December 22, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9944-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Notice of Benefit and Payment Parameters for 2016

To Whom It May Concern,

On behalf of the American Academy of Actuaries'[1] Risk Sharing Work Group, I would like to provide the following comments related to the risk adjustment, reinsurance, and risk corridor components of the proposed rule for the 2016 benefit and payment parameters. In addition, we request clarification on provisions related to benefit coverage and rate review and disclosure.

Risk Adjustment
HHS proposes to update the risk factors used in the risk adjustment methodology for 2016. The risk factors published in the 2014 payment notice for use in 2014 and 2015 were based on 2010 MarketScan data. HHS proposes to update the risk factors for 2016 based on 2010, 2011, and 2012 MarketScan data.

The proposal to use three years of MarketScan data to establish HCC risk scores is reasonable and will help maintain consistent scoring of conditions from year to year. We agree that using multiple years of data will promote market stability and minimize volatility in coefficients for certain rare diagnoses. Consistency in scoring is crucial. Reflecting the most recent condition costs can be volatile because of lower credibility associated with one year of experience, which means that the most recent year's condition costs may not accurately reflect the underlying condition costs. We also agree that blending the coefficients from three separately estimated calibrations would be preferred to pooling data from three sample years because it is more transparent and may ease future calibrations.

The need to reflect accurately the expected risk adjustment transfer in the annual rate-setting of individual and small group ACA-compliant plans is important. Because of changes in HCC

[1] The American Academy of Actuaries is an 18,000+ 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 qualification, practice, and professionalism standards for actuaries in the United States.

scores and the fact that 2015 pricing has already been completed, we believe the three-year average scores from 2010, 2011, and 2012 MarketScan data should not be used in 2015. The 2015 HCC scores should remain the same as the 2014 scores, as they previously have been communicated and used in 2015 pricing. Similarly, the 2013 MarketScan data should not be used in the three-year average to determine 2016 HCC scores unless it is available early enough in 2015 to avoid delaying communication of the final notice of benefit and payment parameters for 2016.

Reinsurance Contribution Submission Process

The proposed rule outlines the process for remitting reinsurance contributions. Contributing entities must complete a submission form no later than Nov. 15, 2014, 2015, or 2016 (or if such date is not a business day, the next applicable business day). In December after the submission date, we recommend that HHS release a report that includes the total amount of reinsurance contributions expected to be collected for the benefit year based on the completed submission forms. This information would be useful for issuers in determining whether the reinsurance pool will be fully funded and whether they should consider any proration in the reinsurance payments when including these amounts in their year-end financial statements.

Uniform Reinsurance Contribution Rate for 2016

The proposed rule requests comments on allowing excess reinsurance funds to roll over for the 2017 benefit year to help stabilize 2017 premiums. If the risk corridor is administered in a budget-neutral manner, the use of all the reinsurance funds in 2016 could increase the likelihood that issuers expecting risk corridor payments will receive full payment. Further, HHS would need to publish final payment parameters for 2017 in early 2016 in order for the impact of reinsurance to be reflected in 2017 premiums. The amount of funds available for 2017 will not be known until after issuers submit final reinsurance claims for 2016 by April 30, 2017. At the time the 2017 payment notice is finalized in early 2016, only the results for 2014 will be final. As it may be difficult to determine the amount of funds that may be rolled over to 2017, we would recommend that reinsurance funds be used in 2016 and not rolled over to 2017.

Uniform Reinsurance Payment Parameters for 2016

The proposed rule provides 2016 reinsurance payment parameters. We recommend that the final reinsurance payment parameters published in early 2015 remain fixed throughout the pricing and rate filing process. During 2014, intent to change the parameters was announced in the May 2014 market standards rule. This created confusion among issuers and regulators because it was unclear whether an intention to propose a change should be relied on for pricing purposes.

Age Limits and Benchmark Plans

The proposed rule clarifies that when designing benefit plans that are substantially equal to a state benchmark plan, even if the benchmark plan includes certain limits or exclusions, the new plan design must be designed to comply with market reforms that applied beginning in January 2014. Specifically, the proposed rule references an example of limiting a hearing aid to children 6 years of age and under, and cautions "both issuers and States that age limits are discriminatory when applied to services that have been found clinically effective at all ages." To the extent a benchmark plan offers hearing aids and/or cochlear implants to children, would a plan need to provide the same coverage to adults? It is important to note that extending benefits to

populations that initially were not included in the state benchmark plan (often these benefits were the result of a state mandate) may result in upward pressure on rates. Clarification on this point would be appreciated.

Rate Review Disclosure

In the section on disclosure and the rate review process, the notice includes a proposal that would change the determination of whether a company has a potentially unreasonable rate increase, thus causing it to be subject to review, to the plan level. One potential implication of this change is a situation in which the company overall has a rate increase less than the threshold rate increase at the product level, but at the plan level (e.g., a bronze plan) may have a rate increase greater than the threshold. This could cause the entire filing to be subject to review, only because of deductible leveraging. This proposal will create additional administrative burden by requiring a higher frequency of issuers' filings to be reviewed, and for each of these, increased effort from the issuer to develop Part II. CCIIO and state regulators potentially would be responsible for reviewing significantly more rate submissions than they do today. We recommend retaining the determination of a potentially unreasonable rate increase at the product level.

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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, Risk-Sharing Work Group
American Academy of Actuaries