Public Comments on Actuarial Value and Cost-Sharing Reductions

(March, 2012)

Health Partners

Minnesota Hospital Association

Blue Cross and Blue Shield of Minnesota

UCare
March 16, 2012

Commissioner Michael Rothman, MN Department of Commerce  
Commissioner Lucinda Jesson, MN Department of Human Services  
Commissioner Edward Ehlinger, MN Department of Health  
State of Minnesota  
St. Paul, MN 55101-2198

Submitted electronically via the HealthReform.MN@state.mn.us email address.

Re: Response to the Request for Comment on the Actuarial Value and Cost-Sharing Reductions Bulletin

Dear Commissioners,

HealthPartners appreciates the opportunity to respond to the Request for Comments on the Actuarial Value and Cost-Sharing Reductions Bulletin released by HHS on February 24, 2012.

Overall, the suggested construct for developing actuarial values is a positive one. We believe that a publicly available Actuarial Value (AV) Calculator that plans nationwide would use is a workable approach. The Bulletin addresses both an Actuarial Value Calculator and Data Set Options. We believe that these two options should be separately addressed for clarity.

Data Source
We strongly believe that state specific data should be used for the creation of actuarial values. This is because we are convinced that the “shape” of the claims distribution in Minnesota is different than for the nation. We believe that Minnesota would not be well represented using a national data set or, worse yet, a national data set with a “state modifier”. It is also important to note that use of a national data set will result in unequal and inequitable subsidy levels by state. While the three tier approach suggested in the Bulletin recognizes this issue, we urge you to request that HHS allow time and encouragement for states to develop their approaches to better address these issues.

We recommend that the state convene a consensus process among technical experts to identify, develop and verify summary data that could inform the Minnesota version of a national Calculator. By identifying key summary data upfront that would be needed, such as claims probability distributions or continuance tables or average charge assumptions, payers could develop and send summarized data to a neutral third party for collation. For example, this neutral third party would compare submissions from Minnesota health plans, and then produce a blended continuance table that reflects the unique “shape” of Minnesota spending patterns. As our representatives in these discussions with HHS, it is crucial that you come to understand the actuarial dynamics of the subsidy formulas. Otherwise, Minnesota’s favorable care patterns (higher lows and lower highs) may create a permanent disadvantage. This approach has significant advantages over attempting to retrofit an existing claims repository to meet the needs of an AV Calculator.

Actuarial Value Calculator
As noted above, we urge you to support the HHS approach of a national Calculator modified with state-specific characteristics. The design of the Calculator should be displayed in a transparent and open manner, one calculator for use nationwide, and allow health plan actuaries opportunities to provide input. Because of the need for timely, the design should be released in stages. The final application could even be released before the data sets are available. This approach would allow health plans to provide feedback, understand
the Calculator more thoroughly and would result in a better final product. It would also allow states time to work on developing appropriate state data sets.

The Bulletin refers to “limited benefit information sufficient to” produce the Actuarial Value. Although we don’t have details on what this means, we are concerned that HHS may be oversimplifying the needed benefit information for a workable and flexible model. We encourage the state to push for a relatively robust set of design features to be incorporated in the Calculator. Such calculators are routinely used now by plans and should be readily adaptable for this purpose. We reiterate that it is important that this Calculator be made publicly available as soon as possible so that plans can get experience in understanding how to use them.

**The de minimus Standard**

We are troubled by the *de minimus* variation standards of +/- 2% at each metal level presented in the guidance. While this does allow for some consistency year to year to prevent annual plan redesign just due to small shifts in AV, it does little to allow for robust competition and innovative options for consumers. This is a very limiting window of AV. Put another way: limiting allowed plans to those with AVs of 60%, 70%, 80% and 90% is equivalent to saying that you can only build a house that is 2000, 3000, or 4000 square feet; houses of 3500 square feet are not allowed. We encourage the state to request full breadth in the allowable AV range.

This approach provides more room for plan options that give consumers real choice in the marketplace. Currently individuals and small employers are accustomed to having a multitude of plan designs from which to choose. The *de minimus* standard unnecessarily limits the choices that consumers and employers will have. While we appreciate the potential challenges for consumers new to the insurance market place, navigating these many options to find the right choice is why there will be navigators and brokers. Existing small groups and individuals should not face having fewer options because of restrictive rules governing Actuarial Value.

**Cost-Sharing Reductions**

Finally, the cost-sharing reduction approach seems reasonable. The limitation to three alternate variations for the silver plan to address those between 133% and 250% FPL appears to be a workable approach. However, we would suggest that plans in states with a Basic Health Plan should only be required to file the cost-sharing variation for the enrollees in the 200-250% FPL range.

Thank you for considering our comments. Feel free to contact me if you have any follow up questions.

Sincerely,

Robert Cumming
Senior Vice President, Actuarial and Underwriting
HealthPartners

Dorothy Petersen
Corporate Actuary
HealthPartners

Stephanie Frost
Senior Policy Manager
HealthPartners
March 15, 2012

Submitted electronically

Commissioner Mike Rothman, Minnesota Department of Commerce
Commissioner Ed Ehlinger, Minnesota Department of Health
Commissioner Cindy Jesson, Minnesota Department of Human Services
Healthreform.mn@state.mn.us

Re: Actuarial Value and Cost-Sharing Reductions Bulletin

Dear Commissioners:

On behalf of our 145 member hospitals and 17 member health systems, the Minnesota Hospital Association (MHA) appreciates the opportunity to comment on the Actuarial Value and Cost-Sharing Reductions Bulletin (AV/CSR) published by the Center for Consumer Information and Insurance Oversight (CCIIOO) on February 24, 2012.

The Minnesota Hospital Association supports a Minnesota-based Exchange that includes clear, concise, and correct information to help consumers make the best health insurance purchase for them. MHA also supports ensuring affordability of health insurance by subsidizing consumers who require additional assistance in order to purchase comprehensive coverage. Finally, MHA supports a robust, comprehensive, primary care-centered benefit set as proposed for the Essential Health Benefits. The proposals put forth in the AV/CSR bulletin attempt to achieve a workable balance of these goals. However, some of the affordability measures seem to be lost in the process.

Overall, MHA supports the actuarial value calculation goal set forth in the bulletin: to “provide consumers with the most direct comparison of plan benefit generosity across multiple issuers.” In particular, the proposal to make the calculation of actuarial value public and transparent is a win for consumers.

MHA continues to support efforts to provide affordable, quality, comprehensive health care and coverage to all Minnesotans. We are concerned the lowered eligibility for cost-sharing reductions and a possible discrepancy in premium tax credits and the cost of silver plan variations could impede efforts to achieve these goals.

MHA is concerned that CMS could not find an actuarially sound way to provide cost-sharing reductions within silver plans for individuals in households with incomes between 250% and
400% of the Federal poverty level (FPL). Although tax credits for premiums presumably will still be available for these households, lowering the maximum amount of out-of-pocket (OOP) costs would have made quality, comprehensive health insurance coverage that much more affordable for middle class families. Instead, some families may choose a catastrophic plan or even an exemption for coverage because the cost of coverage exceeds 8 percent of their income, making it unaffordable under the Affordable Care Act.

The second area of concern regards the premium tax credits and costs of silver plan variations. Individuals eligible for cost-sharing reductions and the silver plan variations will be automatically enrolled in the variation for which they are eligible with the highest AV. However, the premium tax credits will be based on the second-lowest cost silver plan. If the silver plan variation has a higher premium than the silver plan on which the tax credit is based, would the enrollee have to pay the difference? That difference could be another step away from affordable coverage.

Thank you again for the opportunity to comment. If you have any questions, please feel free to contact me at (651) 659-1405 or jmcnertney@mnhospitals.org.

Sincerely,

Jennifer McNertney
Policy Analyst
March 16, 2012

Commissioner Michael Rothman, MN Department of Commerce
Commissioner Lucinda Jesson, MN Department of Human Services
Commissioner Edward Ehlinger, MN Department of Health
State of Minnesota
St. Paul, MN
Submitted electronically via the HealthReform.MN@state.mn.us email address.

Re: Response to the Request for Comment Regarding the Actuarial Value and Cost-Sharing Reductions Bulletin

Dear Commissioner Rothman, Commissioner Jesson, and Commissioner Ehlinger:

Blue Cross and Blue Shield of Minnesota (Blue Cross) appreciates the opportunity to provide input on the Actuarial Value and Cost-Sharing Reductions Bulletin (Bulletin) released February 24, 2012 by the U.S. Department of Health and Human Services (HHS). Blue Cross is a non-profit health service corporation that provides coverage to nearly 2.7 million persons. We are the largest health carrier in Minnesota, providing coverage in both the public and private markets.

For Blue Cross Blue Shield of Minnesota, final rulemaking on the Affordable Care Act’s (ACA) provisions for actuarial value and cost-sharing reductions is critical. Timely guidance on the calculation of actuarial value and the administration of cost-sharing reductions is vital to ensuring that the product cycle of development, filing, and offering is complete for the October 1, 2013 open enrollment period.

Ensuring the standard population reflects Minnesota

Blue Cross supports the flexibility HHS intends to provide to states in the development of a standard population. Adjusting the standard population with state-specific information will allow for a more accurate comparison among health plans for consumers because it will better account for the cost of care, utilization of services, and benefit designs within our marketplace. In particular, recognition of state-specific utilization and cost levels by service type, such as inpatient hospital, outpatient hospital, mental health, or physician services, may improve the accuracy of actuarial values.

Recognizing the challenges associated with timely data collection and validation, we support the use of a Minnesota-specific demographic adjustment of the federal standard population initially while a more robust data source is identified and validated. State-specific data may also inform a policy approach to key related issues, such as area factors. And, on a more practical level, state-specific information will also reinforce the ACA goal that the new marketplace should complement the existing marketplace by ensuring that products reflect those currently available in each state.
**De minimus variation allows for appropriate flexibility**

Blue Cross believes the *de minimis* variation of +/- 2 percentage points for actuarial value allows for an appropriate level of flexibility, particularly given the uncertainty in the short-term of the broad changes in 2014. Absent an allowance for flexibility in actuarial value, health plan designs would have to be modified significantly each benefit year. With multiple market reforms effective in 2014, including but not limited to guaranteed issue, community rating, essential health benefits, and limits on cost-sharing, this flexibility is critical.

A *de minimis* standard will balance that uncertainty with a sufficient level of predictability and choice for consumers. For example, this small variation will allow for minimal difference between plans within the same metal level, which gives consumers the reliability of the expected average level of coverage within a single metal level. In addition, this variation is critical to preserving the ability to offer consumers health plans with simple, easy-to-understand deductibles, coinsurance, and copayments.

Moreover, this flexibility will provide regulatory consistency to ensure that plan designs can be refreshed based upon actual experience and adapted to promote greater value and drive delivery system reform.

**Simplicity needs to be balanced with accuracy**

Blue Cross agrees that it is important to implement a simplified approach to actuarial value calculation that allows for clear comparison of health plans by consumers. However, an oversimplified approach will result in a less accurate, and thus less meaningful, comparisons for consumers. It is important that sufficient information is considered within the calculation of actuarial value.

As the Bulletin discusses, some cost-sharing amounts have a larger impact on actuarial value than others. Cost-sharing for prescription drugs, for example, can have a material impact on actuarial value of a health plan and should be included within the calculation. The calculator’s design should ensure that consumers are in the position of making decisions based upon value with respect to prescription drugs and other benefits, such as separate deductibles for inpatient services and first-dollar coverage for a fixed number of office visits. That is, HHS should develop a calculator that recognizes the variation among prescription drug and other benefits, and that reflects value-based plan designs, such as efforts to promote the use of generics.

At the very least, it is important that whichever option is decided upon for addressing different plan designs has clearly defined parameters for when an insurer may deviate from the calculator. This would still allow for greater movement toward value-based insurance designs, as encouraged within the ACA, which will require flexibility in plan design and actuarial value calculation.

** Appropriately recognizes contributions to HSAs and HRAs**

Finally, Blue Cross strongly supports the inclusion of employer contributions to health savings accounts and health reimbursement accounts within the actuarial value calculation. Such a policy will appropriately recognize the investment employers make toward the cost of health care for their employees and allow employers to continue to offer affordable coverage options to employees.
It remains unclear how the employer’s contribution amount will be included within the calculation. Blue Cross believes the entire employer contribution should apply towards this calculation for the benefit year in which the contribution is made. This would ensure that any amount of the contribution that carried over to a later benefit year would not be counted twice, while simplifying the allowance for full value of the investment an employer makes towards their employee’s health care coverage.

Finally, from an implementation standpoint, it would be best if this amount could be supplied and attested to by the employer without the requirement that an insurer verify this amount. This would align with the goals of the ACA and its implementing regulations that seek to minimize unnecessary administrative burdens.

Blue Cross appreciates the opportunity to discuss the important issues of the calculation of actuarial value and the administration of cost-sharing reductions. If you have any questions about this letter or if we can provide further assistance, please contact me at 651.662.8786 or Scott_Keefer@bluecrossmn.com.

Sincerely,

Scott Keefer
Vice President
Policy and Legislative Affairs
Joint Agency Request for Comments Regarding Actuarial Value and Cost-Sharing Reductions Bulletin

In general, UCare is favorable toward the approaches identified by the Center for Consumer Information and Insurance Oversight (CCIIO) on Actuarial Value and Cost-Sharing Reductions (AV/CSR) as described in the February 24, 2012 bulletin. The comments provided below are designed to further strengthen and/or clarify the intent described therein:

- **Allowing state flexibility to develop State standard populations based on State claims data (page 5).** UCare supports this approach as it will allow Minnesota to model plans consistent with our Minnesota health care experiences. Because state level data will play such a fundamental role in the exchange under this scenario, UCare supports establishing specific data quality standards for individual states seeking to define State standard populations and periodic data audit processes to ensure the State claims data is valid for calculating AV.

- **Establishing three pricing tiers across the United States (page 5).** UCare appreciates the need to keep calculations as simple as possible and can see inherent benefits to a simple three-tier system. However, there are significant variations in utilization patterns and costs of care between Minnesota’s urban and rural areas that may not be adequately accounted for in a single-tier assignment to our state. UCare recommends an approach that would have greater sensitivity to the significant variations in statewide rural and urban geographies.

- **AV Calculator (page 7).** UCare supports the use of an AV calculator to provide both formal and informal estimates of AV for plan designs. At this point, we see no significant barriers to including the limited set of benefits and services as listed in the bulletin. However, as ACOs and other innovative plan-partnerships evolve, there may be limits to only considering in-network hospital stays.

- **Consumer Choice of Silver Plans (page 14).** The following paragraph needs greater clarification:

  “Because silver plan variations with higher AVs would always provide the most cost savings to enrollees while providing the same benefits and provider network, consumer choice would be straightforward – consumers would always be best served by enrolling in the highest AV variation of the standard silver plan selected for which they are eligible. HHS intends to propose that when a consumer selects a silver plan in the Exchange, he or she would be enrolled in the highest AV silver plan variation for which he or she is eligible.”

It appears as if HHS is recommending all subsidized members be automatically enrolled in the highest AV silver plan, regardless of consumer choice. There are many factors that go into a
consumer decision-making that are not directly accounted for in AV calculations such as strong customer service experiences, quality ratings, and ease of working with a plan (e.g., limited complaints, appeals and grievances). HHS needs to clarify the intent of this paragraph. UCare supports consumer choice among available silver plans.

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