Comment on CMS Proposed Rule: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 FR 227 (proposed Jan. 24, 2019)

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Executive Summary

The Affordable Care Act requires issuers of on-exchange Qualified Health Plans to reduce cost-sharing for individuals with incomes between 100% and 250% of the federal poverty level. The law also requires that the Department of Health and Human Services reimburse insurers for these cost-sharing reduction payments (CSRs). However, in October of 2017, the Trump administration announced that it would no longer reimburse insurers’ CSRs in the absence of an express appropriation of funds from Congress. States responded in a variety of ways, but most commonly by Silver Loading, which allows insurers to recoup the unreimbursed payments by “loading” the entirety of the premium increase onto only Silver plans.

In this Comment, we identify a number of considerations CMS should address in future rulemakings pertaining to Silver Loading. We first discuss various state responses to the termination of CSR payments. We recommend that CMS consider how mandating a particular policy may impinge states abilities to address local concerns. We then examine how Silver Loading has preserved consumer choice on the Exchanges by maintaining a marketplace of affordable plan options and protecting enrollees from sharp premium increases. Data suggest that alternative responses may increase premiums and decrease reenrollment by introducing uncertainty into a market that has been stabilized by Silver Loading. Finally, we highlight issues that may arise in the interaction between automatic re-enrollment and Silver Loading.

\(^1\) The authors are all students in the Duke Science Regulation Lab, an interdisciplinary course offered through the Duke University Law and Graduate Schools.
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I. INTRODUCTION

A. Who We Are

The Duke Science Regulation Lab (SciReg Lab)\(^2\) is composed of graduate students from a variety of disciplines at Duke University, including science, law, ethics, and policy. The SciReg Lab was originally inspired by the traditional role of \textit{amicus curiae}: to provide a court with unbiased information necessary to reach a binding decision. As an extension of that concept, we now provide government agencies with the technical and factual information necessary to undertake effective rulemaking.

Modern society requires our government to handle increasingly complex policy issues when deciding cases or engaging in rulemaking. We, the Duke Science Regulation Lab, believe that the general public benefits from judgments that are based on sound data and knowledge. To assist decision makers in understanding the implications of a policy matter at hand, the students of the Science Regulation Lab combine their expertise to offer a non-partisan, accurate, and accessible explanatory brief or comment.

The members of the Duke Science Regulation Lab vary in their academic backgrounds. \textbf{Kelly Hamachi} is a JD candidate who is jointly pursuing an MA in Bioethics and Science Policy; \textbf{John Hamilton} is a JD candidate; and \textbf{Meredith Stewart} is a JD candidate.

B. CMS’s and HHS’s Request for Comments

Center for Medicare & Medicaid Services’ proposed \textit{Notice of Benefit and Payment Parameters for 2020} asks for public input on a variety of subjects, including a change to the

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formula for determining the Affordable Care Act’s premium adjustment factor, several proposed strategies to encourage enrollees to choose generic prescription drugs, coverage of medication assisted treatment for opioid use disorder, and changes to the navigator program. Here, however, we focus only on the ways in which the agency could address Silver Loading in the absence of a congressional appropriation of cost sharing reduction (CSR) payments. We respond to this inquiry by discussing state responses to the termination of CSR payments and by raising a number of issues the agency should consider in future rule makings pertaining to Silver Loading.

II. BACKGROUND

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA), the “most important health care legislation enacted in the United States since the creation of Medicare and Medicaid in 1965.” One of the law’s primary aims was to expand affordable health care coverage to more Americans. An important part of accomplishing this goal was establishing health insurance marketplaces and providing financial assistance to enrollees in the form of advanced premium tax credits (APTCs) and cost sharing reductions (CSRs). APTCs and CSRs work in tandem to make health insurance more affordable for low-income Americans.

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4 Barack Obama, United States Health Care Reform Progress to Date and Next Steps, 316 J. AM. MED. ASSN. 525, 525 (2016).
A. Advanced Premium Tax Credits and Cost Sharing Reductions

1. Advanced Premium Tax Credits (APTCs)

APTCs reduce an enrollee’s premium, which is the fixed amount they pay each month for coverage.\(^6\) To be eligible to receive APTCs, an individual must have a household income between 100–400% of the federal poverty line (FPL).\(^7\) These tax credits are administered by the Internal Revenue Service (IRS) and are either paid directly to the enrollee’s insurance plan each month or are claimed on their income tax returns.\(^8\) In 2017, 8.7 million enrollees comprising 84% of individuals enrolled on the exchanges received APTCs.\(^9\)

Plans on the exchanges are assigned to a metal tier (Bronze, Silver, Gold, or Platinum) based on their actuarial value, which is the standardized percentage of total costs that the insurer pays.\(^10\) The amount of APTCs an individual receives is calculated by subtracting the required premium contribution, which varies by the individual’s income level, from the Essential Health Benefit (EHB) component of the price of the premium for the second-lowest cost Silver plan (the Benchmark Silver).\(^11\) Plans within the same metal tier may differ in premium price, networks, co-pays, etc., but generally, Bronze plans have a higher deductible and a lower premium, while Platinum plans have a lower deductible and a higher premium.\(^12\) Recipients may use their

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\(^7\) 26 U.S.C. § 36B(b)(3)(A)(i). Household income is based off the modified adjusted gross income calculation (MAGI). Individuals who are eligible for Minimum Essential Coverage (e.g. Medicaid, CHIP, Medicare Advantage) are generally ineligible for PTCs. 26 U.S.C. § 36B(d)(2).

\(^8\) *Id.* § 36B.


\(^10\) *Actuarial Value*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/actuarial-value (last visited Feb. 17, 2019). The actuarial values for Bronze, Silver, Gold, and Platinum plans, are 60%, 70%, 80%, and 90% respectively.


APTCs to purchase any plan listed on the exchange but may have to pay more than their required contribution if their plan’s premium is higher than the Benchmark Silver’s. Individuals who choose to purchase a plan that is less expensive than the Benchmark Silver receive a dollar-for-dollar reduction in their personal payments.13

2. Cost Sharing Reduction (CSRs)

In contrast to APTCs, CSRs reduce the out-of-pocket costs of deductibles, copayments, and coinsurance only for qualified individuals enrolled in marketplace Silver plans.14 Individuals qualify to receive CSRs if they purchase a Silver plan on the exchange, have an annual household income between 100–250% of the FPL, and are eligible for APTCs.15 Functionally, these subsidies lower the individual’s out-of-pocket maximum, which is calculated yearly by the Department of Health and Human Services (HHS), and increase the actuarial value (AV) of the purchased Silver plan from a nominal target of 70% (+2%/-4%) to 73%, 87%, or 94% (all +/-1%), depending on the enrollee’s income.16 Native American Indians and Alaska Natives at or below 300% of the FPL are an exception to these parameters – they do not have any cost-sharing if they are enrolled in an on-exchange, individual Qualified Health Plan of any metal tier.17

As of September 2018, approximately 53% of exchange enrollees, or 5.4 million people, received CSRs.18 The ACA requires that insurers provide the CSR price reduction to the enrollee

13 26 U.S.C. § 36B.
15 42 U.S.C. § 18071(c)(2).
16 Id.
17 Id. § 18071(d).
at the time of service, and then insurers are reimbursed later by HHS in the form of CSR payments.¹⁹

B. Termination of CSR Payments

Although Section 1402 of the ACA requires HHS to reimburse insurers’ CSR payments, the law failed to specify their funding source.²⁰ The Obama Administration made the payments by adding CSRs to a list of existing, permanently-appropriated tax credits and refunds.²¹ But in November of 2014, the House of Representatives filed suit against HHS arguing that without an express appropriation by Congress, the CSR payments violated the Constitution’s appropriations clause.²²

In May 2016, Judge Rosemary Collyer of the District Court for the District of Columbia ruled in favor of the House of Representatives, finding that although Congress authorized reduced cost sharing payments in the ACA, it did not appropriate the money for them.²³ She enjoined all further CSR payments in the absence of a valid appropriation but stayed the injunction pending an appeal.²⁴

The Obama Administration appealed the decision in the D.C. Circuit. In October 2017 while the case was pending, the Trump Administration announced that CSR payments were unconstitutional, and that it would no longer make the payments to insurers in the absence of a

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¹⁹ 42 U.S.C. § 18071(c)(3).
²³ See House of Representatives v. Burwell, 185 F.3d at 174–75 (“Paying out Section 1402 reimbursements without an appropriation thus violates the Constitution. Congress authorized reduced cost sharing but did not appropriate monies for it, in the FY 2014 budget or since. Congress is the only source for such an appropriation, and no public money can be spent without one.”). The Obama administration had tried to argue that a CSR appropriation was implied because they were programmatically aligned with APTCs, which were expressly appropriated. Id. at 189.
congressional appropriation. Two months later, the parties signed a settlement agreement that: (1) dismissed the appeal of the injunction barring CSR payments pending in the D.C. Circuit, (2) vacated that injunction, and (3) reserved the parties’ abilities to retain the same positions in future litigation over the same or a similar issue.

As a result, HHS would no longer make CSR payments to insurers, but the ACA still required that the insurers provide CSRs to eligible individuals purchasing insurance plans on the exchanges. Estimates in 2016 suggested that these payments, in the absence of federal funding, would create a $130 billion burden on the insurance companies over the next ten years. Experts worried that insurers would either discontinue offering plans on the exchanges all together or sharply increase premiums for all marketplace plans. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) issued a statement in August 2017 estimating that gross premiums would increase by around 20% in 2018 from the rates in 2016. Furthermore, while those eligible for APTCs would be somewhat protected from the termination of CSR payments and the subsequent premium increases, those over the income eligibility limits for APTCs or CSRs risked being priced out of the exchanges.

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28 Id.
C. State Response to CSR Payment Termination

States responded differently to the Trump administration's decision to terminate CSR payments, but the most popular approach was “Silver Loading.”\(^{31}\) This strategy makes up for the unreimbursed CSR costs by “loading” them onto the premiums of on and off-exchange Silver plans.\(^{32}\) Because APTCs are calculated by taking the difference between the price of the Benchmark Silver premium and the individual’s required premium contribution, an increase in on-exchange Silver plan premiums leads to an increase in APTCs for eligible enrollees. Thus, many enrollees eligible to receive APTCs were able to purchase plans at lower premiums than the previous year.\(^{33}\) Some states also engaged in “Silver Switching,” a subset of Silver Loading, which loads the cost of CSRs only onto on-exchange Silver plans, and not on off-exchange plans.\(^{34}\)

In spring 2018, the CBO and JCT reported that as a result of Silver Loading, “gross premiums for Silver plans offered through the marketplaces [were], on average, about 10 percent higher in 2018 than they would have been if CSRs were funded through a direct payment. The agencies project that amount to grow to roughly 20 percent by 2021.”\(^{35}\) The report also estimated that an appropriation for CSR payments between 2019 and 2021 would decrease total federal

\(^{31}\) See infra, Section III for a more robust discussion about how different states responded.


\(^{33}\) Id.


health care subsidies by $32 billion from 2019 through 2027.\textsuperscript{36} Therefore, with government-funded CSR payments, both APTCs and the pool of eligible recipients would decrease.\textsuperscript{37}

\textbf{D. State Legal Action}

Following the announcement that CSR payments would be terminated, nineteen state Attorneys General and the District of Columbia sued the Trump administration, arguing that CSR payments were essential to the proper functioning of the ACA and that refusing to make them would be unlawful and harmful to the states and their residents.\textsuperscript{38} The states sought a declaration that the ACA “authorizes and compels the Secretaries to make CSR payments . . . without further specific appropriations from Congress,” and a preliminary injunction compelling the Secretaries to make the payments.\textsuperscript{39}

Judge Vince Chhabria of the District Court for the Northern District of California denied the request for a preliminary injunction in October 2017, concluding that the states did not establish a likelihood of success on the merits, and finding no major harm to the public nor to the objectives of health care reform from the termination of CSR payments to insurers.\textsuperscript{40} The case proceeded, but by the summer of 2018, the states no longer wished to reinstate CSR payments. On July 16, the states motioned for a stay of proceedings, or in the alternative, for a dismissal of the case, noting their desire to avoid “disturbing the status quo given the general success of . . .

\begin{flushright}
\textsuperscript{36} \textit{Id.}  \\
\textsuperscript{37} \textit{Id.}  \\
\textsuperscript{38} Complaint at 7, 18, California v. Trump, 267 F. Supp. 3d 1119 (N.D. Cal. 2017) (No. 3:17-cv-05895-VC).  \\
\textsuperscript{39} \textit{Id.} at 23–24.  \\
\textsuperscript{40} See Order Denying Motion for Preliminary Injunction at 10–11, 19–20, California v. Trump, 267 F. Supp. 3d 1119 (N.D. Cal. 2017) (No. 3:17-cv-05895-VC) (“it initially appears the Administration has the stronger legal position.”); (“it appears that because of the measures taken by the states in anticipation of a decision by the Administration to terminate CSR payments, the large majority of people who purchase insurance on the exchanges throughout the country will either benefit or be unharmed”).
\end{flushright}
'Silver loading.' The current threat, the parties wrote, was now the possibility that the federal government would prohibit Silver Loading. Two days later, Judge Chhabria dismissed the lawsuit without prejudice.

E. Insurer Lawsuits

Several insurers also sued the government for reimbursement of the subsidies they had already paid out to marketplace enrollees after the Trump administration's announced it would stop making CSR payments. The first of these cases was decided in September 2018, when the U.S. Court of Federal claims ruled that the Montana Health Co-op was entitled to $5.3 million in unpaid 2017 CSR costs. Although the Government argued that it did not have an obligation to make the payments in the absence of explicitly appropriated the funds, the court nonetheless held that because the ACA obligates the government to reimburse the insurers, they must do so regardless of whether the funds were properly appropriated. Since then, Sanford Health Plan and Maine Community Health Options have also succeeded on similar grounds in the Court of Federal Claims, and numerous other insurer lawsuits are currently pending. Most recently, in Community Health Choice, Inc. v. United States, the Court of Federal Claims held that a Texas non-profit plan could recover unpaid CSR reimbursements for both 2017 ($11,174,299.10) and 2018 (more than 2017’s payment).
F. Subsequent Congressional Action

Following the Trump administration’s decision to stop reimbursing insurers for CSR payments, legislators in both the House and the Senate unsuccessfully attempted to appropriate funding for CSRs. In October 2017, Senator Lamar Alexander (R-TN) and Senator Patty Murray (D-WA) introduced the Bipartisan Health Care Stabilization Act of 2017, which restored CSR payments from 2017–2019 through an express appropriation of funds.\footnote{Bipartisan Healthcare Stabilization Act of 2017, 115\textsuperscript{th} Cong. (2017), https://www.help.senate.gov/imo/media/doc/THE\%20BIPARTISAN\%20HEALTH\%20CARE\%20STABILIZATION\%20ACT\%20OF\%202017-%20TEXT.pdf.} However, this bill failed to make it to a floor vote.\footnote{Murray Not Giving Up on Health Care Stabilization: “I Hope We Can Get Back to the Table and Resume Talks,” S. COMM. HEALTH, EDUC., LAB. & PENSIONS (Mar. 22, 2018), https://www.help.senate.gov/ranking/newsroom/press/murray-not-giving-up-on-health-care-stabilization-i-hope-we-can-get-back-to-the-table-and-resume-talks.} In March 2018, Senator Susan Collins (R-ME) and Senator Alexander introduced a market stabilization package that also included a three year appropriation for CSR payments, but this effort also failed.\footnote{Democrats Block up to 40\% Reduction in Health Insurance Premiums, S. COMM. HEALTH, EDUC., LAB. & PENSIONS (Mar. 23, 2018), https://www.help.senate.gov/chair/newsroom/press/democrats-block-up-to-40-reduction-in-health-insurance-premiums.} That same month, Commerce Committee Chair Frank Pallone Jr. (D-NJ) introduced a bill in the House of Representatives that would expand APTC and CSR eligibility, increase premium tax credits and CSR subsidies, and expressly appropriate money for CSRs, but this bill stalled in committee.\footnote{Undo Sabotage and Expand Affordability of Health Insurance Act, H.R. 5155, 115\textsuperscript{th} Cong. (2018).}

The Administration supports a legislative solution that would appropriate CSRs. In the absence of such an appropriation, however, CMS seeks comment on ways it could address Silver Loading. In this Comment, we propose considerations CMS should take into account in future rulemakings.
III. COMMENTS

A. CMS Should Consider How Mandating a Specific Policy Response to the Termination of CSR Payments Could Impact States’ Abilities to Respond to Local Concerns

The decision to end CSR payments left insurers in a precarious position. Because insurers are legally obligated to provide CSRs to eligible individuals, the termination of CSR payments shifted the cost of CSRs onto insurers. State insurance regulators feared that insurers would leave the ACA marketplace if they were unable to load this cost into plan premiums. To allow insurers to adapt to the financial realities of the CSR payment termination, states allowed or directed insurers to respond to the CSR payment termination in one of five ways:

1. Instruct insurers to make no adjustments to account for CSR payment termination;
2. Instruct insurers to load the cost of CSR onto all QHPs, known as “Broad Loading”;
3. Instruct insurers to load the cost of CSR onto Silver QHPs, known as “Silver Loading”;
4. Instruct insurers to load the cost of CSR only onto Silver QHPs available on-exchange, a subset of Silver Loading known as “Silver Switching”; or
5. Allow insurers to adopt a mixture of these strategies.

The breakdown of state responses is presented in Table 1 below:

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Table 1: State Response to Termination of CSR Payments by Year

<table>
<thead>
<tr>
<th>CSR Response</th>
<th>Number of States Choosing CSR Response for 2018(^{53})</th>
<th>Number of States Choosing CSR Response for 2019(^{54})</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Load</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Broad Load</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Silver Load</td>
<td>37</td>
<td>45(^*)</td>
</tr>
<tr>
<td>Mixed/Unknown Load</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

\(^*\) At least 29 states opted for a Silver Switch strategy in 2019.

1. State Responses to CSR Payment Termination Reflected Local Policy Considerations

States’ decisions regarding how to respond to the termination of CSR payments are driven by both national and local considerations. The economics of insurance markets and the effect of load strategies on APTC inevitability factor into the analysis of all states. However, healthcare and insurance markets are local. Insurance networks are made up of doctors and hospitals within a particular geographic region. Socioeconomic factors and the distribution of subsidized individuals vary from region to region. These regional considerations and insurance regulators’ responses to them can affect QHP enrollment, risk pools, and premiums.\(^{55}\) Such policies are best made at the local and state levels, where regulators are close to the action and


have the best sense of what factors to consider and how to prioritize among these various factors in their particular region.

The structure of the ACA reflects this, using a cooperative federalism model to invite state-led implementation.\(^{56}\) Allowing states to maintain regulatory control over their insurance markets is consistent with longstanding policy in the United States. States have been the primary regulators of insurance since the middle of the 19\(^{th}\) century, and this policy was cemented into law by the McCarran Ferguson Act in 1945.\(^{57}\)

Accordingly, state insurance regulators chose their CSR strategies based on local circumstances and the impact that lack of funding for CSR payments was expected to have on the insurance markets in their state. For example, the District of Columbia opted for a No Load strategy in both 2018 and 2019. This decision was likely motivated by the negligible effect defunding of CSRs has on DC. This is driven by a unique local consideration - only 300 people in DC receive CSR benefits, at a total cost of approximately $150,000 per year.\(^{58}\) Thus, it is possible that the administrative costs of switching to a new strategy would outweigh the minimal costs of sticking with the No Load strategy.

All other states chose to load the cost of CSRs onto QHPs in some way in 2019. While most have opted for Silver Loading, some chose to Broad Load. Again, this decision appears to

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\(^{57}\) 15 U.S.C. §§ 1011-1015. We reference the McCarran Ferguson Act to highlight longstanding policy as to insurance regulation. We take no position on the legality of banning Silver Loading in light of McCarran Ferguson, other than to note that McCarran Ferguson could possibly present a legal obstacle to a Silver Loading ban or other federally mandated response to CSR payment termination.

be driven by state level policy considerations. For example, Mississippi Commissioner of Insurance Mike Chaney stated that Mississippi opted to Broad Load because state regulators think that approach is “more equalized for all consumers,” adding that the state is “trying to be fair to everybody.” Policy concerns have driven most other states to Silver Load. For example, Vermont adopted the No Load strategy for 2018, which appeared to be driven by a concern that a large increase in Silver plan premiums would be unfair to unsubsidized buyers. After enacting legislation allowing insurers to offer “reflective Silver plans” outside of the exchange which would not include a CSR load, the state opted to Silver Load for 2019. Finally, some states took a deregulatory approach, leaving insurers free to adopt whichever strategy they wish. Both Georgia and Texas regulators have taken the approach of allowing insurers to adopt their own strategies.

Accordingly, because states appear to factor local policy considerations into their decision as to how to load CSR payments and Silver Loading is an important tool in the arsenal of state insurance regulators, banning Silver Loading would severely limit states’ policy options in regulating their insurance markets.

60 Charles Gaba, Vermont Officially Jumping on the Silver Switcharoo Train (& Restoring the Mandate as Well), ACASIGNUPS.NET (Mar. 20, 2018), http://acasignups.net/18/03/20/vermont-officially-jumping-silver-switcharoo-train-restoring-mandate-well.
61 An Act Relating to Allowing Silver-level Nonqualified Health Benefit Plans to be Offered Outside the Vermont Health Benefit Exchange, VT Bill No. 88 (2018) (amending 18 V.S.A. §9375(b)).
2. General Trends in Silver Loading’s Effect on State Exchanges

While insurance markets are inherently local, it is possible to track general trends of Silver Loading’s effect on state exchanges. Generally, as Silver Loading drives up premiums for Benchmark Silver plans, the APTC calculated from the Benchmark Silver premiums also increases. Accordingly, states with more CSR utilization will see higher Benchmark Silver premiums, and thus higher APTCs for eligible consumers. To create a standardized measurement of CSR utilization across states, David Anderson has estimated the effect that loading CSR costs onto premiums has on the average actuarial value of the Benchmark Silver plan within a state. We refer to the increase in the average actuarial value caused by the CSR load as a “CSR Bump.” This CSR Bump provides an approximation of the total CSR load within a state, meaning it also approximates the benefit of Silver Loading to consumers receiving APTCs within that state. Very simply, states with larger CSR Bumps benefit more from Silver Loading than states with smaller CSR Bumps.

Various local considerations impact the effect Silver Loading has on individual states. The income levels of individuals in each state significantly affect the total CSR Bump, as income distribution determines the percentage of the population that is eligible for CSRs. Further, members of federally recognized tribes of American Indians and Alaskan Natives with incomes up to 300% FPL are eligible for 100% CSR plans. Thus, states where American Indians or Alaskan Natives represent a larger percentage of the population may see a greater CSR bump.

Finally, the largest factor in determining a state’s CSR bump is whether the state opted for Medicaid expansion. Expanded Medicaid covers individuals with incomes up to 138% of the

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federal poverty line (FPL), leaving only individuals with incomes between 138% and 250% FPL eligible for CSRs in Medicaid expansion states.\(^{64}\) Because individuals with income in this 100% to 133% FPL range receive the largest CSRs, the loss of these individuals from the market means that Medicaid expansion states receive a smaller CSR bump.

Graph 1, below, uses 2018 state enrollment data to show the effects of income distribution and Medicaid expansion on state CSR Bumps:

\(^{64}\) This is compared to individuals with incomes 100% to 250% of the federal poverty line in non-expansion states.
Graph 1:


The state by state nominal CSR bumps were arrived at using the following formula: ((Number of consumers with CSR 94 x .24) + (Number of consumers with CSR 87 x .17) + (Number of consumers with 73 x .03)) / Total number of consumers receiving CSRs.

The multipliers in the numerator reflect the spread between the 70% actuarial value of a Benchmark Silver plan and the actuarial value including CSRs. Thus, 94%-70%=24%; 87%-70%=17%; 73%-70%=3%.
As the graph illustrates, states that opted not to expand Medicaid benefits receive the largest CSR Bump from Silver Loading. The flipside of this trend is that a ban on Silver Loading would have a greater impact on the net premiums of individuals in states that did not expand Medicaid. Because these states have a greater proportion of individuals eligible and likely to enroll in CSR plans, the cost of CSRs spread into Bronze and Gold plans through Broad Loading would be greater than in states that expanded Medicaid.

B. CMS Should Consider How Silver Loading Stabilized the Market and Maintained Consumer Choice in Insurance Plans

With this proposed rule, the Trump Administration stated that it intends to further its goals of “lowering premiums . . . and increasing market stability.” And, that the proposed rule “represents the Trump Administration’s ongoing commitment to improve access to more affordable health coverage options.” CMS should carefully consider the extent to which Silver Loading effectively meets these goals. Beyond being the response of choice of most states to CSR payment termination, there is evidence that Silver Loading helped stabilize the insurance market following CSR payment termination. And, that it allowed many Americans to choose the same or better health insurance at a lower cost.

1. Silver Loading Helped Stabilize the Insurance Market after CSR Payment Termination

Responding in large part to the uncertainty and timing of CSR payment termination, insurers increased insurance premiums drastically for the 2018 plan year. And in a few states,

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67 Id.
insurers left the exchange market altogether. However this was a temporary response. The certainty of and experience with Silver Loading in 2018 enabled insurers to pull back on premium increases in 2019. In fact, in some cases, premiums fell relative to 2018.

Beyond the specific impacts of Silver Loading on the market, CMS should more generally consider the extent to which any constant regulatory change will create uncertainty and volatility in the insurance market. Such uncertainty often leads to increased premiums and varying insurer participation in an industry where “it takes over a year to have sufficient real-world data to gauge the actual effects of changes in a complex market environment.”

2. Silver Loading Maintained Consumer Choice Over Health Insurance

By increasing APTCs for many consumers, Silver Loading allowed enrollees to maintain affordable health insurance and in many cases, it also allowed consumers to enroll in an extremely cost effective plan or one with better coverage. Based on enrollment behavior in the exchanges in 2018, many consumers clearly exercised their ability to choose. On one hand, most exchange consumers in the 100–200% FPL income range chose to remain in the same metal level as their previous year plan, rather than switch to a low or no-cost bronze plan. This is logical, considering that the relatively high CSR eligibilility at this income level means that the

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69 Id.
70 Id. at 5.
71 Id. at 6.
actuarial value (AV) of a Silver plan is higher than an exchange Gold or even Platinum plan, depending on the consumer’s income.\textsuperscript{75} On the other hand, the consumers most likely to switch plan levels were those eligible for little CSR, or no CSR at all, namely those in the 200–400\% FPL income range.\textsuperscript{76} They tended to shift from Silver to Bronze or Gold plans\textsuperscript{77} – choosing whether to decrease cost in Bronze or increase coverage in Gold plans. And, overall enrollment on healthcare.gov in this income range increased by 1.4\% in 2018.\textsuperscript{78} In addition to increasing APTCs in this range due to increased Benchmark Silver plan premiums, some consumers at this income level also became newly subsidy-eligible due to the increase in Silver Benchmark premiums.\textsuperscript{79} The table below shows the increase in overall enrollment in this income level, as well as the shift to bronze and gold plans from Silver plans.

\textbf{Table 2: Enrollment by Metal Level at 300–400\% of Poverty in HealthCare.gov States}\textsuperscript{80}

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Bronze</th>
<th>% Bronze</th>
<th>Total Silver</th>
<th>% Silver</th>
<th>Total Gold</th>
<th>% Gold</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>316,500</td>
<td>40%</td>
<td>409,600</td>
<td>52%</td>
<td>52,500</td>
<td>7%</td>
<td>786,678</td>
</tr>
<tr>
<td>2018</td>
<td>466,000</td>
<td>54%</td>
<td>284,400</td>
<td>33%</td>
<td>116,200</td>
<td>13%</td>
<td>867,198</td>
</tr>
</tbody>
</table>

\textsuperscript{75} Andrew Sprung, \textit{Addled by the metal level}, XPOSTFACTOID (Oct. 5, 2015), https://xpostfactoid.blogspot.com/2015/10/addled-by-metal-level.html.

\textsuperscript{76} Sprung & Anderson, \textit{supra} note 75 (data derived from Centers for Medicare and Medicaid Services State Public Use Files 2017–18, as compiled and reported in the source cited here).

\textsuperscript{77} \textit{Id}.

\textsuperscript{78} \textit{Id}.


\textsuperscript{80} Sprung & Anderson, \textit{supra} note 74.
3. **Silver Switching Protects Unsubsidized Consumers from Premium Increases Due to CSR Payment Termination**

The consumers potentially harmed by any loading strategy are those ineligible for APTCs or CSRs. These unsubsidized consumers bear the full brunt of any increase in premiums. This is clearly a concern. However, under a Silver Switch strategy, CMS\(^{81}\) and states permitted insurers to offer off-exchange plans that mirrored on-exchange plans almost identically, but did not include any premium increase to account for CSR payment termination. In essence, the Silver Switch strategy allowed states to hold unsubsidized consumers harmless for increasing premiums resulting from CSR payment termination. If one of CMS’s concerns regarding the practice of Silver Loading is that unsubsidized consumers will be subject to increased premiums, CMS should consider and determine the extent to which the Silver Switch strategy eliminates or mediates this concern.

C. **Alternative Responses to CSR Payment Termination Pose Budgetary and Coverage Complexities**

1. **Congressional CSR Appropriation**

Before CSR payments were terminated in October 2017, the CBO and JCT estimated that terminating CSR payments would result in a net increase in the federal deficit of $194 billion from 2017 through 2026.\(^{82}\) This increase is due to an increase in the average APTC received by subsidy-eligible consumers based on increased premiums for Benchmark Silver plans, especially those in the 200–400% FPL income range, and an increase in the number of people eligible for

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82 CONG. BUDGET OFFICE, **THE EFFECTS OF TERMINATING PAYMENTS FOR COST SHARING REDUCTIONS 4** (Aug. 2017).
APTCs. The agencies also estimated that increased APTCs for on-marketplace plans could incentivize more people to purchase marketplace plans, and even switch from less-attractive employer plans.

In April 2018, the CBO’s new estimate for “health insurance subsidies and related spending in 2018” was an increase of $10 billion. However, the agency also estimated that from 2019–2028, the average annual growth in spending would decrease from 34 percent in 2018 “to just under 5 percent per year.” Overall, then, “health insurance subsidies and related spending” would total $58 billion in 2018 and increase to $91 billion by 2028. On the other hand, the CBO and JCT estimate that legislating CSR appropriations would result in a net deficit reduction of $32 billion between 2019 and 2027, compared to the alternative of no Congressional appropriation.

While terminating CSR payments has undoubtedly increased the federal deficit, CMS should consider two important points. First, the CBO’s projected federal deficit in fiscal year 2019 is $16.6 trillion. Therefore, even if the entire nine-year increase to the deficit from terminating CSR payments were considered as a whole (instead of over nine years), an increase of $194 billion represents only 1.17% of the current federal deficit.

83 Id.
84 Id.
86 Id.
87 Id.
89 Budget, CONG. BUDGET OFFICE, https://www.cbo.gov/topics/budget
90 This approximation was calculated using the formula: $194 billion/$16.6 trillion
Second, and perhaps most importantly, because the market has already adjusted to CSR payment termination via one of the five strategies previously mentioned, some experts argue that a reinstatement of CSR payments would result in an “increase in premiums or cost sharing for up to 3.3 million moderate-income consumers (up to 36 percent of all HeathCare.gov consumers), in many cases by over $1,000 per year.”91 Specifically, those consumers who benefited from increased APTCs and the resulting reduction of their share of premiums due to CSR payment termination and state responses would find their cost of insurance increased compared to the time period before CSR payment termination. For example, the Center on Budget and Policy Priorities estimates that a typical subsidy-eligible 45-year-old is saving $1,085 in annual premiums on a bronze or gold plan due to CSR payment termination.92 So, while a CSR payment appropriation might save the federal deficit - it does so effectively by removing those dollars from Americans trying to purchase health insurance.

Not surprisingly then, the CBO estimates that appropriating CSR payments against the new baseline of CSR payment termination would mean “fewer people would enroll in—and receive subsidies for—coverage through marketplaces.”93 An appropriation “would [therefore] increase [the number of uninsured Americans] by less than 500,000 in 2019 and by between 500,000 and 1 million in 2020 and 2021,” with the majority being Americans with incomes between 200 and 400% of FPL.94 CMS should therefore consider the effects of increases to the federal deficit in context with the costs and benefits of increasing the cost of health insurance for

91 AVIVA ARON-DINE, CENTER ON BUDGET AND POLICY PRIORITIES, INDIVIDUAL MARKET STABILIZATION PROPOSALS SHOULD AVOID RAISING COSTS FOR CONSUMERS: PROPOSALS SHOULD ALSO ADDRESS GREATEST RISKS TO THE MARKET 2 (2018).
92 Id. at 5.
93 Hall, supra note 88.
94 Id.
middle-income Americans. And, CMS should consider and make clear to what baseline it is comparing the cost of insurance and the number of Americans covered – pre or post-CSR payment termination.

   ii. No Loading

   Barring health insurers from loading the unreimbursed cost of CSR obligations on plan costs in any way would likely make the provision of health insurance financially impossible. As a result, most, if not all, insurers would cease offering non-group insurance plans on the marketplace.

   iii. Broad Loading

   The most likely alternative to Silver Loading and Switching is Broad Loading; however, Broad Loading would negatively impact a significant number of Americans by increasing the cost of insurance coverage. By increasing premiums on plans of all metal levels, Broad Loading spreads the cost of CSR payment termination to all consumers and negates the positive APTC impacts of Silver Loading strategies. As opposed to Silver Loading strategies, fewer consumers could buy low or no-premium Bronze plans, and Gold plans become very expensive. And functionally, Broad Loading results in all exchange healthcare consumers paying for something they are not receiving – higher actuarial value. Calculations by one scholar estimate that approximately 1.8 million enrollees will be disadvantaged if Silver Loading stops. And, for consumers with incomes of 400% FPL or greater, an estimated “6.5 million nonsubsidized ACA

97 Id.
policy enrollees (2.0 million on exchange and 4.5 million off exchange) would have faced the entire rate hike” without Silver Switching strategies.98 These non-subsidized marketplace enrollees will then likely choose to buy a plan off-exchange (where costs have not been Broad-Loaded).99 In other words, Broad Loading “shrinks the market and makes the risk pool sicker.”100 Not surprisingly then, the five states that chose a Broad Loading strategy for 2018 “lost, on average, more enrollment than states that” Silver Loaded or Silver Switched.101

**D. CMS Should Consider the Joint Effect of Silver Loading and Automatic Re-enrollment on Consumers**

The effect of policies regarding CSR loading may be augmented or diminished by policies regarding the process of re-enrolling into a QHP. Because CMS is considering changes to both Silver Loading and automatic re-enrollment, we ask CMS to consider the interaction between these two policies in arriving at a decision for each. We take no position on the proper solution to balancing the automatic re-enrollment policy with Silver Loading, but hope to highlight some potential issues.

We approach the issue of automatic re-enrollment through the lens of behavioral economics.102 Behavioral economics imports lessons from psychology – primarily the effect of cognitive, emotional, cultural and social factors on individuals – into economic analysis in an

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98 *Id.*
99 *Id.*
101 David Anderson et al., *supra* note 96.
102 Behavioral economics has been developed through research from psychologists, economists, lawyers, and other social scientists. It has also been referred to as “behavioral science” or “behavioral law and policy.” CHRISTOPER T. ROBERTSON, I. GLENN COHEN, & HOLLY F. LYNCH, NUDGING HEALTH: HEALTH LAW AND BEHAVIORAL ECONOMICS 24 (2016)
effort to better analyze the economic decisions of individuals.\textsuperscript{103} Essentially, behavioral economics seeks to identify what external factors drive individuals to make decisions.\textsuperscript{104} Behavioral economic theories are derived from psychological research and experimental evidence.\textsuperscript{105}

One possible approach to policymaking is to assume that an individual’s decision to enroll in a QHP reflects a rational analysis of the costs and benefits of all insurance plans available to that individual. This approach would assume that individuals choose between Bronze, Silver, and Gold plans based on an analysis of which plan provides the best balance of AV and premium net of subsidies. However, behavioral economics suggests that this simplifying assumption of rational individual behavior does not comport with reality. Rather, individuals have difficulty independently arriving at optimal choices, as they possess limited willpower and are influenced by externalities such as social norms.\textsuperscript{106}

Behavioral economics posits that the way choices are presented to consumers can correct for otherwise irrational individual decision-making.\textsuperscript{107} The design of this presentation of choices to individuals is referred to as choice architecture.\textsuperscript{108} Choice architecture can channel behavior towards or away from particular outcomes. Accordingly, ostensibly insignificant choices in the design of social programs may actually have a large impact on consumer choice.\textsuperscript{109}

\textsuperscript{104} Id.
\textsuperscript{108} Thaler & Sunstein, supra note 107.
Choice architecture can be used to “nudge” consumers towards socially desirable decisions. Choice architects\(^{110}\) use nudges to indirectly influence the decisions that consumers make. One very strong tool used by choice architects to nudge consumers is the default option. Studies show that when there is a default option, a large number of individuals will stick with the default option whether or not it is value maximizing to them.\(^{111}\) Automatic enrollment is one version of a default option. If an individual is automatically enrolled in a program, he must actively opt-out of that program if he does not desire to be a part of it, rather than needing to opt-in to the program under a regime without automatic enrollment. Automatic enrollment has been shown to drastically increase the proportion of eligible individuals who enroll in a program. For example, a 2001 study found that 401(k) participation in a large U.S. company was significantly higher after the company switched to automatic enrollment with an opt-out option.\(^{112}\)

Accordingly, behavioral economics suggests that we should expect automatic re-enrollment to lead to the maximum number of eligible individuals being enrolled in the marketplace. Automatic re-enrollment also ensures consumers will not accidentally see a gap in coverage due to a failure to re-enroll. However, automatic re-enrollment could also nudge consumers towards a plan that is not value maximizing. The current automatic re-enrollment regime enrolls consumers in the same plan they had the previous year. If a consumer’s old plan is no longer available, CMS regulations direct the consumer to be enrolled in a similar plan,

\(^{110}\) Choice architect is used in behavioral economics to mean someone who is influencing the decisions of consumers through choice architecture. See Thaler & Sunstein, supra note 107.

\(^{111}\) Id. See also, Eric J. Johnson & Daniel Goldstein, Do Defaults Save Lives?, SCIENCE, Vol. 302, 1338 (2003) (using natural and experimental data to examine the impact of policy defaults on the decision to become an organ donor, finding individuals were heavily influenced by the default option).

typically one of the same metal tier level.\textsuperscript{113} Thus, while automatic re-enrollment helps steer the maximum number of individuals towards coverage, it could result in individual consumers re-enrolling in plans that are not best for them. This concern is amplified by Silver Loading. In a Silver Loading state, many individuals who had Silver plans in the previous year will receive more value from a Bronze or Gold plan in 2020.

Various nudging techniques could alleviate this problem. Currently, DC and six states have extended open enrollment periods.\textsuperscript{114} Extending enrollment past the date consumers are automatically re-enrolled or mapped to new plans gives consumers time to verify they are content with the plan they are automatically enrolled into. If extending enrollment is not ideal, the date that consumers are automatically re-enrolled or mapped to new QHPs could be moved earlier in the enrollment period. Both of these enrollment strategies ensure coverage while also providing consumers a time period to internalize the implications of the QHP they are re-enrolled or mapped into. This extra time should help consumers make a value maximizing decision.\textsuperscript{115}

Further, twelve states currently run their own enrollment platforms.\textsuperscript{116} This allows them to nudge consumers towards plans based on the graphical interface of their platforms and the presentation of different plans to consumers, a technique which can be astonishingly powerful.\textsuperscript{117}


\textsuperscript{114} See Louise Norris, \textit{What’s the Deadline to Get Coverage During Obamacare’s Open Enrollment Period?}, HEALTHINSURANCE.ORG (Feb. 15, 2019), https://www.healthinsurance.org/faqs/what-are-the-deadlines-for-obamacares-open-enrollment-period (compiling and analyzing all states enrollment policies).


\textsuperscript{116} \textit{Id.}

\textsuperscript{117} See Peter A. Ubel, David A. Comerford, & Eric Johnson, \textit{Healthcare.gov 3.0 — Behavioral Economics and Insurance Exchanges}, NEW ENG. J. MED., Vol. 372, 695 (2015) (suggesting exchanges should “deemphasize complicated tables of financial information” and proposing that “when the influence of design architecture on choices is unknown, designers should partner with researchers who can run experiments to inform the process”).
CMS could observe this state-level experimentation and gather data in an attempt to administer future guidelines. Additionally, CMS could allow states who administer their own exchanges to continue to make their own decisions as to how to use those exchanges to nudge consumers in their states.

Reassessing how individuals are mapped into replacement QHPs when their former QHP is discontinued could also alleviate some issues that automatic re-enrollment can cause in states that Silver Load. For example, rather than mapping being predisposed to sort consumers into a QHP that is the same metal level as their previous plan, the regulations could direct insurers to derive the value of plans to consumers based on some function of the actuarial value of QHPs compared to the premium of the QHP net of APTCs.118 Consumers could then be mapped into either 1) a new QHP that best matches their former QHP’s AV at the lowest net premium available, or 2) a new QHP that provides the best AV of QHPs offered within a specified standard deviation of their old net premium. Of course, this would require careful planning due to nuances specific to certain classes of individuals. For example, it may be good policy for such mapping regulations to be heavily weighted towards sorting individuals who heavily utilize CSRs into Silver plans. While such mapping would require careful planning, it could ultimately lead to more consumers in QHPs that best suit their needs.

Accordingly, automatic re-enrollment’s interaction with Silver Loading is complicated. Individuals will be affected by automatic re-enrollment based on their particular QHP, whether they receive subsidies, whether their previous plan was discontinued, and whether their state opts

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118 This is conceptually similar to automatically enrolled 401(k) plans use of target-date funds. These target-date funds allocate investments in a way that is meant to best serve the risk sensitives and return needs of potential retirees based on age. See, e.g., Rob Austin, *The Impact of Behavioral Economics on Retirement Plans*, BENEFITS QUARTERLY, Q3, 25 (2013).
for a Silver Loading or Silver Switch strategy. It is unlikely that there is a satisfactory one-size-fits-all solution. While we take no position on the best course of action, we request that CMS consider the issues discussed above.

**IV. Conclusion**

Although the decision to terminate CSR reimbursements introduced uncertainty into the health insurance market, states and insurers were largely able to adjust by adopting strategies like Silver Loading and Switching. Future rulemakings addressing Silver Loading will inevitably implicate states’ abilities to regulate their insurance marketplaces and will also impact enrollee ability to maintain affordable health insurance coverage. Furthermore, any changes made to the automatic re-enrollment process should be considered in light of states’ decisions to Silver Load.

Thank you for considering this submission.