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February 28, 2020

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Attention: CMS-9916-P
P.O. Box 8016
Baltimore, MD 21244-8016
Re: Proposed Notice of Benefit and Payment Parameters for 2021

To whom it may concern:

On behalf of the Individual and Small Group Markets Committee and Risk Sharing Subcommittee of the American Academy of Actuaries,¹ we would like to provide the following comments on the proposed rule for the 2020 Notice of Benefit and Payment Parameters (NBPP).

Comments from the Individual and Small Group Markets Committee

Timing for Final Rule

The proposed 2021 NBPP was released on Jan. 31 with comments due on March 2. Because CMS must consider comments, we expect that the final rule will not be released until April at the earliest. We note that April is very late in the product and rate filing timeline. We suggest that an earlier schedule for release and finalization of the NBPP would be better in general and urge CMS to release the final NBPP for 2021 as soon as possible.

Automatic Re-enrollment

Pursuant to last year's government funding bill (Further Consolidated Appropriations Act, 2020), HHS is not proposing to change automatic re-enrollment directly. However, HHS is proposing to

¹ The American Academy of Actuaries is a 19,500-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.

modify redetermination of advance payments of the premium tax credit (APTC) for individuals who would otherwise be automatically re-enrolled in a plan with a \$0 net premium cost to the enrollee. HHS directly proposed reducing the member's APTC to \$0, leaving the member responsible for the full premium cost until they returned to the Exchange for redetermination of APTC eligibility, and indicated that they were also considering simply reducing the APTC so that the premium was nonzero.

We note that members eligible for \$0 premium likely have a low income as a percentage of the HHS federal poverty guidelines and may be less able to bear unanticipated premium costs. This practice could potentially reduce unintended re-enrollment in this specific population, but reporting around work requirements in Arkansas suggests that many individuals will not comply with additional reporting requirements, even if they are otherwise eligible.² As such, reducing APTCs in this manner could be a de facto nonrenewal of these individuals. With the limited impact of the elimination of the individual mandate penalty along with the sharp reduction in nonsubsidized enrollees, the presence of APTCs has proved to be the primary driver of individual market stability.³ Actions that serve to disrupt the availability of affordable coverage for individuals with low incomes could have a negative impact on the individual market and could lead to issuer exits and potentially higher prices than currently exist in these markets. Further, we note that there are already provisions in place that serve to address those who do not engage in APTC reconciliation at tax filing and do not authorize healthcare.gov to obtain updated income information.⁴

There are also operational concerns related to either change. Members might not find out about this new policy until they read any nonpayment of premium notification sent by the Exchange or by the issuer. Members must then log in to healthcare.gov, enter the information necessary to submit an APTC redetermination, and then potentially wait for validation by the Exchange. This could delay availability of APTCs, and ultimately delay financial ability to pay premiums and avoid termination.

It is also unclear how the proposal to eliminate all APTCs for these individuals will interact with Exchange grace periods and special enrollment period eligibility. Would individuals be eligible for the three-month grace period, or the one-month grace period? Would there be any grace period in the absence of a binder payment for coverage in the new plan year? If APTC redetermination occurs following termination, would enrollees be eligible for the "newly eligible for APTC" special enrollment period?

² Kaiser Family Foundation; [Understanding the Intersection of Medicaid and Work: What Does the Data Say?](#); Aug. 8, 2019.

³ *Health Affairs* blog; ["HealthCare.gov Enrollment Declines Slightly; New Rate Review And AV Guidance"](#); Dec. 22, 2019.

⁴ IRS.gov; ["Premium Tax Credit: Claiming the Credit and Reconciling Advance Credit Payments"](#); Jan. 17, 2020.

We also note that, by virtue of receiving a \$0 premium, the federal government is already spending less than the maximum APTC available to these individuals, increasing the likelihood that the member may not owe a reconciliation payment at time of tax filing.

We recommend that HHS not implement this change. If HHS does elect to implement this change, we recommend that HHS provide robust communication to potentially affected enrollees, plans, and Exchanges about how this change will interact with other enrollment-related provisions, including grace periods and special enrollment periods.

Special Enrollment Periods (SEPs)

CMS is proposing to make a number of changes to current SEP rules in the proposed 2021 NBPP. We note that any loosening of SEP rules can have an impact on the level of adverse selection in the market. In general, adverse selection can increase costs for issuers and the market risk pool. We commend CMS for its recent efforts to strengthen SEP eligibility verification and encourage its continued vigilance to keep adverse selection to a minimum.

User Fees for healthcare.gov

User fees for healthcare.gov and Exchange services should be set at a level that is consistent with projections of operating costs, enrollment, and premium levels. As the cost of care has generally increased faster than general inflation and with the expected continuation of this trend, it would be expected that the user fee will decline over time as a percentage of Exchange premiums. As healthcare.gov has evolved, increased operational efficiencies would be expected to provide some additional downward pressure on the user fee. However, we note that there could be offsetting impacts, such as enrollment decreases, which can impact user fees in the opposite direction. HHS noted that any decrease in the exchange fee for the Federally-facilitated Exchange (FFE) and for State-based Exchanges on the Federal platform (SBE-FPs) for 2021 may necessitate increases in both fees in future years. We note that any fee increase that would be noticeable relative to simple claims volatility and premium changes would be of such magnitude that it would likely necessitate an increase even if Exchange fees were left constant for 2021.

Defrayal and Annual Reporting of State Mandates (§156.111)

HHS solicited comments on its proposal for states to report a comprehensive list of all state-required benefit applicable to qualified health plans (QHPs) in the individual and/or small group market under state mandates that were imposed on or before Dec. 31, 2011, and that were not withdrawn or are otherwise no longer effective before Dec. 31, 2011, and any state benefit

requirements under state mandates that were imposed any time after Dec. 31, 2011, regardless of whether the state believes they require defrayal in accordance with §155.170. The solicitation included comments on the information collection requirements, specifically with regard to whether HHS should require any additional information from states as part of the annual reporting submission on state-required benefits.

We suggest that the information collection also include the following information:

1. Amendments since Dec. 31, 2011, to mandates that were imposed prior to Dec. 31, 2011, or changes to regulations related to mandated benefits, with accompanying clarification as to whether CMS believes these changes may create non-essential health benefits and how the non-essential health benefit would be considered;
2. For state-required benefits newly implemented after Dec. 31, 2011, that are not deemed to be in addition to essential health benefits (EHBs) and thus do not require defrayal, either the benchmark plan benefit or existing EHB that provides the benefit;
3. For non-essential health benefits, identification of the entity performing the cost analysis of the mandate as reflected in the state defrayal process; and
4. For non-essential health benefits, whether reimbursement for mandates requiring state defrayal is paid directly to members or to health plans.

HHS intends to provide template(s) reflecting the form and manner of the report that states would be required to use for reporting the required information. We believe that a public comment period would be helpful to ensure that the templates are complete and understandable. The public could comment on the content of the template(s) and HHS would have an opportunity to clarify any requirements that appear confusing and make revisions as a result of the comments, if necessary.

Clarification is needed concerning when the state is required to defray the cost of a mandate revision. Some believe that if the scope of a mandate is increased after Dec. 31, 2011, for a mandate imposed prior to Dec. 31, 2011, that the state is not responsible for defrayal of the additional cost, and others believe that the state is responsible for defrayal of the additional cost. Additionally, we seek clarification with regard to the extent that any state requirements related to member cost-sharing and any state adjustments to annual service limits could be considered changes to the scope of a non-essential health benefit, as both of these changes can affect actual costs as described in this rule, should changes to scope of an existing mandate be required to be treated as subject to defrayal.

HHS solicited comment on whether states are the appropriate entities to continue making these determinations of which state-required benefits are in addition to EHBs. We agree with HHS that the states are better informed to make the determination of which state-required benefits are in addition to EHBs rather than the Exchange or HHS. Presumably the information collection above would be reviewed by HHS and possibly validated by HHS. This would help align state and federal understanding of non-EHB identification and defrayal requirement.

States' EHB-Benchmark Plan Options (§156.111)

While this was not specifically part of the comment request, we note that HHS identified that there is no de minimis threshold with regard to the generosity limitation for state-selected essential health benefit, and separately indicated that the generosity may not exceed a 0.0-percentage-point actuarial increase. As HHS' intent in this section would appear to be limit flexibility on behalf of states in developing an alternative EHB plan, we note that some states might interpret permissibility of a 0.0-percentage-point actuarial increase to permit, for example, a 0.04-percentage-point actuarial increase. If HHS intends this particular rounding-related de minimis, then no change to language is needed. Alternatively, we believe that the language "may not exceed the generosity" is sufficiently clear as to require the generosity of EHB plan be less than or equal to the generosity of the selected comparison plan.

Premium Adjustment Percentage (§156.130)

CMS is proposing to update the premium adjustment percentage using the same methodology as in the final 2020 NBPP, which used the "most recent" projections from the National Health Expenditure Accounts (NHEA) for calculating the rate of per capita premium growth. For the 2020 benefit year, the draft NBPP calculated a premium adjustment percentage based on CMS' 2017–2026 national health expenditure projections that would have produced a maximum annual limitation on cost-sharing of \$8,200 for self-only coverage (\$16,400 for other than self-only coverage). The premium adjustment percentage in the final 2020 NBPP was based on the 2018–2027 national health expenditure projections released in February 2019 (after the release of the 2020 NBPP) and resulted in a maximum annual limitation on cost sharing of \$8,150 (\$16,300 for other than self-only coverage). This decrease in the maximum allowable annual limitation on cost-sharing relative to that in the draft notice required issuers to revise any benefit plans they had developed using the \$8,200 (\$16,400) cost-sharing limitation. While this change seems small, it can be quite disruptive to health plan product development and pricing. For affected plans, a reduction in the maximum out-of-pocket (MOOP) amount could cause the plan to fall outside of permissible metal levels, necessitating changes to other cost-sharing parameters. More broadly, health plan issuers often design product suites, and these changes could impact plans across the issuer's product portfolio to maintain plan relationships and any desired common cost-sharing parameters. These changes have further downstream impacts on health plan pricing and rate filing processes, and last-minute changes can put significant additional stress on these processes, particularly in the event that forms and rates have already been filed with regulators. If CMS again updates the maximum annual limitation on cost-sharing, coupled with the anticipated later release of the final NBPP, health plans may lose confidence in their ability to develop products with MOOPs at or near the maximum limitation. This could in turn lead to increased prices and reduced plan options for consumers in the marketplace. As such, we

recommend that the premium adjustment percentage be based on the most recent NHEA projections at the time of the proposed NBPP, rather than the most recent as of the publication of the final NBPP, to provide more certainty to issuers and regulators, particularly in years where the final payment notice is released within four months of the earliest filing deadlines.

Value-Based Insurance Design (VBID)

In response to a request for comments regarding obstacles to implementation and operational assistance for a value-based plan, we recommend CMS evaluate and publish the effectiveness of the current actuarial value (AV) calculator when assessing VBID products and to either propose any necessary accommodations beginning with the draft 2022 actuarial value calculator, methodology, and user guide or provide issuers with guidance as to how the actuarial value calculator should be modified to reflect a value-based plan.

In response to a request for comment on “how best [to] demonstrate how the cost-sharing structures who affect different consumers, and how to assist consumers in selecting a value-based QHP if it is an appropriate option,” we recommend CMS consider any selection impacts this may cause and consider how the risk adjustment methodology may need to change to mitigate market-specific selection impacts.

Part 158—Issuer Use of Premium Revenue: Reporting and Rebate Requirements

CMS proposes to require issuers to report pharmaceutical rebates retained by pharmacy benefit managers (PBMs) as an offset to incurred claims for the calculation of MLR rebates and proposes changes to §158.140(b)(1)(i). CMS also proposes conforming changes to §158.160(b)(2) to require issuers to report the prescription drug rebates and price concessions described above as non-claims costs.

For PBM retained rebates, it is appropriate to increase non-claims costs under §158.160(b)(2) because the PBM retained rebates are being deducted from incurred claims. The issuer is not receiving these funds, so the decrease in incurred claims should be equally offset by an increase in non-claims costs as the retained rebates can be seen as a “payment” to the PBM for its administrative services.

However, the proposed rule text for §158.160(b)(2)(vii) also requires issuers to add rebates received by the issuer to non-claims costs. Issuer-received rebates represent funds being received by the issuer and are required to be used as a deduction to incurred claims. There is no need to offset this deduction by adding it to non-claims costs because the issuer is receiving funds. If these funds are also added to non-claims costs, the non-claims costs for these issuers will be artificially inflated.

Comments From the Risk Adjustment Subcommittee

Risk Adjustment Coefficients

We appreciate that the proposed payment notice contains coefficients developed by blending factors from 2016 and 2017, and that CMS believes that they provide a reasonably close approximation of what can be anticipated from blending the 2016, 2017, and 2018 EDGE data. However, given the significance of the magnitude of risk adjustment transfers, issuers need the information for modeling and pricing, even on proposed coefficients, much earlier than the timing of the proposed payment notice. This is especially true if CMS continues to release the proposed Payment Notice early in the year rather than in the preceding fall. For 2021, we urge CMS to not wait until the release of the final payment notice to publish the final 2021 blended coefficients using the most recent three years.

In the future, we hope that CMS will be able to provide the two-year blended factors much earlier, perhaps even before the proposed payment notice. If CMS not able to produce final factors earlier in the pricing cycle, CMS could consider moving to using coefficients developed from the two most recent years of available EDGE data rather than three in the risk adjustment model.

Incorporation of More Acute Conditions and Pre-exposure Prophylaxis (PrEP)

The risk adjustment program was developed as a tool to compensate insurers based on the risks of the individuals they enroll, thereby reducing insurer incentives to avoid individuals likely to have high health costs. The program adjusts payments to plans based on enrollee characteristics or conditions that are predictive of health care costs. Notably, risk adjustment varies payments to plans based on predictable health spending differences, as opposed to differences that arise due to random events. Spending due to random events would not be expected to affect selection differences among plans and is generally priced for by the insurer. In general, spending that is predictable reflects chronic conditions rather than acute conditions, but not always.

In the 2021 NBPP, CMS has added some diagnoses to the risk adjustment program that appear to be acute conditions, such as fractures and severe head injury, and therefore outside the scope of what would normally be included in a risk adjustment program.

CMS also proposes to include PrEP in the demographic factors of the risk adjustment model because this is considered a preventive treatment for HIV. The population that is a candidate for this treatment could have a motivation to select an insurer based on their expectation of using this benefit and as such PrEP is a good candidate for being included within the risk adjustment program as a factor assigned to the enrollee using the treatment rather than spread across the population in the demographic factors. More information on the incorporation of PrEP into the

risk adjustment model would be helpful. Such therapies are quite costly. As they have become classified as a preventive service, physicians are likely to prescribe this therapy more often. Thus, past EDGE data may not properly predict future costs. We are also curious as to how CMS will identify PrEP therapies given the rapid development of new therapies.

Changes in Hierarchical Condition Categories (HCCs)

We believe it is both reasonable and appropriate to modify HCCs in light of the shift to ICD-10. We would appreciate CMS using the most recent year of EDGE data to test these changes and publish the impact on risk adjustment transfers.

Efforts to Improve Model Predictive Ability

We appreciate the desire to determine how the risk adjustment model can be improved in terms of predictive ability. However, we believe that any changes need to be implemented in a manner that does not result in significant swings in transfer amounts. In order to adequately comment on the approaches presented in the proposed payment notice, we would need more granular results of the analyses that CMS conducted, rather than the broad description presented in the notice. We also note that the methods that CMS has considered seem more like “patches” to the model. We suggest that it could be more appropriate to approach improving predictive ability by examining the underlying model as a whole. Again, we continue to stress that stability in transfers and related ability for issuers to model future transfers are extremely important to market stability. Any changes to the risk adjustment model should only be made with that in mind.

Cost-Sharing Reduction (CSR)

We agree that the risk adjustment model should incorporate specific factors for CSR enrollees. CMS has previously indicated that it will examine that update in the current factors. We believe that it is important that CMS do so in the near future.

Risk Adjustment Validation (RADV)

We believe that the proposal to not consider as an outlier any issuer’s failure rate for an HCC group in which that issuer has fewer than 30 HCCs is a positive move. We recognize that this addresses a credibility issue. We would like to understand how many issuers are impacted by this change. Although we agree with this proposal, we view it as a positive “patch” for the process, as opposed to addressing the larger problems with RADV. We encourage CMS to carefully

consider the comments and suggestions in our response to the RADV paper.⁵ We continue to believe that it is important that CMS address these larger RADV issues.

We support the proposal to have the 2019 benefit year serve as a second pilot year for purposes of prescription drug data validation. We note that this is consistent with the two-year pilot for HCCs, and gives issuers time to better understand the financial impact. We encourage CMS to provide each issuer with reports of the findings during the pilot.

We appreciate the opportunity to provide comments on the 2021 proposed Notice of 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 Craig Hanna at 202-223-8196 or hanna@actuary.org.

Sincerely,

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⁵ [Subcommittee Comments on HHS-RADV White Paper.](#)