AMERICAN ACADEMY *of* ACTUARIES

May 16, 2012

Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: Actuarial Value and Cost-Sharing Reduction bulletin

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 the Center for Consumer Information and Insurance Oversight (CCIIO) "Actuarial Value and Cost-Sharing Reduction" bulletin. This letter provides comments on the proposed actuarial value (AV) calculator that supplement comments we made in our April 2 letter.[2]

In particular these comments address issues related to whether the AV calculator needs to incorporate plan designs with benefit limits, whether different claim distributions should be used for plans in the individual and small group markets, how many geographic pricing tiers would be appropriate, whether induced demand should be incorporated into the calculator, and how Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA) contributions should be incorporated. We also provide recommendations regarding ways to enhance the calculator's transparency.

Plan Designs with Benefit Limits
Some health insurance plans include limits on the amount of services that are covered in a particular category. For instance, some plans limit the number of physical therapy visits covered during a year. After 2014, the Affordable Care Act (ACA) prohibits plans from imposing dollar limits on services but limits on the number of services will be permitted. In practice, well-designed limits, in conjunction with care management approaches, are intended to provide appropriate care and mitigate the upward pressure on premiums due to the effects of selection and potential overutilization. Although such limits can affect significantly the out-of-pocket health care costs for certain individuals who receive care beyond the limits, these limits likely have only minor effects on a plan's AV because they typically are associated with low frequency services. For purposes of the AV calculator, therefore, it would be reasonable to ignore such limits.

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[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] http://www.actuary.org/pdf/health/HPC_letter_AVCalc_to_CCIIOA_120402.pdf

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The AV requirements are intended as a rough measure of a plan's generosity. They are not an effective tool to evaluate benefits limits or to determine whether a plan's benefit structure is discriminatory. Other tools would be needed to meet these purposes.

Claim Distributions for the Individual and Small Group Markets
It is unclear whether CCIIO intends for the AV calculator to use the same claim distribution for plans in the individual and small group markets. Whether the same claim distribution should be used depends in part on the goal of the AV determination. If AVs are to be representative of the expected share of spending paid by the plan, it would be appropriate to use a dataset more reflective of the specific market. If, on the other hand, the goal is for plans with the same cost-sharing requirements to have the same AV—regardless of which market they are in—then the same dataset should be used. In the pursuit of promoting transparency and simplicity to consumers, the CCIIO bulletin has expressed the preference that plans with the same plan designs should have the same AVs. With this goal, a combined dataset would be appropriate.

There are also practical considerations that argue for using a combined dataset. To the extent possible, the underlying data should reflect spending in individual and small group plans in 2014 and beyond, which in turn depends on the composition of those markets. There are several factors, however, that complicate projections of the future composition and spending of these markets. Future populations of individual and small group market participants will be a mix of individuals currently with and without coverage, and even those currently with coverage could be transitioning to individual or small group coverage from other coverage sources (e.g., large group coverage, high risk pools). In addition, some individuals currently covered by private insurance may transition to Medicaid, and vice versa. How the enrollee compositions change over time will depend in part on how a state's current issue and rating rules compare to those that will be in effect beginning in 2014. It also will depend on the effectiveness of the individual mandate, insurance subsidies, and other mechanisms in bringing currently uninsured individuals into the insurance markets. With all of these uncertainties, developing claim distribution will be difficult. Developing separate distributions for the individual and small group markets would be even more so. In future years, when a new equilibrium has been reached in the individual and small group markets, it may be more practical to create different underlying datasets for the individual and small group markets. For now, it is reasonable to combine the data from these markets for AV calculation purposes.

Geographic Pricing Tiers
The CCIIO bulletin states an intention to develop geographic pricing tiers[3] that will be applied at the state level. In our previous comment letter, we responded to a question regarding how many pricing tiers should be developed by suggesting that CCIIO first determine a reasonable level of cost variation and use this level to guide how many tiers would be needed. Given that the de minimis tolerance is ±2 percent, the letter noted it might be appropriate to create different pricing tiers for any cost variations that would result in AV variations of greater than ±2 percent.
As we discussed in our previous letter, some states will have wide intra-state variations in costs; some areas of the state may be high-cost and others low-cost. Statewide averages presumably will be used to determine which pricing tier will be used. The AVs, therefore, may not

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[3] The CCIIO bulletin refers to "pricing tiers" in the context of calculating the AV. The prices used in the AV calculation are intended to reflect regional (e.g., state level) or national averages and will differ from the provider rates and utilization trends incorporated into an issuer's premium calculations.

necessarily reflect the costs in any particular area of the state. Plans in high spending areas, relative to the state average, would have more generous plans than their metal tier would indicate; plans in low spending areas, relative to the state average, would have less generous plans than their metal tier would indicate. This is less of a concern in states with a relatively low variation in health costs.

It may be appropriate to consider whether different pricing tiers also should be applied to different areas within a state. One option is to apply different pricing tiers within a state using the same intrastate geographic regions used for premium variations. There would be many potential downsides, however, to such an approach. Using different pricing tiers within a state would mean that to meet the AV targets, issuers would need to develop different plan designs for different parts of the state. This could result in added confusion for consumers and would increase the administrative burden for issuers, state regulators, and the health insurance exchanges. In addition, because risk adjustment is done on a state level, differences between plan designs could make risk adjustment difficult even within a metal tier if plans vary markedly in their designs.

On the other hand, it may be appropriate instead to consider having 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 particularly burdensome for multi-state small group employers and confusing for their workers. By requiring different pricing tiers by state, employers may need to develop different plan designs for workers in different states. Although only a small minority of small employers are in multiple states, this share could increase as the definition of small group increases from 50 to 100 workers. Increasing the burdens for these plans could provide incentives for them to self-insure.

Incorporating Induced Demand
CCIIO intends to incorporate utilization effects into the AV calculator. These would reflect the change in spending due to more or less cost sharing. In our previous letter we recommended methods to ensure that the AV calculator properly determines the AV when incorporating the utilization effects. It is reasonable, however, to consider whether it is even desirable to incorporate utilization effects into the AV calculation.

One argument for not incorporating utilization effects is that doing so could enhance understanding among consumers regarding the generosity differences between plans—differences in AVs would reflect only changes in cost sharing. This would be more consistent with the idea that AVs reflect plan generosity given a particular level of spending. Any differences due to induced demand would be reflected in the premium but not the AV.

Not incorporating utilization effects also could be more straightforward. On average, individuals in more generous plans utilize more health care not only because lower cost sharing can induce more utilization (i.e., induced demand), but also because individuals with higher health care needs are more likely to enroll in more generous plans (i.e., selection). It can be difficult to disentangle the effects of induced demand from the effects of selection. Excluding these effects altogether can avoid this difficulty.

On the other hand, incorporating utilization effects means that AVs would better reflect the actual share of health care spending paid by the plan (although AVs still would not reflect any given plan's particular utilization trends or provider payment rates).

Incorporating utilization effects would compress the differences in plan designs across the metal tiers. For instance, the AVs for platinum plans will be based on higher utilization due to induced demand. As a result, they can meet AV targets with less generous plan designs (i.e., higher cost sharing) than they would if induced demand were not incorporated. On the other hand, bronze plans would need to be more generous (e.g., lower cost sharing) to meet AV targets than if induced demand were not incorporated.

Regardless of whether and how induced demand is incorporated into the AV calculator, it is important to recognize the interactions between how AV, risk adjustment, and premiums are calculated across metal tiers.

Treatment of Health Savings Accounts (HSA) and Health Reimbursement Arrangements (HRA)
As indicated in the AV bulletin, employer contributions to HSAs and HRAs will be counted toward the AV, but the amount will be adjusted downward so that it reflects the same value as it would for first-dollar coverage. Our understanding is this adjustment is intended to recognize that the money all won't be used that year toward health expenses (although depending on the type of account, it could be used in future years). This adjustment may be reasonable and appropriate, but it could have the effect of discouraging employers from contributing to HSAs/HRAs. For a given amount of employer spending toward health insurance, a higher AV likely would be achieved by devoting more of those dollars directly toward a health insurance program than to an HSA/HRA. To the extent that HSAs encourage plan enrollees to seek cost-effective care, discouraging this option may run counter to goals of achieving more effective use of health care dollars.

It also is important to discern the distinctions between HSAs and HRAs. These two arrangements are treated differently both from a federal tax perspective and from an administrative perspective by the employers offering them. Employer HSA contributions are funded in separate bank accounts for the employees and are nonforfeitable. Employers are granted tax deductions for the full HSA contribution funded. Employer HRA contributions are not pre-funded 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.

Enhancing Transparency
The AV bulletin notes CCIIO's goal of providing transparency regarding the AV calculations. To facilitate transparency, it would be appropriate for CCIIO to disclose several elements of the AV calculator, including:
- What health insurance markets the data represent and other details on the underlying dataset, including the data source; whether and how the data were adjusted or appended by data from other datasets or markets; and how spending data were projected forward;

- Whether and how the data were adjusted to reflect pent-up demand among the newly insured;
- Whether and how the data were adjusted to reflect the essential health benefit requirements and preventive care enhancements under the ACA;
- Whether and how utilization effects are incorporated into the calculator to reflect differential utilization trends across benefit tiers; and
- How geographic pricing tier adjustments were determined.

This information will help actuaries using the AV calculator as well as consumer representatives better understand how the calculator works. Such information will be important especially to actuaries performing AV calculations for plans that are not accommodated directly by the AV calculator.

Longer-Term Issues
The AV calculator should be reassessed and modified as appropriate over time. As currently envisioned by CCIIO, the AV calculator will have a limited number of benefit design input parameters and may not be able to accommodate complex plan designs. Plans not directly accommodated by the AV calculator would need to use an adjusted calculation method. For instance, 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 AV calculator framework. By better aligning beneficiary incentives toward high-value care, VBID plans have the potential not only to improve patient outcomes but also to lower health care spending. Although these types of plans make up only a small share of all plans today, interest in them is growing. Future iterations of the AV calculator should attempt more directly to accommodate these types of plans, to ensure that these and other innovative plan designs are not discouraged. The Academy would be happy to work with CCIIO on an ongoing basis to provide input on how to modify the AV calculator over time.

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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,

Cori E. Uccello, FSA, MAAA, FCA, MPP
Chairperson, Actuarial Value Subgroup
Senior Health Fellow
American Academy of Actuaries