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January 27, 2022

Center for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS 9911-P
P.O. Box 8016
Baltimore, MD 21244

Re: Notice of Proposed Rulemaking, "HHS Notice of Benefit and Payment Parameters for 2023" (Published in Federal Register Volume 87, Number 3, page 584 on January 5, 2022)

Dear Secretary Becerra:

The Massachusetts Health Connector ("Health Connector"), a state-based Marketplace (SBM) authorized under the Patient Protection and Affordable Care Act of 2010 ("ACA"), appreciates the opportunity provided by the Department of Health and Human Services (HHS) to comment on the proposed rule, **"HHS Notice of Benefit and Payment Parameters for 2023" (NBPP).**

Founded in 2006 as part of bipartisan state health reform, the Massachusetts Health Connector is the longest-running State-Based Marketplace (SBM) in the country. The Health Connector is designed to connect Massachusetts residents and small businesses with high quality, affordable health coverage and to promote universal health coverage in the Commonwealth. Today, the Health Connector serves over a quarter-million Massachusetts residents, including approximately 250,000 individuals as well as over 10,000 small business employees. The Health Connector's efforts have contributed to the Commonwealth's status as one of the healthiest states in the nation,[1] with a nation-leading health insurance rate over 97%,[2] and the second lowest-cost average Marketplace premiums in the country in 2021.[3]

While HHS offered guidance on a number of important areas for Marketplaces to consider, our comments focus on areas where the proposed rule would have a direct impact on the policy-related or operational aspects of the Health Connector's ongoing work. We respectfully offer the following comments relating to the proposed rule.

The Health Connector has concerns with the State Exchange Improper Payment Measurement (SEIPM) program as proposed and suggests HHS revise the program design to address the diversity of policies and

[1] *See* https://www.beckershospitalreview.com/rankings-and-ratings/50-states-ranked-from-healthiest-to-unhealthiest-090221.html
[2] Kaiser Family Foundation analysis of U.S. Census Bureau data, at https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[3] : Kaiser Family Foundation analysis of data from Healthcare.gov, state rate review websites, and state plan finder tools. Analysis of CMS Public Use Files.

implementation approaches employed by state-based Exchanges, and to reduce overly burdensome program requirements. (45 CFR 155.1500 et seq.)

The Health Connector has long focused on ensuring the program integrity of its operations and has been a leader among Exchanges in areas such as verification for special enrollment periods (SEPs) and residency. HHS itself cites the strong performance of Exchanges and low risks of program integrity concerns as the basis for other portions of the NBPP, namely SEP verification and employer-sponsored coverage verification. Given the extensive evidence that Exchanges are capably performing their duties with respect to public service missions and program integrity alike, as demonstrated by the examples provided by HHS as well as the annual programmatic audits and state Marketplace reporting submitted to the Centers for Medicare and Medicaid Services (CMS), the SEIPM process proposed is unnecessarily burdensome.

The Health Connector began working with CMS in 2016 on a pilot of the EIPM program and discovered that the process, which is ongoing, is complex and resource-intensive, involving extensive engagement of staff from operations, IT, policy, and legal teams. The process has been more difficult than the annual programmatic audit because CMS is attempting to create a standardized approach across Exchanges, often based on the data model and procedures used by the federally facilitated Exchange (FFE) that do not comport with SBM practices, despite the significant flexibility offered to states in the state-based Exchange model more generally under the Affordable Care Act. In addition to outlining and documenting its own detailed procedures, the Health Connector has had to map them against the standardized approach in CMS documents, which has resulted in a number of questions and iterative dialogue with CMS about what is being requested, diverting staff attention and resources from day-to-day operations and responsibilities.

Given the complexities of the pilot program, the Health Connector is concerned that the redetermination and appeal process does not allow for the introduction of new information that may clarify the process used by the Exchange in a particular scenario. Any process related to identifying Exchange errors should include a meaningful opportunity for Exchanges to provide explanatory or supplemental information that could result in a reassessment by HHS and thus result in a more accurate determination of any improper payments allowed by Exchange policies or procedures.

Furthermore, while HHS indicates it will not publish an Exchange's results, the proposal to publish error rates across state-based Exchanges in the aggregate will negatively reflect on higher-performing Exchanges. This is especially concerning given the likelihood of the program as proposed to result in negative findings because it does not address Exchange-specific implementation designs. To the extent that design flaws in the process result in a higher assessed rate of improper payments, it could minimize the essential work Exchanges have done to insure millions of Americans appropriately under the rules of the Affordable Care Act.

The Health Connector is concerned that this process will unfairly penalize state-based Exchanges and discourage the kind of innovation and flexibility that has benefited both their own members and those in the FFE. As such, we strongly recommend CMS consider revamping this proposal to instead build on the existing programmatic audit process to include a measure of estimated payment errors based on the auditor's findings. This would allow Exchanges to continue with audit processes that have been in place for years and that reflect the policy and operational flexibilities adopted by each Exchange without one-size-fits-all procedural models.

The Health Connector requests flexibility on wider *de minimis* variation for Gold and Platinum plans to provide affordable plan choices. (45 CFR 156.140)

The Health Connector was pleased to see the proposal to discontinue Bronze plan variations as low as 56 percent Actuarial Value (AV), as we continue to have concerns about the less consumer protective aspects of health coverage products at such low AVs with such extensive cost sharing exposure, as well as the impact of loosened AV ranges generally which tend to undermine the apples-to-apples comparability of

products within a given metal tier. As such, the proposal makes sense on the Silver tier as well, given proliferation of "high Bronze" plans that incorporate high value care designs and the potential for consumer confusion when comparing Bronze plans at the top of the allowable AV range and Silver plans at the bottom of the allowable range.

However, the Health Connector requests that HHS consider either not adopting the narrow AV variation for Gold and Platinum plans or providing states with flexibility to adopt them. In response to the cessation of federal cost-sharing reduction payments in late 2017 and the subsequent premium increases of on-Exchange Silver plans nationwide, the Health Connector implemented a required but not standardized "low Gold" plan that provides cost-sensitive enrollees with an alternative to Silver tier plans with a roughly 76 percent AV. This design has been popular and now accounts for 51 percent of the Health Connector's Gold plan enrollments. Discontinuing the plan would be disruptive for members in these plans and could result in affordability issues. While we support the concept of tightened AV ranges for comparability purposes, certain circumstances such as the above-noted one may merit individualized responses at a state-level that aim to balance competing consumer-benefitting policy objectives.

Further, while we were pleased to see that CMS made some adjustments to the 2023 Actuarial Value calculator that have the effect of slowing the increase of the AV of Bronze plans, the Health Connector had hoped to see adjustments responsive to previously submitted feedback from the Massachusetts Health Connector and Division of Insurance requesting the ability to enter plans that do not accrue copays to the deductible for services that are not subject to the deductible. This is a common plan design in Massachusetts and other states. Massachusetts again requests that CMS address this issue in the 2023 AV calculator. The Health Connector will also submit separate comments on the AV calculator to this effect.

The Health Connector requests that HHS provide continued flexibility for partial month payment approaches across all Exchanges. (45 CFR 155.240, .305, and .340)

In the proposed rule, HHS cites concerns that individuals in some Exchanges may be subject to repayment of Advance Premium Tax Credits (APTCs) for partial month enrollments and proposes that all Exchanges prorate premiums and APTC as a remedy. While the Health Connector does not prorate by the day, its longstanding approach to partial month enrollments ensures that premiums and APTCs are always applied consistently such that an individual would never receive more APTC than is appropriate for the premium charged. As such, the underlaying problem this proposal seeks to address is moot in the context of the Health Connector's operational practices and the proposed adjustment would require complex and resource-intensive system changes without consumer or public benefit. Consequently, the Health Connector requests continued flexibility for states in this space such that future development work can focus on enhancements to the member experience that will be meaningful for members and applicants.

Further, the Health Connector is concerned that the calculations of partial month APTC under the proposed rule are inconsistent with calculations under the IRS rules at 26 CFR 1.36B-3(d) and could result in someone receiving less APTC than they are entitled to for a partial month.

The Health Connector appreciates HHS's consideration of the trade-offs between network adequacy and cost and welcomes future policy development in this space.

The Health Connector has been working to find policy approaches to balance network breadth and cost for several years, as price competition in our state-subsidized ConnectorCare program has brought this trade-off into stark relief over time. In December 2021, the Health Connector Board of Directors discussed issues of network breadth though the lens of racial equity efforts, particularly given the higher proportion of Black and Hispanic/Latino members served by the program and the strong price and risk selection incentives for carriers to narrow networks to reduce premiums.[4] Staff appreciate and welcome the

[4] https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2021/12-09-21/Equity-Agenda-Program-and-Policy-Work-Update-Presentation-120921.pdf

opportunity to work with HHS as it considers similar tensions, particularly given HHS's equity and member-focused commitments that the Health Connector shares.

HHS also seeks comment on the role of provider negotiating power in the context of Qualified Health Plans (QHPs) and whether "all-or-nothing" provider contracts are an area for future scrutiny. The Health Connector would note that for several years, it has sought to expand the number of carriers participating in the ConnectorCare program on Martha's Vineyard and Nantucket. However, because the hospitals in those counties are part of the Mass General Brigham system, which operates on an all-or-nothing contracting model, it has to date been cost prohibitive for many of our participating carriers to add the hospitals. The Health Connector welcomes additional ideas and guidance from HHS on this issue and appreciates the expression of policy interest in this topic as a part of this proposed rule.

The Health Connector fully supports the proposals to reduce discrimination in Qualified Health Plans and to actively seek ways to enhance equity within Exchanges and their health plans.

The Health Connector applauds HHS's commitment to non-discrimination and equity and appreciates the rule's clarifications with respect to HHS's position on non-discrimination protections for LGBTQ populations under ACA Section 1557. Further, the Health Connector supports and appreciates the equity-focused initiatives included in the NBPP, several of which mirror initiatives the Health Connector has begun to undertake. Specifically, in December, the Health Connector issued a Request for Information seeking public comment on ways it can improve maternal health outcomes, behavioral health treatment, and gender-affirming care and generally prioritize health equity in its plan certification and program design work for plan year 2023.[5] Additionally, in 2020 and early 2021, the Health Connector, in conjunction with the Massachusetts Division of Insurance, reviewed QHPs for discriminatory benefit and formulary designs and identified several areas of possible concern, notably prior authorization requirements for substance use disorder medications, and is working to resolve those concerns on behalf of members. Over the long term, the Health Connector is working to more formally incorporate non-discriminatory benefit review processes into its standard plan management operating procedure as part of its broader equity agenda.

An additional area of focus for the Health Connector related to equity is in data collection. In conjunction with the Massachusetts Medicaid agency, MassHealth, the Health Connector made enhancements to the application questions related to race, ethnicity, and language in December 2021. The agencies are working with an advisory group to recommend further enhancements, with the goal of increasing responses to these optional questions and providing response options that reflect the diversity of the Massachusetts population while maintaining interoperability with other entities' data structures and reporting requirements. The Health Connector would welcome additional guidance from HHS that may support aligning approaches across entities to help make meaningful, comparable progress in data collection that can be used to inform equity-centered policy making, program development, and outreach as it relates to the health coverage landscape.

The Health Connector supports the revised approach to employer-sponsored insurance (ESI) verification and the flexibility it affords Exchanges in crafting processes tailored to their populations. (45 CFR 155.320)

The Health Connector appreciates the information HHS shared about its analysis of ESI verifications in the FFE as well as the opportunity to review its own data and determine an appropriate verification pathway that reduces administrative burdens on both Exchange staff and members.

The Health Connector appreciates the proposed rule's continued accounting for Massachusetts-specific market factors in the risk adjustment methodology. (45 CFR 153.320)

The Health Connector thanks HHS for continuing to include an adjustment to the federal risk adjustment methodology that accounts for unique market dynamics resulting from the design of the ConnectorCare

[5] https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-23-1175-1175C-1175L-69525&external=true&parentUrl=close

program, which provides additional state-funded premium and cost sharing subsidies to individuals ≤300 percent FPL eligible for advance premium tax credits. The ConnectorCare program is integral to the coverage landscape in Massachusetts and currently covers over 150,000 state residents. We appreciate HHS's continued recognition of this unique state program.

We thank you for consideration of our comments and look forward to working with HHS on continued implementation of the ACA.

Sincerely,

Louis Gutierrez
Executive Director