The Commonwealth of Massachusetts
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza
Boston, MA 02108

Maura Healey
Governor

Kim Driscoll
Lieutenant Governor

Mary Beckman
Board Chair

Audrey Morse Gasteier
Deputy Executive Director

January 30, 2023

Chiquita Brooks-LaSure
Administrator
Center for Medicare and Medicaid Services
7500 Security Boulevard Baltimore, MD 21244

Re: Notice of Proposed Rulemaking, "HHS Notice of Benefit and Payment Parameters for 2024" (Published in Federal Register Volume 87, Number 244, page 78206 on December 21, 2022)

Dear Administrator Brooks-LaSure:

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 2024" (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 214,000 individuals and over 12,000 small business employees from over 2,000 businesses. The Health Connector's efforts have contributed to the Commonwealth's status as the healthiest state in the nation,[1] with a nation-leading health insurance rate over 97%,[2] and among the lowest-cost average Marketplace premiums in the country in 2022.[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 strongly supports CMS's proposal to allow Exchanges to accept attestation of projected annual household income when there is no IRS data available. (45 CFR 155.315, .320)

[1] See Sharecare-Community-Well-Being-Index-2021-state-rankings-report.pdf
[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.

This proposal will significantly reduce administrative burdens for individuals seeking health coverage through Exchanges, increase access to coverage and care, and advance health equity. The Health Connector estimates that if this policy had been in effect in 2022, it would have eliminated approximately 75% of the Health Connector's income-related Requests for Information (RFIs), significantly reducing barriers to coverage for members given that RFIs can result in non-responses from applicants, resulting in non-enrollment.[4]

The Health Connector is committed to uncovering and addressing administrative burdens and recently procured a vendor to conduct an "administrative burdens audit" to identify and address areas where we can improve our process for applicants and enrollees.[5] We agree with CMS that the current process is overly punitive to consumers and burdensome to Exchanges. Administrative burdens are a key reason that many people who intend to enroll in health coverage never end up enrolling and can be a barrier to individuals receiving assistance and the benefits they are eligible for. These types of obstacles can disproportionately affect applicants and members from communities of color, immigrant or non-English speaking populations, LGBTQ+ residents, and individuals with disabilities. For these reasons, the Health Connector strongly supports CMS' proposal to allow Exchanges to accept attestation of projected annual household income when there is no IRS income data available.

The Health Connector would appreciate clarification about whether Medicaid agencies could also accept attestation of household income when no IRS income data is available. The Health Connector is particularly focused on ensuring that mixed households (households with both Health Connector/Exchange and MassHealth/Medicaid members) have a streamlined experience. We appreciate any clarification on how this proposal could apply to Medicaid and the impact on mixed households.

The Health Connector also supports CMS' proposed revision to 45 CFR 155.315 to automatically grant an enrollee with income inconsistencies an automatic 60-day extension in addition to the 90 days currently provided (if they have not responded within the 90 days). We agree with CMS that these changes would ensure consumers are treated equitably, ensure continuous coverage, and strengthen the health insurance risk pool. We ask for clarification about whether Exchanges could provide the combined 150 days up front to households or if the extra 60 days may only be provided if there is no response in the first 90 days.

The Health Connector strongly supports future policy making on auto-enrollment policies and supports CMS's proposed revisions to re-enrollment hierarchy. (45 CFR 155.335)

As CMS notes in the proposed 2024 NBPP, auto-enrolling individuals who enter delinquency into zero-dollar plans when possible would help to mitigate the barriers enrollees face to enroll, effectuate, and maintain coverage.

Today, the Health Connector automatically enrolls people who are eligible for $0 premiums.[6] Health Connector members would benefit from additional auto-enrollment policies that reach a wider population, especially individuals who fall into delinquency.

Prior to the implementation of the Affordable Care Act (ACA), the Health Connector employed auto-retention policies in the event someone became delinquent on premiums but could have chosen a $0 premium plan, switching them to the $0 plan in their region instead of terminating them for non-payment. A recent analysis by economic researchers found that the Health Connector's pre-ACA auto-retention process, similar to what CMS is proposing, switched 14% of enrollees annually, keeping them enrolled in coverage rather than

[4] Based on 2022 Health Connector data
[5] Staff presentation to the Health Connector Board of Directors, November 10, 2022. See: https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2022/11-10-22/Administrative-Burdens-Audit-Vendor-Contract-VOTE-111022%20.pdf
[6] As of April 2022, the Health Connector automatically enrolls people into $0 premium plans if they check a box in the application consenting to such enrollment and who qualify for $0 coverage through ConnectorCare.

terminating them for non-payment.[7] The Health Connector strongly supports policies to help individuals and families who stop paying premiums remain in coverage without facing a gap and with members' network needs in mind.

One challenge of auto-enrollment is potentially exposing auto-enrolled members to tax credit reconciliation at tax time. In any future auto-enrollment proposal, the Health Connector asks CMS to consider relief from tax reconciliation to the extent available. To guard against reconciliation issues, the Health Connector has not automatically enrolled individuals who selected a plan with a premium and failed to make a binder payment, even if they could have enrolled in $0 coverage. Further, the complexities around retroactive coverage and terminations associated with automatic retention are material. As CMS considers potential approaches, the Health Connector would welcome opportunities to collaborate with other federal and state-based Exchange staff to determine best practices for effectively resolving complexities in this space.

The Health Connector supports CMS's proposed revisions to the re-enrollment hierarchy that would allow enrollees who are eligible for cost-sharing reductions (CSRs) and who would otherwise be automatically re-enrolled in a bronze-level Qualified Health Plan (QHP) without CSRs, to instead be allowed to be automatically re-enrolled in a silver-level QHP (with CSRs) in the same product with a lower or equivalent premium, regardless of whether the enrollee's current plan is available. We agree with CMS that consumers who are eligible for high-value silver CSR variants may be "leaving money on the table" by enrolling in a bronze plan instead. The Health Connector, through the ConnectorCare program, successfully implements this type of re-enrollment hierarchy and in January 2023, about 2,000 enrollees were moved to ConnectorCare plans (Silver tier) from other metal tiers.[8]

The Health Connector strongly supports CMS's proposal to remove the prohibition on Navigators and Assisters from going door-to-door to offer enrollment assistance or using other unsolicited means of direct contact to help provide consumers with enrollment assistance. (45 CFR 155.210, .215, .225)

Allowing Navigators and Assisters to go door-to-door to offer assistance with enrollment will help more Massachusetts residents access and maintain coverage, particularly in light of the unwinding of federal Medicaid protections beginning after March 31, 2023. Navigators and Assisters play a critical role in raising general awareness about Health Connector coverage, helping members understand their coverage, assisting with eligibility questions, renewals, application updates, shopping for plans, and payment – all in a culturally and linguistically appropriate way. The additional flexibility in outreach processes afforded by this proposal will help Navigators provide support tailored to their community members most in need.

The Health Connector strongly supports extending the time an individual has to reconcile past APTC before being found ineligible for APTC. (45 CFR 155.305)

CMS's proposal to determine enrollees ineligible for APTCs if they failed to file a Federal income tax return and reconcile their past APTC for two consecutive years instead of one will prevent individuals from unnecessarily being denied access to affordable coverage, enhance flexibility for members, and promote continuity of coverage by reducing administrative burden. The Health Connector strongly supports this proposal and recommends CMS finalize this policy as proposed.

The Health Connector supports CMS's proposals to increase Special Enrollment Period (SEP) flexibility by (1) implementing a new special rule that would extend the SEP length for loss of Medicaid or CHIP coverage and (2) allowing a consumer's health care provider dropping out of network mid-year to constitute grounds for a SEP. (45 CFR 155.420)

[7] MacIntyre, A., Shepard, M. and Wagner, M. (2021). Working Paper. "Can Automatic Retention Improve Health Insurance Market Outcomes?" National Bureau of Economic Research. Available at https://www.nber.org/system/files/working_papers/w28630/w28630.pdf

[8] The ConnectorCare program is based on ConnectorCare carriers' lowest-cost unsubsidized Silver plans, supplemented by federal and state subsidies according to program standards

The Health Connector supports additional SEP flexibilities that CMS proposes to ensure that individuals and families land in coverage after losing Medicaid or CHIP. While the Health Connector intends to open a broad SEP to assist with the end of federal Medicaid protections in 2023, we support any efforts to smooth coverage transitions and reduce member burdens across all Exchanges.

In addition, individuals and families make their health coverage choices based on a range of important factors, including whether their health care provider is in network. Ensuring that enrollees can actually use their health coverage to access needed care is essential to the Exchange's role. If an enrollee's health care provider drops out of network mid-year, the individual should be eligible for a SEP to ensure access to care by their provider.

The Health Connector appreciates some of the changes CMS made in its proposed State Exchange Improper Payment Pre-Testing and Assessment (IPPTA) program from the 2023 NBPP's proposed State Exchange Improper Payment Measurement (SEIPM) program. We respectfully suggest that HHS allow flexibility for states already voluntarily participating in pilot activities in order to reduce 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 program integrity associated duties as well as the annual programmatic audits and state Marketplace reporting submitted to CMS, the IPPTA process proposed is unnecessarily burdensome.

The Health Connector was pleased to volunteer to begin working with CMS in 2016 on a pilot of the EIPM program, and appreciates the opportunity to assist CMS with the development of its future processes. The pilot process itself is, however, complex and resource-intensive, involving extensive engagement of staff from operations, IT, policy, and legal teams. It has been more difficult than the annual programmatic audit as a result of the standardized approach across Exchanges, often based on the data model and procedures used by the federally facilitated Exchange (FFE) that do not uniformly comport with SBM practices, despite the significant flexibility offered to states in the state-based Exchange model more generally under the ACA. We applaud CMS's interest in ensuring that these learnings from diverse state pilot experiences such as the one in which we are engaged are carefully incorporated into future planning for the SEIPM.

The Health Connector appreciates changes that CMS made from the SEIPM program proposed in the 2023 NBPP. Specifically, we support CMS's proposal to consider activities already completed by State Exchanges as part of the current voluntary engagement and would be pleased if CMS were to finalize the ability for states to satisfy elements of the proposed IPPTA through existing activities. In addition, we strongly recommend CMS consider building 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.

The Health Connector supports CMS's proposal to consider adding a payment hierarchical condition categories (HCC) for gender dysphoria to the risk adjustment models. (45 CFR 153.320)

The Health Connector supports CMS's efforts to address discrimination based on gender identity. We believe that consideration of gender dysphoria within risk adjustment is in line with both the Health Connector's equity goals as well as the Biden Administration's Executive Order (E.O.) 13985 "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," and E.O. 13988 "Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation."

The Health Connector recommends that CMS consider including social determinants of health in risk adjustment methodology more broadly to advance equity goals, and would welcome the opportunity to further assist CMS to scrutinize equity implications of the ACA risk adjustment methodology. (45 CFR 153.320)

The Health Connector supports and appreciates the equity-focused initiatives included in the NBPP. In order to address inequities that the federal risk adjustment methodology contributes to within the Massachusetts merged market more broadly, the Health Connector respectfully asks CMS to (1) examine the health equity implications of the individual and small group risk adjustment methodology, (2) consider accounting for social determinants of health within the methodology, and (3) consider modifying the use of the statewide average premium.

The Massachusetts Attorney General's Office (AGO) recently examined the current federal risk adjustment methodology and found that health risk scores based upon a population's history of health care utilization entrench resource disparities and health care access barriers. The report found that insurers serving populations labeled as "lower risk" actually serve communities with higher neighborhood stress scores, worse self-reported health scores, more barriers to accessing health care services, and lower rates of preventive care.[9] Please see the Massachusetts Attorney General's Office and the Health Connector's joint comments on this topic for additional details. We welcome future dialogue with CMS on this important topic.

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 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 130,000 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,

Audrey Morse Gasteier
Acting Executive Director

[9] The Office of Attorney General Maura Healey (2022). Examination of Health Care Cost Trends and Cost Drivers. Retrieved from: https://www.mass.gov/files/documents/2022/11/02/2022-11-2%20COST-TRENDS-REPORT_PUB_DRAFT4_HQ.pdf