

*The Commonwealth of Massachusetts*  
*Commonwealth Health Insurance Connector Authority*  
100 City Hall Plaza  
Boston, MA 02108

DEVAL PATRICK  
Governor

TIM MURRAY  
Lieutenant Governor

JAY GONZALEZ  
Board Chair

GLEN M. SHOR  
Executive Director

October 31, 2011

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9989-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

**Re: Notice of Proposed Rule Making Regarding Establishment of Exchanges and Qualified Health Plans consistent with Title I of the Patient Protection and Affordable Care Act (Published in Federal Register Volume 76, Number 136 on July 15, 2011)**

To Whom It May Concern:

On behalf of the Massachusetts Health Connector (Health Connector), we appreciate the opportunity to provide comments on the Notice of Proposed Rule Making (NPRM) regarding the establishment of Exchanges and Qualified Health Plans (QHP) consistent with Title I of the Patient Protection and Affordable Care Act (ACA) published in the Federal Register on July 15, 2011. While the Department of Health and Human Services (HHS) offered guidance on a number of important areas for states and Exchanges to consider, our comments are focused on areas in which we have relevant experience that we think is important for your consideration and/or the NPRM would have a direct impact on the policy or operations of the Health Connector in Massachusetts.

The Health Connector is an independent state authority created by Chapter 58 of the Acts of 2006 to implement key elements of Massachusetts' historic health reform law. The Health Connector serves as an Exchange that assists individuals, families, and small employers in acquiring health coverage either through the Commonwealth Care or Commonwealth Choice programs. Commonwealth Care is a subsidized insurance program available to adults in Massachusetts earning up to 300% of the Federal Poverty Level (FPL) who generally do not have access to Employer Sponsored Insurance (ESI) or other subsidized insurance and who meet certain eligibility guidelines. Commonwealth Choice is a non-subsidized insurance program available to individuals and to small employers with 50 or fewer employees. Current enrollment in these programs is approximately 159,000 and 42,000 members, respectively.<sup>1</sup>

---

<sup>1</sup>The Health Connector also administers a program referred to as Commonwealth Care Bridge. This program provides subsidized insurance coverage to approximately 15,000 legal immigrants who have been in the United States for less than five years.

In addition to managing these two programs, the Health Connector is charged with developing and implementing several policy and regulatory components of reform.<sup>2</sup> Among the most important policy tasks completed and managed by the Health Connector are those associated with the implementation of the state's health care coverage mandate. These include, for example, development of regulations defining what constitutes Minimum Creditable Coverage (MCC), or the minimum level or value of health insurance an adult must maintain, and adoption of an Affordability Schedule, which defines the maximum amount an adult is expected to contribute toward the purchase of MCC-compliant health insurance and determines application of tax penalties for lacking coverage. The Health Connector also administers an appeals program. This program handles both appeals of Commonwealth Care members and applicants, as well as of tax filers who are assessed penalties for failing to comply with the state's coverage mandate.

The Health Connector embraces national health reform and looks forward to the opportunity to further expand access to health insurance coverage to residents in our state through implementation of this law. Moreover, we are very proud to see that many components of the ACA are broadly based on elements of the Massachusetts model, including, for example, the individual mandate, standards defining minimum essential coverage and affordability, and the development of an Exchange to facilitate the purchase of health insurance.

Nonetheless, while many aspects of the ACA are grounded in the elements of Massachusetts' health care reform initiative, we will have much work to do in the coming years to evaluate the consistency of our current policies and operations with new federal requirements. We anticipate that we will need to refine our approach in certain areas in order to comply with those requirements. The Health Connector is strongly committed to successfully adapting to federal health reform requirements to ensure Massachusetts residents have access to the full range of opportunities and benefits presented by the ACA.

### **Specific Comments**

We appreciate the opportunity to provide comments to the proposed rule and offer ours in the following areas:

#### **Initial and annual open enrollment periods**

Section 155.410 of the NPRM specifies timeframes and parameters for initial and annual open enrollment periods. Specifically, the rule proposes an initial open enrollment period of October 1, 2013 through February 28, 2014, noting that it extends beyond the January 1, 2014 to allow for sufficient outreach and education. For coverage starting January 1, 2015, the NPRM specifies an annual open enrollment period of October 15 through December 7, but also discusses an alternative timeframe of November 1 through December 15.

We appreciate the need to define open enrollment periods in an effort to control for adverse selection in the market, but we strongly recommend that Exchanges have the flexibility to set annual open enrollment dates (following the initial open enrollment date) based upon their unique markets and existing laws and practices.

Providing states flexibility to determine the most appropriate time period for an open enrollment period allows the state to include operational considerations in its decision-making regarding the appropriate time for an open enrollment period. For example, if there is a typical time of year in which a large segment of the market is up for renewal (e.g., small businesses in Massachusetts often renew coverage in April or October of a calendar year), it may be administratively burdensome for the

---

<sup>2</sup> See for example, M.G.L. c. 176Q § 3, M.G.L. c. 111M § 1, et. al.

Exchange and carriers if the Exchange non-group open enrollment occurred during this same time period. In instances like this, staggered enrollment periods between non-group purchasers and other purchasers mitigates the likelihood of administrative backlog and enables the Exchange and insurance carriers to best serve customers.

We also think it is important to note that Massachusetts has made a significant investment in educating the non-group market about the state's current non-group open enrollment period. Pursuant to Chapter 288 of the Acts of 2010, the state instituted an annual open enrollment period which runs from July 1 – August 15. This was implemented in part to address concerns associated with adverse risk dynamics resulting from the continuous (i.e., monthly) opportunities for non-group enrollment. Changing that open enrollment period could lead to greater confusion among purchasers and require substantial time and resources to inform them of a changed enrollment period. We recommend that states be given the authority to define open enrollment periods specific to their market needs.

### **Coverage Effective Dates**

Section 155.410(c) of the NPRM limits the initial coverage effective date for QHP purchasers to the first of the month. In addition to flexibility in defining annual open enrollment periods, we believe states should also be granted flexibility in determining initial coverage effective dates.

Consistent with the preamble offered in the proposed regulations, the Health Connector believes in the importance of minimizing the time between enrollment and coverage becoming effective and in ensuring an individual's eligibility for a QHP before transmitting enrollment files to the issuer of the QHP. We believe that states should be provided flexibility to work with QHP issuers participating in the Exchange to determine the timeline between enrollment and coverage becoming effective that meets the objectives described above and is administratively feasible.

### **Payment of Premiums**

Section 1312 of the ACA states that an individual "may pay" any applicable premium to the QHP issuer. Section 155.240 of the NPRM interprets this language to mandate that an Exchange allow a non-group purchaser of a QHP to pay any applicable premium (s)he owes directly to the QHP issuer. We suggest that this interpretation be reconsidered and that states be granted flexibility in how to proceed with respect to directing consumer payments of premiums.

This interpretation could result in administrative complexity as it requires the Exchange to notice non-group purchasers of the option to pay the issuer directly and to then track which purchasers opt to pursue payment to the QHP issuer versus the Exchange.

Another concern with the requirement that consumers have optional processes for providing payment are the challenges this may create for the Exchange in promptly determining consumer delinquency in making premium payments. If the Exchange is required to notice the IRS in regards to terminations of eligibility for the tax credit (i.e., because the consumer has not been contributing his/her share of the premium), a process whereby the Exchange does not receive payments directly could elongate the time period between recognizing delinquency and reporting it to the Treasury.

While we continue to analyze this issue and determine the most appropriate payment mechanism, we also think it is important to note some consumer benefits associated with the Exchange performing premium billing functions. Requiring members to pay the Exchange directly may make account management easier for consumers, the Exchange, and QHP issuers. For example, if a member has a question regarding enrollment information or billing, or wishes to confirm receipt of an application or payment, it would be easier to have a single point of contact that could be reached for all of these issues. Unless transmission of enrollment information to carriers happens real-time (which is

unlikely), the consumer would have to contact the Exchange regarding enrollment processes and the QHP issuer regarding receipt of payment.

Further, enabling an Exchange to require payment only flow through the Exchange may have program integrity benefits if an Exchange were able to offer additional subsidies (e.g., a state subsidy towards the premium in addition to the tax credit) or other benefits to the non-group population (e.g., wellness program participation). Receiving premium payment directly from the purchasers would provide the Exchange more up-to-date information as to the enrollees' continued payment of premiums, enrollment in coverage, and therefore eligibility for these additional benefits.

Finally, given that Exchanges are required to perform premium aggregation functions as part of the SHOP Exchange, there may be economies of scale associated with performing these functions for *all* Exchange purchasers.

### **Support for Small Business Health Options Program (SHOP) Flexibility**

Section 155.705 of the NPRM provides some flexibility with respect to employer choice requirements in the SHOP. As specified in statute, the SHOP must allow an employer to select a level of coverage and then make all QHPs within that level available to employees. The NPRM further provides that the SHOP may also offer additional models for an employer to consider in making coverage available to its employees.

The Health Connector strongly supports the flexibility provided to Exchanges with respect to the development of additional coverage models (i.e., an option other than having an employer select a level of coverage and making all QHPs within that level of coverage available to all employees) that can be offered to employers. Our experience to date suggests that a "one size fits all" approach does not best meet market needs. Enabling Exchanges to offer employers alternative options will ensure the SHOP is able to offer models that appeal to the diverse needs and preferences of small employers.

### **Changes to Exchange Plans**

Section 155.105 of the NPRM mandates that the State notify the Department of Health and Human Services (HHS) in writing before making a significant change to its Exchange Plan and that no significant change to that plan will be effective until it is approved, in writing, by HHS. In the preamble, the rule offers and seeks comment on performing this approval consistent with the State Plan Amendment (SPA) process currently in place for Medicaid and CHIP.<sup>3</sup> While the Health Connector does not have experience in submitting SPAs, we understand that the process requires a proposed change be submitted significantly in advance of the planned implementation timeline and can involve a lengthy approval process.

We recognize the importance of federal oversight associated with this historic health reform initiative, but we would like to recommend consideration of an alternative process for ensuring necessary federal oversight that would provide the Exchange sufficient flexibility to nimbly adapt to changing market circumstances and needs.

Operating the Health Connector has proven that an Exchange is expected to operate like a business akin to other commercial insurers or insurance intermediaries. The Exchange must be able to respond in a timely way to rapidly evolving markets and consumer preferences. Moreover, the Exchange will need to keep pace with the market and health plan product preferences to best serve its customers and ensure its viability. Therefore, the Exchange must be nimble and able to take immediate corrective or new actions when appropriate.

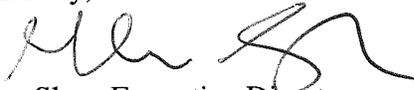
---

<sup>3</sup> §155.105 of proposed rule, CMS-9989-P

We would recommend that a more collaborative and iterative form of federal oversight, perhaps similar to the Gate Review process required for Early Innovator Grantees, would benefit both the state-run Exchange and the federal government. This plan-approval approach should convene appropriate leadership from the federal government and key decision makers from the Exchange to vet the proposed plan changes in a manner that would encourage an iterative review and a more immediate response than the proposed SPA process.

We thank you for consideration of our comments and look forward to continuing to work with the federal government in implementation of the ACA.

Sincerely,



Glen Shor, Executive Director  
Health Connector



Kaitlyn Kenney, Director of Policy & Research  
Coordinator of National Health Care Reform  
Health Connector