



May 2, 2019

NY State's Comments on the Basic Health Program; Federal Funding Methodology ("Proposed Methodology") for Program Years 2019 and 2020

These comments are submitted without waiver of or prejudice to any of New York's rights or claims to litigation.

HHS's Proposed Methodology violates the Affordable Care Act.

The Proposed Methodology violates the U.S. Department of Health and Human Service's (HHS) statutory and regulatory obligations to reimburse the state at 95% of the Premium Tax Credit ("PTC") and Cost-Sharing Reductions ("CSR") that "would have been provided" to Basic Health Program (BHP) eligible individuals if they had enrolled in Qualified Health Plans ("QHP"), as required by 42 U.S.C. § 18051(d)(3)(A)(i); 42 C.F.R. § 600.605(a)(1)-(2).

The Proposed Methodology results in significantly less funding than New York would have received under the Affordable Care Act (ACA). As a result of the elimination of the CSR-portion of BHP funding, instead of the 95% authorized by Congress, New York's payment would be reduced to 89.5% under this administrative action. If adopted, the Proposed Methodology will result in the loss of approximately \$630 million in federal funds to New York State in 2019 and 2020 by:

- Elimination of the CSR portion of the Federal BHP payment;
- Not allowing states to provide alternative premium rates and instead applying a Premium Adjustment Factor ("PAF") that inappropriately applies data from other states to New York; and
- Introduction of the Metal Tier Selection Factor ("MTSF") to reduce the PTC portion of the BHP payment.

The Proposed Methodology, in conjunction with previous administrative actions on BHP, all of which are inconsistent with statutory intent, violates HHS's obligation to provide 95% of the PTC and CSR that would have been provided to BHP-eligible individuals had they enrolled in QHPs.

New York continues to maintain that its approach of providing alternative premium rates that use New York-specific data results in a more accurate calculation of the PTC subsidy amount that would have been provided to BHP-eligible individuals had silver-loading occurred as it did in states that have not adopted a BHP following HHS's decision to stop paying CSR subsidies to health plans. New York also maintains that the proposed adjustment to the PTC portion of the federal payment is inappropriate, but if such an adjustment is made, New York-specific data should be used as the basis of the adjustment.

The Proposed Methodology violates the Administrative Procedures Act.

The Proposed Methodology violates the Administrative Procedures Act's ("APA") provision that prohibits the retroactive application of rules that are not explicitly clarifying or codifying an existing rule, or the retroactive applicability of which are not contemplated in the underlying statute. The Proposed Methodology for calendar years 2019 and 2020 was published in the Federal Register on April 2, 2019, and at the earliest the Methodology could be finalized by June 2019. If finalized, any changes introduced in the Proposed Methodology that are adopted in the Final Rule should not take effect before calendar year 2021 to give the state sufficient time to make any necessary program changes based on a new Federal Funding methodology.

The Premium Adjustment Factor inappropriately applies data from other states to New York.

New York opposes HHS's method of applying data from other states to compute the Premium Adjustment Factor ("PAF") because:

1. New York's rating rules, actual claims experiences, income distribution, among other factors, differ from other states. As such, it is inappropriate to make an unadjusted application of data from other states to adjust New York's BHP funding. The Proposed Rule fails to detail how HHS accounts for the experiences of other states in estimating the median adjustment for silver-level QHPs nationwide. Such differences were accounted for in the alternative rates New York provided HHS in November 2017 for plan year 2018. In response to the same comment New York provided to the Final Administrative Order, HHS stated that "the level of detail New York suggests would be impractical, if not impossible, given (i) the multitude of state specific factors noted above and (ii) the lack of clarity and transparency in how individual QHP issuers took these factors into account in making any adjustments to the QHP premiums." HHS's response concedes the point that the rates they used to derive the PAF are not adjusted to account for the actual experience in New York. Given that New York is one of two states with a BHP, it does not seem impractical or burdensome to develop an alternative that directly addresses the States' experiences.
2. HHS's proposed methodology is based upon a very small sample of state data and does not include an explanation of how the data are adequate to establish a nationwide median. HHS makes the simplifying assumption that the impact of terminating CSR payments on Silver plan premiums in the limited number of plans in other states who responded to HHS's survey should apply to New York. Consistent with the Final Administrative Order, the Proposed Rule states that the PAF is derived only from a very small pool of silver level QHPs (25.8%) and does not provide information regarding how the states represented by the QHPs that responded to CMS's survey compare to New York and Minnesota with regard to size, income distribution, and rating rules. Relying on a small fraction of issuers' rate adjustments is not sufficient to calculate a "nationwide median adjustment" as provided for in the Proposed Methodology. HHS should provide detailed information on the issuers whose information was considered and why that survey is adequate to establish a nationwide median.

3. HHS’s approach to calculate the PAF selectively accounts for past policy changes through 2018, but fails to account for more recent developments that impact 2019 and 2020 premiums. In the Proposed Rule, HHS proposes to apply the same PAF that it developed for 2018 (1.188) for plan years 2019 and 2020. However, there are several relevant policy changes that are expected to impact rates in 2019 and 2020. The Tax Cuts and Jobs Act zeroed out the Individual Shared Responsibility penalty beginning 2019. CBO estimates that “[a]verage premiums in the nongroup market would increase by about 10% in most years of the decade” as a result of this change.¹ HHS also estimates that the introduction of short-term limited duration plans will increase premiums by 1% in 2019, 3% in 2020, and 5% thereafter.² If HHS proceeds with the PAF for 2019 and 2020, it should be revised to more accurately represent the impact these major policy changes have on premiums.

New York should be provided the opportunity to produce alternative rates, and an accompanying methodology for HHS’ review, for 2019 and 2020. Notwithstanding, if HHS chooses to proceed, they must disclose their detailed methodology for applying data from other states to New York. HHS’s attempt to rectify its elimination of the CSR portion of BHP payments by adopting the PAF effectively reduces this part of the payment by 50%.

The Metal Tier Selection Factor inappropriately applies data from other states.

The Proposed Rule introduces a new factor, the Metal Tier Selection Factor (“MTSF”), to account for QHP enrollees with incomes below 200% of FPL who do not use their full tax credit when they select Bronze plans because the full Bronze premium is less than the consumers’ PTC amount. New York opposes the Proposed MTSF derived from data from other states because:

1. The experience of other states’ low-income populations enrolling in Bronze QHPs is not reflective of New York’s experience. In 2015, prior to the implementation of the BHP in New York, fewer than one thousand QHP enrollees (less than 1%) with incomes below 200% of FPL who were eligible for APTC and CSR, chose a Bronze plan with a premium less than the maximum PTC amount for which they were eligible. Among those enrollees with a \$0 Bronze premium after accounting for premium tax credits, the median value of the PTC they gave up was \$12/month. The proposal to reduce the PTC portion of New York’s BHP funding by 3% (nearly \$300 million over two years) for a population that represents less than 1% of the relevant population grossly overcorrects for a practice that is not as common as HHS claims and did not save HHS an amount even close to what it is attempting to strip from New York in BHP funding.

¹ Congressional Budget Office (CBO). “Repealing the Individual Health Insurance Mandate: An Updated Estimate” (November 2017). <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf>

² Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services. “Short-Term, Limited-Duration Insurance” (August 2018). 83 FR 38212 <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance>

2. It is inaccurate to use data from other states with age rating to compute an adjustment for a state that has pure community rating. HHS fails to take into account the impact of age rating on the distribution of Bronze plan enrollment in other states. In its computation of the MTSF, HHS subtracts the ratio of average PTC of Bronze plan enrollees to the average PTC of Silver plan enrollees from one, assuming that applying this factor will effectively capture how much the Federal government saves when individuals select \$0 premium Bronze plans because the populations who select Bronze and Silver plans are the same. HHS's own data, however, critically reveals that those selecting Bronze are significantly younger.³ Unlike other states, New York does not permit age rating, so in other states there is a strong financial inducement for younger individuals to select Bronze plans because their premiums are lower. Lower premiums mean that average tax credits would also be lower for those choosing Bronze, even without \$0 premium Bronze plans. The Proposed Methodology does not separate the difference in tax credits due to differences in age distribution from differences due to \$0 premium Bronze plans, thus overstating the MTSF for New York.
3. The ACA explicitly prohibits BHPs from offering Bronze level coverage to its enrollees, yet is the basis for HHS' proposed adjustment. The ACA requires states operating a BHP to charge enrollees no more than the premium they would have paid for the second-lowest cost Silver plan and cost-sharing must be equivalent to a Platinum plan for individuals with incomes less than 150% of FPL, and to a Gold plan for individuals with incomes from 150 to 200% of FPL. Consistent with the statute and the implementing regulations HHS released, BHP enrollees cannot select lower value, Bronze level coverage which would position them to forfeit part of their PTC. HHS proposes to reduce New York's BHP funding on the basis of a phenomenon that is explicitly prohibited in BHPs under the ACA.
4. New York has made a concerted effort to educate consumers about their plan choices, including considerations of out-of-pocket costs. This includes helping consumers who are eligible for APTC and CSR understand the tradeoffs of selecting any metal level other than Silver. This is reflected in the very low share, less than 1%, of New Yorkers with incomes below 200% of FPL who chose a \$0 Bronze plan over Silver plans in 2015, prior to BHP implementation.

For these reasons, the MTSF should be removed from the Proposed BHP Federal Funding Methodology. If HHS chooses to adopt the MTSF in the Final Federal Funding Methodology for the BHP, the computation of the MTSF should be based on New York's experience before the implementation of BHP, and adjusted based on IRS data that contains the share of QHP enrollees with incomes below 200% of FPL who do not claim their full PTC amount. Finally, because the APA prohibits retroactive rule making, the factor should only be applied beginning calendar year 2021.

³Centers for Medicare & Medicaid Services. "2019 Marketplace Open Enrollment Period Public Use Files" (March 2019). https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.html