



*The Commonwealth of Massachusetts*  
**COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY**  
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**Office of Consumer Affairs and Business Regulation**  
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GARY D. ANDERSON  
Acting Commissioner of  
Insurance

December 22, 2014

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9944-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**Re: CMS-9944-P, Notice of Proposed Rule Making, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 (Published in Federal Register Volume 79, Number 228 on November 26, 2014)**

To Whom It May Concern:

On behalf of the Massachusetts Health Connector (Health Connector) and Division of Insurance, we appreciate the opportunity to provide comments on the Department of Health and Human Services (HHS) Patient Protection and Affordable Care Act (ACA); HHS Notice of Benefit and Payment Parameters for 2016 (Published in Federal Register Volume 79, Number 228 on November 26, 2014). 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 where the proposed rule would have a direct impact on the policy or operations of the Health Connector in Massachusetts.

More than eight years ago, Massachusetts enacted landmark health reform legislation, Chapter 58 of the Acts of 2006, to promote access to affordable health insurance for the Commonwealth's residents and small businesses. While many aspects of the ACA are broadly grounded in the elements of Massachusetts' health care reform initiative, there are differences in the law that require modification of our current policies and operations to align with new federal requirements. The Health Connector and the Division of Insurance are 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. With this background in mind, we offer the following comments to assist your review of the proposed rule.

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

**Annual Eligibility Redeterminations (45 CFR 155.335)**

We support granting flexibility to states to implement alternative renewal hierarchies to best support the needs of their enrollees and promote competition and high-value plans in the marketplace. The Health Connector has implemented renewal processes under both its Commonwealth Care and

Commonwealth Choice programs, and we feel that this experience has provided valuable insight that could inform our renewal procedures as a Marketplace under the ACA.

With regard to the proposal that individuals could opt into a low-cost plan hierarchy across Issuers, it is our experience that these kinds of changes have the potential for unanticipated disruption of coverage and continuity of care, as a new plan may have significantly different benefits, cost-sharing, and provider networks. Our experience has also shown that continued access to an individual's providers is extremely important to most enrollees. Individuals who opt into a low-cost plan hierarchy may not appreciate the differences in benefits, cost-sharing and provider networks until the new plan has taken effect. Although individuals would be given the opportunity to change plans during open enrollment, most people find plan selection extremely complex and would need significant assistance efforts to ensure that they understand the default plan and how it might impact the ways in which they access care.

In our Commonwealth Choice program, which offered unsubsidized coverage to individuals and small businesses, renewals were mapped to the most similar plan offered (if their existing plan was no longer offered) by an enrollee's Issuer on the same provider network. By offering a similar plan through the consumer's current Issuer with the same provider network, we have found that we are able to mitigate some continuity of care issues, as access to existing providers is not compromised. In our Commonwealth Care program, which provided subsidized coverage to individuals through highly standardized plans, we conducted only passive open enrollment periods. In other words, enrollees were not required to actively re-select their plan and if their plan was no longer available, ensuring continued access to existing providers was a priority in mapping members to a new plan.

#### **Enrollment of Qualified Individuals into OHPs (45 CFR 155.400)**

We support modification of enrollment rules to require a first month's premium payment to effectuate coverage. HHS suggests that consumers could be given a window after the coverage effective date to make payment. We recommend that HHS not adopt rules that permit consumers to enroll in coverage before sending a payment to the Marketplace or the Issuer. We have concerns about the implications of such a policy on existing rules for non-payment of premiums and for markets in which the Marketplace aggregates premiums on behalf of Issuers. In our market, for example, the Health Connector collects premiums on behalf of all its participating Issuers and has designed operational and technical processes that do not transmit enrollment information to the Issuer until the first month's payment has been received from the individual. A change in policy permitting enrollment prior to remitting premium would require significant changes for a Marketplace such as ours in Massachusetts, and, as such, we would request that, if HHS adopts such a policy, that state-based Marketplaces have the flexibility to elect whether or not to adopt the policy.

#### **Initial and Annual Open Enrollment Periods (45 CFR 155.410)**

We request flexibility for state Marketplaces to set the timeframe for the annual open enrollment period to allow for responsiveness to market needs and alignment with QHP certification timelines. If states were given such flexibility, requirements could include a minimum period of time for which open enrollment must last, but with the flexibility to set different dates relative to the federal Marketplace or other state based marketplaces. In the alternative, we would recommend that states be able to extend open enrollment, as long as the federal open enrollment period occurs within the period set by the state. This flexibility would allow, for example, states with payment deadlines beyond the 15<sup>th</sup> of the month to align enrollment and payment deadlines during Open Enrollment (*e.g.*, instead of

December 15<sup>th</sup>, closing Open Enrollment on December 23<sup>rd</sup>, the date of that particular Marketplace's payment due date).

**Special Enrollment Periods (45 CFR 155.420)**

We support the proposal to allow individuals a special enrollment period in advance of a permanent move. This change will reduce the potential for gaps in coverage and provide consumers continuous access to care.

We further support the proposal to create a special enrollment period for individuals under a court order to purchase insurance coverage and to allow that coverage to take effect on the first effective date of the court order. Similarly, we support the proposal to allow individuals who lose a dependent or experience loss of dependent status to be determined eligible for a special enrollment period.

**Termination of Coverage (45 CFR 155.430)**

In the preamble to the proposed rule, HHS indicates that it intends to modify the language of several sections in the final rule to indicate situations in which an individual's eligibility for Marketplace-based coverage may terminate without ending coverage through the Issuer. The Health Connector serves as the aggregator of premiums for its Issuers and maintains enrollment records on behalf of its Issuers, transmitting relevant information to Issuers for claims processing. This relationship allows for increased participation in the Marketplace by alleviating technical and operational burdens on small Issuers.

HHS proposes that Marketplaces would be required to terminate Marketplace eligibility without terminating coverage through the Issuer. In a market where the Marketplace manages enrollment for the Issuers, such a change would require a significant shift in technical and operational processes to identify individuals whose coverage should be terminated from those who should continue coverage with the Issuer without the Marketplace as an intermediary. We support the guaranteed availability and renewability provisions of the ACA, but we request that HHS not be prescriptive as to the method by which they are met.

Additionally, we request that HHS outline in more detail the circumstances under which a Marketplace-initiated termination must be accepted by an Issuer, and when the Issuer must maintain coverage despite the Marketplace termination. Because no specific regulatory language was modified in the proposed rule, we were not able to thoroughly assess potential impacts on the Marketplace, Issuers, or consumers.

**QHP Transparency (45 CFR 156.220)**

We request flexibility for states to define the timing, format for reports and method for displaying QHP transparency data. The Commonwealth of Massachusetts currently collects a significant amount of claims, enrollment and enrollee data through our All Payer Claims Database and existing data reporting requirements. Allowing states flexibility to use existing formats and define reporting approaches that are responsive to market needs will reduce duplicative work while strengthening past practice in light of the ACA.

**Timing of Rate Filings**

Massachusetts operates a state-based marketplace and reviews all individual and small group rate filings according to the statutory and regulatory parameters established under state law in a manner

that is consistent with all related federal rules and guidance. Over the past three years, the federal government has examined Massachusetts' rate review practices and has found Massachusetts to be an effective rate review state.

Within the proposed 45 CFR 154.220, it is noted that the Secretary of HHS could identify the date on which the next year's individual and small groups rate filings are to be submitted to state regulators and the federal government; as written, this would establish a date that would apply even in a state with an effective rate review program where the federal government does not review that state's rate filings. As written, under this rule, the date established by the Secretary of Health and Human Services may be in May, which is significantly earlier than the July 1 date required for carriers in Massachusetts' market. Filings submitted in May instead of July would be less reliable since they would not include the most-up-to-date trend information that Massachusetts expects to be reflected in its rate filings.

The Commonwealth respectfully requests that 45 CFR 154.220 be amended so that the rate filing date established by the Secretary of HHS only applies to rate filings submitted for those states with a federally facilitated marketplace or for states that have not been designated as sponsoring an effective rate review program. States with effective rate review programs should be permitted to set their own deadlines for the submission of rate filings and should not be required to satisfy the deadline established by the Secretary.

### **Merged Market Requirements**

Massachusetts has operated with a merged individual and small group market since July 2007 in which carriers are required to offer the same products to all eligible individuals and small groups according to rating rules that have been established in state law. Although Massachusetts has continued its merged market, it also operates under a transition period granted by the federal government on April 5, 2013 allowing for the continued use of certain non-ACA identified rating factors for the duration of the transition period. Due to this federally approved transition period, Massachusetts has been told it is not considered to be merged for the purpose of federal market rules.

Within the proposed 45 CFR 147.104, it is noted that all plans sold in a merged market should be sold on a calendar year basis and renew on January 1 regardless of the current renewal date of a group's coverage. In Massachusetts, all individual coverage and rates are in effect for a calendar year that ends on December 31 but small employers have coverage that renews in differing months throughout the year. The proposed rule would require – only in merged market states – that small employers move their coverage to a January 1 effective date and this would cause significant disruption to their existing coverage systems.

The Commonwealth respectfully requests that 45 CFR 147.104 be amended so that it does not require states with merged markets to apply calendar year coverage and rating rules to small employers in ways that penalize them for the implementation of a merged individual and small group market in their state.

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,

A handwritten signature in black ink, appearing to read "Jean Yang". The signature is fluid and cursive, with a long horizontal stroke at the end.

Jean Yang  
Executive Director  
Commonwealth Health Connector

A handwritten signature in black ink, appearing to read "Gary D. Anderson". The signature is cursive and includes a long horizontal stroke at the end.

Gary D. Anderson  
Acting Commissioner of Insurance