January 30, 2023

Xavier Becerra, Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024 [CMS-9899-P]

Dear Secretary Becerra and Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024" notice of proposed rulemaking.[1] In brief, our letter makes three main comments related to the proposed rule:

- **Transitioning enrollees who miss premium payments to zero-premium plans, rather than disenrolling them, would help hundreds of thousands of people retain coverage annually, benefiting enrollees and advancing the administration's policy goals.** The proposed rule seeks comment on transitioning enrollees who miss required premium payments into zero-premium plans, when possible, rather than disenrolling them. Evidence suggests that this policy would help hundreds of thousands of people retain coverage annually, benefiting the affected enrollees and advancing the administration's coverage expansion goals. The impact would be largest if the policy applied to enrollees who never made a binder payment, not just enrollees who later stopped paying premiums, as evidence suggests that *initiating* premium payments is a common stumbling block for enrollees. Furthermore, there are viable options for coordinating this policy with the three-month grace period available to enrollees who receive the advance premium tax credit.

- **Several changes to Marketplace enrollment processes that are included in the proposed rule would increase coverage or shift enrollees into plans that better meet their needs.** HHS' proposed changes related to data matching inconsistencies and the "failure to reconcile" rules would increase coverage by reducing the administrative burdens enrollees bear to enroll and stay enrolled. Similarly, automatically transitioning certain enrollees eligible for cost-sharing reductions from bronze plans to silver plans would shift affected enrollees into plans that better meet their needs.

- **Recent expansions of the premium tax credit create various other opportunities to expand coverage by changing Marketplace rules.** Recent premium tax credit expansions have greatly increased the number of Marketplace enrollees who are subject to small, positive premiums. Evidence suggests that even small premiums can meaningfully reduce coverage due to the administrative burden involved in remitting them; this could be avoided

[1] Please note that the views expressed in this letter are our own and do not necessarily reflect the views of the Brookings Institution, Harvard University, or anyone affiliated with those institutions other than ourselves.

by allowing or, ideally, requiring insurers to treat enrollees with small premium balances as having paid in full. Recent premium tax credit expansions have also greatly increased the number of people eligible for zero-premium plans; as a result, automatically enrolling people who start the Marketplace enrollment process, but stop before selecting a plan, into zero-premium plans could now generate much larger increases in enrollment. Each of these policies could increase coverage by at least tens of thousands of people.

The remainder of this letter explains our comments in greater detail.

Transitioning Enrollees Who Miss Premium Payments to Zero-Premium Plans

The proposed rule solicits comment on whether enrollees who miss required premium payments should be automatically transitioned into a zero-premium plan when one is available. This type of policy is sometimes called an "automatic retention" policy, and we use this term below.[2]

Effects on Marketplace enrollment

The effect of an automatic retention policy on Marketplace enrollment depends on how often Marketplace enrollees eligible for zero-premium plans miss required premium payments. While we are unaware of published estimates of how often this happens, it is likely very common.

To start, eligibility for zero-premium plans is now widespread in the Marketplace. During 2022 open enrollment, 34% of Marketplace plan selections were by people with incomes below 150% of the FPL, who (at present) typically have access to two zero-premium silver plans. Many higher-income enrollees also qualify for zero-premium plans, typically bronze plans.[3]

Importantly, many enrollees *eligible* for zero-premium plans still *enroll* in plans with positive premiums. In some cases, enrollees actively choose plans with positive premiums. In other cases, an enrollee may select a zero-premium plan for one plan year and then remain in the same plan in a subsequent plan year due to inertia even though the plan begins requiring a premium. This second scenario is likely commonplace: 84% of HealthCare.gov enrollees lived in counties where all silver plans that were available at zero premium in 2021 required enrollees to pay a positive premium in 2022;[4] and 59% of re-enrolling consumers in the HealthCare.gov states actively selected or were automatically re-enrolled in the same plan (or a cross-walked plan) in 2022.[5]

In practice, many enrollees subject to positive premiums miss premium payments. Research examining Colorado's Marketplace has found that being subject to even a small premium reduced enrollment by 11%, with seemingly all of that effect reflecting missed premium payments rather

[2] Adrianna McIntyre, Mark Shepard, and Myles Wagner, "Can Automatic Retention Improve Health Insurance Market Outcomes?," *AEA Papers and Proceedings* 111 (May 2021): 560–66, https://doi.org/10.1257/pandp.20211083.

[3] Centers for Medicare and Medicaid Services, "2022 Marketplace Open Enrollment Period Public Use Files," 2022, https://www.cms.gov/research-statistics-data-systems/marketplace-products/2022-marketplace-open-enrollment-period-public-use-files.

[4] Edward Kong, Mark Shepard, and Adrianna McIntyre, "Turnover in Zero-Premium Status Among Health Insurance Marketplace Plans Available to Low-Income Enrollees," *JAMA Health Forum* 3, no. 4 (April 1, 2022): e220674–e220674, https://doi.org/10.1001/jamahealthforum.2022.0674.

[5] Centers for Medicare and Medicaid Services, "2022 Marketplace Open Enrollment Period Public Use Files."

than reductions in the number of people initially selecting plans.[6] Nonpayment is also likely an important reason that Marketplace enrollment falls substantially over the plan year.[7]

Nonpayment can occur for many reasons. In some cases, it may occur because remitting a premium requires enrollees to remember to take action every month and can involve substantial hassle costs, especially for enrollees who lack bank accounts.[8] Indeed, evidence that even small premiums substantially reduce enrollment suggests that these non-financial hurdles are important.[9] In other cases, enrollees may experience changes in their personal circumstances that make a previously affordable premium difficult to bear. Nonpayment may be especially common among people who are automatically re-enrolled. Some of these enrollees may newly face premiums but not realize it because they remained in the same plan and, as a result, fail to initiate premium payments. Others may face unexpected premium increases that make their premiums difficult to afford.

The discussion above suggests that an automatic retention policy could substantially increase Marketplace enrollment. To derive a quantitative estimate of that increase in enrollment, we turn to research on a similar policy implemented by Massachusetts in its pre-ACA Commonwealth Care program.[10] That research estimated that 14% of enrollees with incomes between 100 and 150% of the FPL (the group eligible for zero-premium plans in that setting) were switched into zero-premium plans rather than being disenrolled on an annual basis. Retained enrollees were younger and had lower medical spending, on average, than others in the same income group.

If an automatic retention policy retained 14% of current Marketplace enrollees with incomes below 150% of the FPL (the group typically eligible for zero-premium silver plans), that would equate to around 5% of all Marketplace enrollees—on the order of 800,000 enrollees—being retained on an annual basis.[11] If the automatic retention policy was also applied to people above 150% of the

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[6] Coleman Drake et al., "Financial Transaction Costs Reduce Benefit Take-Up: Evidence from Zero-Premium Health Insurance Plans in Colorado," January 11, 2022. Calculations based on the Drake et al. estimates imply that *removing* a small premium increases enrollment by 12%, as discussed in Matthew Fiedler, "Eliminating Small Marketplace Premiums Could Meaningfully Increase Insurance Coverage" (Brookings Institution, June 29, 2022), https://www.brookings.edu/essay/eliminating-small-marketplace-premiums-could-meaningfully-increase-insurance-coverage/. It follows that *imposing* a small premium reduces enrollment by 11% (=0.12/1.12).

[7] See, for example, Matthew Fiedler, "Comments on a CMS Proposal to Allow Year-Round Marketplace Enrollment for Low-Income People" (Brookings Institution, August 2, 2021), https://www.brookings.edu/opinions/comments-on-a-cms-proposal-to-allow-year-round-marketplace-enrollment-for-low-income-people/.

[8] In 2021, an estimated 9.2% of households with incomes between $15,000 and $30,000 did not have bank accounts. See Federal Deposit Insurance Corporation, "2021 FDIC National Survey of Unbanked and Underbanked Households," 2021, https://www.fdic.gov/analysis/household-survey/2021report.pdf.

[9] Laura Dague, "The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach," *Journal of Health Economics* 37 (September 2014): 1–12, https://doi.org/10.1016/j.jhealeco.2014.05.001; Drake et al., "Financial Transaction Costs Reduce Benefit Take-Up: Evidence from Zero-Premium Health Insurance Plans in Colorado."

[10] McIntyre, Shepard, and Wagner, "Can Automatic Retention Improve Health Insurance Market Outcomes?"

[11] To estimate the share of affected Marketplace enrollees, we multiply 14% by the share of Marketplace plan selections among enrollees with incomes below 150% of the FPL in 2022. To convert this estimate to a number of people, we multiply by 16.3 million, the number of 2023 open enrollment plan selections through January 15.

In multiplying by total Marketplace plan selections in this income group, we implicitly assume that automatic retention would be applied to people who select plans but fail to make a binder payment, a policy choice we discuss

FPL (many of whom are also eligible for zero-premium plans, typically in the bronze tier), then the number of retained enrollees would be considerably larger than this estimate.

Of course, the effect of an automatic retention policy in the Marketplace might not exactly match its effect in Massachusetts. Notably, the share of zero-premium-eligible enrollees subject to positive premiums could differ (e.g., due to differences in the amount of year-to-year churn in which plans require positive premiums or in enrollees' propensity to select zero-premium plans when available), as could the prevalence of nonpayment. Indeed, if HHS were to pursue this policy, it would be useful to use its administrative records to directly estimate how many zero-premium-eligible Marketplace enrollees are disenrolled for nonpayment. Regardless, even if the share of Marketplace enrollees eligible for zero-premium plans who were retained by an automatic retention policy was just one-third as large as the share observed in the Massachusetts context, the number retained by the policy would still tally in the hundreds of thousands annually.

Costs and benefits of automatic retention policies

We now consider the costs and benefits of implementing an automatic retention policy. We do so first from the perspective of the affected enrollees and then from a broader policy perspective.

The enrollees who retained coverage under such a policy would likely be much better off, at least in expectation. Retained enrollees would gain the financial protection and access to care that comes with insurance coverage, rather than becoming uninsured, and, by design, would pay no premiums during the year. Some could be required to pay back part of the premium subsidies they received if their income turned out to be higher than expected. However, because many enrollees will have no repayment obligations and repayment obligations are capped except for enrollees that experience very large income increases, accounting for repayment obligations is unlikely to change the conclusion that the retained enrollees would benefit substantially in expectation.

Of course, after the fact, some enrollees might still wish that they had not been switched to a zero-premium plan, especially if they did not understand that the alternative to being switched was being disenrolled. That risk could be mitigated by clearly communicating with affected enrollees about why they were being switched to a new plan and how they could disenroll if they wished. We also note that the risk that some enrollees might see themselves as having been made worse off by being switched to a zero-premium plan is in many ways similar to risks that HHS already appropriately accepts when it automatically re-enrolls Marketplace enrollees (and especially when it crosswalks enrollees to a new plan when their old plan is no longer available).

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in greater detail below. We note that Massachusetts' automatic retention policy does not appear to have applied to people who never made a binder payment, and these people are correspondingly not included in the denominator of the 14% estimate. Applying the Massachusetts-derived estimate to gauge the effect of the broader policy we envision here may be somewhat conservative since an automatic retention policy would very likely retain more than 14% of the people in this income group who do not make a binder payment.

The effect on the steady-state level of enrollment could be larger or smaller than the number of enrollees retained annually. Because switches to a zero-premium plan would typically occur mid-year, each person switched would typically receive less than one year of additional coverage in the year the switch occurred. On the other hand, many enrollees retained through this policy would likely remain enrolled into subsequent plan years.

Looking beyond the affected enrollees themselves, the desirability of automatic retention policies depends on whether the benefits of providing coverage to the enrollees retained by the policy are large enough to justify the fiscal cost of subsidizing that coverage. Our view is that these costs are worth bearing. More importantly, however, the administration's statements indicate that it also believes that these costs are worth bearing. Notably, the executive order on health insurance coverage that was issued on April 5, 2022 directed agencies to "identify ways…to help more Americans enroll in quality health coverage" including by examining "policies or practices that make it easier for all consumers to enroll in and retain coverage."[12]

One final consideration that could matter when assessing tradeoffs from either the enrollee's perspective or a broader policy perspective is whether some of the additional Marketplace enrollment spurred by this policy would duplicate other coverage enrollees hold. However, the research on Massachusetts' automatic retention policy cited above found that coverage duplication was rare in practice.[13] Additionally, the net fiscal cost of any coverage duplication would likely be much smaller than it appears at first blush. If enrollees did not use their Marketplace coverage because they held other coverage, the resulting reduction in per enrollee claims spending would ultimately translate into lower premiums, which would reduce premium tax credit costs and thereby offset much or all of the cost of subsidizing duplicate coverage. On the other hand, if enrollees with other coverage *did* use their Marketplace coverage, then the federal cost of subsidizing the *other* coverage would fall substantially. (This would be true even if the other coverage was through an employer since employer coverage is implicitly subsidized by the federal government via the tax exclusion for employer-provided coverage.)

Key design choices

We now offer comments on two aspects of the design of an automatic retention policy that HHS specifically seeks comment on in the proposed rule.

First, the proposed rule asks whether an automatic retention policy should apply to consumers who never make a binder payment or apply solely to consumers who make a binder payment and then stop paying premiums. There is little clear reason to believe that the costs and benefits of covering these two groups of consumers differ in important ways, so we see little rationale for excluding consumers who never make a binder payment from an automatic retention policy.

Moreover, the available evidence suggests that initiating premium payments is a common stumbling block for consumers, which implies that limiting an automatic retention policy to consumers who have made a binder payment would meaningfully reduce how much the policy increases coverage. In detail, the research on Colorado's Marketplace cited above finds that much of the reduction in coverage caused by being subject to a positive premium reflects problems in

[12] "Executive Order 14070 of April 5, 2022, Continuing To Strengthen Americans' Access to Affordable, Quality Health Coverage" (Federal Register), accessed January 12, 2023, https://www.federalregister.gov/documents/2022/04/08/2022-07716/continuing-to-strengthen-americans-access-to-affordable-quality-health-coverage.

[13] McIntyre, Shepard, and Wagner, "Can Automatic Retention Improve Health Insurance Market Outcomes?"

initiating coverage, likely due to challenges in making binder payments.[14] Similarly, the research on the Massachusetts automatic retention policy found that a large share of the impact of the policy was among enrollees whose plans switched from having zero premium to a having positive premium at the start of a new plan year and who then never managed to initiate premium payments.[15] Additionally, a randomized evaluation of strategies to boost take-up of coverage in the Massachusetts Health Connector found that streamlining marketplace enrollment (by allowing people to enroll by mail with a simple check-the-box letter) was significantly more effective than personalized reminder letters for prospective enrollees eligible for zero premium plans, but not those eligible only for positive-premium plans.[16] One plausible contributor to this pattern of results is that setting up premium payments is an independent hurdle in the enrollment process.

Second, the proposed rule seeks comment on how an automatic retention policy should be coordinated with the three-month grace period available to recipients of the advance premium tax credit, and, in particular, when coverage under the new zero-premium plan should become effective. The simplest option would be for the new plan to become effective in the first month after the end of the enrollee's grace period. This approach would only require Marketplaces to know when a grace period ended, not when it started, and thus would not require the Federally Facilitated Marketplace to collect information about grace periods beyond what it already collects. Additionally, it would avoid any confusion about who bears responsibility for claims incurred during grace period since the new plan would not yet have become effective.

A downside of this approach is that the affected enrollees would formally be left without coverage for the final two months of the grace period (since Marketplace plans are only required to pay claims during the first month of the grace period). This downside may not be as significant as it appears since enrollees would retain the option to resume premium payments under the old plan until the end of the grace period, meaning that they would implicitly retain some of the benefits of coverage until the grace period expired. And whatever downsides a two-month coverage gap may have from enrollees' perspective, it is clearly preferable to being uninsured for these two months *and* the months following the grace period, as occurs under the status quo.

Nevertheless, over the long run, HHS may wish to explore options that would avoid a two-month gap in coverage for these enrollees. One option would be to trigger coverage under the new plan only after the grace period expires but make coverage under the new plan retroactive to the start of the second month of the grace period. This approach could cause confusion about who is responsible for claims incurred during the final two months of the grace period, but this might be outweighed by the benefits of ensuring that the affected enrollees have continuous coverage.

Another approach to explore is whether coverage under the old plan could be fully terminated after the *first* month of the grace period rather than the third month. While the ACA clearly prevents

[14] Drake et al., "Financial Transaction Costs Reduce Benefit Take-Up: Evidence from Zero-Premium Health Insurance Plans in Colorado."

[15] McIntyre, Shepard, and Wagner, "Can Automatic Retention Improve Health Insurance Market Outcomes?"

[16] Keith Marzilli Ericson et al., "Reducing Administrative Barriers Increases Take-up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment" (National Bureau of Economic Research, January 30, 2023), https://doi.org/10.3386/w30885.

issuers from terminating coverage before the end of the three-month grace period, it is not clear that *Marketplaces* are subject to the same prohibition.[17] This approach would avoid a two-month coverage gap without creating the same potential for confusion about which (if any) plan is responsible for paying the enrollee's claims during those two months.

A downside of this approach is that it would reduce the time enrollees have to resume premium payments and thereby remain in their original plans. The importance of this downside would depend on how many enrollees resume payment after the first month of the grace period, something HHS may be able to examine empirically using its administrative records. There could also be ways of mitigating this downside. First, HHS could consider offering a special enrollment period to affected enrollees that would allow them to switch back to their old plan if they resumed premium payments under that plan, which is similar to how the Massachusetts automatic retention policy discussed above functioned. Enrollees under 150% of the FPL are already eligible for a special enrollment period that allows them to switch plans at any time (while the recent premium tax credit expansion remains in effect), but a new special enrollment period would be required for other enrollees. Second, HHS could consider limiting "early" plan switches to enrollees who are eligible for zero-premium silver plans rather than also those eligible for zero-premium bronze plans; in the latter case, HHS might appropriately place a higher weight on maximizing enrollees' opportunity to catch up on their premiums under the old plan.

A final design choice that HHS did not discuss in the proposed rule is whether an automatic retention policy should apply to all people who are eligible for zero dollar plans or be limited to a subset of those enrollees, such as enrollees eligible for a zero-premium plan in the same or higher metal tier as their current plan. The main effect of limiting the application of an automatic retention policy would be that more enrollees transition from Marketplace coverage into uninsurance. For the reasons discussed in the last section, this would likely be worse for both the affected enrollees and the administration's broader policy objectives. This suggests that if HHS moves ahead with an automatic retention policy, it should implement that policy on as broad a basis as possible.

Other Enrollment Process Changes in the Proposed Rule

While our focus in this letter is HHS' comment solicitation on automatic retention policies, we wish to comment briefly on other policies in the proposed rule that have potential to expand coverage (or transition enrollees into better coverage), consistent with the administration's goals.

First, HHS proposes to narrow the circumstances in which data matching inconsistencies are generated and give enrollees more time resolve data matching inconsistencies. It also proposes to only end advance premium tax credit payments after enrollees have failed to reconcile tax credit payments for two consecutive years (rather than just one year). There is considerable evidence that administrative burdens can interfere with insurance enrollment and retention, including the

[17] See 42 USC 18082(c)(2)(B).

evidence cited above that being subject to a small premium reduces coverage by requiring enrollees to take action to remit the premium.[18] This implies that HHS' proposals would increase coverage.

Second, HHS proposes to change the rules governing the automatic re-enrollment process so that Marketplaces have the option to transition enrollees who are eligible for cost-sharing reductions but are currently enrolled in a bronze plan into a silver plan in the same product that has the same or lower net premium. While it is unclear how many enrollees would be affected by this policy, enrollees who are affected would almost certainly benefit because they would generally experience large reductions in cost-sharing obligations alongside no increase in premiums.

Additional Opportunities Created by Expanded Subsidies

In closing, we describe two other areas where HHS could change Marketplace policy in ways that would expand coverage, neither of which was considered in the proposed rule. Both opportunities largely stem from the recent premium tax credit expansion, as we have discussed elsewhere.[19]

First, many Marketplace enrollees are in plans that require small, positive premiums. In 2022, an estimated 404,000 Marketplace enrollees in the HealthCare.gov states owed a positive premium of less than 0.5% of their plan's gross premium.[20] Absent the recent premium tax credit expansion, this situation would have been much rarer, affecting only an estimated 77,000 enrollees. These small positive premiums can arise either when enrollees opt for a plan with a premium slightly larger than their tax credit or when an enrollee's plan includes a small amount of coverage for services that are not essential health benefits (e.g., vision or hearing coverage) since the tax credit cannot be used to pay premiums attributable to that coverage.

While premiums of this size will often not be a major financial burden to enrollees, even relatively low-income enrollees, the evidence examined above indicates that the administrative burden of remitting a premium can still reduce enrollment.[21] To avoid that outcome, HHS could build on the existing premium threshold policy at 45 CFR 155.400(g) to allow or, ideally, require insurers to treat enrollees with small outstanding premium balances as having paid in full.[22,23] A policy in this vein would have increased coverage by an estimated 48,000 person-years in 2022.[24]

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[18] Dague, "The Effect of Medicaid Premiums on Enrollment"; Drake et al., "Financial Transaction Costs Reduce Benefit Take-Up: Evidence from Zero-Premium Health Insurance Plans in Colorado."

[19] Matthew Fiedler and Adrianna McIntyre, "Tweaking the Marketplace Enrollment Process Could Magnify Effects of Larger Premium Tax Credits" (Brookings Institution, September 13, 2022), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2022/09/13/tweaking-the-marketplace-enrollment-process-could-magnify-effects-of-larger-premium-tax-credits/.

[20] Fiedler, "Eliminating Small Marketplace Premiums Could Meaningfully Increase Insurance Coverage."

[21] Dague, "The Effect of Medicaid Premiums on Enrollment"; Drake et al., "Financial Transaction Costs Reduce Benefit Take-Up: Evidence from Zero-Premium Health Insurance Plans in Colorado."

[22] Fiedler, "Eliminating Small Marketplace Premiums Could Meaningfully Increase Insurance Coverage"; Fiedler and McIntyre, "Tweaking the Marketplace Enrollment Process Could Magnify Effects of Larger Premium Tax Credits."

[23] The existing policy only applies when the outstanding balance is small *as a percentage of what the enrollee owes*, so it does not apply in cases where the enrollee owes only a small premium but has paid none of it.

[24] Fiedler, "Eliminating Small Marketplace Premiums Could Meaningfully Increase Insurance Coverage."

Second, enrollees sometimes begin the Marketplace enrollment process but stop before actually selecting a plan. As noted above, the newly more generous premium tax credit makes a broad swath of Marketplace enrollees eligible for zero-premium plans, often even in the silver tier. This suggests that Marketplaces could increase enrollment by automatically enrolling people who advance far enough through the Marketplace enrollment process to determine that they are eligible for a zero-premium plan, but stop before selecting a plan, into one of the zero-premium options. We note that a similar policy has recently been implemented by Massachusetts' Marketplace.

We are unaware of estimates of how this type of policy would affect coverage, but estimates from Covered California suggest that tens of thousands of state residents start but do not finish the Marketplace enrollment process during each open enrollment period. This suggests that this type of policy could plausibly increase enrollment by at least tens of thousands of people nationwide.[25]

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

Sincerely,

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[25] Rebecca Myerson et al., "Personalized Telephone Outreach Increased Health Insurance Take-Up For Hard-To-Reach Populations, But Challenges Remain," *Health Affairs* 41, no. 1 (January 1, 2022): 129–37, https://doi.org/10.1377/hlthaff.2021.01000.