

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 4, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius,

The Massachusetts Health Connector appreciates the opportunity to offer comments on the Exchange-related provisions of the Patient Protection and Affordable Care Act (PPACA).

The Massachusetts Health Connector is an independent state authority created by Chapter 58 of the Acts of 2006¹ to implement key elements of Massachusetts' historic health reform law. The Health Connector serves as an intermediary, or Exchange, that assists individuals and small businesses in acquiring health coverage through its Commonwealth Care (CommCare) and Commonwealth Choice (CommChoice) programs. CommCare 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 Insurance² (ESI) or other subsidized insurance and meet certain eligibility guidelines. CommChoice is a commercial (non-subsidized) insurance program available to individuals and to small employers with 50 or fewer employees. The Health Connector has also been responsible for many key policy decisions associated with Massachusetts health reform, centered in implementation of the state's adult health coverage mandate.

The Health Connector carries out many of the roles envisioned for Exchanges in PPACA, such as handling premium subsidies, making health insurance plans available to consumers and small businesses to compare and purchase, and carrying out a risk adjustment program. While these and many other aspects of PPACA are broadly 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.

¹ M.G.L. c. 176Q § 2(a).

² Per M.G.L. c. 118H § 3(4), individuals who are eligible for employer sponsored insurance where the employer covers at least 20% of the annual premium cost for a family insurance plan or at least 33% of the cost for an individual insurance plan are not eligible for CommCare.

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 PPACA. The comments we provide here describe areas of implementation for which flexibility will be important for our state as we move toward refining our approach to align with federal reform requirements for Exchanges. We have organized our comments to respond to some of the specific questions posted in the Request for Comments.

A. State Exchange Planning and Establishment Grants

2.a. What kinds of governance structures, rules or processes have States established or are they likely to establish related to operating Exchanges (e.g., legal structure (such as placement in State agency or non profit organization), governance structure, requirements relating to governing board composition, etc.)?

The Health Connector is an independent public authority. As such, the Health Connector is "not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the Commonwealth except as specifically provided in any general or special law."³

The Health Connector is governed by a ten person Board. The Board approves all major policy, regulatory, and programmatic decisions, and generally meets on a monthly basis in a public forum. The Board's composition reflects diverse backgrounds and areas of expertise, which allows for representation of a broad range of perspectives. The Board is chaired by the state's Secretary of Administration and Finance. Other members of the Board, as required by statute, include, the director of Medicaid; the Commissioner of Insurance; the Executive Director of the Group Insurance Commission;⁴ 3 members appointed by the governor, 1 of whom is a member in good standing of the American Academy of Actuaries, 1 of whom is a health economist, and 1 of whom represents the interests of small businesses; and 3 members appointed by the attorney general, 1 of whom is an employee health benefits plan specialist, 1 of whom is a representative of a health consumer organization, and 1 of whom is a representative of organized labor. No appointee may be an employee of any licensed carrier authorized to do business in the Commonwealth. In 2011, a member of the Massachusetts Association of Health Underwriters will be added to the Board.

The ex-officio state appointments promote coordination across state programs (e.g., Medicaid eligibility determination, alignment with Group Insurance Commission initiatives, alignment with Division of Insurance regulatory policy, etc.) and with larger state health care policy. The appointments of diverse stakeholders from outside state government provide critical policy inputs and promote shared ownership of decisions.

The Health Connector's governance model has been effective in building consensus and broad support for health reform in Massachusetts. The Board represents a diversity of viewpoints yet has been able to make decisions on a unanimous basis with proven positive results. These decisions have included defining standards for who can and cannot afford health insurance and determining what constitutes minimum creditable coverage for purposes of satisfying the individual mandate. Unanimous decision making, especially on particularly contentious issues such as these, has enhanced the legitimacy of these decisions.

Given the success of this governance structure in implementing and maintaining support for health reform in Massachusetts, we believe that this model should be allowed to continue in guiding the Massachusetts Exchange as envisioned under PPACA. We also recognize that other states may have interests in crafting alternative governance models and rules of operation (e.g., requiring application of open meeting laws) to meet their unique needs.

³ M.G.L. Chapter 176 § 2.

⁴ The Group Insurance Commission was established by the Legislature in 1955 to provide and administer health insurance and other benefits to the Commonwealth's employees and retirees, and their dependents and survivors.

To that end, we would recommend that the U.S. Department of Health and Human Services (HHS) provide states with full flexibility to develop a governance structure that best meets the needs of their local marketplace and political structure, so long as an Exchange is operating in a lawful manner.

C. State Exchange Operations

1. What are some of the major considerations for States in planning for and establishing Exchanges?

The definition of the Essential Health Benefits (EHB) package as well as any other benefit design requirements will be critical information for states and health insurers as they develop the health benefit packages and plan designs to be offered through the Exchange. Since decisions regarding what constitutes the EHB package may have significant financial implications for the states, it would be helpful for the states to have the opportunity to be consulted as HHS defines the EHB package.

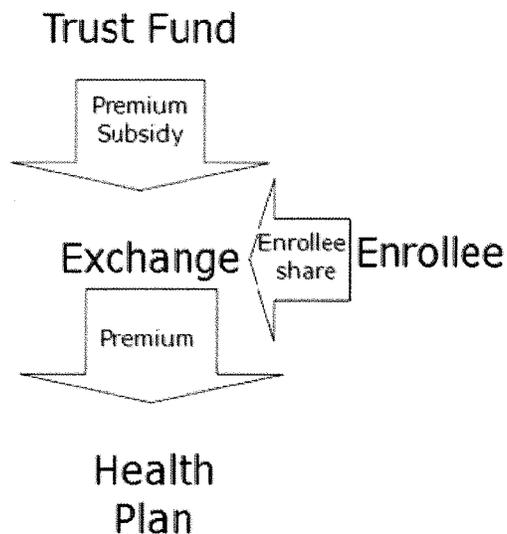
PPACA also indicates that qualified health plans (QHPs) offered through the Exchanges will be required to offer plans that fit within certain tiers based on defined actuarial values (i.e., platinum tier = 90%, gold tier = 80%, silver tier = 70% and bronze tier = 60%) and that a qualified health plan must offer at least one plan in the silver level and one plan in the gold level.⁵ Based on the experience of the Health Connector, there can be significant variation in the determination of a given plan's actuarial value as well as significant differences in benefit design within an actuarial value, making it difficult for consumers to compare plans. States should have authority and flexibility beyond these parameters to define requirements of participation in the Exchange for QHP issuers. This may include, for example, further defining benefit structure within the actuarial value tiers or requiring participation in additional tiers beyond silver and gold (e.g., the Health Connector requires health insurance carriers to meet certain plan design specifications and to offer health plans in all tiers in an effort to minimize potential selection practices). This will enable states to ensure their product offerings are appropriate for their markets, diminish the prevalence of selection practices and concerns, and structure their offerings to enable transparency and ease of comparison for consumers and small businesses purchasing through the Exchange.

2. For which aspects of Exchange operations or Exchange standards would uniformity be preferable? For which aspects of Exchange operations or Exchange standards is state flexibility likely to be particularly important?

One operational area where state flexibility will be important is in the flow of federal premium and cost-sharing subsidies. In operating its subsidized CommCare program, Massachusetts utilizes a cash flow model whereby the Health Connector receives premium contributions from enrollees, pulls down subsidy dollars from the state's Commonwealth Care Trust Fund, and makes a payment to participating insurance carriers ("coordinated" payment model). An alternative model is to allow enrollees to pay their premiums directly to the insurance carrier ("independent" payment model).

⁵ PPACA § 1301(a)(1)(C)(ii).

Coordinated Payment Model



Independent Payment Model



We believe that there are several important advantages to the coordinated payment model. With coordinated payments, the Health Connector knows, without undue delay, whether an enrollee is paying his or her portion of the premium, and thus whether to continue making payments to the insurer. In the independent payment model, if an enrollee ceased to make premium payments, the Exchange would not know until the carrier informed the Exchange. Under the independent payment model, there is the potential that an Exchange/the Treasury may continue to pay subsidies to a carrier for an enrollee who ceased to make his or her premium payments. A second issue is the coordination of the subsidy amount, particularly with changes in income and eligibility. Based on our experience, there can be a high rate of volatility in income and eligibility, particularly among lower-income populations, and thus coordination between government, enrollees, and health plans needs to be accurate, timely and as efficient as possible in order to minimize disruptions to coverage and to reduce administrative costs. The coordinated payment model enhances program integrity, as the Exchange serves as the central mechanism for monitoring eligibility and disbursing payments only for those eligible.

The coordinated payment model also lends itself to operational efficiencies for insurers and employers. For example, the Exchange may handle the eligibility and enrollment processes for a large number of non-group and small group purchasers, transmitting this information along with payments to insurers in aggregated or "batch" files, rather than requiring the insurers to handle these cases individually. This functionality is particularly important for employers if the Exchange is operating according to an employee choice model. Rather than the employer having responsibility for allocation of premium payments to a variety of health plan issuers, the Exchange will collect all payments and distribute via a "batch" transfer, as appropriate. Finally, using a coordinated payment model can facilitate assessment and collection of the Exchange's administrative fee.

The Health Connector recommends that states be granted maximum flexibility to evaluate and implement an optimal cash flow structure.

5. What are the considerations for States as they develop web portals for the Exchanges?

It will be critically important for all state Exchange web portals to be able to electronically exchange "real-time" information with both the Internal Revenue Service (IRS) and the Social Security Administration (SSA) to send information about a prospective purchaser, and receive information regarding citizenship and income to

verify eligibility for Exchange purchasing and the premium tax credit. Ideally, this information exchange would take only seconds and be seamless to the prospective purchaser.

A standardized web service between the state Exchange and the IRS and SSA would work best, though this will require sufficient capacity to handle “real-time” simultaneous requests from all the states operating Exchanges. Interoperability standards would need to be established and enforced for this to function appropriately. Similarly, each state Exchange will need to electronically exchange “real-time” information with QHP issuers for the purpose of displaying individual (non-group) and employee (group) premiums. These web services will also need to comply with interoperability standards and operate in “real-time.” If the process takes too long, prospective buyers will grow frustrated and leave the portal.

A determination needs to be made as to whether there should be and will be a common web address or URL convention to be used by all the states for the purpose of advertisement and public awareness. For example, will something like www.healthexchange.gov/MA be used for Massachusetts? If so, we would recommend that this link to our existing website (www.mahealthconnector.org).

The Health Connector recommends that there be some general design guidelines provided by HHS, but that each Exchange have the flexibility to interpret those guidelines with their own particular user interface design or “look and feel.” There should be some thought given to the establishment of an impartial usability board or panel to routinely evaluate the “ease of use” of each of the state Exchanges.

D. Qualified Health Plans

1. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP State Exchanges, subsidiary Exchanges, regional or interstate Exchanges, or an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange?

We recommend that HHS provide the states flexibility to develop the criteria and process for certifying QHPs offered through the Exchange, beyond that which is expressly specified in statute. This will allow states to identify certification requirements that are most appropriate for their marketplace, while minimizing unnecessary administrative burdens for health plans that may discourage them from participating in the Exchange.

4. What health plan standards and bidding processes would help to facilitate getting the best value for consumers and taxpayers?

In addition to the comments provided in response to D.1, we ask that states be given the flexibility to decide what leverage to use and how to structure it based upon their particular markets and circumstances.

6. What factors, bidding requirements, and review/selection practices are likely to facilitate the participation of multiple plans in Exchanges? To what extent should the Exchanges accept all plans that meet minimum standards or select and negotiate with plans?

The Health Connector administers both subsidized (CommCare) and non-subsidized (CommChoice) health insurance programs. The Health Connector solicits carrier interest in participating in these programs through two separate Request For Proposal (RFP) processes. In both of these processes, the Health Connector employs selective contracting processes that enable it to ensure it is choosing plans that provide the best value (for the state, consumers, and small businesses) and meeting the needs of consumers and small businesses.

For example, in the CommChoice program, the Health Connector has required health plans to meet certain “standardized” plan design specifications in order to participate in the program. This has facilitated ease of shopping for consumers by allowing “apples to apples” comparisons of health plans. Consumer feedback received to date reinforces the importance of this approach in simplifying the purchase of health insurance. With the “Seal of Approval” award to health plans, consumers trust the Health Connector to offer only health plans meeting certain standards, and they value the opportunity to choose among a select offering of plans, rather than being overwhelmed by too many product offerings.

For the CommCare program, the Health Connector has adopted a bidding process that encourages aggressive pricing by carriers (within a federally required actuarially sound rate range). The Health Connector’s leverage as the exclusive distribution channel for this subsidized coverage and its careful procurement strategies have been essential to its ability to offer high value, high quality health insurance to consumers.

Consistent with our experience to date, we recommend that Exchanges be granted the authority to selectively contract with and negotiate with plans. As part of this responsibility, states would balance the need to offer a sufficient choice of options with promoting simplification and competition based on price and value.

E. Quality

1. What factors are most important for consideration in establishing standards for a plan rating system?

1b. Are the measures and standards that are being used to establish ratings for health plans in the Medicare Advantage program appropriate for rating QHPs in the Exchanges? Are there other state Medicaid or commercial models that could be considered?

The Health Connector uses the National Committee for Quality Assurance (NCQA) health plan report card metrics to provide consumers information about the quality ratings of health plans available through the Health Connector. These standards are available for plans that have achieved NCQA Accreditation, and the ratings are based on a well-established and accepted methodology that incorporates measures of both clinical quality and patient satisfaction. We would recommend that states have some flexibility in identifying the appropriate rating system for their marketplace and that the NCQA ratings be included as an acceptable rating system.

J. Consumer Experience

1. What kinds of design features can help consumers obtain coverage through the Exchange? What information are consumers likely to find useful from Exchanges in making plan selections?

As described above, enabling consumers to easily view and compare, enroll, and renew in health plans, which have been certified as meeting certain standards, in a single online location is a critical function of the Exchange. Our consumer research has also highlighted interest in improved account management tools as well as additional decision support tools. These include, for example, a benefit plan selection tool, a cost calculator, and a provider search feature. The Health Connector has responded to this feedback: an e-pay feature for CommChoice members was added to the Health Connector website in the spring of 2009 and has been readily adopted by CommChoice members. In addition, the Health Connector plans to add a cost comparison tool and a provider directory tool this fiscal year. Though this is certainly not an exhaustive list of features that will assist consumers in purchasing through the Exchange, we expect these will enhance the value the Health Connector, or Exchange, brings to the health care purchasing process for consumers and small businesses.

K. Employer Participation

2. What factors are important for consideration in determining the employer size limit (e.g. 50 versus 100) for participation in a given State's Exchange?

There are several important factors that must be considered in determining the employer size limit for participation in a given state's Exchange. For example, states need to evaluate the potential impact on state rating rules and practices that would be associated with expanding employer participation in the Exchange to employers with more than 50 employees. In addition, Exchanges would need to consider the plan design preferences of larger employers and the possibility that the needs of large employers in terms of coverage area may differ markedly from those of small employers. This would then impact the types of health plans the Exchange may need to make available to employers of different sizes, and may impact the consumer experience as well. States need to be mindful of their marketplace and the potential selection issues that may emerge based on this decision. Given the importance of state specific circumstances in evaluating these impacts, this is also an area where it may be practical to allow state flexibility within statutory parameters.

L. Risk Adjustment, Reinsurance, Risk Corridors

1. To what extent do States and other entities currently risk-adjust payments for health insurance coverage in order to counter adverse selection? In what markets (e.g., Medicaid, CHIP, government employee plans, etc.) are these risk adjustment activities currently performed? To the extent that risk adjustment is or has been used, what methods have been utilized, and what are the pros and cons of such methods?

The Health Connector employs a risk adjustment process for the CommCare (subsidized) insurance program. The Health Connector uses DxCG to do predictive modeling in moving capitation dollars across participating health plans based on the expected risk of their population. As part of this approach, members who have been enrolled in the program for less than six months are given a risk score based solely on their age and gender, while members who have been in the program for longer than that time period are assigned a risk score based on their actual claims experience. Each participating health plan is assigned an aggregate risk score based on this methodology. One advantage to this approach is that it further encourages aggressive bidding of the health plans; plans are protected from shifts in the acuity of their population and can bid based on their capacity to manage care effectively since this tool adjusts capitation dollars based on actual risk.

2. To what extent do states currently collect demographic and other information, such as health status, claims history, or medical conditions under treatment on enrollees in the individual and small group markets that could be used for risk adjustment? What kinds of resources and authorities would States need in order to collect information for risk adjustment of plans offered inside and outside of the Exchanges?

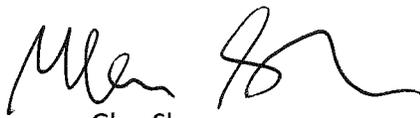
The Health Connector currently collects only demographic and claims information for enrollees in the CommCare program. This information is currently not made available to the Health Connector for individuals and small groups purchasing through the CommChoice program. The state is in the process of constructing an all-payer claims database that would likely capture much of this information for individuals and small groups, but that is still in developmental phases. In order to appropriately conduct risk adjustment within and outside the Exchange, the Exchange and/or the state's Division of Insurance would need the authority to require necessary information pertaining to member demographics and claims experience of health plans offering products in the small and non-group markets.

9. How do other programs (e.g., Medicaid) use risk corridors to share profits and losses with health plans or other entities? How are the corridors defined and monitored under these programs?

As part of its contracts with the health plans participating in the (subsidized) CommCare program, the Health Connector has included an aggregate risk-sharing program. This was included as a mechanism to account for the uncertainty surrounding actual claims experience of CommCare enrollees. This program is structured such that the Health Connector shares half of a health plan's costs if actual medical expenditures are greater than 102% but less than 150% of total capitation payments to the health plan. Conversely, actual medical expenditures greater than 50% but less than 98% of a health plan's total capitation revenue require the health plan to share the savings with the Commonwealth. This contract provision enables the Health Connector to control program costs without exposing the state or the participating health plans to severe financial risk. In addition to the aggregate risk-sharing arrangement, the Connector also included a specific stop-loss element. Under this arrangement, if the costs for a specific enrollee exceed \$150,000, the rest of the cost is covered by the stop-loss pool. The stop-loss pool is funded by a uniform assessment across participating health plans.

Thank you for the opportunity to provide comments on Exchange-related provisions in PPACA. Please do not hesitate to contact us if we can provide any additional information. We look forward to working with you as we continue to implement the provisions of PPACA in Massachusetts.

Sincerely,



Glen Shor
Executive Director
Health Connector



Kaitlyn Kenney
Director, Policy & Research
Health Connector