



The Commonwealth of Massachusetts

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January 22, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2380 -PN
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Basic Health Program: Proposed Federal Funding Methodology for Program Year 2015

Dear Administrator Tavenner:

On behalf of the Massachusetts Executive Office of Health and Human Services and the Commonwealth Health Insurance Connector Authority (the Health Connector), we appreciate the opportunity to provide comments on the Notice of Proposed Rulemaking related to the Basic Health Program option of the Affordable Care Act as published in the Federal Register on December 23, 2013.

More than seven years ago, Massachusetts enacted landmark health reform legislation, Chapter 58 of the Acts of 2006, which has led to Massachusetts having the highest rate of insurance coverage in the nation. Chapter 58 enabled Massachusetts to expand coverage to the uninsured through MassHealth, the state's Medicaid program, and the Health Connector, an independent governmental authority that serves as a health insurance marketplace. The Health Connector has offered the Commonwealth Care subsidized health insurance program for low-income residents and the Commonwealth Choice commercial health insurance program for individuals and small employers. The Commonwealth is proud that many components of the Affordable Care Act (ACA) are based on elements of the Massachusetts model, including Medicaid expansion, the individual mandate, standards defining

minimum essential coverage and affordability, and the development of an Exchange to facilitate the purchase of health insurance.

The Basic Health Program (BHP) provides states with the opportunity to establish a health benefits coverage program for low-income individuals earning at or below 200 percent of the Federal Poverty Level (FPL) who otherwise would be eligible to purchase subsidized coverage through the Exchange. After careful review, Massachusetts respectfully submits these comments for consideration by the Centers for Medicare and Medicaid Services (CMS).

We offer the following comments and requests for clarification on the proposed rule:

1. Apply an adjustment for induced utilization to the calculation of Advance Premium Tax Credits (APTCs)

The Cost-Sharing Reduction (CSR) subsidy calculation (Equation 2) includes an induced utilization adjustment of 1.12 which is applied to the Adjusted Reference Premium (ARP) to reflect induced utilization due to the lower cost sharing available to low income enrollees. However, the APTCs do not have the same induced utilization adjustment of 1.12, even though induced utilization would apply to base costs. Assuming issuers price their standard Silver plan assuming some mix of low income individuals, their premiums would include some small load for induced utilization due to CSRs. If an issuer assumes that 10% of its Silver plan enrollees are low income, the average load would be 1.2% (1.12 x 10% + 1.00 x 90%). Therefore, in the absence of a BHP, the federal cost for APTC would be 1.2% higher in total to account for induced utilization for low income individuals. If BHP individuals are removed, the second lowest Silver premium would presumably decrease by 1.2% (in this simple example, BHP enrollees are assumed to be same as low income). However, the payment to the state under the proposed BHP methodology will not be correspondingly higher to account for induced utilization for low income enrollees. We believe an adjustment equal to the following should be included in Equation 1 to account for the impact of induced utilization on base premiums:

Induced Utilization Adjustment = 1.12 / (Average assumed induced utilization adjustment inherent in commercial premiums in absence of BHP).

2. Allow the use of updated, state-specific data to set the Reference Premium

CMS' proposed BHP funding methodology uses state-specific 2014 premiums, combined with a premium trend factor, to estimate 2015 program year APTCs for the second-lowest-cost Silver plan. CMS furthermore proposes to use the annual commercial cost growth rate from the National Health Expenditure projections to set the premium trend factor. However, this methodology may significantly underestimate or overestimate actual Silver plan premiums for 2015 due to ongoing changes in the individual health insurance market during the initial years of ACA implementation, as well as state-specific market factors that contribute to a premium trend rate that may vary from the national average.

Therefore we recommend that CMS allow the use of actual 2015 premiums to estimate APTCs for BHP funding. This could be achieved either through a retrospective adjustment of BHP funding for the full year, or through an adjustment that occurs in the first quarter of the 2015 program year and applies retrospectively only to the first quarter and prospectively to the remainder of the year.

3. Allow the use of state-specific utilization data in the calculation of Cost Sharing Reduction (CSR) subsidies

It is our understanding that the CSR subsidies will be based on the difference between the actuarial value (AV) of the CSR plan (for example, 94% for members below 150% FPL) and the actuarial value for a standard Silver plan (70%). Unlike Qualified Health Plans on the Exchange, the proposed BHP payment methodology includes no year-end reconciliation. For example, if a population's true AV under the base Silver plan was 50% (instead of 70%) due to differences in actual utilization compared with the assumptions used in the federal AV calculator, CMS will pay the CSR subsidy based on the AV difference between 94% and 70% (instead of 94% and 50%) because there will be no reconciliation at year end. However, for QHP eligible individuals on the Exchange, the CSR subsidy at the year-end reconciliation would be based on the AV difference between the actual experienced AV under the CSR plan and the actual experienced AV under the base Silver plan.

We have completed analysis on credible data for a large cohort of BHP eligible individuals demonstrating that the example described above is a realistic scenario.

We propose that CMS allow states to adjust for the actuarial value difference described above on a prospective basis, based on empirical evidence of the utilization for a typical BHP eligible population in that state. In other words, in the example above, CMS would pay the CSR subsidy based on the AV difference between 50% and 94% under the BHP scenario. This would only apply to such populations where such an adjustment was warranted (in this simple example, it would apply only to BHP members at or below 150% FPL).

4. Apply a reconciliation for the Population Health Factor for BHP program year 2015

The proposed BHP funding methodology uses a Population Health Factor to account for differences in the average health status between the BHP-eligible population and those eligible to purchase health insurance through the Exchange. The factor is applied because it is reasonable to assume that there may be a measurable difference in the average health status of the lower-income population that is eligible for the BHP compared with the higher-income population that remain eligible to purchase insurance through the Exchange. However, due to data constraints, for program year 2015 CMS proposes to apply a Population Health Adjustment factor of 1.00. This implies that there is no difference in average health status between the two populations and is equivalent to not applying any Population Health Adjustment factor in the first year of the program.

We recommend that CMS allow for a Population Health Adjustment to be applied retrospectively for program year 2015, using, as applicable, the state-specific risk adjustment methodology or the federally approved methodology that the state uses for retrospective risk adjustment inside and outside the Exchange.

5. Allow the use of updated, state-specific data to set the Factor for Removing Administrative Costs

CMS' proposed BHP funding methodology uses a Factor for Removing Administrative Costs (FRAC) to represent the average percentage of the total premium that insurers use for providing health benefits rather than for administration. CMS proposes to set the FRAC at the minimum loss ratio (MLR) allowed under the ACA at 0.80. In other words, CMS assumes that health insurance issuers will use 20 percent of the total premium to pay for administration.

This assumption may not accurately reflect the actual administrative costs of health insurance carriers in many states. In some states, insurers may have a significantly higher medical loss ratio (and a correspondingly lower administrative load) than the minimum allowed under the ACA. Issuers may set lower premiums and accept a lower percentage of premiums for administrative costs in order to attract enrollees.

We therefore propose that CMS use state-specific experience to set the FRAC. An updated state-specific FRAC could be achieved either through a retrospective adjustment of BHP funding for the full year, or through an adjustment that occurs in the first quarter of the 2015 program year and applies retrospectively only to the first quarter and prospectively to the remainder of the year. If CMS requires a prospective methodology for the FRAC, at a minimum the FRAC should be set on a state-specific basis using the average MLR for Silver plans in the Exchange in 2014.

6. Clarify the transitional reinsurance adjustment

We request additional clarification on the transitional reinsurance adjustment in the calculation of state BHP revenue. We would expect CMS to include a component in the trend adjustment that would be equal to (% of costs not covered by reinsurance recoveries in year x+1) / (% of costs not covered by reinsurance recoveries in year x). For example, if 2014 reinsurance recoveries were expected to be 10% of total costs, and 2015 recoveries were expected to be 6% of total costs, the adjustment would be:

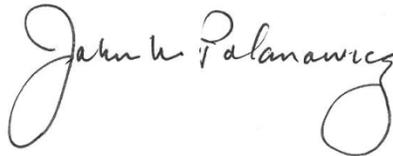
$$(1.00-0.06) / (1.00 - 0.10) = 1.044$$

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

Sincerely,



Jean Yang
Executive Director
Massachusetts Health Connector



John Polanowicz
Secretary
Executive Office of Health and Human Services