



# AMERICAN ACADEMY *of* ACTUARIES

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August 27, 2010

Office of Consumer Information and Insurance Oversight  
Department of Health and Human Services  
Attention: OCIO-9994-IFC  
P.O. Box 8016  
Baltimore, MD 21244

To Whom It May Concern:

On behalf of the American Academy of Actuaries'<sup>1</sup> Benefits and Eligibility Work Group, I appreciate the opportunity to provide comments to the Departments of Health and Human Services, Treasury, and Labor in response to the interim final regulations (IFR) on the elimination of preexisting condition exclusions, the elimination of lifetime limits and restrictions on annual limits, and other patient protections. These regulations implement provisions in the *Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010* (referred to collectively as the *Affordable Care Act* or ACA)

To provide a broad perspective on the issues addressed in this interim final regulation, this work group includes actuaries representing a cross section of the health insurance market. We would like to offer the following comments and requests for clarification related to guaranteed issue for children younger than 19, annual and lifetime limits, and emergency services.

## **Elimination of Pre-Existing Condition Exclusions/ Guaranteed Issue for Children Younger Than 19**

ACA prohibits an insurer from denying claims for children younger than 19 because of preexisting conditions. With the issuance of the interim final regulations, the waiver of the preexisting condition clause has been expanded to require guaranteed issue for all children younger than 19. In insurance there is a material difference between the elimination of the preexisting conditions clause and the guaranteed issue of coverage. The elimination of the right to deny claims because of preexisting conditions does not mean that an insurer must issue the coverage. Once an insurer issues coverage, however, it cannot deny any claims attributable to a preexisting condition. While a guaranteed issue requirement means an insurer must issue coverage, an insurer still may deny claims for preexisting conditions—usually for a specified period of time. This is most observable in high-risk pools in which individuals must be issued coverage, but typically a waiting period exists before claims for preexisting conditions are eligible for payment.<sup>2</sup>

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<sup>1</sup> The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public on behalf of 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 qualification, practice, and professionalism standards for actuaries in the United States.

<sup>2</sup> Kaiser Family Foundation, *State High Risk Pool Pre-Existing Condition Exclusion and Look Back Periods*. (January 2009) <http://www.statehealthfacts.org/comparetable.jsp?cat=7&ind=604>

The interim final regulations have merged these two concepts, resulting in the requirement for insurers to guarantee issue coverage to children younger than 19 without any limitations for preexisting conditions. This merger materially increases the cost of coverage over the cost of a policy with only a preexisting condition exclusion. In addition, this provision creates the potential for significant anti-selection (and, therefore, higher future costs) as parents or legal guardian might seek coverage only if a child develops a serious health condition. While HHS has indicated that open-enrollment periods can be created to mitigate this concern, insurers are not required to coordinate the timing of these open-enrollment periods. As such, continuous guaranteed issue could exist, which would discourage the purchase of insurance for healthy children.

### **Economic Incentives for Anti-Selection**

The combination of preexisting and guaranteed-issue rules may encourage a financially prudent family with healthy children to defer purchase of insurance until a child gets sick. As long as there is at least one carrier with an open-enrollment period available at any time during the year, and no penalty for deferral, then there is an economic incentive to defer purchase of insurance. In addition, with the enactment of ACA, parents or guardians of children with *existing* uninsurable high-cost medical conditions will have a higher economic incentive to purchase coverage than those with little to no current expected costs for medical conditions. This combination of factors may encourage anti-selection and, subsequently, higher claim costs.

### **Group Insurance**

#### *Employer Perspective*

In the group insurance market, employer contributions toward dependent coverage can vary significantly depending on the size of the employer. It is common for very small employers to contribute only a small amount toward an employee's premium and little or nothing toward the premium for dependents.<sup>3</sup> Under ACA, employers may have a financial incentive to encourage an employee, who wants to include a child with higher-than-average health care costs on his or her family plan, to waive that child's group coverage. For example, the employer may pay a child's individual insurance premium on behalf of the employee parent/guardian. The employer also may make up any differences in benefits between the group policy and the individual policy. Prior to the effective date of the IFR, an unhealthy child could not obtain coverage in the underwritten individual market, nor could the child obtain coverage in a state high-risk pool if he or she is eligible for group insurance coverage. This concern disappears if continuous guaranteed issue is not available in the individual market (e.g., with a limited open-enrollment period).

The incentives for small employers to take the above actions are real, particularly in states in which carriers currently have flexibility in determining small group rates based on the aggregate morbidity of a particular small group (and, therefore, a small group's premium can be significantly affected by an individual's claims). The incentives, however, are not limited to small employers. There also would be incentives for fully-insured large employers or self-insured groups, that rate on their own claims experience, to identify high-cost children and encourage the employee (the parent/legal guardian of the higher-cost child) to purchase child-only policies in the individual market. These employers also may assist with the premiums. This would lower costs for the employer's fully insured or self-insured plan.

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<sup>3</sup> Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 2009 Annual Survey*. (<http://ehbs.kff.org/pdf/2009/7936.pdf>)

The availability of guaranteed issue coverage without preexisting condition limitations in the child-only individual market also could result in some employers choosing not to contribute to child coverage.

### *Employee Perspective*

If the regulations impose guaranteed issue and no preexisting condition limitations, employees with lower-cost dependent children who are currently insured through employer group contracts may have an economic incentive to drop coverage for their children (and not seek coverage in the individual market), especially if the employee contribution is high. Depending on the structure of the open-enrollment period, it is likely that coverage could be available in the individual market if the child becomes unhealthy in the future. Employees with higher-cost dependent children will have the incentive to retain coverage through their employers, even if the employee contribution is high. The potential combination of lower-cost children exiting the employer group pool while higher-cost children remain could exert upward pressure on claim costs and premiums in the group market. It is unclear whether this effect of anti-selection was considered in the economic impact analysis of the IFR.

### **Individual Market**

An individual market that allows coverage for children without required coverage of parents will experience the results of anti-selection as children move from the group market. One example of circumstances that could result in anti-selection arises from various types of open-enrollment periods:

If there is a fixed 30-day open-enrollment period each year, the insurance purchaser likely will wait until the end of the open-enrollment period to make the purchase if the child is healthy. Since the probability of a healthy child incurring high-cost claims in the 60-day period prior to open enrollment is very low, the purchaser likely will wait and purchase at the last possible minute to save several months of premium. After the open-enrollment period, the individual would purchase coverage to avoid a long period without insurance. If insurers are required to guarantee the issue of child-only coverage continuously, the insurance purchaser likely will delay purchase until an illness or injury occurs, potentially saving years of premium payment.

The consequence of this would be an increase in the average claim cost relative to today's environment, since there will be a reduced number of healthy children covered. The claim costs are likely to increase as additional children are insured only when they become unhealthy. The increase in average claim costs will necessitate an increase in average premium. This potentially could produce an insurance rating spiral—with an increase in premiums, healthier children will drop out of the pool, increasing the cost for those remaining and leaving only the highest-cost insureds over time. We believe all scenarios should be considered carefully in the development of rules to minimize such unintended consequences.

### *Open Enrollment*

HHS has indicated that companies may create open-enrollment periods, if allowed to do so by state law.<sup>4</sup> As indicated previously, the presence of open-enrollment periods by themselves can reduce, but not eliminate, anti-selection.

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<sup>4</sup> Department of Health and Human Services, *Questions and Answers on Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions*. (See Question 2)  
<http://www.hhs.gov/ociio/regulations/children19/factsheet.html>

To minimize anti-selective behavior further, certain principles should be applied in determining the rules surrounding open-enrollment periods. First, an open-enrollment period should encourage coverage to be purchased early, while discouraging any incentive to postpone securing coverage. Particularly, the practice of dropping current coverage, but seeking future coverage on a “just-in-time” basis should be discouraged.

- A corollary to this principle is that the frequency and duration of open-enrollment periods must balance the need for access to insurance with the need to discourage anti-selection.
- There will be a need to coordinate the timing of the open-enrollment period(s) among all the carriers to avoid a situation in which there is an open-enrollment period occurring continuously, which discourages the purchase of insurance for lower-cost children.
- It may be preferable to have the timing and duration of the open-enrollment period determined by a regulatory entity, either at the state or federal level. This is the current policy for Medicare Advantage and Medicare Part D, for which there are single, predetermined annual open-enrollment periods.

Second, administration of the open-enrollment period should be a process that minimizes administrative expenses and complexities. Simple rules for open-enrollment periods, such as November or December of each year, are administratively efficient and inexpensive. Complex rules, such as those based on birth dates unrelated to the birth month or on varying lengths of prior periods without coverage, are inefficient and administratively expensive.

Finally, there should be a balance among these two principles to maximize access to insurance while minimizing anti-selection.

#### *Third-Party Premium Payers*

Prior to ACA, the vast majority of states allowed carriers and HMOs in the individual market to medically underwrite all applicants and accept them as applied or accept them with a higher premium or reduced coverage. Some states allowed insurers to decline coverage altogether.<sup>5</sup>

Thirty-five states have created high-risk pools for individuals who either have been denied coverage in the individual market or are guaranteed coverage in the individual market as a result of leaving a group contract, as allowed under HIPAA. Thirty-one states that have high-risk pools incorporate limited coverage for preexisting conditions.<sup>6</sup>

A primary policy goal of policymakers responsible for enacting ACA was to increase access to insurance. However, there is the potential for unintended anti-selection that may increase costs in addition to those generated by increased access. For example, HHS allows for the purchase of individual child-only policies by third parties, specifically, but not limited to, Medicaid and Children’s Health

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<sup>5</sup> National Conference of State Legislators, *State High-Risk Pools: Participation and Federal Funding, 2010; State Enrollment in 2008*. Prior to PPACA, five states required guaranteed issue in the individual market: New York, New Jersey, Massachusetts, Vermont and Maine. Three other states required guaranteed issue during an open-enrollment period: Michigan, Ohio and Virginia. Although there is no statutory requirement, the BC/BS plans in Pennsylvania offered open enrollment as insurers of last resort. [http://www.ncsl.org/default.aspx?tabid=14329#2010\\_Pools](http://www.ncsl.org/default.aspx?tabid=14329#2010_Pools)

<sup>6</sup> Kaiser Family Foundation, *State High Risk Pool Pre-Existing Condition Exclusion and Look Back Periods*. (January 2009) <http://www.statehealthfacts.org/comparetable.jsp?cat=7&ind=604>

Insurance Program (CHIP).<sup>7</sup> The provision to allow for third-party payers could create the following scenarios, which threaten the ongoing viability of the *individual child-only market*:

- Government entities will have financial incentives to purchase child-only policies in the individual market for their high-cost members.
- Providers also will have financial incentives, either directly or through affiliated foundations, to purchase individual policies to increase their reimbursement levels.

Prior to ACA, anti-selection generally was managed by underwriting practices. These practices precluded insurance from being purchased only after a child became sick. Practically speaking, it was difficult for third-party payers to purchase insurance for these children. ACA does increase access, but third-party payers may create significant unintended opportunities for anti-selection.

Given the high cost of claims for newborns of low birth weight, as well as the higher cost of claims for children who are unhealthy, insuring a disproportionate share of such children will increase materially the average claims of individual child-only policies. This higher average claim cost, potentially exacerbated by third-party payer anti-selection over a period of time, has the potential to create a rate spiral for child-only policies.

Despite anti-selection concerns, allowing third parties to purchase child-only insurance contracts may provide useful benefits to some segments of the population who have underwriting access—but not affordability access. The following practices could minimize anti-selection associated with premiums paid by third parties:

- Prohibit guaranteed access, even in the open-enrollment period, to those children who might otherwise be eligible for the group market.
- Prohibit guaranteed access, even in the open-enrollment period, to those children eligible for Medicaid or other similar programs, including high-risk pools.
- Allow for rescissions when the presence of third-party premium payers is not disclosed on the application, and enable carriers to recover any claims paid up until that point from the third-party premium payer.

If carriers believe that they are going to be subjected to material anti-selection, they may elect to withdraw from the child-only individual market. This would result in reduced access, reduced insurer competition and fewer choices for individuals who need these policies.

### **Coordination of Benefits /Overinsurance**

A potential unintended consequence of mandating guaranteed issue without the ability to apply preexisting condition exclusions is that, in certain instances, the rules may create a loophole for abuse. Carriers' ability (prior to the IFR) to medically underwrite materially reduces this risk.

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<sup>7</sup>Department of Health and Human Services, *Questions and Answers on Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions*. (See Question 5)  
<http://www.hhs.gov/ociio/regulations/children19/factsheet.html>

In certain instances, current industry practices do not apply coordination of benefits (COB) provisions, nor do they require assignment of benefits<sup>8</sup> for individual coverage. Imposing guaranteed issue without preexisting-conditions exclusions in such an environment could provide individuals with an opportunity to collect more than 100 percent of the cost of care if they have multiple policies in force, which may lead to abuse.

For example, an individual purchases and maintains multiple policies for the months in which he or she obtains all his or her annual preventive care (covered by each policy at 100 percent), an elective surgery, and a few additional and expensive, diagnostic tests. Thereafter, the individual drops all but one policy for the months in which he or she anticipates no routine care.

Industry practices and regulations may need to be changed to eliminate this loophole that could enable abuse. Carriers may need the ability to underwrite for and potentially rescind coverage for policyholders filing the same claims and collecting under multiple policies. Carriers may need the ability to apply COB, and the necessary rules by which to do so, in the individual market.

### **Economic Impact**

It does not appear that the economic impact outlined in the IFR took into consideration many of the opportunities for anti-selection associated with open enrollments, third-party payers, and COB. It also appears HHS assumed any changes in premiums would be spread across the entire individual market, including grandfathered and non-grandfathered plans and all contract types. A more realistic result would be that any additional costs will be spread only to non-grandfathered plans and only to contract types that include a child or children, which is a significantly smaller subset of the entire individual market. This will result in materially higher premium increases for those affected policies.

It also is unclear whether the impact of healthy children leaving employer groups has been considered. The prohibition of preexisting condition exclusions and guaranteed-issue regulation for children younger than 19, when combined with other requirements such as coverage of dependents to age 26 and the insurance mandate that does not become effective until 2014, allows for additional complications not addressed in the economic impact.

### **Annual and Lifetime Limits<sup>9</sup>**

ACA prohibits lifetime dollar limits on “essential health benefits” for plan years beginning on or after Sept. 23, 2010. Plans may impose “restricted” annual dollar limits on essential health benefits until the 2014 plan year. Beginning in 2014, even restricted annual dollar limits will not be permitted. Although not specifically addressed, it appears that these rules apply to both in-network and out-of-network benefits.

### **Additional Capital Required**

With greater coverage for those in need, which is a positive benefit of the legislation, there is associated cost as a result that insurers will have to bear additional risk. The increased liability associated with unlimited annual and lifetime claims will require smaller health carriers and many self-insured employer plans either to hold additional capital or to purchase reinsurance to mitigate this additional risk. Today’s

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<sup>8</sup> Assignment of benefits pertains to the practice of the insurer paying benefits directly to the provider instead of the insured.

<sup>9</sup> Limited-benefit plans and so-called “mini-med” plans are excluded from the scope of the discussion in this section since the regulations provide for a process for these types of plans to be addressed separately by HHS.

reinsurance market does not cover claims fully that are ongoing across years since coverage is limited to a policy or calendar year and is sold on an annually renewable term basis. So, even when companies (i.e., small health carriers and self-insured employers) can purchase reinsurance, they likely will not be able to fully transfer this risk.

### **Impact versus Risk**

The IFR provides an estimate of the number of individuals who are affected (Federal Register, June 28, p. 37217). Based on data utilized, the departments' estimate that 0.033 percent (or 33 for every 100,000) of individuals will incur more than \$1 million in medical spending in a year. The document develops a calculation that 29,000 would incur expenses of at least \$4.7 million by the fifth year. The IFR includes a discussion of why these estimates may be overstated (Federal Register, June 28, p.37218).

Our review of the available data suggests that the number of claims exceeding \$1 million in a year is 10 or fewer per 100,000 covered lives.<sup>10</sup> For those who had a large claim in one year, generally the claim doesn't recur (i.e., the person recovers or dies). Given these factors, it is estimated that not more than 2 per 100,000 will incur \$5 million of claims, in current dollars, over a lifetime. This results in approximately 4,000 individuals with such claims based on the department's estimate of 203 million individuals covered by insurance. With approximately 25 percent of plans providing unlimited lifetime coverage as of the 2009 survey referenced, and up to another 25 percent with limits that are higher than \$2 million a year based on the interim regulation, the impact of the additional limits on the insured population is in the 2,500 to 3,000 life range.

Although the frequency of large claims should be significantly smaller than projected in the interim regulation, insurance plans and self-insured employers will have a new severity risk, as they move from 2013 to 2014, of all claims billed by medical providers, regardless of size. Few claims equal or exceed \$2 or \$3 million in a year, but when such claims occur, there is little ability for the insurance carrier to control costs. The unusual claim that exceeds the \$2 or \$3 million threshold conceivably can result in a claim in excess of \$10 million or higher. Such an unusual level of claim charges poses a new catastrophic claim risk to plans. The risk can be mitigated if the plan has a large capital base or full reinsurance coverage. Regardless of how the risk will be mitigated, the market will require more capital to effectively offset the risk.

### **Coverage or Payment Limits**

In an effort to keep premiums affordable for consumers, insurance coverage available today limits covered benefits in various ways. The scope of services covered under these types of limitations differs between individual policies and group policies, with individual policies generally having more services subject to some type of limitation. Some common examples of annual limits that are applied today include the following:

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<sup>10</sup> Summit Re 2009 presentation at the Actuarial Society of Greater New York (ASNY) stated seven out of 100,000 lives for "loosely managed care" had annual claims based on allowable (negotiated) charges exceeding \$1 million in 2008. Windsor Partners 2010 presentation at April 2010 Self-Insurance Institute of America (SIIA) meeting presented a study of 5.84 million lives that had one claim for every 100,000 lives based on allowable (network) charges exceeding \$1 million in annual claims for 2008-2009 periods. Munich Re Healthcare Summer 2009 Newsletter reported 10 claims per 100,000 had billed charges (before negotiated or network discounts) that exceeded \$1 million in annual claims in 2008. 2010 HealthMaps Medical Stop Loss Manual prepared by Towers-Perrin indicates 8.1 per 100,000 lives with claims exceeding \$750,000 assuming a 20 percent PPO discount.

- Coverage for specific types of service may be limited to a stated number of visits or days, such as 20 or 30 visits per year. This type of limit commonly is applied to such services as physical/occupational/speech therapy, chiropractic services, home health services, and number of days for skilled nursing facilities.
- Coverage for specific types of service may be limited to a stated dollar amount per year. An example of services to which this type of limit commonly is applied includes durable medical equipment and prosthetic devices. Annual dollar amount limitations are also common for mental health benefits in small group and individual policies, where allowed.
- The dollar amount of benefits payable may be limited for a stated condition and episode of treatment (e.g., \$10,000 or \$20,000 for normal maternity is common for individual coverage.)
- An annual dollar limit may be applied at the policy level. For example, a policy may pay benefits until a stated dollar amount has been paid for the year. This type of provision is used rarely in the large group market and periodically in the small group and individual market. When used, the dollar limit is typically quite high (e.g., \$500,000 or \$1,000,000).

Although the regulation allows for restricted annual dollar limits for essential benefits through 2013, and no annual dollar limits thereafter, the application of these restrictions is not entirely clear. Wording of the regulation only prohibits *dollar limits* on essential health benefits and is silent as to other types of limits (e.g., day, visit, treatment). The regulation also is unclear as to whether the restrictions apply to annual limits on essential benefits at the policy level in aggregate, or whether internal limits on individual types of service (e.g., physical therapy, devices, etc.) are affected.

Currently, some of these provisions are more common than others, and the effect that these provisions will have on cost varies. For example, removal of annual dollar limits at the policy level will affect aggregate costs much less than removal of internal limits on specific services. It is important that any rules clearly state what, if any, dollar and visit limits are acceptable to ensure consistency among carriers and across states.

While other interpretations may exist, the following three are the predominate interpretations being considered by various insurers and/or state regulatory agencies:

1. *The restriction and eventual prohibition of annual dollar limits applies at the type of service level; however, these limits may be converted to an actuarially equivalent day, visit or treatment limit.* Under this interpretation, dollar limits on specific services would need to be removed or converted. For example, a policy that currently contains a \$5,000 annual limit on physical therapy treatment could be converted to an actuarially equivalent number of visits. This interpretation would have minimal effect on cost since this type of conversion could be applied to most internal dollar limits and have no effect on policies that already incorporate this type of cost containment.
2. *The restriction and eventual prohibition of annual dollar limits applies at the type of service level, and these limits may NOT be converted to an actuarially equivalent day, visit, or treatment limit.* At least one state has taken the position in the past that day, visit and treatment limits are



essentially the same as dollar limits. Under this interpretation, neither dollar limits nor service limits could remain; a policy that currently contains a \$5,000 annual limit on physical therapy treatment would need to be removed. While this interpretation would have a significant effect in both the individual and group markets, the impact in the individual market would be significantly greater, since internal dollar limits are more common.

3. *The restriction and eventual prohibition of annual dollar limits applies only at the policy level, and internal limits on specific services may continue to be used to control cost.* Under this interpretation, only restrictions on the total amount paid for all services covered under a policy must be increased and eventually removed. A policy that currently contains a \$5,000 annual limit on physical therapy treatment may keep the limit in place or, if desired, convert it to an actuarially equivalent visit limit. Most policies available today do not have annual limits that apply at the policy level. In cases in which annual limits at the policy level are used, the limit usually is quite high (e.g., \$500,000 or \$1,000,000). The effect of this interpretation, therefore, is anticipated to be rather low.

The Commissioner of Insurance for the State of Washington (COI WA) recently posted answers to frequently asked questions on the department website pertaining to how annual and lifetime limits should be addressed. The COI WA interpretation is that, with the exception of preventive services, carriers can “continue to impose benefit-specific annual limits” even for essential benefits.<sup>11</sup> The COI WA’s rationale for this is that “Requiring carriers to discontinue this common practice may compel discontinuation of certain essential benefits prior to 2014 or the imposition of premium increases that make coverage cost prohibitive.”<sup>12</sup>

In reviewing the impact analysis found in the interim final regulation, the third interpretation may have been intent. The departments’ estimate that 8 percent of large employers, 14 percent of small employers, and 19 percent of individual market policies impose an annual limit today; this appears consistent with annual limits that apply at the policy level. If annual limits on specific covered services were considered, these percentages would be significantly higher. Given the uncertainty in the ways this could be interpreted, however, a clarification should be provided to clearly state what, if any, dollar (as well as day, visit, and treatment) limits are acceptable.

## **Emergency Services**

### **Determination of Insurer Liability for Out-of-Network Emergency Services**

Some carriers impose requirements that network providers be used if the insured is within a certain distance (30 miles) of home. In certain cases, an insured may choose to use out-of-network care for his or her emergency service despite the fact that an in-network facility is located within this distance. In this event, per the IFR, the insurer does not appear to be allowed to apply the higher out-of-network cost share provisions and could face resulting higher costs.

Providers negotiate with insurers on price for their services in a number of ways, ranging from fee-for-service reimbursement at the CPT or revenue code level to bundled payment approaches such as Medicare Ambulatory Payment Classes (APCs). As a result, significant administrative burden may be

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<sup>11</sup> State of Washington Office of the Commissioner of Insurance.  
[http://www.insurance.wa.gov/companies/rates\\_forms/HCRFAQsforfilers.shtml](http://www.insurance.wa.gov/companies/rates_forms/HCRFAQsforfilers.shtml); accessed Aug. 18, 2010.

<sup>12</sup> State of Washington Office of the Commissioner of Insurance

placed on insurers as each emergency claim may need to be processed under several different provider arrangements to determine the median reimbursement amount. When determining the “reasonable amount” for out-of-network emergency services, are insurers required to use a specific pricing method such as CPT codes or revenue codes, where the highest of the three amounts (Federal Register, June 28, p. 37194) is chosen? Or could the charges be calculated at the encounter level and then the highest amount selected?

In addition, many carriers and third-party claim administrators do not currently have the system capability to incorporate Medicare pricing into their claim payments. There likely will be additional administrative costs and perhaps capital expenditures associated with updating their systems to handle Medicare pricing. Because software and training can be expensive, these added costs could be quite significant.

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We would invite 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](mailto:Jerbi@actuary.org)).

Sincerely,

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Chairperson, Benefit and Eligibility Changes Work Group  
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