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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF THE ADMINISTRATOR

Confidential Pre-Decisional and Deliberative Materials

TO: Secretary Azar, Department of Health and Human Services

FROM: Seema Verma, Administrator
Centers for Medicare & Medicaid Services

DATE: August 29, 2018

SUBJECT: Key 2020 Payment Notice Issues: Redacted, Non-Responsive
Redacted, Non-Responsive

SUMMARY

Redacted, Non-Responsive

Redacted, Non-Responsive In addition to digesting known policy changes, including cessation of cost-sharing reduction (CSR) payments and elimination of the individual mandate penalty, there is continued litigation uncertainty regarding the outcome of

Texas v. Azar and the final resolution to the New Mexico risk adjustment lawsuit. If additional sources of uncertainty are added to the 2020 pricing mix, issuers will have a difficult time pricing and could take a very conservative approach if theydecide to stay. This is especially true of smaller regional plans with limited surplus.

Redacted, Non-Responsive

The below timeline illustrates the number of new policies and sources of uncertainty currently being assimilated by the market and those under consideration for the 2020 Payment Notice; Redacted, Non-Responsive

Redacted, Non-Responsive

2017	2018	2019	2020	2021
Redacted, Non-Responsive				
Texas v. Azar[1]				
Redacted, Non-Responsive				

[1] Expect lower court decision by EOY, but likely will be appealed/stayed

Redacted, Non-Responsive

Below, we offer considerations and attempt to estimate the impact of each specific issue on premiums and coverage. If all three policies under consideration -- a ban on silver loading, ending auto re-enrollment, and indexing growth in enrollee premiums to Exchange premium growth on a retroactive basis -- were promulgated for the 2020 plan year, OACT estimates that Exchange enrollment would decline by 1.1 million individuals, or approximately 10%, in 2020. Longer-term impacts of the policies are indicated in Table 1 below.

Table 1: Estimated Impact of Changing Premium Indexing, Requiring Plans To Load CSR Payments Across All Metal Tiers, and Ending Auto-Reenrollment Policies

Calendar Year	2020	2021	2022	2023	2024	2025	2026	2027	2028	
Enrollment Impact [millions]										
Premium Indexing Option 2A	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	
Silver-Loading	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	
Auto-Enrollment	-0.2	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	
Interaction	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Total Impact	-1.05	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	
Fiscal Year	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-28
Premium Tax Credit Impact [$billions]										
Premium Indexing Option 2A	-8.7	-9.2	-9.7	-10.2	-10.7	-11.3	-11.8	-12.5	-13.1	-97.1
Silver-Loading	-4.3	-4.6	-4.8	-5.1	-5.3	-5.6	-5.9	-6.2	-6.5	-48.3
Auto-Enrollment	-0.8	-0.6	-0.6	-0.6	-0.7	-0.7	-0.8	-0.8	-0.8	-6.4
Interaction	0.9	0.9	0.9	1.0	1.0	1.1	1.1	1.2	1.2	9.1
Total Impact	-12.9	-13.5	-14.2	-14.9	-15.7	-16.5	-17.4	-18.3	-19.3	-142.7

Note: Premium indexing option 2A would use Exchange premiums for premium growth measure beginning in 2018. Source: OACT.

Some have argued that implementing these policies will migrate consumers away from ACA-compliant plans into alternative options such as short-term, limited duration insurance (STLDI) and association health plans (AHPs). While these forms of coverage should be available and provide a vital alternative for millions of Americans who have been priced out of the ACA-compliant market, we believe this argument is ill-advised for the following reasons: 1) the risk of disruption in the individual market resulting from these polices could be substantial, potentially resulting in bare counties or states with no subsidized coverage available in 2019 and future plan years; 2) it will take some time for the short-term and association health plan markets to fully develop on the scale necessary to provide a smooth transition for consumers to new forms of coverage; 3) STLDI and AHPs may not be a viable option for unsubsidized enrollees with pre-existing conditions who cannot undergo underwriting.

In summary, we recommend not moving forward with changes to any of the first three policies for the 2020 payment year, and we recommend implementing a national drug standard starting with 2021. Underlying this recommendation is our view that the first three issues under consideration will disproportionately impact unsubsidized enrollees; undermine the limited progress made thus far in stabilizing the market; and set back the Administration's priorities of devolving power to states, increasing affordability, and expanding consumer choice in health insurance coverage. Furthermore, policy stability is needed for states and issuers to take advantage of new options for restructuring their markets using expanded flexibility under 1332 waivers and other waiver authorities.

POLICY #1: LOADING OF PREMIUMS FOR LOSS OF COST SHARING REDUCTIONS

Overview

Following the cessation of CSR payments in October 2017, many state departments of insurance (DOIs) permitted or instructed their issuers to increase rates for their silver metal level qualified health plans (QHPs)[1] for the 2018 benefit year in order to account for uncompensated liability for cost-sharing reductions since CSRs are generally only provided to enrollees in silver plans offered through the Exchange.[2] (This practice has been referred to as "silver loading.") CMS did not provide affirmative guidance, but instead, consistent with the Administration's view of states as the primary regulators of premium rates and issuer solvency, deferred to states to determine how the absence of CSR payments should be accounted for in rate setting.

In most states, DOIs provided their issuers with guidance on how to file their rates and what specific assumptions they should make regarding CSR payments, either by including the CSR load on silver plans only, or by spreading the load across all metal level plans. Other DOIs let their issuers decide how to file, while in a few cases DOIs instructed issuers to assume CSRs would be paid (see Appendix A). For the states where CMS directly enforces provisions of the PPACA, the Administration accepted either loading approach for the 2019 plan year.

Considerations

CMS considered two options for the issue of CSR loading for the 2020 plan year: 1) continue to defer to states on the approach issuers should take for loading CSR costs that are no longer being reimbursed by the federal government, which will result in silver loading in the majority of States; or 2) require that issuers load CSR costs onto QHPs of all metal levels. Below are key considerations for this decision:

- **State authority and flexibility.** Federal regulation of CSR loading runs counter to the Administration's priority of returning state authority and recognizing state expertise in regulating their own insurance markets by intervening in rate-setting, a traditional state area of authority. In response to perceived overstepping of their authority, states may file lawsuits against HHS or pursue waivers to get around the nonpayment of CSRs, as Massachusetts did in 2017.[3] In addition, federal regulation of rates reduces states' flexibility to manage their markets, and could be used as a justification for the federal government taking an "active purchaser" role in the market, essentially placing future federal price controls on issuers.

- **Lower federal spending but substantial premium increases for consumers.** Requiring redistribution of the load across all metal levels rather than silver loading could save the federal government up to $4.3 billion in PTCs in 2020 due to lower gross premiums on silver plans, according to OACT estimates. However, this approach would create dramatic increases in premiums for platinum, gold, and bronze plan enrollees, forcing those enrollees to subsidize silver plan CSR benefits they do not receive. OACT has estimated that requiring issuers to load

[1] Qualified health plans are plans that have been certified to be offered through an Exchange. Due to rules around guaranteed availability, issuers must also offer QHPs off-Exchange.

[2] The Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended (PPACA) require health insurance issuers to provide certain enrollees with cost-sharing reductions regardless of whether federal payments are made. CSRs are provided only for on-Exchange silver metal level plans.

[3] In 2017, Massachusetts submitted a waiver to waive acceptance of cost-sharing reduction (CSR) payments and instead establish a Premium Stabilization Fund (PSF) to stabilize premiums via direct issuer reimbursement. Essentially the waiver got around the issue of CSR payment not being paid. Though the waiver met all statutory guardrails, it was not approved because it was submitted too late.

CSRs across all metal levels would increase premiums for non-silver plans by 11%, while reducing premiums for silver plans by 5% for the 2020 plan year (see Table 2). The impact to premiums will vary significantly by state. For example, New York will see minimal impact (silver plan premiums would decrease 1% while other metal tiers would increase 1%) due to its Basic Health Program, which removes the CSR-eligible population from the market. In contrast, unsubsidized enrollees in non-Medicaid expansion states with large CSR-eligible populations would see significant premium impacts. Texas would see silver plan premiums decrease 9%, while other metal tiers would see premiums increase 20% in addition to medical trend. Florida's unsubsidized consumers would be hit particularly hard, as silver plan premiums would decrease about 6% while other metal tier premiums would increase an additional 25% beyond trend.

- **Impact on unsubsidized consumers.** As discussed above, requiring the load to be spread across all metal levels would impact unsubsidized consumers who would either be required to subsidize CSRs for low-income consumers or seek off-Exchange "unloaded" coverage. Based on the experience of several states in 2018 with unsubsidized silver plan enrollees, a significant number of unsubsidized enrollees in gold, bronze, and platinum plans will either pay the increased premium or drop coverage altogether and will not find their way to the unloaded off-Exchange coverage—assuming such coverage is even legal and available in the enrollee's service area. A small number of states do not have an off-Exchange market, do not permit individual market coverage to be offered off-Exchange, or have merged markets in which small group consumers would also be impacted by the broad loading (Vermont, the District of Columbia, Washington, Massachusetts, and North Dakota). For 2018, there are 96 rating areas across 14 states where no off-Exchange only plan is available, representing 10.8% of individual market enrollment nationally.

- **Potential for market disruption.** Changing the rules for loading of CSRs could cause significant disruption for 2020 as declines in silver benchmark premiums could also result in meaningful premium increases for a large number of subsidized consumers compared to 2019. This could cause sizable shifts in enrollment from plan to plan and potentially issuer to issuer, as well as confusion for consumers who need to buy down or switch plans again. This effect will be magnified in states with high percentages of subsidized enrollees. Some issuers may elect to withdraw from the market rather than risk mispricing due to expected disruption.

Table 2: Estimated Impact of Requiring Plans To Load CSR Payments Across All Metal Tiers

Calendar Year	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-28
Enrollment Impact (Exchange only)		-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.4	
Premium Rates in Silver-Loaded States											
Silver Premium Impact		-5%	-5%	-5%	-5%	-5%	-5%	-5%	-5%	-5%	
Other Metal Premium Impact		11%	11%	11%	11%	11%	11%	11%	11%	11%	
Federal Impact											
Premium Tax Credits		-$4.3	-$4.6	-$4.8	-$5.1	-$5.3	-$5.6	-$5.9	-$6.2	-$6.5	-$48.3
Fiscal Year	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-28
Federal Impact											
Premium Tax Credits		-$3.2	-$4.5	-$4.7	-$5.0	-$5.3	-$5.5	-$5.8	-$6.1	-$6.4	-$46.6

Source: OACT

Operational Considerations

In anticipation of a potential decision to require CSR loading across all metal levels, we explored legal and operational avenues to mitigate the impact on unsubsidized consumers, primarily by offering access to unloaded plans through the Exchange. This would provide relief to unsubsidized enrollees by connecting them non-mirrored, unloaded plans. The IT build for this effort would be quite challenging and expensive, but possible with enough lead time. However, there are significant legal challenges in allowing a plan that is not a qualified health plan (QHP) to be sold via the Exchange.[4] Thus far, OGC has only been able to identify one path to allow such plans to be offered through an Exchange, which is for interested states to apply and receive approval for a section 1332 waiver to offer non-QHPs on the Exchange. If approved, the state would be responsible for the cost of federal IT changes as part of a 1332 waiver or operate a state-based exchange platform, creating a further barrier for states seeking such waivers.

Recommendation

In light of the impact on unsubsidized enrollees and the potential of creating a precedent for federal price controls, we recommend no federal regulation of CSR loading for the 2020 plan year. While this option would result in higher federal PTC spending in 2020, it is most consistent with the Administration's priority of returning authority to states, avoids further market disruption, and protects unsubsidized consumers from further substantial premium increases as well as confusion over plan selection and benefit designs.

POLICY #2: ANNUAL REDETERMINATION AND AUTOMATIC RE-ENROLLMENT

Overview

Since its inception, the Federally-facilitated Exchange (FFE)[5] has maintained a re-enrollment process allowing current enrollees who are satisfied with their current plan and that have no eligibility changes to have their enrollment continued for the upcoming plan year without taking further action. This process is consistent with other parts of the private health insurance market, including the employer market, the off-Exchange individual market, the Federal Employees Health Benefit Program, Medicare Advantage, and all State-based Exchanges (SBE). The FFE approach was defined to be consistent with the this precedent, but also to promote continuity of coverage, support a stable risk pool, and limit administrative burden for enrollees, issuers, and Exchanges. Specifically, the annual redetermination and auto re-enrollment process helps ensure that consumers who have minimal medical needs and are thus the least motivated to make an active plan selection every year stay enrolled in coverage and, if eligible, retain their premium tax credit based on the latest verified income information available to the Exchange.[6]

For plan year 2018, 75 percent of re-enrollment plan selections in the FFE were as a result of active selection. Consumers in the auto re-enrollment population were less likely to have APTC than active re-enrollees.

[4] Section 1311(d)(2)(B)(i) of the PPACA prohibits Exchanges from making available any health plan that is not a QHP.

[5] Includes the FFE and SBEs leveraging the federal eligibility and enrollment platform.

[6] The FFE's approach is also similar to the 'ex parte' redetermination process for Medicaid and CHIP, which is required under longstanding Medicaid policy. Under the Medicaid approach, states first attempt to redetermine consumer eligibility based on available data, without requiring action by the consumer.

In general, CMS regulations require that enrollees be renewed into their same plan or product of the same or similar metal level, to ensure that the crosswalked plan provides similar deductibles and maximum out-of-pocket spending limits. (See Appendix C for a more detailed explanation of the crosswalk hierarchy.) Starting with re-enrollment for plan year 2017, CMS worked with states to establish crosswalk plans, often referred to as "alternate plans" or "alternate enrollments," for consumers whose current-year issuer would no longer offer a product in the consumer's geographic area for the upcoming year, to assist those consumers by providing them a suggested alternative plan most similar to their previous plan. This approach is conceptually consistent with how many employers handle situations in which there is a carrier change for a new benefit year. To be clear, any consumer enrolling with a new issuer must pay any initial premium amount owed before coverage is effective; in this sense, the cross-issuer process is more of a "suggested alternative plan" for shopping purposes, and a safety net for current enrollees who do not make a plan selection on or before the deadline for January 1 coverage.

Considerations

CMS considered several potential changes to the auto re-enrollment policy and process for 2020. In addition to maintaining the current policies or completely ending auto re-enrollment, we looked at several intermediate options, including modifying the suggested alternative plan process referenced above, removing APTC for enrollees who were previously auto re-enrolled and have not updated their data when tax data indicates income under 100% FPL, or lowering the threshold for checking tax data for redetermination from five to three years. Key considerations in evaluating these options are below:

- **Existing program integrity safeguards.** The FFE process has several key features that help address potential program integrity concerns. These include: 1) using the newest, verified income data from trusted public and private sources (including IRS, SSA, and Experian) as the basis for redetermination; 2) conducting frequent outreach activities to remind consumers of the requirement to report changes throughout the benefit year; 3) discontinuing APTC for targeted groups of consumers who either do not authorize the Exchange to check tax data, who have tax data that indicates they are over the income limit, who did not comply with the requirement to file taxes and reconcile prior APTC, or who have not updated their eligibility in some time and have no available tax data; and 4) requiring application filers to attest on the application, under penalty of perjury, that they will report changes as they occur and that they understand that the attested tax filer must file a federal income tax return and reconcile advance payments of the premium tax credit (APTC) at tax filing, paying back excess amounts as described in statute.

- **Stress on enrollment and eligibility systems.** Introducing a requirement to take active steps to maintain eligibility and enrollment would further stress the administrative systems and processes of issuers. Despite strong communications efforts, the vast majority of consumers take action on or just before the deadline. This peak volume exceeds call center capacity, which CMS manages by providing more time after December 15 for consumers who were unable to get through due to high traffic. Accordingly, if the FFE were to require all consumers to take action in order to maintain eligibility or enrollment, more consumers would be unable to get through the process by the end of the day on December 15. This would further increase the case for adding more time for plan selection after December 15, which presents challenges for issuers in fulfilling requests for January 1 coverage. Forcing all enrollees to go through active re-enrollment would also require additional budgetary and technical resources to manage IT systems and call center load, conduct additional consumer outreach, and handle higher rates of

appeals and casework associated with the loss of coverage, as well as manual review of an increased number of data matching issues.

- **Impact on coverage and risk pool.** The current redetermination and re-enrollment process plays a crucial role in maintaining the FFE risk pool year over year by avoiding requiring administrative tasks that healthy individuals are less likely to complete than individuals with more substantial medical needs. Over the past four years, returning Exchange consumers have grown accustomed to the consistent Exchange functionality and requirements for annual renewal, similar consumers have learned that if they have no changes to report, and they continue to pay their premiums, their coverage will not be terminated. If the FFE were to deviate from that norm, consumers would be likely to lose coverage and become uninsured, and may not be aware that they were not renewed until after the end of Open Enrollment.

    - Based on analysis from the re-enrollment process for plan year 2016, we estimate that up to 28% of enrollees who would have had coverage with auto re-enrollment would not have it without auto re-enrollment. Analysis of plan year 2018 also shows that the average and median age of auto re-enrollees is slightly lower than those who actively re-enroll, which is an indicator that consumers who have lower health costs are less likely to make an active selection, and would thus be the most likely to drop out of the risk pool in the absence of auto re-enrollment (see Table 3 below).

    - OACT estimates that ending auto re-enrollment would result in 200,000 fewer individuals enrolled on the Exchanges in 2020 and 100,000 fewer in each subsequent year (see Table 4 below). The lower impact in 2021 is due to the assumption that approximately half of those who lost coverage due to the termination of auto re-enrollment would return to the Exchanges and make an active selection in 2021.

    - OACT also estimates that ending auto re-enrollment would lower federal spending on PTC by approximately $0.8 billion in fiscal 2020 and $6.4 billion over the 10 years in the budget window (through fiscal 2028). Therefore, the savings from other less dramatic changes we considered would likely be minimal.

Table 3: 2018 Re-Enrollment Method by Age

Category	Measure	All OE Consumers with Coverage (1)	Returning Active Consumers with Coverage (2)	Consumers with Regular BAR Coverage (excluding cross-issuer) (3)
Average Age	Average Age	41.7	43.6	41.2
	Median Age	45.0	47.0	43.0

1 - All OE Consumers with Coverage are consumers that were auto re-enrolled or made an active selection during Open Enrollment, and had at least one policy created during Open Enrollment that was non-cancelled as of May 8

2 - Returning Active Consumers with Coverage are consumers that had 2017 coverage that included 12/31/2017, made an active selection during Open Enrollment, did not have any non-cancelled regular (i.e., not cross-issuer) BAR coverage, and had at least one policy created during Open Enrollment that was non-cancelled as of May 8

3 - Consumers with Regular BAR Coverage are consumers that had non-active coverage on a regular BAR policy as May 8. Regular BAR includes consumers auto re-enrolled into the same issuer ID as well as consumers crosswalked to a different issuer ID within the same parent company due to administrative changes or mergers (e.g., Coventry to Aetna). Consumers with coverage in a new issuer ID are required to pay a binder payment to effectuate coverage. This category does not include cross-issuer BAR (i.e., suggested alternative enrollment), which occurs when an issuer discontinues all coverage in a service area and consumers are crosswalked to a different issuer.

Table 4: Estimated Impacts of Discontinuing Auto Re-Enrollment

Calendar Year	2020	2021	2022	2023	2024	2025	2026	2027	2028	
Enrollment Impact	-0.2	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	
Premium Impact	1%	1%	1%	1%	1%	1%	1%	1%	1%	
Fiscal Year	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-28
Federal Impact [$ Billions]										
Premium Tax Credits	-$0.8	-$0.6	-$0.6	-$0.6	-$0.7	-$0.7	-$0.8	-$0.8	-$0.8	-$6.4

Source: OACT

Recommendation

We recommend no changes to the current redetermination and auto re-enrollment processes for 2020. Given that the OACT is estimating a drop in enrollment of 200,000 in 2020 if we eliminate auto re-enrollment entirely, and enrollees who are sick will likely come back in the following year, the impact on premiums and PTC will be minimal. While not significant by itself, this in conjunction with other impacts issuers need to price, such as repeal of the individual mandate and the effect of the AHP and STLDI rules, are significant. Given stakeholder feedback, changes to auto re-enrollment would likely be negatively perceived and will likely be considered by the issuers as adding further instability.

POLICY #3: MODIFICATION OF PREMIUM INDEXING PARAMETERS

Overview

The PPACA includes several related but slightly different indexing rules affecting the parameters of major coverage and insurance provisions.[7] Four parameters are indexed to premium growth in excess of income growth, and one of these four parameters, the PTC applicable percentage (which ranges from 2% to 9.56% in 2018 based on household income as a share of federal poverty level), determines the expected enrollee contribution toward premiums.

The PPACA defines the PTC applicable percentage beginning in calendar years after 2014, and requires that it be indexed in subsequent benefit years to reflect the excess of the rate of premium growth over the rate of income growth for the preceding year. The applicable percentage is the percentage of household income that a subsidized family must pay before subsidies apply. Thus, a household at the 399% of the federal poverty level must pay 9.56 percent of its income towards premiums before subsidies apply. The effect of the index is to increase this 9.56 percentage over time, as premiums grow more quickly than income. This is similar to the increase in the percentage of household income required to be paid that an unsubsidized person would see as premiums grow more quickly than income, or that an employee in a group plan subsidized through the tax system would see, as group premiums grow more quickly than income (with either the individual or the employer paying the difference).

In addition, the tax on health insurance (the so-called "9010 fee"), which was set at $14.3 billion in 2018 and suspended for 2019, is also indexed to premium growth in excess of income growth under the statute. This tax increases premiums (individual and group market) by an estimated 2-3 percent. PPACA authorizes the Secretary to define the premium and income measures used to adjust various payment parameters, and IRS has determined that premium and income growth rates for the applicable percentage will be "consistent with the factors used by HHS to define premium growth in indexing the required contribution percentage in section 5000A of the Code."[8]

In the final 2015 Payment Notice, CMS and the Department of Treasury established the rate of premium growth as the rate of growth in per capita premiums for employer sponsored insurance (ESI), published by CMS as part of the National Health Expenditure Accounts (NHEA) dataset. The previous administration decided to use ESI premiums as the measure of premium growth because ESI premiums generally reflect trends in health care costs, instead of individual market fluctuations. HHS noted in the 2015 Payment Notice that we may propose to change the indexing methodology after the initial years of PPACA market reforms, once premium trends stabilize. We are currently examining possible modifications to this methodology for the 2020 plan year and beyond.

The methodology established in the PPACA and the lack of equivalent baseline for Exchange premiums in 2013 (pre-PPACA) require indexing the new measure of premium growth using a "base" year during which PPACA-compliant plans were offered. Below we lay out considerations for both the premium growth measures and potential base years for beginning to use the new measure.

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[7] The employee's required contribution for employer-sponsored individual coverage and the individual's required contribution are determined based on an identical standard set forth in section 5000A of the IRS Code. The provisions include the applicable percentage and affordability thresholds for PTC under IRC § 36B, the coverage exemption provision under § 5000A, the employer shared responsibility provision under § 4980H and PPACA § 1302, and the Health Insurance Providers Fee under PPACA § 9010.

[8] 26 CFR § 1.36B-2T (TD 9683), July 24, 2014 (finalized by TD 9822 on July 26, 2017)

Considerations

- **All potential premium growth measures are flawed.** We considered two alternative measures of premium growth to ESI: the NHEA Private Insurance category (which includes ESI and individually purchased insurance), or actual Exchange premiums. Both of the alternative premium measures under consideration have limitations. The NHEA private insurance option includes property and casualty insurance, and is heavily skewed by the inclusion of ESI, making the growth rates similar to those under the current ESI approach. With respect to Exchange premiums, CMS has not published projections for future years, and making these projections public could impact private market pricing and contracting decisions, ultimately risking an increase in Federal spending. In any event, we recommend use of an OACT index – these indices are well accepted and transparent, and generally seen as immune from political intervention. In addition, because we use an income index that is estimated by OACT, the assumptions that go into the premium and income indices would be consistent, which could help avoid perverse estimates.

- **Higher growth rate reduces PTC spending but increases taxes on issuers and consumers – both directly and indirectly.** Exchange premium growth rates will likely continue to be much higher than those for ESI premiums, and switching to would result in a reduction in federal spending (and an increase in enrollee premiums) if it were used as a measure of premium growth instead of ESI. Indexing to Exchange premium growth could give issuers additional incentive to contain premium increases, particularly because a higher index rate would also result in steeper tax increases for all health insurance coverage (including fully insured ESI coverage and Medicare Advantage) through the health insurance tax. However, many of the premium increases in the individual market since 2013 have been the result of Congressional and administration policy decisions out of the direct control of issuers. In addition, the optics and Congressional reaction to a significant tax increase on health insurance issuers and consumers due to this change should be considered.

    - OACT estimates that Exchange premium rates will grow 9% in 2019 and 6% in 2020, compared to around 4-5% for ESI over the next few years. However, Exchange premium rates may be higher than these estimates due to future policy decisions or policy uncertainty around the future of the individual markets. See below for a list of recent major policy actions outside the control of issuers that have resulted in significant premium increases.

    - A side effect of using a higher premium growth rate that increases enrollee premiums is that sicker consumers who are the least price sensitive are the most likely to maintain coverage, which would push premium rates higher. Unsubsidized enrollees and the federal government would bear the cost of higher premiums. Our analyses have shown that subsidy-eligible healthy enrollees are particularly price sensitive and likely to drop coverage when net premiums increase (after subsidy).[9]

[9] From 2016 to 2017, age-adjusted premiums in the individual market increased by 18%, while enrollment decreased by 9% and the rate of HCCs per 1000 enrollees increased by 8%. This indicates that enrollees without HCCs (healthier individuals) left the individual market between 2016 and 2017 when premiums increased. Unfortunately, we don't have this split by subsidized enrollment.

- **Retroactive approach would exacerbate unfavorable impacts of higher growth rate.** A retroactive indexing approach that reflects cumulative, historic growth in premiums since 2014 (the first year that PPACA-compliant plans were offered) would result in a significantly larger reduction in federal PTC spending and a larger increase in enrollee contributions to premiums, as compared to an index that will account for only premium increases in the most recent prior year and future years. However, an approach that reflects cumulative, historic growth in premiums from 2014 would result in substantial tax increases on issuers (which they would pass through to consumers), drastic net premiums for consumers, and massive coverage disruptions.

    - We considered a "middle ground" retroactive approach, under which we would measure premium growth using ESI through 2017, and use the new measure beginning in 2018. (Option 3). This option would result in significant federal PTC savings, however it would essentially tax consumers for the decision to not pay CSRs due to the impact of silver loading on premium growth from 2017-2018. OACT estimates this approach would require subsidized enrollees to contribute 23% more of their income to premiums and increase enrollee net premiums by 11% in 2020. As a result, OACT projects approximately 600,000 enrollees would lose coverage in 2020.

    - In order to avoid the adverse effects of a retroactive approach, we also considered a prospective approach, under which we would continue to utilize ESI premiums as the growth measure through 2018, and then index premium growth to the new measure for 2019 and subsequent years. A prospective approach would produce modest federal PTC savings while preventing drastic premium increases, enrollment declines, and tax increases (Options 2A and 2B). OACT estimates that a prospective approach using Exchange premiums (2B) would save approximately $2 billion annually beginning in 2020, while only requiring a 4% increase in the percentage of income an enrollee must contribute.

On the following page, Table 5 summarizes the impacts of three potential changes to the indexing methodology on enrollment, total and net enrollee premiums, PTC spending, and the health insurance tax

Recommendation

We recommend no change to the indexing methodology for the 2020 plan year, consistent with the recommendation from Treasury. Both of the alternative premium measures being considered have considerable drawbacks, and the savings in federal PTC outlays must be weighed against the resulting increases in taxes and enrollee premiums, which would cause coverage losses, further premium increases, and market disruption.

Table 5: Impact of Indexing Options on Consumers and Federal Spending

	Calendar Year	Baseline - 2018	2020	2021	2022	2020-2022 change vs. current policy
Option 1: Continue to use ESI premiums as the measure for premium growth (No Change)	Enrollment (million enrollees)	10.2 m	9.5	9.5	9.6	N/A
	Gross Premiums (billion $)	$73.0 b	78.4	82.6	86.9	N/A
	Net Premiums (billion $)	$18.1 b	16.2	15.4	14.6	N/A
	Premium Tax Credits Federal outlays (billion $)	$54.9 b	58.0	61.1	64.4	N/A
	Health Insurance Taxes (billion $)	$14.3 b	$15.5	$16.1	$16.7	N/A
Option 2A: Premiums Indexed by Growth in ESI premiums thru 2018 and by Growth in Private Insurance Premiums thereafter. Required Contribution Change: 0%	**Calendar Year**	**Baseline - 2018**	**2020**	**2021**	**2022**	**2020-2022 change vs. current policy**
	Enrollment impact (million enrollees)	10.2 m	0.0	0.0	0.0	0.0 m
	Gross Premium impact (billion $)	$73.0 b	0.0	0.0	0.0	$0.0 b
	Net Premium impact (billion $)	$18.1 b	0.0	0.0	0.0	$0.0 b
	Premium Tax Credits Federal outlays impact (billion $)	$54.9 b	0.0	0.0	0.0	$0.0 b
	Health Insurance Taxes impact (billion $)	$14.3 b	$0.0	$0.0	$0.0	$0.0 b
Option 2B: Premiums Indexed by Growth in ESI premiums thru 2018 and by Growth in Marketplace Premiums thereafter. Required Contribution Change: 4%	**Calendar Year**	**Baseline - 2018**	**2020**	**2021**	**2022**	**2020-2022 change vs. current policy**
	Enrollment impact (million enrollees)	10.2 m	-0.1	-0.1	-0.1	-0.3 m
	Gross Premium impact (billion $)	$73.0 b	0.3	0.3	0.3	$0.8 b
	Net Premium impact (billion $)	$18.1 b	0.3	0.3	0.3	$1.0 b
	Premium Tax Credits Federal outlays impact (billion $)	$54.9 b	-1.7	-1.7	-1.8	-$5.2 b
	Health Insurance Taxes impact (billion $)	$14.3 b	$0.5	$0.6	$0.6	$1.6 b
Option 3: Premiums Indexed by Growth in ESI premiums thru 2017 and by Growth in Marketplace Premiums thereafter. Required Contribution Change: 23%	**Calendar Year**	**Baseline - 2018**	**2020**	**2021**	**2022**	**2020-2022 change vs. current policy**
	Enrollment impact (million enrollees)	10.2 m	-0.6	-0.6	-0.6	-1.7 m
	Gross Premium impact (billion $)	$73.0 b	1.2	1.3	1.3	$3.8 b
	Net Premium impact (billion $)	$18.1 b	1.8	1.7	1.6	$5.2 b
	Premium Tax Credits Federal outlays impact (billion $)	$54.9 b	-8.7	-9.2	-9.7	-$27.5 b
	Health Insurance Taxes impact (billion $)	$14.3 b	$3.3	$3.4	$3.4	$10.1 b

Source: Based on OACT estimates

As illustrated in the timeline below, a number of policy actions over the 2014-2018 period have contributed to substantial increases in Exchange premium rates, and transferring this burden to consumers retroactively seems inconsistent with the statutory intent of premium indexing.

Timeline of Major Policy Actions Impacting Premiums

January 2014 – Major PPACA market reforms go into effect, including guaranteed issue, single risk pool requirements, and age rating limits.

October 2015 – CMS announces that issuers will receive only 12.6% of 2014 benefit year risk corridors payments due to a significant shortfall in expected collections relative to payments requested.

Fall 2016 – Issuers finalize rates for 2017 plan year that incorporate the end of the transitional reinsurance program.

October 2017 – CMS terminates payment of cost-sharing reductions to issuers, resulting in most state regulators instructing issuers to load CSR costs in silver plan premiums.

December 2017 – The individual mandate is repealed through tax reform legislation.

POLICY #4: ESTABLISHING A NATIONAL DRUG COUNT FOR THE ESSENTIAL HEALTH BENEFITS PRESCRIPTION DRUG BENEFIT

Overview

Section 1302 of the PPACA provides for the establishment of an essential health benefits (EHB) package that includes coverage of ten categories of EHB, as defined by the Secretary of HHS. To date, CMS's approach has given states flexibility in defining EHB by allowing states to select from certain plans a benchmark that will serve to define EHB. Pursuant to the statute, in most instances, states must defray the cost of state-mandated benefits that exceed the state's EHB-benchmark plan.

With respect to EHB formulary requirements, currently, issuers of plans that must meet EHB requirements must cover one drug per United States Pharmacopeia (USP) category and class or the number of drugs in the state's benchmark plan, whichever is greater. Thus, the number of covered drugs per category and class varies from state to state. States are responsible for ensuring issuers' compliance with EHB standards, and issuers have broad flexibility to design formularies. Unlike other EHB benefit categories, under the current EHB drug policy, covered drugs in excess of this drug count are still considered EHB – thus, states are not subject to defrayal requirements if issuers exceed the drug count, enrollees can receive tax credits for these additional drugs, and these covered drugs are required to count towards the enrollee's annual limitation on cost sharing.

CMS is considering a proposal to change this policy by establishing a national drug count minimum and maximum standard that would apply uniformly across all states. States could adopt these standards as their EHB benchmark, or they could establish their own formulary benchmark, but if they establish a formulary above the federal maximum, they would have to defray the cost of EHB to the extent of the difference. Unlike the other topics covered in this rule, CMS believes that an approach that encourages "skinnier" EHB requirements will help limit premium growth and foster greater state and issuer accountability for the cost of coverage in a way that will not result in barriers to affordability or significant loss of coverage altogether. CMS believes that, by encouraging long-term moderation in price increases, this proposal is likely to improve the risk pool, in contrast to the other proposals in this paper.

Minimum Drug Count
Under the minimum standard, issuers would cover at least one chemically distinct drug per USP category and class. Medicare Part D uses a similar approach that generally requires two drugs per USP category and class, and the one drug standard is consistent with CMS's current minimum EHB drug requirement.[10] Using a minimum count creates a quantitative metric that is enforceable and simplifies the current standard by creating a uniform standard across all states and USP categories and classes.

Maximum Drug Count
In conjunction with a minimum drug count, CMS believes that it is important to limit the range of states' and issuers' discretion over declaring prescription drug benefits to be EHB, ensuring that formularies are designed in a manner that balances affordability and access. For this reason, CMS would set a maximum chemically distinct drug count per USP category and class based on an aggregation of states' EHB-benchmark plan counts. The purpose of this new standard would be to contain the scope of the EHB prescription drug benefit beyond the current policy. Issuers' pharmacy and therapeutics (P&T) committees would be responsible for determining the scope of coverage between the minimum (or, state benchmark, as applicable) and maximum.

Under this policy, if an issuer covered a drug above the maximum threshold, the drug would not be EHB. Further, as the drug would not be EHB, the cost of coverage would not be supported by premium tax credits. This policy would provide potential cost savings for issuers and consumers that do not require non-EHB drugs. This policy would provide potential cost savings for issuers and consumers that do not require non-EHB drugs. However, an issuer could possibly decide that the most expensive drugs are non-EHB, which could create adverse selection for issuers that cover those drugs as EHB.

CMS is considering setting the maximum threshold at a particular aggregated percentile of all states' current EHB-benchmark plans' formularies, at the category and class level. CMS recommends using the 60th percentile, which could be argued to reflect a reasonable national consensus, while curtailing certain states' overly generous outlier formularies. Information on which specific states would see a decrease in total drug count and the level of decrease is in Appendix D. As stated previously, we intend to calculate the 60th percentile at the category and class level.

State Defrayal
PPACA section 1311(d)(3) contemplates that, although states may require issuers to cover benefits in addition to EHB, they must assume those costs. In developing a defrayal policy for the national prescription drug benefit, CMS want to ensure maximum state flexibility so that states are able to adopt their own prescription drugs coverage requirements that exceed any national EHB standard. As such, CMS would allow states to maintain or update their current benchmark plan drug benefits. However, to the extent the state-defined benefit requires issues to cover more than the maximum drug count in the federal benefit as determined by the state, that mandate would be considered additional to EHB, and therefore subject to state defrayal. Consistent with current policy, prescription drug benefits mandated by state action prior to or on December 31, 2011, would continue to be considered EHB and would not be subject to defrayal.

Considerations

- **Impact on EHB compliant plan premiums.** Lowering the drug count could provide issuers with more flexibility to adjust their EHB prescription drug benefit to reduce costs beyond what the

[10] Per the Medicare Part D Manual, "Each category or class must include at least two drugs (unless only one drug is available for a particular category or class, or only two drugs are available but one drug is clinically superior to the other for a particular category or class), regardless of the classification system that is utilized." https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf

current policy allows and could allow more competitive negotiations for the EHB prescription drug benefit. By setting a maximum drug count standard and establishing anything over the national drug count as non-EHB, if an issuer covers a drug as a non-EHB benefit, the issuer would not be required to count cost sharing related to the drug towards the plan's annual limitation on cost sharing or apply the prohibition on annual and lifetime dollar limits to coverage of the drug. This has the potential to further reduce plan premiums. The reduction in plan premiums would reduce the federal government's responsibility to pay for these drugs through premium tax credits.[11] OACT noted that a reasonable impact estimate for this proposal would be 0.1%-0.3% of total spending.[2] However, this policy may be administratively more complex for issuers to manage than the current policy.

- **Impact on consumers.** A national standard that significantly lessens required coverage may be insufficient drug coverage for many consumers. There are a variety of conditions in certain categories and classes where an enrollee may need more than the maximum in that category or class. Insufficient coverage could cause conditions to worsen, which could cause public health problems (e.g., preventable spread of contagious diseases) and greater costs to the health care system. We intend to solicit comments on potential exceptions to the one drug per category and class standard. CMS would require issuers to continue to use a P&T committee to design their formulary drug lists to ensure that clinical evidence is being used to design formularies beyond the minimum drug count in cases where the P&T committee determines that coverage of the minimum drug count would be insufficient. Additionally, enrollees could continue to use the drug exceptions process to obtain non-formulary medically necessary drugs.

  By setting a maximum drug count standard, an issuer could exceed that maximum and possibly decide that the most expensive drugs are non-EHB, which could create adverse selection for issuers that cover those drugs as EHB. Consumers that need certain expensive drugs may have a harder time finding a plan that covers the drugs that they need. However, there may be cost savings for consumers who do not need non-EHB drugs and any reduction in premiums may be beneficial to the non-subsidized population.

- **Establishing national count standard could be disruptive to states.** As part of the 2019 Payment Notice, CMS provided additional flexibilities to states in establishing their EHB benchmarks. Requiring states to adopt a national drug count standard could be interpreted as walking back from deferring to states. Requiring states to change standards or defray to come into compliance could be disruptive to states during a period of increased stability. Specifically, we estimate that twenty states would see decreases in their total number of drugs covered in order to come into compliance with the maximum of 60th percentile of all benchmarks.

  We could mitigate disruption on states by phasing in implementation, discussed below, but states may need to take action as a result of this policy and issuers will need to re-design plans to be

[11] An actuarial analysis estimates that this combined approach of setting a maximum and minimum drug count standard could save 1.5 percent to 4 percent on drug spending, depending on the state and drug class. The actual premium impact is dependent on the risk pool.

[2] If we assumed that drugs account for approximately 25% of total spend, the total impact on drug spend of the proposal would be 0.4%-1.2%.

compliant. Consumers may need technical support to ensure they purchase plans that best meet their needs.

- **Timing of implementation of new standard.** CMS is proposing to define a national EHB drug standard for implementation in 2021. To set the EHB maximum count for drugs, CMS believes that it is important to use formularies that are as current as possible. CMS would undertake a process to update current EHB-benchmark plan formularies to use most current counts and this process would require PRA, making 2021 is the earliest possible date for implementation.

  We would propose delay in applicability of the national standard for the prescription drug benefit in states that have selected new EHB-benchmark plans under our new EHB flexibility rules. This would act as a stabilization period that would make it easier for states to make legislative and budgetary accommodations, if necessary, to adapt to the national EHB drug standard. Pursuant to this stabilization period, if a state changed its EHB-benchmark plan for plan year 2020 under the new flexibility, the national standard prescription drug benefit would not apply in the state for three years, after which time the state would be required to defray the costs of prescription drug benefits the state requires issuers to cover that are in excess of the national standard beginning with plan year 2023.

  During this stabilization period, states that selected revised EHB-benchmark plans for 2020 would continue to follow the current policy for defrayal of state mandates. However, any state which did not take action to change its EHB-benchmark plan for plan year 2020 or any state that selects a new EHB-benchmark plan applicable for plan years after 2020, would be required to defray any excess benefits immediately. Thus for these states, if a plan is covering drugs beyond the maximum chemically distinct drugs allowable in a category and class, those drugs would no longer be considered EHB (unless they are benefits mandated by state action on or before December 31, 2011) and issuers would no longer be required to count cost sharing related to the drug towards the plan's annual limitation on cost sharing or apply the prohibition on annual and lifetime dollar limits to coverage of the drug. CMS wants to provide states with an opportunity to align their EHB-benchmark plan with the national prescription drug benefit standard before being required to defray. CMS recommends that states choose from one of the following for plan year 2021: (1) indicate their desire to CMS to keep its current EHB-benchmark plan prescription drug category; (2) revise their EHB-benchmark plan prescription drug category or (3) take no action, defaulting their EHB-benchmark plan prescription drug category to the national standard. If the state opts for the first or second options, it will need to defray the cost of any benefits its EHB-benchmark prescription drug category requires issuers to cover that are above the maximum national standard.

- **Alignment with other EHB categories.** As previously noted, unlike other EHB categories, currently all drugs are considered EHB. Moving to set a maximum drug count makes the prescription drug category more in line with other benefit categories. A state can require issuers to cover additional drugs and be subject to defrayal. Likewise, an issuer can offer more drugs on the formulary beyond the maximum count but must offer those drugs as above EHB.

Recommendation

We recommend proposing a national new drug count standard in the 2020 Payment Notice. The Secretary's broad authority to define EHB can be used to better control the rising price of premiums, and we believe this can be accomplished by moving towards a national ceiling for EHB. Establishing a national minimum and maximum drug count policy will ensure consumer access to drugs, while reducing the overall generosity of the prescription drug benefit of the most generous states. It will result in overall

reductions in federal premium tax credit spending and premiums, and moves toward greater state-to-state parity in EHB.

APPENDIX A

State Approaches to the Loss of CSR Funding for 2018 Plan Year, as of 11/16/2017

Note: This chart was compiled using information from state DOIs and the public domain. It represents CMS's best understanding of each jurisdiction's approach to the CSR rating issue. CMS's understanding is necessarily limited by the accuracy of the information available to CMS.

State	Did issuers assume that CSRs would be paid, or not paid for 2018?	How did issuers build the end of CSR payments into their rates?	Did issuers create an off-exchange silver plan option without an additional CSR load?	How many issuers created this off exchange option?
AL	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	2
AK	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
AZ	Mixed	Some issuers assumed CSRs would be paid. Others assumed they would not be paid and loaded the risk across all metal levels	No	Not available
AR	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
CA	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	All issuers

State	Did issuers assume that CSRs would be paid, or not paid for 2018?	How did issuers build the end of CSR payments into their rates?	Did issuers create an off-exchange silver plan option without an additional CSR load?	How many issuers created this off exchange option?
CO	Assumed Not Paid	They loaded the risk across all metal levels	Not available	Not available
CT	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
DE	Assumed Not Paid	They loaded the risk across all metal levels	Not available	Not available
DC	Assumed Paid	No load	No	0
FL	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	All issuers
GA	Mixed	Some issuers assumed CSRs would be paid, and some assumed they would not be paid and loaded the risk on silver level QHPs	Yes	1
HI	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	2
ID	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
IL	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0

State	Did issuers assume that CSRs would be paid, or not paid for 2018?	How did issuers build the end of CSR payments into their rates?	Did issuers create an off-exchange silver plan option without an additional CSR load?	How many issuers created this off exchange option?
IN	Assumed Not Paid	They loaded the risk across all metal levels	Not available	Not available
IA	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
KS	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
KY	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
LA	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
ME	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	1
MD	Assumed Not Paid	They loaded the risk on silver level QHPs	Not available	Not available
MA	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	4

State	Did issuers assume that CSRs would be paid, or not paid for 2018?	How did issuers build the end of CSR payments into their rates?	Did issuers create an off-exchange silver plan option without an additional CSR load?	How many issuers created this off-exchange option?
MI	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	4
MN	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
MS	Assumed Not Paid	They loaded the risk across all metal levels	Not available	Not available
MO	Assumed Not Paid	Varying approaches	No	0
MT	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	1 issuer
NE	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
NV	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
NH	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
NJ	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0

State	Did issuers assume that CSRs would be paid, or not paid for 2018?	How did issuers build the end of CSR payments into their rates?	Did issuers create an off-exchange silver plan option without an additional CSR load?	How many issuers created this off exchange option?
NM	Assumed Not Paid	All four issuers assumed non-payment, but three spread across all plans while one issuer only loaded Silver plans	Pending	Pending
NY	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
NC	Assumed Not Paid	They loaded the risk on silver level QHPs	Not available	Not available
ND	Assumed Paid	No load	No	0
OH	Assumed Not Paid	They loaded the risk on silver level QHPs	Not available	Pending
OK*	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
OR	Assumed Not Paid	They loaded the risk on silver level QHPs	Not available	Not available

State	Did issuers assume that CSRs would be paid, or not paid for 2018?	How did issuers build the end of CSR payments into their rates?	Did issuers create an off-exchange silver plan option without an additional CSR load?	How many issuers created this off exchange option?
PA	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	All issuers
RI	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	1
SC	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	1
SD	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
TN	Assumed Not Paid	They loaded the risk on silver level QHPs	Not available	Not available
TX*	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	1
UT	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	2
VT	Assumed Paid	No load	No	0

State	Did issuers assume that CSRs would be paid, or not paid for 2018?	How did issuers build the end of CSR payments into their rates?	Did issuers create an off-exchange silver plan option without an additional CSR load?	How many issuers created this off exchange option?
VA	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	4
WA	Assumed Not Paid	They loaded the risk on silver level QHPs	No	0
WV	Assumed Not Paid	They loaded the risk across all metal levels	Not available	Not available
WI	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	4
WY*	Assumed Not Paid	They loaded the risk on silver level QHPs	Yes	1

*These states do not have an effective rate review program; rates for non-Effective Rate Review states are reviewed by CMS.

APPENDIX B

Estimated Impact on 2019 Premiums in Select States if CSR Payments Were Spread Across Metal Levels

Because final 2019 pricing is not yet available, we cannot yet calculate the state-by-state impact of prohibiting silver loading for 2020. Below is the analysis on impacts of prohibiting silver loading for 2019, derived from analysis of 2018 rates. That analysis may be illustrative of effects for 2020.

The following table lists estimated metal level impacts in select states from shifting from a silver loading methodology to one that loads CSR costs on all metal levels. States that instructed issuers to load across all metal levels or not load at all, in which the load was immaterial, or in which issuers elected to load across all metal levels, are omitted, as are certain states where rate filing load patterns were ambiguous.

These impacts were estimated by comparing average 2018 silver plan increases in the state to average 2018 bronze and gold increases. Therefore, factors that led to differential rate increases across metal levels other than CSR loading may also be included. Actual 2019 metal loading decisions may differ significantly from the patterns we observe for 2018, and actual 2019 rate increases will also reflect other factors, such as medical inflation.

State	Effect on Bronze	Silver	Gold
AL	+10%	-4%	+12%
AR	2%	-4%	+4%
CA	+5%	-5%	+5%
FL	+19%	-6%	+21%
HI	+17%	-9%	+23%
ID	+8%	-5%	+8%
IL	+9%	-7%	+3%
KY	+8%	-5%	+3%
LA	+2%	-4%	+3%
ME	+20%	-9%	+13%
MT	+4%	-8%	+8%
NC	+9%	-5%	+11%
OH	+6%	-6%	+3%
PA	+11%	-5%	+16%
RI	+3%	-4%	+10%
SC	+24%	-5%	+14%
SD	+3%	-4%	+4%
TN	+15%	-7%	+5%
TX	+14%	-7%	+2%
UT	+20%	-9%	+29%
WA	+8%	-5%	+10%
WI	+12%	-8%	+13%
WY	+14%	-8%	+27%

APPENDIX C

Auto Re-Enrollment Crosswalk Hierarchy

In accordance with 45 CFR 155.335(j), as part of the qualified health plan (QHP) certification process for each year, QHP issuers submit a Plan ID Crosswalk identifying the plan for the upcoming year that corresponds to the plan for the current year. In general, CMS regulations require that enrollees be renewed into their same plan or product of the same or similar metal level, to ensure that the crosswalk plan provides similar deductibles and maximum out-of-pocket spending limits. See below for a more detailed explanation of the crosswalk hierarchy:

1. The consumer is re-enrolled in the same plan, if available
2. If the same plan isn't available, the consumer is re-enrolled in the same product (indicated by network, such as PPO, etc) with the same issuer, in the same metal level (if the same metal level isn't available, one level higher or lower)
    a. Exception: For a consumer who is currently enrolled in a silver plan, if the same product no longer has a silver plan, then the consumer is re-enrolled in a similar product with the same issuer at the silver level
3. If the same product isn't available, then the consumer is re-enrolled in the most similar product with the same issuer, in the same metal level (if the same metal level isn't available, one level higher or lower)
4. If the issuer has no Exchange coverage available to the consumer and the state has elected to direct the crosswalk, then the consumer is crosswalked to a plan offered by a different issuer in accordance with the direction of the state
5. If the issuer has no Exchange coverage available to the consumer and the state has declined to direct the crosswalk, then the consumer is crosswalked to a plan offered by a different issuer using a hierarchy similar to 1, 2 & 3 above

APPENDIX D

EFFECT OF 60TH PERCENTILE STANDARD TO STATES' CURRENT EHB DRUG COUNTS

We intend to calculate the 60th percentile standard at the category and class level, however this analysis provides a general overview of which states would need to reduce their total drug count to come into compliance with the new standard. Other states may have changes to their individual categories and classes, but may not have to reduce their total drug count. The full analysis of modifications to each category and class is too extensive to present here.

PY 2018 Maximum Available Drugs In Category & Class (USP 7.0)	60th Percentile	General Statistics of State Benchmark Plans		
		Minimum	Mean	Maximum
1302	1,051	616	1,021	1,188

State	Total PY2018 Drug Count	Difference From 60th Percentile	
SC	1,188	137	
AZ	1,178	127	
MA	1,174	123	
IN	1,170	119	
ME	1,170	119	
OH	1,170	119	
VA	1,170	119	
NY	1,109	58	
AK	1,095	44	
RI	1,089	38	
WI	1,082	31	
LA	1,075	24	
AL	1,072	21	
NC	1,067	16	
WA	1,065	14	
VT	1,064	13	
KY	1,063	12	
GA	1,061	10	
NV	1,061	10	
OR	1,057	6	
FL	1,050	-1	
MI	1,050	-1	
CT	1,047	-4	
WV	1,046	-5	
DE	1,042	-9	
TN	1,040	-11	
KS	1,039	-12	

NE	1,039	-12	
MT	1,038	-13	
WY	1,038	-13	
DC	1,037	-14	
MD	1,037	-14	
ND	1,036	-15	
NH	1,032	-19	
PA	1,029	-22	
MO	1,028	-23	
IL	1,023	-28	
OK	1,023	-28	
TX	1,023	-28	
NJ	1,018	-33	
HI	987	-64	
AR	983	-68	
SD	953	-98	
IA	928	-123	
MS	890	-161	
NM	866	-185	
UT	771	-280	
ID	758	-293	
MN	731	-320	
CA	698	-353	
CO	616	-435	

APPENDIX E

PROPOSAL ALIGNMENT WITH SECRETARY'S PRINCIPLES & IMPACT ON UNSUBSIDIZED

	End Silver Loading	End Auto Reenrollment	Adjust premium indexing to reduce PTC	National EHB Drug Standard	Comment
Support Private over Public Coverage	↓	–	–	–	Market disruption and coverage losses resulting from a ban on silver loading could lead states to expand Medicaid and/or bolster calls for a "public option."
Federal Fiscal Sustainability	↑	↑	↑	↑	All three polices would lower federal PTC spending to varying extents.
State Innovation & Local Control	↓	↓	–	↓	Federal regulation of CSR loading intervenes in state authority over rate-setting, ending auto re-enrollment would prevent state exchanges from continuing a practice that they have determined to be beneficial for their markets, and a national drug standard would still allow states to set drug standards, but states would have to defray added costs
Support and Empower Those in Need (Americans Should Have Access to Affordable Insurance)	↓	↓	↓	↓	Ending silver loading and auto reenrollment and adjusting premium indexing would raise premiums for both subsidized and unsubsidized enrollees, and ending auto re-enrollment could reduce access to coverage. A national drug standard would reduce premiums.

	End Silver Loading	End Auto Reenrollment	Adjust premium indexing to reduce PTC	National EHB Drug Standard	Comment
Consumer-Driven	▬	▬	▬	▲	While some enrollees may migrate away from ACA-compliant plans to more consumer-driven coverage such as AHPs or STLDI, those markets may not be developed enough to offer a viable alternative by 2020; these policies would also drive enrollees out of high-deductible bronze plans which are highly consumer-directed (some of which are HSA-qualified)
Impact on Unsubsidized Enrollees	▼	▼	▼	▲	Ending silver loading would require unsubsidized enrollees to subsidize CSRs, and the autoreenrollment and premium indexing proposals would cause the Exchange risk pool to deteriorate, driving up premiums. The drug policy would increase affordability.