Jan. 31, 2012

Center for Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: Essential Health Benefits Bulletin

To Whom It May Concern:

The American Academy of Actuaries'[1] Individual and Small Group Market Task Force appreciates the opportunity to offer comments on the Center for Consumer Information and Insurance Oversight's (CCIIO) initial guidance on essential health benefits (EHB) in its December 2011 bulletin. Our comments relate to benefit design flexibility, scope of benefits, mandated benefits, and actuarial equivalence.

Benefit design flexibility

We recognize the challenges associated with balancing standardization with the need to encourage innovation, but there are a few implications of allowing the flexibility to create multiple benefit sets that should be considered. Such flexibility in benefit design could create confusion for consumers; result in situations in which insurers design benefit packages to minimize certain risks; and have a material effect on premium rates, particularly in the individual market.[2] This is evident in the option to allow plans to decide what to cover in terms of habilitative and pediatric oral/vision services, as well as the flexibility to substitute benefits within and among the 10 benefit categories.

To mitigate some of these potential consequences, specific to the proposals made in the bulletin, we urge HHS to consider or allow states to consider the following:

- Defining the age limit for dependents qualifying for pediatric oral and vision services;
- Defining the standards for "medically necessary orthodontia;" and
- Recognizing that the current private market typically defines "habilitative" as "developing" function. If the definition is revised to include "maintaining" function, the addition of services could result in increased costs.

[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.

[2] Benefits are more likely to be expanded in the individual market, which is most sensitive to premium levels, resulting in upward pressure on premiums. Part of this increase may be mitigated by premium subsidies for those who are eligible. For those ineligible for premium subsidies, the increase in premiums for certain segments could be significant.

Also, clarification is needed on whether the benchmark plan would meet the essential health benefits standard if it covers only *one* service within a given category. While the bulletin states that a plan must cover (or be supplemented to cover) each of the 10 benefit categories, it does not address the range of services that must be covered within each category.

Scope of benefits

It is important for HHS to differentiate between the scope of benefits, which is related to the essential health benefit coverage, and medical management processes. For instance, information regarding provider networks, the use of gatekeepers, the use of step therapies, care/medical/disease management programs, quality initiatives, and wellness programs should not be incorporated into EHB requirements. Some of these, however, may be subject to other Affordable Care Act (ACA)-related provisions (e.g., provider network adequacy requirements). This will allow innovation in coverage and provider contracting. Clarification is needed, however, on how specific exclusions in the benchmark plan coverage documents will be addressed.

Actuarial equivalence

Clarification of the use of the terms "actuarial equivalence" and "substantially equal" as used in the context of essential health benefits is needed as well. Even though actuarial equivalence methods used most often include cost sharing, these methods also can be applied without cost sharing. It is not clear, however, how effective the Children's Health Insurance Program (CHIP) method may be since HHS seems to have indicated that cost sharing will not be taken into account in this circumstance. The CHIP approach includes cost sharing as well as benefit limitations. We recommend HHS modify its proposal so that the CHIP equivalency standard is used *exclusive* of cost sharing.

Each state would need to identify a benchmark plan reflecting 100 percent coverage as well as likely the corresponding anticipated costs per member per month (PMPM) for a standard population for each of the 10 categories. Health plans then would determine "substantially equal" and/or "actuarially equivalent" plans by demonstrating that the total PMPM without any cost sharing is the same. There are a number of issues that would need to be addressed to make this practicable—these are the same practical issues that relate to the determination of actuarial value for the "metal" benefit tiers, such as defining the standard population.[3] Any process that allows substitutions across the 10 categories needs to be clearly defined prior to a plan's acceptance by an exchange to ensure insurers/HMOs cannot design plans to avoid certain risks (e.g., eliminating all habilitative services).

Mandated benefits and annual limits

As benchmark plans are likely to be drawn from plans offered in the states, a benchmark plan might include state mandated benefits. In states' laws, dollar limits on the amount of coverage provided are common for some types of benefit mandates, such as autism/applied behavioral analysis, bariatric surgery, in vitro fertilization, and hearing aids (or cochlear implants). If state mandated benefits with dollar limits are part of a benchmark plan, clarification is needed on the treatment of the limits. Would dollar limits associated with these benefits need to be replaced

[3] For more information, see American Academy of Actuaries issue brief, *Actuarial Value under the Affordable Care Act* (July 2011): http://www.actuary.org/pdf/health/Actuarial_Value_Issue_Brief_072211.pdf

with equivalent permitted limits (e.g., maximum visits per year), which would be equivalent coverage levels? Or would dollar limits associated with these benefits need to be eliminated, which would tend to increase coverage levels and therefore costs?

The concern with dollar limits does not apply to state mandated benefits only. For some benefits it would be difficult to define equivalent permitted limits; if they could be defined and implemented, costs could increase substantially. Current pediatric oral and vision plans, for example, commonly use dollar limits to control costs. But if the pediatric oral and vision benefits are defined as comprehensive (i.e., including eyeglasses, contacts, restorative dental services, etc.) and dollar limits are not allowed, it would be difficult to control potential costs. As another example, the Federal Employees Health Benefits Program (FEHBP) standard option plan covers speech-generating devices up to $1250 per year. Using a limit of even one per year, instead of the dollar limit, could be quite expensive given the range of potential options for those devices.

With the need to balance access to comprehensive coverage, ensure flexibility to update benefits over time, and manage costs, HHS also may want to consider allowing restrictive benefit limitations by state for those benefits that are not commonplace in employer plans. If the benefit limits are less restrictive, an increase in utilization could affect costs adversely. As a result, starting out with more restrictive limits may allow more flexibility to adapt to changing health care needs and keep costs lower.

Reinsurance and risk adjustment

Reinsurance and risk adjusters depend on the scope of services included in EHBs. If plans within a state define EHBs differently, this could make implementing reinsurance and risk adjusters more complex than a uniform scope of services would.

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We welcome the opportunity to discuss any of the comments presented in this letter with you at your convenience. 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 Market Task Force
American Academy of Actuaries