

November 9, 2005

Proposal Submitted in Response to RFP for Consulting Services to the Hawai`i Uninsured Project

MERCER OLIVER WYMAN

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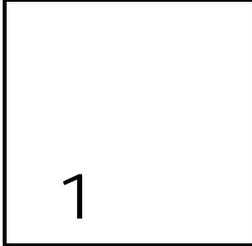
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Executive Summary

Mercer Oliver Wyman Actuarial Consulting, Inc. (Mercer) is a part of the Marsh & McLennan (MMC) family of companies. MMC is a global professional services firm with annual revenues exceeding \$11 billion.

The MMC companies are active in the following sectors: risk and insurance services through Marsh, Inc. and Guy Carpenter; investment management, through Putman Investments; and consulting, through the Mercer, Inc. family of companies. Mercer is one of the Mercer, Inc. companies. Mercer, Inc. is the foremost employer of actuaries in the world. Mercer Inc.'s more than 12,500 employees provide consulting services from 125 offices in the United States, Canada, the United Kingdom, and other parts of the world.

Our actuarial practitioners have the highest professional qualifications. We will have three credentialed actuaries working directly on the project and access to five additional credentialed actuaries if warranted. We combine a broad-range of experience with specialized knowledge of the health insurance market, reflecting over one hundred thirty years of accumulated experience. We have extensive experience modeling the impact of proposed legislation aimed at increasing access to health care and insurance.

Mercer has a long history of providing consulting to large public sector clients such as the South Dakota Division of Insurance and Department of Health, the Florida Department of Insurance, the Arizona Health Care Cost Containment System, Vermont Department of Banking, Insurance, Securities and Health Care Administration, and Maine Department of Insurance. Mercer has been providing significant consulting services to state regulatory agencies since 1990. In 2005 we assisted CMS in analyzing and auditing the bids for the newly passed Part D program of Medicare.

In Section 4 we provide more in-depth information regarding our extensive experience.

Since we could not locate any contract terms and conditions in the RFP, we will work with HUP/HIPA to develop a mutually agreeable contract.

The hourly rates that we are proposing for the contract are:

Level	Hourly Rate
Principal	\$380
Credentialed Actuary other than Principle	\$300
Analyst	\$190
Anticipated Average Hourly Rate	\$275

We are providing proposals for two levels of analysis. The first level is that identified in the RFP. The not-to-exceed budget to complete all the modeling and analysis identified in Section III of the proposal is \$250,000. This assumes that the project will be completed within 90 days of the signing of the contract. It is our experience that if the timing of a project becomes extended significantly beyond the original anticipated length, that the scope of the project changes materially. If the project extends beyond 90 days, then Mercer reserves the right to either extend the contract on existing terms or to increase the maximum.

The second level of analysis is qualitative. No modeling would be completed. This approach entails reviewing existing literature and studies already completed regarding single payer systems and describing the possible implications to Hawaii. We would complete some of this research for the first approach as well. The answers to the questions raised in Section III would not be as definitive as if a comprehensive modeling process was completed. However, there is definitely a lower cost associated with this approach. The cost for this analysis is a budget of \$75,000.

We are assuming that one on-site visit would be possible under the first approach. This is included in the not-to-exceed budget. We are not assuming any on-site visits in the second approach. The costs associated with additional on-site visits would be outside the budget and billed separately.

We believe that the vast resources a company like Mercer can bring coupled with our in-depth knowledge of the health insurance in general, modeling experience, consulting experience makes us uniquely qualified to assist HUP/HIPA in its charge of researching the impact of introducing a single payer system to Hawaii. As actuaries we are required to be fully cognizant of the potentially unanticipated outcomes and to quantify these impacts when possible.

We also understand that while sophisticated modeling may be preferred, there are sometimes cost implications as well. Therefore, we are proposing an alternative that may provide HUP/HIPA with enough information to decide to continue forward with a more in-depth study or to look for other solutions.

Our proposal shows what makes Mercer uniquely qualified to support HUP/HIPA in its analysis of a single payer system. We have experience modeling and studying the impact of proposed health care reforms, experience working with state agencies including testifying about the results of our analyses, experience presenting complex concepts to non-technical audiences such as press conferences and Congressional briefings, experience in the health insurance market on both a theoretic and practical level, vast

experience in working with states in government-funded health initiatives as well as governmental/private cooperatives. Our size provides access to a depth of resources across a broad spectrum of disciplines that cannot be matched by firms focusing solely on actuarial consulting.

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Marsh & McLennan, Inc. is the parent company of Mercer Oliver Wyman Actuarial Consulting, Inc. and Mercer Human Resource Consulting. For the purpose of the proposal response, we will refer to Mercer Oliver Wyman Actuarial Consulting, Inc. and all sister companies collectively as "Mercer."

Scope of the Project (Section III of the RFP)

This proposal was prepared in response to the request for proposal (RFP) entitled "REQUEST FOR PROPOSAL, CONSULTING SERVICES, HAWAII UNINSURED PROJECT" issued through the Hawaii Institute for Public Affairs (HIPA) to provide research and technical support for the Health Care Task Force (HCTF) in developing a plan to provide health care coverage to all of Hawaii's people. The Hawai'i Uninsured Project (HUP) is requesting bids from qualified consulting actuarial firms to analyze the costs and benefits of establishing a single payer system versus Hawaii's existing hybrid system of employer-sponsored and government-supported health care coverage.

The scope of our proposed project is defined as the criteria set out in the RFP. The scope included in our response to the RFP is defined as follows:

The Contractor shall:

A. Analyze the costs and benefits of a single payer system for Hawaii as outlined in H.B. 1617. The cost analysis shall estimate the total cost for a single payer system, to include the amount of state funds required. The cost analysis shall evaluate the financial impact, including:

- (a) the extent to which mandating coverage will increase or decrease the cost of the service;
- (b) the extent to which mandating coverage will increase use of the service and attendant costs;
- (c) the extent to which the mandated service will be used as a substitute for a more expensive service and result in cost savings;

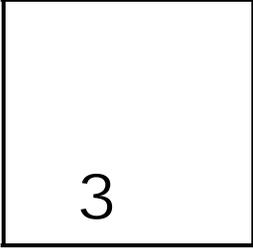
- (d) the extent to which mandating coverage will increase or decrease the administrative expense of carriers, and the premiums and administrative expenses of policyholders, members of mutual benefit societies, and subscribers of health maintenance organizations;
 - (e) the effect of mandating coverage on the total cost of health care;
 - (f) the effect of mandating coverage on consumer access to health insurance, and on employers' ability to purchase health benefits policies to meet employees' needs.
- B. Analyze the cost and benefit differential between the single payer system and the system currently in place in Hawaii, including any administrative cost savings.
- C. Evaluate whether the existing Hawaii healthcare delivery system can support a single payer system.
- D. Evaluate the effects that a single payer system will have on healthcare providers, including their ability and willingness to remain in Hawaii.
- E. Evaluate the costs associated with non-Hawaii residents coming to Hawaii to take advantage of the single payer system.

The basic assumptions to be used in conducting the study are as follows:

1. The benefits package to be offered by the single payer system will be the same as the benefits packaged offered by the Hawaii Employer Union Health Benefits Trust Fund and shall include medical, dental, vision and drug.
2. Reimbursement rates for providers shall be the current Medicare reimbursement rates, current rates plus five percent, and current rates plus ten percent.
3. Assume a moderate level of managed care.
4. Assume that all persons in Hawaii who wish to be part of the program will be covered, except those insured through the Federal Employee Health Benefit Plan, Medicare, and TRICARE.

We are aware that HIPA reserves the right in its sole discretion to reduce the scope of work prior to entering into the Contract because the fee proposals are not yet known.

This response will demonstrate that Mercer Oliver Wyman Actuarial Consulting, Inc. (Mercer) has the requisite skill and expertise in all these areas.



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Statement of Qualifications and Experience (Section VI of the RFP)

In accordance with Section VI of the RFP, we are providing the following information:

About Mercer Oliver Wyman Actuarial Consulting, Inc.

Company Description

1. State the name, address, telephone, e-mail and Internet addresses and fax number(s) of your corporate offices and the principal contact for this RFP.

Mercer Oliver Wyman Actuarial Consulting, Inc.
411 East Wisconsin Avenue
Suite 1600
Milwaukee, WI 53202 4419
(414) 223-7989
Fax: (414) 223-3244

Primary Contact: Karen Bender
Phone: (414) 223-2289
karen.bender@mercer.com

2. Describe fully your company's corporate or other business entity structure, including the state of incorporation or formation and list any controlling stockholders, general partners, principals, etc.

Response to this question is included under the section titled Background.

3. State that the Offeror is in good standing and qualified to do business in the State of Hawaii.

Mercer Human Resource Consulting is registered to do business in the State of Hawaii. Mercer Oliver Wyman Actuarial Consulting, Inc. will submit an application to become qualified as soon as practicable if we are the successful bidder.

4. Given your current contractual obligations, will your company have any problem providing the services required under this RFP?

Mercer will have the capacity and resources available to perform the work described in the scope of the project. The estimated timing of the project is described in Section 5 of this response under Management. Any changes to the proposed timeline will need to be discussed and agreed upon by both Mercer and HIPA.

5. Has any contract of your company ever been terminated for cause? If so, when, by whom and under what circumstances?

The members of the project team assigned to perform the work under this contract have not been terminated for cause. Mercer consists of many offices worldwide, therefore it is difficult to state whether any contracts have been terminated due to cause. To the best of our knowledge, we know of none.

Background

Mercer Oliver Wyman Actuarial Consulting, Inc. (Mercer) is a part of the Marsh & McLennan (MMC) family of companies. MMC is a global professional services firm with annual revenues exceeding \$11 billion.

The MMC companies are active in the following sectors: risk and insurance services through Marsh, Inc. and Guy Carpenter; investment management, through Putman Investments; and consulting, through the Mercer, Inc. family of companies. Mercer is one of the Mercer, Inc. companies. Mercer, Inc. is the foremost employer of actuaries in the world. Mercer Inc.'s more than 12,500 employees provide consulting services from 125 offices in the United States, Canada, the United Kingdom, and other parts of the world.

Our actuarial practitioners have the highest professional qualifications. We combine a broad-range of experience with specialized knowledge of the industry segments we serve.

Mercer has a long history of providing consulting to large public sector clients such as the South Dakota Division of Insurance and Department of Health, the Florida Department of Insurance, the Arizona Health Care Cost Containment System, Vermont Department of Banking, Insurance, Securities and Health Care Administration, and Maine Department of Insurance. Mercer has been providing significant consulting services to state regulatory

agencies since 1990. In 2005 we assisted CMS in analyzing and auditing the bids for the newly passed Part D program of Medicare.

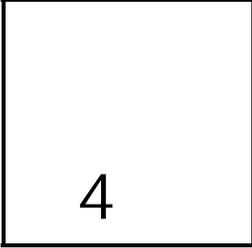
Consulting Philosophy

Our consulting philosophy is formed around the concepts of teamwork, partnership, service, and quality, both in the coordination of our efforts within our firm and in our interactions with our clients. The core project team will include two members of the Society of Actuaries. The strength and qualifications of our staff enable us to provide analysis that is both prompt and thorough.

We strive to form partnerships with our clients. Our best actuarial estimates and recommendations can be delivered only through recognition of each client's unique situation. We design our report formats to meet each client's needs. We will, if desired, provide the report in draft form so that the HUP/HIPA has the opportunity for input and commentary before we issue final report.

Effective communication of our work is a top priority at Mercer. We know that even the best actuarial advice is useful only if it is presented clearly in terms that the audience can understand. We pride our ability to "translate" complex actuarial and econometric theories and jargon into verbiage and concepts that non-actuaries can easily identify with and understand. As an example, Karen Bender, the client manager should Mercer be selected as the consultant, was one of two actuaries who presented the complex issues associated with selection in a voluntary insurance market to U.S. Congressional aides in Washington, D.C. in the summer of 2005. The comments from the aides indicated we successfully described the complicated forces in such a way that people not conversant in insurance easily understood.

We also know that timeliness is essential to a successful assignment. We deliver quality, timely products as promised. We offer our clients superior service and quality, including state-of-the-art actuarial techniques.

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Mercer's Qualifications (Section VI B of the RFP)

In accordance with Section VI B of the RFP we are providing information to demonstrate our qualifications:

1. It is preferred that the Offeror have at least five (5) years experience (within the preceding five (5) years of the award of the Contract) in providing relevant consulting services.

In this section of our submission, we provide information that will demonstrate to the HUP/HIPA that we have the professional expertise, technical experience and depth of resources to perform the type of analysis that HUP/HIPA is seeking.

Analysis of Proposed Legislation in Massachusetts

We are in the process of finalizing the multi-year modeling of proposed legislation in Massachusetts that would impact the nongroup and small group markets. The results will be in a soon to be released paper. In this analysis we gathered data from insurers and HMOs in Massachusetts that represented about 85% of the targeted markets. We incorporated assumptions regarding elasticity of demand for health insurance that vary by market, impact of various rating and underwriting rules and the impact of new, lower cost products on the uninsured. The range in assumptions are supported through reviews of previous pertinent studies adapted to the specific needs of our modeling.

Virginia's Low Cost Policies

Virginia is currently studying the possibility of increasing access to insurance by lowering the premium levels through the introduction of policies that have less comprehensive benefits than those currently allowed in the market. Mercer provided modeling and analysis, supported with a review of existing literature, as to the number of enrollees that Virginia could reasonably expect to enroll in such plans.

Maryland Health Care Commission

The Maryland Health Care Commission (MHCC) is charged with the responsibility of balancing access and affordability to health insurance for small employers. Their approach to this charge is the development of the Comprehensive Standard Health Benefit Plan (CSHBP). Legislation requires that the premiums for the CSHBP not be greater than 10% of the average annual income of working individuals in Maryland. Legislation further defines the “floor” benefits that can be offered. MHCC has a great deal of flexibility in meeting their responsibilities within these broad limits by deciding what types of benefits (such as which mandates) will be included in the CSHBP, the cost sharing levels, the types of medical delivery systems (PPO, HMO, POS type plans), the selection that may result from the introduction of significantly different types of products such as the qualified high deductible health plans/ health savings accounts. MHCC has relied upon Mercer to provide the actuarial expertise to meet these responsibilities since the inception of the responsibilities in the 1990s. Mercer provides analysis of the premium costs and benefits of the CSHBP; cost estimates of proposed plan changes; estimates of proposed changes in enrollment.

Low Cost Policies and Reinsurance in the Individual and Small Group Market

Over the past few years many states have introduced policies that are lower cost either through relief from some or all mandated benefits, lower annual or lifetime maximums, higher cost sharing or a combination of all or some of the previously mentioned items. Karen Bender and Beth Fritchen detailed the success, or lack thereof, of the acceptance of low cost policies to date in the individual and small group market to the 2005 National Finance, Actuarial and Underwriting Conference for Blue Cross and Blue Shield Plans. We also presented the results of two reinsurance programs. The sources of the presentation were existing public information.

Study of Health Insurance Purchasing Pools

Mercer provided a comprehensive study of the effectiveness of health insurance purchasing pools (HIPCs) several years ago for Virginia. This type of study reflected an amalgamation of research currently available, pulled together and modified to reflect the specific circumstances in Virginia. As a result of our study, Virginia elected not to pursue funding for HIPCs.

Presentation of History of Employer Purchasing Arrangements

In 2004 Karen Bender provided a history of employer purchasing arrangement in a presentation to U.S. Congressional aides. The presentation began with multiple employer trusts (METs), described multiple employer welfare arrangements (MEWAs) and ended with association health plans (AHPs). Ambiguities in oversight responsibilities coupled with the less-than-stellar financial history of these arrangements demonstrated the need to balance consumer protections with regulatory efficiencies. This also demonstrates Mercer’s in-depth knowledge of the many and varied attempts of creating more efficient mechanisms to streamline the marketing and delivery of health insurance to employer groups.

Study of the Feasibility of Creating a New High Risk Pool in Florida in 2004

Florida has an existing high risk pool which is not accepting new membership. In 2004 legislation was introduced to study the cost/benefit analysis of creating a new pool and providing relief from certain regulatory requirements concurrently. Mercer developed a sophisticated econometric model incorporating elasticity of demand which produced ranges in expected results using various assumptions for a period of five years. This provided the legislators with the range of funding levels that would reasonably be required under the various scenarios. Karen Bender presented the results to the Florida Health Insurance Plan Board.

Florida has not elected to create a new high risk pool, mainly because of the inability of interested parties to concur on the most equitable means of funding the subsidies that any such pool will require.

Impact Analysis of Proposed Federal Legislation

It is imperative to understand the possibility of unintended consequences of proposed legislation intended to improve access and affordability to health care. Karen Bender and Beth Fritchen (both members of the proposed HUP/HIPA team)) developed an econometric model that studied the possible impacts of proposed federal legislation designed to lower the costs of insurance to small employer groups through association health plans. The model incorporated results from almost 90,000 small groups and over one million members in the small group market. The subsequent report entitled "Impact of Association Health Plan Legislation on Premium and Coverage for Small Employers" showed that the actual consequences of this legislation could be higher premium rates and more uninsureds for this market. Karen Bender held a press conference in Washington, D.C. to discuss its release. This study has been quoted in the Wall Street Journal as well as in the U.S. Congressional House debates. This demonstrates our ability to design models using large data bases as well as communicating the results in a public forum.

In 2004 Karen Bender and Beth Fritchen (the proposed project leader) performed sophisticated modeling for the new consumer driven health plans (health savings accounts and high deductible health plans resulting from the Medicare Modernization Act) for a major insuring entity. In our analysis we showed how such plans affect individuals with high health care costs, as well as low health care costs results over multiple years. Such longitudinal studies are critical to fully understanding the potential ramifications of any proposed major shift in products and/or policy. Karen Bender is currently a member of the American Academy of Actuaries (AAA) committee studying the impact these plans will have on employee benefits, usage of services and providers. An AAA monograph on this subject was released in 2004. Karen and Beth provided some of the results of this study at a national forum.

Proposed Market Reforms in Vermont

During the past several years Mercer has provided modeling an impact analyses for multiple proposed market reforms in Vermont including:

- expanded rating bands for the individual and small group market for the Vermont Department of Banking, Insurance Securities and Health Care Administration (BISCHA),
- tax incentives for small employers and individuals in Vermont,
- premium subsidies for individual insurance in Vermont and
- expanding a Medicaid-like program to small employers.

The impact analysis took into consideration the effect some of the proposals would have on the private health insurance market, review of cost estimates as well as incorporating knowledge of actuarial concepts into the results provided by another consultant, testifying before legislators regarding the results.

Experience in Establishing a High Risk Pool -- South Dakota

In the early 1990's South Dakota implemented reforms that required guarantee issue of a basic and standard plan in the individual market as a means of spreading risk among all carriers. It further limited the number of high risk individuals (high risk cap) that any single carrier would have to insure. In spite of these risk-sharing approaches eight health insurance companies making up half of the individual market withdrew from South Dakota between August of 2000 and the fall of 2002, according to CA, Inc. The withdrawal of these carriers necessitated an increase to the high risk cap on guarantee issue of high risk individual health insurance policies previously imposed to the point where it was projected to be as much as eight percent of their insured business in the state. To offset an impending crisis in the individual insurance market, South Dakota's governor recalled the legislature to create and implement a high risk pool in 2003. Mercer played an active roll in the successful launching on the high risk pool by modeling various financial scenarios including enrollment, premium levels, benefit plans, assessment vehicles in addition to assisting in the development of target premium rates and budgets. We continue to provide actuarial consulting support to the South Dakota high risk pool.

One of the goals of introducing the high risk pool to South Dakota was to attract new insurers into the individual market. South Dakota Governor Mike Rounds announced that since January 2004 States General Life Insurance Company of Fort Worth Texas and Medica Insurance Company of Minnesota announced they will enter the individual health insurance market in South Dakota, bucking a nationwide trend of carriers leaving the market. Gov. Rounds indicated that the creation of the high risk pool has made South Dakota's individual market more attractive for insurance companies. Since that announcement there has been another carrier that exited the individual market nationwide. Still, South Dakota has more carriers in the individual market today than it did prior to the creation of the high risk pool.

Evaluate the Financial Effects of Proposed Mandated Benefits at the State Level

In 2005 we completed a report for the State of New Jersey to provide an analysis for a proposed mandated benefit, mental health parity. In this report we provided information regarding the social impact, financial impact and medical efficacy of the issues related to

the proposed change in mandated benefits. We gathered information from New Jersey insurers, experience from other states that had passed or studied similar legislation as well as national studies to provide an unbiased, object report that legislators could use in the decision making process.

We have assisted the State of Maine in evaluating the financial effects of any proposed health benefit mandates. Legislators use our work in evaluating the pros and cons of any new health benefit mandate. The scope of these analyses includes social, financial, medical efficacy and balancing the impacts of these.

Some of the mandates that we have studied for New Jersey, Maine as well as other states are:

- Managed care malpractice liability
- Prescription drug coverage
- Any willing provider requirements
- Mental health and substance abuse parity variations
- Nurse midwives
- State pharmacy assistance programs
- Chiropractic coverage
- Patient protection legislation
- Nurse practitioners as primary care providers
- Patient protection legislation
- Coverage of clinical trials
- Hearing tests for newborns
- Birth control coverage
- Health Insurance Portability and Accountability Act of 1996
- Infertility coverage including invitro fertilization
- Comprehensive managed and patient protection legislation
- Clinical trials
- Self-referral for a variety of care provided under managed care plan
- Prosthetic devices
- Hearing aids

We have testified before various state legislative committees and/or regulatory boards regarding the results of these studies.

Competitive Analysis for California Department of Managed Health Care

Just as consumers choose which products best suit their needs, companies can choose which states they desire to operate and compete. This extends to the regulatory environment as well. We provided the California Department of Managed Health Care (DMHC) with a comparison of its rates regulations for individual and small groups to those elsewhere in the country.

Regulatory Oversight in a Competitive Market

In 2004 Karen Bender and Beth Fritchen released the paper entitled “Impact of Prior Approval Requirements for Rate Changes of Small Employer Group and Individual Health Policies.” This used several metrics to determine if prior approval resulted in lower premium rates for individual and small employers in a competitive market. The sources for these metrics were published studies. This demonstrates that meaningful results can be obtained through the analysis of existing research adapted for the specific situation.

Experience in Supporting State Departments of Insurance and Attorney General Offices

We currently review rate filings for several Departments of Insurance and/or Attorney General offices including Massachusetts, Rhode Island, Virginia, Vermont and Kentucky. This is one of the ways we keep abreast of product innovation and industry trends. Our reviews consist of analysis of a company’s actual experience, as well as comparisons of risk and/or rating factors to industry norms and our internal database. Our review encompasses formulation of opinions regarding the adequacy and appropriateness of the proposed rates. We review rate filings for non-profit insurance companies, for-profit insurance companies and HMOs for policies ranging from dread disease, long term care, Medical Supplement to medical insurance for individual and small employer groups. Our actuaries regularly participate in rate hearings in Vermont and Rhode Island as expert witnesses. In addition to providing testimony in these rate hearings, our consultants provide strategic advice and support to council during the review of the filing leading up to the hearing. In these cases, we generally provide a formal report that is used as exhibits during the hearings. We also have provided post-hearing support by aiding in the writing of the briefs.

Years and Types of Experience in the Health Care Industry and Performing Actuarial Services to Health Plans

Our team of consultants averages over 15 years experience in the health insurance and managed care industry. All of the actuaries on the consulting team we are proposing to the HUP/HIPA are members of the American Academy of Actuaries and meet that body’s qualification standards for rendering the types of opinions and advice that the HUP/HIPA is seeking.

Members of our staff have been active in the managed care industry from its infancy. We were involved in establishing Harvard Community Health Plan, one of the first staff model HMOs in the northeast, and were involved in product development, rating and provider bonus determination for one of the first capitated IPA-type managed care plans in the early 1970’s. We have continued to play an active role in this arena. In addition to providing services to several managed care plans, we are currently working for the Centers for Medicare and Medicaid Services (CMS) in evaluating the performance of its managed care contractors.

Our consulting team has experience in pricing, evaluating, and managing a broad range health insurance programs -- from traditional HMO benefits programs to newer points of service (POS) plans, to consumer driven plans. This experience extends into prescription drug benefits and other limited service plans, stop loss policies and individual medical policies. We have developed rates for Medicaid HMOs and Medicare+Choice managed care plans (now called Medicare Advantage), and understand the dynamics affecting government-sponsored health care. We are assisting client in analyzing the impact of the Medicare Part D as well as helping clients become PDPs. We recently assisted CMS in auditing the rate submissions for Part D (for PDPs other than our own clients, of course).

We also have experience consulting with health care providers. We feel this experience gives us perspective when it comes to understanding effects of contractual arrangements on the financial performance of health insurance programs and systems. We have assisted numerous providers in evaluating proposed capitation arrangements. We have analyzed the impact that different reimbursement mechanisms (e.g., capitation versus fee-for-service) have on utilization.

We conduct semiannual surveys of the trends that health care insurers and managed care companies are using in their pricing. Most of the BlueCross/BlueShield plans around the country (including their subsidiaries) participate in this survey. Together, the survey participants represent more than 100 million insured lives. In our opinion, this is the most comprehensive health insurance pricing trend survey available. This survey provides us with valuable information as we advise our clients and assess other carriers' pricing trends.

Previous Experience Analyzing and Evaluating Rate Structures, Risk Factors, Rates and/or Filings

Our actuarial team has spent a considerable portion of their careers analyzing and evaluating rate structures.

Rate Filings

We currently review rate filings for several Departments of Insurance and/or Attorney General offices including Massachusetts, Rhode Island, Virginia, Vermont and Kentucky. This is one of the ways we keep abreast of product innovation and industry trends. Part of this review is to determine the appropriateness of the risk factors being employed. We often accomplish this by analyzing a company's actual experience, as well as by comparing the risk factors to industry norms and our internal database. Our review encompasses formulation of opinions regarding the adequacy and appropriateness of the proposed rates.

We review rate filings for non-profit insurance companies, for-profit insurance companies and HMOs for policies ranging from dread disease, long-term care, Medicare supplement to medical insurance for individual and small employer groups.

We reviewed over 180 rate filings in 2004 for government clients. These reviews have taken into consideration key assumptions used to generate the requested rate increases, such as trend assumptions, lapse rate assumptions, incurred claims, administrative expense loads and the expected return to policyholders. We have reviewed long-term care, cancer, disability, individual medical, and Medicare supplement policy forms. Of the 180+ filings, about 50 filings were long-term care, over 60 were individual medical, about 25 were Medicare supplement and 45 were disability, cancer and other accident and sickness policy forms.

Expert Witness Testimony

Our actuaries regularly participate in Medicare supplement rate hearings in Vermont and Rhode Island as expert witnesses. We have participated in hearings for nongroup policies as well. The service provided under these circumstances is very in-depth. Not only are the rates reviewed for reasonableness, the administrative expenses are analyzed, the contribution to surplus is reviewed, and the entire company's financial health is analyzed. Testimony and exhibits are prepared which generally includes an independent analysis of rate changes.

In addition to providing testimony in these rate hearings, our consultants provide strategic advice and support to council during the review of the filing leading up to the hearing. In these cases, we generally provide a formal report that is used as exhibits during the hearings. We also have provided post-hearing support by aiding in the writing of the briefs.

Our actuaries provide testimony to legislators regarding the impact of propose health care reform. The analysis is thorough and every attempt is made to identify potential unintended consequences.

Rating Factors and Structures

Members of the proposed consulting team developed a rating manual that was used firm-wide in one of our sibling companies. This rating manual includes rating factors for age/gender, area, industry, level of managed care and benefit plan design. The rating model is primarily being used to benchmark quotes from insurance companies.

We have developed rating structures for managed care companies as well as commercial PPO products. Development of the rating structures for an existing managed care company can be more complicated than starting from basic principles as it can include re-pricing all products and re-developing all pricing factors. A partial list of the types of companies for whom we have recently completed an evaluation of rate structure and risk factors include:

Company	Type	Premium
HMO	For-Profit HMO w/ Traditional HMO products, POS, and drug. State regulations allow for age/gender, industry, area and morbidity within limits	>\$280 million
Commercial Insurer	For-Profit insurance selling PPO products	\$30 million
Blue Shield	Non-Profit Blue Shield	>\$1 billion

We provided the California Department of Managed Health Care (DMHC) with a model that will enable the DMHC to independently determine the reasonableness of rating factors associated with high deductible health plans (HDHPs) and other consumer directed policies.

In addition to these projects, several of our team members come from large insurance companies where they routinely performed experience studies to update rate structures and risk factors. This includes experience at one of the largest insurance carriers serving the small to midsize group marketplace, and experience at one of the most progressive BlueCross/BlueShield organizations in the nation.

In 2005 Karen Bender (the client manager for HUP/HIPA, should we be awarded the contract) was part of a symposium held in the U. S. Senate to discuss proposed Association Health Plan legislation.

Karen was also a member of the team of actuaries representing the American Academy of Actuaries (AAA) that visited federal decision makers in 2005 to ascertain how the AAA could contribute to the discussions of proposed health issues.

Karen is currently the chairperson of the AAA Association Health Plan Workgroup (AHP Workgroup). The AHP Workgroup recently released an issue brief on frequently asked questions about AHPs. Karen has been a member of this group for several years.

Karen is a member of the AAA Health Savings Accounts (HSA) workgroup that formulated questions for Treasury to assist in the creation of implementation rules. She also is a member of the AAA Reinsurance committee that released a monograph identifying the main issues associated with using the government as a possible reinsurer.

Karen was a member of the AAA Individual Health Rate Filing Committee that studied possible solutions to the closed block problem for individual health policies. The committee submitted its findings to the National Association of Insurance Commissioners (NAIC) in 2004. The NAIC is in the process of reviewing the results.

We believe this demonstrates our significant participation in national regulatory issues. A sample of one of our analyses can be provided upon request.

In addition to this experience, team members have worked with the National Association of Insurance Commissioners (NAIC) in developing guidelines for health valuation work. Karen Bender was chairperson of American Academy of Actuaries' (AAA) team responsible for writing the Provider Liability section of the Health Reserves Guidance Manual released by the NAIC in November 2000. As a member of the AAA team, she provided peer review and input into other sections of the manual that including the sections on Claim Reserves, Contract Reserves and Premium Deficiency Reserves. In 2003 she was a member of the AAA team that updated the Practice Notes upon which valuation actuaries rely when developing opinions.

Surplus Levels for Non-Profits

Traditionally, Departments of Insurance have focused on ensuring that insuring entities have sufficient minimum surplus to adequately fund claims and administration. The positive financial results of the past few years have enabled many nonprofit health insuring entities to make material contributions to surplus. Recently there has been concern regarding the level of surplus that some non profit companies have been able to accrue. We have been assisting two states in determining if and when surplus for a nonprofit may become excessive and identifying possible action that will balance the needs of the consumers while minimizing disruption to the market. House Bill 1617 indicates that a single payer system may be “where one entity covers all the health care for a specific population either directly or through contracts with insurers.” We interpret this to mean that the introduction of a single payer system would not necessarily eliminate the need for all insurers. Therefore, understanding the need for capital for non-profits is a critical part of any type of analysis of a single payer system if they will be part of the system.

Government Funded Health and Welfare Programs

Since 1985, Mercer has been working to meet the specialized needs of publicly-sponsored health and welfare programs such as Medicaid programs, high-risk health insurance pools, and statewide health care reform initiatives, (helping states design, develop, and implement innovative solutions to improve the quality of care while saving the General Fund dollars). Today, there are more than 100 staff working in five offices across the country that specialize in helping government-funded health and welfare programs become more efficient and effective purchasers of health care.

We can draw on our vast, unmatched expertise of these programs to identify those processes that have been effective as well as those that were not successful.

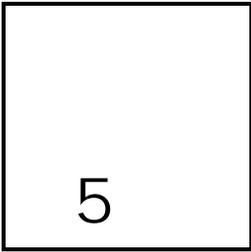
The following table identifies our historical experience with states in a variety of consulting areas including actuarial/financial consulting, clinical quality and behavioral health consulting, pharmacy consulting, data/systems consulting, expert testimony consulting, and assistance with uninsured populations.

STATE	ACTUARIAL/ FINANCIAL	CLINICAL QUALITY/ BEHAVIORAL HEALTH	PHARMACY	DATA/ SYSTEMS	EXPERT TESTIMONY	UNINSURED POPULATIONS
Alabama	X	X		X		
Arizona	X	X	X	X	X	X
California	X	X		X	X	
Colorado	X	X	X		X	
Connecticut	X	X	X	X	X	
DC	X	X	X	X	X	
Delaware	X	X	X	X		
Florida	X	X	X	X	X	
Georgia	X		X	X	X	X
Hawaii	X	X				
Idaho	X	X	X	X		
Indiana	X	X			X	
Iowa	X	X		X		
Kansas	X					
Kentucky	X	X				
Louisiana	X			X		X
Maine	X	X	X	X		X
Maryland	X		X			
Massachusetts	X	X	X	X	X	X
Minnesota	X			X		
Missouri	X		X	X	X	
Nebraska	X	X				
Nevada	X	X	X	X	X	
New Jersey	X	X	X	X		X
New Mexico	X	X	X	X		X
New York	X	X	X			X
North Carolina	X	X	X	X	X	
Ohio	X	X	X	X		
Oklahoma	X			X		
Oregon	X	X	X		X	
Pennsylvania	X	X	X	X		
Rhode Island	X	X	X			
South Carolina	X		X			
Tennessee	X	X		X		
Texas	X		X			
Vermont	X	X				
Virginia	X	X				X
Washington		X	X			
West Virginia	X					

No other consulting firm can match Mercer's breadth and depth of Medicaid experience. Mercer's professional staff includes actuaries, accountants, doctorate level statisticians, pharmacists, clinicians, information technology professionals, policy experts, and former state agency leaders. These experts give a unique and current perspective that allows us to provide creative and innovative solutions to the issues faced by our clients. Mercer continues to be the only multi-faceted consulting firm with such a variety and so many individuals who are solely dedicated to working with clients on publicly-funded health care. By having all of these resources housed under the Mercer banner, we avoid the need to rely heavily on subcontractors and the issues regarding work quality, consistency, and project management associated with them.

Summary

We have demonstrated in this section what makes Mercer uniquely qualified to support HUP/HIPA in its analysis of a single payer system. We have experience modeling and studying the impact of proposed health care reforms, experience working with state agencies including testifying about the results of our analyses, experience presenting complex concepts to non-technical audiences such as press conferences and Congressional briefings, experience in the health insurance market on both a theoretic and practical level, vast experience in working with states in government-funded health initiatives as well as governmental/private cooperatives. Our size provides access to a depth of resources across a broad spectrum of disciplines that cannot be matched by firms focusing solely on actuarial consulting.

5

Management Plan (Section VII, A7 of the RFP)

In accordance with item 7 of Section VII of the RFP, we are providing a management plan. An important part of any project is the assumptions that we employed in developing our bid, the project team and the proposed time table.

Assumptions

In this section we disclose the assumptions employed and our understanding of the deliverables anticipated. These serve as the foundation for our cost estimates, shown in the next section. These assumptions are based upon information contained in the Request for Proposal issued October 25, 2005 by the Hawai'i Uninsured Project.

The ultimate cost of the project may be impacted if any of our assumptions are incomplete and/or incorrect. We reserve the right to modify our costs if there are material changes.

- Because of the accelerated RFP timetable, there was not a bidder's conference.
- The benefits package to be offered by the single payer system will be the same as the benefits package offered by the Hawaii Employer Union Health Benefits Trust Fund and shall include medical, dental, vision and drug. The HUP will provide the successful bidder with the full description of these benefits.
- There will be three sets of scenarios for provider reimbursements which will also apply to Medicaid members:
 - Existing Medicare reimbursement
 - Existing Medicare reimbursement plus five percent
 - Existing Medicare reimbursement plus ten percent
- The assumed reimbursement levels will apply to all Hawaii residents (including those currently covered under the Medicaid program) except those insured through

Medicare and TRICARE. Please note that the RFP includes verbiage that “all persons in Hawaii who wish to be part of the program will be covered;” however subsequent communications from L. Johnston indicates that all residents will be covered.

- Persons who purchase Medicare supplement contracts will not be covered under the single payer system. More importantly, reimbursement for providers servicing this market will not be dependent upon the reimbursement for the single payer system.
- The assumed reimbursement levels will not apply to non-Hawaii residents.
- A moderate level of managed care will be assumed.
- HUP/HIPA will provide information regarding the existing provider reimbursement level for Medicaid.
- HUP/HIPA will assist the successful bidder in identifying existing data bases/statistics pertaining to Medicaid and TRICARE as well as uncompensated care currently provided by Hawaii providers, on a timely basis.
- HUP/HIPA will assist the successful bidder in identifying existing databases/statistics pertaining to the magnitude of services provided in Hawaii to non-Hawaii residents as well as any statistics pertaining to the magnitude of services provided to Hawaii residents off-islands.
- HUP/HIPA will assist the successful bidder in identifying Hawaii-specific statistics regarding the existing insurance expenditures and utilization of services (such as inpatient days per thousand member years) on a timely basis. HUP/HIPA will assist the successful bidder in obtaining historical statistics regarding the costs of health insurance in Hawaii on a timely basis.
- HUP/HIPA will assist the successful bidder in identifying the administrative costs of existing health insurers and/or HMOs in Hawaii. This information should be readily available through the Hawaii Department of Insurance.
- HUP/HIPA will assist the successful bidder in identifying Hawaii-specific statistics pertaining to mutual benefit societies on a timely basis.
- Information pertaining to any other programs (such as SCHIP) that are in place to increase access to insurance. This information will include provider reimbursement levels, utilization, membership, benefits, cost sharing arrangements, premiums, emerging experience, etc.
- Since a single payer system may be funded through numerous vehicles, HUP/HIPA will finalize the funding mechanism (e.g. payroll tax, income tax, general funds, premiums) prior to the time when that portion of the model is developed. If premiums are to be the source of funding, then HUP/HIPA will also define the types of subsidies that will be implemented.

- Whether or not insurers will be part of the single payer system will be finalized before an impact on the economy of Hawaii can be determined.
- HUP/HIPA will issue data requests, if existing data is not readily available, from the insurance companies and forward the completed data to the successful bidder on timely bases.
- If necessary, HUP/HIPA will issue data requests to providers and forward the completed data to the successful bidder on a timely basis.
- Since specific contract language was not included in the RFP, we are basing this response on the assumption we will have the ability to reach consensus on mutually agreeable contract language and that we reserve the right to withdraw this proposal in the unanticipated event that we are unable to do so.
- We will work with HUP/HIPA to define the starting modeling assumptions.
- If an on-site meeting is required, travel expenses are eligible for reimbursement under the contract.
- Additional on-site meetings will be considered outside the scope of this contract and will be negotiated on an as-needed basis.
- We could not find an anticipated delivery date for the report in the RFP. Our response assumes that the delivery date will be within 90 days of the signing of the contract and provides for a limited number of iterations. If the date of the final report is extended and/or delayed, we reserve the right to revise the maximum of the contract since it could entail additional and unforeseen iterations. It is our experience that delivery dates beyond this time frame are generally the result of material changes in the scope of the contract. Therefore, we are willing to accept a “not to exceed” type contract if it is understood that any charges incurred after 90 days of the signing of the contract will not count toward the contract maximum.
- The budget assumes 3 iterations. Additional iterations will be considered outside the scope of the current contract and will be negotiated on an as-needed basis.

To meet the time table, we developed the following schedule:

Process	Responsible Entity	Delivery Date
Award of Contract	HUP/HIPA	<i>To be determined</i>
Contract finalization	Mercer/ HUP	<i>Within two weeks of award</i>
Data Request	Mercer	<i>Within one week of contract finalization</i>
Receipt of Data	HUP	<i>Within three weeks of data request</i>
Modeling and Research	Mercer	<i>30-60 days of contract finalization</i>
Iterations (up to three) begin submitted and reviewed by HUP/HIPA	Mercer	<i>60-75 days HUP/HIPA will have five days to review each iteration</i>
Draft report	Mercer	<i>75 days</i>
HUP/HIPA Response to Pre-report	HUP/HIPA	<i>85 days</i>
Discussion of Comments and Modifications to Report/ modeling, Release of Final Report	Mercer	<i>90 days</i>

We anticipate interaction between HUP/HIPA and Mercer during the modeling and research process. We will provide periodic reports to HUP/HIPA indicating the status of the project, identifying any issues for which we need input and/or guidance, barriers we have encountered and suggested alternative solutions. We envision this process will be a partnership between Mercer and HUP/HIPA to minimize unanticipated results as much as possible. To achieve this, we will need timely and regular communication.

Consulting Team

Mercer has developed procedures, tools and peer review processes that allow us to be efficient and cost effective. Our Principals and Senior Consultants always lead these types of engagements. They lead the initial discussions with the client regarding each actuarial assignment:

- Expected deliverables,
- Verify the assumptions,
- Develop the actuarial models,
- Guide and oversee other actuaries and analysts supporting the project, and
- Peer review and certify all final products.

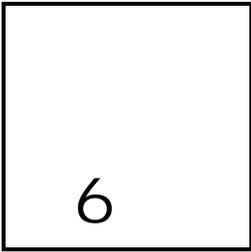
They also participate in ongoing conversations with our clients, make formal presentations when requested, and offer advice based upon our vast experience.

Because of the complexities of modeling the impact of a single payer system, the Senior Consultants and Principals will continue to play a very active roll in the project. While some activities such as the development of specific formulae, the receiving of data, validating completeness of the data, populating of models, checking the initial results against the agreed upon assumptions, may be delegated to non-credentialed analysts, the analyses of outcomes, testing for reasonableness with anticipated results, writing the draft reports and interaction with the client will be completed by Senior Consultants and, in some cases, Principals. Mercer has a rigorous peer review process to further assure the highest quality in our deliverables. When performing modeling for various scenarios of future events for which there is no credible direct experience, there is always the possible and probability that actual results will vary from those predicted for a multitude of reasons. It is extremely important that all parties are fully cognizant of the assumptions employed and the limitations identified when using the results. For these reasons, we believe it is extremely important for Senior Consultants and Principals to perform active rolls in the on-going process.

Karen Bender, FCA, ASA, MAAA, Principal, will lead the Mercer's consulting team and will serve as the HUP/HIPA's primary point of contact. She will be responsible for coordinating Mercer's efforts and for ensuring that our work product is consistent with the HUP/HIPA's needs and expectations. Beth Fritchen, FSA, MAAA, Senior Consultant will serve as Mercer's primary project manager to the HUP/HIPA, overseeing the day-to-day activities related to our work, ensuring that all projects and related services that MOW provides are coordinated and focused on the needs of the HUP/HIPA. Tammy Tomczyk, FSA, MAAA, Senior Consultant, will provide expertise in model building. Jeremiah Reuter, Josh Sober and Susan Poole will provide technical support.

It is Mercer's policy to have all actuarial analyses peer reviewed by a qualified actuary. Our reports will undergo both a technical and consulting peer review. The technical review consists of a detailed "double-checking" of the inputs, calculations and formulas used in our analysis. While no company is able to completely eliminate the potential for errors, this process serves to significantly reduce the potential for problems in this area. This review involves the examination of the analysis for appropriateness of methodology, clarity of presentation, and the reasonableness of the overall results. The consulting peer review process provides the HUP/HIPA with another professional's view of the analysis.

Technical assistants will be assigned in order to provide the most efficient and cost effective work product. Biographies of the consulting team that would support the HUP/HIPA are included in Appendix A for your review.

6

Facilities Resources (Section VII, A7 of the RFP)

We bring the following resources to this project:

Databases

Commercial Data

We have an extensive data base representing hospital and physician utilization for the commercial, under age 65 population. This data base also has extensive information pertaining to drug utilization and costs for this population. However, any data base needs to be calibrated to the target population. In order to accomplish this, we would need cost and utilization information representing the Hawaii population in particular.

Cost Information for Physicians

We have information representing the allowable charges for physicians by CPT code by zip code. We can use this information to determine how various fee schedules compare to Medicare. To calibrate this information to Hawaii, we will need information regarding the prevalent fee schedules in existence today.

Medicare Hospital Utilization

We have a data base representing Medicare hospital utilization for selected states. Unfortunately, Hawaii is not one of these states. Since individuals eligible for Medicare will not be part of the single payer system, this should not be a concern.

Statutory Statement Database

Our statutory statement data base includes information submitted to the Hawaii Department of Insurance for health insuring companies doing business in Hawaii. This database includes all companies licensed in Hawaii that submitted data to the Department. Exhibit of Premiums, Enrollment and Utilization show members, total hospital days, and ambulatory encounters segregated between individual, group, Medicare supplement, Medicare, Medicaid and Federal Employees Health Benefit Plan. Information pertaining

to vision and dental is also requested. This can be a powerful database if the data for the participating companies is accurate.

Being part of the Marsh and McLennan family of companies enables us to have access to extensive information services. Mercer has a special unit, the Washington Resource Group (WRG), dedicated to monitoring state and federal legislative activities. We also have the Information Resource Center (IRC) which provides weekly summaries of recently published articles on a multitude of topics, including health insurance.

Informational resources available from the WRG include:

State Health News

State Health News is a daily e-mail service drawn from Mercer Washington Resource Group (WRG) authored third-party information and analysis relating to state health care issues. *State Health Source* offers information on state developments and Mercer Information Resource Center (IRC) summaries and research on the state topics. *State Health Source* features an extensive library of Web links to governmental and other authoritative sources of information within each of the states.

eLegal News

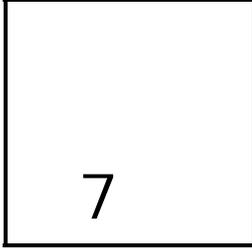
The *eLegal News* Mercer link site is the WRG's principle vehicle for legal, legislative, and regulatory analysis and news for Mercer consultants. Updated throughout the day, the site delivers all the information products published by the WRG. Its summary-based structure provides links to more detailed articles, and source material enables consultants to review and select the level of needed data.

e-Catalog

The *e-Catalog* is Mercer's searchable listing of the more than 3,000 benefits-related periodicals, publications, and surveys in its print collection. Mercer consultants can search the catalog and request or check publications from the US IRC.

iSite

The *iSite* is Mercer's comprehensive vehicle for third-party research and analysis on issues affecting Mercer clients. Researchers examine and synthesize recent surveys, articles or best practices, marketplace developments and trends, and other published materials related to health and benefit plans and human resource issues.



Compensation (Section IV of the RFP)

As requested in the RFP we are providing cost estimates for items A-E separately.

At this time we want to provide an alternative for HUP/HIPA to consider as well. The quantitative cost analysis specifically identified in the Scope of Work requires extensive and complex modeling. Developing models, calibrating them to reflect Hawaii-specific circumstances, testing the various components, checking results for reasonableness is a very time/resource extensive process. This also translates into a very expensive process.

An alternative to this type of modeling would be to conduct a review of existing literature, apply to the uniqueness of Hawaii and provide more qualitative than quantitative results. There are certainly pros and cons to both approaches. In the Qualifications section of this proposal, we have cited many examples of a qualitative approach that capitalized on existing research. It will be up to HUP/HIPA whether such an approach will meet its needs. We will refer to the approach described in the RFP as the “Quantitative Approach” and the alternative as the “Qualitative Approach”.

Quantitative Approach

Please note that Item A must be completed prior to completions of Items B-E.

	<u>Hours by Staffing Level</u>				<u>Charges by Staffing Level</u>			
	<u>Analyst</u>	<u>Consultant</u>	<u>Principal</u>	<u>Total</u>	<u>Analyst</u>	<u>Consultant</u>	<u>Principal</u>	<u>Total</u>
					\$ 190.00	\$ 300.00	\$ 380.00	
<i>Objectives</i>								
<i>Analyze cost/benefits of single payer</i>								
<i>A. Extent to which costs of service will increase or decrease</i>								
1. Identification of current sources of insurance in Hawaii								
Determine size of Hawaii market including commercial (group and individual), Medicaid, TRICARE, Medicare, other programs. Estimates includes members, average benefits existing provider reimbursement levels	20.00	18.00	5.00	43.00	\$ 3,800	\$ 5,400	\$ 1,900	\$ 11,100
Will be segregated between medical, dental, vision and long-term care as well as commercial versus Medicaid								
2. Identification of magnitude of market not subject to single payer: Medicare, TRICARE, FEHP, non-residents								
	20.00	18.00	5.00	43.00	\$ 3,800	\$ 5,400	\$ 1,900	\$ 11,100
3. Identification of existing total health expenditures by source and reimbursement levels								
	10.00	8.00	2.00	20.00	\$ 1,900	\$ 2,400	\$ 760	\$ 5,060
4. Identification of proposed reimbursement rates by source								
	5.00	4.00	2.00	11.00	\$ 950	\$ 1,200	\$ 760	\$ 2,910
5. Estimate magnitude of uncompensated care existing								
What level will remain after single payer is implemented	5.00	4.00	2.00	25.00	\$ 950	\$ 1,200	\$ 760	\$ 2,910
Review existing research	5.00	4.00	2.00	25.00	\$ 950	\$ 1,200	\$ 760	\$ 2,910
6. Comparison of proposed reimbursement rates to existing including consideration of reduction for uncompensated care								
	5.00	4.00	2.00	11.00	\$ 950	\$ 1,200	\$ 760	\$ 2,910
7. Estimate of change in mix of demand for services								
Review existing research regarding morbidity of various segments	5.00	4.00	2.00	11.00	\$ 950	\$ 1,200	\$ 760	\$ 2,910
Review existing research already completed regarding single payer systems	4.00	8.00	10.00	22.00	\$ 760	\$ 2,400	\$ 3,800	\$ 6,960
Total (a)	79.00	72.00	32.00	183.00	\$ 15,010	\$ 21,600	\$ 12,160	\$ 48,770

(b) Extent to which utilization of services will increase	20.00	18.00	5.00	43.00	\$ 3,800	\$ 5,400	\$ 1,900	\$ 11,100
1. Identification of utilization of existing services in Hawaii								
Commercial								
Medicare								
Medicaid								
Uninsured								
TRICARE								
FEHP								
Non-residents versus residents								
Uninsured								
2. Identification of demographics of each sector	5.00	4.00	2.00	11.00	\$ 950	\$ 1,200	\$ 760	\$ 2,910
3. Identification of existing benefit levels by source of insurance	10.00	8.00	2.00	20.00	\$ 1,900	\$ 2,400	\$ 760	\$ 5,060
4. Comparison of existing benefit levels to proposed levels by source	10.00	8.00	2.00	20.00	\$ 1,900	\$ 2,400	\$ 760	\$ 5,060
5. Build model incorporating utilization assumptions based upon changes in cost sharing provisions, provider reimbursement levels	30.00	25.00	15.00	70.00	\$ 5,700	\$ 7,500	\$ 5,700	\$ 18,900
Total (b)	75.00	63.00	26.00	164.00	\$ 14,250	\$ 18,900	\$ 9,880	\$ 43,030
(c) Extent to which mandated service will be used as a substitute for a more expensive service and result in cost savings								
1. Analysis of emergency room utilization	5.00	4.00	2.00	11.00	\$ 950	\$ 1,200	\$ 760	\$ 2,910
2. Identification of magnitude of hospital admissions that may be avoided if access to care is not limited	5.00	4.00	2.00	11.00	\$ 950	\$ 1,200	\$ 760	\$ 2,910
3. Build model	20.00	15.00	5.00	40.00	\$ 3,800	\$ 4,500	\$ 1,900	\$ 10,200
Total (c)	30.00	23.00	9.00	62.00	\$ 5,700	\$ 6,900	\$ 3,420	\$ 16,020

(d) Extent to which administrative expenses and premiums will change

1. Identification of existing administrative costs insurers including HMOs providers	12	12	4	52	\$ -	\$ -	\$ -	\$ -
					\$ -	\$ -	\$ -	\$ -
					\$ 2,280	\$ 3,600	\$ 1,520	\$ 7,400
2. Build model to take into consideration changes in administrative services for affected markets, incorporating costs for unaffected markets	20	20	5	45.00	\$ 3,800	\$ 6,000	\$ 1,900	\$ 11,700
					\$ -	\$ -	\$ -	\$ -
3. Build model incorporating changes in costs, utilization and admin	20	20	5	45	\$ 3,800	\$ 6,000	\$ 1,900	\$ 11,700
Total (d)	52	52	14	118	\$ 9,880	\$ 15,600	\$ 5,320	\$ 30,800
(e) Effect of mandating coverage on the total cost of health care								
1 Analysis for three provider reimbursement levels incorporating results from (a0d)	20	15	10	45.00	\$ 3,800	\$ 4,500	\$ 3,800	\$ 12,100
(f) Effect on access, employers' ability to purchase policies								
Identification of existing costs as percentage of payroll	5	5	2	12.00	\$ 950	\$ 1,500	\$ 760	\$ 3,210
Proposed costs	5	5	2	12.00	\$ 950	\$ 1,500	\$ 760	\$ 3,210
Analysis of impact	10	10	4	24.00	\$ 1,900	\$ 3,000	\$ 1,520	\$ 6,420
Total (f)	20	20	8	48.00	\$ 3,800	\$ 6,000	\$ 3,040	\$ 12,840
Prepare Report	35	30	20	85.00	\$ 6,650	\$ 9,000	\$ 7,600	\$ 23,250
Revisions from first draft	15	15	10	40.00	\$ 2,850	\$ 4,500	\$ 3,800	\$ 11,150
Project Management			35	35.00	\$ -	\$ -	\$ 13,300	\$ 13,300
Total A	311.00	275.00	154.00	740.00	\$ 59,090	\$ 82,500	\$ 58,520	200,110.00

B. Analyze the cost and benefit differential between single payer system and current system

Essentially all the research has been completed.	12	18	19	49.00	\$	2,280	\$	5,400	\$	7,220	\$	14,900
Identify pros and cons												
Write analysis												

C. Evaluate whether the existing Hawaii healthcare delivery system can support a single payer system

Estimate number of providers required for population demographic	5	5	2	12.00	\$	950	\$	1,500	\$	760	\$	3,210
Compare with existing providers	5	5	2	12.00	\$	950	\$	1,500	\$	760	\$	3,210
Compare with other single payer analysis	5	5	2	12.00	\$	950	\$	1,500	\$	760	\$	3,210
Analysis	10	10	5	25.00	\$	1,900	\$	3,000	\$	1,900	\$	6,800
Sub-total	25	25	11	61.00	\$	4,750	\$	7,500	\$	4,180	\$	16,430

D. Evaluate the effects that a single payer system will have on providers including their ability and willingness to stay in Hawaii

Analyze existing provider revenues by sources	5	5	5	15.00	\$	950	\$	1,500	\$	1,900	\$	4,350
Analyze proposed provider reimbursement by sources	5	5	5	15.00	\$	950	\$	1,500	\$	1,900	\$	4,350
Sub-total	10	10	10	30	\$	1,900	\$	3,000	\$	3,800	\$	8,700

Will providers be required to participate?

E. Evaluate the costs associated with non-Hawaii residents moving to Hawaii to take advantage of single payer system

Evaluate living costs in Hawaii compared to rest of U.S.	4	4	1	9.00	\$	760	\$	1,200	\$	380	\$	2,340
Evaluate costs of moving to Hawaii	4	4	2	10.00	\$	760	\$	1,200	\$	760	\$	2,720
Analysis	4	4	5	13.00	\$	760	\$	1,200	\$	1,900	\$	3,860
Sub-total	12	12	8	32.00	\$	2,280	\$	3,600	\$	3,040	\$	8,920

Grand Total 249,060.00

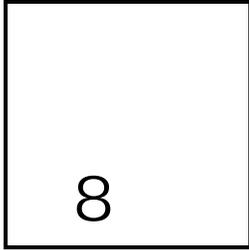
Average hourly rate \$ 273

Qualitative Approach

In the Qualitative Approach we conduct a review of the existing research that has been completed regarding a single payer system. We will apply the results of this approach very broadly to the Hawaii market. There will be no modeling of the Hawaii-specific market. We will discuss, in general the differences in provider reimbursement levels by broad category, discuss various estimates on the impact of uncompensated care on providers, review the general level of benefits in the existing market, discuss what the literature indicates are possible ramifications of a single payer for only part of the market.

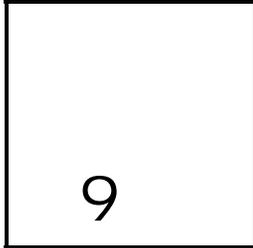
While this approach does not involve the modeling of the Quantitative Analysis, it certainly can provide HUP/HIPA with summaries of the ranges of the impacts on various components. This could enable HUP/HIPA to focus on particular issues, elect to proceed with the entire Quantitative Approach, or possibly provide enough information to elect a different course of action.

We will complete the Qualitative Approach for a budget of \$75,000.



Conflicts of Interest (Section VII, A7 of the RFP)

To our knowledge, we have no conflict of interest that would preclude our ability to render an objective analysis of the proposed single payer system.



References

Vermont Department of Banking, Insurance, Securities and Health Care Administration

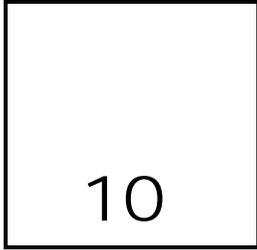
Contact: Mr. Herb Olson
General Counsel
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Montpelier, VT 05620-3601
Phone: 802-828-4869

Florida Department of Financial Services

Contact: Mr. Frank P. Dino
Chief Actuary
Office of Insurance Regulation Life & Health Forms & Rates
Address: 200 East Gaines Street
Tallahassee, FL 32399-0328
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National Small Business Association

Contact: Mr. Todd O. McCracken
President
Address: 1156 15th Street, NW
Suite 1100
Washington, DC 20005
Phone: (202) 293-8830



Resumes

Karen K. Bender, FCA, ASA, MAAA

Karen is a Principal in the Mercer Oliver Wyman Milwaukee office. She specializes in health care and supports the actuarial needs of risk assuming entities in the insurance and managed care industry. This includes providing consulting services to insurance and managed care companies, governmental entities as well as providers.

Karen has 30 years of experience as a managed care health actuary as well as traditional insurance. Her experience includes pricing of products for the individual market, small group market, large group market as well as the pricing of drug, vision, dental and specialty HMO products. She has developed underwriting manuals as well as policy forms; designed reporting and experience systems; forecasting models and pricing models for the entire spectrum of health care benefits.

Karen is qualified to provide opinions for statutory annual statements. She helped formulate practice guidelines regarding reserves for health insurers for the American Academy of Actuaries (AAA). She served as the chairperson of the committee created by the AAA charged with developing standards for provider liabilities for health insuring entities for the National Association of Insurance Commissioners (NAIC).

She is currently the Chairperson of the AAA Association Health Plans (AHP) Workgroup and has been on the Workgroup since its inception, Vice Chairperson of the State Health Committee of the AAA, a member of the AAA Individual Health Rating Filing Committee which recently submitted its recommendations to the NAIC, AAA Defined Contributions (Consumer Driven) Committee, AAA HSA Committee and the AAA Reinsurance Committee.

Karen is Fellow in the Conference of Consulting Actuaries, an Associate in the Society of Actuaries, and a member of the American Academy of Actuaries. Karen has degrees in mathematics and economics. She is a Qualified Health Actuary (QHA), and to her knowledge, is the only QHA who subsequently obtained the Associate in the Society of Actuaries (ASA) credentials.

Karen has co-authored several papers including "Impact of Association Health Plan Legislation on Premium and Coverage for Small Employers," "Impact of Prior Approval Requirements for Rate Changes of Small Employer Group and Individual Health Policies" and the semi annual Mercer Oliver Wyman Trend Survey. Karen is a frequent speaker at professional meetings.

Kurt J.F. Giesa, FSA, MAAA

Kurt is a Director and the leader of the Milwaukee office of Mercer Oliver Wyman Actuarial Consulting, Inc. He has over 17 years of actuarial experience working with health insurers, health care providers, and state regulatory agencies.

His work with health insurers includes the development of trends, the design of group health and HMO rating techniques, rating specialized coverages, estimating actuarial liabilities, developing capitation rates and agreements, financial reporting, developing health care budgets, Medicare Advantage and Medicaid risk contracting, product design, regulatory filing, and litigation support.

His work with health care providers includes assistance in contracting with payers, the design of capitation and risk-sharing mechanisms, the development of fee schedules, HMO creation, and the development of business strategies to anticipate and respond to a changing environment.

His work with state regulatory agencies includes the review of health insurance rate filings, the development of regulation, specifically small group, health reform regulation and long-term care insurance regulation, the examination of health plans' and health insurers' financial condition, and special studies for state regulators in support of legislative committees.

Kurt graduated *cum laude* from the University of Washington with a double major in mathematics and English. He received an MBA from the University of Wisconsin at Madison, with an emphasis in actuarial science. At the University of Wisconsin at Madison, he won the Bicknell Scholarship.

He is a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. He is active in the actuarial profession. He is an editor of the Society of Actuaries' *Record*. He serves on the Society of Actuaries' Project Oversight Group responsible for overseeing a morbidity study. He has served on the Fall Group and Health Benefits Examination Committee of the Society of Actuaries, and has published in the Society of Actuaries' professional journals. In addition, he is a frequent speaker at actuarial meetings.

Beth R. Fritchen, FSA, MAAA

Beth is a Senior Consultant with Mercer Oliver Wyman Actuarial Consulting, Inc. Her primary responsibilities are in the area of health insurance consulting. In particular, she provides consulting services to state regulatory agencies, health insurance companies, Medicare Advantage Organizations and health care providers.

Her present responsibilities include product development for managed care and traditional plans, trend analysis, review of filings for state insurance departments, fee schedule analysis, financial management and forecasting, compliance, underwriting issues, provider capitation development, mental health pricing, Medicare capitation development, Medicaid capitation development, reserve analysis, and legislative analysis.

She has extensive experience with Medicare Advantage, Medicare supplemental and Medicare Select products. She routinely reviews filings for state insurance departments, and has participated in rate hearings regarding Medicare supplement products. She has priced these products for insurance companies and understands the unique characteristics of these products and the population who purchase these products. In addition she is familiar with the requirements these products must meet, both at the state level and at the Federal level.

Prior to joining Mercer Oliver Wyman, she was an actuarial analyst with Wisconsin Physicians Service. During this time she worked with HMO rating, product development, group health reserves, group rating, and other aspects of group health insurance.

She is a member of the American Academy of Actuaries, and a Fellow of the Society of Actuaries. She graduated from the University of Wisconsin-Madison with a Bachelor of Science degree, majoring in mathematics with an emphasis in actuarial science.

Beth has co-authored several papers including “Impact of Association Health Plan Legislation on Premium and Coverage for Small Employers”, “Impact of Prior Approval Requirements for Rate Changes of Small Employer Group and Individual Health Policies” and the semi annual Mercer Oliver Wyman Trend Survey.

Tammy P. Tomczyk, FSA, MAAA

Tammy is a Consultant in the Milwaukee office of Mercer Oliver Wyman Actuarial Consulting, Inc. She has ten years of experience in the health care, actuarial field. Her primary responsibilities are in the area of health insurance consulting.

Tammy provides consulting services to insurers and providers on health insurance pricing, reserving, financial reporting, provider contracting, trend, and underwriting issues. She also assists insurer clients in the preparation of small group certifications and product development issues. In addition, she provides consulting services to regulatory agencies on health, credit and long-term care insurance.

In addition to experience pricing both traditional and managed care products, Tammy has also priced dental and prescription drug programs.

Prior to joining Mercer Oliver Wyman, Tammy was a Pricing Actuary at United Wisconsin Services, Inc. Her primary duties included pricing group PPO, POS and HMO business, renewal rating for large employer groups, trend analysis, financial forecasting, expense studies, product development, and other special studies.

Tammy has used her programming experience to develop various pricing and financial forecasting models, as well as reporting systems.

Tammy is a Fellow in the Society of Actuaries and a member of the American Academy of Actuaries. Tammy graduated *cum laude* from the University of Wisconsin Whitewater with a Bachelor of business administration degree, majoring in finance and mathematics.

Jeremiah Reuter

Jeremiah is a Consultant in the Milwaukee office of Mercer Oliver Wyman Actuarial Consulting, Inc. His primary career focus has been in the health insurance area. He has worked with health insurance plans, Medicare Advantage Organizations, state regulatory agencies and health care providers.

His present responsibilities include data analysis and management, development of actuarial models used in pricing traditional and managed care health insurance products, fee schedule analysis and provider contracting, health care trend analysis, health insurance rate filings and compliance and analysis of financial information of health insurance companies and Medicare Advantage Organizations.

Prior to joining Mercer Oliver Wyman, Jeremiah was a Managed Care Actuary at Assurant Health (fka Fortis Health). The primary focus of his work was in the provider contracting area where he was responsible for pricing PPO networks, monitoring the experience of the contracts and performing ad hoc reviews to determine the main drivers of increasing health costs. In addition, he developed actuarial models to analyze the pharmacy experience and pricing of pharmacy benefits, determined the value of the savings associated with various pharmacy benefit managers (PBMs) and analyzed PBM performance reports.

Jeremiah graduated *magna cum laude* from Mayville State University with a double major in mathematics and physical science. He also holds a Master of Science degree in mathematics from the University of North Dakota. He is currently pursuing his Associate designation with the Society of Actuaries.

Joshua E. Sober

Josh is an Actuarial Analyst in the Milwaukee office of Mercer Oliver Wyman Actuarial Consulting, Inc. He provides consulting services to health insurers, Medicare Advantage organizations, managed care organizations, health care providers and state regulatory agencies.

His present responsibilities include health insurance rate filings, pricing of health benefits, reserving, and regional analysis of managed care organizations.

Prior to joining Mercer Oliver Wyman, Josh was an actuary with Assurant Health. His primary focus was in the development of new experience monitoring systems in support of the pricing and sales areas. Josh's other responsibilities included periodic analysis of Assurant's small group product line, ad hoc analysis for upper management, and testing and development of proprietary software. He was also involved with the pricing and forecasting areas to aid in developing assumptions for their respective models.

Josh graduated with honors from Michigan State University with a Bachelor of Science degree in mathematics. He is currently pursuing his Associate designation with the Society of Actuaries.

Susan M. Poole

Susan serves in an internship position in the Milwaukee office of Mercer Oliver Wyman Actuarial Consulting, Inc. She is engaged in varied projects selected to familiarize her with actuarial work, and she assists with client services under the supervision of organization consultants.

Currently a graduate student at the University of Wisconsin – Milwaukee, Susan will be completing a Master of Science degree in education psychology in December 2005. Her program of studies reflects a specialization in research and evaluation with substantial work in statistical analysis and educational measurement. She is presently responsible for longitudinal analyses of standardized test data for schools chartered through the university.

Susan's previous professional responsibilities include instructing graduate courses in statistics and programming and conducting research in human movement science. Prior to her current educational pursuit, Susan earned a Master of Science degree in human kinetics and a Bachelor of Arts degree in recreation management.

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