HEALTH SECTION NEWS

"For Professional Recognition of the Health Actuary"

Issue Number 41, September 2001

Chairperson's Corner

by Leigh M. Wachenheim

Earlier this year, the Health Section Council posted a Request for Proposals (RFP) to the Society Web site. The RFP was a call for research projects that would result in information, data, or tools useful to practicing health actuaries. We received many fine proposals for worthwhile projects and wished we had the resources to accept them all.

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Financial Reporting for Healthcare Plans: An Outline of Best Practices

by James P. Galasso, reviewed by Anthony Wittman

Overview

This paper was written with the following objectives in mind:

1. To communicate some of the trials and tribulations we "more seasoned" actuaries have experienced in our seemingly never-ending struggle with financial reporting for healthcare organizations to those a little fresher behind the ears. The paper limits discussion to managed care and other short-term medical care policies and avoids the more complex issues related to: long term disability policies, long term care policies, or other health

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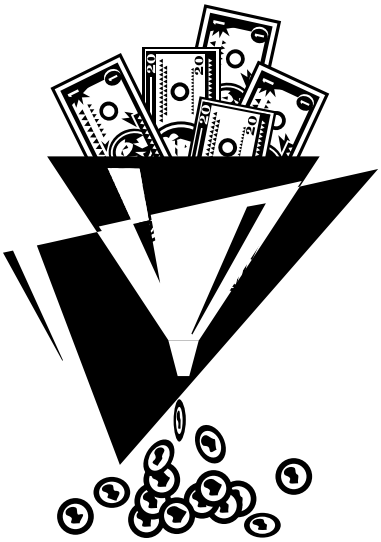

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Accident and Health Working Group of the Life and Health Actuarial Task Force Meeting Summary - June 8, 2001

The working group discussed the March 23, 2001 draft of the Health Insurance Reserves Model Regulation that incorporated recommendations from the Society of Actuaries concerning morbidity standards for the valuation of credit disability insurance. The working group made two revisions to the March 23 draft for clarification and adopted the modified draft.

The working group also agreed to recommend revised language for Statement of Statutory Accounting Principles (SSAP) No. 59 in the Accounting Practices and Procedures Manual. The revised language was needed to reflect the revisions to the Health Insurance Reserves Model Regulation concerning morbidity standards for the valuation of credit disability insurance.

At the 2001 Spring National Meeting, the Accident and Health Working Group sent recommendations to the Statutory Accounting Principles Working Group and the Blanks (E) Task Force addressing the reporting of cost containment expenses in annual statements. The working group discussed a letter from the Health Entities Working Group that proposed revisions to the Accident and Health Working Group's March 23, 2001 recommendations. The working group agreed to send a letter supporting the revisions as modified by the Health Entities Working Group.

The working group discussed a letter regarding the reporting of reinsurance receivables and health care receivables in the Underwriting and Investment Exhibit (U&I) Part 2B of the Health Blank. The working group agreed that the instructions to U&I Part 2B should be revised to reflect the net of the reserves, liabilities, and receivables (reinsurance and health care), and that the column headings should be correspondingly revised. The working group agreed to hold a conference call prior to the 2001 Fall National Meeting to discuss a draft letter addressing this issue.

The working group discussed a request for assistance from the Financial Condition (E) Committee concerning modifications to the Life, Accident and Health Blank. The working group established a new subteam, co-chaired by Tom Foley (KS) and Leslie Jones (SC), to address the issue raised by the Financial Condition (E) Committee relative to consistency between Schedule H in the Life, Accident and Health Blank and the Underwriting and Investment Exhibit in the Health Blank.

The working group briefly discussed the June 4, 2001 draft of the *Guidance Manual for Rating Aspects of the Long Term Care Insurance Model Regulation.*

Leslie Jones (SC), chair of the HMO/HMDI Reserves Subteam, reported that the subteam held two conference calls subsequent to the 2001 Spring National Meeting. A list of issues identified to date was distributed. Ms. Jones reported that the subteam will hold two conference calls prior to the 2001 Fall National Meeting to discuss these issues and any additional issues that may be subsequently identified. The HMO/HMDI Reserves Subteam was established at the Spring National Meeting to review the Standard Valuation Model and Health Insurance Reserves Model Regulation in order to recommend to the Accident and Health Working Group whether the models should be revised to also apply to Health Maintenance Organizations (HMOs) and Hospital, Medical and Dental Service or Indemnity Corporations (HMDIs).

The working group re-activated the Codification Subteam, chaired by John Rink (NE), to address issues that result from recommendations that the Accident and Health Working Group sent to the Statutory Accounting Principles Working Group addressing the reporting of cost containment expenses.

Chairperson's Corner

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However, after some discussion, we decided we were equipped to handle two projects this year. I would like to use my corner in this newsletter to tell you a little bit about each of these projects.

Risk Adjusters

One of the projects we are sponsoring is an independent review of several claim-based risk adjusters. The research team includes Bob Cumming, FSA and Brian Cameron, FSA of Milliman USA and Dave Knutson of the Health Research Center of Park Nicollete Institute. A project oversight group, chaired by John Bertko, FSA, has been convened and is actively involved with the researchers.

The research team is currently reviewing three pharmacy-based models and three diagnostic-based models. The goal is to measure how well the different risk adjusters perform on a comparative basis. First, the researchers plan to measure how well the pharmacy-based models perform compared to the diagnostic-based models. This is important because many health plans are more comfortable with the quality of their pharmacy data than their other claim data. Second, the researchers plan to measure how well the different diagnostic models perform compared to each other.

A number of performance measures are being taken. First, the researchers are measuring how well the risk adjusters perform on both a prospective and concurrent basis. Second, the researchers plan to measure performance at both the individual member and the non-random group level. (Non-random groups are generally composed of people having either a similar medical condition or similar claim levels.)

We are hopeful that this research will help us understand how useful risk adjusters are for predicting experience and how performance might vary based on the type of data or methodology used.

Aging Curves for Older Americans

The HSC also decided to sponsor a project to investigate aging curves for older Americans. The researcher, Jeff Petertil, ASA, says the study will focus on retirees over the age of 70, although, more generally, he also plans to look at aging curves for anyone over age 50. He also hopes to review differences in the aging curve by service category (e.g., chronic care versus acute care facilities). To the extent credible data is available, he may also examine further breakdowns such as differences by gender. Dale Yamamoto, FSA, chairs the project oversight group.

Jeff has two goals for the study. His first goal is to prepare a summary of the assumptions commonly used by practicing actuaries regarding cost differences by age in the retirement years. He will do this by reviewing the available literature and by surveying other actuaries. To the extent the information is available to him, he will also include some commentary regarding the degree to which these assumptions are based on actual data.

Jeff also believes that there would be a lot of value in testing some of these assumptions using multiple and up-to-date databases containing actual experience. Therefore, his second goal is to collect and study real data, to the extent it is available.

Leigh Wachenheim

Past attempts to conduct such studies have been stalled due to difficulties in obtaining reliable data. Jeff hopes that his status as an independent consultant and his commitment to protecting the confidentiality of the data and to using it only for research will encourage others to share their data with him. So, if you have a database that you are willing to share or data summaries that may be useful, please contact Jeff.

We are hopeful that this study will provide actuaries with a broad overview of the assumptions that are being used today and will also be a step forward in testing those assumptions with real data.

Look for the results of these studies in the coming months. They will be made available to members of the Health Section in a readily available format.

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product offerings with long-tail actuarial liabilities.

2. To introduce some potentially controversial subjects in the hopes that they may create an ongoing constructive dialogue.

3. To focus attention on healthcare industry data and financial reporting issues with the hope that actuaries will act as catalysts for company-specific and industry-wide improvements.

4. To provide various specific bench marks against which a company may measure their own financial reporting capabilities and target specific areas for improvement.

> ***"If a company is experiencing a downward trend line in financial performance, a greater potential for continued adversity exists for that company than for a company with lower immediate earnings, but with a positive financial trend line."***

5. To identify the type of reporting necessary to create a clear link between financial reporting and company performance (i.e. profitability, growth, and financial reporting integrity).

I. Overall Objectives of a Financial Reporting Process:

While there may be other equally important questions, I have distilled the ultimate objectives of a financial reporting process down to the ability to answer three key questions:

(i) "Where is the Company making or losing money?"

(ii) "Are things getting better or worse?"

(iii) "Is the Company financially viable?"

Where is the Company making or losing money?

In order for a company to make more money or to stop losing money, it must know where it is currently making money and where it is currently losing money. This is not a very controversial statement. What may be controversial, however, is the belief that most companies do not have a clear understanding, and in sufficient actionable detail, to properly respond to this question. The phrase "actionable detail" in the preceding statement suggests that it is not enough to have a report showing gains or losses; rather, reports need to support specific action steps that can be taken to improve a company's financial position.

Are things getting better or worse?

This is perhaps the single most important financial question that needs answering. More important than where a company is making or losing money is the recent financial trend line, again at an actionable level of detail. Putting potential seasonality aside, one should take little comfort in knowing that a company made $10.0 million last quarter for a particular product if that same product made $20.0 million in the prior quarter, and $40.0 million in the quarter before that. Management's job (and a company's viability) is to make the next quarter better than the prior quarter — not to rest comfortably on a single earnings number. If a company is experiencing a downward trend line in financial performance, a greater potential for continued adversity exists for that company than for a company with lower immediate earnings but with a positive financial trend line.

Is the Company financially viable?

The distinction between financial solvency and financial viability is critical and closely related to the distinction between the first two questions presented above. A company's balance sheet may appear quite adequate and pristine. The company may, in fact, be quite "solvent". The balance sheet, however, is a point-in-time snapshot of a company's condition. It provides little to no indication as to current and emerging trends impacting a company's financial condition. Is the company's cost structure so out of line that it can no longer profitably compete in the marketplace? Is the company's financial trend line such that what appears to be adequate capital, is not adequate at all? Are the company's product lines out of date and subject to replacement by fierce competition? Is there recently passed or impending legislation (or litigation) that threatens the company's solvency? These questions help differentiate the solvency of a company from its longer-term viability.

II. Defining Market Segments:

The first step to review an existing or establish a new financial reporting system generally involves defining the market segments a company would like to monitor and manage. As you may soon appreciate, virtually all of the items presented in this paper are deceptively simple and straightforward. What could be easier than identifying the core market segments that comprise a company? Many companies, however, experience significant difficulties in agreeing on market segment definitions — especially the larger, more complex companies. In

fact, many companies have multiple and conflicting definitions. Market segments are typically categorized by a combination of one or more of the following:

(i) Legal Entity (e.g., ABC-HMO, DEF-HMO, and XYZ Life & Health Insurance Company)

(ii) Product type (e.g., HMO, POS, and PPO)

(iii) Group Size (e.g., Groups with 2-25 employees, Groups with 26 to 100 employees, Groups with 101 to 500 employees, Groups with more than 500 employees)

(iv) Individual Products (e.g., HMO offerings, PPO offerings, Medicare Supplement, Conversion policies)

(v) Geographic Area (e.g., North, South, East, West)

(vi) Provider Network (e.g., Hospital A Network, Hospital B Network, Physician Group A, Physician Group B)

(vii) Government Programs (e.g., Medicare Risk, Medicaid Risk, CHAMPUS)

All of the above categories are fairly common with the possible exception of "Provider Network" defined market segments. Whether or not a company considers a provider network a market segment, provider risk arrangements may very well require that financial reports be prepared by provider network and shared with the participating providers.

Market segment categories must satisfy a company's multiple constituencies. For example, specific individuals may have bottom-line accountability for specific markets. Individuals may have product-specific accountabilities, others may be accountable for groups of a certain size, and yet other individuals may have provider-network-bottom-line or relationship accountabilities. Aside from a company's desire to define and manage its markets in a specified way, all companies must also comply with numerous laws, regulations, and accounting requirements. This creates other constituents such as accountants, lawyers, actuaries, and compliance officers who must also participate in the market segment definition process.

Finally, defining market segments, more often than not, is a dynamic process. Most companies change market segment definitions with a regularity that is quite frustrating to those responsible for financial reporting and compliance. Whether such change is attributable to acquisitions, divestitures, group size definitions, geographic definitions, or some other combination of events, a company's financial reporting and information system processes must be flexible enough to accommodate major and often frequent changes.

III. Preparing a Market Segment Monitoring Report:

Once the market segments have been defined, the next step involves putting in place the financial reports that help a company answer the three key questions noted in Section I. Best Practices suggest that these reports be part of the monthly closing ritual of the finance department. Not only must a company prepare basic monthly income statement and balance sheet information, but a month-by-month report by defined Market Segment should be prepared ***that reconciles to corporate totals*** and includes at least the following key components:

(1) Members

(2) Earned Premium

(3) Other Income

(4) Total Revenue

(5) Paid Fee for Service Claims

(6) Unpaid Claim Liability Estimates

(7) Capitation Payments

(8) Provider or Other Contractual Risk Sharing Settlements

(9) Other Paid Medical Costs

(10) Other Medical Cost Liabilities

(11) Net cost of reinsurance

(12) Total Medical Costs

(13) Administrative Expenses

(14) Commissions

(15) Premium Taxes

(16) Miscellaneous Expenses

(17) Total Expenses

(18) Pre-tax Operating Gains (Losses) = (4) – (12) – (17)

Note the emphasis on capturing a significant amount of financial statement detail with respect to medical costs. Given the complexity of managed care arrangements and claim payment details, this is the area that generally provides the greatest frustration to company actuaries, company accountants, and external auditors. Item (5) [Paid Fee for Service Claims] is, by this paper's definition, *exactly equal* to the paid claims in the claim lag reports provided to the actuary for Unpaid Claim Liability (UCL) estimation (most often erroneously referred to as IBNR — Incurred But Not Reported claims). To the extent claim payments are made that are not captured by the claim lag reports, such payments are included in item (9) [Other Paid Medical Costs]. Item (6) [Unpaid Claim Liability Estimates] captures the estimates derived from the paid claims in item (5). Item (10) [Other Medical Cost Liabilities] captures the estimates derived from the paid medical costs in item (9).

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Items (7) thru (10) are often collectively referred to as the "non-lagged" medical costs since they represent the medical costs that are never captured by the claim lag reports that the actuary traditionally relies on for the UCL estimates. Non-lagged medical costs may include such items as capitation payments, provider risk sharing payments and corresponding liability estimates, and prescription drug claims paid by a Pharmacy Benefit Manager (PBM).

The difficulty of estimating provider risk sharing liabilities, potential liabilities related to capitation payments, and other liabilities related to third parties for which access to detailed financial records is limited or unavailable is a significant issue deserving of special attention. The topic, however, is too complex for this discussion and deserving of a separate paper.

IV. Recasting a Market Segment Monitoring Report:

Once a set of Market Segment monitoring reports have been developed that reconcile to a company's reported financial results, the actuary should update historical actuarial liability estimates based on the most current available information. These updated estimates should be more accurate than the original reported estimates and will often differ materially from the company's reported numbers. Accordingly, to obtain a more accurate analysis of the company's (or a Market Segment within the company) financial performance and financial trend line, the actuary should prepare a "Recast" market segment monitoring report by replacing reported estimates with the updated (or, "Recast") estimates. This should provide a more accurate picture as to the financial health and financial trends currently being experienced by the company.

V. Identification and Quantification of All Potential Actuarial Liabilities:

In addition to UCL and possible provider liabilities, the actuary must also review the potential need for recognizing other liabilities in a company's financial statements. Such liabilities might include (but are not limited to):

i Loss Adjustment Expenses (LAE) – This is an estimate of the administrative expenses required to pay the claims represented by the UCL estimate. Some companies make the assumption that the relative conservatism of their UCL estimate along with the investment earnings on the assets backing this liability is sufficient to cover the LAE. The actuary should be comfortable that this implicit approach to covering potential LAE costs is appropriate.

ii Extension of Benefits (EOB) – This is an estimate of the liabilities that may exist upon the termination of individual employee certificates covered by an employer contract. Such liabilities are generally related to disabled or hospitalized employees at time of individual certificate termination. Specialized procedures that are beyond the scope of this paper may be needed to properly estimate potential EOB liabilities. Such procedures should start with a review of actual contract forms to determine the existence and relative magnitude of any potential liability. EOB reserves are fairly common among health insurance companies but are quite rare within the HMO industry. Nevertheless, the actuary should review an HMO's contracts and provider agreements to determine if an EOB liability may exist.

iii Premium Deficiency Reserves (PDR) – This is a liability that originated in Generally Accepted Accounting Principles (GAAP) accounting, gradually became prevalent in Statutory Accounting (STAT) as various States mandated its recognition, and has now been standardized in STAT accounting due to the National Association of Insurance Commissioners' (NAIC) adoption of codification standards effective January 1, 2001. The liability is effectively an estimate of losses attributable to contractual agreements currently in place that will occur after the current financial reporting period.

Many actuaries have expressed concerns over the application of PDR reserve requirements since they have the effect of significantly distorting a company's income statement by accelerating future losses. The effect is to understate earnings in the financial reporting period for which the PDR is recorded and to overstate earnings in the financial reporting period when the PDR is released.

When PDRs are recorded in a company's reported financial statements, they should be removed when attempting to analyze a company's actual financial trend line.

VI. Reconciliation of Claim Payments (Actuarial Reserves, Other Medical Costs, and Total Incurred Medical Costs):

All medical costs must find a home in a defined category (e.g., one of the seven items identified as (5) through (11) in Section III) so that the entire market segment report reconciles and is internally consistent with all other financial reports. The actuary must understand the Total Medical Costs presented in these market segment reports — both the paid claims used in developing the UCLLiability estimates and the remaining medical costs.

Without such a complete understanding, it is difficult to impossible for the actuary to state with any degree of certainty that the actuarial estimates included in a financial report are consistent with the data making up the financial reports that he may be certifying. In addition, if total medical costs are not understood, the accuracy of a company's financial reports may be called into question.

Please note that the preceding statements of concern are irrespective of whether the actuary accurately estimated the UCL based on the data provided for the actuarial analysis. If a reconciliation from (1) the claim lag reports to (2) the actuarial estimates to (3) the Total Medical Costs is not made, any retrospective look at the ultimate "accuracy" of the actuarial estimates is an interesting but largely irrelevant exercise.

VII. Medical Management Reports:

This is probably the area that offers the greatest potential for unlimited analysis with limited actionable results. While it is essential for a managed care company to understand the details of its medical costs, the complexity of interpreting results increases exponentially as additional reporting procedures evolve with time. A healthy industry movement that is beginning to emerge is the conversion from a focus on the ever-expanding list of medical procedures to the monitoring of individuals with specified diseases and treatment patterns. This holds out the ultimate promise made by managed care — that it will help control costs while identifying the most effective medical procedures for specified conditions. If managed care can withstand the current onslaught of criticism from providers, the public, legislators, and litigators, it may be offered the opportunity to significantly improve the practice of medical care. If we appropriately apply our analytical capabilities, this offers the actuarial profession an opportunity to assist the companies with whom we work and the healthcare industry itself. How we might apply our unique skills in this area is a potential topic for another paper.

VIII. Expense Control, Allocation and Recovery:

Administrative expenses is another key area that requires significant attention if a company is to remain financially viable. There are three major areas for consideration with respect to a company's administrative expenses:

i Expense Control – this refers to a company's ability to maintain administrative expenses at a level below that of its major competitors. The actuary may not drive the expense control process itself (i.e. the budgeting process), but certain reports can have a very definite influence. For example, the actuary must ensure that the company understands the impact expense control has on the pricing of each of the company's product offerings.

ii Expense Allocation – aside from the potential need for company downsizing initiatives, the greatest area for potential conflict within an organization with respect to expenses is the allocation of company expenses to each of the defined market segments and subsets of those market segments. In fact the conflict is so great that many, if not most, companies simply ignore this essential financial measurement. Allocation, by definition, is subjective and many would argue arbitrary. Accordingly, companies that do attempt to appropriately allocate expenses to defined Market Segments can be assured that every recipient of those allocations will consume considerable corporate time explaining why their particular allocation is inappropriate. Quite often all involved individuals will have their credibility and/or motives called into question. The purpose of this paper is not to discuss various expense allocation methodologies. Suffice it to say that pricing and financial monitoring of gains and losses by market segment is impossible without the implementation of an acceptable expense allocation methodology. The actuary should play a key role in developing this methodology.

iii Expense Coverage – this is perhaps the actuary's primary responsibility with respect to administrative expenses. Expense coverage is the degree to which the expense component of a company's premium (along with any other administrative fees charged by the company) is sufficient to cover the company's total administrative expenses. Any difference is often referred to as the "expense gap." The expense gap can be either positive (aggregate expense charges and administrative fees exceed total company expenses) or negative (aggregate expense charges and administrative fees fall short of total company expenses). The actuary must ensure that company management understands the direction and absolute value of any expense gap. Even if a company does not formally allocate total expenses to defined market segments, the actuary should develop reports capable of monitoring the premium component related to expense charges for each such market segment. This enables the actuary to determine the aggregate expense gap that can then be communicated to company management.

IX. Company Plans, Financial Projections, and Budgets:

All companies generally have business and financial plans that are prepared for at least a one-year time horizon. Ideally the financial plan will be prepared in a format consistent with that described in Section III with respect to monitoring defined market segments. While it is not necessary for a financial plan to have all of the components identified in Section III, the basic components that make up a company's balance sheet and income statement should be specified (e.g., members, premium, medical costs, administrative expenses, and risk-based capital ratios). Various assumptions applied to these basic elements can generally be made to complete a financial plan (e.g., interest earnings on the unpaid claim liability to obtain most of what may make up "other income," premium tax rates to obtain projected premium

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taxes, commission rates to obtain projected commission payments).

Member projections should reflect market conditions and company plans and expectations. Premium projections must reflect the actual months and the expected amounts by which premium rates will change (e.g., renewal dates and corresponding loss ratios for group customers).

Medical cost projections, as defined by a company's medical cost trend expectations, are generally the most volatile and significant risk factor in the business plan. Many of the other business plan variables are highly dependent upon the actuary's detailed analysis of medical cost trends. Required premiums and, consequently, membership assumptions are directly related to the assumed medical cost trends. Given this variability and dependency, financial projection models are often prepared on a dynamic (versus static) basis in an effort to evaluate plan sensitivities to various medical cost trend levels.

Administrative expenses, also indirectly dependent upon medical trends (due to the influence on membership and related service levels), are generally derived from an approved corporate budget.

The whole projection process generally requires the use of a fairly sophisticated model capable of developing multiple scenarios that reflect various assumptions. This provides the actuary and management with a tool to evaluate the impact various assumptions have on a company's projected financial performance.

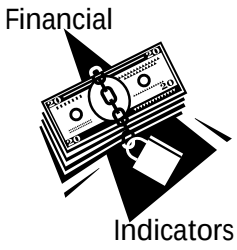
The capital position (sometimes referred to as surplus, contingency reserves, or equity) of healthcare companies has received increased scrutiny since the NAIC promulgated Risk-Based Capital (RBC) standards for regulators. The Risk-Based Capital ratio is a measure obtained by dividing a company's "Total Adjusted Capital" by what is called the "Authorized Control Level" (ACL). The ACL is a number that represents the bare minimum amount a company should have as capital given the risk characteristics of that company. In states where the NAIC's RBC Model Bill has become law, if a company's capital falls below the ACL, a regulator may seize control of that company (in fact, the regulator is required to seize control at a specified level of capital deficiency). Accordingly, this has become an extremely important indicator within the healthcare industry.

The administrative expense budget should be prepared in fairly excruciating detail in order to address the three key areas noted in Section VII (i.e. expense control, expense allocations, and a projection for expense coverage).

Finally, a financial plan should not be a once-a-year exercise. Rather, the actuary should continuously (i.e. monthly) evaluate how close actual company results by defined market segment match the financial plan numbers. Management can then take actions to correct or exploit significant deviations.

X. Financial Indicators and Measurements:

While there is no one best set of company financial measurements, a company should define consistent measures and communicate these measures to its various stakeholders (e.g., its Board of Directors, employees, investors, providers, rating agencies, major customers). Basic indicators of financial performance are often expressed in ratio form as a percent of premium and include: the medical loss ratio, the administrative expense ratio, and operating gains/losses.



For managed care companies, "per member per month" (PMPM) indicators for premiums, medical costs, and administrative expenses are always included as performance measurements. Annual trends in these PMPMs are additional indicators worthy of attention.

A vast array of medical management performance measurements that are generally expressed in terms of "unit cost" and "utilization per 1,000 members per year" are also typical of a managed care company's array of key indicators.

Consistent with the previously noted emphasis on Risk-Based Capital, capital adequacy and return on capital are becoming standard measurements of financial performance. Best practices suggest that such equity measurements be applied to each of a company's defined set of market segments. This necessitates the ability to allocate a company's total Risk-Based Capital to its defined market segments, consistent with the risk characteristics of those segments.

Financial reporting involves a large number of fairly complex topics that, as noted in the introduction, can often frustrate the most experienced healthcare actuary. Hopefully, this paper has some value for individuals at various experience levels — whether the value is just the sharing of common frustrations or the actual transfer of knowledge.

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ERISA Preemption and Managed Care Organizations

by Louis G. Lana

The Employee Retirement Income Security Act (ERISA) of 1974 has had a large impact on the design and administration of self-funded employee benefit plans. Managed care organizations (MCOs) that market their products to these plans are directly affected by this legislation. And no provision has been the object of more legal scrutiny than the ERISA preemption clause.

ERISA Preemption

The ERISA preemption clause states simply (or maybe not so simply) that ERISA bars, or "preempts," any and all state laws that relate to any employee benefit plan subject to ERISA. In recent years, there have been a number of court cases that have called into question the breadth of scope of that preemption. I will focus on three cases in particular: *Corcoran* vs. *United HealthCare, Inc., Pegram* vs. *Herdrich,* and *Kearney* vs. *U.S. Healthcare, Inc*. These three cases illustrate the different areas where the ERISA preemption clause has been utilized as a defense.

Corcoran vs. United HealthCare, Inc.

This case, decided in 1992, concerned utilization review decisions by MCOs. Florence Corcoran, an employee of South Central Bell Telephone Company, became pregnant in 1989. As Mrs. Corcoran neared her delivery date, her obstetrician, Dr. Jason Collins, recommended hospitalization to monitor the fetus. United HealthCare, which provided utilization review services for the plan, denied the hospitalization and instead authorized 10 hours per day of home nursing care. During a time when no nurse was on duty, the fetus went into distress and died.

Mrs. Corcoran and her husband sued United in Louisiana State court, alleging wrongful death as a result of negligence and medical malpractice. United argued that the claim was relating to an ERISA plan, and thus fell under the broad scope of the preemption clause. The district court agreed with United. The Corcorans filed an appeal, and the case was moved to the U.S. Court of Appeals for the Fifth Circuit.

The Court of Appeals ruled in favor of United, agreeing with its claim that under the utilization review arrangement, United makes benefit determinations, not medical decisions. Since the decision by United to reject Mrs. Corcoran's hospital stay was inseparable from its benefit determinations under the plan, the claim by the Corcorans was preempted by ERISA. This case has been used as precedent for other ERISA claims arising from utilization review decisions.

Pegram vs. Herdrich

In this case, Cynthia Herdrich sued her health plan under Illinois law for state-law fraud. When an inflamed mass was discovered in Herdrich's abdomen, her physician, Dr. Lori Pegram, did not order an ultrasound examination at a local hospital but instead decided that Herdrich should wait eight days for an ultrasound, at a hospital staffed by Pegram's HMO, the Carle Health Insurance Management Co, Inc. During the delay, Herdrich's appendix ruptured, causing peritonitis.

The district court rejected Herdrich's claim under ERISA, but an appellate court reinstated it, holding that Carle HMO was acting as a fiduciary when Dr. Pegram made her decision to delay treatment. The Supreme Court agreed to take the case last fall.

The Supreme Court reversed the appellate court's decision, stating that Congress did not intend HMOs to act as fiduciaries with regards to "mixed" eligibility decisions, that is, decisions taking into account eligibility and treatment. However, the ruling left open the possibility that since such "mixed" decisions fall outside ERISA's preemptive scope, the health plan could be sued again under state law. Therefore, what appeared to be a victory for MCOs could result in a narrowing of the broad parameters of the ERISA preemption clause.

Kearney vs. U.S. Healthcare, Inc.

Kevin Kearney, an employee of Scott Paper Company, had health coverage under his employer's plan with U.S. Healthcare. Mr. Kearney's primary care physician under the plan was Dr. Michael Stupin. In March of 1990, Mr. Kearney twice saw Dr. Stupin, at which times Dr. Stupin failed to diagnose his patient's condition or refer him to a specialist or hospital. Mr. Kearney died on March 22, 1990, of thrombotic thrombocytopenic purpura.

The estate of Kevin Kearney sued U.S. Healthcare in Pennsylvania district court on the grounds of misrepresenting Dr. Stupin's competence, breaching its promise to supply specialized care, and negligence in selecting the physician. The estate also claimed U.S. Healthcare was vicariously liable for the malpractice of Dr. Stupin. U.S. Healthcare maintained that Kearney's claims were preempted by ERISA.

The court ruled that claims of misrepresentation, breach of contract, and negligence "relate(s) to the manner in which benefits are administered and provided" by the plan and are thus preempted by ERISA. However, U.S. Healthcare was found to be vicariously liable for the malpractice of Dr. Stupin.

Conclusion

It can be argued that when Congress enacted ERISA, it could not have foreseen the current complexity of the managed health care system in the United States. The broad scope of the preemption clause has made it difficult, but not impossible, for members of ERISA plans to sue MCOs for medical malpractice. The recent failure of the Senate to pass the House version of the patients' bill of rights legislation, which would have given consumers the right to sue their health plan in the case of injury or death resulting from delayed or withheld care, is reflective of this difficulty.

There are numerous other cases where the ERISA preemption clause has been invoked by managed care organizations as a defense in state lawsuits. The Health Administration Responsibility Project Web site, *www.harp.org,* while somewhat biased against MCOs, provides a comprehensive source of information regarding the legal issues involving health plans, with special attention paid to ERISA.

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Current Issues In Stop Loss Market

by Daniel L. Wolak

The stop loss insurance market is emerging through a period of unprecedented losses. What are the current trends and issues facing the market as it regains profitability? The panel of Ray Marra of The Hartford, Mike McLean of Medical Risk Managers (MRM), and Jerry Winkelstein, who is an independent consultant, moderated by Dan Wolak of GeneralCologne Re, discussed their views at the SOA 2001 Spring Meeting in Dallas.

The major focus currently for the insurers and reinsurers in the marketplace is in improving loss ratios to the point of meeting their profit targets. The panel generally feels that many companies are moving in the right direction, but many others are still falling short.

Claim Experience

Mike McLean presented two surveys of loss ratios from a sample of direct insurance writers. In his study from 1999, loss ratios increased by 16% from 1996 to 1998 underwriting years. In a recent survey of five carriers, the projected loss ratio peaked in 1999, and is expected to decline for the 2000 underwriting year. It is still too early too tell how the loss ratio for the 2001 underwriting year will develop. The panel predicted that there is a reasonable chance that well disciplined programs will be profitable for the 2001 underwriting year. Of course, actual emerging trend is key.

The Trend in Trend

With the recent history of poor results from the product, the panel next discussed average rate increases in the marketplace. Based on the panel's and the audience's feedback, a "normal" rate increase at renewal for a program is currently in the area of 40% or more. A good portion of the rate increase is to cover trend; the rest to improve the financial results for the product line. The panel was split on their views of current trend on a $50,000 specific deductible. Jerry Winkelstein shared that for his clients, which are large MGUs, large claim management programs and centers of excellence are limiting leverage trend to the range of 18% to 20%. Mike McLean and Ray Marra, who both are on the stop loss carrier side, believe that leveraged trend is in the 25% to 30% range.

The annual increase in cost for stop loss is impacted, naturally, by underlying trend on the first dollar medical plans, by leveraging, and also by type of fee arrangements with HMO or PPO networks.

With the successive years of losses for the stop loss product line, the panel explored the role that reserving, or in this case under-reserving, played. Generally, few companies' actuaries have recognized the under-priced, high emerging loss ratios in reserves until claim patterns were fully developed. Ray Marra presented also the need to vary the lag factor by level of deductible. For example, for a lower specific deductible, 68% of ultimate claims are paid within 12 months of the anniversary date. For a high deductible, only 44% may be paid at that point in time.

Once you seen one PPO, you have seen....

Jerry Winkelstein discussed the issue regarding how different one PPO is from another. The concern is that the data available to analyze a PPO may be limited or confidential. In addition, available data is retrospective and may not be a good indicator of how prospective cost will develop for a future point in time. The issue is: how should the "PPO effect" be taken into account in the premium development? If manual rates reflect past experience, wouldn't the "PPO effect" already be in the manual?

Outlier Fee Schedule Impact On Stop Loss

Hospital costs are rising; hospitals are negotiating significant fee increases, updating per diems that have been frozen for a number of years. In addition, stop

loss carriers and underwriters are challenged to correctly factor in the impact of a given PPO network when setting the stop loss rates.

Mike McLean discussed that many PPO fee scales provide incentives that adversely impact stop loss results. Mike has found that many contracts have had per diems that provide less than the needed revenue to a hospital but also provide an outlier that applies at a relatively low-level claim amount. Though carriers may receive "20% or more" off of "billed charges" for large claims, this translates into an area of significant profits for the hospitals. The concern and fear is that stop loss carriers have paid at a fee level much higher than average hospital cost per day because of the existence of outliers.

Mike provided an example of a low outlier in a negotiated contract with a low per diem payable up to the outlier. For the sample case, negotiated savings resulted in a 60% discount on claims under $30,000, and 30% savings on claims over $30,000. The lower discount on high claims is very "stop loss unfriendly."

He discussed examining $1 billion of claims from a major carrier over a 10-year period. He said that the average reimbursement for claims subject to a discount off of billed charges increased at the rate of 10% a year. For claims subject to a per diem, the average reimbursement increased only 2% a year. Yes, hospital costs increased by 6% a

year, but the high claims shared in a disproportionate amount of the increase. Mike recommends that network contracts be renegotiated to level the amount paid between low claims and high claims.

Jerry Winkelstein asked if such a change would really help the employer. The change is revenue neutral to hospitals and to employers' claim payments. Are employers willing to make such a change with little direct benefit to them? The panel had a lively discussion on this issue.

The solution outlined by Mike is:

1. Partner with select PPOs and eliminate the outlier provision in network hospital contracts.
2. Raise the per diem to remain revenue neutral for the hospital.
3. Steer employers towards these PPOs.

Can Claims Manage the Billing Practices of Providers?

Ray Marra discussed the need to monitor the effectiveness of inside claims departments as well as TPAs. Ray provided several examples of how a review of submitted stop loss claims resulted in requiring the TPA to request a repricing from a hospital. In one case, a one-day hospitalization charge resulted in a $96,000 bill. Most of the cost was associated with a medical device, which the hospital had marked up their cost of $18,000 to a billable charge of $75,000! The most gross situation of over-billing was a $97,000 charge for a gel foam sponge, an item which costs the hospital only $10!

Reinsurance Capacity... Is the Glass Half Empty??

The panel discussed the current situation with reinsurers. Mike McLean noted that virtually all of his contacts in the '90s from reinsurers are no longer there, primarily due to the former major players having dropped out of the market. Dan Wolak discussed that today, unlike the late '90s, the reinsurance risk taker is now requiring greater control. In the past, reinsurers had little control on rating and underwriting. Because of the poor results incurred by reinsurers over the past several years, reinsurance capacity for a new program currently is difficult to find. There is what is called "naïve" capacity in the stop loss market place which refers to new reinsurers with little knowledge of the product. The "naïve" capacity has been able to enter since there are few barriers for a new reinsurer to enter the market. Mike McLean noted that reinsurers who are "naïve" and add no value, have been a major problem with the underpricing in the marketplace.

Because of the above, there are fewer reinsurers today than there were three years ago. This change makes it difficult for new programs to find reinsurers when the direct writer desires to keep a minimum amount of risk.

Daniel L. Wolak, FSA, MAAA, is senior vice president at General Cologne Re in Stamford, CT and a member of the Health Section Council. He can be reached at dwolak@gclifere.com.

Plans Laid for Academy's Life and Health Qualifications Seminar

Emphasizing real-world professional needs, the American Academy of Actuaries will again offer its seminar on life and health annual statement certifications in Washington, DC on November 12–15, 2001.

The seminar gives life and health actuaries the opportunity to demonstrate by examination that they have obtained the necessary basic education to function as valuation actuaries under the Qualification Standards for Prescribed Statements of Actuarial Opinion.

Building on participants' knowledge of financial statements, actuarial mathematics, life insurance valuation, insurance finance and investments, and life, health, and annuity products, the 3½ day seminar will cover such topics as valuation and non-forfeiture requirements, statutory accounting, and expense analysis.

The primary purpose of the seminar is to provide state-specific and country-specific basic education for actuaries who did not fully meet the basic education requirements as part of their SOA examination process. However, actuaries seeking to refresh their basic education or add to their continuing education will find the seminar useful. Additionally, candidates for fellowship in the SOA may earn 15 units of professional development credit for attending.

There will be an examination on the final day for those seeking to meet qualification standards or professional development credit.

For more information on the seminar, contact the Academy's legal assistant, Rita Winkel, either by phone at 202-223-8196, or e-mail at *winkel@actuary.org.*, or visit the Academy's Web site, *www.actuary.org/seminar/index.htm.*

Data Quality in Real Life

by Karl G. Volkmar

The following is an excerpt from an article I wrote for the August 2000 edition of the *Health Section News*:

"Many times, the precise company-specific data you need to do your job…does not exist. This may be true because it has never been recorded, or because no one has ever requested or used it before (including the actuary that preceded you!). This can make an actuary's job extremely difficult or even impossible from a purist viewpoint.

As if this is not difficult enough, attempts to establish the infrastructure needed to collect, record and report needed data will be met by another fact of life…the majority of home office personnel do not want to collect, record, and report what they view to be ***additional*** *data. In fact, they are generally incented to do otherwise."*

This excerpt summarizes my career as it relates to data quality.

In response to the above excerpt, I was asked to moderate a session entitled "Session 96IF – Data Quality Concerns for Health Actuaries" at the recent SOA meeting in Dallas. I began my preparation by asking a number of health actuaries the following question: Do you consider yourself a data quality expert? I was surprised to find out that not one of them, not even those that worked with data day-to-day, considered himself/herself an expert.

How could this be true given that virtually all actuaries working in the profession work with data, either directly or indirectly, every day? Based on some additional discussions, I believe it is true because actuaries know that the data quality situations/scenarios an actuary can be faced with are endless. Every situation is different, and all require analysis and, ultimately, professional judgment. This is a perfect lead-in to a discussion regarding ASOP No. 23.

If you have not read ASOP No. 23 before or it has been a while since you did, I suggest that you do so both now and on a regular basis. Every time I read it (assuming sufficient time between readings), I take something new from it. It not only provides guidance on a tough subject, but it is the authority — every member of the SOA is bound by it! It applies to all SOA members in every area of practice.

The following is the opening paragraph to the standard.

"Data which are completely accurate, appropriate and comprehensive are seldom, if ever, available. An actuary performs an analysis with available data and includes in the report sufficient information so that users may be aware of material data limitations known to the actuary, and their implications.

Furthermore, a review of data may not always reveal imperfections. This standard does not recommend that an actuary audit data."

As indicated from this opening paragraph, the following is a three-point summary of ASOP No. 23:

1) Know what your data represents and where it comes from.
2) Understand the impact that has on what you're working on.
3) Document, document, document.

In more detail, the standard of practice addresses the selection of data including the extent of any needed review and the number of data alternatives to be reviewed. In addition, it includes a list of items to consider when selecting data.

The standard also includes a section on imperfect data that basically boils down to two questions:

1) Will the imperfections produce material biases in the results?
2) Are the data so inadequate that they cannot be used?

Disclosure, the responsibility for the accuracy and comprehensiveness of the data, the review for reasonableness and consistency and the extent of that review are all outlined in a section discussing an actuary's reliance on data supplied by others.

The last section addresses appropriate communications and disclosures including direction on how long to maintain documentation, what should be included in the actuary's report, and the standard ASOP directive "If any procedure departs materially from this standard, the nature, rationale, and effect of the departure must be disclosed."

If you would like to read more about this subject, the Record will contain a summary of the session referenced above. After I begin the session by outlining ASOP No. 23, the session panelists discuss various subjects relating to data quality given their differing backgrounds/perspectives. The interactive portion of the session, which revolves around case studies, includes excellent participation from the audience.

If you have any questions or comments regarding this article, please feel free to contact me at (317) 580-8661 or via e-mail at *kvolkmar@tici.com.*

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Accident and Health Working Group of the Life and Health Actuarial Task Force Meeting Summary

March 23, 2001

The working group agreed to send recommendations to the Statutory Accounting Principles Working Group addressing the reporting of cost containment expenses in annual statements.

The working group agreed to expose a draft of the Health Insurance Reserves Model Regulation that incorporated recommendations from the Society of Actuaries concerning morbidity standards for the valuation of credit disability insurance. The working group also discussed the impact that adopting a morbidity standard table for credit disability insurance could have on the Statement of Statutory Accounting Principles (SSAP) No. 59 in the Accounting Practices and Procedures Manual. Mike Boerner (TX) volunteered to draft revised language for SSAP No. 59 for the working group to consider.

The working group briefly discussed the March 12, 2001 draft of the *Guidance Manual for Rating Aspects of the Long Term Care Insurance Model Regulation.* The Long-Term Care Subteam will hold a conference call prior to the Summer, 2001 National Meeting to discuss the March 12 draft.

The working group established two new subteams. The first subteam, chaired by Katie Campbell (AK), will address revisions to the Small Employer and Individual Insurance Rating Guidance Manual to reflect revisions to the NAIC models that were adopted in order to make the models comport with the Health Insurance Portability and Accountability Act of 1996 and other federal legislation. The second sub-team, chaired by Leslie Jones (SC), will review the Standard Valuation Model and Health Insurance Reserves Model Regulation to determine whether they should be revised to also apply to Health Maintenance Organizations (HMOs) and Hospital, Medical and Dental Service or Indemnity Corporations (HMDIs).

The working group also discussed the progress of the Life and Health Actuarial Task Force (LHATF) on revisions to the Actuarial Opinion and Memorandum Regulation (AOMR). The attached documents were referenced during the discussions. The Life and Health Actuarial Task Force voted to adopt the revised Actuarial Opinion and Memorandum Regulation (AOMR). As previously reported, two significant features of the draft are: 1) the requirement that all companies perform an asset adequacy analysis (i.e., elimination of the current Section 7), and 2) the incorporation of provisions which give commissioners flexibility in accepting actuarial opinions based on the laws of a company's state of domicile. As has been previously discussed, these proposed changes have generated a great deal of controversy. While the Task Force is recommending that the A and B Committees adopt the revised AOMR, it suggests that these votes be deferred until the Summer National Meeting. At that time, updated information may be available relative to the status of the revised Actuarial Standards of Practice which have been developed in conjunction with the changes to the AOMR.

Letter from the Editor...

by Jeffrey D. Miller

Greetings! As I write this letter the Midwest is boiling in summer heat and Florida is drowning in rain. Sounds like this year is fairly normal. However, this is not a normal year for health actuaries. Our largest market, medical insurance, is on the brink of collapse in many segments. Most reinsurers have exited all but the highest excess markets. Many HMOs are exiting markets, particularly the Medicare risk contracts. Individual medical insurance is becoming more difficult to obtain, especially for those who are near Medicare eligibility with chronic health conditions (that's most of them). On top of all of that, our friends in Washington are working feverishly on a "Patients' Bill of Rights." Many believe that HIPPA caused most of the current problems. New federal legislation similar to the Senate version of the "Patients' Bill of Rights" could kill medical insurance all together.

What is the solution to all of this gloom and doom? The same as it has always been — back to basics. Health actuaries are highly experienced at this shift. Each time a segment of the health insurance market gets into trouble, the market returns to strategies and tactics that we have been proposing for a long time. Two of the lead articles in this edition are prime examples. Jim Galasso's article about financial reporting reminds us all of the best practices that are so critical to success in our business. Dan Wolak's summary of the Dallas session on stop loss also reminds us of the importance of basics in this volatile market.

Jeff Miller

As you are reading this edition, summer is nearly over and the fall approaches. Fall has always been a time of renewal for my actuarial practice. September is an exciting month when new projects are started and people generally work harder. I wish you all the best for a joyous and prosperous fall season.

Letter to the Editor

by Mark Troutman

DEAR JEFFREY:

I read with great interest the back cover article from Mr. Gary Smeddinghoff on HMOs in the December 2000 edition. I have enclosed a counterpoint article for publication consideration in your next Health Section News. Please contact me if you have any questions. Thank you for your consideration and constructive comments.

HMO Is Not A Four-Letter Word

Mr. Smeddinghoff is, in my opinion, wrong from the start. Everyone doesn't hate HMOs. I don't and there are many more like me who don't hate them. There are good HMOs and bad HMOs just like there are good eggs and bad eggs. Allow me to address Mr. Smeddinghoff by way of counterpoint.

A. ERRONEOUS PREMISES – I BELIEVE THE ARTICLE HAS SEVERAL ERRONEOUS PREMISES REGARDING HMOS.

1. *Everyone hates HMOs.*
I could point to a number of surveys which show that the vast majority (80+%) of people in HMOs and other managed care plans are satisfied or highly satisfied with their healthcare plan. Surveys such as those performed by Sachs / Scarborough, National Research Corporation, Consumer Reports and others report high HMO satisfaction ratings. Published data on quality of care is also favorable.

As far as the providers, no one makes them contract with HMOs to deliver more benefits at lower costs and actually monitor usage of healthcare. It's a free market. If providers begrudgingly contract with managed care plans, they must not have any other economically viable alternatives or they would exercise them. Ah, the free market. Are we saying that's bad?

Does the fox hate it when someone else guards the henhouse? When you cut out the fat, you can add more beef! How is it that most HMOs provide higher benefits at comparable or lower costs to traditional indemnity plans? By eliminating unnecessary costs. I was always impressed by candy bar companies when they advertised a bigger candy bar for less cost.

2. *There is no feedback loop.*
I assert the feedback loops are much quicker than with an indemnity program as member services units and customer satisfaction surveys are part and parcel of a managed care plan. When was the last time your doctor sent you a card and said "how did I do," "how long did I make you wait," etc.? Let the price, benefits, service, quality and access points compete in the market.

HMOs are also more likely than traditional indemnity plans to have grievance and appeals committees, wellness benefits and healthy lifestyle newsletters.

3. *The HMO market is overregulated.*
What seems to be missing here is some description of why the HMO Act was put into place. The healthcare system was broken. It also focused on treating sick people rather than promoting health maintenance. Medical cost increases continued to rise at two or three times normal inflation rates. The U.S. government also instituted Medicare and Medicaid reform and instituted programs aimed at providing people with choices for managed care programs which offered better benefits at attractive rates. Their attempts to control cost increases in these areas is a normal ebb and flow of a major purchaser trying to obtain favorable terms from its vendors.

The author indicates that it is the government which has propped up HMOs. Admittedly, the HMO act allowed HMOs to get a foothold by allowing them to mandate employers to offer that choice, but it is hardly enough at this point in time to justify the significant market penetration of HMOs. If nearly 80 million people are involved in HMOs in some fashion, there must be more to it than a government mandate. Employers who pay for the healthcare and consumers who consume it must find it satisfactory.

4. *One-stop shopping / coordination of care is bad.*
The author also seems to overdramatize the ineffectiveness of one-stop shopping as embodied by an HMO, (i.e., you must get your healthcare from the network providers unless it is an emergency). One-stop shopping is not such a terrible thing. I agree we should let the consumers decide whether it's appropriate to do one-stop shopping in a given situation. Taken to extremes, the author might oppose a supermarket because it allows all goods to be placed in one spot. Why not only have meat markets only, vegetable markets, fruit markets only, etc.? Hey, if people like picking up milk at the same time they're getting gas, let them do so. If they don't, then pay for the gas and leave. This is another point where we agree. Let the consumers decide what they like and don't. Vote with your pocketbook!

The other point forgotten in the rhetoric was that the original concept of Health Maintenance Organizations was not to be all things to all people at the highest quality and low cost as described in the article. It was through the concept of "an apple a day keeps the doctor away." (Apples cost less than physician office visits.) Provide wellness visits and physicals, so that people stayed healthy. An ounce of prevention is worth a pound of cure. Promote healthy lifestyles. What a great idea.

B. THE ECONOMICS OF HEALTHCARE

The article seems to forget the pressure points and the mutual exclusivity of choice versus cost. HMO plans may restrict choice, but they also favorably impact cost. Indemnity plans provide the widest array of choice, but their costs are significantly greater because of this. Many opponents of managed healthcare don't like it because somebody actually tries to be a gatekeeper and take control of a system which is out of control. Maybe we should get rid of quarterbacks on football teams and just let everyone run around aimlessly with the football?

Another point is the natural component in economic theory of supply and demand. Healthcare costs were increasing at two to three times normal inflation rates all while there were too many hospitals and too many doctors in the system. Hospitals were 33% unoccupied and many should have closed if economic theory was correct. The thought of managed care was to bring the element of supply and demand into this product as well. Healthcare is being overutilized and continues to be overutilized in various fashions. Doctors often prescribe too many tests as there is no economic incentive not to provide those. Why is it that lab tests are dramatically increased when providers doing the prescribing also run the lab? It must be a statistical anomaly? Everyone knows when you don't pay for something, you tend to overutilize it. When you go to a buffet and it's all you can eat, you eat a couple more pieces of pizza or desserts than usual, don't you? Healthcare is no different. Note there is one point where I agree with the author — the tax advantageous nature of employee benefits does lead to overutilization as people have less incentive to actually be wise consumers.

The current backlash against managed care is a logical, inevitable competitive swing back against any program which becomes too successful. It's also a function of a tight labor market and a booming economy. Rest assured, employers would pay less attention to employee desires and more attention to costs when their profits are under attack.

Another big debate today is regarding patient rights. I think they should have rights to sue people who make medical care decisions. Unfortunately, HMOs don't make medical care decisions, they make coverage determination decisions. Information made available by the American Association of Health Plans shows that only 1–3% of services are denied by HMOs, depending on the type. Any employer who develops a plan document or buys a group health insurance plan actually makes coverage determination decisions by putting exclusions of limitations in the contract. It would be ludicrous to assume that we should cover everything under every circumstance or to hold them accountable for the medical care on benefits they provide. Doctors make medical decisions and hospitals make medical decisions. They should be held accountable for making the medical decisions regardless of the presence or absence of medical benefits. Admittedly, some fail-safe system should exist in the United States so that everyone receives a minimum amount of healthcare for both wellness and catastrophic situations

C. POSITIVES OF HMOS

HMOs, like any other product, have advantages and disadvantages. If one product were superior in all regards, everyone would buy it (if they were rational). As the author has pointed out several potential disadvantages of HMOs, I would like to point out several potential advantages.

HMOs actually do provide a greater credentialing of providers than indemnity plans. There's no guarantee that they're all the highest quality, but they do provide greater quality than the randomness associated with picking your own doctors. Many people appreciate the fact that somebody has taken a look at physician's credentials. Also, take a look at provider malpractice records. If physicians and hospitals were perfect, there would be no need for malpractice insurance. If there are no issues associated with malpractice insurance, then the AMA and AHA wouldn't so vigorously oppose making such records available to the public.

As stated above, HMOs typically provide more benefits for comparable or lower price. They also provide better coordination of care.

Though I understand Minnesota is a hot bed of HMO activity, I didn't realize that the area is being consolidated into 10,000 lakes and one health plan. Perhaps the author means one type of health plan given HMO penetration. The only threat to one health plan is a government plan which would be mismanaged because of the government's inability to make the hard choices regarding what to pay for and not pay for and how to fund it through taxes while still maintaining control of providers and utilization.

Summary

It's funny that what goes around comes around. This includes ties, skirt lengths, etc. Scheduled indemnity plans were a start. Then came major medical. Then managed care. Now maybe back to scheduled plans? I agree with the author that a defined contribution approach he has spoken of in many other venues may be a logical next step as a reaction to consumerism responses to managed healthcare ala HMOs. Critics of the current employer-based system contend that managed care is ineffective and that employee benefits programs continue to shelter consumers from the true cost of healthcare and unnecessarily restrict their choices. Defined contribution models now being promoted by companies like HealthMarket give consumers information regarding provider cost and quality and allow them to choose. It allows the employer to facilitate the employee taking more responsibility for their healthcare decisions and gives them the informational tools they need to effectively handle this new authority.

Whether these new models can continue the important aspects of the current employer-sponsored program with government tax advantages remains to be seen since it promotes the pooling of risk and reduction of adverse selection which are also important to controlling healthcare cost. It is obvious that employers would flee en masse in many programs if they were held more responsible for medical care liability when offering and funding a managed care plan. Employers should fear the government and the legal profession attempts to place blame or liability in areas where it doesn't belong.

I thank the author for his thought-provoking article.

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Mark Troutman is President of Summit Reinsurance Services, an independent managing general underwriter / reinsurance intermediary broker working with Employers Reinsurance Corporation to provide HMO excess of loss reinsurance.

International Health Seminar to be Held during the International Congress of Actuaries (ICA) in Cancun, Mexico - March 17-22, 2002

The Committee for Services to Individual Members of the International Actuarial Association and Mexican Organizing Committee for ICA 2002 are collaborating to organize a health seminar to be held during the first half of ICA 2002. The International Health Seminar Organizing Committee is jointly chaired by Howard Bolnick (Society of Actuaries), Ibrahim Muhanna (Cyprus Actuarial Association) and Edward Levay (ASTIN). The Organizing Committee is composed of 25 actuaries representing twenty different countries.

The Organizing Committee's goal is to provide practicing health actuaries with an opportunity to learn from practical experiences of their colleagues in a variety of countries and to give actuaries in countries developing new health insurance products access to important information needed to advance their health product management skills. During the two-day Seminar there will be sessions on Public Health and Policy topics and Health Insurance Practices topics.

Current plans being developed by a Health Insurance Practices Subcommittee, chaired by Bernie Rabinowitz (Institute of Actuaries, Society of Actuaries) are to cover practical issues for the following health insurance product lines:

- Long term care insurance
- Income replacement insurance
- Critical illness insurance
- Supplemental private medical indemnity insurance
- Full coverage medical indemnity and managed care

The Public Health and Policy Subcommittee, chaired by Ibrahim Muhanna, is developing sessions featuring lectures on key topics presented by various health experts. In addition, this subcommittee is planning sessions on international issues in private sector health insurance supervision and on practical state-of-the-art modeling techniques. A separate ASTIN Colloquium will be held during the last half of ICA 2002. Plans are being made to include topics of interest to health actuaries in the ASTIN program.

We invite you to attend ICA 2002 and this important International Health Seminar. In addition, your questions, comments and suggestions are welcome.

Information about ICA 2002 and instructions about how to register can be found on the IAA Web site (*www.actuaries.org*). Further information about the Health Seminar can be obtained by contacting any of the Organizing Committee co-chairs and Subcommittee chairs at their email addresses below.

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