



January 12, 2023

Ellen Montz, PhD  
Deputy Administrator and Director  
Center for Consumer Information & Insurance Oversight (CCIIO)  
Centers for Medicare & Medicaid Services (CMS)  
200 Independence Avenue SW, Room 739H-02  
Washington, DC 20201

Re: Draft 2024 Actuarial Value Calculator Methodology

Dear Dr. Montz:

On behalf of the Individual and Small Group Markets Committee of the American Academy of Actuaries (“the committee”),<sup>1</sup> I appreciate the opportunity to submit these comments regarding the Draft 2024 Actuarial Value Calculator Methodology.<sup>2</sup>

### **Concerns Regarding AVs Across Metal Levels**

The committee has previously commented<sup>3</sup> that the Actuarial Value (AV) Calculator should use a single standard population for all metal levels adjusted to reflect induced utilization differences based on the standard AV for each metal level to produce the continuance tables by level. Under tables designed in this manner, the AVs for a given plan design would increase monotonically from bronze to platinum, reflecting only the effect of induced utilization. The current metal level continuance tables are developed from the experience of enrollees with plan designs assumed to match the metal level. Cost Sharing Reduction (CSR) enrollees in the highest CSR variants are included in the platinum metal level continuance table. The current process results in metal level tables that reflect morbidity differences in the underlying population. The committee notes that the CMS analysis in the 2021 Risk Adjustment technical paper<sup>4</sup> indicates that high-AV CSR enrollees do not exhibit induced utilization for the higher benefits compared to standard silver enrollees, so their experience may not be appropriate for platinum enrollees.

The 2024 AV Calculator shows monotonically increasing AVs for a given plan design over bronze through gold, but the platinum AV is less than the gold AV. This is an improvement over the 2021 AV Calculator, which for some plan designs also had an inconsistency with the silver AV compared to the bronze AV. These results, illustrated in Table 1, are counterintuitive.

---

<sup>1</sup> 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.

<sup>2</sup> <https://www.cms.gov/files/document/draft-2024-av-calculator-methodology.pdf>.

<sup>3</sup> [Comments of January 31, 2022](#) and comments of [November 9, 2020](#).

<sup>4</sup> [2021 RA Technical Paper 102621](#).

**Table 1. Actuarial Values Produced by the 2020, 2021, and 2024 AV Calculators, Select Plan Designs**

<b>Plan Option</b>		<b>Bronze</b>	<b>Silver</b>	<b>Gold</b>	<b>Platinum</b>
\$8,250 Deductible 100% Coinsurance \$8,250 MOOP*	2020	59.1%	59.8%	60.0%	60.8%
	2021	61.9%	60.9%	63.8%	61.3%
	2024	62.4%	64.0%	65.9%	64.3%
\$3,000 Deductible 80% Coinsurance \$6,000 MOOP	2020	69.4%	70.3%	70.7%	71.6%
	2021	71.1%	70.9%	73.5%	71.5%
	2024	71.4%	73.4%	75.0%	73.8%
\$1,500 Deductible 80% Coinsurance \$5,000 MOOP \$25 PCP/MH/SA copay** \$35 SCP copay***	2020	79.0%	79.4%	79.5%	80.0%
	2021	79.7%	79.7%	81.4%	80.0%
	2024	79.7%	81.2%	82.0%	81.1%
\$500 Deductible 90% Coinsurance \$1,000 MOOP \$2 / \$5 / \$25 / \$100 pharmacy copays	2020	91.3%	91.8%	92.0%	92.3%
	2021	91.3%	91.7%	92.8%	92.1%
	2024	91.4%	92.6%	93.2%	92.9%

\*MOOP—Maximum out-of-pocket

\*\*PCP—Primary care physician/MH—Mental Health/SA—Substance abuse

\*\*\*SCP—Specialty care physician

Because the metal levels are meant to indicate the relative richness of the cost-sharing designs to help consumers make their plan choice, the committee suggests that the AVs be standardized to be measured on the same standard population where only benefit richness is being measured, and not morbidity differences. The benefit richness measure is being distorted by the morbidity differences in the AV Calculator, which reduces the usefulness of the AV as a tool for helping consumers understand the relative generosity of different benefit plans. In addition, the Affordable Care Act (ACA)<sup>5</sup> requires the use of a standard population and is referenced in Actuarial Standard of Practice (ASOP) No. 50.<sup>6</sup>

The inclusion of morbidity in the continuance tables adds confusion to the purpose of the AV Calculator. The AV Calculator is an aid in consumer shopping, and not a pricing tool, but

<sup>5</sup> Sec. 1302(d)(2): Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

<sup>6</sup> [http://www.actuarialstandardsboard.org/wp-content/uploads/2015/10/asop050\\_182.pdf](http://www.actuarialstandardsboard.org/wp-content/uploads/2015/10/asop050_182.pdf).

consistency is an important element here. Issuers are not required (or even encouraged) to use the AVs produced by the AV Calculator as pricing factors. Instead, issuers are allowed to determine their plan relativity factors using relevant ASOPs and their own experience, and must comply with the single risk pool requirements. The inclusion of morbidity in the AV Calculator could be interpreted as implying its use for pricing. In particular, the separate standard populations underlying each metal tier suggest that the single risk pool can reflect the characteristics of enrollment in that metal tier while maintaining a single risk pool. This approach is not in alignment with how pricing is determined in the individual and small group markets using the single risk pool approach and may mistakenly lead stakeholders to compare AV and pricing plan actuarial values or to use AV as a proxy for plan pricing factors.

The committee thanks CMS for continuing to “investigate potential methods for creating a single continuance table AV Calculator in future updates.” The committee is appreciative of these efforts and is willing to assist in reaching this goal with the next AV Calculator update.

The committee also appreciate CMS’s efforts to analyze plan actuarial values using External Data Gathering Environment (EDGE) claims data. The committee believes EDGE data is a more appropriate actuarial data source for the AV Calculator than Health Intelligence Company, LLC (HIC) data, for many reasons including:

- EDGE represents claims data of the population for which the AV Calculator is intended, and
- EDGE eliminates the need to infer benefit design characteristics such as member cost sharing as benefit plans are identified and cost sharing can be directly derived through a link to Product Benefit Templates.

The committee asks CMS to share their analysis using EDGE data with stakeholders. The committee supports and appreciates CMS’s desire for AV stability and believes that guardrails or a multi-year plan could be put in place for a smooth transition to EDGE data.

Another continuing issue with AV Calculator updates is the difficulty in designing a bronze plan AV. The leanest possible ACA-compliant plan design<sup>7</sup> produced by the 2024 AV Calculator has an actuarial value of 60.17%, which is above the lowest de minimis value of 58% for the bronze tier. This is an increase over the 2023 AV Calculator, where the leanest compliant plan design had an AV of 59.86% for a plan with a \$9,100 MOOP.

The committee notes our continued support for the current practice of trimming high outlier claims in the Actuarial Value Calculator (AVC) continuance tables for the 2024 Calculator, as was done for the 2023 Calculator. Costs for these high cost claimants are more likely to reach the attachment point for high cost risk pooling. The committee notes that the ongoing struggles with designing metal tier compliant plans (particularly bronze plans) are the result of the disconnect between the premium growth measure used to establish the maximum annual limitation on cost sharing, which grows more slowly than typical medical cost inflation. It is likely that outlier trimming on its own will at some point in the future be insufficient to enable robust variation in plan designs at the bronze metal tier. The committee encourages regulators to explore avenues

---

<sup>7</sup> Plan design with an \$9,450 deductible and MOOP and 100% coinsurance.

within the law to promote the availability of bronze plans, but recognizes that meaningful change may require Congressional action.

### **Other Concerns Regarding the AV Calculator**

The committee notes that the discrete component continuance tables in the AV Calculator do not typically align with the composite claims in the cumulative table. For example, consider the silver combined continuance table. For claims capped at \$2,000, the silver population spent \$1,163.13 on average. Meanwhile, component costs for those members (the sum of all service-specific continuance tables) are only \$610.12. The model's calculation logic makes an assumption that the total \$1,163.13 is essentially allocated similarly to the component services underlying the \$610.12. However, differences in service mix at the various utilization levels may potentially drive actuarial value differences in the standard population relative to that implied by the model.

The committee is generally supportive of CMS's change to the copay accrual logic that discussed in last year's comment letter. The new logic aligns with the most common industry practice, in which copays for services obtained prior to the deductible do not accumulate toward the deductible. The committee encourages further innovation in this area to allow flexibility in the model to allow the user to choose whether and which copays do or do not accumulate to the deductible.

The committee also appreciates that CMS recognized the need to update the AV Calculator with the ability to allow users to input more benefit-specific cost sharing, expanding the number of drug tiers, and changes with respect to Mental/Behavioral Health and Substance Use Disorder Outpatient Services (MH/SUD) cost-sharing. Continued efforts in this area will produce more actuarially appropriate AVs for consumers. While users of the AV Calculator may and can apply workarounds, an AV model that reflects how cost sharing truly varies by benefit plans in the market will create efficiencies for all stakeholders, especially regulators and issuers, and could reduce AV differences in similar plan designs.

### **Minimum Value Calculator**

The committee recommends that CMS continue to work with the Department of the Treasury to update the Minimum Value (MV) Calculator, which has yet to be updated since its initial launch, to reflect more recent large group data and to incorporate appropriate model changes that have been made to the AV Calculator. Going forward, the committee further recommends the MV Calculator be updated regularly and, in a manner, consistent with improvements that are made to the AV Calculator, including MOOP limits, fixes to underlying logic, and trend. As the current MV Calculator reflects 2014 plan year experience and plan limits, the Calculator cannot accommodate many compliant plan designs, and results are increasingly unlikely to provide an accurate representation of the generosity of plan designs in 2024 and beyond. Assuming a 5% cost trend from 2014 through 2024, total cost levels for 2024 plans would be over 63% higher than suggested by the current MV Calculator. This increased level of costs means the current MV Calculator most likely underestimates the generosity of a given plan design when that plan design can be entered into the Calculator. Given the differences in the underlying population

used for the MV Calculator and for the AV Calculator, it is not appropriate to use the AV Calculator to demonstrate compliance with the MV requirement. Of concern to the Academy is that actuaries working with large employers could increasingly be left without uniform usable federal guidance as to how to assess whether a given plan design complies with the minimum value requirement.

\*\*\*\*\*

The committee welcomes the opportunity to speak with you in more detail and answer any questions you have regarding these comments. If you have any questions or to discuss further, please contact Matthew Williams, the Academy's senior health policy analyst, at [williams@actuary.org](mailto:williams@actuary.org).

Sincerely,

Joyce E. Bohl, MAAA, ASA  
Chairperson, Individual & Small Group Markets Committee  
American Academy of Actuaries

CC:

Jeff Wu, Deputy Director for Policy, Center for Consumer Information & Insurance Oversight  
Catherine Crato, Senior Leader, Health Tax Analysis, U.S. Department of the Treasury