



AMERICAN ACADEMY *of* ACTUARIES

Dec. 31, 2012

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9964-P
PO Box 8016
Baltimore, MD 21244-8016

Re: Notice of Benefit and Payment Parameters for 2014

To Whom It May Concern:

On behalf of the members of the American Academy of Actuaries'¹ Risk Sharing Work Group, I appreciate this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) on the proposed rule, *Benefit and Payment Parameters for 2014*. Comments specific to the medical loss ratio (MLR) provisions in the proposed rule are being submitted separately.

Generally speaking, the details provided in the notice were very helpful and answered several of the questions our work group identified after the March 2012 release of the final rule on *Standards Related to Reinsurance, Risk Corridors and Risk Adjustment*. In order to better understand, analyze, and assist CMS, we need clarification and additional information on several issues. Throughout this letter we will designate those areas on which additional information would be appreciated.

SECTION COMMENTS

III.B. Provisions and Parameters for the Permanent Risk Adjustment Program

(3) Overview of the Risk Adjustment Methodology HHS Would Implement When Operating Risk Adjustment on Behalf of a State

Newborn age (December/Jan): According to the notice, the age of an infant is defined as of the end of the policy year. Thus, for January renewals, a premature baby born in the previous month (December) would get a much lower risk adjustment factor starting in January. We would like to confirm that this definition of age is consistent with the methodology used to develop the risk

¹ The American Academy of Actuaries is a 17,000 member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

factors. As an alternative, defining age as “the age at initial enrollment” would align with premium rating procedures.

Newborn Birth Weight: Since the birth weight of babies is not recorded by a carrier to which membership is switched mid-year, we would like HHS to clarify whether the infant risk factors were developed by including or excluding birth weight information from the prior carrier.

No age 65 and older data for the age 60 and older tier: The individual and small group market may include some participants age 65 and older. The risk model was calibrated using data for people age 0 through 64 and includes demographic factors with the top age band at 60 and older. This suggests that it may not predict cost levels adequately for enrollees age 65 and older and would affect risk adjustment results to the extent that carriers differ in their proportion of 65 and older members.

Beta testing model availability: It is our understanding that Center for Consumer Information and Insurance Oversight (CCIO) is considering making available the diagnoses mapping to Hierarchical Condition Categories (HCCs) and their hierarchy. If this information is provided in a timely manner, we could provide additional feedback on specific rate factors (e.g., the multiple sclerosis and cystic fibrosis weights appear to us to be low), the slope of the calibrated weights (e.g., for which diseases the risk weights should increase rather than decrease with decreasing actuarial value benefit designs), and the reasonableness of not including severity interaction factors for the child model.

Predictive Ratios: The discussion related to model performance statistics includes references to R-squared and predictive ratios. Table 8, however, includes only R-squared statistics. CMS may consider expanding Table 8 to include predictive ratio statistics by groupings such as disease and cost percentile.

Typographical Error: The induced demand factor (IDF) definition supporting the formula for plan i 's transfer amount (T_i) is incorrect: it should refer to induced demand factor rather than to allowable rating factor.

Cost-sharing reductions (CSR) and risk adjustment: We would like to clarify the statement on Page 73138—“This higher utilization (to the extent not covered by required cost sharing by the enrollees or cost sharing reductions reimbursed by the Federal government) would neither be paid by cost sharing reductions nor built into premiums.” We would appreciate confirmation that plan liability (as opposed to out-of-pocket cost sharing) for the increased utilization is not covered by HHS CSR payments or risk adjustment and that issuers need to build in additional premium.

Clarification as to whether issuers have a choice of how they build in the needed revenue to cover the increased plan liability associated with CSR plan variations also would be appreciated. Since plans will not be able to increase premiums for the CSR silver plan variations, do issuers have a choice of spreading the aggregate increase in utilization across all silver premiums or spreading it across more metal plans? Likewise, for Indian CSR plan variations, do issuers have

a similar choice of where to build in the additional revenue needed to cover the associated increases in utilization?

Indian CSRs: Regarding Table 7, it appears that the order of the induced utilization factors for the Indian CSR recipients category is reversed. The factors should be 1.00 for platinum, 1.07 for gold, 1.12 for silver, 1.15 for bronze and 1.00 for those greater than 300 percent of federal poverty level (FPL). That would be consistent with Table 17.

We also request confirmation as to whether the above reversal had any impact on the calibration of the risk adjustment model.

Interim scores for pricing and valuation: It is important that issuers receive information pertaining to their relative risk during the benefit year. Such interim reports during the benefit year will create greater premium stability and help protect against uncertainty in rates because issuers would reference them in their pricing and valuation efforts.

Since interim risk score calculations would not reflect true relative risk due to the underlying calibration, HHS may instead publish informational interim reports with details like market average prevalence by metal plan, disease, demographics, interaction cells, and infant immaturity and severity combinations. We suggest that HHS collect information from issuers on a quarterly basis and provide the interim reports each quarter, as is done with the reinsurance program. HHS might consider beginning the process in June 2014.

III.C. Provisions and Parameters for the Transitional Reinsurance Program

(1) State Standards Related to the Reinsurance Program

State High Risk Pools (HRPs) phase-in: We request clarification regarding how HRPs will be treated post reform. It is our understanding that HRPs will not be part of the premium stabilization programs. All else being equal, phasing in HRP members, combined with an already increasing enrollment in eligible plans and a decreasing amount of total reinsurance dollars, could further exacerbate potential rate increases in the individual market as the per capita reinsurance subsidy declines². We request information on what situations make it worth keeping HRPs open after 2013.

To the extent that HRPs are not self-supporting and continue to be subsidized by carriers, will such subsidization be recognized as an adjustment to risk-corridor calculations and MLR rebates as a state fee or tax?

² See explanation of the reinsurance subsidy impact in the American Academy of Actuaries comments on the proposed rule for standards related to risk adjustment, reinsurance, and risk corridors: http://www.actuary.org/files/publications/RSWG_comment_letter_on_3R_proposed_rule_111028.pdf (Oct. 28, 2011).

(2) Contributing Entities and Excluded Entities

Specific Entities: Our requests for clarification are listed below:

1. We seek clarification whether health issuers not regulated by departments of insurance, such as the California Managed Care Department, HMOs in some states, etc., are subject to the assessments and, if not, whether they also would not be eligible for reinsurance payments.
2. In some states large-group policy provisions are filed in basic form with the state and the variations therein are approved for use for insured groups. In most of those cases, the policies that are fully insured by the employer are not filed subsequently. In other states, various degrees of fully insured policy provisions/policies are filed. We recommend consideration that large-group employer coverages classified as insured in annual reporting be the defining element.
3. While the preamble to the notice clarifies that federal, state-based, and/or Tribal employee plans are included in the assessment base, we suggest that this be detailed explicitly in the regulation.

(7) Uniform Adjustment to Reinsurance Payments

Reinsurance contributions that remain unused after 2016: The proposed rule states that “The total amount of contributions considered for this purpose would include any contributions collected but unused under the national contribution rate during any previous benefit year.” Clarification regarding what will happen if funds remain unused after reinsurance payments are made under the published parameters for 2016 would be helpful.

III.D. Provisions for the Temporary Risk Corridors Program

(1) Definitions

Profits: The example given for the profit calculation applies the 3 percent margin to pre-tax premium, while the draft regulation states “three percent of after tax premiums.” It is our understanding that the 3 percent margin applies to after-tax premiums. Please clarify whether this is the case. We agree that this approach to defining the target amount is reasonable.

Risk Corridors Ratio: The Academy’s MLR Work Group is submitting a separate comment letter to CMS concurrent with this comment letter. The Risk Sharing Work Group concurs with the modifications that the MLR work group is recommending. If CMS implements those recommended modifications, we suggest that CMS also revisit the risk corridors ratio formula in order for the 20 percent administrative cap to be consistent with the complementary 80 percent MLR threshold formula. We believe that the risk corridors ratio formula would accordingly need to change from

$$\frac{\text{Claims} + \text{RAR Charges} - \text{RAR Payments} + \text{RI Contributions} - \text{RI Payments} - \text{CSR}}{\text{ATP} - \text{Min}[0.20 \times \text{ATP}, \text{Admin}] + \text{Max}\{0.03 \times \text{ATP}, \text{Profit}\}}$$

to

$$\frac{\text{Claims} - \text{RI Payments} - \text{CSR}}{\text{ATAP} - \text{Min}[0.20 \times \text{ATAP}, \text{Admin}] + \text{Max}\{0.03 \times \text{ATAP}, \text{Profit}\}}$$

where

ATP (After-Tax Premium) = Premium – Tax, and

ATAP (After-Tax Adjusted Premium) = ATP – RAR Charges + RAR Payments – RI Contributions.

Iterative nature for profits and taxes: Margin, taxes, etc., are calculated based on all data prior to risk corridor payments or charges. Risk corridor impacts are then captured in income. New margin and taxes are subsequently recalculated, but the new margins are not used again to recalculate a new risk corridor. Please clarify whether this is the intent of the regulation. An illustration is provided below for each of two scenarios—one that results in a payment, the second that results in a charge. The illustration stops after one iteration, but theoretically can be continued for more iterations.

Note: The illustration below applies the 3 percent margin to the post-tax premium and uses the risk corridor ratio formula from the draft notice (and not the formula suggested in this comment letter’s preceding section).

Illustration #1

Positive Risk Corridor				Risk Corridor calculation			
				"Initial"	"2nd Iteration"	... may iterate on ...	
Claims	\$ 293.00			\$ 276.02	\$ 276.02		
Risk Adjustment receipt	\$ 19.90						
REIN receipt	\$ 43.39						
Member Premium	\$ 276.02		Premium	\$ 276.02	\$ 276.02		
Total Revenue (with 2Rs)	\$ 339.30		Allowable costs	\$ 235.66	\$ 235.66		
			Non-claim costs	\$ 59.53	\$ 60.62	:	:
			Taxes without FIT	\$ 8.06	\$ 8.06	:	:
			FIT	\$ (4.79)	\$ (3.70)	:	:
			Total Taxes	\$ 3.26	\$ 4.36	:	:
			Admin costs	\$ 56.27	\$ 56.27	:	:
			After tax premium	\$ 272.75	\$ 271.66	:	:
Admin / Commissions	\$ 56.27		Profits for allowable admin formula	\$ 8.18	\$ 8.15	:	:
Reinsurance Cost	\$ 5.95		Allowable admin costs	\$ 57.81	\$ 58.69	:	:
Taxes	\$ 8.06		Target amount	\$ 218.20	\$ 217.33	:	:
Margin before risk corridor	\$ (23.97)		Risk Corridor ratio	108.00%	108.44%	:	:
Federal Income tax before risk corridor	\$ (4.79)		Risk Corridor percent	2.5%	2.8%	:	:
Margin After "Initial" risk corridor	\$ (18.51)		Risk Corridor payment	\$ 5.46	\$ 6.19	:	:
Federal Income tax after risk corridor	\$ (3.70)						
Margin after "2nd iteration" risk corridor	\$ (17.78)						
Federal Income tax after "2nd iteration" risk corridor	\$ (3.56)						
:	:						
(may iterate on) :	:						
Negative Risk Corridor				Risk Corridor calculation			
				"Initial"	"2nd Iteration"	... may iterate on ...	
Claims	\$ 252.00			\$ 276.02	\$ 276.02		
Risk Adjustment receipt	\$ 19.90						
REIN receipt	\$ 43.39						
Member Premium	\$ 276.02		Premium	\$ 276.02	\$ 276.02		
Total Revenue (with 2Rs)	\$ 339.30		Allowable costs	\$ 194.66	\$ 194.66		
			Non-claim costs	\$ 67.73	\$ 66.66	:	:
			Taxes without FIT	\$ 8.06	\$ 8.06	:	:
			FIT	\$ 3.41	\$ 2.34	:	:
			Total Taxes	\$ 11.46	\$ 10.40	:	:
			Admin costs	\$ 56.27	\$ 56.27	:	:
			After tax premium	\$ 264.55	\$ 265.62	:	:
Admin / Commissions	\$ 56.27		Profits for allowable admin formula	\$ 13.62	\$ 14.69	:	:
Reinsurance Cost	\$ 5.95		Allowable admin costs	\$ 64.37	\$ 63.52	:	:
Taxes	\$ 8.06		Target amount	\$ 211.64	\$ 212.50	:	:
Margin before risk corridor	\$ 17.03		Risk Corridor ratio	91.98%	91.61%	:	:
Federal Income tax before risk corridor	\$ 3.41		Risk Corridor percent	-2.5%	-2.8%	:	:
Margin After "Initial" risk corridor	\$ 11.70		Risk Corridor payment	\$ (5.33)	\$ (5.98)	:	:
Federal Income tax after risk corridor	\$ 2.34						
Margin after "2nd iteration" risk corridor	\$ 11.05						
Federal Income tax after "2nd iteration" risk corridor	\$ 2.21						
:	:						
(may iterate on) :	:						

Illustration for illustrative purposes only – prepared by the Risk Sharing Work Group

(2) Risk corridors establishment and payment methodology

Settlements versus timing of the three risk sharing programs and MLR: The regulations specify that issuers will be notified of the risk adjustment and reinsurance payments and charges annually by June 30 of the year following the benefit year; qualified health plan (QHP) issuers must submit required information on risk corridors by July 31 of the year following the benefit year. And the MLR and rebate calculations will be due by July 31 of the year following the benefit year. There likely will be settlements resulting from unplanned events such as claims adjustments past the reporting deadlines, claims run out past the reporting deadlines, ongoing audit findings, and enrollment and eligibility status (e.g., CSR or Medicaid eligibility) reconciliations. Because these settlements will affect the reported data, clarification on treatments of these future settlements on risk adjustment, reinsurance, risk corridor, and MLR rebate calculations would be appreciated.

III.E. Provisions for the Advance Payments of the Premium Tax Credit and Cost-Sharing Reduction Programs

We make the following comments and requests for further clarification regarding the proposed rule on the CSR program:

- To be consistent with the rules governing the determination of actuarial value (AV), when silver plan alternatives cannot be accommodated by the AV calculator, HHS should regulate that AV determinations should be required to be certified by a member of the American Academy of Actuaries.
- According to the proposed rule, cost sharing for silver plan variations cannot exceed the corresponding cost sharing for a standard silver plan or a silver plan variation with a lower AV. Is it allowable for a plan to switch between copayments and coinsurance for silver plan variations, as long as the cost sharing is not greater than that for plans with lower AVs?
- Which “desired metal tier” level should be input when using the AV calculator to determine the AV for the silver plan alternatives?
- It could be difficult for HSA-compatible plans to meet lower deductible requirements for 94 percent AV silver plan alternative, given the statutory deductible levels for HSA plans. How should silver plan alternatives be designed for HSA-compatible plans?
- Any information that HHS can share from its modeling regarding the expected rate of changes in CSR eligibility within a plan year would be appreciated. Such information would be helpful for issuers to adequately set appropriate reserve levels and ensure they have the required administrative and actuarial resources to make any associated eligibility changes.

III.G. Distributed Data Collection for the HHS-Operated Risk Adjustment and Reinsurance Programs

(3) Risk Adjustment Data Requirements

Admission Date in risk adjustment year, Discharge Date in subsequent year:

The proposed rule states that “Institutional and medical claims and encounter data where the discharge date or through date of service occurs in the applicable benefit year will be allowed for risk adjustment, provided that all other criteria defined under this section are met.”

In this regard, consider a case with an admission date of Dec. 15, 2014 and a discharge date of Feb. 10, 2015. Clarification as to whether or not this case would be included in the 2014 concurrent risk adjustment and the rationale for the selected approach would be appreciated. A risk adjustment methodology that is concurrent would ideally include cases that straddle two calendar years in the first year’s risk adjustment since issuers typically book the entire cost liability for such cases in the first year.

We also request confirmation on whether the risk weights were/will be calibrated consistent with how such cases will be included or excluded in the risk adjustment year.

(4) Reinsurance Data Requirements

Admission Date in reinsurance year, Discharge Date in subsequent year:

The proposed rule states “Medical and pharmacy claims, where a claim was incurred in the benefit year beginning on or after January 1 of the applicable benefit year and paid before the applicable data submission deadline (provided all other criteria are met) would be accepted for consideration.”

Please clarify whether the case described in the example above (admission Dec. 15, 2014, discharge Feb. 10, 2015) would be considered under the proposed rule to be entirely within the 2014 reinsurance program or if it would need to be split into two portions with only the Dec. 15, 2014 to Dec. 31, 2014 portion considered as part of the 2014 reinsurance program. While commercial reinsurance is available on both bases, inclusion of the entire inpatient stay as part of the 2014 reinsurance program would be consistent with the Early Retiree Reinsurance Program approach as well as with how issuers typically book their liability.

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We welcome the opportunity to discuss with you at your convenience any of the comments presented in this letter. If you have any questions or would like to discuss these items further, please contact Heather Jerbi, the Academy’s senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

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