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December 18, 2018

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Attention: CMS-9936-NC
P.O. Box 8010
Baltimore, MD 21244-1810

To Whom It May Concern,

The American Academy of Actuaries[1] Individual and Small Group Markets Committee appreciates the opportunity to provide comments on the Oct. 22, 2018, guidance (hereafter referred to as "the guidance") from the Department of the Treasury and the Department of Health and Human Services ("the Departments") on State Relief and Empowerment Waivers under Section 1332 of the Affordable Care Act (ACA). Our comments focus on three areas: evaluation of coverage comprehensiveness and affordability, evaluation of coverage, and waiver funding.

Evaluation of Coverage Comprehensiveness and Affordability

The guidance makes clear that the departments intend to evaluate the comprehensiveness and affordability of coverage together. Within comprehensiveness and affordability, we have comments addressing the combined nature of the guardrail evaluation, comprehensiveness standards, and the impact of risk selection.

The combined nature of the guardrail evaluation

The guidance notes that consumers must have "access to coverage options that are at least as affordable and comprehensive as the coverage options provided without the waiver." This stipulation appears to require that states use the same essential health benefit (EHB) benchmark when evaluating the comprehensiveness of available benefits in the baseline without the waiver and in the benefits proposed under the waiver. Appropriately, this requirement would result in an "apples to apples" comparison of coverage available to consumers with and without the waiver. It would be helpful for CMS to confirm this interpretation or further clarify the guidance as to the permissibility of benefit differences between the baseline market and the waiver market.

We additionally believe clarification is needed as to how the evaluation of comprehensiveness and affordability should be performed in the case in which the currently available level of benefits is in excess of the minimum EHB standards. The guidance notes that comprehensiveness "refers to the scope of benefits provided by the coverage as measured by the extent to which

[1] The American Academy of Actuaries is a 19,500+ member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted 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.

coverage meets [EHB] requirements."[2] This stipulation appears to us to suggest that a state currently offering benefits more comprehensive than minimum EHB standards could reduce its benefits to the minimum EHB standards and use any resulting savings in its evaluation of affordability.

Lastly, clarification is needed on whether a state could use coverage outside the individual market, such as an association health plan (AHP), in its evaluation of comprehensiveness and affordability. For instance, if a state were to include a non-individual-market option that provides comprehensiveness equal to or in excess of the baseline market in its waiver, could that coverage then be used to determine affordability?

Comprehensiveness standards
The guidance indicates that individuals must have access to coverage that meets the EHB standards. The guidance further notes that such coverage can be evaluated with respect to any of the EHB options made newly available in the 2019 HHS Notice of Benefit and Payment Parameters, even if the EHB standard that a state uses in the waiver application differs from the EHB standard actually required by the state. The guidance is unclear as to whether any of the additional documentation steps required under 45 CFR §156.111(e) are required if a state intends to use an EHB standard based on one of the new EHB options. Failure to require documentation and approval of the new EHB standard could add additional time and complexity within the 180-day review period for waivers or in an evaluation against a benefit package that does not adequately represent comprehensive coverage.

Impact of risk selection
Any waiver that increases the availability of coverage that disproportionately appeals to healthier individuals (such as short-term limited duration insurance (STLDI) and potentially AHPs) would result in upward price pressure on the remaining ACA-compliant market. It appears that states would need to model the expected impact on access to comprehensive and affordable coverage in a way that is consistent with its estimation of what coverage will actually be obtained. In other words, if the ACA-compliant risk pool were estimated to become less healthy under the state waiver, those increased premiums would need to be factored into the comprehensiveness and affordability estimates. Depending on how a state uses federal ACA funds (e.g., how premium tax credits are structured), additional state funds might be needed to address any shortfalls in meeting the comprehensive and affordability standards. We would appreciate additional clarity on any modeling requirements related to the impact of adverse risk selection against ACA-compliant markets as a result of the changes made by the waiver.

Evaluation of coverage

Under the coverage guardrail, at least as many state residents eligible for coverage must have coverage under the waiver as would have it without the waiver. In a change from prior guidance, coverage is not limited to ACA-compliant coverage. Instead, the new guidance indicates that coverage should be measured across all segments that constitute either minimum essential coverage for purposes of the ACA's individual mandate or health insurance coverage as defined

[2] The new EHB flexibility is outlined in 45 CFR §156.111.

in 45 CFR §144.103. This definition includes most forms of major medical coverage, including AHPs and STLDI, as recently expanded by action by the administration. It would be appropriate for the Departments to ensure that coverage is evaluated against the same coverages in the baseline and under the waiver. For example, if a waiver application estimates that coverage in the baseline without the waiver would be 100,000 lives in ACA-compliant individual market plans, and coverage under the waiver would be 52,000 lives in ACA-compliant plans and 52,000 lives in STLDI plans under the waiver, the application would not have fully evaluated this guardrail. Coverage in the baseline would need to also consider the number of lives enrolled in the STLDI market. Similarly, it is important for a waiver to also consider changes to the number of state residents with group coverage in their application. For example, if a waiver seeks to promote usage of health reimbursement arrangements (HRAs) as recently proposed by the Departments[3] in order to move lives into the individual market from the group market (both fully insured and self-insured), coverage in the group market will be impacted.

The guidance does not make clear what other excepted benefits may be included in the evaluation of coverage. Health insurance coverage as defined in 45 CFR §144.103 is broad, and further specificity as to which excepted benefits (if any) may be included could be appropriate. Incorporation of fixed indemnity or specified disease products may offer more finely tailored availability of desired products to individuals that better align with their personal risk tolerances; however, these plans may provide less coverage than other options explicitly contemplated in the guidance and would also lead to increased adverse selection in the ACA-compliant markets.

Deficit Neutrality

The guardrails require that the federal funding under a 1332 waiver be budget-neutral. That is, federal spending under the waiver must not exceed that without the waiver. Any savings in federal spending for advance premium tax credits (APTCs), small business tax credits, and cost sharing reductions (CSRs) under the waiver would be passed through to the state, which must then use the pass-through savings toward implementing the waiver.

To date, the most prominent source of federal savings in approved 1332 waivers has been the reduction in APTCs due to reinsurance programs that lower premiums. Federal spending for APTCs is based on the cost of the second-lowest silver plan and depends in part on how CSRs are funded. As a result of the administration's Oct. 12, 2017, decision to cease further reimbursement of CSR subsidies to insurers, premiums in almost all states have increased to offset the additional insurer liability.[4] Because the vast majority of CSRs are provided to enrollees in silver plans, most states have allowed and even require insurers to increase only silver premiums to limit the impact on premiums for other coverage levels. If CSR-related increases are spread across all metal tiers rather than being levied only on silver plans, federal spending for APTCs would decline. This would reduce the amount of federal funds available for a 1332 waiver and could impact the ability of current waiver states to fund their programs. If instead the administration were to reinstate CSR reimbursements to insurers, premiums would go

[3] Also including the Department of Labor.
[4] The ACA provides a legal obligation to issuers to provide CSRs to eligible enrollees, regardless of reimbursement by the federal government.

down, resulting in a reduction in federal spending for APTCs, but federal spending for CSRs would increase.

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We appreciate the opportunity to provide these comments and would welcome the opportunity to speak with you regarding these comments in more detail and answer any questions you might have. If you have any questions or would like to discuss further, please contact David Linn, the Academy's senior health policy analyst, at 202-223-8196 or linn@actuary.org.

Sincerely,

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Chairperson, Individual and Small Group Markets Committee
American Academy of Actuaries