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December 20, 2015

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-9937-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Notice of Benefit and Payment Parameters for 2017

To Whom It May Concern,

On behalf of the American Academy of Actuaries'[1] Risk Sharing Subcommittee, I would like to provide the following comments related to the risk adjustment, reinsurance, and risk corridor components of the proposed rule for the 2017 benefit and payment parameters. In addition, we offer comments on a number of other provisions in the proposed rule.

Proposed Updates to the Risk Adjustment Model (§153.320)

Interim Estimates

It is important that issuers receive information pertaining to their relative risk during the benefit year. Such interim reports during the benefit year will create greater premium stability and help protect against uncertainty in rates, especially after issuers gain more experience with how the interim estimates change from quarter to quarter. In addition, providing interim estimates would help issuers to derive more accurate risk adjustment accruals and, therefore, more accurate financial reporting and solvency measurement for the experience year.

Interim reports would be valuable, particularly for issuers with a small market share. Issuers with a large market share are more likely to have average risk scores close to the market average, which gives these issuers a potential advantage in pricing because they may have more confidence about the market risk level and subsequent risk adjustment transfers when pricing the upcoming benefit year. Consequently, the existence of interim reports would help level the playing field across issuers.

Interim reports should include the issuer's calculated risk scores, the market-wide risk scores, and the other components of the payment transfer formula, including the state average premium. Because interim risk-score calculations may not fully reflect eventual risk adjustment payments

[1] The American Academy of Actuaries is an 18,500+ 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 qualification, practice, and professionalism standards for actuaries in the United States.

and receipts, CMS may want to consider publishing additional details such as the issuer's market share, market average distribution by metal plan, market allowable rating factor, and market proportion of claims with hierarchical condition categories (HCCs).

We suggest that CMS collect information from issuers and provide interim reports on a quarterly basis. Issuers would need to populate the distributed data server as completely as possible on a quarterly basis to assure validity of the interim reports. CMS may want to disclose any issues with completeness of data in the report so that issuers can take this into account when reviewing results. CMS might consider beginning the process in the spring of 2016, after the deadline for submissions for the early reinsurance payment, by providing an interim report on 2015 risk score results. We believe it is important to begin the interim report process as soon as practicable so that issuers have a history of interim estimates that can be used to interpret future reports.

Prescription Drug Data in the Risk Adjustment Methodology

Including prescription drug data in risk adjustment has been shown to improve a risk adjustment methodology's predictive power. It also would allow diagnoses to be identified sooner in the calendar year, which could increase the accuracy of any interim reports provided.

We see other potential benefits from incorporating drug data into risk adjustment. Currently, some issuers provide supplemental files with diagnoses documented by chart reviews when these diagnoses are not recorded on medical claim records with service dates in the benefit year. In principle, drug claims could be used to assign the HCC for a diagnosis that may not have been recorded on a medical claim by a provider during that benefit year. Using claims to assign the HCC could benefit issuers that are not currently providing supplemental files and could save some administrative expense for issuers that are providing supplemental files.

In implementing this concept, it would be important to consider situations in which a given drug may be approved (or, in practice, used on an off-label basis) to treat multiple chronic conditions, thus raising the possibility of inaccurate HCC assignments. Consideration also should be given to whether using drugs in risk adjustment could create an incentive to overprescribe. Because prescription drugs are more treatment-based than diagnosis-based, and more discretionary in nature than some medical procedures, pharmacy data are more susceptible to gaming than diagnosis-based data. These concerns need to be balanced with the desire to enhance the risk-adjustment methodology's predictive power.

High-Cost Enrollees

We agree that it is important for the risk adjustment methodology to adequately compensate issuers for high-cost conditions so that issuers do not engage in risk avoidance of high-cost enrollees. In particular, it is important for the risk adjustment methodology to adapt to new high-cost treatments. We acknowledge that the incorporation of new data (e.g., 2014 data being incorporated for the 2017 model) in the calibration of the risk weights helps matters, but that help is limited because the use of three-year averaging means it will take three years for the risk weights to fully reflect changes in treatment patterns.

Partial-Year Enrollment

Partial-year enrollees may have experience that is not adequately predicted by the current methodology of prorating the risk score by the proportion of the year enrolled. Many medical

events for enrollees in the commercial market represent acute (e.g., maternity, surgeries) rather than chronic events, so the enrollee can incur most of their annual medical expenses during a short period of time. In addition, with respect to partial-year enrollees with chronic conditions, the likelihood is increased that the enrollee may have prescription drug claims related to that chronic condition but not a provider encounter with a documented diagnosis. The incorporation of drug data in the risk adjustment methodology as discussed above could help with this type of circumstance.

The impact of partial-year enrollment could be measured by taking a population that had multiple years of enrollment and comparing risk scores and health care costs when only a partial year is considered. Massachusetts implemented adjustments for partial-year enrollment. CMS may want to consider additional analysis to determine whether that approach is appropriate for the federal risk adjustment methodology.

Preventive Services

We agree that incorporating no-cost-sharing preventive services in the modeling of plan liability for the calculation of risk weights is appropriate.

Risk Adjustment Payment Methodology – Use of Total Premium rather than Premium Net of Certain Expense Components

Although comments were not requested on the payment transfer formula, we would like to reiterate a comment this group made previously regarding an element of the payment transfer formula that may create a bias against enrollees without HCCs. The payment transfer formula is based on state average premium rather than the portion of premium for claims costs and expenses that may vary based on claims. As this group commented in its April 30, 2013 comments on the final benefit and payment parameters for 2014:[2]

> "This results in the formula transferring portions of the expense loads that are needed to support members with low risk scores. For example, some administrative expenses (e.g., billing and the temporary reinsurance contribution) could be expressed as fixed dollar amounts per member. Other regulatory fees, including exchange fees, and taxes are based on a percent of premium charged to the member. Transferring a portion of these expenses may create a shortfall for issuers with large numbers of members with low risk scores. While it is appropriate for the risk-adjustment methodology to compensate issuers for insuring members with certain conditions, all members should be treated the same so that the risk-adjustment methodology does not create biases towards certain segments of enrollees."

We suggest that CMS consider basing the payment transfer on a portion of state average premium—namely, the portion representing the sum of claims, claims adjustment expenses, and taxes that are calculated on premium after risk adjustment transfers. Such an undertaking could be accomplished by using a specified percentage of state average premiums. The specified percentage would be determined based on data submitted by issuers on the Unified Rate Review Template (URRT) for the portion of premium needed for claims and on data from financial reporting statements for claim adjustment expenses and relevant taxes as a percent of premium.

[2] http://actuary.org/files/Acad_letter_on_3Rs_IFC_043013.pdf

The specified percentages could be calculated so as to vary by state or market. Some taxes (e.g., premium taxes) may be calculated on premium after risk adjustment transfers, so it would be appropriate to include provision for these taxes in the risk adjustment transfers.

Risk Corridor/Medical Loss Ratio (MLR) Data Requirements (§153.530)

CMS proposes, for 2015 and later benefit years, to require issuers to true-up claims liabilities and reserves used to determine the allowable costs reported for the preceding benefit year risk corridor to reflect the actual claims payments made through June 30 of the year following the benefit year. In addition, the runout period for both risk corridors and MLR will be extended to six months. CMS requests comments on how to handle the runout true-up for the final risk corridor calculation, suggesting four alternatives: true-up in a 2017 calculation, a simplified true-up process, require 2016 IBNR to be based on 2014 and 2015 actuals, or no true-up.

We understand the desire to ensure accuracy in the calculation of the risk corridors. The results of the risk corridor calculation are incorporated into issuers' MLR calculations, which impact the resulting calculation of potential customer rebates. Because the risk corridor calculation is an input into the MLR, we concur that the runout requirement for the MLR and risk corridor should be consistent.

The main actuarial issue is whether six months of runout is materially more accurate than three months of runout. This question was raised and studied by regulators and interested parties in 2010 in assessing the length of runout to use in the calculation of the MLR for rebate purposes. The National Association of Insurance Commissioners (NAIC) did its own study using data regulators received from health issuers, and in Issues Resolution Document (IRD010),[3] the NAIC determined that the potential effect of errors resulting by using three months of runout instead of six months in the MLR calculation would be minimal.[4]

Administratively, and for auditability of results, the length of runout period to use for MLR purposes was first determined to leverage the work of issuers' quarterly financial filings; the resolution to use three months of runout instead of six months was a balance between accuracy and timeliness of potential rebates to consumers.

Two additional issues that result from changing the MLR and risk corridor runout periods from three months to six months should be considered.

First, there would be an administrative burden to issuers to change the processes that they have created to support the MLR and risk corridor calculations using three months of runout. Issuers have created processes that support the annual statement view of incurred claims, as reported in the NAIC's Supplemental Health Care Exhibit (SHCE), as well as the need to reconcile the MLR to the SHCE, and then reconcile the RC to the MLR. This process is important, as risk corridor-eligible segments of business generally are subsets of MLR-eligible segments, and there are

[3] See pages 19-22 in the following: http://www.naic.org/documents/committees_lhatf_ahwg_ppaca_ird_master.pdf

[4] In IRD010, the study showed that after three months of runout following the end of the calendar year, the remaining reserves were roughly 1 percent of the total incurred claims for that calendar year. Therefore, any error in the remaining reserves after three months should be isolated to a portion of approximately 1 percent of incurred claims, and should have minimal impact on the ultimate results in either the risk corridor or in the MLR.

classification differences that may exist among them. To change these processes to reflect six months of runout instead of three months is a significant amount of work for a minimal expected change to risk corridor results.

Second, given that the risk corridor is a temporary program that expires after 2016 is reported, these additional burdens should be considered in light of the permanent impact it would have on the MLR. If such a change were introduced, it would permanently alter the timing of the MLR form, and delay the payment of potential rebates to consumers. It should be noted that the original MLR filing was due June 1, which was used to allow issuers sufficient time to complete first-quarter financial filings due May 15 and then compile additional data needed for the MLR. If six months of runout were required, the earliest reasonable date for issuers to complete the MLR form would be Sept. 1. Not only does that delay payment of potential rebates to consumers, the additional delay may make it more difficult to find eligible consumers.

For these reasons, we recommend maintaining the use of three months of runout for both the MLR and risk corridor calculations. Additionally, given the temporary nature of the risk corridor program, and the likelihood that the results of the risk corridor calculation will not be improved materially by using additional runout, we recommend that once the annual risk corridor calculation is completed, that it not be recalculated at a future point in time with further runout.

Treatment of Risk Corridor in MLR Due to Proration

Adjustments to risk corridor and MLR calculations are described to reflect changes to risk adjustment, CSR values, and reinsurance payment amounts that developed after the prior-year submission of risk corridor and MLR. But what about adjustments for changes to the risk corridor estimate, particularly in the context of the proration (reduction/deferral) of 2014 benefit year payments?

The current MLR formula presumes full payment of risk corridor amounts. However, the current revenue-neutral status of the risk corridor programs makes the timing and magnitude of risk corridor payments uncertain. This uncertainty could put issuers in a position of paying rebates due to the full reflection of risk corridor amounts that the issuer may never receive.

We suggest the following:

- The 2015 MLR calculation should include an adjustment for the amount of 2014 risk corridor that is unpaid at the time of the MLR filing;
- In the 2015 MLR calculation, issuers should be required only to include the portion of the 2015 risk corridor receivable that they are allowed to admit under NAIC accounting guidance (taking into account funding and associated collectability concerns);
- Future MLR calculations beyond 2015 should include risk corridor payments received during the benefit year on a cash basis, rather than on an accrual basis.

Fair Health Insurance Premiums (§147.102)

Rating Areas (§147.102(b))

CMS seeks comments on whether there should be more uniformity in the size of rating areas or whether it should establish a minimum size for rating areas, how CMS could improve uniformity and sufficient size for risk pooling, and whether and how to align rating areas and service areas.

Contiguous geographic areas and relative population are mentioned as two ways to possibly achieve uniformity and sufficient size.

States are best suited to determine how rating areas should be established, based on their geographies and issuer networks. The current guideline for establishing a maximum number of rating areas, without detailing the composition of such areas, serves to limit the number of rating areas in each state and allows each state flexibility to work with its issuers to craft rating area boundaries. This process allows rating areas to appropriately align with patterns found in the delivery of health care services, rather than forcing rating areas to align with other geographic boundaries or to represent a minimum population size.

Child Age Rating Factor (§147.102(e))

CMS seeks comment and data on the most appropriate child age curve, and the policy reason underlying any recommendation.

The current default child age rating factor is 0.635, and the factor for ages 20-24 is 1.000. The curve assumes that the cost of the child is 63.5 percent of the cost of ages 20-24, which could mean that the child age factor may be set too low. Also, there is wide variation in cost within the current child age range of 0-20, with costs at the very young ages being several multiples of the cost at the high end of the range. CMS should consider using data consistent with data used to calibrate risk adjustment to determine child age factors.

Student Health Insurance Coverage (§147.145)

CMS proposes to exempt student health coverage, effective Jan. 1, 2017, from the actuarial value (AV) requirements under Section 1302(d) of the ACA; however, the plans would still require an actuarial certification that they provide an AV of at least 60 percent. CMS is requesting comments on whether the AV calculator should be used to determine the AV for student health plans.

If the goal for student health coverage is to ensure that the benefits are consistent with exchange plans, then using the AV calculator is appropriate. In the ACA individual and small group markets, AV is intended to give a general sense of plan generosity, regardless of who in particular signs up for that plan.

However, if the goal is to ensure that the student health insurance provides at least 60 percent AV for a student population, then the AV calculator may not be appropriate due to the differences between the student population characteristic compared to the population underlying the current AV calculator. An AV calculator based on a student population would provide a more accurate determination of the benefit actuarial value for student populations. Requiring AV to be calculated with a student-based population would require lower cost-sharing requirements, which in turn could result in higher premiums from using an AV calculator.

Grace Period (§155.400(g))

CMS proposes to allow on renewal a three-month grace period to enrollees who are receiving advance premium tax credits (APTC), regardless of whether a binder payment is required. This proposed change has a potential adverse actuarial impact on the risk pool and adequate premium determination. Under this proposal, an enrollee could exercise this option any January on

renewal. The existence of a three-month grace period allows an enrollee an opportunity to wait and see whether a medical event is likely to occur before paying premium, or alternatively to receive costly medical services during this extended grace period, complete treatment, and avoid paying premium. APTCs received by the issuer during the grace period were not intended to, nor do they in practice, offset this adverse selection risk. Enrollee adverse selection is a difficult actuarial challenge, and the existence of additional adverse selection opportunities results in higher premiums. Because there is no material downside risk to the enrollee for exercising this option, such a change could contribute to financial losses in an issuer's block of business. These losses create further pressure to increase premiums and exacerbate potential solvency issues.

Hardship Exemptions §155.605(d)(2)

CMS proposes to add many additional criteria to enable individuals to claim the hardship exemption and not be subject to the financial penalties resulting from failure to purchase health insurance.

Any expansion of these criteria would weaken the individual mandate, which, in turn, exerts upward pressure on rates because it is more likely that healthy people would have more financial incentives to seek the hardship exemptions. Many of the criteria listed are not well defined and would be difficult to verify. Furthermore, individuals could claim a hardship exemption up to three years from the date of the criteria. We believe this would be difficult to administer.

While upward pressure on premium rates for any one of the proposed changes discussed may appear to be minimal, the cumulative impact of these proposals over time may be material.

Small Group Considerations

Guaranteed Availability (§147.104)

CMS is considering whether to prohibit issuers from employing minimum participation or contribution rules, both with respect to states that have expanded their definition of small employers up to 100 employees and with respect to all small employers.

For the following reasons, we suggest CMS retain the existing minimum participation and contribution rules in the small group market.

Currently issuers in the small group market are able to employ minimum participation and contribution requirements as a condition of guarantee issue. The only exception is for the one-month period, Nov. 15-Dec. 15 of each year, when issuers must accept all small groups regardless of whether the group meets the participation and contribution requirements.

Participation and contribution requirements historically have been employed in the group market for several reasons:

- Minimum Participation Requirements
  - To minimize selection that could occur if only the less healthy employees (and/or employees with less healthy dependents) enrolled while the healthy employees opt out.
  - To prevent “case stripping” or “group splitting” in which a few employees and/or dependents with expected high medical costs remain under the plan and the remainder

drop coverage, purchase less expensive group coverage elsewhere, or participate in a self-funded plan with the same employer.
    - Prior to ACA, some states would not allow a small group to be insured unless the group met minimum participation levels.[5]
- Minimum Employer Contribution Requirements
    - To ensure that the employer is a bona fide group as opposed to a group that was formed for the sole purpose of obtaining insurance. Individuals with high claim costs would be more interested in joining a group formed solely for the purpose of obtaining insurance than healthy individuals.
    - To reduce selection by making insurance more affordable to the employee, thus encouraging healthy individuals as well as high-cost individuals to enroll. Without an employer contribution, there would be more incentive for high-cost individuals to enroll than low-cost individuals, resulting in a higher-risk group.
    - To help groups meet minimum participation requirements, thus minimizing selection.
    - Prior to ACA, some states would not allow a small group to be insured unless the employer contributes a minimum level of the premium.

We recognize that issuers can no longer require participation and contribution levels in the large group market. However, issuers have much more rating flexibility in the large group market and can impose surcharges to groups that fail to meet minimum standards.[6] This rating flexibility is not available in the small group market, and the employer mandate does not apply to small employers.[7] Minimum group participation requirements and employer contribution requirements help to negate the absence of the employer mandate in the small employer market and provide the conditions that allow for the creation and preservation of a small group pool with enough healthy members to subsidize the higher-cost members.

Elimination of these requirements could create a situation in which it is possible that the small group pool will lack sufficient healthy members to subsidize higher-cost individuals, which will exert upward pressure on premiums. As premiums increase, there will be more incentives for healthier individuals to drop group coverage.[8] This is one of the conditions that can contribute to a premium spiral over time.

Employer Choice (§155.705(b)(3))

CMS proposes new approaches for employer purchasing options on a Small Business Health Options Program (SHOP) marketplace: 1) a "vertical choice" option under which employers could offer employees a choice of all plans across all available levels of coverage from a single issuer, and 2) an option under which employers could select a level of coverage and employees could choose from plans available at that level and at the level above it across multiple issuers.

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[5] William F. Bluhm, principal editor, *Group Insurance*, pages 513-514. 2007.

[6] The Affordable Care Act (ACA) also requires large employers to offer insurance to 95 percent of their full time employees or face financial penalties as well as penalties to the employer if their employees purchase insurance through the exchange and receive a premium subsidy.

[7] Beginning in 2016, employers with 51 or more full-time employees are subject to the employer mandate. If a state expanded its definition of small employer to 100 employees, there will be a subset of the small employer group pool subject to the employer mandate.

[8] Employees and/or dependents could migrate to the individual market where they may be eligible for premium subsidies or drop coverage altogether, depending upon their premiums after subsidies, if applicable.

Enrollment in the SHOP has been minimal, and as such we understand CMS's efforts to make the SHOP more attractive. Versions of "vertical choice" have been and continue to be prevalent outside the SHOP. Some issuers may provide limits on how many options are available to an employer and/or the variation in options (e.g., the limitation proposed in option 2), while other issuers may allow free choice among all plans being offered by the issuer.

While any employee choice introduces selection, issuers may be more open to choice if they insure the entire group and have some control over which plans are being offered. If employees are given the flexibility to choose among all the plans offered by a single carrier, some issuers may be more hesitant to offer platinum plans, because of the inherent selection possible.[9] The selection could be exacerbated depending on the employer contribution. An employer contribution based on a reference plan would pose the greatest potential for selection because the employee would have to make up the entire difference in premium between the reference plan and the chosen plan. If an employer elects to base a contribution as a percentage of any plan, then the selection will be less, but still greater than if there were no individual choice.

Option 2 would enable the SHOP to differentiate itself from the off-SHOP market. As referenced above, many issuers are offering some type of choice off-SHOP, but only within products marketed by the single issuer insuring the group. Participation requirements off-SHOP effectively preclude the employer from offering plans from multiple issuers. As indicated previously, any expansion in choice at the individual level increases the probability of selection. Under Option 2, we would expect individuals selecting more generous plans have a greater probability of being higher cost than the individuals selecting the lower-cost plans. The one-metal-above limit will help to mitigate some of the selection. CMS needs to consider the additional administrative costs of allowing this.

SHOP Employer and Employee Eligibility Appeals Requirements (§155.740)

CMS proposes to allow employers and employees who successfully appeal a denial of SHOP eligibility to select whether the effective date of coverage or enrollment will be 1) retroactive to the effective date of coverage or enrollment that the employer or employee would have had if they had correctly been determined eligible, or 2) prospective from the first day of the month following the date of the notice of the appeal decision. Currently, the regulations require all SHOP appeal decisions to be retroactive to the date the incorrect eligibility determination was made.

Allowing the employer to choose the effective date of the coverage following the appeals process will result in selection and upward pressure on rates. Groups that incurred significant claims will opt for the earlier effective date, and groups that did not incur significant claims will opt for the later effective date. We can look to COBRA history to ascertain the impact such choices have. Under COBRA, an employee can wait 60 days to elect the extension of coverage. Coverage must be retroactive, but employees do not have to choose coverage at all. Those individuals who have claims during the 60-day election period have a financial interest to opt for the extension (and the retroactive effective date), and those that have not had claims generally waive coverage. The

[9] Presumably, issuers that currently impose a limitation to employee choice among plans would be the issuers most apt to eliminate the most generous plans.

COBRA experience routinely shows that claims are much greater than 100 percent of premiums. We would expect the same type of pattern for groups if allowed the choice of effective dates.

We suggest that either CMS retain the current regulatory language or adopt an effective date that is the first of the month following the appeals decision, but does not allow each group to choose.

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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,

Barbara W. Klever, MAAA, FSA
Chairperson, Risk Sharing Subcommittee
American Academy of Actuaries