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February 19, 2019

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9934-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Re: Proposed Notice of Benefit and Payment Parameters for 2020

To Whom It May Concern,

On behalf of the Individual and Small Group Markets Committee and Risk Sharing Subcommittee of the American Academy of Actuaries,<sup>1</sup> we would like to provide the following comments on the proposed rule for the 2020 notice of benefit and payment parameters (NBPP). Our comments are organized by provisions related to risk sharing, as well as on additional items the Department of Health and Human Services (HHS) specifically requested comments on such as automatic re-enrollment, cost-sharing requirements, the exchanges, silver loading, premium adjustment percentage, and treatment of brand drugs.

## **Comments on Risk-Sharing Provisions**

### **Use of 2016 EDGE, 2017 EDGE, and 2017 MarketScan for 2020 risk scores**

Since establishment in 2015 of the process of blending three years of separately solved coefficients to develop risk adjustment model coefficients, HHS has sought to spread the impact of new experience by removing one year of data while adding a new year to incorporate more recent data. We note that the proposed 2020 coefficients represent a change from that practice. Similar to past practice, 2019 risk adjustment coefficients reflect 2014 and 2015 MarketScan data and 2016 EDGE data. If consistent with this practice, the 2020 risk score coefficients would be based on the 2015 MarketScan, 2016 EDGE, and 2017 EDGE data. However, HHS proposes using 2016 EDGE, 2017 EDGE, and 2017 MarketScan. Thus, only one of the three data sets used to develop the 2019 coefficients will be included in the development of the 2020 coefficients—the 2016 EDGE data. While we appreciate the goal of incorporating more recent MarketScan data, we have concerns about potential volatility in the resulting coefficients relative to prior years. Commentary in the payment notice suggests that there is some volatility, particularly in hierarchical condition categories (HCCs) that are associated with a prescription drug category (RXC) and an RXC-HCC interaction term (though the total of the three is

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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 in the United States.

relatively stable). It would be helpful to have more information on whether this volatility would be reduced if 2015 MarketScan data were used in place of 2016 MarketScan or, when available, 2017 MarketScan data, consistent with prior-year coefficient development methodology. Use of 2015 MarketScan data, rather than 2017 MarketScan data, would be more consistent with the gradual phase-in of the impact of new experience on coefficients.

If the desire in using 2017 MarketScan data is simply to reflect recent data, we suggest that HHS evaluate whether coefficients based solely on 2016 and 2017 EDGE are materially different from those that include 2017 MarketScan. If differences in these coefficients are driven by large group or self-insured components of MarketScan, then use of EDGE-only coefficients could better reflect costs in the Affordable Care Act (ACA) market that the risk adjustment program pertains to.

Additionally, we note that use of both 2017 EDGE and 2017 MarketScan data would double-count any ACA-compliant 2017 individual and small group market experience included in the MarketScan database. MarketScan does not publish sufficient information about contributing insurers to determine whether any of the MarketScan data include a variety of ACA insurers or whether it is concentrated in insurers that might not have experience typical of the rest of the market. If any double-counted experience is not consistent with the broader ACA market, then use of both 2017 EDGE and 2017 MarketScan could create distortions in coefficients. Use of 2015 MarketScan would not entirely address this issue but would have the advantage of reflecting a different year of care patterns and would not overweight any 2016- or 2017-specific fluctuations in experience.

Finally, HHS might consider the timing of risk adjustment coefficient publication and the ability of issuers to reflect the impact of changes on their rate development process. The 2015 MarketScan data would already be available and complete coefficients reflecting 2015 MarketScan, 2016 EDGE, and 2017 EDGE are available and could be provided prior to the release of the final rule. So doing would give issuers more time in this year's unanticipated and compressed period between proposed rulemaking and rate filing deadlines.

### **Impact of Negative Outliers on Other Issuers in the Market**

The current Risk Adjustment Data Validation (RADV) error estimation process has the potential to have large unexpected negative impacts on issuers' financial results for 2018 and 2019—specifically in states where an issuer is an outlier on the low end of the group failure rates, meaning that their error rates were lower than average and/or that diagnoses were added due to the audit. Because the intervals used to determine outliers are very large (based on the 2016 pilot RADV) and the adjustment for outliers is based on the difference between the outlier issuer's group failure rate and the nationwide weighted average failure rate, the estimated error adjustment for the outlier issuer is significant. If the outlier issuer has more than a small amount of enrollment in the state, its adjustment can move the state average risk score up substantially, which would negatively impact the transfers for other issuers in the state.

Consider an illustrative example where a single carrier with 30 percent market share has a 10 percent aggregate error rate (meaning its risk score will be increased by 10 percent) and slightly

below-market-average risk. In this scenario, the statewide average market risk score increases by 2.8 percent, resulting in a significant negative impact on other issuers of a magnitude similar to a typical profit and risk charge. Changes in statewide average market risk score of this magnitude could result in moving an issuer from a risk adjustment receiver to becoming a risk adjustment payer. If the outlier issuer has a larger market share, a larger negative error rate, or a higher risk score, the impact on the other issuers can be even larger.

### Hypothetical Example

Issuer	Market Share	Pre RADV			Post RADV			Change as Percent of Premium	
		Risk Score	Normalized Risk Score	Simplified Risk Transfer Payment as % of Premium	RADV Adjustment to Mean of CI	Adjusted Risk Score	Normalized Risk Score		Simplified Risk Transfer Payment as % of Premium
A - Outlier	30%	0.95	0.941	-5.9%	10%	1.045	1.006	0.6%	6.6%
B	40%	1.05	1.040	4.0%	0%	1.050	1.011	1.1%	-2.9%
C	20%	1.10	1.089	8.9%	0%	1.100	1.059	5.9%	-3.0%
D	10%	0.85	0.842	-15.8%	0%	0.850	0.818	-18.2%	-2.3%
Total		1.01	1.000			1.039	1.000		
				Increase in Market RS		2.8%			

The results of the 2017 RADV will be used to adjust payment transfers for the 2018 benefit year. Issuers have already priced their 2018 (and 2019) plans and likely did not expect the impact of RADV to be as large as indicated by the 2016 pilot, results of which were finalized in July 2018. In fact, the most significant components of the current RADV methodology were not even finalized until April 2018.

The unexpected impact and uncertainty of the possible RADV adjustment for 2018 is a significant concern for accruing for financials and financial planning. In addition, issuers will be pricing for 2020 plans before the results of the RADV for 2018 are known, although states may allow adjustments after the risk adjustment report is released on June 30. At this time, issuers are only aware of the 2016 pilot results, which the Centers for Medicare and Medicaid Services (CMS) has indicated are unlikely to be a good predictor of non-pilot-year RADV performance. Continued uncertainty could lead issuers to increase rates above what they would have been to account for this additional risk.

It is unknown whether the RADV adjustments will be stable from year to year. A state might have an issuer that is a negative outlier in one year, but within the confidence interval the following year. Such a scenario could have a large unanticipated impact on the statewide average risk score from year to year, decreasing the ability of issuers to price to statewide market risk.

The RADV process calculates HCC failure rates, which represent HCCs validated or added during the audit divided by HCCs reported on EDGE. The HCCs are grouped into three cohorts for HCCs with low, medium, and high failure rates. The current adjustment compares issuer HCC group failure rates against nationwide weighted average HCC failure rates, rather than using the statewide weighted average. Thus, the methodology provides an adjustment that could result in adjusted risk scores that are too large in states where prevalent practices result in lower

failure rates of particular HCC groups relative to the nationwide average, potentially penalizing issuers that are typical in that state if that state is atypical relative to the nation. Likewise, the methodology produces adjusted risk scores that could be too low if the state's prevalent practices result in higher failure rates of particular HCC groups relative to the national average. In such states, adjusting failure rates with respect to a statewide average failure rate might be more equitable.

While the 2016 RADV audit was a pilot, error results could continue to exhibit large variability. The 2016 pilot results excluded 77 outlier issuers in determining the error intervals, which were large even with these exclusions. The inclusion of these issuers could contribute to intervals that are potentially equally large or larger for the 2017 RADV unless these issuers have very substantial improvements.

It could be appropriate to consider adjusting negative (and positive) outliers to the applicable lower (upper) bound of the confidence interval. This practice would minimize adjustments and resulting unexpected impacts on transfers. Additionally, it would remove the extreme impact of small adjustments in HCC accuracy for issuers whose failure rates are near the edges of the confidence interval. Currently, if the mean failure rate and upper failure rate threshold for a given HCC group were 25 percent and 47.5 percent respectively, an issuer with a 47.4 percent failure rate would have no adjustment, while an issuer with a 47.6 percent failure rate would incur a 22.6 percent failure rate adjustment for that HCC group, which in turn would be expected to result in about a 5-6 percent decrease to issuer risk scores.

## **Additional Comments**

### **Automatic Re-enrollment**

In response to a request for comments on the processes and capabilities of automatic re-enrollment, we believe auto re-enrollment is convenient for consumers and encourages continued participation in the insurance markets. It helps ensure broad coverage and provides additional stability for insurance markets. Elimination of the auto re-enrollment process would negatively impact those who are used to auto re-enrollment and thus could forget to re-enroll, a particular challenge in light of the inability to obtain coverage outside of the open enrollment window. In addition, it is likely that it would be predominately lower-risk enrollees who would not actively re-enroll, leading to a deterioration of the risk pool and placing upward pressure on premiums.

We appreciate HHS' concerns that auto re-enrollment might not be appropriate for all individuals and families, particularly those whose health needs or income might have changed since their prior enrollment decision. However, these concerns could be better addressed through robust, multi-channeled outreach and communication. This effort could include communication from the exchanges and the carriers, both directly to consumers and through brokers and others in the community which promote effective health insurance. Additionally, we note that auto re-enrolled members must actively pay premiums in order to continue coverage. Members who are not eligible for zero-premium coverage thus will not be forced to purchase a policy they do not want.

## **Standard Related to Exchanges; Essential Health Benefits (EHB) Package; Prescription Drug Benefits**

Reference pricing is discussed in the notice as it pertains to prescription drugs. However, other coverages such as durable medical equipment benefits are also cited. More information is needed on whether the intent is to extend reference pricing beyond prescription drugs and if so, whether reference pricing would be allowed for hospital and physician services as well. A broad extension of reference pricing would materially change provider contracts, definitions of “allowed amounts,” and the amount consumers would have to pay out of pocket.

If reference pricing is intended to be extended to some but not all services, it should be clearly stated which services could be subject to reference pricing and what services are not subject to reference pricing, as well as how the costs above the reference price would apply to EHB and out-of-pocket accumulators. Without clear understanding of how the reference price relates to a provider contracted “allowed amount,” some portion of the amount in excess of the reference price could be considered additional cost-sharing, potentially (up to the “allowed amount”), and some portion could be considered balance billing (excess above the allowed amount in an out-of-network provider situation) and not considered part of the patient cost-sharing requirement.

Reference-based pricing could have a favorable impact on premium rates as long as amounts in excess of the reference base level are not allowed to accrue toward deductibles and the maximum out-of-pocket limit. We suggest more clarity regarding how the reference price relates to a provider’s “allowed amount,” whether balance billing is allowed, and how member cost-sharing in excess of the reference price is considered for deductibles and maximum out-of-pocket limits. If amounts in excess of the reference-based price are credited toward the maximum out of pocket, savings due to reference-based pricing would be mitigated.

## **Silver Loading**

As comments were requested by HHS about how to possibly address silver loading for potential future rulemaking, we would point out that cost sharing reductions (CSRs) will also contribute to premium changes if insurers are required to change the way they load premiums for CSRs in 2021 compared to 2020. For instance, if insurers that loaded only silver premiums for CSRs in 2020 were required to spread the CSR cost across all plans for 2021, the loads on silver plans would go down, but the premiums for other metal tiers would increase. Insurers would expect enrollees, including those not eligible for premium subsidies, to re-evaluate their coverage and metal level choices. In states with competitive environments, insurers might be incented to not offer the lowest- or second-lowest-cost silver plans because these plans would expect to enroll the majority of more highly CSR-subsidized enrollees. A greater concentration of highly CSR-subsidized enrollees would increase the chance that the average load applied to all plans would be insufficient to cover the CSR cost. This dynamic could lead to insurers re-evaluating participation on exchanges.

If off-exchange plans are not exempted from imposing a CSR load on premiums, insurers with only off-exchange plans would have a competitive advantage relative to insurers with both on-

and off-exchange plans, unless the risk adjustment program is changed to spread the risk to all issuers. If the risk adjustment program is changed to spread the risk to all issuers on and off the exchange, premiums will increase for unsubsidized enrollees and off-exchange enrollment could decline.

### **Premium Adjustment Percentage**

HHS proposes a change to its methodology for calculating the premium adjustment percentage. The premium adjustment percentage, intended to reflect the growth in underlying health spending, is used to set the rate of increase for three key parameters: the maximum annual limitation on cost-sharing, the required contribution percentage for eligibility for a hardship exemption, and the affordability percentage for the employer mandate. In addition, it is expected to impact the percentages used to determine premium tax credits and the indexing of the Health Insurance Tax. CMS proposes to use a new premium measure that incorporates changes to individual premiums for private insurance (excluding Medigap and property and casualty insurance) in addition to the group health plan premiums used today to determine the rate of premium growth from 2013 for purposes of calculating the premium adjustment percentage for 2020 and beyond. According to CMS, this change would increase the premium adjustment percentage, resulting in higher cost-sharing ceilings for beneficiaries; a higher required contribution percentage and thus lower the Advance Premium Tax Credits; reduced enrollment in subsidized exchange plans; an increased affordability threshold for employer-sponsored coverage; increased employer mandate penalties; and lower federal spending.

Including individual market premium growth from 2013 would capture many factors beyond the growth in underlying health spending. For instance, it would capture the change in the composition of the individual market risk pool due to the elimination of pre-existing condition exclusions (i.e., the influx of higher-cost individuals into what, in most states, was an underwritten market prior to 2014), the introduction of a richer benefit package, and lower cost-sharing than typically provided in the individual market in 2013. In addition, premiums in the individual market during 2014–2016 were reduced by the transitional reinsurance program. Premiums also increased in most states in 2018 to reflect the cessation of federal funding of CSRs. The recent elimination of the individual mandate penalty and availability of noncompliant coverage could affect individual market risk pool and premiums. As a result, it might not be appropriate to include premium changes due to changes in risk pool composition, covered benefits, and plan designs in the calculation of premium increases. If premium increases in the individual market are incorporated into the premium adjustment percentage, increases in the individual market premiums should use a base year no earlier than 2018 to eliminate the impacts of risk pooling changes, the transitional reinsurance program, and the cessation of government funding for CSRs. In addition, individual market premiums reflect the impact of state waivers under Section 1332 of the ACA. If Section 1332 waivers continue to expand, then a premium adjustment percentage that incorporates individual market premium changes would also reflect the impact of these waivers and could result in additional federal expenditures on premium tax credits through reduced required contributions. The impact of this is uncertain, and there could be challenges for states seeking new waivers to reflect the impact of this consideration when evaluating compliance with the deficit neutrality guardrail and the available amount of federal pass-through funding in their waiver applications.

We note that if the proposal to change the premium growth index used in developing the premium adjustment percentage is not finalized or is otherwise changed from that specified, other elements of the proposed payment notice including the final maximum annual limitation on cost-sharing would change as a result. With the already short timelines available to issuers for developing products and rates for 2020, doing so could create some timeline concerns for them. One approach to address this concern would be to allow issuers to use the proposed maximum out of pocket (MOOP) for 2020 and revert to the MOOP based on the premium adjustment percentage in 2021.

### **Treatment of Brand Drugs With Generic Equivalents as Non-Essential Health Benefits**

CMS discusses several considerations in the Notice surrounding a proposal to allow issuers to treat brand drugs with generic equivalents as non-essential health benefits. We would like to address several of the issues raised.

With regard to potential non-coverage of affected brand drugs, we note that enrollees will still be able to request coverage as an EHB through the issuer's formulary exception review process. However, this scenario would create administrative hurdles for individuals, particularly those who currently use affected brand drugs and have valid reasons for using the brand in lieu of the generic equivalent. Many individuals might not be aware of formulary exception processes and could choose to forgo treatment rather than accept the generic equivalent or engage in the formulary exception process. Additionally, it might be difficult for plans to estimate the number of formulary exception requests, which could complicate cost estimates and premium rate setting, limiting the potential savings to consumers.

With regard to treatment of accumulation of cost-sharing toward a plan's maximum out-of-pocket limit, CMS proposes to allow plans that treat brand equivalents as non-EHB to count only cost-sharing that would have been otherwise paid for the generic equivalent toward the annual limitation on cost-sharing. This description is ambiguous if a brand drug has two generic equivalents that are either subject to deductibles and/or coinsurance or are placed on two different formulary tiers. If this provision is finalized, we request that CMS provide clarification on how plans should handle such situations. Additionally, we request clarification on whether plans could treat only the cost of the generic equivalent as applying toward meeting any relevant deductibles when treating brand equivalents as a non-EHB. In general, the provision to require application of generic-equivalent cost-sharing when a brand drug is used is more challenging to administer than the alternative mentioned to exclude all cost-sharing for these brand drugs from accumulation and might be more straightforward for consumers enrolled in plans that elect this flexibility. Similarly, compared to excluding all cost-sharing for these brand drugs from accumulation toward the annual cost-sharing limitation, the provision to require application of generic-equivalent cost-sharing when a brand drug is used is much more challenging to administer. Although crediting the generic-equivalent cost-sharing would be more generous, it could be more difficult for consumers to understand.

In addition to items addressed by the proposed rule, we note that if either plans are required to treat affected brand drugs as non-EHB or plans have a choice about non-EHB treatment and elect

that treatment but in either case still provide coverage for these drugs, then consumers who purchase these plans could be forced to pay more for the non-EHB portion of premium. Additionally, if the second-lowest-cost silver plan treats these drugs as non-EHB, then premium tax credits will decrease because the amount of premium required to provide EHB would decrease.

With regard to the optional nature of the various aspects of this proposal, we note that this proposal would have the potential to create a different set of EHBs for issuers operating in the same state and market. This in turn could have a material impact on actuarial values (AVs), which are based on the proportion of total EHB costs covered by the plan. This adjustment would be more complicated than many other adjustments, as it would impact both the numerator (paid EHB claims) and the denominator (allowed EHB claims) of the actuarial value calculation. Federal regulations require actuaries to certify adjustments to AV Calculator output during rate filing. Claims used to develop the AV Calculator do not reflect the impact of this provision, so only issuers that elect this new flexibility would have to consider making AV adjustments as a result of this change. Depending on cost-sharing and formulary construction, consumers could find that plans with higher actuarial values are unambiguously less generous (e.g., cover a less comprehensive range of prescription drugs), potentially creating confusion in the market. Additionally, if this proposal is made mandatory at some future date, HHS should consider adjusting values in the AV Calculator to be consistent with this new rule, as otherwise all issuers would be forced to consider adjustment to actuarial value calculations.

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We appreciate the opportunity to provide comments on the 2019 proposed benefit and payment parameters. We would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments. If you have any questions or would like to discuss further, please contact David Linn, the Academy's senior health policy analyst, at 202-223-8196 or [linn@actuary.org](mailto:linn@actuary.org).

Sincerely,

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