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POLICY & ACTION FROM CONSUMER REPORTS

December 21, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9980-P
Baltimore, MD 21244–8010

Submitted via www.regulations.gov

RE: Proposed Rule on Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, dated November 26, 2012

Dear Secretary Sebelius:

Consumers Union, the policy and advocacy division of *Consumer Reports*, congratulates you on bringing out these important proposed regulations. Together with the other provisions of the Act, these regulations will help ensure that millions of consumers realize their new rights and protections as intended by the Affordable Care Act (ACA).

We strongly support the following provisions of the proposed rule:

- Selection of a single actuarial value (AV) calculator to ensure uniformity when measuring health plan coverage levels;
- A robust standard for measuring employer minimum value; and
- A strong process for identifying state EHB-benchmark plan designs.

However, to realize the full promise of health reform, we urge revision of some of the proposed regulations, particularly those dealing with the AV calculator, benefit substitution for essential health benefits (EHB), and anti-discrimination provisions.

Our comments address the proposed AV calculator first, and then address specific language in the EHB NPRM.

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The AV Calculator

Clarity on the Purpose of the AV Calculator

In the introduction to the *Actuarial Value Calculator Methodology*,[1] HHS's stated goal is to develop a calculator that can "provide a close approximation" of "actual average spending" for "a wide range of consumers in a standard population." Further, the calculator should be able "to accommodate the majority of plans."

However, the ultimate purpose of the calculator is not to approximate "average **spending** by consumers" but to accurately measure whether "the benefits are **actuarially equivalent** to [60] percent of the full actuarial value of benefits under the plan." [ACA Sec. 1302 (d)(1)] Further, the AV calculation is to be made using the EHB definition of benefits provided to a standard population. [ACA Sec. 1302 (d)(2)]. Put more simply, the purpose of the calculator is to measure the **percentage** of the cost of all EHB services paid by the plan, if its cost-sharing provisions were applied to a standard population of both sick and healthy enrollees. A leading goal of the ACA is to provide consumers with more standardized insurance options and transparency, so that they shop with confidence. The AV calculator is our common "yardstick" for measuring whether or not issuers provide benefits that meet those ACA-defined standards with respect to portion of costs paid by the health plan.

Consumers Union recommends that HHS clarify the ultimate purpose of the AV calculator, referring to the requirements from the ACA statute. Specifically, the goal is to measure the **proportion** of spending paid by the plan, for a standard population, for EHB services. Based on this revised purpose, we heartily agree that the calculator should provide a "close approximation" of the AV percentage and that it should be accurate for the majority of non-group and small group plan designs.

We further recommend that the goals of the AV calculator be quantified by requiring that the accuracy of the AV estimate be within 1 percent of what a more sophisticated tool would show[2] and that it be able to accommodate a sufficient number of benefit designs so as to represent 95 percent or more of overall enrollment in non-group and small group products. We hope HHS will do an assessment to ensure that these goals are being met in the proposed AV calculator design.

To the extent that states substitute their own calculator in the future, **we recommend** that HHS augment federal rules to require that state AV calculators be at least as robust as the

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[1]Centers for Medicare & Medicaid Services, HHS. *Patient Protection and Affordable Care Act; Actuarial Value Calculator Methodology*, posted November 26, 2012 http://cciio.cms.gov/resources/EHBBenchmark/av-calculator-methodology.pdf

[2] A more sophisticated tool might use a micro-simulation modeling approach and would include additional benefit categories, including the ability to model service limits. Such a model is described in: McDevitt and Lore, *Actuarial Valuation Under the Affordable Care Act: Plan Valuation with the Consumer in Mind*, June 8th, 2012. http://www.consumersunion.org/pdf/Plan_Valuation_with_the_Consumer_in_Mind.pdf

federal calculator. In other words, alternate AV calculators should provide AV estimates that are within 1 percent of what a sophisticated tool would show and the alternate must be able to accommodate plan designs representing 95 percent or more of overall enrollment in non-group and small group products.

Calculator Incorrectly Incorporates Four Standard Populations

All approaches to actuarial estimation start with a detailed understanding of medical spending, typically gleaned from claims data. The approach taken by the proposed AV calculator uses continuance tables, which are essentially spending distributions – one for each type of benefit being modeled. As an example, the AV calculator includes a distribution corresponding to inpatient facility spending, in order to model cost-sharing specific to that service.

However, the AV calculator does not use spending distributions from a single, uniform standard population, as required by the statute, but instead carves up the underlying claims data into four populations based on an imputed coverage level assigned to each annual spending record. To illustrate, if annual spending appears to be associated with a "bronze" level of coverage, that record is assigned to the bronze spending distribution in the AV calculator and excluded from other distributions representing silver, gold and platinum levels of coverage.

The methodology document justifies this approach by claiming that it is necessary to capture "induced demand" associated with varying levels of coverage. This would be correct ***if*** the actuarial estimation exercise were to estimate a premium for the product -- but the purpose of the AV calculator is not to estimate premiums. The goal of the AV calculator is to isolate and reveal differences between plans associated with their cost-sharing provisions, as described above. Indeed, the objective of using a single AV calculator approach is to ensure that plans with the same cost-sharing features will receive the same AV estimate, allowing for clearer comparisons across plans. However, the proposed approach using four spending distributions does not do this (Exhibit 1), and will mask true differences in cost-sharing.

Exhibit 1: Population Differences Yield Different AV Estimates for Same Plan Design (Estimate is for a plan with deductible=$6,000 and OOPM=$6,000)

Spending Distribution:	AV for sample plan is:
Platinum	57
Gold	58
Silver	58
Bronze	59

Source: Actuarial Value Calculator, http://cciio.cms.gov/resources/EHBBenchmark/av-calculator-final-locked-11-20-2012.xlsm

Not only is the use of four populations at odds with statutory intent, but the exercise complicates the use and understanding of the model and leads to differences in service specific distributions that are at odds with common sense.

As illustrated in Exhibit 2, overall spending is higher in the "platinum" distribution than the "bronze," as one would expect in the real world and one an actuary would want to account for ***if*** pricing a product. However, even if it were appropriate to capture utilization effects, the populations in the AV calculator are "fixed" and not responsive to plan-specific variations in cost-sharing. For example, preventive services by law are associated with zero cost-sharing. Therefore we would expect utilization to occur at high levels and to be identical across all four populations. However, as shown in Exhibit 2, population spending on preventive services varies by 20%. Speech therapy also does not follow an expected distribution, with spending being greatest for enrollees that presumably face the highest cost-sharing.

Exhibit 2: Spending Averages by Coverage Level from AV Calculator

Spending Distribution:	Overall Average Cost per Enrollee	Average Cost per Enrollees for Selected Services		
		Imaging	Speech Therapy	Preventive Services
Platinum	$5,823	$202	$3.64	$207
Gold	$5,418	$188	$3.86	$186
Silver	$5,159	$173	$3.41	$170
Bronze	$4,989	$177	$4.97	$173

Source: Actuarial Value Calculator, http://cciio.cms.gov/resources/EHBBenchmark/av-calculator-final-locked-11-20-2012.xlsm

Consumers Union recommends that the data underlying the AV calculator be streamlined to represent a single, standard population. This revised approach is consistent with statutory intent, it allows consumers to more accurately compare plans across the metal levels, it makes the AV calculator less confusing to use and explain, and reduces the presence of data inconsistencies such as described above.

We further recommend that this single, standard population reflect the usage associated with a generous plan design. Using a population with access to a generous plan is

necessary to properly value the more generous plans in the Exchanges and it is appropriate to measure less generous plans *relative* to this benchmark.[3]

Adding Precision to the Denominator - EHB Covered Services

There are several areas where additional accuracy could readily be added to the proposed AV calculator:

Skilled Nursing Facility (SNF)

Coverage for SNF services is included in some employer plans and not others.[4] Hence, we would expect that the claims data underlying the AV calculator reflects a mix of plans that cover SNF and plans that do not cover SNF. Furthermore, some state EHB benchmark plans cover this service and others do not. It is not appropriate to include a "diluted" amount of SNF in the AV calculator and for it to be present for all AV calculations whether or not the EHB in that state includes SNF.

We recommend (1) the underlying claims data be parsed to indentify those populations where SNF is clearly covered and to identify average SNF spending per enrollee in these populations (age and sex adjustment can be applied). (2) The AV calculator user interface and underlying estimation logic should be altered to include SNF in the continuance tables when SNF is part of the EHB package and excluded when SNF is not part of the EHB package. When included, the average amount should be distributed across overall spending levels, as indicated by the underlying claims data for populations with SNF coverage.

This recommendation will have the impact of applying a larger and more accurate amount of SNF spending in states where SNF is included in the EHB. It will also increase the accuracy of AV estimates for all states.

Pediatric Dental

Pediatric dental is a required component of the EHB package. The ACA allows stand-alone pediatric dental plans in exchanges. As a result, qualified health plans (QHPs) may offer coverage that excludes this service. Benefit designs that exclude pediatric dental from the rest of the EHB package requires careful consideration of the AV target that such a plan would have to hit, the method of calculation, and the impact on patient out-of-pocket (OOP) limits.

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[3] See McDevitt and Lore, *Actuarial Valuation Under the Affordable Care Act: Plan Valuation with the Consumer in Mind*, June 8th, 2012. In addition, the Massachusetts exchange uses a similar approach, benchmarking other designs relative to their "gold" level.
http://www.consumersunion.org/pdf/Plan_Valuation_with_the_Consumer_in_Mind.pdf

[4] *Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services*, April 15, 2011.

Accommodating stand-alone dental plans should hold consumers harmless with respect to overall coverage levels promised by the ACA (the metal tiers and reduced cost-sharing targets) and maximum permitted patient OOP costs. In the AV calculator, it is consistent with the law that pediatric dental spending be included in the denominator of the AV estimate (as it is a component of overall EHB spending). However, **we recommend** that this pediatric dental spending also be separately identified in the continuance tables and when this service is not covered by a carrier, it should clearly be reflected in the AV estimate. The AV calculator's user interface will have to be modified so that the insurer's cost-share can be set to 0% (no coverage) when issuers do not cover this service.[5]

Consumers Union recommends that medical insurers and pediatric dental insurers be required to coordinate benefits to ensure that a family's OOP spending does not exceed ACA limits across the two plans. Coordination of benefits is common in the industry today when enrollees have coverage from more than one issuer. In addition, compared to consumers, insurer claims systems are better equipped to track and reconcile the order in which claims are incurred. Under a scenario where coordination of benefits is required (in and outside of the Exchange), the current OOP maximums in the AV calculator can stay the same.

If HHS does not require medical and stand-alone dental carriers to coordinate their benefits, then the consumers' OOP maximums required by the ACA will have to be broken into three limits. (1) Integrated plans can continue to have benefit designs that contain OOP limits up to the maximum permitted by law. (2) HHS rules would assign a lower OOP limit (reflecting the absence of an EHB service) to medical plans that exclude pediatric dental coverage and (3) the dental plan designs would incorporate the balance of the maximum OOP limit permitted by law. Breaking the OOP maximums into three separate limits would not be the ideal solution, as many consumers will not use the pediatric dental benefit and, hence, will pay slightly higher prices than they would under an integrated plan (all other things being equal). However, if HHS does not require coordination, it becomes paramount to protect consumers that do use pediatric dental services, to ensure their overall OOP spending does not exceed the amount permitted by law, particularly for lower income families.

Maternity

Maternity cost-sharing often follows a very different pattern than cost-sharing for other medical conditions. For example, according to one survey, roughly one-third of employer plans charge a co-pay for the first pre-natal visit but none after that.[6] **Consumers Union recommends** that maternity services be separately accounted for in the AV calculator, at

[5] This adjustment may make it more difficult for issuers that do not offer pediatric dental to hit the AV targets of 60%, etc. Whether or not their target should be revised depends, in part, on the proportion of overall spending represented by pediatric dental. Unfortunately, HHS denied our requests to provide this information.

[6] *Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services*, April 15, 2011.

least for a few years, until it can be determined whether or not unique cost-sharing continues to apply to maternity services. Specifically, a separate spending distribution for this service should be constructed and the user interface altered to accept common cost-sharing variations. If HHS declines to include this specificity, we ask that an analysis of maternity spending in the underlying claims data be publicly released so that the public can better understand the actuarial impact of non-standard cost-sharing for this service.

AV Calculator: Better Transparency Is Needed

While the proposed AV calculator is a significant step in the right direction, we believe that this tool is not yet transparent enough. The estimates produced by this calculator have a profound impact on the coverage available to consumers in the individual and small group markets and also serves to anchor the amount of the tax credit some families will be eligible for. We can think of no good reason why additional underlying data should not be released allowing a more complete understanding of the how the calculator implements the law. While raw claims data contains personally identifying information, by the time it is de-identified and aggregated to the levels used by this calculator tool, such concerns are no longer relevant. HHS should not enter into contracts with any entity that refuses to make this high level data publicly available. If regular vendors of this data will not cooperate with such efforts, HHS should use data from state's all payer claims databases. As described below, methodological considerations also require greater clarity.

Pediatric Dental Spending. **We recommend** publicly releasing the average amount of dental spending included in the calculator spending distributions. Furthermore, greater transparency and clarity about the method by which pediatric dental spending was distributed across the continuance tables included in the proposed AV calculator. It defies common sense that this "puts the bulk of [pediatric dental] costs in the highest spending brackets." The footnote in the methodology document describing this allocation cannot be reconciled back to the columns of information in the calculator itself.

Maternity Spending. **We recommend** publicly releasing the average amount of maternity spending included in the calculator spending distributions, defining maternity as pre-natal, delivery and post-natal care.

Unclassified Services. These services represent about 22% of overall spending in the AV calculator. Because they are unclassified, by default they will always be subject to the medical deductible, coinsurance and OOP provisions. **We recommend** that HHS release additional detail about the services in this category. For example, DME, home health and hospice are likely in this category. We would like to see average spending by major category of service, to ensure that this very limited approach to cost-sharing is appropriate for such a large portion of the spending.

Age-sex distributions used to weight Claims Data. According to the methodology document, separate continuance tables representing age/sex groups for a given metal tier are assembled and then weighted to reflect expected market participation for each sex/age

group to form a single distribution for the metal tier. These weights are derived from 2007-2011 data from the Census Current Population Survey (CPS) and a series of decision rules to predict individuals' behavior in the 2014 health insurance marketplace.[7] The CPS is a less robust survey than the American Community Survey (100,000 sample size vs 3 million sample size). Even though multiple years of CPS were used, only about 10 percent of the records in the survey represent people likely to purchase in the non-group market.[8] **We recommend** HHS release additional information about expected market participation for each sex/age group. Expected participation by age-sex group and a description of the decision rules should be released so that the public can be confident that the result conforms to the goals for this tool.

Apparent Data Inconsistencies in Continuance Tables. According to the methodology document, "[t]he continuance tables rank enrollees by allowed total charges … and group them by ranges of spending. These ranges of spending define the rows of the continuance table. The data are then used to calculate the number of enrollees with total spending falling within each range[A], the cumulative average cost in the range for all enrollees, and the average cost for all enrollees whose total spending falls within the range[B]" (letter designations added).[9] Mathematically, multiplying the information in [A] by the information in [B] should result in the total amount of spending for the population and, once divided by total enrollees, should result in the correct amount of average spending for this population. However, this type of reconciliation cannot be done in the continuance tables released to date. **We recommend** that this discrepancy be clarified.

We urge HHS ***not*** to finalize the AV calculator until HHS publicly releases additional information and provides an additional opportunity for public comment.

[7] Centers for Medicare & Medicaid Services, HHS. *Patient Protection and Affordable Care Act; Actuarial Value Calculator Methodology*, posted November 26, 2012 http://cciio.cms.gov/resources/EHBBenchmark/av-calculator-methodology.pdf

[8] State Health Access Data Assistance Center. 2010. "Comparing Health Insurance Estimates from the American Community Survey and the Current Population Survey." Issue Brief #22. Minneapolis, MN: University of Minnesota. http://www.shadac.org/files/shadac/publications/IssueBrief22.pdf

[9] Centers for Medicare & Medicaid Services, HHS. *Patient Protection and Affordable Care Act; Actuarial Value Calculator Methodology*, posted November 26, 2012 http://cciio.cms.gov/resources/EHBBenchmark/av-calculator-methodology.pdf

Allowing for *De Minimis* Variation

HHS proposes to allow for *de minimis* variation around the relevant actuarial targets as follows:

Exhibit 3: Proposed *De Minimis* Variation Around Actuarial Value Targets

Metal Tier AV Targets	Proposed *de minimis* variation	Cost-sharing reduction AV Targets	Proposed *de minimis* variation
60%	+/- 2 percentage points		
70%	+/- 2 percentage points	73%	+/- 1 percentage points*
80%	+/- 2 percentage points	87%	+/- 1 percentage points
90%	+/- 2 percentage points	94%	+/- 1 percentage points

* Further, for each issuer, the AV of the standard silver plan and the AV of the silver plan variation applicable to individuals with household incomes between 200 and 250 percent of the FPL must differ by at least 2 percentage points.

While the ACA allows for *de minimis* variation, HHS provides this rational for the proposed amount of variation:

- Metal tiers: allowing plans the flexibility to use convenient cost-sharing metrics, while still ensuring comparability of plans within each metal level (EHB NPRM)

- Reduced Cost-sharing plans: because cost-sharing reductions are reimbursed by the Federal government, the degree of flexibility afforded to issuers of silver plan variations in the cost-sharing design should be somewhat less, while still preserving some flexibility to use convenient cost-sharing metrics (Benefits and Payment NPRM, dated December 7, 2012)

Consumers Union will file comments on the Benefits and Payment NPRM confirming our strong support for the proposed 2 percentage point differential between silver plans' actual AV and the AV of silver plan variations offered by the same insurer.

However, we have two concerns about the proposed *de minimis* variation. Our key concern is that a family's tax credit is tied to the second lowest-cost silver plan available to them. The proposed variation means that the tax credit could be benchmarked against a 68% AV plan instead of a 70% AV plan, resulting in a tax credit that is $100 lower than it otherwise would be for an individual below 150% of FPL, with even greater discrepancies for low-income families.[10] Furthermore, that second lowest-cost silver plan might exclude pediatric dental coverage, reducing the premium and therefore the associated tax credit even more.

[10] This differential was calculated using the proposed AV calculator to compare a 68% AV plan and a 70% AV plan I assumed that second lowest cost plan featured a premium equal to average spending for the population, adjusted for AV plus 20% for administration.

While some *de minimis* variation might be beneficial for consumers, Consumers Union cannot endorse a +/-2 percentage point spread for silver plans, absent a more nuanced rule from IRS that specifies the second lowest-cost silver plan must hit the 70% AV target and must include the pediatric dental benefit.

Further, the proposed +/- 2 percent variation provides insurers with much more latitude than is needed for "convenient cost-sharing metrics." As the Exhibit 4 shows, a +/-2 percentage point spread for a 70% AV plan, i.e. a 72% plan and a 68% plan, creates a jump in deductible of $600 dollars!

Exhibit 4: Sample Plan Designs Associated with +/-2% de minimis standard (Silver Level)

	Plan 1	**Plan 2**
AV	71.6%	68.0%
Deductible	**$1,200**	**$1,800**
Coinsurance	75%	75%
OOPM	$6,400	$6,400

Source: Actuarial Value Calculator, http://cciio.cms.gov/resources/EHBBenchmark/av-calculator-final-locked-11-20-2012.xlsm

While we agree that federal government has a fiduciary responsibility with respect to federal monies spent to reduce cost-sharing, surely this also applies to coverage that is partially paid for by federal tax credits. Furthermore, we strongly believe that consumers have a right to similar expectations, namely, that their coverage should adhere to statutory requirements at least as closely as coverage in which the federal government has an interest.

For these reasons, **Consumers Union strongly recommends** that all forms of *de minimis* variation be restricted to +/- 1 percentage point and that the AV calculator be updated to reflect this change. Section 156.140(c) should be updated to reflect this recommendation. We further recommend that HHS and IRS work together to modify their mutual rules to ensure that the second lowest cost plan used for benchmarking the tax credits adhere as closely as possible to a silver plan with an actuarial value of 70% and includes coverage for pediatric dental.

Accounting for Service Limits-Establishing Actuarial Equivalence

Service limits are a form of cost-sharing. A 15 day visit limit for outpatient mental health is functionally the same as patient coinsurance of 100% for visits 16 and beyond.

As the ACA's 2014 consumer protections rein in insurer practices with respect to dollar-denominated cost-sharing, we should expect a significant expansion of other types of limits. Experience with the 1996 federal mental health parity law is instructive. Group plans were prohibited from imposing annual and life-time dollar caps on mental health

benefits that were more restrictive than those for Med/Surg. Overnight group plans switched to day and visit limits.[11]

HHS has proposed including any service limits contained in a state's EHB-benchmark plan in the state's EHB standard for the individual and small group market. Further, HHS proposes to allow insurers to make substitutions in covered services within a benefit category, as long as the change is actuarially equivalent. In theory, the AV of the benefit category and overall AV would not be reduced by any substitution. In reality, however, wide discrepancies in how actuarial estimates are made could mean that consumers would face reductions in coverage.

HHS has proposed that benefits substitution be certified as being actuarially equivalent using an analysis that is:

- Conducted by a member of the American Academy of Actuaries;
- Performed in accordance with generally accepted actuarial principles and methodologies, and
- Uses a standardized plan population.

Consistent Methods of Assessing Actuarial Value must be Used

Significant work to date has shown that using the proposed AV standards actually results in a broad array of possible outcomes. Actuarial estimates are very dependent upon the underlying data being used[12] and the estimation methodology.[13] Unless these sources of variation are controlled for, actuarial equivalence using the proposed methods may be a meaningless test. (That is why we applaud HHS for adopting a single model for use in assigning metal tiers.)

In our comments on the EHB and AV bulletins, **Consumers Union strongly urged** that the AV calculator be enhanced so that it can be used to establish actuarial equivalence by taking into account both dollar denominated forms of cost-sharing *and service limits*. The claims data underlying the current AV calculator should have the claims detail needed to build the necessary distributions or HHS should consider a micro-simulation approach to estimation. Micro-simulation can much more easily accommodate a wide variety of benefit designs – including service limit detail - than can a series of continuance tables.[14]

The coverage that a consumer ends up with will be a function of both the dollar denominated cost-sharing and the service limits in the plan. It makes sense that a consistent tool should be used for both aspects of benefit design, lest flexibility with

[11] U.S. General Accountability Office. Washington, DC: 2000. *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*. GAO/HEHS-00-05.
[12] See for example: Levitt, Larry and Claxton, Gary. "What the Actuarial Values in the Affordable Care Act Mean," Kaiser Family Foundation (2011).
[13] McDevitt and Lore, *Actuarial Valuation Under the Affordable Care Act: Plan Valuation with the Consumer in Mind*, June 8th, 2012.
[14] McDevitt and Lore, *Actuarial Valuation Under the Affordable Care Act: Plan Valuation with the Consumer in Mind*, June 8th, 2012

respect to service limits undermine the benefits of having a standard way of measuring dollar-denominated cost-sharing.

Accounting for the Generosity of Family Coverage

In the non-group and small group markets, family coverage is often characterized in terms of multiples of the cost-sharing facing individuals.[15] For example, if the individual's deductible is $500, the family deductible might be $1,000 (2 times individual deductible) or $1,500 (3 times the individual deductible).

The proposed AV approach does not measure plan generosity with respect to family coverage. It relies exclusively on individual cost-sharing. Two plans that have the same AV when measured using a single person's cost-sharing could be very different in terms of generosity when family deductibles and cost-sharing are taken into account.

For example, in Exhibit 5, Plan 1 is more generous than Plan 2, but the AV calculator would produce the same estimate.

Exhibit 5: Example of Plans with Identical Individual Coverage but Different Amounts of Family Coverage

	Plan 1		**Plan 2**	
	Med/Drug Combined		Med/Drug Combined	
	Individual	**Family Multiple**	**Individual**	**Family Multiple**
Deductible ($)	$500	2x individual	$500	3 x individual
Coinsurance (%, Insurer's Cost Share)	75%	75%	75%	75%
OOP Maximum ($)	$5,000	2xindividual	$5,000	3 x individual (or maximum allowed by law)
AV	78%	??	78%	??

While there are actuarial adjustments that could be made to account for family coverage, the NPRM does not speak to this.

Consumers Union recommends additional discussion among stakeholders to answer the following:

- For purposes of assigning metal tiers, were any family coverage adjustments considered?

[15] Plan design information for the non-group market is difficult to come by, but this survey does report individual vs. family deductibles (averages only): http://www.kff.org/kaiserpolls/upload/8077-r.pdf (see Appendix 2). This 2012 employer survey shows that family coverage can be associated with an "aggregate deductible" or a family deductible that is a multiple of the individual deductibles. See Exhibits 7.11 and 7.16. Some information is available separately for small firms: http://ehbs.kff.org/pdf/2012/8345.pdf

- For purposes of conveying plan generosity to consumers, were any family coverage adjustments considered?

The EHB Rule

Section 156.115(b) Provision of EHB-Benefits Substitution

As described in more detail above, Consumers Union is strongly against issuer-derived benefit substitutions. **We urge** HHS to permit the proposed benefits flexibility **ONLY** if the Department is prepared to provide a robust and methodologically consistent tool for establishing equivalence as described above.

When Outside Estimates Must Be Used, Requirements Must Be Stronger

Section 156.115 (b) - For benefit designs (including service limit substitutions) that cannot be assessed with an *improved* AV calculator, **Consumers Union recommends** that outside assessments be permitted, but the standards must be strengthened. Proposed new wording is underlined.

".. the analysis must be":

- Conducted by an independent actuary (not affiliated with the insurer) who is a member of the American Academy of Actuaries,
- Performed in accordance with generally accepted actuarial principles and methodologies, with this restriction: it is not appropriate to include an adjustment for induced demand as part of this estimation exercise;[16]
- Using a standardized plan population that has been benchmarked to the overall spending distribution in the Federal Actuarial Value Calculator and to the spending distribution for the EHB service category being analyzed.[17]
- These analyses must be public documents, clearly describing the standard population, the benchmarking process and the estimation approach.

Section 156.115(b)(2) states that the carrier must "Submit evidence of actuarial equivalence to the state." (underline added). **We recommend** that this be broadened to include a copy to CMS. This may be important for states with a federally-operated Exchange.

[16] Induced demand is not appropriate in this type of exercise for the reasons described above in the discussion of the standard population in the AV calculator.

[17] In order to assess the impact of change in service limits, a distribution of visits (or days) will be needed. But these visits will have spending associated with them and the corresponding spending can be benchmarked. At present, spending distributions in the AV calculator do not correspond exactly with the EHB categories; however the underlying data would permit this level of specificity.

Not All Benefits in an EHB-Benchmark Plan Fall into a Statutory EHB Category

The NPRM is silent on benefit substitutions that are part of an EHB-benchmark plan but do not fall cleanly into a statutory EHB category (for example, SNF, home health or imaging).

Consumers Union recommends adding language to clarify the substitution constraints with respect to these types of services. Further, **we recommend** that substitutions be made only within the service categories associated with these types of services (as is required for standard EHB service categories). For example, substitutions made with respect to X-ray and imaging services would have to be actuarially equivalent to coverage offered for these services in the EHB-benchmark plan, if services are assumed to be covered at 100%. Reductions in SNF could not be accounted for by increases in imaging.

State Preferences Must Trump Insurer-Directed Benefits Flexibility

The preamble to the proposed rule notes that states are permitted to limit or prohibit benefit substitution. However, the actual proposed rule does not address state flexibility.

We agree that states must have the option of curtailing the proposed benefits flexibility if they feel it is in the best interests of their residents. Leaving substitution up to insurers could result in their crafting benefit packages that attract certain populations at the expense of others. Indeed, the benefits flexibility permitted to Medicare Advantage plans has been shown to result in designs that attract favorable risk.[18] To illustrate, an insurer could put together a benefit package that substitutes physical therapy services that treat short-term sports injuries for services that treat more chronic conditions (thus attracting a younger, healthier population) for services more commonly used by people with disabilities, who have an ongoing need for regular physical therapy. Moreover, states should be required to evaluate substitutions for risk selection effects, including whether the risk adjustment mechanisms included in the ACA are sufficient to counter any concerns.

Moreover, issuer flexibility would make it extremely challenging for state regulators and the Secretary to assess the essential health benefits in each product and for the Secretary to accurately report to Congress about their adequacy and need for modifications and updates to meet the requirements of the ACA.[19]

Consumers Union strongly recommends that Section 156.115(d) be revised to explicitly state, as the preamble does, that states may establish stricter standards for benefit substitution or prohibit benefit substitution completely (page 70651 of the Federal Register).

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[18] Brian Biles, Lauren Hersch Nicholas and Stuart Guterman, *Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?*, The Commonwealth Fund, May 2006.
[19] Affordable Care Act, Section 1302(b)(4)(G) and (H)

Substitutions Must be Transparent to Consumers

Consumers Union recommends that a standard method of conveying benefit substitutions be developed so that consumers can understand where benefits vary across issuers. This could be incorporated into the *Summary of Benefits and Coverage (SBC)*. Each state could place the SBC for the EHB-benchmark plan in a prominent location. Where coverage varies from the EHB-benchmark plan, this could be noted in a central location on the SBC. In the absence of such a disclosure, consumers are likely to assume (incorrectly) that benefits are more standardized than they are.[20]

Improve Clarity in the Rule

Two areas of Section **156.115** are ambiguous and should be improved:

- The section requires that EHB benefits be "substantially equal" to the EHB-benchmark plan, while still permitting some benefits substitution. **We recommend** that HHS add language to clarify when substitutions become so extensive that the plan benefits are no longer "substantially equal" to the EHB benchmark plan. HHS should identify a standard, test or metric that states will be required to use uniformly to determine when benefits are no longer substantially equal.
- Section 156.115(b)(3) requires that "Actuarial equivalence of benefits is determined regardless of cost-sharing." Cost-sharing is not defined in the rule, which could lead to ambiguity about the requirement. **We recommend** the proposed rule be revised to be more precise, such as, "Actuarial equivalence of benefits is determined based on the value of the service(s) as if the plan paid 100 percent of total allowed costs of benefits for the service(s)."

Section 156.125 Anti-discrimination Provisions are Important, but Insufficient as Currently Drafted

The proposed EHB-benchmark plans must also adhere to nondiscrimination standards in benefit design. While this is an important protection for consumers, it is not a workable remedy for preventing discriminatory effects and practices before they happen.

Under Section 1302, the Secretary is prohibited from discriminating against individuals because of their age, disability, or expected length of life in defining EHBs.[21] Section 1557 of the ACA additionally prohibits discrimination on the basis of race, color, national origin, sex, age and disability in health programs or activities that receive federal financial assistance, are administered by an Executive agency, or were established by Title I of the ACA.

The proposed rules do not articulate how HHS and the states will evaluate health plans to ensure these non-discrimination requirements are met. **We recommend** that HHS

[20] People Talk Research and Consumers Union, *Early Consumer Testing of New Health Insurance Disclosure Forms*, (December 2010).
[21] Affordable Care Act, Section 1302(b)(4)(B).

develop rigorous evaluation criteria to prospectively and retrospectively identify and enforce violations of the non-discrimination requirements. Further, we would like to see strong rules prohibiting specific discriminatory practices with respect to benefit design.[22] Overt discriminatory intent may be hard to evince, but discriminatory impact can be tracked. A great deal of enrollment data will become available through Exchanges and through risk adjustment, for example, and that information should be used to track patterns which may show discriminatory impact.

Section 156.120 Prescription Drug Benefit

We are heartened that the rule improves upon the EHB bulletin by requiring that plans in the individual and small group market offer drug options that are the greater of either (1) one drug per class or (2) what is offered by the state's EHB benchmark plan. Many benchmark plans have multiple drug options per class, so this will provide most consumers with more than one option within a drug class. However, it leaves open the possibility that consumers may be faced with the minimum of one drug per class which we feel is too limited. Some classes include multiple "families" of drugs and consumers may benefit from having coverage in the alternate families. For example, there are at least three families of diuretics. If a consumer is allergic to a thiazide, under our proposal they could take a diuretic in another family that is in that class.

Consumers Union recommends that this section be altered to guarantee patients the greater of (1) at least two options per category or class that are not pharmaceutically equivalent or (2) the number of drugs covered by the EHB-benchmark plan in each category and class. Thus, a brand and generic version of the same drug would not count as two options.

Section 156.130 – Cost-sharing Requirements

While we agree with the rationale for section 156.130(b)(3) [higher deductibles allowed if a plan cannot hit their AV target], **we recommend** this requirement be expanded to state that the federal AV calculator must be used to make this determination (or federally-approved state calculators that may be approved and be in use).

[22] For example, this GAO report examined Medicare Advantage benefits designs and found that "[p]lans in the good health group had higher cost sharing, weighted by enrollment, for inpatient hospital care, skilled nursing facility stays, and renal dialysis than plans in the poor health group. Plans in the good health group were more likely to have an out-of-pocket (OOP) maximum, but the average OOP maximum for plans in that group, weighted by enrollment, was 55 percent higher than that for plans in the poor health group. Comprehensive dental and hearing aid benefits were more likely to be included in the benefit packages for beneficiaries in the poor health group of plans whereas fitness benefits were more likely to be included in the benefit packages for beneficiaries in the good health group of plans." GAO, *MEDICARE ADVANTAGE Relationship between Benefit Package Designs and Plans' Average Beneficiary Health Status,* April 2010. http://www.gao.gov/new.items/d10403.pdf

Section 156.135 – AV calculation for determining level of coverage

In addition to the above comments on the AV calculator tool, we recommend the following clarifications:

- Section 156.135(b) does not state who the certification should be submitted to. **We recommend** that this certification be submitted to states, with a copy to CMS.
- Section 156.135(c) describes the treatment of health savings account (HSA) and health reimbursement account (HRA) contributions made by an employer. We support the methodological approach proposed, but feel the current wording is ambiguous with respect to the requirement to use the federal AV calculator to incorporate this type of benefit. **We recommend** that this sub-section be clarified to say that the proposed approach is to be accomplished by inputting the employer contributions into the federal AV calculator.

Section 156.140 Levels of Coverage

Section 156.140(c) incorrectly states that a variation of +/-2 percentage points "does not result in a material difference in the true dollar value of the health plan." We object to this wording on two counts. One, as discussed above, the measurement of AV is not to ascertain the dollar value of the health plan, but to accurately isolate and reveal the **proportion** of covered services paid by the health plan. Two, the proposed *de minimis* variation **is** a material difference to the consumer. As Exhibit 4 (above) shows, the proposed *de minimis* rule is associated with a $600 increase in the deductible at the silver level metal tier (holding coinsurance and OOPM constant).

As discussed in detail above, **Consumers Union recommends** reducing the allowable variation and changing the wording. In light of the implications for consumers, we recommend that the proposed spread be tried for two years, with the impact on consumers monitored. We strongly suggest alternate wording along these lines: "*De minimis* variation. The allowable variation in the AV of a health plan shall be +/- 1 percentage points for 2014 and 2015, at which time the rule will be revisited."

Section 156.145 Determination of Minimum Value

In general, we support the strong rules that have been proposed for minimum value. We applaud the reference to the "percentage of the total allowed costs of benefits,"[23] ensuring that consumers will have a common basis for assessing a coverage floor (EHB) in both the non-group and group markets.

[23] The proposed rule defines the *Percentage of the total allowed costs of benefits* means the anticipated covered medical spending for EHB coverage (as defined in § 156.110(a) of this subchapter) paid by a health plan for a standard population, computed in accordance with the plan's cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and expressed as a percentage.

When outside valuations are permitted, we recommend strengthening the rules along the same lines as proposed above. Proposed new wording is underlined.

"... the determination of MV must be:

- Made by an independent actuary (not affiliated with the insurer) who is a member of the American Academy of Actuaries, based on an analysis
- Performed in accordance with generally accepted actuarial principles and methodologies, with this restriction: it is not appropriate to include an adjustment for induced demand as part of this estimation exercise;[24]
- Using a standardized plan population that has been benchmarked to the overall spending distribution in the Federal MV Calculator and to the spending distribution for the EHB service category being analyzed;
- The analysis should be submitted to HHS (and/or DOL) and made public. These documents must clearly describe the standard population, the benchmarking process and the estimation approach."

On behalf of Consumers Union, I thank you for the opportunity to comment on these important regulations and would be happy to answer any questions.

Sincerely,

Lynn Quincy
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[24] Induced demand is not appropriate in this type of exercise for the reasons described above in the discussion of the standard population in the AV calculator.