



January 8, 2024

Centers for Medicare & Medicaid Services (CMS)  
Department of Health and Human Services (HHS)  
Attention: CMS-9899-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Re: Proposed Notice of Benefit and Payment Parameters for 2025

To Whom It May Concern:

On behalf of the Individual and Small Group Markets Committee of the American Academy of Actuaries (“the committee”),<sup>1</sup> I appreciate the opportunity to provide comments regarding the [proposed rule](#) for the 2025 Notice of Benefit and Payment Parameters (NBPP).

### **Timing of the NBPP**

The committee appreciates timely publication by the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS) and the Department of the Treasury (“the Departments”) of the proposed 2025 NBPP. This prompt release gives actuaries, regulators, and other industry stakeholders more time to digest the provisions of the proposed rule and determine how to best plan for incorporation into product designs and practices if finalized. The committee hopes that the publication of the final NBPP early in 2024 will be similarly accelerated relative to prior years, as the final rules have not been consistently published in time to accommodate updates to provisions prior to state filing submission deadlines, which typically begin in early to mid-May.<sup>2</sup>

### **Enhanced Scope of EHB vs. Benefits in Addition to EHB**

The Departments are proposing to allow benefits required by state action after December 31, 2011, to be considered essential health benefits (EHB) when such benefits are included in the

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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 practicing in the United States.

<sup>2</sup> “[State Plan Management Systems and Submission Deadlines for Plan Year 2024](#)”; serff.com; May 2, 2023.

EHB benchmark plan. Additional clarity on how this proposed EHB expansion aligns with the statutory guardrails intent to limit taxpayer exposure to new state benefit requirements is needed, as we note that the headers to Sec. 1311(d)(3)(B) and d(3)(B)(ii) read that “States may require additional benefits” and “State must assume cost.”

The committee is concerned about the impact of the proposal on affordability and the inequitable shift of payment responsibility from one party to another. As proposed, this modification increases the number and cost of benefits that could be considered EHB. This change increases the amount of premium that could be paid by premium tax credits, generally increasing affordability of coverage for subsidized individuals in the individual market. However, it also results in a shift of payment responsibility from state taxpayers to federal taxpayers. It is also important to recognize that affordability would not be improved for the nonsubsidized enrollees in the individual market and will create even more risk to the small group market. Such a change has the potential to further narrow the small group risk pools, leading to increasing adverse selection over time, as employers who do not want to cover the cost of additional EHBs can choose to be self-insured. We would urge the Departments to offer additional clarification and consider further study on the potential impacts of implementing a policy that could have significant fiscal implications, as we look back to 2011 and carry the mechanism forward.

### **Expanding the Scope of Services That May Be Considered Essential Health Benefits— Adult Dental Coverage**

The Departments propose to expand the scope of services that states may consider as essential health benefits to include routine non-pediatric dental services. This proposal would give states the flexibility to expand benefits in the individual and small group markets. However, there may be a number of operational challenges to implementation and there isn’t sufficient clarity with respect to key elements of the departments’ proposal. Currently, dental benefit offerings and mechanisms vary by state and, as such, these considerations could affect different states differently – some states may not be impacted at all, while in some states, challenges could be significant enough to negatively impact market participation. Key questions for consideration include:

- *What services would be considered routine non-pediatric services?*

Current typical employer dental coverage places coverage limits and exclusions that tend to be cost-based rather than service-based, and typically do not have a maximum out-of-pocket (MOOP) but rather have a benefit coverage maximum. The cost of a benefit would vary significantly if all benefits covered under a typical employer dental benefit are considered EHB (e.g., orthodontia).

- *Would benefit structures for dental coverage in Qualified Health Plans (QHPs) vary from coverage in standalone dental plans (SADPs)?*

SADPs have low MOOPs (the proposed dental MOOP is set at \$425 for 2025). Would QHPs have these same limits? Or would they have other limits? Would SADPs be required to modify benefits to comply with the new EHB?

- *How would dental benefits be reflected in the federal AV Calculation?*
- *How would dental benefits be reflected in the medical loss ratio (MLR) calculation?*
- *How would network adequacy requirements be affected?*
- *How would this affect the premium adjustment percentage used to index MOOPs?*

Coverage of adult dental services may create challenges for actuaries and health plans offering coverage in the individual and small group markets. On the other hand, the proposal would provide additional flexibility to states to enhance coverage available for their residents. The committee encourages the departments to comprehensively evaluate the proposal for intended and unintended consequences as the departments weigh finalization and implementation of this optional state flexibility.

### **Special Enrollment Periods**

The Departments are proposing several modifications to special enrollment periods (SEPs). The committee is generally supportive of aligning effective dates of coverage across exchanges thereby preventing or minimizing coverage gaps. The committee has a concern with the proposal to remove the tax percentage criterion from the monthly SEP available to individuals in households with incomes up to 150% of the federal poverty level (FPL). While the enhanced subsidies made available under the American Rescue Plan Act and extended through plan year 2025 by the Inflation Reduction Act are in place, this SEP has limited potential for abuse because silver coverage with a 94% AV can be purchased by these individuals with no upfront premium payments. As such, members are likely to be enrolled in appropriate coverage. If the enhanced subsidies expire, these individuals will face upfront premium costs of roughly 2% to 4% of household income for silver 94% coverage, but will likely retain access to zero-premium bronze plans with significantly leaner coverage. If enhanced subsidies expire in 2026, this provision could create a higher risk of anti-selection beyond 2025 given the demonstrated cost sensitivity of this population, with the likelihood of additional unintended consequences.

## **Automatic Reenrollment Hierarchies and Catastrophic Coverage**

The Departments propose to amend existing rules to require Exchanges to automatically reenroll people currently enrolled in catastrophic coverage into a QHP for the upcoming plan year. The committee generally supports actions taken to prevent enrollees from becoming uninsured but acknowledges that the proposed language would require that exchanges automatically enroll enrollees losing eligibility for a catastrophic plan, in certain circumstances, into a bronze or higher coverage level QHP. This action would transfer risk from the catastrophic risk pool into the non-catastrophic individual market risk pool for the HHS risk adjustment program. Enrollees previously electing catastrophic coverage would likely face increased premiums for a higher level of coverage. However, some of this increase could be offset by premium subsidies to the extent individuals are eligible. On the other hand, individuals would face lower out-of-pocket costs. Currently, individuals enrolled in catastrophic coverage are not eligible to receive premium tax credits.

## **Pharmacy Benefits and EHB**

The Departments are proposing to require any prescription drugs in excess of the minimum EHB benchmark plan be considered EHB. The committee notes this is consistent with current guidance applicable in the individual and small group market, where coverage is required to provide the prescription drug EHB. This guidance is particularly important in the individual market, where premium subsidies are only available for the EHB portion of the premium. Codification of this guidance ensures that all prescription drug coverage is considered EHB. Insurers would have fewer incentives to limit prescription drug coverage for subsidy-eligible members, though the committee notes that smaller and more tightly controlled drug formularies may reduce costs somewhat and lead to lower premiums, so an incentive remains to avoid the broadest possible formularies.

## **Risk Adjustment Transparency**

The committee also notes that, while regulatory text and updates each year describe the changes to the risk adjustment model, the current level of disclosure is insufficient for stakeholders to independently evaluate the reasonability of federal assumptions or identify key drivers of changes in model outcomes year over year. For example, the committee is aware that an adjustment is made for the availability of hepatitis C generic medications in 2019, but not of the magnitude of any such adjustment nor whether this adjustment varies by year. Similarly, the committee is aware that there were significant changes to specialty drug trends from the 2023 model to the 2024 model, but not of the magnitude of trend in either year or of how pharmacy rebates are reflected in any trends. The committee encourages federal regulators to provide additional information related to key assumptions underlying the risk adjustment calibration process so that actuaries and other stakeholders could better understand the model and key drivers of model changes every year and provide constructive feedback on these changes. The committee would welcome the opportunity to discuss this further with the departments.

### *Use of Data from 2020 and 2021 in Risk Adjustment Calibration*

The committee notes that CMS is utilizing EDGE data from 2020 and 2021 in risk adjustment coefficient calibration “r.” There is value in data recency, particularly with regards to price levels. However, during the arrival of COVID-19 in 2020 and the public health emergency in 2021 and 2022, there were significant shifts in utilization, and the level of any changes on overall medical expenditures and treatment protocols is still evolving. The committee remains concerned that this data may not be consistently reliable for predictive purposes, though the committee notes that federal regulators have indicated they have reviewed the data and find it to be valid. However, the shifts in the structural nature of health care during the public health emergency make it challenging to demonstrate the level of predictive value that health care costs and conditions may have when applied to future years’ experience.

### **CSR Adjustment Factors for Individuals Enrolled in American Indian/Alaska Native CSR Plan Variations**

The committee appreciates the modification to cost-sharing reduction (CSR) adjustment factors in the plan liability risk score for CSR plan variations available to American Indians and Alaska Natives (AI/AN). As CMS noted in its October 26, 2021, [technical paper](#), utilization for this population has been historically underpredicted by the risk adjustment model, and CMS has developed sufficient EDGE data to meaningfully evaluate the level of underprediction present. The revised factors should reduce incentives for health insurers in states with material AI/AN populations to avoid covering this population and may increase access to coverage over time for these individuals. The committee encourages continued evaluation of utilization data for this population and for other CSR-eligible members. While there is no change proposed to CSR adjustment factors for other CSR-eligible members, the committee reiterates [our prior comments](#) regarding the need for careful evaluation of the current CSR adjustment factors and consideration of any health equity issues associated with the low observed utilization levels for individuals enrolled in the silver income-based CSR plan variations, as noted in CMS’ October 26, 2021, [technical paper](#).

### **State Flexibility and Health Equity**

The Academy’s Health Equity Committee and Individual and Small Group Markets Committee (the committees) recognize and support HHS proposals that are intended to provide states with greater flexibility to offer equity-enhancing benefit coverage based on state-specific market dynamics and acknowledge that the ability to act on these proposals may be limited by existing regulatory constraints. The committees welcome the opportunity to have additional conversations to explore these issues in depth with the Departments.

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The committee appreciates the opportunity to provide comments on the 2025 proposed Notice of Benefit and Payment Parameters. The committee welcomes 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 American Academy of Actuaries senior health policy analyst, at [williams@actuary.org](mailto:williams@actuary.org).

Sincerely,

Jason Karcher, MAAA, FSA  
Chairperson, Individual & Small Group Markets Committee  
American Academy of Actuaries