Commonwealth of Massachusetts

Requests for State Flexibility to Support Commercial Insurance Market Stability and Reforms

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Executive Summary

Introduction

The Commonwealth of Massachusetts has long embraced innovation and reform in its health insurance market. In 2006, Massachusetts enacted landmark health reform legislation that yielded the highest rate of insurance in the nation. The unique Massachusetts model served as a successful example of a bipartisan health reform effort that embodied the spirit of shared responsibility, calling on consumers, employers, insurers, providers, and a state and federal partnership to join together to support coverage expansion. Starting in 2010, Massachusetts implemented the additional reforms of the Patient Protection and Affordable Care Act (Affordable Care Act). In 2010 and 2012, Massachusetts enacted legislation to promote health care quality and cost-containment.

Because of these efforts, the Commonwealth has enjoyed one of the most stable insurance markets in the country, and residents' access to the high quality health care available in the Commonwealth is strong. Despite these successes and stable features of the overall Massachusetts health care landscape, the Massachusetts market has experienced losses of covered lives in its small group market and an overall decline in the percentage of residents covered through commercial insurance. Additionally, recent uncertainty surrounding federal Cost-Sharing Reductions (CSRs) has threatened to destabilize our long-steady market.

In order ensure that our commercial market remains stable, sustainable, and vigorous in the future, Massachusetts has identified opportunities to adjust or re-examine particular federal policies in areas where we believe we could further strengthen the employer-sponsored coverage and ensure stability in the commercial insurance market more broadly.

Massachusetts respectfully requests to enter into dialogue with the federal Departments of Health and Human Services and Treasury ("Departments") regarding these suggested flexibilities. Massachusetts appreciates federal consideration of this initial proposal, and looks forward to future collaboration on opportunities for state flexibility and innovation.

Massachusetts Market Overview

Over the past two decades, Massachusetts has engaged in a series of state health insurance reforms that collectively generated the highest rate of insurance coverage in the nation, introduced critical protections for health insurance consumers, and launched initial steps toward cost containment and to further quality improvement. In the commercial market, key state milestones have included[1]:

1992 - 1996
• Massachusetts introduced consumer protections to the nongroup and small group market, including guaranteed issue and rating rules.
2006 - 2008
• Massachusetts enacted Chapter 58 of the Laws of 2006 (Chapter 58), comprehensive reforms that aimed to achieve near-universal health coverage. • Key components of Chapter 58 and subsequent amendments included:

[1] *See generally* Ch. 58 of the Acts of 2006; Ch. 288 of the Acts of 2010; Ch. 224 of the Acts of 2012; M.G.L. ch. 176J.

○ The creation of the Health Connector, an independent agency that serves as an "exchange" marketplace to assist individuals and small employers in accessing health insurance, as well as subsidies to promote affordable coverage for residents with incomes up to 300% FPL through the Commonwealth Care program. ○ State shared responsibility requirements for individuals and employers. ○ The merger of the nongroup and small group markets into a single risk pool.
2010 - 2014
• Massachusetts prepared to implement the ACA, opting to retain its state-based marketplace and merged market structure. • Massachusetts enacted comprehensive cost-containment legislation.[2]
2014 - 2017
• Massachusetts retained its state-based marketplace, the Health Connector, and transitioned Commonwealth Care enrollees to ConnectorCare, a new program for residents with income up to 300% FPL that includes new federal premium tax credits and cost-sharing reductions and maintains a federally-matched "state wrap" via a Medicaid Section 1115 waiver to further support affordability. Residents between 300-400% FPL are also eligible for premium tax credits. • As of July 2017, the Health Connector has over 250,000 enrollees, including nearly 190,000 ConnectorCare enrollees under 300% FPL and nearly 10,000 APTC-only enrollees with incomes between 300-400% FPL.

Until recent signs of distress, Massachusetts has had one of the most robust health insurance markets in the nation. Over 96 percent of Massachusetts residents are insured, 89 percent of residents report regular access to health care, and the Commonwealth is beginning to make strides toward better value in health care.[3] Roughly two-thirds of Massachusetts' residents have commercial health coverage.[4] The commercial market has been competitive, with over a dozen companies actively marketing coverage throughout the Commonwealth.[5]

The Commonwealth's insurance marketplace, the Commonwealth Health Insurance Connector Authority (Health Connector), has nine participating health insurance issuers and over 250,000 enrollees[6], representing roughly 85 percent of nongroup covered lives.[7] Over three-quarters (77%) of Health Connector members report satisfaction with their experience.[8] The Health Connector administers an innovative subsidized insurance program, ConnectorCare, for low income enrollees that leverage federal and state subsidies to promotes affordability and enhance competition in the state's unique merged (nongroup and small group) market.

[2] Chapter 288 of the Acts of 2010 and Chapter 224 of the Acts of 2012.
[3] Center for Health Information and Analysis, "Findings from the 2015 Massachusetts Health Insurance Survey" (Dec. 2015) available at: http://www.chiamass.gov/assets/docs/r/survey/mhis-2015/2015-MHIS.pdf.
[4] Center for Health Information and Analysis, "Enrollment Trends Databook" (March 2017), available at: http://www.chiamass.gov/enrollment-in-health-insurance/.
[5] Center for Health Information and Analysis. (2015, Sept.) *2015 Annual Report: Performance of the Massachusetts Health Care System (report).* Retrieved from www.chiamass.gov/annual-report/.
[6] Health Connector Board Materials (July 13, 2017), available at: https://www.mahealthconnector.org/about/leadership/board-meetings.
[7] Center for Health Information and Analysis, "Enrollment Trends Databook" (March 2017), available at: http://www.chiamass.gov/enrollment-in-health-insurance/.
[8] Commonwealth Health Connector Member Experience Survey (Oct. 2016), Market Decisions Research, on file.

Summary of Requests

The Commonwealth of Massachusetts respectfully seeks to partner with the Departments to implement the following flexibilities to support the commercial insurance market:

- **Request #1: Promote Market Stability with a Premium Stabilization Fund in Lieu of Cost-Sharing Reductions**

The Commonwealth seeks to establish a Premium Stabilization Fund in lieu of Cost-Sharing Reductions (CSRs), and requests authority to waive CSRs and receive any federal premium tax credit savings that will accrue in the form of a "pass-through." The Commonwealth would use this pass-through funding to stabilize premiums via direct issuer reimbursement, an approach that would eliminate any consumer-facing changes to coverage costs or benefits.

- **Request #2: Revive State Employer Shared Responsibility Program in Lieu of Delayed and Less Comprehensive Federal Program**

The Commonwealth proposes to work in partnership with the Departments to seek transition relief from the federal employer mandate and the related reporting requirement, while immediately reviving a comprehensive state approach to ensuring employers appropriately contribute to health coverage.

- **Request #3: Revive Permissibility of Section 125 Plans for Non-Benefits Eligible Employees to Enhance Consumer Savings and Promote Private Coverage**

The Commonwealth requests the opportunity to work with the Departments to find a pathway to allow Massachusetts employers to establish Section 125 plans to allow non-benefits eligible employees to purchase their own nongroup health insurance plans through public exchanges with pre-tax dollars.

- **Request #4: Permission for Commonwealth to Administer the Federal Small Business Health Care Tax Credit**

The Commonwealth requests flexibility to administer the federal Small Business Tax Credit (SBTC) at the state level in order to better support Massachusetts employers' ability to obtain the credits and help maximize their intended purpose: to help the small employers struggling the most to stay in the group market to offer commercial coverage to their workers. Administering the tax credit at the state level, aligned with the Health Connector's existing Wellness Track program, affords Massachusetts the opportunity to craft an easy-to-use, effective and meaningful support structure for the most "benefits-vulnerable" small businesses.

- **Request #5: Allow for State Option to Continue to Use Select State-Based Rating Factors**

The Commonwealth requests permission to continue, at the state's option, the ability to allow carriers in its merged market to continue to apply state-based rating factors beyond Plan Year 2018. This flexibility is requested in the interest of preserving market continuity and stability given current rating rules, and will help support the Baker-Polito Administration's ability to protect the features of the employer-sponsored coverage market.

- **Request #6: Commence Process to Evaluate Future of Risk Adjustment in the Commonwealth**

The Commonwealth seeks to convene a multi-stakeholder state workgroup to consider the potential need for increased flexibility under the Risk Adjustment program (with potential changes effective for Plan Year 2019 at the earliest). Massachusetts believes that the application of Risk Adjustment in its market, as currently designed, would benefit from thorough review and reexamination by relevant state agencies, market participants, and stakeholders.

Flexibility Request #1: Promote Market Stability with a Premium Stabilization Fund In Lieu of Cost-Sharing Reductions

Overview

For well over a decade, the Commonwealth has enjoyed one of the most stable insurance markets in the country, with robust health insurance issuer participation and strong enrollment.

However, recent uncertainty about whether Cost-Sharing Reductions (CSRs) under the ACA will continue to be paid has introduced significant new risk into Massachusetts' insurance market. If the result of pending litigation is to find that CSRs were not validly appropriated, the federal government would no longer be able to reimburse insurers for CSR-enriched plans, rendering Massachusetts issuers immediately liable for an estimated $46 million for the remainder of 2017 and an additional $132 million in 2018. Without mitigating action, Massachusetts would experience a significant decline in issuer participation, coverage disruptions for hundreds of thousands of residents, and double-digit premium rate increases. As a further consequence of these premium rate increases, the Commonwealth and federal government would face increased aggregate liability for premium subsidies, including Advance Premium Tax Credits/Premium Tax Credits (APTC/PTCs).

To address this risk, Massachusetts seeks the immediate assistance of the Departments to establish a Premium Stabilization Fund in lieu of CSRs for 2018 and potentially beyond. Toward this goal, Massachusetts is evaluating a waiver under ACA Section 1332 for potential submission in August 2017, requesting authority to waive CSR and receive any federal APTC/PTC savings that will accrue due to eliminating CSR uncertainty in the form of a "pass-through" to the Commonwealth. The Commonwealth would use this pass-through funding to stabilize premiums via direct issuer reimbursement, an approach that would eliminate any consumer-facing changes to coverage costs or benefits. The Commonwealth's proposal would meet all Section 1332 "guardrails", including scope of coverage, comprehensiveness of coverage, cost of coverage, and deficit neutrality.

Recognizing the time-sensitivity of this request as 2018 plans are currently under review, Massachusetts respectfully requests an opportunity to enter into dialogue with the Departments about seeking such as waiver, as well as whether there may be an opportunity to make "fast-track" guidance regarding this potential Section 1332 request available to interested states.

Background: Recent Market Destabilization

Under the ACA, CSRs are available to Exchange enrollees with incomes below 250% of the Federal Poverty Level (FPL) and certain American Indians. CSRs help make coverage affordable by increasing plan richness and lowering the out-of-pocket costs enrollees face when they access care, such as deductibles, coinsurance, and co-pays.

In Massachusetts, CSR-eligible individuals are enrolled in the Health Connector's ConnectorCare program. Over 155,000 ConnectorCare enrollees receive federal CSRs, which the Commonwealth supplements with federally-matched funds to meet state-specific affordability standards.

Certain Exchange issuers must provide CSR-enriched plans to eligible enrollees, and the federal government has to date reimbursed issuers for those costs. However, the manner in which CSR payments were funded has been called into question, leaving Exchange issuers with uncertainty about whether they will continue. A federal lawsuit *House v. Price* (originally *House v. Burwell*) challenges the constitutionality of the manner in which the executive branch funded CSR payments. A lower court ruled in favor of the House, holding that CSRs were not properly appropriated, but put its ruling on hold while the Obama Administration appealed the decision. The Trump Administration inherited the case from the Obama Administration. At appellate court status updates, the parties have received permission from the appellate court to delay in the case to allow time for a resolution. This resolution has not yet occurred, leaving the issue in limbo.

Under a number of different potential resolutions, federal CSR funding could end, leaving issuers immediately liable for the cost of CSR-enriched plans for the remainder of the 2017 plan year and headed into the 2018 plan year. Issuers and other stakeholders have expressed deep concerns with this prospect, indicating:

- **America's Health Insurance Plans**: "Plans will likely drop out of the market. Premiums will go up for everyone. Costs will go up for taxpayers."[9]

- **Massachusetts Association of Health Plans**: "Should CSR payments cease, health plans that participate in the Massachusetts merged market will still be required to develop products without cost sharing... Without the federal payments, health plans will have no choice but to raise premiums substantially to adjust for the loss of federal reimbursement or determine that they can no longer offer coverage to this segment. Without adjustments in premiums, health plans could sustain substantial losses. For consumers, who benefit from these products, they will have fewer options and/or be forced to purchase a product that is unaffordable or go without coverage altogether."[10]

- **State Legislature:**[11] The State Senate passed an amendment in their initial budget that directs the Division of Insurance (DOI) and the Health Connector to develop a contingency plan to address the risk of CSR withdrawal.

[9] American's Health Insurance Plans, "Letters to the President, Congress Regarding CSRs", available at: https://www.ahip.org/letters-to-the-president-congress-regarding-csrs/

[10] Letter from the Massachusetts Association of Health Plans to Governor Charlie Baker (May 24, 2017), available on file.

[11] Senate Bill 2076 (May 25, 2017), available at: https://malegislature.gov/Budget/FY2018/SenateBudget.

In addition to these concerns, several issuers participating in ConnectorCare have expressed reservations about their ability to participate in the Health Connector in 2018 if CSR funding ends. At least one region of the state faces the possibility of thin issuer participation for 2018 for ConnectorCare enrollees due to deteriorating market conditions, though state regulators continue to attempt to address this evolving situation.

The Commonwealth has taken steps to verify the credibility of issuer concerns, including actuarial estimates by the Health Connector and a special data call by the Division of Insurance, and finds the concerns to be fully warranted for both issuers and their enrollees. *See Figure 1*.

Figure 1. Estimated Massachusetts Market Disruption Due to CSR Uncertainty

Issuer Impact	• In CY 2017, Massachusetts carriers are expected to receive an estimated $104 million in total federal CSRs, an amount that is expected to increase to $132 million in 2018. • Based on current and projected enrollment, some carriers could face tens of millions of dollars in risk if CSRs are eliminated. • Carriers with low risk-based capitals measures could potentially face solvency challenges. The Division of Insurance is actively monitoring all of the carriers' financial conditions, given market instability to date.
Enrollee Impact	• Over 155,000 ConnectorCare enrollees receiving federal CSRs with incomes under 250% FPL would have their coverage directly disrupted. • In addition, because of the design of Massachusetts' ConnectorCare program, over 30,000 additional enrollees with incomes between 250-300% FPL and nearly 10,000 additional enrollees with incomes between 300-400% FPL would be indirectly impacted.

Rationale: Potential for Further Market Deterioration

Facing the prospect that Massachusetts' once-thriving health insurance market could deteriorate further, the Commonwealth is working closely with issuers to assess the potential risk, absent immediate intervention.

Massachusetts issuers have indicated that if federal CSRs are withdrawn, they would need to incorporate the experience of diminished CSR payments into their premium rates as soon as possible to avoid other adverse outcomes.

In keeping with the approach of many other Divisions of Insurance across the country, Massachusetts's Division of Insurance has addressed this issue by instructing issuers of the possibility of a supplementary rate filing to account for the impact of ceased CSR funding.[12] Based on the timing of federal withdrawal, this supplementary rate filing could potentially occur prior to 2018 plan year when rates are approved

[12] Division of Insurance, "Health Coverage Filing Guidance Notice 2017-D" (June 15, 2017), available at: http://www.mass.gov/ocabr/docs/doi/companies/checklists/2017-d.pdf.

(typically in mid-August), after rate approval but prior to the start of the 2018 plan year, or during the 2018 plan year.

Though the premium impact differs under each of these scenarios, preliminary estimates indicate that issuers would need on average to increase premiums by over 16 percent solely on the basis of CSRs uncertainty (not accounting for other potential premium increase factors), depending on each carriers' enrollment and other parameters.[13] This market-wide estimate draws from the analysis of Commonwealth actuaries based on 2016 actual blended total CSR reconciliation[14] and data collected in a special Division of Insurance data examination. At least one local carrier has estimated a higher premium increase of 20 percent. Both estimates are in line with national estimates of about 19 percent increase on average due to CSR payment uncertainty.[15]

This double-digit premium increase would shock the Massachusetts market, resulting in disastrous consequences:

- Issuers would accrue liability for their CSR-enriched plans at a rate of approximately $11 million per month during any market transition to new rates.
- Hundreds of thousands of Massachusetts residents would face unexpected rate increases. Unsubsidized enrollees would face the full increase of the rate spike, potentially affecting their enrollment behavior and therefore the stability of the risk pool.
- Because Massachusetts has a merged insurance market, these rate increases could impact over 550,000 persons covered through small businesses[16] as well as nongroup enrollees.
- State agencies and issuers would face grave operational risks and costs as they transition coverage as quickly as possible.
- Low-income residents in rural or remote regions of the state could be left without coverage.

In addition to these market impacts, there is analytical consensus that the federal and state government would face significant new liability for premium-based subsidies because these subsidies are designed to grow in proportion to premium growth.[17] The projected 16.6% increase in Massachusetts premiums is estimated to result in:

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[13] These estimates assume that the Division of Insurance would permit issuers to increase the rate of their merged market silver-level plans only to offset the loss of federal CSRs. It is unclear whether this would be possible under federal and state risk pool rules. All estimates subject to change based on additional information from issuers.

[14] Health Connector analysis of 2016 actual blended total CSR reconciliation, at 14.4% of actual premiums.

[15] Kaiser Family Foundation, "Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19% to Compensate for Lack of Funding for Cost-Sharing Subsidies" (April 6, 217), available at: http://kff.org/health-costs/press-release/estimates-average-aca-marketplace-premiums-for-silver-plans-would-need-to-increase-by-19-to-compensate-for-lack-of-funding-for-cost-sharing-subsidies/.

[16] Center for Health Information and Analysis, "Enrollment Trends Databook" (March 2017), available at: http://www.chiamass.gov/enrollment-in-health-insurance/.

[17] *See, e.g.,* Levitt, L., Cox, C., Claxton, G. "The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments" (April 25, 2017) Kaiser Family Foundation, available at: http://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/; Yin, W. and Domurat, R. "Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding" (Jan. 26. 2017), available at: http://www.coveredca.com/news/pdfs/CoveredCA_Consequences_of_Terminating_CSR.pdf; Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation "Issue Brief: Potential Fiscal Consequences of Not Providing CSR Reimbursements" (Dec. 2015), available at: https://aspe.hhs.gov/system/files/pdf/156571/ASPE_IB_CSRs.pdf.

- An increase of $49.91 PMPM in APTC/PTC liability for the federal government for eligible enrollees under 300% FPL;
- An increase of $52.66 PMPM in APTC/PTC liability for the federal government for enrollees between 300-400% FPL;
- An increase in $3.50 PMPM in state premium subsidies for eligible enrollees under 300% FPL, assuming no changes in enrollee contribution as a result of the rate increase, which are matched at 50 percent federal financial participation (FFP) under the terms of Massachusetts' 1115 waiver.

With an estimated total 220,500 affected enrollees projected for 2018, this would result in approximately $141 million in additional federal and state liability total, $132 million of which is solely a new cost to the federal government. These estimates are expected to change once Massachusetts reviews recently proposed rates for 2018 to assess additional market trend.

Request: Fast-Track Premium Stabilization Waiver

In light of the untenable risk to the Massachusetts insurance market that stems from CSR uncertainty and the risk of higher subsidy costs, Massachusetts seeks to waive requirements associated with CSRs, and to replace these requirements with a state-based Premium Stabilization Fund (PSF). Because such a waiver would eliminate the upward pressure on premiums that would result from CSR payments not being paid, it would reduce premiums and thus federal APTC/PTC spending. In keeping with the logic of the recently-approved Alaska State Innovation Waiver, the savings that result from these premium reductions could then be shared back with the state to fund the PSF.

There may be several options for which specific provisions would be waived under such an approach. One approach would be to waive 42 USC § 18071(c)(3)(a), which requires "An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of reductions." Another approach would be to waive a broader set of requirements related to CSRs, including the plan richness requirements.

Massachusetts seeks these changes effective for Plan Year 2018, starting January 1, 2018.

Proposal: Market Stability with Waiver

Without flexibility from the Departments in the form of a waiver, the Commonwealth will permit carriers to file supplementary rates that include a load for CSR contingencies. This will seriously destabilize the market and increase federal liability for APTC/PTCs and related premium wrap FFP.

If Massachusetts receives waiver flexibility, the Commonwealth will prohibit issuers from filing supplementary rates that include a CSR-related load, as there will be no CSR-related contingencies that could occur. Rather, Massachusetts issuers will be instructed to use ordinary course of business rates for the entirety of 2018, maintaining a premium rate that is over 16 percent lower than it would otherwise be without the waiver. This will lower premiums, reducing the second lowest cost silver plan premium, resulting a reduction in federal government spending on APTC/PTCs.

To ensure issuer participation in this premium stability proposal, Massachusetts will establish a PSF using pass-through funds available from APTC/PTC savings for 2018. Massachusetts estimates that the

amount of pass-through funding due under the statute for the 2018 calendar year would be $141 million dollars, though additional analysis can be shared with the Departments pending additional 2018 rate information.

Under the proposed PSF, the Departments could provide advance payments of a pro-rated amount of pass-through funds, deposited into an already-established and dedicated state-administered fund, the Commonwealth Care Trust Fund (CCTF). Because the CCTF is used to reimburse issuers on a monthly and annual basis for state-based subsidies already, the Commonwealth could leverage the fund to distribute the PSF in an equitable fashion to account for each issuers' premium stabilization needs. The Commonwealth proposes that an annual re-baseline and reconciliation could account for any changes in estimated enrollment and other variable factors used in calculation of the PSF.

Under this proposal, Massachusetts and federal partners could stabilize the insurance market, preventing disruption to hundreds of thousands of residents, without impacting federal deficit neutrality. Massachusetts residents would receive coverage that is at least as comprehensive and affordable as today, since their premiums, cost-sharing, and benefits will be equal to or better than a without waiver scenario. Similarly, the federal government will be held harmless, with PTF funds expected to account for no more than the cost of APTC/PTCs attributable to market uncertainty.

Next Steps

Massachusetts recognizes that CSR payments and related processes could be waivable subject matter under ACA Section 1332, and the Commonwealth is prepared to submit such a waiver if this pathway is suggested by the Departments.

The Commonwealth would appreciate the opportunity to discuss how an application for flexibility could be implemented in an expedited fashion, given the pressing need for market stability prior to rate finalization for the 2018 plan year. Massachusetts respectfully suggests that it may be possible for the Departments to engage with the Commonwealth on a "fast-track" process that could be available to Massachusetts and possibly other interested states in short order, given the fact that this proposal is neutral with respect to all the Section 1332 guardrails.

Flexibility Request #2: Revive State Employer Shared Responsibility Program in Lieu of Delayed and Less Comprehensive Federal Program

Overview

For over a decade, Massachusetts has viewed shared responsibility by employers as critical to maintaining the Commonwealth's near-universal coverage rate in a sustainable fashion. Prior to the ACA, Massachusetts enacted a robust state health reform package via the Acts of Chapter 58 of 2006. Among other components, this set of state reforms included a state employer shared responsibility program known as the Fair Share Contribution. Though the Fair Share Contribution was implemented successfully and worked in conjunction with other policies to maintain a sustainable mix of employer-sponsored insurance (ESI), other private coverage, and public coverage, the program was repealed in

2013 in preparation for the ACA's employer shared responsibility provisions (colloquially known as the employer mandate).

Today, while Massachusetts continues to share the interest of the Departments in supporting employer responsibility, the Commonwealth has found that the federal employer mandate is not meeting state needs as currently implemented. Massachusetts employers have invested considerable effort into compliance with detailed federal employer mandate reporting requirements, yet the federal penalties have never been fully enforced. Moreover, the federal mandate does not extend to many circumstances where Massachusetts considers employer responsibility important, such as smaller firms or those with employees that access Medicaid.

This has created an untenable circumstance for the Commonwealth, wherein responsible employers are tasked with complicated reporting requirements, while employers that do not offer coverage are not effectively penalized. These shortcomings have resulted in a missed opportunity to help address the continued and unsustainable growth of Massachusetts' public coverage programs, including the Commonwealth's Medicaid program (MassHealth) and state-based Exchange (Health Connector), both of which feature state subsidies in addition to federally-funded subsidies.

To remedy this concern, Massachusetts proposes to work in partnership with the Departments, seeking transition relief from the federal employer mandate and the related reporting requirement, while immediately reviving a comprehensive state approach to ensuring employers appropriately contribute to health coverage. Massachusetts requests this flexibility for an initial period of tax years 2016 through 2019, which will allow the Commonwealth to implement urgently-needed state reforms, while simultaneously pursuing an ACA Section 1332 waiver and permanent state approach.

Massachusetts respectfully suggests that this interim flexibility could be granted in the form of Internal Revenue Service (IRS) transition relief specific to Massachusetts employers. The Departments may have specific authority to grant such relief under the ACA, given Massachusetts's unique status as a pre-ACA reform state under ACA Section 1321(e), or more general authority as part of the Departments' long-standing authority to grant transition relief when implementing new federal legislation.

Background

Previous State Employer Shared Responsibility Program

Prior to the ACA, Massachusetts enacted a comprehensive employer shared responsibility program that included five components administered jointly by the Department of Unemployment Assistance and the Health Connector[18]:

- Fair Share Contribution (FSC)[19]: Massachusetts employers with 11 or more employees were required to make a "fair and reasonable" contribution toward the health care costs of their employees, or pay an annual "fair share contribution" of up to $295 per full-time equivalent employee.

[18] Prior to the Health Connector's regulatory role in the Fair Share Contribution and HIRD policies, the Massachusetts Division of Health Care Finance and Policy set and governed these regulations.
[19] Chapter 58 of the Acts of 2006, 956 CMR 11.00 (repealed, 2014).

- Section 125 Cafeteria Plans[20]: Massachusetts employers subject to the FSC that had non-benefit-eligible employees were required to establish a Section 125 cafeteria plan that allowed these employees to purchase nongroup health insurance using pre-tax wages, without any contribution by the employer. The requirement was designed to give part-time workers and other non-benefit-eligible employees the opportunity to obtain tax advantages in purchasing health insurance, similar to those received by benefits-eligible employees.

- Health Insurance Responsibility Disclosure (HIRD)[21]: Massachusetts employers subject to the FSC were required to submit annual and quarterly HIRD forms listing their full and part-time employees, whether offers of insurance were provided and accepted, and whether offers of Section 125 plans were provided and accepted.

- Free Rider Surcharge[22]: Massachusetts employers subject to the FSC that did not offer a Section 125 plan for non-benefits-eligible employees and whose employees accessed medical care through Massachusetts' Health Safety Net program could be assessed a penalty between 20-100% of the cost of any medical services received by the employee that exceeded $50,000.

- Eligibility Firewall[23]: Under the Health Connector's pre-ACA eligibility rules, non-disabled adults could not access state and federal subsidies via the Health Connector if they had access to employer-sponsored insurance. The standards for this eligibility firewall were more extensive than the ACA's requirements for Exchange premium tax credits, and many of the impacted population are now eligible for Medicaid Expansion, which does not include a firewall.

Together, these state policies were successful in promoting a balance between employer-sponsored insurance and public coverage programs. Upwards of 95 percent of Massachusetts employers met the standards,[24] while the remaining non-compliant employers generated approximately $17 million annually, used to fund the Health Connector's subsidized coverage.[25]

While Massachusetts' approach was effective, the Commonwealth decided to repeal its state employer shared responsibility provisions in 2014 as part of ACA implementation due to concerns about burdening employers with duplicative requirements.[26] Recognizing the continued risk that the Commonwealth could face liability for public coverage if employers did not offer coverage, however, Massachusetts retained a modest assessment on employers with 6 or more employees, the Employer Medical Assistance Contribution (EMAC). This broad-based assessment applies to affected employers regardless of whether they offer health insurance to their employees, and is used to fund the Health Connector's subsidized coverage. At the time, Massachusetts officials expressed concerns that the federal employer mandate and EMAC may not be sufficient, with then-Governor Deval Patrick warning

[20] Chapter 58 of the Acts of 2006, 956 CMR 4.00 (repealed, 2014).
[21] Chapter 58 of the Acts of 2006, 956 CMR 10.00 (repealed, 2014).
[22] Chapter 58 of the Acts of 2006, 956 CMR 9.00 (repealed, 2014).
[23] Chapter 58 of the Acts of 2006, 956 CMR 3.00 (repealed, 2014).
[24] *See, e.g.,* Worcester Business Journal, "Briefing: Fair Share Health Insurance Contributions" (Sept. 26, 2011), available at: www.wbjournal.com/article/20110926/PRINTEDITION/309269973/briefing-fair-share-health-insurance-contributions.
[25] Information on file.
[26] The Fair Share Contribution was repealed effective July 1, 2013 via Chapter 38 of the Acts of 2013 (the Fiscal Year 2014 budget). The Section 125 Requirement, HIRD, and Free Rider Surcharge were repealed on March 17, 2014 in Chapter 52 of the Acts of 2014.

that the state may need to "…act to re-implement [the requirements] if employers in the Commonwealth dropped coverage..."[27] There is now growing evidence that this concern was warrant

Evidence of Declines in Employer-Based Coverage

In the years since the Commonwealth repealed its state approach to employer shared responsibility, Massachusetts' insurance market has shown growth in public coverage and declines in employer-sponsored insurance. Since December 2013, the number of people with MassHealth coverage increased by 349,000 new enrollees[28] while employer-sponsored coverage lost 112,000 enrollees.[29]

While this market shift has been driven by multiple factors, including labor market and population trends that pre-dated the ACA, these macroeconomic trends do not alone account for the change. For example, the decline in employer-sponsored insurance from 2013 to 2016 occurred even as employment in the Commonwealth increased by 128,500 over the same time period.[30] Based on this employment growth, the Commonwealth would expect to see unsubsidized commercial enrollment that is several hundred thousand greater than it is today. However, data indicates there are other factors at play: roughly 40 percent of the shift appears to be attributable to a decline in coverage through employers,[31] due to both lower employee uptake and employer offer rates.

Overall, the majority of Massachusetts employers continue to offer health insurance to their employees, with over 65 percent of all employers offering in 2016. However, the offer rate dropped among smaller employers with between 3-24 employees from 2009 to 2016.[32] *See Figure 2*. Many of these groups were subject to Massachusetts' version of employer shared responsibility, but are not subject to the federal version.

Similarly, 75 percent of eligible Massachusetts employees chose to enroll in a plan in 2016. However, the take-up rate fell notably among smaller employers with between 25-49 employees from 2009-2016.[33] *See Figure 3*. While Massachusetts coverage options prior to the ACA generally would have barred these employees from seeking subsidized coverage, ACA standards are more lenient – for example, income-eligible employees may seek coverage through Medicaid Expansion even if an offer of employer-sponsored coverage is available.

Though Massachusetts remains firmly committed to universal coverage for its residents, the Commonwealth cannot afford inaction in the face of this trend away from employer-sponsored insurance. The state's Medicaid program, MassHealth, now accounts for 40 percent of the state budget

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[27] *See* Proskauer Client Alert, "Massachusetts Repeals Fair Share Contribution, HIRD Requirements" (July 25, 2013), available at: www.proskauer.com/publications/client-alert/massachusetts-repeals-fair-share-contribution-hird-form-requirements/

[28] Note: This number does not include MassHealth members who are enrolled in Medicare, commercial plans or MassHealth Limited.

[29] Center for Health Information and Analysis, "Enrollment Trends Databook" (March 2017), available at: http://www.chiamass.gov/enrollment-in-health-insurance/. *See also*: Executive Office of Health and Human Services, "Massachusetts Insurance Market Reforms" (Feb. 23, 2017), on file.

[30] Bureau of Labor Statistics, "Employed individuals in Massachusetts" (as of Dec. 2013), available at: https://www.bls.gov/data/.

[31] Executive Office of Health and Human Services, *Ibid*.

[32] Center for Health Information and Analysis, "Massachusetts Employer Survey: 2016" (March 2017), available at: http://www.chiamass.gov/massachusetts-employer-survey/.

[33] Center for Health Information and Analysis, "Massachusetts Employer Survey: 2016" (March 2017), available at: http://www.chiamass.gov/massachusetts-employer-survey/.

and covers 30 percent of Massachusetts residents.[34] It is clear that the federal employer mandate, while aligned with Massachusetts' own policy goals, is not sufficient to maintain balance between public and employer-based coverage.

Figure 2. Offer Rates by Establishment Size, 2009-2016.

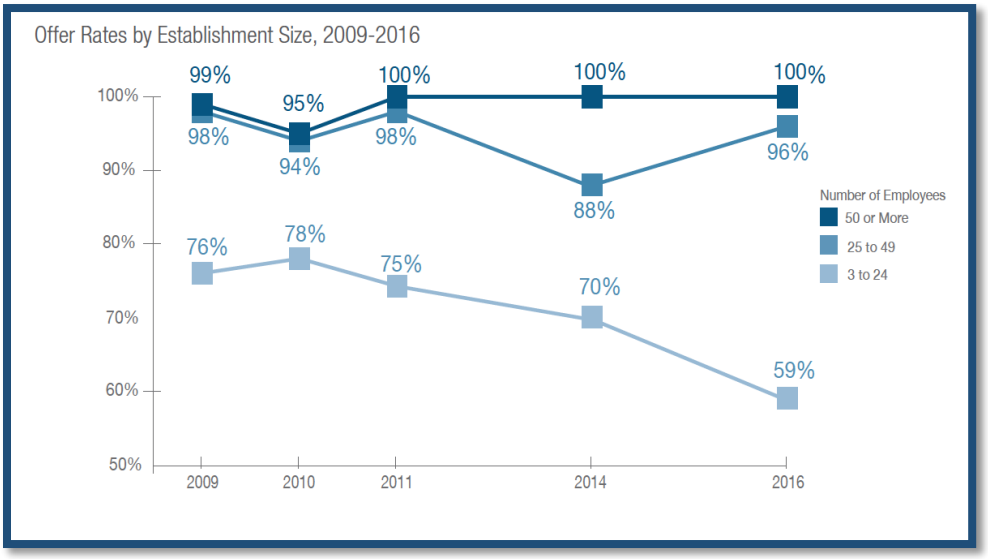
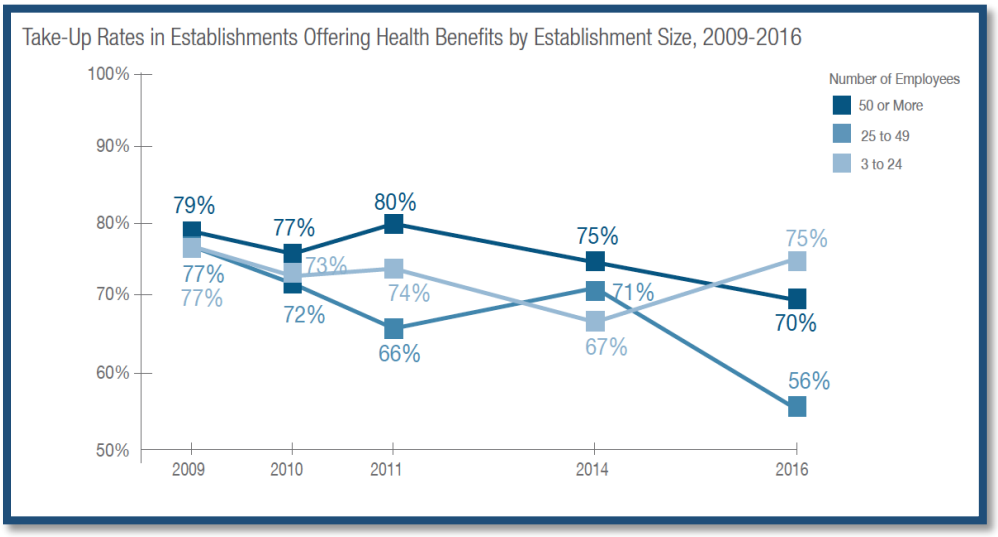


Figure 3. Take-Up Rates by Establishment Size, 2009-2016.



Federal Employer Shared Responsibility Approach

The ACA introduced several provisions that collectively form the federal employer mandate. At a high level, these provisions require employers with over 50 full-time equivalents to offer coverage that meets affordability and actuarial/minimum value standards or pay a penalty. Specifically:

[34] "Baker's Health Price Cap Plan May Be Seen As A Hybrid Between A Free And Regulated Market" (Jan. 26, 2017), available at: www.wbur.org/commonhealth/2017/01/26/price-caps-masshealth-baker

- Section 6056 requires annual information reporting by applicable large employers (ALEs) relating to any health insurance that the employer offers or does not offer to its full-time employees. Generally, employers with 50 or more full-time equivalents are considered ALEs. These employers are required to report information to the IRS about whether they offered coverage to employees, via Form 1094-C ("Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns") and Form 1095-C ("Employer Provided Health Insurance Offer and Coverage"). ALEs are also required to send the Form 1095-C to each employee.
- Section 4980H(a) imposes an assessable payment on an ALE that fails to offer minimum essential coverage to at least 95% of its full-time employees (and their dependents) under an eligible employer-sponsored plan, if at least one full-time employee enrolls in a qualified health plan for which a premium tax credit is allowed or paid. The amount of the payment is $2,000 annually per employee for the number of full-time employees minus 30, calculated on a monthly basis.
- Section 4980H(b) imposes an assessable payment on an ALE that offers minimum essential coverage to at least 95% of its full-time employees (and their dependents) under an eligible employer-sponsored plan, but has one or more full-time employees who enroll in a qualified health plan for which a premium tax credit is allowed or paid (for example, if the coverage offered does not meet federal standards for affordability or minimum value). The amount of the payment is $3,000 annually per full-time employee who receive the premium tax credit, or the payment calculated under Section 4980(a), whichever is less, calculated on a monthly basis.

Request: Relief from Employer Shared Responsibility Requirements

As part of a comprehensive effort to revive the Commonwealth's pre-ACA approach to employer shared responsibility, Massachusetts seeks immediate relief, through at least tax year 2019, from Sections 6056 and 4980H of the Internal Revenue Code for applicable large employers doing business in Massachusetts with respect to any Massachusetts-based employees. Applicable entities in Massachusetts would continue to comply with Section 6055, which requires annual information reporting by health insurance issuers, self-insuring employers, government agencies, and other providers of health coverage.

Rationale: Need for Flexibility Given Federal Delay and Limited Scope

Because the ACA stated that the federal employer mandate would be effective starting in 2014, Massachusetts employers made a good faith effort to comply with the federal approach, investing considerable time to transitioning from the previous state employer contribution.[35] The Commonwealth acknowledges and appreciates these efforts by employers, but unfortunately they have not yielded the intended results because the federal implementation process has been delayed and contains gaps that limit its impact.

Implementation Delays Have Limited Effectiveness of the Federal Mandate

Though the federal mandate was scheduled to take effect in 2014, the Administration made widespread transition relief available in tax years 2014 and 2015 and show no sign of fully implementing it for 2016.

[35] For example, one major employer association indicated in a Health Connector public stakeholder meeting on October 16, 2015 that its employer members were spending between $5,000-$10,000 on an ongoing basis on vendors or software to assist in compliance reporting.

To the Commonwealth's knowledge, federal implementation of the employer mandate has been delayed or non-enforced for virtually all Massachusetts employers. *See Figure 4*.

Figure 4. Delays in Implementing the Federal Employer Shared Responsibility Provisions.

Tax Year	Departments' Transition Relief Policy
2014	Comprehensive transition relief – no payments owed and no reporting required.[36]
2015	Transition relief remained available for many employers, including:[37] • Employers with fewer than 100 full-time employees in 2014 owed no payments provided certain conditions were met regarding the employer's maintenance of workforce and pre-existing health coverage; • Employers with at least 100 full-time employees were afforded a relaxation in the calculation of the penalty, allowing an 80 employee reduction rather than a 30 employee reduction; • Employers were afforded a relaxation of the requirement that 95% of full-time employees are eligible for coverage, instead requiring only a 70% threshold; • Employers were afforded a relaxation of the requirement to offer coverage to full-time employees' dependents, provided certain conditions were met; • Employers were permitted a shorter 6-month period for determining ALE status, rather than a 12-month status; • Employers were permitted to adopt a transition measurement period for determining full-time employee status that is between six and 12 months; • Employers sponsoring non-calendar year plans were afforded additional time to come into compliance, in line with their plan's yearly renewal, provided certain conditions were met; and • Employers offering coverage prior to the first payroll period of January 2015 are deemed compliant for January 2015.
2016 and Beyond	While formal transition relief has not yet been made available for 2016 or later years, it appears that the IRS is not yet fully administering the federal employer mandate. An April 2017 evaluation by the Treasury Inspector General for Tax Administration indicates that the IRS has experienced significant operational readiness issues with respect to systems needed to identify and calculate penalties for noncompliant ALEs.[38] The report indicates, among other outstanding issues: • The development and implementation of key systems needed to identify noncompliant employers have been delayed, not initiated, or cancelled; • Other filing season priorities delayed processing paper information returns; and • Programming errors inaccurate identifies some employers as noncompliant ALEs.

[36] Internal Revenue Service, "Notice 2013-45: "Transition Relief for 2014 Under §§ 6055 (§ 6055 Information Reporting), 6056 (§ 6056 Information Reporting) and 4980H (Employer Shared Responsibility Provisions)" (July 9, 2013), available at: www.irs.gov/pub/irs-drop/n-13-45.pdf.

[37] Internal Revenue Service, "Shared Responsibility for Employers Regarding Health Coverage" 79 FR 8543 (Feb. 12, 2014), available at: www.federalregister.gov/documents/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage#footnote-12-p8570.

[38] Treasury Inspector General for Tax Administration, 2017-43-027: "Affordable Care Act: Assessment of Efforts to Implement the Employer Shared Responsibility Provisions" (April 7, 2017), available at: www.treasury.gov/tigta/auditreports/2017reports/201743027fr.pdf.

While it is possible that the IRS will move forward with a more robust implementation in the coming tax years, the IRS has not yet given any indication it will do so. The IRS has indicated that it intends to issue sub-regulatory guidance to provide more specific information prior to assessment of the employer penalties.[39] The fact that IRS has not yet done so for the ACA's employer shared responsibility provisions is a signal that additional delays are possible.

Federal Mandate Does Not Extend to Some Employers

In addition to enforcement delays, the federal employer mandate is limited in its impact because it does not extend to the full range of circumstances under which an employer's workers might seek public coverage.

The federal mandate penalty is only designed to be triggered if an ALE has an employee that accesses premium tax credits through an Exchange, and if no safe harbor applies. This scheme does not address a number of other circumstances, such as:

- The employer is not an ALE – for example, an employer with 49 full-time equivalents will not be subject to the penalty;

- The employee accesses subsidized coverage programs other than the premium tax credit – for example, a worker that accesses Medicaid or state safety net programs will not trigger the penalty; or

- The employer's offer of insurance meets safe harbor standards – for example, the employer is generally exempt from penalties if the offer is affordable based on wages paid to the employee, even if the employee can still receive the premium tax credit.

In these and other circumstances, the federal mandate may inadvertently permit or encourage employers to rely on public coverage programs rather than employer-sponsored insurance.

Proposal: State Alternative Employer Shared Responsibility Program

Given shortcomings in the ACA's employer mandate and Massachusetts' pressing need to rebalance employer-based and public coverage, the Commonwealth is moving forward to implement its own employer contribution program.

In January 2017, Governor Baker introduced a package of reforms to the state Legislature that proposed reviving a permanent state-based employer contribution. After months of dialogue with the state Legislature and stakeholders, the Baker-Polito Administration proposed a compromise employer

[39] IRS, "Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act, Question 57", available at: https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act.

contribution approach[40] that was enacted on July 7, 2017 and is now pending Governor's signature and further legislative affirmation.

The proposal enacted into law builds on the Employer Medical Assistance Contribution (EMAC), the assessment on employers doing business in the Commonwealth with over six employees (part and full time) that Massachusetts retained when repealing the Fair Share Contribution. Starting January 1, 2018, EMAC will include a temporary two-tiered structure, scheduled to sunset after two years. *See Figure 4*.

Figure 5. Massachusetts' Tiered Employer Contribution Structure.

Tier	Goal	Rate
Tier 1	Broad-based funding mechanism to support public coverage.	Raises the current EMAC rate from 0.34% of annual wages to 0.51% of annual wages, up to an annual per-employee wage cap of $15,000. This would raise the rate from $51 per employee to $77 per employee.
Tier 2	Targeted penalty, only for employers with employees that access subsidized public coverage via MassHealth or the Health Connector.	For each non-disabled employee on public coverage, employers must pay an additional 5% of annual wages, up to an annual per-employee wage cap of $15,000.

The revised EMAC program will continue to be administered via the state Department of Unemployment Assistance (DUA), but will feature a revived HIRD form to ensure accurate reporting by employers. The DUA is prepared to implement these new processes prior to 2018, including the issuance of regulatory guidance. Funds collected from the contribution will be deposited in the Commonwealth Care Trust Fund for use to support public coverage programs.

Together with ongoing state reforms, the Commonwealth anticipates that this proposal will serve as the first step toward slowing the trend toward public coverage where employer-sponsored insurance may be available. Massachusetts' approach has several advantages over the federal employer mandate:

- Broader Applicability: The state employer contribution will apply to employers with six or more employees, while the federal employer mandate generally applies only to employers with fifty or more employees (including full-time equivalents). This broadened applicability will allow the Commonwealth to better address the market segments where the starkest declines in employer-sponsored coverage are occurring.

- Immediate Effectiveness: The state employer contribution will begin January 1, 2018. Massachusetts will be able to manage this implementation toward a successful near-term roll-out, rather than relying on the federal system, which could continue to experience delays.

- Administrative Simplicity: The state employer contribution will leverage an existing reporting and contribution system that employers doing business in Massachusetts use for unemployment insurance reporting and administration of the existing EMAC assessments. Any additional reporting

[40] Associated Industries of Massachusetts Blog, "Governor, Business Community Reach Compromise on Health Assessment" (June 20, 2017) http://blog.aimnet.org/aim-issueconnect/governor-business-community-reach-compromise-on-health-assessment

will build off Massachusetts' pre-ACA HIRD process, a reporting structure that will be familiar to most employers doing business in Massachusetts.

- Shared Savings: Because Tier 2 of the state employer contribution is tied to employees' enrollment in MassHealth and subsidized Health Connector coverage, the Commonwealth anticipates a chilling effect on employers' reliance on these public programs to cover their low-income workers. Under the federal employer mandate, employers do not face a penalty if their employees take up coverage in MassHealth, and smaller employers are exempt from the penalty for subsidized Health Connector coverage. The state employer contribution addresses these gaps, encouraging employers to provide employer-sponsored insurance for a broader swath of their employees. This will reduce subsidized coverage expenditures for both the Commonwealth and the federal government, offsetting future federal revenue that may be anticipated from the employer mandate.[41] While employer-sponsored insurance is excluded from income for federal tax purposes, the low incomes of affected employees means that any associated reduction in federal income tax revenue would be minimal.

- Complementary Reforms: The state employer contribution is designed to complement other state initiatives, such as ongoing efforts to improve program integrity, maximize premium assistance, and explore innovative mechanisms to encourage employer-sponsored insurance.[42] Massachusetts expects to continue to seek opportunities to use its revived HIRD forms to build stronger mechanisms to protect against inappropriate state and federal liability for subsidies.

- Built-in Flexibility: The state employer contribution is designed to be re-evaluated on an ongoing basis, as other state and federal reforms take shape. After two years, Massachusetts anticipates making a formal decision to either continue the current approach or revise its approach based on employer reaction and coverage trends. At that point, Massachusetts could enact a permanent state employer contribution, contingent upon continued federal flexibility via a Section 1332 waiver.

Next Steps

Massachusetts recognizes that the federal employer mandate and related requirements could be waivable subject matter under ACA Section 1332, and the Commonwealth is prepared to submit such a waiver if deemed necessary by the Departments. To the extent that Massachusetts develops a permanent state employer contribution following its current two-year program, Massachusetts would expect to prepare a more extensive and detailed Section 1332 waiver. However, given the immediate need for a state program, the Commonwealth requests flexibility in the interim prior to a Section 1332 waiver.

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[41] The Commonwealth is aware that the Office of Management and Budget has projected receipts from collection of the employer mandate penalty. (*See* Supplemental Materials to the President's Budget, FY 18, available at www.whitehouse.gov/omb/budget/Supplemental). The Commonwealth respectfully suggests that these figures overstate receipts for the first years of enforcement, given the outstanding guidance needed to collect this revenue and the status of the mandate as an assessable penalty requiring proactive enforcement. In addition, the high rate of employers offering coverage in Massachusetts and the offsetting chilling effect of the state employer contribution suggest that Massachusetts employers will account for only a very small share of any actual receipts collected, even absent any transition relief. The Commonwealth is prepared to engage in further dialogue with the Departments regarding deficit neutrality via a longer-term Section 1332 waiver, but requests immediate relief in the meantime.

[42] For example, the Baker-Polito Administration proposed introducing an employer-sponsored insurance "firewall" for Medicaid similar to that applicable to Exchange coverage as part of the FY 2018 budgeting process. While it has not yet been approved by the state Legislature, the Baker Administration will continue to consider and propose similar measures to ensure program integrity and an appropriate balance between public and private coverage.

The Commonwealth sees two sources of authority for such relief. First, the Departments could grant transition relief to the Commonwealth under ACA Section 1321(e), which provides a presumption of compliance for Massachusetts given its history of state reform. This provision states:

> "*(1) In general. In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards. (2) Process. The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section."*

In the past, Massachusetts has worked collaboratively with the Departments to identify areas where flexibility may be appropriate, given the Commonwealth's unique health reform and coverage expansion efforts. In these past discussions, the Departments have recognized that flexibility under Section 1321(e) is warranted for insurance market issues that extend beyond the minimum federal functions of an Exchange, given the fact that the Health Connector has authority over a variety of insurance market issues that exceed the role of other state-based Exchanges. Because the Health Connector played an active role in administering the pre-ACA state employer contribution and would continue to do so under the new state program, such flexibility may be appropriate for the current request.

More broadly, the Departments have authority to grant transition relief in a broad or targeted fashion when implementing new laws such as the ACA. For example, the Treasury Department has previously issued relief via its long-standing administrative authority under Section 7805(a) of the Internal Revenue Code, which has been used to postpone the application of new legislation when immediate application would have subjected taxpayers to unreasonable administrative burdens or costs.[43]

Under either or both of these authorities, Massachusetts respectfully requests relief the federal employer mandate. As a next step, Massachusetts requests to engage in a dialogue toward the goal of identifying and implementing, prior to January 1, 2018, any transition relief that may be warranted. Given the transitional nature of Massachusetts' state employer contribution approach, Massachusetts would expect that any such flexibility could be re-evaluated on a regular basis to ensure that the state approach continues to suffice.

The Commonwealth would appreciate the opportunity to discuss how such flexibility could be implemented in a fashion that meet the Departments' needs. Under one possible implementation pathway, the IRS could instruct employers to continue to count Massachusetts-based employees toward the definition of an applicable large employer, but permit employers to remove these employees when reporting under Section 6056. This approach would reduce reporting burdens for these employers and eliminate the possibility that Massachusetts-based employees could trigger Section 4980H penalties,

[43] *See generally*, Testimony of J. Mark Iwry, Senior Advisor to the U.S. Department of Treasury, Before the House Energy and Commerce Subcommittee on Oversight and Investigations (July 18, 2013), available at: https://murphy.house.gov/uploads/iwry.pdf.

without requiring significant changes to the processes or operations of the IRS. The Commonwealth is open to other possible implementation processes that may be suggested by the Departments.

Flexibility Request #3: Revive Permissibility of Section 125 Plans for Non-Benefits Eligible Employees to Enhance Consumer Savings and Promote Private Coverage

Overview

Massachusetts requests the opportunity to work with federal partners to find a pathway to allow Massachusetts employers to establish Section 125 plans to allow non-benefits eligible employees to purchase their own nongroup health insurance plans through public exchanges with pre-tax dollars.

In Massachusetts, approximately 80,000 individuals purchase nongroup insurance without a contribution from an employer and without federal and/or state subsidies.[44] These individuals pay for premiums without the two major affordability benefits enjoyed by their fellow residents who get their coverage from adjacent market segments. Specifically, they do not benefit from the tax exclusion enjoyed by people who get coverage through employer plans (nor are they aided by the employer contribution in that circumstance), and they do not benefit from the premium tax credit that many lower-income individuals receive, leaving them to shoulder a disproportionate burden of growing premium costs. This population of "betwixt and between" residents are required, per the federal individual mandate and – in Massachusetts – the state's individual mandate, to carry health insurance but have neither the benefit of subsidies nor the benefit of tax treatment of contributions towards income. Trends in the labor market suggest that the share of individuals with nongroup coverage (as opposed to group coverage) is likely to grow over time, suggesting that the creation of parity in the treatment of their health insurance expenditures merits meaningful consideration from a public policy perspective.

However, a federal policy shift that allows such individuals to purchase their nongroup coverage with pre-tax income would afford cost savings to middle-income individuals who are employed but not benefits-eligible, increase the attractiveness of private nongroup coverage (potentially helping promote scale and further stabilization to Exchange enrollment), address affordability issues for the population earning just over the current subsidy eligibility threshold, and help support "benefits vulnerable" workers affected by shifts in the labor market (*i.e.,* the so-called "1099 economy").

Background

Section 125 Plans as Benefits Tool

A Section 125 plan, or "Cafeteria Plan," is a plan created under Internal Revenue Code (IRC) § 125, in which employees can use salary on a pre-tax basis to purchase a range of benefits, including health insurance, medical care, or other qualified benefits, such as dependent care assistance. Excluding these benefits from income saves employees up to 40% of their payroll deductions, depending on their tax

[44] Estimate calculated using nongroup market enrollment as of Sept. 2016 from Center for Health Insurance and Analysis Enrollment Reports (available at: http://www.chiamass.gov/enrollment-in-health-insurance/), subtracting ConnectorCare enrollment from same time period. ConnectorCare enrollment, available at: https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2016/2016-09-08/Summary-Report-August2016.pdf.

bracket. Employers save the matching Social Security (6.20%) and Medicare (1.45%) taxes, which equates to 7.65% of the amount put through the plan.[45]

How Section 125 Plans Differ from QSEHRAs

In December, President Obama signed into law the 21st Century Cures Act (H.R. 34). Section 18001 of the Act establishes stand-alone Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs). These arrangements, which are not considered to be group health plans for the purposes of many federal laws, may be used to reimburse employees for premiums paid to purchase a health plan in the nongroup market, and other qualified health expenses, such as qualified out-of-pocket expenses. Annual payments to QSEHRAs must be limited to $4,950 for the employee and $10,000 for family members (subject to annual indexing for inflation after 2016).

QSEHRAs introduce a new mechanism for small employers to connect employees to coverage and to facilitate an employer contribution. The flexible and low-touch role for the employer and its contribution can be a meaningful incentive for employers to offer a coverage option to employees who may otherwise go without any means of employer benefits support, or make involvement in coverage more attractive and feasible to small employers that may not otherwise be able to offer a group health insurance benefit. Massachusetts and the Health Connector are open to these arrangements as an additional purchasing vehicle from which small businesses may choose.

However, as a policy tool and as a purchasing mechanism, QSEHRAs differ in important ways from Section 125 plans. Most notably, a QSEHRA plan does require some offer of monetary contribution from the employer. However, there may be employee categories for which many employers do not wish to or are not able to make any contribution at all (e.g., part-timers), and QSEHRAs are not designed to assist these individuals with the benefit of pre-tax contributions towards their purchase of their own plan. Section 125 plans remain an important tool for the many types of employees who are and will remain "on their own", without a contribution from an employer, but who would benefit from the ability to make pre-tax contributions. Further, since the employer's contribution to the QSEHRA may be quite limited (the law caps the employer contribution, but imposes no minimum), the participating employee may remain required to use post-tax income to pay a large share of the nongroup plan premium, which can minimize the usefulness of the benefit in certain instances.

Massachusetts History of Section 125 Requirement Promotion

As part of its state health reform law, Chapter 58 of the Acts of 2006, and subsequent regulations, Massachusetts required employers with 11 or more full-time equivalent employees to establish a Section 125 plan that allowed employees to purchase nongroup health insurance on a pre-tax basis; no employer contribution was required. This requirement was designed to give non-benefit eligible employees, such as part-timers, the opportunity to obtain tax advantages in purchasing health insurance on their own similar to those received by benefits-eligible employees participating in employer-sponsored insurance (ESI). The Health Connector facilitated compliance with the Section 125 requirement by providing guidance to employers regarding how to establish Section 125 plans for non-

[45] Social Security Administration Website, available at: https://www.ssa.gov/OACT/ProgData/taxRates.html); Cafeteria Plan Advisors, Inc., available at: http://www.cpa125.com/.

benefits eligible employees and a convenient one-stop marketplace to purchase affordable nongroup health insurance.

The Health Connector's 'Voluntary Plan' (VP) Program

Although employers were free to set up Section 125 plans that facilitated coverage directly though carriers, the Health Connector created the "Voluntary Plan" (VP), which was a program under which employers could set up one Section 125 plans that could then be used by non-benefits eligible employees to purchase from the full array of nongroup health insurance offered through the Health Connector. The employer then only had to facilitate payments to one entity, and employees were able to shop from a wide and competitive product portfolio with offerings from a number of carriers. Enrollment in this program was modest but steady: in the last year of the program, approximately 2,500 individuals (including employees and their dependents) were enrolled, and approximately 700 employers had active accounts with the VP program (meaning they had at least one employee utilizing the program). During its inception, the Health Connector actively worked with large employers to promote the program. The Commonwealth of Massachusetts also utilized the program for its non-benefits eligible state employees.

Repeal of the Section 125 Requirement and Closure of VP

The ACA, enacted in 2010, contained a provision (Section 1515) that amended IRC § 125, effective January 1, 2014, to provide that Section 125 plans cannot be used to purchase nongroup insurance on public health exchanges, such as the Health Connector.[46] The Health Connector responded by closing its VP program at the end of 2013. It was expected that employers would continue to satisfy their offer Section 125 plan requirement by offering non-benefits eligible workers nongroup insurance outside of the Health Connector, such as through private exchanges or via direct purchase from insurance carriers. However, in September 2013, federal guidance addressing this issue was issued by the Department of Labor and the IRS via Technical Release 2013-03 and IRS Notice 2013-54. The guidance coined the new term "employer payment plan" (EPP). An EPP includes a Section 125 plan and other arrangements that pay or reimburse employees, directly or indirectly, pre-tax or post-tax, for the premium cost of any nongroup health insurance policies purchased by employees on their own, regardless of the source of the policies.[47] The guidance explains that EPPs are group health plans under the ACA but cannot meet certain ACA insurance market reforms that apply to group health plans. Because violating the market rules makes an employer subject to an excise tax of $100 per day per applicable employee, the guidance effectively prohibited the use of EPPs.[48] This guidance directly conflicted with the Health Connector requirement that employers offer Section 125 plans to non-benefits eligible employees for the purchase of nongroup health insurance on a pre-tax basis without any employer contribution. Consequently, Massachusetts suspended and then eventually repealed its Section 125 requirement.

[46] 26 USC § 125 (f)(3) as added by ACA section 1515.
[47] IRS Notice 2013-54 and DOL Technical Release 2013-03 (Sept. 13 2013), available at: https://www.irs.gov/pub/irs-drop/n-13-54.pdf and https://www.dol.gov/ebsa/newsroom/tr13-03.html.
[48] IRS Notice 2015-17, (Feb. 18, 2015), available at: https://www.irs.gov/pub/irs-drop/n-13-54.pdf.

Rationale: Economic Trends Suggest Increased Usefulness of Section 125 Flexibility

Since the repeal of the Section 125 requirement in Massachusetts, three key trends in the insurance market and labor market have emerged that suggest there may be value to revisiting the prohibition of this mechanism of employee health insurance purchasing in Massachusetts, and point to a need for new approaches to promote affordability and parity across types of insurance purchasing.

Decline in ESI-Covered Lives, Especially in Small Group Coverage

The percentage of small employers offering health insurance in Massachusetts has declined since passage of Chapter 58 (current offer rate is about 65%, down from 77% in 2010).[49] Specifically looking to the small group market, issuer enrollment data indicates that the number of covered lives via the small group market has been steadily declining in recent years; in late 2013, 556,000 lives were covered in the Massachusetts small group market, whereas current small group enrollment has declined to comprise approximately 495,000 covered lives. These state-level trends track with national ones, as well.[50] This could be a result of the fact that more employees are being classified as non-benefits eligible, or that employees are becoming eligible for other programs. Nevertheless, policymakers should seek to ensure that employees of small businesses continue to have access to affordable coverage, even if that is not through a traditional group coverage model, and should work to ensure that small businesses continue to stay 'at the table' in brokering access to coverage for employees.

Affordability Challenges for Middle-Income Residents

Even as health insurance coverage rates across the country have risen in recent years and new individuals continue to enter the ranks of the insured, affordability of coverage remains a pressing concern and policy priority. While the ACA introduced subsidies to lower income individuals (and in Massachusetts, a combination of such federal subsidies and state subsidies are used), affordability concerns remain for individuals and families just over the subsidy eligibility threshold (400% FPL),[51] sometimes referred to as the "affordability cliff" or "subsidy cliff", beyond which the individual or family without access to ESI must pay 100% of the premium and cost-sharing. This full cost exposure is notably assumed using *post-tax* dollars for individuals not purchasing through a group plan. As these individuals continue to struggle to afford rising premiums, it merits consideration whether those who need to purchase nongroup coverage should be afforded tax benefits commensurate with those who purchase through a group health insurance plan. Considering that being able to purchase health insurance with pre-tax income can save an individual up to 40 percent,[52] depending on their tax rate, the cost savings could be substantial and could provide much needed relief for the population that needs to buy coverage 'on their own.'

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[49] Center for Health Information and Analysis, "2016 Massachusetts Employer Survey" (March 2017), available at: http://www.chiamass.gov/massachusetts-employer-survey/.

[50] Kaiser Family Foundation, "2015 Employer Health Benefits Survey" Exhibit 3.1, available at: http://kff.org/report-section/ehbs-2015-section-three-employee-coverage-eligibility-and-participation/

[51] $47,520 for an individual and $97,200 for a family of four per 2016 FPL schedule.

[52] Note that 40% savings example would be reflective of savings realized by a very high income earner. An individual just above APTC eligibility cut off at 400% of FPL would experience more modest, but still meaningful, savings.

Rise of Contingent and 'Gig-Based' Workforce

A growing body of evidence suggests that the national economy is moving towards greater dependence on "gigs" and contract-based work of the non-benefits-eligible nature. Labor economists Lawrence F. Katz of Harvard and Alan B. Krueger of Princeton have found that the percentage of workers in "alternative work arrangements" (*e.g.,* those working for temporary agencies, contractors, or on-call) was 15.8 percent in the fall of 2015, up from 10.1 percent a decade earlier.[53] These work arrangements are often characterized by limited access to traditional employer-provided benefits, including access to group health insurance coverage. Should these trends continue, the approximately 10 million people in the US that obtain or are eligible to obtain their coverage through the nongroup market would be expected to grow,[54] intensifying the need for policy solutions to their premium affordability.

Enabling the employers who rely on this type of contingent workforce to administratively usher such employees into mechanisms for accessing coverage and to allow employees to use pre-tax income to buy nongroup coverage would be a "win-win": (1) it allows the employee access to health insurance coverage with enhanced affordability enabled by tax savings and (2) allows the employer to stay involved in the equation while reducing their financial and administrative enmeshment compared to a traditional group coverage model. As Massachusetts seeks to find ways to shore up its private, commercial market, it seeks to activate this alternative means of connecting employees to coverage. In addition to the ever-critical health of *employer-sponsored* coverage, this mechanism could be characterized as *employer-enabled* coverage. Both avenues – to truly support affordability of coverage, both for the benefit of those with coverage and the stability of private markets – require tax-preferential treatment.

Rise of Part-Time Work

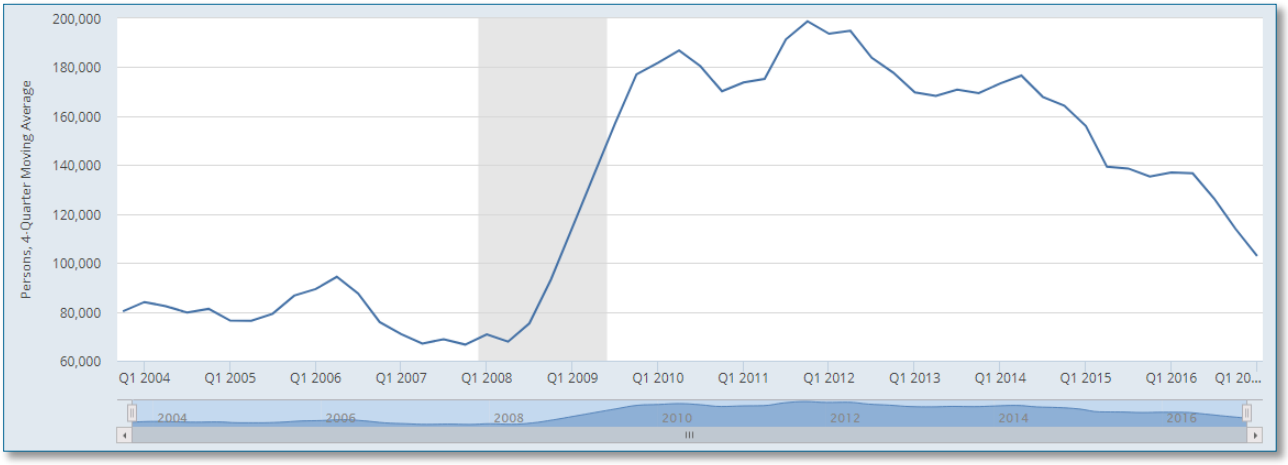
In addition to an increase in contract or gig-based employment, the post-recession economy has seen a stark rise in part-time employment. This trend is evident both nationally and within Massachusetts. While, of course, many workers chose to work part-time hours, after the Great Recession, many workers in Massachusetts joined the ranks of the "employed involuntary part-time" workforce: individuals who wish to work full-time, but are only able to secure part-time employment.[55] *See Figure 6.*

[53] Sometimes referred to as the "1099 economy" or the "contingent workforce." See more information at: (1) GAO Letter to Sen. Patty Murray and Sen. Kirsten Gillibrand, Contingent Workforce: Size, Characteristics, Earnings, and Benefits. Available at: http://www.gao.gov/assets/670/669766.pdf ; (2) *The Rise and Nature of Alternative Work Arrangements in the United States, 1995-2015*: http://krueger.princeton.edu/sites/default/files/akrueger/files/katz_krueger_cws_-_march_29_20165.pdf

[54] Growth in nongroup on account of these labor market trends assumes the growth in such jobs is not associated with lower incomes, in which case some of these individuals may become eligible for subsidized health insurance via Exchanges or Medicaid.

[55] U.S. Bureau of Labor Statistics, "Employed Involuntary Part-Time for Massachusetts [INVOLPTEMPMA0]", retrieved from FRED, Federal Reserve Bank of St. Louis; (July 21, 2017), available at: https://fred.stlouisfed.org/series/INVOLPTEMPMA.

Figure 6. Total Employed Involuntary Part-Time Workers in Massachusetts



The rise in part-time based work is meaningful for the purposes of Section 125 plans because, similar to the dynamics in the contract-based workforce, these individuals are less likely to be provided benefits, including health insurance, by their employer. Only 31 percent of Massachusetts employers offered employer-sponsored coverage to part-time workers in 2016 (which is higher than the national rate of 16 percent).[56] For a part-time employee who is not income-eligible for federal or state subsidies, there is no formal policy framework in place devoted to facilitating affordability regarding their purchase of coverage. Section 125 plans can be a key policy tool to effectively fill this void.

Request: Possible Paths to Reviving Section 125 Plan Capability

Massachusetts welcomes the opportunity to discuss possible paths to reviving the ability of Massachusetts employers to establish Section 125 plans for non-benefits eligible employees. We would be interested in obtaining this capability for employers of all sizes, but are especially interested in seeking it for small employers (<50 employee firms). We could envision multiple paths worthy of consideration, which could include but not be limited to:

- **Guidance/Policy Flexibility Pathway**: Revisit the September 2013 federal guidance issued by the Department of Labor and the IRS via Technical Release 2013-03 and IRS Notice 2013-54, to allow for a special allowance for Massachusetts to permit these plans, at least for small employers, given (1) their modest but valuable (and non-disruptive relationship to risk pools and ESI markets in the Commonwealth) history in the state, (2) the fact that small employers already have access to a community rated risk pool, and (3) the recognition by Congress in the 21st Centuries Cures Act that special considerations apply to smaller employers.

- **Creative Program Design Pathway:** Federal flexibility, either through a section 1332 state innovation waiver or otherwise, could permit the Health Connector, through its SHOP platform, to create a sub-SHOP program for small employers to allow a "VP-like" offering to certain classes of

[56] Center for Health Information and Analysis, "2016 Massachusetts Employer Survey", available at: http://www.chiamass.gov/massachusetts-employer-survey/.

employees (*e.g.,* part-timers), whereby the requirement to offer to all full-time employees would be waived.

Proposal: Opportunity to Revisit Section 125 Policy

Massachusetts's experience promoting Section 125 plans for non-benefits eligible workers suggests that this policy approach is an administratively easy way to promote affordability for workers that may not have access to group health insurance through an employer, yet may be just over the subsidy-eligibility threshold, making them vulnerable to health insurance premiums that may strain their household budgets. A revived capacity for businesses to use Section 125 plans in this way could enable material savings for a population of "in-between" individuals earning too much for subsidies but vulnerable to full premium cost, saving money for employers, and keeping businesses "at the table" in connecting employees to health insurance, even in a changing economy where group plan arrangements may not always be realistic. Further, this capacity ensures that there are no perverse incentives for workers to cross the subsidy eligibility line, by ensuring that affordable options await them beyond 400% of the poverty level. A shift of this nature could promote urgently needed affordability for the population shouldering a greater share of premium burden than the populations obtaining subsidized or employer-sponsored coverage.

Next Steps

The policy concept of pre-tax nongroup coverage (via Section 125 plans, HRAs, etc.) has historically enjoyed bi-partisan support[57] and – in Massachusetts – Section 125 plans specifically are a tested policy tool with minimal observed downsides. Massachusetts viewed Section 125 plans as helpful policy tool during its initial state-based health reform implementation period, yet sees an even more salient and pressing need for this vehicle now that there is evidence of a growing share of the workforce using contract-based and part-time work as its primary means of income, meaning reduced access to traditional group coverage. Massachusetts welcomes a dialogue to determine viable pathway(s) to reviving the use of Section 125 plans for those middle-income employees in Massachusetts who would be greatly aided, from an affordability perspective, by the ability to use pre-tax income to purchase health coverage, thereby further strengthening our commercial insurance market and broader health care landscape.

[57] HR 2911/S. 1697, "Small Business Health Care Relief Act" (June 22, 2015). *See also*, www.grassley.senate.gov/news/news-releases/grassley-heitkamp-boustany-and-thompson-introduce-health-reimbursement.

Flexibility Request #4: Permission for Commonwealth to Administer the Federal Small Business Health Care Tax Credit

Overview

Massachusetts respectfully requests flexibility to administer the federal Small Business Tax Credit (SBTC) at the state level in order to better support Massachusetts employers' ability to obtain the credits and help maximize their intended purpose: to help the small employers struggling the most to stay in the group market to offer commercial coverage to their workers. If this tax credit could be state-administered through the Commonwealth's state-based marketplace, the Health Connector, and aligning with its existing Wellness Track program, Massachusetts could craft an easy-to-use, effective and meaningful support structure for the most "benefits-vulnerable" small businesses. This would be an innovative approach to targeting help to the small group market in a way that would promote competition, access, and help tilt recent trends of declining offer rates among smaller firms with lower wage employees. Further, the opportunity to align a combination of federal and state program goals to expanding coverage options is a tested approach in Massachusetts, and one that has afforded us meaningful success in the individual and family market. Here we seek to use the same state-and-federal partnership model to help deliver the same value and opportunities for our small businesses.

Background

ACA Small Business Tax Credits

The Affordable Care Act (ACA) introduced a tax credit for small employers with low-wage employees to incentivize and enable their participation in the small group insurance market, by helping them afford the cost of covering their employees. The credit is designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have. These goals are closely aligned with those of the Baker-Polito Administration in its effort to strengthen the Massachusetts small group market, particularly for those employers who may not offer or may be inclined to discontinue offering coverage.

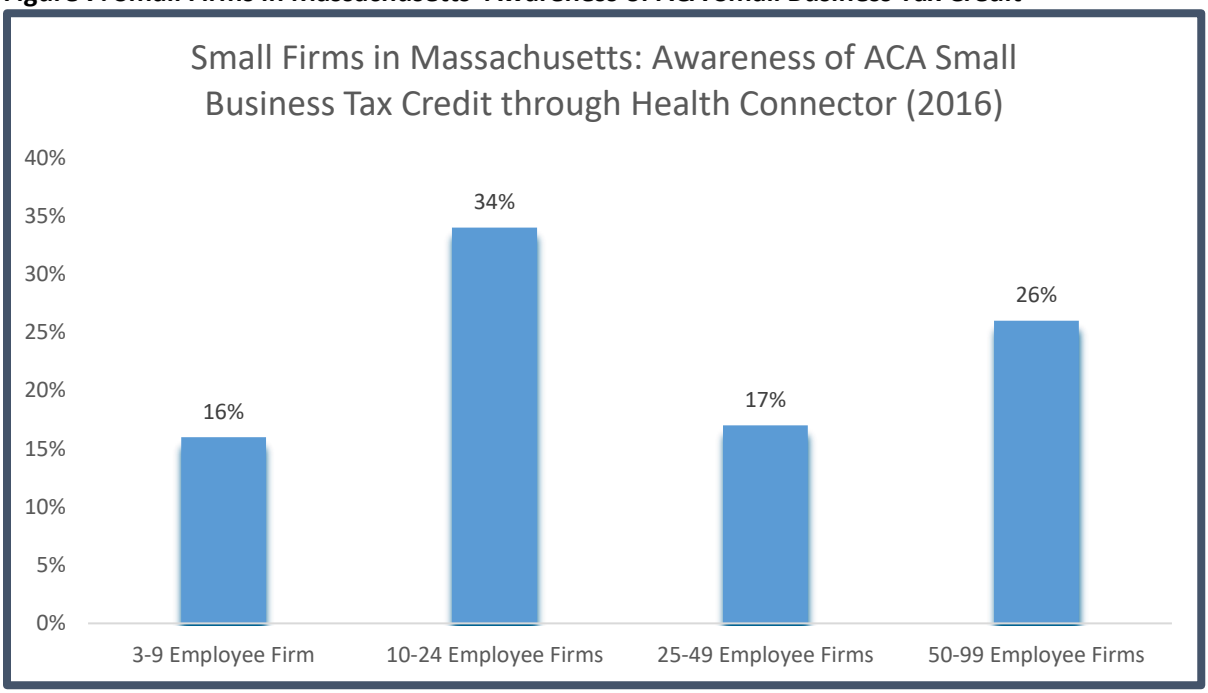
The ACA Small Business Tax Credit is available to small employers that:

- Have fewer than 25 full-time equivalent employees;
- Pay average wages of less than $50,000 a year per full-time equivalent (indexed annually for inflation beginning in 2014);
- For tax years 2015 and 2016, the inflation-adjusted amount is $52,000;
- Pay at least half of employees' health insurance premiums;
- Purchased group coverage through the small business health options program, also known as the SHOP marketplace (in Massachusetts, this is being re-launched for 1/1/2018 under the name "Health Connector for Business"); and

- Employers must use Form 8941, Credit for Small Employer Health Insurance Premiums, to calculate the credit.[58] Tax-exempt organizations include the amount on line 44f of the Form 990-T, Exempt Organization Business Income Tax Return. These employers must file the Form 990-T in order to claim the credit, even if they do not ordinarily file it.

To date, there is limited uptake of these tax credits. Employer associations, brokers, and health care experts in the Massachusetts market have noted that this is likely a result of the apparent complexity involved in determining eligibility, as well as low levels of awareness. A recent survey by the Massachusetts Center for Health Information and Analysis (CHIA) bore out that market-wide hypothesis.[59] *See Figure 7.*

Figure 7. Small Firms in Massachusetts' Awareness of ACA Small Business Tax Credit



Massachusetts Wellness Track

The Health Connector's Wellness Track is a free program offered to eligible employers enrolled in a small business group health plan through the Health Connector. Wellness Track's online website provides participating small employers and their employees with a suite of tools, such as health and nutrition trackers and exercise videos, to promote a healthier work environment. Eligible employers who participate may qualify for a Wellness Track rebate of up to 15 percent on their group's health insurance premium contribution for coverage purchased through the Health Connector. To qualify for a rebate, employers must promote a healthy work environment by implementing their choice of three wellness toolkits: nutrition, physical activity or stress management. The stress management toolkit

[58] Form 8941 is available at: https://www.irs.gov/pub/irs-pdf/f8941.pdf. For detailed information on filling out this form, see the Instructions for Form 8941, available at: https://www.irs.gov/pub/irs-pdf/i8941.pdf

[59] Center for Health Information and Analysis, "2016 Massachusetts Employer Survey", available at: http://www.chiamass.gov/massachusetts-employer-survey/.

includes smoking cessation resources. Each toolkit includes wellness activities (*e.g.,* walking programs, healthy eating plans, time management worksheets), resource lists and flyers for distribution to employees.

The program was implemented in a period of low penetration of wellness programs in the small group market, and also during a time of reduced policy and program attention to the small group market in Massachusetts, potentially resulting in lower-than-desired awareness among small businesses. As the Health Connector launches its new Health Connector for Business platform, it seeks to revise and refresh its policy goals and the accessibility of this program. The ability to combine this program with the ACA Small Business Tax Credits will only strengthen its future direction, as the two can mutually reinforce one another.

Request

The Commonwealth seeks the opportunity to develop a Section 1332 waiver request to receive a pass-through of funding available under IRC Section 45R that would have otherwise been available for Massachusetts small employers.

Massachusetts seeks to implement a state-based approach by January 1, 2019 or sooner.

Rationale: Opportunity for ACA Small Business Tax Credits in Massachusetts

In 2016, only 48 percent of MA employers with 3-9 employees offered health insurance coverage to their employees. When compared to the 97 percent and 99 percent offer rates for MA employers with 25-49 and 50-99 employees respectively, it is evident that the Commonwealth's smallest employers are at higher risk of declining to offer coverage.[60] As individuals employed at businesses with between 2 and 9 employees account for approximately 500,000 jobs in the Commonwealth,[61] this is an employer population the Commonwealth – and the Health Connector, as its state-based marketplace, tasked with helping connect individuals and small businesses to coverage – cannot afford to overlook. The underutilization of the ACA Small Business Tax Credit suggests an opportunity gap, and one the Health Connector is well positioned to bridge.

In addition to the Commonwealth's assessment that the smallest size firms may be in greatest need for assistance, it is also evident that workers who earn low wages in small firms are the least likely to be offered health benefits by their employers, to be eligible for benefits in companies that do offer them, and to be covered by their companies' health plans.[62] In keeping with the Baker-Polito Administration's efforts to help stabilize the growth of subsidized insurance programs, opportunities to help make it easier for small businesses with low-income employees deserve careful consideration.

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[60] Center for Health Information and Analysis, "Massachusetts Employer Survey: 2016" (March 2017), available at: http://www.chiamass.gov/massachusetts-employer-survey/.

[61] Data pull from the Department of Unemployment Assistance (DUA) for the Health Connector, June 2017.

[62] Commonwealth Fund, "Realizing Health Reform's Potential: Jobs Without Benefits: The Health Insurance Crisis Faced by Small Businesses and their Workers" (November 2012), available at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2012/oct/1640_robertson_jobs_without_benefits_small_businesses.pdf

In addition to the fact that the ACA Small Business Tax Credits' purpose is closely linked to a policy goal held at the state level, the Health Connector would be well positioned to help administer this credit for three additional reasons:

1. **Launching Modernized Group Market Exchange Platform**: Massachusetts is working with its state-based marketplace partner in the District of Columbia to launch a new, modernized platform for the small business community in Massachusetts to shop for and enroll their employees in health coverage. This new platform will include new "choice models" that promote competition and smart shopping, as well as an easy to use consumer experience for business owners, brokers, and employees alike. As the Health Connector unrolls its outreach and engagement campaign this fall and next winter to build awareness in the employer community, the ability to highlight easier-to-access savings through this tax credit would receive heightened market attention.

2. **Closer Proximity to the Massachusetts Employer Community**: The Health Connector works closely with employer associations, Chambers of Commerce, fellow state agencies that interact closely with local businesses, and other business groups, making it better able to build awareness of the tax credit and get the relevant information into the right hands.

3. **Existing Wellness Program for Similar Population**: Alignment between the ACA Small Business Tax Credit and the Health Connector's existing Wellness Track Program creates a unique confluence of tools to promote savings, shopping, and wellness to the smallest employers in the Commonwealth. These programs and opportunities can help reinforce each other, resulting in more small employers shopping for private coverage for their workers.

Proposal: Development of Coordinated Small Employer Incentive

The Health Connector's Wellness program will combine its allocated state funds with the pass-through funding from the Small Business Tax Credit in order to provide financial support and incentives to small businesses. The program will encourage small businesses that provide coverage aligning with the Commonwealth and Health Connector's goals in the small business health insurance market:

- Retention of employer-sponsored coverage, particularly among the smallest groups;
- Retention of significant employer financial contributions to coverage;
- Promotion of community wellness; and
- Selection of high value insurance plans.

Next Steps

The Commonwealth is in the process of considering state legislative authority to enable the Health Connector to administer the Small Business Tax Credit on a state level. Concurrent with this process, Massachusetts is evaluating a Section 1332 waiver request and will seek to enter into dialogue with the Departments as appropriate.

Flexibility Request #5: Allow for State Option to Continue to Use Select State-Based Rating Factors

Overview

Massachusetts requests permission to continue, at the state's option, the ability to allow carriers in its merged market to continue to apply state-based rating factors beyond Plan Year 2018. This flexibility is requested in the interest of preserving continuity and stability in current rating rules and other time-tested market features in Massachusetts. This request will help support the Baker-Polito Administration's ability to protect the features of the employer-sponsored coverage market that helped deliver Massachusetts's historical health coverage rate after the passage of Chapter 58 of the Acts of 2006.

Background

With the implementation of the ACA, new federal rules limited the types of rate adjustment factors that could be used in rating individual and small group plans on and after January 1, 2014. As a result of the unique features of the Massachusetts merged market structure and an interest in ensuring premium stability in this distinctive market framework, the Commonwealth formally requested permission, under authority enabled by Section 1321(e) of the ACA, to transition its market away from usage of state-based rating factors over a transition period to more slowly come into alignment with federal rules.

On April 6, 2013, CMS granted Massachusetts a transition period to gradually eliminate issuers' use of the following rating factors which had been regularly used in Massachusetts's merged (nongroup and small group) market since July 1, 2007: industry code, participation-rate, group size, intermediary discount, and group purchasing cooperative. The original waiver, as extended in later years, allowed small group insurers to continue to use 2/3 of the state rating factors in effect in July 2013 through January 1, 2017, after which rating factors would be reduced to 1/3 until December 31, 2018. On January 1, 2019, plans are expected to be in full compliance with Public Health Services Act section 2701.[63]

For additional detail on the history of Massachusetts's merged market regulatory landscape, including permissions related to usage of rating factors, please see Appendix C.

Rationale

Massachusetts has studied the potential impact of transitioning away from its state-specific rating factor approach. When last evaluated in 2013,[64] actuarial analysis indicated that:

[63] Most recent flexibility from CMS available at: https://www.mahealthconnector.org/wp-content/uploads/CMS-MA-Rating-Waiver-Letter-07182016.pdf

[64] Oliver Wyman, "Report to the Massachusetts Divison of Insurance: The Projected Impact on Health Insurance Premiums in the Merged Individual/Small Group Market with the Implementation of Federal Rating Rules that Restrict the Use of Massachusetts Rating Factors" (May 2013), available at: http://www.mass.gov/ocabr/docs/doi/oliver-wyman-052013.pdf.

- 83,000 small group enrollees would see premiums decrease by more than 10 percent, while
- 181,000 small group enrollees would see premiums increase by more than 10 percent.

While these estimates have likely changed since the time of the study, particularly given Massachusetts' phase-down in recent years, they are indicative of the potential swings in premium rates that could arise due to an abrupt end to state-specific rating factors. Given other forces threatening to destabilize Massachusetts' commercial market at present, the Commonwealth seeks to avoid any unnecessary disruptions in coverage.

Request: Continue State Rating Factors at State Option

Massachusetts again seeks permission to continue to use, at the state's option, these state-based factors beyond Plan Year 2018, in the interest of continued market stability, under its Section 1321(e) authority, which provides additional time for states with pre-existing Exchanges (prior to implementation of the ACA) to come into compliance. The provision states:

> *"(1) In general. In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards. (2) Process. The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section."*

Massachusetts appreciates the flexibility it has been afforded under this authority to date and has used its allowances to help support general market stability, which has continued its high coverage rate among state residents (currently 96.4%), and seeks to do so again. We respectfully seek permission to extend these rating factors through at least the end of Plan Year 2021.

Proposal: Commitment to Continued Evaluation of Factors

While Massachusetts is requesting the flexibility to exercise the option of continuing to utilize these rating factors beyond Plan Year 2018, the Commonwealth also appreciates that the spirit of the CMS rating rules are designed to ensure fair health insurance premiums overall. .

While we believe that continued applicability of these rating factors will help maximize market stability given the unique features of the Massachusetts coverage landscape, we plan to continue to evaluate their appropriate usage and levels in our market as our state continues to fine-tune and evolve its approaches to strengthening the employer-based coverage market, with a particular sensitivity to the needs of small businesses. These evaluations and decisions are, specifically in the case of Massachusetts with its long history of consumer protection in the insurance regulation arena, most capably and responsively navigated at the state level. We welcome the opportunity to keep CMS and other federal partners apprised of our ongoing evaluation in this regard.

Next Steps

The Commonwealth appreciates the opportunity to continue dialogue with CMS about this request.

Flexibility Request #6: Commence Process to Evaluate Future of Risk Adjustment in the Commonwealth

Overview

Massachusetts seeks to promptly convene a multi-stakeholder state workgroup to consider the potential need for increased flexibility under the Risk Adjustment program (with potential changes effective for Plan Year 2019 at the earliest). Massachusetts believes that the application of Risk Adjustment in its market, as currently designed, would benefit from thorough review and reexamination by relevant state agencies, market participants, and key stakeholders. This reexamination could result in requests to change to the applicability of Risk Adjustment, as a policy tool and a program, in the Commonwealth. The Commonwealth anticipates that this exploration would weigh whether or not to continue to have Risk Adjustment conducted in the Massachusetts market, and if so, whether there are parameters that might be advisable to apply to how it is conducted. In no event would any methodology change be made prior to the ability of carriers to incorporate such changes into their rates. Massachusetts is not contemplating returning the administration of Risk Adjustment to a state-level, having just transferred the function to the federal level, effective January 1, 2017 which is the start of the 2017 benefit year.[65]

Given the important role the Centers for Medicare & Medicaid Services (CMS) plays in Risk Adjustment for the individual and small group markets, we wish to advise our federal partners of our soon-to-commence efforts and welcome the opportunity to establish an ongoing dialogue with CMS as our efforts proceed. We recognize that under existing regulations there are opportunities for state flexibility and seek to study options enabled therein, but believe there may be opportunity and cause for further increased flexibility consistent with CMS's renewed emphasis on state-based innovation.

Background

Risk Adjustment was established as one of three market stabilization programs under the ACA,[66] along with reinsurance and risk corridors.[67] Of the three, risk-adjustment is the only premium stabilization program that extended beyond the first three years of ACA operations (*i.e.* past 2014-16). Under the ACA, Risk Adjustment operates to redistribute funds within a given market in relation to the relative

[65] CMS is now administering the RA program for the Commonwealth. All of the Commonwealth's (via the Health Connector) current RA activities relate to the 2016 Benefit Year.

[66] Risk-adjustment was established under §1343 of the Affordable Care Act. Risk Adjustment applies to all insured (non-grandfathered and non-transition) individual and small group health insurance in a state. The Risk Adjustment program provides payments to carriers with plans that have higher-than-average "actuarial risk," funded by payments form carriers with plans that have lower-than-average "actuarial risk".

[67] The 3Rs were implemented with different stability goals. For example, reinsurance was designed to mitigate selection against the market and risk corridors were developed to mitigate the risk of mispricing for an unknown population. Risk Adjustment is designed to mitigate adverse selection as between carriers operating in a market.

actuarial risk measured at the plan level across competing carriers. The process entails assessing risk in relation to demographic (*e.g.,* age and gender) and diagnosis-related factors, and applying a range of other market-based factors through a payment transfer formula. In general, under the ACA, Risk Adjustment was designed to account for those factors that health insurance carriers would no longer be permitted to account for in their premiums.

When Risk Adjustment is designed soundly, carriers should be agnostic to who enrolls in their plans. This is because if a carrier were to enroll a disproportionally sick or healthy population, they receive or pay funds into the Risk Adjustment pool so that their revenue ideally reflects what the carrier would have charged for the population if they had known its health status. When carriers are not permitted to account for health status in the development of their rates, as is the case under the ACA, which prohibited medical underwriting, Risk Adjustment plays a key role in ensuring a more even distribution of risk, thereby bringing stability to the market.

In a market where carriers were not permitted to rate for health status, but no risk-adjustment mechanism was present, carriers would most likely file higher premiums to protect themselves from the possibility that their enrolled risk pool could reflect higher than average levels of risk. These higher premiums could lead to more price-sensitive, healthier individuals leaving the market, leading to an overall deterioration of the risk pool—and possible compensatory premium increases.

Prior to the ACA, Massachusetts merged its individual and small group markets as part of its state-based health reform effort in 2006. CMS has since recognized that— although there is some flexibility for the updating of rates in the context of small group insurance coverage—the market is considered merged for purposes of Risk Adjustment. Furthermore, Massachusetts operates its ConnectorCare program under which individuals (<300% FPL) (previously covered under "Commonwealth Care") receive coverage through subsidized Qualified Health Plans offered through the Health Connector. In order to ensure that those enrolled in ConnectorCare could afford the coverage and make use of it, the Commonwealth developed a wrap-around subsidy to offset premium costs and raise the effective actuarial value of the plan (thus reducing cost sharing) beyond that provided for through federal CSRs.

These unique features of the Massachusetts system were driving factors in Massachusetts's decision to administer its own Risk Adjustment program – a decision that was later reversed, with Risk Adjustment now slated to return to the federal government for administration. *For more information on both decision-making processes, please see Appendix B.*

Rationale: Renewed Interest in Risk Adjustment Flexibility

In addition to the continued interest from Massachusetts in optimizing the existing Risk Adjustment methodology to be highly tailored to the characteristics of our state, we also anticipate the need for Risk Adjustment to adapt to other possible changes in a market driven by both federal policy and local market dynamics. In general, in an environment with increased focus on state-level innovation, we anticipate necessary flexibility in the operation of Risk Adjustment, reflecting the basic principle that Risk Adjustment works best when customized to the specific market's rules and dynamics. Thus, the potential for state flexibility under Section 1332 waivers and other potential avenues for state innovation make this a particularly appropriate time to consider how flexibility in Risk Adjustment might be achieved. The state review process will seek to contemplate a wide range of options (*e.g.,* ranging from possible ability for federal partners to take on state-tailored functions to allowing states greater

leeway to adjust Risk Adjustment to their markets on a more predictable and timely basis to considering elimination of program in the Commonwealth in full).

As it crafts the forum for these state-specific considerations, the Commonwealth believes it is important to specifically explore the relationship between Risk Adjustment and the following topics and dynamics:

- Federal CSR funding remains uncertain. The Commonwealth is currently seeking to determine how to best address deep market instability this risk presents regarding carrier participation in market, premium impacts, and member impacts.
- Possible changes to other health care regulations *(e.g.*, Essential Health Benefits, metallic tiers, etc.) which might serve to complicate Risk Adjustment.
- Other fundamental changes to the functioning of the individual and small group markets.
- Population dynamic between MassHealth and ConnectorCare, driven by income changes and driven by state-level eligibility requirements.
- Impact of Risk Adjustment on plan design innovation, limited provider networks, and the effect of medical coding pattern differences by geography on Risk Adjustment results.

Request: Evaluate Dimensions of Risk Adjustment Flexibility

At present, Massachusetts has identified three potential dimensions of its desired exploration of Risk Adjustment flexibility: the specific needs identified, the government entity/level best positioned to carry out needed changes, and the timing of such changes.

- **Content of flexibility need**: A primary goal of the proposed state workgroup is to assess the need for flexibility (*e.g.*, whether the Commonwealth wishes to seek to end Risk Adjustment), with careful examination of the impacts of such a change, and outline potential approaches.

- **Agent of flexibility**: Another aspect of flexibility to consider is whether flexibility would enable a state to have increased latitude to tailor the application of Risk Adjustment (e.g., without further CMS approval, particularly if the changes fall within certain parameters) or whether CMS would be able to tailor Risk Adjustment on behalf of states and operate the tailored methodology.

- **Timing:** Finally, a further consideration relates to timing. Ideally, any enhanced flexibility agreed upon for Risk Adjustment could be acted upon beginning with the 2019 benefit year, if so determined by the state workgroup and the Commonwealth. However, the current CMS process and timing for releasing its Notice of Benefit and Payment Parameters (NBPP) and related requirements for states regarding the issue of state-specific notices may need to be addressed.

Proposal: Risk Adjustment Redesign Workgroup

Workgroup Structure

Considering its interest in further refining Risk Adjustment's role in the Massachusetts merged market, Massachusetts expects to convene a Risk Adjustment Re-Design Workgroup that would meet between September 2017 and February 2018 to develop a recommended approach to Risk Adjustment in Massachusetts for Plan Year 2019 and forward. This workgroup will be convened by the Health

Connector, reporting to its Board of Directors and Baker-Polito Administration leadership, and be responsible for developing timelines, policy options and considerations, implementation and operational approaches/paths, and stakeholder engagement. The workgroup will also be responsible for convening at least two public meetings with all stakeholders to present the policy options and considerations, and seek their feedback. The workgroup may conduct one-on-one meetings with stakeholders as well.

Workgroup will include key personnel from:

- Health Connector;
- The Division of Insurance;
- Executive Office of Health and Human Services;
- Blue Cross Blue Shield of Massachusetts;
- Massachusetts Association of Health Plans and/or individual representatives from the MAHP plans;
- Governor's office; and
- Health Policy Commission.

Stakeholders will provide comments and feedback to the workgroup and may include the following entities, in addition to the workgroup, and would be invited to join workgroup meetings with relevant agenda items of interest to these constituencies:

- Consumer advocacy community;
- Employer community;
- Health care provider community;
- Health policy and health economics experts; and
- Staff from state legislative committees with health care focus.

Workgroup Guiding Principles

As the workgroup convenes and develops recommended adjustments to Risk Adjustment in Massachusetts for Plan Year 2019 and beyond, its primary goals should include:

- Enabling health insurance carriers to be indifferent to the types of individuals they enroll without creating unsustainable cash flow or solvency issues by addressing concerns related to adverse selection against any carrier;
- Creating an environment of premium stability whereby transparency in risk mitigation and related insurance pricing rules improves certainty, thereby reducing "risk premium;"[68] and
- Creating a market environment that allows for a maximal amount of predictability for carriers to the best of the Risk Adjustment program's ability.

In addition, while not perhaps the direct goal of a risk mitigation program, also important are considerations relating to the role of risk mitigation in pursuing broader goals for the Massachusetts health care market such as:

- Affordability of coverage;

[68] That is, minimizing the additional amounts that are built into premiums for risks related to uncertainty and volatility.

- Enhancing market competition at the carrier or possibly even health care provider level;
- Payment and delivery system reform and the movement toward more integrated, collaborative care models; and
- Creating a market environment where carriers promoting care at low-cost, efficient provider systems are not disadvantaged.

Next Steps

Synthesizing these considerations, recommendations developed by the state workgroup should seek to look at the role of Risk Adjustment, and risk management generally, from a health care system perspective and should examine and balance these goals with careful attention to trade-offs.

With that system-wide view and a commitment to continuing to striking the right balance between effective risk management and predictability for market participants, Massachusetts looks forward to commencing the convening of this workgroup, and looks forward to regular engagement with its federal partners as its work proceeds.

Appendix A: Frequently Used Abbreviations

ACA	Patient Protection and Affordable Care Act of 2010
Health Connector	Commonwealth Health Insurance Connector Authority
CMS	Centers for Medicare and Medicaid Services
DOI	Massachusetts Office of Consumer Affairs and Business Regulation, Division of Insurance
FPL	Federal Poverty Level
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
APTC/PTC	Federal advance premium tax credit or premium tax credit available under the ACA
CSR	Federal cost-sharing reductions available under the ACA
QHP	Qualified Health Plan available through the Health Connector

Appendix B: Historical Background of State-Administered Risk Adjustment Program

Original Reasons for a State Alternative Risk Adjustment Program

Under the Affordable Care Act, a state that operates a certified Exchange (like the Health Connector in Massachusetts) has the option to: (1) adopt the Federal model; or (2) develop its own model and obtain Federal certification for usage of such a methodology. Federal guidance available suggested that states would have considerable flexibility to design their reinsurance and Risk Adjustment programs.[69]

After the passage of the ACA, Massachusetts faced an open question as to whether the Federal methodology, which was designed to "fit" a wide range of state conditions, would ultimately provide the best options for Massachusetts.

While it was important to fully leverage Federal guidance, Massachusetts was uniquely positioned to define and pursue its own approach to Risk Adjustment that best fit our market, which was and is characterized by:

- Market structure and population mix that are likely materially different from other states;
- Lowest rate of uninsured in the nation;
- A guaranteed issue state for over a decade;
- Substantial experience developing and administrating similar programs; and
- The Health Connector administered Risk Adjustment for its Commonwealth Care program.

Additionally, Massachusetts (as noted above) has unique market characteristics that are not addressed under the current Federal methodology for Risk Adjustment. Examples include a "merged" individual and small group market, state wrap for eligible low-income members enrolled in ConnectorCare plans, several years of experience with market reforms, including an individual mandate that had already brought many of the uninsured into the ranks of coverage. In administering Risk Adjustment at a state level, Massachusetts sought to:

- Provide flexibility in the methodology to support ongoing healthcare reform initiatives in Massachusetts, and maintaining or enhancing incentives for good clinical management.
- Address technical considerations related to the merged market and the higher actuarial value of ConnectorCare plans.
- Promote administrative simplicity for carriers by leveraging Massachusetts' existing data collection infrastructure and data submission processes. As an accompanying result, administering the Risk Adjustment program also improved APCD data quality, which is used for other state policy purposes.
- Provide for more information to carriers on Risk Adjustment relativities and conduct additional data analyses. The level of detail Massachusetts was providing to their issuer community was not made available to carriers at all in other states or the state was providing this information to carriers more frequently.

[69] 45 CFR § 153.330.

- Provide more opportunities for interaction amongst all stakeholders, including consumers, providers, and carriers, alongside the State agencies running and helping to coordinate the program to ensure the implementation of the program was reflecting market realities.
- State agencies' interactions with stakeholders and in-depth knowledge of our own market allowed the State to exercise greater precision in the methodology, resulting in more equitable redistribution of premiums in relation to health status.

The Massachusetts methodology was generally able to achieve the goals set out through the additional flexibility provided by the State model. For example, generally about 3-4% of premiums market wide were transferred because of Risk Adjustment (slightly more than the Federal model). Additionally, the model under several measures more accurately predicted costs for those with multiple chronic conditions than the Federal model and adjusted effectively for the higher demand associated with the additional state wrap around subsidy provided under Massachusetts's ConnectorCare program.

As has been the case with the Federal methodology and operation of the Risk Adjustment program, Massachusetts's operation of Risk Adjustment has not been without its challenges. In particular, a number of new and smaller carriers in the markets perceived Risk Adjustment as creating instability and resulting in their having to pay a substantial portion of their overall premium revenue into the Risk Adjustment pool. These carriers raised a number of issues that remain resident in the public debate over Risk Adjustment including whether Risk Adjustment is sufficiently sensitive to regional or geographic differences in diagnostic coding and whether it promotes or discourages innovation such as with respect to provider network design.

Transferring Risk Adjustment to Federal Government

In seeking to best assess how to weigh the benefits of operating its own Risk Adjustment program against these challenges and the substantial resources required of the program, and mindful of the fact that Massachusetts was the only State in the nation to operate its own Risk Adjustment program, the Health Connector issued a Request for Information on November 6, 2015 seeking comment from the market about whether to retain a state-based Risk Adjustment program. CCA received responses on November 20, 2015 from nine Massachusetts carriers and the Massachusetts Association of Health Plans (MAHP).

Some plans advocated that the Commonwealth keep the State program, in the hope that the State could substantially alter the terms of the program and to do so immediately. Several carriers commented more broadly on the implications of Risk Adjustment programs given that the methodology (whether state or federal) serves to penalize smaller, "low cost, high growth" carriers in favor of larger, more expensive carriers; these commenters proposed conceptual changes that would require significant modeling and consensus building to achieve. One issuer supported transitioning both the operation and methodology of the Risk Adjustment program to the Federal Government. Another plan supported State administration for 2017 (and consideration of methodology changes for 2018), but only if the State would use the Federal Risk Adjustment methodology. Yet another plan supported State administration for 2017 but was unwilling to pay more than the federal amount.

When analyzing the comments and feedback received from stakeholders, along with its own considerations, CCA developed the following framework to consider our path forward on Risk Adjustment taking into account the likelihood of whether:

1. The state would be allowed by the Federal Government **flexibility** to redesign it – to add genuinely unique value;
2. The state could operate with comparable **efficiency** to the Federal program;
3. Massachusetts market **consensus** could be reached on substantially different terms; and
4. We were able to predict with **relative certainty** the transfer outcomes in out-years under either program.

Our application of this framework led us to the following conclusions:

- **Redesign Flexibility**. Even under a state-based Risk Adjustment methodology, state redesign flexibility was not available for 2015-2016; and not feasible for 2017, given the timeline. The Federal Government required approval for all State-based changes even when it was questionable whether a change was of material effect. Additionally, it was recognized that the Federal Government was moving to implement several changes to its methodology a number of which the State either had been considering or that better aligned with the Massachusetts methodology. These changes included: incorporation of Rx claims information, adjustments to the statewide average premium calculation, and partial year eligibility adjustments.[70] In addition, the Federal methodology now proposes to implement a high-risk pooling program for high cost individuals and for whom Risk Adjustment it is believed still under-predicts costs.[71]

- **Efficient Operations**. State administration of Risk Adjustment was viewed as inefficient when compared to Federal government economies of scale resulting in Massachusetts taxpayers / premium payers disproportionately bearing cost in a state-administered program.

- **Market Consensus.** Achieving market consensus at the state-level is difficult, given the relative closeness of state agencies with market participants and ongoing uncertainties at the federal level.

- **Benefit to Market.** Risk Adjustment outcomes can vary widely simulation to simulation, making long-range predictions uncertain. Improving on this uncertainty was an original goal of the state opting to administer their own program. The simulation results Massachusetts has provided to carriers has proved helpful in helping carriers incorporate Risk Adjustment into their premium development and operational planning, but swings in results can still prove challenging.

As a result of the above, on balance, particularly given costs and relative benefits, the Health Connector did not pursue continued authorization to operate a state-based Risk Adjustment program.

[70] The Federal methodology still lacks specific considerations for the presence of a merged market and the different levels of CSRs available through the state.
[71] In particular, the Federal methodology creates high-risk pooling for individual with costs above $1 million.

Appendix C: History of Massachusetts' Merged Market Regulatory Landscape

History

M.G.L. c. 176J, initially enacted in 1991, is Massachusetts' statute governing the standards for products and rates offered to eligible individuals and eligible small employers. Amendments made in 2006 to M.G.L. c. 176J led to the merger of Massachusetts guarantee issue individual and guarantee issue small group markets. The same amendments established rating and premium calculation rules (including those for permissible rate adjustment factors) that insurance carriers have followed in Massachusetts' merged market since 2007. The Massachusetts Division of Insurance (DOI) promulgated 211 CMR 66.00 to enforce the provisions of M.G.L. c. 176J.

Prior to 2010, carriers were required under the regulation to submit an annual actuarial certification that the rate adjustment factors used were in compliance with all the relevant statutory and regulatory limitations. Beginning in 2010, carriers were required to submit any changes to existing rate adjustment factors so that they could be reviewed in relation to statutory changes put in place in that year. Along with these statutory changes, the revised law included a clause at M.G.L. c. 176J, section 6(c) that "…rating factors included in the rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter."

With the implementation of the federal ACA, new federal rules limited the types of rate adjustment factors that could be used in rating individual and small group plans on and after January 1, 2014. In response to requests from the Commonwealth of Massachusetts, on April 6, 2013, CMS granted Massachusetts a transition period to gradually eliminate carriers' use of the following rating factors which had been regularly used in Massachusetts's merged (individual/small group) market since July 1, 2007: industry rate adjustment factor, participation-rate rate adjustment factor, group size rate adjustment factor, intermediary discount adjustment factor and group purchasing cooperative adjustment factor. In response to the CMS letter, DOI issued Bulletin 2013-05 to make clear how carriers could use rate adjustment factors on and after January 1, 2014. In effect, any carrier wishing to use such factors was instructed in 2014 to limit the factor to 2/3 of what was in effect as of July 1, 2013.

The Commonwealth was subsequently notified by CMS that Massachusetts could continue the use of the noted transition period rate adjustment factors until the end of 2017, a flexibility that was later extended until the end of 2018.

Relevant State Regulations

As written within 211 CMR 66.08, carriers participating within the merged market were permitted, but not required, to use specified rating factors provided that they adhered to the limitations established within the regulation. The following identifies the regulatory restrictions associated with the five transition period rate adjustment factors as they were developed through July 1, 2013.

211 CMR 66.08: Restrictions Relating to Premium Rates

…

211 CMR 66.08(1)(b):

…

2. Industry Rate Adjustment Factor

a. If used for eligible individuals, the industry rate adjustment applicable to an eligible individual must be based on the industry of the eligible individual's primary employer and must be the same adjustment applied to eligible small groups in the same industry.

b. A carrier may not apply an industry rate adjustment to an eligible individual who is not employed.

c If a carrier establishes an industry rate adjustment, it must be applied to every eligible small group in an industry.

d. If a carrier uses an industry rate adjustment for eligible individuals, it must be applied to all eligible individuals based on the industry of an individual's identified primary employer.

3. Participation-Rate Rate Adjustment Factor.

a. A carrier may establish participation-rate rate adjustments for any health benefit plan or plans for any ranges of participation rates below the following minimum participation requirements:

i. For groups of five or fewer: not to exceed 100%.

ii. For groups of six or more: not to exceed 75%.

b. The participation-rate rate adjustments must be based upon actuarially sound analysis of the differences in the experience of eligible small businesses with different participation rates.

c. If a carrier chooses to establish participation-rate rate adjustments, it must apply the adjustment to every eligible small business within the ranges defined by the carrier.

d. If an eligible small employer does not meet a carrier's minimum participation or contribution requirements, the carrier may separately rate each employee as an eligible individual.

…

211 CMR 66.08(2):

…

(d) Group Size Rate Adjustment.

1. If a carrier chooses to establish group size rate adjustments, every eligible individual and eligible small group shall be subject to the applicable group size rate adjustment.

2. The group size rate adjustment applies to both eligible individuals and eligible small groups, the value of which shall range from 0.95 to 1.10 and for eligible small groups must be based on the number of eligible employees who are enrolled in an eligible small business.

3. If an eligible small business does not meet a carrier's participation or contribution requirements, the carrier may apply the group size adjustment that applies to eligible individuals to each employee who enrolls through the eligible small business.

(e) Intermediary Discount. If a carrier provides coverage to eligible small businesses and eligible individuals through an intermediary, the carrier may apply a discount factor to the total premium for each eligible small business and eligible individuals. The factor must be calculated to account only for the savings to the carrier due to the administrative and marketing activities of the intermediary which are related to the purchase of health benefit plans for its members from that carrier. The factor may not be calculated based on the claims experience, duration of coverage, health status or case characteristics

of the eligible small businesses enrolled in the carrier's health benefit plan through the intermediary. The discount may be negotiated between the carrier and each individual intermediary according to the range of services offered by each intermediary.

(f) Group Purchasing Cooperative Adjustment Factor. A carrier may apply a group purchasing cooperative adjustment factor that is specific to one group purchasing cooperate and based on the actuarially projected different experience of that cooperative's potential eligible employers compared to the experience of those eligible individuals and eligible employers who have coverage outside group purchasing cooperatives. Any such group purchasing cooperative adjustment factor is to be applied uniformly to the rates of all employers who obtain coverage through that group purchasing cooperative.

Appendix D: State Contact Information

The Commonwealth wishes to acknowledge the agencies contributing to this proposal, which was led by the Health Connector and supported by the Executive Office for Administration and Finance, Executive Office of Health and Human Services, the Division of Insurance, and the Center for Health Information and Analysis. Inquiries regarding this document can be directed to the Health Connector as follows.

Flexibility Request Leads	**Audrey Morse Gasteier** Chief of Policy and Strategy Commonwealth Health Insurance Connector Authority **617-933-3094** audrey.gasteier@state.ma.us **Emily Brice** Deputy Chief of Policy and Strategy Commonwealth Health Insurance Connector Authority **617-933-3156** emily.brice@state.ma.us
Permanent Contact	Commonwealth Health Insurance Connector Authority 100 City Hall Plaza Boston, MA 02108 **617-933-3030** StateInnovations@state.ma.us

Appendix E: Public Notice and Comment Process

The Commonwealth is releasing this draft for at least thirty day public comment period starting on July 24, 2017 by posting the draft and instructions for commenting on the Health Connector Innovations website. The Commonwealth welcomes public comment on this proposal, as detailed below.

Publicly Available Materials

Materials describing the flexibility request may be obtained on the Health Connector's website: www.mahealthconnector.org/about/policy-center/state-innovation-waiver. Additional updates and final submissions will also be posted on this website. Paper copies of the documents may be obtained in person by request from 9:00 AM through 5:00 PM EST at the Health Connector, 100 City Hall Plaza, 6th Floor, Boston, MA 02108.

Tribal Consultation

The Commonwealth will provide a summary of the proposal through an email to all Tribal leaders or their designees and additional Tribal health contacts. The summary will include links to the documents

and instructions for providing comment. The Commonwealth will also consult with tribal contacts via a Tribal Workgroup meeting on August 9, 2017.

Public Meetings

The Commonwealth will host two public meetings in various regions of the Commonwealth to seek input regarding these requests.

Both meetings will include a conference line available, as well as Communication Access Realtime Translation services and American Sign Language (ASL) interpretation for individuals attending in person.

Listening Session #1:
Date: Friday, August 4, 2017 Time: 9 a.m. – 11 a.m.
Location: 1 Ashburton Place, 21st Floor, Boston MA
Conference Line: 1-888-822-7517 Participant Code: 163 4530#

Listening Session #2:
Date: August 16, 2017 Time: 10 a.m. – 12 p.m.
Location: Castle of Knights, 1599 Memorial Drive, Chicopee, MA
Conference Line: 1-888-822-7517 Participant Code: 163 4530#

Public Comments

The Commonwealth will consider comments received by August 25, 2017 for the final documents that will be submitted to the Departments. Comments may be submitted by e-mail to: StateInnovations@state.ma.us.

Appendix F: Statutory Authority for Section 1332 Waivers

With the support of the Massachusetts General Court (legislature), Massachusetts has explicit statutory authority to apply for and implement the proposed waiver application. Ch. 119, Sec. 20 of the Acts of 2015 authorizes the Commonwealth Health Insurance Connector Authority to apply for and implement a Section 1332 waiver application.[i]

Specifically, the Health Connector has authority "to make applications to the United States Secretary of Health and Human Services to waive any applicable provisions of the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended from time to time, as provided for by 42 U.S.C. § 18052, and to implement the state plans of any such waiver in a manner consistent with applicable state and federal laws, as authorized by the United States Secretary of Health and Human Services pursuant to said 42 U.S.C. § 18052."

[i] Ch. 119, Sec. 20 of the Acts of 2015, available at: https://malegislature.gov/Laws/SessionLaws/Acts/2015/Chapter119.