Center on Health Policy at BROOKINGS

November 7, 2024

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 2026; and Basic Health Program [CMS-9888-P]

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the proposed 2026 Notice of Benefit and Payment Parameters issued by the Centers for Medicare and Medicaid Services (CMS).[1] In response to the proposals and comment solicitations in the proposed rule, this letter makes three main points:

- **CMS' proposal to allow Marketplace enrollees with small premium balances to remain enrolled would increase enrollment, as CMS intends. However, it would have a larger effect if it also applied to binder (initial) payments.** CMS appears worried that applying this policy to binder payments would make it easier for unscrupulous brokers to enroll people without their knowledge. This is unlikely, however, because there are already plans that can be enrolled in without a binder payment in most markets.

- **Accounting for the time value of money and insolvency risk in risk adjustment would make the program more effective at mitigating selection incentives.** CMS could account for the time value of money by scaling up risk adjustment transfers to reflect the interest that issuers that pay into risk adjustment can earn between when claims are paid and when transfers occur. I estimate that an adjustment in this vein would have increased transfers for the 2023 benefit year by 5.6%. The risk that insolvent issuers will default on their risk adjustment liabilities could also be addressed by scaling up transfers; however, if feasible, it might be preferable to require issuers to make interim risk adjustment payments during the benefit year, which could reduce the underlying risk of default.

- **CMS' proposal to create a new risk score factor for receipt of HIV preexposure prophylaxis (PrEP) would reduce issuers' incentives to limit coverage of PrEP, likely without creating a major risk of overuse.** However, if this new factor were applied only when enrollees receive a brand-name version of PrEP (as CMS seeks comment on in the proposed rule), this would create incentives for issuers to limit coverage for generic forms of PrEP. This would increase health care spending without offsetting benefits.

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

[1] The views expressed in this letter are my own and do not reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than myself. I thank Loren Adler for helpful comments, Samantha Crow for analytic assistance, Ben Graham for research assistance, and Rasa Siniakovas for editorial assistance.

Revisions to premium threshold policies

I first comment on CMS' proposal to revise its premium threshold policies. CMS is proposing to allow issuers to keep enrollees with small premium balances (defined as $5 or less or, under an alternative approach, less than 1% of the gross premium) enrolled in coverage rather than requiring issuers to begin the process of terminating these enrollees' coverage for non-payment. At present, CMS allows this only when enrollees pay a large enough percentage of the net-of-subsidy premium; issuers are permitted to set any "reasonable" threshold percentage, but CMS has previously suggested that 95% is a "reasonable" threshold. Thus, under current policy, enrollees who fail to pay even very small net premiums (e.g., $1) must be terminated for non-payment.

CMS' proposed changes would likely meaningfully increase Marketplace enrollment, as CMS intends. As CMS reports in the proposed rule, around 81,000 Marketplace enrollees with premium balances of $5 or less were terminated for non-payment during the 2023 plan year. This finding is not surprising in light of prior estimates that many Marketplace enrollees are in plans with small net premiums,[2] as well as research findings that even very small premiums commonly go unpaid, likely due to the hassle and cognitive costs involved in remitting payment.[3]

CMS' proposal does not apply to the binder payments used to effectuate coverage, just subsequent premium payments. Expanding CMS' proposal to apply to binder payments would likely substantially magnify the proposal's effects on enrollment. The research cited above suggests that small premiums reduce enrollment in substantial part because enrollees have difficulty *initiating* premium payments. Importantly, enrollees who are never enrolled due to failure to make a binder payment may often be locked out of coverage until the beginning of the next plan year.

CMS indicates that it does not wish to apply this policy to binder payments because of "concerns about program integrity." It appears that CMS is concerned that allowing enrollment without a binder payment would facilitate efforts by some brokers to fraudulently enroll people in coverage without their knowledge, an issue CMS discusses at length elsewhere in the proposed rule. However, it is doubtful that applying the proposed policy to binder payments would have much effect on the number of unauthorized enrollments. There are already typically many plans (and almost always at least one plan) in a market that carry a $0 premium at some income levels.[4] Thus,

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[2] See 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/.

[3] For a brief summary of this evidence, see Fiedler. The key studies reviewed therein are 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; 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; Coleman Drake et al., "Financial Transaction Costs Reduce Benefit Take-up Evidence from Zero-Premium Health Insurance Plans in Colorado," *Journal of Health Economics* 89 (May 1, 2023): 102752, https://doi.org/10.1016/j.jhealeco.2023.102752. For additional evidence, see also Adrianna McIntyre, Mark Shepard, and Timothy J. Layton, "Small Marketplace Premiums Pose Financial And Administrative Burdens: Evidence From Massachusetts, 2016–17," *Health Affairs* 43, no. 1 (January 2024): 80–90, https://doi.org/10.1377/hlthaff.2023.00649.

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

by choosing a suitable plan and fabricating a suitable income estimate, a broker willing to engage in fraud can avoid the need for a binder payment even under the status quo.

Accounting for the time value of money and insolvency risk in risk adjustment

The goal of risk adjustment is to break the link between an issuer's enrollee mix and the claims costs the issuer incurs and, in turn, eliminate issuers' incentives to avoid people with greater health care needs. The risk adjustment program aims to achieve this by estimating how the claims risk of each issuer's enrollees differs from the market average and transferring a corresponding amount of money from issuers with below-average risk to issuers with above-average risk.

In the proposed rule, CMS highlights two phenomena that risk adjustment is failing to account for, both of which lead it to undercompensate issuers that attract higher-risk enrollees:

- *Time value of money:* The first is the time value of money. Risk adjustment transfers occur 8-10 months after the end of the benefit year, whereas the differences in claims liability that those transfers aim to offset largely accrue during the benefit year or shortly thereafter. Issuers with below-average risk can invest their claims savings during the months between when claims are paid and when transfers occur, so they retain some benefit from attracting lower-risk enrollees even after transfers occur. By contrast, issuers with above-average risk lose the ability to invest these funds during this period, so they bear some cost of attracting higher-risk enrollees even after transfers occur. In effect, issuers with above-average risk give an "interest-free loan" to their lower-risk competitors.

- *Insolvency risk:* The second is insolvency risk. Issuers with below-average risk may default on their risk adjustment obligations, as occurred following the issuer insolvencies that CMS highlights in the proposed rule. This risk of default reduces the expected value of risk adjustment transfers to issuers with above-average risk and correspondingly reduces the expected cost of those transfers to issuers with below-average risk.

In practice, there are likely also other features of CMS' current risk adjustment methods that cause it to undercompensate issuers that attract higher-risk enrollees. Notably, economic theory and empirical evidence suggest that the risk adjustment program may be understating the claims risk borne by issuers with higher-risk enrollees because it does not capture all relevant dimensions of enrollee health risk.[5] Together, these limitations of CMS' current risk adjustment methods mean that issuers likely retain substantial incentives to avoid higher-risk enrollees; indeed, this is a likely explanation for why more generous plan types (e.g., platinum, preferred provider organization, point-of-service, and broad network plans) are often unavailable in the individual market.[6]

[5] For a review of the relevant theory and evidence, see Matthew Fiedler and Timothy Layton, "CMS Should Abandon Its 'Two-Stage' Risk Adjustment Estimation Proposal," January 27, 2022, https://www.brookings.edu/essay/cms-should-abandon-its-two-stage-risk-adjustment-estimation-proposal/.

[6] See, for example, Centers for Medicare and Medicaid Services, "Plan Year 2024 Qualified Health Plan Choice and Premiums in HealthCare.Gov Marketplaces," October 25, 2023, https://www.cms.gov/files/document/2024-qhp-premiums-choice-report.pdf; John A. Graves et al., "Breadth and Exclusivity of Hospital and Physician Networks in

The proposed rule seeks comments on how CMS could better address the time value of money and insolvency risk. Below, I explain how risk adjustment could be modified to address these issues.

Accounting for the time value of money

CMS could account for the time value of money by scaling up transfers to include the interest that issuers with lower-risk enrollees can earn on their claims savings between when savings accrue and transfers occur. In doing so, CMS would need to make three key design choices:

- *Timing of claims savings:* The first design choice is when to treat low-risk issuers' claims savings as accruing. One straightforward approach would be to assume that the claims savings accrue on the same schedule as overall claims payments during the relevant benefit year.[7] CMS can directly estimate the distribution of claims payments over time using the data it obtains from the External Data Gathering Environment (EDGE).

- *Timing of risk adjustment transfers:* The second design choice is when to treat risk adjustment transfers as occurring. The main complication here is that risk adjustment collections occur slightly before risk adjustment payments. An ideal approach would be to apply a factor to risk adjustment *collections* that is based on when collections occur and for CMS to then pay out slightly larger amounts that incorporate the interest savings accrued by the federal government while those funds are in its possession. If, however, the risk adjustment program must be budget neutral in nominal (rather than present value) terms, then a pragmatic alternative would be to treat transfers as occurring on a date between when collections occur and when payments occur.

- *Interest rates:* The final—and perhaps most consequential—choice is what interest rate to apply. Because I am envisioning that CMS would address default risk separately (see below), a risk-free borrowing rate would be appropriate. One source of suitable rates would be the daily Treasury yield estimates published by the Department of the Treasury.[8] CMS could apply the interest rates published for each date to the claims savings assumed to be realized on that date. While Treasury only publishes estimates for certain borrowing durations, it is straightforward to interpolate these estimates to obtain an interest rate that applies through the exact date when risk adjustment transfers are assumed to occur.[9]

US Insurance Markets," *JAMA Network Open* 3, no. 12 (01 2020): e2029419, https://doi.org/10.1001/jamanetworkopen.2020.29419.

[7] A caveat with this approach is that the claims savings realized by low-risk issuers (and the additional cost borne by high-risk issuers) may accrue earlier in the year since high-risk enrollees are presumably more likely to fulfill their deductibles or reach their out-of-pocket maximums earlier in the plan year. While more analysis on this point could be useful, I suspect that a more sophisticated approach would generate very similar overall results.

[8] Department of the Treasury, "Daily Treasury Par Yield Curve Rates," accessed October 23, 2024, https://home.treasury.gov/resource-center/data-chart-center/interest-rates/TextView.

[9] In detail, let $d_1, d_2, \ldots d_K$ be the durations for which Treasury publishes estimates, and let $\tilde{r}_t^k$ be the published yield for date t and duration d_k. For a date $d_k \leq T - t \leq d_{k+1}$, where T is the date on which transfers are treated as occuring, define a weight $w_t = [T - t] \,/\, [d_{k+1} - d_k]$. The appropriate interpolated interest rate is then $\tilde{r}_t = (1 - w_t)\tilde{r}_t^k + w_t\tilde{r}_t^{k+1}$. The published yields correspond to a bond that pays interest semi-annually, so the desired

Concretely, under the approach described above, the final scaling factor would be given by

$$f = \sum_t s_t \, [1 + r_t]^{T-t}, \tag{1}$$

where s_t is the share of claims payments for the relevant benefit year that occur on date t, r_t is the interpolated interest rate applicable to date t, and T is the date on which CMS has chosen to treat risk adjustment transfers as occurring. In essence, the resulting factor is an average of the interest factor applicable to each date, weighted by the share of claims payments occurring on that date.

There are ways that CMS could simplify the procedure summarized in equation (1), at the cost of some loss in accuracy. First, CMS could treat all claims savings as being realized at a single point in time; one natural choice would be the weighted mean date on which claims were paid during the benefit year (that is, $\bar{t} \equiv \sum_t t s_t$). Under this assumption, the appropriate scaling factor would be simply $[1 + r_{\bar{t}}]^{T-\bar{t}}$. The advantage of this approach is that the scaling factor would depend on just two parameters: the mean payment date $\bar{t}$ and the interest rate $r_{\bar{t}}$. This could make the scaling factor easier to calculate and explain. This approach would give reasonably accurate results if interest rates do not vary too much over time.[10] Second, rather than calculating a new value of $\bar{t}$ based on that year's EDGE data, CMS could simply assume that $\bar{t}$ always falls the same amount of time after the beginning of the benefit year and only update the interest rate from year to year. This approach could modestly reduce the burden on CMS and would likely work well as long as the timing of issuer claims payments does not vary too much from one year to the next.

If the scaling factor presented in equation (1) had been calculated for the 2023 benefit year, it would have generated a scaling factor of 1.056, meaning that transfers would have been increased by 5.6% from their actual level.[11] In practice, the first simplified approach described above would have generated a slightly higher scaling factor of 1.059, although the two approaches could differ by more or less in other years depending on how interest rates varied over the year.

Accounting for insolvency risk

The proposed rule discusses steps that CMS could take to improve regulators' ability to identify issuers at risk of insolvency and potentially limit those issuers' enrollment before a default occurs.

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annual percentage yield would be calculated as $r_t = [1 + \tilde{r}_t/2]^2 - 1$. For additional details, see Department of the Treasury, "Treasury Yield Curve Methodology," October 19, 2022, https://home.treasury.gov/policy-issues/financing-the-government/interest-rate-statistics/treasury-yield-curve-methodology; Department of the Treasury, "Interest Rates - Frequently Asked Questions," accessed October 29, 2024, https://home.treasury.gov/policy-issues/financing-the-government/interest-rate-statistics/interest-rates-frequently-asked-questions.

[10] In particular, over the range of interest rates and durations at issue here, $[1 + r_t]^{T-t}$ is very well approximated by $1 + r_t[T - t]$. It follows that if r_t equals some constant $\bar{r}$ at all times t, then $f \approx 1 + \bar{r}[T - \bar{t}] \approx [1 + \bar{r}]^{T-\bar{t}}$. That is, this simplified scaling factor will very closely approximate the more complex scaling factor in equation (1).

[11] This calculation relies on a distribution of claims spending over time calculated using the 2019 EDGE Limited Data Set since those were the most recent data available to me. This estimate was calculated by excluding claims with a missing payment date. Dates were shifted forward by four years to proxy for the timing of claims payments during the 2023 benefit year. The calculation assumes that transfers occur on September 15.

While steps like this may be worthwhile, they are unlikely to eliminate the risk that issuers default on their risk adjustment liabilities. Thus, ensuring that risk adjustment creates the intended incentives likely requires directly accounting for insolvency risk in the design of the program.

One approach to doing so would be to scale up transfers to reflect insolvency risk. Specifically, CMS could scale up transfers by a factor $1 / (1 - \hat{u})$, where $\hat{u}$ is an estimate of the share of risk adjustment collections expected to go uncollected due to insolvency, averaging across outcomes where default does and does not occur. Under this approach, issuers that receive money in risk adjustment would receive larger transfers when no default occurs and, as such, receive the full amount in expectation. Conversely, issuers that owe money in risk adjustment would pay larger transfers when no default occurs and, as such, pay the full amount in expectation. Economic theory generally suggests that *expected* risk adjustment transfers are what shape issuers' plan design decisions, so this approach should create the desired incentives for issuers.[12]

The key challenge under this approach is how to obtain a suitable estimate of default risk. CMS could generate such an estimate by calculating the share of risk adjustment collections that went uncollected over some historical period, such as the prior ten years. In practice, default risk likely varies over time and across markets, so this method would likely overestimate default risk in some cases and underestimate it in others. However, this approach would likely be more accurate than the status quo, which treats default risk as zero and thus *always* underestimates it.

Nevertheless, there could be advantages to approaches that would not require constructing good estimates of default risk. One such approach would be to require issuers that are expected to owe money in risk adjustment to make interim payments during the plan year.[13] Under this approach, the key challenge would be forecasting issuers' transfer liability. It may be possible to construct reasonable forecasts prospectively based on the characteristics of an issuer's plan offerings, particularly how its premiums compare to its competitors. Alternatively, CMS could look back at an issuer's transfer liability in prior years; however, this approach would not work for new issuers, which might be an important limitation since insolvencies may be particularly likely for new issuers. This approach would also require developing a system to track issuers' compliance with their obligations to make interim payments. While additional work would be required to fully assess the viability of approaches like this, they do have potential advantages.

Creation of a risk score factor for PrEP

I close by commenting on CMS' proposal to use receipt of PrEP as a predictor in its risk score models. In general, CMS' rationale for this change is sound. CMS is correct that issuers who attract more enrollees who need PrEP will tend to incur higher costs than those who do not since PrEP is

[12] A caveat is that, under some circumstances, fully compensating high-risk issuers would require incorporating a "risk premium" in addition to adjusting for the expected amount of the default. Economic theory generally implies that a risk premium will be required only to the extent that insolvency risk is correlated with asset returns economy-wide; this correlation is plausibly relatively small, which suggests that the required risk premium may also be small.

[13] This requirement could be structured as a requirement to deposit funds in an escrow account to avoid depriving the issuer of the ability to invest those funds during the intervening period.

relatively expensive.[14] CMS is also correct that the current risk adjustment system will do a poor job of compensating issuers for those costs; current risk score models predict enrollees' costs mainly based on diagnoses, but because PrEP is a preventive service, it is not reliably associated with any active diagnosis. As a result, the current system gives issuers incentives to try to avoid enrollees who need PrEP, such as by imposing onerous prior authorization requirements.[15]

Introducing a PrEP predictor variable is an effective way of mitigating these incentives. Moreover, while incorporating utilization measures into risk scores can, in principle, diminish issuers' incentives to discourage overuse of the relevant services, CMS makes plausible arguments that overuse (or, at a minimum, uses beyond those reflected in relevant treatment guidelines) is not a major concern in this case. CMS is also correct that its existing categories of predictor variables cannot accommodate enrollee characteristics that are not associated with an active diagnosis, so its proposal to create a new category of variables called affiliated cost factors (ACFs) is reasonable.

The proposed rule also seeks comment on whether a PrEP ACF should be triggered by the use of any form of PrEP or only by the use of a brand-name form. This question appears to be motivated by a concern that defining a PrEP ACF to include all forms of PrEP would lead risk adjustment to overpredict plan liability for enrollees who receive generic forms of PrEP because generic forms are much less expensive than brand-name forms.

However, limiting a PrEP ACF to brand-name forms would have no clear benefits, as overpredicting costs for enrollees who use generic PrEP is unlikely to cause major problems. While overprediction would create incentives for issuers to attract enrollees who use generic PrEP, the main lever issuers have to do so would be to relax prior authorization requirements or otherwise make it easier to access PrEP. Since, as noted above, overuse of PrEP is relatively unlikely, encouraging issuers to remove barriers to accessing PrEP is likely not a major concern.

At the same time, limiting a PrEP ACF to brand-name forms would have clear downsides. Notably, it would discourage issuers from covering generic PrEP; because the coefficient on the PrEP ACF would reflect the average cost of brand-name PrEP under this approach, an issuer who shifted an enrollee from generic to brand-name PrEP would often come out ahead financially, even after accounting for the branded version's higher cost. This would directly increase health care spending and could allow manufacturers of brand-name PrEP to negotiate higher prices with issuers.

Shifting utilization from generic PrEP to the same drug in branded form would have no clinical benefits to patients. Shifting from generics to forms of PrEP that are not available as generics could, in principle, have clinical benefits. However, if that is the goal, the appropriate response would be to limit a PrEP ACF based on their clinical features (e.g., oral forms versus injectable

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[14] Sean Dickson and Katelyn James, "Trends in HIV Preexposure Prophylaxis Utilization and Spending among Individuals with Commercial Insurance," *AIDS* 38, no. 4 (March 15, 2024): 610, https://doi.org/10.1097/QAD.0000000000003809.

[15] Notably, prior authorization requirements appear to be common in individual market plans. See Kathleen A. McManus et al., "Geographic Variation in Qualified Health Plan Coverage and Prior Authorization Requirements for HIV Preexposure Prophylaxis," *JAMA Network Open* 6, no. 11 (November 10, 2023): e2342781, https://doi.org/10.1001/jamanetworkopen.2023.42781.

forms), not brand/generic status. Alternatively, CMS could create multiple PrEP ACFs corresponding to forms of PrEP with different clinical features. Of course, before CMS adopted any of these approaches, it would need to carefully consider whether adverse selection would lead issuers to offer overly stingy coverage for the relevant forms of PrEP and assess risks of inappropriate use, in keeping with the principles for ACFs articulated in the proposed rule.

Thank you for the opportunity to comment on this 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,

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