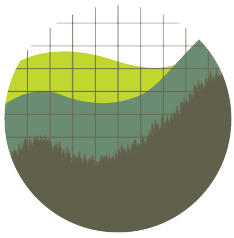

Institute *for*
Policy Integrity
NEW YORK UNIVERSITY SCHOOL OF LAW

December 30, 2020

VIA ELECTRONIC SUBMISSION

Department of Health and Human Services

Attn: Centers for Medicare & Medicaid Services

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates To State Innovation Waiver (Section 1332 Waiver) Implementing Regulations, 85 Fed. Reg. 78,572 (proposed Dec. 4, 2020)

Docket ID: CMS-2020-0151-0005

The Institute for Policy Integrity at New York University School of Law[1] respectfully submits the following comments to the Centers for Medicare and Medicaid Services ("CMS" or the "agency") at the Department of Health and Human Services ("HHS") regarding the proposed notice of Patient Protection and Affordable Care Act benefit and payment parameters for the 2022 coverage year ("Proposed Rule").[2] Policy Integrity is a non-partisan think tank dedicated to improving the quality of government decisionmaking through advocacy and scholarship in the fields of administrative law, economics, and public policy.

These comments focus on serious flaws in the Proposed Rule's regulatory impact analysis. Specifically, CMS fails to consider the potential health costs of several elements of the Proposed Rule, including: (1) its authorization of entirely privatized insurance marketplaces; (2) its promotion of the use of private enrollment websites by enrollment assisters; (3) its reduction of marketplace user fees; and (4) its continued reliance on a 2019 change to the formulas used to calculate premium-adjustment percentages and cost-sharing limits for consumers.

I. CMS does not adequately account for the Proposed Rule's costs

The regulatory impact analysis for the Proposed Rule does not satisfy the requirements of either Executive Order 12,866 or the Administrative Procedure Act ("APA").

Executive Order 12,866 requires agencies to assess the costs and benefits of any economically significant regulatory action, including, but not limited to, the action's expected effects on "the

[1] This document does not purport to present New York University School of Law's views, if any.

[2] 85 Fed. Reg. 78,572 (proposed Dec. 4, 2020).

efficient functioning of the economy and private markets," "health," and "safety."[3] An agency should "propose or adopt a regulation only upon a reasoned determination that the benefits of the intended regulation justify its costs," and after considering "all costs and benefits of available regulatory alternatives."[4]

Separate from the requirements of Executive Order 12,866, courts have held under the APA that "when an agency decides to rely on a cost-benefit analysis as part of its rulemaking, a serious flaw undermining that analysis can render the rule unreasonable."[5]

Because CMS entirely fails to consider the likely health costs of several of the Proposed Rule's provisions, as detailed below, its conclusion "that the benefits of this regulatory action justify the costs" is arbitrary and capricious.[6] Finalizing the Proposed Rule in reliance on CMS's fatally incomplete analysis would violate both Executive Order 12,866 and the APA.

II. CMS fails to consider the health costs of marketplace privatization

CMS proposes to allow states "to transition to private sector-focused enrollment pathways" instead of centralized, government-operated marketplaces.[7] Such privatization will likely result in reduced health coverage for at least two reasons. First, some customers may be confused by the new process and thus fail to enroll in any insurance plan.[8] Second, private brokers and insurers may not provide customers with sufficient information regarding all available insurance plans and/or may steer customers to lower-quality (but more profitable) plans.[9]

The adverse health consequences of such enrollment changes qualify as costs that should be accounted for in a regulatory impact analysis.[10] Indeed, HHS's own analytic guidelines explicitly

---

[3] Exec. Order No. 12,866 § 6(a)(3)(C), 58 Fed. Reg. 51,735 (Oct. 4, 1993). The Department has concluded that the Proposed Rule is an economically significant regulatory action for the purposes of Executive Order 12,866. 85 Fed. Reg. at 78,654.

[4] Exec. Order No. 12,866 §§ 1(a), (b)(6).

[5] *Nat'l Ass'n of Home Builders v. EPA*, 682 F.3d 1032, 1040 (D.C. Cir. 2012); *see also Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (APA requires agency to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made" (internal quotation marks omitted)).

[6] 85 Fed. Reg. at 78,654.

[7] *Id.* at 78,661.

[8] Tara Straw, *Trump Proposal Threatens Coverage of HealthCare.gov Enrollees*, Ctr. for Budget & Policy Priorities (Dec. 7, 2020), https://www.cbpp.org/blog/trump-proposal-threatens-coverage-of-healthcaregov-enrollees; *see also* Tara Straw, *Tens of Thousands Could Lose Coverage Under Georgia's 1332 Waiver Proposal*, Ctr. for Budget & Policy Priorities (Sept. 1, 2020), https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal.

[9] *Id.*

[10] Exec. Order No. 12,866 § 6(a)(3)(C)(ii) (agency's assessment of "costs anticipated from the regulatory action" should include "any adverse effects on . . . health"); *Michigan v. EPA*, 135 S. Ct. 2699, 2707–08

cite "change[s] in health" as an example of a regulatory effect "should be addressed in [an HHS agency's] benefit-cost analysis, if significant."[11]

Int its analysis of the Proposed Rule, however, CMS makes no attempt to describe, much less quantify, how marketplace privatization could affect enrollment decisions and, in turn, health outcomes. Instead, it notes only that privatization "may have varied impacts on consumers."[12] This is patently insufficient to satisfy the APA's requirement that CMS consider "important aspect[s] of the problem" it seeks to address through rulemaking.[13]

III. CMS fails to consider the health costs of allowing enrollment assisters to rely on private enrollment websites

CMS proposes to allow enrollment assisters "to use web-broker non-Exchange websites to assist consumers with [health plan] selection and enrollment."[14] As noted in Section II, private brokers may have financial incentives to withhold information regarding some available plans and/or to steer consumers to lower-quality plans. Thus, this provision, too, could cause reduced health coverage and attendant health costs, which CMS fails to consider in its regulatory impact analysis.

IV. CMS fails to consider the health costs of reducing marketplace user fees

CMS proposes to lower from 2021 benefit-year levels the fees paid by insurers for use of federally facilitated exchanges or state-based exchanges on the federal platform.[15] But while the agency acknowledges that these fee changes will result in "reduced transfers to the federal government,"[16] it does not discuss the potential coverage and health consequences of those forgone transfers. Specifically, CMS does not discuss the potential for the cuts to translate to reduced marketing efforts and fewer platform improvements relative to a baseline scenario in which the current fee levels are maintained. Nor does the agency consider the extent to which such forgone outreach efforts or site improvements could reduce enrollment and, in turn, lead to health costs.[17]

(2015) (explaining that "[a]gencies have long treated costs as a centrally relevant factor when deciding whether to regulate" and that costs "include[] more than the expense of complying with regulations"; instead, "any disadvantage could be termed a cost.").

[11] HHS, Guidelines for Regulatory Impact Analysis 23 (2016), https://aspe.hhs.gov/system/files/pdf/242926/HHS_RIAGuidance.pdf.

[12] 85 Fed. Reg. at 78,611.

[13] *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

[14] 85 Fed. Reg. at 78,612.

[15] *Id.* at 78,664.

[16] *Id.*

[17] *See, e.g.,* Sarah Gollust et al, *TV Advertising Volumes Were Associated with Insurance Marketplace Shopping and Enrollment in 2014*, 27 Health Aff. 6 (2018), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1507 (finding "that people living in counties

V. CMS fails to consider the health costs of maintaining its 2019 change to the formulas used to calculate premium-adjustment percentages and cost-sharing limits

CMS proposes to maintain a discretionary change it made in 2019 to the formulas used to calculate premium-adjustment percentages for consumers in marketplace plans and cost-sharing limits for consumers in both marketplace and employer plans. The agency denies that the percentages and limits it derives from these formulas "would result in a significant economic impact."[18] Relative to the pre-2019 formulas, however, CMS's approach raises post-tax-credit premiums by 4.7% for most subsidized marketplace consumers and increases the limit on out-of-pocket costs by $400 for individuals and $800 for families.[19] Any harmful behavioral changes that these consumer-cost increases might prompt—such as failure to enroll in insurance or seek needed care[20]—are costs that should be considered in the Proposed Rule's regulatory impact analysis.[21] But in the analysis for the Proposed Rule, CMS neither acknowledges the possibility of reverting to its pre-2019 formula nor discusses the health costs that might be avoided by doing so. The agency thus violates its duty to consider available regulatory alternatives under both Executive Order 12,866 and the APA.[22]

---

with higher numbers of ads sponsored by the federal government were significantly more likely to shop for and enroll in a Marketplace plan").

[18] 85 Fed. Reg. at 75,664.

[19] Tara Straw, *Trump Proposal Threatens Coverage of HealthCare.gov Enrollees*, Ctr. for Budget & Policy Priorities (Dec. 7, 2020), https://www.cbpp.org/blog/trump-proposal-threatens-coverage-of-healthcaregov-enrollees.

[20] *Cf.* David Machledt & Jane Perkins, Nat'l Health Law Program, Medicaid Premiums and Cost Sharing 1 (2014), https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing

(noting, in the Medicaid context, that "numerous recent studies indicate that heightened premiums and cost sharing increase the risks of adverse health outcomes").

[21] HHS, Guidelines for Regulatory Impact Analysis 23 (2016), https://aspe.hhs.gov/system/files/pdf/242926/HHS_RIAGuidance.pdf ("Where the imposition of transfer payments affects behavior, associated impacts should be taken into account in the benefit-cost analysis.").

[22] Exec. Order No. 12,866 § 6(C)(iii) (agency must assess "costs and benefits of potentially effective and reasonably feasible alternatives" and explain "why the planned regulatory action is preferable to the identified potential alternatives"); *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.,* 463 U.S. 29, 48 (1983) (holding that a clear alternative to the agency's preferred policy "[a]t the very least . . . should have been addressed"); *Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1915 (2020) (finding recission of Deferred Action for Childhood Arrivals program arbitrary and capricious because government failed to consider lawful alternatives to full rescission that would have been less harmful to affected individuals).

Respectfully,

Jack Lienke

Regulatory Policy Director
Institute for Policy Integrity at New York University School of Law
jack.lienke@nyu.edu