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1730 M Street NW, Suite 500, Washington, DC 20036-4561 ■ 202-785-3910 ■ www.nationalhealthcouncil.org ■ info@nhcouncil.org

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April 10, 2012

Mr. Steve Larsen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services

Re: Actuarial Value and Cost Sharing Reductions Bulletin

Submitted electronically to ActuarialValue@cms.hhs.gov and CostSharingReductions@cms.hhs.gov

Dear Mr. Larsen:

The National Health Council (NHC) appreciates the opportunity to submit comments on the pre-regulatory guidance, Actuarial Value and Cost Sharing Reductions Bulletin. Since the passage of the Affordable Care Act (ACA), the NHC has made enacting an essential health benefits (EHB) package that provides access to affordable and adequate coverage a top priority. The NHC has regularly engaged with the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare and Medicaid Services (CMS) to share its perspective as a voice for the patient community as the agency drafts regulations on actuarial value (AV) and cost-sharing reductions (CSR).

The NHC is the only organization of its kind that brings together all segments of the health care community to provide a united voice for the more than 133 million people with chronic diseases and disabilities and their family caregivers. Made up of more than 100 national health-related organizations and businesses, its core membership includes approximately 50 of the nation's leading patient advocacy groups, which control its governance. Other members include professional societies and membership associations, nonprofit organizations with an interest in health, and major pharmaceutical, medical device, biotechnology, and insurance companies.

The development of requirements to align the vast majority of individual and small group plans across the country is undoubtedly a challenge. It is impossible for any set of standards to satisfy the complex and often conflicting goals of all interested stakeholders. In general, the NHC agrees with the methodology of calculating AV, as laid out in the bulletin, with some specific exceptions. For well over a year, the NHC has carefully studied essential health benefits and actuarial value, and we have closely examined the best methods for achieving an appropriate balance of coverage and costs. In fact, since December 2011, the NHC has advocated for the use of the value of a standard benefit package to be used as the denominator of the actuarial value calculation.[1]

In its bulletin, HHS proposes to allow plans flexibility to design cost-sharing structures that meet AV requirements. Based on the definition of AV included in this bulletin, it

[1] *Memorandum: An Alternate Process for Developing Essential Health Benefits* is available at the National Health Council website at: http://www.nationalhealthcouncil.org/NHC_Files/files/NHC_EHB_12_2011.pdf.

seems that HHS intends for AV to allow patients to make broad comparisons between the different cost-sharing structures of plans. The bulletin introduces the concept of the proposed methodology to calculate AV using a national standard population dataset based on claims data, reflecting average utilization patterns and pricing. HHS also proposes to assign states to three pricing tiers, to reflect local utilization and pricing.

The bulletin also presents the operational method for putting these practices into action through the development of an AV calculator. The AV calculator would permit plans to submit a limited set of information that has the largest impact on AV (deductibles, co-insurance, maximum out-of-pocket, and cost sharing). However, the calculator will not consider out-of-network benefits, innovative plan designs such as Value-Based Insurance Design, or capture structures with multiple co-insurance rates.

The NHC would like to provide comments on the following five specific topics on AV and CSR addressed by the Actuarial Value and Cost-Sharing Bulletin:

- Standard Population
- Ensuring Innovation
- Non-Discrimination through Patient Protections
- Federal and State Oversight
- Out-of-Pocket (OOP) Limits for Individuals with Income at 250 to 400 Percent of the Federal Poverty Level (FPL)

Standard Population

The NHC is supportive of CCIIO's decision to standardize the methodology for calculating AV, particularly in terms of the use of a standard population. The standard population and assumptions will allow patients to compare the overall value of a plan more effectively. Though we understand that standardizing assumptions will lead to less precision for the AV of an individual plan, we believe that the policy will allow for better comparisons among plans, as individuals shop for and compare health insurance plan options.

Though the concept of a standard population is preferred over the other options presented in the bulletin, the NHC stresses the importance of ensuring that the standard population data set used by CCIIO in the AV calculator reasonably reflects the demographics of likely individual and small group enrollees. If the demographics and assumptions lean towards a healthier population covered by employer sponsored insurance, this could lead to an actual plan value far less than the value captured by an AV calculator. We suspect that CCIIO would need to adjust current datasets to adequately capture the demographics and utilization patterns expected in the new individual and small group markets, both in and outside the exchanges. The NHC strongly believes that the dataset as well as adjustments to the dataset must reflect the appropriate population and should be released publically.

NHC Comment: The NHC supports CCIIO's decision to standardize AV calculations through the use of a single nationwide dataset. This dataset and its adjustments should be publically available to ensure transparency in the AV calculation process.

Ensuring Innovation

The bulletin briefly refers to limits of the AV calculator's ability to incorporate innovative plan design, such as Value-Based Insurance Design (VBID). The NHC believes that innovations in plan design, including VBID and other efforts, are an important method that plans use to help their enrollees maximize value from their benefits

package. The federal government also has stressed the importance of innovation in health insurance coverage. For these reasons, the NHC urges CCIIO to account for this increased focus on innovation in AV calculations. The bulletin offers only limited explanation as to how plans could employ actuaries to assist in the process of assigning value to health insurance plans with innovative plan designs.

NHC Comment: The NHC encourages CCIIO to closely monitor and evaluate the process that plans use to value their plan designs when they fall outside of the range that the AV calculator can manage. Additionally, we believe that CCIIO should utilize this evaluation to formalize the process that plans use when they have complicated plan designs or use innovative structures.

Non-Discrimination through Patient Protections

An AV calculation is inherently limited in its ability to capture issues such as medication tier placement, utilization management practices, and formulary drug coverage. When this fact is considered in conjunction with the broad cost-sharing flexibility allowed to plans, it leads the NHC to fear that patients' access to needed medications and health services may be limited. Such limits may occur either through high cost-sharing or other utilization management practices. HHS should reaffirm that plans must follow all non-discrimination requirements when developing benefit designs to ensure benefit categories are not unduly weighted, as well as provide specific guidance to plans on how to meet the non-discrimination requirements set forth in the ACA.

As CMS develops regulations to implement AV and EHB, the NHC strongly encourages the agency to include comprehensive patient protections in the rule. The NHC has developed and shared with CMS model regulatory language for its envisioned set of patient protections.[2] In this document, the NHC offers the case for a spectrum of patient protections to be included in the EHB regulations that will safeguard people as they enroll in and navigate qualified health plans. Strong patient protections must include clarifications of cost sharing, discrimination, medical necessity, and exclusions. Specifically, the NHC recommends three coordinating layers of patient protections: 1) transparent medical necessity processes; 2) assurance of non-discrimination; and 3) access to useful information for selecting an appropriate plan through navigators.

These patient protections are critical to the success of qualified health plans and exchanges and to the health needs of the many people who will rely on EHB. Health plans that must meet AV standards will be a critical, if not sole, option for health insurance coverage for the millions of people who are expected to enroll.

NHC Comment: The broad flexibility of plan design afforded throughout the pre-rule bulletins on EHB and AV lead to legitimate concerns for patient access to needed medications and services. The NHC encourages the agency to define in regulation a spectrum of patient protections to ensure access and assure enrollees of non-discriminatory plan design.

Federal and State Oversight

As yet unmentioned in the pre-rules on EHB and AV are the vastly important topics of federal and state oversight. Such oversight is necessary to ensure that qualified health plans meet all appropriate and necessary criteria. The ACA leaves substantial discretion to states to oversee qualified health plans operating in state

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[2] *A United Patient Voice on Essential Health Benefits* is available at the National Health Council website at: http://www.nationalhealthcouncil.org/NHC_Files/files/EHB_UnitedPatientVoice.pdf.

exchanges. Currently, states are engaged in widely different levels of exchange implementation activity, with some state governors refusing all participation in exchange development.

Further, while a plan's AV may be useful to help patients compare the overall generosity of plan designs, it will not be able to sufficiently help patients distinguish between the intricacies of a plan. Plan design elements, such as utilization management, provider networks, and formulary tier placement, are very often the intricacies that patients should use to distinguish plans. A plan that focuses solely on AV would not provide adequate information to help patients discern which health insurance coverage is best for them, especially for people with multiple chronic conditions. For this reason, the NHC stresses that clear oversight mechanisms—both federal and state—are critical to ensuring that plans provide real coverage to the people who need it most. We understand that some level of flexibility within plans could lead to greater competition, more choice, and better innovation. However, the NHC believes that any permitted flexibility should first be subject to state oversight mechanisms. All state oversight efforts also should be subject to strict federally defined boundaries and oversight to ensure non-discrimination against any group of potential enrollees.

NHC Comment: Any AV or EHB regulation should require federal oversight of plan implementation to ensure that plans meet all ACA-defined requirements of essential health benefits. Further, the federal government should also oversee any state process that validates that health plans meet the benchmark requirements.

OOP Limits for Individuals with Income 250 to 400 Percent FPL

The language of the ACA creates a conflict for CCIIO in implementing cost-sharing reductions for some individuals, and the bulletin highlights the inherently poor design of the reduced out-of-pocket limits in the ACA. The mathematical conflict of the language of the ACA to define these cost-sharing reductions for individuals with limited income placed the agency in a challenging spot as it attempts to implement the statute, according to the legislative intent. Though the ACA clearly establishes reduced limits on the OOP maximum for people between 250% and 400% FPL, it also retains the 70% AV of the silver plan. Reducing the OOP limit without raising the AV would require some increase to the cost sharing parameters of the plan. The majority of people may not hit an OOP limit during a plan year. Therefore, the agency acted to minimize the overall out-of-pocket spending for most enrollees by maintaining the OOP maximum, even for individuals with income between 250% and 400% FPL.

The NHC understands the difficult position of the agency to implement this conflicting policy. However, we first would prefer to see data to support CCIIO's argument that the necessary increase in cost sharing to reduce the OOP limit would not be appropriate.

NHC Comment: The NHC asks that CCIIO analyze the expected population enrolled in silver level plans (across income levels) to determine the actual estimated amounts that cost sharing would rise to accommodate a reduced OOP limit for a subset of enrollees in a silver plan.

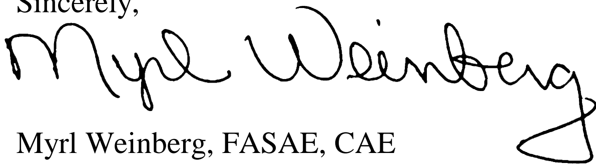
Second, we also suggest that CCIIO consider this policy temporary, pending the results of the analysis. If the analysis indicates that cost sharing for all silver plan enrollees would rise by a minimal amount, the NHC would encourage CCIIO to consider the policy laid out in the bulletin as temporary and develop an alternative strategy for this population. In either case, the NHC believes that data supporting the agency's position would strengthen the argument and encourage buy-in to the policy. The timeline for such evaluation could mirror the timeline laid out in the initial bulletin on EHB, released in December 2011. As such, this CSR policy would be in place for 2014 and 2015, with analysis informing the policy for 2016 and beyond.

Conclusion

The National Health Council believes that the approach to actuarial value and cost-sharing reductions outlined in this bulletin is an appropriate starting point. However, we stress that in order for these processes to work to meet the needs of the millions of people who will rely upon EHB, including AV standards, some provisions need to be strengthened and important details must be clarified in regulation. We believe the final regulation must include clear guidance on the standard population, federal and state oversight, and ensuring access and non-discrimination through patient protections.

We would like to thank you for this opportunity to share our comments. The NHC supports your efforts to ensure that EHB meets the intended objectives of improving and standardizing health care coverage. Please do not hesitate to contact Eric Gascho, our Director of Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable by phone at 202-973-0545 or via e-mail at egascho@nhcouncil.org. You may also reach me on my direct, private line at 202-973-0546 or via e-mail at mweinberg@nhcouncil.org.

Sincerely,



Myrl Weinberg, FASAE, CAE
President