



AMERICAN ACADEMY *of* ACTUARIES

June 3, 2010

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: DHHS-9996-IFC
P.O. Box 8014
Baltimore, MD 21244-8014

Re: Comment to DHHS-9996-IFC, Interim Final Rule on Early Retiree Reinsurance Program

To Whom It May Concern:

On behalf of the American Academy of Actuaries' Joint Committee on Retiree Health, I submit the following comments on the interim final rule (DHHS-9996-IFC) to implement Sec. 1102 of the *Patient Protection and Affordable Care Act* (PPACA). This provision establishes a temporary reinsurance program for early retirees.

Early Retiree Definition

The rule defines "early retiree" as a plan participant age 55 or older and not eligible for Medicare. In addition, covered dependents of the early retiree are deemed eligible for the reinsurance payments. This definition should provide clear guidance with regard to some typical situations. For example, certain individuals are not eligible for Medicare at age 65 because they work for an entity that opted out of the program or they do not have enough credits under the system to be eligible for coverage. At the same time, some spouses and dependent children of early retirees may be eligible for Medicare. As the rule is written, it appears that these dependents are covered under the reinsurance program.

Data Requirements to File for Reinsurance Program

The goal of the reinsurance provisions under PPACA is to reduce plan costs for the plan sponsor offering group health insurance to early retirees. We agree that this goal can be achieved without burdensome administrative requirements or lengthy reporting exercises. We also agree that a filing procedure that mirrors the reporting steps required to file for a retiree drug subsidy under the *Medicare Modernization Act* of 2003 would adequately provide the needed information.

Insurance carriers will now have to track early retirees between ages 55 and 65 (and their dependents) in order to satisfy reporting requirements for the reinsurance. The claims experience of the retiree group younger than age 65 will have to be identified separately. The separate tracking and reporting of claims experience for this retiree group will likely result in additional retention charges to the plan sponsor. Allowing the use of reinsurance funds to be at the discretion of the plan sponsor as stated in the interim rules will help offset additional charges made by the insurance carrier to the plan sponsor.

We encourage HHS to specify in the regulations (or companion interim rule) a checklist of data items needed to support the plan sponsor's filing for the reimbursement. The list of data items needed to support a sponsor's application for reinsurance should be provided to the sponsor upon notification by HHS that the initial application is acceptable and complete.

Funding Limitation

The interim rule, as written, would allow the Secretary to stop accepting applications once there appeared to be sufficient requests to exhaust the available funding. We suggest that instead of limiting applications to a potentially arbitrary funding limit, a specific application period be established (e.g., July 1, 2010 through Aug.15, 2010). The prorate payment process suggested later in this letter addresses how payments are made to allow for the funding limit imposed by the PPACA.

Two-Year Reinsurance Estimate

We have concerns about the requirement under Sec. 149.40(f)(6) of the interim rule for a projection of expected reimbursements under the program in the first two years. The request for such projection implies that these estimates will be used to cut off applications submitted by plan sponsors. This encourages plan sponsors to be overly optimistic (i.e., estimate high expected payments) because it could be used to freeze out other plan sponsors from participating in the program. This could be exacerbated if a few very large employers are the first applications processed.

One suggestion for avoiding complaints or inequity in the application process is to set a fixed period to make applications (e.g., June 15 through June 30). This way, all applicants can be accepted. It also avoids a reliance on reinsurance estimates that would be calculated in a variety of ways and likely overestimate the actual payment cash flow. Because the short application period may not provide enough time to remediate, applications should not be rejected for minor issues.

Another suggestion for keeping the total reinsurance payments under the established limit is described in the section on *Allocation of Funding*.

Pharmacy Rebates

Estimation of pharmacy rebates are not discussed in Subpart C of the interim regulations regarding reinsurance amounts. We suggest that the rule either explicitly state that rebates are not to be considered in determining the reinsurance amount or provide a process in order for plan sponsors to make estimates. Again, due to the temporary nature of this program and the fact that pharmacy rebates will have a small impact on the calculation, we suggest explicitly stating that rebates do not need to be considered.

Retiree Cost-Sharing Payment Documentation

Sec. 149.335(b) of the interim final rule requires "prima facie evidence that the early enrollee paid his or her portion of the claim." In general, claim administrators do not audit providers to assure that patient obligations are paid. In most cases, the patient does pay the required cost sharing, but occasionally a provider may forgive a portion of the payment due to hardship reasons. The prevalence of forgiving a portion of the payment is not widespread and given the

temporary nature of this reinsurance program, we suggest removal of this language because there is nothing that a plan sponsor can submit to support that an early enrollee has paid his or her share of the cost. Additionally, the current retiree drug subsidy (RDS) program under Medicare does not require any evidence that a patient has paid his or her portion of the pharmacy claim.

Allocation of Funding

Our understanding is that the intent of this reinsurance program is to provide affordable coverage to the early retiree population prior to the establishment of the insurance exchanges in 2014. The first-come, first-served claim payment procedure described in the interim rule seems to be counter to this purpose. If the \$5 billion allocated by PPACA to fund the program is exhausted in the first couple of years, there are two years during which retirees could be vulnerable. We suggest an alternative strategy to paying the claims.

We believe that if most plans covering retirees between ages 55 and 64 apply for claims reimbursement, the \$5 billion allocated to fund the program will be insufficient to cover claims over the entire period through Dec. 31, 2013. To stabilize premiums net of reimbursements we suggest that the \$5 billion funding be allocated by calendar year, with a smaller allocation to the short 2010 year and taking into account projected increases in claims due to increases in the medical CPI. Within each calendar-year period (including the short 2010 year), funding would be allocated to each plan's claims in proportion to its relationship to total calendar-year claims submitted.

The rule states that claims will be processed based on the date of service (Sec.149.100 states that it is based on "claims incurred during the plan year"). As such, some lag time will need to be included in the reimbursement process. Unlike pharmacy claims collected under RDS that are adjudicated within days, medical claims typically take a month or longer to process. Because of this typical claim lag, actual payment calculations will need to be made months after the incurred period. We suggest that the reinsurance payments be based on a calendar basis (calendar quarter or year)—regardless of the legal plan year. Otherwise, it may put some plan sponsors at a disadvantage because of the time necessary for an early retiree to accumulate costs in excess of the cost threshold during a year.

To aid plan sponsors budgeting future net premiums, it would be helpful if the application for participation in the program included a request for information as to the number of early retirees between the ages of 55 and 64 who are covered by the plan. If the grand total of the numbers of all applicants accepted were publicly available, it would aid plan sponsors in making rough estimates of the proportion of their reinsurance claims that might be reimbursed. For example, if at the beginning of 2012, plan sponsors are told that there is \$1.5 billion remaining of the allocation and that there are 5 million covered plan members requesting the reinsurance, they will know that only \$300 per member will be available that year.

If a process similar to the above is not adopted, there will need to be some control(s) on claim submission. Again, the larger programs would be in a position to submit claims on a daily basis, which would put smaller programs at a disadvantage. There should only be periodic times that claims would be adjudicated (monthly or quarterly) and when it gets to the end of the available

funding, all claimants should be able to receive partial payments—not totally shut out on the basis of first-come, first-served.

* * * * *

We would appreciate the opportunity to discuss any of these items with you at your convenience. If you have any questions or would like to discuss these items further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

Dale H. Yamamoto, MAAA, FSA, FCA, EA
Chairperson, Joint Committee on Retiree Health
American Academy of Actuaries