statement at our leadership meeting in August, for those of you who will be participating in that.

The mission of the Academy is extremely important. There's a rule of thumb that all practice areas can use as a decision-making model for identifying those issues that it feels that it must engage in, and how to go about those engagements. Obviously, depending on the sphere of influence, whether you are looking at interfacing with federal officials, state officials, or regulators, there's going to be a difference in your approach. The new frontier now is the international audience. The entire community has discovered that there is a global village, and whether you can water down or raise a standard is something that comes back home very quickly. That's an area in which the Academy is currently looking to expand its presence.

Even within a specific practice council, as Jan and Cori are going to discuss today, we all have to moderate exactly how we engage on a particular issue. It depends on the history of that issue, the history of the audience that we're speaking to, as well as the stage of the process that issue may be in. You perhaps have your greatest opportunity for influencing an outcome if you get there early, if you are able to help formulate the thinking, the conventional wisdom on a particular issue. You do it before there's some stratification of either partisan or other political considerations.

Within the Academy, we look at each and every issue and the question of how to engage through different perspectives. I'm sure each of you has had different experiences if you've had any involvement with the Academy, working either in professionalism or specifically within public policy or communications, which is really kind of a supporting role in terms of the "Academy Awards" for what we do.

Let's start with professionalism. When you're looking to expend any kind of capital in order to influence outcome, you have to assess your strong suit. The strong suit for the actuarial community is professionalism. Its prestige is built upon standards, as well as the expertise of the various practice areas. That is your ticket into whether you have anything worthwhile to say to a regulator or legislator, to give you a seat at the table when it comes time to decide how to shape a particular

issue. How you then express yourself within that public discourse is very important. So I'll get to it in a minute.

Here's a quick rundown of the infrastructure. We have organized the Academy in such a way that we have professionalism, communications and public policy. But we also have finance and administration, which is essentially where you all come in. It's whether the Academy has the support of the actuarial community. We are strengthened by greater numbers, greater representation with more membership for rank-and-file, as well as a volunteer base. Those of you who are willing to part from your very busy daily professional lives can spend some time and energy and engage in this process.

Technology, which I'm going to come back to at the end, is the second new frontier. This consists of creative ways of using our resources to communicate with policymakers. But we also have a profession-wide discussion to build consensus behind different approaches. We use a number of publications when it comes time to put together our thoughts or ideas, many of which you are familiar with. A monograph obviously is something that has a long-term benefit. It's meant to be a publication that perhaps can speak to an issue at the formulative stage that I spoke to earlier. An issue brief has a shorter shelf life; it's typically more plugged into a moving issue, or a known issue where we're trying once again to provide value-added information.

Comment letters are very short term, whether it's in concurrence with or detracting from a particular issue that's moving either at the regulatory stage or at the legislative stage of development. Practice notes—again these are cutting edge, these are for new practice areas that you, the community, are lending your expertise to. That oftentimes acts as the foundation upon which someone communicates directly to policymakers. Technical white papers are sort of an amalgam used to craft ideas on unconventional issues that don't fit neatly within other practice areas or may be slightly a half-step outside of an actuarial perspective on a particular issue. Then the law manuals obviously are used to navigate the patchwork of state regulatory issues.

That leads me directly into the National Association of Insurance Commissioners (NAIC) and National Conference of Insurance Legislators (NCOIL) presentations. These other means of communication are typically verbal. I'm going to go down the list and speak a little bit to generally what we do, and then Jan and Cori will give you the specifics of some of the more recent activities that we've been engaged in.

The NAIC and NCOIL obviously are associations that are very important to us. They are governmental/quasi-governmental in terms of trying to figure out whether there can be some consistency within that patchwork of regulation that I just spoke to. You know we're all making considered decisions as to whether we engage in a number of issues. I would say that at the NAIC in particular, the Academy has a very strong presence. In fact, it's one of those relationships where they come to us

perhaps before we even need to go to them to seek our advice and expertise on various issues. At every national meeting, on every conference call and at other meetings in between, there are many hours of Academy volunteer resources utilized to develop and put together our reports for them.

Testimony before Congress and/or state legislatures is typically by invitation only. Again, this is a "they come to us" rather than "we go to them" dynamic. This very high-visibility activity is usually arrived at with a lot of hard work at developing relationships and ongoing work with various legislators who recognize the value of what the Academy has to bring to this particular issue. We also submit written testimony, which doesn't have to have that kind of by-invitation-only kind of dynamic. But it typically does not receive the kind of visibility that you get when you actually sit in front of a microphone, in front of the cameras, in front of members of Congress for the back and forth.

Capitol Hill briefings: Cori will speak to one that we just did a week ago on association health plans (AHPs), but these are typically what I call "Issues 101." We are attempting to raise the level of understanding of federal policymakers. This is congressional and administration, as well as interested parties who are invited to these sessions. Capitol Hill visits, rather than "101," are more "one-on-one" on general issues. We're trying to associate a face, an individual, with the actuarial community so there is some opportunity to interface with the key policymakers.

Networking events: These are typically Capitol Hill visits with cocktails, essentially. It's a social activity in which we engage with policymakers in a more informal setting.

Interested parties and partnerships: This, from my perspective, has the potential to be a very important aspect of activity for the Academy, in that by coupling with other non-actuarial organizations, we have the ability on particular issues to raise the level of visibility on an issue through that alliance, oftentimes using that other organization's resources.

And finally, the international community is again something that our current leadership, Barbara Lautzenheiser, and president-elect Bob Wilcox are spending a tremendous amount of focus on, both on a proactive as well as perhaps defensive perspective, so that there aren't standards passed out of the International Actuarial Association (IAA) or the International Accounting Standards Committee (IASC) that will come back to haunt us.

The communications program again supports everything we do and say at the Academy. Obviously, if you have a good work product and nobody ever picks it up, nobody ever reads it, nobody knows about it, it's of little use in the mainstream. It may be of some use in particular niches. But again, we're always looking to develop a good level of exposure. I think several of the candidates for SOA president spoke yesterday about the image of the actuary. We're always very cognizant of how the actuarial community is regarded in terms of its engagement on public policy issues

in general. And again, to the extent that you come to the table as an interested party, but with an enlightened self-interest (in that you're looking to perfect and correct specific policies that are coming out), I think this is important to how you are perceived.

Another communication issue—this goes back to the forum for discussion for the key issues at large— is whether there can be a process by which the actuarial community develops consensus behind different issues. This is to the extent that there's a public policy role that we're trying to use here to influence outcomes. If we're only able to do that to the extent that there is agreement, then to the extent that there's discord within the profession on key issues, we are not going to have a very easy time convincing policymakers that the Academy speaks in a unified voice.

In addition to the fact that we have to communicate with each other, afterward we have to be able to communicate with policymakers on a very fundamental understandable level. The Academy's official spokesperson program provides media training and interpersonal communication skills to train several of our key volunteers who are liaisons to Capitol Hill, or who speak to the media on their issues of expertise.

All of the resources that come out of the Academy are available on www.actuary.org. And *Contingencies*, the magazine, has its own Web site. I invite any of you who have not had much exposure to the Academy to visit these Web sites. These are your first step toward understanding what we're doing, and perhaps you will consider becoming part of the volunteer base that the Academy uses to influence the outcome.

I'm now going to go to Jan Carstens, who's going to talk about the specifics of the Health Practice Council.

MS. JANET M. CARSTENS: I have to correct some information that I gave to Geoff. I was vice president for the Conference of Consulting Actuaries for health last year. But there's a new person filling that role. In fact, the Conference of Consulting Actuaries has restructured how they're organized and there is a vice president of practice areas. That person is Ken Buffin, and I don't want to take away his glory.

Craig gave an overview of the Academy and I'm going to give a bit of an overview of the Health Practice Council. I'll talk quite a bit about how we're organized. I want to let you know what we've identified as being our key issues for 2004. Then I want to talk a little bit about how we identify projects, the types of projects that we get engaged in, what some of our current projects are, and by no means am I going to be summarizing what all of our projects are. But then I also want to talk a little bit about how we go about completing a project once it's been identified. Lastly, I want to follow up with some of the activities of the Academy staff as they relate to the Health Practice Area, because the staff is so crucial to us.

The Health Practice Council has access to all of the Academy resources for items such as communications, publications, legal review, etc. We also have two dedicated staff people, and these people are crucial to making sure that the activities of that Health Practice Council and all of its different committees and task forces get done. Holly Kwiatkowski is the senior health policy analyst for federal issues. Joanna Ossinger is the health policy analyst for state issues.

These two coordinate pretty much all of the activities of the different work groups and committees that report to the Health Practice Council. We also have a senior health fellow, Cori Uccello, and you're going to hear from Cori in a bit about some of the specific work that we do. Cori's role is to provide independent actuarial expertise to the policymakers at both the federal and state levels. We started the Senior Health Fellow Program in 1998; it's one of two senior fellow programs the Academy has. Cori represents our outside voice. She's our external communications expert.

Reporting to the Health Practice Council are five specific committees. There's the Committee on Federal Health Issues; Al Bingham chairs that committee. There is the Committee on State Health Issues; Mike Abroe chairs that committee. Darrell Knapp chairs our Health Practice Financial Reporting Committee. Tom Wildsmith chairs the Medicare Steering Committee, and there's a new committee that is actually a joint committee. This is something that I'm not aware that we've done before. It's a joint committee between the Health Practice Council and the Pension Practice Council—the Joint Committee on Retiree Health. Jeff Petertill and Adam Reese jointly chair the committee. We also have work groups and task forces that report up through the various committees, and we generally assign a committee member to head up that work group or task force.

When we identify a new work group or a task force, sometimes we haven't gotten so far as to identify which committee it will reside under. For example, for the Disease Management Work Group, chaired by Rob Parke, we decided it would fall under the state health issues committee. Then there's another new work group just starting, that's the Experience Rating Work Group chaired by Bill Weller. We haven't decided where that one will go yet.

To make sure that we maintain close ties with the Professionalism Practice Council, we have a liaison to that council. That liaison is Geoff Sandler. We have several other liaisons, too. Dave Axene is our liaison to the Property & Casualty Work Group for Medical Malpractice. We also have somebody who is our international liaison. There are several different subjects that are covered by work groups or task forces that fall under the federal health issues committee. Some of those topics include long-term care, prescription drugs, defined-contribution health plans, association health plans (AHPs), the uninsured and CMS Medicaid rate certification. There is a new project, which, when I think about it, is a resurrection of an old work group—the Mental Health Parity Work Group.

The structure for the Committee on State Health Issues is a little bit more complicated. The Committee on State Health Issues is involved in public policy issues related to state regulation and other actuarial issues at the state level. The committee works primarily through the NAIC. But periodically the committee may respond to specific requests by state legislators. The topics that are covered by various work groups and task forces that report up to the state health issues committee include health-risk-based capital, and then there are a couple of subjects under there, long-term care, stop loss, disability income and asset codification. There is a State Long-Term-Care Task Force in addition to the Federal Long-Term-Care Task Force. The sub-group underneath it is the Long-Term-Care Reserving Work Group. Other topics that fall under the state health issues committee include Medicare supplement, Medicaid and individual health insurance rate filing.

I talked about the purpose for the state health issues committee; I just want to go back and summarize the federal health issues committee and what it is that they are responsible for. As you can probably guess, they're responsible for public policy issues related to the design and cost of the nation's healthcare system. They monitor federal legislative and regulatory activity. They also are involved in planning the Capitol Hill visits for the Health Practice Council.

The Health Practice Financial Reporting Committee monitors activities related to financial reporting that affect all areas of health practice. But they also review proposals on accounting and auditing issues related to the health area. There are two groups that report up to the Health Practice Financial Reporting Committee. They are the Health Liquidity Work Group and the Practice Notes Work Group.

The Medicare Steering Committee oversees any initiatives related to Medicare and has a sub-group reporting to it that has been responsible for responding to the Medicare trustees' report.

The Joint Retiree Health Committee has no sub-groups that report up to it at this point. They are responsible for addressing public policy issues related to health care benefits for retirees.

Obviously, there are a lot of items that cross each of these topics. We have a concerted effort to make sure that there's a lot of coordination and communication between the different committees and the different work groups and task forces. In particular, there is a brand new group, the Medicare Coordination Work group. Do I have that title right? It's chaired by Cori Uccello. It represents individuals from all of the different work groups or committees that are affected by the Medicare Modernization Act. We're making sure there's communication among the different committees, and that when we're following up on projects we're not duplicating efforts.

The Health Practice Council has a significant number of volunteers. We're trying to remember how many volunteers there are for the Health Practice Area. It's more

than 200. I think if we were to add it up, because of the different committees and work groups that are new this year, we'd find out that it probably is significantly more than 200.

Yesterday I had a conversation with an individual who was interested in volunteering and who wondered how much of a time commitment would be associated with volunteering. If you're just on one committee, you're probably talking about a time commitment of somewhere between one and two days per month. If you are on a work group or a task force, that time commitment might be a little bit less. It varies so much because some of the projects that we work on may have a very short time frame, so you condense that amount of volunteerism into a very short period of time.

We identify key issues on an annual basis. We also then look at those key issues throughout the year to make sure that we think they continue to be our key issues. The key issues that we've identified for 2004 include Medicare reform, prescription drugs, health care affordability, coverage for the uninsured, consumer-driven health care and retiree health insurance. There are also other issues and ongoing priorities. Obviously, we have several different work groups and task forces, and each of those work groups and task forces is addressing different issues that fall into its main topic. We're not ignoring these other non-key issues and priorities, we've just at this point in time put them a little bit lower on the priority scale.

The key issues are thought out by the members of the Health Practice Council and by the various committees and task forces. Then we verify the key issues through our annual Capitol Hill visits. If you were to compare this list for the past three years, probably it would remain pretty consistent. Some items would fall to a lower priority, under other issues or ongoing priorities. But in general, our top issues remain the top issues on Capitol Hill.

So how do we go about identifying the different projects that we want to undertake? The Health Practice Council has monthly conference calls, where we've reverted more to what I'll call a consent agenda format. We have printed updates of the work group and the committee and task force activities that are circulated before the call, so we can spend most of the time that we have on our conference calls discussing new items that have come up, professionalism issues and other projects that people have identified that we should be working on. We also have face-to-face meetings a couple of times a year.

I've already mentioned that we identify projects based on our annual Hill visits. These are coordinated by the staff and by the federal health issues committee. They generally cover two days of visits in which we meet with a lot of representatives on the Hill.

We may receive a specific request from the NAIC. We may receive a specific request from an individual insurance commissioner. Academy staff and/or Cori may comb

through new legislation that comes up to see if there are issues that affect health practitioners. So we may identify new projects that way. There's an Academy leadership meeting where not only are there representatives from the health practice, but there's also a representative from other practice councils. In general, it ends up being a brainstorming session where we talk about what are some projects that cross practice areas, etc.

Then we have other requests. Maybe it's a specific member, a volunteer request; maybe there are requests that come through from other practice councils. Maybe there's a request that comes through some of the Academy leadership or the Academy board.

Our role is to be the voice of U.S. actuaries on public policy and professionalism issues that relate to health practice. We do this through a number of vehicles. Craig has already touched upon what these vehicles are in general. But I thought I'd summarize some of the recent projects that we've completed that are related to each of the different publications or activities that we embark on.

The first project is monographs. Monographs are those documents that take a little bit more time to produce than most other items. A recent monograph that we had completed is the consumer-driven health plans monograph. We also do issue briefs. We can put together issue briefs and get them out on a quicker basis than monographs. We've done two issue briefs on Medicare's financial condition relatively recently. That's our response to the Medicare trustees' report. We had a recent issue brief on the uninsured.

Then we also had the NAIC-specific reports and requests. An example of completed projects there would be one that we did on Medicare supplement loss ratios. We also did one on health liquidity testing. We also responded to a request recently on long-term-care reserves.

Craig mentioned practice notes. There's a work group that reports under the health practice financial reporting committee that is in the process of updating several different practice notes that were created back in the early- to mid-1990s. We also have a couple of recent practice notes. One is a practice note on long-term-care compliance with rate stability regulations.

We also have other publications. There are many that we put out on a pretty regular basis either through the volunteer efforts or through the Academy staff efforts. Here's a list. One is a letter to the Equal Employment Opportunity Commission (EEOC) about a proposed retiree health benefit rule. But I wanted to just read through some of the ones that have gone out just in the months of March and April, and I'm sure I'm missing some.

We sent a letter to the Financial Accounting Standards Board (FASB)—a comment letter on FASB staff's position regarding accounting and disclosure requirements

related to the new Medicare law. We put out a guidebook on Medicare issues: *The Questions Candidates Should Answer about Medicare Reform*. You've seen copies of it. I think there are copies in the back of the room. We put together a letter for the Department of Treasury, regarding treasury guidelines on health savings accounts (HSAs). We did testimony for the House Ways and Means Committee regarding the 2004 Medicare trustees' report. We have another guidebook that we recently put together: *The Questions Candidates Should Answer about Americans without Health Insurance*. We also did the Health Rate Filing Task Force's report, which is also in the back of the room.

We have so many different activities and projects that we work on. They are all listed on the Academy's Web site. But it's probably a little too daunting to go through them here. We do the Hill briefings; we had one mid-last year that Cori participated in on the actuarial equivalence of Medicare prescription drug plans.

Now I want to talk a little bit about some of the current projects that we're involved in. As I just mentioned, the Health Rate Filing Task Force responded to a request from the NAIC regarding rate filing guidelines and the closed block problem. Copies of that report are in the back room.

We have the CMS Medicaid Rate Certification Work Group working on a practice note on CMS regulations requiring actuaries to certify that Medicaid rates are actuarially sound. A draft is in the process of being reviewed. The Mental Health Parity Work Group is working on a white paper on mental health parity, covering items such as: What is full parity? How much does it cost? What diagnoses are covered? We continue dialoguing with the NAIC regarding long-term-care reserves. I've already mentioned the group that's working on updating the practice notes. We had a Hill briefing on AHPs that just happened last week. I think Cori is going to talk about it a little bit. We also have a monograph planned for retiree health issues.

How do we complete a project once we've identified it? First, we identify the need either through the Hill visit, through our monthly conference calls of the Health Practice Council or through a special request. Then we verify that that project is an appropriate use of volunteer time and staff time. Through the leadership meeting we developed a guide for decision-making. It basically walks us through the steps necessary to determine whether a project is worthwhile for us to pursue, with respect to resource allocations, with respect to whether we'll have something to say on an issue that's identified, etc.

So once we identify and verify the needs for the project, then we communicate with the appropriate committee or task force and assign it to them to complete. They may assign an individual to draft content or maybe assign a work group to draft content. Once that content is created, then it goes back to the committee or task force that was identified in the first place for that group to review and basically provide their signoff. Once they provide the signoff, then it goes to an external peer reviewer. The ideal situation is that we have everything peer reviewed. The peer

reviewers provide comments. It then goes back to the committee or work group. That committee or work group reviews the comments and decides whether to incorporate the comments. Once they've done that, they provide the final product for signoff.

The work product then goes through the Academy's legal and communication review. It then goes to the communications department for prettying up and distribution to the members, to Congress, or whomever we decide is the ultimate audience.

I'd like to wrap up a little bit with some of the staff activities. I mentioned that both Holly and Joanna basically run the show. They coordinate all the activities of the Health Practice Council—the different committees, the work groups and the task forces. They also not only attend external meetings of external organizations, but they help to identify volunteers and members who might also be able to attend some of these meetings to talk about the Academy and what it is that the Academy does. They promote Academy participation at the different conferences, especially NCOIL and the National Conference of State Legislatures (NCSL), and in fact, also identify volunteers to speak at these conferences on various topics. They also schedule all the annual Capitol Hill visits and meetings with congressional staff, and they maintain contact with staffers throughout the year. There are many different meetings that are set up, and there are different volunteers who participate in those meetings. So, there's ongoing communication with Capitol Hill. And then of course, there are the Capitol Hill briefings: scheduling of those and identifying speakers. The one thing I forgot is the cocktail parties—they also schedule those.

MS. CORI E. UCCELLO: I also want to acknowledge that we really do appreciate all the work that our volunteers put in. I know your time is valuable, but we really couldn't do it without you.

I'll talk a little bit more about what I do specifically. But then we'll get into a little more meat, into some of the issues that the Academy has been involved with and some of the activities that we've undertaken.

In my role, one of the things I do is to reach out to congressional staff. I do this through, as well as with, the Health Practice Council, through Academy publications that are targeted to Hill staff. I also participate in Hill briefings. Then I also have more substantive meetings, more on a one-on-one basis, with key health staffers on issues that they're working on. A lot of the Hill briefings are usually more general in nature and have a more general audience who aren't necessarily the key experts in those areas. We talk to the key experts more on a one-on-one basis than in those types of forums.

Another thing I try to do—and this has been one of my particular interests—is to reach out more to key policy organizations. I come from the policy world and so I've been trying more to link up with them and to provide more opportunities for

collaboration between the actuarial community and the public policy community. I participated in providing input into several meetings and conferences that they've had, as well as research projects. I'll go into a little more detail on some of those later on.

Now I'll talk about two of the key issues that I've worked on over the past few years. I've worked on several. Jan talked about all the various issues that we do at the Academy. But these are the two that I really put most of my time in during the past few years. The first is the uninsured and insurance coverage issues, and the second is Medicare. These have also—just on the federal side—been the issues that have gotten most of the attention during the past couple of years or so. But I would say that if you picked up the *Washington Post* any day this week or last week or next week, you've probably seen more about the cicadas than you would about any of these issues.

In terms of the Academy, sometimes we hear from members who think we should be out there more advocating certain things. And other people say we're too strong against something or for something. It's really a fine balance that we need to strike. Some things are just more political ideology on the way to help solve a problem. In particular: expanding health insurance coverage. Some policymakers prefer to pursue public expansion. Others prefer to pursue private expansion. And part of that is just really more of an ideological difference, and that's not really where we can add as much value as we can on the technical side. So we really try to keep the work that we do more focused on technical issues, and in that way we can still be nonpartisan and independent, and really be seen as a professional organization that's nonpartisan.

The various uninsured-related issues that we worked on are health coverage tax credit, AHPs, consumer-driven health plans, health saving accounts and the election-year guide. So I'll talk about each of these in a little more detail.

As many of you may know, the Trade Act of 2002 includes a 65 percent health insurance tax credit for workers who are displaced by international trade, as well as early retirees who receive pension benefits from the Pension Benefit Guaranty Corporation (PBGC). This is a relatively narrowly focused tax credit. The tax credit can be used for COBRA. It can be used for non-group coverage or for some alternative coverages. The Academy did some work on this. We submitted some written testimony, and we discussed in particular whether the premiums would change what the impact on COBRA would be, and the high-risk pool subsidies. This is an example in which the House Ways and Means Committee came to us, asked us to provide them with some information, and we were able to do that.

Now there is talk about expanding the tax credit into a broader population: either all the unemployed or all individuals with incomes below a particular threshold, and the Academy has been involved in looking into these types of proposals. We've had several meetings with the Department of Treasury, with congressional staff, and

with various policy experts. I found that they are most interested in learning how the non-group market works. The policy community and policymakers don't necessarily have a good sense of how the non-group market works, and they are really coming to us for information on how it works currently and how the market would respond to tax credits if they were to be implemented.

We've also spent a lot of time on AHPs. Last week the House just passed again their association health plan bill, although it is stalled in the Senate and it's unlikely that it will pass. But it comes up every year. As you probably know, this AHP bill would allow small businesses to band together through trade and professional associations to purchase health benefits. These certified AHPs would be exempt from state regulations.

Every year this bill is introduced and every year we write a comment letter to Congress citing concerns about these types of plans. The letter in summary pretty much says that AHPs could contribute to an unlevel playing field, and thereby destabilize the small group market. There are also concerns about inadequate surplus requirements that could increase the risk of insolvency. We just had a Hill briefing last week that again talks about these issues, as well as some general risk-pooling mechanisms.

Moving on to consumer-driven health plans. By moving to these types of plans, employers are hoping to increase the quality of care while at the same time decrease cost growth. Consumer-driven health plans attempt to address these concerns, especially that consumers are immunized from the cost of health care and, therefore, aren't behaving as efficiently as they would otherwise. Policymakers have really shown an interest in using these types of plans to expand health insurance coverage, and the new health savings accounts are an example of this.

A couple of years ago the Academy put out an issue brief that was really just a primer on describing what these kinds of plans are, and we presented that brief at an Employee Benefit Research Institute (EBRI) conference. Then we followed that up with a monograph that talked more about what the potential impact on cost these plans could have. Our next step—and we're going to try to do this in cooperation with the SOA—is to try to gather and analyze actual data to look at the actual impacts of these plans rather than just looking at a model that looks at the potential theoretical impacts.

The health savings accounts were implemented as part of the new Medicare law. These new accounts replace and expand medical savings accounts (MSAs). They combine a high deductible health plan with a savings account, and the health plan has to have a minimum deductible of $1,000 for individuals and $2,000 for family coverage. Contributions to the health savings accounts are limited to the lesser of the deductible or $2,600 for self-only coverage, or $5,150 for family coverage. A couple of months ago the Department of Treasury and the IRS issued some regulatory guidance that addresses these types of plans. We drafted a comment

letter on that guidance. We addressed in particular their guidance related to the appropriate standards for preventive care; the relationship between HSAs and other account-based medical plans, as well as the non-discrimination rules. Our next step will be to revise the Academy's monograph on MSAs. That was done five or more years ago, and we want to update it so it reflects the HSAs.

As Jan has already told you, we've also been working on the election-year guide on the uninsured. We really wanted to put some key issues down that we hope will be used by reporters as they are examining the candidates' proposals. We list some questions that reporters can pose to candidates to help get a better idea of what their policies would be. You read the papers. Every day or so, either President Bush or John Kerry seems to give some information about what their proposals would be. But there aren't necessarily a lot of details in there. So through these guidebooks we tried to go a little deeper to get a little more information on what their plans include.

Now on to Medicare issues. There were two sessions here that included a lot of information about the Medicare Modernization Act. I'm going to repeat some of that, so I apologize. But the Academy has also done some work on Medicare's financial condition, and we did a Medicare guidebook, an election-year guide on Medicare. In the new Medicare guide, we focused on the prescription drug portion of the new law. The new law would create a voluntary and federally subsidized outpatient prescription drug benefit that's available through prescription-drug-only coverages from private plans or through the Medicare Advantage plans, which are the renamed Medicare+Choice plans.
The standard drug plan would have a $250 deductible, and then the plan would pay 75 percent of drug cost up to initial coverage limit of $2,250. Then there would be a coverage gap, or the "hole in the doughnut" as you may have heard it referred to. After reaching an out-of-pocket maximum of $3,600, the plan would again kick in and pay 95 percent of the drug cost. There would be government subsidies for premiums and plan reinsurance, and there would be additional subsidies for low-income enrollees and for qualified retiree plans. I think the Congressional Budget Office (CBO) estimated that the average premium for 2006 would be about $35.

I've spent probably most of my time in the past year on the Medicare prescription drug bills and then the law. We had several Hill briefings, one of which Corey Berger helped us out with, looking at actuarial equivalence. I'll talk about that a little bit more later. We also had a briefing on whether the drug benefit should be provided through public sources or private sources. It sounds like I'm contradicting myself from earlier. But what we did was, we didn't have actuaries talk about that issue. Instead, we brought in outside experts, one that was a proponent for offering drug benefits through the public Medicare program and another who proposed doing it through private plans. That way we could bring these people together, but we didn't have to choose a side ourselves.

We also wrote a white paper, "Medicare Prescription Drug Plans," and it addressed three particular issues: adverse selection, drug utilization management and risk sharing. This was an incredibly popular white paper, and it really opened the door for us; a lot of outside organizations read it and then wanted to become involved with us. A lot of Senate and House staffers read it and then invited us to be more involved with them as they wrote their legislation.

We also collaborated with other outside organizations. The Kaiser Family Foundation put together a report, "Medicare Prescription Drugs through Private Drug-Only Plans: A Discussion with Actuaries." They called us up and wanted to interview several actuaries to get their feedback on how drug-only plans would work, and so this was a great opportunity for actuaries to get more exposure in the policy community. There were other conferences held by the National Council on Aging and the National Health Policy Forum, which actually in their handout package included our white paper. So again, that was really great for us to get a little more exposure.

Most of my time working on the drug bill was spent on the risk-sharing provisions in the bill. The final bill has both risk corridors and individual reinsurance. These are for the private plans that are participating. The plans when they submit their bids will submit a target or expected plan cost. The plans will bear the full risk within 2.5 percent of that target. So if the actual costs are a little higher than expected, they have to bear the cost; if the costs are a little lower than expected, they get to keep their gain.

Beyond those corridors, however, the government will share in the risk. The government will bear 75 percent of the risk between 2.5 and 5 percent of the target. In other words, if the actual plan costs are less than expected the government will take back some of that money, and if they're more than expected the government will pay the plan a little more. The government will bear 90 percent of risk over 5 percent of the target. Over time, however, as plans get more experience and more understanding of how the drug costs are going to be, the government's threshold is sliding and the government risk-sharing will decrease. In other words, the private plans will have to bear more of the risk over time. There's also an individual reinsurance component, where 80 percent of the drug costs exceeding the plan's out-of-pocket maximum will be covered by the federal government.

As I said, the Academy had a lot of activity related to risk-sharing provisions. We had several discussions with key health staffers on the Hill regarding these provisions. At one point, I went up there every Friday afternoon at 2 p.m. to meet with Senate finance staff, talked to them and had a conference call with some other actuaries around the country to discuss their particular risk-sharing provision ideas.

We gave some written testimony to House Ways and Means, which had a hearing, and our testimony was based on our white paper. We also gave a comment letter to

the Medicare Conference Committee regarding the risk-sharing provisions in the House- and Senate-passed bills. The House had one version of risk-sharing; the Senate had another; and we wrote a comment letter that essentially recommended that the Senate approach made more sense. In the end, the provisions in the final bill were consistent with our recommendations. I don't know if that's causation or correlation, but it seems to work.

Again, as you know, there are actuarial equivalence requirements in the new law. Plans can offer the standard benefit package with that $250 deductible and the specified coinsurance rates. Or they can provide plans that are at least actuarially equivalent to the standard plan, subject to a few requirements: the deductible can't be higher than the standard deductible, and it has to have the same out-of-pocket maximum. But the plan can change other things. The specific regulations are still to come from CMS on how all of this is going to work.

As I said earlier, we had a Hill briefing that was done in conjunction with the SOA on the actuarial equivalence of the Medicare Drug Plans. You wouldn't think that this would be a really popular Hill briefing, but I think it was our most widely attended Hill briefing that I had ever been involved with. It was standing-room only, people clamoring to get in to hear about actuarial equivalence. Who knew? I'm still getting calls about it. That was a great success!

We've also had several discussions, again with key Hill staffers, who are very interested in what types of plans could potentially be actuarially equivalent. We've also had preliminary discussions with CMS regarding actuarial equivalence. In the coming months we expect CMS to come out with regulations on how actuarial equivalence will be evaluated, and we have already put together a work group that will put out a comment letter when the regulations come out. We're already trying to look at some of the particular issues that are going to be related to this, so we can be fully prepared.

In terms of other Academy activity related to the new Medicare law, we've had several discussions with key health staffers and other organizations regarding the retiree health provisions and also the actuarial equivalence provisions related to the retiree health provisions. We also submitted a comment letter that recommended Academy membership be required for any actuarial work called for under the bill, and now the law.

I'll turn next to some activities that the Academy has done related to Medicare's financial condition. What we did in the past years after the trustees' report was usually to put out just a quick one-pager that highlighted some of the trustees' report findings.

But in the past year we decided to step back and take a more comprehensive look at Medicare's financial condition. We looked not only at trust fund solvency, which is what much of our work in the past has done. But also, we looked at Medicare's

potential impact on the federal budget, as well as the impact on the economy. We also provided written testimony to the House Ways and Means Committee based on the new issue brief. I think we all know that hospital insurance (HI), which is Medicare Part A, covers hospital services. If things don't change, the HI trust fund will go bankrupt in the year 2019. What's important to note here is that we've all read in the papers that these dates are sooner than projected last year, and that a lot of it is due to higher projected expenditures, while at the same time lower projected payroll taxes.

But it's important to note that we've seen it stated in newspaper articles that the new drug program is contributing to this. But it's not, because the prescription drug program is actually included in the supplementary medical insurance (SMI) trust fund figures. The SMI trust fund will not go bankrupt, because its revenues are reset every year so that they meet expected expenditures.

Clearly, total expenditures are increasing fairly rapidly for Medicare, especially when you consider Medicare along with Social Security. If you combine them they make up about 7 percent of GDP in this year. Under current law projections these could grow to over 19 percent in the year 2070 and beyond. What's important to note here is that total federal revenues are historically at about 19 percent. So we can see by the year 2070 or so, Medicare and Social Security alone, if there aren't any changes and the projections follows these patterns, would take up all of the federal revenue. I'm not suggesting that this is actually going to happen. But I think this highlights the magnitude of the potential problem and highlights that something needs to be done. So we highlighted this in our brief.

There's a less–reported-on provision in the new Medicare law that limits general revenue financing. If general funding sources account for more than 45 percent of Medicare spending within the next seven years, the president is required to recommend ways to reduce this share. Of course, options include increasing beneficiary premiums, reducing provider payments and so on. Congress could implement these recommendations, but it would not be required to do so. Now this latest Medicare trustees' report estimates that the threshold won't be reached until about 2012, so it didn't trigger that provision this year, but it could as soon as a couple of years from now.

Back to the election-year guides again. We're mailing them to the people who are running the presidential debates, to give the reporters some ideas for questions that they can ask the candidates regarding Medicare and the uninsured.

And I just wanted to say thanks again to all the volunteers. I don't think we can stress enough how we really can't do it without you.

MR. SANDLER: We're going to open the floor for questions and comments in a moment. I'd like to make a few comments first myself. We could have just as well titled this session "The Growing Influence of the American Academy of Actuaries on

Health Policy." If you go back to the early 1990s, when our Capitol Hill visits were relatively new, we first of all had to work very hard to get the people to even meet with us. When we did meet with Capitol Hill staff we spent about the first half of each session explaining to them what an actuary was and what the American Academy of Actuaries is. The situation is very different today, where not only do we not have to explain what an actuary is, but most of the people who we meet with are already familiar not just with actuaries, but also with the Academy of Actuaries. They have read our publications, and they oftentimes have reached out to us on particular issues. It's very fulfilling for us as professionals to see how the knowledge of the actuarial profession, and the reputation of the American Academy of Actuaries, has really flowered over the last 10 to 15 years.

As our other speakers have mentioned before, none of this could happen without Academy members like you volunteering your time and expertise. This is a volunteer activity. The volunteer activity is coordinated by the Academy staff, but it happens because of your willingness to participate. As Cori said, we can't emphasize that enough.

Another thing that I want to emphasize, in terms of what we try to contribute to the public policy debate, is that we work very hard not to take positions. We try to be considered bi-partisan. Our approach is to make sure that policymakers understand the implications of public policy decisions, not to recommend a particular public policy decision. Public policy decisions are a matter of social policy and other influences and not purely actuarial, although they do have actuarial implications. Our role is to try to help policymakers understand what the implications are of making one set of decisions versus another.

I want to roll the clock back about five years or so to the monograph that was mentioned earlier on MSAs. I think that is the ideal outcome for us as actuaries. The monograph that we put together on MSAs was used in Congress by both sides of the public policy debate. Both of them referred to our monograph as a source for information. We could not have expected a better outcome than to have both sides in a public policy debate turn to us for our expertise.

Cori mentioned before the reference to the definition of an actuary in federal legislation as being a member of the Academy. That is another issue not just at the federal level, but around the country at the state level. There are many things at the state level that require some kind of actuarial certification. If you go back 10 years or longer, what you would find is that there might be references to actuarial certification with no particular definition of what an actuary is. We have tried over the years to have state and federal legislation that refers to actuaries as being members of the American Academy of Actuaries, and again that's one of those fulfilling things where we have to work less to get that to happen. Many times now it's becoming more automatic at the state legislature level. They will associate the idea of an actuary with being an American Academy of Actuaries member, without us having to go and bring that up.

We have talked about the many publications and other kinds of work products, Hill briefings, etc., that we do at the Academy. I just want to emphasize there are really two audiences for that. One is the policymakers themselves. The other is our membership, because we want to try to inform you of the public policy issues. Particularly for areas where you may not be working personally, we want to help you be better educated, so that you can spread the gospel of actuarial knowledge and expertise.

So with that I'd like to open the floor to questions and comments.

MR. MARK E. LITOW: First, the Academy is doing great; they just need to go faster before the whole health care system falls apart. I have two questions. One for Jan: you talked about the leadership committee. What are the mega-issues that the leadership committee has identified on a cross-discipline basis? And I probably will give you two suggestions. The second is for Cori: you talked about heading toward case studies. Have we considered or done any case studies where we took legislation that was implemented after the fact, and did a study to see what the impacts are versus what was estimated to show what the implications are from an actuarial basis?

MS. CARSTENS: What are the mega-issues that the leadership has identified? You already touched on it a little bit, Mark, and that is that we need to move and we need to move as quickly as we can to address different issues. One of the things that we've been working on at the leadership meeting is to come up with our vision statement, and then the specific activities around the vision statement that cover public policy, communication and professionalism. And obviously there's a lot of overlap between public policy, communication and professionalism. So anyway, that I guess would be the most recent mega-issue that we've been tackling—to specifically come up with the vision statement, and then the specific activities associated with that to make sure that we are addressing the issues that we need to be addressing from a public policy and a professionalism standpoint.

MS. UCCELLO: In terms of case studies, we haven't really done any while I've been here, and I don't believe there were any prior to that. But I think that's an interesting idea. I think the closest to that is what we might be doing going back to the consumer-driven health plans and looking at some actual data, but not necessarily on a case-study-type method.

MR. LITOW: If you want a suggestion, my suggestion would be to do one on the small group market and implications over time of the rating bands and guarantee issue that had been implemented. That would be a beauty—very difficult to study, but it would be a beauty.

MR. VLADIMIR Y. ITKIN: Janet mentioned the experience rating work group. Could you expand a little bit on what exactly they are going to work on?

MS. CARSTENS: The experience rating work group specifically is working on addressing experience rating in the individual market. It's somewhat of an offshoot of the health rate filing work group. So it's taking some of the ideas and some of the issues that were generated from that work group and exploring them a little bit further.

MR. JOSEPH A. ROLLING: Several years ago the Academy put out this great thing about Social Security, and it was very interesting what you've shown—how Social Security and Medicare combined will, in the not-too-distant future, take up all the revenues that the government takes in. I have just a general question. We just had a huge boost from Alan Greenspan in that regard, and given that boost do you see any real movement in the next half decade, or are all our representatives going to keep their heads buried for at least the next half decade?

MR. HANNA: I think that's a safe assumption, especially in an election year. I think the unfortunate dynamic in federal politics, at least recently, is there's a continual campaign going on. But I think the Academy has elevated the level of discussion on these issues. There's been some good dialogue back and forth between those members working on Medicare solvency issues and those members working on the social insurance committee, which oversees the Social Security solvency issues, where in fact, they're beginning to use the same language in terms of characterizing the combined effect on the economy, and what perhaps may be in the offing in future generations.

In my experience in working on Capitol Hill, immediacy of an issue in hand drives decisions. Obviously the unfortunate events of Sept. 11, 2001, were an example of where Congress put down its partisan differences and worked together on various issues. The unfortunate dynamic involved in Social Security and Medicare perhaps is that the more immediate you get the more difficult it is to find solutions, or the more onerous it may be on beneficiaries. So the question is: How can you build a sense of urgency now so that there are more options available to you? And I think it's working in conjunction with both health and pension practice members, working with other interested parties and doing things like this, to get to the mainstream discussion. There's also a third election-year guidebook in the series, which addresses Social Security. We're trying to expand our efforts by working with other interested parties, working with media to try to be a little more mainstream in this type of discussion.

FROM THE FLOOR: I have one unrelated question. I'm not sure if anyone knows this or even has an opinion. But with the new drug bill that was just passed, there's been a lot of discussion about how they specifically said that federal government cannot bargain for prices and that's left to the pharmacy benefit managers (PBMs). I was just curious if anyone knows or has an opinion about at least what the current Veterans Administration (VA) discounts are versus what a good PBM discount would be?

(No responses.)