We really like the multi option apporach including the Affordable Care Plan as an option within the overall product offering.....

See below...

A Dangerous Game -- Testing the Limits of the MV Calculator as Sole Determiner of Minimum Value

MyHealthGuide Source: **Hobson D. Carroll, FSA**, President, MedRisk Actuarial Services, Inc., 8/13/2014

A lot of people in our self-funded industry think they have got the ACA's Minimum Value (MV) requirement all figured out. After all, HHS/CMS made the work fairly straightforward for us, didn't they? They gave us the MV Calculator, and after the initial reaction to anything with math and numbers in it, we realized that it definitely doesn't take an actuary or other mathematician to actually use the thing. And, hey, we have even been able to figure out a lot of tricks to obtain higher values for a given plan simply by conveniently checking or unchecking certain boxes, and by "interpreting" what the different categories mean. Yes, there are a lot of very clever people out there who have turned playing with the MV calculator into a computer game, and think it will allow them to "pull a few over" on the Feds, or at least their clients.

I believe this might be a very dangerous game indeed.

First of all, I want to make sure people don't think this is just sour grapes on my part at the law not requiring actuaries to sign off on ***any*** MV calculation, even those using the ready-made calculator. Sure, it would be great (professionally) if that had been part of the regulation, and in actuality I think it would probably have been the intent of the person authoring this portion of the ACA if they had known at the time exactly how the HHS secretary was going to promulgate the rules and regulations given that the creation of the MV calculator was in fact a major actuarial exercise. Understanding the underlying methodology, its application, and what goes on behind the scenes of the main spreadsheet itself does require some actuarial training. However, in attempting to create a more generally accessible means of simplifying the determination of MV for a plan, the regulators made some assumptions that sacrificed clarity, and in the process introduced a bit of "play" in the interpretation of terms and concepts.

One of those assumptions is that for the most part, the kinds of plans that needed certification as meeting the 60% requirement would do so easily -- typical major medical plans being offered by larger ASO/Self-Insured employers -- because this is what their database (the infamous surveys ordered by HHS) showed them should be the case. After all, the calculator was designed to produce 60.0% for a $6,350 integrated deductible/ 100% coinsurance plan. In standard terms, this is the "worst plan" that the authors could imagine someone would try to use. You can't have a higher deductible, and since that is the out-of-pocket maximum allowed as well, there could be no copays or coinsurance. However, it also made the implicit assumption that ***all*** of the categories of ***any allowed Essential Health Benefit (EHB) benchmark*** were the starting point of the plan in question, and in particular every ***listed*** category on the spreadsheet, with its implicit meaning, would be covered without any additional costs or

limitations.

OK, let's cut to the chase. The fact is that almost immediately people who had been involved in what the government feels is the shadowy peripheral of employee benefits (those attempting to provide a more useable, affordable (in a practical, not the ACA sense) benefit that usually came in the form of what was called a "Mini-Med" plan, or a major medical type plan, but with a materially lower annual or lifetime maximum (such as $25,000) than the ACA now allowed) began searching for two sorts of magic plans.

- The first sort would be a plan that met the requirements of *Minimum Essential Coverage* (MEC) in order for an employer to avoid the strong (sledgehammer) penalty, and could cost (at least the employer) as little as possible. For such plans, there was really no MV issue involved. As such, I will not be addressing these kinds of plans further in this paper, as while they do bring to the fore their own set of administrative, underwriting, and financial considerations, those are really for another time and place.
- The other type of magic plan being sought was one that could provide an MV calculation meeting the 60% requirement in order to avoid the weak (tack-hammer) penalty.

However, even if you could design a plan coming in at the very minimum (such as the $6,350/100% coinsurance plan discussed previously), such plans tended to fail two needs of the employer who was suddenly faced with offering such a plan to a heretofore unoffered employee population (perhaps his/her hourly workers versus the salaried who had previously been covered by a carve-out small group fully insured plan).

- First of all, the cost needs to be kept to a minimum, for both the reason that the employer is looking at an expenditure he/she did not even have previously, and to meet the MV requirement's sibling of Affordability as defined by the ACA. The more expensive the overall cost, the less the 9.5% safe-harbor on W-2 income would cover of the projected monthly cost, and therefore the more the employer would have to kick in.
- The second reason such plans as the $6,350 deductible design fails this set of employers is that it provides very little in "useable" benefit for a significant majority of their employee population.

Let's face it, the total spectrum of health care financing is made up of essentially two pieces -- the "true insurance" piece for expenses in a year on a person that exceed some perceived "catastrophic" level, perhaps the $6,350 level of our high-deductible plan, and the piece that I will call "Primary Health Care" (PHC). Now, perhaps 25-30% of employees will have annual expenses exceeding $6,350 (at 100% of a general commercial network set of allowed charges and a typical PBM formulary price list). More importantly, the other 70-75% will have expenses that ***average*** only about $800 in that year.

My own rating calculations suggest that at $6,350, the total cost of such benefits is, indeed, 60% of the 100% cost of claims for an average group, so in deciding to offer the high deductible plan, the employer is looking at the majority of total expected claims of his/her employee population, but it will only provide "perceived" benefits to 25-30% of those employees. That perception of useable value by those

employees usually leads to bad (low) participation by the employees, especially if the employer has designed the contributions in such a way as to maximize the employee cost and still keep the plan "affordable." However, we are all familiar with what happens in this instance, especially when this employee population was not previously offered major medical type coverage by this employer -- there is no experience, and low expected participation, and therefore significant underwriting challenges from potential anti-selection risk for any potential stop-loss carrier (or fully insured carrier for that matter), and this leads to either a withdrawn offer of coverage, or coverage terms that shifts massive extra potential risk or real premium cost directly onto the employer, with either option being essentially untenable.

If a plan wishes to provide the kinds of benefits that most of the employee population "wants" and (at least on a perceived basis) "needs," then it must drop down below that $6,350 level and provide things like doctor office visits, basic DXL benefits, and at least generic drugs with more accessible cost sharing. However, that means using up the "budget" covering more of that average of $800 for most of the people, which means there is less money to pay for the things that cause expenses to exceed the $6,350 level. If the employer is insisting that the plan meet the 60% MV level, this trade-off is very difficult to achieve.

So, what to do? The search for the magic plan has focused on finding a way to get to the target 60% for MV, while minimizing potential ***real*** cost to the employer, or excess "spikey" risk to the stop-loss partner, by eliminating the "high risk" types of claims such as inpatient, high cost drugs, and certain kinds of other treatment deemed "risky," but for which the MV Calculator ***appears*** to not reduce the plan value as much as the user believes they can reduce the risk, and therefore, the actual cost of the plan.

- This approach is based on the principle that a self-insured plan does not have to provide a "category" of medical services (particularly, one of the EHB categories), but if they do offer it, they cannot have an annual limit, and the out-of-pocket maximum applies in aggregate to all categories that are covered. So, one can simply exclude anything done with an inpatient "situs," for example, or anything done in the outpatient department of a hospital (but do cover things done in a non-hospital outpatient facility).

Creative minds believe that they have successfully designed such magic plans by essentially gaming the MV Calculator. And, indeed, perhaps they have. But, before discussing the potential pitfalls of this approach it is important to note that this discussion will now be focused strictly on the types of services and cost sharing aspects of a plan used to manipulate the MV calculation, and not on other aspects of general plan design that can have an impact on real expected cost, but do not affect an MV determination.
(Please see Sidebar)

Attempting to eliminate the "high cost items" from a benefit plan, but still get to a 60% MV calculation, should almost sound like an oxymoron. However, the previously discussed problems with clarity and

consistency that were introduced to the MV Calculator by the attempt at simplification does allow for some apparent ways to "pick and choose" benefits that will allow a plan to still reach the 60% level while appearing to eliminate most, if not all, of the higher cost types of claim situations. These include inpatient, high cost specialty drugs, and selective use of copays, deductibles, and coinsurance arbitrage of some structural inconsistencies in the calculator, and ways it may be used. In addition, some clever people believe they can remove items such as renal dialysis, chemo therapy, infusion therapy, and radiation therapy by choice of the category ***on the spreadsheet list*** in which they may be found, or deciding that they aren't in there at all, and so may be eliminated for "no penalty" in terms of a reduced plan value.

Many believe that to use the MV Calculator, you take the (usually abbreviated) schedule of benefits you want to rate, set it down next to your computer, and then go to the MV calculator spreadsheet and start entering the plan information as regards copays, coinsurance, and deductibles. For many plans, and especially those that provide the kind of big self-insured employer rich major medical type benefits I mentioned previously, this is not a problem. However, for those attempts to create the magic plan that will get to 60% in the calculator but somehow manage to get rid of anything that really costs a lot of money, life is not so simple. ***Why? Because the latest IRS proposed regulation update suggests that the starting point for determination of MV is to choose an EHB benchmark plan that will define the "denominator" of the MV ratio calculation. In defining Minimum Value, IRS Update 26 CFR Part 1 (May 2, 2013) states (emphasis is mine):***

- (c) MV percentage--(1) In general. An eligible employer-sponsored plan's MV percentage is--(i) The plan's anticipated covered medical spending for benefits provided under ***a particular essential health benefits (EHB) benchmark plan*** described in 45 CFR 156.110 (EHB coverage) for the MV standard population based on the plan's cost-sharing provisions; (ii) Divided by the total anticipated allowed charges for EHB coverage provided to the MV standard population; and (iii) Expressed as a percentage.

It is only reasonable to assume that the EHB coverage referred to in both (i) and (ii) are the same one chosen as the basis for your starting point. Even though the MV Calculator was derived from data utilizing an assumed common core list of EHB categories, it was also assumed that since the data came from large, rich, self-insured employer groups, there would be little variation in the underlying benefits to be assumed in the "default" plan against which a particular plan is to be valued. **The IRS language above seems to suggest that while we know that a self-insured employer plan does not have to cover all EHB categories, you do have to choose a starting EHB benchmark in order to have something to compare with in obtaining the ratio of plan value to total value. If you look at the latest list of all the states' EHB benchmark plans (http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html), you will find a much more expansive and clarifying list to the rather limited set of categories represented on the MV Calculator worksheet.**

So, this "schedule" of covered benefits, and not the one you necessarily want to use, is the basis from which you "take out" stuff you are not going to cover. However, the only things you are allowed to "take out" directly by utilizing the MV Calculator are the things you can ***see*** on the calculator spreadsheet, ***and***

can match up exactly to the meaning utilized in the MV methodology. At least, that is my opinion from a great deal of blood, sweat, and tears being frustrated by the lack of information available from either the government, or currently available profession guidance. In other words, you have to be concerned with what you don't provide inside what you don't see, as well as what you don't provide in what you do see, in the calculator.

What this means is that anyone wishing to reduce exposure to high cost treatments that they can't prove are exactly contained within one of the MV worksheet categories excluded entirely will have to resort to seeking certification from a qualified actuary. This presumes they will be able to do this at all given the probable lack of adequate acceptable data for carving out the specific types of treatment of particular interest. In other words, being able to back up the MV plan valuation is not just a matter of evaluating the cost sharing/coverage features of your plan against the explicit categories you can see on the MV Calculator spreadsheet, it's also taking into account what portions of those categories you may not be covering at all, as well as how your plan stacks up against the other categories not listed at all in the calculator, but are part of an appropriately chosen EHB benchmark plan. Doing anything less could result in an incorrect MV determination, and that might certainly be a dangerous game.

- **Will a plan relying on the initial, simplified interpretation of the MV calculator be able to appeal to the presumption it was "safe" to use for the purposes of plans impacting 2015?**
- **Or will the IRS or HHS come out with final clarifying rules per their update language sometime yet between now and November 1 to be applied to plans effective 1/1/15?**

We'll have to wait and see. Remember, there aren't any real consequences to not offering MV plans effective this year, even though employees were to be told whether they had it or not to smooth the subsidy process. But, if the rules change for plans starting in 2015, calculations may have to be redone under the new clarifications, and that could greatly change the strategies that have built up around the use of clever MV plans. One should always remember the old adage, if something sounds too good to be true (for example, "I can get you an MV plan that doesn't cost you anything, Ms. Employer!"), it probably is.

Sidebar

Describing the difference between benefit value for MV calculation,
and expected cost for an actual benefit plan

Let's view the value of 100% of the potential benefits covered by a plan as a circular pie of some kind. The average expected plan benefit for determining whether or not it meets a MV level of 60% may be described as the "Pac Man" profile that results from removing slices of the pie that represent items not covered at all, and the impact of cost sharing such as deductible and coinsurance, all removed on an "expected basis" for the standard population. For MV purposes the total volume of the pie represents 100% of the EHB basis being compared against, with the Pac Man residual being the expected value of

what the plan is going to pick up. Simply stated, the MV requirement is that the volume of pie remaining (the Pac Man profile) be at least 60% of the total volume of the whole pie you started with. Notice that we haven't said a thing about just how big the pie actually is, only that the relative size of the portion removed can't be larger than 40% of the original pie.

Now, the actual expected "cost" for this employer plan can be looked at as the price we have to pay for the remaining piece of an ***actual*** pie that is determined by not only the "relative" value of the benefits, but also important external factors such as any allowed charge definition, and the age, sex, and area demographics of the population involved. (For example, if pie costs so much per ounce, we will need to know how many ounces of pie are actually left in a real pan, taking into account all the ingredients we actually use.)

Now, the allowed fee amount schedule or other mechanism for determining what portion of ***covered*** billed charges are actually allowed to be "counted" by the plan has no bearing on either the size of the whole original pie, or the relative size of the remaining part of the pie, ***as far as the MV calculation is concerned***. For purposes of the MV Calculation, it's just a pie pan of an arbitrary size, with a certain portion having been removed. It is a "virtual" calculation, and has no associated dollar value.

However, the allowed fee schedule may have a lot of bearing on both the ***size*** of the pie circle itself, ***and*** the relative size of the slice/portion being removed when we want to know the actual amount of pie we will have to ***pay fo*** r. Similarly, the relative age, sex, and area factors generated by the actual plan population of covered employees will also adjust the size of the pie and possibly the slice as well. It is important to understand that the adjustments for allowed fees, age, sex, and area impact the actual expected cost of a plan, but do ***not*** affect the MV calculation (at least not for now based on the latest information from CMS).

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