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March 18, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9958–P
P.O. Box 8010
Baltimore, MD 21244–8010

Re: Notice of Proposed Rule Making Regarding the Department of Health and Human Services Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions (Published in Federal Register Volume 78, Number 22 on February 1, 2013)

To Whom It May Concern:

On behalf of the Massachusetts Health Connector (Health Connector), we appreciate the opportunity to provide comments on the Department of Health and Human Services (HHS) Patient Protection and Affordable Care Act (ACA); Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions Notice of Proposed Rule Making (NPRM) published in Federal Register on February 1, 2013. 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 the NPRM would have a direct impact on the policy or operations of the Health Connector in Massachusetts.

More than six years ago, Massachusetts enacted landmark health reform legislation, chapter 58 of the Acts of 2006, and created the Health Connector, an independent governmental authority, to promote access to affordable health insurance for the Commonwealth's residents and small businesses. The Health Connector serves as the state's Exchange, assisting individuals and small employers in acquiring health insurance through our Commonwealth Care and Commonwealth Choice programs. Commonwealth Care is a subsidized insurance program available to adults in Massachusetts earning up to 300 percent of the Federal Poverty Level (FPL) who generally do not have access to Employer Sponsored Insurance (ESI) or other subsidized insurance and who meet certain eligibility guidelines. Commonwealth Choice is a non-subsidized insurance program available to individuals and small employers with 50 or fewer employees. Current enrollment in these programs is approximately 198,000 and 44,000 members, respectively.

In addition to managing these two programs, the Health Connector is charged with developing and implementing several policy and regulatory components of reform.[1] Among the most important policy tasks completed and managed by the Health Connector are those associated with the implementation of the state's health care coverage mandate. These include, for example, development of regulations defining what constitutes Minimum Creditable Coverage (MCC), or the level or value of health insurance an adult must maintain, and construction of an Affordability Schedule, which defines the maximum amount an adult is expected to contribute toward the purchase of MCC-compliant health insurance and determines application of the individual mandate. The Health Connector also administers an appeals program. This program handles both appeals of Commonwealth Care members and applicants, as well as of tax filers who are assessed penalties for failing to comply with the state's coverage mandate.

The Health Connector has learned a considerable amount from running an Exchange for the last six years and as a result, we have taken an extremely thoughtful approach toward compliance with the ACA to ensure the law's benefits are realized by consumers, small businesses and the health insurance market. The ACA offers new tools that will help the Health Connector improve access to affordable coverage, including advance premium tax credits (APTC) for individual shoppers up to 400% FPL, resources to help us fashion real-time eligibility determinations and a risk adjustment program for our state's merged small/non-group market. Moreover, we are very proud to see that many components of the ACA are based on elements of the Massachusetts model, including, for example, the individual mandate, standards defining minimum essential coverage and affordability, and the development of an Exchange to facilitate the purchase of health insurance.

Nonetheless, while many aspects of the ACA are broadly grounded in the elements of Massachusetts' health care reform initiative, there are differences in the law which require modification of our current policies and operations to align with new federal requirements. The Health Connector is 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.

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

Renewal Process for Certificates of Exemption (§155.605(c)(2))
Massachusetts's experience has shown that the individual mandate is an integral component of health care reform. We believe that the existence of a renewal reminder discounts the importance of the insurance coverage that is at the heart of the ACA. While the certificate of exemption process allows for essential flexibility in the application of the mandate, most exemptions are granted on the basis that they are temporary. The absence of a reminder service does not preclude individuals from applying for and receiving exemptions in future years, but it does reinforce that insurance coverage is the ultimate goal of health care reform and that all individuals are expected to participate. We respectfully recommend that the Exchange need not be required to provide a renewal reminder for those who have previously requested a certificate of exemption (COE).

Religious Conscience Exemptions (155.605(c))
The proposed rule requires that Exchanges issue COEs based on objections due to religious conscience. Although 26 USC 5000A states that an individual shall not be penalized if he has an exemption from the Exchange on religious conscience grounds, it does not state that such exemptions

[1] See for example, M.G.L. c. 176Q § 3, M.G.L. c. 111M § 1, et. al.

may be issued solely by an Exchange. Especially where the ACA limits consideration of religious groups to those listed in Section 1402(g)(1) of the IRS code, we believe that either the IRS or the Social Security Administration is the entity in the best position to issue exemptions based on religious conscience. Such an arrangement would eliminate the need for individuals to submit documentation of the tax exemption already granted to them by the IRS, as suggested in 155.615(b)(1).

We foresee administrative difficulties for individuals who wish to appeal the denial of their exemption request due to the absence of their religion from the list provided by federal agencies. It does not appear that Exchanges will be in a position to provide any remedy, resulting in fruitless appeals that are costly to appellants and Exchanges. One solution to this problem would be to allow individuals attesting to membership in a religion not included on the official list the ability to appeal a COE denial to the appropriate federal agency instead of to the Exchange. Individuals denied on a basis other than the failure of their religious group to appear in the approved list would still appeal to the Exchange under this modification.

Noticing and Appeals for Certificates of Exemption (155.605 and 155.610)

While we support the ability of individuals to request exemptions under multiple categories through one application, we request clarification on procedures for notifying applicants when the Exchange allows exemptions in some categories but not others. We believe that sending a notice saying that the individual is both exempt for a given month and denied an exemption for the same month is unnecessarily confusing and could lead to avoidable appeals. Once an individual is granted one exemption, no further exemption for that time period is warranted. However, the Exchange should issue a denial notice with appeal rights for any month with respect to which an exemption was requested but not granted. For example, suppose an individual requests a full year exemption on the grounds that he was both incarcerated and suffered a financial hardship, and he provides proof of incarceration from January through June and no other documents. The Exchange should issue a COE for January through June and a denial notice for July through December on the grounds that the applicant failed to provide proof of a hardship. Under the modification we propose, no denial would be issued for January through June for failure to demonstrate a hardship.

Hardship Certificate of Exemption Verifications (§155.615(f))

Flexibility for an Exchange to determine what constitutes a hardship dictates corresponding flexibility in the variety of acceptable supporting documentation. We appreciate the broad language in the proposed rule that would allow us to consider extenuating circumstances for those very low income individuals who have obstacles to maintaining enrollment, such as homelessness or mental illness. Furthermore, access to employer-sponsored insurance may prevent individuals from obtaining premium support while still leaving them with difficult choices between health care and other essential expenses. We respectfully request Exchange discretion in this area as it allows for meaningful hearings in which a hearing officer can use his or her best judgment in determining the totality of the applicant's circumstances.

Timeframe for Requesting a Certificate of Exemption (155.610)

Section 155.610(h) proposes that requests for exemption on religious conscience and hardship grounds may be submitted after December 31 of the year for which they are requested. The preamble elaborates that "[HHS considers] the availability of exemptions from the Exchange necessary only until an individual can file an income tax return claiming an exemption for a given coverage year." We seek clarification as to whether HHS intends to limit the ability to request such an exemption to the original tax filing due date or if a taxpayer who applies for and is granted a filing extension or who amends a previously filed return could apply for an exemption at that time.

Our experience in administering an individual responsibility exemption process has found that the vast majority of individuals file for an exemption at the time they file their taxes rather than during the applicable calendar year. We expect that many individuals will request an extension on their filing due date in order to submit an exemption request and believe that this should be permissible.

Recognition of other plans as minimum essential coverage compliant (§156.604)

Per section 5000A of the Internal Revenue Code (Code), the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, may designate types of health benefits coverage not otherwise designated minimum essential coverage in statute or regulation as minimum essential coverage. Section 156.604 of the proposed rule outlines the process by which plan sponsors may apply to HHS for such recognition. Given the Commonwealth's significant experience with and ongoing maintenance of a state-level mandate, the Health Connector respectfully requests modification to the proposed rule to provide states the opportunity to work in collaboration with HHS to review such applications.

Massachusetts's state-level mandate requires most adult residents to maintain affordable health insurance that meets the state's MCC standards (*i.e.,* coverage that provides a minimum value or level of coverage), if an affordable plan is available to them. These MCC requirements have been in effect since 2007 and the regulations have been updated periodically since that time.[2] While MCC does not directly impose any standards on employers or plan sponsors, under MCC rules, businesses of all sizes are accustomed to providing coverage to Massachusetts employees that meets certain standards.

The Health Connector operates an "MCC Certification" process by which a health benefit plan that does not meet every element of the MCC Regulation may apply to the Health Connector for review. Similar to the process defined under §156.604, if the Health Connector, in its discretion, felt that the coverage was sufficiently comprehensive, the Health Connector could deem such health benefit plan as being actuarially equivalent to MCC standards despite its deviation(s) from the MCC standards.[3] This process is critical to ensuring that Massachusetts residents covered under self-insured national plans or a group insurance plan issued in another state have robust coverage consistent with what is required under the state regulations.

The Health Connector has worked to ensure our existing state individual mandate requirements, including the state MCC regulations, "mesh" with insurance market reforms instituted by the ACA and other components of the federal individual mandate. In order to maintain these important state-level consumer protections and prevent consumer confusion with similar ACA requirements, we respectfully request the opportunity to work with HHS in the review of any plans available in the Commonwealth applying for minimum essential coverage compliance. Further, such flexibility would enable the Health Connector to coordinate the MCC Certification process with HHS's process for recognizing other types of coverage as minimum essential coverage compliant.

Other types of minimum essential coverage (§156.602)

By statute, Minimum Essential Coverage (MEC) is defined to include specific government-sponsored plans, employer plans, individual plans, grandfathered plans, and "other" categories to be defined by HHS. Per Section 155.305(f)(ii)(B) of the Exchange final rule, individuals are not eligible for an APTC if they are eligible for MEC "with the exception of coverage in the individual market."

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[2] Details regarding the Minimum Creditable Coverage requirements may be accessed via http://tinyurl.com/mccbackground.

[3] The MCC Certification process is further described in Health Connector Administrative Bulletins (released in November 2008 and February 2010). Administrative bulletins issued by the Health Connector are available online at, http://tinyurl.com/MCCbulletins.

Since § 147.145(a) of the student health final rule defined student health plans as individual plans, we have interpreted this to mean that students could be found eligible for an Advance Premium Tax Credit (APTC). However, this proposed rule defines self-funded student health plans as a separate category of per se MEC-compliant coverage, and it is thus unclear whether students enrolled in these plans could be found eligible for an APTC.

While the IRS APTC final rule clarifies that an individual with access to MEC may nevertheless be eligible for an APTC if that MEC is coverage obtained in the individual market or if that coverage is group coverage but it is either not affordable or does not meet minimum value standards, there is no language that says an individual eligible for a per se MEC compliant category defined by HHS could be eligible for an APTC, or whether any exceptions apply to per se MEC compliant coverage. Further, this NPRM is silent on how per se MEC compliant categories of coverage impact APTC eligibly. Given this analysis, we believe access to per se MEC coverage could preclude APTC eligibility.

We respectfully request clarification of this issue. Specifically, we seek guidance as to whether this interpretation is accurate and whether the proposed rule precludes those students with access to self-funded student health insurance from obtaining APTCs.

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,

Jean Yang
Executive Director
Massachusetts Health Connector