*The Commonwealth of Massachusetts*
*Commonwealth Health Insurance Connector Authority*
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*Boston, MA 02108*

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July 18, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9958–P
P.O. Box 8010
Baltimore, MD 21244–8010

**Re: Notice of Proposed Rule Making, Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards (Published in Federal Register Volume 78, Number 118 on June 19, 2013)**

To Whom It May Concern:

On behalf of the Massachusetts Health Connector (Health Connector), we appreciate the opportunity to provide comments on the Department of Health and Human Services (HHS) Patient Protection and Affordable Care Act (ACA); Exchange, SHOP, Premium Stabilization Programs, and Market Standards (Published in Federal Register Volume 78, Number 118 on June 19, 2013). While 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.

More than six years ago, Massachusetts enacted landmark health reform legislation, chapter 58 of the Acts of 2006, and created the Health Connector, an independent governmental authority, to promote access to affordable health insurance for the Commonwealth's residents and small businesses. The Health Connector serves as the state's Exchange, assisting individuals and small employers in acquiring health insurance through our Commonwealth Care and Commonwealth Choice programs. Commonwealth Care is a subsidized insurance program available to adults in Massachusetts earning up to 300 percent 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 small employers with 50 or fewer employees. Current enrollment in these programs is approximately 206,000 and 42,000 members, respectively.

In addition to managing these two programs, the Health Connector is charged with developing and implementing several policy and regulatory components of reform.[1] 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 level or value of health insurance an adult must maintain, and construction 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 the individual mandate. 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 has learned a considerable amount from running an Exchange for the last six years and as a result, we have taken an extremely thoughtful approach toward compliance with the ACA to ensure the law's benefits are realized by consumers, small businesses and the health insurance market. The ACA offers new tools that will help the Health Connector improve access to affordable coverage, including advance premium tax credits (APTC) for individual shoppers up to 400% FPL, resources to help us fashion real-time eligibility determinations and a risk adjustment program for our state's merged small/non-group market. Moreover, we are very proud to see that many components of the ACA are 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 broadly grounded in the elements of Massachusetts' health care reform initiative, there are differences in the law which require modification of our current policies and operations to align with new federal 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:

**Incomplete applications (155.310)**

We seek clarification on how CMS envisions the proposed approach to processing incomplete applications. Specifically, 45 CFR 155.310(k)(3) requires that the Exchange provide an eligibility determination for unsubsidized QHP enrollment to applicants who requested financial assistance when enough information has been provided to validate eligibility for Exchange participation. Massachusetts is building a joint eligibility system to be shared by its Exchange and its Medicaid office, and we have concerns that unsubsidized QHP eligibility may be confusing for some members. We also seek flexibility to use our current Medicaid program's response deadline of 10 days.

**Risk Adjustment (153.310 and 153.740)**

We seek clarification on the reporting requirements for state-based risk adjustment programs. Specifically, we seek additional guidance on expectations for the interim recertification report required during the first year of operation. We suggest that an independent audit not be required, given the interim nature of the report and the proposed due date of December 31, 2014. Further, we seek clarification on whether a summary report as described in 45 CFR 153.310(d)(4) will also be

[1] See for example, M.G.L. c. 176Q § 3, M.G.L. c. 111M § 1, et. al.

required at the conclusion of the first benefit year and whether an interim report as described in 45 CFR 153.310(d)(3) would be required at any time after the first year.

We appreciate that HHS recognizes the lengthy process of recertification, but we seek clarification as to how HHS will treat the second year of operations, including whether additional information will be required during the second year. Similarly, we seek clarification on the programmatic components HHS anticipates a state would report on through audits during the recertification process. We support a recertification process tailored to assess a state's adherence to and success with the specific construction of its risk adjustment program. Since a federally-certified State-based risk adjustment program may be structured differently to that administered by the Department of Health and Human Services, we recommend state flexibility in terms of reporting.

Finally, we seek clarification on how the enforcement authority HHS codifies in 45 CFR 153.740 will be applied in states where HHS will operate the reinsurance program but not the risk adjustment program to gain a better understanding of how that authority interacts with the state's own enforcement mechanisms regarding the provision of data by issuers.

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,

Jean Yang
Executive Director
Massachusetts Health Connector