



AMERICAN ACADEMY *of* ACTUARIES

Dec. 18, 2012

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Proposed rule on standards related to actuarial value (AV)

To Whom It May Concern:

On behalf of the members of the American Academy of Actuaries'¹ Actuarial Value Subgroup, I appreciate this opportunity to comment on “Proposed Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation.” This letter focuses on issues related to actuarial value. In a separate letter, we provide comments on issues related to essential health benefits.

In general, the data and methods used to develop the AV calculator and continuance tables appear reasonable. However, we need additional information regarding the details that underlie the calculator in order to provide a fuller assessment and for actuaries to have the information they need to perform any required actuarial certifications.

Our specific comments and responses to questions posed in the rules are detailed below.

Section 156.130

Allowing small group plans to exceed the deductible limit in order to meet a required AV level

Given the Affordable Care Act (ACA) maximum deductible and out-of-pocket limitations, it could be difficult for plans to achieve required AV levels. In particular, it could be difficult to achieve an AV as low as 60 percent—that is, a bronze tier level. Doing so likely would require unusually high out-of-pocket copayment or coinsurance features. To address this issue, the proposed final rule would allow a small group plan to exceed the annual deductible limit if it cannot reasonably reach a given benefit tier level without doing so. The rule requested comments on how to implement a “reasonableness” standard.

A potential method of assessing reasonableness would be to determine the maximum allowable deductible for a given metal tier level by using the issuer’s cost-sharing features of its next

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.

highest metal tier. For instance, an issuer's silver plan cost-sharing features would be used to determine the maximum allowable deductible for its bronze plan. In other words, the silver plan's non-deductible cost-sharing parameters (if any) would be used in the AV calculator to determine the deductible level that would achieve a bronze level AV. This would be the maximum deductible allowed for the bronze plan. The bronze plan could use a lower deductible (but still higher than that in statute) if it increases the non-deductible patient cost-sharing features compared to the silver plan. To meet the reasonableness standard, however, CMS may wish to consider not allowing plans to reduce non-deductible patient cost-sharing features to achieve the need for a higher deductible.

This approach to the reasonableness standard would continue to allow plan flexibility and innovation. An implication of this approach is that different issuers could have different maximum deductibles. One issue that would need to be addressed under this approach is determining which silver plan's cost-sharing features are used as the benchmark when an issuer has more than one silver plan. Potential options include, but are not limited to, the silver plan with the highest deductible or the silver plan with the highest (expected) enrollment.

Not increasing allowable deductible levels by the amount available under a Flexible Savings Account (FSA)

The proposed rule notes that the Department of Health and Human Services (HHS) considered but ultimately did not increase allowable deductible levels by the amount available to employees in an FSA. Not including such an adjustment is reasonable, especially to the extent that FSA contributions are funded by and vary among employees.

Not counting cost sharing for out-of-network benefits toward the annual limits on cost sharing or deductibles

The proposed rule specifies that for network plans, cost sharing for out-of-network benefits does not count toward annual deductible or cost-sharing limits. Such a rule is reasonable—otherwise, the ability of a plan to steer enrollees to cost-effective providers would be limited. That said, such an approach is reasonable only if provider network adequacy requirements are met.

Section 156.135

Methodology for the development of the AV calculator and the continuance tables

In general, the data and methods used to develop the AV calculator and continuance tables appear reasonable. More information is needed, however, that clearly defines both the actual medical services that are included in each of the benefit categories and the fields in the continuance tables. A mapping of a standard plan to the categories, including coding logic, would be useful. In addition, information on how data were trended forward to 2014 is needed. Moreover, for enhanced transparency, more detail on the underlying formulas and calculations is needed. Providing an open-source model would facilitate a better understanding of the underlying methodology. Such information will be vital, especially to actuaries who will be required to determine and certify the actuarial value for plans that are not accommodated by the AV calculator.

After examining the AV calculator spreadsheet, it appears to us that in some instances, benefit parameters entered by the user are overridden and replaced by a different benefit structure which is not typical in the individual and small group markets. In particular, spending for certain categories is split between the outpatient facility and physician categories, even though only one input parameter is entered. Moreover, that input parameter is not actually used in the AV calculation. For instance, when users input a deductible/coinsurance plan design for imaging, that spending is split between the imaging facility and the imaging physician—benefits on the outpatient facility row are applied to the imaging facility portion and benefits on the outpatient physician row are applied to the imaging physician portion. Instead of using the coinsurance entered for imaging, the coinsurance for outpatient surgery and outpatient facility is used. It would be more appropriate to apply the user parameters as input, without splitting the benefit between categories.

Options when the AV calculator cannot accommodate all material aspects of a plan’s cost-sharing structure

The proposed rule outlines two options for determining the AV for plans that cannot be accommodated by the AV calculator. Under Option 1, plans would be permitted to decide how to adjust the plan benefit design (for calculation purposes only) to fit the parameters of the calculator. The rule requires that “an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies.”

Under Option 2, plans would be permitted to use the calculator for the plan design provisions that correspond to the parameters of the calculator. The rule requires that “an actuary, who is a member of the American Academy of Actuaries calculate, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments, to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV calculator.”

It is appropriate for plans to have the choice of either of these options, because some plan designs may be better accommodated by Option 1, while others would be better accommodated by Option 2.

Treatment of Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs)

The proposed rule states that any current year employer contributions to HSAs and HRAs would count toward the AV and be treated the same as first-dollar coverage. These amounts would be an input to the AV calculator. We request clarification on whether the intention of this rule is for issuers to set the required employer HSA contribution for each HSA design that is filed.

As noted in our May 16, 2012 comment letter to the Center for Consumer Information and Insurance oversight (CCIIO),² it is important to discern the distinctions between HSAs and HRAs. These two arrangements are treated differently by the employers offering them both from a federal tax and administrative perspective. Employer HSA contributions are funded in separate

² Comment letter available at: http://www.actuary.org/files/AV_comment_letter_05_16_2012_final.pdf

bank accounts for the employees and are nonforfeitable. Employers are granted tax deductions for the full HSA contribution that is funded. Employer HRA contributions are not prefunded and are paid from employer general revenues as eligible reimbursement requests are received. HRA amounts may or may not carry over to subsequent years. Even if carryover amounts are allowed, they might be limited. And HRAs generally are forfeited if an employee leaves the company. Employers are granted tax deductions for the amounts actually paid from the HRA. If these two accounts are treated similarly under the AV calculation, there could be an incentive to discourage the use of HSAs in favor of HRAs.

Interstate geographic variation

In the *Actuarial Value and Cost-Sharing Reductions Bulletin* released Feb. 24, 2012, HHS stated the intention to develop three geographic pricing tiers that would be applied at the state level when calculating an AV. However, the proposed rule does not appear to include such adjustments. Instead, the proposed rule requests comments on whether geographic price adjustments should be included.

It would be reasonable to exclude geographic pricing adjustments from the AV model. If geographic pricing adjustments are included, it would be advisable to include them beginning in 2014. Otherwise, a change in methods could cause a disruption in plans that need to undergo plan design changes to meet revised AV requirements. As a practical matter, however, plans would have little time to incorporate a revised AV model with geographic adjustments into their 2014 plan designs and meet product and rate-filing deadlines.

Previous Academy comment letters discussed whether geographic pricing tiers should be used in the AV calculator, and if so, how. Those comments are summarized here.³

Whether geographic pricing tiers should be used. AVs tend to increase when health spending increases—whether due to high provider prices and/or higher utilization—because both the deductible and out-of-pocket limits are more likely to be exceeded. Applying different geographic pricing tiers across the states could result in AVs better reflecting the costs of care in that state. Note that a result of this would be that plans in high-spending states would be able to meet AV targets with less generous cost-sharing requirements compared to plans in lower spending states.

However, even if state-level geographic pricing tiers are incorporated, AVs won't necessarily reflect the costs of care in any particular area for states with wide intra-state variations in costs. Applying different pricing tiers within a state would address this issue, but would mean that issuers would need to develop different plan designs for different parts of the state, resulting in potential consumer confusion, increased administrative and regulatory burden, and risk adjustment difficulties.

³ For more information, see comment letters from April 2, 2012 http://www.actuary.org/files/AV_calculator_q_and_a_4_02_2012.pdf and May 16, 2012 http://www.actuary.org/files/AV_comment_letter_05_16_2012_final.pdf.

On the other hand, it could be appropriate instead to have only one national pricing tier. States with both high-spending and low-spending areas already might end up using the average pricing tier—so there may be less need for different pricing tiers. In addition, having different pricing tiers could be burdensome, particularly for multistate small-group employers, as well as confusing for their workers.

How to implement geographic pricing tiers, if incorporated. If geographic pricing tiers are incorporated, it could be appropriate to first determine a reasonable level of cost variation and use this level to guide how many pricing tiers are needed. Given that the de minimis tolerance is ± 2 percent, it might be appropriate to create different pricing tiers for any cost variations that would result in AV variations of greater than ± 2 percent.

Use of state-specific standard population for the calculation of AV

The proposed rule would allow the use of a state-specific dataset as the standard population beginning in 2015 if it meets certain requirements, such as being large enough to be statistically reliable and stable. Another consideration is that if certain states use state-specific standard populations with the AV calculator, the average cost among the remaining states will be either higher or lower than the national average. Thus, to the extent that states exercise this option, the default national dataset may need to be adjusted such that the representation of the total standard population is unchanged. Decisions on whether to implement such an adjustment should consider the magnitude of changes in resulting AVs and the potential disruption to plans.

Section 156.150

Annual cost-sharing limits for stand-alone dental plans in the exchange

Stand-alone dental plans in an exchange would be allowed to have separate annual cost-sharing limits based on what would be reasonable for coverage of pediatric dental. When determining a reasonable limit, it is appropriate to consider that pediatric dental costs are highly predictable and low cost—except for medically necessary orthodontia, which can be quite expensive. Therefore, a reasonable cost-sharing limit could be low if medically necessary orthodontia is not included. A higher cost-sharing limit could be appropriate if orthodontia is included. If orthodontia is included, it is also important to consider the definition of medically necessary.

A Milliman, Inc. analysis cited by the National Association of Dental Plans concludes that 95 percent of children are expected to incur total dental and orthodontia claims of \$900 or less, with \$270 or less paid out of pocket.⁴ It also concludes that the average orthodontia claim, for those incurring such services, is \$6,350, with half being paid out of pocket. The Milliman analysis estimates that about 30 percent of pediatric orthodontic claims would qualify as medically necessary. Although in a given year there may be a relatively small share of children receiving medically necessary orthodontia, those that do would incur high out-of-pocket costs, especially if there is no cost-sharing limit.

⁴ National Association of Dental Plans, “Consumer Out of Pocket Expenses for Pediatric Dental Benefits,” Nov. 14, 2012.

If the cost-sharing limit is set too low, the costs to provide pediatric dental coverage (and therefore the premiums) could increase considerably. On the other hand, if the cost-sharing limit is set too high, there is the potential for financial hardship for the insured.

Actuarial value standards for stand-alone dental plans based on high/low criteria

The rule proposes that any stand-alone dental plan with an 85 percent AV \pm 2 percent would be considered a high plan, and a plan with a 75 percent AV \pm 2 percent would be considered a low plan. The rule requests comments on the appropriateness of the de minimis range and the high/low approach.

\pm 2 percent de minimis range. A consideration when setting the de minimis range for stand-alone dental coverage is that the relatively lower costs of dental coverage mean that a \pm 2 percent range would translate into very small differences in expected costs.

High/low approach. Pediatric dental costs are low and predominately preventive in nature, especially if medically necessary orthodontia is not included. Preventive coverage tends to be the majority of the costs, and those costs would be covered at 100 percent. As a result, a high/low approach appears appropriate, given there is a large portion of the total benefit that can't be adjusted in terms of cost sharing. In addition, a simplified approach is reasonable because dental care is a small portion of the overall essential health benefit requirement. Using frequency limits (e.g., coverage of two exams per benefit period), could be an alternative method of varying AV levels.

Another issue related to AVs of stand-alone dental plans is that it could be difficult for consumers to compare medical plans with embedded dental coverage with those with a stand-alone dental plan. This is because it is difficult to compare on an apples-to-apples basis the combined AV under either option. It also may be difficult for consumers to use an AV measure to compare the dental benefits embedded in a medical plan with those offered in a stand-alone dental plan.

Stand-alone dental plans, as well as dental coverage embedded in medical plans, could include non-EHB benefits. Clarification is needed on how any non-EHB dental benefits would be treated in risk adjustment calculations. In addition, clarification is needed on how any non-EHB dental benefits are treated in metal tier AV calculations for medical plans that include dental coverage and in the high/low AV standard for stand-alone dental plans.

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We welcome the opportunity to discuss with you at your convenience any of the comments presented in this letter. 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,

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