December 30, 2020

Centers for Medicare & Medicaid Services (CMS),
Department of Health and Human Services (HHS)
Attention: CMS-9914-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Proposed Notice of Benefit and Payment Parameters for 2022

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 2022 Notice of Benefit and Payment Parameters (NBPP).

Comments from the Individual and Small Group Markets Committee

Special Enrollment Periods (SEPs) (§ 155.420)

The availability of special enrollment periods (SEPs) for individuals who encounter certain life events, such as losing health insurance coverage, moving, or getting married/divorced, are necessary to promote continuous coverage. However, abuses of SEPs can also increase average claim costs. Eligibility requirements for SEPs in the marketplaces have not always been consistently enforced.

Exchange Enrollees Newly Ineligible for Advanced Premium Tax Credits (APTCs)
In response to the request for comments on the various proposals for exchange enrollees to enroll in a different metal level if they qualify for a SEP due to becoming newly ineligible for APTCs, we believe that allowing flexibility will encourage continued participation, eliminate gaps in coverage, and allow for those enrollees to reassess the metal level that best fits their financial means. However, this must be paired with needed consumer education regarding the impacts of midyear plan changes such as resetting deductibles and out-of-pocket maximums.

[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.

Enrollment Periods—Untimely Notice of Triggering Event
If an individual did not receive timely notice of a triggering event, it is appropriate to allow the qualified individual to select a new plan within 60 days of the date they became aware that an event triggered their qualification for a SEP.

Cessation of Employer Contributions to COBRA as a SEP Trigger
Similar to exchange enrollees becoming newly ineligible for APTCs, individuals who lose their employer's contribution to Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage must re-evaluate the financial impact of their health insurance purchase. It is appropriate to consider the cessation of an employer's contribution to COBRA coverage as a SEP-qualifying event. Therefore, it would be appropriate to ensure that state exchanges and off-exchange coverage follow the same rules as the federal exchange regarding loss of minimum essential coverage SEP-qualifying events. In addition, more consistent SEP rules between plans on and off the marketplace could reduce any related disadvantages for on-marketplace plans.

Special Enrollment Period Verification
The proposed rules are intended to increase verification of SEP eligibility by requiring all state and federal exchanges to conduct eligibility verification for at least 75% of new enrollees.

Stricter SEP enforcement mechanisms have the potential to improve the risk profile. Tightening enforcement should reduce abuses of SEP eligibility that might be occurring. However, any requirements regarding SEP enrollment should not be so onerous as to reduce participation among those legitimately eligible—otherwise the consequences could be to reduce participation among the healthy SEP population, thus worsening the risk pool.

User Fee Rates for the 2022 Benefit Year (§ 156.50)

HHS has the authority under sections 1321(c)(1) and 1311(d)(5)(A) of the Patient Protection and Affordable Care Act (PPACA) to collect and spend user fees. The user fee rates for benefit years 2014 through 2019 were 3.5%. The user fee rates for benefit years 2020 and 2021 were reduced to 3.0%. HHS is proposing to lower the federally facilitated exchange (FFE) and state-based exchange on the federal platform (SBE-FP) user fees rates to 2.25% and 1.75% of total monthly premiums, respectively, in order to reflect enrollment, premium, and HHS contract estimates for the 2022 plan year. HHS also proposes 2023 user fee rates of 1.5% of total monthly premiums for FFE and SBE-FP states that elect the proposed direct enrollment option discussed later in the preamble.

For the 2022 benefit year, issuers participating in an FFE will receive special benefits from the following federal activities:

- Provision of consumer assistance tools;
- Consumer outreach and education;
- Management of a Navigator program;
- Regulation of agents and brokers;
- Eligibility determinations;
- Enrollment processes; and

- Certification processes for Qualified Health Plans (QHPs) (including ongoing compliance verification, recertification, and decertification).

We are concerned about lowering the exchange user fees again. The provision of consumer assistance tools; consumer outreach and education; and the management of a Navigator program are important to supporting individuals and families in enrolling into the exchange, resulting in a robust membership pool. If expenditures for these activities are reduced due to the reduction in the funding from the exchange user fees, it could threaten the number of individuals that enroll in exchange products.

Alternatives to Exchange User Fees
We do not have any specific suggestions for alternative sources of revenue to support the exchange, but note that as long as exchange costs are included in the premium development process, the exact method of collection of these user fees is unlikely to have any material effect on member premiums or related incentives because member premiums are not statutorily permitted to vary by distribution channel. Use of a per-member fee would still be implicitly reflected in premiums proportionally to premium due to the application of the permissible rating factors. A percentage of premium basis for the fee aligns best with premiums, inducing the least amount of additional rating uncertainty.

Publication of the Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost-Sharing, and Required Contribution Percentage (§156.130)

We are in accord with the proposal to publish the premium adjustment percentage, maximum annual limitation on cost-sharing, reduced maximum annual limitation on cost-sharing, and required contribution percentage parameters through guidance by January of the year preceding the applicable benefit year instead of through the annual Payment Notice. As the Final Payment Notice has been released as late as April, this proposal will provide actuaries with an expanded time frame for development and submission of rates for 2023 and later.

We would like to take this opportunity to reiterate that incorporation of individual market premiums in the premium adjustment percentage results in significant additional premium variation outside of the impacts of secular inflation (i.e., premium inflation excluding the impacts of major regulation and other market changes). Most notably, the pre-2014 individual insurance market featured significantly lower premiums due to the presence of underwriting and leaner benefits, which reduces the starting point for the premium growth index and thus increases the overall premium growth percentage. Please refer to the committee/subcommittee comment letter dated February 19, 2019, on the Proposed 2020 Notice of Benefit and Payment Parameters for a more detailed discussion of this issue.[2]

Actuarial Value Calculator

As no changes are proposed to be made to the 2022 Actuarial Value (AV) Calculator other than to allow for a higher out-of-pocket maximum (which reduces the actuarial value of the leanest

[2] https://www.actuary.org/sites/default/files/files/publications/2020_NBPP_Comments_021918.pdf

possible bronze plan design to 60.31% from 61.35%), the same issues as found in the 2021 AV Calculator would persist in the 2022 calculator. We reiterate the comments in our letter dated November 9, 2020,[3] that it is important that a single standard population be used for all metal levels (and only adjust for induced utilization differences[4] for each metal level's continuance table), in particular to ensure morbidity differences are not reflected in actuarial values across metal levels. It appears that CMS is reflecting morbidity differences in the continuance tables, or otherwise using inconsistent populations for the determination of actuarial values across different metal tiers.

We note that not increasing the underlying continuance tables to reflect medical inflation would lead to more generous benefits being offered at each metal level in 2022 relative to if the tables were trended, leading to higher premiums, as the pricing AVs will increase to ensure actuarially sound rates that are reasonable in relation to the benefits. Therefore, when the continuance tables are updated in the future to align with current medical costs, patient cost-sharing may experience a larger single-year increase than it otherwise would, which could lead to instability in the market.

We recognize that the coronavirus pandemic has created uncertainty surrounding overall cost levels in 2020 and beyond, but we note that many of these changes would be anticipated to be shorter term in nature and focused on utilization rather than unit cost. We would not anticipate any decrease in medical cost inflation as a result of COVID-19. While it is more challenging to adjust the underlying experience for utilization changes only relative to the past, we note that it would be reasonable to anticipate that 2022 could look more like the 2017 experience that underlies the AV Calculator than 2020 or 2021 will—particularly in light of what appears likely to be broad distribution of a coronavirus vaccine in 2021. As such, applying another year of medical trend would be at least as actuarially appropriate as applying no trend, as the issue is not with the anticipated 2021 experience in the 2021 AV Calculator, but rather with actual 2021 experience that will occur in light of the pandemic.

Comments From the Risk Adjustment Subcommittee

Data Updates

We understand HHS' reasons for not updating the data used to derive the risk adjustment coefficients for 2022. We recognize that there are advantages and disadvantages of this action. For 2022, we do not see any major problems with the proposal. However, we encourage the use of the most recent EDGE data for developing future years' coefficients, and note HHS should continue to update the coefficients for future years using the most recent three years available at the time of the proposed rule. We also urge HHS to carefully evaluate the 2020 EDGE data, given the impact of COVID-19, to determine whether its use will have unintended impacts on risk adjustment coefficients, and whether it is appropriate for use.

[3] https://www.actuary.org/sites/default/files/2020-11/MEDMARKETS_AV_Calculator_Comments.pdf

[4] Utilization differences for silver plans should be based on the standard silver plan benefit and not the actual utilization of silver plan enrollees, which will include individuals with cost-sharing reductions that raise their AVs to 87% and 94%.

Model Calibration Updates

We appreciate HHS' desire to improve the risk adjustment model. The proposed changes for 2022 appear to be in recognition of longstanding concerns about the model's performance for the lowest- and highest-cost beneficiaries. In response to these concerns, HHS appears to have taken a multi-pronged approach—modifications to duration factors and the interaction/severity components as described appear targeted at higher-cost enrollees, while HHS' proposed two-stage calibration would serve to put more emphasis on lower-cost enrollees. We have the following observations on this proposed approach:

We note that HHS appears to be viewing increasing model performance as measured by R-squared as the primary goal of the risk adjustment model. We note that while R-squared is one common and useful metric, there are many other established and useful metrics that may be more relevant to the way that these models are used in practice, such as mean absolute prediction error or predictive ratios for subsets of the population. The choice of metric(s) used to evaluate model performance should be aligned with HHS' policy goals, and use of more than one metric may be appropriate.

In the analysis provided in the proposed rule, HHS notes that the proposed changes in aggregate improve cost predictions across all deciles. However, the weighting function chosen in the two-stage calibration appears to be arbitrary, with the key feature that it results in the best model performance statistics. In particular, there is no clear rationale underlying the choice of weights and of bounds. This might imply that HHS is attempting to overfit the model data, a common challenge facing those developing predictive models. We note that all available EDGE data are used in the model calibration process, which is appropriate. However, this means there is no ability to evaluate model performance on an independent data set to assess whether these proposed changes actually improve predictions. As such, we cannot say with any confidence whether the current changes will improve performance of the model in practice. We caution against an overemphasis on improving model performance in the absence of both a sound theoretical basis for changes and an independent data set to confirm an increase in accuracy. HHS might also consider using industry-standard methods to test modeling choices for overfitting. For example, HHS could develop the model withholding some of the data, then evaluate model performance on the unused data prior to developing coefficients using all of the EDGE data. Alternatively, HHS could use techniques commonly associated with machine learning methods such as use of k-fold cross-validation. HHS is encouraged to consider publishing the results of these tests when explaining modeling decisions.

We also note that there is limited quantification of the impacts of the different model changes, such as can be found in rulemaking for Medicare's risk adjustment programs. This limits stakeholder ability to understand the implications of each change. For example, the specific two-stage calibration approach chosen should better predict lower-cost enrollees, but would be expected to have notably worse performance for higher-cost enrollees, reducing the overall R-squared statistic, since the single-stage calibration currently performed produces, by definition, the coefficients with the largest possible R-squared value across all data points in the training data for that linear model specification. As such, the increase in R-squared that is observed is found despite the two-stage calibration, rather than because of it, unless the R-squared is calculated using the weights from the second stage of the two-stage calibration. However, we

note use of a weighted R-squared value would not be appropriate unless the weights will also be applied in the actual risk score model, which we understand will not be the case. However, HHS' analysis is stated as if revisions to severity and duration components alone would result in worse model performance among lower-cost deciles even as they result in higher R-squared values overall.

Perhaps most importantly, we note that the most important effects of coefficient changes to the market as a whole are the effects on risk transfers. HHS does not currently collect sufficient information from issuer EDGE servers (specifically, sufficient detail on issuer and geography) to recalculate estimated risk transfers for the calibration data, and there is no alternative comprehensive data source available to the industry to do so. As such, there is little to no insight on how risk adjustment changes will affect market stability. We strongly encourage HHS to begin to collect this information to help inform future rulemaking surrounding the risk adjustment model. We would be happy to work with HHS to determine what performance metrics may be most useful to stakeholders to understand the practical implications of any changes the risk adjustment model specification or calibration changes.

Changes to Duration Factors

We understand the desire to change the duration factors used in risk adjustment. However, the proposed changes seem to be aimed more at addressing durational issues in the individual market. The small group market dynamics can be very different from the individual market, particularly for small group coverages that do not have a January 1 effective dates. Also, the reasons for enrollees having less than one full year duration in small group coverage differ from those associated with individual coverage, though we understand that HHS evaluated duration factors separately by market and found no meaningful difference in costs among individuals with hierarchical condition categories (HCCs). As such, we encourage HHS to undertake additional research and study in this area, especially regarding the impacts on the different markets and non-calendar-year policies in the small group market. Perhaps such research would indicate the need for or advantages of different duration factors for small group risk adjustment for non-calendar-year policies. We would be happy to work with HHS to assist in these evaluations.

State Flexibility Requests for Risk Adjustment

HHS proposes to allow states to request a reduction to risk adjustment transfers for up to three years beginning with the 2023 benefit year. Currently states must submit this request annually and provide supporting documentation. HHS proposes to reserve the right to require states with approved requests to submit supplemental evidence when circumstances warrant. This could occur if HHS becomes aware of an anticipated change, such as new competitors or significant shifts in enrollment, in the state market risk pool.

We note that the market share and enrollment by issuer could change dramatically over a three-year period, especially if there is a significant reduction in risk adjustment transfers in the individual market where selection risk is higher and enrollees are much more sensitive to changes in price. The ability to request supplemental evidence after approval could help mitigate this concern if HHS is proactive in using its authority, but this provision also undermines the predictability of the three-year application itself. As such, these provisions appear to be at cross-purposes. We also note that risk adjustment changes annually, sometimes with substantial

changes (such as those proposed this year), and it may be premature to set state flexibility percentages three years in advance. Should HHS retain this provision and its intermediate reevaluation authority, HHS should consider stating explicitly that changes to risk adjustment alone may still constitute valid reason for states to be required to reassess flexibility requests.

Taken altogether, we are more in agreement with three-year flexibility requests in the small group market than the individual market, and would not agree with three-year flexibility requests in the individual market unless HHS takes a proactive midcycle review posture.

Risk Adjustment Data Validation (RADV) Timing Changes
The revised RADV timing changes will much better align with state financial reporting requirements. With this acceleration, however, comes some concern regarding the alignment of the 2017, 2019, and 2020 RADV adjustments in medical loss ratio (MLR) reporting year 2021 and 2018 and 2021 RADV adjustments in MLR reporting year 2022, but these concerns are more directly related to the 2017 and 2018 RADV than the revised timelines associated with 2019–2021 RADV. We note that the "average error rate" approach adopted by HHS for issuers participating in both 2019 and 2020 RADV will effectively result in a single year's magnitude of RADV transfer adjustments for both years' RADV experience, so this imbalance affects 2021 and 2022 MLR reporting approximately equally despite three years of RADV in 2021 MLR and only two years in 2022 MLR.

With regard to rate filing instructions, we note that there is still a misalignment between the benefit year that incurs RADV and the benefit year in which it is reflected in MLR filings. However, few if any issuers have reflected 2017 RADV in their 2021 premium development or have indicated they are planning to do so for 2018 amounts in 2022 premiums, nor do any states appear to have required this treatment. Additionally, issuers will have at best limited information to project RADV transfer adjustments for the 2021 benefit that will be included in 2022 MLR filings. Issuer flexibility would be appropriate in this regard, as would be removing current specificity in the instructions surrounding how RADV may permissibly be incorporated in premium development. The first sentence in the existing RADV rate filing guidance appears to provide sufficient flexibility, namely, "The risk adjustment amount entered may also account for Risk Adjustment Data Validation (RADV), including default data validation charges (DDVCs) and allocations, to the extent a state allows."

EDGE Discrepancy Materiality Threshold
The $10,000 as a minimum was clearly too low, so a higher threshold would be appropriate. While it is less clear whether $100,000 is the correct threshold to use, it is a step in the right direction. We note we do not have sufficient data to suggest an alternative estimate.

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We appreciate the opportunity to provide comments on the 2022 proposed Notice of Benefit and Payment Parameters. We would welcome the opportunity to speak with you to provide more detail and answer any questions you might have regarding these comments. If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy's senior health policy analyst, at williams@actuary.org.

Sincerely,

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