



To: Standard Plan Working Group  
From: Grant Porter and Peter Van Loon  
Re: (Re-)Defining the Exchange's Standard Plan Designs  
Date: February 27, 2013

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On February 25, 2013, HHS published its final rule on “standards related to essential health benefits, actuarial value, and accreditation.” As part of this publication, HHS released the final AV calculator. The final calculator will require us to make changes to our standard plans; we will have to increase the amount paid by enrollees for the bronze and silver plans.

CMS has told us this final calculator is the ultimate arbiter of actuarial value. Further, HHS does not anticipate making annual changes to the AV calculator logic or underlying standard populations. Beginning in 2015, a state-specific data set that is approved by HHS may be used as the standard population in place of the HHS-issued continuance tables that are based on national utilization and expenditure data.

For the most part, any non-grandfathered health plans must have its actuarial value validated against the calculator and the computed actuarial value must fall within the allowed +/- 2 percentage point *de minimis* range of each of metal tier. This requirement applies to both Exchange and non-Exchange products sold in the state's non-group and small group market.

For the most part, Staff appreciates that that final calculator more accurately computes the actuarial value of each of the exchange's standard plan designs.

For example, the final calculator includes technical corrections that adjust the actuarial values computed by the calculator given the cost sharing parameters associated with the following benefits:

- generic drugs
- rehabilitative services
- skilled nursing facilities

More generally, CCIIO amended the calculator to more accurately reflect actuarial value associated with copayment-based plans and the actuarial impact associated with changes to the maximum out-of-pocket limit.

These changes impacted the computed actuarial values of the standard plans—sometimes significantly.

Exceptions to the regulatory-required use of the federal AV calculator will be allowed only in specific situations where the calculator cannot credibly accommodate the proposed plan design. Only in such a situation will the carrier—or an exchange in the case of the development of its standard plan designs—be allowed to have an actuary, who is a member of the American Academy of Actuaries, to calculate and certify that the plan design meets the actuarial value requirements of the specific metal tiers in accordance.

**Table 1** summarizes the relative actuarial values computed by the draft calculator, which we used for the standard plan designs approved in January, and final calculator. (**Appendix A**, presents the

corresponding cost sharing parameters and actuarial values for the standard plans as recommended by the working group and approved by the Board. )

**Table 1.** Computed Actuarial Value of Standard Plan Designs for Qualified Health Plans

	Bronze	Silver	Gold	Platinum	Silver-73	Silver -87	Silver – 94
<b>Draft Calculator</b>	62.7%	71.2%	81.8%	90.4%	74.0%	87.8%	94.4%
<b>Final Calculator</b>	68.7%	74.5%	81.8%	89.2%	77.2%	87.8%	93.5%
<b>Difference</b>	6.0%	3.3%	0.0%	-1.2%	3.2%	0.0%	-0.9%

The magnitude of the impact is greatest for plans with a lower actuarial value (i.e. for the Bronze and Silver standard plan designs) than for plans with a higher actuarial value. For the plan designs at the Bronze and Silver metal tiers as well as the Silver Alternative plan design for households with incomes between 200 and 250% of poverty, the draft calculator significantly underestimated the generosity of the plans.

**As a result, the exchange will need to adjust the cost sharing parameters of its standard plans upwards in order to remain in compliance with the federal statutory and regulatory requirements for all plans to meet the allowed *de minimis* ranges for each of the metal tiers.**

Staff recognizes that these changes will increase the out-of-pocket costs paid by a plan’s membership and will be unpopular with certain constituencies. But, such adjustments are necessary to remain in compliance with federal regulations.

**Appendix B** presents some alternative options to the Silver plans. And **Appendix C** offers some alternative options to the Bronze plan.

Staff’s intent was to incorporate the general principles used to derive the original standard plans. But, these proposals are not presented as recommendations; rather, they are examples intended to initiate a conversation around different solutions to the requirement that Connecticut increase the cost sharing requirements imposed on a plan’s membership.

**Resources**

The Actuarial Value Calculator with Continuance Tables is available from the Center for Consumer Information and Insurance Oversight (“CCIIO”). This final tool allows users to measure the actuarial value of health plans and validate the plan against the allowed actuarial value standards established under Section 1302(d) by the Affordable Care Act. The Microsoft Excel file can be downloaded here:

<http://cciio.cms.gov/resources/files/av-calculator-2-25-13.xlsm>

The methodology for the AV calculator can be reviewed here:

<http://cciio.cms.gov/resources/files/av-calculator-methodology.pdf>

**Appendix A. Standard Plan Design for Qualified Health Plans, Summary of Metal Tiers (Working Group Recommendation, as approved by Board 1/24/2013)**

		Silver Alternatives (i.e. Cost Sharing Reduction Plans)									
		Bronze - 60 AV	Silver - 70 AV	Gold - 80 AV	Platinum - 90 AV	Silver - 73 AV	Silver - 87 AV	Silver - 94 AV			
						Exclusive to Households with Income of 200-250% of FPL	Exclusive to Households with Income of 150-200% of FPL	Exclusive to Households with Income of 100-150% of FPL			
Prof Actuarial Value		62.7%	71.2%	81.8%	90.4%	74.0%	87.8%	94.4%			
FINAL Actuarial Value		68.7%	74.5%	81.8%	89.2%	77.2%	87.8%	93.5%			
Deductible(s)											
Medical Benefit	\$ 4,000	\$ 2,500	\$ 500	\$ 150	\$ -	\$ 2,250	\$ 500	\$ -	\$ -	\$ -	\$ -
Prescription Drug Benefit	250	200	150	150	-	150	-	-	-	-	-
Out-of-Pocket Maximum	\$ 6,250	\$ 6,250	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,200	\$ 2,250	\$ 2,250	\$ 2,250	\$ 2,250	\$ 2,250
<b>Medical Benefits</b>		<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>
<b>Office Visits</b>											
Preventive Care/Screening/Immunization	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Primary Care Visit to Treat an Injury or Illness	30	30	20	15	20	20	15	15	15	5	
Specialist Visit	45	45	45	30	45	45	30	30	30	15	
Mental Health Visits	30	30	20	15	20	20	15	15	15	5	
Rehabilitative Services (inc. PT, OT, ST)	30	30	20	15	20	20	15	15	15	5	
Laboratory Services	30	30	20	15	20	20	15	15	15	5	
X-Rays	45	45	45	30	45	45	30	30	30	15	
High-Tech Imaging (CT/PET Scans, MRIS)	75	75	75	50	75	75	50	50	50	25	
Emergency Room Services	150	150	100	75	100	100	75	75	75	25	
Inpatient Admission	500	500	500	250	500	500	250	250	250	125	
Apply Copayment per Day (max days per admission)	yes - max 4	yes - max 4	yes - max 4	yes - max 4	yes - max 4	yes - max 2	yes - max 2	yes - max 2	yes - max 2	yes - max 2	
Outpatient Surgery	500	500	500	250	500	500	250	250	250	125	
Skilled Nursing Facility	500	500	500	250	500	500	250	250	250	125	
Apply Copayment per Day (max days per admission) Coverage for up to 90 days/member	yes - max 4	yes - max 4	yes - max 4	yes - max 4	yes - max 4	yes - max 2	yes - max 2	yes - max 2	yes - max 2	yes - max 2	
<b>Prescription Drug Benefit</b>		<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	
Tier 1 (i.e. Generics)	\$ 10	\$ 10	\$ 10	\$ 10	\$ 10	\$ 10	\$ 5	\$ 5	\$ 5	\$ 5	
Tier 2 (i.e. Preferred Brand Drugs)	25	25	25	25	15	25	15	15	15	15	
Tier 3 (i.e. Non-Preferred Brand Drugs)	40	40	40	40	30	40	30	30	30	30	
Specialty Tier (i.e. Specialty/High-Cost Drugs)	50%	50%	50%	50%	50%	50%	40	40	40	40	

**Appendix B. Alternative Cost Sharing Arrangements for SILVER Standard Plan Design**

	Original Plan	Option B	Option C	Option D	Option E
	Separate Deductibles, Copayments	Separate Deductible - Copayment Plan, Version 2	Integrated Deductible - Copayment Model	Separate Deductible - Coinsurance Plan	Integrated Deductible - Coinsurance Model
<b>Actuarial Value Final AV Calculator)</b>	<b>74.5%</b>	<b>72.0%</b>	<b>70.3%</b>	<b>71.7%</b>	<b>72.0%</b>
<b>Deductible(s)</b>					
Medical Benefit	\$ 2,500	\$ 6,000	\$ 3,000	\$ 6,000	\$ 3,000
Prescription Drug Benefit	200	200		200	
<b>Out-of-Pocket Maximum</b>	<b>\$ 6,250</b>	<b>\$ 6,250</b>	<b>\$ 6,000</b>	<b>\$ 6,250</b>	<b>\$ 6,000</b>
<b>Medical Benefits</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>
<b>Office Visits</b>					
Preventive Care/Screening/Immunization	\$ -	\$ -	\$ -	\$ -	\$ -
Primary Care Visit to Treat an Injury or Illness	30	30	30	30	30
Specialist Visit	45	45	45	60%	70%
Mental Health Visits	30	30	30	30	30
Rehabilitative Services (inc. PT, OT, ST)	30	30	30	60%	70%
Laboratory Services	30	30	30	60%	70%
X-Rays	45	45	45	60%	70%
High-Tech Imaging (CT/PET Scans, MRIS)	75	75	75	60%	70%
Emergency Room Services	150	150	150	60%	70%
Inpatient Admission	500	500	500	60%	70%
<i>Apply Copayment per Day (max days per admission)</i>	<i>yes - max. 4</i>	<i>yes - max. 4</i>	<i>yes - max. 4</i>		
Outpatient Surgery	500	500	500	60%	70%
Skilled Nursing Facility	500	500	500	60%	70%
<i>Apply Copayment per Day (max days per admission)</i>	<i>yes - max. 4</i>	<i>yes - max. 4</i>	<i>yes - max. 4</i>		
<b>Prescription Drug Benefit</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>
Tier 1 (i.e. Generics)	\$ 10	\$ 10	\$ 10	\$ 10	\$ 10
Tier 2 (i.e. Preferred Brand Drugs)	25	25	25	15	25
Tier 3 (i.e. Non-Preferred Brand Drugs)	40	40	40	30	40
Specialty Tier (i.e. Speciality High-Cost Drugs)	50%	50%	50%	50%	50%

Appendix C. Alternative Cost Sharing Arrangements for BRONZE Standard Plan Design

HSA-Eligible HDHP

	Original Plan	Option B	Option C	Option D	Option E	Option F	Option G
	Separate Deductibles, Copayments	Separate Deductibles, Copayments Version 2	Integrated Deductible, Copayments	Separate Deductible, Coinsurance	Integrated Deductible, Coinsurance	HSA-Eligible HDHP, Copayment	HSA-Eligible HDHP, Coinsurance
<b>Actual Value Final AV Calculator)</b>	<b>68.7%</b>	<b>64.1%</b>	<b>61.9%</b>	<b>63.5%</b>	<b>63.7%</b>	<b>60.2%</b>	<b>60.9%</b>
<b>Deductible(s)</b>							
Medical Benefit	\$ 4,000	\$ 6,000	\$ 6,250	\$ 6,000	\$ 5,000	\$ 5,000	\$ 4,000
Prescription Drug Benefit	250	250		250			
<b>Out-of-Pocket Maximum</b>	\$ 6,250	\$ 6,250	\$ 6,250	\$ 6,250	\$ 6,250	\$ 6,250	\$ 6,250
<b>Medical Benefits</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>	<b>Subject to Medical Deductible</b>
<b>Office Visits</b>							
Preventive Care/Screening/Immunization	\$ -	\$ -	\$ -		\$ -	\$ -	
Primary Care Visit to Treat an Injury or Illness	30	30	30	30	30	30	30
Specialist Visit	45	45	45	50%	50%	45	60%
Mental Health Visits	30	30	30	30	30	30	30
Rehabilitative Services (inc. PT, OT, ST)	30	30	30	50%	50%	30	60%
Laboratory Services	30	30	30	50%	50%	30	60%
X-Rays	45	45	45	50%	50%	45	60%
High-Tech Imaging (CT/PET Scans, MRIs)	75	75	75	50%	50%	75	60%
Emergency Room Services	150	150	150	50%	50%	150	60%
Inpatient Admission	500	500	500	50%	50%	500	60%
<i>Apply Copayment per Day (max days per admission)</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>
Outpatient Surgery	500	500	500	50%	50%	500	60%
Skilled Nursing Facility	500	500	500	50%	50%	500	60%
<i>Apply Copayment per Day (max days per admission)</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>
<i>Coverage for up to 90 days/member</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>	<i>yes - max 4</i>
<b>Prescription Drug Benefit</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>	<b>Subject to Rx Deductible</b>
Tier 1 (i.e. Generics)	\$ 10	\$ 10	\$ 10	\$ 10	\$ 10	\$ 10	\$ 10
Tier 2 (i.e. Preferred Brand Drugs)	25	25	25	15	25	15	25
Tier 3 (i.e. Non-Preferred Brand Drugs)	40	40	40	30	40	30	40
Specialty Tier (i.e. Specialty High-Cost Drugs)	50%	50%	50%	50%	50%	50%	50%