Actuarial Value and Cost-Sharing Reduction Bulletin
Issued by HHS February 24, 2012

I. Purpose

The Department of Health and Human Services (HHS) issued on February 24, 2012 a Bulletin setting out the approach the Department plans to propose to implement policies under the Affordable Care Act (ACA):

- defining actuarial value (AV) for qualified health plans (QHPs) and other non-grandfathered coverage in the individual and small group markets under section 1302(d)(2) of the ACA;
- implementing the required cost-sharing reductions for households with income below 400 percent of the federal poverty level (FPL) under section 1402 of the ACA.

The Department is soliciting public input, and provides no deadline for comments. Comments on the proposals for AV should be sent to ActuarialValue@cms.hhs.gov; comments on cost-sharing reductions should be sent to CostSharingReductions@cms.hhs.gov.

II. Actuarial Value

Introduction and Background

HHS describes AV as a measure of the percentage of expected health care costs a health plan will cover, generally calculated by computing the ratio of:

- Total expected payments by the plan for essential health benefits (EHB) in accordance with the plan's cost-sharing rules for a standard population; over
- The total expected costs for a standard population for the EHB.

For example, a plan with an AV of 80 percent is expected to pay, on average, 80 percent of the expected expenses for the EHB for a standard population. HHS notes that this is an average; a plan with an average AV of 80 percent may pay zero percent for an individual who does not meet the deductible, and well in excess of 80 percent of incurred claims for an individual who incurs high costs that exceed the maximum out-of-pocket payment level.

Section 1302 of the ACA requires issuers offering non-grandfathered health plans inside and outside the Exchange in the individual and small group markets to meet specified levels of coverage, the "metal tiers," defined by their AV.

Table 1: The "metal tiers"

Tier	Actuarial Value
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

Actuarial Value and the Essential Health Benefits

HHS notes the AV is calculated based on cost sharing for the EHB. HHS set out its proposed intent for defining the EHB in its December 16, 2011 Bulletin[1] with follow-up on Frequently Asked Questions on February 17, 2012.[2]

Intended Regulatory Approach

HHS sets out its intended regulatory approach in the following sections.

Calculation of Actuarial Value: HHS notes that one option for assuring that plans meet the AVs in each of the metal tiers would be to require that each plan have exactly the same cost-sharing structure. HHS proposes instead that plans have the flexibility to develop cost-sharing structures so long as each plan's AV meets the required AV level. HHS presents two general options set out by the American Academy of Actuaries[3] for how insurers could determine AV.

Table 2: Review of Options for Calculating Actuarial Value (AV)

Option for Calculating AV	HHS comments
Option 1. An insurer could use its own plan-specific data on population, utilization and provider pricing to determine the AV. The plan would have to apply demographic adjustments to standardize the plan population.	Plans with the same cost-sharing could have different AVs, because of different provider prices or utilization controls. This approach most accurately reflects the actual percentage of costs paid by that particular plan.
Option 2. All insurers could use a single set of data and assumptions for population, utilization and provider pricing to determine the AV. Under this approach, the Centers for Medicare & Medicaid Services (CMS) would develop a data set based on claims for a standard population, reflecting average unit prices and utilization, weighted for the expected market enrollment.	Plans with the same cost-sharing would have the same AV. A plan that has the same AV but with lower prices with providers, or better utilization control, would have lower premiums. This approach best allows consumers to compare plans within a metal tier.

HHS intends to propose the second option: a standard national data set for population, utilization and health care pricing. HHS further identifies several adjustments it intends to propose.

- To account for geographical differences in provider pricing, HHS intends to propose applying three pricing tiers across the country and assigning each state to a tier. HHS specifically requests comment on whether applying more pricing factors would improve the accuracy of the AV calculations.

[1] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf
[2] http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf
[3] http://www.actuary.org/pdf/health/Actuarial_Value_Issue_Brief_072211.pdf

- To promote State flexibility and account for variation in provider prices, utilization, and benefits across states, HHS sets out an option for a state to define a state standard population based on state claims data. A state could either:

    - Define a standard state population based on state claims data for the non-elderly population likely to be covered; or
    - Modify the national standard population developed by CMS using state adjusters in accordance with sound actuarial practices.

Operational Method for AV Calculation Using Standardized Data: HHS identifies three methods to provide plans with the national standard population with which to calculate plan AV:

- Method 1: Distribute a standard set of de-identified claims data to issuers.
- Method 2: Distribute continuance tables to issuers (these are aggregated data derived from de-identified individual level claims data, that show paid claims at each increasing level of expenditure).
- Develop a publicly available AV calculator, using a set of claims data weighted to reflect the expected standard population, which all plans would use. Plans would input their own information on cost-sharing parameters. The logic and tables of aggregated data used for the calculator would be transparent.

HHS intends to propose method 3, and provides several comments.

- HHS expects a small number of cost-sharing features to have a large impact on AV. HHS intends to propose that the calculator only consider the value of in-network service use because only a small percentage of total inpatient costs comes from out-of-network utilization.
- HHS recognizes that a large number of inputs could theoretically improve the accuracy of the AV calculator, and recognizes the need to accommodate innovative plan design such as Value-Based Insurance design. At the same time, HHS notes a limit on the number of features that can be incorporated in such an AV calculator. HHS seeks comment on which inputs, benefits, and services are most appropriate for the calculator.
- HHS notes that its EHB bulletin allows each state to select a benchmark plan to define the EHB for a state. The calculator will be powered by national claims data reflecting "typical employer" plans representing the range of potential benchmark benefits chosen by the states. HHS notes that while the benchmark will vary state by state, the variation in benchmarks is very small, and is expected to have limited impact on the calculation of plan AV.

While HHS anticipates that the AV calculator will be appropriate for the vast majority of QHP issuers, it sets out two potential options for plan designs that the calculator is unable to accommodate.

- Allow QHP issuers to fit plan designs into the calculator logic and have an actuary certify that the plan design was fitted appropriately.

- Allow issuers to use the AV calculator for major plan provisions, and calculate appropriate adjustments in accordance with actuarial standards of practice for design provisions that deviate substantially from commonly used cost-sharing features.

De Minimus Variation Standards: HHS intends to propose a *de minimus* variation standard of +/- 2 percentage points to accommodate the type of simpler cost sharing options (such as round-number $10 copayments) that may come close to but not exactly reach the precise AV standards required. For example, a silver plan (70 percent AV standard) could have an AV between 68 and 72 percent. HHS notes that this approach will also mitigate the need for annual plan redesign.

Treatment of Health Savings Accounts and Health Reimbursement Arrangements in Calculating Actuarial Value: HHS notes the challenge of calculating the AV of high-deductible health plans (HDHP) linked to a health savings account (HSA), or of a health plan linked to a health reimbursement arrangement (HRA). HHS intends to propose to include in the numerator of the calculation of AV the annual employer contribution to an employee's HSA, and the amount made available for the first time in a given year under an HRA. In the individual market, an individual contribution to an HSA would not count toward the AV calculation.

III. Cost-Sharing Reductions and Out-of-Pocket Limits

Introduction and Background

HHS reviews the statutory requirements for reduced cost sharing for EHBs for individuals with household income of below 400% of the FPL. Those reductions start with the mandatory increases in the AV, reductions in the maximum out-of-pocket (OOP) limits for covered benefits, and then reduced deductibles, coinsurance, or copayments to reach the higher AV levels required.[4]

Intended Regulatory Approach

Out-of-Pocket Limits for Individuals with Household Income Less than 250% of the Federal Poverty Level[5]*:* HHS reviews the statutory requirements for income-related reduced cost sharing, which are based on the standard silver plan with required variations in AV and maximum OOP limits. By way of background, this summary reviews the required OOP limits as well.

The standard silver plan has an AV of 70 percent, and the statute calls for a maximum OOP limit for all QHPs that is not higher than the limit established under federal law for an HDHP linked to an HSA. For 2012, that limit is $6,050 for individual coverage and $12,100 for family coverage.

[4] The Bulletin notes that special statutory cost sharing provisions for an Indian will be addressed in future rulemaking. In general, there is no cost-sharing for those with household income at or below 300 percent of the FPL enrolled in an Exchange QHP, and no cost-sharing, regardless of household income, for services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or though referral under contract health services. QHP issuers are prohibited from reducing payments to any such entity for items or services.

[5] The FPL for 2012 is $11,170 for an individual, $15,130 for a couple, and $23,050 for a family of four.

Table 3 below sets out the standard silver package, and then the required variation in AV and maximum OOP limits for the various income tiers set out in the statute.

Table 3: Maximum Out-of-Pocket Limits and AV Requirements, by Household Income		
	AV Requirement	**Maximum OOP Limit (with 2012 amounts for individual/family coverage)**
Basic Silver Plan	**70%**	**100% of HSA Qualifying HDHP amount ($6,050/$12,100)**
Household Income		
100-150% of FPL	94%	1/3 of maximum OOP limit ($2,017/$4,033)
150-200% of FPL	87%	1/3 of maximum OOP limit ($2,017/$4,033)
200-250% of FPL	73%	1/2 of maximum OOP limit ($3,025/$6,050)
250-300% of FPL*	70%	1/2 of maximum OOP limit ($3,025/$6,050)
300-400%*	70%	2/3 of maximum OOP limit ($4,034/$8,067)
*As noted, HHS intends to propose that the reductions in the maximum OOP limit not apply for those with income above 250% of the FPL		

HHS intends to propose an annual three step process for the design of the cost-sharing structures for silver plan variations.

- HHS would set the annual maximum OOP limit generally applicable to all QHPs.
- HHS would publish the reduced maximum OOP limits for individuals with income between 100 and 250 percent of the FPL in an annual notice of benefits and payment. If HHS determines that the reduction in the maximum OOP limit is infeasible in achieving the required AV, then HHS would alter the reduction to make it feasible. For example, if the maximum OOP limit for all QHPs is $6,050[6] (2012 example), a reduction to one-third of that level (to about $2,017 for an individual) would be required for those with income between 150-200 percent of the FPL. If, however, HHS determines that it is not possible to construct an insurance package with a $2,017 maximum OOP limit and the required AV of 87 percent, then HHS would set a higher maximum OOP limit for that income for that year.
- Each QHP issuer would submit, along with the standard silver plan it will offer through the Exchange, three variations to match the reduced cost sharing required in Table 3 for those with income between 100 – 250% of the FPL. The standard for *de minimus* variations (+/- 2 percentage points) applies to the higher AVs for these income tiers.

Variations in Cost-Sharing Structures: HHS intends to propose several policies for reductions in cost sharing as a QHP issuer's silver plan's AV increases for those in lower income tiers.

- The cost sharing applicable to a particular benefit or provider would be required to either remain constant or decrease as AV increases: cost sharing would not be permitted to increase on any benefit or provider as the AV is increased.

[6] This example for this summary uses the actual 2012 maximum OOP limits for HSA qualifying HDHPs noted in Table 3 – it is slightly different than the general example provided in the Bulletin.

- Issuers would have flexibility, subject to non-discrimination and network access requirements, to vary cost sharing on particular benefits or providers – they are not required to make the same pro rata reductions in all cost sharing as the AV increases.
- Issuers would not be allowed to vary the benefits or provider networks as AV changes.

HHS intends to propose that when consumers select a silver plan in the Exchange, they will be enrolled in the highest AV silver plan for which they are eligible. The Exchange would also process changes in eligibility and enrollment and notify HHS through the year of changes to facilitate accurate advance payments.

Out-of-Pocket Limits for Individuals with Household Income 250-400% of the FPL: HHS intends to propose not to reduce the maximum OOP limits for those with household income between 250 and 400 percent of the FPL. HHS finds that such reductions in the OOP limit would require plans to significantly increase plan deductibles, coinsurance and copayments in order to reach the required 70 percent AV level.

Method of Payment: HHS proposes to implement a hybrid system for paying issuers for the value of the cost sharing reductions that are required for individuals with income below 250% of the FPL.

- Advance payment: Each issuer would submit for approval estimates of the average cost-sharing reduction amounts for each silver plan, and HHS would make a monthly advance payment to cover projected cost-sharing reduction amounts.
- Annual reconciliation: HHS would reconcile the advance payments at the end of the calendar year to the actual cost-sharing reduction amounts.

HHS describes this approach as similar to that used for the low-income subsidy in Medicare Part D. HHS solicits comments on whether its approach for paying for cost-sharing reductions should change over time. In particular, HHS seeks comments on the approach that might eventually be taken, what metrics should be used to determine whether and when a transition to a new approach may be accomplished with minimal risk to program integrity.