AMERICAN ACADEMY *of* ACTUARIES

December 21, 2012

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9980-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Proposed rule on standards related to EHB

To Whom It May Concern:

On behalf of the members of the American Academy of Actuaries'[1] Individual and Small Group Market Task Force, I appreciate this opportunity to comment on the proposed rule, "Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation." This comment letter focuses on issues related to essential health benefits (EHB). We provided comments on issues related to actuarial value in a separate letter.

General Comments

Benefits exceeding EHB

We request clarification on whether plans can offer benefits that exceed EHB levels on and/or off an individual/Small Business Health Options Program (SHOP) exchange. We specifically are interested in guidance for situations in which a plan voluntarily offers benefits that exceed EHB—not including state-mandated benefits that must be offered in a plan even though they are not part of the EHB. If plans can offer benefits that exceed EHB (on or off an individual/SHOP exchange), will the premiums have to be isolated for consumers? If premiums and claims associated with benefits that exceed EHB levels have to be segregated for the purpose of administering the risk mitigation programs, please provide specifics as to how this will be accomplished.

State-mandated benefits

In the benefits elements template accompanying this proposed rule, issuers are asked to indicate whether there are any state mandates beyond those benefits listed (Field 69). We are aware of questions related to which state mandates fall into which category. Many states previously have considered and mandated different benefits or benefit levels between the individual and small group markets, including considerations as to

[1] The American Academy of Actuaries is a 17,000 member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

affordability between the markets. We request clarification on the following specific items:

- It is our understanding that state mandates that do not apply to a particular market would continue not to apply. For example, state mandates that apply only to the individual market would continue not to apply to the small group market. If any state mandates applying only to the individual market are not included in the benchmark plan for small group coverage, they are considered non-EHB. As such, if they are included in any issuer's small group plan, the state would not be responsible for defraying the costs of those benefits. The same would hold for any mandates that apply only in the small group market but not in the individual market. In other words, the EHBs for individual and small group plans in a state could differ somewhat if state mandates differ between the two markets. We request that CMS confirm whether our understanding of this issue is correct.

- If after Dec. 31, 2011 a state increased the inside limits for a mandate passed before Dec. 31, 2011, is the increase portion in that state's EHB or is it state funded? This involves an interpretation of Number 4 in HHS's Frequently Asked Questions on Essential Health Benefits—"*We intend to clarify that under the proposed approach any State-mandated benefits enacted after December 31, 2011 could not be part of EHB for 2014 or 2015, unless already included within the benchmark plan regardless of the mandate. Note that any State-mandated benefits enacted by December 31, 2011 would be part of EHB if applicable to the State-selected EHB benchmark plan.***"**

- Some states have mandated "offers" (i.e., the benefit is mandated to be offered in a particular market), but it is an optional purchase on the part of the employer or individual. We request clarification on the treatment of such offers with respect to their inclusion or exclusion from EHB.

Specific Section Comments

Section 156.110 — EHB Benchmark Plan Standards

Proposing options for supplementing plans to meet standards for pediatric oral and vision care

Stand-alone dental plans in an exchange would be allowed to have separate annual cost-sharing limits based on what would be reasonable for coverage of pediatric dental. When determining a reasonable limit, it is appropriate to consider that pediatric dental costs are highly predictable and low cost—except for medically necessary orthodontia, which can be quite expensive. Therefore, a reasonable cost-sharing limit could be low if medically necessary orthodontia is not included. A higher cost-sharing limit could be appropriate if orthodontia is included. If orthodontia is included, it is also important to consider the definition of medically necessary.

A Milliman, Inc. analysis cited by the National Association of Dental Plans concludes that 95 percent of children are expected to incur total dental and orthodontia claims of

$900 or less, with $270 or less paid out of pocket.[2] It also concludes that the average orthodontia claim, for those incurring such services, is $6,350, with half being paid out of pocket. The Milliman analysis estimates that about 30 percent of pediatric orthodontic claims would qualify as medically necessary. Although in a given year there may be a relatively small share of children receiving medically necessary orthodontia, those that do would incur high out-of-pocket costs, especially if there is no cost-sharing limit.

If the cost-sharing limit is set too low, the costs to provide pediatric dental coverage (and therefore the premiums) could increase considerably. On the other hand, if the cost-sharing limit is set too high, there is the potential for financial hardship for the insured.

The rule proposes that any stand-alone dental plan with an 85 percent AV ±2 percent would be considered a high plan, and a plan with a 75 percent AV ±2 percent would be considered a low plan. The rule requests comments on the appropriateness of the de minimis range and the high/low approach.

±2 percent de minimis range. A consideration when setting the de minimis range for stand-alone dental coverage is that the relatively lower costs of dental coverage mean that a ±2 percent range would translate into very small differences in expected costs.

High/low approach. Pediatric dental costs are low and predominately preventive in nature, especially if medically necessary orthodontia is not included. Preventive coverage tends to be the majority of the costs, and those costs would be covered at 100 percent. As a result, a high/low approach appears appropriate, given there is a large portion of the total benefit that can't be adjusted in terms of cost sharing. In addition, a simplified approach is reasonable because dental care is a small portion of the overall essential health benefit requirement. Using frequency limits (e.g., coverage of two exams per benefit period) could be an alternative method of varying AV levels.

Another issue related to AVs of stand-alone dental plans is that it could be difficult for consumers to compare medical plans with embedded dental coverage with those with a stand-alone dental plan. This is because it is difficult to compare on an apples-to-apples basis the combined AV under either option. It also may be difficult for consumers to use an AV measure to compare the dental benefits embedded in a medical plan with those offered in a stand-alone dental plan.

Stand-alone dental plans, as well as dental coverage embedded in medical plans, could include non-EHB benefits. Clarification is needed on how any non-EHB dental benefits would be treated in risk adjustment calculations. In addition, clarification is needed on how any non-EHB dental benefits are treated in metal tier AV calculations for medical plans that include dental coverage and in the high/low AV standard for stand-alone dental plans.

[2] National Association of Dental Plans, "Consumer Out of Pocket Expenses for Pediatric Dental Benefits," Nov. 14, 2012.

Section 156.115—Provision of EHB
Allowing substitution of benefits, subject to non-discrimination requirements, within benefit categories that are actuarially equivalent to the benefits being replaced; outlining standards for actuarial certification of equivalence by a member of the American Academy of Actuaries and performed in accordance with generally accepted actuarial principles and methodologies

We applaud that the actuarial certification of benefit substitutions must be done by a member of the American Academy of Actuaries. While qualified actuaries would be capable of calculating the cost of benefit substitutions, actuaries likely would not be able or qualified to make a determination of non-discrimination with respect to such substitutions in the absence of a clearly prescribed testing methodology. We would appreciate clarity around this matter.

We also request clarification on whether issuers are to use the AV calculator to determine whether benefit substitutions are actuarially equivalent. We would note that the AV calculator likely does not have enough detail to make such determinations. Assuming the AV calculator is not used, we request more information regarding whether the underlying requirements for AV calculations apply (e.g., the use of a standard population).

Section 146.120—Prescription drug coverage
In this section, prescription drug coverage in the prescription drug portion of the EHB requires plans to cover the greater of:

- One drug in every category and class; or
- The same number of drugs in each category and class as the EHB-benchmark plan.

This means that in a few states in which the proposed EHB-benchmark plan has an open formulary covering almost every drug, all competing plans also will have to cover almost every drug. In other states, like California and Colorado, in which the proposed EHB-benchmark plan is an HMO with a much narrower formulary, competing plans will have more flexibility to negotiate better rates with pharmaceutical companies in exchange for formulary coverage through rebates. If plans are forced to cover almost all drugs in many states, negotiating leverage will be eroded with pharmaceutical companies. This will increase the costs of pharmacy coverage in the exchanges.

In addition to losing negotiating leverage with pharmaceutical manufacturers, the proposed rule also will increase complexity for health plans. Most plans not chosen as the benchmark plan will have to change their current formularies, and plans offering products in more than one state most likely will have to maintain separate formularies in each state.

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We welcome the opportunity to discuss with you at your convenience any of the comments presented in this letter. If you have any questions or would like to discuss

these items further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

Karen Bender, MAAA, ASA, FCA
Chairperson, Individual and Small Group Task Force
American Academy of Actuaries