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AMERICAN ACADEMY *of* ACTUARIES

January 31, 2012

Sherry Glied, Ph.D.
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: ASPE Research Brief, "Actuarial Value and Employer-Sponsored Insurance"

Dear Dr. Glied:

The American Academy of Actuaries'[1] Health Practice Council appreciates the
opportunity to provide comments on the recently released ASPE research brief,
"Actuarial Value and Employer-Sponsored Insurance." The work group that developed
this letter includes health actuaries with a broad spectrum of actuarial experience who
have particular expertise in employer-sponsored insurance (ESI).[2]

This letter responds to questions posed in the research brief and provides additional
comments for consideration. In particular, we highlight the following:

- Although small and large employers tend to cover the same scope of services, there
  may be differences in the level of coverage. In particular, the use of inside limits on
  costs or services covered will have different effects on actuarial value, depending
  on whether they are considered cost-sharing increases or covered service
  reductions.

- Using different models, methods, or data to calculate actuarial values could result in
  differences in actuarial values. These differences could be larger than those
  resulting from the inclusion or exclusion of certain benefits.

- Further analysis exploring how actuarial values vary by employer size, plan type,
  and fully insured versus self-insured plan status would provide insights into the
  characteristics of plans at or near the 60 percent actuarial value threshold and how
  changes in the benchmark used or other parameters would affect the actuarial value
  for those plans.

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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] The primary drafters of these comments are: Douglas B. Levit, MAAA, FSA, FCA; Daniel S. Pribe,
MAAA, FSA; and Cori E. Uccello, MAAA, FSA, FCA, MPP.

Background
Under the Affordable Care Act, actuarial value (AV) measures are to be used to establish minimum value requirements for ESI plans. These requirements are relevant for whether workers who are offered ESI coverage are eligible for premium subsidies in the health insurance exchanges and for whether employers are subject to penalties if any of their employees purchase subsidized coverage in the exchanges.

Premium subsidies are available for certain people to obtain coverage in the individual market health insurance exchanges. People who are already offered employer-sponsored coverage, however, are not allowed to obtain subsidized coverage through the individual market exchanges unless the employer coverage is deemed unaffordable (i.e., the employee would have to pay more than 9.5 percent of household income for the lowest-cost employee-only coverage) or if it does not meet the minimum value requirements. An eligible employer-sponsored plan would generally provide minimum value if the plan's share of total allowed costs of benefits provided under the plan is at least 60 percent of these costs. Notably, allowed costs will reflect the benefits the plan covers, as opposed to the actuarial values that determine the metallic (e.g., platinum, gold) benefit tier levels, which reflect essential health benefit requirements. If an employer-sponsored plan does not offer minimum value and if any full-time employees opt to purchase subsidized coverage in the exchange, the employer must pay a penalty.[3]

The ASPE brief explores the distribution of plan AVs for individuals enrolled in ESI. It computes AVs using two approaches, each of which uses a plan's actual cost-sharing provisions. The approaches differ on how the covered services are defined. In the first approach, the plan's actual covered services are used. In the second approach (referred to as the hybrid approach), an external benchmark is used. Two external benchmarks are used—a broader benchmark based on the Federal Employees Health Benefits Program Blue Cross/Blue Shield PPO plan (FEHBP-PPO) and a narrower benchmark based on a more limited set of services.

The brief concludes that the overwhelming majority of ESI plans meet or exceed an AV of 60 percent and that the share meeting the threshold varies only minimally by the definition of covered services used. An estimated 1.6 to 2.0 percent of individuals covered by ESI are estimated to be enrolled in plans with an AV below 60 percent when the AV is assessed relative to the services covered in the FEHBP-PPO plan. This share declines slightly to 1.4 to 1.8 percent under the narrower benchmark and to 1.2 to 1.6 percent using services actually covered by the plan. The brief also concludes that plans not meeting the 60 percent AV threshold are likely to be PPO plans with high deductibles or so-called "mini-med" plans, which have low annual limits.

Comments on the definition of covered services
The ASPE brief includes an analysis which calculates AVs under three definitions of covered services. The "internal benchmark" uses each plan's actual covered services. The "broader external benchmark" uses the services covered by the FEHBP-PPO plan. The

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[3] In addition, even if coverage meets the minimum value requirement, the employer must pay a penalty if any employees whose coverage is deemed unaffordable purchase subsidized coverage in the exchange.

"narrow external benchmark" covers a more limited set of health services—physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits, and laboratory and imaging services. The results find only very slight differences in the share of plans meeting the 60 percent AV threshold under the different definitions of covered services.

There are additional factors that should be considered when interpreting the results and formulating policies to regulate AV calculations for ESI:

- Small and large employers currently tend to cover the same scope of services and differ primarily in the cost-sharing requirements for those services. As a result, differences in AVs for small and large employers primarily will reflect differences in cost-sharing requirements rather than covered services (and, therefore, the benchmark used).

- The requirement that fully insured small employers offer essential health benefits likely will keep the scope of benefits offered by small and large employers comparable over time. It also likely will reduce any differences in AVs caused by using different coverage benchmarks.

- If over time, however, small and large employers do diverge in their scope of services, or if there are particular segments of the ESI market that currently cover a different scope of services, then AVs will vary more depending on what benchmark is used to reflect services covered. If the goal is for AVs to provide a relative comparison between plans, then an external benchmark would be appropriate as AVs would reflect a common set of covered services. If, on the other hand, the goal is for AVs to reflect more directly what share of its covered services are paid by the plan, then an internal benchmark would be more appropriate.

- Although the scope of benefits is fairly similar between small and large employers, there may be differences in the level of coverage (e.g., inside limits) for the various services covered. Whether/how those differences are incorporated into the denominator could affect the AV.

  o It is our understanding that, due to data limitations, inside limits (e.g., limits on the number of visits covered) were not incorporated into the ASPE analysis. Whether and how such limits would affect AVs depends on whether they are considered cost-sharing differences or benefit limits. If inside limits are considered cost-sharing differences, then the numerator of the AV calculation would be reduced, but not the denominator, thereby reducing the AV. If inside limits are considered benefit limits, then both the numerator and the denominator would be reduced, thereby lessening the reduction in the AV.

  o Recent trends suggest that ESI plans are increasing cost-sharing requirements. If these trends continue, then ESI AVs will decrease over time. As these plans approach the 60 percent threshold, employers could consider decreasing the breadth of services covered to meet the threshold. Using an external benchmark would limit an employer's ability to alter its AV in this way.

- Depending on how covered services in the denominator are defined, employers with plans just above or below the 60 percent AV threshold could include or exclude benefits to alter actuarial value. It is important, therefore, to consider how the different benchmarks would affect AVs for plans close to the 60 percent threshold. For instance, if an internal benchmark is used, then a plan potentially could increase its actuarial value by eliminating a service that has a high cost-sharing requirement (as long as that would not violate any applicable essential health benefit requirements). Such treatment would not be possible if an external benchmark is used. Services not in the essential health benefits benchmark potentially could provide a particular opportunity this type of action.

- Whether and how out-of-network cost-sharing requirements are incorporated into the AV calculation could affect the results. It is our understanding that the ASPE analysis was done using in-network cost-sharing requirements only. Actuarial modeling typically allows for the valuation of out-of-network benefits and includes an assumption for out-of-network utilization. Because this assumption is usually quite low (e.g., 5 percent), the effect on AV likely is minimal. Nevertheless, the effect can be consequential for plans near the 60 percent AV threshold.

- Administrative burdens also should be considered when formulating policies to regulate AV calculations for ESI. Depending on the specifics of the approach, an external or internal benchmark could be more administratively feasible.

Comments on the data and modeling approach used in the analysis

The underlying data used in the ASPE analysis include the 2005 Bureau of Labor Statistics National Compensation Survey (NCS) and expenditure profiles on persons with ESI from the Medical Expenditure Panel Survey-Household Component (MEPS-HC). It is our understanding that for this analysis the MEPS data were scaled upward to better reflect average ESI per capita costs by service based on National Health Accounts data. Although this adjustment helps ensure that average costs are accurate, it does not address the understatement of MEPS claims at the upper end of the distribution. Because the underlying distribution of claims can affect AVs, if the intention is for plans to use a standardized dataset to determine AV, it is important that the data used are accurate not only in terms of average costs, but also in terms of the distribution of costs.

The ASPE analysis computes AVs by taking the ratio of the benefits paid to underlying covered expenses. The standard population used in this computation reflects the MEPS population with employer-sponsored coverage. Health insurance plan parameters are applied against the utilization and expenses of the standard population to determine the richness of the plan (i.e., the AV).

On a conceptual basis, the modeling approach used in the brief is reasonable. As a practical issue, however, employers will need to compute the AVs of their plans. To the extent that they use different models, methods, or data, the resulting AVs could differ. Analysis from the Kaiser Family Foundation illustrates how different models (using different methods, datasets, and plan parameters) can result in different deductible requirements when targeting a 70 percent AV and holding coinsurance rates constant (Table 1). In other words, holding all cost-sharing requirements equal would produce

different AVs across the different models. The choice of the modeling tool arguably could be a bigger factor than the inclusion or exclusion of certain benefits.

Table 1
Estimates of Plan Designs Meeting the Requirements for a Silver Plan (AV=70%)

Actuarial and Benefits Consulting Firm	Coinsurance	Deductible
Actuarial Research Corporation	20%	$4,200
Aon Hewitt	20%	$2,050
Towers Watson	20%	$1,850

Source: Kaiser Family Foundation, "What the Actuarial Values in the Affordable Care Act Mean," April 2011.
Note: Estimates reflect the standard silver plan with an out-of-pocket maximum of $6,300 and no cost-sharing subsidies.

In addition, each model's level of complexity, or lack thereof, could limit its sensitivity to small changes in covered benefits. While a detailed model may be able to measure the small changes in AV estimated by ASPE under the broader and narrower covered services benchmarks, it is possible that the proprietary models potentially to be used by the firms that will be determining AVs for the ESI market will not be as nuanced. The additional benefits covered by the ASPE brief's broader benchmark typically experience lower incidence rates and low severity. When implemented within the current set of modeling tools, the differences in AVs under the different benchmarks therefore could be even smaller than those found in the ASPE brief.

Comments on potential additional analysis
Factors influencing the decision to offer ESI, and the form that coverage takes, vary from employer to employer. While the preliminary results of the ASPE research indicate that the share of individuals with ESI who would be offered a plan below the 60 percent threshold would be fairly small (about 2 percent to 3 percent), the affected individuals could be concentrated in a particular group size or plan type. Aggregate results may be masking the impact to certain subsets. Further analysis might help determine the characteristics of plans that are just above or below the 60 percent AV threshold and how changes in the benchmark used—or other parameters—would affect the AV for those plans. In particular, we suggest exploring how AV varies by employer size, plan type (e.g., PPO, HSA-eligible HDHP), and insurance status (fully insured, self-insured).

In addition, as acknowledged in the ASPE brief's appendix, ESI generosity has been declining somewhat over time as cost-sharing requirements have increased. It would be useful to project the impact of continuing declines in generosity on the share of plans not meeting the 60 percent AV threshold.

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We welcome the opportunity to discuss any of the comments presented in this letter 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).

Sincerely,

Thomas F. Wildsmith, MAAA, FSA
Vice President, Health Practice Council
American Academy of Actuaries