

# Protecting High-Risk, High-Cost Patients: “Essential Health Benefits,” “Actuarial Value,” and Other Tools in the Affordable Care Act

## Timely Analysis of Immediate Health Policy Issues

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### Summary

The shortcomings of the health insurance market for individuals purchasing insurance directly (rather than through their employers) are both well-documented and widely recognized. This market has been characterized by benefit exclusions, denials of coverage, premiums that vary greatly by prior health experience and current health status, risk selection, and lack of clear information on plan details prior to purchase. Some of these problems have been addressed previously in the small group market, thanks to earlier federal and state laws, but problems persist in many states.

The Affordable Care Act (ACA) will dramatically reduce these problems in both the nongroup and small group markets, with reforms that establish benefit standards, require readily understandable and comparable information from plans, and prohibit many long-standing market practices designed to avoid enrolling those with high health needs and to limit the payment of legitimate claims.

The Department of Health and Human Services’ (HHS) proposed approach to implementing two key ACA requirements in the nongroup and small group markets—for minimum or “essential health benefits” and insurance plan actuarial value—reflects an effort to balance two competing goals: consistent protection across all consumers and accommodation of variation—whether in experience across states, insurance benefit design, or in the needs and preferences of individual consumers. But our analysis shows that these rules, even in combination with the above insurance protections, may still not ensure that the highest-need, highest-cost consumers receive predictable and adequate insurance protection. Insurers able to avoid the very sick population, whose care accounts for such a large share of spending, may reap substantial financial benefits. Although risk-adjusted payments are intended to mitigate this powerful incentive to select risk, consumer protection will be strongest with policies designed to minimize, not encourage, risk selection. Achieving this goal would require refinement, reinforcement and reevaluation of HHS’ proposed practices, both at initial implementation and over time, in order to minimize risk selection and discrimination that may inevitably remain a part of even much-improved insurance markets.

**Essential Health Benefits (EHBs).** Under HHS guidance, states are given flexibility to define EHBs within 10 required categories of services, choosing one of 10 designated insurance plans available in the state (without regard to their cost-sharing requirements). Thus, states’ initial choices of benchmark benefits will accommodate state insurance markets where they are today, while eliminating the least protective plans from the market and thereby improving options facing consumers. Guidance suggests that insurers would be permitted to deviate from benefits in the state benchmark plan as long as the package they offer is “actuarially equivalent” to the benchmark package.

But actuarial equivalence is not constructed to measure benefit design changes that have little impact on average spending but a substantial impact on spending for a small number of patients. As a result, the more insurers can vary benefits based on a standard of “actuarial equivalence,” the greater the potential that risk selection is likely to occur. One example of the potential for insurers to tweak benefits in a way that could discourage enrollment by high-cost patients is illustrated by the coverage of oral cancer drugs, which has virtually no effect on “actuarial equivalence” because such a small share of the population uses them, but has a great effect on covered costs for particular cancer patients. To discourage risk selection through benefit design, HHS could refine its proposed approach to defining EHBs by requiring evidence on the effect of benefit changes on high-risk populations for purposes of assessing the “actuarial equivalence” of any proposed substitutions for benchmark benefits. And it could require—or, at a minimum, allow—states to limit the number of variations from benchmark benefits that plans can offer.

**Actuarial Value (AV).** AV is a measure of the relative generosity of health insurance plans intended to enable consumers to compare the average cost-sharing for an average population across different plans. Under the ACA, AV will be used to classify plans into one of the law’s cost-sharing tiers (bronze, silver, gold and platinum) and to guide calculation of premium tax credits and application of the law’s cost-sharing subsidies. HHS proposes to standardize AV calculations to reflect standard populations and standard use and cost in each state.



Standardization isolates cost-sharing from other differences among plans, like payment rate differences and utilization review features, and ensures consistency. But these other differences among plans could also give rise to out-of-pocket costs for high-cost patients. HHS can refine its AV calculations by developing methods for appropriately reflecting the impact of in-network or innovative cost-sharing designs before approving their use. Additionally, high-cost patients could be protected by counting any cost-sharing resulting from such cost-sharing structures toward the annual out-of-pocket cap. Tracking and evaluating experience will be needed to ensure affordable access for low- and modest-income enrollees, whose cost-sharing subsidies may not be as broad as expected.

**Other tools.** Additional policies may be needed to reinforce EHB and AV rules, to alert consumers to—or protect consumers from—specific plan characteristics that will determine their access to expected benefits. These include easy-to-understand plan summaries for consumers, effective network adequacy rules, and development of standards for “wellness incentives” and other innovative cost-sharing design features.

The ACA’s requirement for risk-adjusted payments to plans aims to minimize incentives to select risks by preventing both overpayment of plans that avoid the sick and underpayment of plans that cover them. Further, the explicit prohibition on benefit designs that discriminate against high-cost patients allows enforcement of appropriate access. A

full commitment to effectively applying both risk-adjustment and anti-discrimination rules will be essential to minimizing plans’ interest in and pursuit of risk selection practices.

**Ongoing monitoring and reevaluation.** Finally, effective protection of high-cost and even average-cost patients will require a reevaluation of EHB, AV, and all other rules as the ACA implementation goes forward. Explicitly limiting the proposed benchmark for EHB determination to two years (from 2014 to 2016) reflects recognition of the uncertainties regarding the adequacy, effectiveness or general impact of the initial approach. Collection and comparison of benchmark benefits across states will be essential to informing next steps in the definition of EHBs—in particular, lessons from state variation. Though not explicitly limited, other rules will similarly benefit from an assessment of experience and appropriate modifications, in order to avoid unintended consequences and promote adequate coverage.

In sum, there is little question that the ACA will improve the nongroup and small group insurance markets for everyone in them, including the high-risk population. But insurance reforms, guided by requirements for EHBs, AVs and other tools provided by the ACA, are and will remain a work in progress. This analysis suggests the way these tools—working together and reevaluated over time—can help ensure that ACA implementation actually progresses toward the ACA’s goals of effective, affordable insurance protection, especially for the highest-need, highest-cost patients.

## Introduction

The shortcomings of the health insurance market for individuals purchasing insurance directly (rather than through their employers) are both well-documented and widely recognized. This market has been characterized by benefit exclusions, denials of coverage, premiums that vary greatly by prior health experience and current health status, risk selection, and lack of clear information on plan details prior to purchase. Some of these problems have been addressed previously in the small group market, thanks to earlier federal and state laws, but in many states problems persist.<sup>1</sup>

The Affordable Care Act (ACA) will dramatically reduce these problems in both the nongroup and small group markets, with reforms that establish benefit standards, require readily understandable, comparable information

from plans, and prohibit many long-standing market practices designed to avoid enrolling those with high health needs and to limit the payment of legitimate claims.<sup>2</sup> Yet even these reforms may not fully protect the sickest individuals from limits on covered services or expenses likely to create unexpected and significant financial exposure, even beyond apparent limits on out-of-pocket spending.

Choices now confronting both federal and state policy-makers can make a significant difference to how much risk the sickest individuals will face. Our analysis of these choices demonstrates the importance of a broad set of tools that, working together, are likely to achieve the ACA’s goal of ensuring adequate, affordable health insurance coverage when people get sick. We begin with an examination of recent federal guidance on the development of

standards for essential health benefits (EHBs) and actuarial value (AV). These standards significantly improve the value of benefits for the average purchaser in the nongroup and small group markets. But these general standards are not designed to protect the sickest patients from financial exposure that might result from incentives insurers have to avoid high-cost individuals. We therefore examine companion strategies related to transparency and accountability that, in combination with the standards for EHB and AV, can help minimize risk selection and promote effective consumer protection for all consumers in the health insurance marketplace.

## Essential Health Benefits

**HHS’ proposed “benchmark” approach.** The ACA requires that, starting January 1, 2014, insurance plans in the nongroup and small group markets provide at least the EHBs described

in the law.<sup>3</sup> HHS' proposed approach offers significant improvements to the current nongroup and small group insurance markets. It will eliminate the marketing of plans offering minimal benefits, and covered benefits will be more similar across states.<sup>4</sup> Under the ACA, every qualified health plan (QHP) offered in a state's exchanges, and in the nongroup and small group markets outside of exchanges, must offer EHBs.<sup>5</sup> The law, however, specifies only the general categories of care and services that will constitute EHBs: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The Secretary of HHS is directed to define EHBs in more detail, subject to a requirement that EHBs be consistent with the "scope of benefits provided under a typical employer plan, as determined by the Secretary."<sup>6</sup> Essential health benefits' definitions do not address cost-sharing, which is handled under actuarial value rules (discussed in the section that follows).

In December 2011, HHS issued a bulletin<sup>7</sup> proposing a "benchmark" approach to defining EHBs and designating a key role for states in selecting the benchmark. The bulletin describes a number of options from which each state will select its benchmark plan for the first two years that the reforms are fully in place (2014 and 2015).<sup>8</sup> These options are as follows:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
2. Any of the three largest enrollment state employee health benefit plans;
3. Any of the three largest enrollment Federal Employees Health Benefits Program (FEHBP) plan options available to all federal employees;

4. The largest insured commercial non-Medicaid health maintenance organization (HMO) in the state.

The December bulletin also indicates HHS intends to evaluate the benchmark approach for the year 2016 and beyond.

The benchmark approach has precedent under the Children's Health Insurance Program (CHIP). Since the enactment of CHIP in 1997, states have had the option of defining covered benefits under this public program based on coverage under benchmark private sector health insurance policies that meet enrollment thresholds.<sup>9</sup>

**Implications of the benchmark approach.** Politically, the benchmark approach has the advantage of allowing state flexibility and initially defining EHBs where markets are today, with benefit designs that large numbers of people are already used to. By choosing a benchmark plan subject to already-enacted state-mandated benefits, states can also avoid the ACA requirement that they pay for mandated benefits outside the EHB for exchange enrollees.<sup>10</sup>

Once a benchmark plan is selected, services covered under that plan will generally become the EHBs for a state. Any limits on the scope of covered benefits under the benchmark plan will generally constrain the coverage of those EHBs; and any excluded benefits under the benchmark plan will generally be excluded from EHBs.

An HHS analysis finds that, for the most part, benchmark small group policies cover about the same benefits as large, employer-sponsored group health plans. The differences are primarily around cost-sharing, which EHBs do not address, and which tends to be much higher under small group policies than in large plans.<sup>11</sup> However, some uncertainty remains as to what the actual benchmark policies will be, as well as to the comprehensiveness of coverage under all benchmark plans. A master list of potential benchmark policies has not been published or made available for independent study. Among the illustrative options published by HHS, some private

health insurance plans—which may or may not qualify as benchmark plans—may have some worrisome coverage gaps.

In January 2012, HHS released an illustrative list of potential benchmarks in each state, including the three largest small group "products" by enrollment in each state.<sup>12</sup> However, "products" are different from "plans." The small group benchmark is the largest plan within a product offered in the small group market, and these plans have not been identified. Often plans within a product vary only according to cost-sharing options, but sometimes plans within a product may also vary covered benefits or benefit limits.

For example, certain Anthem PPOs are identified as two of the three largest products in a state. Anthem offers dozens of PPO plan options, including many under a product called "Employee Elect." All of the Employee Elect product plan options cover prescription drugs, but three of the plans cover only generic prescriptions and exclude coverage for brand-name drugs.<sup>13</sup> Several other small group plans (which may or may not turn out to be potential benchmark policies) exclude coverage for durable medical equipment (DME).<sup>14</sup> Others limit DME coverage to \$1,500 per year.<sup>15</sup> Although the ACA ultimately prohibits annual or dollar benefit limits, it does not address an insurer's ability to limit the maximum dollar amount payable per unit on a specific benefit. In addition, HHS' FAQ permits plans to impose non-dollar limits that are actuarially equivalent to dollar limits,<sup>16</sup> such as limiting wheelchair rental to a specific time period rather than a specific dollar amount. In some small group policies, mental health parity applies to coverage of treatments for severe behavioral and emotional disorders, but a limit of 30 inpatient days and 20 outpatient visits applies to all other mental health care.<sup>17</sup> With respect to organ transplants, one small group plan (which may or may not be a potential benchmark plan) limits coverage of transplants performed by nonpreferred providers to \$30,000 per transplant;<sup>18</sup> another limits coverage

to \$100,000 per organ for certain transplants performed in network by nondesignated transplant providers.<sup>19</sup> Yet another imposes a benefit-specific waiting period and will not cover any organ transplants until individuals have been enrolled in the plan for six consecutive months.<sup>20</sup>

A benchmark plan with significant benefit exclusions or coverage limits could lead to severe access problems for some patients who might find the services they need limited in scope or left completely uncovered by the plan. The EHB bulletin indicates that improvements or supplementation of the benchmark plan will be necessary if the benchmark does not cover some required categories of services. The bulletin offers as examples plans that fail to cover certain services within the 10 EHB required categories of services—habilitation (under the category of rehabilitative and habilitative services and devices) and pediatric dental and vision care (under the category of pediatric services, including oral and vision care)—and offers some specific approaches to supplementing benchmark policies when these three benefits are missing. As states evaluate benchmark plan options, they might consider using supplementing authority to address other types of coverage gaps to ensure the adequacy of benchmarks for the average patient and for patients with high medical needs. For example, if HHS allows, a state might supplement a benchmark policy to add coverage for brand-name drugs or for DME (where those benefits would otherwise be excluded).

Adequacy of each state's benchmark choices is not the only source of concern with regard to protections for high-need patients. The HHS bulletin indicates that HHS will allow insurers flexibility in plan design around the benchmark EHB chosen by the state. The appeal of flexibility around a benchmark is that it provides consumers with multiple choices of benefit designs and accommodates innovations in benefit design that might lead to more efficient and appropriate service use. At the same

time, however, flexibility to vary benefits from a benchmark enables insurers to use benefit design in order to discourage high-cost patients from enrolling in their plans—that is, to select risks. Insurers able to avoid the highest-cost patients may reap substantial financial benefits, since the top 10 percent of patients account for nearly two-thirds of all spending.<sup>21</sup> Other insurers, however, would have a stake in minimizing those rewards through measures like the risk adjustment systems the ACA requires.<sup>22</sup> Whether insurer risk selection practices will remain profitable, therefore, remains an open question.

However, risk adjustment systems are challenging to implement and are likely to have significant limitations.<sup>23</sup> Because the ACA's insurance reforms significantly restrict what have historically been the most common methods of avoiding high-risk patients or payment of their claims, insurers that are newly required to accept everyone and charge them the same price regardless of health status may look increasingly to benefit design as a means to minimize financial losses from high-cost enrollees. To ensure adequate access for high-cost patients, it is therefore important to minimize incentives for plans to avoid high-risk patients in the first place.

Once a specific benchmark plan is chosen for a state, insurers would be permitted to deviate from that plan's benefits as long as the package they offer is "actuarially equivalent" to the benchmark package. Actuaries have not established a standard definition for measuring equivalence, but it is most easily understood as equivalence in the average dollar spending across a standard population. For example, if the total cost of EHBs under a benchmark policy is estimated at \$4,000 for an average enrollee, and if an insurer uses the flexibility to vary benefits from the benchmark in order to reduce coverage for one benefit by \$100, the insurer must add back \$100 worth of coverage for another benefit(s) in order for the policy to remain actuarially equivalent to the benchmark.

Regardless of how it is measured, actuarial equivalence on average does not prevent benefit variation that significantly limits a plan's value to selected high-cost patients. That is because the cost of any particular covered benefit may not contribute much to the average per-enrollee cost of the policy. Actuarial equivalence is not designed to measure the impact of benefit design changes that have little impact on average spending but have a major impact on spending for a small number of patients. As a result, the more insurers can vary benefits based on a standard of "actuarial equivalence," the greater the potential that risk selection will occur.

One example of the potential for insurers to tweak benefits in a way that could discourage enrollment by high-cost patients is illustrated by the coverage of oral cancer drugs. A recent analysis of the cost of one state mandate to cover oral cancer drugs concluded that adding this benefit could save individual cancer patients up to \$7,000 per year, but because cancer patients who would need such drugs were estimated to make up only 0.4 percent of enrollees, the cost of this new benefit was estimated to increase employer premiums overall by 0.014 percent.<sup>24</sup> If an insurer were to vary benefits from the benchmark to exclude oral cancer drugs, the impact on actuarial equivalence might not be detected; if it were, it might be offset with other modest benefit changes associated with less costly enrollees. But the impact on cancer patients of such a limitation could be substantial, and it could deter some cancer patients from enrolling or remaining enrolled in the plan, thereby allowing the insurer to avoid the total cost of care for those patients. By avoiding sicker patients, the insurer could lower premiums and try to expand market share.

HHS has proposed two options for product variation around a state's benchmark—allowing variation only within benefit categories (as delineated in the law and listed above) or allowing variation across benefit categories. The bulletin indicates a preference for

the within-category approach. With this approach, an insurer could adjust quantitative limits and substitute covered services within a category, such as ambulatory patient services, but could not substitute covered services or quantitative limits across categories (e.g., between ambulatory patient services and hospitalization). The bulletin suggests that flexibility would apply only to benefit limits or substitutions, and would not permit cost-sharing adjustments on different services within a category.

Although narrowing opportunities for risk selection through benefit design, restricting benefit flexibility to within categories does not eliminate the potential to limit benefits for small numbers of high-cost patients. In particular, the EHB bulletin explicitly provides for considerable flexibility in the prescription drug category. The bulletin proposes that plans be required to cover the categories and classes of drugs set forth in the benchmark plan; further, it suggests that drug categories and classes will have to follow classification systems established by the U.S. Pharmacopoeia, AHFS Pharmacologic-Therapeutic Classification, or a similar standard.<sup>25</sup> However, plans would be allowed to choose the specific drugs that are covered within categories and classes and would only be required to offer one drug in a category or class. For example, a carrier might be allowed to cover only one chemotherapy drug or one antidepressant drug. The bulletin emphasizes that HHS does not “intend to adopt the protected class of drug policy in (Medicare) Part D....,” which requires that plan formularies cover at least two drugs in every therapeutic class in addition to key drug types that are not therapeutically equivalent. In addition, for six drug classes (antineoplastics, antidepressants, antipsychotics, antiretrovirals, anticonvulsants, and immunosuppressants used by transplant patients) Medicare requires plans to cover “all or substantially all” of the drugs in the class.<sup>26</sup> Plans can charge different levels of cost-sharing for nonpreferred drugs under Medicare, but can apply

fewer limitations than the EHB bulletin would allow. No explanation for this departure from Medicare’s coverage policy prescription has been provided, leaving questions as to the implications for certain types of patients. Using the oral cancer drug example above, this flexibility would seem to allow insurers to delete coverage for oral cancer drugs, offsetting it with coverage for other drugs in a different category, potentially discouraging enrollment by some cancer patients.

The second approach the HHS bulletin puts forward would allow plans to trade off benefits and benefit limits not just within category of service, but also across categories of service. Such broad flexibility would increase opportunities for insurers to vary benefit design—whether to avoid enrolling certain types of people with high health needs and to exclude expensive services from plans’ covered costs; or to steer high-cost beneficiaries into exchange plans and lower-cost beneficiaries into lower-premium plans outside the exchanges. The greater the variation in benefits and benefit design, the more challenging it will be to prevent selection with mechanisms like risk adjustment or antidiscrimination protections. Under either the within-category or the across-category flexibility approach, regulators would need to specify the benefit categories under which covered services belong. Without consistent classification, there is no way of knowing whether a tradeoff is occurring within the category. Indeed, some of the categories are so broad as to leave insurers considerable room for interpretation as to what belongs where. For example, is occupational therapy an ambulatory care benefit, hospitalization, or rehabilitation benefit—or all of the above?<sup>27</sup> Would durable medical equipment fall under one of those three categories, or possibly under the category of chronic disease management?

Another challenge to assessing actuarial equivalence is that changes in benefit limits on services in one category could also have significant effects on service

use in another category. For example, limits on outpatient mental health visits could reduce use of prescription drugs to control anxiety or depression if the patient does not access prescriptions due to reduced interactions with physicians, or it could increase use of those drugs as a replacement for therapy visits. Assessing this effect would require HHS to develop multiple sets of behavioral assumptions. The challenge is compounded by innovative benefit designs, for which experience on effect is lacking.

***Refinements to HHS proposed approach.*** The tradeoffs inherent in benefit design flexibility relative to standardization of benefits are clear. Flexibility provides more choices of plans to consumers, with some products providing more value to those with certain health needs than others, while standardization provides predictability, comparability and reduced opportunities for risk selection. If HHS pursues either type of flexibility in benefit design, the potential consequences for risk selection could be limited by establishing a high standard of evidence to establish actuarial equivalence. For example, insurers could be required to submit data demonstrating the consequences of benefit limits different from those in the benchmark, not only for the average beneficiary but also for specific categories of beneficiaries, with diagnoses likely to be affected both positively and negatively.

States may wish to do even more to limit opportunities for risk selection. Consumers would gain the greatest predictability of covered services and benefit limits if all nongroup and small group plans subject to EHB requirements in the state had to provide the exact benefits and services that compose the benchmark plan. In this case, the state would choose the benchmark plan that policy-makers believe has sufficiently adequate benefits, with the covered services and particular benefit limitations defined. Consumers would still have a choice of plans that would differ according to levels of cost-sharing that apply to covered benefits. With

this approach, those seeking coverage in this market would know to plan for the possibility that they would need to self-finance the services that fall outside of the benchmark, since all plans would follow the same approach. The state could prepare one set of consumer information materials informing enrollees in these markets of services covered and not covered by the plans, and this information could become common knowledge under a well-planned educational effort.

To accommodate the desire to allow consumers some choice of benefits, an alternative approach would be to require states to offer a modest number of variations from the benchmark plan. A recent study of plans offered in the Massachusetts Exchange shows that a large number of plan choices and benefit variations can easily overwhelm and confuse consumers.<sup>28</sup> In addition, price comparisons become very difficult, and plans keep premiums low by competing to avoid high risks rather than competing in the efficient delivery of quality care.

The EHB bulletin and the related FAQ document<sup>29</sup> do not address the issue of whether states will have the option of requiring a single or small set of variations in plan offerings, regardless of the variation that the federal government allows. Ensuring that states have this option would enable states that have already established standardized benefit packages in one or more of their markets, such as Massachusetts, to maintain their current state-preferred policies.

## Actuarial Value

As noted earlier, the EHB rules do not address the level of cost-sharing permitted in qualified health plans, either in general or for particular services; this is the role of AV requirements. AV is a measure of the relative generosity of health insurance plans, intended to enable a consumer to compare the average cost-sharing for an average population across different plans. Under the ACA, the most important roles of AV will be to classify plans into one of the law's four cost-sharing tiers and to guide calculation of

premium tax credits and the application of the law's cost-sharing subsidies. The law establishes four "metallic coverage tiers": bronze plans (the least comprehensive plans, at 60 percent AV), silver plans (70 percent AV), gold plans (80 percent AV) and platinum plans (90 percent AV). Premium tax credits will be based on the premium of the second-lowest cost plan in the silver tier.

AV will also be used to compute the value of cost-sharing subsidies. The ACA provides cost-sharing subsidies for some low-income individuals, with the highest subsidies available to those with incomes below 150 percent of the federal poverty level (FPL) and phasing out at 250 percent of the FPL. The cost-sharing subsidies are intended to effectively increase the 70 percent actuarial value of a silver plan to 94 percent for those with incomes between 100 and 150 percent of the FPL; to 87 percent AV for those with incomes between 150 and 200 percent of the FPL; and to 73 percent AV for those with incomes between 200 and 250 percent of the FPL.

Although methods for its calculation vary, AV can be generally understood as the share of average expenses paid by a plan for covered services for a standard population. The remaining share is the average level of cost-sharing that applies to covered benefits (i.e., EHBs) under a plan. As such, the AV is intended to give consumers an important, standardized measure they can use to compare plans. For this to be true, however, the AV must be calculated objectively and consistently applied.

**HHS' proposed approach to calculating AV.** In February 2012, HHS issued a bulletin outlining the expected federal regulations for calculating AV.<sup>30</sup> To calculate a plan's AV, the AV bulletin proposes developing a simple calculator in which a plan's cost-sharing parameters are applied to the state's standardized cost database via a simple, publicly available interface. HHS proposes the use of standardized datasets, allowing for state-specific standardized datasets at state discretion, as the basis for the AV calculations.

In calculating the share of benefit costs a plan covers, the denominator of AV would be total standardized costs for EHB-covered services, while the numerator of AV would be the standardized costs for EHB-covered services paid for by the plan net of cost-sharing features including co-payments, co-insurance, deductibles and out-of-pocket maximums. The HHS approach implies that standardized assumptions about the behavioral responses to different cost-sharing regimes will be developed and applied. Exceptions to this method would be allowed when a plan's benefit categories have a design the calculator cannot accommodate. Specifically, when a benefit category has multiple co-insurance rates, the plan's actuaries will be allowed to substitute a simplified version of the plan's design that fits the calculator, subject to actuarial certification; or to have the plan's actuaries calculate the plan's AV in accordance with "actuarial standards of practice."

**Implications and refinements in HHS' approach.** Using standardized populations and standardized assumptions achieves the fundamental purpose of determining AV, which is to isolate the cost-sharing from other differences between plans, like payment rate differences and utilization review features. Further, standardization ensures consistency in these calculations, rather than allowing insurers to calculate AV for their own competitive advantage.

Despite its advantages, calculating AV based on standardized population information instead of plan-specific information may cloak plan characteristics that may affect consumers' access to benefits. With standardized data, the AV will not capture aggressive discounting or utilization management that may lower premiums but may limit access, rather than promote efficiency. These plan characteristics will be particularly important to high-need patients. The use of standardized data will tend to boost the AV (or apparent generosity) of plans whose enrollees are healthier or whose use of medical services is lower than

the population reflected in the standard data. Actual spending by such plans will be lower than plans that apply fewer restrictions. With standardization, it will become particularly important that consumers have information on plan restrictions in order to appropriately assess plan value.

A second issue HHS' proposed approach could create is an incentive for issuers to develop more complex approaches to cost-sharing, which the HHS bulletin explicitly exempts from evaluation through the HHS calculator. The result could be to allow higher cost-sharing on services used by high-need patients as a means to discourage these patients from enrollment.<sup>31</sup> If HHS aims to encourage innovative cost-sharing arrangements to promote efficiency, developing the capacity to evaluate such arrangements is preferable to creating loopholes in the calculation of AV.

A specific example of such innovation is the development of tiered networks where the cost-sharing varies, such as between preferred providers and regular providers, all of whom are considered in-network (the cost of out-of-network services are explicitly excluded from the AV calculation). For example, within network a consumer might pay a \$10 copay per visit with a preferred provider, but 20 percent coinsurance for visits with all other network physicians. As a variation on this theme, some insurers are experimenting with "reference pricing." This practice essentially creates service-specific tiers within the overall plan provider network. In some plans so far, reference pricing focuses on covered tests and procedures for which there is high demand and for which the insurer has contracted to pay a wide range of prices among its network providers. For such procedures, the plan will cap its reimbursement for the consumer based on a reference price (such as the median allowed charge the plan has contracted with network providers). So, for example, if an insurer's provider fee agreements for a magnetic resonance imaging (MRI) scan ranges from \$900 to \$3,700, even if the insurer otherwise covers imaging services at 100 percent,

it will nevertheless tie the consumer's benefit to a reference price—say, \$2,000. Consumers then have an incentive to seek out the lower-cost providers within the plan's network. However, not all consumers will have a choice. For example, an individual in a car accident may be taken to the nearest hospital and then receive an MRI, not knowing that the hospital's MRI charges are well above the reference price. A consumer who gets an MRI from the most expensive in-network facility will owe the difference between that facility's contracted price with the insurer and the reference price, or \$1,700 in this example. Further clarification by the Administration could specify that such variable cost liabilities for in-network care are, indeed, patient cost-sharing, subject to annual out-of-pocket limits on cost-sharing, and accounted for in the measure of a plan's actuarial value.

To ensure that AVs accurately reflect consumer cost-sharing obligations, calculations would ideally take these designs into account. The AV calculations proposed by HHS could enable consumers to assess these aspects of benefit design by requiring that each plan be evaluated either using the cost-sharing provisions related to the least generous in-network outcome of the plan or using a blended rate that reflects average use across the tiers or utilization assumptions derived by HHS. Similarly, if a plan includes a maximum dollar amount payable per unit on a specific benefit or service, or if a plan imposes reference pricing on any in-network provider (either preferred providers or regular providers), the cost of the benefit or service not covered by a plan could be considered as cost-sharing in the AV calculation, either in full or using a blended cost, weighting by utilization. And, to ensure consumer protection, it would also be counted toward the annual limit on cost-sharing.

Measures like these will mitigate but not eliminate cost-sharing liabilities that have a large impact on a small number of enrollees, but will not materially affect the AV for the standard population. Other tools, in particular enforcement of the

ACA's antidiscrimination provisions, which prohibit qualified health plans from adopting benefit designs that discourage enrollment of high-need consumers, would therefore be needed to prevent risk selection and should be reinforced by effective risk adjustment. Additionally, attention will be needed to ensure affordable access for low- and modest-income enrollees, whose cost-sharing subsidies may not adequately protect them. Access to Medicaid, CHIP, or to a newly ACA-authorized Basic Health Program may be beneficial for these populations, because these programs significantly limit or eliminate cost-sharing for low-income enrollees. However, their typically low payment rates may limit providers' availability.

Depending upon experience and HHS regulations, the Basic Health Program may also offer states a means to address an apparent inconsistency in the ACA between the law's caps on out-of-pocket spending and the law's specification of AV requirements. For example, the ACA specifies that the out-of-pocket limit for covered services for a family of four with income of 200 percent of the FPL, \$44,100 in 2010, would be two-thirds of the Health Savings Account (HSA) law limit, \$3,967 in 2010. That level of protection may result in plan AV greater than 87 percent—the maximum specified under the law for people in this income group. The AV bulletin suggests an increase in the annual out-of-pocket limits (that is, a reduction in insurance protection) for people receiving subsidies, relative to limits specified in the ACA, in order to remedy the statutory inconsistency.

A Basic Health Program may have the capacity to offer people with incomes below 200 percent of the FPL a low out-of-pocket limit as well as low cost-sharing. If it pays lower provider rates or has a less costly enrollee population than the silver plan to which the premium tax credits are tied, the federal subsidies it receives (95 percent of the value of the tax credit for each enrollee) may be sufficient to provide this broader protection. Until HHS issues regulations and exchange plan

premiums are known, the feasibility of this option remains uncertain.

## Oversight and Transparency in Implementing EHB and AV Rules

In the EHB bulletin, HHS indicated that it intends to evaluate the benchmark approach in its first two years to determine whether patients have problems accessing medical care due to coverage or cost; to determine whether EHBs need to be changed or modified due to changes in medical evidence, scientific advancement, or market changes; and to assess the affordability of coverage for EHB.<sup>32</sup> Presumably formal rulemaking or other guidance will elaborate on what kinds of oversight, data collection and other monitoring activities will be used. The greater degree of flexibility ultimately extended to insurers in following the EHB benchmark plan and using the standard AV calculator, the more important it will be to promote transparent implementation and to monitor it carefully. In addition, it is unknown how the different combinations of regulations will interact in each state, and what the consequences will be for vulnerable populations such as those with high health needs or modest incomes.

Implementation that ensures transparency and accountability begins with a clarification of the policy choices states actually make—enabling consumers to understand the EHB benchmark, relative to alternatives the state might have chosen and to benchmarks chosen by other states. Full disclosure and public engagement could be accomplished if, in promulgating its benchmark, each state identified all 10 potential benchmark policies; posted the full “policy document” defining covered benefits on a public web site (e.g., the state’s Department of Insurance website); and summarized benefit differences across the 10 policy options. HHS could summarize the selected benchmark, with each covered benefit clearly assigned to an EHB category. State actions to supplement the benchmark would also be clearly

summarized and posted on this site. HHS would monitor this information by state and analyze coverage commonalities and differences across states. The comparative state analysis could be prominently posted on [healthcare.gov](http://healthcare.gov) or another federal web site.

To the extent insurers are provided flexibility to modify the benchmark policy, oversight can ensure that consumers understand the choices they face and that insurers are transparent in the benefits they offer. Insurers could submit each benchmark modification for review and prior approval, specifying which category (or categories) of EHB are affected and demonstrating that the benefit modification does not have a discriminatory impact on a subset of enrollees. For example, for each modification, the insurer could describe the enrollees who would be affected, estimate the number, share of total enrollees, and the per-person difference in total cost among that subset of enrollees. Policies that differ from the benchmark could be prominently labeled on the insurer’s web site, as well as on the Exchange web site and on [healthcare.gov](http://healthcare.gov), along with a link to a brief summary of the modification. Experience could be monitored and evaluated over time by having State Consumer Assistance Programs collect and report data on consumer complaints, problems, and inquiries related to EHBs and, in particular, related to EHB modifications.

Similarly, to the extent insurers are provided flexibility not to use the HHS AV calculator, they could be required to seek prior approval, based on a specific description of the policy’s unusual cost-sharing feature(s) and demonstration as to why the AV calculator is not appropriate to measure them. To alert consumers, HHS could post a list of “calculator waivers” on its web site, along with a description of the features triggering the waiver, and waived policies would be labeled on the insurer’s web site, the Exchange web site, and [healthcare.gov](http://healthcare.gov). To ensure that waivers are temporary—and that independent calculations can ultimately

be implemented—HHS could gather data from waived plans to evaluate experience and develop behavioral assumptions to improve and extend the AV calculator.

## Establishing Consumer Protections beyond EHB and AV

Regardless of how the EHB regulations and AV targets are specified and monitored, additional tools would be essential to achieve the consumer-focused objectives of adequacy, affordability, simplicity and comparability among exchange plans. Even if flexibility is bounded across and within states, carriers will continue to have opportunities for risk selection and high-need consumers will continue to face unanticipated costs. Standardized and independent calculations of actuarial value provide consumers with useful information in comparing alternative plans, but do not fully reflect plan restrictions and, because they only assess cost-sharing on average, will not reflect limitations that may leave high-need consumers financially exposed.

Effective implementation of other policy tools can play a role in protecting these consumers:

**Coverage Examples.** Alongside benefit summaries, as of September 2012, the ACA requires plans to provide examples of what patients would pay for covered care under the plan using standardized, illustrative care scenarios called coverage examples.<sup>33</sup> Although coverage examples may not tell consumers everything they might need or want to know about a policy, they help consumers see and compare how, together, key health plan features—cost-sharing and benefit limits and exclusions—might affect the level of protection different policies offer in specific circumstances.

At the outset, only two coverage examples are required, illustrating how each plan might cover a typical uncomplicated pregnancy, and how each plan might cover typical care for the management of diabetes in a year. To be more useful to high-risk patients,



other coverage examples would help to illustrate how plans cover (or limit or exclude coverage for) other care scenarios—such as treatment for cancer or heart attack—that involve a much broader set of EHBs, such as surgery, outpatient medical therapies, rehabilitation and mental health services. Recent guidance issued by the U.S. Department of Labor indicates that such scenarios will not be made available until after 2014.<sup>34</sup> However, states can develop scenarios of their own and require exchange-participating carriers and others operating in the nongroup and small group markets to provide them in time for consumers to choose their plans prior to January 1, 2014.

**Network Adequacy.** Neither EHB nor AV regulations can address the risk of inadequate provider networks and high out-of-network costs, which are major consumer concerns. Preventing plans from claiming to provide services at a specified level of cost-sharing when they lack the provider participation to deliver requires regulation and oversight of network adequacy. States have flexibility in determining network adequacy rules for exchange plans and the flexibility to go beyond federal rules.

Under Section 1311(e) of the ACA and Section 2715A of the Public Health Service Act, health plans inside and outside of exchanges are required to report data on a series of plan performance measures, including claims payment practices, information on cost-sharing and payment with respect to out-of-network coverage, and other information determined appropriate by the Secretary. In June 2012, HHS proposed data collection standards for defining EHB and accreditation rules for plans to be certified as QHPs.<sup>35</sup> Although HHS intends to collect a detailed list of plans' benefits and limitations, regulators as well as consumers, would benefit from additional data to evaluate the adequacy of provider networks, as well as the adequacy of network tiers in more complex plan designs. In particular, HHS proposes to assess network adequacy for QHP accreditation at the “product-level” (e.g., the package of benefits)

rather than at the “plan-level” (e.g., the pairing of benefits and cost-sharing). As a result, regulators will be unable to detect whether enrollees in a particular plan have insufficient access to providers due to high cost-sharing in certain in-network provider tiers. Oversight could also focus specifically on how often consumers incur higher cost-sharing for care provided in higher tiers or care that is subject to reference pricing. In addition, data reported by Consumer Assistance Programs could inform more detailed data collection related to areas where problems may arise. For example, plans might report specifically on a practice known as “balance billing”—how often patients who receive surgery or other care in in-network hospitals or other facilities are treated by non-network professionals such as anesthesiologists or pathologists, whom patients have no voice in selecting, and get a bill for fees not covered by the patient's insurance. Finally, provider network adequacy requirements could ensure that consumer data and predictive modeling techniques are not used to avoid marketing to those with high health needs (e.g., those who are predicted to have diabetes).<sup>36</sup> Network adequacy determination is a new role for Departments of Insurance, although most state Medicaid Departments have had related experience. Thus, this is an area where state agencies potentially have a great deal to learn from one another.

**Health Care Utilization Review.** Review and oversight of utilization management rules by federal and state regulators, with careful examination of plan rules that target denial of expensive tests and treatments, could limit the impact of these practices on those with significant health care needs. In addition, clear information provided to consumers at the time of plan choice could help limit overly aggressive practices. The ACA gives authority to HHS and Exchanges to collect and make public these types of practices under Section 1311(e) of the ACA and Section 2715A of the Public Health Service Act. To help HHS determine which plans that may be inappropriately limiting service, HHS could request that plans

submit AV calculations based on their own data as a means to track plan features that are not revealed in the standardized AV calculations.

**New and “Innovative” Cost-Sharing Features.** Innovative plan designs such as wellness programs, reference pricing, or value-based insurance design features may exacerbate consumers' difficulties understanding and comparing plans, since these features are not captured in EHB or AV regulations. In particular, under current regulations,<sup>37</sup> wellness programs are permitted to establish rewards or penalties based on an enrollee's ability to achieve certain health status related targets, such as normal blood pressure or blood cholesterol. These rewards/penalties can include varying the amount of cost-sharing under the plan by an amount equal to up to 20 percent of the total cost of the plan. Under the new law (2705(j) of PHSA), the maximum variation will increase to 30 percent of the total cost of the plan starting in 2014, and the Secretaries of Labor, Health and Human Services, and the Treasury are given authority to expand the maximum variation to 50 percent of total costs. Other standards apply—in particular, for enrollees who can document that they are medically unable to achieve the health status related target. The law requires that these enrollees be offered an alternative way to obtain the reward or avoid the penalty. Nonetheless, to the extent that these features allow significant additional cost-sharing based on enrollee health, the value of coverage for some enrollees—or many enrollees—could be significantly eroded. Further guidance from HHS could clarify how AV calculations would take these provisions into account. Additional guidance could also improve consumers' understanding of plan designs that allow additional cost-sharing based on an individual enrollee's characteristics.

**Effective Risk Adjustment.** Under the ACA, a risk-sharing mechanism based on a risk adjustment system will be put in place for plans in the nongroup and small group markets. Risk adjustment is an actuarial technique of adjusting

payments to health plans to reflect the relative health of the plan's enrollees. The purpose of risk adjustment is to compensate health plans that experience adverse selection and/or higher than average costs, particularly since insurers have a limited ability to set premiums based on the health spending of enrollees. Risk adjustment need not be perfect in order to dissuade insurers from risk selection; the adjustments need only to diminish the benefits of risk selection enough that they balance with the administrative costs associated with carrying out risk selection. Yet while effective risk adjustment is a critical component of well-functioning exchanges, it is not yet clear whether it will be functioning adequately in all states.<sup>38</sup> Thus, risk adjustment will remain a policy focus and will require continual assessment over the next several years. Assessing, evaluating and learning from the experience of risk adjustment in Medicare, as well as other private purchasing pools, may provide additional guidance. And, until each state's risk adjustment mechanism is established and has been shown to work adequately, other means of providing transparency, accountability and other consumer protections will be particularly essential.

#### ***Nondiscrimination Protections.***

In final regulations published March 27, 2012, nondiscrimination rules were extended to qualified health plans, prohibiting marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.<sup>39</sup> HHS could extend the nondiscrimination rules to prohibit the use of consumer data and predictive modeling techniques to selectively avoid marketing plans to those whose lifestyle and other demographic characteristics correlate with significant health needs.<sup>40</sup> Even with these protections, the greater the variation in benefits and benefit design across plans, the harder it will be to detect discriminatory practices and enforce antidiscrimination protections. Regardless, data collection and complaint monitoring strategies will be essential to ensure that consumers are protected

against discriminatory benefit or cost-sharing manipulation.

***Attention to Impact on Low- and Modest-Income Populations.*** The calculation of premium and cost-sharing subsidies available to those with low or modest family income is tied to the second-lowest premium plan in the silver tier. That low premium will reflect plan features that limit plan costs, potentially including tiered in-network providers, limited in-network provider depth, cost-sharing and reference pricing for out-of-network use, utilization control mechanisms, claims denials, and selective marketing. Special attention to tracking and evaluating the experience of this population will be essential to guiding future policy on the adequacy of subsidies, access to public programs, and plan requirements to ensure affordable access to care for this population.

### **Looking to the Future**

HHS' proposed approach to implementing ACA requirements for minimum benefits and insurance plan value in the nongroup and small group markets reflects an effort to balance two competing goals: consistent protection across all consumers and accommodation of variation—whether in experience across states, insurance benefit design, or in the needs and preferences of individual consumers. States' initial choices of benchmark benefits will accommodate state insurance markets where they are today, while eliminating the lowest-value plans from the market and thereby improving the options facing consumers. An independent calculation of actuarial value will accommodate flexibility in benefit design, while promoting objective comparison of plans' benefit offerings. However, our analysis shows that these rules may not ensure the highest-need, highest-cost consumers have predictable and adequate insurance protection. Achieving this goal would require refinement, reinforcement and reevaluation of HHS' proposed practices, both at initial implementation and over time, in order to minimize risk selection and discrimination that may inevitably

remain a part of even much-improved insurance markets.

To discourage risk selection through benefit design, HHS can refine its proposed approach to EHBs by establishing a high standard of evidence to establish the “actuarial equivalence” of any proposed substitutions for benchmark benefits. It can also require—or, at a minimum, allow—states to limit the number of variations plans can offer. To ensure accurate consumer information on likely cost-sharing within a plan, HHS can refine its AV proposal to develop methods for appropriately reflecting the impact of in-network or innovative cost-sharing designs before approving their use. Additionally, high-cost patients could be protected by counting any resulting cost-sharing toward the annual out-of-pocket cap. Tracking and evaluating experience will be needed to ensure affordable access for low- and modest-income enrollees, whose cost-sharing subsidies may not be as broad as expected.

Initial efforts to allow choice while preventing selection can be reinforced by oversight and transparency in implementing these rules. In implementing EHBs and any “equivalents,” states can be required to publicly explain their selection of a benchmark plan, and insurers can be required to seek prior approval for deviations from benchmark benefits—by describing, justifying and analyzing the impact on specific populations of the proposed variation. Similar prior approval and justifications could be required of any waivers from independent calculation of a plan's AV. And in both cases, experience can be collected and evaluated to assess burdens or barriers facing high-cost patients.

Neither EHB nor AV rules by themselves, however, are designed to alert consumers to, or protect consumers from, detailed plan characteristics that will determine their access to expected benefits. Enabling consumers and regulators to understand the implications of actual choices in the marketplace would require reinforcing these rules through the collection and

dissemination of information on plan practices that can affect coverage of high-cost cases. Key information would include scenarios of coverage of specific high-cost conditions like cancer or heart disease to illustrate the actual share of incurred costs a plan is likely to pay; data on the frequency and out-of-pocket cost implications of out-of-network use to indicate the adequacy in practice of plan networks; data on the nature, frequency, and impact on use of prior approval or other utilization control mechanisms to indicate barriers to access; description of cost-sharing innovations or wellness initiatives and their cost-sharing implications in high-cost cases; and data on claims payment policies, claims denials, access to external appeals, and outcomes of appeals, to detect the reliability of or barriers to payment of costly claims.

If the EHB regulations and AV calculations are well-specified and additional information and tools are available to policy-makers and consumers, consumers will be able to regard premiums as measures of plans' relative efficiency, rather than a reflection of the underlying health risk of the plans' enrollees. Well-informed consumers

within a well-regulated system will also provide insurers with balanced incentives in making tradeoffs between lower premiums and adding benefits or expanding networks, ultimately fostering competition between plans on quality and efficiency.

These measures to reinforce choice without risk selection rely primarily on information on and exposure of potentially restrictive plan practices. Importantly, however, the ACA also requires risk-adjusted payments to plans, intended to avoid overpayment of plans that avoid the sick and underpayment of plans that treat them. Equally important are the ACA's explicit prohibitions on benefit designs that discriminate against high-cost patients. A full commitment to effectively applying both risk-adjustment and antidiscrimination rules would minimize plan's interest in and pursuit of risk selection practices.

Finally, effective protection of high-cost and even average-cost patients may require a reevaluation of EHB, AV, and all other rules as the ACA implementation goes forward. Explicitly limiting the proposed benchmark to EHB determination to two years (from

2014 to 2016) reflects recognition of the uncertainties regarding the adequacy, effectiveness or impact of the initial approach. Collection and comparison of benchmark benefits across states will be essential to informing next steps in the definition of EHBs—in particular, lessons from state variation. Though not explicitly limited, other rules will similarly benefit from an assessment of experience and appropriate modifications, in order to avoid unintended consequences and to promote adequate coverage.

In sum, there is little question that the ACA will improve the nongroup and small group insurance markets for everyone in them, including the high-risk population. Yet insurance market reforms, guided by requirements for EHBs, AVs, and other tools provided by the ACA, are and will remain a work in progress. This analysis suggests the way these tools—working together and reevaluated over time—can help ensure that ACA implementation actually progresses toward the ACA's goals of effective, affordable insurance protection, especially for the highest-need, highest-cost patients.

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