VIA ELECTRONIC SUBMISSION

July 12, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health & Human Services
200 Independence Ave SW
Washington, D.C. 20201

RE: CMS–9928–NC, Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act and Improving Healthcare Choices to Empower Patients

Dear Ms. Verma:

The Bipartisan Policy Center appreciates the opportunity to submit comments on the Centers for Medicare and Medicaid Services' (CMS) request for information concerning changes to Patient Protection and Affordable Care Act (PPACA) regulations that could promote increased stability of the individual health insurance market and affordability of coverage. Earlier this year, BPC convened a bipartisan group of leading national health policy experts to identify a path forward for a consensus approach to improving health care in the United States. With the assistance of this Future of Health Care panel of experts, BPC stands ready to work with CMS and the Congress to advance policies that will improve access to affordable health care and insurance coverage in America.

Although maintaining stability in the individual health insurance market has been a challenge during the implementation of PPACA, early indications suggest that the risk pool may have begun to stabilize in 2016 and 2017. After initially escalating in 2014 and 2015, average medical loss ratios (MLRs) for individual market plans declined in 2016, and fell even further in the first quarter of 2017,[1] indicating improvements in medical claims experience relative to premiums. After incorporating the significant premium increases of 2017, market analysts have projected that, absent other changes to the market, most individual market insurers should achieve close to break-even financial performance in 2017.[2] In addition, CMS data demonstrate that risk scores for individual market enrollees stabilized in 2016.[3]

As a part of its recent Market Stabilization Rule, CMS finalized several changes for the Health Insurance Marketplaces (hereinafter Marketplaces) that will be implemented in 2018 and could further improve financial performance among individual market insurers. CMS is also requesting regulatory waiver applications from states seeking to innovate their individual market insurance models. If structured properly within the framework of important guardrails, such state-level changes could help to stabilize premiums in the Marketplaces, as could the Market Stabilization Rule's policy to delegate exclusive authority over individual market network adequacy standards to state regulators. In 2015, BPC recommended several policies to improve state flexibility in the individual market. BPC will continue to examine the issue as a part of our Future of Health Care efforts.

However, given that the reformed individual market has not fully matured and that political uncertainty surrounding ongoing PPACA implementation is likely to complicate that market maturation process, BPC agrees that additional regulatory actions by CMS could be helpful in stabilizing the market. Such actions, in conjunction with legislative fixes where necessary, could help control future premium cost growth in the individual market.

Below BPC highlights several policy changes that CMS should consider.

Cost-Sharing Reduction Subsidy Payments

BPC and its Future of Health Care panel of experts strongly encourages CMS and the Department of Treasury to continue to make cost-sharing reduction (CSR) subsidy payments to health insurers through plan year 2018, at a minimum. To accomplish this, CMS could continue making CSR subsidy payments throughout the period of ongoing litigation concerning CSR subsidy appropriations issues, and, if necessary, work with the Congress to ensure that CSR subsidy payments can continue to be made, irrespective of the outcome of the court dispute. It is important not only to make the CSR subsidy payments during the course of the litigation, but also to announce in advance a clear position that CMS and the Department of Treasury will continue to make such payments. This advance notice is critical for health insurance issuers weighing options for ongoing participation in the Marketplaces, as well as for State Insurance Commissioners who are in the process of approving or modifying premium rate increases that hinge on assumptions regarding the future status of CSR subsidy payments.

The present experience suggests that uncertainty surrounding CSR subsidy payments can have a significant impact of premium pricing for individual market insurers. For example, available information demonstrates that a lack of insurer certainty regarding government payment of CSR subsidies could result in individual market premiums that are 14 percent higher for most North Carolina consumers,[4] 11 percent higher for Pennsylvania enrollees,[5] and 14 percent higher for many Tennessee consumers.[6]

Although uncertainty surrounding possible legislative changes to PPACA or replacements for the health law may persist, providing certainty for ongoing CSR subsidy payments is an immediate step that the federal government could take that would contribute to stabilizing the market, promoting affordability, and reducing corresponding federal spending on advance premium tax credits.

Transitional Policies and Market Segmentation

BPC staff urge CMS to study the impact of the agency's longstanding "transitional policy" that allows for the continuation of certain non-PPACA-compliant health insurance products. To the extent feasible, CMS should examine alternative options that would move more enrollees into PPACA-compliant plans, whether inside or outside of the Marketplaces, or develop a process for applying PPACA's risk adjustment mechanism to non-PPACA-compliant plans.

Since November 2013, CMS has allowed for consumers in many states to continuously renew non-grandfathered health insurance policies that do not comply with PPACA's market reform rules, so long as the consumer initially purchased the insurance policy prior to October 1, 2013.[7] State insurance regulators from 36 states elected to allow these non-PPACA-compliant "transitional" insurance products to be offered in their state. Transitional insurance products are likely to still be available in 32 of those 36 states for 2018.[8]

While the transitional policy offered relief to consumers during the challenges in the early years of implementation of PPACA market reform rules (and the troubled initial launch of the HealthCare.gov enrollment portal), the allowance for continuation of these insurance products has resulted in an unfortunate segmentation of the risk pool in many markets.[9] Because the transitional insurance products are not required to provide comprehensive coverage (including essential health benefits) and are allowed to vary premiums based upon the age and health of the enrollee, these insurance policies are more likely to be retained by younger and healthier individuals, which can result in the PPACA-compliant individual market developing a less healthy risk pool. Moreover, the transitional insurance products are not subject to PPACA's risk adjustment program, which could have ameliorated some of the impact of adverse selection resulting from the transitional policy. While more data are needed, it appears that states that elected to opt-out of the transitional policy had smaller rates of individual market premium increases in 2017 on average, as compared to states that allowed for transitional insurance products.[10] However there was wide variation, with some states exhibiting large individual market premium increases despite not allowing the continuation of transitional insurance products.

Research does suggest that PPACA-compliant individual market issuers in states that have no active transitional insurance products tend to exhibit lower average MLRs, have lower average risk scores among enrollees, and show stronger average financial performance, as compared PPACA-compliant individual market issuers in states with a high penetration of transitional insurance products.[11]

The Marketplaces, and the individual market as a whole, could benefit from enrollment from younger and healthier consumers who are currently enrolled in transitional insurance products. CMS should analyze the impact of the continuation of the transitional policy on individual market premiums, publish those results, and, if necessary, develop a regulatory policy for moving transitional insurance product customers into the PPACA-compliant individual market, or explore options for incorporating transitional insurance products into the PPACA risk adjustment program.

Fixing the "Family Glitch"

Consistent with recommendations from 2015, BPC urges CMS to work with the Internal Revenue Service (IRS) and Congress to develop a legislative solution to ensure that a family's eligibility for advance premium tax credit assistance is based upon having a lack of affordable employer-sponsored *family coverage*, rather than hinging premium tax credit eligibility on whether a specific member of the family has access to affordable *single policyholder coverage* through his or her employer. This eligibility conundrum, often referred to as the "family glitch," results in an estimated six million low- and middle-income individuals being ineligible for tax credit-subsidized family coverage.[12]

There is evidence to suggest that eliminating the family glitch could have the effect of strengthening the individual market risk pool, as it would not only increase enrollment among children, but would also increase enrollment of younger adults between ages 19 and 35 in Marketplace coverage[13]—a subpopulation for whom CMS has long-sought to promote Marketplace enrollment.

Under PPACA, taxpayers are eligible for advance premium tax credits for the purchase of Marketplace-based health insurance coverage if, among other criteria, they: (1) have household income under 400 percent of the Federal Poverty Level; and (2) are not eligible for another form of minimum essential coverage offered through another federal program or through their employer, unless the taxpayer's personal contribution to such coverage would exceed 9.69 percent of the

taxpayer's household income.[14] IRS regulations and the agency's statutory interpretation of this provision provides that availability of affordable coverage will be determined based upon whether a taxpayer could obtain single policyholder coverage through his or her employer with an employee contribution of less than 9.69 percent of the taxpayer's household income—regardless of whether the employee contribution for family coverage offered by the employer would greatly exceed 9.69 percent of the taxpayer's household income.[15] In such scenarios, the taxpayer's family members would be ineligible for tax credits to purchase Marketplace coverage, because the taxpayer would be deemed to have access to "affordable" minimum essential coverage—even though only *single policyholder coverage* was affordable.

In addition, PPACA requires that married couples file jointly in order to be eligible for advance premium tax credits, and prohibits premium tax credits from being made available to an individual who is claimed as a dependent by another taxpayer.[16] As a result, a non-working spouse could not file taxes separately from his or her employed spouse (who has access to "affordable" single policyholder coverage) in order to circumvent the "family glitch."

It is likely that a statutory change would be required to address this issue. We encourage CMS and IRS to work with Congress to develop a solution that would not only provide access to health insurance for millions of additional uninsured Americans, but would also help stabilize the individual market.

Again, BPC appreciates the opportunity to provide comments on this request for information. Please do not hesitate to contact us if you have any questions.

Sincerely,

/s/

G. William Hoagland
Senior Vice President

/s/

Katherine Jett Hayes, J.D.
Director of Health Policy

SOURCES

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[14] Internal Revenue Code § 36B(c)(2) [26 U.S.C. § 36B(c)(2), as added by PPACA § 1402.

[15] 26 C.F.R. 1.36B-2(c)(3)(v)

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