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December 26, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9980–P
P.O. Box 8010
Baltimore, MD 21244–8010

RE: CMS-9980-P:
Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

To Whom It May Concern:

The Commonwealth of Massachusetts appreciates the opportunity to comment on CMS-9980-P, as published in the Federal Register on November 26, 2012. This rule proposed by the Department of Health and Human Services applies to Section 1302 of the Public Health Service Act, as added and amended by the Patient Protection and Affordable Care Act (Affordable Care Act or ACA) and is proposed to be effective for plan years starting on or after January 1, 2014. The Department of Health and Human Services proposes changes to 45 CFR 156 in order to implement rules associated with essential health benefit plans, actuarial values and accreditation.

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

Clarification About Wellness Programs within Essential Health Benefits

In CMS-9980-P, it is proposed at 45 CFR 147.150 that health insurance coverage in the individual or small group market include essential health benefits as defined by a state for coverage made effective on or after January 1, 2014. There are further items proposed in 45 CMR 156.110 about the benefits included in a benchmark plan and at 45 CFR 156.140 about the manner in which a state would select a benchmark plan which will be used to define essential health benefits in a state. The Commonwealth of Massachusetts has identified – as is illustrated in CMS-9980-P – that its benchmark plan is the Blue Cross and Blue Shield of Massachusetts, Inc. HMO Blue 2000 Deductible Plan and that this plan is supplemented for pediatric oral benefits by the state's CHIP plan.

The Commonwealth requests that 45 CFR 156.110 be amended to indicate that an individual state may choose, when designating a benchmark plan, whether certain plan features that are

wellness program benefits and not insurance benefits, per se, – including reimbursement for gym memberships and participation in weight loss programs – may be excluded from what is part of the essential health benefits choice. This change will reduce potential confusion about whether these wellness features are required to be included in a state's essential health benefits choice.

Plans Fitting within Metallic Tier Actuarial Value Limitations

In CMS-9980-P, it is proposed at 45 CFR 156.140 that the actuarial value calculated by the Actuarial Value calculator will determine whether a health plan offers a "bronze," "silver," "gold," or "platinum" metallic tier level of coverage. It is also proposed that there be an allowable variation in the AV of a health plan within a metallic tier level of coverage that permits a variation of not more than +/- 2 percentage points.

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 require that all products currently being offered to eligible individuals and eligible small employers be made available to all other individuals and all other small employers. The changes proposed at 45 CFR 156.140 will impact the coverage that is currently held by many of these individuals.

Our actuaries have reviewed how these changes would impact our markets on January 1, 2014 and have found that many existing plans offered in the Massachusetts market fall outside the ranges established in 45 CFR 156.140. In order to comply with the standards defined within 45 CFR 156.140, more than 300,000 members who are in plans currently outside the acceptable metallic tier AV levels will need to either remove benefits or increase benefits to meet the ACA actuarial value standards.

The Commonwealth respectfully requests that 45 CFR 156.140(c) be amended to permit individual states to apply to expand the de minimis variation from "+/- 2 percentage points" to "+/- 3 percentage points" to expand the array of products that may be available to eligible individuals and eligible small employers within a state. It is our position that this will provide more options than would be available under the proposed 45 CFR 156.140. Since this would be closer to what is available in markets such as Massachusetts, we believe that this would reduce any potential disruption as individuals and small employers look for coverage options closer to what they currently have in 2013. As part of the state-based risk adjustment methodology that the Commonwealth has developed and will be submitting to HHS for federal review certification in early January, we have incorporated mechanisms that would allow for appropriate modifications of the "induced utilization adjustment" to accommodate the requested flexibility and ensure accuracy of risk adjustment.

Common Actuarial Value Calculation Tool

In CMS-9980-P, it is proposed at 45 CFR 156.135 that a health plan's actuarial value is to be determined through the use of the AV calculator developed and made available by HHS. CMS has proposed a standard tool in order to create greater uniformity of calculation across plans to ensure that plans fit within the levels of coverage identified in 45 CFR 156.140. It is further noted that there are exceptions to the use of a calculator if a plan's design does not fit into the Actuarial Value calculator.

The Commonwealth of Massachusetts recommends that the Actuarial Value Calculator be examined in detail prior to its use in all applications and that appropriate instructions be developed to minimize the variability in its use across health plans and reviewing regulators. From a preliminary use of this calculator, the Commonwealth's actuaries note that many common Massachusetts benefit features are not addressed, including the following:

- Outpatient surgery copayments;
- Deductibles that differ for different services;
- Prescription drug copayments that differ by retail and mail-order pharmacies; and
- More than 2-levels of provider benefit tiering.

In addition, according to this review, it appears that different values may be calculated if the inputs are added to the worksheet in different ways or in different order. It is imperative that carriers and regulators have confidence in the output actuarial values and that they are applied as consistently as possible from one carrier-to-another carrier.

The Commonwealth recommends that 45 CFR 156.140 require the use of a standard Actuarial Value calculator in a state only after it has been certified by an independent board of actuaries in that state so as to minimize disruptive differences in the application of the AV calculator from one carrier to another..

Additional Required Benefits Payments

Section 155.170(a) of the NPRM requires states to defray the cost of certain state mandated benefits in addition to the Essential Health Benefits (EHBs). The language in the regulation indicates that a state must defray costs for benefits beyond the EHBs in Qualified Health Plans (QHPs), and defines QHPs as plans certified by the Exchange. The regulation further requires Exchanges to identify which state-required benefits are in excess of the EHBs and therefore must be state-funded.

The Commonwealth respectfully requests a narrower interpretation of the requirement codified in Section 1311(d)(3)(B) that states assume the cost of any additional benefits that a state may require a QHP to offer. The language in Section 1311 permits states to offer QHPs with benefits beyond EHBs, and the proposed rule permits states to determine which benefits fall outside EHBs for purposes of determining the benefits for which a state must assume the cost. We propose that a state be permitted to determine that only those benefits falling outside of the EHB in QHPs sold to persons with the assistance of advanced premium tax credits (APTCs) be subject to the requirement that the state must defray the cost of the additional benefits. We respectfully submit that any interpretation beyond that unfairly burdens states with defraying the cost of benefits generally codified into state law as a result of a state's representative legislative process.
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Pediatric Dental Benefits for Plans Sold Outside of the Exchange

Section 156.150 of the proposed rules allows Qualified Health Plans (QHPs) to be offered through an Exchange without the inclusion of pediatric dental benefits as long as a stand-alone Qualified Dental Plan is offered separately on the Exchange. In Massachusetts' Exchange, the

Health Connector intends to offer stand-alone Qualified Dental Plans that provide coverage for pediatric dental EHB, which would allow QHPs that do not include an embedded dental benefit to be offered on the Exchange. The NPRM does not clarify, however, whether the same mechanism of allowing the combination of medical plans and stand-alone dental plans to provide EHB coverage would be permitted outside the Exchange. We believe that section 156.150 should be amended to clarify that such a mechanism is permissible both inside and outside the Exchange. Absent this consistency, pricing in the Exchange will be potentially different for the same product relative to pricing outside the Exchange, which creates consumer confusion, raises potential gaming and selection concerns, and increases administrative complexity for carriers.

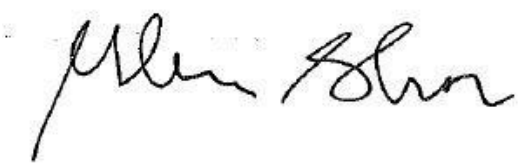
Separate Out-of-Pocket Maximum for the Pediatric Dental Benefit

Section 156.150 discusses several potential approaches to applying the out-of-pocket limit to stand-alone dental plans. The challenge, as noted in the NPRM, is how to appropriately apply the statutory out-of-pocket limit to the entire set of EHBs in a manner that can be reasonably administered. We agree with the proposed rule that stand-alone Qualified Dental Plans offered through an Exchange include an out-of-pocket maximum that is separate from the out-of-pocket maximum for the EHBs in the QHP, as long as there is a reasonable annual limit on cost-sharing and on the total of both out-of-pocket maximums.

We request that section 156.150 be amended to clarify that the same treatment is allowed consistently across the market, including for plans sold inside the Exchange and plans sold outside the Exchange. We similarly request that the treatment be permitted for both situations in which dental EHB is offered through a stand-alone plan and in which dental EHB is an embedded benefit of an integrated plan. Many of the operational challenges associated with coordination between QHPs and stand-alone dental plans also exist with embedded dental plans and should be appropriately recognized. In addition, this also strengthens pricing and product consistency in the market, which will make it significantly easier for consumers to navigate their options.

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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