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Department of Treasury
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Re: Notice of Proposed Rule Making Regarding the Health Insurance Premium Tax Credit (Published in Federal Register Volume 76, Number 159 on August 17, 2011)

To Whom It May Concern:

On behalf of the Massachusetts Health Connector (Health Connector), we appreciate the opportunity to provide comments on the Notice of Proposed Rule Making (NPRM) regarding the Health Insurance Premium Tax Credit published in the Federal Register on August 17, 2011.

The Health Connector is an independent state authority created by Chapter 58 of the Acts of 2006 to implement key elements of Massachusetts' historic health reform law. The Health Connector serves as an Exchange that assists individuals, families, and small employers in acquiring health coverage either through the Commonwealth Care or Commonwealth Choice programs. Commonwealth Care is a subsidized insurance program available to adults in Massachusetts earning up to 300% 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 to small employers with 50 or fewer employees. Current enrollment in these programs is approximately 159,000 and 42,000 members, respectively.[1]

In addition to managing these two programs, the Health Connector is charged with developing and implementing several policy and regulatory components of reform.[2] Among the most important policy tasks completed and managed by the Health Connector are those associated with the

[1]The Health Connector also administers a program referred to as Commonwealth Care Bridge. This program provides subsidized insurance coverage to approximately 15,000 legal immigrants who have been in the United States for less than five years.

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

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 minimum level or value of health insurance an adult must maintain, and adoption 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 tax penalties for lacking coverage. 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 embraces national health reform and looks forward to the opportunity to further expand access to health insurance coverage to residents in our state through implementation of this law. Moreover, we are very proud to see that many components of the ACA are broadly 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 grounded in the elements of Massachusetts' health care reform initiative, we will have much work to do in the coming years to evaluate the consistency of our current policies and operations with new federal requirements. We anticipate that we will need to refine our approach in certain areas in order to comply with those 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:

§ 1.36B-1 (h) Premium tax credit definitions.
This section of the NPRM defines the Federal Poverty Level (FPL) for computing premium tax credit eligibility as the FPL in effect on the first day of the initial or annual open enrollment period preceding the coverage effective tax year. [See also §155.300 of the Exchange eligibility NPRM, "Definitions and general standards for eligibility determinations. Definition of 'Federal Poverty Level.'"]

As noted in the comments on the Exchange eligibility NPRM, in determining eligibility for Medicaid, states do not use the FPL amounts when they are published but rather when they become effective (usually in March). The Commonwealth has a concern about using different FPL effective dates (and potentially differing FPL amounts) for Exchange and for Medicaid eligibility as this will increase the complexity in the eligibility determination rules.

§ 1.36B-2(c)(3)(v) Eligibility for premium tax credit. Affordable coverage.
According to this section of the NPRM, eligible employer-sponsored plans are considered affordable for the employee and related individuals if the portion of the annual premium the employee must pay for self-only coverage does not exceed 9.5 percent.

The Health Connector would like to express concern regarding this approach for determining affordability. Given that employers may provide differential subsidization of insurance for dependents, or no subsidization, utilizing self-only coverage as a proxy of affordability of ESI for a family seems inappropriate. This methodology may require some families to spend significantly more

than 9.5% of income on health insurance and will preclude the family members of the employee from accessing tax credit subsidized insurance through the Exchange. Though the proposed regulation indicates that households that do not have an affordable family plan option may be exempt from the mandate (pending further proposed regulations), this proposed approach will still preclude these individuals from having access to potentially subsidized, affordable coverage through the Exchange.

§ 1.36B-2(c)(3)(vi) Eligibility for premium tax credit. Minimum value.
Section 1.36B of the NPRM, indicates that an employer-sponsored plan is defined as providing minimum value only if plan's share of total allowed costs of benefits is at least 60 percent.

Based on our experience in Massachusetts ensuring residents are aware as to whether their plan meets our state MCC standards, we would recommend that the plan or plan administrator be required to indicate on the schedule of benefits or other summary benefit information whether a plan meets the "minimum value" requirement. The value of a plan will be difficult for an individual to assess, and the Exchange will not be able to perform such an assessment for every applicant. While we understand that the requirement that a plan or plan administrator must inform consumers of a plan's value *may* appear in future rules on the definition of minimum value, we would recommend that this requirement be included here to mitigate consumer confusion.

§ 1.36B-4 Reconciling the premium tax credit with advance credit payments.
According to this section of the NPRM, a taxpayer whose premium tax credit for the taxable year exceeds the taxpayer's advance credit payments may receive the excess as an income tax refund. A taxpayer whose advance credit payments for the taxable year exceed the premium tax credit owes the excess as an additional income tax liability.

The proposed rule also indicates that household income will be determined on an annual basis and prorated for each month to determine the monthly premium assistance amount, and that the income will likely be determined based on FPL standards in effect prior to the start of the tax year for which the coverage and tax credits are effective. Given these procedures, and the fact that incomes for low-to-middle income people can often fluctuate throughout the course of a year, it may be difficult to ensure that a given individual or family's initial tax credit calculation will remain the same throughout a given tax year. Moreover, it may be difficult for an individual or family to recognize if/when their income has risen or dropped sufficiently to merit a modification to their tax credit amount. There may also be some processing time associated with acquiring the necessary documentation and filing of this information with state and federal entities.

Since the reconciliation process may have material financial consequences for some individuals and families, the Health Connector would recommend that the IRS consider a federally administered appeals process of the reconciliation determination. This process would allow individuals to demonstrate cause to appeal a reconciliation decision imposed at tax time.

The Health Connector would also like to seek clarification on section 1.36B-4(a)(2) of the proposed rule. This section of the NPRM indicates that if the applicable benchmark plan changes during the taxable year, the taxpayer may be required to use *a different* applicable benchmark plan to determine the premium assistance amounts for coverage months. This language seems inconsistent with other sections of the NPRM. For example, Section 1.36B-3(f)(4) and (5)(example 9) indicate that a taxpayer is locked in to the rate for a benchmark plan for the year upon enrollment; even if that particular benchmark plan closes during the course of the year, it still remains the benchmark for the taxpayer's calculation.

Example 9 (page 51) states:

> **Benchmark plan closes to new enrollees during the year.**
> Taxpayers X, Y, and Z each have coverage families consisting of two adults. In the rating area where X, Y, and Z reside, Plan 2 is the second lowest cost silver plan and Plan 3 is the third lowest cost silver plan covering two adults offered through the Exchange. The X and Y families each enroll in a qualified health plan that is not the applicable benchmark plan in November during the regular open enrollment period. Plan 2 closes to new enrollees the following June. Thus, on July 1, Plan 3 is the second lowest cost silver plan available to new enrollees through the Exchange. The Z family enrolls in a qualified health plan in July. Under paragraphs (f)(1), (f)(2), and (f)(4) of this section, the applicable benchmark plan is Plan 2 for X and Y for all coverage months during the year. The applicable benchmark plan for Z is Plan 3, because Plan 2 is not offered through the Exchange when the Z family enrolls.

These sections suggest that the benchmark rate is fixed at the time a taxpayer enrolls and does not change. One interpretation of the language in section 1.36B-4(a)(2) might be that the rate for the benchmark plan is "locked-in" for the course of the year at enrollment, and that remains the calculation for the tax credit calculation throughout the course of the year, even if that plan closes. However, at the end of the year, during the tax and reconciliation process, the taxpayer must use the actual rate for the benchmark plan as it was at the end of the year when completing their tax return. Based on this interpretation, if the rate for the benchmark plan increased, the taxpayer would be entitled to an additional credit, paid as a refund. On the other hand, if the rate of the benchmark plan was reduced, the taxpayer would be responsible for any necessary reconciliation. However, the regulation uses the language "if the *benchmark* changes" as opposed to "if the rate changes" so it is difficult to determine if this is the correct interpretation of this section.

Based on our experience, rates may change on a monthly basis. This would have important ramifications based on the aforementioned interpretation. The Health Connector would recommend clarification as to the appropriate interpretation and application of this section. We thank you in advance for your clarification of this issue.

Sincerely,

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