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Plan Management Policy Team
Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically to PMPolicy@cms.hhs.gov

Re: Draft 2022 Federal Actuarial Value Calculator Methodology

To Whom It May Concern:

On behalf of the Massachusetts Division of Insurance and the Massachusetts Health Connector, we write to provide stakeholder feedback to the Center for Consumer Information & Insurance Oversight (CCIIO) on the draft 2022 Federal Actuarial Value Calculator. Specifically, we are providing feedback regarding: (1) a technical issue related to whether a copay for a service that is offered before the deductible is applied accrues toward the deductible amount; and (2) more broadly, the increasingly difficult challenge of designing plans that meet metallic tier actuarial value (AV) requirements, especially for the bronze metallic tier. Even though there will not be an impact in 2022, we ask CCIIO to consider changes to the methodology to ensure attainable AV requirements in future years. In addition, we ask that CCIIO consider how COVID-19 impacts on claims may affect AVC methodology going forward and ways to mitigate potential volatility.

We also respectfully request an opportunity for State Divisions of Insurance (DOIs) and State-Based Marketplaces (SBMs) to provide stakeholder feedback before CCIIO develops the draft Federal Actuarial Value Calculator (FAVC) methodology for Plan Year 2023. We recommend that CCIIO meet with state SBMs and DOIs to discuss challenges in the FAVC through a "user group" forum, prior to publishing the draft 2023 FAVC. Please see below for background and details on our request.

__Massachusetts Market Context__

The Massachusetts Division of Insurance is the primary regulator of Massachusetts' fully insured health insurance market, including a merged market that serves over 750,000 non-group and small group enrollees. The DOI ensures consumer protection in the insurance industry, licenses issuers and producers, reviews rates and forms, and monitors and manages issuer financial solvency. The Massachusetts DOI has been actively engaged in state health reform since the 1990s, and subsequently managed the market's transition to compliance with the Patient Protection and Affordable Care Act (ACA).

The Massachusetts Health Connector is an SBM authorized under the ACA. Founded in 2006 as part of state health reform, the Massachusetts Health Connector is the longest-running SBM in the country. The Health Connector is designed to connect Massachusetts residents and small businesses with health coverage, with the goal of promoting universal health coverage in the Commonwealth. Today, the Health Connector serves over a quarter-million Massachusetts residents, including over 275,000 individuals and over 8,000 small business employees. In addition to its other functions, the Health Connector establishes annual "standardized" plan designs which participating issuers must offer to ensure that on-Exchange health plans meet affordability expectations, such as lower deductibles.

The Massachusetts DOI and Health Connector have jointly worked to build one of the strongest insurance markets in the country, with a nation-leading health insurance rate over 97%.[1] The ACA is largely working as designed in Massachusetts. However, in recent years the Massachusetts market has had increasing difficulty designing affordable health plans owing in part to the federal requirement to use the FAVC to gauge the AV of health plans.

Issues with the Current FAVC Methodology

Massachusetts has observed two issues with the current FAVC methodology we would like to bring to the attention of CCIIO staff if the FAVC is to continue as a tool that is useful in all markets:

1. **We recommend that CCIIO add an option to the FAVC so that it may be used to calculate actuarial value for a plan design which features copays that do not accrue toward the deductible.**

We recently learned that the FAVC includes instructions that are inconsistent with a plan design that is common in Massachusetts and many other ACA-compliant states. The issue arises when a plan design has a covered service that is not subject to the deductible but requires a copay, and the copay does not count toward the plan's overall deductible. For example:

- Plan has a $2,000 medical deductible
- Primary care office visits are not subject to the deductible but have a copay of $20
- Primary care office visits do not count toward meeting the $2,000 medical deductible.

In Massachusetts and other states, this plan design is common. The Health Connector has featured this design in several of its "standard plans," which use copays rather than coinsurance in an effort to offer greater transparency to consumers about cost-sharing expectations.

However, in the current AV Calculator, it does not appear to be possible to input a plan in which a service is not subject to the deductible and also has a copay that does not count toward the deductible. According to Table 1 in the AV Calculator User Guide, when the "Subject to the Deductible" checkbox is not checked, the benefit's copays in the deductible phase will apply to the deductible. It is our understanding that if a user wishes to submit a plan design in which a service is not subject to the deductible and also has a copay that does not count toward the deductible, the user will need to manually calculate an adjustment to reflect the difference in benefits, and if the adjustment results in a materially different actuarial value, will need to certify a unique plan design that complies with the regulations at 45 CFR § 156.135(b).

This FAVC solution is impractical and out of step with the market in many states. Based on information we gathered from issuer actuaries, other states, and actuarial firms, it is standard market practice to allow services not subject to the deductible to have copays that do not count toward the deductible. Many of those surveyed were not aware of the FAVC guidance on this matter and surprised to hear that CCIIO would adopt this policy in the FAVC given that the FAVC is supposed to accommodate standard benefit designs. Further, while we appreciate the option of a unique plan design, it would be inordinately burdensome for

[1] U.S. Census Bureau, at www2.census.gov/programs-surveys/demo/tables/p60/264/table6.pdf and www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

SBMs to create unique plan designs for standard plans. As a practical matter, if CMS retains this policy in the FAVC for future years, Massachusetts will face a choice of: (1) changing plan designs for some of our most popular plans, disrupting coverage needlessly; (2) engaging in the burdensome process of unique plan design, which undermines the FAVC as a standard tool; or (3) allowing issuers to non-comply with this FAVC instruction, which undermines the FAVC as a standard tool. Since we do not believe that any of these options are reasonable, we request that CCIIO revisit this approach to ensure it reflects market standards and includes sufficient flexibility so that users can correctly and consistently use the FAVC in an easy fashion.

2. **We request that CCIIO convene stakeholders to discuss the growing challenge of designing ACA-compliant tier plans that feature reasonable cost-sharing levels.**

Before the introduction of the FAVC, Massachusetts health plans already met benefit and cost-sharing standards well above the ACA's minimum bronze-level metallic tier. Today, it is increasingly difficult to design affordable bronze-level plans that meet the FAVC requirements. CCIIO's annual updates to the FAVC have often resulted in disproportionately large year-over-year jumps in actuarial value for bronze plan designs. As a result, the Massachusetts Health Connector and issuers in the market are usually forced to increase enrollee cost-sharing in bronze plans each year to stay within federal AV thresholds.

In 2016, the Massachusetts Health Connector had to discontinue all its standard bronze plans because they no longer met federal AV requirements, which at the time were 60% (+/-2%). Starting in 2018, CCIIO relaxed its AV requirements, such that bronze plans could meet an expanded range of 65% AV. While Massachusetts has appreciated the additional latitude of the expanded range, which has allowed Massachusetts plans to retain the richer benefits to which our state residents are accustomed, this is no longer sufficient to maintain stable plan designs. As a result of annual changes in the FAVC, Massachusetts has had to significantly disrupt bronze plan designs for several years running (Table 1).

Table 1. Year-over-Year AV Changes to Health Connector Standard Plans Due to FAVC Methodology

	2017-2018	2018-2019	2019-2020	2020-2021
Platinum	-4.5%	0.7%	0.6%	-0.1%
Gold #1	-2.1%	1.2%	1.2%	0.6%
Gold #2	N/A	N/A	1,3%	1.8%
Silver #1	1.7%	1.8%	1.8%	-1.1%
Silver #2 (HSA-Compatible)	N/A	N/A	1.9%	-0.5%
Bronze #1	4.3%	2.3%	2.3%	2.0%
Bronze #2 (HSA-Compatible)	N/A	2.0%	2.0%	3.0%

We understand that the continuance tables underlying the FAVC methodology are based on historic utilization and spending information for enrollees in different metallic tiers, which can influence different year-over-year AV impacts for each metallic tier. Even though there will not be an impact in 2022, we ask CCIIO to reflect critically on the impact of this methodology to resolve issues prior to the 2023 AVC, particularly as high health care cost trends encourage a greater share of enrollees to select bronze plans. In addition, we ask CCIIO to consider how the impact of the COVID-19 pandemic on claims may create instability or new claims dynamics that need to be addressed.

We believe that the level of cost-sharing required of bronze plan enrollees is no longer sustainable. For example, the Health Connector's Standard Bronze #1 design in 2021 will include copays of $1,200 *after* the deductible for inpatient hospitalization—and that is for a plan at the very top of the allowed AV, at 64.98%. This level of cost-sharing cannot be managed by Health Connector enrollees, over half of whom report they do not have $400 to pay an unexpected medical expense. Health Connector enrollee survey

data indicates that in 2019, bronze tier enrollees were most likely to report experiencing problems paying medical bills compared to other metallic tiers. Over half of bronze tier enrollees reported delaying or foregoing care due to cost, compared to 26% of enrollees overall. Additionally, bronze tier enrollees reported increasing amounts of out-of-pocket spending year over year since 2016. We expect that if plan designs continue to worsen due to the FAVC, some enrollees will become uninsured rather than pay for plans with diminishing value.

Rather than allowing this trend to continue unabated, we seek CCIIO's active leadership in addressing the enrollee cost-sharing impacts of the FAVC. Massachusetts is aware that the FAVC outputs reflect the underlying data, and as such, national increases in health care costs will be represented in the FAVC. However, we ask for creative solutions to mitigate this trend, such as:

- A comprehensive review of the FAVC methodology, with particular focus on the relativity of the allowed total costs between metallic tiers in the continuance tables used to inform the calculator. We understand that CCIIO made some changes to the 2021 FAVC that may have affected this relativity, such as the shift to 2017 claims and changes to the adjustments applied to the underlying data. We seek to understand whether CCIIO could adopt a different approach on these finer points of the methodology.

- Greater regulatory flexibility in use of the FAVC. For example, it may be appropriate for CCIIO to grant greater flexibility to states like Massachusetts that have reined in health care cost growth on a year-over-year basis, as the national health care cost growth trends may not reflect the reality of Massachusetts plan trend. This kind of solution would "reward" states that are making earnest efforts to control health care cost growth.

We welcome other ideas CCIIO may have to address the growing challenge of bronze plan affordability under the FAVC requirements.

3. **We request that CCIIO seek review and feedback from stakeholders prior to the annual publication of the draft FAVC.**

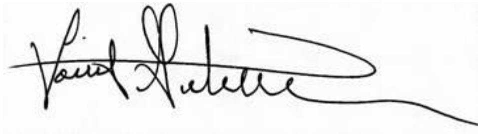
Since the FAVC was introduced in 2014, the Massachusetts health insurance market has struggled to adapt to the national methodology as detailed above. Despite these challenges, the Massachusetts DOI and Health Connector have not weighed in on the draft FAVC methodology prior to 2020, largely because the timing of the draft methodology is not compatible with our market timelines.

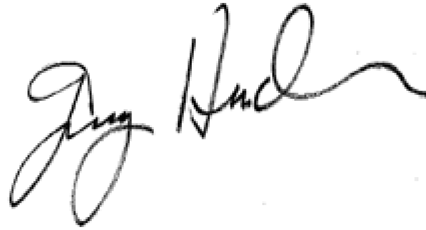
Each year, CCIIO releases its draft FAVC in the late fall, well after the Health Connector and issuers have begun to design plans for the upcoming plan year. The FAVC is typically finalized in mid-spring, after the Health Connector's governing Board has voted to approve standardized plans, which must occur prior to issuers setting their final plan designs for the upcoming year and preparing for open enrollment. This timeline leaves little room for the market to provide meaningful input on the draft methodology or adapt to the final FAVC. As a practical matter, the annual FAVC timeline means that plans must be solidified in the January timeframe, prior to the publication of the final methodology. Moreover, we have observed that the FAVC does not often change from the draft to the final version, perhaps because other states and health plans need to rely on the draft methodology as final, given the timing challenges identified above.

To mitigate this issue, we ask that CCIIO provide an early opportunity going forward for stakeholders to discuss the FAVC methodology, prior to the publication of the draft methodology. We recall that CCIIO offered a similar opportunity in 2016, when CCIIO published a white paper on the risk adjustment methodology, with the goal of seeking feedback on how to best refine the methodology. While state and federal attention is rightly focused on the COVID-19 pandemic right now, we suggest that it is still important to prioritize such a discussion, particularly as the national insurance market convulses as a result of COVID-19, with unknown impacts on the FAVCs of future years. We would be pleased to participate in such a convening.

We thank you for consideration of our requests and would be pleased to provide additional information from our actuarial and policy staff if helpful to CCIIO. Please contact kevin.beagan@mass.gov and audrey.gasteier@mass.gov if any questions or follow-up.

Sincerely,





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