

# USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY

July 28, 2021

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9906-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

## **Re: Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule**

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the “Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule” notice of proposed rulemaking issued by the Centers for Medicare and Medicaid Services (CMS) and the Department of the Treasury. This letter comments on CMS’ proposal to create a Marketplace special enrollment period (SEP) that would allow people with incomes below 150% of the FPL to enroll in the Marketplace at any time during the year even in the absence of a specific life event.<sup>1</sup>

This letter makes three main points:

- Experience from Massachusetts, which has a similar SEP policy already in place, suggests that CMS’ proposal would increase Marketplace enrollment. A reasonable estimate based on the Massachusetts evidence is that CMS’ proposal would increase Marketplace enrollment among people with incomes below 150% of the FPL by around 350,000 life-years in its second year in effect.
- Analysis suggests that the proposed policy would cause, at most, modest increases in the premiums of ACA-compliant plans. This fact, together with the fact that the premium tax credit shields the large majority of individual market enrollees from premium increases, implies that any decline in enrollment due to higher premiums would offset only a small portion of the gross coverage gains due to the policy.
- The low-income people who gained coverage via the SEP would benefit from greater financial protection and improved access to care. In light of the modest estimated effect on individual market premiums and the small number of unsubsidized enrollees, the overwhelming majority of the additional claims and other costs resulting from the policy would be financed by the federal government via higher premium tax credit payments. I view this as a high-value use of federal funds, so I recommend that CMS finalize its proposal.

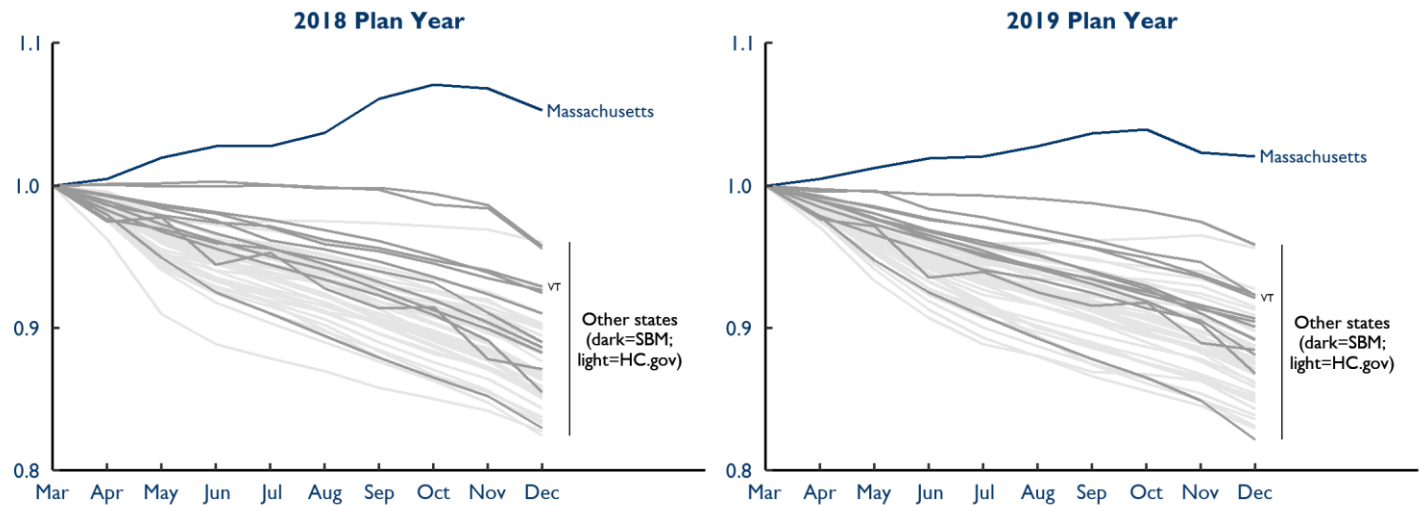
The remainder of this letter discusses these points in greater detail.

---

<sup>1</sup> The views expressed in this letter are my own and do not necessarily reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than myself.

## Figure I. Effectuated Enrollment Trends by State and Year

Enrollment relative to March (March = 1.0)



Source: CMS effectuated enrollment reports; author's calculations.

Note: March is treated as the base period to capture all open enrollment plan selections in Massachusetts.

### Estimating Effects on People with Incomes Below 150% of the FPL

The proposed new SEP could affect Marketplace enrollment among people with incomes below 150% of the FPL through three main channels. First, some people would enroll in coverage via the new SEP. Second, some people who initially enrolled via the new SEP would subsequently reenroll during the next open enrollment (OE) period. Third, some people who would previously have enrolled during OE might no longer do so because they intended to enroll via the new SEP later in the year. I assess each channel in turn.

#### *Enrollment directly via the new SEP*

The most direct way the new SEP could affect Marketplace enrollment is by increasing the number of people who enroll via an SEP. To assess the potential size of this increase, I draw on evidence from Massachusetts, which is the only state that currently has an SEP similar to CMS' proposed SEP. (The Massachusetts policy is broader than CMS' proposal in that it extends to people with incomes up to 300% of the FPL.)

Figure 1 depicts how overall Marketplace enrollment evolved after the end of OE in Massachusetts and in other states during the 2018 and 2019 plan years.<sup>2</sup> The seasonal pattern of enrollment in Massachusetts is an extreme outlier. In both years, Massachusetts enrollment rises over the year, whereas enrollment in other states falls.<sup>3</sup>

Massachusetts' SEP policy could plausibly generate this seasonal pattern by increasing the number of people who enter the Marketplace outside of OE. Moreover, the other significant policy differences between Massachusetts and other states do not appear to be able to fully explain the observed pattern:

- *State-based marketplace status:* One difference between Massachusetts and most other states is that Massachusetts operates a state-based marketplace (SBM). SBMs may be better positioned to transition people leaving their state Medicaid programs into Marketplace coverage. They may also take a different approach to data matching or conduct more robust outreach. In principle, these policy differences could

<sup>2</sup> I focus on 2018 and 2019 to avoid policy and other changes related to the COVID-19 pandemic. Prior years are similar.

<sup>3</sup> Others have previously noted the unique seasonal pattern of Marketplace enrollment in Massachusetts and suggested that it may be linked to Massachusetts' liberal SEP policies. See, in particular, Sarah Lueck, "Proposed Change to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage" (Center on Budget and Policy Priorities, July 2019), <https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve>.

affect the seasonality of Marketplace enrollment. Indeed, Figure 1 shows that SBMs experience smaller declines in Marketplace enrollment over the year, on average, than HealthCare.gov states. However, Massachusetts is a significant outlier even relative to other SBMs, indicating that practices common to SBMs are not a full explanation for the distinctive seasonal enrollment pattern in Massachusetts.

- *Supplemental subsidies:* Another notable difference between Massachusetts and most other states is that Massachusetts supplements the federal Marketplace subsidies with additional premium and cost-sharing assistance for enrollees with incomes below 300% of the FPL. These supplemental subsidies could make enrollees more likely to persist in coverage, attenuating coverage declines over the year. However, Vermont also offered supplemental subsidies to people below 300% of the FPL during the years examined in Figure 1, yet it still experienced substantial enrollment declines over the course of the year. While Vermont’s supplemental subsidies are less generous than those in Massachusetts, the fact that Vermont performs only modestly better than the typical SBM suggests that Massachusetts’ supplemental subsidies are unlikely to be a full explanation for its distinctive seasonal pattern of enrollment.
- *Individual mandate:* A final notable difference between Massachusetts and the rest of the country is that it retains an individual mandate, while the federal mandate was effectively repealed starting in 2019. A desire to comply with an individual mandate could, in principle, make people who enroll during OE more likely to retain that coverage for the full year. However, as depicted in Figure 1, Massachusetts differed starkly from the rest of the country even in 2018, when the federal mandate was still in effect. Thus, the mandate is likely not a major contributor to the observed difference in seasonal patterns.

While conclusions based on cross-state comparisons like the ones considered here are necessarily subject to uncertainty, it appears that the most likely explanation for Massachusetts’ distinctive seasonal enrollment pattern is that Massachusetts’ SEP policy spurs meaningful enrollment outside of OE. To obtain a point estimate of the amount of additional enrollment, I compared Massachusetts’ enrollment trajectory for 2019 to a counterfactual trajectory based on trends in Vermont (with an adjustment to account for Massachusetts’ more generous subsidies).<sup>4</sup> I then scaled up the estimated difference to account for the fact that Massachusetts’ policy only applies to people with incomes below 300% of the FPL (and extrapolated the estimated effect for two months to correspond to a December OE period).<sup>5</sup> This yields an estimate that CMS’ proposal would increase Marketplace enrollment in the targeted population by 7.6% on average over the year and by 17.0% in December. This translates to an increase of 257,000 people on average over the year and an increase of 533,000 people in December.<sup>6</sup>

#### *Reenrollment during subsequent OE periods*

To the extent that the new SEP changed the number of people enrolled in Marketplace coverage at the end of the calendar year, the new SEP would likely also increase the number of people reenrolling in Marketplace coverage

---

<sup>4</sup> In detail, I start with the enrollment trajectory in Vermont. I then add the difference between the enrollment trajectory observed in Vermont and a trajectory that reflects the median attrition rate in each SBM other than Vermont and Massachusetts as a crude way of accounting for the fact that Massachusetts’ subsidies are more generous than Vermont’s.

<sup>5</sup> Specifically, CMS’ plan selections data indicate that 69% of Marketplace plan selections in Massachusetts were by people with incomes below 300% of the FPL in 2019, so I divide the estimated effects by 0.69.

<sup>6</sup> To translate the percentage effects into numbers of enrollees, I estimate monthly enrollment among people with incomes below 150% of the FPL without the new SEP. I start with monthly effectuated enrollment for 2019, as reported by CMS. I then estimate the portion of this enrollment that is attributable to people with incomes below 150% of the FPL using CMS data on 2019 OE plan selections. I then scale up the resulting estimates by 21% to account for enactment of the ARP subsidies based on estimates from Jessica Banthin et al., “What If the American Rescue Plan’s Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022” (Urban Institute, April 2021), [https://www.urban.org/sites/default/files/publication/104072/what-if-the-american-rescue-plans-enhanced-marketplace-subsidies-were-made-permanent-estimates-for-2022\\_0\\_0.pdf](https://www.urban.org/sites/default/files/publication/104072/what-if-the-american-rescue-plans-enhanced-marketplace-subsidies-were-made-permanent-estimates-for-2022_0_0.pdf). My final estimates imply that Marketplace enrollment in this income group would average 3.4 million over the year without the new SEP.

during OE. Indeed, in light of the fact that the population targeted by the new SEP would typically be eligible for zero premium silver plans (and the fact that people who do not take action to change their enrollment are typically automatically reenrolled), it is likely that the large majority of people who take up the new SEP during a given plan year would reenroll in Marketplace coverage during OE for the subsequent plan year. In light of the estimates presented above, this suggests that reenrollment during OE might rise by on the order of 500,000 people.

Importantly, the net increase in coverage from this increase in reenrollment is likely to be much smaller. Many of those taking up the new SEP would likely have enrolled at the next OE even under current policies. The modeling I describe in the next section suggests that around 20% of people taking up the new SEP would be people who would not otherwise have enrolled in coverage at the next OE. This suggests that total enrollment at the end of the first OE after implementation of the new SEP would be around 100,000 higher than it would be under current policies. This increase in enrollment would likely be larger in subsequent years since some of the people who enrolled in Marketplace coverage via the new SEP would likely remain enrolled for multiple plan years.

Together with the direct increase in SEP enrollment, this suggests that CMS' policy would increase total enrollment of people with incomes below 150% of the FPL by around 350,000 people on average over the year.

#### *Reduced new enrollments during OE*

In principle, the new SEP could cause some people who currently enroll in coverage during OE to delay enrollment until later in the plan year, offsetting some of the increase in coverage estimated above. In practice, however, this type of behavior seems likely to be rare. Because CMS' proposal is limited to people eligible for zero premium silver plans (if the ARP subsidy expansion remains in effect), there is no financial incentive to delay enrollment until after OE. Indeed, from a purely financial perspective, enrolling during OE is essentially always going to be superior to enrolling later since a person could incur unanticipated medical expenses before coverage could be obtained via an SEP. Thus, the only motivation for delaying enrollment would be to put off any near-term hassle costs associated with the enrollment process. For people who currently successfully enroll during OE, most of whom presumably place a relatively high value on coverage, those hassle costs seem unlikely to loom particularly large. Moreover, some enrollees may not even be aware of the option to delay enrollment. For these reasons, I conclude that these types of enrollment changes are likely to be relatively small.

#### **Estimating Effects on Individual Market Premiums and Unsubsidized Enrollees**

By changing enrollment patterns among people below 150% of the FPL, CMS' proposal could also change the risk mix of individual market enrollment and, in turn, change the premiums that individual market plans charge. Most individual market enrollees receive the premium tax credit and, hence, would be shielded from any premium changes; as of 2020, around 71% of people enrolled in ACA-compliant individual market plans received APTC, and that fraction is likely to be higher in future years as long as the subsidy expansions in the ARP remain in effect.<sup>7</sup> However, the minority of unsubsidized enrollees would be affected by any premium changes.

To gauge how CMS' proposal might affect premiums, I use data from the Medical Expenditure Panel Survey, Household Component (MEPS-HC). In brief, I use the MEPS-HC to create a simulated population of potential individual market enrollees with incomes below 150% of the FPL. For each person, the dataset contains monthly health spending for a 24-month period; I treat the second 12-month period as representing the plan year of interest. For that 12-month period, I then estimate average spending for three types of member months:

- (1) *Current policy member months*: These are member months of enrollment that would exist without the new SEP. To identify these months, I assign each person a probability of enrolling in individual market coverage during OE under current policies. This enrollment probability is a function of the person's

---

<sup>7</sup> This estimate was derived using data from CMS' effectuated enrollment and risk adjustment program reports for 2020. It was erroneously listed as 75% in the version of this letter that was submitted to CMS.

expected health spending and is calibrated so that overall take-up and the claims risk of enrollees relative to non-enrollees align with the enrollment patterns likely to prevail under the ARP. To simplify the analysis, I assume that people who enroll during OE remain enrolled for the full 12-month plan year, and I ignore enrollment that occurs through the SEPs that currently exist.

- (2) *New SEP member months*: These are member months of enrollment that would exist because a person enrolled via the new SEP during the current plan year. To identify these months, I assume that people who take up the new SEP do so after experiencing a health shock. For these purposes, I treat a person as experiencing a health shock in any month in which the person incurs health spending that exceeds a dollar threshold. I assume that the first month of SEP coverage is the month in which the health shock occurs (unless the month includes an emergency room visit, in which case I assume coverage starts the month after). Because these SEP enrollees would typically be eligible for zero premium silver plans, I assume that the new SEP enrollees would then remain enrolled for the rest of the plan year.
- (3) *New reenrollment member months*: These are member months that would exist because a person enrolled via an SEP during the prior plan year and then reenrolled for the subsequent plan year during OE.<sup>8</sup> To identify these members months, I identify people who experienced a health shock during the prior year (defined as for category #2 above) and then exclude member months that would have arisen via OE even under the status quo (which are included in category #1 above) as well as member months that would have arisen via an SEP during the current plan year (which are included in category #2 above).

The appendix provides additional detail on my methods.

Under this modeling approach, a key question is what level of claims spending constitutes a health shock that would trigger SEP enrollment. In my base analysis, I assume that a shock involves incurring at least \$1,750 of spending in a single month. This threshold was chosen so that the simulated number of member months of new SEP enrollment is roughly consistent with the estimate derived from the Massachusetts evidence.

Before presenting the results, I note that there are a few respects in which my modeling approach may overstate any increase in premiums attributable to the new SEP. First, some of the health spending associated with a health shock may be unanticipated and, thus, occur before the person can enroll via the new SEP. My assumption that SEP enrollment happens in the month after the health shock in cases where that shock involves an emergency room visit should mitigate this problem to some degree, but likely not completely. Second, availability of the SEP may cause some health spending that would have occurred after the next OE to instead occur during the current plan year, thereby reducing future spending. Third, and perhaps most importantly, my approach assumes that selection into the new SEP is *perfectly* predicted by whether a person experiences a health shock as I define it. If some people who experience a shock do not enroll and some who do not experience a shock do enroll, then average spending among those who take up the new SEP might be lower, perhaps considerably so.

As a crude way of addressing these possibilities, I present supplemental results in which the spending threshold defining a health shock is \$500. I also present results in which the threshold defining a health shock is \$4,000. The latter results can be understood to correspond to a scenario in which there is a much larger population of people with high claims risk who do not currently enroll during OE than suggested by the data and evidence used to construct my base analyses. I view this scenario as less likely, but I include it for the sake of completeness.

---

<sup>8</sup> This approach misses reenrollment member months attributable to people who enrolled via the new SEP more than one year in the past. Because the MEPS-HC data provide only 24 months of data for each respondent, this problem is difficult to remedy.

**Table 1: Effects of SEP Policy on ACA-Compliant Premiums and Unsubsidized Enrollment**

Health shock threshold	PMPM spending for new member months (% of PMPM spending under current policy)		Change in ACA-compliant premiums (%)		Change in unsubsidized enrollment (1000s)	
	New SEP enrollees	New reenrollees	Only SEP enrollees	SEP enrollees + reenrollees	Only SEP enrollees	SEP enrollees + reenrollees
\$500	129	29	0.4	0.0	-6	0
\$1,750 (base)	239	52	1.9	1.6	-28	-24
\$4,000	371	65	3.7	3.5	-56	-53

The first two columns of Table 1 present estimated per member per month (PMPM) health spending for the additional member months of enrollment spurred by the SEP. Consistent with the fact that I have assumed that the people who take up the new SEP are spurred to do so by a health shock, new SEP member months have higher spending than current policy member months across all scenarios. On the other hand, the reenrollment member months spurred by the SEP policy have very low spending, reflecting the fact that people who would have previously declined to enroll during OE *and* not experienced a shock that would cause them to take up the new SEP during the current plan year are likely to have very low realized spending.

The third and fourth columns of Table 1 combine the estimates in the first two columns with the enrollment effects estimated in the first section of this letter to estimate the effect of the SEP policy on ACA-compliant premiums.<sup>9</sup> The first set of estimates account only for the new member months contributed by people who took up the new SEP during the current plan year, while the second set of estimates also account for the new member months contributed by people who enrolled via an SEP during the prior year and then reenrolled during OE. The estimated premium impacts are all in the low single digits, and they are close to zero in the more optimistic scenario. Notably, the premium impacts are modestly smaller when reenrollments spurred by the policy are accounted for, which suggests that any premium impacts of CMS’ proposal might be largest in the policy’s first year.

The last two columns of Table 1 translate the premium effects into changes in unsubsidized enrollment.<sup>10</sup> The enrollment impacts are modest in all scenarios, reflecting the modest size of the premium impacts and the relatively small amount of unsubsidized enrollment at baseline. Notably, the estimated reductions in unsubsidized enrollment are only a small fraction of the increase in enrollment among people eligible for the new SEP.

<sup>9</sup> These calculations incorporate a few assumptions. First, I assume that 90% of premiums reflect costs that scale with claims spending. Second, I assume that, under the status quo, PMPM spending by people with incomes below 150% of the FPL is approximately equal to PMPM spending by other individual market enrollees. Third, I assume that there would be 16.6 million people enrolled in ACA-compliant plans without the new SEP; this reflects ACA-compliant enrollment as of 2019, as reported in CMS’ risk adjustment and effectuated enrollment reports, updated to reflect implementation of the ARP using estimates from Banthin et al., “What If the American Rescue Plan’s Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022.” For simplicity, my calculations ignore any changes in the age mix of individual enrollment, which could also affect premiums; my simulations suggest that the age mix of people induced to enroll by the SEP would be similar to the age mix of current enrollees.

<sup>10</sup> For these calculations, I assume that, without the SEP policy, there would be 3.0 million people in ACA-compliant plans who are not receiving the premium tax credit; this reflects an estimate of unsubsidized enrollment in 2019 derived from CMS’ risk adjustment and effectuated enrollment reports, updated to reflect implementation of the ARP using estimates from Banthin et al. I assume that the elasticity of enrollment with respect to premiums is -0.5, based on the brief review of prior research presented in Matthew Fiedler, “Taking Stock of Insurer Financial Performance in the Individual Health Insurance Market through 2017” (Brookings Institution, October 2017), <https://www.brookings.edu/wp-content/uploads/2017/10/individualmarketprofitability.pdf>.

## **Weighing the Proposal's Benefits and Costs**

In closing, I offer comments on how CMS should weigh the benefits and costs of this proposal.

Fundamentally, this policy would have two effects. First, some low-income people would obtain Marketplace coverage via the new SEP. As a result, they would incur lower out-of-pocket costs and likely receive additional health care. Second, individual market insurers would incur additional claims spending. That additional claims spending would overwhelmingly be borne by the federal government, partly through the premium tax credit payments it made on behalf of the new enrollees and—to the extent that premiums rose due to the policy—partly through higher premium tax credit payments made on behalf of all enrollees. In light of my estimate that the policy would have only modest effects on premiums and the relatively small number of unsubsidized enrollees, only a very small portion of the new costs would fall on individual market enrollees themselves.

Thus, the fundamental question presented by CMS' proposal is whether purchasing coverage for low-income people is a good use of federal funds. My view (one that was presumably shared by Congress in crafting the Affordable Care Act and the ARP subsidy expansion) is that this generally is a high-value use of federal funds, so I recommend that CMS finalize the SEP policy as proposed.

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

Sincerely,

Matthew Fiedler  
Fellow, USC-Brookings Schaeffer Initiative for Health Policy  
Economic Studies Program  
Brookings Institution  
Email: [mfiedler@brookings.edu](mailto:mfiedler@brookings.edu)  
Phone: (202) 238-3515

## Appendix

This appendix gives more detail on the methods used to estimate how CMS' proposal would affect premiums.

### *Construction of the Simulated Population*

This analysis relies on Panels 18 through 22 of the MEPS-HC. To construct the simulated population, I first limit the sample to people ages 20-64 since children in this income range are generally eligible for Medicaid or the Children's Health Insurance Program. Next, I limit the sample to people who report holding employer-sponsored coverage in all 24 months of the panel. I focus on people with employer-sponsored coverage since take-up of employer-sponsored coverage is relatively high; this ensures that the simulated population encompasses the types of people who might not enroll in coverage in the individual market context and contains information on the claims costs those individuals would incur if they were enrolled in health insurance.

For most major types of health care spending, the MEPS-HC event files report spending at a monthly frequency. However, some categories of spending (most importantly prescription drugs) are not reported monthly. For these categories of spending, I assume that the distribution of spending across months is the same as for spending categories that are available at a monthly frequency. I rescale all spending variables in each MEPS-HC panel so that mean spending in the second year of that panel matches mean spending in the second year of Panel 22.

To maximize sample size, the simulated population includes respondents at all income levels, not just respondents with incomes below 150% of the FPL. Thus, I am implicitly assuming that the distribution and dynamics of health care spending do not vary too substantially across income groups.

### *Imputation of Enrollment Probabilities*

As described in the main text, I assume that the probability that a person enrolls in coverage via OE is a function of that person's expected spending in the upcoming year. Formally, I assume that the probability  $p_i$  that person  $i$  enrolls during OE takes the following logit form:

$$p_i = \text{logistic}(\alpha + \beta c_i^e),$$

where  $c_i^e$  denotes expected claims spending for person  $i$  over the course of the upcoming year.

I construct a measure of  $c_i^e$  by regressing actual claims spending in the second year of the panel on two sets of variables: (1) a restricted cubic spline for health care spending over the preceding twelve months; and (2) a restricted cubic spline for the enrollee's age. Both restricted cubic splines are specified to have two knots, which I set at tercile boundaries. The fitted values from this regression are the desired estimates of  $c_i^e$ .

I calibrate the parameters  $\alpha$  and  $\beta$  so that simulated enrollment behavior has two features. First, I target an overall take-up rate of 62.8%. I derive this target by starting with an estimate of the take-up rate of ACA-compliant individual market coverage among people with incomes below 200% of the FPL as of 2019 and then adjusting it based on projections of the effects of the ARP subsidies in that income group.<sup>11</sup> Second, I ensure that realized claims spending in the unenrolled population is 50.5% of spending in the enrolled population. This target is derived to align with prior research on the relationship between claims risk and insurance enrollment.<sup>12</sup>

---

<sup>11</sup> For the 2019 take-up rate, see the data underlying Figure 6 in Matthew Fiedler, "Enrollment in Nongroup Health Insurance by Income Group" (Brookings Institution, March 2021), <https://www.brookings.edu/research/enrollment-in-nongroup-health-insurance-by-income-group/>. The adjustment to incorporate the effects of the ARP is based on Banthin et al., "What If the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022."

<sup>12</sup> See the estimates reported in Table 7 in the online appendix of Amy Finkelstein, Nathaniel Hendren, and Mark Shepard, "Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts," *American Economic Review* 109, no. 4 (April 2019): 1530-67, <https://doi.org/10.1257/aer.20171455>.