January 30, 2023

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 2024

To Whom It May Concern:

The Individual and Small Group Markets Committee and Risk Sharing Subcommittee of the American Academy of Actuaries Health Practice Council ("HPC Committees")[1] are pleased to provide comments on the proposed rule[2] for the 2024 Notice of Benefit and Payment Parameters (NBPP).

Specifically, the HPC Committees are commenting on risk adjustment, lifelong permanent conditions, gender dysphoria hierarchical condition category (HCC), meaningful difference & non-standardized plans, exchanges directing re-enrollment for cost-sharing reduction (CSR)-eligible enrollees, the implications of a special enrollment period (SEP) that mirrors the Medicare Advantage SEP for the loss of a significant provider, prohibiting issuers participating in exchanges on the federal platform from terminating dependent child coverage, age calculation standards for stand-alone dental plan (SADP) issuers, and network adequacy.

Data for risk adjustment model recalibration for 2024 benefit year (45 CFR 153)

The HPC Committees appreciate the information provided by CMS with regard to the use of 2020 data for risk adjustment coefficients and the range of different options considered. The HPC Committees note that CMS' review of other coefficients based on 2020 data reveals relatively little variation from coefficients used in 2017, 2018, and 2019. The HPC Committees appreciate the desire to use this more recent data when possible. However, the HPC Committees

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[1] The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries practicing in the United States.
[2] https://www.cms.gov/files/document/cms-9899-p-patient-protection-nprm.pdf.

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are concerned about the inconsistency of treatment between the adult age-gender coefficients and other coefficients. While more recent data generally is preferable, a linear regression model is determined by all of the factors used in the model. CMS publishes an R-squared value for the 2020 model (which the HPC Committees observe is noticeably lower than the R-squared for the other separately solved coefficients), but the HPC Committees have little to no information to evaluate the fit of only the coefficients being retained. It is unclear if this additional variation is broadly applicable across all coefficients, or primarily the effect of any specific subset of these coefficients. It is initially plausible that the lower value is associated with these out-of-line coefficients. However, the reduced correlation is observed across child and infant coefficients as well, suggesting that the variability in cost in 2020 data may be more broadly integrated with the data. The HPC Committees note that the similarity of the 2020 values to previous values could also be viewed as a justification for retaining 2017 data for this year, as the additional insight gained from 2020 data is outweighed by the influence of COVID-19 on model fit and coefficient values. As noted previously,[3] the HPC Committees generally would prefer to exclude 2020 data from calibration, consistent with industry practice in rate development. The HPC Committees note that CMS could ignore 2020 as a data year for risk adjustment, and treat 2021 as the next year of data. In most cases, utilization patterns appear to have been more typical of a "new normal" and are likely to be more appropriate for inclusion in risk adjustment. As with 2020 data, the HPC Committees suggest that CMS review the 2021 data for any anomalous patterns and seek to understand its cause prior to use of this data in the coefficient calibration.

CSR Adjustments in the Risk Score Model

The HPC Committees have no additional comment at this time on the proposed factors. The HPC Committees note again our 2021 comments[4] regarding potential risk score model changes for CSRs included in the October 26, 2021, technical paper[5]. The HPC Committees encourage CMS to continuously evaluate the purpose and appropriateness of the current CSR adjustment factors in light of an absence of funding of CSR subsidies and the potential socioeconomic health equity issues associated with the lower-than-anticipated induced utilization levels identified in the technical paper.

State Flexibility Requests

Regarding Alabama's request for transfer reductions for the 2024 benefit year, the HPC Committees note that last year, Blue Cross Blue Shield of Alabama indicated that it increased individual market rates by 2% in 2022 as a result of the 50% reduction in risk transfers, and the continuation of that increase in 2023 would result in a similar load.[6] In 2023, CMS ultimately elected to reduce the transfer adjustment to 10% in the individual market (which would reduce

[3] https://www.actuary.org/sites/default/files/2022-01/American_Academy_of_Actuaries_NBPP_2023_Comments_01.26.22.pdf.
[4] https://www.actuary.org/sites/default/files/2021-11/Academy_Comment_Letter_CCIIO_RA_Technical_Paper_11.24.21.pdf.
[5] https://www.cms.gov/files/document/2021-ra-technical-paper.pdf
[6] https://downloads.regulations.gov/CMS-2021-0196-0195/attachment_3.pdf.

that putative 2% increase to a value below the required 1% de minimis threshold). Alabama is again proposing a 50% reduction for the individual market.

The HPC Committees are concerned that the trajectory of Alabama's individual market may not have evolved enough in the last year such that the proposed request for a 50% reduction in the risk adjustment transfer payment in the individual market could result in a premium increase that will exceed the required de minimis threshold. It may be appropriate to directly solicit feedback from issuers on how any adjustment may impact their filings (particularly issuers who have paid into risk adjustment in Alabama in recent years), and to incorporate those responses into federal analysis and ultimate determination with regard to the 2024 request.

Lastly, the HPC Committees note risk adjustment flexibility is intended to address imbalances in the risk adjuster applicable for a given state, and dominant market share on its own is not an indication of imbalance in the risk adjuster if available and credible data do not otherwise support this assertion. States currently have the ability to develop their own risk adjustment models if the federal risk adjuster is not an appropriate representation of their market, and this avenue will remain available to states concerned about the performance of the federal model.

Additional Risk Adjustment Data Extraction from EDGE

The HPC Committees remain supportive of efforts to capture additional information out of the External Data Gathering Environment (EDGE) server. Extraction of plan ID and rating area for earlier years of EDGE data will give CMS the information necessary to model risk adjustment transfers for additional years of experience, giving federal regulators a broader range of data against which model modifications may be tested, while collecting Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) indicators will further assist in the analysis of differences between different classes of enrollees as determined by their utilization of health reimbursement arrangements (HRAs). The HPC Committees support HHS' approach of phasing in reporting requirements for the QSEHRA indicator similar to other indicators newly added last year, as it may be challenging for issuers to capture this information for years already in progress.

Risk Adjustment Data Validation Materiality Threshold

The HPC Committees support the proposed modification of the current $15 million in premiums threshold below which issuers are subject to targeted random sampling to a 30,000-member threshold. This aligns the basis for targeted random sampling with the 500-member basis used for exclusion from Risk Adjustment Data Validation (RADV) audits. The similarity noted by CMS of this threshold to roughly $17 million in premiums is indicative of the role which non-indexed dollar values can play in increasing the number of plans over that threshold over time. A membership-based RADV threshold also increases the likelihood that issuers at or below the targeted random sampling threshold will experience similar variation in outcomes, as this is logically more closely associated with the number of members enrolled than the cost of health care, which can vary significantly between different geographies.

The Lifelong Permanent Conditions List

The Lifelong Permanent Conditions List has been a tool intended to streamline the validation of certain RADV items but has not been used in the population of HCC data to the EDGE server. The HPC Committees note that the lifelong permanent conditions list may have value but would generally prefer that the basis for claims on EDGE be more closely aligned with the sources used in claims validation. The HPC Committees suggest that any changes in practice only be applied prospectively. RADV can influence statutory financial reporting, and a modification of this treatment after any related liabilities or assets have already been recorded may cause uncertainty and volatility in financial reporting. To avoid disruption in financial reporting processes already underway, it may be appropriate to delay application of this policy until after the current benefit year.

A Potential Gender Dysphoria HCC

The HPC Committees have no comment on the specific need for/appropriateness of an HCC for gender dysphoria. However, the HPC Committees note that coefficients would need to be based on appropriate data for this condition. It is not clear how consistently this data may be coded by medical practitioners or reported by different issuers. Additionally, medical practice in this area is evolving, creating further complications for any predictive model. This could create unforeseen challenges in the calculation of coefficients should federal regulators add such an HCC.

Meaningful difference & nonstandardized plans (45 CFR 156)

The HPC Committees appreciate that the selection of an appropriate health care plan by a consumer in the individual market can be challenging, and too much choice can be a significant contributing factor. A Rand study noted that a greater number of choices results in poorer health coverage selections.[7] This may be particularly challenging for lower-income individuals, who must evaluate the interplay of coverage options at the competitive silver metal tier alongside their premium subsidies. Streamlining choices may have a role in addressing this issue, however, an arbitrary solution that overly restricts what kinds of plans may be made available may stifle carrier innovation and reduce the attractiveness of entering commercial markets for new issuers or for issuers continuing in the market who become limited in their ability to differentiate offerings from those present in the market today. What each consumer deems important is not uniform. There are many different components of a health care plan and the factors commonly used by consumers to determine which plans are most attractive to them include one or more of a wide number of options, including but not limited to:

[7] *Consumer Decisionmaking in the Health Care Marketplace*; Rand; 2016.

- Premiums
- Cost-sharing structures, such as deductibles, maximum out-of-pocket (MOOP) limitations, which services are subject to copay/covered before the deductible/etc.
- The location, depth and breadth of an issuer's provider network, both locally and more broadly
- Inclusion of specific providers/pharmacies/facilities in a network
- Inclusion of and cost sharing for specific drugs on the formulary
- Presence of out-of-network benefits
- Presence of desired wellness benefits

While the standardized options are based on plans that were popular in previous years, over time these plans may fail to keep up with consumer desires and market changes, and a reduced number of nonstandard options may render the broader set of offerings in the market less appealing to different consumers. As such, significant limitations on plan choice could have a negative impact on the market and its ability to meet the needs of consumers.

The HPC Committees note that CMS has proposed two options. The first would limit issuers to two nonstandard options per product network type and metal tier in a given rating area. Product network type may be too broad of a classification if CMS elects this option. While some members may distinguish between an HMO and a PPO, there are many consumers whose primary consideration is maintaining a specific provider relationship. As an example, some HMOs may include multiple narrow network options, and a restriction on the number of options available under an HMO could negatively affect those plans' consumers. This in turn could decrease the value of negotiating separate contracting arrangements with multiple providers in an area and placing more emphasis on single provider group and/or carrier relationships. Changes in these networks would then be more disruptive for patients, providers, and carriers, and could have unpredictable effects on the value of exclusive provider contracts, creating additional volatility in market prices and premiums. The HPC Committees suggest an alternative of a standard that permits plans to offer options that appeal to consumers across more than one commonly used dimension based on their expert knowledge of markets.

The HPC Committees recognize that CMS proposed a second option that creates a new meaningful difference standard, and which would require variations in deductibles of at least $1,000 to justify the existence of separate plans in a rating area under a given product network type and issuer. While deductibles are one cost-sharing element that may receive significant scrutiny from consumers, other parameters receive at least as much attention, if not more, from consumers who examine plans. In particular, the MOOP and the sum of the premium and the MOOP are common evaluation tools, particularly for high utilizers who routinely attain their MOOP. The HPC Committees appreciate the desire for a stronger meaningful difference standard than existed in prior years, but again note that the goal of a meaningful difference standard is generally not solely the limitation of the number of plans available on the Exchange,

but rather to ensure that consumers are not overwhelmed by minor variations. The HPC Committees suggest that a meaningful difference standard recognize more dimensions than the deductible, product network type, and metal tier. A strict limit to the number of options could actually suppress consumer engagement and erroneously convince consumers that the only factors that matter are those included in the assessment.

Alternatively, the reduced number of options could cause some members to leave the risk pool. These members would most likely be healthier members who do not find a product that provides sufficient value to them, thereby injuring the single risk pool. Considering the significant transition in the risk pool that will likely emerge out of the end of maintenance of effort requirements for Medicaid in 2023, adopting an additional change that could disrupt the single risk pool may be less advisable. As another example, an issuer may want to design plans that appeal to members who are used to Medicaid benefits and services. Medicaid covers a broader range of services than typical in the individual market, and the presence or absence of these supplementary services may be a decision point for consumers. The limitations outlined by CMS in both cases may limit issuers from leveraging their full portfolio of products in pursuit of attracting consumers in this transition population, and could result in those consumers electing not to be covered because they could not find a plan that met their increased expectations of health coverage.

The HPC Committees note that one of the greatest challenges of either approach is their broad application. The causes of choice overload and key consumer discriminators can vary significantly from one geographic region to another, and application of a uniform standard across all states on federally funded exchanges is likely to have negative impacts on many markets that could be reduced or avoided if standardized plan options and meaningful difference restrictions are tailored to each state's specific characteristics. The HPC Committees suggest working with state regulators to incorporate their input on meaningful difference/plan choice standards that may apply in their jurisdictions.

Given the relative maturity of this market, it may be more appropriate to prioritize creation of better consumer tools to help consumers evaluate plans using plan options based upon their preferred criteria rather than limiting consumer choice. Standardized plan options represent an appropriate filter for consumers who do not want as many choices, and the current availability of differential display may be sufficient to reduce some of the aspects of choice overload without requiring excessive limitation on the variety of plan designs in the marketplace. The HPC Committees recognize that choice overload can cause poor consumer decisions. Reducing options will likely make it easier for consumers to compare plans and make a choice as to what best meets their needs. However, choice reduction makes it less likely that members will find choices that meet their needs. Alignment of choice limitations with common consumer preferences, in conjunction with consumer tools that allow for effective evaluation of plans, would create a more meaningful set of consumer choices while avoiding most of the negative effects.

Exchanges to direct re-enrollment for CSR-eligible enrollees from a bronze QHP to a silver QHP with a lower or equivalent net premium under the same product and QHP issuer, regardless of whether the enrollee's current plan is available (45 CFR 155.335(j))

Consumers consider factors other than premiums when choosing a plan, such as deductibles, copays, MOOPs, and specific providers in the plan's network. The MOOP may be higher for certain consumers, even if the net premiums (premiums after advance premium tax credit [APTC] are the same or lower, because of their unique health situation(s). If consumers are automatically moved to other plans based solely on net premium costs, these other factors will be overlooked. If making this change, consumers should be made aware of the impact of changes from their old plan to their new plan, with sufficient time to either affirmatively retain their current plan or else choose a different plan. This consideration may be of more relevance for individuals eligible for CSR plan variations, where the reduced cost-sharing creates a greater likelihood of reduced overall spending. However, automatic enrollment processes may not take into consideration the many factors that influence plan selections. It may be more appropriate to provide proactive communication with regard to the availability of more generous coverage without any increase in premium costs, or a special enrollment period (SEP) for individuals in this situation to switch to CSR coverage (i.e., allowing CSR-eligible individuals enrolled in a plan without CSRs to switch into a CSR plan when net premium is no more expensive than the net premium of their current plan). The HPC Committees note that CMS already allows individuals eligible for zero premium silver plans to switch coverage any month, and we expect most individuals affected by this proposal will be those same individuals, so that an additional SEP may be of limited value.

For some consumers with less stable income, forecasting and estimating future annual income is not simple, such that consumers may inadvertently underestimate their income for the subsidy calculations. Consumers who underestimate income are subject to repaying the difference between the subsidy they received and the subsidy they were actually eligible for when they file their taxes. IRS data[8] show that consumers typically receive more in advance payments of the premium tax credit than their actual premium tax credit—in 2020, roughly $33.0B in PTCs were indicated on income tax returns, versus $33.9B in APTCs provided. 2019 data show only $39.6B in PTCs against $43.5B in APTCs[9]. The proposal outlined could cause this variation to increase. A consumer could be moved to a richer plan with higher gross premiums but the same or lower net premiums (for example, their current plan and their nominal new plan both have $0 premium using their estimated income). If that consumer underestimated their income when applying for subsidies, their actual subsidy would be lower. The resulting repayment amount indicated on the consumer's income tax return might be higher than under the less expensive plan. For example, a consumer may be eligible for a $100 premium tax credit, but the plan that they might select could be one with a lower premium cost of $75. If they get automatically enrolled in a plan that costs $100, they may be subject to more increased taxes. It is even possible that the less

[8] https://www.irs.gov/pub/irs-soi/soi-a-inpr-id2201.pdf.
[9] Ibid.

expensive plan may have caused no repayment obligation. This dynamic could create an affordability issue for the consumer as well as confusion.

The implications of a SEP that mirrors the Medicare Advantage SEP for the loss of a significant provider (42 CFR 422.62(b)(23))

Consumer plan choices are frequently based on provider options under a plan, often because they wish to retain existing patient-provider relationships. These consumers are particularly impacted when plan networks change. Medicare Advantage currently provides members affected by such a change to switch plans. The overall morbidity burden and medical need in the individual market is generally thought to be lower than that of Medicare Advantage. However, consumers in this same situation may want the opportunity to switch, given that their choice was contingent on network construction. Offering such an SEP in the commercial market would address this concern. It is reasonable to assume that this would have the greatest positive effect for individuals with greater health care needs. However, changes (particularly changes to inclusion of entire provider groups) will create opportunities for healthy individuals to switch plans as well. The greater prevalence of healthy members in commercial coverage creates the possibility that a larger number of members without a direct relationship concern will switch coverage midyear.

Significant uptake of this SEP could create imbalances in the risk adjuster that may favor issuers who enroll these members. Duration factors are currently only applied for adults with HCCs and six or fewer months of experience. If an issuer modified their provider network to shift certain providers out of the plan's network prior to midyear, causing member shifting, the issuer could benefit from the duration factor without exposure to the full year of claim experience. The issuer to who that member transferred would then be less likely to receive the risk adjustment duration increase (unless the transition was exactly halfway through the year), but could be liable for a greater portion of claims, particularly when a condition results in a lengthier course of treatment.

The HPC Committees note that plans already have the ability to transfer cost-sharing accumulations from prior experience at other carriers during the year, though this is not currently required (nor frequently done) in most situations. Individual and most group plans' cost sharing are based on calendar-year cost-sharing accumulations.

The balance of power in payer/provider negotiations is dependent on specific market conditions, and is likely to vary by provider type. If this SEP is adopted, providers are likely to gain negotiating power when there is less provider competition, as threats by providers to pull out of payer contracts midyear could have significant influence on member enrollment and overall plan revenue. Payers may benefit where there is more provider competition and less patient

attachment. In these cases, payers are more likely to be sensitive to retaining patient volume, giving payers a limited boost.

Proposal to add § 155.430(b)(3) to explicitly prohibit QHP issuers participating in exchanges on the federal platform from terminating coverage for a dependent child prior to the end of the plan year because the dependent child has reached the applicable maximum age (45 CFR 155.430)

The HPC Committees agree that this new paragraph is expected to provide clarity to members so that coverage is not prematurely disrupted and also to qualified health plans (QHP) issuers participating in exchanges on the federal platform.

Proposal to require stand-alone dental plan (SADP) issuers to use age on effective date as the sole method to calculate an enrollee's age for rating and eligibility purposes beginning with Exchange certification for PY 2024 (45 CFR 156)

The HPC Committees agree with CMS and supports making this standard to ensure consistency between issuers and eliminate confusion among consumers regarding using age on effective date as the sole method to calculate an enrollee's age for rating and eligibility purposes on stand-alone dental plans.

Network adequacy (45 CFR 156.230, 156.235)

The proposed rule continues the network adequacy reviews that began in plan year 2023. CMS would continue to conduct network adequacy reviews in all states with a federally facilitated marketplace except for states performing plan management functions that adhere to a standard as stringent as the federal standard and elect to perform their own reviews. In addition, the provider wait time standards promulgated in the 2023 NBPP will be implemented for plan year 2024. Specifically, issuers must attest to compliance with the wait time standards for 2024, and "work with their network providers to collect the necessary data to assess appointment wait times and determine if their provider network meets the wait time standards … as CMS will begin conducting such reviews of issuer attestations for PY 2024."

Local health care markets vary significantly, with wide differences in the number and variety of health care providers that are available. Certain underserved areas can have limited access to health care providers, and consumers in those areas often must travel significant distances to access certain types of providers. If the network adequacy review process fails to appropriately recognize these differences, insurers may find it difficult to offer coverage in these areas due to a lack of providers necessary to create a network that will pass regulatory review. This standard would disproportionately impact rural populations and consumers in other historically underserved areas. This risk could be significantly mitigated if CMS would detail county-specific time and distance parameters that reflect differences in population size and density. To

further protect groups that have been historically marginalized, the HPC Committees suggest that CMS consider developing parameters that reflect such differences even within counties.

The current network adequacy review process often does not result in a clear determination that an insurer's network has been deemed to meet the regulatory requirements (or does not meet the regulatory requirements). As a result, issuers are often left uncertain about whether their network strategies are viable or are likely to be disallowed in future years. CMS could mitigate this concern by modifying the network adequacy review process to clearly communicate back to the issuer, at the end of the review process, and before QHP contracts are signed, whether CMS has approved the proposed network as being in the best interests of consumers.

While the numerical thresholds for provider wait times were promulgated in the 2023 NBPP, the data that issuers must collect to demonstrate compliance has not been defined. Without understanding what data will be required or the process that will be used by CMS for the retrospective review of that data, issuers could face a significant compliance risk when signing the required attestation. CMS can mitigate this risk by providing clear guidance on the data collection requirements and review process before imposing a formal attestation requirement.

Not every compliance question can be answered through regulation or sub-regulatory guidance. However, regulatory uncertainty concerning the long-term viability of products and network strategies can discourage issuers from market participation. Eliminating or reducing regulatory uncertainty will help stabilize the market and encourage ongoing participation by issuers.

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The HPC Committees appreciate the opportunity to provide comments on the 2024 proposed Notice of Benefit and Payment Parameters. The HPC Committees welcome the opportunity to speak with you to provide more detail and answer any questions you might have regarding these comments. If you have any questions or would like to discuss further, please contact Matthew Williams, the American Academy of Actuaries senior health policy analyst, at williams@actuary.org.

Sincerely,

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