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July 2, 2020

Centers for Medicare & Medicaid Services (CMS)  
Department of Health and Human Services (HHS)  
Attention: CMS-9913-P  
Mail Stop C4-26-05  
P.O. Box 8010  
Baltimore, MD 21244-8010

Re: Amendments to the HHS-Operated Risk Adjustment Data Validation Under the Patient Protection and Affordable Care Act's HHS-Operated Risk Adjustment Program

To Whom it May Concern:

On behalf of the Risk Sharing Subcommittee of the Health Practice Council of the American Academy of Actuaries,<sup>1</sup> we would like to provide the following comments on the proposed Amendments to the HHS-Operated Risk Adjustment Data Validation Under the Patient Protection and Affordable Care Act's HHS-Operated Risk Adjustment Program rule.

We appreciate CMS' desire to improve the RADV program, and in particular the efforts to lessen transfers and reduce uncertainty for insurers. What follows are comments on specific aspects of the proposed rule.

### **HCC Grouping for Failure Rate Calculation**

CMS proposes to modify the creation of HHS-RADV Hierarchical Condition Category (HCC) failure rate groupings and place all HCCs that share an HCC coefficient estimation group in the adult risk adjustment models into the same HCC failure rate grouping. We believe that this change will be an improvement to the HHS-RADV methodology. If an HCC is not validated but is replaced by an HCC within the same group with the same coefficient, there is no effect on the risk score and the deletion and replacement should not be counted as a failure. We suggest that CMS continue to review the grouping methodology with respect to hierarchies. As noted in the proposed rule, if HCCs within a hierarchy are in different failure rate groups, a deletion and replacement may result in an error if the issuer is an outlier in one of the failure rate groups.

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<sup>1</sup> 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.

However, the error may not be in the same direction as the difference in risk score. If the HCCs within a hierarchy are in the same failure rate grouping, the deletion and replacement offset each other, even though the risk scores are different. This could mask systemic upcoding.

### **Sliding Scale Adjustments**

Broadly speaking, equitably reducing RADV transfers would promote stability. The sliding scale adjustment proposed by HHS would generally accomplish this, according to modeling done by HHS, by phasing in the RADV adjustment from zero at the edge of the confidence interval to the full adjustment to national average coding for issuers at least three standard deviations from the mean (the 99.7% confidence interval). However, we note that HHS has proposed to move the edge of the confidence interval from the 95<sup>th</sup> percentile to the 90<sup>th</sup> percentile, which would be expected to approximately double the number of issuers identified as outliers and increase the number of state risk adjustment pools with RADV transfer adjustments. This will increase the number of issuers that will be required to reflect RADV transfer adjustments, and while financial impacts will be smaller, logistical impacts may be greater. Ultimately, it would be appropriate for issuers to be adjusted to the edge of the confidence interval rather than to the mean failure rate, or at least for the 95% outlier determination threshold to be retained.

### **Flooring Group Failure Rates at 0 When Calculating Error Rates**

HHS is considering flooring group failure rates at zero in the error rate calculation process. This would generally prevent issuers that were identified as coding fewer HCCs in a given failure group than were actually present in their data from benefiting from the portion of diagnosis codes that were not identified. This would reduce potential issuer incentives to try to take advantage of the RADV process through an intentional under-representing diagnosis codes in EDGE data in an attempt to get a large enough RADV adjustment to offset the lost revenue during the standard risk adjustment process, though we note we anticipate this incentive to be relatively minor, particularly given the extended time period between risk adjustment and RADV transfer adjustments finalized in the 2019 notice of benefit and payment parameters. However, we also note that this does not necessarily reflect the “outlier” portion of the negative outlier, as results from both 2017 and 2018 indicate the lower bound for both the low and medium HCC failure groups are negative.

### **Prospective vs. Concurrent Application**

HHS is considering updating the plan transfer calculation to apply concurrently—that is, to adjust risk scores from benefit year used to determine the RADV adjustment, instead of applying adjustments prospectively to the following year’s risk scores. This change would be appropriate, as HHS currently applies adjustments concurrently for issuers that exit the market. More importantly, this connects the RADV transfer adjustments with the benefit year that causes those transfers, which would remove the impact of differing premium levels, plan mix, and market penetration between the two benefit years on risk adjustment transfer payments. We further note that the original basis for prospective application was driven by the desire to administer RADV transfers as part of the standard risk adjustment transfer process. With the significant extension of the RADV transfer timeline put forth in the 2020 HHS Notice of Benefit and Payment

Parameters final rule, that support no longer exists and there is little other support for using prospective application.

We note that HHS is proposing to use an “average error rate approach” in order to facilitate a single payment transfer for both 2020 and 2021 risk adjustment data validation. This specific approach would create a single “average” error rate that applies to 2021 risk scores. We note that we are aware of many issuers that report RADV transfer adjustments as applicable to the benefit year being adjusted. For these issuers, the “average error rate approach” would align well with their reporting practices, as it is in effect a single-year adjustment. However, some issuers may choose to attribute RADV to the benefit year used to develop the adjustment. For these issuers, the “average error rate approach” would effectively dampen the RADV component attributable to 2020 and 2021 risk adjustment in financial reporting. For these issuers, separate adjustments for both years would align better with their financial reporting. We are not aware of any specific National Association of Insurance Commissioners (NAIC) guidance on how RADV should be reflected in risk adjustment reporting for financial statements, and it may be worthwhile to solicit feedback from NAIC regulators or accounting professionals on how they anticipate RADV results should be reflected in insurer financials before electing a final methodology. We note that separate adjustments for both years would result in the same net transfers as the “alternative combined plan liability risk score methodology,” and would allow issuers that reflect RADV in risk adjustment financials for the benefit year to close 2020 books one year earlier and avoid the need for special processes to handle a hypothetical combined transfer.

Finally, HHS requested comment on whether HHS should consider switching to concurrent application with 2020 benefit year RADV given COVID-19-related delays to the 2019 benefit year RADV process. It would be appropriate to shift to concurrent application at the earliest opportunity, but we note that the same considerations would apply to these adjustments as to a switch in 2021.

We would not consider the need for an additional pilot year for prescription drug category (RXC)-related RADV adjustments for 2020 as being as necessary for the transition, given that RXC issues are currently expected to be addressed in the demographic and enrollment error process. We recognize the intuitive appeal of applying similar rules to 2019 and 2020 benefit year RADV should HHS elect to switch to concurrent application with the 2020 benefit year. However, we note that 2020 RXC validation results would have impacted 2019 benefit year RADV risk score changes in the absence of the COVID-19 pandemic because they are already scheduled to be applied concurrently. However, an additional pilot year for RXC RADV may be appropriate given the disruption that COVID-19 may have on 2019 benefit year RADV even in light of the procedural delay. Extending the pilot period would allow plans to focus on addressing existing RADV processes in the midst of the COVID-19 pandemic, and allow them to refine RXC processes in the 2020 benefit year RADV when the pandemic’s effects on plan operations are more limited or at least more able to be addressed.

Again, we appreciate CMS' efforts to deal with the RADV issues, and we hope these comments are helpful. We stand ready to assist CMS. Please contact Craig Hanna ([hanna@actuary.org](mailto:hanna@actuary.org); 202-223-8196) if you have any questions.

Sincerely,

Alfred A. Bingham, Jr., MAAA, FSA, FCA  
Chairperson  
Risk Adjustment Subcommittee  
Health Practice Council  
American Academy of Actuaries