November 12, 2024

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

Re: Proposed Notice of Benefit and Payment Parameters for 2026

To Whom It May Concern:

On behalf of the Individual and Small Group Markets Committee of the American Academy of Actuaries ("the Committee"),[1] I appreciate the opportunity to provide comments regarding the proposed rule for the 2026 Notice of Benefit and Payment Parameters (NBPP).[2] Specifically, the Committee is commenting on the following provisions Expiration of Enhanced Premium Subsidies, Codification of Cost-Sharing Reduction Loading, Allowable Premium Payment Thresholds, the Movement of Medical Loss Ratio Risk Adjustment, Risk Adjustment, including Data Validation, Basic Health Plan Proposals, Standardized Plan Updates, and the 2026 Actuarial Value Calculator.

Expiration of Enhanced Premium Subsidies

HHS frequently refers to the looming expiration of enhanced premium subsidies for eligible individuals purchasing coverage in the individual market as instituted by the American Rescue Plan Act of 2021 (ARPA) and extended by the Inflation Reduction Act of 2022 (IRA). Under the IRA, the individual market premium subsidies will return to their original specifications for plan year 2026, reducing premium subsidy levels for individuals in households with incomes at or below 400% of the federal poverty level (FPL) by 2 percent of household income and ending any subsidies for individuals in households with incomes over 400% of FPL. Most observers anticipate that this would result in a significant reduction in enrollees in the individual market. We also anticipate that this will increase the average claims incurred per member in the individual market single risk pool, because healthier individuals are more likely to drop coverage when premiums increase. We anticipate that transitions from exchange coverage to employer coverage will not include a material portion of exchange enrollees due to cost sensitivities.

[1] The American Academy of Actuaries is a 20,000-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.
[2] "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program"; *Federal Register*; 2024, October 10.

In the NBPP, HHS indicates that it expects exchange enrollment to decline in a similar pattern to Congressional Budget Office (CBO) projections.[3] In June 2024, the CBO report projected Exchange enrollment dropping from nearly 22 million in 2024 to roughly 16 million enrollees over the course of 2026 and 2027, which is roughly in line with 2023 enrollment levels. However, overall Exchange enrollment was closer to 11 million before the COVID pandemic, the last time period without any increased subsidies or COVID-related special enrollment periods.[4] If exchange enrollment drops faster or more than expected, 2026 user fee estimates may be low compared to fixed Exchange-related costs. We request that HHS provide comments on any potential impact of inadequate fees on Exchange and risk adjustment operations, and how any underfunding in 2026 may affect fee levels in 2027 and later.

For the risk adjustment user fee in particular, the preamble indicates that the user fee level of $0.18 per billable member per month was developed by incorporating HHS' projections of the impact of the expiration of enhanced subsidies. This rate is the same as the finalized 2025 user fee level, which commentary indicates is based on having the same budget levels as 2025 and "[no estimated increase in] enrollment." However, if enrollment is expected to decrease, the same budget level would result in a higher user fee. We request that the CMS confirm this calculation and clarify its explanation as to why decreased enrollment would not result in an increase in the risk adjustment user fee.

Codification of Cost-Sharing Reduction Loading

In the proposed rules, HHS solicits comments regarding whether and how to codify current federal permission for "reasonable and actuarially justified" cost-sharing reduction (CSR) loading. CSR loading is a response to the October 2017 cessation of federal CSR reimbursements. Beginning in 2018, issuers in nearly all states increased their premiums via CSR loading to cover the costs associated with providing CSRs to eligible enrollees. Currently, most states allow or require issuers to increase the premiums only for silver plans (i.e., silver loading), often specifically only on exchange silver plans. A few states allow or require issuers to increase the premiums for all plans (i.e., broad loading).

As outlined in August 2018 guidance,[5] CMS' Center for Center for Consumer Information and Insurance Oversight (CCIIO) clarified its view that a plan-level adjustment to reflect "the impact of the loss of anticipated federal funding for CSR payments" was allowable under the existing regulatory permission for plan-level adjustments related to the actuarial value and cost-sharing design of the plan in 45 CFR 156.80(d)(i). As noted in the proposed rule, HHS explicitly "affirms that silver-loading and broad-loading practices to increase premiums to offset amounts of unpaid CSRs that are permitted by State regulators are permissible under Federal law to the

[3] *Health Insurance Coverage for the U.S. Population, 2024 to 2034*; Congressional Budget Office; 2024, June 18.
[4] Full Year Effectuated Enrollment Report (2016-2023) for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight; 2024, July 2.
[5] *Insurance Standards Bulletin Series – INFORMATION*; Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight; 2018, August 3.

extent that they are reasonable and actuarially justified." The proposed rule suggests adding explicit language to 45 CFR 156.80(d)(i) to permit such loading.

The codification of the allowability of CSR loading—for instance by explicitly noting that the actuarial value and cost-sharing factor in 45 CFR 156.80(d)(i) includes unfunded cost-sharing subsidies—provides more certainty for plans and regulators regarding how plans should account for these obligations as part of plan premiums.

Notably, the current requirements for plan-level adjustments in 45 CFR 156.80(d) already require all such adjustments to be "actuarially justified." Any new and specific regulatory context would need to define "reasonable."

The exact language used to codify CSR loading could have implications regarding might be viewed as reasonable by actuaries in the absence of a direct definition of reasonability. In general, it is our understanding that federal regulators intend that "reasonable" CSR loads would reflect the amount that the federal government would have reimbursed. The current guidance suggesting that CSR loading is permissible as part of a plan's actuarial value and cost-sharing factor has been referenced as supporting CSR loads based on the average actuarial value of silver plans' variants in lieu of the unfunded amount of subsidy provided.

HHS uses both "CSR loading" and "actuarial loading" to describe the premium loads arising due to the lack of federal funding for CSRs. The "CSR loading" term is more appropriate because it is more specific; "actuarial loading" could refer to a broader range of premium loads, including those related to new benefits or administrative expenses.[6]

Allowable Premium Payment Thresholds to be Considered Payment in Full

Current regulations in 45 CFR 155.400(g) permit Exchanges to allow (and note that Federally-facilitated Exchanges (FFEs) and State-based Exchanges using the Federal platform (SBE-FPs) will allow) issuers to establish a threshold percentage of premium payments to be considered payment in full. Issuers are allowed to establish a threshold, as long as it is "reasonable" and applied uniformly to all enrollees. Issuers calculate amounts as a percentage of total premium paid by the member out of total premium owed by the member. Premium in this case is gross premium net of any advance payment of premium tax credits. Issuers may apply the threshold to effectuation of coverage, initiation of a grace period, or termination of coverage for nonpayment. While there is no codified minimum threshold that would be considered reasonable, HHS noted it had previously recommended a percentage greater than or equal to 95% in the Federally-facilitated Exchange (FFE) Enrollment Manual.[7] We refer to this flexibility as the "net premium threshold."

[6] *Insurance Standards Bulletin Series – INFORMATION*; Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight; 2018, August 3.
[7] *Federally-facilitated Exchange (FFE) Enrollment Manual*; Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight; 2023, July 12.

In the Payment Notice, HHS proposes to modify/extend this current flexibility in three ways:

Change to the current net premium threshold

HHS proposes codifying the current recommended minimum net premium threshold of 95% as the threshold percentage. It is important to note that net premiums can be small. For 2024, the average net premium for all Exchange enrollees is about $100, which means that this threshold equates to $5 per month on average.[8] The administrative cost for reaching out to members and performing required tasks related to termination of coverage can significantly exceed this amount, particularly for enrollees with very low net premiums. There is no public information regarding issuer-specific premium thresholds and, as such, it is unclear whether a 95% threshold would result in increased or decreased disruption for members currently protected by an issuer's net premium threshold policy. HHS may wish to solicit more information from issuers regarding current levels of protection offered before instituting a fixed protection percentage for the current net premium threshold, particularly if the goal is to improve health equity outcomes.

Creation of a gross premium threshold policy

In addition to the current net premium threshold policy, HHS proposes a gross premium payment threshold policy, set at 99% of total premiums paid. Based on average 2024 effectuated Exchange premiums of roughly $600, this would equate to a $6 per month threshold on average.[9] Citing program integrity concerns, HHS proposes that this threshold could not be applied to a member's binder payment to effectuate coverage. The overall threshold is similar to that for the net premium threshold but would result in a smaller spread of dollar amounts between different individuals. For members whose net premiums are below this gross premium threshold, coverage could be maintained without additional payment through the end of the year. This proposed threshold is generally in line with the net premium payment in aggregate but presents a larger threshold for individuals with reduced net premiums, which will naturally tend to have lower incomes than members with larger net premiums.

In general, members with higher incomes are more likely to benefit from the established net premium percentage, while members with lower incomes are more likely to benefit from this gross premium threshold, which is consistent with CMS' goals.

This consideration means that the binder payment element of this provision primarily affects lower-income individuals. The binder payment provision limits the cases to which the threshold may apply, which may limit the health equity benefit that HHS indicates it is seeking. Similar to the above, the per member cost of processing terminations may significantly exceed the threshold forgiveness amounts, which may warrant a lower specified percentage. Specifying the binder payment provision would likely result in modest improvement to program integrity. Other proposed provisions related to agent and broker activities may limit the practical benefit of this provision when viewed in combination.

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[8] "The February effectuated enrollment and premium data and methodology for plan years 2017-2024"; Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight; 2024, February.
[9] "The February effectuated enrollment and premium data and methodology for plan years 2017-2024"; Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight; 2024, February.

Creation of a fixed dollar threshold

In addition to the percentage-based thresholds discussed above, HHS also proposes a fixed $5 premium forgiveness threshold. Unlike the percentage-based thresholds, this threshold would be applied on an annual rather than a monthly basis. Compared to the premium thresholds discussed above, this annual $5 threshold is thus significantly more stringent. This provision would limit the value of this threshold to individuals with larger net premiums, and as such, primarily benefits individuals with lower incomes, in alignment with CMS' health equity goals for the provision. However, failure to pay premiums may result in an inconsistent member experience. For a member whose net premium is $0.99, a member subject to this policy would not be put into a grace period or terminated for five consecutive months of non-payment. The member may then be surprised by or otherwise fail to notice that the sixth missed payment results in entry into a grace period and ultimately termination of coverage, incurring potentially significant plan cost and member care disruption. As such, it may be prudent to establish this threshold as a monthly rather than an annual threshold, because doing so would ensure consistent member experience during the year. This threshold is not available for binder payments, and we refer to the aforementioned comments on the gross premium threshold with regard to that provision.

General comments on premium thresholds

These premium threshold provisions generally serve to keep individuals in the risk pool, which supports market stability. They could offer benefits to members experiencing financial duress and streamline plan administrative requirements. Actuarially, these provisions would likely have limited effect on premiums in either case, particularly in light of the general level of premium thresholds proposed to be codified. The current regulatory text permits different issuers to have different thresholds. As a result, it is possible that some issuers may currently offer greater consumer protection than the currently proposed thresholds. It may be prudent for HHS to seek more information regarding current threshold levels prior to codification of any percentages into regulatory text. As an alternative that may minimize disruption, HHS could avoid setting a specific threshold, but instead incorporate any specific standardization efforts into rate review, where regulators could review thresholds in light of the facts and circumstances applicable to each plan.

Movement of Medical Loss Ratio (MLR) Risk Adjustment from Numerator to the Denominator for Certain Issuers

HHS proposes to change the MLR treatment of risk adjustment payments for issuers receiving a risk adjustment payment equal to at least half of their billed premium, with a stated purpose of incentivizing innovation by health plans that enroll underserved consumers with high health needs. HHS asserts that this relationship between risk adjustment and premiums generally occurs because an issuer has both less healthy members and lower premiums. Shifting risk adjustment from the MLR numerator to the MLR denominator would effectively dampen the influence of this risk adjustment payment, resulting in a higher MLR and potentially reducing or eliminating any MLR rebate that might have otherwise been owed. Current risk adjustment processes already

apply an administrative cost adjustment of 86% to convert the statewide average premium to an incurred claims basis, so the risk adjustment payment is already on an incurred claims basis, consistent with other MLR numerator items. However, if such issuers typically have lower premium rates than the statewide average, the claims effect would appear to be overstated—in effect reimbursing the issuer too much for its cost to treat the health conditions of those it has enrolled. To the extent that owing MLR rebates may be construed as discouraging lower-cost issuers from enrolling less healthy members, this idea appears to have some appeal. However, it has two main drawbacks. First, this adjustment would require an assertion that risk adjustment in essence overcompensates these issuers for the relative health risks, and that they are entitled to retain that overcompensation. Second, any rebates that are owed are ultimately paid to the members. Ignoring any behavioral implications for affected issuers, changing the treatment of risk adjustment would shift payment from members back to health plans. This may result in a health equity impact opposite of what regulators indicate they are seeking.

The alternative proposal (shifting all risk adjustment to the denominator) runs contrary to the indicated design of the risk adjustment program, which already includes adjustments designed to ensure that risk adjustment is on a claims/MLR numerator basis rather than a premium/MLR denominator basis. As such, it may not be appropriate to implement this change. Rather, we suggest CMS consider exploring ways to make risk adjustment more responsive to the specific concerns and/or the nature of affected issuers.

On a more technical note, there are some definitional contradictions between the MLR process and the statutory financial reporting on which MLR is largely modeled. Much confusion arises as statutory revenues include both billed premium and risk adjustment transfers. Conversion of statutory premium to MLR premium must account for this distinction. Our understanding of the statutory MLR language—indicates that it requires shifting certain amounts from where they are considered in statutory financials (as revenue adjustments) to their functional natures (as claims adjustments). This warrants care when defining MLR terms using terminology with a specific (and different) statutory definition. In particular, the Payment Notice text describing the calculation is quite clear that risk adjustment is compared to billed premiums, rather than to statutory/earned premiums.[10] However, the suggested regulatory codification is less clear, and could lead issuers to inadvertently evaluate their status as eligible issuers incorrectly, because the 50% criteria could lead issuers whose risk adjustment payment from the government is 33% of their billed premium (and this 50% of billed premium reduced by this risk adjustment payment) to incorrectly identify themselves as eligible and incorrectly use the eligible issuer MLR computation. This modification has the potential to require these issuers to run a second MLR process, which would incur additional administrative expense and potentially trigger consumer concern.

[10] 89 FR 82390, 2024, Thursday, October 10.

Risk Adjustment

Data update

CMS is retaining the 2020 and 2021 plan years as part of the data update process. We refer to our prior comments regarding potential issues over using this data.[11] However, r^2 values for the 2022 coefficients continue the gradual reduction in predictive power of the U.S. Department of Health and Human Services Hierarchical Condition Category (HHS-HCC) risk adjuster. We have fewer relative concerns regarding 2022 experience, although 2022 data, while less directly impacted by COVID-19, may not reflect a "standard population" as a large segment of enrollment was likely retained in Medicaid due to the continuous coverage requirement. We are curious whether HHS has explored the continued reduction in r^2 and, if so, could share its observations.

Affiliated Cost Factors (ACFs)

HHS proposes to establish a new class of risk adjustment factors for relevant costs that are not associated with a diagnosis and thus do not fit into the current framework for hierarchical condition categories (HCCs) or prescription drug classes (RXCs). We note that this is primarily a conceptual issue, but this change may not require the addition of a new framework. It may be more straightforward to modestly update existing HCC/RXC conceptual frameworks to incorporate any factors that would otherwise fall under the new ACF classification. Specifically, PrEP is specifically associated with avoidance of HIV/AIDS, and expanding the framework to permit HCCs and/or RXCs to be specifically associated with avoidance of a condition as well as with presence of a condition may bypass the need for an additional structure and avoid introducing this additional complexity into the risk adjustment model.

The addition of ACFs as a framework would establish a precedent of coverage of these "affiliated costs" via risk adjustment. This could become particularly impactful if other chronic high-cost services that are not correlated with an identified medical condition become more prevalent in the market. One potential area of concern is coverage of weight loss medications. Obesity is currently not an identified HCC for risk adjustment purposes. Even so, while obesity may trigger eligibility for glucagon-like peptide-1 (GLP-1) treatment, current research suggests that maintenance of any accompanying weight loss requires medication adherence.[12] With the noted cost of these medications in mind, this may generate a significant chronic cost that is no longer associated with any medical condition. In conjunction with last year's discussion of a potential future switch to the U.S. Pharmacopeia drug classification (USP DC) guidelines, which include GLP-1s for weight loss as a drug class, we encourage federal regulators to consider implications for such a future coverage requirement.

Pre-Exposure Prophylaxis (PrEP) as an ACF

Although PrEP does present unique considerations because it is not a condition, it serves to help members avoid a condition. In general, this is the kind of chronic cost that risk adjustment seeks to address to avoid creating incentives to either attract or exclude these members. Without access

[11] *Proposed Notice of Benefit and Payment Parameters for 2024*; American Academy of Actuaries; 2023, January 30.
[12] See for example, "Continued Treatment With Tirzepatide for Maintenance of Weight Reduction in Adults With Obesity: The SURMOUNT-4 Randomized Clinical Trial", JAMA, 2024, 331(1):38-48.

to the data and trends used to develop these costs and the illustrative coefficients in the rule, it is challenging to thoroughly evaluate this proposal in a meaningful way.

Reflection of the Time Value of Money

HHS requests comments on the impact the time value of money may have on issuers' assessment of actuarial risk and incentives for adverse selection. Under the Affordable Care Act (ACA) risk adjustment program, HHS announces state transfer amounts by June 30 of the year following the benefit year and collects charges and distributes payments in the fall of the year following the benefit year.

Reflecting the time value of money is consistent with actuarial practice generally and is included in health-specific Actuarial Standard of Practice (ASOP) No. 8—*Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*.[13]

As HHS notes in the NBPP, interest rates have increased recently relative to the level experienced at the inception of the ACA. Issuers owing risk adjustment payments collect premiums throughout the year and can earn interest on the excess funds not needed for claims until the transfer is collected in the fall of the year following the benefit year. Issuers receiving risk adjustment payments collect premiums that are less than needed to cover their expected claims and expenses and receive the transfer that is meant to make up for this shortfall late in the fall of the year following the benefit year. To the extent issuers are considering the time value of money, this could lead to lower premium rates for issuers owing risk adjustment transfers due to the higher expected revenue, including interest payments. If issuers expecting to receive transfers have relatively higher premium rates, they may attract higher risk individuals given that lower risk individuals are more price sensitive, contributing to adverse selection. Given that the risk adjustment program is meant to level the playing field between insurance companies and minimize the incentives for adverse selection, reflecting the time value of money may support risk adjustment goals.

There are several issues to consider if such a policy were to be implemented. First, there is a time gap between when the funds are collected and when they are paid out to the receiving issuers. This results in a differential in the time value of money to risk adjustment payers and receivers, which would require determination of how to fairly calculate the interest. A second consideration would be whether to also reflect the time value of money on the Risk Adjustment Data Validation (RADV) processes, which have an even longer timeframe. We note that CMS has already identified a potential methodology to determine the rate and how this rate ought to be applied to transfer payments. The use of the applicable federal rate as outlined would be a reasonable choice of interest rate. However, the timing issues associated with payment and receipt and furthermore with RADV may create additional challenges to operationalizing a proposal that best aligns the actual time value of money impact experienced by issuers who pay or receive risk adjustment transfers.

[13] *Actuarial Standard of Practice (ASOP) No. 8 – Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*; American Academy of Actuaries; 2014, March, see section 3.4.5.

Risk Adjustment Data Validation (RADV)

We suggest HHS consider our previous comments regarding RADV, because as currently structured the proposed modifications to the program would not meaningfully address our concerns with the ACA implementation of RADV.[14] In particular, HHS notes that the purpose of RADV is "to ensure issuers are providing accurate high-quality information to HHS." In terms of RADV's key base measurement, accuracy would be characterized as having group failure rates of 0. Due to the zero-sum nature of ACA risk adjustment, this is challenging to implement in an effective way because risk scores and actuarial risk are ultimately measured relative to other issuers in that risk pool. Treating RADV as a relative measure, as is done currently, represents a relatively reasonable approach to resolving this fundamental disconnect. However, as stated elsewhere, this approach does not target accurate data, but rather precise data–encouraging group failure rates that are close to the overall average.

Removing non-HCC members from the initial validation audit sample

We recognize HHS' interest to increase the number of plans that have credible failure rate groups, as measured by meeting the thirty External Data Gathering Environment (EDGE) Super HCC criteria. Removing individuals who have no HCCs from the sample does further that goal, since these members have no EDGE HCCs and thus no EDGE Super HCCs. However, these members may have HCCs that could be identified in RADV. Currently, the ACA's RADV structure does not encourage accurate risk adjustment coding. Rather, it encourages issuers to engage in "industry average" coding accuracy, encouraging precision of risk adjustment rather than accuracy. Furthermore, higher failure rates that do not meet the outlier threshold result in even more favorable risk adjustment rates. The current RADV approach additionally penalizes issuers with data that is closer to accurate through the application of 0% floor on group failure rates, further compounded by the current sliding scale adjustments and group failure rate lower bounds. Collectively, this creates incentives for more risk adjustment coding (e.g., higher group failure rates/more inaccurate risk adjustment coding), rather than less. Removing individuals without any HCCs from RADV sampling may serve to further encourage increased diagnosis coding for these individuals as well because issuers can no longer get any failure rate credit for diagnoses that may have been under consideration but left unreported. Moreover, as long as all issuers engage in this practice at similar rates, industry average failure rates would increase and accuracy would decrease, but RADV outcomes would be unlikely to change.

Removing the finite population correction adjustment

The proposed provision to remove the finite population correction adjustment would be expected to increase the number of plans that have credible failure rate groups, which HHS indicated was a key consideration. There is less direct coding incentive change associated with this proposal as compared to the previous one. However, this modification would generally increase the number

[14] *Proposed Notice of Benefit and Payment Parameters for 2025*; American Academy of Actuaries; 2024, January 8. *December 2019 HHS-RADV White Paper*; American Academy of Actuaries; 2020, January 2. *Amendments to the HHS-Operated Risk Adjustment Data Validation Under the Patient Protection and Affordable Care Act's HHS-Operated Risk Adjustment Program*; American Academy of Actuaries; 2020, July 2.

of sampled members. For plans that would have fewer than 200 sampled members with finite population correction, this represents an absolute increase in the number of sampled members and, correspondingly, the number of medical records required for these issuers. In essence, this proposal would burden smaller issuers without any of the relative benefits that larger issuers may enjoy if all of HHS' RADV proposals are implemented.

Changing the data source for Neyman allocation used in member sampling

We generally support updating the Neyman allocation data source. While the Medicare Advantage (MA) and ACA single risk pool risk adjusters share a common heritage in that they are driven by condition hierarchies and demographic factors, the significantly higher r^2 value of the ACA's risk adjustment model suggests that a Neyman allocation based on the MA model would normally expect more variation in information by risk score outliers, which are generally expected to be in the "high" risk score group. As such, an MA-based allocation would oversample the high-risk score group relative to others. This makes the resulting allocation shifts described by HHS in the rule reasonable. This change may also shift incentives regarding which members issuers may choose to focus on for chart reviews because it places more emphasis on lower risk score individuals. However, the timing associated with RADV may make it harder to determine whether any such efforts are fruitful in the future.

Increasing the minimum second validation audit size

We do not have any specific suggestions regarding the minimum second validation audit (SVA) size. This likely does grant more precision regarding identification of meaningfully different initial validation audit (IVA) and SVA results. We are interested in how much improvement in the identification of false negatives arises from this proposal as opposed to a change in the IVA/SVA comparison methodology, as well as how much of any increase in cost is attributed to each proposal.

Changing IVA/SVA comparison from a t-test to a bootstrap distribution evaluation

We are concerned about the potential reliance on a bootstrap distribution in this context, particularly for smaller sample size. While a bootstrap distribution can present a clearer picture of the distribution of a given sample, it does not address any underlying issues associated with smaller sample sizes and can instead give a false sense of precision when bootstrap distributions are used on smaller samples, and one that cannot be meaningfully addressed by simply choosing a wider confidence interval. The structure of a t-test, on the other hand, is geared specifically to handle small sample size uncertainty. If switching from a t-test to a bootstrap distribution at the same confidence interval and same sample size meaningfully reduces the incidence of false negatives, we would suggest further exploration of the reliability of identification of false negatives for validation purposes. If this review then suggests that this evaluation is appropriate, a switch from one distribution to another may be appropriate, Otherwise, we generally expect a t-test to be a better statistical representation in this instance.

RADV appeal materiality threshold for payment updates

We remain neutral on the proposal. It's important to note that the nationwide nature of RADV means that an immaterial adjustment for the appealing issuer may still create material changes

for other market participants. If CMS' intent is to avoid or otherwise minimize RADV appeals impacts, CMS could alternatively limit application of appeals to the state and market in which the appeal is filed, or prohibit RADV appeals from changing group failure rate classifications or bounds if appeals are submitted after transfer adjustments are posted; either approach which would also serve to limit the scope of effect of a successful appeal.

Federal Facilitation of Solvency Review for Multi-state Issuers

CMS seeks comments on how to increase its coordination with state insurance departments and the National Association of Insurance Commissioners (NAIC), particularly for multi-state insurers. CMS notes in the NBPP that the agency would engage in increased coordination only among insurers operating in the FFE, not for insurers in the SBEs or SBE-FPs, and they could increase coordination with state departments of insurance (DOIs), individually and collectively in the case of multi-state issuers, and the NAIC. Under this approach, CMS indicates that the agency could review qualified health plans (QHP) applications in FFE states to identify issuers that are at risk of experiencing solvency-related difficulties, both at the time of an issuer's application for QHP certification and on a rolling basis throughout the plan year. To assess issuer solvency, CMS also suggests that they could examine well-understood and industry-standard financial measures, such as the risk-based capital ratio and quick ratio, in partnership with state regulators.

There may be a recency bias borne in this topic, and the communicated focus is to address solvency issues via ACA Rate/Enrollment controls that would stem from ACA business performance challenges. For a proper coordinated multi-state insurer review, a holistic line of business (LOB) approach beyond commercial and major medical (e.g., long-term care insurance) is needed to ensure that the optimal levers are identified to address prospective solvency/liquidity challenges.

There is publicly available information for CMS to review. States also have access to confidential information to assess the financial health and risk of the entities under their jurisdiction to determine appropriate actions. Conclusions drawn using only publicly available information may be different from conclusions based on all information (confidential and non-confidential) to which a state has access. In particular, the approach that CMS suggests uses some of the information reported to states and would not necessarily identify carriers that are under-reserved or whose products are underpriced.

To promote insurer solvency and protect the public, we encourage collaboration between governmental entities overseeing exchange plans.

Basic Health Plan Proposals

We support HHS' changes to Basic Health Program (BHP) funding, although relying on silver CSR loads from 2018 in the development of the population adjustment factor may not reflect actual silver loads because these 2018 premiums are based on experience from a time when CSRs were fully funded. At the same time, we recognize that silver loads may also reflect a variety of other factors, including state-specified loads, the impact of state 1332 waivers, the effects of the COVID-19 pandemic and related Medicaid coverage policies, and other factors that may limit the ability for priced silver loads to reflect the impact of a state BHP on silver loads within that state.

Standardized Plan Updates

With regard to CMS' proposal that an issuer's standardized plan options within a region, product network type, and metal tier must vary by at least one of product ID, network ID, and formulary ID, this simplified meaningful difference criteria may not, in practice, capture reasonable causes of variation. For network ID and formulary ID in particular, a quantitative measure of difference (e.g., the number of different hospitals or the percentage of overlapping providers, or the average number of different drugs by essential health benefit (EHB) drug class) may both better validate differences and retain issuers' confidence in their ability to offer differing variations. However, the current standard is simpler administratively and is likely to be effective in most cases.

In particular, this functional network-level variation for standardized plan options better aligns with regional product patterns in various markets. A similar degree of variation may be appropriate for non-standard plan options as well. Other regulations for non-standardized plan options are functionally unchanged from last year, and we have no additional comments to make in this regard beyond our approval of aligning codified text with regulatory intention as expressed in guidance.[15]

2026 Actuarial Value Calculator

The actuarial value (AV) calculator is a key part of the benefit development process for plans and the Committee supports the earlier publication timeline. We also recognize that there have been no material methodological changes to the final AV calculator relative to the draft AV calculator in recent years. We are still uncertain that a general statement that there will be no draft calculator would be appropriate.[16] Updating a draft calculator based on notice and comment and publishing a final calculator does add time to the process. Condensing this process may be appropriate in certain limited cases, for example when updating a constant value such as the maximum annual limitation on cost-sharing. For other broader changes that affect the output of

[15] For more information and a discussion on "Meaningful difference & nonstandardized plans," please refer to our comments: *Proposed Notice of Benefit and Payment Parameters for 2024*; American Academy of Actuaries; 2023, January 30.
[16] *Final 2026 Actuarial Value Calculator Methodology*; Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight; 2024, October 16.

the calculator, however, notice and comment may be more appropriate. In particular, a formal opportunity for comment and review by the stakeholders including the actuarial community is likely appropriate if the underlying data itself changes, or if changes are made to the underlying computational methodology. Trend values used to project base data forward to the pricing year may appear to be a straightforward element of an update but have significant influence on actuarial values produced. It may be possible to handle some of these considerations via a robust beta testing process incorporating feedback from stakeholders. HHS indicates that it currently consults with the NAIC and the Academy regarding changes to the calculator. However, this does not clarify which changes reflect stakeholder input and what decisions regarding the calculator are made by HHS without input. If HHS opts to proceed with elimination of the draft/final AV calculator, we suggest that the agency provide more details of how stakeholders were involved in determination of any updates to the AV calculator.

We also reiterate our general comments on the actuarial value calculator, as discussed in our comments on the Draft 2025 Actuarial Value Calculator Methodology.[17]

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The committee appreciates the opportunity to provide comments on the proposed 2026 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.

Sincerely,

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

[17] *Draft 2025 Actuarial Value Calculator Methodology*; American Academy of Actuaries; 2024, January 2.