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December 21, 2012

Gary Cohen  
Deputy Administrator and Director  
Center for Consumer Information and Insurance Oversight (CCIIO)  
US Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Submitted electronically: <http://www.regulations.gov>

**Re: Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation (CMS-9980-P)—AHIP Comments**

Dear Mr. Cohen:

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Proposed Rule on Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation (CMS-9980-P). AHIP is the national association representing health insurance plans that provide coverage to more than 200 million Americans.

The Affordable Care Act (ACA) makes numerous and far-reaching changes to the nation's health care system that will be effective on January 1, 2014. As these changes take effect, health plans are focused on providing recommendations to the proposed regulations that address affordability issues as well as areas that could potentially disrupt coverage for the millions of individuals, families, and employers they serve.

We appreciate that the Department—in the proposed rules addressing insurance market reforms—is soliciting feedback on ways "to minimize disruption of rates in the current market and encourage timely enrollment in 2014." In developing our comments, we solicited hundreds of health plan policy and operations leaders across the nation to develop specific recommendations to achieve this goal. Based on this feedback and the experience of health plans in the states, we believe specific steps are needed to make coverage more affordable, ensure broad participation in the system, and guard against adverse selection. This is especially important during the initial years of implementation when the penalties for not having insurance are at their lowest.

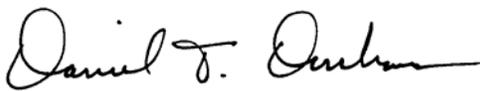
As the Department finalizes these regulations, we also ask that it carefully consider how the proposed regulations interact with statutory provisions that will add to the cost of coverage. For

example, the new \$100 billion health insurance tax will add \$5,080 over ten years to the cost of a family's premium in the individual market.<sup>1</sup> In addition, the requirement that all policies cover ten categories of coverage, many of which are not included in some policies today, will require millions of people to buy coverage that is more comprehensive – but also more costly – than the coverage they currently have. Another provision in the ACA would reduce costs for older individuals purchasing coverage by requiring younger individuals and families in 42 states to pay for higher rates than they do today.

Unless coverage is affordable, younger and healthier people may choose to forgo purchasing insurance until they are sick or injured. If that happens, costs will increase for everyone. This is why it is crucial that more flexibility be provided in the regulations to help ensure broad participation in the system and help mitigate disruption for consumers. While these recommendations will not eliminate cost increases, they will help stabilize the market and set the stage for a broader national conversation on addressing the soaring cost of medical care.

The comments submitted in this letter represent AHIP's initial comments on this proposed rule. Given the limited duration of the comment period, the interactive effect of all of the proposed regulations, and the complexity of the federal/state allocation of responsibilities, we have endeavored to provide a timely reaction to this proposed regulation. We continue to analyze this proposed rule and its relationship to the *Insurance Market Reforms* proposed regulation and the *Notice of Benefit and Payment Parameters* proposed regulation, as well as the collective impact of these rules. We are aware that the Department is operating within tight timeframes to finalize these regulations and as a result has established only a thirty (30) day comment period, which is shorter than the typical timeframe for proposed rules of this magnitude. As the Department proceeds to finalize these foundational rules and moves forward with implementation, we will continue to provide feedback from health plan operations leaders who are preparing for 2014 by designing benefits, developing products, and pricing offerings.

Sincerely,



Daniel T. Durham  
Executive Vice President  
Policy and Regulatory Affairs



Gregory Gierer  
Vice President  
Policy and Regulatory Affairs

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<sup>1</sup> Oliver Wyman—Estimated Premium Impacts of the Annual Fee on Health Insurance Plans. October 31, 2011.

## **AHIP Detailed Comments on Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rules (CMS-9980-P)**

What follows are our detailed comments and recommendations on the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule. We have organized our feedback into the following sections:

- I. Benefit Design Innovation Is Key to Affordable Coverage;**
- II. Prescription Drug Coverage Requirements—Providing Flexibility in Formulary Design Will Promote Access to High-Quality and Cost-Effective Coverage;**
- III. State Flexibility for Defining Coverage for Habilitative Services Can Promote Access to Appropriate Care;**
- IV. Flexibility to Waive Caps on Small-Group Deductibles Will Help Promote Affordable Coverage;**
- V. Clarification with Respect to Annual Limits on Cost-Sharing Allows Plans to Use Their Networks of Providers to Promote Cost-Effective Care;**
- VI. Actuarial Value;**
- VII. Pediatric Dental Coverage Requirements; and**
- VIII. Accreditation Requirements.**

Recognizing that 2014 will be an extremely challenging transitional year, our comments identify different tools that could be employed to help minimize disruption for those with existing coverage and promote stability in the market. We appreciate the opportunity to share this feedback and stand ready to continue to work in partnership with the Department as health reform implementation moves forward.

The “essential health benefits” (EHB) package requirements are a critical element of the health reform law—detailing both the benefits required to be covered and how cost-sharing will be structured for health insurance plans as part of the new insurance marketplaces beginning in 2014. These requirements will have broad and far-reaching implications for the affordability of health insurance coverage—both for individuals and families newly-seeking Exchange plan coverage beginning next fall as well as existing policyholders in the individual and small-group marketplace.

The proposed regulation largely follows HHS’ intended regulatory approach outlined in the Essential Health Benefits Bulletin, released on December 16, 2011. Under this approach, states will have broad flexibility to choose among several alternative “benchmark” plans for the purposes of defining EHB requirements. Specifically, the EHB-benchmark plan would

serve as the reference plan, reflecting both the scope of services and limits offered by a typical employer plan in that state. The proposed rule also provides benefit design flexibility by allowing insurers to have limitations on coverage that differ from the benchmark plan (as well as permit substitution in benefits within categories) so long as such changes are “actuarially equivalent” to the coverage provided under the benchmark plan. As HHS has recognized, benefit design flexibility “would provide greater choice to consumers, promoting plan innovation through coverage and design options, while ensuring plans providing EHB offer a certain level of benefits.”<sup>2</sup>

According to HHS, the benchmark selection approach—proposed to apply for at least the 2014 and 2015 benefit years—“will allow states to build on coverage that is already widely available, minimize market disruption, and provide consumers with familiar products” while balancing “consumers’ needs for comprehensiveness and affordability.” AHIP agrees with the need for balancing these goals in order to assure consumers and families have a wide range of high-quality and affordable choices in a competitive marketplace.

Assuring that coverage is affordable is critical to promoting the broad-based participation that is necessary to achieve the health reform law’s central goal: that is, providing high-quality and affordable coverage to the tens of millions of Americans who are currently uninsured. Therefore, in defining EHB, HHS and the states must consider affordability to be the primary objective. As the non-partisan Institute of Medicine (IOM) noted in its recommendations to HHS:

“If cost is not taken into account, the EHB package becomes increasingly expensive and, individuals and small businesses will find it increasingly unaffordable. If this occurs, the principal reason for the ACA—enabling more people to purchase health insurance, and covering more of the population will not be met.”<sup>3</sup>

The imposition of broader benefit packages will result in millions of people purchasing coverage that is more comprehensive, but also more expensive than the coverage they have now.<sup>4</sup> The Congressional Budget Office (CBO) found that “average premiums in the individual market would be 27 percent to 30 percent higher because a greater amount of coverage would be obtained.”<sup>5</sup> This is largely due to the fact that individual plans “would cover a substantially larger share of enrollees’ costs for health care (on average) and a slightly wider range of benefits.”<sup>6</sup> CBO’s updated estimates for the insurance coverage provisions of the Affordable Care Act found that “because of the [EHB] bulletin, CBO and JCT now expect that the scope of benefits that will qualify as allowable health insurance expenses for the purpose of exchange subsidies will be slightly broader than previously estimated.”<sup>7</sup>

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<sup>2</sup> HHS Essential Health Benefits Bulletin. December 16, 2011.

<sup>3</sup> IOM Report—*Essential Health Benefits: Balancing Coverage and Cost*. October 7, 2011.

<sup>4</sup> Implementation of the Affordable Care Act’s Health Insurance Exchanges and Related Issues. Testimony for the House Ways and Means Subcommittee on Health by Daniel T. Durham, Executive Vice President, Policy & Regulatory Affairs, America’s Health Insurance Plans, September 12, 2012.

<sup>5</sup> CBO Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act. November 30, 2009.

<sup>6</sup> Ibid.

<sup>7</sup> CBO Updated Estimates for the Coverage Provisions of the Affordable Care Act. March 2012.

Moreover, in recent months, many state departments of insurance and state exchange boards have requested formal actuarial and economic forecasts of the new insurance reforms in their state. These independent studies have found that several provisions, including the EHB and actuarial value requirements, will result in higher premiums. The following chart indicates the estimated impact from these independent state studies.<sup>8</sup>

<b>State</b>	<b>Increase in Non-Subsidized Individual Market Premiums Due to EHB</b>
<b>Alaska</b>	3.2%
<b>Colorado</b>	2.2%
<b>Connecticut</b>	13%
<b>Indiana</b>	20%-30%
<b>Maine</b>	33%
<b>Maryland</b>	8%-10%
<b>Minnesota</b>	8%-11%
<b>Nevada</b>	3%
<b>Ohio</b>	20%-30%
<b>Oregon</b>	6%-10%
<b>Rhode Island</b>	0.13%
<b>Wisconsin</b>	6%-7%

As the EHB provisions will have a major impact on affordability, we believe that a flexible approach is the most appropriate way forward in order to both minimize disruptions in coverage for existing policyholders as well as help assure more affordable coverage for those newly-entering the market through exchange-plan coverage.

We believe the proposed regulations seek to balance the requirements of the statute while providing flexibility to minimize disruptions for businesses and consumers—which represents an important step forward in addressing affordability of coverage for all Americans.

Below are our specific comments and recommendations on the proposed regulation.

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<sup>8</sup> Research Findings: Independent Studies Estimate the Cost and Coverage Impact of the Affordable Care Act in Selected States <http://ahip.org/Issues/Essential-Benefits.aspx>

## **I. Benefit Design Innovations Key to Affordable Coverage (§ 156.115)**

The proposed rule provides for benefit design innovations for insurers subject to the EHB provisions—including flexibility for plans to use their proven care management tools and the ability to adopt different limits or substitute benefits within categories, subject to actuarial equivalence requirements.

Health plans are focused on providing the most affordable, highest quality coverage to consumers. To accomplish this, health plans are using innovative care management tools that focus on improved quality and greater value.

Benefit design innovation is an important element to assuring affordable and high-quality care and are a mainstay of administering benefits in the private health insurance marketplace. Moreover, a flexible approach—as provided for under the proposed rules—can play an important role for plans to continue to encourage high-quality care through innovations in benefit design, care management, and related strategies that can help promote greater value throughout the health care system.

### **Recommendations:**

- **We broadly support the proposed rule’s approach to assuring benefit design innovations—including applying different limits and for substitution of benefits within categories, subject to an actuarial equivalence standard.** We agree with HHS that the approach provided for under the proposed rules allows for flexibility for “plans to promote innovation in benefit design.”<sup>9</sup>
- **We support the proposed regulation’s aim of providing benefit design innovations—in part by allowing plans to use care management tools that help assure access to safe and effective medical care while promoting affordability.** The preamble to the proposed rule provides that insurers implementing the EHB standards would be allowed to apply utilization management techniques as well as the use of medical management tools. As recognized by the Institute of Medicine, “these practices help hold down premiums, as do higher levels of deductibles and cost-sharing.”<sup>10</sup> The proposed rule—in implementing and codifying the ACA’s non-discrimination requirements—states that “an insurer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual’s age, expected length of life, or other health conditions.” In implementing the regulation’s non-discrimination requirements, we recommend HHS provide the benefit

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<sup>9</sup> HHS Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule, November 20, 2012

<sup>10</sup> Institute of Medicine Report—*Essential Health Benefits: Balancing Coverage and Cost*. October 7, 2011.

design flexibility necessary to facilitate innovation in benefit and care delivery models to encourage both the right type of care as well as access to safe and effective care.

- **We support the proposed rule’s requirements that allow plans offering EHB to exclude coverage for routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or cosmetic orthodontia.** As noted by HHS, these services are not routinely covered in the group marketplace today and instead are offered as an option under an “excepted benefits” policy. Allowing flexibility for plans to exclude these services can help assure more affordable coverage under the EHB standard.
- **State mandated benefits—including state requirements for health plans to cover certain provider-types, cost-sharing requirements, or limits on reimbursements—enacted after December 31, 2011 should not be considered part of the EHB benchmark plan and states should be required to defray the costs of these state required benefits.** As recognized by the Institute of Medicine (IOM), many state-required benefits lack strong evidence on their safety, effectiveness, or value and HHS has stated that mandates enacted after 2011 would not apply to the EHB benchmark standard in a state. However, the proposed rule contemplates providing an exception for certain state-required benefits that will potentially undercut the approach previously outlined in the bulletin and subsequent regulatory guidance. Adding new and expensive mandates to the state-selected benchmark after 2011 raises affordability and quality of care concerns and would create unnecessary administrative challenges for states and health plans.

## **II. Providing Flexibility in Formulary Design Will Promote Access to High-Quality and Cost-Effective Prescription Drug Coverage (§ 156.120)**

The proposed rule specifies that plans subject to the EHB standard provide prescription drug coverage that is at least the greater of the following: (1) one drug in every United States Pharmacopeia (USP) category and class; or (2) the same number of prescription drugs in each category and class as the EHB-benchmark plan. In addition, the proposed rule requires that plans subject to EHB standards have procedures in place that allow an enrollee to request clinically appropriate drugs not covered by the health plan.

According to HHS, this approach “permits plan flexibility in the drug design benefit and the use of medical management tools, while ensuring that plans offer drug coverage consistent with that of the typical employer plan.”<sup>11</sup> We agree that flexibility in formulary design—including use of pharmacy and management tools—can help assure access to high-quality and cost-effective

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<sup>11</sup> HHS Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule, November 20, 2012

prescription drug coverage. However, we believe greater flexibility is necessary to meet these goals.

**Recommendations:**

- **We recommend that HHS eliminate the requirement that plans cover all of the categories and classes defined under the USP-classification system and instead require plans to cover the same categories and classes covered under the EHB benchmark plan in a state.** The USP classification system is not typically used in the commercial marketplace and including this as part of the EHB prescription drug standards is unnecessary—as health plans typically cover multiple drugs in categories and classes included in the USP classification system. Under our recommendation, prescription drug coverage would broadly reflect coverage provided under the benchmark plan in the state—with flexibility for plans on the specific and number of drugs to be included in the categories and classes covered by the benchmark plan.
- **HHS should clarify that plans can continue to make routine adjustments (including midyear formulary changes) in their pharmacy benefits to reflect advances in prescription drug safety and effectiveness, such as removal of drugs for safety reasons as well as formulary changes to reflect brand name drugs going off-patent or moving to over-the-counter (OTC) status.** These routine formulary changes help protect patients from potentially unsafe drugs (as a result of new information on safety and effectiveness) as well as maximize consumer savings by maximizing generic drug use and promoting use of less expensive but equally effective drug alternatives.
- **HHS should not require plans subject to EHB standards to include coverage for certain drugs—even if they are covered under the EHB benchmark plan in the state.** Specifically, in forthcoming final rules, HHS should establish a list of excluded drugs—similar to the requirements under Medicare Part D—that plans may exclude from coverage under the EHB standards. These include drugs used for cosmetic purposes, prescription vitamin and mineral products (except pre-natal vitamins), and certain lifestyle drugs.<sup>12</sup> Permitting such exclusions can help assure affordable pharmacy coverage while promoting access to essential and medically necessary prescription medicines.
- **Health plans routinely make non-formulary drugs available to their enrollees—if the patient’s physician believes it’s medically necessary.** As recognized by HHS, this type of exceptions process is common in the marketplace today. We recommend that HHS clarify that health plans’ existing exceptions processes that allow access to

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<sup>12</sup> See Section 20.1 Excluded Categories in CMS Medicare Prescription Drug Benefit Manual.

non-formulary drugs are recognized under the proposed rules and recommend that HHS clarify this requirement by changing the language from “clinically appropriate” to “medically necessary.” This will ensure access to effective non-covered medicines in the event that none of the formulary drugs are likely to provide the desired outcome for a particular patient.

### **III. State Flexibility in Defining Habilitative Services Can Promote Access to Appropriate Care and Help Address Affordability (§156.110(f))**

The proposed rule provides additional flexibility for states to define habilitative services—to the extent the benchmark plan in the state does not provide coverage for habilitative services. By providing additional state flexibility, this approach included in the proposed rule can help assure that states can appropriately tailor benefits to meet the needs of their population and ensure consistency with current state-level requirements.

As recognized by HHS in the EHB Bulletin, habilitative services are one of the categories of benefits not routinely covered today under typical employer plans and are a less well defined area of care. Because such services are not routinely covered, it will be important to assure that coverage for habilitative services is affordable and that there is some level of flexibility in the administration of the coverage—especially given the lack of a strong evidence-base on the effectiveness of such services.

#### **Recommendation:**

- **We support provisions in the proposed rule that provide additional state flexibility to determine which habilitative services to cover under the EHB standard in a state.** Providing such flexibility can help assure consistency with existing state requirements and help promote benefit designs that are tailored to the state population’s specific needs.

### **IV. Flexibility to Waive Caps on Deductibles Will Help Promote Affordable Coverage for Small Businesses and Their Employees (§156.130(b))**

The proposed rule permits a health plan’s annual deductible to exceed the amounts set forth under ACA § 1302(c)(2)—\$2,000 for single coverage and \$4,000 for family coverage in 2014—if the plan cannot reasonably reach the actuarial value of a given level of coverage. The current caps on deductibles in the small-group marketplace would make it difficult, if not impossible, for plans to offer “bronze” level coverage to small businesses and their workers. Research for the Kaiser Family Foundation estimated that annual deductibles for “bronze” level coverage would range from \$3,475-\$4,375 for single coverage—well exceeding the \$2,000 limit set forth under

§ 1302(c)(2).<sup>13</sup> Allowing additional flexibility for health plans to exceed these deductible limits, therefore, can help promote access to more affordable choices for many small firms and their employees—particularly at the “bronze” level of coverage.

**Recommendations:**

- **We support the provisions in the proposed rule that provide flexibility for health plans to exceed these deductible amounts.** Allowing such flexibility will help minimize disruptions for small businesses and their employees while promoting access to affordable choices that meet the ACA’s metal-level requirements. In implementing this requirement, we recommend HHS adopt a “reasonableness” standard under which health insurers can exceed the deductibles in the small-group market. Under a reasonableness standard, an insurer may exceed the deductible limit in order to maintain typical plan cost-sharing features in the small-group marketplace (e.g. 20% co-insurance after the deductible is met).
- **We also urge the release of the annual limit on cost-sharing estimates for 2014 as soon as practicable so that plans have the information they need to develop and price products in time for next fall’s open enrollment.** The Notice of Benefit and Payment Parameters proposed rule states that the IRS will publish the 2014 dollar limit in the spring of 2013. However, we believe that this information should be made available sooner than contemplated under the notice, as these dollar OOP maximum levels are a critical component to the plans’ benefit design and are needed to develop and assure that products are available on state exchanges by next fall.

**V. Annual Limits on Cost-Sharing Requirements (§156.130(a))**

The ACA limits annual cost-sharing to levels required under health savings account (HSA) compatible high-deductible health plans (HSA/HDHPs)—estimated at \$6,400 for individuals and \$12,800 for families in 2014. The proposed rule provides that—in the case of a plan using a network of providers—cost sharing “paid by an enrollee for benefits provided outside of such network shall not count toward the annual limitation on cost-sharing or the annual limitation on deductibles.”

**Recommendation:**

- **We support the proposed rule’s requirements that clarify that only in-network cost-sharing would count toward the annual limit on cost-sharing (e.g. OOP caps) and the annual limits on deductibles in the small-group market.** Providing such flexibility is consistent with current requirements for HSA/HDHPs and for health coverage generally in the market today and will promote affordability by allowing plans to

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<sup>13</sup> Kaiser Family Foundation. Patient Cost-Sharing Under the Affordable Care Act. April 2012.

effectively use their networks of providers and other tools to promote high-quality, safe, and cost-effective care to their enrollees. Moreover, providing such flexibility is essential to fostering the continued innovation toward more accountable care, in part, by utilizing plans' high-value provider networks to deliver high-quality care more efficiently and cost-effectively.

## **VI. Actuarial Value (§156.135)**

The proposed rule includes standards related to health insurers for meeting the Affordable Care Act's metal level actuarial value (AV) requirements. Specifically, health insurers in the individual and small-group market will be required to meet a new minimum actuarial value (e.g. 60% actuarial value for bronze level coverage) as well as require new and existing policies to meet the new metal-level requirements provided for under the health reform law: (1) bronze coverage—60% AV; (2) silver coverage—70% AV; (3) gold coverage—80% AV; and (4) platinum coverage—90% AV.

Similar to the intended regulatory approach outlined in the HHS Bulletin on Actuarial Value and Cost-Sharing Reductions released earlier this year, the proposed rule provides that actuarial value will be calculated based on an AV calculator that has been developed and made available by HHS. The data and assumptions for the AV calculator are based on a standard population with a consistent set of assumptions. The proposed rule made the AV calculator publicly available along with a description of the standard population and continuance tables.

Also consistent with the HHS Bulletin, the proposed rule would also permit the use of state-specific standard populations for the calculation of AV in future years. The use of a standardized data set and assumptions is intended to facilitate better comparisons for consumers as plans with the same cost-sharing features would have the same AV.

### **Recommendations:**

- **We support the proposed rule's requirements for an AV calculator based on a standard population and common set of assumptions—including adjustments to reflect expected utilization for current high-risk pool enrollees.** This approach to calculating AV can help enable consumers to make clearer and meaningful comparisons across plans because actuarial values will be similar for plans with comparable cost-sharing designs. This, in turn, may better enable consumers to compare plans (within a metal tier) based on premiums, quality of care, provider networks and other factors.
- **We support the proposed rule's flexibility to permit employer contributions to HSAs and other account based plans to count toward the actuarial value of a plan—as it will encourage employers to continue funding and making HSA/HDHP coverage available to their employees, helping preserve an affordable option in**

**the marketplace today.** The proposed rule permits “annual employer contributions to HSAs and amounts newly made available under health reimbursement arrangements (HRAs) for the current year” to count toward the AV of the plan—both to reflect total anticipated medical spending of the standard population as well as current-year contributions to account-based plans. We believe the full amount of the annual employer contribution should be credited when determining the AV of the accompanying health coverage—as provided for under the proposed rules.

In implementing this requirement, we believe the best approach to assuring consistency in calculating actuarial value for HSAs/HDHPs (and similar account-based plans) would be to incorporate the employer’s HSA/HRA contribution into the plan offering and require employers to certify that they have made a minimum contribution to the account. Moreover, plans should be provided an enforcement “safe harbor” if the employer does not make the intended HSA/HRA contribution for the plan.

- **We support the proposed rule’s approach of allowing flexibility around the actuarial value tiers.** Consistent with the HHS Bulletin, the proposed rule permits variation around AV metal levels to accommodate a plan that may have an AV near but not exactly on the metal level. For example, a “silver”-level plan could have an AV between 68%-72%. We agree with HHS that 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.”
- **We recommend that actuarial value (AV) be calculated based on the plan’s network of providers that provides the highest benefits and meets network adequacy standards.** The proposed rule provides that plans must include all network tiers in the AV calculation and only exclude costs for non-contracted providers. For plans that use multi-tier networks, calculation of AV based on the first tier of benefits is a better approach—as it can help facilitate comparison of plans by consumers and promote more cost-effective options. Moreover, calculating AV on the first tier can help simplify the AV calculation for plan administrators and reduce unnecessary regulatory burdens by decreasing the need for actuarial certifications for plans that do not fit easily into the AV calculator.
- **Actuarial value (AV) calculator technical feedback.** We are currently providing comments to HHS on the AV calculator—based on feedback from health plan operational leaders—in order to facilitate timely feedback and identify potential issues and concerns. We will continue to work with HHS to ensure an accurate, workable calculator in order to evaluate and compare benefit packages and health plan options.

**VII. Application to stand-alone dental plans inside the Exchange (§156.150)**

In this section HHS is asking for suggestion on the setting of a separate annual limitation on cost-sharing for dental plans. We believe the approach suggested by HHS for a separate annual cost-sharing limit for the pediatric oral health EHB is appropriate and will remove concerns regarding the difficulty of administrating combined major medical and stand-alone dental cost-sharing limits. The separation of the major medical and dental cost sharing limits are a much more workable process for both “bundled” QHP EHB products as well as stand-alone pediatric oral health EHB products.

Below are recommendations concerning the appropriate level for the annual cost-sharing limit and your request for input regarding setting a high and low actuarial value (AV) for stand-alone pediatric oral health EHB products.

**Recommendations:**

- **We suggest that an appropriate level for the annual limitation on cost-sharing for dental plans offered on the Exchanges providing the pediatric EHB be set at \$1000.** A limit set at \$1000 will ensure a reasonable cost-sharing level capping catastrophic losses under the pediatric oral health EHB as well as maintaining a more predictable premium for the benefits purchased on a stand-alone basis or on a bundled QHP basis.
- **Setting the calculation of AV for stand-alone dental plans providing the pediatric oral health benefits at 75% (low level coverage) and 85% (high level coverage) with the annual limitation on cost-sharing set at \$1000 seems reasonable and achievable.**
- **We urge CMS to specify that health plans offering essential health benefits (EHB) to individuals and small groups outside of the Exchange are not required to offer the pediatric oral health EHB, as long as there are stand-alone dental plans available that include the pediatric essential benefit.** This would assist both stand-alone dental plans and health plans by aligning the outside and inside Exchange markets on this point. ACA clearly has provided such guidance for QHPs inside the Exchange; we would like to see the same language extended to the outside exchange market for health plans providing EHBs.

**VIII. Comments related to the “Supporting Statement for Information Collection Requirements contained in the Recognized Accrediting Entities Data Collection” Paper Reduction Act**

We support HHS’s amendment to the phase one recognition process to include additional organizations to certify QHPs in the Exchange. Such an approach provides more options for QHPs seeking certification. It is critical that these new entities meet the same criteria and requirements as NCQA and URAC prior to being able to certify QHPs.

**Collection of Accreditation Survey Data.** The accrediting bodies offer a slightly different approach to the accreditation of a health plan exchange product. As a result, we recommend that the submission of the accreditation survey data allow for these variations and give accredited health plans the option to include the exchange population under their existing health plan accreditation or report the accreditation survey data for the exchange population separately.

**Collection of the Accreditation Score Data Element.** We recommend that reporting of accreditation data elements include only the QHP's accreditation status and not the accreditation score for several reasons. First, the accreditation score is not publically reported by the two approved accrediting bodies, NCQA and URAC. URAC publically reports accreditation at the issuer level and does not share the accreditation score with the health plan. While NCQA's accreditation status is based on the health plan accreditation score, NCQA does not publicly report the score. Given the differences in approach of these two organizations, it would be preferable to have a consistent way to address reporting that only includes the accreditation status. Second, we believe that the collection of the accreditation status level is sufficient since this is the outcome of the accreditation score value. The accreditation status level is typically set at a range, i.e. Excellent for achieving a score between 90-100 on the NCQA health plan accreditation survey, and score variations within each rating are sometimes too small to be of value and could add another layer of duplicative data which could lead to confusion on the part of consumers. For example, in viewing a plan with a score of 84, it may be looked upon less favorably than a health plan with a score or 87 when the actual score does not translate into any material difference. It is also important to note that the display and ranges do not reflect statistically significant differences between the achieved accreditation level. We recommend that when displaying any rankings or individual measure results for public use that they be statistically significant to accurately capture any differences.

**Collection of Adult and Child CAHPS Survey Results.** Currently NCQA and URAC health plan accreditation collection of CAHPS surveys differ where NCQA only requires the Adult CAHPS survey. It is our understanding that Exchanges will not be required to report HEDIS and CAHPS data until 2016. Current CAHPS survey questions inappropriately hold health plans accountable for areas beyond their control, such as communications and interactions between patients and their physicians. We recommend that in order to be truly reflective of a health plan's performance, measures of patient satisfaction should be applicable to areas that health plans can directly influence.

Since health plans will be applying these measures to a population, many of whom may be accessing the health system for the first time and whose needs are not yet known, we also recommend that measurement and reporting of adult and child CAHPS measures be delayed until there is a better understanding of the exchange population prior to including the collection of the adult and child CAHPS survey results.