IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES HOUSE OF REPRESENTATIVES, Plaintiff, v. SYLVIA MATHEWS BURWELL, in her official capacity as Secretary of the United States Department of Health and Human Services, et al., Defendants.	Case No. 14-cv-01967-RMC

EXHIBIT R

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: June 19, 2015

Subject: Cost-Sharing Reduction Amounts in Risk Corridors and Medical Loss Ratio Reporting

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On February 13, 2015, CMS announced that the cost-sharing reduction (CSR) portion of the advance payments for the 2014 benefit year will be reconciled in April 2016, rather than in April 2015.[1] The new timetable was established to enhance the accuracy of reconciliation of CSR payments to issuers, and to fully reimburse issuers for reductions in cost sharing provided to eligible low- and moderate-income enrollees and American Indian/Alaska Native enrollees in 2014.

As a result of the new timetable for CSR reconciliation, the actual value of CSRs provided by the issuer will not be available in time for risk corridors and medical loss ratio (MLR) program reporting for the 2014 benefit year. Therefore, for the purpose of adjusting allowable costs in the risk corridors calculation and incurred claims in the MLR calculation for the 2014 benefit year, issuers should use the amount of the CSR portion of the advance payments received by the issuer for 2014 (to the extent not reimbursed to the provider furnishing the item or service).[2][3]

If an issuer believes that the CSR portion of advance payments it received are substantially different from the CSRs it actually provided in 2014, CMS will permit the issuer to report a certified estimate of the amount of CSRs provided in 2014 (to the extent not reimbursed to the provider furnishing the item or service) in its risk corridors and MLR reporting for the 2014 benefit year. Allowable costs in the 2014 risk corridors calculation and incurred claims in the 2014 MLR calculation will be adjusted by the amount (whether the advance amount or the certified estimate) that the issuer reports on the 2014 Annual MLR Reporting form.

For a certified estimate, the issuer may use (a) the CSR amount on the issuer's annual financial statement as submitted as part of the NAIC Supplemental Health Care Exhibit, or (b) any other estimate certified as the issuer's best estimate by the issuer's chief financial officer and chief actuary.

As required under 45 CFR 156.430(e)(1)-(e)(2), when CSR reconciliation occurs in April 2016, the issuer's advance CSR payments received in 2014 and the issuer's advanced CSR payments received in 2015 will be reconciled against the actual value of CSRs provided by the issuer in the respective benefit years.

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[1] https://www.regtap.info/uploads/library/APTC_CSR_Recon_timing_guidance_5CR_021315.pdf

[2] Advance payments to issuers consist of a cost-sharing reduction and a premium tax credit portion. Here we discuss only the cost-sharing reduction portion of those advance payments.

[3] Allowable costs in the risk corridors calculation and incurred claims in the MLR calculation are adjusted for payments of CSR as set forth at 45 CFR 153.530(b)(2)(iii) and 45 CFR 158.140(b)(1)(iii), respectively.

Additionally, to ensure the integrity of data used in risk corridors and MLR calculations, we intend to propose a policy in the HHS Notice of Benefit and Payment Parameters for 2017 under which CMS would implement an adjustment to the risk corridors and MLR calculations for 2015 to correct for any inaccuracies in the estimated CSR provided in 2014 that were reported in the 2014 risk corridors and MLR reporting form. We intend to propose that, for the 2015 risk corridors and MLR reporting cycle, if an issuer used a certified estimate of 2014 CSRs provided on the 2014 risk corridors and MLR forms that is lower than the actual CSRs provided (as calculated under CSR reconciliation), CMS would adjust the issuer's 2015 risk corridors payment or charge amount, as applicable, by any difference between the estimated 2014 CSR amount reported in the 2014 risk corridors and MLR forms, and the reconciled actual value of CSRs provided by the issuer for the 2014 benefit year. CMS would intend to implement this adjustment as a direct dollar-for-dollar adjustment to the issuer's risk corridors payment or charge amount, or as an adjustment to one of the risk corridors parameters such that the net effect would be a dollar-for-dollar adjustment to the risk corridors payment or charge amount. This adjustment would be made by issuers at the time they report MLR and risk corridors data for the 2015 reporting cycle.

When reporting CSR amounts for the 2015 risk corridors and MLR reporting cycle (July 2016 submission of 2015 benefit year data), issuers that elected to report advance CSR amounts in the 2014 reporting cycle and issuers that reported estimated CSR amounts that were above the actual value of CSRs provided in 2014 should include any CSR reconciliation payments or charges for the 2014 and 2015 benefit years in their reported CSR amount for the 2015 risk corridors and MLR reporting year. These issuers would simply make a direct adjustment to the cost-sharing reduction amount reported in the 2015 risk corridors and MLR reporting form, as necessary to account for any differences with the actual amount of CSRs provided, consistent with the standard processes for adjusting for changes in amounts reported.[4] CMS will not recalculate risk corridors and MLR amounts for the 2014 benefit year, based on the reconciliation of the cost-sharing reduction portion of the advance payments or the certified estimate.

[4] 45 CFR 153.710

Actuarial Value and Cost-Sharing Reductions Bulletin

I. Purpose:

The purpose of this bulletin is to provide information and solicit comments on the regulatory approach that the Department of Health and Human Services (HHS) plans to propose to define actuarial value (AV) for qualified health plans (QHPs) and other non-grandfathered coverage in the individual and small group markets under section 1302(d)(2) of the Affordable Care Act as well as to implement cost-sharing reductions under section 1402 of the Affordable Care Act.[1] AV is a measure of the percentage of expected health care costs a health plan will cover. AV is calculated based on the cost-sharing provisions for a set of benefits.

Section 1402(a)-(c) of the Affordable Care Act directs issuers to reduce cost-sharing on essential health benefits (EHB) for individuals with household incomes below 400 percent of the Federal Poverty Level (FPL) who are enrolled in a QHP in the individual market through an Affordable Insurance Exchange (Exchange). These cost-sharing reductions are designed to have the effect of achieving certain AVs and therefore follow the same definitions and calculation of AV.

We welcome public input on this bulletin – please send comments on AV to ActuarialValue@cms.hhs.gov and cost-sharing reductions to CostSharingReductions@cms.hhs.gov

[1] Section 2707(a) of the PHS Act requires non-grandfathered coverage in the individual and small group markets to include the EHB package described in Section 1302(a) of the Affordable Care Act including providing coverage at one of the metal levels.

II. Actuarial Value

Introduction and Background:

Actuarial value (AV) is a measure of the percentage of expected health care costs a health plan will cover and can be considered a general summary measure of health plan generosity. Section 1302(d)(2) of the Affordable Care Act defines AV relative to coverage of the EHB for a standard population. AV is generally calculated by computing the ratio of (i) the total expected payments by the plan for essential health benefits (EHB), computed in accordance with the plan's cost-sharing rules (i.e., deductibles, co-insurance, co-payments, out-of-pocket limits), for a standard population; over (ii) the total costs for the EHB the standard population is expected to incur. For example, a plan with an 80 percent AV would be expected to pay, on average, 80 percent of a standard population's expected medical expenses for the EHB. The individuals covered by the plan would be expected to pay, on average, the remaining 20 percent of the expected expenses in the form of deductibles, co-payments, and coinsurance.

As a summary measure, AV is expected to be used by consumers to compare QHPs and non-grandfathered individual and small group market plans with different cost-sharing designs and as a method for consumers to understand relative plan value. Other consumer products have successfully used summary metrics that are calculated in a standardized way to compare the relative value of competing products.[2] To promote plan competition based on premiums, quality, provider network, and customer service, the Affordable Care Act directs issuers to meet certain levels of plan cost-sharing using AV.

The Affordable Care Act requires issuers offering non-grandfathered health plans inside and outside of the Exchange in the individual and small group markets to assure that any offered plan must meet distinct levels of coverage specified in section 1302, called "metal tiers" -- bronze, silver, gold, or platinum.[3] Under the statute, each metal tier corresponds to an AV, calculated based on the cost-sharing features of the plan as described above. The expression of AV as a metal tier will allow consumers to easily compare plans based on cost-sharing features.

Section 1302(d)(2) directs the Secretary to issue regulations on the calculation of AV and its application to the metal tiers. Pursuant to section 1302(d)(1), a bronze plan is required to have an AV of 60 percent; a silver plan, 70 percent; a gold plan, 80 percent; and a platinum plan, 90 percent. Section 1302(d)(2) also provides that a plan's AV must be based on the provision of the EHB to a standard population without regard to the actual population to which a plan provides benefits. The law does not specify the definition of a standard population or a methodology for calculating a standard population.

[2] Consumers Union, "Creating a Usable Measure of AV," January 2012. Available at: http://www.consumersunion.org/pub/pdf/CU_Actuarial_Value_2012_Report.pdf Accessed on January 28, 2012.
[3] Catastrophic coverage, as defined in section 1302(e), is a permissible benefit design offered to certain qualified individuals that does not meet a specific AV but must comply with the maximum out-of-pocket limit.

Actuarial Value and the Essential Health Benefits

AV is calculated based on the cost-sharing provisions for a set of benefits. Section 1302(d)(2) specifies that the AV of a qualified health plan is required to be based on the provision of EHB. HHS released a bulletin on December 16, 2011, describing its intent to define EHB by reference to a benchmark plan.[4]

Intended Regulatory Approach

This bulletin describes the Department's intended proposed approach to implementation of AV calculation.[5] In subsequent sections the Bulletin considers:

- Calculation of Actuarial Value
- Operational Method for AV Calculation Using Standard Data
- De Minimis Variation Standards
- Treatment of Health Savings Accounts and Health Reimbursement Arrangements in Calculating AV

Calculation of Actuarial Value

Section 1302(d)(2) (entitled "Actuarial Value") of the Affordable Care Act directs the Secretary to issue regulations under which the level of coverage of a plan "shall be determined on the basis that the essential health benefits described in subsection [1302](b) shall be provided to a standard population…" This bulletin describes the intended proposed methodology for calculating AV for qualified health plans (QHPs) and non-grandfathered health plans in the individual and small group markets. We intend to propose a methodology for the calculation of AV for these plans that provide consumers the most direct comparison of plan benefit generosity across multiple issuers. We note that in other markets in which plans are not required to offer EHBs, there is greater variation in plan design covered across issuers.

One way to ensure that QHPs and non-grandfathered individual and small group market plans meet the AVs in the metal tiers is to standardize the cost-sharing for each plan. For example, all silver plans could be required to have the same cost-sharing structure. As a potential alternative, plans could have the flexibility to independently develop cost-sharing structures as long as each plan's AV is equal to 60 percent, 70 percent, 80 percent or 90 percent. AV would be defined using formal rules that ensure actuarial equivalence within a metal tier. We intend to propose the

[4] In the Essential Health Benefits Bulletin, we consider proposing benefit design flexibility in the form of permissible benefit substitution within each of the 10 statutory categories so long as the benefits substituted are actuarially equivalent and meet other statutory requirements. It is important to note that this actuarial equivalence is not the same as the AV determination discussed in this bulletin. The bulletin is posted at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

[5] For employer-sponsored plans, guidance on the determination of minimum value will be issued in the near future.

latter approach; QHPs and other non-grandfathered individual and small group market plans must meet the AVs in the metal tiers.

While there are many ways insurers currently determine AV, a white paper published by the American Academy of Actuaries describes two general options on how to determine AV using a standard population.[6]

Under the first option, an issuer would use its own plan-specific data on population, utilization, and pricing to determine the AV of the plan. In order to meet the statutory requirement in section 1302(d)(2)(A) that the AV reflect a standard population, the plan would then apply demographic adjustments to standardize the plan population. Because plan-specific data vary by issuer, using these data to determine AV means that plans with the same cost-sharing design could have different AVs, even after making demographic adjustments.[7] While this plan-specific AV calculation accurately reflects that a particular health plan in practice historically covers a specified percentage of the cost of care for an average plan enrollee, for consumers shopping for QHPs on an Exchange, it could be difficult to understand why two plans that appear to have the same cost sharing have substantially different AVs.

The second option proposed by the American Academy of Actuaries for use in determining AV for QHPs and non-grandfathered individual and small group market plans directs issuers to use a single set of data and assumptions for population, utilization, and health care pricing for QHPs and non-grandfathered health plans in the individual and small group markets. With consistent data on which to base the AV calculation, regardless of actual plan enrollees' experience, plans with the same cost-sharing design would have the same AV, allowing consumers to choose among plans of comparable levels of coverage for the set of benefits. Therefore, consumers could differentiate plans based on plan features such as premium, quality rating, provider network, and customer service. Under this approach, a silver plan that negotiates lower prices with providers or better manages care will have lower costs and, rather than supplementing benefits or reducing cost sharing, these plans may offer lower premiums while remaining silver plans.

Under the second approach, the Centers for Medicare & Medicaid Services (CMS) would develop a data set based on claims for a standard population, weighted for the expected market enrollment. The claims data would reflect average unit prices and utilization patterns. These data would be used to calculate AV based on a broad range of benefit design parameters, such as deductibles and copayments. The goal of this approach is that two QHPs or two non-grandfathered health plans in the individual or small group markets with the same cost-sharing design would have the same AV.

[6] Available at: http://www.actuary.org/pdf/health/Actuarial_Value_Issue_Brief_072211.pdf
[7] This could occur due to other differences in a plan's enrollee population, and/or due to differences in a plan's provider reimbursement or efficiency in providing and paying for care.

Both options represent valid methodologies for determining the AV of a plan. For purposes of calculating the AV of QHPs and non-grandfathered individual and small group market plans, the choice between these two approaches involves tradeoffs. Plan-specific data relies on patterns of utilization in a particular plan, resulting in an AV that most accurately estimates the percentage of total costs that will be covered by that plan for an average enrollee.[8] Yet, the use of standard data allows for clearer comparisons across plans because AVs will be similar for comparable cost-sharing designs, enabling enrollees to compare plans within a metal tier based on premiums, quality, networks, and other factors. The use of standard data helps to ensure that the plans that are most successful in managing utilization and total costs will stand out as having the lowest premiums in the metal tier.

To promote transparency and simplicity in the consumer shopping experience, we intend to propose using the second approach: a standard data set for AV calculations for QHPs and non-grandfathered health plans in the individual and small group markets, for which HHS would develop a national standard population. To promote State flexibility and account for variation in prices, utilization, and benefits across States, we intend to propose an option that would permit States to develop State standard populations based on State claims data. The State standard population would need to reflect a non-elderly population likely to be covered by private health plans in the individual and small group market and be large enough to be stable over time. We intend to propose that States choosing not to supply their own standard population may modify the national standard population developed by HHS using demographic and other adjustors in accordance with sound actuarial practices.

Because AV is calculated as the share of total costs of care paid for by the plan, the price of care and patterns of service utilization are important factors in this calculation. As with all goods and services, health care input prices and utilization may vary geographically. Although the standard population data is representative of the entire country, accuracy can be improved by applying an approach to recognize local prices and utilization. Therefore, in addition to the flexibility we intend to provide States regarding demographic adjustments, we intend to address geographic differences in pricing for the AV calculation. We intend to propose applying three pricing tiers across the country, with each State assigned to one of the three tiers, but specifically request comment on whether applying more pricing factors would improve the accuracy of AV calculations.

Operational Method for AV Calculation Using Standard Data

Although section 1302(d)(2) requires that AV be determined based on the provision of EHB to a standard population, it does not specify a method for calculation. As discussed above, we intend to propose use of a standardized population that reflects standard prices and utilization, weighted

[8] This would only be true on average. An enrollee with very high utilization, who reaches the maximum out-of-pocket limit, would experience a plan spending percentage that is higher than the plan's AV, while an enrollee with little spending would experience a plan spending percentage that is lower than the plan's AV.

for the expected enrollment and characteristics in 2014, for the AV calculation. Consistent with this approach, we considered three methods to provide plans with the national standard population with which to determine AV:

1. Distribute a standard set of de-identified individual level claims data to issuers and allow them to estimate the AV of their plans by comparing that standard set of claims against their plan designs. This method would give issuers more flexibility in AV calculation because issuers could apply their own set of assumptions about induced demand, in-network utilization, and other calculation assumptions to the standard data set. Because this method could result in variation in determined AV among plans with the same cost sharing design, it could make comparison shopping for consumers more difficult. Operationally, this approach would also be difficult due to the data requirements; we are not aware at this time of a sufficiently robust person level data set that could be made publicly available.

2. Distribute continuance tables, which are aggregated data derived from a set of de-identified individual level claims data to issuers to perform AV calculations.[9] Using this method, the set of assumptions would be more uniform, but there would still be inconsistency and variation among issuers depending on the calculation method and logic.

3. Develop a publicly available AV calculator that plans would use to determine AV. The calculator would be developed using a set of claims data weighted to reflect the expected standard population in the individual and small group markets for the year of enrollment. Plans would input information on cost-sharing parameters. Both the logic and the tables of aggregated data used to develop the calculator would be made public to maximize transparency. The calculator method ensures a consistent set of assumptions and methods in AV calculation, maximizing comparability for consumers since plans with the same cost-sharing design would have the same AV.

We intend to propose the third approach to be used to determine the AV of QHPs and non-grandfathered individual and small group market plans. Our intention is that the proposed AV calculator would be a publicly available, dynamic tool. Health plans could input their plan design and the calculator would provide the AV of the plan. The calculator would be universally available for both formal and informal calculations and could be used as a tool to assist issuers in the design of health plans. This would allow health plan issuers to devise an optimal plan without the burden of making the assumptions needed for an AV calculation themselves. Thus, the AV calculator would reduce issuer burden in calculating AV.

[9] A health insurance continuance table is a distribution of annual paid claims arranged in a format that shows the amount of claims paid at each increasing level of expenditure, adding up to the total amount of expenditures of a covered group of enrollees.

We intend to propose that issuers would be able to input into the AV calculator a limited set of information on the benefits offered in a plan and this information would be sufficient to produce the AV of the plan.[10] We expect a handful of cost-sharing features to have a large impact on AV including: deductible, co-insurance, maximum out-of-pocket costs, and to a lesser extent: cost-sharing for emergency room visits, inpatient admissions, and diagnostic imaging. However, because the vast majority of medical costs are dedicated to physician and mid-level practitioner care; hospital and emergency room services; pharmacy benefits; and laboratory and imaging services, not all cost-sharing information will have a material impact on AV.[11] Further, because only a small percentage of total inpatient costs come from out-of-network utilization, we intend to propose that the calculator only consider the value of in-network service use.

HHS recognizes that including a larger number of inputs could theoretically improve the accuracy of the AV calculator. We also recognize the need to accommodate innovative plan design features that are meaningful to consumers, such as Value-Based Insurance Designs that vary the copayment or coinsurance for items and services based on expected value. At the same time, there is a limit on the number of features that can be recognized for incorporation in a practical and easy-to-use AV calculator. Given the intended uses of the AV calculator, we seek comment on which inputs, benefits, and services are most appropriate to include.

The EHB bulletin released by HHS on December 16, 2011 describes an intended proposed approach to allow States to select a benchmark plan to define EHB. The bulletin permits States to select one benchmark for their non-Medicaid population. However, all of the benchmarks options are within the Secretary's definition of EHB because they are options offered by the Secretary to States.

Consistent with section 1302(b)(2)(A) of the Affordable Care Act, the AV calculator described in this bulletin is expected to be powered by one or more sets of national claims data reflecting "typical employer" plans of all levels of plan generosity. The data underlying the AV calculator represents the entire range of potential benchmark benefits available to be chosen by States. Relative to total covered health expenditures, the variation among benchmarks is very small. Therefore, although the benchmark for EHB will vary by State, that variation is expected to have limited impact on the plan AV.

Although we anticipate that the vast majority of QHP issuers would be able to calculate the AV of any given plan using the proposed calculator, it is possible that the calculator would be unable to accommodate some plan designs directly. For example, if a QHP issuer designed a plan with a $1,000 deductible, 20 percent copayment up to $2,000 out-of-pocket, and then 40 percent copayment up to a $6,000 out-of-pocket maximum, we expect the calculator would not be able to

[10] Claims data has shown that only a small percentage of overall utilization occurs out of network. Therefore, determination will assume only in-network services will be used.

[11] ASPE Research Brief, "AV and Employer Sponsored Insurance" November, 2011. Available at: http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.pdf Accessed on January 29, 2012.

directly accommodate those parameters, because of the two coinsurance rates. Similarly, if an insurer offers a multi-tier network with substantial amounts of utilization expected in tiers other than the lowest priced tier, adjustments to the calculator output may be needed. In order to facilitate innovation in plan design, we are considering two options:

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

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

De Minimis Variation Standards

Section 1301(a)(1)(B) of the Affordable Care Act directs issuers of QHPs and non-grandfathered health plans in the individual and small group markets to offer plans that meet one of the following levels of coverage specified in section 1302: bronze, silver, gold, or platinum. A bronze plan is required to have an AV of 60 percent; a silver plan 70 percent; a gold plan 80 percent; and a platinum plan 90 percent. Section 1302(d)(3) of the Affordable Care Act authorizes the Secretary to determine a reasonable "*de minimis*" variation in the AVs used in determining the level of coverage of a plan to account for differences in actuarial estimates.

We expect that by using the AV calculator, actuaries using a standard set of claims will be able to create plan designs to meet any specified level of AV. However, in order to balance the issuers' ability to create market-friendly plan designs using simple, easy-to-understand cost-sharing arrangements with the AV requirement, we intend to propose that a range of variation be allowed among plans at a given metal level. For example, issuers may want to offer a plan that provides simple cost-sharing options, such as $10 copayments for drugs or $20 copayments for physician visits, and providing these levels of cost-sharing may result in an AV near, but not exactly at a metal level. We intend to propose a *de minimis* variation of +/- 2 percentage points in AV (e.g., a silver plan could have a value from 68 percent to 72 percent) so issuers have the flexibility to set cost-sharing rates that are simple and competitive while ensuring consumers can compare plans of similar generosity. We believe this approach strikes the right balance between ensuring comparability of plans within each metal level and allowing plans the flexibility to use convenient cost-sharing metrics. A practical AV range would mitigate the need for annual plan redesign, allowing plans to retain the same plan design year to year and remain at the same metal level.

Treatment of Health Savings Accounts and Health Reimbursement Arrangements in Calculating Actuarial Value

Section 1302(d)(2)(B) of the Affordable Care Act directs the Secretary to issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer. Calculation of the AV of high-deductible health plans (HDHP) linked to a health savings account (HSA) or a health plan linked to a health reimbursement arrangement (HRA) poses a special challenge. Simply calculating the AV of the HDHP based on the insurance product could understate the value of coverage and some HDHPs could fall below the level of a bronze plan based on the HDHP alone. Yet accounting for the total coverage provided by the combination of the HDHP and the full value of the HSA or HRA could overstate the AV because, empirically, only a portion of these accounts are used toward health in a given year. The AV calculation should, therefore, reflect an appropriate adjustment to these contributions. We intend to propose that for purposes of calculating the AV of an employer health benefit plan, the annual employer contribution to the employee's HSA associated with a qualifying HDHP and the amount made available for the first time in a given year under a HRA that is linked to an employer health benefit plan shall be considered part of the benefit design of the health plan. In calculating the AV of the combined HDHP and HSA or combined employer health benefit plan and HRA, the calculation would assume that the employer contribution to the HSA or HRA is used by the employee to pay for cost-sharing. Accordingly, these amounts would be credited to the numerator of the AV calculation. This means that the AV calculator would include any current year HSA contributions and amounts first made available under an HRA as an input into the calculator that can be used to determine the AV of an employer health benefit plan. For example, if a HDHP with a $3,000 deductible has an AV of 55 percent and the employer provides an HSA contribution of $1,000, that contribution would be applied towards the numerator of the AV calculation. However, because generally only a portion of an HSA is used in a year for health services, HSA contributions would be adjusted so that the employer receives the same credit for HSA contributions in the numerator of the AV calculation as it would receive for the same amount of first-dollar insurance coverage. The same rule would apply for amounts first made available under an HRA. In the individual market, we intend to propose that HSA contributions paid directly by the individual would not count towards AV.

Finally, we note that the method used to evaluate the HSA or HRA impact on health plan AV has no bearing on the opportunity of employers to offer HSAs or HRAs, or the tax treatment of HSA contributions or amounts made available under an HRA.

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

Introduction and Background

Section 1402(a)-(c) of the Affordable Care Act directs issuers to reduce cost sharing on essential health benefits (EHB) for an individual with a household income of 400 percent of the Federal Poverty Level (FPL)[12] or below who enrolls in a silver-level qualified health plan (QHP) in the individual market through an Exchange. The statute directs that the reduction in cost sharing should first be achieved by reducing the maximum out-of-pocket limit and then by reducing cost sharing in the form of deductibles, coinsurance, or copayments. Cost-sharing reductions exclude reductions in premiums, balance billing amounts for non-network providers, and spending for non-covered services. Finally, the statute directs the Secretary to make payments to issuers equal to the value of these reductions.

In addition, section 1402(d) of the Affordable Care Act directs a QHP issuer to eliminate cost sharing for an Indian (as defined in Section 4(d) of the Indian Self-Determination and Education Assistance Act) with a household income of 300 percent of the FPL or below who is enrolled through the Exchange in a QHP at any level of coverage. Further, the statute directs a QHP issuer to eliminate cost sharing for an Indian, regardless of household income, for items or services furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, and prohibits the QHP issuer from reducing payments to any such entity for such items or services. This bulletin does not address these provisions, which will be addressed in future rulemaking.

This bulletin describes HHS's intended approach to implementing cost-sharing reductions for eligible individuals and to making payments to QHP issuers for these reductions. When an individual applies for coverage through the Exchange, the individual's eligibility for cost-sharing reductions will be determined. We intend to propose that individuals eligible for cost-sharing reductions will be offered variations of the silver plan QHPs with the cost-sharing structures modified to reflect the AV for which the individual is eligible (silver plan variations).

Under our intended proposal, when an individual receives covered EHB, the provider would collect from the individual only the amount of cost sharing specified in the silver plan variation in which the individual is enrolled. The Federal government would pay in advance to the issuer amounts estimated to cover the cost-sharing reductions associated with the specific silver plan variation. We intend to propose that this advance cost-sharing reduction payment to the issuer would occur monthly, and that after the end of the calendar year, the Federal government would reconcile the advance payments to actual cost-sharing reduction amounts. Additional detail on this intended approach is included below. We welcome public input on this approach.

[12] FPL is updated periodically in the Federal Register by the Secretary pursuant to 42 USC §9902(2).

Intended Regulatory Approach

In developing our intended proposal for implementation, we are seeking to balance a number of factors, including consumer protection and privacy; transparency in consumer choice; issuer flexibility in plan design; administrative and operational simplicity; and integrity in program costs.

Consistent with the statute, we intend to propose an implementation of cost-sharing reductions that directs QHP issuers to design silver plan variations for individuals of qualifying income levels based on reductions in the maximum out-of-pocket limits required by section 1402 of the Affordable Care Act and specified by HHS. We intend to direct issuers to design silver plan variations such that, for any particular benefit or provider, a silver plan variation with a higher AV would require no greater cost sharing than that required by a variation with a lower AV. Initially, and until we can predict with greater certainty cost-sharing reduction amounts, we intend to propose making periodic advance payments to issuers based upon projections of cost-sharing reduction amounts, with those payments reconciled after the end of the calendar year to actual cost-sharing reduction amounts. This is similar to the approach taken in the Medicare Part D low-income subsidy program.

Out-of-Pocket Limits for Individuals with Household Income Less than 250% of the FPL

Section 1402 of the Affordable Care Act requires reductions in the maximum out-of-pocket limits on silver plans for individuals with household incomes between 100 and 400 percent of the FPL. However, the statute also requires the Secretary to ensure that the reductions in the maximum out-of-pocket limits do not cause the AVs of these silver plan variations to exceed certain levels. The chart below lays out the initial reductions in the maximum out-of-pocket limits (subject to revision by the Secretary) and AV requirements applicable to silver plans for individuals with qualifying household income levels:

Table 1. Reductions in Maximum Out-of-Pocket Limits and AV Requirements, by Household Income

Household Income	Reduction in Maximum OOP Limit	Plan AV Requirement
100-150% of FPL	2/3	94%
150-200% of FPL	2/3	87%
200-250% of FPL	½	73%
250-300% of FPL	½	70%
300-400% of FPL	1/3	70%

For reasons described in more detail below, we do not plan to reduce the maximum out-of-pocket limits for individuals with income between 250 and 400 percent of FPL. Our implementation of §1402 of the Affordable Care Act therefore focuses on those individuals with household income no greater than 250 percent of FPL.

To accomplish these statutory purposes, HHS intends to propose an annual three-step process to the design of cost-sharing structures for silver plan variations. In the first step, we intend to propose that the maximum out-of-pocket limit generally applicable to all QHPs will be set as described in §1302(c)(1) of the Affordable Care Act.

In the second step, we intend to propose that HHS publish in an annual notice of benefits and payment parameters, the reduced maximum out-of-pocket limits for individuals with household incomes between 100 and 250 percent of the FPL, based on reductions in the second column of Table 1. To determine these reduced maximum out-of-pocket limits, HHS would analyze the effect of the reductions on a model silver plan designed by HHS. If the effect of reducing the maximum out-of-pocket limit makes achieving the required AV (as displayed in the third column of Table 1) practically infeasible for the model silver plan, HHS would alter the reduction to make it feasible. HHS would publish a summary of its analyses in the annual notice, along with a description of the model.

In the third step, we intend to direct that a QHP issuer submit, along with each standard silver plan that it proposes to offer through the Exchange, three variations of that standard silver plan to match the statute's three levels of cost-sharing reductions. The standard silver plan will have an out-of-pocket limit no greater than the maximum out-of-pocket limit required for all QHPs, and will have a 70 percent AV. The three silver plan variations would then be required to meet the out-of-pocket limits and AV requirements set forth below:

a. For individuals with household incomes between 200 and 250 percent of the FPL, a silver plan variation with an AV of 73 percent and an out-of-pocket limit no greater than that set forth in the annual Federal notice;

b. For individuals with household incomes between 150 and 200 percent of the FPL, a silver plan variation with an AV of 87 percent and an out-of-pocket limit no greater than that set forth in the annual Federal notice; and

c. For individuals with household incomes between 100 and 150 percent of the FPL, a silver plan variation with an AV of 94 percent and an out-of-pocket limit no greater than that set forth in the annual Federal notice.

The *de minimis* amounts discussed in the AV section of this bulletin apply to these AV limits.

If the application of the reduced maximum out-of-pocket limit set forth in the annual Federal notice results in an AV for a particular silver plan variation that differs from the required 73, 87, or 94 percent AV level, as applicable, by more than a *de minimis* amount, the QHP issuer would be required to adjust the cost-sharing structure in that silver plan variation to achieve the applicable AV level, subject to the reduced maximum out-of-pocket limit set forth in the annual Federal notice.

For example, the statute calls for up to a 2/3 reduction in maximum out-of-pocket limit for individuals with household income between 150 and 200 percent of the FPL. If the maximum out-of-pocket limit generally applicable to QHPs in 2014 is $6,000, a 2/3 reduction would lead to a maximum out-of-pocket limit of $2,000 for individuals with such incomes. However, HHS might determine that the out-of-pocket limit for an 87 percent silver plan variation should be permitted to be as great as $2,300, because it would be infeasible for the model silver plan to achieve an 87 percent AV with a $2,000 out-of-pocket limit. Even following HHS's determination, however, a particular issuer might find that the application of a $2,300 out-of-pocket limit to the cost-sharing structure in its standard silver plan results in an AV of 84 percent – three percent less than the required level. The issuer would then be required to amend its cost-sharing structure by decreasing co-payments and deductibles or lowering coinsurance (or further reducing the out-of-pocket limit) so that the silver plan variation achieves the required AV of 87 percent. The AV of the silver plan variation could be calculated using the AV calculator or the other methods described earlier in this bulletin.

We intend to propose that QHP issuers be required to submit to the Exchange for approval each standard silver plan it intends to offer along with the three silver plan variations of that plan.

Variations in Cost-Sharing Structures

Section 1402(c)(2) of the Affordable Care Act requires the Secretary to establish procedures under which a QHP issuer further reduces cost sharing, beyond the reductions in out-of-pocket limits, to meet the applicable AV requirements set forth in the table above.

HHS intends to propose an approach to silver plan variations under which cost sharing across a particular benefit or provider would be required to decrease or remain constant as silver plan variations increase in AV. Thus, cost sharing would not be permitted to increase on any benefit or provider as a silver plan's AV is increased. For example, if the co-payment on an emergency room visit at a particular university hospital is $30 in the 73 percent AV silver plan, the co-payment in the 87 percent AV silver plan for that issuer would be required to be $30 or less. If the issuer lowered the co-payment in the 87 percent AV silver plan to $20, the co-payment in the 94 percent AV silver plan would be required to be $20 or less. This requirement would apply to

all types of cost-sharing reductions, including reductions to deductibles, coinsurance, and co-payments.

An issuer would have the flexibility, subject to applicable non-discrimination and network access requirements, to vary cost sharing on particular benefits or providers so long as that cost sharing did not increase for a particular benefit or provider across higher AV silver plan variations. An issuer would not be required to reduce cost sharing pro rata on all benefits or providers across the board. For example, an issuer could elect, subject to applicable non-discrimination and network access requirements, to lower co-payments on prescription drugs but not lower co-payments on emergency room visits in its 73 percent AV silver plan variation compared to its standard silver plan.

Note that under this proposed approach, issuers would be permitted to vary only the cost sharing structures – not the benefits or provider network – of each variation of the standard silver plan. In other words, an enrollee in any silver plan variation would have access to the same benefits and the same providers as those provided under the standard silver plan.

Because silver plan variations with higher AVs would always provide the most cost savings to enrollees while providing the same benefits and provider network, consumer choice would be straightforward – consumers would always be best served by enrolling in the highest AV variation of the standard silver plan selected for which they are eligible. HHS intends to propose that when a consumer selects a silver plan in the Exchange, he or she would be enrolled in the highest AV silver plan variation for which he or she is eligible. The Exchange would also process changes in eligibility and enrollment throughout the year and notify HHS of those changes to facilitate accurate advance payments pursuant to the process described below.

Out-of-Pocket Limits for Individuals with Household Income 250-400% of the FPL

As described above, section 1402(c)(1)(A) of the Affordable Care Act requires reductions in the maximum out-of-pocket limits (i) for individuals with household incomes from 200 to 300 percent of the FPL of 1/2, and (ii) for individuals with household incomes from 300 to 400 percent of the FPL of 1/3. However, section 1402(c)(1)(B) states that "[t]he Secretary shall adjust the out-of-pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective AVs to exceed [70 percent for individuals with household incomes between 250 and 400 percent of the FPL]."

Without any change in other forms of cost sharing, any reduction in the out-of-pocket limit will cause an increase in AV. Therefore, a reduction in the maximum out-of-pocket limit for the standard silver plan could require corresponding increases in other forms of cost sharing to maintain the required 70 percent AV for individuals with household income between 250 and

400 percent of the FPL. For example, if a plan were required to lower its out-of-pocket limit for individuals with household income between 250 and 400 percent of the FPL from $6,000 to $5,000, the issuer might be required to significantly increase plan deductibles, coinsurance, and co-payments in order to maintain the required 70 percent AV. Most individuals would not expect to reach the out-of-pocket limit, and would therefore expect to pay more under such a cost-sharing structure.

Given the effect of the reductions in the maximum out-of-pocket limit outlined above and the additional administrative burden required in designing and operating additional silver plan variations, HHS intends to propose not to reduce the maximum out-of-pocket limits for individuals with household income between 250 and 400 percent of the FPL. We believe that this approach is consistent with the Secretary's authority under section 1402(c)(1)(B), and would benefit those individuals who do not expect to reach the out-of-pocket limit, who are likely to represent the majority of applicable individuals.

Method of Payment

Section 1402(c)(3) of the Affordable Care Act directs QHP issuers to notify the Secretary of actual cost-sharing reductions for eligible individuals and directs the Secretary to reimburse the applicable QHP issuer for the value of those reductions. That section also permits the Secretary to establish a capitated payment system.

HHS intends to propose implementing a hybrid payment system that combines the two approaches. HHS intends to make monthly advance payments to issuers to cover projected cost-sharing reduction amounts, and to reconcile those advance payments at the end of the calendar year to the actual cost-sharing reduction amounts. Such an approach does not require issuers to fund the value of the cost-sharing reductions prior to reimbursement, and ensures that payments are made only for actual cost-sharing reduction amounts realized by Exchange enrollees. This approach is similar to the one employed for the low-income subsidy in Medicare Part D.

Under this hybrid approach, a QHP issuer would be directed to submit for approval estimates of the per enrollee or per policy average cost-sharing reduction amounts for each silver plan variation it will provide in the upcoming year. Using eligibility and enrollment information submitted by the Exchange, HHS would make monthly payments to issuers in accordance with those approved estimates, and would adjust those payments as enrollments change. Annually, HHS would reconcile the advance payments made to the actual cost-sharing reduction amounts. HHS or the issuer, as applicable, would be responsible for any shortfall.

HHS considered a number of alternative approaches to reimbursement of cost-sharing reductions. An approach in which HHS reimburses issuers after the cost-sharing reductions are

provided would require issuers to fund the value of the reductions until reimbursement from HHS. A pure capitated payment methodology (*i.e.*, without reconciliation to actual costs) would rely heavily upon the accuracy of issuer estimates of cost-sharing reductions. That accuracy could be confirmed only through audit. At least initially, we anticipate that those estimates may vary significantly from actual cost-sharing reduction amounts.

HHS solicits comment on whether its intended approach to reimbursing cost-sharing reductions should change over time. In particular, we seek comment on what approach might eventually be taken, and what metrics should be used to determine whether and when a transition to a new approach may be accomplished with minimal risk to program integrity.