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November 27, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9934-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Notice of Benefit and Payment Parameters for 2019

To Whom It May Concern,

On behalf of the Risk Sharing Subcommittee and the Premium Review Work Group of the American Academy of Actuaries,[1] we would like to provide the following comments on the proposed rule for the 2019 notice of benefit and payment parameters (NBPP). Our comments are organized by provisions related to risk sharing, special enrollment periods, essential health benefits and other qualified health plan minimum certification standards, minimum essential coverage, and medical loss ratios.

Comments on Risk Sharing Provisions

Recalibration using EDGE

CMS proposes to use a 3-year blending of separately calculated coefficients using 2014 MarketScan, 2015 MarketScan, and 2016 EDGE data. This approach would provide stability in the coefficients (using a 3-year blending approach) and improve credibility for conditions with limited sample sizes. It would be helpful for CMS to perform a comparison of EDGE to MarketScan data, to demonstrate the reliability of the EDGE as a data source. In addition, we request that CMS disclose the volume of data available through the EDGE compared to MarketScan and review the impact of ICD-9 to ICD-10 on significant changes to HCCs. We do not believe it would be appropriate to make changes to age/gender, HCC, or RXC categories in the final 2019 NBPP, as any structural changes to the risk adjustment program should first be proposed with a comment period. Lastly, we recommend that CMS publish final risk adjustment model coefficients as soon as possible, but no later than the final NBPP. The incorporation of EDGE data could result in substantial changes to coefficients, and issuers will need time to analyze the impact for pricing.

[1] The American Academy of Actuaries is a 19,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Comment on CSR Adjustments
CMS proposes maintaining current CSR adjustment factors for 2019 and proposing new factors based on the EDGE experience for 2020. We agree with the proposal, but we recommend that the new factors be based on EDGE experience and analysis be released as soon as feasible, even before the 2020 proposed rule, for review and comment.

14 Percent Administrative Expenses Reduction
It is appropriate to reduce the statewide average premium to remove administrative expenses that do not vary with claims. We request that CMS provide more information on the analysis that was used to determine the 14 percent statewide average premium reduction factor. Based on the 2018 final NBPP, the analysis was based on the medical loss ratio (MLR) reporting data, which is publicly available. It would be useful to provide the analysis in sufficient detail that a qualified actuary could follow the development of the factor, including the line items from the MLR reporting that were assumed to be administrative expenses that do not vary with claims, along with any other assumptions that were made in the analysis.

Interim Reports
A significant challenge for issuers is the lack of having risk adjustment transfer information in time for rate setting and accurate financial reporting. The consulting market offers studies to inform estimates; however, these are not available with sufficient participation to be credible in all markets. CMS has released interim reporting in markets deemed to have sufficiently complete information. Relevant information includes statewide average premium, geographic cost factors, billable member months, average allowable rating factor, and metallic tier distribution. Expanding on this reporting by increasing the frequency of reports and applying consistent claim-through dates for all issuers in the market would improve the utility of the reports. For instance, CMS could provide quarterly reporting after six months of claims data are available in EDGE. Issuers could also benefit from preliminary indications from industry average risk adjustment data validation (RADV) error rates in advance of those rates impacting 2018 risk transfers.

Small Group Flexibility
If states can demonstrate that the actuarial risk differences due to adverse selection are mitigated by the market dynamics in their small group market, CMS proposes to allow state insurance regulators to request a percentage adjustment in the calculation of the risk adjustment transfer amounts in the small group market beginning for the 2019 benefit year—by up to 50 percent for the applicable year.

Risk adjustment is important in the small group market under the current ACA rating rules, which do not allow for varying premium for health status of enrollees among small groups. An effective risk adjustment program reduces the incentives for issuers to avoid higher risk small groups. While the selection dynamic in the small group market is different than in the individual market due to employer choice of plans and the employer contribution and participation requirements, the same HHS risk adjustment methodology

structure can be used for both individual and small group markets since it measures expected risk at the individual enrollee level compared to the risk factors allowed in rating. The payment transfer results for years 2014 – 2016 appear to reflect the differences in selection dynamics, by market segment, in that the absolute value of transfers is less, as a percent of premium, for the small group market than for the individual market. For the 2016 risk adjustment results, the absolute value of risk adjustment transfers was 6 percent of premium for the small group market and 11 percent of premium for the individual market.[2]

The risk adjustment model has been subject to much research and development over the past several years and is fairly complex. It is unlikely that the application of a flat percentage reduction to the transfer amounts would produce equitable outcomes for all the issuers in a state. The model is continually being revised and these updates are expected to continually improve the results. States have the ability to develop their own risk adjustment methodology within federal guidelines if they feel the national model is not working well in their state. That said, individual states may not have the resources needed to develop a state-specific risk adjustment model. CMS should consider whether EDGE recalibration could lead to developing separate small group coefficients or other transfer formula factors if the experience is different than individual market experience. In particular, it is possible that individuals choosing higher metal levels in the individual market have a higher severity within a condition compared to individuals choosing lower metal levels, while in the small group market the mix of severity within a condition remains relatively constant by metal level due to the employer choice of metal level. CMS could consider reviewing EDGE data by metal level for the individual and small group markets separately to determine whether the coefficients or the induced demand factors should vary by market.

CMS has stated that the risk adjustment methodology has produced reasonable results for both the small group and individual markets.[3,4] Other analyses, including an Academy analysis of the 2014 individual results, concluded that risk adjustment generally worked as intended.[5] It has been noted that in the case of outlier results there may be issues with the completeness of the data being loaded to the EDGE server and the completeness of condition coding by providers. These types of issues would not be appropriately addressed by a reduction of the statewide average premium. And this adjustment would be expected to negatively impact issuers that are receiving risk adjustment transfers, which could result in an increase of rates due to a riskier population. This is exactly the

[2] Center for Consumer Information and Insurance Oversight (Centers for Medicare & Medicaid Services, Department of Health and Human Services), "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year," June 2017.
[3] Ibid.
[4] Center for Consumer Information and Insurance Oversight (Centers for Medicare & Medicaid Services, Department of Health and Human Services), "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year," June 2016.
[5] American Academy of Actuaries' Risk Sharing Subcommittee, "Insights on the ACA Risk Adjustment Program," April 2016; Kurt Giesa and Chris Carlson, "Potential Changes to Risk Adjustment in 2019 Through a 2015 Lens," November, 21 2017.

situation that risk adjusters were designed to negate. Issuers should not be penalized, either via financial losses or the necessity to increase premiums at faster rates than their competitors, because they have a riskier population. This could cause issuers to leave the market.

In addition, improvements to the risk adjustment methodology are being put in place for 2017 – 2019, including partial year factors, using drug data to impute diagnoses, and EDGE recalibration. It would be difficult for state regulators to determine the impact of these improvements until the payment transfer results are published.

The NBPP proposes that states would submit their proposals for such adjustments to the statewide average premium in the small group market within 30 calendar days after publication of the proposed NBPP for the applicable benefit year. CMS would publish the requested state adjustments for public comment in guidance while it begins its initial review of the state proposal and would make a final determination on state requests by March 1 of the benefit year prior to the applicable benefit year, in time for issuers' initial rate setting deadline.

We don't recommend finalizing state flexibility for the small group market. However, if this proposal is finalized, CMS should consider requiring an actuarial report describing the method of estimating the proposed adjustment factor. We do not believe the timing will work for the 2019 calendar year. We note that changes to 2019 risk adjustment in the small group market impacts the experience for small groups issued and renewed after Jan. 1, 2018, because small group policy years are not required to coincide with a calendar year.

States should submit a detailed actuarial report that justifies the need for the adjustment by showing that the HHS risk adjustment methodology overstates differentials in uncompensated predicted risk in the small group market, demonstrates that the risk adjustment experience in the state did not result from operational or pricing issues, discusses consequences of selection on issuers and certifies that the resulting risk adjustment methodology will still comply with ASOP 12 on risk classification.[6] We believe states will need more than 30 days from the issue of the proposed rule to develop this report. In addition, March 1 is very close to 2019 filing dates for issuers. It would be better to have the final risk adjustment formula published in the final NBPP, especially since changes in small group risk adjustment impact 2018 new business and renewals. In order to have final factors for the final NBPP, the state proposal and actuarial report would need to be submitted prior to the release of the proposed NBPP, to provide issuers and other stakeholders adequate opportunity to provide comments. Under this timing, states would not have knowledge of other changes CMS proposes in the NBPP. But, we note that final coefficients are typically not published in the proposed NBPP, so the final model factors are not generally available to analyze until after the final rule. We agree with a public comment period for issuers within the state and other stakeholders to comment on any state proposals.

[6] Actuarial Standards Board, "Actuarial Standard of Practice No. 12: Risk Classification," adopted Dec. 2005.

CMS requests comments on whether state flexibility should also be considered for the individual market. We do not recommend state flexibility for the individual market. The selection concerns are even greater in the individual market.

Comments on Special Enrollment Period (SEP) Provisions

CMS has proposed a change to Section 155.420(a)(5) related to how a qualified individual seeking coverage through a special enrollment period can satisfy prior coverage requirements. This proposal would exempt qualified individuals from the prior coverage requirement if their qualifying event is the result of a permanent move and they lived in an area for at least one of the 60 days prior to the date of their move in a service area where there are no qualified health plans (QHPs) offered through an exchange.

We understand the desire to provide an SEP for people who lived previously in a region that did not offer QHPs on the exchange, so they can get coverage if they move to a region that does offer QHPs on the exchange. However, requiring that a person only lives one day in the last 60 in a region that did not have coverage could result in gaming, with people moving on a transitional basis for the purpose of gaining availability of a SEP. This could create adverse selection, causing instability in the individual market.

It may be more appropriate to require that individuals wishing to be exempt from prior coverage requirements had established residency in the service area in which there were no QHPs offered on the exchange. Prior coverage requirements could be met if individuals had coverage for one of the 60 days prior. For individuals without prior coverage, requiring that they were residents in an area without marketplace QHPs for the entire 60 day period would eliminate the adverse selection caused by transitional moves compared to if the residency requirement was only one day. This would not preclude HHS from granting the "exceptional circumstances" SEP in cases where the residency requirement does not adequately capture an individual's prior access to health insurance coverage.

Comments on Provisions Related to Essential Health Benefits and Other Qualified Health Plan Minimum Certification Standards

Increased Flexibility in State Essential Health Benefit Package Specification
HHS seeks to expand state options when selecting the essential health benefit (EHB) benchmark plan. In particular, new state EHB benchmark options would include selecting another state's 2017 EHB benchmark plan (option 1); replacing one or more EHB categories with the same categories from another state's 2017 EHB benchmark (option 2); or otherwise selecting benefits that would become the EHB benchmark as long as it doesn't exceed the generosity of the most generous among a set of comparison plans (option 3). Additional requirements must be met if one of these new options is chosen—a state's EHB benchmark plan must provide an appropriate balance of coverage for the 10 EHB categories, be equal in scope to benefits provided under a typical employer plan, not

have benefits unduly weighted toward any benefit categories, and provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups.

States selecting another state's EHB benchmark plan may need to supplement that plan to comply with the selecting state's mandated benefits. It is unclear whether this would be allowed under option 1 or whether instead adding benefits would necessitate using option 3 and abiding by option 3's additional state documentation requirements.

The statutory and regulatory requirements to maintain an appropriate balance between EHB categories and to provide benefits for diverse segments of the population are vague. HHS should provide guidance to further clarify these requirements. With increased flexibility, these requirements, along with the non-discrimination requirements in Section 156.125, become more important. The non-discrimination requirements prohibit EHBs from discriminating based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. It is unclear whether compliance related to health conditions is assessed based on the group of individuals with health conditions in the aggregate, or based on groups of individuals with particular health conditions.

The proposed rule would also allow issuers to substitute benefits between EHB categories as long as the benefits are actuarially equivalent and that the plan meets the same benchmark requirements related to maintaining an appropriate balance among categories and providing benefits for diverse segments of the population. HHS notes that states would be required to determine whether issuers that substitute benefits between categories meet these latter requirements. We note that additional HHS guidance to issuers and states on the substitution-between-benefits proposal would give more clarity to the entire benefit substitution process.

Finally, we note that as currently constructed, all 2019 EHB building blocks are required to come from 2017 EHB benefit packages and base-benchmark plan options. While this is certainly sufficient in the short term, greater flexibility and further innovation may be encouraged if it is clear that, in the future, states can take advantage of newer approved EHB benefit packages created by other states under this proposed regulation. Additionally, the generosity testing required under option 3 is currently linked to 2017 benefits and may not keep pace with future market developments.

Actuarial Certification Required When Creating New Plan

It is appropriate to require actuarial certification of the state benchmark plan when a state chooses to customize its own EHB plan, whether by designing its own plan or mixing and matching benefit categories from other states' EHB benchmark plans. The proposed information collection (CMS-10448) includes an actuarial certification that appears to note the required regulatory and statutory requirements. We appreciate that actuaries would not be required to certify EHB balance or diverse population segment requirements given the current lack of definition around these concepts. The PDF version of the actuarial certification required form may not provide sufficient space for

appropriate responses, especially on the second page of the certificate where short responses are requested. This may lead actuaries to reply "Please see the accompanying report for the methods used" to maintain a readable response. Further, the second and fourth response boxes on page two of the PDF form appear to be linked, requiring the same response for both. While the methodologies used to determine compliance with each requirement are likely to be similar, they may not be identical and the certifying actuary should be able to document the methodologies of each.

Proposed Process for Generosity Testing of Proposed State Plan

States choosing to use option 3 to design their EHB benchmark must ensure it doesn't exceed the generosity of the most generous among a set of comparison plans, including the three largest small group plans and the state's 2017 EHB plan if different. CMS provided a draft example of a methodology for comparing benefits under a state's proposed EHB benchmark to a typical employer plan. We note that using the small group market index rate as the basis of claims, as suggested in step 2 of the example, may not be appropriate since the index rate is adjusted for any quarterly trend assumed in quarterly rate updates. Additionally, the index rate excludes the impact of any state-required benefits that are not EHB but are still included in either the typical employer plan or the 2017 EHB benchmark plan. These considerations may make the index rate as suggested an inappropriate choice as a basis for the evaluation of all benefits of the typical employer plan without appropriate adjustment. Since large group plans may be more likely to be chosen as the typical employer plan, we suggest that the example of using small group index rates be removed.

In the draft example, we note that the current test in step 3 ensures that the state's proposed EHB plan is no richer than approximately 102 percent of the typical employer plan (since the typical employer plan must have costs at least 98 percent of the EHB plan). There is no separate requirement that the state's EHB plan must be no less rich than the typical employer plan. In effect, this serves as an additional cap on EHB benefit richness as currently constructed. Given the existing cap of benefit richness proposed under Section 156.111(e)(2), this seems likely to be duplicative. A change in the order of comparison (i.e., that the state plan covers at least 98 percent of the typical employer plan's covered benefits) would be more useful, since that would require that the state's proposal was at least as rich as the typical employer plan.

Definition of Typicality of Employer Plan

The proposed rules define a typical employer plan as one with at least 5,000 enrollees. It may be appropriate to add additional criteria. For instance, HHS may wish to consider requiring that a plan meet minimum value requirements in order to be defined as a typical employer plan and/or that it covers all or most of the EHB categories and supplement any missing categories.

A typical employer plan that does not operate in a given state might not meet that state's mandated benefits, complicating the required analysis. In addition, a self-funded employer plan might not meet benefit requirements in a given state due to ERISA pre-emption. When performing analysis with the typical employer plan selected, HHS should

require that this plan be supplemented with all state-required benefits prior to any testing of comparable generosity.

By allowing states significant flexibility in selecting the typical employer plan, HHS is allowing states significant leeway in the evaluation of comparable generosity. When combined with the cap on plan generosity, this proposal appears to be enabling states only to choose to maintain or reduce benefits to their consumers relative to the current EHB benchmark process.

If HHS chooses to institute state-specific enrollment requirements on the typical employer plan, another state's EHB benchmark plan may no longer automatically meet the plan generosity requirement. As such, HHS should consider the interaction between these two proposals when making a decision, as each consideration has effects on the state.

Issuer Ability to Substitute Between EHB Categories

Offering issuers the ability to substitute between EHB categories would increase the ability for issuers to offer flexible plan designs. However, determining actuarial equivalence between benefits in different EHB categories may not be straightforward. When evaluating benefits within the same EHB category, it can be relatively simple to calculate the allowed cost associated with particular types of services and limits on those services; these amounts are directly comparable, as the same dollar amount represents the same proportion of all services in that EHB category. This equivalence of dollar amounts and proportionality breaks down when comparing between different categories. Additionally, issuers would require additional guidance when evaluating their changes against the statutory EHB balance and diverse population segment requirements. While HHS would defer regulation of these items to the states, varying state requirements would unduly impact issuers with broad national penetration, adding an additional layer of complexity should these issuers wish to make changes to the state benchmark plan.

As noted above, increased EHB flexibility increases the need for adherence to non-discrimination requirements. Otherwise, issuers could adjust benefit offerings as a selection tool to avoid individuals with certain health conditions.

Downstream Impacts of EHB Package Flexibility

Essential health benefits are integral to many components of the ACA. In particular, the risk adjustment model coefficients and actuarial value (AV) calculator utilization are built around the concept of nationally representative EHBs. To the extent that states come up with different mixes of EHBs, actuarial value may be less representative of the level of benefit richness of a given plan and risk adjustment coefficients may be less predictive of costs for plans in any given state. Given modifications to the risk adjustment program to reflect EDGE data, EHB flexibility could further complicate the ability of the risk adjustment program to accurately predict costs.

Timing of EHB Changes
The proposed rule anticipates finalizing 2019 EHBs in March 2018. That would provide very little time for issuers to incorporate any new EHB requirements into their 2019 rate filings.

Premium Adjustment Percentage
The premium adjustment percentage described in Section 156.130 is used to set the annual increases for the maximum annual limitation on cost sharing, the required contribution percentage used to determine if an individual is eligible for certain exemptions, and the assessable payment amounts.

Because the premium adjustment percentage affects the maximum annual limitation on cost sharing, it also affects the ability of plan designs within the ACA metal plans that can be considered HSA-qualified high-deductible health plans. Yet the IRS determines the maximum annual limitation on cost sharing for HSA-qualified plans. As noted in the proposed rules, these two maximum limitation amounts are diverging. This could complicate the development of HSA-qualified plans within the ACA.

It would be appropriate for CMS and IRS to consider coordinating the increases to the maximum annual limitation on cost sharing under the ACA and the maximum out-of-pocket cost limits for HSA-qualified plans.

Application of Actuarial Value (AV) Requirements to Stand-alone Dental Plans
The proposed rules would remove the AV requirement for stand-alone dental plans. This would allow more flexibility for issuers and more options for consumers.

Value Based Insurance Designs
CMS requested comments on how value based insurance designs (VBID) could be encouraged in the individual and small group markets. These types of plans generally include programs to incent consumers to choose and providers to offer high quality cost effective care. Current ACA rules facilitate the use of VBID in various ways. For instance, all health insurance plans are required to offer coverage for certain preventive services with no patient cost sharing. In addition, tiered network plans in which providers are tiered based on both quality and cost are permitted—lower cost sharing may be applied to the providers with the highest quality and lowest cost metrics. Value-based contracting with providers (e.g., Patient Centered Medical Homes, value-based contracting for pharmacy based on outcomes) may be considered a VBID approach and is permitted as it may not affect benefits within a plan design. HHS can further promote VBID and other plan design innovation by allowing insurers flexibility in plan design offerings; creating mechanisms to share information and research related to successes and challenges with VBIDs; and providing education to consumers related to VBIDs as the benefits and cost sharing for these plans can be more complex and difficult to understand.

Cost Effective Drug Tiering
CMS also requested comments on how to encourage VBIDs that focus on cost effective drug tiering. Many issuers first began incorporating a VBID approach by allowing

waivers of cost sharing for chronic prescription drugs with member compliance. For example, members with high blood pressure may have their cost sharing waived if they purchase their medication three months in a row. This type of drug tiering is not currently reflected in the AV calculator; however, the actuary can estimate an average cost share and provide a certification that would allow these types of waivers.

Minimum Value Calculator
While not a comment related to the payment notice, we wish to take this opportunity to suggest that the minimum value calculator (MVC) be updated to reflect more recent underlying experience. The MVC has not been updated since its initial release, and is expected to be used to determine the minimum value of employer group plans. The AV calculator has been updated numerous times, and now the two are out of synch. As claims cost increase, a set benefit design generally increases in real actuarial value. Therefore, continuing to use the original MVC is likely to result in MVs that are understated. Therefore, it would be appropriate to update the MVC on a regular basis, similar to the AV calculator update schedule.

CSR Settlement
HHS proposes changes to the cost-sharing reduction reconciliation process. It does not appear that details related to the proposed changes are included in the NBPP, however. Further guidance on this is needed.

Comments on Minimum Essential Coverage Provisions

Other Coverage that Qualifies as Minimum Essential Coverage (MEC) and CHIP Buy-in Programs
The proposed rule would allow CHIP buy-in coverage that is identical to a state's CHIP program to qualify as MEC. CHIP buy-in programs only offer coverage for children, so they may not have all of the benefits that are included in a state's benchmark plan (and, thus, may not qualify as a QHP under ACA requirements). However, if these programs are allowed to be considered MEC, there are concerns that they may create adverse selection in the individual market if they do not cover the same scope of benefits. In addition, there are questions regarding how the CHIP buy-in plans would interact with premium subsidy determinations. The proposed rule (in footnote 68) suggests that MEC CHIP buy-in plans may be eligible for premium subsidies. That means it would be necessary to determine the buy-in program's actuarial value and metal tier. It is unclear how those determinations would be performed. In addition, if the buy-in plans are deemed silver plans, that could affect the determination of the second lowest silver plan and premium subsidy amounts. Cost-sharing reductions could also become more complicated if buy-in plans are deemed to be silver plans yet offer richer or less rich benefits as other silver plans.

Comments on Medical Loss Ratio (MLR) Provisions

Employment Tax Adjustment to Premium
Currently, issuers must include all federal and state employment taxes in earned premiums in their MLR calculations. To encourage issuer participation in the market, HHS is considering allowing issuers to deduct employment taxes from premiums in the MLR calculation, beginning with the 2017 reporting year. Deducting employment taxes would make the MLR threshold of 80 percent for the individual and small group markets and 85 percent for the large group market somewhat easier to meet, reducing any potential MLR rebates. Making it easier for issuers to meet the MLR requirement could increase the incentive for issuers to enter or remain in the market. This would be similar to a reduction in the MLR threshold. This would also allow issuers that had experienced past losses to improve their financial condition prospectively and better enable them to meet state risk-based capital (RBC) requirements. This is a concern for issuers and insurance regulators.

However, the goal of the MLR rebate is to protect customers from having a large share of their premiums spent on non-claims costs (administrative costs, contributions to surplus, and profit). Reducing premium by employment taxes in the MLR calculation may somewhat weaken that protection. Employment taxes are directly related to employee salaries, which are considered part of administrative costs and not excluded from premiums. Changing the treatment of employment taxes in the MLR calculation would be inconsistent with the treatment of employee salaries, but consistent with how other taxes are treated.

Quality Improvement Activity (QIA) Expenses
Quality improvement expenses are added to claims in the MLR calculation. The proposed rule would allow issuers to continue reporting actual QIA expenses or use a flat amount of 0.8 percent of premiums. Because QIA expense tracking is administratively burdensome, using a flat 0.8 percent would likely help issuers reduce this administrative burden. However, many existing issuers have already implemented systems to aid in tracking of these expenses and would likely continue to track expenses in order to make sure they incorporate actual expenses into the MLR calculation if they exceed 0.8 percent.

Another alternative to reduce the administrative burden of QIA tracking would be to remove the necessity to split QIA into five categories, while still requiring actual QIA expenses rather than a flat percentage.

QIA costs will vary among issuers, and for a given issuer QIA can vary by market type. These differences would be lost using a flat 0.8 percent. Also, changing to a flat 0.8 percent could reduce the incentive for issuers to invest in activities to improve quality. In 2018, increases in some or all silver premiums were implemented to account for the removal of CSR subsidies; assuming QIA expenses of 0.8 percent of premiums may not be appropriate for these plans. In addition, as premiums continue to increase faster than

non-medical expenses, using a flat 0.8 percent may overstate QIA expenses in the future. Nevertheless, the amount would be very small compared to the total premium.

State Adjustments to the Individual Market MLR Threshold
The proposed rules would make it easier for states to request adjustments to their MLR threshold, thereby allowing states to be more responsive to their particular market situations. Lowering the MLR standard would have a similar impact as reducing the premium by employment taxes, although the magnitude could be different. Making it easier for issuers to meet the MLR requirement could increase incentives for issuers to enter or remain in the market by allowing a higher administrative costs, profit, or contribution to surplus without having to issue rebates. This could allow issuers to improve their financial condition and enable them to meet state RBC requirements. However, lower MLR thresholds could weaken the MLR regulation's customer protections.

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We appreciate the opportunity to provide comments on the 2019 proposed benefit and payment parameters. We would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments. If you have any questions or would like to discuss further, please contact David Linn, the Academy's senior health policy analyst, at 202.223.8196 or linn@actuary.org.

Sincerely,

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