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February 28, 2020

Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-9916-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Notice of Proposed Rulemaking, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans" (Published in Federal Register Volume 85, Number 25, page 7088 on February 6, 2020)

To Whom It May Concern:

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 and the Centers for Medicare and Medicaid Services ("CMS") to comment on the proposed rule, "Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans" (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 300,000 individuals as well as over 8,000 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 lowest-cost average Marketplace premiums in the country.[3]

While CMS 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

[1] *See* www.mass.gov/news/massachusetts-named-healthiest-state-in-the-nation.
[2] U.S. Census Bureau, at www2.census.gov/programs-surveys/demo/tables/p60/264/table6.pdf.
[3] Analysis of CMS Public Use Files, at www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html.

aspects of the Health Connector's ongoing work. We respectfully offer the following comments relating to the proposed rule.

1. The Health Connector requests that CMS continue to allow automatic re-enrollment according to state redetermination and renewal plans at the time of renewal for Marketplace enrollees without making any changes to automatic renewal for enrollees with zero-dollar premiums. (85 FR 7119)

The Health Connector has significant concerns with the suggestion that future rulemaking might disrupt the automatic annual re-enrollment process states have used for years to promote continuity of coverage and reduce burdens on consumers and insurance carriers by requiring reduction or discontinuance of subsidies for individuals whose premiums are reduced to $0 by advance premium tax credits (APTCs). This proposal runs counter to standard insurance market practices, infringes upon state-developed eligibility and enrollment processes that meet local market and policy needs, would disrupt insurance coverage for a population of enrollees solely because of their income in a way that would threaten coverage gains and overall market stability, would be operationally burdensome and costly, and lacks the specificity that would properly allow the public to provide adequate comment.

Automatic re-enrollment for non-group coverage is codified in state and federal guaranteed renewability laws that apply to all markets, including the individual market, and it is consistent with the automatic process used in employer-sponsored coverage and other insurance markets. Specifically, both the ACA and Massachusetts law require an issuer to renew coverage at the option of the individual or group, unless very limited exceptions apply.[4] In no other context would renewal be contingent on enrollee activity, nor would an enrollee be penalized for automatically renewing. Creating a new standard for non-group enrollees shopping through the Marketplace is confusing and burdensome to the enrollee, onerous and costly to the Marketplace that will have to address and remedy that confusion and burden, and at odds with the concept of guaranteed renewability. Indeed, as CMS acknowledges in the rule, Congress recently reminded CMS of its expectation of automatic re-enrollment by amending ACA section 1311(c) to prohibit departures from the automatic re-enrollment process. It is therefore unclear on what basis suggested changes in this area are premised.

CMS has previously codified flexibility for states to tailor their annual redetermination and renewals process to meet the needs of their specific populations and local markets, within the guardrails of guaranteed renewal. It is unclear why CMS suggests departing from this emphasis on state flexibility now. The Health Connector has collaborated closely with its insurance carriers and state Medicaid partners to design an eligibility redetermination process confirming or updating eligibility of Marketplace households, including those with Medicaid members. This process carefully considers member-reported data, manual eligibility verifications, and electronic data sources to provide individuals with the most accurate prediction of their renewal year circumstances possible. Members are also strongly encouraged to return to their applications and provide any updated information. To date, our process has excelled at prompting members to successfully report changes, with an 85% increase in the number of requests for documentation in the weeks directly following preliminary annual redetermination notices. This approach, combined with periodic data matching and outreach to consumers reminding them to make updates periodically, is the foundation of program integrity and determination of appropriate eligibility. It is not clear what the discontinuance of subsidies adds to the annual eligibility redetermination process. Instead of achieving the purported goal of targeting individuals with outdated or inconclusive eligibility information, the contemplated proposal simply penalizes a specific class of Marketplace enrollees -- low-income individuals -- who have chosen to buy a low-cost plan.

Further, individuals and families purchasing their own coverage already have strong incentives to shop for coverage that meets their needs at the lowest cost. There is no need to disrupt coverage to achieve this goal. The Health Connector's experience is that many individuals who review their options ultimately choose to continue in their existing plan, suggesting that, in the absence of major changes

[4] 42 USC 300-gg2; Massachusetts General Law c. 176J, §4.

year-over-year, automatic re-enrollment is an efficient and effective way of maintaining the right plan. For example, for 2020, over 55,000 Health Connector enrollees reviewed their options but ultimately did not change carriers or metallic tiers. Importantly, individuals who have achieved a $0 premium by applying APTCs are already likely to have "bought down" to a lowest-cost Silver or Bronze plan, so it is unclear what additional premium savings they can expect to gain by being forced to shop in order to continue accessing the benefits and coverage they are eligible for and entitled to.

We ask that CMS also consider the broader insurance market harms of its proposal to reduce or eliminate subsidies for individuals whose premiums are reduced to $0 by APTCs, as these individuals are more likely to be younger or lower income. Not only are these individuals more likely to struggle with reinstituting their subsidies, those who fail to keep their coverage are likely to be the healthiest. Individuals who have achieved a $0 premium by applying APTCs to a lowest-cost Silver or Bronze plan demonstrate a concern for costs as well as low intended utilization. Introducing unnecessary confusion, abrasion, and burden to their member experience is likely to weed out those who do not face immediate health care needs. In other words, this policy is likely to reduce "net contributors" in the insurance market. Their exit from the market is therefore likely to increase premiums for the insureds who remain. An approach to target individuals with large APTC amounts is likely to commence a downward cycle in which fewer enrollees are covered, but those remaining (including unsubsidized enrollees) face higher premiums. Further, these increased premiums each year will likely increase overall APTC amounts, unnecessarily burdening the federal taxpayer, and will lead to more $0 payers as a result of increased APTC, which lead to more renewal disturbances. The analogy of discontinuance of federal Cost Sharing Reduction subsidies, and concomitant increase in federal APTC, comes to mind in considering the net effect on premiums and subsidies.

If CMS were to proceed with changes to automatic re-enrollment policies for 2021, SBMs would need to modify their systems and processes, including allocation of significant call center, Navigator, and other consumer support resources to assist confused consumers attempting to regain their subsidy eligibility. Such a change in direction would require substantial changes to SBM infrastructure that would represent an unfunded mandate on states and require significant cost and time to complete, at the expense of other priorities designed to enhance our market and improve coverage and customer service experience for members. The Health Connector's experience demonstrates that without automatic re-enrollment, gaps in coverage as well as significant customer service needs would be commonplace. In 2014, the Health Connector faced the challenge of transitioning roughly 90,000 members enrolled in the pre-ACA Commonwealth Care subsidy program into Qualified Health Plans (QHPs). A diverse and robust outreach campaign sparked no action in 18% of Commonwealth Care members as the end of open enrollment for 2015 approached, and another 30% were still in the process of applying five days before open enrollment ended, resulting in substantial burdens on consumers, carriers, and the agency as individuals scrambled to secure coverage. The Health Connector expects that if CMS finalizes a proposal to change auto-enrollment practices in April, it would be difficult -- if not impossible -- for SBMs to make technical and operational changes and sufficiently re-allocate resources before Open Enrollment 2021.

Finally, and importantly, the contemplated proposal was not sufficiently outlined in this proposed rule such that it could result in a policy change affecting state-based Marketplaces in the final Notice of Benefit and Payment Parameters. Administrative procedure requires that regulatory provisions be clearly proposed for public comment before finalization. It is unclear what CMS believes may be "finaliz[ed] in a final rule" on this topic without first proposing draft regulations with adequate specificity to understand what would be implemented and how any proposal fits within with the Congressional directive noted above.

2. The Health Connector appreciates the opportunity to provide comments on whether changes are necessary to how Marketplaces administer Eligibility Pending Appeal and has specific feedback from our local experience. (45 CFR 155.525)

The Health Connector appreciates that CMS is reviewing the standards for how Marketplaces administer Eligibility Pending Appeal. The questions CMS raises are ones the Health Connector has considered over the course of administering its appeals process since 2014, and we believe that it would be helpful for CMS to provide guidance in this space, while also ensuring room for state flexibility, where appropriate.

Below, the Heath Connector provides specific comments to CMS's areas of discussion. In general, however, we believe it is worthwhile to articulate our understanding of how Eligibility Pending Appeal fits into Marketplace eligibility. Unlike Medicaid benefits, for which eligibility is generally individual and binary (*i.e.,* a given individual is eligible or not eligible for a given benefit), Marketplace benefits do not reduce so simply. Instead they function across tax households and on a sliding scale, one which moves based on the multiple variable inputs underlying the eligibility. Because of this, the Health Connector believes that Eligibility Pending Appeal is less about the particular "benefit level" for which an appellant was eligible immediately before the eligibility determination on appeal, but instead is about ensuring that the appellant can be restored to the same position they otherwise would have been in, had the disputed eligibility determination not occurred. Since eligibility determinations often change based on a single factor, we generally believe it is appropriate to regard the disputed factor as fixed, and allow the other factors around it to "float," as in the normal course, such that an appellant may be (a) restored to the exact benefits they had prior to the disputed determination, if everything else is the same, or, alternatively, (b) placed into a different appropriate benefit, if something has changed since the disputed determination.

The following comments are animated by this general framework, and track CMS's structure of questions on this topic.

a. Retroactive Applicability of Eligibility Pending Appeal; Enrollee Plan Selection

   We request that CMS, if it codifies a rule addressing this scenario, permit states the flexibility to ensure that enrollment tracks eligibility in a manner consistent with individual state programs.

The Health Connector believes that the most accurate understanding of Eligibility Pending Appeal means not merely that the appellant is theoretically eligible for certain benefits, but instead that the appellant is in fact able to access the benefits they were eligible for immediately before the eligibility determination on appeal. For the Health Connector, this often means that the person was eligible not just for APTC and cost sharing reductions (CSR), but also the Massachusetts-specific ConnectorCare program, which layers additional state premium and cost-sharing subsidies on top of federal APTC and CSR for qualifying residents below 300% FPL. If an appellant enrolls in a bronze plan after losing eligibility for ConnectorCare, and then validly requests Eligibility Pending Appeal, we always restore the appellant's enrollment in a ConnectorCare plan, in addition to APTC, in order to ensure that the appellant is able to access the full scope of benefits for which they are eligible.

b. Timeliness of Filing for Eligibility Pending Appeal

   The Health Connector recommends that Marketplaces should have the flexibility to set their own timeliness standards, based on individual Marketplace and local market circumstances.

The Health Connector believes that appellants should have additional time beyond the deadline for requesting an appeal to request Eligibility Pending Appeal, if the appellant requested the appeal at the end of the deadline. We have already operationalized a rule consistent with that policy. Specifically, we give appellants 15 days from the date on the acknowledgment of appeal we send upon receipt of a valid appeal. We chose 15 days, instead of a longer period of time, because we believe that 15 days is adequate for an appellant to make their request, since they have already demonstrated engagement with the process by filing the appeal. This further avoids issues that may arise with implementing retroactive coverage changes as time passes, including problems with carrier timelines for such requests.

c. Life Events Occurring During the Pendency of the Appeal

The Health Connector recommends that it is critical for appellants to be able to report changes while receiving Eligibility Pending Appeal, in order to ensure that they remain in the same position they otherwise would have been in, had the disputed eligibility determination not occurred, and that all household members can timely access coverage.

The Health Connector today permits appellants to report changes impacting eligibility while an appeal is pending. For example, if an appellant disputed an eligibility change that was caused by an underlying change in income, we would grant the appellant Eligibility Pending Appeal as if the income used in the determination in effect immediately before the eligibility determination in dispute is the correct income, and let other factors, such as family size, "float" around it. This means that the appellant's household's income as a percentage of the Federal Poverty Level might change with the addition of a new family member, such that the appellant is eligible for a different amount of APTC, of CSR, or ConnectorCare plan type. The Health Connector suggests that this approach is best suited to the kinds of eligibility administered through the Marketplace, which occurs at a tax-household level and which slides on a gradient, rather than on a binary basis. This also tailors the amount of APTC an appellant receives to minimize the amount of tax credit reconciliation that occurs when they subsequently file their taxes.

d. Impact of Eligibility Decision on Eligibility Pending Appeal

The Health Connector does not believe that CMS should set forth a rule limiting a hearing officer's ability to determine the appellant eligible for a richer benefit than the one the appellant received pending appeal.

The Health Connector believes that the decision of an independent hearing officer must be implemented as issued, in order to ensure the fairness and independence of the hearing process. Therefore, if a hearing officer ordered the Health Connector to provide an appellant with the option for retroactive coverage at a given level of eligibility, the Health Connector would do so, even if the appellant had been receiving Eligibility Pending Appeal at a level less rich than the hearing officer's decision. The only exception is that a hearing officer cannot reduce the eligibility level of an appellant who had received Eligibility Pending Appeal, since this would be inconsistent with the appellant's rights under 45 CFR 155.525.

e. Eligibility Pending Appeal and Non-Payment of Premiums

The Health Connector believes that grace period rules should apply to coverage received through Eligibility Pending Appeal, as if such coverage were received in the normal course, and supports a rule clarifying this, to the degree it is not sufficiently clear from current rules.

Consistent with the statement provided above, the Health Connector believes that an appellant receiving Eligibility Pending Appeal should be treated like any other enrollee receiving that level of eligibility, since this has the effect of putting the appellant in the position they would have otherwise been in had the disputed eligibility determination not occurred. This means that the grace period rules applicable to non-payment of premium should apply to an appellant receiving Eligibility Pending Appeal based on the level of eligibility they are receiving. An appellant receiving APTC would receive the 3-month grace period, while an appellant not eligible for any APTC would not. This is how the Health Connector, which serves as a premium aggregator for its QHPs and therefore directly administers these grace period rules, currently functions. The Health Connector believes this approach is the most consistent with the requirements of due process and Eligibility Pending Appeal and believes this is the simplest manner in which to administer non-payment of premiums, since information about Eligibility Pending Appeal or is not reflected in our enrollment and billing system.

3. The Health Connector recommends that CMS allow states to continue their own processes reviewing and defraying state-mandated benefits. (45 CFR 156.111 and 115)

Massachusetts has coordinated a robust inter-agency process since 2013 to comply with section 1311 of the ACA and has defrayed the cost of benefits in excess of Essential Health Benefits (EHBs) since 2014. Our process offers data to support legislators during deliberations about new mandated benefits, a state determination of any defrayal need immediately following passage of a new state requirement, a state-led process with carriers to determine the appropriate amount of defrayal, and regular payment of defrayal amounts accounting for QHP enrollment on- and off-Marketplace. This process is well-established and has become a routine part of legislative and carrier expectations. Consistent with its approach of deference to states and their expertise in local market issues, Massachusetts believes that CMS should continue to allow states to establish their own processes to do their own assessment of mandated benefits requiring defrayal. To do otherwise would be disruptive and unnecessary, especially in states such as Massachusetts which have set up a fully functional process.

4. The Health Connector supports continued exploration of value-based insurance design (VBID) in Qualified Health Plans and suggests CMS convene a technical workgroup to recommend how to best implement VBID in relation to Marketplace display, SERFF templates, and the Actuarial Value Calculator's methodology. (45 CFR 156.130)

The Health Connector applauds CMS's support for VBID, which helps support health care consumers pursue high-value care in a clinically nuanced fashion.

The Health Connector has extensive experience designing plans for the QHP market, as we require participating issuers to offer standard benefit categories and associated cost-sharing at each metallic tier and the majority of Health Connector members are enrolled in those standard plans. In recent years, we have encouraged VBID as part of our standard plan designs, allowing carriers to optionally deviate from standard cost-sharing for high value services where such deviations are in favor of the enrollee. Additionally, the Health Connector has required carriers to implement a VBID program in our ConnectorCare program, where participating carriers must offer medication assisted treatment for opioid use disorder services at a zero cost-sharing level. Most recently, the Health Connector participated in the "VBID-X" Workgroup organized by the Center for Value-Based Insurance Design at the University of Michigan and appreciate CMS's recognition of this effort. The Health Connector is now considering whether to require standardization of additional VBID elements in plan designs for future years in accordance with the VBID-X recommendations.

As the Health Connector and its participating carriers consider VBID, however, we suggest that CMS play a convening role in overcoming the significant technical barriers to VBID in the individual and small group markets. In particular, we suggest that CMS form a technical assistance group with representatives from carriers, the National Association of Insurance Commissioners, the Federally-Facilitated Marketplace, State-Based Marketplaces, and appropriate experts such as economists, actuaries, and providers to:

- Review and revise the federal Actuarial Value Calculator (AVC) methodology to better accommodate VBID plan designs. The current AVC methodology makes it increasingly difficult to implement any reductions in cost-sharing for high-value services, even where these services may improve health outcomes over the long term;
- Devise specific changes to the SERFF templates that would support a member-friendly display of clinically-nuanced VBID in plan benefits "grids." This is essential because Marketplaces like the Health Connector use SERFF data to feed into our member plan comparison and shopping websites; and
- Determine and promote best practices in how to communicate with individual and small group enrollees about VBID, as VBID has traditionally been limited to the large employer setting.

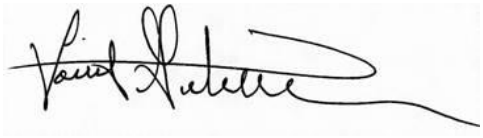
We suggest that achieving agreement on these topics and moving forward with technical revisions to the AVC and SERFF templates would support greater adoption of VBID plan designs. We would be pleased to participate in any such group.

5. 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 CMS for continuing to include an adjustment to the federal risk adjustment methodology that accounts for different market dynamics resulting from the ConnectorCare program, which provides additional state-funded premium and cost sharing subsidies to individuals eligible for advance premium tax credits. The ConnectorCare program is integral to the coverage landscape in Massachusetts and currently covers over 200,000 state residents. We appreciate CMS's recognition of this unique state program.

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

Sincerely,



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