April 30, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9964-IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

On behalf of the American Academy of Actuaries'[1] Risk Sharing Work Group, I am submitting the following comments on the final rule, *HHS Benefit and Payment Parameters for 2014*, and the interim final rule (with comment period) that includes amendments to the *HHS Benefit and Payment Parameters for 2014.*

Interim Final Rule – Amendments to HHS Benefit and Payment Parameters for 2014

Calculation of Allowable Costs for the Risk Corridors Program

Allowable costs as a pro rata portion of a QHP issuer's incurred claims

The work group supports the proposed change that would allocate allowable costs based on incurred claims at an aggregate level, rather than using incurred claims specific to each qualified health plan (QHP). As a general rule, risk corridors should mitigate the pricing risk that insurers face when they lack data on health spending for potential enrollees instead of providing protection from fluctuations at a benefit plan level. While using QHP-specific allowable costs does provide some protection, it likely would produce payments to and from the government based on plan-by-plan fluctuations of high-cost claimants and lead to unintended outcomes. For example, consider a QHP issuer with three benefit plan offerings all with identical membership and earned premium. Assume two of these plans have a ratio of allowable costs to target of 97 percent while the third benefit plan has a ratio of 106 percent. In this instance, the QHP issuer would have allowable costs that are 100 percent of target, in aggregate, but would be a recipient of risk corridor payments. The proposed method would not provide a payment for this plan, and the work group believes that is appropriate.

Inclusion of allowable costs for both QHPs and non-QHPs

While the work group agrees with allocating allowable costs based on incurred claims at an aggregated level, we have concerns about including experience for risk corridors for non-QHPs.

[1] The American Academy of Actuaries is a 17,000-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.

As a general rule, risk corridors are intended to apply only to QHPs and, therefore, favorable or unfavorable experience in non-QHPs should not affect the calculation.

As an alternative, incurred claims could be aggregated for all QHPs and then allocated to each QHP on a pro rata basis. This could be based on the earned premium of each QHP as a percentage of total earned premium for all QHPs. Although the single risk pool includes non-QHPs, we believe that premium rates developed for this single risk pool will be appropriate for the portion of the single risk pool comprised of QHPs. It would be inconsistent to disconnect the premiums used for the risk corridor target calculation from the premiums and claims used to develop the allowable costs. Since issuers have the ability to offer QHPs (on and off exchanges) and non-QHPs, and since risk adjustment should effectively mitigate selection differences between QHPs and non-QHPs, there is no need for that inconsistency. This proposal would require issuers to separate QHP and non-QHP claims and risk adjustment payments and charges.

Cost Sharing Reduction (CSR) Reimbursement Simplified Methodology

The proposed simplified method of CSR reimbursement would allow an issuer to use an approximation of cost-sharing differences based on a model of cost sharing derived from experience based on a standard silver plan. The methodology segregates the experience by size of total annual allowed charges into three buckets: effective deductible (D); between D and the effective claim ceiling (EC); and over EC. The resulting formulas are labeled as Formulas A, B, and C.

The actuary should be able to determine if the prescribed formulas replicate the actual cost sharing of the members in the standard silver plan since cost-sharing amounts are readily available from claims data. If the formulas do not replicate the actual cost sharing of the standard silver plan, the actuary could conclude that the formulas also will not accurately estimate the cost sharing that would occur for members in an enhanced plan if they had been enrolled at the standard silver level.

With respect to the benefit design, it is likely that there would be members in Formula B with total allowed charges in excess of D that have claims that contributed to that level from benefits paid at 100 percent and have had encounters with copays. As an example (albeit an outlier), consider a plan with an out-of-network deductible with all in-network benefits only subject to copays or coinsurance. The effective deductible would equal the out-of-network deductible, but most members will not satisfy the deductible or incur charges that apply towards the deductible. In other words, they have not all experienced D cost sharing as defined in Formula B. The same issue occurs when defining EC and application above the EC. We propose that the actuary be allowed some flexibility to use average deductibles and average total cost-sharing parameters to replicate the standard silver cost-sharing experience.

Because the patterns of prescription drug spending (Rx) are relatively distinct, we recommend the actuary not be limited to segregating Rx only when it is administered by a separate vendor.

In addition, if the actuary is not obtaining a reasonable replication of results, the actuary could be allowed flexibility to reduce potential variability. Several examples follow:

a. Allow the actuary to remove benefits paid at 100 percent from the experience in both standard silver and enhanced silver plans since there is not CSR reimbursement on these plans.
b. Allow the actuary to remove out-of-network allowed charges if the cost-sharing parameters are the same in the standard and enhanced plan and thus no cost sharing reduction occurs out-of-network.
c. Allow the actuary to calculate and accumulate "other than self" policies at the enrollee level, if appropriate, based on the underlying plan design (e.g., for plan designs applying individual level deductibles first).

The rule requires an actuarial memorandum developed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies that describes how the effective cost-sharing parameters were calculated for the standard silver plan. If the actuary deviates from the prescribed formula in accordance with the areas outlined above, the actuarial memorandum should include justification to show that the modifications were necessary due to benefit design and result in a more accurate replication of the actual standard silver cost-sharing amounts.

Final Rule—HHS Benefit and Payment Parameters for 2014

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

The payment-transfer formula is based on total average premium rather than the portion of premium for claims costs and expenses that may vary based on claims. 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.

This work group previously commented on this issue in its Oct. 28, 2011, comments[2] filed on the proposed rule related to risk adjustment, reinsurance and risk corridors (Page 24):

> "Relevant to all the premium multiplier options is a discussion of the non-medical component of premium. In general, the administrative costs and target underwriting gain do not change significantly based on the overall morbidity profile of an issuer's enrollees. As such, instead of premium, the average actuarial risk may be multiplied by the premium amount lowered by allowed administrative costs and target underwriting gain. Under the risk corridor discussion, we label this as the *target amount* or *projected medical cost*."

[2] http://www.actuary.org/files/publications/RSWG_comment_letter_on_3R_proposed_rule_111028.pdf

We suggest that HHS consider basing the payment transfer on a portion of premium representing claims and claims-adjudication expenses. This could be accomplished by using a specified percentage of premium to represent an industry-wide level of claims loss ratio and loss-adjustment expenses.

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. This is because issuers would reference them in their pricing and valuation efforts.

Interim reports should include the issuer's calculated risk scores as well as the market-wide risk scores. Since interim risk-score calculations would not reflect true relative risk due to the underlying calibration, HHS also may want to consider publishing informational interim reports with details such as market average prevalence by metal plan, disease, demographics, proportion of claims with HCCs, interaction cells, and infant immaturity and severity combinations along with the issuer's specific prevalence in the same categories.

We suggest that HHS collect information from issuers on a quarterly basis and provide the interim reports each quarter, as is done with the reinsurance program. Issuers should populate the distributed data server as completely as possible on a quarterly basis to assure validity of the interim reports. HHS may want to consider including any issues with completeness of data in the report so that issuers can take this into account when reviewing results. HHS might consider beginning the process in June 2014, which would include first quarter claims data with a three-month runout period.

Risk Adjustment and Reinsurance Data Requirements

The final rule states that the member discharge date rather than the admission date will be used to allocate claims to a benefit year because HHS believes this will ensure that services provided across benefit years will be considered in their entirety rather than being partially or fully excluded from consideration as a result of the data submission guidelines. However, allocation based on the admissions date and "service from" date for reinsurance and risk adjustment better aligns with financial reporting, the medical loss ratio (MLR) calculation, and the risk-corridor program. To address the issue of partially or fully excluding services as a result of the data submission deadline, payments and diagnoses from interim bills could be considered for admissions during a benefit year with discharge dates after the data submission deadline.

We would like to point out that calculation of the issuer's liability is based on admission date. Admission date is the basis of the financial liability and accruals at year-end. All systems are geared to that contractual liability, including claims accumulators. Further, the application of discharge date in the current year likely cuts off a significant number of hospitalizations from the month of December.

In addition, the rule is not aligned with the MLR or risk-corridor calculation methodologies. The MLR and risk-corridor programs match earned premium to incurred liabilities, which is consistent with how health plans are priced. Since the MLR and risk-corridor programs are based

on claims incurred in the benefit year with a three month runout and remaining claim liability, admissions beginning in the benefit year continuing into the next will be included in MLR and risk corridor calculations for the year of admission. However, the reinsurance recovery will occur in the next benefit year's reinsurance settlement. For example, a December 2014 admission with discharge date in 2015 will be included in the issuer's 2014 MLR and risk-corridor calculations, but the reinsurance settlement related to the admission will be recovered in 2016 for the 2015 benefit-year settlement. Similarly, the diagnoses related to the admission will not be considered in the risk-adjustment settlement for 2014, but will be included in the 2015 risk-adjustment calculation.

Issuers with large claims for members who switch issuers at the beginning of the benefit year will not be compensated under reinsurance or risk adjustment for their portion of the claims incurred during the benefit year under this rule unless a process of accepting claims without the discharge date or an interim-type bill is adopted. Clarification is needed on whether the issuer assuming the liability at the beginning of the benefit year will be able to report its portion of the hospitalization when the discharge date falls within the benefit year but the admission date occurred before the member was enrolled with the issuer. In addition, clarification is needed on how admissions spanning renewal dates in the small-group market will be handled. For example, if a small group changes issuers on July 1 and a member is hospitalized with an admission date in May and discharge date of August, are either issuer or both issuers able to report this hospitalization for risk adjustment purposes? Many of these issues can be avoided if issuers were allowed to report based on admission date and allowed to report interim bills for hospitalizations.

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Thank you for this opportunity to provide input. If you have any questions or would like to discuss these comments in more detail, 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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American Academy of Actuaries