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THE VOICE FOR HEALTH CARE CONSUMERS

December 30, 2020

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

The Honorable Secretary of the Treasury Steven T. Mnuchin
U.S. Department of the Treasury
1500 Pennsylvania Ave., N.W.
Washington, D.C. 20220

The Honorable Secretary of Labor Eugene Scalia
U.S. Department of the Labor
200 Constitution Ave NW
Washington, DC 20210

RE: CMS-9914-P, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates To State Innovation Waiver (Section 1332 Waiver) Implementing Regulations,

Submitted electronically on regulations.gov

Dear Administrator and Secretaries:

We write to comment on many aspects of this proposed Rule.

We observe, first, that this rule addresses a long and complex set of issues, but the public did not receive an adequate opportunity for notice and comment. The proposal was published in the Federal Register on December 4, with a comment deadline of December 30 – less than the 30-day period required by law, and at a time when holidays interfere with the public's ability to comment. Further, it proposes a number of initiatives that depart from prior policy in major ways involving substantial risk to health care access. These changes require careful analysis before a well-supported decision can be made in promulgating final rules.

It is imperative for the Department to allow a meaningful opportunity for serious comment and analysis regarding complex, major policy changes; instead, it has made a startling departure from past practice. The 2021 NBPP, for example, was proposed in January and finalized in May 2020. The current proposal is no less complex, and industry needs for advance notice are no more pressing than was the case in

FamiliesUSA.org
1225 New York Avenue, NW, Suite 800
Washington, DC 20005
Direct 202-626-0629 / Cell 202-841-7192

previous years. One glaring example involves the proposed, radically different approach to risk adjustment. Discussed at greater length below, the proposed new approach would clearly benefit from the kind of thoughtful discussion, based on carefully developed White Papers, that preceded risk adjustment's initial launch in 2014. In addition to general concerns about complying with the Administrative Procedure Act's (APA) generally applicable notice periods, this abandonment of past practice violates the settled expectations of multiple stakeholders and requires a clear rational basis.

For the great majority of changes encompassed in the rule, no objective circumstances call for the Department's unprecedented haste, which the proposed Rule does not even acknowledge, much less attempt to justify. However, for a few issues, quick rulemaking is required due to the COVID-19 pandemic. We begin by singling out those issues. We then address one overarching issue, involving multiple portions of the proposed Rule. Finally, we proceed, part-by-part, through the proposed Rule's other specific provisions.

We conclude this introduction with one final note. We are sending these comments to the Treasury and Labor Departments, not just to the Centers for Medicare & Medicaid Services (CMS), for two reasons. First, some of the issues we touch on would benefit from administrative action involving group coverage under the regulatory authority of the Labor Department and premium tax credits (PTCs) regulated by the Treasury Department. Second, an important section of the proposed Rule seeks to convert guidance announced by two Departments (Health and Human Services [HHS] and Treasury) into regulations. As we explain below, this step requires concurrence from both Departments. Even if the regulation was an appropriate and helpful exercise of CMS's authority — which it is not — CMS cannot act in isolation. It must act in concert with the Treasury Department, its partner in promulgating the guidance proposed for regulatory incorporation, as we explain below.

I. Areas Where Final Rulemaking is Warranted, Given the Public Health Emergency

Urgent Risk-Adjustment Improvements

Partial-year risk adjustment. We strongly support the proposed implementation of partial-year risk adjustment in modified form, limited to consumers with at least one Hierarchical Condition Category (HCC) who enroll for six months or less. Plans are currently unable to recover premiums for the foreseeable additional costs that result from such part-year enrollees' higher average risk level, including those who enroll during a Special Enrollment Period (SEP). Risk adjustment is needed to cover those costs so that carriers are not deterred from enrolling people seeking coverage during an SEP.[1]

[1] Stan Dorn, Bowen Garrett, and Marni Epstein. "New Risk-Adjustment Policies Reduce But Do Not Eliminate Special Enrollment Period Underpayment." *Health Affairs.* 37:2, 308-315; Laura F. Garabedian, Robert LeCates, Alison Galbraith, Dennis Ross-Degnan, and J. Frank Wharam . "Costs Are Higher For Marketplace Members Who Enroll During Special Enrollment Periods Compared With Open Enrollment." *Health Affairs* 2020 39:8, 1354-1361

This change is needed now. Past research shows that workers losing employment have benefited far less than other populations from the Affordable Care Act (ACA).[2] Solving this longstanding problem is now an urgent priority, with millions of people losing employer-sponsored insurance (ESI) due to the novel Coronavirus. Those coverage losses have been documented by a number of public and private surveys conducted in 2020.[3] Unless carriers are incentivized to enroll laid-off workers and their families, the families are likely to remain uninsured. This is precisely the sort of selection-driven carrier risk-avoidance that risk adjustment is intended to prevent, as we explain in detail below.

Cost-sharing reduction adjustments. One other provision of the proposed Rule, specified in Table 7, urgently requires modification and rapid implementation – namely, the proposed continued application of cost-sharing reduction (CSR) induced utilization factors (IUF) within silver-level plan liability risk scores (PLRS). The IUF was developed based on MarketScan data, primarily from the large group market. In setting the IUM, CMS effectively assumed, in the absence of other data, that low-income consumers enrolled in 87%- and 94%-actuarial value (AV) silver plans would affected by low cost-sharing in the same way as relatively affluent employees of large employers that offer unusually generous health benefits. In truth, substantial research documents that low income reduces utilization substantially.[4]

Anecdotal reports from carriers confirm that the current risk-adjustment formula significantly overcompensates insurers for silver-level exchange coverage, which is dominated by low-income membership enrolled in high-AV plans. Since risk adjustment is zero-sum, overcompensating silver plans means that plans at other metal levels are undercompensated (or overcharged).

Conceptually, this is a serious problem. The goal of risk-adjustment is to ensure a match between foreseeable claims costs and the revenue insurers receive from the combination of risk-transfer payments and premiums charged under the ACA's rules for modified community rating. Risk adjustment fails when an identifiable cohort of consumers generates predictable costs at variance with ACA-allowed revenues. Such variation means that some consumers become more profitable than others, simply by virtue of who they are. This incentivizes insurers to compete based on avoiding predictably unprofitable risks and seeking profitable ones. Risk-adjustment gaps thus prevent accomplishment of the core ACA

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[2] Christen Linke Young James C. Capretta, Stan Dorn, David Kendall, and Joseph R. Antos. "How To Boost Health Insurance Enrollment: Three Practical Steps That Merit Bipartisan Support." *Health Affairs Blog.* August 17, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200814.107187/abs/

[3] See, e.g., NPR, The Robert Wood Johnson, Foundation, and Harvard T.H. Chan School of Public Health. *The Impact of Coronavirus on Households Across America* (September 2020), https://cdn1.sph.harvard.edu/wp-content/uploads/sites/94/2020/09/NPR-RWJF-Harvard-National-Report_092220_Final-1.pdf, finding that 6% of all U.S. adults report that someone in their household lost health insurance since the start of the Coronavirus outbreak. Based on U.S. Census Bureau estimates that 255.2 million adults age 18 and older live in the U.S., that translates into more than 15 million adults reporting health insurance losses during the pandemic. U.S. Census Bureau. "Estimates of the Total Resident Population and Resident Population Age 18 Years and Older for the United States, States, and Puerto Rico: July 1, 2019 (SCPRC-EST2019-18+POP-RES)." December 2019. https://www2.census.gov/programs-surveys/popest/tables/2010-2019/state/detail/SCPRC-EST2019-18+POP-RES.xlsx.

[4] See, e.g., National Center for Health Statistics. *Summary Health Statistics*: National Health Interview Survey, 2018. Center for Medicare and Medicaid Services. [Cited 2020 Oct 15]. Available at https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2018_SHS_Table_P-9.pdf.

goal that "individual-market insurers … no longer compete based on their ability to avoid risk, but rather on their ability to deliver high-quality care at an affordable price."[5]

In the context of metal-level misalignment, this conceptual problem has serious practical implications. Such misalignment undermines affordability in ways that are particularly dangerous during the current public health emergency. The failure of risk adjustment to take income into account in estimating foreseeable costs makes silver-level enrollees more profitable and those at other metal levels less profitable. This incentivizes plans to attract silver members by lowering silver premiums, making up lost revenue by raising premiums at other metal levels, where enrollment is less profitable and discouragement of membership may fit corporate strategy. As a result, metal-level premiums are misaligned with the generosity of underlying coverage, defined based on paid-claims projected for a standard population.

The preamble to the proposed Rule notes, based on 2020 premiums, that "in states using the federal enrollment platform, on average silver plan premiums are 34 percent more expensive than bronze plan premiums, and gold plan premiums are 14 percent more expensive than silver plan premiums." But public-use files (PUF) for 2020 show that, among silver qualified health plan (QHP) enrollees in the federal enrollment platform, 12% were in 70%-AV plans, 9% were in 73%-AV plans, 25% were in 87%-AV plans, and 54% were in 94%-AV plans. That yields a weighted average AV of 87% in silver – 9% higher than the 80% AV used for gold and 46% higher than the 60%-AV used for bronze.[6] Silver premiums are thus too low, and gold and bronze too high, relative to plans' coverage generosity.

Consumer costs are affected dramatically as a result, since advance premium tax credits (APTCs) are lower and gross premiums for non-benchmark plans for bronze and gold are higher than they should be. The latter also affects people buying coverage without APTCs, putting modest-deductible gold coverage out of reach for most consumers. Based on state-level premium averages reported by the Kaiser Family Foundation and the distribution of QHP members in each state described in PUF files, we estimate that, in 2020, the disconnect between metal-tier exchange premiums and coverage generosity raised consumer costs by $5.9 billion, on net. People earning between twice and four times the federal poverty level (FPL) experienced the greatest effects, paying $940 more, on average. If premiums had been realigned in proportion to coverage generosity, the median state would have seen bronze and gold premiums drop by 10% and silver premiums rise by 7%. That would have given roughly half of uninsured adults who were potentially APTC-eligible in 2019 access to QHPs costing no more than their APTC, based on American-Community-Survey data about the income, ages, and citizenship-status of uninsured adults, if metal-level premiums had been aligned to coverage generosity. These significant affordability gains would have induced much more enrollment by relatively healthy consumers, lowering risk levels and unsubsidized premiums market-wide. The appendix to these comments explains our methodology and sets out our findings in more detail.

An analogy makes the mechanics clear. Suppose risk-adjustment did not take into account the impact of cancer on covered claims. Carriers would do their best to avoid cancer patients, instead seeking to enroll

[5] Corlette S., J. Blumberg L, and Lucia K. The ACA's Effect On The Individual Insurance Market. *Health Affairs* 39, NO. 3 (2020): 436–444.

[6] If one considers induced demand factors that would apply to a standard population, unchanging across metal-tier enrollment, the mismatch is even greater. In addition to paying a higher percentage of covered claims, coverage with increased AV experiences higher total utilization, assuming enrollment of a standard population.

people who are cancer-free. Risk-adjustment's failure to compensate for this cancer-related disconnect between foreseeable costs and permitted premium variation under the ACA would give carriers an incentive to compete, not by offering valuable coverage at low cost, but by attracting profitable members (those without cancer) and discouraging enrollment by unprofitable members (cancer patients and survivors). Insurers could easily achieve those goals by manipulating provider networks and formularies. Without strong regulatory oversight, pressures in competitive markets would push premiums to approximate costs, with premiums declining for the plans that deter cancer patients' enrollment and rising for those that foreseeably attract cancer patients. Premiums would come to reflect foreseeable costs of members in ways that involve health status factors far beyond age, geography, and tobacco use – the only risk rating permitted by the ACA. Put simply, the ACA's basic protection of people with preexisting conditions would be seriously compromised. Plan premiums would vary based on the distinctive characteristics of enrollees in each plan, rather than plan features that generate higher or lower costs for a standard population.

A similar pattern emerges with the current failure of risk-adjustment to take into account the impact of low income on utilization in silver plans. Even without this failure, insurers would have incentives to lower silver premiums aggressively in order to attract market share in ways that distort other metal-level premiums, given the extreme price-sensitivity of low-income consumers qualifying for high-AV coverage.[7] Those incentives are compounded by risk-adjustment's overcompensation of silver enrollees and consequent under-compensation of gold and bronze plans.

This issue cannot await later resolution. As a pandemic of deadly disease rages, enrolling the uninsured into coverage needs to be a top national priority. Emerging research shows that insurance gaps dramatically increase both the incidence and death rate from COVID-19.[8] The majority of APTC-eligible consumers are uninsured,[9] and the main factor cited as a reason for remaining uninsured is the unaffordability of coverage.[10] Addressing the misalignment of metal-level premiums would make a

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[7] Finkelstein A, Hendren N, and Shepard M. Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts. 2019. *American Economic Review*, 109 (4): 1530-67.

[8] A very recent study "provides the most comprehensive multivariable analysis of county-level predictors of rates of COVID-19 cases and deaths conducted to date," with "findings current through August 2020." Examining all U.S. counties, researchers found that, controlling for multiple factors (population density, urbanicity, residential crowding, air pollution, gender, age, race/ethnicity, housing segregation, education, employment, income, income inequality, prevalence of diabetes, obesity, and smoking, rates of sexually-transmitted disease as an indicator of risky close-contact behaviors, and rates of travel outside the home), **for every 10% increase in the proportion of a US county that was uninsured, the number of COVID-19 cases increased by 70% and the number of COVID-19 deaths rose by 48%.** McLaughlin JM, et al. (2020) County-Level Predictors of COVID-19 Cases and Deaths in the United States: What Happened, and Where Do We Go from Here? *Clin Infect Dis*. 2020 Nov 19:ciaa1729. doi: 10.1093/cid/ciaa1729. Very few other factors had comparable effects.

[9] Only 43% of the potential APTC-eligible population is enrolled. Kaiser Family Foundation. "Marketplace Enrollees Receiving Financial Assistance as a Share of the Subsidy-Eligible Population: Timeframe 2019." *Statehealthfacts.org.* July 2020. https://www.kff.org/health-reform/state-indicator/marketplace-enrollees-eligible-for-financial-assistance-as-a-share-of-subsidy-eligible-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[10] See, e.g., Gunja MZ and Collins SR. Who Are the Remaining Uninsured, and Why Do They Lack Coverage? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018. The Commonwealth Fund. August 2019. Available at https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage.

major contribution to improving affordability and minimizing death and disease from the novel Coronavirus. As soon as possible, CMS should take the following steps:

- *Estimate risk-adjustment coefficients separately for enrollees in 87%- and 94%-AV silver plans*, using real-world EDGE-server data to replace the outdated IUF. In effect, high-AV silver would become its own risk-adjustment category under this proposal, along with catastrophic, bronze, standard silver, gold, and platinum plans. Making this change known to carriers in the final version of the 2022 NBPP would reduce pressure to aggressively underprice silver and overprice gold and bronze plans in ways that violate the ACA, making it easier for state insurance regulators to improve carrier compliance and lower consumer costs.
- *Clarify that silver-tier exchange premiums and only such premiums must reflect the cost of paid claims incurred in high-AV silver variants*, since these claims are incurred only with silver plans offered in the marketplace.[11]
- *Remind insurance regulators that metal-tier premium variation must reflect projected paid claims incurred for a standard population*,[12] without varying that population by metal level. That reminder could note that fidelity to this principle will generally require silver exchange premiums to exceed gold premiums and to exceed bronze by a much larger margin than is typically the case today. Whatever induced demand factors actuaries use to price metal-level tiers may not assume higher demand for gold plans, with greater overall cost-sharing, than with silver, with lower overall cost-sharing.

Special Enrollment Period Expansion

Proposed expansion. We support the proposed changes that will make it possible for enrollees to change metal levels outside of an open enrollment period when they become newly eligible or ineligible for ATPCs or CSRs. As the economy improves, many people will experience changes in income that they cannot reasonably anticipate during open enrollment. This proposed SEP expansion will assist such people beginning in January 2022, and we encourage CMS to make this change as soon as possible.

We also support the proposed changes that would consider the date of a triggering event for special enrollment to be the date that the person received notice and could reasonably be expected to know that they had experienced a triggering event. This will protect people when their employer fails to provide a timely notice that their health insurance is ending, or that their dependent is aging out of coverage, for example. This sort of relief is appropriate not only given the public health emergency but on a permanent basis. In the short-term, we know that many employers have lacked the capacity to provide timely notices. We recommend that DOL consider such a rule for the group market as well, writ large.

Finally, we agree that a change permitting special enrollment when an employer reduces contributions to COBRA benefits would be helpful. This will encourage employers to assist laid off workers with ESI premiums while still allowing consumers to make the best choice for themselves financially. As a

[11] 45 CFR § 156.80(d)(2)(i) permits the premium for a particular plan to vary based on "the actuarial value and cost-sharing design ***of the plan.***" (Emphasis supplied). It does not permit a plan's premium to vary based on the benefit design of a *different* plan, which is what would result if, for example, gold premiums rose to pay CSR costs incurred by silver plans. Put simply, only silver exchange plans should have premiums that reflect CSR costs, since only those particular plans have a benefit design that results in such costs.

[12] CMS. 2020 *Unified Rate Review Instructions*. https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2020-URR-Instructions.pdf.

practical matter, the cost-benefit calculus of individual-market enrollment changes radically when an employer stops paying for COBRA premiums or significantly cuts premium contributions. Consumer enrollment in an exchange plan during the proposed COBRA SEP would typically be a response to reduced affordability of ESI, not to a change in health status that leads to destabilizing adverse selection. We expect that younger people will benefit by enrolling in the marketplace earlier, and that will be helpful to the risk pool.

Additional expansion. We urge two further expansions of SEPs. The first is a general COVID-19 emergency SEP. We understand that, in theory, many who have lost employment due to the COVID-19 economic downturn may have access to an SEP. However, the complexity of documenting eligibility for current job-loss SEPs deters enrollment by laid-off workers, given the limited bandwidth most have to learn about health insurance programs and complete required procedural requirements. State experience with general COVID-19 emergency SEPs has been that communicating a simple message – "if you are uninsured, come get health care now" – has led many to enroll. Illustrating how simple messaging is critical and often more important than the technical details of SEP qualification, states like Maryland that operated general COVID-19 SEPs found that the majority of enrollees qualified for Medicaid: they likely would not have signed up without a general invitation to enroll, despite the complete absence of open-enrollment period (OEP) constraints in Medicaid.[13]

Second, a new standing SEP should permit enrollment, at any time, of consumers who are offered coverage with net premium costs at or near zero. Open-enrollment requirements seek to prevent consumer gaming, based on information asymmetries. In an individual-insurance market with guaranteed issue and even modified community rating, consumers who face significant premium costs to enroll in coverage may delay enrollment until they develop health problems. Without premium costs, no such gaming delays cause adverse selection. Basic Health Programs operated in Minnesota and New York thus do not impose OEP limits. Massachusetts also permits year-round enrollment of consumers with incomes up to 300% of FPL, who benefit from that state's supplemental affordability assistance. Rather than cause a fatal increase in risk selection, Massachusetts has some of the country's lowest exchange premiums (despite an unusually high-cost provider community),[14] and researchers report that neither Minnesota's nor New York's Basic Health Program has experienced notable adverse selection.[15] A national SEP should reflect this favorable experience, eliminating a needless barrier to enrollment by low-cost consumers who would improve the risk pool.

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[13] In Maryland, fully 67% of the nearly 90,000 consumers who enrolled through the COVID-19 SEP received Medicaid. *Maryland Health Connection Data Report.* October 31, 2020. https://www.marylandhbe.com/wp-content/uploads/2020/11/Executive-Report_10312020.pdf

[14] Kaiser Family Foundation. "Marketplace Average Benchmark Premiums: Timeframe 2014-2021." *Statehealthfacts.org.* (Undated) https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%222021%22,%22sort%22:%22asc%22%7D.

[15] Jennifer Tolbert, Larisa Antonisse, and Stan Dorn. Improving the Affordability of Coverage through the Basic Health Program in Minnesota and New York. Kaiser Family Foundation and the Urban Institute. December 8, 2016. https://www.kff.org/report-section/improving-the-affordability-of-coverage-through-the-basic-health-program-in-minnesota-and-new-york-issue-brief/.

Increasing User Fees Charged to Insurers

The proposed user fees for 2022 are grossly inadequate to assure satisfactory performance of core exchange functions. The proposed Rule itself makes this clear when it uses past inadequate exchange performance as a core reason for supporting private enrollment alternatives. None of the problems cited by the rule – including the exchange's challenges processing applications at peak times – are insurmountable. High functioning exchanges are possible, but only if adequate administrative resources are available.

The exchange was starved for administrative resources even when user fees were set at 3.5%. Vital improvements to the exchange's information technology architecture were routinely placed on waiting lists. None of that is an inherent feature of a publicly-operated exchange. Adequate funding would enable adequate consumer service. Rather than further reduce user fees, the Department should increase fees above the 3.5% level with which the exchange began ongoing operations.

Consumer assistance, including navigator and facilitated enrollment services, needs increased funding during the current economic downturn. Much research attests to the difficulty of enrolling laid-off workers into health coverage. The only past approach that has succeeded involved intensive, individual help, up to and including facilitators completing all forms on behalf of the newly unemployed. Job loss is often associated with depression, anxiety, and even grief. Many focus on core survival priorities. Few laid-off workers have the bandwidth to learn about health insurance programs and complete paperwork.[16] Not only do millions more need help now, including those without prior experience navigating public programs, the average effort required to enroll each uninsured person into coverage has increased considerably because so many unemployed are now uninsured.

The required intensity of necessary assistance, hence the necessary magnitude of investment, has risen for a second reason as well. Much assistance must now be provided remotely, not in person. Navigators report that this change has roughly doubled the amount of time required, on average, to enroll a consumer into coverage, including navigating through the process of plan selection. An effective approach to the COVID-19 crisis, which is likely to persist for some time (albeit, one hopes, in much less intense form) requires increased investment in exchange functionality, which in turn requires higher user fees.

A more functional exchange is likely to lower gross premiums by improving the market's risk pool. Younger and healthier individuals will be induced to enroll if the amount of work required to sign up for coverage declines. Such streamlined enrollment could become possible if adequate administrative resources let the exchange provide additional individual assistance, improve call center operations, and strengthen website functionality to match private-sector levels. In effect, the cost of coverage would fall in ways that are immediate and thus especially likely to affect behavior,[17] because significantly less work would be required to enroll. The resulting risk-pool improvements would almost certainly outweigh the small impact on unsubsidized premiums resulting from higher user fees.

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[16] See sources cited in Young, et al., op cit.

[17] Andrea Caceres-Santamaria, William Bosshardt. "Behavioral Economics Lesson Four – Why Are We So Impatient?" *EconEdLink.* Updated: December 10 2020. https://www.econedlink.org/resources/behavioral-economics-lesson-four-why-are-we-so-impatient/#:~:text=A%20particularly%20impatient%20person%20discounts,in%20the%20future%20it%20happens .

II. The Proposed Rule's Overall Approach Lacks Statutory Authority and Would Significantly Harm Consumers

The Rule overall would shift enrollment responsibilities from public to private entities, arbitrarily and capriciously underfunding the public sector to justify a switch of responsibilities to the private sector. Two parts of the proposed Rule fit together in a very troubling way. One large set of rules radically extends the Department's past efforts to increase the role played by profit-maximizing brokers, agents, and other vendors in working with consumers, displaying plan options, and enrolling them into coverage. This portion of the proposed Rules even goes so far as to give states the option to eliminate health insurance exchanges' shopping functions in their entirety, replacing them by web brokers and other direct enrollment entities. Key justifications for this effort involve the inability of federal enrollment platforms to offer the same quality of consumer experience as for-profit vendors provide. A second part of the proposed Rule continues the Department's past efforts to reduce funding for the federal exchange by cutting user fees charged to carriers.

It is not hard to see the connection between these two general segments of the rule. The latter "starves the beast," denying the exchange the revenue it needs to serve consumers in a highly effective way. The former notes the inability of underfunded public entities to compete with for-profit entities, an inability that is used to justify outsourcing enrollment functions to private entities. In effect, underfunding the exchanges in one part of the rule is used, in another part, to necessitate a shift of responsibilities to private entities. This bootstrapping, self-justifying combination cannot pass muster under the APA's prohibition of arbitrary and capricious agency decision-making.

The proposed shift of governmental responsibilities to private-sector, profit-driven entities has no rational basis in fact. No external circumstances have changed to justify this major change in policy. The empirical claims made in the rule could have been made in the past. The proposed major change therefore lacks the evidentiary justification required under the APA.

The proposed shift would harm consumers, for reasons we detail at greater length below. The proposed Rule includes a number of changes to direct enrollment and enhanced direct enrollment that would allow states to replace the functions of healthcare.gov with direct enrollment and that would result in the growth of private web brokers and a lessening of healthcare.gov capabilities. Taken together, these proposals undermine key provisions of ACA. They will make it difficult or impossible for consumers to determine which websites are legitimately selling them comprehensive insurance eligible for premium tax credits; underfund healthcare.gov; underfund navigators and consumer assistance; reduce access to in-person assistance; reduce help for people who have limited proficiency in English; make it harder (and in some cases, impossible) to achieve streamlined enrollment with PTCs, Medicaid and CHIP; promote the sale of products that are not comprehensive health insurance and thereby undermine risk pools; and fail to provide sufficient information to consumers about their rights and how to use health insurance.

The proposed shift cannot be justified as implementing the ACA because it represents a radical departure from law's basic structure. Congress made clear that health insurance exchanges, rather than the pre-ACA landscape of brokers and agents, should provide one-stop-shopping where consumers can make apples-to-apples comparisons of available options, enabling wise choices and effective functioning of insurance markets. The Department's leadership evidently disagrees with this Congressional vision, preferring that the private sector's multiplicity of brokers, agents, and other vendors handle these

functions. But regulation is legally required to implement Congressional directives, not subvert them. Having failed to persuade Congress to overturn the ACA's basic structure, the administration now seeks to accomplish some of those same goals in the guise of regulation. The proposed Rule's two-part jettisoning of the basic ACA exchange framework is a clear violation of the APA. The Department's proposed radical sea-change cannot be accurately characterized as implementing the law.

The language used to justify the proposed Rule shows how it deliberately spurns the ACA's structure for private enrollment. The regulatory preamble contains the following astonishing statement:

> "Finally, we have heard criticisms from some stakeholders that the Exchange-operated application and enrollment website model competes directly with and may crowd out market players such as web brokers, licensed agents and brokers, and issuers, dampening commercial investments in outreach and marketing by these market players to reach new consumers."

This statement candidly acknowledges a conflict between the ACA's exchange model of enrollment and the more privatized, profit-driven, fragmented system preferred by the Department's current leadership. In the contest between the system enshrined in statute at the ACA's heart and the Department's preference for a very different approach, the proposed Rule shockingly comes down firmly on the side of rejecting core Congressional choices made in structuring the ACA. Rather than perform the Executive Branch's constitutionally-mandated duty to "take Care that the Laws be faithfully executed,"[18] the agency has clearly identified a conflict between its policy preferences and the law and, in the proposed Rule, come down firmly opposed to the law it purports to implement.

III. Administrative Procedures Act Violations, Waivers, and 31 CFR Part 33

The proposed conversion of sub-regulatory guidance into binding regulations illegally seeks to subvert the APA. Families USA was among more than 2,100 commenters on the 2018 guidance regarding Waivers for State Innovation. (See docket folder for CMS-9936-NC on regulations.gov.) As our comments explained, the guidance is illegal and does not comply with the guardrails set forth in statute. The Administration has not responded to comments filed at the time. Neither has the Department, in the proposed Rule, referenced the voluminous comments on the guidance, including those we filed. To comply with the APA, the Department must make a good-faith effort to address the concerns articulated about the precise policies that the proposed Rule seeks to concretize into regulation. It is shocking that the Notice of Proposed Rulemaking does not even note the existence of those directly relevant comments, much less set out the kind of careful analysis that is required to justify action. Accepting this approach to regulations would permit a regulatory agency to sidestep the APA's requirements by promulgating a policy as informal guidance, failing to respond to comments, and then changing that guidance into a regulation.

Any regulation that seeks to embody the 1332 guidance must be jointly promulgated by the Treasury Department and CMS. As noted earlier, the Treasury Department and HHS jointly issued the guidance that is the subject of this part of the proposed Rule. CMS cannot act alone in converting multi-agency guidance into binding regulations. If Treasury's participation was required to issue guidance, such

[18] U.S. Constitution, Article 2, Section 3.

participation is no less necessary when federal agencies take the more consequential step of converting guidance into binding regulations.

Much of the substance of the proposed 1332 policy involves premium tax credits under Treasury's jurisdiction. Presumably, officials at the Treasury Department reviewed the many comments on the guidance that fell within their area of jurisdiction. Treasury's absence from the proposed regulation shows, once again, that this step is being taken without factoring in the expertise of the directly affected sibling Department, including its analysis of comments that must be considered before promulgation of final rule, under the APA. HHS's decision to move forward alone on this matter is not justified anywhere in the notice. The absence of such justification makes the proposed regulation arbitrary and capricious. As a matter of substantive agency jurisdiction, the proposed Rule is *ultra vires*, exceeding HHS's permitted legal range of action. Treasury has no authority to issue regulations about public health, and HHS is not authorized to issue regulations about PTCs governed by the Internal Revenue Code.

The Department's purported justification for converting guidance into regulations is overbroad and unsound. The Department asserts that converting guidance into regulations would give states more predictability. That rationale would justify converting into regulations all guidance that gives states substantive policy direction. The Department does not articulate a rational basis for singling out this particular item of guidance for setting into the concrete of final regulation.

The form of the proposed regulation is inconsistent with regulatory practice. The regulation simply directs stakeholders to informal guidance. It does not contain the clear articulation of specific policy that is a core element of regulation. The cross-reference to an amorphous, imprecise set of sub-regulatory guidance does not fit the definition of "rule" under 5 U.S.C. § 551.

The absence of regulatory specificity prevents the rule from achieving its purported advantage of improving predictability. Without clear, specific policy definition, it is impossible for stakeholders to understand the boundaries of regulatory application. Moreover, judicial interpretation is almost impossible to predict with such a nebulous rule. Stakeholders deprived of any reasonable basis for predicting judicial interpretation are less able to guide their decisions based on predictable federal policy. Put simply, the proposed Rule is internally consistent, using a form that makes it impossible to achieve its supposed goal. The irrationality of internal inconsistently makes the proposed Rule inherently arbitrary and capricious, in violation of the APA.

The underlying guidance embodies subjective policy preferences that are outside the statute and contradict the Affordable Care Act. Without a shred of evidentiary support, the 2018 guidance opines that, by requiring adherence to ACA standards, the prior guidance "deterred states from providing innovative coverage that, while potentially less comprehensive than coverage established under the [ACA], could have been better suited to consumer needs." 83 FR at 53578. This language candidly admits that the Department's leadership disagrees with Section 1332's comprehensiveness guardrails and seeks to allow a different policy approach than Congress allowed. The proposed Rule, which would turn this guidance into regulation, embodies statutory disregard, not implementation of Congress's commands.

The 2018 guidance prioritized "fostering health coverage through competitive private coverage, including Association Health Plans and Short-term Limited Duration Insurance (STLDI) plans, over public programs." That judgment is nowhere found in the ACA itself, which featured a balance of public and private options, using careful market regulations that STLDI does not follow. The subjective judgement expressed by Department officials connects more with the Administration's proposed repeal of the ACA than with an honest implementation of the law's statutory commands, including those involving Section 1332.

The 2018 guidance also went beyond the statutory requirement for federal deficit neutrality. That guidance urged states to "be fair to the federal taxpayer by restraining growth in federal spending commitments." That subjective policy preference for federal cost *savings* disregards the express Congressional judgment that deficit *neutrality*, not federal budget savings, is the fiscal touchstone for judging 1332 waivers.

The guidance's elevation of federal budget savings as more fundamental than the coverage, affordability, and comprehensive goals that received equal Congressional weighting under the language of section 1332 does not even pretend to be a straightforward and objective interpretation of the statute that warrants enactment in regulatory form. The guidance similarly exhorts states to "promote consumer-driven healthcare," promoting an agenda entirely absent from the ACA, including section 1332. The Department's current leadership is free to advocate its policy preferences in seeking statutory change, but the policy agenda embodied in the proposed Rule cannot legally be included in regulations that purport to apply the existing statute.

The 2018 guidance violates specific requirements of the ACA. Our previous objections to this policy, none of which are discussed in the proposed Rule, set out straightforward legal violations that include the following:

a) **Actual provision and potential availability are not the same**. At §1332 (b), the statute says "The Secretary may grant a request for a waiver under subsection (a) (1) only if the Secretary determines that the State plan (A) ***will provide*** coverage that is at least as comprehensive…. (B) ***will provide*** coverage and cost sharing protections against excessive out of pocket spending as the provisions of this title would provide; (C) ***will provide coverage*** to at least a comparable number of its residents as the provisions of this title would provide…." (Emphasis supplied.) The statute requires a comparison between the benefits and cost-sharing that the ACA "would provide" and that the waiver "will provide." Ignoring this language, the 2018 guidance requires nothing more than making "available" coverage that will do those things. If millions of people receive less comprehensive or more costly coverage under a waiver, or millions more become uninsured, so long as ACA-level coverage was theoretically "available", the waiver would pass muster under the guidance, even though the waiver "will provide" consumers with substantially less than the statute "would provide." Such a result does not square with Congressional language or intent.

b) **1332's guardrails must be construed together**, in *pari materia*, as a matter of black-letter law and the canons of statutory construction. States cannot be allowed to count enrollment in short-term plans and other plans that offer a lesser set of benefits and no protection against pre-existing conditions as meeting Guardrails B and C, involving the number of people with coverage and the cost of such coverage, if the form of that coverage does not pass muster under Guardrail A, which requires insurance no less comprehensive that what consumers would be provided through Exchanges.

c) **The guidance's encouragement of non-ACA-compliant coverage is not permitted by Section 1332**. As noted earlier, the October 2018 guidance states, "A section 1332 state plan should foster health coverage through competitive private coverage, including AHPs and STLDI plans, over public programs." Such plans violate Congress's requirements to protect people with pre-existing conditions by prohibiting, among other things, medical underwriting into coverage exempt from guaranteed issue and modified community rating. Congress carefully regulated the scope of grandfathered coverage temporarily exempt from the ACA's comprehensiveness requirements. The Department's promotion of non-ACA-compliant plans ignores those careful boundaries, implementing a judgment that differs starkly from Congress's and therefore goes beyond the permitted bounds of regulation. Moreover, the statute does not allow waiver of the parts of the Affordable Care Act that protects people with pre-existing conditions, nor does it allow a waiver of Subtitles A through C of Title I, all of which would be required to permit non-ACA-compliant plans like AHPs and STLDI plans.

d) **Statutory language is inconsistent with the Guidance's emphasis on "available" rather than "provided" coverage that meets ACA standards**. Section 1332 states that waivers can only be granted if the Office of the Actuary certifies that coverage is at least as comprehensive as would otherwise be offered through Exchanges "based on sufficient data from the State and from comparable states about their experience with programs created by this Act and the provisions of this Act that would be waived." Regulations must be consistent with this standard. The statute at Section 1402 has explicit protections for people with incomes below 250 percent of FPL (including extra cost-sharing subsidy levels at 100-150, 150-200, and 200-250 FPL), below 400 percent FPL, and protections for older adults and less healthy adults that would otherwise be subject to higher rate-ups or exclusions under the proposed Rule. Waivers that would significantly increase costs or reduce covered benefits for any of these groups or make health care unaffordable to them should be rejected as failing to provide coverage and cost-sharing protections that are at least as affordable as the ACA would otherwise provide.

e) **The guidance's very definition of "health insurance coverage" effectively presumes that the Administration succeeded in its efforts to "repeal and replace" the ACA**. The guidance uses a definition that predates the ACA to count the number of residents covered, rather than the number who have "individual health insurance" and "group health insurance," as defined by the ACA. The ACA's definition of what counts as insurance coverage is plainly the relevant definition for purposes of section 1332, not the preferences for less generous coverage articulated by the Department's current leadership.

The Department will violate the APA if it does not respond to comments filed with respect to the Guidance it now proposes for regulatory enshrinement. We incorporate by reference all comments we submitted on December 21, 2018, as well as the comments filed by other organizations. If the agency does not respond to all of those comments, it will be in clear violation of the APA.

The Department's leadership cannot have it both ways in deciding between guidance and regulations. The agency can use guidance without the APA requiring it to respond to comments. But if the Department's leadership wants to embody its policy preferences in more durable, regulatory form, as under the proposed rule, that choice has consequences. The procedural requirements of regulatory promulgation then apply, which means that the Department cannot lawfully promulgate the final Rule without responding to all comment that were filed with respect to the Guidance.

IV. Excluding 2019 Data from Risk Adjustment under 45 CFR Part 153

2019 Edge Server Data should be incorporated into the final rule's risk-adjustment coefficients, just as the agency has incorporated the latest available data in past years. As before, the final NBPP for 2022 should include coefficients that fit the most recent data, even that requires departing from coefficients in the proposed rule. In a transparent effort to permit the hurried promulgation of a final Rule, the Department implausibly argues that taking the few weeks required to incorporate 2019 data would deny insurers essential certainty and predictability. The purported advantages of relying on outdated information in providing certainty applied with no less force in earlier years. The Department's revised timeline has no legitimate motivation rooted in policy. No external circumstances have changed warranting the accelerated approach proposed in the rule. No rational basis is apparent for modifying previous year's weighing of the trade-off between accuracy and speed. Without such a rational basis, the proposed change cannot pass muster under the APA.

The Department's rationale for ignoring 2019 EDGE server data is internally inconsistent. The proposed Rule insists that the Department cannot wait several weeks for the 2019 EDGE server data to become available, supposedly because it is a matter of supreme importance for carriers to obtain notice as soon as possible. But carriers have been assuming a continuation of past practice, through which flaws in the proposed Rule's coefficients are corrected in the final rule to include new data. The proposed disturbs those settled expectations. This departure from predictably cannot rationally be justified as improving predictability. Such internal inconsistency marks the proposed Rule as inherently arbitrary and capricious.

The Department's delay in promulgating the proposed Rule bars it from using predictability as an excuse to ignore the most recent EDGE server data. If the Department truly was concerned about insurers' need for the earliest possible information, the proposed Rule would have been published much earlier during the year, as was true with most previous NBPPs. The Department's delay in promulgating this set of proposed Rules shows that the predictability advanced as the supposed rationale for rushing ahead without waiting for the 2019 EDGE server data is not, in fact, the Department's operative priority. No legitimate, rational purpose is served by this change in approach.

Last year, the U.S. Supreme Court faced a similar issue in reviewing the Commerce Department's decision to add a citizenship question to the Census form. The Court struck down that decision as violating the Administrative Procedures Act, finding that the rationale articulated to justify the decision was pretextual. The test articulated by Chief Justice Roberts' opinion for the Court fits the circumstances

of the current proposed Rule, both with this particular proposal and others discussed in our comment letter:

> "We are presented … with an explanation for agency action that is incongruent with what the record reveals about the agency's priorities and decisionmaking process. …. Our review is deferential, but we are "not required to exhibit a naiveté from which ordinary citizens are free." United States v. Stanchich, 550 F.2d 1294, 1300 (CA2 1977) (Friendly, J.). The reasoned explanation requirement of administrative law, after all, is meant to ensure that agencies offer genuine justifications for important decisions, reasons that can be scrutinized by courts and the interested public. Accepting contrived reasons would defeat the purpose of the enterprise. If judicial review is to be more than an empty ritual, it must demand something better than the explanation offered for the action taken in this case."[19]

V. Other Risk-Adjustment Issues

The Department's analysis of risk adjustment does not focus on the most important goal of risk adjustment and so misses the mark in many key details. The goal of risk adjustment is not to ensure a the closest possible correspondence between paid claims actually incurred and plan revenues. Rather, its purpose is to eliminate insurers' incentive to gain financially by avoiding unprofitable risks and enrolling profitable ones. If successful, risk adjustment means that all risk profiles, all foreseeable enrollment cohorts, can be equally profitable. It fills the gap, resulting from modified community rating, between the costs that are foreseeable at enrollment and the combination of premium revenues and risk adjustment available to the issuer. It is indispensable to accomplish the fundamental policy objective, noted above, of shifting insurer competition from the pre-ACA imperative of risk avoidance to offering consumers good value for their premium dollar.

That is not the same thing as devising risk-adjustment formulas to yield the closest possible retrospective correspondence between plan revenues and paid claims. Something like that goal may be implicit in the Department's analysis of the centrality of minimizing R-squared values.

Many claims result from unforeseeable acute episodes. Some of those episodes are reflected in HCCs recorded in EDGE-server data. Adjusting risk-transfer payments to compensate for acute care costs that were not foreseeable at the point of enrollment does not do anything to prevent carriers from competing by avoiding unprofitable consumer categories. If costs are unforeseeable at the point of enrollment, they do not belong in risk adjustment.

Here is one way to think about this issue. Some insurance veterans describe risk adjustment as making up the difference between (1) premiums that can be charged under the ACA and (2) premiums that would have been charged after conducting medical underwriting in the pre-ACA individual market. That calculus, by definition, excludes acute-care costs and other claims information included in retrospective analysis of EDGE-server data that could not have been the subject of medical underwriting.

Optimizing for the wrong result yields problematic outcomes. Seeking close correspondence with acute-care and other unexpected costs contained in retrospective claims data requires sacrificing other dimensions of modeling that are far more important to preventing insurers from engaging in harmful risk avoidance. Here are two examples of the kind of specification that is more important in achieving

[19] Department of Commerce v. New York, No. 18–966, 588 U.S. ___; 139 S. Ct. 2551; 204 L. Ed. 2d 978 (2019).

risk-adjustment's goals than squeezing the ultimate increment of correspondence between model coefficients and paid claims:

- Selection patterns and the dangers of carrier misbehavior are quite different in the small group and individual markets. Consumer protection could be enhanced if the two markets had separately calibrated risk adjustment.
- As noted earlier, consumers would benefit greatly if CMS replaced the current IUF formula for CSR adjustment by a separately calibrated set of risk-adjustment coefficients that reflect the actual claims of low-income silver members.

Improving risk adjustment in these two ways that actually matter to remedying insurance company incentives for anti-competitive and anti-consumer behavior cannot be done if the Department's top priority is maximizing correspondence between incurred claims, whether foreseeable at the time of enrollment or not, and carrier revenues.

The Department's proposal to substantially modify risk-adjustment so that it better fits claims at both extremes of the HCC continuum threatens one of the ACA's most notable accomplishments in the individual market: encouraging carriers to provide good consumer service to people with chronic illness. Increasing compensation for extremely high-cost conditions, many of which are aggravated by acute illness or complications that first emerge in the hospital, may come at the expense of compensating carriers for the cost of fully predictable chronic conditions. The same is true of increased payment for non-HCC consumers. This redirection of finite risk-adjustment dollars would jeopardize an extraordinary accomplishment of ACA risk adjustment: namely, converting an individual market where insurers avoid the chronically ill to one where they seek out such consumers. The proportion of people with preexisting conditions who receive individual-market coverage doubled once the ACA went into effect.[20] These are the consumers whose health, thriving, and survival most hinge on obtaining good coverage. The gains they have achieved should not be put at risk by the Department's abstract pursuit of R-squared values, divorced from the danger of carrier risk avoidance.

The Department's proposed approach to substantially modify risk-adjustment so that it better fits claims at both extremes of the HCC continuum requires considerable further analysis before implementation. The Department has long understood the importance of risk adjustment as well as the need for deep analysis and significant back-and-forth among researchers and stakeholders before major policy change is finalized. The original start of ACA risk adjustment in the individual market was preceded by publication of multiple white papers and conferences. A similar level of analysis is needed before CMS makes other truly major changes in this core market bulwark, such as those in the proposed Rule.

The Department's proposed approach to letting states modify the risk-transfer formula, both with Alabama and elsewhere, violates the ACA's core policy goals and legal requirements. Alabama's proposal, which reduces risk-transfer payments by 50%, illustrates the high stakes of the Department's authorization for states to scale down the magnitude of risk-transfer payments in the individual market. As explained earlier, risk transfer payments that fully compensate plans for the expected costs of the chronically ill have been indispensable to the development of an individual insurance market that meets

[20] David Blumenthal, Sara R. Collins, and Elizabeth J. Fowler, "The Affordable Care Act at 10 Years—Its Coverage and Access Provisions," *The New England Journal of Medicine*, (March 2020) 382:963-969, https://www.nejm.org/doi/full/10.1056/NEJMhpr1916091

the needs of those consumers. Letting states substantially reduce the volume of such transfer payments means that carriers may no longer be assured of adequate payment for the chronically ill. The ACA's fundamental goals will be thwarted if insurers once again are incentivized to succeed by risk avoidance, rather than offering good products at reasonable prices. The Department's original authorization for states to make across-the-board cuts to risk-transfer payments must be revoked, and the Department should not move forward with the proposed three-year authorization of such dangerous measures.

VI. Core Exchange Functions, Privatization, and 45 CFR Part 155

Most comments in this section apply to each proposed expansion in the role of private, for-profit entities, including brokers, agents, and web vendors, marketing coverage to consumers and performing roles originally assigned to the exchange.

The proposed Rule departs radically from the ACA's core design and greatly exceeds agency authority. The proposed regulations in this area sketch out a radically different vision of enrollment into individual-market coverage than what the ACA describes. The statute specifically assigns exchanges the duty of certifying qualified health plans and then offering carefully curated enrollment experiences, making it easy for consumers to tackle the conceptually challenging tasks of comparing health options and making good decisions. To illustrate, an exchange may not offer a plan that meets all applicable legal standards unless "the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates."[21] The statute has Exchanges serve as a funnel ensuring that each qualified health plan is a solid option, without traps for the unwary or inexpert. Navigators and enrollment assisters, paid by the exchange to act as fiduciaries on behalf of consumers, are supposed to help people enroll into ACA-compliant coverage, including Medicaid and CHIP. The proposed Rule moves in a very different direction, breaking up these functions and dividing them among a multitude of for-profit, private actors. None of these actors, under the proposed rule, is limited to offering ACA-qualified coverage. The proposed rule does not require them to present each option on fair and equal terms so each consumer can easily see which plan best meets their family's needs. This radical change is a clear attempt to usurp Congress's legislative role. Whether or not these changes are beneficial – and we strongly believe they are not – the issues raised by the proposed Rule belong for resolution in the legislative sphere, not the regulatory realm.

The proposed Rule violates the ACA's requirement of a single, streamlined application process through which consumers are considered for every insurance affordability program and enrolled in coverage for which they qualify. This requirement is reflected most clearly in ACA sections 1413 and 2100. For example, the latter section requires each Medicaid program to establish procedures for "enrolling, without any further determination by the State…, individuals who are identified by an Exchange… as being eligible for [Medicaid or CHIP]."[22]

In carrying out this statutory duty, Medicaid eligibility regulations specify that, to make a Medicaid eligibility determination, the exchange must be a "government agency which maintains personnel standards on a merit basis."[23] In promulgating that language, CMS added that "For purposes of

[21] ACA §1311 (e)(1)(B).
[22] Social Security Act §1943(b)(1)(B), added by ACA §2201.
[23] 42 CFR §431.10 (c)(2).

delegation, we are treating a quasi-governmental entity or public authority running an Exchange and employing merit system protection principles as a government agency such that delegation to it would be permitted."[24] Direct enrollment entities, brokers, agents, and other private vendors do not fit this description. Medicaid cannot legally credit any of their determinations, which will prevent the accomplishment of a core ACA goal and, as we explain below, increase the number of uninsured.

The proposed Rule is not supported by any data showing the impact of increased use of web brokers and direct enrollment on the exchange's financial sustainability. Many of these private entities have financial incentives to steer consumers to non-ACA-compliant options that do not pay exchange user fees. The proposed Rule, as a procedural matter, is required to assess the impact of this change on exchange sustainability. Without such a careful analysis, no rational decision is possible to move forward with the rule.

The proposed Rule is likely to trigger a death spiral in exchange funding. Increased use of brokers and direct enrollment entities, without constraints about marketing to non-ACA compliant plans, will reduce exchange administrative funding, as noted earlier. As a result, the exchange will have less capacity to provide consumer assistance, operate highly responsive call centers, and maintain a state-of-the-art website. Such deficiencies will increase the comparative marketing advantage of private brokers and vendors, further eroding exchanges' funding base, further advantaging private brokers in a self-reinforcing cycle that ends with a purely privatized system. An approach that begins with theoretical options for consumers winds up without the single enrollment option preferred by Congress. The proposed Rule's promise of diversity and plurality will ultimately reduce diversity of enrollment choices by taking away the most reliable path to coverage, the one enshrined by Congress in the text of the ACA. The proposed Rule is thus self-defeating and inconsistent in its fundamental rationale, rendering it arbitrary and capricious under the APA.

The proposed Rule's potential damage to the ACA-regulated individual market is not supported by any empirical analysis of the risks to the ACA-compliant market that could result from the Rule moving relatively young and healthy consumers to plans outside the individual-market risk pool. The proposed Rule allows entities that benefit financially from enrolling consumers in non-ACA-compliant plans to move consumers out of ACA-compliant coverage into non-compliant plans or to steer consumers into non-compliant plans who otherwise would have signed up for qualified health plans that meet all ACA requirements. The impact on the ACA risk pool could be considerable if STLDI and other non-ACA-compliant plans offer medically-underwritten discounted premiums that lure lower-cost members out of the individual market, risking a death spiral and the potential disappearance of comprehensive, secure coverage that meets the needs of consumers with preexisting conditions who attempt to buy insurance without the aid of APTCs.

The non-partisan Congressional Budget Office (CBO) and the Joint Tax Committee (JCT) analyzed a similar policy proposed in the American Health Care Act, which Congress ultimately rejected on a bipartisan basis. This bill, which purported to "repeal and replace" the ACA, would have allowed waivers that let medically underwritten coverage compete with ACA-compliant individual market plans. CBO and JCT explained as follows the destabilizing impact of such waivers:

[24] 78 FR 42160, 42188 (July 15, 2013).

> "CBO and JCT anticipate that most healthy people applying for insurance in the nongroup market in those states would be able to choose between premiums based on their own expected health care costs (medically underwritten premiums) and premiums based on the average health care costs for people who share the same age and smoking status and who reside in the same geographic area (community-rated premiums). By choosing the former, people who are healthier than average would be able to purchase nongroup insurance with relatively low premiums. CBO and JCT expect that, as a consequence, the waivers in those states would have another effect: Community-rated premiums would rise over time, and people who are less healthy (including those with preexisting or newly acquired medical conditions) would ultimately be unable to purchase comprehensive nongroup health insurance at premiums comparable to those under current law, if they could purchase it at all—despite the additional funding that would be available under H.R. 1628 to help reduce premiums. As a result, the nongroup markets in those states would become unstable for people with higher-than-average expected health care costs. That instability would cause some people who would have been insured in the nongroup market under current law to be uninsured."[25]

While the young and healthy may flock to STLDI and other nominally "cheaper" substandard health product options, those with pre-existing conditions and other underlying health issues will have no choice but to purchase more comprehensive plans in the remaining ACA-compliant market. The comprehensive plan carriers will no longer serve an evenly distributed risk pool. They will, in turn, be forced to increase premiums to cover beneficiaries with known chronic health conditions, for whom STLDI is allowed to medically underwrite, raise premiums, limit benefits, or deny coverage altogether. This cycle leads to the kind of "death spiral" CBO anticipated from similar policies proposed in Congress, resulting in higher premiums and unaffordable health care for people with preexisting conditions.

Significant empirical work is needed before a rational decision could be made to finalize the proposed Rule. Such work would include an assessment of CBO's projection and its potential application to this proposed policy change. It would also include a comprehensive analysis of the financial interests served by brokers, agents and other vendors, to understand incentives to divert consumers into non-ACA-compliant plans. A careful actuarial study would then be essential to assess the sustainability of comprehensive individual coverage that serves the chronically ill following a major shift of favorable risks out of the ACA-compliant market. No such analysis is cited in the proposed Rule, rendering it bereft of essential factual underpinning needed for a rational policy decision.

The proposed Rule's separation of Medicaid and exchange eligibility functions will cause a significant loss of health insurance coverage. On its face, the regulation disrupts the connection between exchange enrollment and Medicaid eligibility. Unlike exchanges, which are legally required to either assess or determine Medicaid eligibility, direct-enrollment entities, brokers, and agents can completely ignore Medicaid and CHIP. Indeed, they have a strong incentive to do just that. They receive no commissions when a client joins these public programs. Moreover, the enrollment process into insurance affordability programs is time-consuming. Helping with Medicaid and CHIP applications is a guaranteed money-losing strategy, with higher costs than for other clients and a complete absence of payment. All of this is in addition to the above-cited legal barriers against state Medicaid programs honoring the eligibility assessments of these non-governmental, for-profit companies.

[25] CBO. H.R. 1628: "American Health Care Act of 2017." *Congressional Budget Office Cost Estimate,* May 24, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.

The peer-reviewed literature documents significant reductions in Medicaid and CHIP coverage when exchanges merely assess rather than determine eligibility.[26] The proposed Rule does not even mention these studies, much less conduct the required comprehensive assessment of whether the proposed major change in enrollment mechanisms serves the national interest in view of its likely impact directly undermining the ACA's most basic objective: covering the otherwise uninsured.

The proposed Rule completely ignores a robust literature in behavioral science about consumer health insurance choices. Consumers face major challenges in making complex decisions, like that involved in choosing insurance. Volumes of peer-reviewed studies attest to the enormous challenge consumers have faced, whether in employer-sponsored insurance, the ACA marketplace, or Medicare, in making choices that advance their personal well-being.[27]

The proposed Rule's fragmentation of enrollment methods makes a difficult set of consumer decisions significantly more complex. Consumers would bear the burden of navigating an even more fragmented system without having options presented in a comprehensible fashion by a single, unbiased source informed by health literacy research. The likely result is significantly worse health insurance choices, raising consumer costs needlessly and reducing coverage as added complexity undermines effective decision-making. It is shocking that the proposed Rule does not even mention this abundant literature, much less grapple with it in the serious and comprehensive way required to inform any rational decision to move forward along the proposed lines.

The proposed Rule multiplies direct financial conflicts of interest that endanger consumers. Brokers, agents, and other for-profit vendors have no duty, under the proposed Rule, to act in the fiduciary interests of their clients. Their financial interest is to steer consumers to the insurers that pay them the most. The proposed regulatory safeguards do not prevent them from acting on those incentives in ways that harm their clients. The simple expedient of taking longer to display a disfavored ACA option can

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[26] See, e.g., Julie L. Hudson and Asako S. Moriya. "The Role of Marketplace Policy on Welcome Mat Effects for Children Eligible for Medicaid or the Children's Health Insurance Program." *Inquiry.* Published November 7, 2020; Julie L. Hudson and Asako S. Moriya. "Association between marketplace policy and public coverage among Medicaid- or children's health insurance program-eligible children and parents." *JAMA Pediatr.* 2018; 172(9):881-882; Sara Rosenbaum, et al. "Streamlining Medicaid Enrollment: The Role of Health Insurance Marketplaces and The Impact of State Policies." Washington, DC: Commonwealth Fund Issue Brief. 2016;1869(8). http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2016/mar/1869_rosenbaum_streamlining_medicaid_enrollment_ib.pdf.

[27] See, e.g., Richard Frank and Kaine Lemiraud, 2008. "Choice, Price Competition And Complexity In Markets For Health Insurance," National Bureau of Economic Research Working Paper 13817; Tanius, B.E., op cit. "Aging and choice: Applications to Medicare Part D." *Judgment and Decision Making*, Vol. 4, No. 1, February 2009, pp. 92–101; Handel, B.R., 2013. Adverse selection and inertia in health insurance markets: When nudging hurts. American Economic Review, 103(7), pp.2643-82; Ericson, Keith M. 2014. "Consumer Inertia and Firm Pricing in the Medicare Part D Prescription Drug Insurance Exchange." American Economic Journal: Economic Policy 6, 38-64; Ericson, K.M., Kingsdale, J., Layton, T. and Sacarny, A., 2017. "Nudging leads consumers in Colorado to shop but not switch ACA marketplace plans." Health Affairs, 36(2), pp.311-319; Domurat, R., Menashe, I. and Yin, W., 2019. "The Role of Behavioral Frictions in Health Insurance Marketplace Enrollment and Risk: Evidence from a Field Experiment." National Bureau of Economic Research Working Paper 26153; Ericson, K.M. and Sydnor, J.R., 2018. "Liquidity constraints and the value of insurance." National Bureau of Economic Research Working Paper 24993; Saurabh Bhargava, George Loewenstein, and Justin Sydnor, 2015. "Do Individuals Make Sensible Health Insurance Decisions? Evidence From A Menu With Dominated Options." National Bureau of Economic Research Working Paper 21160.

suffice, given the role of presentation in shaping decisions. The ACA's basic exchange structure, which relies on navigators and other application assisters whose compensation does not hinge on which option the client selects, avoids this direct financial conflict of interest, and the proposed Rule stokes it. A comprehensive analysis of how brokers, agents, and others have responded to similar incentive structures in the past is needed before a rational decision can be made to move forward.

Low-income consumers and communities of color are certain to be disproportionately adversely affected by the conflicts of interest that the proposed Rule would authorize. As noted earlier, brokers, agents, and other vendors have no financial interest in enrolling consumers in Medicaid or CHIP, since such an enrollment choice generates no revenue. These private entities also have a direct financial incentive to avoid qualifying consumers for APTCs and CSRs. It takes time to complete the required forms, and no additional revenue accrues. The proposed Rule would thus have a clear and direct adverse impact on low-income consumers and communities of color by systematically discouraging enrollment into insurance affordability programs tailored to meet the needs of these consumers and communities. The rule thus threatens to violate federal civil rights statutes, including section 1557 of the ACA itself, as well as Title VI of the Civil Rights Act of 1964. Once again, these obvious issues do not receive the kind of in-depth analysis required for sound decision-making. Not one word in the proposed Rule so much as hints at any analysis of how the proposed policy would affect different people based on race, ethnicity, income, or education.

The proposed Rule's adverse impact on consumers who qualify for insurance affordability programs directly contradicts the ACA's core objective of streamlining and maximizing enrollment of eligible consumers into these insurance affordability programs. The rule takes a statutory enrollment structure carefully developed to promote low- and moderate-income people's enrollment into health coverage and distorts it into a mechanism guaranteed to shortchange precisely such consumers' enrollment. In ACA provisions like Sections 1413, 2201, and 1311, Congress sought to simplify and streamline enrollment. The proposed Rule moves in the opposite direction, discouraging receipt of assistance for which people qualify under the ACA. This is a clear abuse of agency discretion, violating rather than effectuating statutory intent.

Other structural features of web brokers cause systemic underservice to and thus discrimination against historically disadvantaged communities. By definition, web brokers cannot help people who do not use the internet or who are functionally illiterate. An English-language internet does not meet the needs of those who are literate in other languages. Web brokers and other agents and vendors are under no obligation to affirmatively reach out to communities that are underinsured. These entities do not invest time and finite resources in uncompensated activities, however important, needed to help someone who is buying insurance for the first time learn about prior authorization, appeals, or the meaning of provider networks. As noted earlier, this built-in underservice to low-income people and communities of color conflicts with both the ACA's core goals as well as federal civil rights statutes.

The proposed Rule conflicts directly with ACA Section 1311. The very first requirement the statute applies to Exchanges provides that "An Exchange shall be a governmental agency or nonprofit entity that is established by a State."[28] Instead of "an" exchange operated by "a" single government agency or nonprofit, the proposed regulations would encourage for-profit direct enrollment technology providers

[28] ACA §1311(d)(1).

to serve as multiple *de facto* exchanges within a single state. Both the Rule's authorization for states to dispense with exchanges entirely and other, less extreme provisions in this part of the rule would let for-profit vendors largely or entirely supplant the consumer-facing operation of exchanges by government agencies or entities whose advice to consumers is not distorted by profit-seeking incentives. Effectively, the proposed Rule's extended use of direct enrollment and brokers converts the notion of one exchange in a state, a single place to shop for health insurance, with services provided by a disinterested public-oriented entity, into the kind of profit-driven free-for-all that the ACA was intended to replace. This may be an authentic expression of Department leadership's policy preferences, but it is not agency rulemaking that implements the statute.

In reporting out the bill that became the ACA, the Senate Finance Committee described the legislation's vision as follows:

> "The [bill] would make purchasing health insurance coverage easier and more understandable by creating state-based web portals, or ''exchanges'' that would direct consumers to all available health plan options. The exchanges would offer standardized health insurance enrollment applications, a standard format companies would use to present their insurance plans, and standardized marketing materials. Small businesses would have access to state-based Small Business Health Options Program (SHOP) exchanges. These exchanges—like the individual market exchanges—would be web portals that make comparing and purchasing health care coverage easier for small businesses.
>
> The [bill] standardizes benefits to force insurance companies to compete on price and quality and not their ability to select the healthiest individuals and ensures that every policy offered in the individual and small group market provides meaningful coverage for essential services."[29]

Both in this provision and others, the proposed Rule moves in a direction opposite from that clearly and expressly intended by Congress.

The proposed Rule's permission to delay linguistically-competent service will limit coverage received by populations that have limited English proficiency, creating racial and ethnic disparities that raise serious questions under both the ACA and broader federal civil rights laws. The proposed Rule gives web-brokers and insurers participating in direct enrollment programs 12 months to translate websites and furnish taglines in prominent languages. This will impede the ability of limited English speakers to find and enroll in health plans. As the rule is drafted, during those first 12 months, these sites need not even inform people of how to get written information and telephonic or in-person help in their own languages. Although the proposal would require earlier translation in states using direct enrollment under **§** 155.221(j), this still does not provide sufficient protection for limited English speakers. Nothing in the proposal assures limited English speakers that help for them will be prominently marketed, nor that they will have in-person assistance or even a telephonic or chat function to provide further explanations and assistance in a language they comprehend.

As an illustration of these problems, we searched for health plans in Albuquerque, NM on web-broker sites that are listed as "full-service partners" on healthcare.gov. "Catch," one of those entities, provides

[29]Committee on Finance, United States Senate. "America's Healthy Future Act of 2009: Report to Accompany S. 1796." *Report 111–89*. October 19, 2009. https://www.finance.senate.gov/imo/media/doc/prb102109a3.pdf

no information in Spanish – and does not even list a number to call to get help in Spanish. In a state where 26% of residents speak Spanish,[30] this is a serious barrier to entry, and it is far from unique to this particular vendor.

Though we appreciate that under the proposed Rule, entities would have to comply with some language requirements after 12 months, many people will be left without protection in quickly changing markets. The Department claims that the 12-month period allows brokers to "test the market" before incurring translation costs – but providing language assistance should be a key aspect of marketing insurance to people who may have lacked it in the past. It is an essential part of public functioning in an increasingly diverse country, and the proposed Rule is startling in its failure to fully safeguard this basic functionality.

As an empirical matter, web brokers and direct enrollment sites have often done a poor job giving consumers necessary information, which makes the proposed Rule arbitrary and capricious. These entities should not be entrusted with additional responsibilities until the Department has done a comprehensive analysis of their service to date and articulated a plausible plan for greatly improved performance.

The web broker sites that we have reviewed categorize consumers' insurance needs into a few scenarios, such as someone who uses few health services, someone who uses several doctor visits and prescriptions, someone who uses more health services – but they do not offer assistance with more individualized and complicated health needs. Their algorithms are not made public, despite the core role algorithms play in routing consumers to particular plan choices. The algorithms direct consumers to think about the number of doctor visits and medicines they typically use, and suggest cost-effective plans based on the reply. They do not, however, walk people through their use of particular services (like behavioral health). They do not discuss the trade-offs between premiums and deductibles, nor examine what services are pre-deductible, which is important for someone with limited savings and little income. They do not help people think through their next steps over the course of the year, such as requirements to keep up to date with premiums or what might happen if their incomes or circumstances change. All of these are functions for which navigators and assisters will continue to be needed. However, since direct enrollment websites contain no specific links to healthcare.gov's "find local help" pages nor to the marketplace call center, it is unlikely that people working with web-broker direct enrollment sites will find their way to the assistance they need.

These problems have worsened during the pandemic. Some sites listed by the Center for Consumer Information and Insurance Oversight (CCIIO) as entities "approved to use enhanced direct enrollment" do not provide specific information regarding special enrollment during the COVID-19 pandemic. Some do not thoroughly screen for all scenarios that might allow a consumer to be eligible for Medicaid, despite losing employment and earnings during the current downturn. Subtle and important changes already made by CCIIO are nowhere reflected in most web brokers' sites, including those that determine the exact application of existing SEPs during the public health emergency. These gaps together result in an egregious lack of information, leaving many consumers without a clear picture of their options. Such information gaps threaten to leave more consumers uninsured precisely at the time they most need coverage — namely, while the worst public health crisis in a century is spreading across the country.

[30] Families USA analysis of American Community Survey data from 2014-2018, via IPUMS USA, University of Minnesota, www.ipums.org.

Web brokers and other direct enrollment entities should be required to pay a fee to the exchange to cover core functionalities. Web-brokers would receive valuable business under the proposed Rule. It would be irresponsible for the Department to let these businesses convert taxpayer investments in exchanges' core operational functions into private profit — but that is exactly what would happen under the proposed approach that lets them simply pocket and exploit proffered "sales leads" completely free of charge.

In failing to charge for such valued leads, the proposed rule sells taxpayers short. No private entity would be irresponsible in this way. Instead of effectively giving away valuable information for free, the federal government should charge web brokers a fee commensurate with the value those entities receive. Such fees could then be used to support core exchange infrastructure, including outreach, public education, eligibility determination, and impartial navigation and assistance functions.

HHS should not move forward with the proposed Rule until it has analyzed the value of the business it is providing to web brokers. A careful business plan must assess vendors' likely responses to various fee structures and calculate the impact of such fee structures on funding specific core exchange functions that will remain necessary under the proposed Rule. HHS should set this fee as well as user fees in a manner calculated to provide adequate outreach and enrollment assistance to reach the exchange-eligible population, as well as to enable the effective functioning of the exchange.

Web brokers, vendors, agents, and other direct enrollment entities should be required to fulfill basic consumer protection functions. Such entities should not be allowed to display excepted benefits on any page of their websites. Enhanced Direct Enrollment sites (EDEs), agents, brokers and other private vendors often sell STLDI and fixed indemnity plans that are not comprehensive forms of insurance. Many of these plans can discriminate based on pre-existing conditions, exclude essential benefits, and set high cost-sharing. These types of "junk plans" put consumers at high financial risk and allow for brokers to "cherry pick" their beneficiaries, providing another path to the "death spiral" described above. Merely putting these excepted benefits on a separate webpage is not an adequate protection, particularly in the face of sales agents with incentives to route their clients there.

Web brokers, agents, and other vendor websites and other marketing materials should feature prominent links to and from healthcare.gov, along with clear and explicit explanations of all financial interests that affect the entities' service to consumers. As we understand the proposed Rule, to be used by navigators and assisters, these sites would need to list all QHPs, and include the information about each of them that is included on an exchange website, but they would not be required to allow for direct enrollment into each of them. Without equal direct enrollment capabilities, this would strongly bias enrollments towards the plans in which it is easier to enroll (presumably, plans which pay the web-broker a fee).

The proposed Rule's authorization of exchange dissolution conflicts with specific ACA provisions. As a part of the NBPP proposed Rule, states would be allowed to dissolve the use of exchanges for health plan enrollment by consumers, without even requesting a waiver to do so. This violates the statute. ACA section 1311(d)(2) requires the exchange, not a different entity, to "make available" plans, and (b)(1)A requires it to "facilitate the purchase" of plans. Section 1311(d)(1) provides for exchanges that are government entities or nonprofits entities established by the state. These provisions cannot reasonably read as permitting a state to use multiple for-profit entities to replace the essential governmental functions of displaying comparative information about plans, assessing eligibility for premium tax

credits, cost-sharing reductions and Medicaid/CHIP, and providing for enrollment through a single portal.

Deficiencies in the evidentiary record supporting the Georgia waiver that forms the proposed rule's template prevent the rule from passing muster under the APA. The proposed rule comes on the heels of recent approval by CMS for the state of Georgia to eliminate the use of healthcare.gov and replace it with privatized enrollment through multiple for-profit entities. During the application process, the state of Georgia claimed that by dissolving the use of healthcare.gov and replacing it with broker and direct enrollment mechanisms, they would increase enrollment in health insurance by 25,000. This assertion was not supported by any adequate factual basis. To the contrary, the proposal would place at risk coverage for about 400,000 Georgians who actively rely on the state's individual market to acquire health insurance.[31] We incorporate by reference comments submitted in connection with that state's waiver. There are gaping holes in the supporting record justifying Georgia's waiver, which the proposed Rule suggests should become a template for future national policy. The notice of proposed Rulemaking does not show any effort to assess with care the record from Georgia's waiver proceedings or to fill the holes in the evidentiary record, which highlights, once again, the problems of moving forward on the current evidentiary record.

The proposed Rule articulates no realistic method of ensuring accountable performance. The rule proposes to unleash a vast assortment of new players performing vital consumer assistance functions. In performing these tasks, those entities are not overseen by state insurance regulators. The Department is at pains, elsewhere in the rule, to insist on new federal oversight mechanisms to assure adequate performance by state-based exchanges. No such concern is evident when it comes to making sure that private vendors furnish adequate service to consumers, free of discrimination and harmful self-dealing. The absence of any realistic accountability mechanism would doom the rule to failure. The fact that the rule, taken in its entirety, embodies such a clear double-standard — cracking down on public exchanges while averting scrutiny and permitting the largely unhindered operation of private, for-profit actors — makes the rule inherently arbitrary and capricious.

VII. Consumer Affordability, Indexing, and 45 CFR Part 156

The proposed Rule continues a faulty and detrimental 2019 administrative change in the formula used to calculate premium tax credits, maximum out-of-pocket costs, and other specific standards for both individual and group markets. This faulty formula wrongly calculates premium increases from a baseline that includes pre-2014 individual market coverage exempt from any requirement for comprehensive benefits or modified community rating. The cost of unhealthy consumers was excluded from such premiums, before the ACA's main coverage provisions took effect in 2014. Pre-ACA individual-market coverage typically excluded such basic services as prescription drugs, treatment of mental-health and substance use disorders, and maternity care. Comparing that coverage with insurance costs under an ACA-regulated individual market does not serve the purpose of the ACA's statutory requirement of indexing affordability assistance based on changing costs for a fixed market basket of health insurance

[31] Aviva Aron-Dine, Tara Straw, and Sarah Lueck. "Georgia's Unprecedented 1332 Waiver Would Endanger Consumers and Violate Federal Law: Tens of Thousands of Low- and Moderate-Income Georgians Would Likely Lose Subsidies and Become Uninsured." Center for Budget and Policy Priorities, December 17, 2019, https://www.cbpp.org/research/health/georgias-unprecedented-1332-waiver-would-endanger-consumers-and-violate-federal-law

and health care. Much of the individual market's premium increase from 2013 to later years reflected the ACA's higher standards for coverage, not higher underlying costs.

The Department's own cost analysis shows why the final rule should reject this approach as arbitrary and capricious. The proposed Rule sets maximum out-of-pocket (MOOP) limits at $9,100 for 2022. This is 43% higher than the 2014 MOOP of $6,350. According to national health expenditures reported by the CMS Office of the Actuary, health care costs rose by 13% during this time span and general inflation rose by 16% or 17% (depending on the measure used).[32] Put simply, the Department's approach has made health care and coverage substantially less affordable in real terms. This does not serve the goals articulated in the very title of the "Patient Protection and Affordable Care Act." It privileges federal spending reductions over consumers' need for affordable coverage and care. For the Department to implement rather than undermine the law it is charged to administer, it must return to its prior approach to indexation, which honors the priorities expressed by Congress.

The proposed Rule does not explain how indemnity plans will be held accountable for meeting applicable standards involving out-of-pocket cost limits, reasonable reimbursement of essential community providers, and provision of consumer information to guide plan choice. The proposed §156.230 would permit indemnity plans to be sold on the marketplace without the need to demonstrate network adequacy. We are not familiar with any indemnity plans that are currently sold on the marketplace. Most important, without a network, the rule does not explain how such plans would comply with the ACA's limitation on maximum out-of-pocket charges; how they would assure the accuracy of coverage examples and consumer costs listed in their summary of benefits; or how they would guarantee access to essential community providers through assuring adequate reimbursement. ACA Section 1311 specifies responsibilities of plans to include essential community providers in their networks and responsibilities for quality rating. The rule is silent on how these responsibilities will be fulfilled with indemnity plans and how performance of such plans will be gauged. Once those explanations are forthcoming, the Department should allow further comment before proceeding to final rulemaking. Without that explanation, it is impossible to adequately assess and comment on the impact of this change.

By eliminating network specification requirements for indemnity plans, the proposed Rule eliminates a crucial tool for accountability and insurance oversight. Network analyses are vital to assessing the adequacy of plan performance and insurer compliance with non-discrimination rules. The proposed Rule must establish alternative mechanisms for insurance oversight and set out a factual basis for concluding that such mechanisms will suffice. The centrality of this function is evident in the name of the applicable federal agency: the Center for Consumer Information and Insurance Oversight.

Proposed provisions for quality rating and enrollee satisfaction take important positive steps, but further action is needed to promote equity. We support the proposals in §156.1120 and §156.1125 to make more information available regarding quality and consumer experience in public use files. We urge CMS to require stratification of at least some quality measures by race, ethnicity, primary language, and disability. The National Quality Forum's *Roadmap for Promoting Health Equity and Eliminating Disparities* provides recommendations of measures particularly useful for promoting health equity. It

[32] Families USA analysis of CMS Office of the Actuary, April 15, 2020. "Table 1. National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2012-2028," in *NHE Projections 2019-2028 - Tables (ZIP)*, https://www.cms.gov/files/zip/nhe-projections-2019-2028-tables.zip-0

would be appropriate to stratify some of the measures CMS already requires for QHPs to address highly prevalent conditions in communities of color. California's Exchange also stratifies some quality measures and reports on disparities improvement, which furnishes a useful model.[33]

VIII. Premiums and Rebates: 45 CFR Part 158

The proposed reporting and deduction requirements for "prescription drug rebates and other prices concessions" are a positive step, but bona fide fees should be included as well. Families USA supports the proposal to codify and clarify in §158.103 the definition of this phrase to allow for more accurate reporting of the costs incurred by issuers associated with enrollee's prescription drug utilization for purposes of the medical loss ratio (MLR) calculation. However, we believe that true transparency around those concessions, and therefore a more accurate account of utilization and cost information, should include all negotiated concessions, including bona fide services. The proposed Rule defines the latter term as "including but not limited to distribution service fees, inventory management fees, production stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs)." Bona fide service fees may already be, or could easily become, a multi-purpose venue for price concessions. The proposed Rule would risk that such concessions could avoid being reported in the MLR or included in Medicaid best-price calculations. We agree with CMS's original intent to bring transparency to prescription drug rebates and price concessions received from drug manufacturers. To effectuate that intent, bona fide fees should be added so that all concessions are considered in MLR calculations and Medicaid best-price determinations.

The proposed approach to premium rebates deserves support, but the final rule should explicitly specify that premium tax credits are based on the premium at initial enrollment, rather than the post-rebate benchmark premium. The proposed §§ 158.130, 158.240 and 158.241 would allow temporary premium credits, offered to struggling families during a public health emergency, to count as a reduction in earned premium for purposes of MLR reporting. We support this proposal, which is fair to insurers and consumers alike and will encourage insurers to similarly reduce premiums in other public health emergencies.

For this positive step to achieve its goal of improving affordability and lowering consumer costs, either the final rule or guidance from the Treasury Department must make clear that premium tax credits are based on the initial benchmark premium, rather than the post-rebate premium. Otherwise, insurer rebates will have the paradoxical and unintended effect of making health coverage more expensive for many of the individual-market participants who purchase non-benchmark coverage with the aid of APTCs. If post-rebate premiums determined PTC amounts, consumers who did nothing wrong could receive a year-end tax penalty as APTC calculations done in good faith are upended by well-intended insurer rebates that lower benchmark premiums, hence PTC amounts. Unless benchmark premiums reflect original rather than post-rebate charges, rebates will harm many consumers, which is not the intent of either insurers or the Department.

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[33] See Covered California, *Holding Plans Accountable for Quality and Delivery System Reform*, December 2019, https://hbex.coveredca.com/data-research/library/CoveredCA_Holding_Plans_Accountable_Dec2019.pdf.

IX. Reporting and Price Concessions: 45 CFR Part 184

The proposed Rule's reporting requirements for prescription drug rebates and price concessions for Prescription Benefit Managers (PBMS) and QHPs are a positive step, but bona fide fees should be included as well. In analyzing proposed §§ 184.10 and 184.50, Families USA agrees with CMS that the "role of PBMs in the prescription drug landscape, including any impact on the rising cost of prescription drugs, is not well understood." Further, we agree that detailed data have not been collected by plans, or state and federal regulatory bodies, to shed light on the practice of spread pricing despite a robust debate on the practice's impact on prescription drug cost and utilization. Therefore, we encourage CMS to add to PBM data reporting requirements, detailed in this section, the requirement that PBMs (or QHPs in the absence of a PBM contractor), report all price concessions ***including*** bona fide service fees, which the proposed Rule defines to include, without limitation: "distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs)." If the goal is to understand the role of PBMs in the rising cost of prescription drugs, then reporting of all concessions is paramount. The opacity of the supply and financing chain in the prescription drug market is truly notable. Allowing a continued venue for unreported price concessions that can impact fundamental guardrails such as MLR and Medicaid best price is inconsistent with the goal of this reporting and is surely not what CMS intends.

Thank you for considering these comments. Please contact Stan Dorn, sdorn@familiesusa.org, or Cheryl Fish-Parcham, cparcham@familiesusa.org, with any questions.

Sincerely,

Frederick Isasi
Executive Director

Appendix: Analysis of the Impact of Consumers on Metal-Level Misalignment between Premiums and Coverage Generosity in Health Insurance Exchanges

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Stan Dorn, J.D., Gregory G. Fann, FSA, FCA, MAAA, and Hannah Markus, B.A.[34]

Abstract

Premiums in today's individual market are supposed to reflect plan characteristics, not the population expected to enroll. All else equal, less generous plans should charge lower premiums.

Analyzing 2020 data from 46 states' health insurance exchanges, we find widespread violation of this core principle, with significant misalignment between metal-level premiums and coverage generosity. In the median state, bronze and gold premiums should be roughly 10% lower. Silver premiums, which define premium-tax-credit values, should be 7% higher. If 2020 premiums matched coverage generosity, 97% of exchange consumers would spend less, with net annual savings totaling $5.9 billion. People earning between twice and four times the poverty level would save $940 a year, on average. Half of uninsured adults eligible for premium tax credits could buy plans costing no more than their credits. To achieve these affordability gains, state regulators could strengthen pricing guidelines, and federal regulators could update risk adjustment.

Introduction

One of the Affordable Care Act's (ACA's) most underappreciated cornerstones is that premium variation in the individual market should reflect differences between plans, not differences between the people expected to enroll in each plan. This helps achieve the goal that "individual-market insurers … no longer compete based on their ability to avoid risk, but rather on their ability to deliver high-quality care at an affordable price."[1] It also prevents premiums from rising for plans based on their attraction of people with preexisting conditions. Accordingly, ACA regulations provide that, after an insurer determines the average cost of covered benefits for all of its individual market enrollees, premium variation between plans is limited to specific "actuarially justified" factors, such as "actuarial value and cost-sharing."[2] All else equal, plans with less generous coverage should charge lower premiums.

Actuaries report widespread departures from this basic principle.[3] Especially after President Trump ended federal payments for cost-sharing reductions (CSRs) legally required for silver-tier exchange enrollees with incomes below 250% of the federal poverty level (FPL), metal-level premiums have diverged from coverage generosity in most states' exchanges.

History and algebra clarify the nature of this divergence. When exchanges began, silver premiums financed only baseline silver coverage with 70% actuarial value (AV), because separate federal payments covered CSR costs. Starting in 2018, the first year after federal CSR payments ended, most state regulators required or allowed insurers to cover CSR costs through silver exchange premiums. This followed the actuarial principle that "insurance premiums [must] accurately reflect the coverage that they insure."[4] By increasing silver premiums, such "actuarial loading" or "silver loading" increased

[34] Mr. Dorn is the Director of the National Center for Coverage Innovation at Families USA. Mr. Fann is a consulting actuary with Axene Health Partners, LLC. Ms Markus is Strategic Partnerships Coordinator at Families USA.

APTCs, which are calculated based on the "benchmark" premium charged by the second-cheapest silver plan.

Typically, silver premiums now finance paid claims for enrollees at multiple AV levels. Nationally, more than 70% of silver exchange members are in 87%- or 94%-AV plans,[5] suggesting that overall coverage generosity is greater in silver than in 80%-AV gold. But by how much? And how does that compare to premiums?

Quantifying coverage generosity involves both the percentage of covered claims a plan pays and the increased utilization that results from lower cost sharing. To estimate such induced demand, the ACA forbids taking into account the characteristics of each plan's expected enrollees. Instead, utilization must be projected for a standard population that has the "average demographics of the single risk pool" made up of all the carrier's individual market members.[6] The U.S. Department of Health and Human Service's Center for Consumer Information and Insurance Oversight (CCIIO) developed one such estimate of the relationship between AV and utilization in a representative population.[7] Applying that estimate to the national distribution of silver exchange members among CSR-variant plans[8] yields the conclusion that silver's overall coverage generosity is 60% higher than in bronze and 12% higher than in gold.[9] By contrast, national average lowest-cost silver premiums are just 6% (rather than 60%) above lowest-cost bronze and 12% below (rather than 12% above) lowest-cost gold.[10]

Something seems seriously amiss. But is this apparent misalignment between coverage generosity and premiums anything more than an abstract, actuarial quibble? How are consumer costs affected?

Except for actuarial reports like those noted above, no previous research addresses this issue. Here, we make a preliminary assessment based on state-level data showing enrollee characteristics and average premiums in exchanges. We find widespread misalignment between premiums and coverage generosity that substantially raises costs for consumers, with particularly large cost increases for consumers with incomes above 200% of FPL.

Study Data and Methods

Data Sources. For the income and age of exchange enrollees by state and metal level, we use CCIIO's 2020 Marketplace Open Enrollment Public Use Files.[11] For the characteristics of uninsured adults, we analyze American Community Survey data for 2018, accessed via IPUMS USA, University of Minnesota, www.ipums.org.[12] For 2020 bronze-, silver-, and gold-tier lowest-cost premiums and for benchmark premiums, we use the Kaiser Family Foundation's state averages for 40-year-old non-smokers.[10] We exclude (1) Idaho and Nevada, because of incomplete federal enrollment data and (2) the District of Columbia, Minnesota, and New York, whose exchanges do not provide high-AV silver coverage to people with incomes below 200% of FPL.[13]

Measures. We develop state measures in three categories. First, we estimate "premium misalignment," the difference between (1) the ratio of average metal-level premiums and (2) the ratio of average metal-level coverage generosity. We quantify the latter based on paid claims that would result from utilization by a standard population.[14] Second, we calculate "realigned premiums" in each state that would fit relative coverage generosity.[15] Third, we assess the impact of such realigned premiums on consumers by examining three factors:

- Changes to "net premiums" — that is, the premiums consumers pay. For APTC beneficiaries, net premiums equal the difference between gross premiums and APTCs.
- Changes to average out-of-pocket costs for consumers moving from silver coverage with 70% or 73% AV to gold coverage with 80% AV.
- Changes to the number of uninsured adults with access to "zero-net-premium" bronze plans — that is, plans with premiums that do not exceed APTCs.

Analysis. In each state, we quantify coverage generosity for silver plans, based on members' distribution by FPL (hence CSR eligibility) and CCIIO's above-noted estimated relationship between AV and utilization. These factors let us calculate average paid claims for each state's silver exchange enrollees, assuming a standard population, compared to members in bronze and gold exchange plans with 60% and 80% AV, respectively. We determine premium misalignment by comparing the ratio of premiums and the ratio of coverage generosity between all three metal tiers.[16]

We calculate realigned, lowest-cost premiums that meet two criteria: (1) The ratio between bronze, silver, and gold premiums is the same as the ratio of coverage generosity between metal tiers; and (2) the same combined premium revenue for these three metal levels results from current and from realigned premiums. We determine realigned benchmark premiums by applying the current percentage difference between lowest- and second-lowest-cost silver premiums shown in Kaiser Family Foundation averages.

With both actual and realigned premiums, we calculate net premiums for 40-year-old non-smokers, assuming enrollment at current metal tiers except when switching from silver to gold would lower consumers' overall costs, including average out-of-pocket costs. To determine the latter, we (1) assume, consistent with medical loss ratio requirements, that 80% of premiums pay covered claims, then (2) apply both AV and CCIIO's estimated impact of AV on total utilization to calculate the covered claims paid by consumer and by the plan. We adjust cost estimates based on the average age of enrollees in each metal tier and state, modifying the federal age-rating curve in states with less than the federally permitted 3 to 1 maximum ratio.[17]

We then determine, for adults at each age from 19 through 64, whether zero-net-premium bronze plans are available, with current and realigned premiums, within income bands that do not exceed 50 FPL percentage points. The lowest income band begins at 139% of FPL in states that expanded Medicaid by January 2020 and 100% of FPL elsewhere. We exclude a fixed percentage of non-citizens from estimated APTC eligibility, based on past results using imputations developed by the Urban Institute, the Pew Hispanic Center, the Department of Homeland Security, and the Center for Migration Studies.[18] We do not estimate access to unaccepted employer coverage offers that would preclude APTC eligibility. We analyze the cost to uninsured adults of single-adult bronze coverage, assuming APTCs for one-person households at each age and the top of each income band. We do not estimate access to zero-net-premium plans in Massachusetts and Vermont, because such states limit age rating, which greatly affects access to zero-net-premium coverage.

Limitations and scope. This analysis is approximate. We rely on state averages, rather than county-specific data, and we make many simplifying assumptions.[19] Given these limitations, our results are not precise predictions. Rather, they seek to indicate the likely direction and approximate magnitude of consumer-cost effects that could result from realigning metal-level premiums to fit coverage generosity. Future work will undertake more granular analysis.

Results

Current premium misalignment

Exhibit 1 shows each state's relationship between coverage generosity and average premiums. Out of 46 states, 41 have silver premiums more than 10% too low, relative to either bronze or gold, including 35 where misalignment exceeds 10% relative to both. Only one state has silver premiums that exceed expected levels by more than 10%. In the median state, silver premiums are 15% too low, relative to bronze, and 18% too low, relative to gold.

Impact of realigned premiums

Premiums. If metal-tier premiums were realigned to fit coverage generosity, bronze and gold premiums would fall and silver premiums rise in 39 out of 46 states (Exhibit 2).[20] In the median state, bronze and gold premiums would drop by 9% and 11%, respectively. Silver premiums would rise 7%, increasing APTC values.

People currently in exchange plans. Both overall and with most specific populations, premium realignment would help many more than it would harm, and average savings would far exceed average cost increases.

An estimated 97% of everyone covered through exchanges would experience savings (Exhibit 3). Costs would fall for 10.9 million consumers. Their annual savings would average $553, totaling $6.0 billion. Costs would rise for fewer than 300,000 consumers, with increases averaging $250 a year and totaling $70 million. On net, consumers would save $5.9 billion.

With specific populations, the simplest situation involves bronze and gold plans bought without APTCs:

- In 44 states where bronze premiums fall, 750,000 bronze non-APTC enrollees would save an average of $557 a year, totaling $418 million. In two states where bronze premiums rise, 40,000 would pay $255 more, on average, totaling $10 million.
- In 42 states where gold premiums fall, 635,000 people buying gold plans would save an average of $935 a year, totaling $594 million. In four states where gold premiums rise, 56,000 would pay more, with increases averaging $271 a year and totaling $15 million.

The second-simplest situation involves APTC beneficiaries buying bronze or gold plans. Their net premiums equal (1) income-based payments required to purchase benchmark coverage, plus or minus (2) the difference between benchmark and premiums for each beneficiary's chosen plan. In states where silver (hence benchmark) premiums rise as gold and bronze premiums fall, consumers would benefit from both increased APTCs and reduced bronze and gold premiums:

- In 44 states, 2.7 million people who use ATPCs to buy bronze plans would save an average of $1,083 in annual net premiums, totaling $2.9 billion. In two states, 34,000 APTC beneficiaries would pay an average of $619 more for bronze, totaling $21 million.
- In 42 states, 568,000 APTC beneficiaries would pay $1,374 less for gold plans, on average, saving a total of $780 million. In 4 states, 78,000 APTC gold beneficiaries would see average costs rise by $285, totaling $22 million.

The most complex situation involves enrollees in silver plans. Most would save, but the path to savings varies:

- APTC beneficiaries with incomes below 200% of poverty save money on lowest-cost silver coverage if realignment increases the difference between lowest-cost and benchmark premiums. Accordingly, in 43 states, 4.6 million such beneficiaries could save an average of $21 a year, totaling $97 million. In two states, 72,000 people would see net premiums rise by an average of $16 a year, totaling $1 million.
- For APTC silver enrollees with incomes between 200% and 400% of FPL, outcomes differ by state:
    - In 28 states, 508,000 APTC beneficiaries could lower net premiums by moving to gold plans. They would save an average of $1,074 on net premiums and out-of-pocket costs combined, for a total of $546 billion.
    - In 18 states, 710,000 people would pay more in net premiums for realigned gold coverage than they now pay for lowest-cost silver plans. However, their average savings in out-of-pocket costs would exceed increased premium payments. Net individual savings would average $427 a year. Savings would total $303 million.
- For silver enrollees without APTCs, outcomes similarly vary:
    - In 28 states, 203,000 people would save on premiums by moving from silver to realigned gold coverage. On average, they would spend $1,227 less on premiums and cost sharing combined, for a total savings of $249 million.
    - In 18 states, 236,000 people would pay higher premiums for realigned gold than for current silver, but their average out-of-pocket savings would exceed premium increases. Net annual savings would average $481 per person, totaling $114 million.

Aggregating effects by income band, ATPC beneficiaries with incomes between 200% and 400% of FPL would experience the greatest gains. Comprising 32% of exchange members, they would realize 56% of net savings, averaging $940 per person (Exhibit 4). Consumers ineligible for APTCs would save $704, on average. APTC beneficiaries earning below 200% of FPL would experience the smallest average net savings: $222 a year.

Uninsured adults with access to zero-net-premium coverage. In most states, realignment would increase APTC amounts by raising silver premiums and lower bronze premiums. Many more uninsured adults would thus gain access to bronze plans with premiums that do not exceed their APTCs. The number of such adults in the states we analyze would rise from 3.0 million — 30% of uninsured adults who potentially qualify for APTCs, based on income and immigration or citizenship status — to 5.1 million, or 51% of all such uninsured (Exhibit 5).

Discussion

This preliminary assessment suggests that metal-level premium misalignment is widespread and imposes significant costs on consumers. Aligning premiums with coverage generosity could help address the serious affordability challenges that many consumers now face in the individual market.[21] In 42 out of 46 states, more than 75% of exchange beneficiaries would realize savings; and in all but one state, total savings would exceed total cost increases (Exhibit 6).

To analyze misalignment's causes and remedies, we focus this section's discussion on two topics: state insurance regulation and federal risk adjustment.

State insurance regulation

Insurers' incentives. Some insurers have incentives to aggressively underprice silver plans, into which low-income consumers must enroll to obtain high-AV coverage. Comprising the bulk of silver exchange

enrollees, consumers with incomes below 200% of FPL typically make enrollment decisions based on small premium differences.[22] Whichever insurer wins the "pole position" by offering the lowest-cost silver plan is thus likely to garner considerable market share.

Regulators' limited scrutiny of aggressively underpriced premiums. It is understandable why the underpricing of silver exchange plans has received little attention from regulators traditionally focused on guarding against excessive premiums. With every other form of insurance, lowering premiums saves consumers money, triggering less need for regulatory scrutiny. Only silver exchange premiums have the counterintuitive feature that costs for many consumers rise when premiums fall, since only silver exchange premiums determine the financial assistance consumers receive under the federal tax code.

Moreover, the individual insurance market experienced significant instability several years ago. Some carriers left. Many regulators understandably prioritized retaining and recruiting insurers. Despite greater stability and profitability in today's markets, some regulators may still shy away from measures they fear might discourage insurer participation.

Finally, media accounts and government reporting often mischaracterize silver exchange premiums as the key measure of affordability. A regulator who holds insurers accountable for following the ACA's pricing rules risks public criticism for silver premium increases, even if overall consumer costs fall.

Correcting misalignment. State insurance regulators can address metal-level premium misalignment by incorporating three principles into rate review and their instructions to pricing actuaries. The first involves "induced demand," increased utilization that results from lower cost-sharing. Some insurers assume greater induced demand in gold than in silver, even though overall cost-sharing is lower in silver than gold. The ACA's anti-discrimination rules forbid precisely this kind of price setting, which effectively bases premiums on the risk profile of members expected to enroll in a particular plan, rather than the generosity of coverage. Federal guidelines[6] specify that any "utilization difference" between plans "may reflect the impact higher cost-sharing has on utilization but **cannot reflect differences due to health status**." (Emphasis added.)

Insurance regulators can address this problem by requiring insurers to make induced-demand assumptions that project higher utilization when plans have lower overall cost sharing. For example, regulators could borrow Virginia's directive to pricing actuaries that "only allow the use of the induced demand factors established by CMS and used in the Federal Risk Adjustment program."[23]

Second, regulators can reject efforts to vary metal-level premiums based on past utilization in each metal tier. To justify higher premiums in gold than silver, actuaries sometimes characterize proposed premiums as filling the gap between paid claims and risk-transfer payments.[24] This bases premiums on plan-specific claims experience, rather than the insurer's total risk pool. The ACA prohibits such risk-rating as undermining market efficiency and raising premiums for people with preexisting conditions, as explained earlier.

Third, regulators can instruct insurers to use common assumptions about the distribution of silver members among AV variants. Ideally, carriers would assume that all silver members receive high-AV coverage. That resembles current market conditions in most states. It also reflects rational consumer behavior. Rational purchasers would not pay premiums based on AV above 70% for a plan that provides

70%-AV coverage. This is especially true in states where some silver plans are sold only off-exchange, neither providing CSRs nor raising premiums to cover CSR costs.

Assuming rational consumer behavior stabilizes markets. If silver exchange premiums reflect the assumption that most silver enrollees receive high-AV coverage, silver prices will exceed gold. Fewer consumers ineligible for high-AV plans will choose silver, since they can buy more comprehensive gold coverage at lower cost. Precisely such patterns have emerged in the few states with silver prices higher than gold.[25] Assumed consumer behavior and the resulting actual consumer behavior will thus be consistent, mutually reinforcing, and stable.

By contrast, insurers in competitive markets now face an inherently unstable pricing paradox. An insurer that assumes significant enrollment in high-AV silver must increase silver premiums, which inhibits enrollment by the low-income people who qualify for high-AV coverage. An insurer that instead assumes limited high-AV enrollment will lower its silver premiums, increasing high-AV enrollment. In other words, *assuming significant enrollment into high-AV plans reduces such enrollment, and assuming limited enrollment increases it*. Regulators can remedy this inherently unstable dynamic by directing insurers to use consistent, market-wide enrollment assumptions that both assume and encourage rational consumer behavior.

Without focused regulatory enforcement that incorporates these three principles, insurers that break the ACA's pricing rules can profit by amassing market share, while law-abiding insurers lose enrollment and may become less profitable. If instead a regulator requires all of a state's insurers to follow common guidelines, industry can benefit, along with consumers. More affordable coverage means more customers. Moreover, increased enrollment in gold promotes retention, since consumers are likely to see lower-deductible plans as offering greater value.

Risk adjustment

A gap in federal risk adjustment may contribute to misalignment of metal-level premiums. Cost deters more care when people earn less.[26] Low-income consumers are particularly likely to enroll in silver exchange plans, as the only source of high-AV coverage. Nevertheless, neither risk adjustment nor ACA-permitted premium variation address the foreseeable impact of income on utilization in high-AV silver plans.

CCIIO's original risk-adjustment model primarily reflected claims data from large-group plans. This implicitly assumed that consumers respond to low cost sharing by increasing utilization in similar ways, whether they are low-income people in high-AV silver or affluent corporate employees with generous group coverage.

When the ACA's full coverage provisions became effective in 2014, federal payments outside premiums covered paid claims attributable to AV above 70%. Those costs therefore were excluded from risk adjustment, which seeks to fill the gap between premiums allowed by ACA rules and expected paid-claims covered by those premiums. However, risk adjustment compensated for induced utilization affecting the 70% baseline silver AV, assuming such baseline coverage would pay 12% more claims for consumers in 87%- or 94%-AV plans.[27] Under today's very different conditions, it is not clear whether this "induced utilization factor" factor fits utilization trends in high-AV silver that premiums cannot lawfully reflect.

ACA risk adjustment is generally cost-neutral within each state.[28] If silver plans are overcompensated because risk-adjustment ignores income's impact on utilization, other plans must pay more into risk adjustment. That could increase profitability of silver enrollees and reduce profitably of other metal tiers. Insurers might gain by manipulating premiums to encourage profitable silver enrollment.

In competitive markets, insurers face pressure to base premiums on claims costs for actual members, plus or minus risk-adjustment. If risk adjustment overpays silver and overcharges other plans, these competitive pressures would encourage offsetting premium decreases in silver and increases in other plans.

CCIIO has made important changes to its original risk-adjustment model. For example, the agency now uses data from individual and small-group markets to calculate risk-adjustment factors for each metal level. CCIIO could build on that approach by calculating risk-adjustment factors that fit paid claims for enrollees in 87%- and 94%-AV individual-market plans. Such enrollees far outnumber people in platinum, gold, and catastrophic plans, each of which already has separately calculated risk-adjustment factors. Risk adjustment based on the actual utilization patterns of high-AV silver members would probably fit current conditions more closely than an induced utilization factor left over from a very different past.

Conclusion

To promote high-functioning insurance markets and limit discrimination against people with health problems, the ACA forbids plan premiums from rising or falling based on insurers' expectations about the characteristics of each plan's enrollees. Instead, premium variation between plans is supposed to match the underlying generosity of coverage. In most states, insurers are departing from this principle by underpricing exchange plans at silver levels and overpricing plans in bronze and gold. This has substantially raised consumer costs in the individual market, especially for APTC beneficiaries with incomes between 200% and 400% of FPL. Both state and national regulators may have important roles to play in fixing what appears to be a significant affordability problem.

Exhibit 1. Misalignment between exchange plan premiums and coverage generosity, by state and metal tier: 2020

	Estimated paid claims for a standard population		Lowest-cost premiums charged to 40-year-old non-smokers		Premium misalignment	
	Ratio of silver to bronze	Ratio of silver to gold	Ratio of silver to bronze	Ratio of silver to gold	Ratio of silver to bronze	Ratio of silver to gold
Alabama	1.63	1.13	1.36	0.81	-17%	-28%
Alaska	1.65	1.14	1.56	1.10	-5%	-4%
Arizona	1.48	1.03	1.20	0.75	-19%	-27%
Arkansas	1.52	1.06	1.12	0.78	-27%	-27%
California	1.53	1.06	1.26	0.89	-17%	-16%
Colorado	1.45	1.01	1.26	0.92	-13%	-9%
Connecticut	1.43	1.00	1.61	1.03	12%	3%
Delaware	1.62	1.13	1.40	0.98	-14%	-13%
District of Columbia	n/a					
Florida	1.74	1.21	1.34	0.91	-23%	-25%
Georgia	1.68	1.17	1.24	0.88	-26%	-25%
Hawaii	1.47	1.02	1.27	1.01	-14%	-1%
Idaho	n/a					
Illinois	1.56	1.09	1.20	0.87	-23%	-20%
Indiana	1.45	1.01	1.23	0.71	-15%	-29%
Iowa	1.62	1.13	1.60	1.21	-1%	7%
Kansas	1.66	1.15	1.33	1.00	-20%	-14%
Kentucky	1.51	1.05	1.35	0.78	-10%	-26%
Louisiana	1.57	1.09	1.24	0.82	-21%	-25%
Maine	1.55	1.07	1.32	0.83	-15%	-23%
Maryland	1.47	1.02	1.46	1.04	-1%	2%
Massachusetts	1.42	0.99	1.25	0.84	-12%	-15%
Michigan	1.56	1.08	1.39	0.91	-11%	-16%
Minnesota	n/a					
Mississippi	1.68	1.17	1.06	0.78	-37%	-33%
Missouri	1.59	1.11	1.23	0.79	-23%	-29%
Montana	1.60	1.11	1.39	0.91	-13%	-19%
Nebraska	1.69	1.18	1.43	1.09	-16%	-7%
Nevada	n/a					
New Hampshire	1.49	1.03	1.29	0.86	-13%	-17%
New Jersey	1.44	1.00	1.22	0.58	-16%	-42%
New Mexico	1.61	1.12	1.27	0.95	-21%	-15%
New York	n/a					
North Carolina	1.69	1.17	1.42	0.94	-16%	-20%
North Dakota	1.56	1.09	1.36	0.91	-13%	-16%
Ohio	1.51	1.05	1.32	0.83	-12%	-21%
Oklahoma	1.66	1.15	1.44	1.01	-13%	-12%
Oregon	1.49	1.03	1.36	0.91	-8%	-11%
Pennsylvania	1.55	1.07	1.34	0.92	-13%	-14%
Rhode Island	1.66	1.15	1.43	0.97	-14%	-16%
South Carolina	1.67	1.16	1.41	0.94	-15%	-19%

	Estimated paid claims for a standard population		Lowest-cost premiums charged to 40-year-old non-smokers		Premium misalignment	
	Ratio of silver to bronze	Ratio of silver to gold	Ratio of silver to bronze	Ratio of silver to gold	Ratio of silver to bronze	Ratio of silver to gold
South Dakota	1.60	1.11	1.34	0.89	-16%	-19%
Tennessee	1.63	1.13	1.38	0.79	-15%	-31%
Texas	1.68	1.16	1.42	0.89	-15%	-24%
Utah	1.66	1.16	1.66	0.79	0%	-32%
Vermont	1.50	1.04	1.36	0.99	-9%	-5%
Virginia	1.61	1.12	1.33	0.99	-17%	-11%
Washington	1.47	1.02	1.27	0.89	-14%	-13%
West Virginia	1.51	1.05	1.12	0.77	-26%	-27%
Wisconsin	1.63	1.13	1.36	0.97	-16%	-14%
Wyoming	1.70	1.18	1.48	1.20	-13%	1%
Median state	**1.58**	**1.10**	**1.34**	**0.91**	**-15%**	**-18%**

SOURCES: Analysis of data from Center for Consumer Information and Insurance Oversight, 2020, and Kaiser Family Foundation, 2020.

NOTES: Premium misalignment is a measure of how the ratio between premiums charged for plans of different metal-tier levels diverges from the ratio of coverage generosity, defined in terms of paid claims estimated based on a standard population. For example, in Alabama, silver premiums are 17% lower, relative to bronze premiums, than what one would expect based on paid-claims at these two metal tiers, estimated based on a standard population.

Exhibit 2. How realignment would change exchange plan premiums, by state and metal tier: 2020

	Bronze	Silver	Gold
Alabama	-14%	3%	-26%
Alaska	-2%	4%	0%
Arizona	-13%	8%	-21%
Arkansas	-21%	8%	-21%
California	-12%	7%	-10%
Colorado	-7%	7%	-2%
Connecticut	7%	-4%	-1%
Delaware	-6%	9%	-5%
District of Columbia	n/a		
Florida	-17%	7%	-20%
Georgia	-21%	7%	-20%
Hawaii	-10%	4%	3%
Idaho	n/a		
Illinois	-14%	11%	-11%
Indiana	-10%	6%	-25%
Iowa	-4%	-3%	4%
Kansas	-12%	9%	-6%
Kentucky	-5%	6%	-21%
Louisiana	-14%	9%	-19%
Maine	-7%	9%	-16%
Maryland	-1%	-1%	1%
Massachusetts	-11%	2%	-14%
Michigan	-6%	6%	-11%
Minnesota	n/a		
Mississippi	-35%	3%	-31%
Missouri	-18%	7%	-24%
Montana	-5%	10%	-11%
Nebraska	-9%	8%	0%
Nevada	n/a		
New Hampshire	-8%	6%	-12%
New Jersey	-12%	5%	-39%
New Mexico	-12%	12%	-4%
New York	n/a		
North Carolina	-11%	6%	-15%
North Dakota	-5%	9%	-9%
Ohio	-6%	7%	-15%
Oklahoma	-8%	6%	-7%
Oregon	-4%	5%	-7%
Pennsylvania	-8%	6%	-9%
Rhode Island	-6%	9%	-9%
South Carolina	-9%	8%	-13%
South Dakota	-10%	7%	-13%
Tennessee	-10%	6%	-27%
Texas	-10%	6%	-19%
Utah	0%	1%	-32%
Vermont	-6%	3%	-2%

	Bronze	Silver	Gold
Virginia	-11%	8%	-4%
Washington	-7%	7%	-7%
West Virginia	-18%	10%	-19%
Wisconsin	-9%	9%	-6%
Wyoming	-12%	1%	2%
Median state	**-9%**	**7%**	**-11%**

SOURCES: Analysis of data from Center for Consumer Information and Insurance Oversight, 2020, and Kaiser Family Foundation, 2020.

NOTES: This exhibit shows how lowest-cost premiums at each metal tier (and second-lowest-cost silver premiums) would change if metal-tier premiums were realigned based on coverage generosity, defined in terms of paid claims estimated for a standard population.

Exhibit 3: Impact of realigned premiums on consumers currently enrolled in exchange plans: 2020

APTC status	Current metal tier	Other characteristics	Lower costs				Higher costs				Overall effects	
			States	People (thousands)	Per capita savings	Total savings (millions)	States	People (thousands)	Per capita cost increases	Total cost increases (millions)	Net savings (millions)	Percentage of consumers with savings
APTC beneficiaries	Bronze		44	2,689	$1,083	2,913	2	34	$619	21	$2,892	99%
	Silver	<200% FPL	43	4,571	$21	$97	3	72	$16	$1	$96	98%
		200-400% FPL, net premium and OOP savings in gold	28	508	$1,074	$546	0				$546	100%
		200-400% FPL, average OOP savings in gold exceeds net premium increase	18	710	$427	$303	0				$303	100%
	Gold		42	568	$1,374	780	4	78	$285	22	$758	88%
Not APTC beneficiaries	Bronze		44	750	$557	$418	2	40	$255	$10	$408	95%
	Silver	Premium and OOP savings in gold	28	203	$1,227	$249	0				$249	100%
		Average OOP savings in gold exceeds premium increase	18	236	$481	$114	0				$114	100%
	Gold		42	635	$935	$594	4	56	$271	$15	$579	92%
APTC beneficiaries and non-beneficiaries, combined			*n/a*	*10,872*	*$553*	*$6,014*	*n/a*	*280*	*$250*	*$70*	*$5,944*	*97%*

SOURCES: Analysis of data from Center for Consumer Information and Insurance Oversight, 2020, and Kaiser Family Foundation, 2020.

NOTES: This exhibit shows the estimated impact on consumers in 46 states if metal-tier premiums were realigned to fit differences in coverage generosity, defined in terms of paid claims estimated for a standard population. APTC=advance premium tax credit. FPL = federal poverty level. OOP=out-of-pocket costs.

Exhibit 4: Distribution of Exchange Enrollment and Savings from Premium Realignment by Income and Advance Premium Tax Credit Status

		Total exchange enrollment		Net cost savings		Average savings per person
		Thousands	%	Millions	%	
Not APTC beneficiaries (Generally >400% of FPL)		1,921	17%	$1,352	23%	$704
APTC Beneficiaries	200-400% of FPL	3,557	32%	$3,343	56%	$940
	<200%ofFPL	5,674	51%	$1,258	21%	$222
Total		**11,152**	**100%**	**$5,953**	**100%**	**$534**

SOURCES: Analysis of data from Center for Consumer Information and Insurance Oversight, 2020, and Kaiser Family Foundation, 2020.

NOTES: APTC = advance premium tax credit. FPL = federal poverty level. Estimates include consumers in 46 states.

Exhibit 5: Uninsured adults potentially eligible for Advance Premium Tax Credits who have access to zero-net-premium plans: Current vs. realigned premiums (millions)

All potentially eligible uninsured	Currently offered zero-net-premium plans		Offered zero-net-premium plans with realignment		Difference	
	#	%	#	%	#	%
9.8	3.0	30%	5.1	51%	2.1	21%

SOURCES: Analysis of data from Center for Consumer Information and Insurance Oversight (CCIIO), 2020, Kaiser Family Foundation, 2020, and American Community Survey, 2018, IPUMS USA, University of Minnesota, www.ipums.org.

NOTES: This exhibit shows the estimated impact on consumers if metal-tier premiums were realigned based on coverage generosity, defined as paid claims estimated for a standard population. Totals do not include the District of Columbia, Idaho, Massachusetts, Minnesota, Nevada, New York, or Vermont, due to gaps in CCIIO enrollment data, exchanges' exclusion of consumers below 200% of the federal poverty level, or state limits on age rating. Potentially eligible uninsured adults are age 19-64 who meet requirements for advance premium tax credits that involve income and citizenship or immigration status. Someone is offered "zero-net-premium" coverage if the lowest-cost bronze plan's premium does not exceed the individual's premium tax credit.

Exhibit 6. The overall impact of premium realignment, by state: 2020

	Cost effects for consumers already purchasing exchange coverage								Potentially eligible uninsured adults gaining access to zero-net-premium plans	
	People with cost savings			People with cost increases			Overall statewide cost effects			
	Number	Average per capita savings	Total savings (millions)	Number	Average per capita cost increase	Total increased cost (millions)	Net savings (millions)	The percentage of consumers with savings	Number	Percentage of all potentially eligible uninsured adults
Alabama	163,894	$615	$101	-		$-	$101	100%	32,661	15%
Alaska	22,368	$328	$7	-		$-	$7	100%	3,848	11%
Arizona	153,983	$607	$94	-		$-	$94	100%	60,521	25%
Arkansas	65,224	$551	$36	-		$-	$36	100%	23,634	27%
California	1,464,428	$541	$792	-		$-	$792	100%	199,113	25%
Colorado	164,094	$359	$59	-		$-	$59	100%	10,241	7%
Connecticut	30,194	$1,134	$34	75,800	$424	$32.1	$2	28%	(6,509)	-13%
Delaware	29,654	$683	$20	-		$-	$20	100%	4,438	23%
District of Columbia	n/a									
Florida	1,945,589	$564	$1,097	-		$-	$1,097	100%	300,162	26%
Georgia	475,918	$604	$287	-		$-	$287	100%	168,852	30%
Hawaii	17,343	$440	$8	5,073	$219	$1.1	$7	77%	1,821	14%
Idaho	n/a									
Illinois	306,529	$815	$250	-		$-	$250	100%	102,121	35%
Indiana	142,585	$425	$61	-		$-	$61	100%	21,405	11%
Iowa	7,324	$1,363	$10	66,900	$379	$25.3	$(15)	10%	(379)	-1%
Kansas	103,585	$689	$71	-		$-	$71	100%	28,877	29%
Kentucky	84,863	$542	$46	-		$-	$46	100%	20,016	21%
Louisiana	92,410	$818	$76	-		$-	$76	100%	42,641	33%
Maine	62,280	$739	$46	-		$-	$46	100%	16,180	37%
Maryland	64,375	$386	$25	89,733	$70	$6.3	$19	42%	-	0%
Massachusetts	314,550	$227	$71	-		$-	$71	100%	n/a	
Michigan	268,421	$402	$108	-		$-	$108	100%	27,812	13%
Minnesota	n/a									
Mississippi	99,344	$447	$44	-		$-	$44	100%	66,958	41%

	Cost effects for consumers already purchasing exchange coverage								Potentially eligible uninsured adults gaining access to zero-net-premium plans	
	People with cost savings			People with cost increases			Overall statewide cost effects			
	Number	Average per capita savings	Total savings (millions)	Number	Average per capita cost increase	Total increased cost (millions)	Net savings (millions)	The percentage of consumers with savings	Number	Percentage of all potentially eligible uninsured adults
Missouri	203,240	$667	$136	-		$-	$136	100%	77,656	28%
Montana	45,604	$715	$33	-		$-	$33	100%	6,547	17%
Nebraska	114,359	$669	$77	-		$-	$77	100%	6,225	10%
Nevada	n/a									
New Hampshire	44,729	$458	$20	-		$-	$20	100%	3,964	12%
New Jersey	245,972	$410	$101	-		$-	$101	100%	23,493	13%
New Mexico	50,410	$546	$28	-		$-	$28	100%	18,169	27%
New York	n/a									
North Carolina	539,408	$690	$372	-		$-	$372	100%	65,525	14%
North Dakota	24,529	$483	$12	-		$-	$12	100%	3,880	19%
Ohio	199,045	$456	$91	-		$-	$91	100%	39,434	13%
Oklahoma	180,756	$601	$109	-		$-	$109	100%	26,619	12%
Oregon	154,590	$392	$61	-		$-	$61	100%	17,997	16%
Pennsylvania	376,968	$601	$226	-		$-	$226	100%	54,354	21%
Rhode Island	34,646	$453	$16	-		$-	$16	100%	2,425	15%
South Carolina	224,363	$710	$159	-		$-	$159	100%	50,595	20%
South Dakota	29,731	$780	$23	-		$-	$23	100%	6,354	17%
Tennessee	201,353	$614	$124	-		$-	$124	100%	49,637	17%
Texas	1,154,725	$493	$569	-		$-	$569	100%	344,334	19%
Utah	185,381	$177	$33	15,553	$8	$0.1	$33	92%	75	0%
Vermont	25,288	$388	$10	-		$-	$10	100%	n/a	
Virginia	301,742	$636	$192	-		$-	$192	100%	102,123	44%
Washington	209,088	$430	$90	-		$-	$90	100%	15,664	10%
West Virginia	20,609	$1,245	$26	-		$-	$26	100%	24,370	51%
Wisconsin	215,998	$735	$159	-		$-	$159	100%	28,668	20%
Wyoming	10,362	$692.8	$7	27,428	$184.2	$5.1	$2	27%	725	3%

	Cost effects for consumers already purchasing exchange coverage								Potentially eligible uninsured adults gaining access to zero-net-premium plans	
	People with cost savings			People with cost increases			Overall statewide cost effects			
	Number	Average per capita savings	Total savings (millions)	Number	Average per capita cost increase	Total increased cost (millions)	Net savings (millions)	The percentage of consumers with savings	Number	Percentage of all potentially eligible uninsured adults
Total	**10,871,845**		**$6,014**	**280,487**		**$70.0**	**$5,944**	**97%**	**2,093,247**	**21%**

SOURCES: Analysis of data from Center for Consumer Information and Insurance Oversight, 2020, Kaiser Family Foundation, 2020, and American Community Survey, 2018, IPUMS USA, University of Minnesota, www.ipums.org.

NOTES: This exhibit shows the estimated impact on consumers if metal-tier premiums were realigned based on coverage generosity, defined as paid claims estimated for a standard population. Potentially eligible uninsured adults are age 19-64 and meet the requirements for advance premium tax credits (APTCs) involving income and citizenship or immigration status. Someone has access to “zero-net-premium” plans if the lowest-cost bronze plan's premium does not exceed the individual's APTC.

Appendix Endnotes

[1] Corlette S., J. Blumberg L, and Lucia K. The ACA's Effect On The Individual Insurance Market. *Health Affairs* 39, NO. 3 (2020): 436–444.
[2] 42 C.F.R. 156.80(d)(2).
[3] Fann G, Cruz D. Fields of Gold: Reaping a Harvest from the ACA. Axene Health Partners. 2019 Apr 26. Available at: https://axenehp.com/cost-sharing-reduction-paradox-defunding-help-aca-markets-not-make-implode/.
[4] Fann G. The Cost Sharing Reduction Paradox: Defunding Would Help ACA Markets, Not Make Them Implode. *Axene Health Partners*, 2017 Aug 9. Available at https://axenehp.com/cost-sharing-reduction-paradox-defunding-help-aca-markets-not-make-implode/.
[5] The Center for Medicare and Medicaid Services (CMS) 2020 Marketplace Open Enrollment Period Public Use Files. 2020 OEP State, Metal Level, and Enrollment Status Public Use File (ZIP). [cited 2020 Oct 14]. Available at https://www.cms.gov/files/zip/2020-oep-state-metal-level-and-enrollment-status-public-use-file.zip.
[6] CMS. 2020 Unified Rate Review Instructions. [cited 2020 Oct 14]. Available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2020-URR-Instructions.pdf.
[7] To develop its risk-adjustment formulas, CCIIO estimated that, relative to bronze-level plans with 60% AV, a standard population increases utilization by 15% in 87%- and 94%-AV silver plans; by 8% in 80%-AV gold plans; and by 3% in 70%- and 73%-AV silver plans. Analysis of Tables 1 and 11 in CMS. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014. 78 (47) *Federal Register* 15410-15541. 2013 Mar 11.[cited 2020 Oct 14].
[8] According to the above-cited federal open enrollment report for 2020, 45.5% have incomes below 150% of FPL, qualifying for 94%-AV plans; 26.7% earn between 150% and 200% of FPL, receiving 87%-AV coverage; 11.6% have incomes between 200% and 250% of FPL, qualifying for 73%-AV coverage; and 16.2% receive baseline 70%-AV coverage.
[9] Taking into account both CCIIO's induced-demand assumptions and AV, paid claims would equal the following percentages of covered claims in 60%-AV bronze plans:

- For 94%-AV silver, 108% (1.15 x .94 = 1.08)
- For 87%-AV silver, 100% (1.15 x .87 = 1.00)
- For 80%-AV gold, 86% (1.08 x 0.8 = 0.86)
- For 73%-AV silver, 75% (1.03 x 0.73 = 0.75)
- For 70%-AV silver, 72% (1.03 x 0.7 = 0.72)
- For 60%-AV bronze, 60% (1.0 x 0.6 = 0.60)

The above-noted national distribution of silver-tier exchange enrollees would thus generate, for a standard population, paid claims equaling 96% of average utilization in bronze plans, since (45.5% x 108%) + (26.7% x 100%) + (11.6% x 75%) + (16.2% x 72%) = 96%. Accordingly, the generosity of overall silver coverage is approximately 60% greater than in bronze (.96/.60 = 1.6) and 12% greater than in gold (.96/.86 = 1.12). Note: The term, "covered claims," references the total cost of essential health benefits, including both the plan's share and the member's. "Paid claims" references the plan's share.

[10] Kaiser Family Foundation. Average Marketplace Premiums by Metal Tier, 2018-2020. State Health Facts. [Cited 2020 Oct 15]. Available at 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.

[11] We use information from Colorado's exchange to fill gaps in federal data about Colorado's gold-tier enrollees.

[12] Ruggles S, Flood S, Goeken R, Grover J, Meyer E, Pacas J and Sobek M. IPUMS USA: Version 10.0 [dataset]. Minneapolis, MN: IPUMS, 2020. https://doi.org/10.18128/D010.V10.0.

[13] The District covers such people through Medicaid. Minnesota and New York provide them Basic Health Program coverage.

[14] For example, if the ratio of silver to bronze estimated paid claims for a standard population was 1.6 but the ratio of premiums between metal levels was 1.4, premium misalignment would be -13% ([1.6-1.4]/1.6=.13). This would indicate that silver premiums were 13% lower, relative to bronze, than what one would expect based on coverage generosity.

[15] For example, if we estimated silver plans' paid claims for a standard population as 10% above gold and 40% above bronze, realigned silver premiums would be 10% above gold and 40% above gold premiums.

[16] We do not include catastrophic or platinum plans, because of limited state-specific data and limited membership at such metal tiers in most states' exchanges.

[17] For states that forbid age rating, we do not adjust costs based on age. For Massachusetts, which permits age rating to vary by a 2 to 1 rather than a 3 to 1 ratio, our age adjustment is 66% of the amount calculated under the standard federal age-rating curve.

[18] See Blumberg L, Holahan J, Karpman M, and Elmendorf C. Characteristics of the Remaining Uninsured: An Update. Urban Institute. July 2018. Available at https://www.urban.org/sites/default/files/publication/98764/2001914-characteristics-of-the-remaining-uninsured-an-update_2.pdf

[19] Examples include assuming bronze and gold AV of 60% and 80%, respectively; factoring in only on-exchange enrollment in determining the distribution of silver QHP members by AV level; disregarding the impact of American Indian/Alaska Native CSRs; assuming that members in 70%- and 73%-AV silver plans will shift to 80%-AV gold when premium costs plus average out-of-pocket costs are lower in gold, even though many have below-average out-of-pocket costs, and many do not change plans when required to protect their financial well-being. The latter consideration suggests that exchanges should give consumers the option to use a default renewal protocol through which, if they do not select a plan, and their current plan is certain to cost them more than another available option, they are shifted to the latter plan. The analysis of cost would take into account both premium and out-of-pocket costs. The consumer electing this option would receive advance notice before the plan shift occurred, and opportunities to opt out and return to their prior plan, including soon after the shift takes place. Such a mechanism could be useful under any circumstances, but it would be particularly important when market dynamics change significantly from one plan year to the next.

[20] In Alaska, gold premiums fall by 0.45%, which Exhibit 2 displays as a 0% change.

[21] Much research identifies unaffordable cost as a major barrier to individual-market enrollment. See, e.g., Gunja MZ and Collins SR. Who Are the Remaining Uninsured, and Why Do

They Lack Coverage? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018. The Commonwealth Fund. August 2019. Available at https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage.

[22] Finkelstein A, Hendren N, and Shepard M. Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts. 2019. American Economic Review, 109 (4): 1530-67.

[23] This directive is available only to subscribers to the System for Electronic Rates and Forms Filing (SERFF) maintained by the National Association of Insurance Commissioners. For CCIIO's factors themselves, see endnote 6.

[24] E.g., "Anthem Response to BOI Questions Sent 7.9.2020." Available at https://filingaccess.serff.com/sfa/search/filingSummary.xhtml?filingId=132385538#.

[25] Fann G. Focused ACA Rate Review: Tangible Ways for States to Address Metalball. Axene Health Partners. [Cited 2020 Oct 15]. Available at https://axenehp.com/metalball/.

[26] National Center for Health Statistics. Summary Health Statistics: National Health Interview Survey, 2018. Center for Medicare and Medicaid Services. [Cited 2020 Oct 15]. Available at https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2018_SHS_Table_P-9.pdf.

[27] This raises risk adjustment payments by 8.4% (.12 x .70 = .084).

[28] The one exception involves very high-cost consumers, with annual claims that exceed $1 million. For such extreme outliers, all states' risk-adjustment systems make payments.