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Economic Studies

Center for Health Policy

March 7, 2017

Patrick Conway
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–9929–P
P.O. Box 8016
Baltimore, MD 21244–8016

Re: Patient Protection and Affordable Care Act; Market Stabilization [CMS-9929-P]

Dear Acting Administrator Conway:

I welcome the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) "Patient Protection and Affordable Care Act; Market Stabilization" notice of proposed rulemaking. This letter discusses two proposals contained in the proposed rule: (1) modifying the actuarial value *de minimis* range; and (2) implementing pre-enrollment eligibility verification for special enrollment period enrollees. Contrary to CMS' stated objectives, both proposals are likely to reduce the number of people with insurance coverage and to harm, rather than improve, the individual market risk pool. The remainder of this letter discusses each proposal in turn. Please note that the views expressed in this letter are my own and do not necessarily reflect the views of other staff members, officers, or trustees of the Brookings Institution.

Modification of Actuarial Value *De Minimis* Range

Under current regulations, in order to fall in a given metal tier, a plan's actuarial value (AV) may be no more than 2 percentage points below the AV level that defines that metal tier. The proposed rule would expand this so-called *de minimis* range to 4 percentage points. For example, this change would allow silver plans to have an AV as low as 66 percent, rather than the 68 percent currently allowed. As discussed below, changing the *de minimis* range for silver plans would likely have the effect of reducing the value of the premium tax credit for many families, thereby reducing individual market enrollment and worsening the individual market risk pool.

In greater detail, competitive pressures drive insurers to offer plan designs at a wide range of cost-sharing levels. As a result, it is likely that many insurers will elect to offer silver plans with AVs at or near the bottom of the new *de minimis* range. This means that the lowest-cost silver plans

available in any particular area will generally have a lower AV and a correspondingly lower premium than they would have under existing regulations. Because the premium tax credit is calculated based on the premium of the second-lowest-cost silver plan offered in an individual's area, the value of the premium tax credit will fall accordingly.

The reduction in the value of the tax credit will directly increase health care cost burdens for families who receive the premium tax credit but do not also receive cost-sharing reductions (CSRs). This will be the case no matter how the family changes its choices in response to the reduction in the tax credit. If a family continues to purchase coverage with the same AV as it did before, it will be required to pay a higher net premium in order to do so. Alternatively, the family could decide to hold premium costs constant by purchasing a plan with a lower AV, but this would increase the family's average out-of-pocket costs.[1] Either way, the family's total health care cost burden will have increased. (Families that do receive CSRs will be largely protected against higher costs if they are able to switch to a lower AV plan. This is because switching to a lower AV plan would keep their premium costs from increasing, and the CSRs they receive would automatically increase to cover the additional out-of-pocket costs.)

The regulatory impact analysis of the proposed rule solicited comments on how to quantify the overall impact of reductions in the value of the premium tax credit. The Department has estimated that the weighted average second-lowest cost silver plan premium would be $5,586 per year in 2017 in states using the HealthCare.gov enrollment platform.[2] Reducing the AV of the benchmark plan by 2 percentage points from 68 percent to 66 percent would reduce the average benchmark premium by $131 per year, assuming that claims costs account for 80 percent of the total premium.[3] CMS data indicate that, as of June 2016, there were 2.9 million individuals receiving advance premium tax credits who did not also receive CSRs (and thus will bear the full burden of the reduction in the value of the premium tax credit). At this enrollment level, the $131 reduction in the benchmark premium estimated above would reduce the aggregate financial assistance the Federal government provides to consumers by $381 million per year.[4] The aggregate premium and out-of-pocket costs borne by consumers would increase by approximately the same amount as the reduction in financial assistance.

In practice, the reduction in financial assistance could be smaller or larger than this estimate. The reduction in financial assistance could be smaller if the AV of the benchmark plan does not fall by a full 2 percentage points in all markets; indeed, there is reason to believe that less competitive

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[1] An analysis by the Center on Budget and Policy Priorities provides a concrete example of the choices faced by a particular sample family. See Aron-Dine, A. and Park, E. (February 15, 2017). Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families. Center on Budget and Policy Priorities. Retrieved March 6, 2017 from http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

[2] Office of the Assistant Secretary for Planning and Evaluation (ASPE). (October 24, 2016). Health Plan Choice and Premiums in the 201 Health Insurance Marketplace. Retrieved March 6, 2017 from https://aspe.hhs.gov/system/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf.

[3] In detail, the $131 change in the value of the tax credit can be calculated as $5,586*0.8*(0.66 – 0.68)/0.68.

[4] Centers for Medicare & Medicaid Services (CMS). (October 19, 2016). First Half of 2016 Effectuated Enrollment Snapshot [Press Release]. Retrieved March 6, 2017 from https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html.

markets will see smaller reductions.[5] On the other hand, the reduction in financial assistance could be larger if some families who are eligible for CSRs do not switch to lower AV plans, for example because a lower AV plan that includes their preferred providers is not available. Unlike families receiving CSRs who are able to switch to lower AV plans, the reduction in premium tax credits for these families would not be offset by larger CSRs. Lower financial assistance is also likely to reduce individual market enrollment, which would further reduce financial assistance spending.

The reduction in individual market enrollment spurred by lower financial assistance is worrisome in its own right. However, this reduction in enrollment is also likely to have negative consequences for the individual market risk pool. Both economic theory and empirical evidence imply that the individuals most likely to drop coverage in response to reduced financial assistance will be healthier than the individuals who remain enrolled.[6] Thus, expanding the *de minimis* range is likely to worsen the individual market risk pool, not improve it as CMS intends.

In the proposed rule, CMS suggests that increased enrollment spurred by the greater variety of plan designs allowed by the expanded *de minimis* range will offset any negative effects from reduced financial assistance. This is very unlikely to be the case. With respect to bronze plans, the expanded *de minimis* range will have literally no effect. This is because insurers must continue to comply with the out-of-pocket maximum requirements created by the Affordable Care Act (ACA). According to the 2018 AV Calculator, the minimum AV that a bronze plan can achieve while still complying with the out-of-pocket maximum requirements is 58.54 percent.[7] This falls within the existing *de minimis* range for bronze plans, so expanding the *de minimis* range will not increase plan variety in the bronze coverage tier and thus cannot spur additional enrollment.

The expanded *de minimis* range will permit insurers to offer a broader range of plan designs in the silver, gold, and platinum metal tiers. However, the availability of additional plan designs in these coverage tiers is unlikely to spur meaningful additional enrollment. The newly available plan designs in these coverage tiers will all be more generous than plans in the bronze coverage tier that were already available. Most economic models of consumer behavior imply that individuals who prefer these new plan options to being uninsured would also have preferred the existing bronze plan options to being uninsured. This implies that the availability of new options in the silver, gold, and platinum tiers is likely to spur little if any new enrollment.

Recommendation: For the reasons outlined above, I recommend that CMS not finalize its proposed expansion of the AV *de minimis* ranges. If CMS nevertheless wishes to make some

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[5] In less competitive markets, some insurers may decline to take full advantage of the expanded *de minimis* range because they realize that doing so would reduce the value of the premium tax credit. In more competitive markets, however, insurers are largely to make significant use of the expanded *de minimis* range since most of the negative consequences of reducing the value of the premium tax credit would be borne by the insurer's competitors, while the full benefits of offering a plan at the bottom of the expanded range would be received by the insurer itself.

[6] For two leading examples, see: Einav, L and Finkelstein, A. (2011). Selection in Insurance Markets: Theory and Empirics in Pictures. *Journal of Economic Perspectives,* 25(1), 115-138. http://economics.mit.edu/files/5810; and Hackmann, M.B., Kolstad, J.T., and Kowalski A. E. (2015). Adverse Selection and an Individual Mandate: When Theory Meets Practice. *American Economic Review,* 105(3), 1030-1066. https://www.aeaweb.org/articles?id=10.1257/aer.20130758.

[7] While relaxing the ACA's out-of-pocket maximum requirements would expand the range of bronze plans that insurers are permitted to offer, doing so would be unwise, as it would jeopardize financial security for enrollees and exacerbate adverse selection concerns.

modifications in this area, CMS should finalize an expanded *de minimis* range only for bronze, gold, and platinum plans and leave the *de minimis* range for silver plans unchanged. This alternative policy would avoid reducing the value of the premium tax credit and thereby avoid the proposed policy's negative effects on individual market enrollment and the individual market risk pool, while still providing insurers with additional plan design flexibility.

Expansion of Special Enrollment Period Pre-Enrollment Verification Pilot

Last fall, CMS announced a pilot of a process under which individuals seeking to enroll in Marketplace coverage through a special enrollment period (SEP) would be required to have documentation proving their eligibility for the SEP verified before coverage could begin. At that time, CMS indicated that this process would be implemented for a randomly selected 50 percent of SEP applicants starting in June 2017. The proposed rule proposes to expand this process to all enrollees without waiting for the pilot's results.

CMS's new proposed approach would be unwise, as there is a significant risk that pre-enrollment verification will reduce the number of people with health insurance coverage and worsen, rather than improve, the individual market risk pool. Inevitably, some *eligible* individuals will fail to provide suitable documentation when they initially apply for their SEP, whether due to confusion about what documentation is required or other factors, and will then be required to submit additional documentation before their coverage can begin. Research in behavioral economics finds that even small "hassle costs" to enrolling in a program can substantially reduce take-up, implying that attrition at this stage of the process could be significant.[8] At a minimum, many individuals required to submit additional documentation will face delays in accessing coverage.

These reductions and delays in coverage will directly impair access to care and financial security for the affected individuals. However, they may also damage the individual market risk pool. The SEP population includes people with a range of health care needs. Both economic theory and empirical evidence imply that the sickest individuals will be the most motivated to invest the effort to navigate the pre-enrollment verification process, while healthier individuals will be most likely to be deterred.[9] It therefore seems likely that the SEP enrollees discouraged from enrolling by pre-enrollment verification will be healthier than the average individual market enrollee.

CMS' experience with its existing SEP eligibility verification process supports the view that pre-enrollment verification will drive significant reductions in SEP enrollment, particularly among the healthy. CMS previously reported that 45 percent of SEP enrollees ages 18-24 who were selected for a post-enrollment review under the existing process failed to submit satisfactory documentation after an initial round of outreach.[10] By contrast, the failure rate was much lower among individuals

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[8] Baicker, K., Congdon, W. J., and Mullainathan, S. (2012). Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics. *The Milbank Quarterly,* 90(1), 107-134. http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2011.00656.x/full.

[9] Einav, L and Finkelstein, A. Selection in Insurance Markets: Theory and Empirics in Pictures; and Hackmann, M.B., Kolstad, J.T., and Kowalski A. E. Adverse Selection and an Individual Mandate: When Theory Meets Practice.

[10] Centers for Medicare & Medicaid Services (CMS). (December 12, 2016). Pre-Enrollment Verification for Special Enrollment Periods. Retrieved March 6, 2017 from https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

ages 55-64: just 27 percent. While age is only a crude proxy for health status, these data strongly suggest that the discouraged SEP enrollees would be comparatively healthy.

These data also suggest that the total number of lost enrollees could be substantial. Data on HealthCare.gov enrollment show that 1.4 million people enrolled through a SEP during 2015.[11] If pre-enrollment verification had been in place in 2015 and even one-quarter of those individuals had failed to submit need documentation on their first try, a conservative assumption in light of the data cited above, then around 345,000 people would have faced delays in obtaining coverage or lost their coverage entirely.

The costs of implementing pre-enrollment verification that are outlined above could, in principle, be justified if there were clear evidence that SEP abuse was widespread and that pre-enrollment verification will keep high-cost SEP-ineligible individuals from obtaining coverage. However, the proposed rule does not provide evidence establishing that significant numbers of ineligible individuals are currently accessing SEPs or that inappropriate use of SEPs is having a substantial adverse effect on the risk pool. Moreover, the evidence of SEP abuse that has been cited by insurers and others has serious shortcomings.[12] In the absence of compelling evidence of SEP abuse, there is a substantial risk that the costs of pre-enrollment verification for SEP enrollees will exceed its benefits, which implies that CMS should take a cautious approach.

Recommendation: For the reasons outlined above, I recommend that CMS not finalize its proposal to expand pre-enrollment verification to all SEP enrollees. Rather, in light of the considerable uncertainty about the effects of implementing pre-enrollment verification, I believe that CMS' initial decision to test these procedures through a rigorously designed pilot was appropriate. The pilot's randomized design will allow it to provide compelling evidence on how pre-enrollment verification affects individual market enrollment and the risk pool. This evidence will allow CMS to reach an evidence-based decision about whether to expand pre-enrollment verification when the results become available in the spring of 2018.

In the proposed rule, CMS sought comment on an alternative approach under which it would still expand pre-enrollment verification but would retain a small control group to evaluate the effects of these procedures. In light of the potential unintended consequences of pre-enrollment verification discussed above, it would be preferable to continue the pilot in its current form, rather than increasing the share of SEP applicants at risk of these negative consequences. Nevertheless, this alternative would be better than discontinuing the pilot entirely. If CMS pursued this alternative, it would be important to ensure that the share of enrollees left outside the pre-verification process was large enough to facilitate a rigorous evaluation of the effects of the policy.

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[11] Apostle, K. (June 28, 2016). Key Findings from the Health Insurance Marketplaces: Marketplace Activity in 2015 and 2016. Presentation. Retrieved March 6, 2017 from https://academyhealth.confex.com/academyhealth/2016arm/meetingapp.cgi/Session/4923.

[12] Fiedler, M. (February 17, 2017). Trump Administration's Proposed Change to ACA Special Enrollment Periods Could Backfire. *Up Front* Blog, Brookings Institution. Retrieved March 6, 2017 from https://www.brookings.edu/blog/up-front/2017/02/17/trump-administrations-proposed-change-to-aca-special-enrollment-periods-could-backfire/.

Alternative Approaches to Improving the Individual Health Insurance Market

While the two CMS proposals discussed in this letter are unlikely to improve the functioning of the individual health insurance market, improving the individual market is a worthy goal. There are at least two important areas where CMS and the Administration could take action to clarify how the individual market will operate in 2018 and thereby foster better market outcomes. The benefits of appropriate action in these areas would likely be considerably larger than the benefits of the policy changes included in the proposed rule.

First, the Administration should clearly state that it intends to retain and enforce the ACA's individual responsibility requirement. The Congressional Budget Office (CBO) has estimated that repealing this provision of the ACA would cause large reductions in individual market enrollment and that the lost enrollees would be disproportionately healthy, thereby necessitating increases in individual market premiums of around 20 percent.[13] Not only would retaining this requirement foster better outcomes in the individual market over the long term, but it would also eliminate an important source of near-term uncertainty about how the individual market will operate in 2018. This uncertainty may cause some insurers to curtail their individual market offerings for 2018 and will likely cause insurers who do participate to charge higher premiums than they otherwise would.

Second, the Administration should clearly state that it intends to continue making payments to compensate insurers for the cost of providing cost-sharing reductions. CBO estimates that cost-sharing reduction payments will total $10 billion in fiscal year 2018.[14] This is a substantial fraction of total individual market premium revenue, so withdrawing these payments would cause serious disruption in the individual market. Furthermore, as with repealing the individual responsibility requirement, insurer uncertainty about whether these payments will be made during the 2018 plan year could cause some insurers to curtail their individual market offerings for 2018 and will likely cause insurers who do participate to charge higher premiums than they otherwise would.

Thank you for the opportunity to comment on CMS' proposed rule. I hope this information is helpful. If I can provide any additional information, I would be happy to do so.

Sincerely,

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[13] Congressional Budget Office (CBO). (December 8, 2016). Options for Reducing the Deficit: 2017 to 2026: Repeal the Individual Health Insurance Mandate. Retrieved March 6, 2017 from https://www.cbo.gov/budget-options/2016/52232.
[14] Congressional Budget Office (CBO). (January 24, 2017). Federal Subsidies Under the Affordable Care Act for Health Insurance Coverage Related to the Expansion of Medicaid and Nongroup Health Insurance: Tables from CBO's January 2017 Baseline. Retrieved March 6, 2017 from https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf.