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December 26, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9964–P
P.O. Box 8016
Baltimore, MD 21244–8016

Re: CMS-9964-P:
HHS Notice of Benefit and Payment Parameters for 2014

To Whom It May Concern:

The Commonwealth of Massachusetts appreciates the opportunity to provide comments on CMS-9964-P, as published in the Federal Register on December 7, 2012. The comments in this letter are intended to assist CMS with the implementation of the Affordable Care Act (ACA) in the most expeditious, yet orderly, way, and reflect areas in which we have relevant experience that we think is important for your consideration and/or the proposed rule would have a direct impact on the health insurance market in Massachusetts.

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

Silver Plan Variation Requirements

Section 156.420 of the proposed rule requires all Qualified Health Plan (QHP) issuers submit three Silver Variation plans for each of the Silver plans submitted to the Exchange for certification. While this provision is intended to meet the federal requirements with respect to providing individuals eligible for cost sharing reductions (CSRs) access to plans that meet these CSR and actuarial value targets, the Commonwealth believes that under certain circumstances, this requirement may constrain a state's ability to construct its Exchange efficiently.

In particular, Massachusetts is exploring the possibility of providing enhanced premium and cost sharing subsidies (i.e., a state-funded "wrap" in addition to the federal advanced premium tax credits and CSRs) to eligible Exchange purchasers with income up to 300% FPL. Under this proposed approach, availability of the state wrap would be limited to a selection of the lowest-

priced silver plans in order to ensure that consumers have adequate choice and access to needed providers, while at the same time encouraging carriers to price aggressively in order to qualify. This vision is very consistent with the Commonwealth Care program currently offered by the Health Connector, where a select group of competitively priced issuers serve the up-to-300% FPL population that is not eligible for Medicaid.

Under our proposed approach, we anticipate that similar to the current pattern of Commonwealth Care, enrollment of the CSR-eligible population will be concentrated in the "wrap" plans; this will likely result in virtually no enrollment in non-wrap silver variation plans. In this example, the requirement for all issuers to submit silver variation plans would lead to unnecessary administrative and operational costs for both Exchanges and issuers. We also believe that this requirement, which results in Silver Variation plans with different CSR levels, will be a source of confusion for members.

The Commonwealth thus respectfully recommends a modification to the proposed rule that would provide flexibility to states to avoid the operational burden on carriers who would likely have very low or no enrollment in the silver variation plans. It is our understanding that other states may also be exploring opportunities to provide additional state subsidies. Depending on the approaches under consideration, the concern we have raised here may also be applicable in those states. To that end, we would respectfully request consideration of an approach that would permit federal discretion, informed by collaboration with a state-based Exchange, in determining whether all QHP issuers participating in a given state-based Exchange must submit silver variation plans.

Transitional Reinsurance Program

Within CMS-9964-P, CMS identifies the manner in which a Transitional Reinsurance Program is to be implemented to help stabilize premiums for coverage in the individual market from 2014 through 2016.

It is noted in CMS-9964-P that the Reinsurance Program is designed to reduce the potential losses of carriers as they shift into the guaranteed issue of individual health coverage. Under this program, group health plans are to be assessed $20 billion between 2014 and 2016 to finance the cost of payments to carriers covering high-cost individual enrollees. Although individual states may apply to operate the Transitional Reinsurance Program, the federal government will operate the program if they do not apply.

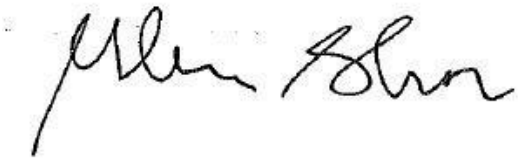
Massachusetts has operated guaranteed issue markets for individuals since 1997 and for small employers since 1992, and took the step to combine its individual and small employer markets into one merged market in 2007. The rates charged to individuals and employers are based on the same experience rules and the same rating factors. Although Massachusetts had state-mandated reinsurance pools in existence for its individual and small employer market to stabilize the premiums available in those markets, these reinsurance programs were statutorily terminated in 2006 as they were no longer deemed to be necessary following the merger of our individual and small employer markets.

The Commonwealth is interested in seeking a waiver from the Transitional Reinsurance Program due to the existence of the merged market and the early termination of our state reinsurance plans. In a merged individual-small employer market such as ours, the reinsurance payments may not have a direct impact on individual policy premiums because the rates in a merged market are based on the collective experience of all individual policies and small group plans. In certain cases, the Transitional Reinsurance Program may lead to increased individual premiums for carriers who pay higher reinsurance assessments for their small employer business than they receive in reinsurance payments for their high-cost individual members.

The Commonwealth respectfully requests that 45 CFR 153.210 be amended to permit individual states to request waivers from the required implementation of a Transitional Reinsurance Program, especially if a state has a mechanism already in place, such as a merged individual-small employer market, that has addressed the need to stabilize individual policy premiums as high-cost individuals buy coverage in a guaranteed issue environment. Under the requested waiver, a state would be waived from the requirement to implement reinsurance assessments on health insurance issuers and third-party administrators in the state, and the individual market of the state would not be subject to reinsurance recoveries in relation to the Transitional Reinsurance Program under Section 1341 of the ACA.

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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