June 11, 2012

Internal Revenue Service
CC:PA:LPD:PR (Notice 2012-31)
Room 5203
PO Box 7604 Ben Franklin Station
Washington, DC 20044

Re: Notice 2012-31

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 provide comments on IRS Notice 2012-31, "Minimum Value of an Employer-Sponsored Health Plan." This letter provides comments regarding how to account for non-core benefits and non-standard plan features. It also provides suggestions regarding the safe harbor checklists and discusses certain additional considerations regarding the treatment of health savings account (HSA) contributions.

Accounting for Non-Core Plan Benefits

According to the IRS Notice, the minimum value (MV) calculator would require users to input information regarding which of the four core benefit categories are covered by the plan being tested and the applicable cost-sharing features for each of the covered categories. The four core benefit categories are: physician and mid-level practitioner care; hospital and emergency room services; pharmacy benefits; and laboratory and imaging services. The notice requests input on whether and how the MV calculator could be adjusted to account for benefits provided by the plan which fall outside the scope of the four core benefit categories.

Whether and how to adjust the calculator to account for the provision of non-core plan benefits depends on how broadly or narrowly the four core benefit categories are defined. The more broadly the categories are defined, the less likely it is that non-core benefits would have a significant impact on the MV. Also important is what non-core benefits would be allowed to be taken into account. For instance, many employers provide generous dental benefits—if these are considered non-core medical benefits, then there could be a significant impact on the MV.

Whether and how to adjust the calculator also depends on whether the data used in the calculator already include non-core benefits. This in turn depends on the extent to which these non-core benefits were offered by plans underlying the data used by the calculator and whether the cost of these benefits is included in the data and thus the denominator of the MV calculation. If non-core

[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.

benefits are not included already in the dataset, then adjusting for non-core benefits would require that they be added to both the numerator and denominator. As a result, including an adjustment for these benefits likely would not have a significant effect on the MV, especially if the service is used infrequently.

If non-core benefits are included already in the dataset, and thus the denominator in the MV calculation, then the value of non-core benefits would need to be added only to the numerator. In this instance, MVs would be understated for plans not covering non-core benefits.[2] Adding non-core benefits to the numerator could result in a larger change (increase) in the MV; whether or not that change would be material would depend on the relative cost of the non-core benefits compared to the core benefits. It is possible that the denominator would need to be adjusted upward, if most plans in the dataset do not cover and include spending for the non-core benefit in question. Otherwise, the covered non-core benefit spending added to the numerator will be disproportionately high compared to the non-core spending in the denominator, thus artificially increasing the MV.

The hypothetical example below illustrates the amount of non-core benefits that would be needed to increase a plan's MV to 60 percent.[3] In this example, allowed benefits for the four core categories are assumed to equal $10,000. For three sample plans, paid benefits are assumed to equal $5,900, $5,800, and $5,700, with MV calculations of 59 percent, 58 percent, and 57 percent, respectively. Assuming that non-core benefits would be included in both the numerator and the denominator in the same amount, non-core benefits valued at $250 would be needed to increase a plan's minimum value from 59 percent to 60 percent. This amount would equal 2.5 percent of core allowed costs and 4.2 percent of paid costs. Lower initial MVs based on core benefits only would require greater non-core benefit values—$500 for an initial MV of 58 percent, and $750 based on an initial MV of 57 percent. These would equal larger shares of core benefit allowed and paid costs. In this example, in fact, moving from an MV of 57 percent to 60 percent would require that non-core benefits equal more than 13 percent of core benefit paid costs. In other words, non-core benefits must be a relatively large portion of the otherwise paid core benefits to affect the MV.

[2] If non-core benefits are already included in the dataset, information should be provided regarding the share of costs in the dataset attributable to non-core benefits. This information then could be used to adjust the denominator downward so that MVs are not understated for plans not covering non-core benefits.

[3] The example ignores any allowable de minimis variation in the calculated MV. The results would be similar under the situation which allowed for a ±2 percent variation and plans needed to increase their MVs to meet a 58 percent target.

Example
Required Amount of Non-Core Benefits Required to Increase MV to 60%

	Plan Design A	Plan Design B	Plan Design C
Total allowed costs, core categories	$10,000	$10,000	$10,000
Total paid costs, core categories	$5,900	$5,800	$5,700
MV, core categories (paid/allowed)	59%	58%	57%
Assuming non-core benefits are added to the numerator and denominator of MV calculation*			
Amount of non-core benefits required to increase MV to 60%	$250	$500	$750
Non-core benefits required, as a % of:			
Total allowed costs, core categories	2.5%	5.0%	7.5%
Total paid costs, core categories	4.2%	8.6%	13.2%
Assuming non-core benefits are added to only the numerator of MV calculation			
Amount of non-core benefits required to increase MV to 60%	$100	$200	$300
Non-core benefits required, as a % of:			
Total allowed costs, core categories	1.0%	2.0%	3.0%
Total paid costs, core categories	1.7%	3.4%	5.3%

* Assumes that non-core benefits are are added in the same amount to the numerator and denominator.

If non-core benefits already are included in the denominator so that non-core benefit values are added to only the numerator of the MV calculation, then a lower amount of additional benefits would be required to meet the 60 percent MV threshold. But it would still be the case that the further below 60 percent the MV is, the greater the non-core benefits would need to be as a share of core benefits in order to meet the 60 percent threshold.

Note that these examples assume that paid costs for non-core benefits are included in both the numerator and the denominator. Or alternatively, that non-core benefits are paid at 100 percent of allowed costs. If non-core benefits are covered to a lesser extent than core benefits, including paid costs in the numerator and allowed costs in the denominator would reduce the MV. In other words, employers providing non-core benefits could have a lower MV than employers not providing non-core benefits. To avoid this result, both the numerator and denominator could reflect paid costs for non-core benefits.

In summary, the subgroup does not expect non-core benefits to have a large effect on the MV calculations. That said, the methods for including non-core benefits in the MV calculation must be considered carefully, otherwise unintended conclusions could result. And importantly, information regarding the degree to which non-core benefits are included in the data underlying the MV calculator needs to be made available to actuaries performing MV calculations.

Non-Standard Features in Employer-Sponsored Plans
In the subgroup's experience, quantitative limits are not common in employer group plans for the four core benefit categories. For example, quantitative limits on physician visits or inpatient hospital days typically are not included in employer-sponsored plans. Quantitative limits more commonly are applied to benefits outside of the specified core benefits, such as rehabilitative benefits and home health care visits. These services are used less frequently than the core benefits and make a minimal contribution to actuarial value (AV).

A feature that could require the plan to make adjustments to the MV calculation is a tiered copayment or coinsurance structure. To encourage appropriate utilization of certain services, health plans may charge a lower copayment for a certain number of visits and a higher copayment for visits over the limit. This type of plan design could apply to emergency room visits and certain types of physician visits. In addition, depending on the granularity of the MV calculator inputs, plans may need to make adjustments if cost-sharing requirements vary within benefit categories. Although uncommon, a similar tiered-design variation is to have many cost-sharing tiers that are determined at the provider affiliation level. Reference based pricing, also uncommon, can result in cost-sharing requirements that vary by service and provider.

As mentioned in the subgroup's comment letter on the AV calculator,[4] plans with a value-based insurance design (VBID), which vary cost sharing based on the value of the treatment, won't readily fit into the MV calculator framework. Although these types of plans make up only a small share of all plans today, interest in them is growing. Future iterations of the MV calculator should attempt to accommodate more directly these types of plans to ensure that these and other innovative plan designs are not discouraged.

Safe Harbor Checklists
Because of the numerous plan design parameters and definitions of covered benefits, it may be difficult to create a safe harbor checklist for meeting the MV requirements. An option would be to allow plans covering all four core benefit categories that have coinsurance rates less than a certain percentage (or copayments less than a certain amount), deductibles less than a certain amount, and out-of-pocket limits less than a certain amount to be considered as having met the MV requirements. The thresholds would need to be set based on the underlying MV claims distribution and would need to be reset each year. Tables could be created that develop various combinations of allowable thresholds.

It will be important to provide educational information to employers to clarify that not meeting safe harbor requirements for MV does not necessarily mean that the plan does not meet MV requirements. Plans not meeting safe harbor requirements potentially could meet MV requirements through use of the MV calculator or through separate actuarial certification.

HSA Considerations
Special considerations may need to be made for calculating the MV for HSA plans in which the employer contribution is based on a match of the employee contribution. As indicated in the IRS notice, employer contributions to HSAs and health reimbursement arrangements (HRAs) will be

[4] See the May 16 letter from the Academy's Actuarial Value Subgroup to CCIIO: http://www.actuary.org/files/publications/AV%20comment%20letter%2005%2016%202012%20final.pdf.

counted toward the MV, but the amount will be adjusted downward so that it reflects the same value as it would for first-dollar coverage.

When employer contributions depend on the employee contribution, the MV in effect would vary by employee. In addition, contribution information likely would not be available prospectively. Several options are available for estimating HSA contributions on a prospective basis. One option is to use average expected employer contributions in the MV calculation. But that would overestimate the MV for workers who receive lower employer contributions than average and underestimate the MV for others. Another option is to exclude any employer contributions that are not automatic. That option would understate the MV for certain workers who receive employer contributions. As an alternative, the maximum potential contribution could be used, but this would overstate the MV for employees who do not contribute enough to maximize the employer contribution. Another option would be to perform the MV calculation on a worker-by-worker basis, which could be more accurate but administratively burdensome, not only for employers determining the MV, but also for determining worker eligibility for premium subsidies and assessing employer penalty payments. In addition, worker-specific information might not be available prospectively.

Another issue regarding HSA/HRA funds is that they can be used for spending on non-core services. It is unclear whether the downward adjustment to HSA/HRA contributions would be based on core benefits only, or core and non-core benefits.

Actuarial Certification
The notice provides options for actuaries to certify the MV for plans that are not accommodated by the MV calculator. The subgroup recommends that any rules or regulations attempting to define an actuary qualified to perform such certifications use the following language:

> An actuary who is a member of the American Academy of Actuaries and qualified to provide such certifications as described in the U.S. Qualifications Standards promulgated by the American Academy of Actuaries pursuant to the Code of Professional Conduct.

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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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