Oct. 4, 2011

Guenther Ruch
Chair, NAIC Medigap PPACA Subgroup
Senior Issues Task Force
National Association of Insurance Commissioners

Re: NAIC Discussion Paper on Medicare Supplement Insurance First Dollar Coverage and Cost-Shares

Dear Mr. Ruch,

The American Academy of Actuaries[1] Medicare Supplement Work Group appreciates the opportunity to provide comments to the NAIC Medigap PPACA Subgroup on its discussion paper, *Medicare Supplement Insurance First Dollar Coverage and Cost-Shares*. The work group that developed this letter consists of actuaries who have particular expertise in the area of Medicare Supplement insurance. Our objective in offering these comments is to provide you with an actuarial perspective on the information presented in the discussion paper. Rather than refer to specific sections of the discussion paper, we provide overall comments on the key issues and considerations, some of which are found throughout the paper.

As you probably are aware, the Academy has been outspoken in recommending that policymakers develop sound public policy proposals to improve the long-term solvency and sustainability of the Medicare program. Accomplishing this goal will require slowing the growth in health spending. As part of an overall strategy to improve Medicare sustainability, the ACA directs the Secretary of HHS to request the NAIC to consider changes to Medicare Supplement insurance. It is important to evaluate the effects, both intended and unintended, of such changes on Medicare costs, access, and quality of care as well as the effect on current and future Medicare Supplement policyholders.

We have organized our comments below into two categories: 1) issues that already have been addressed in the NAIC discussion paper and 2) questions related to the recent Congressional Budget Office (CBO) report[2] and estimates.

[1] The American Academy of Actuaries is a 17,000 member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

[2] Congressional Budget Office. *Reducing the Deficit: Spending and Revenue Options.* (March 2011). *http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf*

Issues addressed in the NAIC discussion paper

Individuals most affected

The PPACA subgroup notes that those individuals who are most affected by additional cost sharing already have paid substantial premiums for coverage. Introducing additional cost sharing also is a rate equity, reserving, and administrative issue for issue-age rated (or otherwise prefunded) policies. The introduction of cost-sharing, however, can be expected to reduce future premium rates, all else being equal, although not necessarily on a dollar-for-dollar basis. In addition, if the result of additional cost sharing is an overall reduction in Part B utilization, then future premium rates would be even lower than they would have been otherwise.

Impact of Cost Sharing

Items 12 and 13 in the discussion paper address whether cost sharing encourages policyholders to be more cost conscious in their use of medical care and whether this is influenced by payment being made at the point of service. Our work group assumes that any introduction of nominal cost sharing to the Medicare Supplement market will be accompanied by an informational/educational campaign targeted to the public. The work group believes that both patients and providers should be aware of coverage provisions and financial implications regardless of the time of payment.

One of the factors that could influence an individual's decision to seek medical services is his or her financial ability to cover the costs of those services. In many cases this may not be based solely on an individual's awareness of his or her health needs (i.e., self-diagnosing). For the Medicare population, which is older and more easily compromised by diseases and chronic conditions, delay of health care services may have a much larger impact on the need for and cost of medical care.

The issue is whether a Medicare beneficiary considers the presence of supplemental coverage when seeking medical advice or treatment. Any conclusions should consider incentives for both the patient's decision to seek care and the level and degree of care a provider may offer. As noted in Section 3210 of the ACA, however, any changes to incorporate nominal cost sharing must be based on appropriate evidence or current examples used by integrated delivery systems. Any evidence that nominal cost sharing encourages the use of appropriate (or discourages the use of inappropriate) Part B services should reflect the senior population. In addition, such evidence should demonstrate that utilization of unnecessary services would be reduced and that no significant delay of needed care or further increases in future medical care and expense would result. As the PPACA subgroup recognized in the white paper, its research does not appear to have uncovered any published peer reviewed journal articles or examples that meet these criteria. To the extent it would be practical, insightful, and applicable to the senior population beyond the current research to date, it may be helpful and we would encourage the subgroup to reach out to other insurers with integrated delivery systems.

Determination and enforceability of medical necessity

The paper implies that the underlying Medicare program causes higher utilization of medical services and that supplemental coverage (which is required to rely on Medicare's determination

or definition of medical necessity) is not a significant contributing factor to the over utilization of medical services. This point may be debatable, but it appears to be a separate issue from whether cost sharing will serve to alleviate the problem.

We encourage you to consider the extent to which private Medicare Supplement insurers' fraud and abuse programs have an impact on the final medical necessity determination and how much emphasis would be placed on these programs in the future if the insured portion of the beneficiary obligation is reduced.

Additional questions specific to the recent CBO report and estimates

It may be useful to request information from the CBO to answer certain questions on the assumptions (explicit or implicit) used to estimate savings under Medicare Supplement-related options. For instance:

- Are there explicit assumptions and modeling with respect to reduced utilization of necessary services and unnecessary services?
- Do savings result from Medicare Supplement changes on all in-force policies or just policies issued in 2013 and later?
- What is the projected volume of Medicare Supplement coverage through the years, and are there any explicit assumptions regarding reductions in coverage exposure as a result of individuals dropping their coverage and/or shifting to other types of supplemental coverage?
- Are there explicit assumptions regarding cost shifting to higher-intensity services in conjunction with assumed reductions in what are defined as unnecessary services?

In addition to seeking additional information from the CBO, it also may be appropriate for the subgroup to request similar information from the Centers for Medicare & Medicaid Services' Office of the Actuary.

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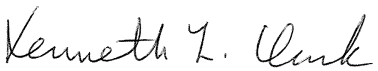
Our comments are intended to identify areas for further consideration and suggest issues that should be clarified or expanded upon in the final recommendation. We welcome the opportunity to discuss any of the above comments with you at your convenience. If you have any questions or would like to discuss these comments further, please contact Tim Mahony, the Academy's state health policy analyst (202.223.8196; Mahony@actuary.org).

Sincerely,



Kenneth L. Clark
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American Academy of Actuaries