AMERICAN ACADEMY *of* ACTUARIES

December 20, 2013

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9954-P
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Notice of Benefit and Payment Parameters for 2015 proposed rule

To Whom it May Concern,

On behalf of the American Academy of Actuaries'[1] Health Practice Council (HPC), I am submitting the following comments on several components included in the recently-released *Benefit and Payment Parameters for 2015* proposed rule. These comments represent input from three of the HPC's work groups[2] on the following topics: composite rating, proposed changes to the actuarial value calculator and methodology, and the three risk-sharing mechanisms.

Proposed Changes for Composite Rating

We recommend HHS clarify the proposal for composite rating. Currently, it is not clear whether the composite premium for covered children is a rate per child or a rate per employee with covered children regardless of the number of children. Similarly, it is not clear whether the composite premium for covered adults under the two-tier structure or the composite premium for covered adult dependents under the three-tier structure is a rate per adult or a rate per employee (under the two-tier structure) or per employee with covered adult dependents (under the three-tier structure).

Additionally, we request clarification on whether carriers can use both per member and composite premium calculations in the small group market as is done in today's market. In other words, can carriers use per member for groups up to a certain size (e.g., 15) and composite for larger small groups?

Proposed 2015 AV Calculator and Methodology

Our comments focus primarily on near-term issues related to the 2015 actuarial value (AV) calculator; however, we will continue to offer additional input to HHS on an ongoing basis, including whether new adaptations are needed in the AV calculator to accommodate new industry practices, methods to trend continuance tables, and potential methods and resources for

[1] The American Academy of Actuaries is a 17,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

[2] The comments in this letter were developed by three Academy work groups—the Actuarial Value Subgroup, the Risk Sharing Work Group, and the Individual and Small Group Market Task Force.

updating data. In addition, as we continue to explore the calculator, we will submit any inconsistent findings to the provided email address (actuarialvalue@cms.hhs.gov).

Using effective coinsurance to determine when the maximum out-of-pocket limit is reached
The proposed 2015 AV calculator uses effective coinsurance to determine when the maximum out-of-pocket limit is reached instead of the general coinsurance rate. This change is reasonable and is straightforward to implement for AV calculator users. This improvement eliminates the need for some of the workarounds that were needed in the 2014 AV calculator.

Expanded functionality to accommodate a wider range of plan designs
The increased flexibility means the AV calculator now accommodates plans with separate medical and prescription drug deductibles, even if the sum of these deductibles is greater than the plan's overall out-of-pocket maximum. This reduces the need for out-of-model adjustments.

Although the revised model addresses many of the inconsistencies that occurred with the previous version, some concerns remain. For instance, holding all other plan design parameters constant, the AV calculator produces a higher AV for a plan with a prescription drug deductible than for a plan without a prescription drug deductible.

Minimizing the potential for plan disruptions
Although the 2015 AV calculator appears to have fewer inconsistencies than in 2014, the changes in the calculator could require changes to some plan designs in order to meet AV targets. For instance, plans for 2014 were designed in part to meet the AV requirements as measured by the AV calculator. Changing the structure or underlying data of the calculator could necessitate changes to plans in order to meet AV requirements in 2015 that might have not been required if the calculator was not changed.

Preliminary analyses of plans using the proposed 2015 AV calculator reveal that many plans that previously met the AV target now fall outside of the de minimis range. Moreover, many plans falling outside of the range will require increases in plan generosity—which in turn may result in premium increases—in order to meet the target.

The ±2 percent de minimis range will reduce the likelihood that a plan will need to make changes in its cost-sharing parameters. However, when major changes are made to the AV calculator, either in its structure or underlying data (e.g., rebasing the continuance tables), it may be appropriate for HHS to consider widening the de minimis range for a limited time in order to minimize plan disruptions.

Timing of the proposed and final AV calculators
Actuaries use the proposed AV calculator to begin the process of assessing the actuarial values of plan designs. To the extent that the final calculator varies from the proposed calculator, changes may need to be made to plan designs to ensure they meet AV requirements. Therefore, it is advantageous for the proposed calculator to be as close to the final version as possible. To this end, a robust system of beta testing can help facilitate the discovery of any AV calculator problems or inconsistencies before it is released in proposed form.

Robust beta testing, along with a proposed calculator release that is close to the final version, also would help facilitate an early release of the final AV calculator. Ideally, we suggest the final version be released by Jan. 31 (or sooner).

Enhancing transparency

The details regarding the AV calculator data and methods are important to actuaries performing AV calculations, especially for plans that are not accommodated by the AV calculator. To this end, we request additional disclosure of:

- The underlying elements of the AV calculator, including how claims were distributed across the various service categories;
- The definitions of the fields and columns in the continuance tables; and
- The frequency units for each of the service categories (e.g., per visit, per service).

More clearly defining these categories can help AV calculator users assess whether they need to make adjustments for benefit variations that do not fit the calculator and, if so, to make these adjustments more appropriately. This level of detail also will be important to share with any states creating their own continuance tables so that state and federal tables can be developed on a consistent basis.

In addition to these items for the current continuance tables, we suggest documentation for future updated tables include detailed information on:

- What health insurance markets the data represent and other details on the underlying dataset, including the data source; whether and how the data were adjusted or appended by data from other datasets or markets; and how spending data were projected forward;
- Whether and how the data were adjusted to account for pent-up demand among the newly insured;
- Whether and how utilization effects are incorporated into the calculator to reflect differential utilization trends across benefit tiers; and
- How geographic pricing tier adjustments were determined, if applicable.

Other issues

The following is a list of other issues that we wanted to address. We would be willing to discuss any of these with HHS in more detail.

- In the near term, the priority should be to focus on ensuring the calculator works well for the most common types of plan designs. In the longer term, it is appropriate to expand the calculator to accommodate more unusual design features.

- We request additional clarity regarding how to incorporate family cost-sharing requirements, and how the methodology may differ depending on whether deductibles accumulate over the family or for each individual separately, or whether the deductible can be reached at either the family or the individual level. A basic question is whether the AV is intended to reflect the AV for an individual or the AV for a purchasing unit (e.g., a family).

- We believe the process for updating the AV calculator should strike an appropriate balance between minimizing disruptions in plan design parameters and maximizing calculator

accuracy by ensuring the data appropriately reflect underlying claims. The former goal would lead to less frequent updates while the latter would lead to more frequent updates.

- Will any state-specific data used to determine a standard population need to conform with any federal data changes? For instance, the proposed rule notes that changes to the AV calculator's underlying continuance tables would be made every three to five years. Will state-specific data updates be required to follow a similar time frame?

- It would be preferable for the AV calculator to be released unlocked. That would facilitate batch processing.

- We support the added feature to allow users to save their calculation output with a customizable prefix tab. However, it would be helpful if this functionality could be turned off when the actuary is in the plan testing process. Initial plan designs often need minor changes to ensure they pass the calculator, but it is not necessary to capture these interim plan designs.

<u>Proposed Changes to the Risk-Sharing Mechanisms</u>

Risk adjustment

Reporting the risk adjuster score

With respect to reporting the risk adjuster score, the proposed rule states (on page 72350) "we anticipate that issuers of risk adjustment covered plans would receive interim reports that include preliminary risk scores…." The proposed rule further suggests that those scores, to be provided to each carrier, will be shared on a quarterly basis. We commend this step not only to ensure that the data and calculations are in alignment (as issuers must review the scores and get back to HHS within 30 days), but also to provide some insight for issuers on their risk levels.

HHS also may want to consider providing state and market average information, in addition to issuer-specific risk scores, so issuers could calculate a total risk score (i.e., state average premium, AV, induced demand factor, average rate factor, geographic cost factors, the market/state normalizing factors found in the denominator of the payment transfer formula, and risk score). This could help provide premium stabilization over the long term by enabling each issuer to understand if their risk is relatively higher or lower than the average market. This information represents a critical assumption for issuers as they work to set premiums because the effect of risk transfer payments directly correlates to future premium levels. This also is critical information for financial reporting. Issuers will need to provide estimates of risk adjustment transfers in 2014 financial statements. The range of estimation error is substantially greater absent interim information on the relativities of each issuer's risk scores.

A key point here is timing of available information in order to price accurately for future plan years. While it may be difficult for HHS to provide interim estimates in time to impact 2015 pricing, interim reports in late 2014 and early 2015 could be used for 2016 pricing since 2014 actual risk adjustment transfers will not be known until June 30, 2015, which likely will be after 2016 pricing is complete. Without this change, even 2016 premiums will be set without knowledge of risk adjustment effects. For financial reporting, it is important for issuers to have this information before the end of 2014 for year-end financial statements.

Geographic cost factor
HHS requested comments in the proposed rule regarding how to best adjust geographic cost factors. The concern seems to relate to states that have defined a large number of rating areas—"(S)everal States have defined a large number of rating areas. Less populous rating areas raise concerns about the accuracy and stability of the calculation of the geographic cost factor because in less populous rating areas the geographic cost factor might be calculated based on a small number of plans. Inaccurate or unstable geographic cost factors could distort premiums and the stability of the risk adjustment model."

The work group would suggest that the extra time and resources needed to calculate and implement the adjustment to geographic cost factors is not necessary. Based on modeling, we believe that the use of the calculated geographic cost factors may have a limited impact on the final risk adjustment results. If HHS decides that an adjustment to the geographic cost factor should be implemented, however, we recommend HHS adopt a credibility adjustment when calculating the factors. To illustrate this point, we can provide HHS with a detailed example.

Reinsurance
In response to HHS' request for comments on increasing coinsurance rates above 100 percent, we would not recommend increasing coinsurance rates above 100 percent. The purpose of the transitional reinsurance program is to mitigate the risk of an issuer having a higher-than-expected number of higher-cost patients. Once coinsurance exceeds 100 percent, HHS reimbursement changes from a risk mitigation technique to providing rewards for having higher-cost patients. This would eliminate incentives to keep costs down for higher-cost individuals, and may create a perverse incentive encouraging additional costs for these individuals (up to the reinsurance maximum).

In addition to increasing the coinsurance rate, HHS could consider increasing the reinsurance maximum or reducing the attachment point—this could be done separately or in conjunction with increasing the coinsurance rate up to 100 percent—to increase the expected reinsurance payout. Increasing the reinsurance maximum would fulfill the purpose of the transitional reinsurance program by mitigating costs for higher-cost individuals, and it would not have the same effects as increasing coinsurance above 100 percent.

HHS should consider the potential implications for the commercial reinsurance market. Some issuers have already entered into commercial reinsurance arrangements that provide coverage starting at $250,000. If the transitional reinsurance maximum were to increase, a portion of the coverage provided by these commercial arrangements effectively would be eliminated due to "double indemnity" clauses in the reinsurance contracts. Unless these contracts were renegotiated, issuers would be overpaying for reinsurance as a result of the transitional program changes. However, potential problems associated with increasing the reinsurance maximum can be resolved through re-negotiation of individual reinsurance contracts. HHS also may consider further reducing the attachment point. Lowering the attachment point, however, also has some negative implications in that it increases the overlap between reinsurance and risk adjustment and is less effective at mitigating claims for higher-cost individuals.

If the revised reinsurance formula results in lower reinsurance claims than the reinsurance contributions collected, excess reinsurance contributions could be rolled over to the next year as permitted by Section 1341(b)(4) of the ACA.[3]

Risk Corridor

2014 Transitional Adjustment

HHS is considering an adjustment to the risk corridor formula that would help mitigate any unexpected losses for issuers of participating qualified health plans (QHPs) that are attributable to the effects of the 2014 transition policy. One option is implementing an adjustment to the formula in an amount sufficient to offset the effects of the 2014 transition policy on the claims costs of a model plan (that is, a plan with an 80 percent allowable costs-to-premium ratio). Anticipating that the effect on a risk pool may vary state-by-state, HHS is considering state-specific percentage adjustments that vary with the percentage enrollment in these transitional plans in a state. HHS is considering calculating the state-specific percentage adjustment by analyzing the effects of the transitional policy on a plan with specified characteristics.

The preamble describes the methodology and sample assumptions that may be used to calculate state-specific adjustments. Under this option, HHS anticipates collecting enrollment counts from all issuers in the individual and small group market in a state for transitional and non-transitional plans.

We do not have a recommendation on the structure of this adjustment, but we would like to outline some potential issues with the approach and suggest possible alternative methods. The proposed state-specific adjustment uses standard assumptions for claims, expenses, profit, and relative utilization of transitional enrollees. However, there are factors other than those mentioned in the preamble that may affect actual results on a state-specific basis. For example, a state that previously required guaranteed issue may have different expected morbidity in transitional plans than states that previously allowed medical underwriting. The tax liability assumption may differ by state due to varying levels of premium tax or other taxes and fees. The rollout difficulties and early renewals also may contribute to experience that is higher than anticipated when issuers completed their 2014 pricing.

The modeling described in the preamble is straightforward, but it may add complexity and administrative burden for all issuers and may not lead to accurate results. In addition, this adjustment will be calculated in 2015 and will create uncertainty in financial results for issuers in 2014. Issuers will need to estimate the risk corridor payments and charges for year-end financial statements, but the effect of the potential adjustments to the 2014 formula will not be known at year-end. To mitigate the timing issue, enrollment counts could be requested in July 2014 so that the risk corridor adjustment could be determined before year-end.

A nation-wide approach may help alleviate the unexpected losses with less complexity and administrative burden. Under this option, issuers also could be protected partially against losses due to the rollout difficulties and early renewal programs. Another option would be to provide changes to the risk corridor formula for certain categories of states, such as those allowing transitions, those with rollout difficulties, and/or those allowing early renewals.

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[3] http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf

Calculation of Allowable Costs
HHS defines the allowable costs in Section 153.500 as the incurred claims for all of the QHP issuer's non-grandfathered health plans in a market within a state, allocated to the QHP based on premiums earned. This definition appears to include non-grandfathered, non-ACA compliant products.

We recommend that the allowable costs definition in Section 153.500 exclude the incurred claims from non-grandfathered, non-ACA compliant plans. The claims used in the calculation should not include non-grandfathered, non-ACA compliant plans (including non-ACA compliant plans subject to the recently announced "transition policy" since these plans are not part of the risk corridor program). The rationale provided by HHS in pooling non-grandfathered claims for the risk corridor calculation was based on the single risk pool pricing concept. However, non-grandfathered, non-ACA compliant plans are not included in the single risk pool.

Counting methodology for small group
In the proposed rule, HHS asked for guidance regarding the employee counting methodology for small group business. Suggestions on how to determine small group designation (50 employees) were outlined in the proposed rule for both risk adjustment and risk corridors. Previously, definitions have been offered by HHS for employee counting methodology for minimum loss ratio rules, for application of modified community rating, and SHOP determination.

The work group is recommending the same methodology be used for determining small group designation for each of these items to ensure accuracy, consistency, and reduce both confusion and operational/administrative expense for tracking different cutoff points.

To ensure consistency and simplicity, the work group recommends that in the short term, HHS align the definition for rating rules, risk adjustment, and risk corridors. In the future, though, it may be helpful to align the definition for all states with respect to risk adjustment, risk corridors, market reform qualifications (modified community rating and essential health benefit coverage), and SHOP determination.

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We appreciate the opportunity to provide comments on the proposed rule regarding benefit and payment parameters for 2015. We will be happy to discuss any of these comments with you if would like more information. Please contact Heather Jerbi, the Academy's assistant director of public policy (202.785.7969; Jerbi@actuary.org), if you have any questions or would like to discuss further.

Sincerely,

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Vice President, Health Practice Council
American Academy of Actuaries