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THE VOICE FOR HEALTH CARE CONSUMERS

May 2, 2019

The Honorable Alex Azar, Secretary
United States Department of Health and Human Services
The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services (CMS)
Attention: CMS-2407-PN
P.O. Box 8016
Baltimore, MD 21244-8016

**Re: CMS-2407-PN, Basic Health Program: Federal Funding Methodology for Program Years 2019 and 2020**

**Submitted electronically via Regulations.gov**

Dear Secretary Azar and Administrator Verma:

Families USA, a leading national voice for health care consumers, is dedicated to achieving high-quality, affordable health care and improved health for all. We seek to make concrete and tangible improvements to the health and health care of the nation – improvements that make a real difference in people's lives.

We ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety.

Families USA appreciates the opportunity to comment on the proposed rule involving federal funding for the basic health program (BHP). This rule proposes two major changes, compared to previously published annual federal payment methodologies:

- It adds a premium adjustment factor (PAF) to respond to the administration's termination of cost-sharing-reduction (CSR) payments. The PAF estimates the increased premium tax credit (PTC) amount that would have resulted from silver-loaded premiums in BHP states if they had they not implemented BHP.[1]
- It adds a Metal-Tier Selection Factor (MTSF) to account for enrollment of BHP beneficiaries in bronze rather than silver plans if the state had not implemented BHP.

We comment on each change separately and conclude with general remarks.

[1] The PAF was added through a special administrative order, rather than through the standard process of proposing and finalizing annual federal payment rules for BHP. As far as we know, the proposed rule that is the subject of this letter presents entities other than litigants with their first chance to comment on the PAF.

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## PAF

**Recommendation: Replace the PAF with a CSR component that reflects the value of CSRs that would have been furnished to eligible individuals had the state not implemented BHP.**

CMS added the PAF in the context of litigation brought by New York and Minnesota ("BHP states"), challenging CMS's decision to stop the CSR component of federal BHP payment. That decision followed the administration's cessation of CSR payments to carriers, which in turn reflected the Department of Justice's conclusion that such payments were not mandatory but instead required appropriations. The BHP states argued that CMS's approach did not accurately capture the counterfactual of what would have taken place in those states had they not implemented BHP. Under that counterfactual, BHP states would have increased silver premiums to compensate plans for claims resulting from CSR requirements, taking an approach often deemed, "silver loading"—the approach used in most non-BHP states.

CMS ultimately accepted this general claim, adding a PAF to raise the "reference premium" used to calculate BHP payments. In both the proposed rule that is the subject of this comment letter and in the methodology adopted in the midst of litigation, the PAF is calculated by estimating the median increase in silver plans, nationwide, resulting from silver loading in non-BHP states, compared to the median such increase in BHP states. Based on survey results, CMS determined that the median such increase in non-BHP states was 20 percent, compared to just 1 percent in BHP states. (The latter conclusion reflects information from New York alone, since relevant data from Minnesota was not provided to CMS by any Minnesota QHPs.) The PAF thus equals 1.188 (1.20/1.01=1.188).

This approach is flawed both legally and factually. Legally, §1331(d)(3) of the Patient Protection and Affordable Care Act (ACA) requires BHP payments to equal "95 percent of the premium tax credits under section 36B of the Internal Revenue Code of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange established under this subtitle."

This language does not permit CMS to eliminate the CSR component of the federal payment formula based on the administration's cessation of CSR payments <u>to plans</u>. The federal BHP statute requires the CSR component to reflect "the cost sharing reductions… that would have been provided … *to eligible individuals*" (emphasis supplied). When the administration stopped paying plans to cover the cost of CSRs, plans were still required to furnish CSRs by increasing actuarial value (AV) for consumers with incomes at or below 250 percent of the federal poverty level (FPL). The terms of the statute compel including in federal payments the value of those CSRs <u>furnished to consumers</u>, in addition to the value of PTCs that such consumers would have received, regardless of whether plans would have received payments from CMS to cover CSR costs.

Factually, the approach is flawed because it undercompensates BHP states for the increased claims that would result from furnishing CSRs to individuals with incomes under 200 percent of FPL. Silver-loading reflects the average impact, distributed across all enrollees in silver-level QHPs, of increased claims resulting from CSRs furnished to a subset of silver enrollees: namely, those with incomes at or below 250 percent of FPL. That average is necessarily less than the value of the CSRs that BHP consumers would have received had they enrolled in QHPs, because people below 200 percent of FPL receive the most significant and costly CSRs.

A simple calculation shows the magnitude of underpayment that results from CMS's proposed approach. The value of CSRs equals 30.7 percent of reference premiums for consumers with incomes at or below 150 percent of FPL and 21.8 percent for those between 150 and 200 percent of FPL.[2] Especially for those in the former income group, these values exceed the 20 percent increase in median silver premiums resulting from silver loading in non-BHP states, under CMS's calculations.

This means that the proposed PAF would substantially undercompensate BHP states, because such states are legally required to provide enrollees with at least the increase in AV that would have been required in the exchange. A QHP can cover its CSR costs by raising silver premiums charged to enrollees at all income levels, including those above and below 200 percent of FPL. A state cannot take comparable steps to fund its BHP program.

The clear policy goal underlying §1331's federal funding provisions is to give BHP states the federal resources they need to meet the minimum requirements they must fulfill under the BHP statute, assuming that such states can achieve a 5 percent efficiency gain per enrollee. CMS's proposed PAF prevents the accomplishment of that goal, because of the divergence between silver-loaded premiums averaged across all silver enrollees and the cost increases concentrated on consumers below 200 percent of FPL. If BHP states cannot receive payment that covers the costs of an efficiently run program, states will be unlikely to implement BHP, and the statute may not achieve its goal. CMS should not interpret a statute in ways that prevent it from achieving its objectives.

<u>To fit both the plain meaning of its statute and its underlying purpose, CMS should return to calculating a state's BHP payment by combining:</u>

- <u>A PTC component, reflecting 95 percent of the PTC for which the BHP beneficiary would have qualified if the state was not implementing BHP; plus</u>
- <u>A CSR component, equaling 95 percent of the CSR that "would have been provided to [the] eligible individual," had the state not implemented BHP.</u>

[2] EHB claims for BHP enrollees are 1.28 times the reference premium, based on the following calculation: such claims equal the premium multiplied by .8 to eliminate administrative costs, divided by 0.7 to add EHB claims paid by enrollees in baseline silver coverage, and multiplied by 1.12 to account for increased utilization resulting from higher AV. For those below 150 percent of FPL, the CSR's value is 24% of such EHB claims (94% AV – 70% AV), or 30.1 percent of the reference premium amount. For those between 150 and 200 percent of FPL, the CSR's value is 17% of EHB claims (87% AV – 70% AV), or 21.8 percent of the reference premium amount.

## MTSF

**Recommendation #1: Do not add an MTSF to the federal payment methodology.**

There is no rational basis for the proposed change in policy. The stated justification is to replicate, for BHP states, the effect of bronze-tier enrollment by PTC beneficiaries in non-BHP states. That rationale is arbitrary and capricious as a basis for policy change effective in 2018, since it applied from the first moment BHP became available as an option for states in 2015. As early as the conclusion of the first open enrollment period in 2014, the administration reported that 15 percent of consumers in the Federally Facilitated Marketplace who purchased coverage using PTCs enrolled in bronze plans.[3] National numbers are not available for 2014 showing more detailed cross-tabulations involving income and metal levels, but the largest state-based exchange, Covered California, reported that in June 2014, 58,050 out of 427,670 consumers with incomes at or below 200 percent of FPL enrolled in bronze plans, or 14 percent of all consumers at that income level. If bronze enrollment was relevant to federal BHP payment amounts, it should have been part of the federal payment methodology from the start.

CMS's notice itself illustrates that consumers under 200 percent of FPL were enrolling in bronze before silver-loading began. The notice explains that the percentage of such consumers enrolling in bronze rose from "about 11 percent in 2017 to about 13 percent in 2018." Neither this change, nor the larger change in average impact of bronze enrollment on PTC amounts, are legally relevant. If bronze enrollment was irrelevant to prior methods of calculating federal BHP payments, it remains irrelevant today.

CMS had good reasons not to take bronze enrollment into account in its original federal payment methodology, reasons that remain applicable in 2019 and beyond. The level of assistance a state must provide to BHP consumers is based on the costs that consumers would pay if they enrolled in silver plans. See 42 CFR §600.520(c)(1) and (2), cross-referencing 45 CFR § 156.420, subsections (a)(1), (a)(2), (c), and (e). The federal payment methodology originally promulgated by CMS thus provided federal funding sufficient to support the legal-required level of BHP cost-sharing assistance. This reflected the obvious policy judgment that, for BHP to be a viable option, funding levels and state BHP duties needed to align. The proposed MTSF overturns that judgment without any stated rationale, so that state duties and federal funding become disconnected. As explained earlier in connection with the PAF, delinking federal BHP payment levels from federal requirements that BHP states must uphold would prevent the BHP statute from accomplishing its objective. This methodological change, contradicting prior policy and fundamental statutory goals, is arbitrary and capricious, not remotely justified by the increased use of bronze plans cited in the notice – a factual change that is merely a matter of degree, not anything involving a difference in kind or a legally relevant change.

[3] https://aspe.hhs.gov/system/files/pdf/76876/ib_2014Apr_enrollment.pdf

**Recommendation #2: If an MTSF is added to the methodology, it should be 99.05 percent.**

States vary enormously in the proportion of residents under 200 percent of FPL who are enrolled in bronze plans. Based on data from the 2019 public use files released by CMS, the proportion of consumers in that income range who buy bronze QHPs ranges from:

- 0.9%, 1.8%, 4.9%, and 6.9% in Massachusetts, Mississippi, Alabama, and Indiana, respectively;[4] to
- 29.7% in Montana, 29.4% in Alaska, and 23.5% in Ohio and Maine.

One cannot assume that BHP states would necessarily fall in the mid-point of this wide spectrum. The best evidence we have of where such states would fall comes from the real-world experience of New York before it first implemented BHP, in 2016. New York officials report that, in 2015, fewer than 1 percent of QHP enrollees with incomes at or below 200 percent of FPL enrolled in bronze, resulting in an average drop in PTC levels of $12 per consumer per month.[5] The latter reductions amounts to a 5.4 percent reduction, compared to average PTC levels of $220.[6] Even if one assumes that "less than 1 percent" is the same thing as 1 percent, the applicable MTSF for New York would be 99.05 percent.[7]

No comparable data are available for Minnesota, since it never enrolled people with incomes below 200 percent of FPL in QHPs. If CMS decides to add an MTSF—which it should not do!—CMS should take the same approach to filling in missing data that it took to determining the PAF. When it comes to calculating the PAF for BHP states, the notice of proposed methodology used New York data showing silver-loading levels in QHP coverage to determine the PAF for both New York and Minnesota, since evidence of such levels was available only for New York. That same approach should apply here, where once again data are available only for New York. Accordingly, the payment rule should provide that, for both BHP states, the MTSF is 99.05 percent.

One could argue that bronze enrollment patterns could have changed in New York if the state had not implemented BHP. Projecting such patterns is a highly speculative endeavor; with an extensive network of application assisters comparable to Massachusetts's, New York could have replicated Massachusetts patterns if it had not implemented BHP. The sounder approach is to rely on what is known for BHP states, which leads to an MTSF of 99.05 percent.
Even if New York's 2015 bronze numbers were modified to reflect the median state's 2018 changes as documented in the notice—namely, an 18 percent relative increase in bronze

[4] The District of Columbia's 0.0% rate is not relevant, since the District extends Medicaid adult eligibility to 200 percent of FPL.
[5] Community Service Society Comments in Response to Proposed Rulemaking: Basic Health Program; Federal Funding Methodology for Program Years 2019 and 2020, May 2019.
[6] https://info.nystateofhealth.ny.gov/sites/default/files/2015%20NYSOH%20Open%20Enrollment%20Report.pdf
[7] Using the formula stated in the notice, the MTSF would be calculated as follows: 1-(1% x 94.5%) = 99.05%.

enrollment and a 109 percent relative increase in average PTC reductions per bronze enrollee——the MTSF factor would be 98.92 percent.[8]

If other states gain approval to operate a BHP, and CMS decides to include an MTSF in its future federal funding methodology, those other states will have a history of QHP enrollment that would let CMS calculate, based on state-specific experience, the proportion of BHP consumers who would have enrolled in bronze plans without BHP. If Indiana implements BHP, the result will be a radically different MTSF than if the adjacent state of Ohio implements BHP, based on CMS data about enrollment patterns in 2019. In the meantime, any MTSF should be calculated for existing BHP states based on the real-world experience of New York with QHP enrollment, rather than experiences of other states that have radically different conditions than those obtaining in New York and Minnesota.

**Recommendation #3: If an MTSF is added to the methodology, it must be adjusted based on the age of actual BHP enrollees.**

The ACA's statutory language is clear. Federal BHP payments vary by BHP beneficiary. Depending on income, age, and county of residence, federal financial assistance levels in the exchange, hence federal BHP payments, can change.

If CMS decides, against our advice, to add an MTSF to the federal payment formula, the MTSF must vary by age, no less than the determination of what PTC would have been paid for enrollment in benchmark coverage. That is because the availability of zero-premium bronze and the amount of PTC reduction resulting from enrollment in bronze varies dramatically by age.

The following example assumes national average premiums for lowest-cost-bronze and benchmark plans, as estimated by the Kaiser Family Foundation for 2019,[9] for a single person with income at 200 percent of FPL:[10]

- Zero-premium bronze is not available for people under age 39.
- For adults at age 39, zero premium bronze is available, but it equals the maximum possible tax credit and so does not result in a PTC reduction.
- At age 40, the maximum possible tax credit would exceed the bronze premium by only $2, resulting in a very modest MTSF.

[8] In that case, the calculation would proceed as follows: 1-(1.2% x .9151)=98.92%.

[9] https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[10] The analysis displayed in bullets applies the federal age-rating curve to the premiums for 40-year-old non-smokers listed by Kaiser. It then calculates PTC amounts as the difference between the benchmark premium, for each age, and $136, which is the monthly income-based payment amount for a one-person household with income at 200 percent of FPL ($2,081.61 per month multiplied by 6.54% of income = $136.14). It then compares the PTC amount for each age to the lowest-cost bronze premium to determine whether the former exceeds the latter and, if so, by what margin.

- As age rises above 40, PTC savings from bronze enrollment skyrocket, rising from $2, $4, and $7 for ages 40, 41, and 42, respectively, to $174, $183, and $188 for ages 62, 63, and 64, respectively.

The CMS approach implicitly assumes the same age distribution for BHP enrollees and for QHP enrollees in non-BHP states with incomes below 200 percent of FPL. That assumption is plainly false. According to CMS's own 2019 public use files:

- Adults under age 35 comprised 38 percent and 36 percent of adult BHP enrollees in New York and Minnesota, respectively. By contrast, among adults with incomes below 200 percent of FPL who received QHP coverage in non-BHP states, only 28 percent were under age 35.
- Adults age 45 and older comprised 39 percent and 43 percent of adult BHP enrollees in New York and Minnesota, respectively. By contrast, among adults with incomes below 200 percent of FPL who received QHP coverage in non-BHP states, such older adults made up fully 54 percent of all adults with incomes at or below 200 percent of FPL.

The CMS methodology uses median state estimates that are based on a greatly different age distribution than what prevails in BHP states. As a result, it significantly overestimates the applicable MTSF. To avoid this error, the MTSF should be applied based on the age of each individual BHP enrollee, just as other factors in the federal payment methodology are applied based on the characteristics of individual BHP enrollee. Otherwise, BHP programs will be underpaid by substantial amounts.[11]

## General comments

In closing, we make two general comments. First, no reduction in federal BHP payment levels should be made through a retroactive change in federal methodology. BHP states construct their programs, in good faith, based on federal payment rules. Such reliance is particularly reasonable when, as in this case, such rules remain fixed year after year. To penalize a state with a substantial and unexpected loss in federal funding under those circumstances is sufficiently unfair that it raises serious procedural due process concerns under the 14th Amendment. Even if it does not rise to the level of violating constitutional requirements for fundamental fairness, such a retroactive application violates 42 C.F.R. § 600.610(a) and (b), which mandate a specific timeline for announcing and applying federal payment methodologies.

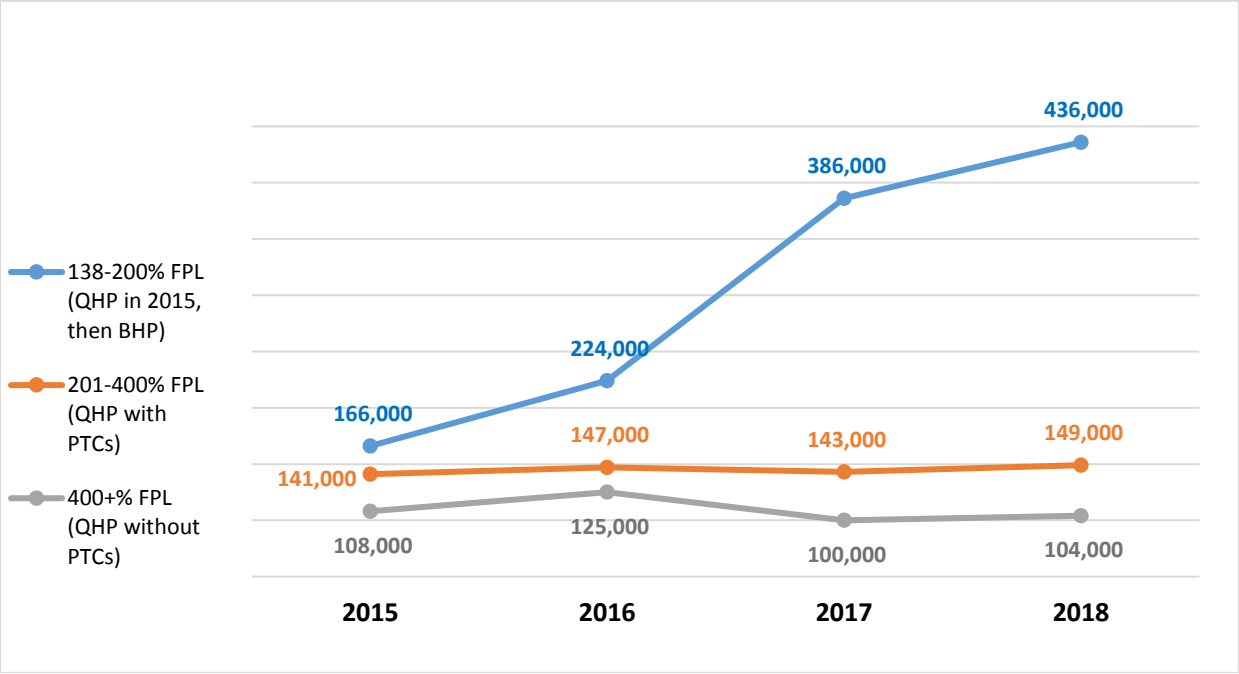
As a matter of reasonable policy rather than minimum legal requirements, no major reduction should be promulgated without giving states appropriate lead time for planning. At this

[11] An alternative approach to achieving this goal would adjust the MTSF to reflect the difference between the age distribution of BHP enrollees and the age distribution of QHP enrollees in the median non-BHP state with incomes at or below 200 percent of FPL.

juncture, with states on the verge of beginning their 2020 fiscal years, this means that no federal payment reduction should take place until 2021, at the earliest.

Second, it is critically important for the federal government to maintain a sufficient level of financial support for BHP. Two states, Minnesota and New York, have used BHP to provide substantially more affordable coverage to their residents. New York provides a natural experiment showing the potential impact of BHP, since that state did not implement BHP until after operating several years of exchange coverage. After BHP went into effect in 2016, the substantial affordability gains for consumers under 200 percent FPL triggered substantial coverage gains within the affected income range, at a time when enrollment at other income levels, unaffected by BHP, remained essentially flat (figure 1).

**Figure 1. Enrollment through New York's Marketplace, by income level: 2015-2018**




*Source*: New York State of Health (Open Enrollment Reports, 2015-2018).

The federal government should avoid making policy changes that could undermine the efforts of states like these to lower their residents' health coverage costs and reduce the number of uninsured. In health policy, as in medical practice, "first do no harm" must always be top of mind.

To avoid doing harm, CMS should retract the methodological changes proposed in its notice.

Thank you for the opportunity to submit these comments. If you have any questions, please contact Stan Dorn at SDorn@familiesusa.org or 202-628-3030.

Respectfully submitted,

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