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Session 88
Affordability: The Regulatory Response Seminar Part 3

Track: Health

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Summary: Panelists discuss how the regulatory environment is being reactive and proactive to improve affordability in the market. Attendees gain better insight on regulatory and legislative hot topics. What topics are hot at the NAIC, state level and federal level?

MR. STUART D. RACHLIN: Welcome to the third of three sessions. I'm a consulting actuary with Milliman in the Tampa office. We're going to start as an interactive group session and then we're going to bring on a couple of presenters after that. Jim will explain it in more detail.

MR. JIM TOOLE: These are going to be stakeholder discussion groups. We spent the first couple of sessions talking about the goals of a health-care system and who the stake-holders are, so I hope we bring some background to the table. Many of us work for the side of the payers or regulators and fewer of us work for providers and consumers, so we're going to put people at the different tables and talk about your perspectives. In order to make public policy, it requires a great deal of

NOTE: Charts referred to in this text can be downloaded at: http://handouts.soa.org/conted/cearchive/neworleans-june05/088_uccello.pdf

flexibility. Actuaries are often seen as one-dimensional, and that's something we picked up in the image campaign and all the research that went into that. For our voices to be heard, actuaries need to think outside of their traditional role and be able to understand the perspectives of different people. That's the idea behind this exercise. Our goal is to position our profession to play a greater role in shaping health policy in the years ahead.

Each table will have a stakeholder. We have the health plans, or payers. We have the drug companies, employers, providers, retirees, consumers and regulators. We don't ask you to sit at a table where you're most comfortable. We want you to be at a table where you are challenged to think outside of your normal space. At most of the tables we have some of the participants who have been speaking during the day and they will facilitate your conversations. We've got some people at different tables. We are going to position ourselves to help move the conversation along. We're going to discuss stakeholders' issues and concerns. We've got sample questions that have been provided. So we need to have one person volunteer to be a recorder and then report back to the room after the discussion has ended at your table. Are you interested in being the public policy face for your group? You could be the last person to leave the island. Here are some current public policy topics that we identified: AHPs, tax credits, federal reinsurance pools, health savings accounts (HSAs) and Medicare Part D. Any one of these could be what you have to discuss.

Here's an example of what you might want to think about at your table. For AHPs, for the payers, what is your concern about AHPs—or what's the good side, what's the upside and what's the downside? There are a number of concerns that it would provide an unlevel playing field with regard to mandates and rating and other aspects, so payers generally wouldn't be favorable. However, employers, small groups and associations would see this as positive for writing affordability and access. Consumers, on the other hand, are mostly unaware or uneducated on the issue and would the consumer protection laws continue to help them or would they find out further down the road that they got a bad apple? Regulators really need to be concerned about clarifying the responsibility of who's in charge of implementing and regulating the law if passed at the federal level. Is it the states and the federal government? A potentially large new bureaucracy would need to be formed at the Department of Labor if AHPs were put into place. What are the solvency requirements for these new institutions?

This is our hot topic for discussion among the groups.

MR. RACHLIN: I'm just going to set the table for our discussion, just give you a little bit of background. Is there anybody who does not know anything about Medicare Part D? I imagine everybody is at least familiar with it, if they didn't just spend the last six to eight weeks not seeing their families as I did. It was a killer exercise for a lot of us in the industry to prepare and continue to prepare for the 2006 Medicare Part D, a prescription drug program for seniors. Although it's

Medicare, so it's disableds, DSRDs. There are others besides just the elderly, although that's obviously the predominant population. So finally, there's this prescription drug coverage. Is it going to be affordable? Is it comprehensive? Most important, will it be long-lasting? I think some of the discussion topics we have will get into that.

Just for those who may not be as familiar with it as others, let me give you some background so you'll feel comfortable with the discussions. Again, the discussion is going to focus on the effective date of Jan. 1, 2006 for Part D coverage for Medicare. It is a voluntary program. There's a six-month initial enrollment period. There's some standard coverage and there's a significant penalty for late enrollment – it's 1 percent per month if the senior fails to enroll during that time, similar to the Part B penalty.

This, for those who may not know, is what the standard plan looks like. There's a $250 deductible and then the next $2,000 of coverage is $75/$25 coinsurance. Then there's what is famously called the doughnut hole, although this is a rectangle, not a doughnut. So there's a corridor where there's no coverage, and then finally $5,100 of drug spanned, which is $3,600 of member out-of-pocket. There is catastrophic coverage, which is mainly covered by the government through a reinsurance subsidy to the payers. The beneficiary then pays the greater of 5 percent or $2 generic/$5 brand and the plan pays the difference, which is roughly 15 percent or so. We actually think the beneficiary co-pay coinsurance is about 5.5 percent when you take the greater. That's what the plan looks like. This is Milliman's estimates of the drug spend in the various buckets. Significant folks will be in that catastrophic level of drug spend. A good amount will be in that doughnut hole. The preponderance will have a drug spend in that 75 percent coverage period. About 15 percent won't even meet the deductible, which leads to an issue that there's an anti-selection factor. I'm sure this will come up in the groups. Who should buy the coverage and who shouldn't? There's a certain educated decision that someone could make and on the Centers for Medicare & Medicaid Services (CMS) Web site there's a tool where you're supposed to pop in your numbers. I don't know exactly what pops out. It's like – yes, you should buy it, or no, you shouldn't buy it, but it's some kind of tool like that.

The offerings and beneficiaries have a choice of at least two standard plans in each region. There are PDP regions, as you probably know. They buy in at the first opportunity or else they have that penalty. The insurers offer standard equivalent plans. They can offer something richer, but that's a big issue for the payers, the anti-selection potential of offering multiple plans. A lot of my clients really scratch their heads. We really try to strategize about what the anti-selection load should be for an enhanced plan, so that's a good discussion item for the groups.

The government has latitudes to encourage insurers to participate. There are a lot of new regulations still being written. All the rules are still not known, so a lot is going on there.

The drug offerings come in two flavors: basically, your Medicare advantage in the old world, the Medicare risk and the HMO plans, which could be PPO as well. They offer the medical and drugs combined. It's the managed care angle of that. Then there are the prescription drug plans (PDPs). That's just a drug plan and it's still fee-for-service. There are two ways for a Medicare-eligible person to get involved in Medicare Part D, through either the MAPDs or the PDPs.

MR. TOOLE: The first step is getting somebody who is going to report out, and we're going to come join your group.

MR. RACHLIN: There are five questions on the bottom of the page. Go through them one at a time; spend a couple of minutes on each. We're going to bring the groups back together and see what we get for answers. Again, it's stakeholder discussions regarding Medicare Part D.

MR. TOOLE: To make sure that the tables are comfortable with what they're going to be presenting and there are no dissenting views, you can prepare your dissenting view. I'll point to different tables and get up and talk. I don't know if you're having discussions or just enjoying yourselves, so we want to get started now. If you could just tell everybody what you were talking about and say first which stakeholder you are and then talk about your response.

MR. RACHLIN: Can we do the stakeholders in pairs so the employers are all at the same time?

MR. TOOLE: We don't have pairs for all of them. If there are two employers, the second one will add in what they had that was different.

FROM THE FLOOR: As far as the goals of the stakeholders, we're the health plans and we had several goals: making money, understanding the risk, protecting our other business, and as a growth opportunity, co-ops as a company. As far as the aspects of the proposed policy that are likely to be beneficial to us, government reinsurance offers a high-level protection from downside risk. We have the potential to cross-market other products and there's a good reimbursement potential. The government is making a sweet deal right now.

We're worried about the long-term viability of the plan. Medicare Plus Choice is starting out really good and then you've got words that are off. The government's funding level is good right now, but we know there's a federal deficit and they are going to be looking to cut the deficit somewhere. There are an infinite number of benefit designs and we're going to be competing on a nonstandard basis with a lot of different people. The risk-investment process that CMS is using is untested. Theoretically, it appears good.

Where we had the most discussion and the least amount of consensus, I would say that we tended more toward the neutral of either not being for it or necessarily

against it. Some people were optimistic; some people were slightly pessimistic. The bottom line is you saw there were several promos to look at that we talked about, but the kinds of business are bad and so it really comes down to the individual company's decision as to which is the worst of the two evils. Which one would they rather live with the least, upset the loss in market share if they don't do something versus the profitability if they do something. Consequently, if it fails, there's a brand image problem.

The last question is what will likely be the stakeholder's plan of action if the proposal passes? We will probably start our product development process and look into it even if we try to minimize the exposure that we have with the early part. We definitely would be anxious to work with CMS as they fill up the rules and guidelines and help them come up with reasonable data.

FROM THE FLOOR: The first question was, review the goals of the stakeholder in the health-care system. Basically, the overriding goal for legislators and policy-makers is to get reelected, but in order to do that, they have to make their constituents happy. So we want to make sure we can get access to Rx coverage for seniors. You want to make sure that the elderly population isn't financially bankrupt due to high prescription drug costs. The other goal is just long-term reportability of the plan. Question two pretty much overlapped over question one. The aspects of the proposed policy, they're likely to be beneficial to the stakeholder to the extent that it's going to get them reelected. As far as negative impact, most of the negative impact is around cost and making sure that we can fund this program over the long term. There may be a potential issue with the out-of-pocket cost to the seniors since it's still somewhat significant at $3,600. There are also selection issues in regard to the funding. Basically, you know the people who have the highest drug costs are the ones who are going to want to join this plan. Question four – overall, is this particular stakeholder likely to support this proposed policy or be against it? They're going to support it as long as their voters do. For question five, what will likely be the stakeholder's plan of action if the proposal passes? Once again, it's going to be to figure out how to pay for it over the long term now that you've decided to enact it. That government will probably have a greater interest in keeping prescription drug costs low since they are going to be writing the checks for a good portion of it. They also want to ensure that employers aren't going to start dropping their employer-funded retiree plans based on the implementation of this program.

FROM THE FLOOR: We are the retirees, the consumers. Our goal is to get drugs at the lowest price we can get them covered. What aspects of the proposed policy are likely to be beneficial to the stakeholder? We felt retirees are split into two groups today. Some have employer coverage and some don't, so the ones who have employer coverage will be worried about what their employers are going to do and will they drop that coverage or will they eliminate it? For those who don't have coverage today, they'll just be glad that they'll have some opportunity here to have some coverage. What aspects of the proposed policy are likely to have negative

impact? We have a lot of those. There are different carriers. It's too confusing. We're not used to having a large deductible, not used to this doughnut hole, and not used to this indexing. It's just very confusing for the retiree. Is my drug covered? Is it in the network, etc.? Is my pharmacy in the network? Overall, is this particular stakeholder likely to support this proposed policy or be against it? We feel the retirees will support it; it's better than nothing, they have no coverage at all today for the most part. What will likely be the stakeholder's plan of action if the proposal passes? They'll need to do a lot of research, investigation, figure out what plan to take, what's their best choice. We feel younger consumers won't count on it at all. They don't think the program will last and so therefore they won't pay a whole lot of attention to it. They'll just be upset they have to pay more taxes.

FROM THE FLOOR: We also represented the retirees and consumers. Excuse me if I repeat some of the ones that were already said. First, I will talk about goals. The number 1 goal is free drugs -- in particular, the drugs that they need. Anything at all they can get out of the plan. In some cases, people who have chronic conditions may have catastrophic drug costs in a financial sense and those people would definitely hope to get something out of this. They hope that the drugs are on a formulary and they hope to see savings over the current payments and then a similar theme – more than what they're getting now. In terms of things that the people see that are beneficial – if nothing else this is another option for these people. For the people who have extremely high usage, they will get more drugs at more reasonable prices. Many people have improved financial positions by the fact that they don't have to shell out hundreds of dollars per month, and this program does have a subsidy. There will be less fear of having to make the choice in the future of paying for food or paying for drug choices. And notice we're not saying that they necessarily will have to make that choice, but they probably have fears of that.

In terms of things that the consumers and retirees would probably find negative, confusion has already been mentioned. There's the possibility that they will make bad choices and then have to live with it. There is change involved here. The information is confusing or will be confusing. It will be very hard to compare plans and other ideas. With any change there is an opportunity for scam artists and con artists to take advantage. So there will probably be scams out there. The benefits will change over time. The premiums will change over time, which might catch people by surprise. An example of a bad choice someone could make is they don't realize their drug is not on the list because they are confused by all the different trade names and generic names and things like that.

What's their general reaction? In terms of being supportive of the policy or against the policy, we thought it probably depended on the person who was involved. So we thought that people tend to stick with what they have, at least initially. We had the opinion that probably the younger and new retirees would have a positive attitude toward this, but that the older people would probably have a less positive attitude. The general opinion of the people at the table was that CMS is probably

being overly optimistic about how many people will enroll. And then there's obviously the fear change.

In terms of plan of action, we just realized that this has passed and therefore we didn't talk about what will happen if it fails. The people will be scared. The people will ask questions. Some will be ecstatic and some of them allegedly dropped their AARP coverage because AARP supported the plan.

FROM THE FLOOR: I'm going to be covering the employers. Questions one and two have slight overlap. Question 1 said what are they trying to get out of it? Question 2 said what aspects of the policy are likely to be beneficial to this stakeholder? I'm going to lump one and two into kind of the same category. The first one we came up with, we assumed partly was already in place so we said they have to be in compliance with the law. Second thing was the beneficial aspect, reduce financial liability for Rx coverage and meet coverage needs of the work force. For employers, getting a 28 percent subsidy with an option, getting out of Rx coverage is another option, as well as employee goodwill. So these would be all good things for the employer. There was also one more issue raised that if they were not in the medical supplement area, this could be an opportunity for them to get into it. Negative impact on the stakeholder, administrative burdens, calculating eligibility for rebates – if anything, all this was going to produce more burdens for the employer. And if any of the employers wanted to reduce coverage, this, in fact, would get them more involved.

Question four – Since we kind of assume that Medicare was already in place, I just put down no choice and we said that it would be a social question for employers, but it has financial implications for employees. I asked my table what they thought about the overall process. Because if you want to look to see just evaluating the proposal, some of the things that varied was the MAPD bid process was not very smart because there's a lot of uncertainty in it. So those are our conclusions.

FROM THE FLOOR: Our role is as regulator. We came at it from a little bit of a different perspective. We were struggling to figure out who exactly we were as regulators. In other words, were we state regulators or were we federal regulators? Who regulates what and how do those regulations interrelate with each other? In sort of having to pick who we wanted to be, we picked the common federal regulator. What I mean by that is for the outside of the political realm at the upper echelons. In reviewing the goals of the program, we sort of saw it as ensuring that the regulations are administered appropriately, that they are fair and accurate and that they're doing the right thing according to how the regulations are written. In the second one, it's likely to be beneficial to the stakeholder. Again, we're at this regulator level, so one thing we thought of was that more work might help job security. This certainly seems like more work. Since they don't get paid a whole lot, they just have the satisfaction of a job well done.

In terms of the aspects that are likely to have a negative impact, sort of on the flip side of the job well done, they really want to avoid failure or they want to avoid consumers who don't understand what this is and are really dissatisfied and other issues like the lack of carriers participating and the whole thing falling apart.

The job at this level is not really to support or not support an issue, it's to implement the regulations. In terms of the weight and its determination, ultimately the job goes up to the highest level of position appointed by the President, and so it's doing the job that the administration directs. The last one is the plan of action if it passes. Again, the plan is to implement it correctly and appropriately. I would say the biggest role is to make sure that the people impacted by this are educated as best as possible.

FROM THE FLOOR: I'm representing seven CEOs of drug companies, and don't be fooled by our high-tech presentation. Our financial situation is quite bleak and we really need to upgrade and expand our fleet of corporate jets. So we think that some of our goals out of this are to maximize our profits. We, of course, are also looking out for the consumer; we want to make people healthier by getting our drugs out on the market. Additionally, we can expand our market share. We also are interested in getting preferred status on the formula list of Medicare Part D.

As for things that are going to be beneficial to us, as part of this the market can dictate reimbursement as opposed to the government. There will be increased spending on drugs, which will obviously mean more money in our pockets. It will also generate additional money for us, which we can then reinvest in research and development.

Something that may have a negative impact on us is that we may see lower unit costs, perhaps loss of discounts. There will be more collective bargaining power in the market, which will drive down prices. We'll have to deal with that. There's also the slippery slope that all of this could end up resulting in increased regulation of the drug industry and that the path of higher revenue for the drug companies and higher costs and so on could result in something that is unsustainable.

I think overall we're likely to support this. It's really the least of all evils. The big things for us would be the additional revenue and profits would probably be significant versus other proposals, which might have included price caps or importing drugs from other countries.

In terms of our plan of action, we want to get on the formulary lists. We could potentially refocus our research and development into drugs that would serve the Medicare market. I think we'd also spend a lot of money on advertising and public relations, really trying to get the word out that we're working collaboratively with everyone else to create something that works really well. We're doing our part and we're the good guys and maybe we'll just kind of lay low for a while. Another piece

would be gearing up to address over-the-counter conversions and issues around specialty generics.

In summary, we, the drug companies, love Medicare Part D. If you'll just help us out for the providers, we'll be happy to take you on our new corporate jets anywhere you want to go. All in all, we're pretty happy with it.

FROM THE FLOOR: I'm reporting on behalf of my fellow physicians and hospital administrators. Indeed, none of us have really thought much about this program until today, but we think that overall, this is going to be beneficial to the patients that we take care of. Because now we think that they will have access to prescription drug coverage and so there will be greater compliance with the drug regimens that we prescribe. We also think that because this is going to be managed by PBS or by managed care companies and maybe their PBMs, that this could be highly beneficial to Medicare members because of all the controls that are built into the commercial prescription drug program, such as monitoring drug utilization and just keeping track of all the drugs that are given individual hats. Even to the extent that the handheld devices that are being used by some of the commercial payers that are provided to physicians so that they can prescribe drugs electronically, that would help reduce errors in the hospitals, in particular with a leapfrog initiative. That's one of the things that have been required under leapfrog and we're hoping that the drug companies will be able to provide these handheld devices for us.

On the negative side, how is this going to be paid for since it's obvious that the estimates are already too low and it's probably going to come out of what Medicare currently pays us as hospitals and physicians? We're going to turn around to the health-care plans and we expect you to make up the difference on the commercial side. Another negative is, although I guess other people might think this is a positive, we think that CMS is just going to be even more intrusive into our offices and it's going to require us to purchase IT systems and electronic medical records. We just don't have the money for that.

MR. TOOLE: We would finally like to bring up Cori Uccello, who is our senior health fellow for the American Academy of Actuaries and serves as the actuarial profession's chief public policy liaison on health issues. Her alternate is Ron Gebhart-Sauer, who does the pension side. In this role she promotes the formulation of sound health policy by providing non-partisan technical assistance to congress and federal regulators. She wrote or co-wrote several Academy publications. In fact, I used this on AHPs in preparing my presentation. There's a lot of really good stuff on the Web site, and I participated in several briefings for and meetings with progressional staff. She has also prepared congressional testimony relating to health insurance expansions and the Medicare prescription drug coverage.

MS. CORI E. UCCELLO: Show of hands, how many people here are members of the Academy? Excellent. How many people are Academy volunteers? Not bad. How many people have a fairly good understanding of what the Academy does,

especially in terms of public policy stuff? I thought it would be good just to step back, even though I think you already know this, and talk a little bit about the Academy just in general. The mission of the Academy is as the organization representing the entire U.S. actuarial profession, it serves the public and the actuarial profession both nationally and internationally through establishing, maintaining and enforcing high professional standards of actuarial qualification, practice and conduct, assisting in the formulation of public policy by providing independent and objective information, analysis and education and in cooperation with other organizations representing actuaries, representing and advancing the actuarial profession and increasing the public's recognition of the actuarial profession's value.

I'm going to focus most of my remarks on assisting in the formulation of public policy and, I would add, sound public policy. Here's a very legible organization chart for the Academy. We're split into four departments: communications, legal and professionalism, public policy and finance, and administration. The public policy department is further divided by different practice councils. Each practice council has its own policy analyst, except for the health practice council, which has two because we do so much work. We have a policy analyst for state policy issues, Darelynn Trahejo. Holly Kriokowski is the policy analyst for federal issues. They're the ones to go to for those of you who do raise your hands as Academy volunteers. They're the ones to go to to volunteer.

In terms of the Health Practice Council, each year we get together and we talk about what are the key issues we're going to work on over the next year. When we do that, we try to keep in mind what we think is going to happen in Congress or at the state level. What are the issues that are going to be important? For 2005, we have put forth five key issues: long-term Medicare viability, health-care affordability, coverage for the uninsured, individual health accounts, which include HSAs, consumer-driven health plans (CDHPs) and that kind of thing, and finally implementation of the Medicare Modernization Act (MMA). You'll notice, we have a separate issue here for health-care affordability, but in effect, affordability really underlies either directly or indirectly the other issues as well.

Other priorities for this year: We have retiree health insurance, Medicaid, long-term care, HPs and risk pooling, health improvement and disease management, genetic information, risk management and solvency protection, and finally, mental health parody and other mandates. You can see we have an awful lot on our plates.

In terms of the activities that the Health Practice Council undertakes, I mention each year when we set forth our key issues, what helps inform what those issues are is that we make our annual Capitol Hill visits and visits to federal departments and agencies such as CMS, the congressional budget office, general accountability office, and those kinds of places. So in the past, what those visits were is we would just go in, introduce ourselves and let them know what the Academy is, what we do. Now, however, they're really very familiar with the work of the Academy and so

we're able to actually talk about more substantive issues and get down to specifics on what they're going to be doing over the next year and how we can help them.

The Health Practice Council also puts forth several public statements each year, including issue briefs, monographs and the like. We write comment letters to Congress. We've put together practice notes and we also have reports to the NAIC. Occasionally, we will also provide Congressional testimony, either appear in person or have written testimony. Several times a year, we have Capitol Hill briefings for Capitol Hill staff to go more in-depth about some of the policy issues that they're working on. We also do a lot of behind-the-scenes activities. For those of you who heard Steve Goth talk about some of the times when they talk to Capitol Hill staff, the staff doesn't want us going around shouting to the world what it is they're thinking about doing because they're in initial stages of thinking about a proposal. If it's done, they don't want us to call them out on it publicly. They don't want to read in the *New York Times* the next day. Oh, Senator so-and-so has this idea, how dumb. They know that they can trust us for not shouting to the world the things that they're thinking about. So they really have a lot of trust in us that they can come to us with some of their questions.

We also work with the communications staff to get our word out to the media. We also have outreach to other policy organizations, different think takes and other organizations that work collaboratively with them on different things.

Now, I'll go into some of the different topics and what the Academy has done in those areas. In terms of AHPs, as Jim just pointed out, we have an issue about facts on AHPs. We've also put out several comment letters to Congress voicing our serious concerns with AHP legislation. In addition, we have a Capitol Hill briefing, "Is There Strength in Numbers, Will AHP Work?" We've also had several discussions with Capitol Hill staff on AHPs and risk-pooling issues in general. The AHPs are a little different than most of the issues that we work on. We generally do not take a position. We take seriously our charge to be a non-partisan, independent voice in the policy debate and we try to not address specific legislation. The one place that we have done this is with AHP plans. We have talked about some of the weaknesses of the current AHP legislation and have tried to work with Congress to help solve some of those weaknesses. We're also currently working on an issue brief examining risk-pooling issues more generally because this is another topic that is important.

Tax credits are another key issue for addressing covering the uninsured. The President and others have proposed providing tax credits to people to use toward their health insurance purchases. We're currently working on an issue brief that's examining tax credit issues. Last year, before the election, we put together a little guidebook, "The Questions Candidates Should Answer about Americans without Health Insurance," that talked about different aspects of providing coverage to the uninsured. We tried to bring up some details that would need to be addressed when candidates started making serious proposals.

We've also met with economists to discuss consumer and insurance company reactions to tax credits. Economists who are out there trying to model some of these different policy approaches really like having the input of the actuarial profession on what some of the implications of these approaches would be.

We've also had several discussions with Department of the Treasury staff regarding the health care tax credit, which was implemented as part of the trade act. We also put together some Congressional testimony for a House Ways and Means Committee hearing on health care tax credits.

Now I'll discuss Medicare Part D, which was the topic just now. Before the passage of the MMA, we were really quite busy on several activities. A few years ago, John Bertko and I wrote a white paper and also had related testimony that looked at some of the details that would have to be addressed in legislation regarding Medicare prescription drug plans, including adverse selection, risk-sharing and things like that. That paper really opened the door for us for the CMS and Congressional staff to come to us with questions that they have to help them work through some of their issues. We also had several Capitol Hill briefings. I'm still amazed by this one. We had one on actuarial equivalence of prescription drug plans and you think, "Who on earth would want to come to see a briefing on actuarial equivalence?" It was our most attended briefing we've ever had. It was standing room only. Who knew we could be so popular? I also want to mention that we did that in conjunction with the Society of Actuaries, who had just released a paper, so it's a way the Academy has collaborated with the SOA.

We also had frequent discussions with key Capitol Hill staff regarding risk-sharing provisions in the bills, and there was a three- or four-month period in which every Friday at 2:00 I was up meeting with Senate finance people talking about specific provisions and trying to help them work through those issues. Again, this is one of those things we couldn't really tell anyone about until now. What's interesting about this is that the House- and Senate-passed bills had different versions of risk-sharing provisions in their legislation, and we wrote a comment letter to the conference committee that recommended which option to choose. The provisions in the final bill, I'm happy to report, did follow our recommendations. I'm not sure if it's causation or correlation, but I'm going to go with causation.

Finally, we also had a comment letter recommending that any actuarial work that the new law requires be done by a qualified actuary who is a member of the Academy and that was in the regulations that were written after that. I was really busy and the Academy was really busy before the passage of the MMA. Once it passed, we thought we could take a break. No, I was busier after it passed because I don't know how many of you saw the regulations that were put out. They were very thick, and I had to read them all. It was not exactly exciting reading.

The Academy put together some comment letters on the draft regulation. In particular, we looked at some of the actuarial equivalence issues and also talked about some general Part D MMA issues. We're continuing to have ongoing discussions with CMS staff regarding some of the regulations, as well as data set, actuarial equivalence, risk adjustment and other miscellaneous issues. We are putting together some practice notes on actuarial equivalence. A draft should be ready in July or so regarding the retiree actuarial equivalence provisions. I think the ones on prescription drug plans in general will be available some time after that.

We also do a lot with Medicare solvency issues. Each year we put out an issue brief within a week or so of the release of the Medicare Trustees' Report. We're trying to highlight Medicare's financial problems. I also put together an issue brief that talks about how Medicare prescription drugs were added, but there's still a lot to do regarding Medicare, including trying to shore up its financing. I did a couple of things about that.

We also have done some work on federal reinsurance pool. Patrick Collins has headed up a committee that put forward an issue brief, "Medicare Reinsurance: Considerations for Designing a Government-Sponsored Program." This is really helpful to Capitol Hill staff who are trying to think about different ways to address the cost issue. We've also had discussions with Capitol Hill and administration staff about these kinds of things.

We've also done some work with HSAs. We had a monograph on the impact of CDHPs on health care costs. We had an issue brief that we put out before that that tried to talk about in general what these plans are. We also had a comment letter to the IRS on HSA draft guidance.

So those are the federal issues that we've worked on and the hot topics that we talked about earlier. But I also wanted to point out that we do also a lot of state-related activities. We have a computer model and we've put together a report to the NAIC on potential regulatory solutions to the closed block problem. Tom Stoiber mentioned this in the individual market workshop. We have a practice note on certification of Medicaid managed care rates and so on.

The bottom line here is that the Academy activities do help the formulation of sound public policy by providing non-partisan input to health policy issues. We're proactive in this—we try to figure out where Congress is going, what kinds of issues that they're going to be talking about and make sure that we can get out some materials to them that can help them when they are trying to put forward proposals and make their decisions. They actually also call us when they are in the beginning stages of putting together things to see if we have any thoughts on some of the implications. In general these activities really help increase the exposure and the appreciation of the actuarial profession, not only among policy makers but also among research organizations, the media and the general public.

I just want to thank all of you Academy volunteers because without you we wouldn't really be able to do any of it. Finally, I want to quickly say that we try to keep members informed of our activities. We put out several publications that try to highlight the activities we're doing. I hope that when you get these in the mail you'll take a little time to look them over so you can be more informed about the things we do.

FROM THE FLOOR: Can you comment on the impact of Part D on Medicare's financial status?

MS. UCCELLO: Medicare Part D does not impact that Medicare default date, or the bankruptcy date, or whatever you want to call it. The financing for Part D is actually included in Part B. That's clear as mud for everyone. So it doesn't actually change that date where the outgo is going to exceed the income, but it does increase the general revenue funding of Medicare program, which is, in turn, going to put increased strain on the federal budget. It's also just going to increase the pressures in terms of the long-run sustainability of the program. On our Web site, we have an issue brief that talks about Medicare's financial condition that will explain that a little more for you.

MR. TOOLE: Jorgen Have is going to talk a little bit about what's going on in Canada and the health care actuary.

MR. JORGEN D. HAVE: There has been one report after another about all the problems in Medicare. The Canadian Institute of Actuaries actually had a health care committee set up that would take positions on the various reports, typically agreeing with some parts and questioning other parts. However, one of the things that became pretty obvious is that none of the provincial health care plans employ actuaries. How could that possibly be?

Back in 2003, then-president Mike Lombardi said, "Well, this is crazy. Why don't we see if we have any actuaries that are interested in this?" We formed a task force to see if we couldn't get actuaries involved as a profession and try to help the various provinces make some better decisions. We've had quite a few polite meetings. They've said, "I'm sure what you do is useful, but we already have some people who do a lot of those calculations." We've persisted and made some progress. We had a private members bill introduced into parliament that could well be going through in the next few weeks if they don't adjourn for the summer. Basically it calls for a completely independent federal actuaries' office, which would report directly to parliament. Essentially, its role would be to make comments on every social program in Canada, to make sure they actually made some sense. It's sitting there. In addition, the Conservative Party has made it part of their platform that we should have an actuary.

In the meanwhile, we've also had promising meetings with six or seven provinces. I've been present at a few of them. Typically we meet with the deputy minister.

It's a polite meeting, as I indicated, and they say, "We'll get back to you." In some cases that was 15 months ago; in some cases it was two years ago. In the last couple of months we've had some more positive meetings, one in British Columbia and one in Ontario. British Columbia is at the forefront of several things. It has actually instituted a significant amount of data gathering. In fact, it now gathers data on all the drugs that are being prescribed. I understand that it even includes drugs prescribed by vets.

One of the interesting things that we learned at some of these meetings is that we often sit across from our competition. As a profession, we suddenly have competition. Who is the competition? It's typically a health care economist, Masters or Ph.D. level, who has written several papers on the topic. The question is: "Have you written any papers?" "Well, really not lately." Of course they also have the normal accountants and statisticians in the back room. Perhaps we made a mistake a year or two ago, because we started looking at the various government reports and we came out with policies. I've actually worked in workers' compensation boards as an outside contractor for a number of years. I was involved in developing policy. One of the scary things about policy is, when you are developing that, you basically want it unbiased; you don't want someone in there helping you develop policy who is extremely biased or who might be feeding stuff externally. So you're always very careful, and I'm sure you've run into that, Cori. They really need to trust you before they start opening up the database. I think that's one of the problems that we've run into, but we're certainly working on it. Hopefully one of these days we'll be able to expand the profession. One of the problems we're running into is that suddenly we may be called upon to do a job, and we start looking around at how many actuaries we have in Canada who actually have experience working with provincial. We really don't have anyone, so we end up looking at a consultant such as me. There's probably only a dozen or two dozen actuaries in Canada who have that level of experience, so we may well come calling.

MR. TOOLE: As a reminder, this is a three-part session. This was a wrap-up. This was an experiment and we certainly hope that we'll get your feedback.

FROM THE FLOOR: What do you think about the Quebec move?

MR. HAVE: Well, I think everybody's digesting it to see what it will actually mean. My guess is that the provincial plans will have to get serious about the waiting list. There was a Supreme Court decision that essentially had to do with the monopoly that the provincial health plans have, first in terms of you cannot insure something that's covered in the medically necessary category, and second it can only be part of the system. In other words, you cannot start up a private hospital to cover those same items. Those basically are items that were challenged. It went to a couple of levels and they took it to the Supreme Court. The Supreme Court agreed to a hearing. They basically sided with the doctor and his patient. In this case, the patient was actually waiting 12–18 months with a severe hip problem. He really

couldn't do much. He was asked to sit in a corner and wait. He challenged that. He said, "I have certain rights. They have a charter; you have your constitution." The Supreme Court didn't give a lot of direction in terms of where it goes from there. The immediate response, of course, from the federal government and from the provincial people, essentially ministry, was that they would put more money in this and make sure the lines are shortened.

I think in the background of all this was there were already a lot of complaints about the long waits. They'll have to drop some standards in terms of what are acceptable waits. How long should you have to wait for a hip replacement? How long for a knee replacement? More seriously, in some critical cases, such as cancer, there were waiting lines, but I think that's been largely taken care of. It's quite a challenge. It will be interesting to see what happens in the other provinces and whether an insurer is going to take advantage of this and whether this particular doctor will set up a private hospital. My own bias is I believe one of the beneficial things out of this may in fact be the setting up of specialized clinics to do exactly that. I think that would be far more efficient than hospitals. I think that's been proven time and time again in whatever country they do the studies. People who do a lot of a certain thing do it better and have fewer fatalities.