HEALTH SECTION NEWS

"For Professional Recognition of the Health Actuary"

NUMBER 35 JUNE 1998

Chairperson's Corner

by Thomas R. Corcoran

I would like to take this opportunity to address a subject that was always a big question for me, and may be a question for you. That is "What does the Health Section do?"

Two major responsibilities of the Health Section are establishing the content and quality of health sessions at the Society of Actuaries meetings and recruiting authors and collecting news for this newsletter.

Developing session content and quality for SOA meetings requires co-ordination of a huge effort. The Council and numerous volunteers have been extremely busy preparing for the Health Specialty Meeting in Hawaii, June 22–24. The Health Section is sponsoring 54 diverse sessions, so there should be plenty of interest to each of you.

We will be kicking things off with a welcoming Health/Pension reception on June 21 for you and your guests. In addition, the Section Council is jointly sponsoring an open session with the SOA Health Benefit Practice Advancement Committee and the Academy Health Practice Council on June 24. This session will tell you what we have planned for the upcoming year and
and will give you an opportunity to tell us what we ought to be doing. We look forward to seeing you there.

continued on page 2, column 1

"Credibility"—The Health Actuary's Nemesis or Friend?

by Thomas J. Stoiber

Most professionals exhibit an almost innate understanding of certain fundamental concepts developed through education and experience. The benefits to clients are obvious—no time wasted working through what would otherwise be time-consuming, usually complex, issues. But did you ever wonder what would happen if the professional had only a vague understanding of a key concept or its application to a practical situation? And what if two professionals working on the same practical issue have a different understanding of that concept and can't reconcile their differences? "Credibility" seems to be one such concept for health actuaries.

Health actuaries often rely on projections of historical experience. The actuary knows that experience that is not "fully credible" (whatever that really means) may deviate from expected simply due to random variation implicit in the nature of the business. The expected magnitude of the variation is well understood to be larger as the dataset becomes smaller. Removal of this size-dependent variation is important to get to the underlying statistic of the experience. Commonly that statistic is the mean cost, which in many cases will be the basis for premiums or reserves. The question becomes how to quantify the value of credibility in health situations and then how to apply it to reach the goal of understanding the underlying experience.

The SOA has now formally taken up this question for the health insurance actuary. The Credibility Task Force for Health Coverage was assembled nearly two years ago to identify needs, evaluate them, and find solutions.

So far, the Task Force has identified multiple needs:

- *Education.* Some of the members of the Task Force expressed concern that many actuaries have either forgotten the mathematics of credibility or don't know how to apply it in real situations.

  There is little on practical applications of credibility theory in the health syllabus. Practical application of credibility theory has received more emphasis among casualty actuaries. However, direct application to health insurance is not appropriate because of the highly dependent nature of a health

continued on page 2, column **3**

In This Issue

	page
1998 Hawaii Spring Meeting	2
Affordable Health Insurance Pricing for Faithful Persisters *by Dinkar B. Koppikar*	6
Chairperson's Corner *by Thomas R. Corcoran*	1
"Credibility"—The Health Actuary's Nemesis or Friend? *by Thomas J. Stoiber*	1
ERISA—A Focal Point for Healthcare Debate and Reform *by James Murphy*	9
Health Benefit Systems Practice Area/Health Section Status Report	12
"Managed Care" Capitation and Beyond"—Two-Day Seminar	12
Minutes of the Health Section Council Conference Call *by Bernie Rabinowitz*	11
Section Elections	12
A Simplified Method for Calculating Contract Reserves *by Robert Cummings* and *Leigh Wachenheim*	3
Statutory Valuation Morbidity Standards for Individual and Group Disability Benefits	10

Chairperson's Corner
continued from page 1

Planning for the SOA Annual Meeting in New York City is in full swing as well. The Health Section is sponsoring 16 sessions, including a luncheon meeting of the Section. We can look forward to hearing Michael Millenson, a nationally recognized author and speaker, on issues affecting the cost and quality of medical care.

On the news front, Leigh Wachenheim, the newsletter editor, has worked diligently to produce this issue, with timely articles on "Affordable Health Insurance," "Credibility and Health Insurance," "ERISA—A Focal Point for Healthcare Debate and Reform" and "Contract Reserves for Health Insurance." We hope you find some points of value in these articles. Leigh encourages letters to the editor to discuss these or other issues of interest.

Producing a timely newsletter requires a big effort from Leigh and her coeditors. They are already busy on the third and fourth quarter issues.

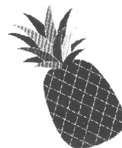
The meetings and the newsletter are the most visible efforts of the Health Section, but much other work goes on that is less visible. The Health Section also works with the SOA Health Practice Advancement Committees, the Academy Health Practice Council, and various task forces on a multitude of other projects. A comprehensive array of Section activities is addressed in columns throughout this newsletter.

I hope this issue of the newsletter gives you a better feel for the activities of the Health Section and also gives you ideas about additional things that you would like to see happen. We look forward to hearing from you.

Thomas R. Corcoran, FSA, is an actuary with Tillinghast-Towers Perrin in Weatogue, Connecticut and the Chairperson of the Health Section Council.

SOA 1998 Spring Meeting

Maui, Hawaii
Health & Pension
June 22–24, 1998



The Health Section is sponsoring 54 sessions at this meeting. Please refer to your meeting program for further information.

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Credibility
continued from page 1

insurance event to prior history. (Many casualty insurance events are independent, accident related.)

- *Standardization.* Others noted the lack of any single "acceptable" formula.
- *Access to Data.* Still others thought that even if the mathematics and formula issues were addressed, only those actuaries employed in the largest of companies who had access to large datasets could apply credibility theory effectively.

Actuaries working with small- to medium-size health blocks, either because of company size or an immature line of business, lack access to larger datasets. The SOA has addressed this issue for life, pension, and, to a lessor extent, disability income and long-term-care plans with intercompany studies and published mortality and morbidity tables.

Before explaining what our Task Force has been up to, and what to expect from us, it would be helpful to use one real-life situation that is prompting our effort at this time to better focus the issue.

Premium rate regulators have become particularly sensitive to approving premium rate increases that are either too small or too great in recent years. A premium rate increase is only "approvable" where experience justifies the actuary's cost estimates. The problem, of course, is determining what constitutes "justification." But there is no question that justification is dependent upon the credibility of the experience. Where historic experience is not deemed to be "credible," we actually need to answer three questions:

(1) What other data (industry, or within one's own company) are reasonable sources of similar information?

(2) What are the acceptable formulas for the nature of business being evaluated?

(3) What are the appropriate credibility factors within the formulas of question 2?

continued on page 7, column 1

A Simplified Method for Calculating Contract Reserves

by Robert B. Cumming
and Leigh M. Wachenheim

For individual medical insurance, many actuaries may think that traditional seriatim contract reserves are difficult to implement and are not realistic. As a result of these factors and discretionary reserve requirements, many companies have tended not to set up contract reserves. This article discusses a simplified method for implementing contract reserves. This simplified method is fairly easy to implement and helps provide more realistic financial reporting.

Regulatory Requirements for Contract Reserves

Contract reserves refer to reserves used to fund future increases in claim costs. The NAIC model regulation for minimum reserve standards requires contract reserves if level premiums are used or if "due to the gross premium structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time." A key issue in determining the value of future benefits is whether or not duration-related cost increases are included in the morbidity basis. (Duration-related cost increases include the wear-off of underwriting selection and the effects of antiselective lapsation.) For medical insurance, the NAIC model reserve standard seems to leave this issue, more or less, to the discretion of the actuary with little guidance provided.

Many companies find it difficult or undesirable to keep rate increases apace with duration-related cost increases. As a result, the loss ratio for a given cohort of business tends to increase over time. In this scenario, if the actuary uses realistic assumptions for the morbidity basis and gross premium structure, the value of future benefits will exceed the value of future valuation net premiums. As a result, a contract reserve would be required under the NAIC model regulation.

The NAIC model regulation also states that "when an insurer determines that adequacy of its health insurance reserves requires reserves in excess of the minimum standards specified herein, such increased reserves shall be held and shall be considered the minimum reserves for that insurer." The regulation goes on to say that "a prospective gross premium valuation is the ultimate test of reserve adequacy."

Other Reasons to Establish Contract Reserves

As indicated above, contract reserves may be required due to regulatory financial requirements. However, even if contract reserves are not explicitly required by regulation, there are other reasons to consider establishing realistic contract reserves. Some of the advantages of setting up realistic contract reserves include:

- Allows more meaningful financial reports, facilitating better management of the block of business.
- Helps justify rate increases with regulators, especially during the early years for a new block of business.
- Helps prevent future losses and/or rate increase spirals.
- Provides a better matching of expenses to revenue streams.
- Helps emphasize a long-term view of managing the financial results for a block of business, which should help companies avoid being forced into drastic rating or underwriting actions on older blocks of business.

Some of the possible disadvantages of setting up contract reserves include:

- Lower statutory surplus due to increased reserves.
- Increased costs associated with implementation and maintenance.

Contract Reserves: A Simplified Method

We have developed a new methodology for calculating contract reserves to help companies prepare more meaningful financial reports and better manage their blocks of individual medical business. This approach is intended mainly for companies that prefund some or all of the duration-related increases in claim costs. The advantages of this methodology are that it is fairly simple to implement and it provides a realistic result.

Our approach involves setting up a contract reserve fund. Each year, amounts are added or removed from this fund. The amount added or removed is based on a set of factors that are applied to earned premium segregated by policy duration. The reserve factors vary by policy duration. For early policy durations, when claim levels are low, amounts are added to the reserve fund. For later policy durations, when claim levels are high, amounts are released from the reserve fund.

The effect of this reserving approach is to levelize the benefit ratio, adjusted for investment income, over time. The interest-adjusted benefit ratio equals (incurred claims plus change in contract reserves less investment income) divided by earned premium. If actual experience develops as expected, the interested adjusted benefit ratio will be constant over time.

This reserving approach can also be applied to expenses. Since expenses are typically a higher percentage of premium in the early durations, this would create a negative reserve. This negative reserve might be treated as an offset to the benefit reserve or as an asset. If both benefit and expense contract reserves are implemented using this approach, the effect is to levelize the profit ratio over time.

Illustration of Simplified Contract Reserve Approach

We have modeled the experience of a comprehensive individual major medical block of business to illustrate the impact of this approach on financial results. We assumed this policy form will be sold over a four-year period beginning January 1, 1998. Premium levels are calculated to produce a target lifetime profit margin of 3%. Expenses

continued on page 4, column 1

A Simplified Method
continued from page 3

are assumed to be 30% in the first year and 15% in subsequent years. Lapse rates are summarized in Table 1.

TABLE 1
Illustrative Lapse Rates

Duration	Lapse Rate
1	30%
2	25
3+	20

Annual secular claim cost trend is 5.0%. The policy is attained-age rated with both annual claim cost trends and the annual rate increases due to aging equal to 2.5%. The policy is fully medically underwritten. Durational claim factors for durations one through seven are summarized in Table 2. The durational claim factor is assumed to increase 3% each duration after duration seven. Annual premium rate increases are 5%.

TABLE 2
Durational Claim Factors

Duration	Factor
1	65%
2	85
3	95
4	100
5	105
6	110
7	115

FIGURE 1
Projected Financial Results (Aggregate)

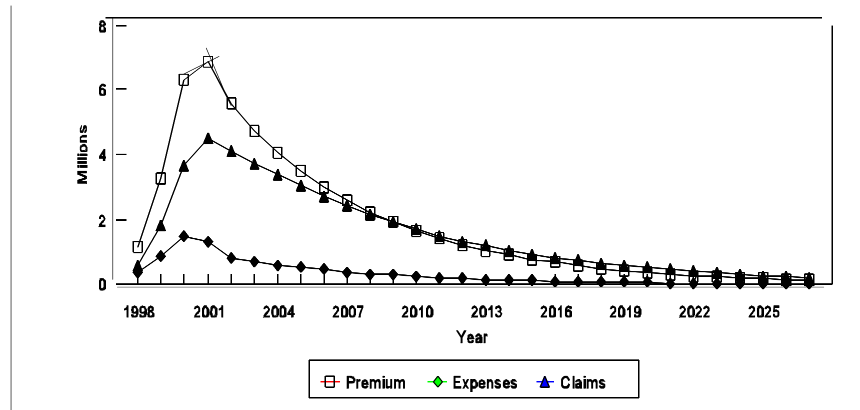

FIGURE 2
Comparison of Reserves

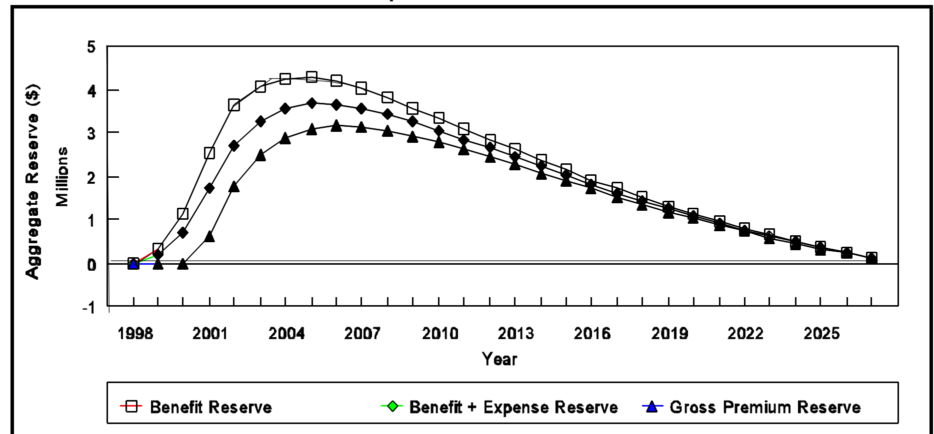

Figure 1 shows premium, claims, and expenses for this block of business over a 30-year period.

Figure 2 illustrates the contract reserves held for this block of business under three scenarios:

- *Gross Premium Reserves.* This equals the present value of future losses (or zero, if negative). In this case losses are equal to earned premium less incurred claims and expenses. Gross premium reserves are the minimum reserve required by the NAIC model reserve standard.
- *Benefit Reserves Only.* This equals the present value of future incurred claims less the present value of future valuation net premiums.
- *Benefit and Expense Reserves.* This equals the benefit reserve calculated above plus an adjustment for an expense reserve.

The expense reserve is calculated as the present value of future expenses minus the present value of future premium times the lifetime expense ratio. The lifetime expense ratio is the present value of expenses divided by the present value of gross premium at issue. In this example, this reserve is less than the "benefit reserve only" since the expense reserve is always negative.

Figure 3 shows the benefit ratio for this block of business over 15 years under three scenarios:

- No contract reserves
- Benefit reserves only
- Benefit and expense reserves.

The effect of holding only the benefit reserve is to levelize the interest adjusted benefit ratio. If benefit and expense reserves are held, the benefit ratio is level after the block is closed. Where no contract reserves are held, the benefit ratio increases continuously over time, reflecting the impact of durational claim trend.

Finally, Figure 4 shows the profit ratio for this block under the same three scenarios. The effect of holding the

continued on page 5, column 1

A Simplified Method
continued from page 4

benefit and expense reserve is to levelize the profit ratio. Again, where no contract reserves are held, the profit ratio decreases continuously over time due to durational claim trend.

Readers interested in learning more about policy reserves may want to consult the following prior works that deal with related issues:

- Pharr, Joe B. "The Individual Accident and Health Loss Ratio Dilemma," *TSA XXXI* (1979):373-406
- Koppel, S., O'Grady, F.T., See, G.N., and Shapland, R.B. "Reserve Principles for Individual Health Insurance," *TSA XXXVII* (1985):201-40
- Bluhm, William F. "Duration-Based Policy Reserves," *TSA XLV* (1993): 11-53

The contract reserve methodology described in this article is easy to implement and produces more realistic financial results than methodologies used in the past. Whether it is used for internal reporting purposes or for external financial statement work, we believe this methodology will be useful to many practicing actuaries.

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FIGURE 3
Interest-Adjusted Benefit Ratio

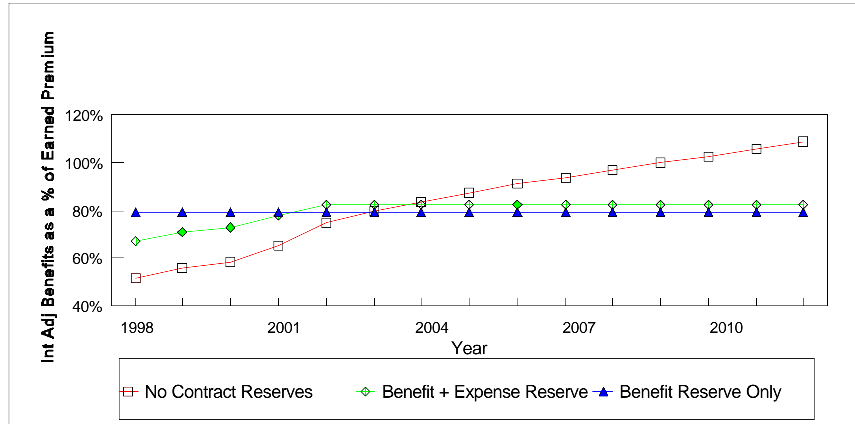
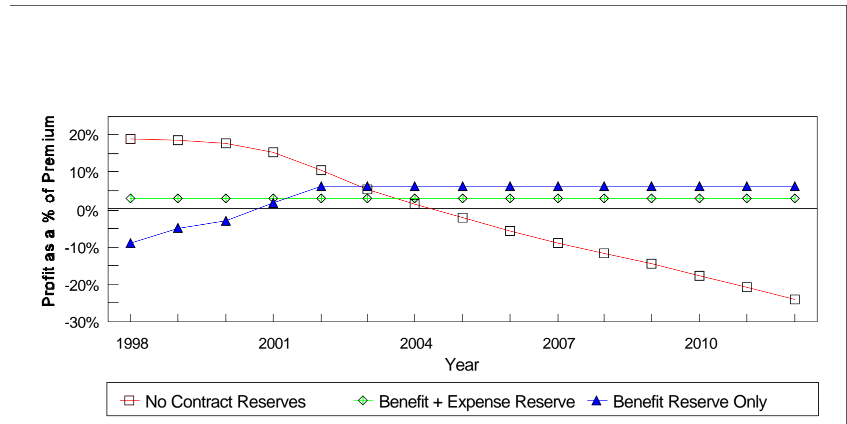


FIGURE 4
Profit Ratio



Affordable Health Insurance Pricing for Faithful Persisters

by Dinkar B. Koppikar

Editors Note: *This is an abridged version of Mr. Koppikar's paper. The unabridged version, which includes detailed calculations, is to be published in the Fall 1998 edition of* ARCH.

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Each individual needs access to health care services throughout life, regardless of his or her financial or employment situation. Therefore, health care financing mechanisms should be devised and regulated with the objective of providing for this life-long need. Many problems in health insurance pricing could be solved by requiring a minimum mandatory paid-up period (MMPP)—a premium period shorter than the insurance period. A MMPP will generate significant investment income for insuring programs and reduce the cost of insurance. The MMPP must be supplemented with adequate pricing information for insureds to promote persistency.

Pricing by Assessment Spiral in Health Insurance

Readers of the *Health Section News* are well aware of how assessment spirals can result from common pricing practices in health insurance. Insurers initially offer competitive initial rates to healthy insureds. When rates are increased, those who remain healthy are tempted to lapse, especially if lower rates are available in the market.

Persisters are then loaded, not only with the cost of aging and inflation, but also with a part of the expenses incurred to attract new insureds. Soon this renders the insurer's existing policies uncompetitive for healthy insureds, compelling it to come out with still newer policy forms. Many unhealthy insureds may be ultimately compelled to lapse and join the growing ranks of uninsureds. This process has continued ad nauseam for the past several decades, encouraging a short-term mentality even among insurers selling "guaranteed renewable" business.

The Problem with the Loss Ratio Methodology

Laws in many states require premiums to be reasonable in relation to benefits—neither inadequate, nor excessive, nor unfairly discriminatory. Regulators often define reasonableness in terms of loss ratio standards and believe they can best serve the public by resisting rate increases unless past experience exceeds the loss ratio standard.

Repeated sales and high lapses can concentrate most of the insureds at early durations where premium rates tend to be lower, creating illusions in the insured public's mind about the true cost of insurance. It becomes politically imperative for regulators to resist rate increases in order to "protect" insureds from "excessive rates," even if the solvency of an insurer may be at stake. At the same time, the stigma attached to rate increases induces insurers to contemplate increases only after losses have been sustained for a while.

Impact of NAIC Loss Ratio Methodology

Many readers are familiar with the NAIC's "Guidelines for Filing of Rates for Individual Health Insurance Forms." This formula combines past experience with future projections. In practice, the comparison of low actual paid losses at early durations with high lifetime projections encourages regulators to question the projections. Then, if the past experience exceeds the loss ratio standard in later durations, it must be disregarded. Only an increase to bring projected experience in line with the loss ratio standard is allowed.

If premium and insurance terms are identical, it is not easy to justify higher rate increases at early durations in order to reduce later rate increases. The regulators' natural argument will be that the insurer can file for another rate increase later on if the experience so justifies. Similarly, the argument that rate increase should allow for antiselection caused by shock lapses is likely to be looked upon by skeptical regulators as opening the door to unending increases.

Confining the consideration of rate increase to a one-year time frame gives power and authority to regulators to control rates, but no accountability for the ultimate outcome. Attention is concentrated on minimizing the current increase. For insureds it provides the illusion of lower rates now, but no long-term security. For the insurance program as a whole, the day of reckoning is only postponed.

Advantages of Requiring MMPP

Requiring that a policy be made paid-up for the last few years of insurance would force all parties to view pricing from the perspective of the life of the policy instead of one year at a time. I propose an MMPP equal to 20% of insurance period, but not more than five years or less than two years.

MMPP will primarily benefit persons between 60 and 65. Health problems tend to mount at these ages, and attained age premium rates will be high. Paid-up coverage at these ages will encourage long-term thinking and keep the awareness of medical emergencies and catastrophic medical costs alive amongst healthy and young.

In addition, price stability can be promoted by making persistency advantageous to insureds and by maximizing the role of investment income in the MMPP pricing structure. In contrast, the NAIC regulations make only a passing reference to an interest rate assumption, and its use has noticeable effect only if the claim cost pattern follows the premium pattern after a time lag. Since identical insurance and premium periods generate no significant investable funds, health insurance is denied the powerful alleviating force of investment income.

Additional Considerations

Managed Care

By encouraging a long-term perspective in pricing, MMPP will enable managed care carriers to plan to provide health care services to insureds over their coverage period in a cost-efficient manner, instead of trying to cut costs over short

continued on page 8, column 2

Credibility

continued from page 2

In fact, these same questions must be answered by any actuary who needs to price a health product, regardless of the involvement of a regulator.

Unfortunately, we are beginning to see some oversimplification on the regulatory front. In some cases, volume thresholds are being used to make simple "all or nothing" determinations regarding credible, ignoring the concept of partial credibility.

These questions are equally important to valuation actuaries. How many valuation actuaries have not battled with issues related to setting reserves based on a claim triangle that is less than fully credible? Three years ago, the NAIC model reserve standards were changed to allow a company to use its own experience to compute group disability income claim reserves, provided the experience was "credible." However, the DI actuary may not have the resources necessary to evaluate credibility.

Up until now, we health actuaries have gotten by without much more than an intuitive approach to handling credibility issues, because the penalty for error was not severe. Errors in predicting the morbidity costs of a health product for purposes of pricing could be made up later in premium rate adjustments. Competition has a major impact on the prices that could be charged in the market anyway on products and/or groups with less than "credible" experience. Similarly, an error in valuation would often be self-correcting in the following period.

Now things have changed. Downward pressure on premium rates is making it more difficult to correct for past errors in future rate increases.

Valuation is increasingly being used to determine the transaction price of the sale/purchase of blocks of business. Premium is actually being refunded in the case of Medicare Supplement policies based on federal regulation that specifies thresholds of credibility. Consequently, the unanswered questions surrounding credibility issues are becoming more critical.

Now who's to question health actuaries' grasp of credibility theory? Isn't it simply the application of the classic "*z*-factor" formula:

$$C = Z \times R + (1 - z) \times H,$$

where

C is the underlying cost of a specific experience set

R is the statistic derived from the specific experience set

H is the corresponding statistic in a similar general "universe" set

Z is the credibility factor, ranging between 0 and 1.

Simple. Right? Sure, if one really knows the value for all of these variables. But the fact is only those actuaries working in a large company have access to the values and then only in limited situations. Referring to the questions listed above, we can see how difficult this formula can be. Before we can calculate a value for *H*, we must answer Question 1, "Where does one get the "universe" data?"

Z can be derived by statistical techniques that consider the size and variability of the statistic in both the general "universe" and specific "experience" datasets. Those techniques must take into consideration the nature of the business, including parameters that measure correlation or independence. So before we can calculate a value for *Z*, we must answer Questions 2 and 3.

"The SOA has now formally taken up this question for the health insurance actuary …"

Now that I have convinced you of what you already knew, that you really don't have the tools to effectively apply credibility to health activities, just what can the Task Force do for you, what are their plans, and just who are they?

The Task Force is rather a unique composition in SOA efforts of this type. Ten members were assembled from both academic and company backgrounds.

It took nearly all of the first year of meetings to agree on what the needs are and to identify what the SOA could do to meet those needs. The rest of the time has been used to formulate a plan of action. Here's our plan to date in a nutshell:

(1) Provide a health orientation to educating the actuary in the application of credibility theory. As a result, we hope that generally accepted methods will evolve throughout the health actuarial community.

(2) Provide the general "universe" statistics that credibility theory requires but are lacking in all but the largest company environments.

(3) Train actuaries on the correct way to blend the general "universe" statistics developed in step 2 with their own specific company experience.

(4) Provide practical advice on credibility theory in regulation, including:
   - Defining the thresholds of "credible experience" in the NAIC model minimum reserve standards for group disability income claims
   - Suggesting how state regulators reviewing premium rates can blend general universe and specific experience in reaching their conclusions
   - Revising the Medicare Supplement Refund Credibility Tables.

Later this year you should begin to see some of the results of our efforts. We are planning a two-day teaching seminar on the application of credibility theory to health insurance. Our current thought is to spend the first day covering the mathematics of credibility (a refresher to us who believe we already know credibility theory mathematics). The second day would be devoted to practical case studies, using real data, in pricing medical and limited benefits products and in valuation of disability income and medical expense policies.

Gathering the needed general universe type statistics is proving to be very difficult. Right now we are concentrating on medical insurance products, but plan to move into other lines such as disability income, long-term-care and limited-benefit policies. Another SOA task force is currently working on an update to the large claims intercompany study prepared a few years ago. We are actively working with that group to determine whether it is feasible to enhance their collection criteria so that we can publish a general "universe" dataset. These data are

continued on page 8, column 1

Credibility
continued from page 2

required to compute the "*H*" and "*Z*" of our credibility formula. Final results could be two years away.

For nonmedical lines, we are hopeful that recent intercompany studies may provide enough information to extract the credibility values without the need to gather additional data. The long-term- care study and the recent experience study on disability income products are prime sources that we will be reviewing.

Once the data collection/analysis effort nears completion, we think we would be ready to make a serious contribution to regulators' needs. The NAIC has already expressed interest in our efforts, particularly regarding long-term disability, long-term care, and limited- benefit health plans. These efforts typically fall under the realm of the American Academy of Actuaries. So as we near completion, we as an SOA task force may have to reconstitute ourselves or in some other fashion turn the baton over to the Academy. We have no target date yet set for this facet of our plan, but 1999 is a best guess.

As you can see, we have a lot on our plate. The good news is that we have moved from the early design stages to production mode in several areas. Since we see our efforts potentially affecting all health actuaries, we want to regularly update members on our progress. Look for more articles in this newsletter and sessions at upcoming meetings. We'll be giving senior managing actuaries the opportunity to help focus the design of our next steps at the Annual Meeting this fall. Any input you would like to provide is welcome. Please feel free to contact any of the following members of our Task Force.

- Brett Gant, AFLAC
- Charles Fuhrer, BCBS of the National Capitol Area
- P. Anthony Hammond, Principal Healthcare Inc.
- Thomas Herzog, U.S. Department of Housing and Urban Development
- Leonard Koloms, Trustmark Insurance Company
- James Robinson, University of Wisconsin, CHSRA
- Craig Shigeno, Tillinghast-Towers Perrin
- H. Dennis Tolley, Brigham Young University
- Andrew Wang, PREMERA
- Thomas Stoiber (Chair) In. Health Actuarial Associates.

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Affordable Health Insurance
continued from page 6

pricing periods but at the cost of increases over longer periods.

A Substitute for Medicare

If Medicare becomes increasingly irrelevant in providing health care security at older ages, insureds can be persuaded to use the paid-up period to prefund old age health care security under a separate policy.

MMPP for Employer-Sponsored Group Health Insurance

The concept of MMPP can be used in employer-sponsored health insurance programs in several ways. An employee may enter employment with his own prior policy (if any), negotiating for compensation without health insurance and continuing his policy with or without an employer premium subsidy. For employees without prior personal coverage, active life reserves may be generated in employees' accounts on MMPP basis, with the employees taking over premium payments if separated from employment.

The extra premiums required under MMPP in early years may be subsidized by the employer. Employees could be encouraged to deposit additional funds at a discount to cover probable periods of layoff or low income or to accelerate the paid-up period. If the policy is paid up or prepaid for some period, a laid-off employee will have a competitive advantage in seeking new employment or in becoming self-employed.

Voluntary Offer to Existing Insureds

A paid-up period option could be offered to existing insureds if the current premium scale for a policy appears adequate.

Impact of MMPP on Premium Pattern

With no changes in actuarial assumptions except zero voluntary lapses and no antiselection during the paid-up period, MMPP will result in only a modest increase in premiums during early years compared with an existing scale, but a significant decrease in total premiums over the insurance period. If lapses remain unchanged during the premium-paying period, the savings to persisters will be large. If early lapses are lower the force of antiselection will be less and the savings for a much larger population will be even more significant. The investment income will pay an increasing proportion of benefits. A pricing comparison will be included in the Fall 1998 edition of *ARCH*.

Increasing the Effectiveness of MMPP

In order to make MMPP effective and to beneficial and to minimize its abuse, the following measures will also be necessary.

Right to Revise Premiums Whenever Actuarially Necessary

Each insurer should have the right to revise rates once a year if necessary, in the judgment of its actuary, to ensure the solvency of the program. However, this should be balanced by the following requirements:

- *Disclosure of Pure Premiums and Expenses*. The market, and not regulators, should determine whether an insurer's expenses are reasonable.
- *First-Year Expense Charge to be a Certain Minimum Multiple of Renewal Charge*. Insurers should be discouraged from loading renewal charges with what are really marketing costs added for the purposes of reducing initial charges to new insureds. This will help make renewal charges to persisters consistent with and closer to actual expenses incurred and will encourage persistency.
- *Good-Faith Estimates of Projected Premiums and Charges in the Near Future*. Good-faith estimates together with regulatory oversight would promote competitiveness of premiums consistent with solvency. These estimates should be based on reasonable projections of rates of inflation, antiselection, and so forth. This will enable insureds to plan ahead, minimize financial hardship resulting from rate increases, reduce shock lapses, and discourage insurers from offering artificially low initial premiums and charges to entice insureds.

  An insurer should be free to charge, but required to justify, rates that fall outside a reasonable range based on these good-faith estimates. It should show that both the good- faith estimates and the actual

continued on page 9, column 1

Affordable Health Insurance
continued from page 8

premiums and charges were computed in bona fide manner using all the relevant information available at the time and appropriate actuarial projection techniques. By keeping actual premiums within the acceptable range of good faith estimates, insurers could enhance their credibility and help improve persistency.

- *Increase in Paid-up Period or Payment of Any Residual Cash at Expiry.* A longer paid-up period may be justified if the accumulated fund at any point exceeds the single premium (computed on reasonably conservative actuarial basis, but with zero future lapses) required for paying future benefits.
- *Other Disclosures to Insureds.* Insureds should be given additional information related to the administration of policy (e.g. premiums, investment income, claims) and reasons for any proposed rate revisions.

Transfer of Contract to Another Insurer

A well-regulated transfer option will promote competition among carriers and persistency among insureds. In any such transfer, the active life reserves would be transferred from the existing carrier to the carrier selected by insureds. Comparison of benefits and good-faith estimates of premiums from both carriers should be required. The receiving carrier should be prohibited from underwriting transferring insureds.

Introducing the Proposed Pricing Principles through Regulation

Voluntary acceptance of MMPP pricing is unlikely, since it will require higher early premiums, which will be uncompetitive. Mandatory participation will make it possible to resist pressures to require nonforfeiture values based on reserves and inculcate the habit of viewing health care costs for the whole insurance period instead of one year at a time.

Dinkar B. Koppikar, ASA, is an actuary with Mennonite Mutual Aid Association in Goshen, Indiana.

ERISA—A Focal Point for Healthcare Debate and Reform

by James Murphy

Editor's Note: *The information in this article was based, in part, on the Employee Benefit Research Institute* Issue Brief *Number 193, January 1998.*

With respect to health and welfare benefits, a key point of ERISA is to make it easier to provide health care to a national employee base. It was created to protect both employers and employees, but critics of ERISA claim that the protection has backfired. Since ERISA plans are not subject to state regulation, critics claim that participants are denied effective legal remedies and have only limited consumer protection. They maintain that ERISA provides inadequate regulation and that health care quality cannot help but suffer because of it.

The very immunity granted by ERISA to protect can also, according to Capitol Hill policymakers, deny individuals their rights to legal recourse in those instances when the system does not work. These claims are based on "instances of individuals who have found themselves without the desired legal recourse under ERISA after having health services denied." Amendments to ERISA have been introduced that would allow additional rights and solutions to participants.

There is no doubt that ERISA has played a crucial role in allowing employers and unions to provide uniform multistate cost effective coverage to their employees. ERISA proponents maintain that it has provided a foundation for an innovative and cost effective employment-based health care system. The common belief among proponents is that ERISA has been a successful benefits framework, and that it contains adequate participant protection as it stands. They fear that amending ERISA could lead to more red tape with no increase in quality and possibly result in employers dropping health insurance coverage altogether due to rising expense and fear of lawsuits.

Both sides have strong arguments, and both are concerned with the bottom line of providing high-quality health care to participants. The challenge to policymakers will be to make sure that amendments provide a higher level of quality and decide if that quality is improved by heightened liability. Additional regulations and mandates will inevitably lead to increased costs, and there is the possibility that more individuals could end up uninsured when costs increase.

One of many factors shaping future legislation is the report of recommendations from the President's Advisory Committee on Consumer Protection and Quality in the Health Care Industry. The preliminary report outlines seven consumer "rights" (see below) and one recommendation of consumer "responsibilities." The commission recommends voluntary compliance; however, congressional action on the "Bill of Rights" is part of Democratic legislative agenda.

Following is a summary of three of the most comprehensive and significant proposals potentially affecting ERISA Health Plans.

PARCA—The Patient Access to Responsible Care Act of 1997

- Bans gag rules or clauses
- Prohibits preauthorization for emergency room care
- Guarantees specialist coverage when recommended by treating health professional
- Requires network-based health plans to offer a point-of-service option at enrollment
- Prohibits discrimination based on health status or anticipated needs
- Limits provider discretion in network structuring
- Establishes an external review process for denied claims appeal
- Requires standard for due process
- Permits suits in state court for personal injury or wrongful death. Any person providing insurance or administrative services could be liable.

continued on page 10, column 1

ERISA: A Focal Point
continued from page 9

This last proposal is perhaps the most frightening, because it opens the door for lawsuits in state courts with the high costs of both frivolous suits and potential punitive damages. Some say PARCA goes beyond "Clinton Care." There are currently 225 cosponsors of the bill in the House of Representatives.

Consumer Bill of Rights

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry

Seven Rights

- Choice of providers and plans
- Participation in treatment decisions
- Confidentiality of health information
- Nondiscrimination
- Access to emergency room
- Information disclosure
- Grievance and appeals process (with external review when appropriate)

EPHIC—Expansion of Portability and Health Insurance Coverage Act of 1997 (EPHIC)

EPHIC would actually expand ERISA. The bill allows small businesses and individuals to collectively purchase health insurance through association. This multiemployer welfare arrangement (MEWA) would be called an Association Health Plan. When enough participants are enrolled in such a plan, the plan would be allowed to self-fund under ERISA. Small employers would have an incentive to purchase insurance with the advantage of self-funding. This arrangement offers flexibility and control over costs.

James Murphy, FSA, is with Howard Johnson & Co. in Seattle, Washington and is the SOA Vice President overseeing the Health Benefit Systems Practice Area.

Statutory Valuation Morbidity Standards for Individual and Group Disability Benefits

The SOA has formed a task force to respond to a request from the NAIC Life and Health Actuarial (Technical) Task Force to address disability reserving issues.

Request

The NAIC model for Minimum Reserve Standards for Individual and Group Health Insurance Contracts references specific morbidity tables as the basis for calculating minimum statutory disability insurance reserves. The NAIC Life and Health Actuarial (Technical) Task Force (LHATF) requested the assistance of the Society of Actuaries to review the current tables (that is, 85CIDA, 85CIDB and 87CGDT) and, as appropriate, recommend revised disability morbidity tables. The reason for this request is that the NAIC has received reports that statutory reserves based on the current morbidity tables frequently fail the tests of adequacy and reasonableness. Further, the NAIC requests that this review extend to contract and claim reserves and across all lines of disability insurance—group and individual, and short and long term.

The LHATF would also appreciate the comments of the Society of Actuaries regarding appropriate conditions that should exist when an insurer uses its own experience in establishing claim reserves. The NAIC Model currently permits this under certain circumstances during the initial period of disability.

SOA Response

The SOA has appointed Tom Corcoran to organize and chair this task force. The SOA believes a reasonable goal is to accomplish the following by the June 21, 1998 SOA Board meeting:

- Clarify and quantify the issues involved
- Recommend a timetable to develop new or revised valuation tables, as appropriate
- Identify the appropriate conditions for an insurer to use its own experience
- Recommend interim procedures and controls to be used pending the development of new or revised valuation tables

If you would like additional information regarding this task force, please e-mail Tom Corcoran at corcort@tillinghast.com or Karen Haywood at khaywood@soa.org.

Minutes of the Health Section Council Conference Call

Friday, February 6, 1998

In Attendance: Mike Abroe, Jan Carstens, Lois Chinnock (SOA staff), Tom Corcoran (Chair), Robert Grignon, Tony Hammond, John Heins, Lee Launer, Gena Long (SOA staff), Jim Murphy, Jim O'Connor, Bernie Rabinowitz, Leigh Wachenheim, Tom Wildsmith, and Dale Yamamoto.

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Chairperson's Opening Remarks

Tom Corcoran opened the meeting with the following comments:

The purpose of this meeting is to confirm the role of the Health Section Council (HSC). Primary responsibilities include:

- SOA meeting sessions (commitment to content and quality)
- Newsletter content, quality and relevance (commitment to four timely issues per year)
- Shared responsibilities (with HBSPAC)
- Education (especially continuing education)
- Research (responsibility is primary for funding and reporting to members, shared for oversight)

The HSC is an elected, representative body. It is critical that we represent our members' views by staying close to a very diverse body through personal contacts and surveys.

Status Reports

Newsletter

Leigh Wachenheim reported that in addition to the February issue, which is being mailed now, issues are planned for May, August, and November of this year. The results of the Health Section survey will appear in the May issue if they are ready. Special topic issues are planned for August and November.

Regular columns will include:

- Chairperson's Corner (Tom Corcoran)
- Minutes from HSC/HBSPAC Meetings (Bernie Rabinowitz)
- Education and Research (Dale Yamamoto will follow up on this)
- Letters to the Editor (Leigh Wachenheim)

Mike Abroe and Lee Launer will serve on the August issue editorial committee with Leigh. Jim O'Connor and David Wille volunteered for the November issue committee.

Hawaii Meeting

Jim O'Connor reported that he still needed moderators and speakers by March 10 for the following topics:

- Impact of technology on health-care delivery
- Pricing issues regarding student and special risk coverages
- Pricing issues regarding cancer and specified disease plans
- Effective approaches to disease management

Tom Corcoran will assist Jim on the first three topics and Bernie Rabinowitz will assist on the fourth.

Annual Meeting

John Heins reported that the program for the SOA Annual Meeting in October needs to be finalized before the Program Committee meeting on February 26–27 in New York. There will be 16 health sessions including the luncheon meeting. The luncheon meeting is scheduled for October 19 from 12:15 to 1:45, and its purpose is for the section members to meet the HSC/HBSPAC members.

The following people will serve as John's program advisors:

- Credibility and Health Insurance, Bernie Rabinowitz
- Long-Term Care (2 sessions), Robert Young
- Specialty Products, Tom Corcoran
- HIPAA: One Year Later, Jim O'Connor
- HMOs: Role of the Actuary, Jan Carstens
- Large-Group Insurance, Bill Bluhm
- MSAs, Mark Litow
- Risk-Based Capital, Bill Bluhm
- Med-Supp and BBA of 1997, Dawn Helwig
- Managed Care Effectiveness, Jim Murphy
- HEDIS, Jim Murphy
- Disability Income (5 sessions) , Robert Beal
- Group Life, Tom Corcoran

Surveys

Tom Wildsmith reported that results of the Health Section survey are being tabulated.

EBRI Update

Lois Chinnock reported that so far the Section has sold 244 EBRI databooks. An order form has been placed in the February newsletter, which is being mailed. Any copies unsold by April will be offered to the SOA membership at $10 per copy.

Treasurer's Report

Bernie Rabinowitz reported that the surplus at 10/31/97 was $277,083. The auditors are currently reviewing November and December 1997. Effective 1/1/98, the fiscal year will be changed to a calendar-year basis, consistent with that of the Society.

HBSPAC

Jim Murphy explained that the HSC funds the research, whereas the HBSPAC gets the research performed. The most important role of the HSC is communication to the HSC members, staying close to the members' needs, and making sure that the research is useful to them. He mentioned that Ken Avner is handling the NAHDO project.

continued on page 12, column 1

Minutes
continued from page 11

SOA/AAA Work Group on Communication for Health

Janet Carstens, chair of this group, said that their mission statement is similar to that of the HSC newsletter but their audience includes the general public. She will address their issues during the March 5 conference call.

Next Meeting

The next meeting, a joint conference call with the HBSPAC, is set for Thursday, March 5 at 1:30 p.m. CST.

Vote in the Section Election

Section election ballots will be mailed the week of July 6. Take an active role in the Health Section Council election process! Review the list of candidates and biographical material and determine whom you would like to represent you on the Section Council. Mail your ballot so it will reach the SOA office no later than Friday, August 7. If you are a section member and do not receive the election mailing by July 21, please call Jeanette Selin at the Society office, 847-706-3581.

Collaborating at the Health Section Breakfast in Washington, D.C.

Left to right: Tony Hammond (Chairperson 1996–1997), Tom Corcoran (Chairperson 1997–1998) and Leigh Wachenheim (Newsletter Editor).

Health Benefit Systems Practice Area/Health Section Status Report

Editor's Note: *The Health Practice Advancement Committee (SOA), the Health Section Council (SOA), and the Health Practice Council (Academy) will host an open meeting in Hawaii on June 24, 1998 from 1:00 to 2:30 p.m. This status report provides a "heads up" on some of the work in progress. Please bring your questions and comments on the report to the meeting.*

Practice Area Committees

1. Practice Advancement Committee

Results from the recent Health Section membership surveys were presented for discussion on a surveys subcommittee conference call on February 19. It was decided that further cross tabulations were needed (to be completed by the SOA Information Services Department), as well as a summary/analysis of the data (to be prepared by Jill Schield of Northwestern University).

Development of an employer-based survey will begin when cross tabulation and summary/analysis of the membership survey is complete.

The Practice Advancement Committee and Health Section Council held a March 5 conference call and are also planning two joint meetings with the AAA Health Practice Council during the SOA Spring Meeting in Hawaii:

- Tuesday, June 23 (11:45 a.m.–4:30 p.m.) Working Meeting
- Wednesday, June 24 (1:00 p.m.–2:30 p.m.) Open Session—Reporting and Feedback

2. Practice Education and Development Committee

A two-day seminar titled "Managed Care: Capitation and Beyond" will be held August 27 and 28, 1998 at the Westin O'Hare Hotel in Rosemont, Illinois. The seminar will feature double track offerings for attendees who have both limited as well as advanced experience in the area of managed care. Field experts will use informative and interactive formats to present the latest information.

Thursday, August 27

Track I
Managed Care Pricing: Nuts and Bolts (little or no experience required)

Track II
Three advanced sessions throughout the day. Topics include:

- Health data sources
- Federal and state regulation of managed care and provider organizations
- Risk contracting: health plans and providers

Friday, August 28

Tracks I and II
All attendees participate in panels and interactive forums. Topics include:

- Specialty risk transfer mechanisms
- Risk adjusters

For more information, contact Sheri Abel, SOA Program Manager, at 847-706-3536.

3. Research Committee

Research projects and experience committees activities are listed below.

4. Joint AAA/SOA Communications Committee

Led by committee chairperson Janet Carstens, the joint communications committee is moving to reaffirm its purpose and receive feedback on the mission statement to establish whether activities of the committee could be modified to better accomplish its mission. The mission statement for the task force is: "Promote the availability and awareness of health issues information and activities of the Society of Actuaries and the American Academy of Actuaries to actuaries, health policy academics, government, and the public."

continued on page 13, column 1

Health Benefit System
continued from page 12

The Task Force completed the developed of a World Wide Web page and publicized it through Actuaries Online and various Internet search engines. Check it out at the URL: "http://www.geocities.com/WallStreet/1647/"

Note: Please consider the Web page experimental, and feel free to offer suggestions for improvement. The committee plans to eventually incorporate this page into the SOA home page.

Further discussion of these issues, as well as the possibility of establishing a Web Page editor, is planned for the Hawaii meetings.

5. Health Benefit Systems Principles Committee

The committee's objective is to develop a health principles document similar to the "Exposure Draft of Principles Regarding Provisions for Life Risks," which was released in November 1994.

Health Section Council

The Council held a conference call on February 6, 1998. Agenda topics included:

- Increased involvement in the production of the *Health Section News*, to expand the number of issues per year and ensure continued high quality of the publication.
- Assignment of Council members to assist in recruiting for SOA meeting sessions.

The Council also participated in the March 5, 1998 joint conference call with the Practice Advancement Committee.

The Council is planning a conference call for mid-May.

Research and Education Task Forces—Managed Care Effectiveness Issues

1. Definition of Managed Care Effectiveness

The purpose of this study was to produce a paper or monograph on the definition of managed care effectiveness, focusing on the perspectives of the various stakeholders. Jill Schield, a technical writer from Northwestern University Institute for Health Services Research and Policy Studies, was hired to assist in the development of this document.

The paper was presented at the May 4-5 Managed Care Symposium in Minneapolis, Minnesota.

2. Quality of Managed Care Symposium

The Committee on Health Benefit Systems Research sponsored a symposium entitled, "Managed Care in a Time of Transition." The symposium included presentations of the two HEDIS studies (HP119 and HP122) and the Managed Care monograph. The day and a half event was held at the Marquette Hotel, Minneapolis, Minnesota on May 4-5, 1998.

Tapes from the "Managed Care in a Time of Transition" symposium will be available for purchase. To obtain your copy, contact Teach'em at 800/225-3775; in Illinois call 312/467-0424.

3. HEDIS Studies

The HEDIS 3.0 Measures (HP119) will be completed by the Utah Department of Health. Of the $47,000 committed from the 1996-1997 budget, $30,000 was used to fund the Utah study, HP119. The researchers determined the NCQA Quality Compass was not suitable to use in the study. Work is proceeding well using the HBS/Mercer data and Utah's data.

The Relationship between HEDIS Measures and Health Plan Choice (HP122) will be completed by the University of Michigan. The $17,000 remaining from the $47,000 commitment was applied to the Michigan study along with $13,000 coming jointly from the health practice area research budget and the Health Section.

Work is proceeding well on the project. Results were presented at the May 4-5 Managed Care Symposium in Minneapolis, Minnesota. The University of Michigan is planning to submit abstracts to the Association of Health Services Research (AHSR), the American Public Health Association (APHA), and others for presentations next summer.

4. The Actuarial Role in Managed Care

A working group, chaired by Bruce Pyenson, has completed a report titled, "The Actuary's Role in Managed Care." The report has been accepted for publication by the *North American Actuarial Journal* and will appear in the July 1998 issue.

The SOA public relations area is directing a news release to editors and reporters of trade and industry publications covering managed care and health care management issues. A review group will assist in guiding future directions of the report.

Research and Education Task Forces—Other Issues

1. SFAS 106 Task Force

The task force will continue to monitor the basic education available to support *SFAS 106* practitioners. The dual disciplined nature of this actuarial work makes the packaging of *SFAS 106* education less efficient.

The task force will also continue to monitor the research efforts supporting *SFAS 106* practitioners.

2. Health Care Data Base Project (NAHDO/NHIRC)

The NHIRC is an online interactive resource for information about current health data/information projects and data bases in operation on the World Wide Web at "http://www.nhirc.org."

After reviewing a proposal to expand and enhance the NHIRC web site, the Health Section Council has approved $36,700 for the project. A letter of agreement has been approved by the Council and will be offered to NAHDO.

3. Integrative Medicine Study

David Eisenberg, M.D., of the Center for Alternative Medicine Research at Harvard Medical School, has initiated a study of alternative medicine with funds from the John E. Fetzer Institute and an SOA contribution of $25,000.

Lee Launer, chair of the Integrative Medicine POG, will present "Actuarial Aspects of Alternative Care" on

continued on page 14, column 1

Health Benefit System
continued from page 13

Wednesday, June 24, 1998 at the Society of Actuaries 1998 Spring Meeting in Hawaii (Session 85 TS). This session will contain a description of the history, demand, and activity of alternative care in the United States during the 1990s, and a description of the Society of Actuaries' Committee on Alternative Care.

4. Credibility for Health Coverages (HP121)

The purpose of this project is to create guidelines for establishing full and partial credibility for experience under each type of health coverage.

The subcommittee established to pursue a seminar on credibility for practicing health actuaries has decided to present another version of the seminar plans to the Task Force before formally commissioning the SOA to begin the process of setting up the seminar.

Experience Committee Reports

1. Group Life Insurance Experience Committee

Input on the feasibility of the study has been requested with the distribution of the 1985-89 study. Copies of the questionnaire are available through Actuaries Online or by calling Karen Haywood at 847-706-3547. Most people thought a follow-up study should be done, but very few companies are in a position to provide data in the near future.

2. Group-Long-Term Disability Termination Study

A meeting was held in May in Palm Desert on expanding the number of contributors and studying additional years of experience. An extensive draft report on the experience was available on the web site in advance of the meeting. The contribution and general meetings and the session in Palm Desert were well attended and well received. Expansion of the study to additional contributors and years of experience is under way.

3. Canadian Group Long-Term Disability

For the Canadian experience study, 24 companies have contributed data and the initial processing was done at the SOA office. Final results were presented at the November 1996 CIA Meeting. The final report will be published by the CIA shortly.

4. Individual Disability Insurance Experience Committee

The committee met on September 23 to discuss the future of the 1986-1991 Study. It was decided that the study should be continued, but that significant changes are required to reflect current products and product features. Work will begin now that the 1986–1991 report is complete.

A draft complete report was distributed to the committee for review and comments in March. The report should be generally available in the second quarter. It will be published in the *TSA 1997–98 Reports.*

5. Long-Term-Care Experience Committee

The 1992–1993 study will update the 1984–1991 report with two more years of data and additional contributors. Data were tabulated during 1997. A final draft report is expected in the second quarter of 1998.

6. Noninsured/Noninstitutional Long-Term-Care Experience

The purpose of this study is to review the 1989 LTC survey from an actuarial perspective.

Preliminary results were discussed at the Colorado Springs meeting in June 1996. This work was discussed at the committee meeting in May 1997 in Palm Desert. The final report on this work is being reviewed.

7. CCRC Experience Task Force

Phase I of the project (recruiting retire ment communities and establishing data definitions) is complete.

Phase II is actual data collection. The application for Phase II funding has been reviewed by the National Institutes of Health (NIH), and funding for the first year has been approved. The completion date is uncertain at this time. The task force may recommend follow- up work to be funded by the SOA once Phase II is complete.

Data are being collected from 56 communities, covering 20,000 residents and 57,000 life-years of experience.

A conference call was held on April 7 to review the work in progress and to develop plans for further analyses. The next conference call has been scheduled for May 20 to discuss peer review of these data. A committee member was selected by the SOA to perform this task.

8. Group Medical Large Claims Experience Committee Catastrophic Claims Health Database (HP123)

The Board of Governors approved the idea of funding the Large Claims Experience Study from practice area research funds, rather than through the experience studies assessment process. This study is the follow-up to the Group Medical Insurance Large Claims Database Collection and Analysis (HP 105), which is available as a monograph from the SOA Books department.

A conference call was held on March 3 to review the development of the data specifications and other issues. Conference calls have since taken place on March 24 and April 22. During these calls, the researcher was chosen and some additional revisions to the data request were made. The next conference call is scheduled for May 27.