African Services Committee ☙ Actors Fund ☙ Children's Defense Fund-New York
Community Service Society of New York ☙ Consumers Union ☙ Empire Justice Center
Make the Road New York ☙ Medicare Rights Center ☙ Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition ☙ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices-New York ☙ Schuyler Center for Analysis and Advocacy ☙ Young Invincibles

May 1, 2019

VIA ELECTRONIC SUBMISSION

Seema Varma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2407-PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Comments in Response to Proposed Rulemaking: Basic Health Program; Federal Funding Methodology for Program Years 2019 and 2020 (Docket No. CMS-2407-PN)

Health Care for All New York (HCFANY) respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) in response to the Notice of Proposed Rulemaking posted on April 2, 2019. HCFANY is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers. We strive to bring consumer voices to policy conversations, ensuring that real New Yorkers' concerns are heard and reflected. Our Steering Committee members have expertise in all aspects of health coverage, including groups focused on the needs of immigrants, children, young adults, the elderly, people with disabilities, women, and people who are self-employed.

The Basic Health Program (BHP), which operates as the Essential Plan in New York, provides coverage to almost 800,000 New Yorkers in every county of the state.[1] The program covers working New Yorkers who are not eligible for Medicaid but who cannot easily afford private market plans and whose employers do not offer affordable coverage.[2] For an individual the upper income cutoff is about $25,000; for a family of four it is about $50,000.[3] New Yorkers could first enroll in the BHP for 2016; the program has increased enrollment every year since.

[1] NY State of Health, "Number of Enrollees, By Program and County", 2019, available at https://info.nystateofhealth.ny.gov/news/press-release-ny-state-health-announces-2019-enrollment-increases-all-counties-new-york-state.
[2] 42 U.C.S. § 18051(e)(1)(B and C)
[3] NY State of Health, Fast Facts on the Essential Plan, available here: https://info.nystateofhealth.ny.gov/sites/default/files/Essential%20Plan%20Fact%20Sheet_1.pdf.

It is clear that the Basic Health Program contributed to a precipitous decline in the number of uninsured New Yorkers, despite having a large immigrant population that is ineligible for public programs and is not allowed to purchase their own health coverage through the Marketplace. New York has cut its overall number of uninsured people in half since implementing the Affordable Care Act. That drop has continued even as other states saw the number of uninsured increase in recent years. Only four states saw statistically significant decreases in the uninsured rate between 2016 and 2017 – California, Louisiana, Michigan, and New York.[4] Of those states New York had the second biggest decrease in the uninsured rate, second only to Louisiana which was in its first year of Medicaid expansion. This is not only due to the BHP providing another affordable option but due to the "welcome-mat" effect – the BHP is part of a smooth enrollment process that offers many options and so encourages people to enroll in other programs as well.[5] The BHP provides a bridge between public coverage and Marketplace coverage which makes obtaining health insurance feel seamless. New York's welcome mat not only provides options for people eligible for public coverage, it encourages others to purchase private plans – one of the reasons New York saw the second highest increase in qualified health plans enrollment in the country in 2019 (at a time when most states saw declines).[6]

Funding for the program was set at "95 percent of the premium tax credits under section 36B of the Internal Revenue Code of 1986 [26 USCS § 36B], and the cost-sharing reductions under section 1402 [42 UCSC § 18071], that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State" if they had been allowed to enroll in qualified health plans instead of the Basic Health Program.[7] Public health plans cost less per enrollee than private health plans, and so the state has insured many more New Yorkers using the 95 percent funding for a public program than it would have achieved if individuals had received 100 percent of the funding to buy private plans.[8] This efficiency was one of the motivations behind New York's pursuit of the Basic Health Program option.[9] People who are

[4] Laura Skopec, "Losses of Private Non-Group Health Insurance a Key Driver Behind 2017 Increase in Uninsurance," September 2018, available at https://www.urban.org/sites/default/files/publication/99059/losses_of_private_non-group_health_insurance_a_key_5.pdf.

[5] Benjamin Sommers, Robert Blendon, and E. John Orav, "Both the 'Private Option' and Traditional Medicaid Expansion Improved Access to Care for Low-Income Adults," Health Affairs, Vol. 35 (1), January 2016, https://doi.org/10.1377/hlthaff.2015.0917.

[6] Data provided by The Henry J. Kaiser Family Foundation in "Marketplace Enrollment, 2014-2019," available at https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[7] 42 U.C.S. § 18051(d)(3)(Ai)

[8] John Holahan and Stacey McMorrow, "Slow Growth in Medicare and Medicaid Spending per Enrollee Has Implications for Policy Debates," February 2019, Urban Institute, https://www.rwjf.org/en/library/research/2019/02/slow-growth-in-medicare-and-medicaid-spending-per-enrollee.html.

[9] Elisabeth Benjamin and Arianne Slagle, "Bridging the Gap: Exploring the Basic Health Insurance Option for New York," June 2011, available at https://www.health.ny.gov/health_care/medicaid/redesign/basic_health_program_workgroup/docs/css_policy_brief.pdf

eligible for the BHP are not allowed to purchase plans in the Marketplaces set up through the Affordable Care Act, and so the program is their only source of health coverage.[10]

The proposed rule creates a metal tier selection factor that would result in an estimated $300 million cut in BHP funding for New York and Minnesota, the only states that created Basic Health Programs.[11] Most of this funding cut would likely fall on New York because of the much larger size of our program. The change would retroactively alter funding for the current plan year. HCFANY asks that CMS withdraw the proposed changes and continue to use the BHP formula that was created by previous regulations and follows the requirements of the original statute.

I. The funding decrease is based on an increase in the number of people enrolling in Bronze plans outside of New York State. However, data from those states is an inappropriate way to estimate the behavior of New Yorkers.

The proposed rule states that Marketplace shoppers have changed their behavior substantially since the Administration stopped paying for cost-sharing reductions (CSRs). Plans subsequently chose to "silver-load," that is recoup the cost of the CSR payments they would no longer receive by raising silver-level premiums. High silver-level premiums means higher tax credit values, and CMS asserts that more people would now select Bronze-level plans because the tax credits would be more likely to completely cover Bronze-level premiums. The proposed rule states that it is no longer appropriate to calculate BHP funding under the assumption that 100 percent of enrollees would select a silver plan given the newly increased number of people enrolling in Bronze plans. CMS estimates that factoring in the number of people choosing Bronze plans would result in a 3 percent decrease in BHP rates, leading to a large $300 million cut.

There are two reasons why New Yorkers would shy away from Bronze plans even in a world in which New York's plans silver-loaded. First, New York has robust consumer assistance programs that educate people on the trade-offs between premiums and deductibles. Most of the people who buy plans on New York's Marketplace or who enroll in the BHP use in-person assistors to do so.[12] Second, New York offers a user-friendly Marketplace that allows people to easily compare the trade-offs and financial assistance associated with different metal levels. It is true that in the absence of complete information, many people choose plans based on premium levels without understanding that the lowest premiums mean higher financial risks.[13] However, when consumers are provided with estimates of total cost spending, as many New Yorkers are by their in-person assistor, they choose differently. New Yorkers are sensitive to having a higher

[10] 42 U.C.S. § 18051(e)(2)
[11] Robert King, "Health program proposal may cause New York, Minnesota to lose millions," Modern Healthcare, March 29, 2019, https://www.modernhealthcare.com/government/health-program-proposal-may-cause-new-york-minnesota-lose-millions.
[12] NY State of Health, "2018 Open Enrollment Report," page 6, available at: https://info.nystateofhealth.ny.gov/2018openenrollmentreport
[13] Andrew J. Barnes et al., "Moving Beyond Blind Men and Elephants: Providing Total Estimated Annual Costs Improves Health Insurance Decision Making," Medical Care Research and Review, September 12, 2016, Volume 74:5 (625-635), https://doi.org/10.1177/1077558716669210.

deductible, and because they have so many chances to be educated on the meaning of Bronze versus Silver they have historically chosen Silver-level plans.

CMS may see different results in the non-BHP states that it uses to estimate the number of people enrolling in Bronze plans. However, those results are not useful for estimating the number of people in New York who would do so. Actual data on the likelihood of New Yorkers who earn below 200 percent of the federal poverty level choosing Bronze plans shows that it is a vanishingly small number. New York implemented the BHP two years after its Marketplace began enrolling people and so it has two years of data to show how New Yorkers behaved in the absence of a BHP. Out of 115,000 people earning below 200 percent of the federal poverty level, only about a thousand chose a Bronze plan.[14] That is less than one percent. The median amount of premium tax credits consumers gave up by choosing Bronze plans was only $12, which means that the total difference in funding would be only $12,000. If fewer than one percent of New Yorkers can be expected to choose a Bronze plan, there should be no significant difference in total funding after applying the metal-tier selection factor.

II. Metal-selection is not one of the allowable funding criteria included in the statute creating the BHP.

In the proposed rule, CMS states that "Section 1331(d)(3)(A)(ii) of the Affordable Care Act specifies that the payment determination shall take into account all relevant factors necessary to determine the value of the PTCs and CSRs that would have been provided to eligible individuals, *including but not limited to*" age, income, geographic region, individual or family-only enrollment, health status, and reinsurance payments.[15] However, the statute says "the Secretary shall make the determination under clause (i) on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals described in clause (i), *including* the age and income…." and then continuing to list the same factors.[16] It is not clear whether or not Congress intended that list of factors to contain the entire universe of possible factors. If that list of factors does contain all allowable factors, it precludes CMS from using the metal-tier selection factor.

III. CMS does not have the legal authority to eliminating the cost-sharing reduction portion of the BHP funding formula.

The statute creating the BHP clearly states that the federal government will provide 95 percent of what individual enrollees would have received through both premium tax credits and cost-sharing reductions.[17] CMS asserts that it can remove the CSR portion of the formula because of Congress' failure to appropriate funding for CSR payments. However, eligible individuals still receive cost-sharing reductions, even if the federal government fails to pay insurers for that mandated benefit. The amount the federal government is spending on CSRs is

[14] Data provided by New York State.
[15] Federal Register, Vol. 84, No. 63, Tuesday, April 2, 2019, p. 12554.
[16] 42 U.C.S. § 18051(d)(3)(Ai)
[17] 42 U.C.S. § 18051(d)(3)(Ai)

zero – but eligible individuals are receiving CSR benefits as though there was no change. The Administration does not have the authority to eliminate the value of the CSRs provided to eligible individuals from the BHP funding calculation – such a change must be accomplished through statute.

Further, courts have found that the federal government does owe insurers the CSR payments.[18] The assertion that the value of the CSRs is $0 is not a settled matter.

IV. CMS does not have the legal authority to retroactively cut Basic Health Program funding.

The proposed rule was released in April 2019 and would affect program funding for calendar years 2019 and 2020. This is not in accordance with CMS' requirements, which are that the proposed rule be published in October in the calendar year two years prior to the program year that would be effected, and that the final rule be published in February one calendar year prior to the effected program year.[19] This rule was released three months after the program year started. CMS is allowed to make retroactive funding changes in the event of a mathematical error in its original calculations or to adjust for actual enrollment. Neither of those factors are applicable.

As discussed in the proposed rule, New York would be limited in its response to this funding loss to coming up with new revenue to cover current enrollees or by cutting many enrollees from the program. New York's budget is done for 2020, and its contracts with the plans that administer the BHP are underway. CMS should not move forward with such a disruptive change knowing that states will likely be forced to take away health coverage from low-income people with no other options. This rule should have been proposed in October 2017 if CMS wanted it to take effect this year – since it was not, CMS should change the timeline so that the final rule would not take effect until at least 2021.

Thank you for your attention to these comments. Please do not hesitate to contact me with any questions you might have about our position.

Sincerely,

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Community Service Society of New York on behalf of Health Care For All New York

[18] Katie Keith, "More Insurers Win Lawsuits Seeking Cost-Sharing Reduction Payments," *Health Affairs*, February 17, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190217.755658/full/.
[19] 42 C.F.R. 600.610.