AMERICAN ACADEMY *of* ACTUARIES

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March 7, 2017

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Market Stabilization Proposed Rule

To whom it may concern:

On behalf of the Individual and Small Group Markets Committee of the American Academy of Actuaries,[1] I appreciate the opportunity to offer the following comments on the recent market stabilization proposed rule for the individual and small group markets. In addition to the proposed rule, we are also including our comments on the revised filing deadlines provided in the Feb. 17 CMS draft bulletin.[2]

**Modified Interpretation of Guaranteed Availability Rules (§147.104)**
The proposed rule would change the interpretation of guaranteed availability rules with respect to non-payment of premiums. Under the proposed rule, issuers would be able to attribute a premium payment for coverage under the same or a different plan to the outstanding debt associated with non-payment of premium for coverage from the same issuer during the prior 12 months. It would also allow an issuer to deny new coverage for failure to pay past-due premiums. This would encourage individuals to maintain coverage throughout a plan year and limit the ability to have a full year of coverage but pay premiums for only nine to 11 months.

Such a rule would be most effective for individuals who have access only to a single carrier, and it is consistent with the Health Insurance Portability and Accountability Act (HIPAA) rules for guaranteed renewability, that allowed issuers to non-renew for failure to pay premium. The proposed rule would be less effective for individuals who have access to multiple carriers. In these situations, individuals who were terminated for failure to pay premiums could enroll with a different issuer during open enrollment without any consequences. As a result, individuals receiving premium subsidies would still able to effectively obtain 12 months of coverage while

[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.
[2] Centers for Medicare & Medicaid Services, "DRAFT Bulletin: Revised Timing of Submission and Posting of Rate Filing Justifications for the 2017 Filing Year for Single Risk Pool Coverage; Revised Timing of Submission for Qualified Health Plan Certification Application," Feb. 17, 2017.

paying only nine months of premiums.[3] Thus, the rule change could be even stronger if it applied across issuers as well as within the same issuer. We recommend that CMS (or the marketplaces) collect administrative data to enable such application across issuers as long as this process does not result in undue administrative reporting requirements.

While it may be reasonable to allow issuers the flexibility of whether and how to implement a premium threshold under which an individual is deemed to have paid all amounts due, this flexibility could result in an inconsistency in how enrollees are treated by the various issuers. For instance, if a percentage of premium threshold is used, an individual may be terminated for non-payment of premium by one issuer while being allowed to continue coverage by another issuer, even though the individual paid the same percentage of premiums.

Issuers incorporate procedures regarding termination of coverage due to non-payment of premiums in their policy documents to enrollees, so requiring notification to individuals that they are adopting this policy should not be an onerous requirement unless it necessitates re-filing policy forms. We recommend that notifications be incorporated into the billing function.

**Annual Open Enrollment Periods (§155.410)**
CMS has proposed to shorten the open enrollment period for the 2018 plan year from the original period of Nov. 1, 2017 to Jan. 31, 2018, to a period of Nov. 1, 2017 to Dec. 15, 2017. The new proposed period is similar to the Medicare open enrollment period as well as the open enrollment period already scheduled to begin for the 2019 plan year. A shorter period that ends before the start of calendar year 2018 would encourage a full 12 months of coverage and would decrease adverse selection by limiting opportunities for individuals to wait until they need coverage to enroll.

For plan years 2014 to 2017, open enrollment periods have extended into the calendar year of coverage and sometimes even extended beyond the initial published deadlines. As a result, many individuals enrolled after the year began, and many dropped coverage prior to the end of the year. Partial-year enrollment is not unexpected in the individual market, as individuals move between it and other sources of coverage (e.g., employer group coverage). Nevertheless, partial-year enrollment can be especially prone to adverse selection. If individuals are allowed a longer period to enroll, they may wait until they need health care after year-end to enroll in coverage, causing adverse selection. Further mitigating adverse selection and encouraging full-year enrollment can improve the profile of the individual market and, thus, market stability.

However, having a shorter open enrollment period for the individual market would reduce the time available for outreach and enrollment efforts. In addition, individuals may need until December to know what their financial situation for the next year will be (e.g., whether they get a raise can affect enrollment decisions). Nevertheless, an enrollment period that ends prior to Jan. 1 could reduce the potential for adverse selection, thus improving the average risk profile. In addition, it would help issuers understand their enrollee population sooner, direct members into

[3] Individuals receiving premium subsidies have a 90-day grace period for premium payment. Therefore, they can wait until the 89th day and, if they had no claims, not pay premium for the last quarter of the year. During open enrollment, they can simply select a new issuer and still be guaranteed coverage without having to pay any past-due premiums.

care management programs earlier, provide more time to send welcome materials to enrollees, and better ensure enrollees access to insurance benefits closer to Jan. 1.

It is possible that shortening the open enrollment period may result in fewer individuals enrolling due to expectations of a longer enrollment period, so we recommend that outreach to educate individuals about the shortened time period and about the consequences of not enrolling in a timely fashion. In addition, we also recommend that once the time period is finalized, that it not be extended. Extending the open enrollment period after it is finalized would result in individuals believing that deadlines are flexible, which allows for more adverse selection and could result in fewer individuals having a full 12 months of coverage.

**Special Enrollment Periods (§155.420)**

The availability of special enrollment periods (SEPs) for individuals who encounter certain life events, such as losing health insurance coverage, moving, or getting married/divorced, are necessary to promote continuous coverage. However, abuses of SEPs can also increase average claim costs. Eligibility requirements for SEPs in the marketplaces have not been strictly enforced, creating opportunities for individuals to delay enrollment until health care services are needed. On average, SEP enrollees have had higher claim costs and higher lapse rates than individuals enrolling during the open enrollment period.[4]

*Tighten SEP eligibility and enrollment verification.*

These proposed rules are intended to reduce the number of SEPs and increase verification of SEP eligibility. Further limiting SEP eligibility and tightening enforcement should reduce abuses of SEP eligibility that might be occurring. However, any requirements regarding SEP enrollment should not be so onerous as to reduce participation among those legitimately eligible, otherwise the consequences could be to reduce participation among the healthy SEP eligible, thus worsening the risk pool.

It is appropriate to eliminate triggering an SEP when losing health insurance coverage for non-payment of premium. Allowing such an SEP can result in enrollees dropping coverage and then re-enrolling when they need health care services, which would, in turn, result in adverse selection and higher premiums.

It is also appropriate for marriage to trigger an SEP only if one of the individuals already had coverage. If neither party had coverage prior to the date of the marriage, then neither would be eligible to enroll during an SEP. This is another means of minimizing selection for the pool.

*Consistent SEP enforcement mechanisms.*

Stricter SEP enforcement mechanisms have the potential to improve the risk profile. In addition, more consistent SEP verification processes between plans on and off the marketplace could reduce any related disadvantages for on-marketplace plans.

[4] Chris Carlson and Kurt Giesa, *Special Enrollment Periods and the Non-Group, ACA-Compliant Market*, Oliver Wyman, February 24, 2016.

**Continuous Coverage**

Encouraging continuous coverage would help to stabilize the individual market risk pool. One of the additional policies being considered in the proposed rule would be to require continuous coverage for 6 to 12 months for individuals trying to enroll during a special enrollment period. This is consistent with the intent of SEPs and would minimize the ability to buy insurance only after health care needs arise. The longer the continuous coverage requirement, the stronger is the incentive to remain insured and therefore there is less opportunity to game the system. This could result in lower enrollment during an SEP and some individuals having higher out-of-pocket costs because they are uninsured due to delaying the purchase of insurance until they knew they had a claim. However, such an administrative rule is consistent with insurance principles, consistent with other rules such as HIPAA, and will promote the creation of a sustainable pool. Note that a 6 to 12 month lookback only for SEPs and not for open enrollment could result in a situation in which an enrollee who initially purchases coverage without penalty during open enrollment is penalized when they use an SEP in the first part of the year for a valid reason, such as a relocation. One option to avoid this possibility is to waive the requirement for those who enroll during the most recent open enrollment period.

Another way in which to encourage continuous coverage is implementation of a 90-day waiting period prior to coverage beginning if an individual cannot demonstrate proof of continuous coverage when enrolling during an SEP. This is not as effective as denying coverage altogether, since there could be some high-cost procedures that could be deferred for 90 days (e.g., knee replacement). However, it is more effective than not having any penalty.

CMS is also considering assessing a late enrollment penalty when an individual cannot demonstrate proof of continuous coverage when enrolling during a SEP. This type of penalty is consistent with Medicare Parts B and D in which a premium surcharge is imposed on beneficiaries who enroll after their initial eligibility date. The surcharge is increased for each month coverage is deferred after the initial eligibility date and is payable for as long as the beneficiary has coverage. Coupled with government subsidized premiums for all Medicare-eligibles, these surcharges have resulted in extremely high Parts B and D enrollment rates. The effectiveness of the penalty will be dependent on the amount, which, as with Medicare Parts B and D, could increase with the length of time the individual is lacking continuous coverage, and the length of time that the penalty would be paid. Presumably, current law would preclude such a penalty when an individual enrolls during the annual open enrollment period. The penalty could be structured such that the penalty, plus the remaining months of premium for the rest of the year (since this applies during a special enrollment period which is, by definition, after the close of the open enrollment period and thus would represent coverage for less than a full calendar year), would exceed an annual premium, thus removing any financial incentive from trying to use an SEP to avoid a full year of premium costs.

**Levels of Coverage – Actuarial Value (§156.140)**

The proposed rule would amend the definition of *de minimis* to –4/+2 for all non-grandfathered individual and small group plans that are required to comply with actuarial value (AV).

*Impact on AV Compliance*
This proposed rule does not expand the range of choices for bronze plan design from the previous regulations. An expanded band could make it easier for plan designs to comply with the range, especially for ensuing years. The current band coupled with an updated AV calculator requires more frequent changes in cost sharing to existing plans in order to stay within the required range. An expanded band will allow for less frequent changes.

We support efforts to limit changes to plan designs from year to year. While decreasing the lower bound of the *de minimis* range for standard plan actuarial values from –2 percent to –4 percent would increase the range of plan choices, this change would not necessarily help 2017 plan designs that are no longer compliant under the 2018 AV calculator. Actuarial values generally increase from one year to the next due to the leveraging of fixed cost-sharing parameters. A wider *de minimis* band would give plans that start closer to the –4 percent lower band in 2018 more room to grow for 2019. This has a limited effect on the need for issuers to change plan designs for 2018, as actuarial values are more likely to have increased beyond the upper end of the *de minimis* range of their 2017 metal tier. Correspondingly, delaying the implementation of this change to 2019 likely would not help promote plan design stability until 2020. In order to help stabilize plan designs in the year of implementation, an increase to the upper end of the *de minimis* range would be more beneficial. We recognize that this could cause problems specifically for the 73 percent silver cost-sharing reduction plan variation in the individual market, which is currently required to have an actuarial value two percentage points higher than the standard plan on which it is based. Since the AV calculator is used to evaluate both individual and small group plan designs, any efforts to promote plan design stability through the expansion of the AV *de minimis* range would benefit both markets.

*Impact of Plan Variations*
A wider *de minimis* band would increase the variety of possible plan designs, which could in turn increase consumer choice in both the individual and small group markets but could also create consumer confusion due to the number of alternatives within a metal level. This change would not impact bronze plans because, as noted in the 2018 Notice of Benefit and Payment Parameters (NBPP), the leanest possible bronze plan that is compliant with federal restrictions has an AV of approximately 58.5 percent. Widening the *de minimis* range makes it possible to have plan designs that are more similar to plans in a different metal tier than within a metal tier (e.g., a gold plan with 76 percent AV would be more similar to a silver plan with a 72 percent AV than another gold plan with an 82 percent AV).

With no other changes, the new *de minimis* rules for AV would allow plan designs that are simultaneously compliant with the bronze and silver metal tiers in the 2018 AV calculator. This could occur because the 2018 NBPP also expanded the upper end of the *de minimis* range to +5 percent for certain bronze plans (i.e., those that are either qualified high deductible health plans or provide coverage for a significant service prior to meeting the deductible). The proposed rule retains this exception for certain bronze plans. Furthermore, the AV calculator uses different underlying data tables for calculating bronze AVs than silver AVs. Because of the use of different underlying data for the different metal levels, it is possible to design a plan with AVs that are simultaneously less than the upper end of the bronze AV range of 65 percent using the

bronze tables, and greater than the proposed lower end of the silver AV range of 66 percent using the silver tables, through the most recently published version of the 2018 AV calculator.

*Impact on Premiums and Out-of-Pocket (OOP) Costs*
We note that allowing lower AVs within each metal tier could provide rate relief to enrollees in the form of lower premiums, except at the lowest cost bronze tier as previously discussed. This would benefit both markets, but lower premiums in the silver tier could serve to decrease the cost of the marketplace benchmark plan in the individual market. This would decrease premium tax credits for those under 400 percent of the federal poverty level. Depending on the degree of decrease, this could prevent members with premium tax credits from experiencing rate relief, based on the same considerations that saw these consumers cushioned from the higher rate increases often associated with 2017 plans. These lower premiums (and lower tax credits) would be offset by higher member-paid cost sharing for enrollees who are not enrolled in silver cost-sharing reduction plan variations. Enrollees with silver CSR plan variations may or may not see lower premiums, but would not experience the corresponding change to cost sharing, as cost-sharing reduction subsidies owed to issuers by the Department of Health and Human Services (HHS) would increase to offset any leaner standard plan actuarial values. Given the current uncertainty around appropriations of cost-sharing reduction subsidies, increasing CSR subsidy amounts is likely to create greater concern among marketplace issuers and as such may destabilize the market unless cost-sharing reductions for 2017 and 2018 are fully funded.

*Impact on Risk Adjusters*
We note that changes to the *de minimis* range should be accompanied by an evaluation of the risk score coefficients. As the *de minimis* range expands, especially in a non-symmetric fashion, the plan designs used to develop the risk score may no longer be representative of the most common plan designs in the market. Additionally, as the AV gap between metal tiers decreases, the cost difference between plan designs at the upper end of one metal tier and the lower end of the adjacent metal tier may no longer be accurately represented by their difference in risk scores.

**Revised Timeline for Rate Filings**
According to the CMS Feb. 17 2017, bulletin,[5] Qualified Health Plan (QHP) applications for coverage effective Jan. 1, 2018, are required to be submitted by June 21, 2017. However, in states with an effective rate review program, the date for filing proposed rate filings for single risk pool coverage is set by the state, as long as it is not later than July 17, 2017. CMS should be aware that if a state sets a date after June 21, 2017, it is possible that the QHP application, which contains a rate table template, will include "dummy rates," which will need to be refiled once the Unified Rate Review Template (URRT) and proposed rates are completed by an issuer. This may require additional work by reviewers of the QHP application. Some states require earlier filing dates, which will be problematic for affected issuers if they are required to submit rates prior to finalization of all the regulations.

[5] Centers for Medicare & Medicaid Services, "DRAFT Bulletin: Revised Timing of Submission and Posting of Rate Filing Justifications for the 2017 Filing Year for Single Risk Pool Coverage; Revised Timing of Submission for Qualified Health Plan Certification Application," Feb. 17, 2017.

However, having a date of July 17, 2017, as the latest date for filing proposed rates allows issuers a short amount of time to consider the results of the 2016 risk adjustment results, which may result in fewer revised rate filings.

With the Aug. 16, 2017, date for finalized rate filings that include QHPs in the URR system, CMS should be aware that for states that require rate filings no later than July 17, 2017, the turnaround time of 30 days for reviewing, requesting additional information, and finalizing rates is unrealistic. This will result in reviewers having to rush the process in order to meet deadlines and could potentially result in filing errors that are not identified in the review process where historically 60-90 days has been required. An alternative would be to establish a later date on which the rates must be finalized on the URR system.

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We appreciate the opportunity to provide these comments and would welcome the opportunity to discuss them with you in more detail. If you have any questions or would like to discuss further, please contact Heather Jerbi, the Academy's assistant director of public policy, at 202-785-7869 or Jerbi@actuary.org.

Sincerely,

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Chairperson, Individual and Small Group Markets Committee
American Academy of Actuaries