January 26, 2022

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 2023

To Whom It May Concern:

The Individual and Small Group Markets Committee, Risk Sharing Subcommittee, and Health Equity Work Group of the American Academy of Actuaries Health Practice Council ("HPC Committees")[1] are pleased to provide comments on the proposed rule for the 2023 Notice of Benefit and Payment Parameters (NBPP).

Specifically, the HPC Committees are commenting on network adequacy, standardized plan options, health equity provisions (guaranteed availability of coverage, prohibiting discrimination based on sexual orientation and gender identity, refining essential health benefits [EHBs], nondiscrimination policy for health plan designs, special enrollment period [SEP], and updating quality improvement strategy [QIS] standards to require issuers to address health and health care disparities), risk adjustment, HHS Risk Adjustment Data Validation (HHS-RADV), and de minimis changes to actuarial value.

[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.

Enhancing Consumer Options & Choice

Network Adequacy (§ 156.230)

Under the proposed Rule, beginning in plan year 2023, CMS would conduct network adequacy reviews in all federally facilitated marketplace (FFM) states except for states performing plan management functions that adhere to a standard as stringent as the federal standard and elect to perform their own reviews.

The federal standard would expand the list of provider specialties subject to quantitative time and distance standards, calculated at the county level, include new appointment wait time standards for certain critical service categories (e.g., behavioral health services, primary care [routine], and specialty care [non-urgent]), and require the network adequacy reviews to occur prospectively during the Qualified Health Plan (QHP) certification process. Issuers that are unable to meet the specified standards could submit a justification to explain why they are not meeting the standards, what they are doing to work toward meeting them, and how they are protecting consumers in the meantime. If finalized, the revised standards could better meet the health care needs of QHP enrollees. The HPC Committees understand that CMS will detail county-specific time and distance parameters in future guidance and encourages CMS to develop parameters that reflect differences in population size and density even within counties.

Starting with the QHP certification cycle for plan year 2023, CMS also proposes to collect data from issuers on which of their in-network providers offer telehealth services. This information could be helpful to evaluate whether a QHP meets network adequacy standards and would inform future development of network adequacy standards that reflect the availability of telehealth services.

CMS proposes to increase the Essential Community Provider (ECP) threshold that issuers must include in their network from 20% to 35%. As stated in the notice, in 2021, 80% of medical plans and 74% of dental plans met the 35% threshold, and the mean Essential Community Provider percentage across FFM issuers was 55%. The increase in the threshold helps ensure that low-income and other medically underserved individuals have increased access to health care services, which helps advance health equity. Because most health plans already meet the 35% threshold, and QHP issuers falling short of the standard could satisfy the standard by using ECP write-ins, the HPC Committees does not expect that this change would have a disruptive impact on the market.

Standardized Plan Options (§ 156.220)

CMS proposes to require issuers in the FFMs and state-based marketplaces on the federal platform (SBM-FPs) to offer plans with standardized cost-sharing parameters at every product network type, metal level, and throughout every service area that they offer non-standardized options in plan year (PY) 2023. For example, if an issuer offers a non-standardized gold plan for a particular product network in a particular service area, that issuer must also offer a standardized gold plan in that same service area in that product network.

CMS is not proposing to require issuers to offer standardized plan options at product network types, metal levels, and throughout service areas in which they do not offer non-standardized options. CMS has designed two sets of standardized plan options at each of the bronze, expanded bronze, silver, silver cost-sharing reduction (CSR) variations, gold, and platinum metal levels of coverage, with each set being tailored to the unique cost-sharing laws in different sets of states.

CMS also proposes to display these standardized options differentially on HealthCare.gov and to resume enforcement of the existing standardized plan option differential display requirements for web brokers and QHP issuers utilizing a Classic Direct Enrollment or Enhanced Direct Enrollment pathway.

These standardized plans would be required in all FFMs and SBM-FPs assuming a one-size-fits-all within FFMs and SBM-FPs. The HPC Committees note that because health care is primarily locally focused and different states have different market dynamics, it is unlikely that standardized plans would work the same in all FFMs and SBM-FPs.

The appeal of standardized plans is to give individuals access to a set of plans that can be easily compared against one another, rather than the potentially complex evaluation that can result from the many plan options available in competitive marketplaces. Standardized plans facilitate both comparison of different cost-sharing structures and comparison of different issuers in the same market. However, adding more plans to a crowded marketplace will not make purchasing easier, even if these plans are standardized. Instead, the additional offerings may add to the confusion, particularly as it is likely the standardized plan options may not meet the needs of some consumers.

We encourage CMS to consider state experiences as it pursues adding additional standardized plans. For example, Vermont requires standard plans, but Vermont also restricts the number of non-standardized plans that can be offered. Additionally, California requires standardized plans on its exchange, with a prohibition on non-standardized plans. State experience is not uniformly positive. Florida initially defined standardized small group medical plans in 1992 as part of the establishment of the small group rating laws. In November 2002, the Florida Small Employer Benefit Plan Committee proposed several new basic and standard plans, which were later formally adopted by the Department of Insurance in April 2003. Importantly, Florida did not

restrict the number of non-standardized plans that can be offered to 2-50 life groups. One life groups were also eligible for small group coverage, but their choices were limited to the new standardized plans. Reports from the Florida Office of Insurance Regulation indicate that the new business annualized premiums for these standardized plans were less than 0.05% of the total small group market annualized premiums for calendar years 2006–2012. [2]

Adding standardized plan options without limiting the number of non-standardized plans offered is not consistent with the stated goals of streamlining and optimizing the plan selection process on the exchange and would likely result in minimal change in plan selections. The HPC Committees urge caution against using a single, nationwide set of standardized plans. Having state-specific standardized plan options would also help to mitigate disruption to the local market. It may be prudent for CMS to exempt FFM and SBM-FP issuers that are subject to existing state standardized options requirements if those state standardized plan options were implemented or are in the process of being implemented. State-specific standardized plans may better reflect the needs of the enrollees within the state, and the proposed standardized plan options may not.

Advancing Health Equity

Guaranteed Availability of Coverage (§ 147.104(i))

CMS requested comments regarding a proposal to reinterpret Guaranteed Availability of Coverage (§ 147.104(i)) requirements such that issuers could not refuse to effectuate new coverage based on failure of an individual or employer to pay premiums owed for prior coverage. The HPC Committees have strong concerns about the potential impact to health plans and rates for other plan participants that could arise from members gaming the system if CMS finalizes the proposal to allow past-due premiums to be forgiven for re-enrolling members.

The HPC Committees support removing barriers to access for coverage. However, this proposal may adversely affect premiums, as premiums for all members would have to increase to offset the increased bad debt assumed by issuers. The resulting premium increase could be in the range of 0.3% to more than 3%. In the proposed rule, CMS notes that 12.4% of individuals enrolled in 2018 were terminated for nonpayment. If it is assumed that each of these individuals has up to 3 months of nonpayment and that all enrollees were enrolled for a full 12 months, the resulting load could be determined as follows assuming an average of three months of past-due payments and uniform premiums in each month: number of months of nonpayment divided by the total number of months paid:

$$\{0.124 * 3\}/ \{0.124 * 9 + 0.876 * 12\} = 3.2\%.$$ [3]

[2] FLOIR industry reports.
[3] This assumes the premium is the same for the 12.4% and the 87.6%.

Should this provision be finalized as proposed, it is expected that the rate of disenrollment would increase. As the rate of disenrollment rises, any required premium load would increase at an even higher rate as the amount of unpaid premiums increases are compounded by decreases in paid premiums.

Combating access issues for low-income individuals is a laudable goal, but it is one most appropriately addressed through management of premium subsidies and cost-sharing. Effective forgiveness of premiums that are past due transfers this responsibility directly to those consumers who do pay.

CMS also requested that the HPC Committees provide comments on affordability, and access for the individuals who reliably pay. As stated above, premiums are expected to increase to account for the lost revenue. This is expected to reduce overall affordability for consumers if this policy results in significant gaming. Additionally, it could reduce access if issuers exit the market.

The primary benefit would be reduced administrative costs for issuers. CMS also requested comments regarding whether issuers that implemented policies requiring payment of past-due premiums prior to re-enrollment experienced declines in administrative costs related to the collection of past-due premiums. The HPC Committees would anticipate some decreases in administrative costs, as most systems are heavily integrated.

It is unlikely that modifying guaranteed issue will create a meaningful impact on risk transfers, though the HPC Committees note that this dynamic depends on the relative morbidity of the people who pay their premiums on time compared to those with past-due premiums. For example, this proposal may result in a modest improvement in overall risk score levels if the members who are current with their premium payments are less healthy or have higher average claims than those who have outstanding premiums that are past their due date.

Prohibit Discrimination Based on Sexual Orientation and Gender Identity (Amends §147.104(e))

CMS proposes to prohibit marketplaces, issuers, agents, and brokers from discriminating against consumers based on sexual orientation and gender identity. CMS rules previously prohibited discrimination based on "race, color, national origin, disability, age, sex, gender identity or sexual orientation," but amendments made in 2020 to § 155.120(c) removed gender identity and sexual orientation from these non-discrimination protections by revising CMS regulations. If finalized, this proposal would revert § 155.120(c) to the pre-2020 nondiscrimination protections.

Prohibiting discrimination based on sexual orientation and gender identity would increase access to health care and decrease health disparities experienced by people who identify as lesbian, gay,

bisexual, transgender, queer, or intersex (LGBTQI+), thereby promoting health equity. It is our understanding that few, if any, issuers changed their practices in response to the 2020 amendment to § 155.120(c). Therefore, the HPC Committees expect that this change would have little to no impact on premiums or issuer practices. The HPC Committees support this proposed change as it advances health equity.

Refine Essential Health Benefits (EHBs) Nondiscrimination Policy for Health Plan Designs (§ 156.125)

CMS proposes to refine the EHB nondiscrimination policy to ensure that benefit designs, and particularly benefit limitations and plan coverage requirements, are based on clinical evidence that incorporates evidence-based guidelines into coverage and programmatic decisions and relies on current and relevant peer-reviewed medical journal article(s), practice guidelines, recommendations from reputable governing bodies, or similar sources. CMS proposes refining CMS regulations and providing examples that illustrate presumptive discriminatory plan designs, such as discrimination based on age, health conditions, and sociodemographic factors.

CMS current rules provide that an issuer does not provide EHB "if its benefit design, or the implementation of its benefit design, discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions."

The proposed rule is consistent with the current rule and supports the consistent application of § 156.125 to ensure that enrollees can access covered benefits equitably.

Special Enrollment Period (SEP) Verification (§ 155.420)

CMS proposes to relax the pre-enrollment SEP verification requirements for exchanges using the federal platform. Exchanges using the federal platform are currently required to meet pre-enrollment verification requirements for certain SEPs in order for their coverage to be effective; this requirement does not extend to state-based exchanges. Under the proposal, exchanges using the federal platform would only be required to conduct pre-enrollment SEP verification requirements for the SEP associated with consumers losing minimum essential coverage. While this circumstance involves ~60% of SEP enrollments, there is still a significant number of other types of circumstances that would no longer be subject to verification.

Less restrictive SEP enforcement mechanisms have the potential to worsen the risk profile. Loosening enforcement could increase abuses of SEP eligibility that might be occurring. On the other hand, onerous SEP verification requirements could reduce participation among those legitimately eligible, potentially reducing participation among the healthy SEP population, thus worsening the risk pool.

Updating Quality Improvement Strategy (QIS) Standards to Require Issuers to Address Health and Health Care Disparities (§ 156.1130)

CMS proposes to update the QIS standards beginning in PY2023 to require QHP issuers to address health and health care disparities as a specific topic area within their QIS. Currently, QHP issuers participating in a marketplace for two or more consecutive years are required to implement and report on a QIS that includes at least one topic area defined in section 1311(g)(1) of the Affordable Care Act (ACA) (activities to improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, promote wellness, and health and reduce health and health care disparities). The HPC Committees wholeheartedly support this proposal to reduce disparities in health and health care.

Lowering Premiums and Strengthening Markets

Risk Adjustment (§ 153.320)

Calibration Data

The HPC Committees encourage CMS to use 2017, 2018, and 2019 EDGE data for calibration of the 2023 risk adjustment model. CMS has requested additional input regarding potential use of 2020 EDGE data in future years of risk adjustment. The HPC Committees note that 2020 data is unlikely to be consistent with experience in other benefit years due to influence of COVID-19. The pandemic had variable effects on different avenues of treatment, which is likely to have resulted in meaningful changes to the relative cost of treating conditions that are primarily addressed in different settings. For example, many procedures were canceled and delayed due to the impact of COVID-19. This in turn is likely to distort risk adjustment coefficients relative to a more typical delivery pattern (i.e., experience in years where medical treatment patterns were not impacted by the pandemic). It is anticipated that the major care capacity constraints associated with COVID-19 are likely to be gone when this data would first be available for use in the 2024 risk adjustment. Note that a similar issue is likely true for 2021 EDGE data as well, albeit to a smaller degree in many geographies. If CMS chooses to use 2020 or 2021 EDGE data, CMS should review any relative changes in risk adjustment coefficients between conditions and evaluate these changes for clinical reasonability and applicability in a health care ecosystem without large interruptions in certain service delivery platforms attributable to the novel nature of the SARS coronavirus 2 in 2020 and 2021. The HPC Committees anticipate these variations will be more impactful than any inaccuracies that arise from using older risk adjustment coefficients. This aligns with current practice of many industry participants. The HPC Committees note that not relying on 2020 experience to develop risk adjustment coefficients is consistent with industry practice, including CMS guidance, as the vast majority of Medicare Advantage and ACA issuers used 2019 data in lieu of (or to supplement or adjust) 2020 data for 2022 pricing, which is a key indicator of the health insurance industry's faith, or lack thereof, in 2020 data as a predictor of future experience.

Updated Risk Score Model

CMS is again proposing changes first offered in the Proposed 2022 Payment Notice,[4] including a two-stage linear regression, modification to an interacted hierarchical condition categories (HCC) counts severity designation, and modifications to the enrollment duration to focus on individuals with HCCs and six or fewer months of enrollment. These proposals follow a risk adjustment white paper published on October 26, 2021.[5] Health Practice Council comments on this proposal are generally aligned with our prior comments. The HPC Committees appreciate the additional detail, and finds the justifications behind the modification to enrollment duration factors and the updated approach to severity to be reasonable. However, the HPC Committees still have concerns that the two-stage model process was developed with the singular goal of improving predictive ratios for low-risk enrollees and modestly reduces overall model fit and accuracy.

The HPC Committees thank CMS for publishing the December 28, 2021, transfer results simulation report that assesses the impact of proposed model changes. This is a significant benefit that CMS should consider replicating for future updates to the risk adjustment model, assuming results can be produced in a timely fashion. As the primary purpose of risk adjustment is to insulate issuers from member selection, understanding the effects of risk adjustment changes on financial outcomes is of particular use. The HPC Committees reviewed the simulated transfer results and came to the following observations:

- The new transfers in general do produce some modest compression of risk adjustment transfers, both in terms of total dollars transferred under the program and in terms of transfers as a percentage of premium. Most favorable adjustments appear to be the result of decreased payments into the program and most unfavorable adjustments appear to be the result of decreased receipts from the program.
- The simulated transfer report shows that impacts are very issuer-specific, and smaller issuers appear likely to see much larger swings in risk scores and risk transfers. Some changes are in excess of 15% of issuer premium reported for 2020 on 2022 Unified Rate Review Template (URRTs).
- The changes may be challenging to estimate for each state, as there is notable variation in the change in risk score even on a risk pool level across states and markets—risk score changes are not uniform in direction or in magnitude.

In addition to the above observations, the unique nature of 2020 data and the impacts of the COVID-19 pandemic could have some influence on the direction and magnitude of risk score changes that will be felt in practice. This is mitigated to some degree by CMS' publication of transfers for all four simulations using the same base data, an approach the HPC Committees

[4] Academy comments on the 2022 model changes can be found beginning on page 4 here.
[5] Academy comments on the model proposals in the white paper can be found here.

reiterate that it appreciates, though it is likely that somewhat different patterns of variation could be experienced in a benefit year with more historically typical utilization patterns.

Another key limitation of the simulated transfer results is the inability to review effects of the various proposed changes on their own. As noted in our earlier comments on the technical paper, the HPC Committees observed that the more intuitively reasonable changes to severity and enrollment duration show significant improvement over the base model and would have liked to see simulated transfer results for all three proposed model changes separately, along with the combined effect of the updated approaches to enrollment duration and severity. The HPC Committees remain largely supportive of implementation of both proposals in tandem, though it is still noted that small group market issuers with non-calendar-year business may prefer the original enrollment duration factor approach due to the timing issue noted above. The HPC Committees would like to understand the influence of the two-stage weighted calibration on transfers on its own, given the overall decrease to model performance and fit that naturally arise from this methodology. Because of this limitation in the risk adjustment transfer analysis, the HPC Committees are unable to provide more specific responses to the requested comments on whether CMS should implement the separate proposals rather than all three at once.

RXC (Prescription Drug Category) Mappings

The change to RXC mappings used for calibration data is likely appropriate, as this will align condition identification in that experience year with concurrent relevancy of particular drugs for each RXC. While not the focus of the proposal, the HPC Committees note that some of the later-stage changes to RXC mappings, such as the initial removal of hydroxychloroquine sulfate from the RXC mapping incorporated in calendar year 2020 risk scores was announced in April 2021, after the close of annual financial statement reporting. This removal had significant financial implications for many issuers, and the prospect of similar changes in the future could drive some issuers to price with higher margins to offset potential negative implications of late-stage risk score model changes following the conclusion of annual financial statements. In the future, CMS should consider the relative benefit of removing an RXC at such a late stage relative to potential impact on market stability and financial outcomes for issuers.

CSR Adjustments in the Risk Score Model

The HPC Committees have no additional comment at this time on the proposed factors, though it reminds CMS of our comments regarding potential risk score model changes for CSRs included in the October 26, 2021, technical paper, most notably that CMS should continue to evaluate the purpose and appropriateness of the current CSR adjustment factors in light of continued non-funding of CSR subsidies and the potential socioeconomic health equity issues associated with the lower-than-anticipated induced utilization levels identified in the technical paper.

Model Performance

The HPC Committees note that the model as proposed shows modestly improved R-squared values relative to prior models and reiterates our comments from the 2022 payment notice that this occurs despite the two-stage weighted calibration approach, not because of it. Additionally, model changes related to the interacted HCC counts and enrollment duration factors will require issuers to update their process, incurring an additional administrative burden. The CMS-HCC model still remains materially less predictive than other industry risk adjustment models available in 2016, and the HPC Committees recommend that CMS review these relatively modest trade-offs versus the potential market disruption and related complexity.

State Flexibility for Risk Adjustment

The HPC Committees do not have any specific comments regarding the termination of state flexibility for risk adjustment. For Alabama's request for continued flexibility in the small group market, the HPC Committees note that Alabama's ability to satisfy the de minimis standard has been predicated on the dominant market participant declining to price the risk adjustment receivable it typically accrues into premiums, while other market participants priced in risk adjustment payables. As such, risk adjustment flexibility did not increase any premiums. However, if market dynamics have changed to the extent that non-dominant market participants begin to anticipate a material risk adjustment recovery in pricing, then this may be a sign that the dynamics that supported the previous request may no longer apply. At the same time, the HPC Committees recognize (as noted elsewhere in our comments) that 2020 was a very atypical year, which would support the idea that 2020 data should not be considered as a sole basis for this determination. However, risk adjustment flexibility is intended to address imbalances in the risk adjuster applicable for a given state, and dominant market share on its own is not an indication of imbalance in the risk adjuster if available and credible data do not otherwise support this assertion.

Expanded Data Requests

Starting with the 2023 benefit year, CMS proposes to collect and extract the following five new data elements from issuers' EDGE servers through issuers' EDGE Server Enrollment Submission (ESES) files and risk adjustment recalibration enrollment files: (1) ZIP code, (2) race, (3) ethnicity, (4) subsidy indicator, and (5) ICHRA (Individual Coverage Health Reimbursement Arrangement) indicator. For race and ethnicity data, CMS proposes to require issuers to report race and ethnicity in accordance with the October 30, 2011, HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary

Language, and Disability Status (2011 HHS Data Standards), which is collected at a granular level that would allow CMS to better analyze more subpopulations than the current data allows, thereby allowing CMS to consider more areas of health equity, as well as to better address discrimination in health care and health disparities. Beginning with the 2022 benefit year, CMS also proposes to extract plan ID, rating area, and subscriber indicator, which issuers are already required to provide as part of the enrollee-level EDGE data. In conjunction with the proposed collection and extraction of the new and current data elements in this proposed rule, CMS also proposes to exclude plan ID, ZIP code, and rating area from the limited data set containing enrollee-level EDGE data that the U.S. Department of Health and Human Services makes available to qualified researchers. However, CMS proposes to include race, ethnicity, ICHRA indicator, subsidy indicator, and subscriber indicator in the limited data set once they are available.

The HPC Committees supports CMS' collection of data elements required to perform simulations of risk adjustment transfers, as the HPC Committees have suggested in previous comments to the departments. Evaluation of model fit is useful, but the effects of the change are most important in terms of how they impact transfers. Once CMS has this data available for use, the HPC Committees anticipate that the additional insights from this information will help ensure program changes are effective on both a theoretical and practical basis, and will not lead to significant market and premium changes. The HPC Committees also support the collection of the additional data elements for the stated purpose of analyzing health equity impacts and determining whether new policies, regulation, or guidance may be necessary or appropriate to further advance equity in the individual, small group, and merged markets. However, the HPC Committees note that issuers populate the EDGE servers for the single purpose of supporting risk adjustment transfer calculations, and the data elements that do not support risk adjustment may not be accurate and could impact any analysis that is not related to risk adjustment. Additionally, data elements that are not directly used for risk adjustment may not be quality checked (or even populated correctly). It may be appropriate to collect such information separately, so that the appropriate data validation processes could be applied.

The HPC Committees also acknowledge that the collection of such data is important for the analysis of disparate health outcomes and is concerned about the potential for inappropriate use or abuse of the protected class information, in particular the race and ethnicity data elements. Therefore, the HPC Committees urge transparency in the planned use of such data and the precautions expected to be taken to protect the privacy and security of this enrollee-level data and the potential for public disclosure.

The HPC Committees appreciate the confidentiality considerations that led to the exclusion of plan ID, ZIP code, and rating area from the limited data set file. However, the HPC Committees note that this puts significant limits on the potential usability of this report from any actuarial and other research perspective given the significant regional variability in health care utilization and

cost. One approach CMS could take to inclusion would be to adopt a formal data use standard for publication. Data sources available to and within the industry typically contain data use constraints that limit publication of certain information when it is likely to become identifiable. For example, CMS could choose to only publish state and rating area data when there is more than one issuer with at least 5% of the enrollment in the rating area. While exclusion of state and rating area data would prevent researchers from accurately simulating risk adjustment transfers in states where at least one rating area had a single dominant issuer, this likely would permit more research into cost and use patterns in areas with larger populations.

HHS Risk Adjustment Data Validation (HHS-RADV) (§§ 153.350 and 153.630)

Changes to RADV

The proposed Hierarchical Condition Category (HCC) Super Group changes to RADV make theoretical sense, as they serve to better align RADV evaluation with the calculation of risk scores. It is challenging to provide meaningful comment without any indication of prevalence of multiple diagnoses in a Super Group. The HPC Committees would appreciate clarification of how, if at all, RADV would accommodate the interacted HCC counts variable in the RADV process, should interacted HCC counts be finalized as proposed.

The HPC Committees support the recent recalculation of 2018 error rates to be consistent with the methodology outlined in the *Federal Register*. The HPC Committees encourage CMS to ensure that protocols used in practice align with other guidance published by the agency, particularly when said guidance is included in notice-and-comment rulemaking.

Enhancing the Consumer Experience

De Minimis Changes to Actuarial Value

CMS proposes to make changes to actuarial value by making changes to de minimis ranges. It appears that CMS may be motivated by factors that are specific to the individual health insurance market. If these narrower de minimis ranges were applied to the small group market, small employers could be required to change benefit plan designs more frequently. Cost trend tends to increase the actuarial value of a given plan design over time, and the smaller ranges would result in plans exceeding the de minims range more quickly. If CMS finalizes some or all of this proposal, the agency should consider limiting the proposed changes to the individual market, with the current de minimis ranges continuing to apply in the small group market to maintain stability and flexibility for small employers. With regard to the individual market specifically, the HPC Committees are concerned that an exceedingly narrow range of permissible actuarial

values could result in meaningful increases to premiums, particularly for silver plans sold on the exchange. This may be offset to some degree by higher premium tax subsidies, which are driven the premium for the second-lowest-cost silver plan. However, current law would see the number of unsubsidized customers increase due to the expiration of enhanced subsidies made available pursuant to the American Rescue Plan Act of 2021. As such, this change could enhance the already significant increase in net premiums that is already anticipated in 2023.

One benefit of raising the lower end of de minimis range for silver plans in particular is that this would remove the ability to design a plan which is silver when evaluated using the silver continuance tables and expanded bronze when evaluated using the bronze continuance tables. However, this dynamic currently only exists between bronze and silver, which could support a more limited revision. The HPC Committees note that recent changes to the continuance tables underlying the actuarial value calculator have increased the range of possible bronze plans significantly, so that such a revision would not necessarily need to be confined to the silver de minimis. Moreover, plans are not priced using the AV calculator actuarial values, but are independently calculated by plan actuaries. This may limit the practical benefit of changing the AV de minimis ranges, given how price-sensitive consumers can be in the individual market. With that said, a narrow de minimis range would still likely limit the ability of issuers to offer plan designs in one metal tier that are of similar practical generosity to plan designs in a different metal tier.

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The HPC Committees appreciate the opportunity to provide comments on the 2023 proposed Notice of Benefit and Payment Parameters. The HPC Committees welcome the opportunity to speak with you to provide more detail and answer any questions you might have regarding these comments or on issues related to the advancement of health equity through QHP certification standards. If you have any questions or would like to discuss further, please contact Matthew Williams, the American Academy of Actuaries senior health policy analyst, at williams@actuary.org.

Sincerely,

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