# IAAHS future project subcommittee

Prepared for the
**IAAHS Committee**
and for the
**IAAHS 2004 Annual Meeting**
to be held in conjunction with the
**IAAHS 2nd International Health Colloquium, Dresden, Germany**
April 18, 2004

## Introduction

In January 2004 the IAAHS Committee established a future projects subcommittee, with Claude Ferguson and Ibrahim Muhanna as members, and Yair Babad as chairperson. Its objectives are to review and recommend project topics to promote that are either (1) internally-oriented - communications and joint activities of health actuaries in various supranational organizations, or (2) externally-oriented - joint activities with other organizations (such as a IAA - World Bank meeting on health topics). The subcommittee was also requested to figure out how best develop the proposed projects.

At the Beginning of March 2004 the subcommittee distributed for comments a draft of its report to the IAAHS Committee members and to the IAAHS national liaisons. Several comments were received; we are grateful for all the responses and support. This memo is the culmination of the thoughts and efforts up to this time.

We intentionally kept the list of recommended projects as broad as possible, as we believe that an early determination and selection of a few "desirable" projects may be detrimental to such a discussion. Our goal is to **foster a discussion of possible projects, and to encourage our members to select projects which they would like to work on, and participate in joint IAAHS projects**. We thus ask you for comments and suggestions, and request **each of you who is interested to participate in one of the projects listed in here, or in another project, to please contact Yair Babad at ybabad@uic.edu**.

**What is a project**

Actuaries have a great deal to add, and in particular in the following areas:

- Risk. While many believe there is little risk in health financing, because individual choice/selection is not permitted, the trend is towards more, not less, risk. Actuaries are the pre-eminent professionals to quantify risk (and not only financial risk) and its effects on cost.
- Validity: A study design that allows clinical professionals to draw conclusions about clinical efficacy may not be valid for financial projection purposes. Actuaries are particularly qualified at estimating financial effects from indirect data.
- Data mining: Actuaries are trained to perform statistical and other data mining activity to extract meaning out of (often ambiguous, incomplete or otherwise poor quality) data.
- Data credibility: Actuaries are trained to ensure that data reconcile to valid or audited sources.

For a diversified and internationally dispersed group like the IAAHS, a project should be an activity that is of interest to and can be done by people in different locations, with most of the interactions through e-mails and telephone calls, and with small part of it in meetings, colloquia, seminars, etc. Taking into account the nature of the IAAHS membership, and the nature of other organizations with whom we may conduct a project, most - if not all - projects should have a significant practical element, if not being fully practical.

The IAAHS has close professional contacts with other organizations and audience. A WHO researcher, for example, may benefit from an actuarial perspective; the actuarial community at large may benefit from an international exchange on a health-related subject; or a given subject may help a national actuarial community develop leadership in its country on health related issues.

Thus, a project is then a subject or issue which affects many if not all of the membership or related audience, for which we do not have at this time a satisfactory answer or response, and which requires collective thinking, research and brain-storming to come to a conclusion that will benefit both the participants in the project and the membership of the IAAHS. The results of the project will then be publicized through seminar / colloquia / conference presentations, report / article publication, the IAAHS Online Journal, etc.

However, the key will be to identify areas of contributions that will put us on the map. There is obviously a temptation to look for the short-cut, any insight that could be gained with hardly any effort/resource required. For example, a lot has been done already over the last 10-15 years on impacts of ageing on various aspects of Western economies, including healthcare. It will be difficult for a group of part-time benevolent participants to impress the Western world scientific and economic community with comparable or even superior deliverables without comparable resources.

Thus, we should limit our expected scope; rather than taking a subject that requires considerable investment of time and resources, we should – within the proposed projects below, or other, similar topics – concentrate on practical problems actually faced by our target audience (below). These (hopefully) will be of limited scope, and will entail more brainstorming, the use of expertise and knowledge available within IAAHS membership, and the search for practical solutions (rather than the discovery and deep research of new ground).

## Our target audience and possible action to reach them

The IAAHS committee identified several target audiences. First, there are the members of the IAAHS. Second, since we would like to attract other actuaries to the IAAHS and to healthcare issues, we may consider other IAA members. Third, other organizations, national or international, which are interested in healthcare issues. Finally, there is the general professional (mostly healthcare) public, mostly in national frameworks.

It seems that we, as the IAAHS, can only initiate projects within the IAAHS framework; initiation of projects with other audiences, such a national organizations or professionals, should be initiated by local IAAHS members. Similarly, once a contact has been established by the IAAHS with an organization, the idea of a joint project may be promoted. Thus, we have two target audiences and roles:

- A proactive role – present possible projects to the IAAHS membership, help in creating "project teams", request additional support from the IAAHS membership-at-large, publish and distribute the results of the teams' work, etc.
- A reactive role – once requested to support a project (whether initiated by a local group or due to a contact with an organization), we may provide help through suggestions of possible projects, requests for additional support from the IAAHS membership-at-large, helping in recruiting other IAAHS members to participate in these projects, publicize the results of the work, etc.

In the proactive role, we can use the Online Journal, special newsletters or e-mails, sessions in meetings and colloquia, etc. It should possibly be a structured effort, on a periodical basis – since "far from sight – far from mind". Thus, we should consider carefully the periodicity, what to announce at each time, etc. Alternatively, it can be done on a "per need" basis, responding only when a request for a project (either a general request, or a request for a specific topic) comes our way.

Further, we should keep a list of IAAHS members and their expertise, so that we can do directed communications, with the hope of addressing only the people with the expertise – and hopefully also the interest to participate – in specific projects.

The approach described above is a somewhat passive approach. We may instead take a more active approach: Developing our credential on important topics would mean that we would have to release thoughtful (or even thought provoking) position papers on any of these

specific subjects. For some subjects, the work required to come up with an original position may be more or less demanding. It is particularly true of subjects already well researched by WHO or other organizations.

We may consider one particular project that can be the initiator to other projects. We should consider developing reading abstracts that would be shared among ourselves, and would serve as a source of inspiration to identify areas where a minute contribution could lead to major findings - and world community attention & recognition. We would need to start building a map of the action to be targeted, and start exploring and reporting. It's almost like a search for life on some foreign planet ...

Similarly, we may consider a project to collect state-of-the-art wisdom and knowledge on any given subject - like some of the ones proposed above. Many of these subjects are well known subjects for most of us, but in our own national context only. These fall along the lines of things already covered somewhere, but where an international perspective could add value.

These last projects can be considered as "initiator projects", to be carried by members of the IAAHS committee or close associates, so as to keep "the flame burning". However, they – like all other proactive projects – require commitment and action by the participants. Thus, without a group of active participants, they "will not fly".

Finally, we should not underestimate the amount of resources needed to develop original material that establish the credentials of a profession. Will we be able to rely on some budget? Sounding boards and presence with the World Bank and WHO?

## The experience of the SOA Health Section Practice Management

Few cautionary notes, from Ian Duncan (the U.S. liaison to the SOA Health Section and an active researcher):

- There are very few practicing actuaries active in research. There is little or no incentive now for research and publication. Practitioners are generally not rewarded for research and publications (although there are exceptions in the consulting field).
- Research is done by academic actuaries; however, the research is often criticized as being just that: academic.
- Much research in health care is done by other professionals: economists, epidemiologists, etc.

To overcome the implications of these observations, the External Relations Committee of the SOA is grappling with the issue of bringing together actuarial and non-actuarial researchers. However, we decided to begin by fostering relationships between the parties. They have arranged meetings between CMS (the government provider) and actuaries, as well as contacts with large research sponsors (the Commonwealth Fund; Robert Wood Johnson Foundation). A meeting with Harvard/Kennedy School of Government is in planning. They

had an Applied Actuarial Research conference held in Orlando in March, aiming to bring together actuarial and non-actuarial researchers with mutual interests for two days of seminars and dialogue. It appears to have been successful, and a second is planned for next March. Out of these interactions, some joint discussions have begun.

It should also be noted that we do not have funds to promote research, while the SOA has the funds to develop – through the Practice Management – area of interest and respond to individual researcher proposals. For example, to promote research among practitioners they will arrange one day seminar on research methods in the next Applied Research conference in Orlando (March 2005), and sponsor fellowships for students (with the results to be presented in conferences).

## The role of the IAAHS projects subcommittee

The subcommittee will act as the liaison and coordinator of the projects selected for research and implementation. In this role, the committee will help coordinating the project teams, help in recruiting additional members to participate in projects, promote new projects, help publicize the results to the IAAHS membership (e.g., through the IAAHS Online Journal) and to other audiences, etc. As noted above, to contact the subcommittee please send an e-mail to the chairperson, Yair Babad, at ybabad@uic.edu.

It should be noted that the Society of Actuaries Healthcare Practice Committee established an SOA Health Benefit Systems Practice Advancement Committee / Health Section Council, which is working on several proposed projects. The Health Section liaison is Ian Duncan, FSA, which can be reached at iduncan@lotteract.com. For the sake of completeness, the list of their 2004 projects, and draft descriptions of their three top issue projects for 2004, which the Practice Committee considers as the top issues faced by the profession in the U.S., are enclosed. They informed us that they would gladly work with us. There is no doubt they are much ahead of us; but they also provide us with a great example to follow.

## List of possible projects

Following is the list of possible projects that have been proposed so far:

1. Expected rate of increase in average medical cost per person for drug expenses as a function of his age - we worked on it in early 2003, and we have quite a material collected - but it is far from finished.
2. Health databases - identification, contents, usage, etc.
3. Insurance products
    a. Managed care
    b. Supplemental health insurance
    c. Income protection insurance
    d. Voluntary vs. non-voluntary health insurance
    e. Medical care insurance

    f. Long term care insurance
    g. critical illnesses insurance
    h. Dental insurance
4. Healthcare financing / funding
    a. Healthcare risk adjustment
    b. Healthcare financing in developed nations
    c. Healthcare financing in underdeveloped nations
    d. Long and short term increases in healthcare costs - drivers, analysis, projection, and containment
    e. Estimating the value of investing in health, including preventive health measures
    f. Public-private partnership in financing healthcare systems
5. The role of the actuary
    a. In public healthcare system
    b. In social healthcare system
6. Healthcare, pension, and other public safety net coverages
7. Healthcare reinsurance

**DRAFT**
**SOA Health Benefit Systems Practice Advancement Committee/**
**Health Section Council**

## Proposed Key Issue #1: Healthcare Affordability

**Overview.** In the U.S., healthcare cost trends continue to outpace increases in other types of goods and services. The U.S. spends more on healthcare per capita than any other country in the world. The percent of GDP attributable to healthcare has risen to a new high of approximately 15% and is expected to continue to increase to approximately 18% by 2013. Healthcare benefits are the second largest employee expense for those corporations that offer them. Employers are trying to manage their healthcare expenses through a variety of means, including increasing employee contributions and cost-sharing provisions, offering consumer driven health plans and/or implementing defined contribution approaches, and at times, through reducing or eliminating coverage (for actives and/or retirees) altogether. Consumers are finding the increase in their costs to be reaching unaffordable levels and at times are having to make decisions between purchasing health insurance or other basic necessities. While not limited to these groups, the problem is especially acute for early retirees, small business employees, the self-employed, and others with limited group insurance purchasing options. As a result, the number of uninsured is growing, which limits access to healthcare and puts additional pressure on providers of care and those who are financing health insurance programs, whether private or public. In addition, the healthcare industry lags far behind many others in terms of its technological infrastructure. Updating these systems will require capital investments that may put even more financial pressure upon an already tenuous system.

Challenges and issues related to affordability are not limited to individuals and employers. Government bodies around the world, including state, provincial, and federal governments specifically in the U.S. and Canada, will also need to consider how much healthcare can be afforded under various resource bases. Cost effectiveness evaluations, which have not been typically considered in coverage decisions, will play a greater role in future public policy as governments consider how to best meet the healthcare needs of their citizens.

Finally, in the U.S., the new Medicare Prescription Drug, Improvement, and Modernization Act has been the greatest expansion of the social insurance program since its inception in 1965. The new legislation impacts affordability issues for a wide-range of stakeholders in the system, including individuals, health plans, providers, employers, and pharmaceutical companies.

**The Actuarial Implications.**

**Macro (profession-wide) level.** A greater level of involvement of the actuarial profession relative to long-term financial forecasting of social insurance programs is desirable. In addition, actuarial input is desirable in the development stage of healthcare reform proposals. Once developed, actuarial perspectives on the advantages and disadvantages of various reform proposals add value and allow for a more informed discussion of the issues in the

public arena. The profession needs to partner with other disciplines, associations, and professional bodies in order to ensure that the actuarial perspective is valued and sought.

In addition, the members of the profession need to be looking to new ways to structure healthcare financing relative to stakeholder incentives and the needs of the healthcare system. Cost-shifting as a stand-alone mechanism has its limitations, and the public has pushed back on managed care. New financing structures may encompass or depend on a range of inputs; actuaries will need to consider how to consolidate and integrate different types of data into meaningful financial models. Actuaries also need to become familiar with the role of cost-effectiveness evaluations as part of policy (and therefore, often, private) coverage decisions.

**Micro (individual-member) level.** The affordability issue will impact the work of the individual member in several ways. Employee benefits (and some health plan) actuaries will be engaged to help their employer clients with challenging decisions relative to offering health insurance benefits to their employees and retirees (in terms of plan offerings, plan design, and financing, including from a cash basis and an accrued liability basis). Health actuaries will also be involved in the development and financial modeling of new potential approaches to healthcare purchasing, which are intended to help consumers be more efficient purchasers of healthcare and to (ideally) manage healthcare costs and increases. These approaches will include (but are not necessarily limited to) consumer driven health plans, MSAs, and tiered networks. Actuaries will also need to be cognizant of issues that arise due to the blurring of group, small group, and individual health plans due to the emergence (and now tax favored treatment) of these newer approaches. Finally, actuaries will be engaged in helping their clients understand and respond to the new Medicare DIMA.

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**Health Section Council**

## Proposed Key Issue #2: Healthcare Variability

**Overview.** Healthcare variability is a significant challenge facing the U.S. healthcare system. Variation exists along a number of dimensions, including access to care, demand for care, delivery of treatment, and pricing of services. Research indicates that those that are uninsured are less likely to access preventive care services. Sources have documented extensive variation in treatment patterns by location—not only in the U.S. but also around the world. Recent reports from the IOM (check source) suggest that inappropriate care (relative to evidence based clinical guidelines) is delivered approximately 50% of the time. Pricing of services has also been shown to vary significantly between local providers as well as between geographic regions.

Some variation in the system is both understandable and desirable. For example, there are legitimate differences in healthcare risks between populations and individuals. Some variability is necessary to further research relative to technological advances in understand and treating disease or for health promotion. Some variation may also be desirable relative to an individual patient's specific "risk tolerance", preferences for treatment, and values. Healthcare variability that is either unexplained or that represents an inefficient use of resources may require further investigation. Reducing costly inefficiencies is a major focus of many stakeholders in the system, especially given current affordability pressures.

In the future, however, greater (rather than less) healthcare variability may be desirable as more is known about an individual's distinct biological make up and the corresponding appropriate treatment. Such variation may actually result in a more efficient use of healthcare resources by steering treatment courses along a path that is most effective for the specific patient in question.

**The Actuarial Implications.**

**Macro (profession-wide) level**. Actuaries have a role to play in helping to identify and quantify areas of healthcare variability, and to work with other professionals (especially relative to policy decisions) in developing appropriate financing structures to align stakeholder incentives and reduce variability where appropriate. Actuaries also have a role to play relative to developing appropriate measurement methodologies (for example, for disease management programs—how do you measure what "didn't" happen?) or in providing insights into the considerations for different approaches to measurement if a consistent methodology is not feasible or adopted. In addition, actuaries need to be looking ahead to a future of personal-medicine and considering how such technological advances can and will change the financing of healthcare services.

**Micro (individual-member) level**. Healthcare variability may impact the work of the individual actuary along several dimensions. Predictive modeling, risk assessment, and risk

adjustment are all related to the issue of variability—trying to better understand and anticipate future health care consumption. Having a better understanding of these issues supports a more efficient healthcare system along several dimensions. A risk-adjustment mechanism between health plans provides greater financial support to those plans that have assumed enrollees that are higher health risks, and lesser support to those plans that have enrolled healthier lives. Such an adjustment encourages plans to compete on the basis on efficiency of care delivery rather than for healthier lives. Predictive modeling can be used to help identify potential high-cost insured before they become high-cost, to help better provide and manage their care for better health and financial outcomes. Although risk adjustment models and predictive modeling are in wide-use, there are still opportunities for greater application of these approaches.

Disease management programs are another means by which a reduction in healthcare variability is sought. These programs are designed to ensure that insureds with certain chronic disease states are receiving appropriate care treatments, such that future acute and costly episodes are minimized. Actuaries may be involved in assessing the financial implications such disease management programs. Provider profiling is also a means for reducing healthcare variability through raising provider awareness of how measures of their treatment protocols compare to their peer groups. Actuaries may also be involved in working alongside clinicians to develop financial reimbursement structure that align provider incentives with appropriate care delivery (see Key Issue #1: Affordability).

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**Health Section Council**

## Proposed Key Issue #3: Healthcare Transparency

**Overview.** At least two forces are contributing to the issue of healthcare transparency. First, a number of corporate scandals over the past few years have increased financial reporting scrutiny over all industries. Specific regulations now require greater independence of auditing organizations and greater accountability of corporate officers. Regulators, shareholders, employees, or customers are no longer willing to "take someone's word" for the integrity of business operations and reporting. Enterprise risk management has gained considerable momentum as organizations are facing greater demand to appropriately consider, assess, and plan for all kinds of risks from a holistic viewpoint.

In healthcare, the consumerism movement has also contributed to the issue of healthcare transparency. As consumers are being expected to either share in more of the cost of healthcare or to assume responsibility for managing a pool of funds dedicated to healthcare expense, or both, they are in need of better information from and about health plans, providers, and treatment options in order to be more efficient users and purchasers of healthcare services.

### The Actuarial Implications.

**Macro (profession-wide) level.** As a profession, actuaries are facing increasing demands to justify the models used for actuarial work (particularly for establishing liabilities estimates). "Professional judgment" as a general concept has come under greater scrutiny over the past few years. Actuaries need to be able to clearly explain the rationale behind specific estimates as well as the modeling tools and the assumptions on which they are based. Actuaries need to ensure that explanations are clearly understood and accepted by the profession's "end-users"; to the extent they are not, the end-users will be left to develop their own means for determining whether they will accept the actuary's results.

Enterprise risk management offers the actuarial profession some great opportunities. Health actuaries have the ability to assume Chief Risk Officer positions, but may need additional education on the concepts of ERM and their skill sets relative to those demanded of CROs.

**Micro (individual-member) level.** Individual members will need to maintain high standards in their roles as stewards of the liability side of the balance sheet. In doing so, members will need to address the issues noted relative to models and communication within their own business responsibilities and professional networks. General scrutiny of current processes may result in the development of new methodologies and/or more robust modeling; actuaries need to be on the forefront in developing these tools. Individual members also need to be active in defining data needs—what kind of information would be ideal relative to some of their modeling work and to support improved decision making? This input needs to be shared

with other professionals (IT, etc) so that actuaries have the best information and input available for the work they do.

WORKING DRAFT

# HEALTH BENEFIT SYSTEMS PRACTICE ADVANCEMENT COMMITTEE (HBSPAC)
# KEY ISSUES, PROJECTS AND PRIORITIES – 2004

| COMMITTEE | KEY ISSUES | PROJECTS | VOLUNTEER/ STAFF | AUDIENCE | STATUS | DELIVERY DATE |
|---|---|---|---|---|---|---|
| Health Benefit Systems Practice Advancement Committee (HBSPAC)<br><br>Jan Carstens, *Chairperson* | Healthcare Affordability and Reform | Healthcare System in Crisis Task Force | Jeff Allen/Kara Clark | • General public<br>• Academic community | To develop a descriptive model of the stakeholder dynamics of the U.S. healthcare system | 2004 |
| | | • Steady-State Subgroup | John Cookson | | | |
| | | • Small Group Reform Subgroup | Bill Lane | | | |
| | | • ER Subsidies Subgroup | Al Ford | | | |
| | | • Medicare Reimbursement Subgroup | Dave Tuomala | | | |
| | Expanding Role and Visibility of Actuaries | Educational and networking meeting in Minneapolis | Amy Pahl<br>Louise Anderson<br>Harry Sutton<br>Kara Clark<br>Susan Martz | Health actuaries and health services researchers (HSRs) | Planning a meeting of HSRs and health actuaries with the assistance of the Twin Cities Actuarial Club | December 2003 |
| | | Meeting with CMS | John Cookson<br>Kara Clark | • CMS | | Ongoing |
| | | *FAS 106 Webcast (with CMS)* | Maryellen Beach | Health actuaries | Planning stages | TBD |
| | | Create relationships with other professional organizations and produce a database of organizations and contacts. | Ian Duncan<br>Kara Clark | • Health actuaries<br>• Board Advisory Group on external relations<br>• External organizations & professionals | Conference scheduled for January | Ongoing |

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| | | *Giving health policy researchers a greater understanding of the factors involved in the pricing of various types of health insurance* | Kara Clark | Health policy researchers (at AcademyHealth Annual Research Conference) | In planning stages | June 2004 |
| | | Disability (DI) Chartbook (w/HIAA) | Tom Corcoran<br>Win Cashdollar<br>Maryellen Beach | • Media outlets<br>• Policymakers<br>• EE benefits decision-makers<br>• Consumers | Populating the charts with "real" data, adjusting some data sets and identifying additional sources of data | January 2004 |
| | Financial reporting issues | *To support the development of better financial reporting metrics for improved disclosure and comparisons* | John Lloyd<br>John Stenson<br>Kara Clark | TBD | Have issued a survey of financial reporting metrics; will meet mid-Dec to review aggregated results | TBD |
| | Risk adjustment | *Form a group to develop projects to pursue related to risk adjustment topics* | Kara Clark | | A number of actuaries responding to a solicitation in *Health News* will hold a conference call to get acquainted and discuss potential projects in mid-November | TBD |
| E&E Advisory Group | Revise educational system | *Refining health FSA elements in SOA exams and define material that needs to be tested* | Judy Anderson<br>Judith Powills<br>Kara Clark | Future health actuaries | Conference call scheduled for mid-November | 2005 (?) |
| Health Benefit Systems Seminars Committee<br><br>Stuart Rachlin, Chairperson | Addressing the continuing education needs of practicing health actuaries | Provider Contracting Seminar<br>Salt Lake City | Stuart Rachlin<br>Sandy Neuenkirchen | Provider contractors<br>Network managers | Complete | October 2-3, 2003 |
| | | Senior Market Seminar | John Lloyd<br>Nick Simmons | Health actuaries | In the planning stages | TBD |

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| | | Risk Adjustment Primer Seminar | Bernie Rabinowitz<br>John Heins | Health actuaries | Have some speakers lined up. HFMA also interested in the topic. | February/March, 2004 |
| | | Clinical Quality Measurement Seminar | Ian Duncan<br>Chuck Fuhrer | Health actuaries | Seven speakers committed to-date | TBD |
| | | Group DI/Group Life Seminar | Tom Corcoran<br>Karl Volkmar | Health actuaries | Preliminary agenda drafted, recruiting speakers | 2004 |
| | | Enterprise Risk Management Seminar | John Lloyd<br>Kara Clark | Health actuaries | Repeat of ERM symposium just complete. | April 2004 |
| | | Advanced Health Modeling Seminar (Course 7 Seminar) | Chuck Fuhrer or John Lloyd and Stu Rachlin | Health actuaries | | |
| | | Enterprise Risk Management Webcast | Sandy Neuenkirchen | Webcast participants | Posted on the SOA website, advertised in *Health News* | 11/19/03 |
| Committee on Health Communications<br><br>Grady Catterall, Chairperson | Promoting the availability and awareness of health issues, information and activities of the SOA to actuaries and other professionals and organizations related to the health care field | Health News (electronic, monthly newsletter) | Grady Catterall<br>Susan Martz | Health Section members and other actuaries who list "Health" as their main area of practice | October issue released | Monthly |
| | | *"Top 10 Articles Every Health Actuary Should Read" project* | Rob Bachler<br>Maryellen Beach | Health actuaries in need of valuable reading material not part of the E&E system | Gathering sources and establishing "review teams," and finalizing project timeline. | TBD |
| Committee on Health Benefits Research<br><br>Bill Lane, *Chairperson*<br><br>Al Ford, *Vice-Chair, Experience Studies* | | *Linking Quality and Cost: An Analysis of the Hospital Quality Information Initiative Measures RFP* | Steven Siegel | Health actuaries | RFP recently issued. Proposals to be received by January 12, 2004. | |

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| | | *Efficacy of Specific Prescription Drugs or Categories of Drugs RFP* | Steven Siegel | Health actuaries | RFP recently issued. Proposals to be received by January 12, 2004. | |
| | Troubled Healthcare System with Rising Costs | *Develop an annotated bibliography for nine topics relating to the healthcare reform debate* | Bill Lane<br>Steve Siegel | Health actuaries | Completed | |
| Individual Disability Insurance Experience Committee | Individual Disability Insurance | | Bob Beal<br>Jack Luff | Health actuaries | | |
| Task Force on LTC Insurance Valuation Issues | LTC Insurance | *Multivariate analysis of the implications of the experience data for a valuation table* | Mark Litow<br>Jack Luff | LTC actuaries | Held a conference call on 9/16/03 to review the work of its subcommittees. | |
| Group Life Insurance Experience Committee | Group Life | • *Group term life study*<br>• Waiver-of-premium study | Sue Sames<br>Karen Edgerton<br>Jack Luff | Health actuaries | Received 13 contributions for the group-term life study and 16 contributions for the waiver-of-premium study. Three additional companies have committed to supplying data and three more may commit in the future | Reports on both studies to be completed by the end of 2004, with some preliminary results presented at the SOA Spring Meeting. |
| Group Long-Term Disability Insurance Experience Committee | Group LTD | *Working with Solucient on issues related to the processing of aggregate data* | Todd Fuhs<br>Jack Luff | Health actuaries | Received contributions from 14 companies with up to 10 additional companies possibly making contributions | Some results expected by the 2004 Spring Meeting |
| Long-Term Care Experience Committee | LTC | *Data tabulation* | Gary Corliss<br>Jack Luff | LTC actuaries | Committee members working on their individual sections of the report | Report should be complete by the 2004 Spring Meeting |
| Credit Insurance Experience Committee | Credit Life Regulation | *Responding informally to the NAIC's draft credit life regulation* | Chris Hause<br>Jack Luff | Health actuaries | Plans are being made for the next experience study. | |

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| Medical Large Claims Experience Committee | Medical large claims | | Tony Houghton | Health actuaries | Held a conference call in Sept. to discuss report design and to identify a target completion date. Also considering what other end products to produce and how to address insurer confidentiality issues | |
| Analysis of Claims by Policy Duration for Individual Insurance Major Medical Insurance | | *To analyze the effect of underwriting wear-off and cumulative antiselection on individual major medical claim costs* | Alan Ford<br>Cindy Miller<br>Steven Siegel | Health actuaries | | |
| Alternative Care Experience Study | | *To collect and analyze insurance company data on coverage of integrative and alternative care treatements* | Lee Launer<br>Steven Siegel | Health actuaries | | |
| Health Section<br>Cindy Miller, Chair | 2004 Spring Meeting | *Develop health-related sessions* | Catherine Liang, Karl Volkmar, HSC | Health actuaries | Ongoing | May 2004 |

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| | Healthcare crisis | *Develop a Q&A article for the* Health Section News *that examines the reasons behind runaway increases in HC costs and their potential solutions* | Dan Wolak<br>Kara Clark<br>Sue Martz | Health actuaries | E-mail sent to those who indicated interest in participating. Will be asked four questions concerning the HC system, what's wrong and how can it be fixed. | April 2004 issue of *Health Section News* |
| | Neural Network Applications to Disability Claim Management | *Investigates the use of neural networks to predict disability claim recovery and to aid in claim management.* | Daniel Skwire<br>Steven Siegel | Health actuaries | | |

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| | Evaluating the Results of Medical Management Interventions: Comparative analysis of different outcomes measures | *Examines various methods to measure and quantify the financial effect of a health plan's medical management interventions.* | Cindy Miller | Health actuaries | | 2004 |
| | Health actuary communication | Listserves:<br>• Large Group Medical<br>• Individual and Small Group Medical<br>• U.S. healthcare Policy<br>• EE Benefits<br>• Performance Assessment | Maryellen Beach | Health actuaries | The Large Group Medical list serve was recently activated and the other list serves will be launched as more members sign up for them. | TBD |
| Health Risk Management Subgroup (of the Risk Mgmt. Task Force) | To research risk management in health insurance companies and document risk definitions and risk mgmt. Techniques appropriate for health insurance companies | • *Specialty Guide* | Rajeev Dutt<br>Kara Clark | Health actuaries | Cataloguing and organizing exhaustive list of risks for practicing health risk managers to consider | TBD |

| COMMITTEE | KEY ISSUES | PROJECTS | VOLUNTEER/ STAFF | AUDIENCE | STATUS | DELIVERY DATE |
|---|---|---|---|---|---|---|
| | | • *Solvency Issues* | *Trevor Pollitt*<br>Kara Clark | *Health actuaries* | *Evaluating metrics used by "industry watchers" to determine which are better for health companies* | *TBD* |
| | | • *Modeling* | *Doug Fearrington*<br>Kara Clark | *Health actuaries* | *Developing more rigorous techniques for quantifying health risks* | *TBD* |