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Submitted via PMPolicy@cms.hhs.gov

Ellen Montz, PhD
Deputy Administrator and Director
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
Department of Health and Human Services,
200 Independence Avenue, SW
Washington, DC 20201

Re: Proposed Draft 2024 Actuarial Value Calculator

To Director Ellen Montz, PhD:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments regarding the Draft 2024 Actuarial Value (AV) Calculator.

By way of background, HBX is a private-public partnership established by the District of Columbia (District) to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). We cover approximately 100,000 people -- District residents and people who work for District small businesses. DC Health Link fosters competition and transparency in the private health insurance market, enabling individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance. Since we opened for business, we have cut the uninsured rate by 50% and now more than 96% of District residents have health coverage.

While HBX appreciates CMS's on-going effort to improve the AV Calculator, we are concerned that the proposed approach would inadvertently curtail state health equity initiatives. To support efforts to address health disparities, we recommend either creating flexibility in the de minimis values and/or creating a special approach toward reviewing AV for equity-based coverage design.

<u>The Proposed 2024 AV Calculator Is a Barrier to Equitable Benefit Design Addressing Health Disparities</u>

HBX is committed to addressing health disparities and getting to equity in health coverage and care. We are using the tools we have available in our state-based marketplace to narrow racial

and ethnic disparities in health outcomes and access to care. Changing our coverage design to equity-based benefit design is one of a few tools we have to address financial barriers to care – a major contributor to health disparities.

- In the District of Columbia, people who are Black or Hispanic are twice as likely as White people to have difficulty accessing care due to cost.[1]

To address this, we developed and are implementing equity-focused benefit design for our standard plans.[2] Our stakeholders, including all our health plans, consumer and patient advocates, brokers, clinicians, and other experts, developed equity-focused benefit design for our standard plans in the individual marketplace and small group marketplace.

- Plan Year 2023 Standard Plans cover medical care for Type 2 Diabetes including physician visits, blood tests, vision and foot exams, prescription medications, and supplies with no cost-sharing – no deductibles, no copays, and no co-insurance. This includes free insulin. Eliminating cost barriers for diabetes care will help address financial barriers to care for patients with diabetes, which disproportionally impacts communities of color in the District with much higher rates of Type 2 Diabetes than White residents. Eliminating cost barriers will help address disparities in health outcomes.

- Plan Year 2024 Standard Plans will cover pediatric mental health services and prescription drugs at just five dollars. Reducing copays to $5 for pediatric mental health will help narrow the wide racial and ethnic mental health treatment disparities among privately insured children in the District and address a crisis that has worsened during the COVID-19 pandemic.[3] Note that Children's National Hospital, in addition to all our health plans' clinicians, provided extensive clinical support to help develop treatment protocols grounded in experience treating privately insured children.

There are other conditions that disproportionally impact the District's Black and Brown Communities, including cardiovascular disease, cerebrovascular disease, adult mental health, and HIV, as well as cancer of the breast, prostate, colorectal and lung/bronchus .[4] Although we would

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[1] *See* Behavioral Risk Factor Surveillance System (BRFSS) data, Table 4 at page 11, at: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC_BRFSS_2020_AnnualReport_Tables.pdf.

[2] Our standard plans cover physician visits, specialist visits including mental health and behavioral health, urgent care and generic prescription medications without deductibles. And, there are no limits on how many times you can see your doctors. This standard plan design means that everyone has access to essential care without the financial burden of a high deductible. Access to essential care without deductibles is how we eliminate financial barriers to care and ensure that residents can access essential care.

[3] See the discussion of pediatric mental health benefit design for the District's standard plans at: https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/SPWG_Report_FINAL%2011-9-22_0.pdf

[4] *See* Recommendations of the Social Justice & Health Disparities Working Group to the District of Columbia Health Benefit Exchange Authority (July 12, 2021), at: https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/HBX%20Social%20Justice%20and%20Health%20Disparities%20Working%20Group%20Final%20Report_0.pdf

like to continue to transform our standard plans to equity-based benefit design, the reality is that regulatory implementation of the ACA AV standards is now a barrier. Stakeholders in our standard plans working group identified AV Calculator requirements as a major problem and that without additional flexibility on AV, it will not be possible to transform plan design to equity-based benefit design in order to address health disparities related to financial barriers to care. Our working group members discussed meeting AV standards by increasing the maximum out-of-pocket amount (MOOP), which disproportionately affects the sickest enrollees, including the patients we are seeking to help with equity-based benefit design.[5]

Applying the proposed 2024 AV Calculator, the following summarizes AV for our 2023 equity-based benefit design standard plans and separately calculates changes for 2024 (reducing cost sharing for pediatric mental health to $5 for services and medication).

AV Analysis for Equity-Based Benefit Design DC Health Link Standard Plans

		2023 No cost sharing for Insulin and Type 2 Diabetes Care			**2024*** Reduced copayment to $5 for pediatric mental health care and Rx
Plan	**Allowed de minimis Range**	**2023 AV Calculator**	**Proposed 2024 AV Calculator**	**Difference in AV**	**2024 AV Calculator**
Platinum (90%)	+2/-2	89.89%	90.42%	0.53%	90.45%
Gold Plan (80%)	+2/-2	81.92%	82.83%	0.91%	82.90%
Silver (70%)	+2/0	71.95%	70.34%	-1.61%	70.46%
Bronze (60%)	+5/-2	64.91%	64.93%	0.02%	65.04%

Reducing cost-sharing to $5 for pediatric mental health only adds .03-.12 to AV. (Note that copayments currently are as high as $45 per visit and as high as $150 for certain medications.) However, the proposed 2024 AV Calculator would necessitate increasing MOOP for Gold by $700 and Bronze by $50. As discussed above, increasing MOOP devalues equity-based benefit design and adds additional financial burdens disproportionally impacting communities of color in accessing care. Also, note that only 2.8% of our individual market enrollees qualify for cost-sharing reductions.

[5] The Working Group discussions are reported in: Recommendations of the Standard Plans Advisory Working Group to the District of Columbia Health Benefit Exchange Authority (Nov. 9, 2022), at https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/SPWG_Report_FINAL%2011-9-22_0.pdf

<u>Recommendation to Eliminate the AV Calculator's Impediment to Equity-Based Benefit Design</u>

President Biden's Executive Order No. 13985 calls on the entire Federal Government to address disparities. It states:

> Entrenched disparities in our laws and public policies, and in our public and private institutions, have often denied that equal opportunity to individuals and communities. Our country faces converging economic, health, and climate crises that have exposed and exacerbated inequities, while a historic movement for justice has highlighted the unbearable human costs of systemic racism. Our Nation deserves an ambitious whole-of-government equity agenda that matches the scale of the opportunities and challenges that we face.[6]

We applaud CMS's efforts to prioritize health equity in the 2024 NBPP.[7] Consistent with CMS's stated goals and the directive from President Biden to address disparities, we ask CMS to make changes to its AV Calculator to recognize equity-based design. We recommend:

- Eliminating the AV Calculator as a barrier to achieving equity in benefit design for Plan Year 2024 by <u>allowing a de minimis value of +3 for Gold and +6 for Bronze</u>.

CMS developed the AV Calculator a decade ago before there were focused efforts by states to address disparities in health outcomes through benefit design. To this end we recommend for CMS to initiate a review of how the AV calculator inadvertently has become a barrier to equity-based benefit design. CMS should identify and implement changes to eliminate the barrier that the AV calculator presents. We recommend that CMS:

- deem equity-based design to comply with AV standards; and/or
- allow actuaries to adjust AV so equity benefits are not penalized. For example, run AV without zero or reduced cost-sharing for equity benefits. This would be for all benefits (care, services, Rx, etc.) that are specifically identified as equity-based design benefits for conditions disproportionally impacting communities of color and other historically discriminated populations. For example, DC Health Link's standard plans with Type 2 Diabetes benefits covered at zero cost-sharing and pediatric mental health covered at reduced copays of $5 would be run as regular cost sharing benefits in the AV Calculator. This approach would ensure that equity benefits, e.g., $0 cost sharing for Diabetes and insulin, are not penalized.

In the alternative, CMS could:

- establish a stakeholder working group—to include state-based marketplaces, actuaries

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[6] Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, No. 13985, Jan. 20, 2021. 86 Fed. Reg. 7009 (Jan. 25, 2021).
[7] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, 87 Fed. Reg. 78,206 (Dec. 21, 2022) (to be codified at 45 C.F.R. pts. 153, 155 & 156).

with expertise in the AV Calculator and health equity, and others—to identify different ways to eliminate the barriers to equity-based design in the AV Calculator. CMS would need to act to adopt an effective solution.

To be clear, we recommend that CMS develop an approach in the AV Calculator that will enable states to use benefit design to address disparities in health outcomes. Because of the time sensitivity of finalizing the AV Calculator for 2024 and the time it may take to develop a more comprehensive approach, we recommend that CMS at the very least allow a *de minimis* value of +3 for Gold and +6 for Bronze for 2024 plans, while working on a more comprehensive approach for future plan years.

By adopting these recommendations, CMS would enable SBMs to use coverage design to reduce health disparities. Absent changes to the proposed 2024 AV Calculator, CMS's implementation of the ACA's AV standards would have an unintended effect of halting efforts by states to use plan design to address health disparities.

In addition to health equity objectives, there are other reasons CMS should revisit the AV Calculator. The AV Calculator is a critical tool in benefit design but is not set up to help achieve cost-effective long term health care spending. If CMS establishes a working group to improve the AV Calculator, this working group should also consider ways to adapt the AV Calculator to address areas where there are evidence-based "smart" benefit designs with reduced cost-sharing for services where there is evidence that net savings can accrue. In other words, the AV Calculator should be revised to give "credit" for plan designs that promote the use of effective and low-cost primary and preventive services that may help hold down health care costs.[8] The current AV Calculator inadvertently penalizes "smart" benefit design.

<u>Conclusion</u>

Thank you for considering our comments on issues that will directly impact District residents and the continued operations of our marketplace. We appreciate CMS's continued support for state flexibility, consumer protections, and working to ensure a more equitable future. We look forward to working with you on these issues.

Sincerely,

Mila Kofman, J.D.
Executive Director
DC Health Benefit Exchange Authority

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[8] Email communications between Mila Kofman and Dr. Leighton Ku, HBX Executive Board Member and Chair of HBX Standard Plans Working Group. Dr. Ku is a nationally recognized expert on equity and access to affordable health care for vulnerable populations. He is a Professor in the Department of Health Policy and Management and Director of the Center for Health Policy Research at George Washington University in Washington, D.C.