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December 26, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9972–P
P.O. Box 8010
Baltimore, MD 21244–8010

Re: CMS-9972-P:
Health Insurance Market Rules; Rate Review

To Whom It May Concern:

On behalf of the Commonwealth of Massachusetts, we appreciate the opportunity to provide comments on the CMS-9972-P, as published in the Federal Register on November 26, 2012. This rule proposed by the Centers for Medicare and Medicaid Services (CMS) applies to Sections 2701, 2702 and 2703 of the Public Health Service Act, as added and amended by the Patient Protection and Affordable Care Act (ACA) and are proposed to be effective for plan years (group market) and policy years (individual market) starting on or after January 1, 2014.

The comments presented in this letter are intended to assist CMS with implementation of the ACA and are focused on areas that we think are important for your consideration and/or that might benefit from clarification of a particular issue.

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

Standardization of Small Group Rating Factors

In CMS-9972-P, it is proposed at 45 CFR 147.102(a)(1) that the rates that are to be applied to individuals and small employers with respect to a particular plan may only vary based on (i) whether the plan covers an individual or family, (ii) rating area, (iii) age, and (iv) tobacco use. It is further noted at 45 CFR 147.102(g) that noted restrictions would apply to all group plan years and individual policy years beginning on or after January 1, 2014.

The Commonwealth has had a strong guarantee issue market for individual coverage since 1997 and for small employer coverage since 1992. These separate markets were merged in 2007 into one market that covers approximately 720,000 Massachusetts residents. Our state laws restrict the rates that may be charged to eligible individuals and eligible small employers, using statutorily required rating factors within a 2-to-1 rating band. The changes proposed at 45 CFR 147.102(a)(1) will make the following changes to our longstanding rating rules:

- Restrict use of age rating;
- Remove industry as a rating factor;
- Remove participation-rate as a rating factor;
- Remove group size as a rating factor;
- Remove intermediary discount as a rating factor; and
- Remove group purchasing cooperative discount as a rating factor.

Our actuaries have reviewed how these changes would impact our markets and have found that on a revenue-neutral basis, while many individuals and small group members in the Commonwealth will see premium decreases, a significant number will see extreme premium increases as a result of these changes.

It is noted in CMS -9972-P that CMS is interested in comments that "CMS or states might deploy to avoid or minimize disruption of rates in the current market…[including]a phase-in or transition period for certain policies." The Commonwealth points out the need for such flexibility to mitigate the substantial rate impacts that will likely disrupt coverage markets in states such as Massachusetts.

The Commonwealth respectfully requests that 45 CFR 147.102(a)(1) be amended to permit individual states to request waivers from the ACA-prescribed rating rules when rating factors advance a state's sound public policy.

The Commonwealth respectfully requests that 45 CFR 147.102(a)(1) be further amended to permit individual states to request a reasonable transition period during which the state would gradually modify its rating rules to ultimately comply with 45 CMR 147.102(a)(1).

During the years in which the Commonwealth implemented its guaranteed issue markets, it employed three-year transition periods to mitigate overall market rate disruption and led to the orderly acceptance of our own market rating restrictions. Allowing states to gradually implement the rules through a reasonable transition period can reduce the premium impacts to more reasonable levels of increase on a year-to-year basis.

In addition, allowing for a transitional period to implement the ACA rating factors would not thwart the overall goals and purpose of the ACA. The preamble to the proposed market and rating rule states that "the provisions of the proposed rule, combined with other provisions in the Affordable Care Act, will improve the individual health insurance market by making insurance affordable and accessible to millions of Americans who currently do not have affordable options available to them." In Massachusetts, those goals have already been realized, and a shift to the

ACA rating factors represents a different approach to the same solution. The goals of the ACA are not thwarted in any way by allowing a transition to the ACA rating rules. *See* Preamble to Proposed Rule, Federal Register, at. 70585.

Clarification of Area Rating Factors

In 45 CFR 147.102(b), there are proposed rules regarding the development of rating areas associated with the rating area factor permitted in 45 CFR 102(a)(1)(ii) which are generally consistent with rules being applied in the Commonwealth. However, when applying rating area factors to premiums charged to the Commonwealth's merged small group/individual markets, the variation in the rating area factor is limited to a 1.5-to-1 band and there do not appear to be any items in the rules that contemplate an individual state having such limitations in the permissible variation in area rating factors.

The Commonwealth respectfully requests that 45 CFR 147.102(b) be amended to clarify that individual states may request that rating area factors be limited to a permissible range when such limits advance a state's sound public policy.

Guaranteed Availability of Coverage

45 CFR 147.104 of the NPRM proposes implementation of a market-wide initial and annual open enrollment period, consistent with those required by Exchanges for individual market QHPs. The NPRM solicits comments on whether this sufficiently addresses the open enrollment needs of individual market customers whose coverage renews on dates other than January 1 and whether aligning open enrollment periods with policy years (based on calendar years) in the individual market is more desirable.

Based on our experience implementing open enrollment periods in our nongroup market, the Commonwealth respectfully requests that states be provided flexibility to mandate a common anniversary or renewal date of January 1, even for those who initially purchased on a different date. This significantly reduces confusion in the market and promotes a streamlined approach to benefit design associated with deductibles and out-of-pocket expenses for consumers.

Special Enrollment Election Period

45 CFR 147.104 of the NPRM allows for special open enrollment periods for individuals based on certain qualifying events. For those individuals eligible to enroll during these special open enrollment periods, the NPRM proposes a 30-day election period for individuals to enroll and/or change plans, but requests comments "as to whether another standard, such as 60 calendar days, generally consistent with the Exchange, is more appropriate."

Based on our experience implementing open enrollment periods in our nongroup market, we recommend that the same election periods apply both inside and outside of the state's Exchange marketplace to minimize consumer confusion and ease state administration. We would further recommend that 63 days, instead of 60 days, be the required election period for individuals shopping in a state's nongroup market, whether inside or outside of the state's Exchange marketplace. The recommended 63-day election period is based on Massachusetts' current open enrollment rules, which capture a full two calendar months' time and which we believe provide

the appropriate amount of time needed for individuals to take advantage of a special open enrollment period. In addition, this standard is more in line with existing market practice and would be least disruptive for nongroup members.

Catastrophic Health Plans

45 CFR 156.155 describes Catastrophic Health Plans and indicates that these plans must "provide coverage for at least three primary care visits per year before reaching the deductible." We seek clarification as to if the intent is to provide coverage for three primary care visits prior to the deductible *in addition to* preventive care visits which must be covered prior to the deductible and with no cost-sharing per insurance market reforms introduced by Title I of the Affordable Care Act (ACA). If that is the intended definition, then a Catastrophic Health Plan may not meet the definition of a federally qualified High Deductible Health Plan (HDHP) and would not, therefore, be compatible with a Health Savings Account (HSA). For those consumers that are eligible to purchase Catastrophic Health Plans, we would respectfully recommend that these plans be deemed to be federally qualified HDHPs so that they would be HSA compatible, providing maximum support to those consumers that may need to purchase Catastrophic Health Plans.

Common Rate Filing Tool

In CMS-9972-P, it is proposed at 45 CFR 154.215 that if any health insurance product is subject to a rate increase that a health insurance issuer must submit a Rate Filing Justification for all products on a form and in a manner prescribed by the Secretary. It is further clarified at 45 CFR 154.215(b) that the Rate Filing Justification must consist of a standardized data template that must include items as listed in 45 CFR 154.215(d). It is also proposed at 45 CFR 154.220 that a health issuer must submit a Rate Filing Justification for all rate increases that are filed in a State on or after April 1, 2013, or effective on or after January 1, 2014 in a State that does not require the rate increase to be filed.

Within CMS-9972-P, CMS proposed the use of a standard data collection tool in order to create greater uniformity for effective rate review information, creating efficiencies and also providing issuers with a standardized, electronic format for submitting this uniform data. It was suggested that this should, on net, reduce the burden of providing similar data in multiple formats to each state and the federal government. CMS requested comments about the additional burden, if any, it would impose on health insurance issuers and the state.

The Commonwealth of Massachusetts is concerned that the required use of the federal tool described in 45 CFR 154.215 will not assist our existing rate review process and will create additional regulatory burdens. Massachusetts has been deemed an "effective rate review state" by CMS following a review of the manner that our staff has used in reviewing health insurance rate increase filings. Over the past year, the Commonwealth has developed and employed a standard rate filing data submission tool to collect the information that Massachusetts has deemed necessary and appropriate to conduct rate reviews in our state. This tool has provided the right level of detail for our consulting actuaries to collect, analyze and report on small group/individual health insurance rate filings within the 45-day period allowed under

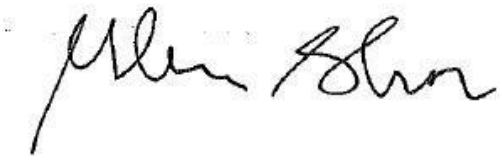
Massachusetts statutes. The Massachusetts tool enables our actuaries to review rate filings in a way that reduces the burden on state regulators and regulated parties.

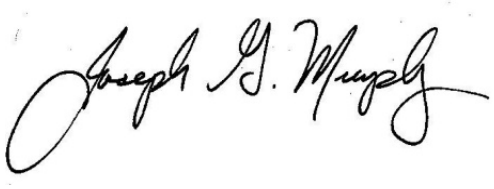
From a review of the standardized date template proposed by CMS, the Commonwealth does not find that the template includes the level of information necessary and appropriate to conduct the Commonwealth's rate reviews in an orderly and timely manner and that the Commonwealth would need to continue to collect information according to its own rate filing submission tool. The tool required under 45 CFR 154.215(d) would decrease the efficiency of the rate review process in Massachusetts as issuers would be required to complete a CMS tool that would not be used in the rate review process, and Massachusetts regulators would be required to ensure that information reported in its own tool were consistent with what is reported in the CMS tool.

The Commonwealth respectfully requests that 45 CFR 154.215(d) be amended to permit individual states to request a waiver from the required standardized data template if the state has been found to be an effective rate review state, if the state collects more detailed information than included in the federal tool, and if the information in the state toolis more necessary and appropriate information to conduct reviews within that 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,





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