March 28, 2012

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

Dear Director Larson:

AARP is pleased to offer comments on the Actuarial Value (AV) and Cost-Sharing Bulletin issued by the Department of Health and Human Services (HHS) and its Center for Consumer Information and Insurance Oversight (CCIIO) on February 24, 2012. The Department's approach to the AV and cost-sharing, coupled with its approach to implementing the essential health benefits (EHB), will affect the financial security and access to health services of many of AARP's members as well as many other Americans. AARP recognizes the need for the Department to strike the proper balance among competing objectives in crafting the rules, and believes the policy should be guided by the principle that all individuals have access to comprehensive, affordable, quality health care coverage that provides adequate financial protection against health care costs.

In particular, in examining the AV and cost-sharing issues, AARP emphasizes the need to focus on key priorities: clarity for the consumer in making decisions based on substantive distinctions among the AV and cost-sharing in the various plans, which entails minimizing the potential for a confusing array of subtle differences that preclude informed choice; and avoidance of selection issues that can result in consumers not getting the coverage they need and the risk pool itself becoming more costly. We would note throughout that all of these proposals are dependent, in part, on the risk mitigation measures in place under the recently issued final rule on Standards for Reinsurance, Risk Corridors and Risk Adjustment that was published March 23, 2012, and the forthcoming Advance Notice this fall that will provide critical information on such elements of these provisions as the risk adjustment methodology.

Calculation of Actuarial Value

HHS reviews two options for calculation of AV based on a white paper published by the American Academy of Actuaries: insurer-specific data versus a standard single data set on population, utilization, and provider pricing. AARP agrees with HHS' stated intent to propose the second option: a standard national data set for population, utilization and pricing. We believe that use of a standard national data set will be helpful in assuring that plans with the same cost-sharing will have the same AV, and it best allows consumers to compare plans within a "metal" tier. As the HHS analysis points out, under this approach, plans that negotiate better prices with providers, or have lower use of health care services, would not have that difference reflected in the AV calculation but in the premium itself, which is a clear comparator for consumers.

In constructing the standard data set, HHS proposes three tiers to reflect the range of provider prices in different geographic areas across the country, and requests comment on whether more tiers would yield more accurate AV calculations. We recognize that three tiers are a step toward a more accurate calculation than one national set of prices, but would still leave some variation due to regional and local pricing differences within the three tiers. There is no "right" number of tiers, but we recommend that the Department model different numbers of tiers to determine the tradeoffs between the desire for lesser variation within tiers and the need to limit the absolute number of tiers. The results of this modeling should be reported in the proposed rule to allow for public comment. In addition, as we understand the proposal, these tiers (whether three or more) would be part of the standardized data infrastructure, and not presented on the website for consumer review at the time of plan selection, but we would urge that CMS confirm this understanding.

HHS further proposes an option allowing a state to use state standard populations to account for variation in population, utilization, and health care pricing among the states. We recognize the importance of state flexibility in the evolving model, but we would urge CMS to provide more information about the implementation and implications of this approach. Specifically, what standards would HHS apply in reviewing, approving and monitoring such an approach? What are the implications for consumers for the resulting AV and cost-sharing structures in a state that opts to use state standard data and which has lower than average prices and use versus those in a state with a higher than average set of prices and use? Would HHS re-standardize the national data set to remove data from those states that have opted to use state-specific data, and what are the implications of that decision?

Operational Method for AV Calculation Using Standard Data

HHS sets out three approaches for providing issuers with standardized population data. In brief, the three options are to distribute a standard set of de-identified claims to issuers; distribute continuance tables to issuers; or develop a publicly available AV calculator using a set of claims data weighted to reflect the expected standard population, which all plans would use.

AARP generally supports HHS' stated intent to pursue the third option, the publicly available AV calculator, but would urge clarification of a number of potential features.

First, how would the publicly available calculator adapt to the multiple tiers of cost-sharing, and to the individual state options noted above? Further, while this calculator is "publicly available," we infer from review of the Bulletin that its purpose and use is for issuers in developing their cost-sharing within the AV tiers identified in the statute; it is not intended as the tool to facilitate consumer choice. As we have commented in previous letters, AARP believes that consumers need a calculator that will assist them in determining the potential impact of the various cost-sharing options. We assume that the publicly available AV calculator for issuers is not also intended for consumer use. We urge the agency to take the necessary steps to assure that consumers will not be confused by the availability of the issuer-focused calculator. AARP also reiterate the urgency of providing a calculator suitable for consumer use. We also have questions about some of the comments the Department makes in discussing the proposed AV calculator. In particular, the Department notes that a "handful" of cost-sharing features would have a large impact on AV, and that not all cost-sharing will have a material impact. It further notes that the calculator would consider only the value of in-network service use.

We recognize the need to balance the desire for a clear, easy-to-use calculator for issuers with the need for the most accurate AV calculation possible, but seek clarification about the Department's proposal. Under the proposal, a subset of cost-sharing features that constitute the major factors with a material impact would presumably be used to compute the AV and determine whether the issuer meets the standard. We would urge the Department to be fully transparent regarding the process of elements included and not included. We would also appreciate the Department's view about whether there is a risk (and possibly an incentive) for issuers to make decisions about the remainder of cost-sharing (those items not included in the calculator), which could, in sum, have an effect on the real AV itself, as compared with the AV computed by the calculator. We note that such variations would be in addition to the +/- 2 percentage point *de minimis* variation noted below. It does not take a substantial amount of variation in actual AV to have an impact on premium and on the affordability of services

subject to the cost-sharing. Plans that can lower their real AV outside the scope of the calculator would appear to have an unfair premium advantage because they would have a greater amount of actual cost-sharing.

Further, we would urge additional review and analysis of the Department's proposal to consider only the value of in-network service use, especially among issuers not meeting the standard that presumes only a small percentage of inpatient costs come through out-of-network providers. For example, what about plans with a relatively large percentage of inpatient use out-of-network (with higher cost-sharing); and what about plans with a relatively large percentage of out-of-network use for outpatient services?

Finally, HHS proposes options for plan design that are not accommodated by the AV calculator. The examples given are: (1) a plan with two different coinsurance rates and (2) a plan with a multi-tier network and with expected utilization across each of the tiers. In the evolving world of benefit design, such alternatives are increasingly prevalent. Again, this raises questions that HHS needs to clarify about the calculator itself and the consequences on plan design and consumer information.

De Minimis Variation Standards

HHS proposes to allow a *de minimis* variation in AV of +/- 2 percentage points. For example, a silver plan (70 percent AV) could have an AV of between 68-72 percent. We recognize the need (and statutory authority) for a *de minimis* standard, and recommend that the Department clarify several features of the proposal.

How will the Department monitor the combination of *de minimis* variation and the variation in AV noted above that is outside the scope of the calculator? Will there be mechanisms to assess the total variation? Will the Department be able to assess and publicly report on whether the *de minimis* variation in each Exchange is distributed relatively evenly around the metal level, or are most plans coming in at the low end of the allowed variation (68 percent AV versus 72 percent AV in the above example)? If so, what remedy might be proposed? Finally, would it be appropriate for different and tighter standards for the *de minimis* standard for the statutory AV set out for the income-related cost-sharing subsidies – including the silver plan on which those subsidies are based?

Treatment of Health Savings Accounts and Health Reimbursement Arrangements in Calculating Actuarial Value

HHS notes the challenge of calculating the AV of a high deductible health plan linked to either a health savings account (HSA) or a health plan linked to a health reimbursement account (HRA). HHS intends to propose to include in the numerator of the calculation of the AV the annual employer contribution to an HSA, and the amount made available for the first time in a given year in an HRA.

There appears to be logic to these approaches to computing health plan AV in the context of determining the AV of an employer-based health benefits program in which the employer makes account contributions. However, it is important to clarify explicitly that this policy is relevant only in that employer market, and not applicable inside the Exchange. We appreciate the Bulletin pointing out that the HSA contributions paid directly by the individual would not count towards AV. It is an important clarification for individual contributions to such programs in the employer market, and means the AV calculation for a product in the individual market (including the Exchange) cannot include the value of an HSA contribution.

Cost-Sharing Reductions and Out-of-Pocket Limits

HHS sets out its approach for implementation of income-related reductions in cost-sharing and in the maximum out-of-pocket (OOP) limits. As prescribed by statute, those reductions are based on the standard silver plan, which has an AV of 70 percent and a maximum OOP limit that is no more than the limit established in federal law for a high deductible health plan linked to an HSA. HHS notes the two types of reduction called for in statute based on the income tier of the family: reductions in cost-sharing (increases in AV), and reductions in the maximum OOP limits, and sets out a chart specifying the statutory provisions by income tier.

HHS then sets out an annual three-step process for implementation which AARP believes is a practical and transparent approach for proceeding:

- First, the department would set the maximum OOP limit generally applicable to all QHPs.
- Second, it would establish the reduced OOP limits for those in income tiers below 150 percent of the FPL, between 150 and 200 percent of the FPL, and between 200 and 250 percent of the FPL, along with the associated higher AV levels required for those income tiers. If HHS determines that the reduced OOP limit for a particular income tier makes it infeasible to reach the higher AV required for that income tier, then HHS would set a higher maximum OOP limit for that tier. HHS notes that it

would publish a summary of its analyses in its annual notice, along with a description of the model it uses.

- Third, it would require each QHP issuer to submit, along with each standard silver plan it proposes to offer, three variations in cost-sharing to meet the revised AV and maximum OOP limits for the three income tiers noted.

HHS intends to not implement reductions in maximum OOP limits for those with income between 250 percent of the FPL and 400 percent of the FPL, because of the difficulty of achieving that reduction without substantial increases in plan deductibles while still achieving the 70 percent AV level in the silver plan. While we recognize this is consistent with the Secretary's authority, we believe it is important the Department take the opportunity to follow the procedure noted in the second step above, which is to publish a summary of its analysis of this issue along with a description of the model it used to reach that conclusion. Such a summary will provide all stakeholders a good example of the approach and transparency that can be expected in the future.

AARP supports HHS' clarification that issuers would be permitted to vary only the cost- sharing structures – not the benefits or provider networks – in their silver plan variations meeting the higher AV and lower maximum OOP levels for the income-tiers noted. Further, we support HHS' intent to require that cost-sharing across a particular benefit or provider would be required to decrease or remain constant as silver plan variations increase in AV. Those policies, in combination, will help assure clarity for consumers in their choices.

Consistent with our views on benefit design flexibility expressed most recently in our January 31, 2012, letter on the essential health benefits bulletin, we believe HHS should require a higher level of scrutiny by the Exchanges of issuer approaches to cost-sharing for the three income-related AV levels that apply to individuals qualifying for cost-sharing reductions. This is important for the priorities we identified earlier: clarity for the consumer, without a confusing array of difficult to understand options, and avoidance of the potential for risk selection.

Payment

HHS sets out its approach to payment to plans for the value of the AV and maximum OOP reductions. AARP believes that the proposed hybrid system makes sense: advance payments to cover the projected amounts, followed by reconciliation to the actual cost-sharing reductions. We recommend, however, that HHS clarify several items. First, both the advance payments and the reconciliation presumably need to account for actual cost-sharing reductions as well as the actuarial estimates of the utilization impact of changes in cost-sharing. And second, we urge that you clarify whether the reconciliation will have any direct impact on consumers for the applicable year.

Thank you for the opportunity to provide these initial comments. We look forward to further discussions and providing additional input in response to the Department's proposed rule. If you have any questions, please feel free to contact Leah Cohen Hirsch of our Government Affairs staff at 202-434-3770.

Sincerely,

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